Bundle Trust Board Public 7 December 2023

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates
October SOX of the month – Bibin George, Housekeeping and the Peter Gillam Team
October Patient Centred SOX – Britford and Stoma and Eddison Riviera, Natahan Noble and Rogeme Platino, Radiology
November SOX of the month –
November Patient Centred SOX –

1.2 10:10 - Patient Story

1.3 Welcome and Apologies

1.4 Declaration of Interests, Fit & Proper / Good Character

1.5 10:30 - Minutes of the previous meeting
Minutes attached from meeting held on 5 October
For approval
1.5 Draft Public Board mins 5 October 2023

1.6 10:35 - Matters Arising and Action Log
1.6 Trust Board Action Log Dec 2023

1.7 10:40 - Chair's Business

1.8 10:45 - Chief Executive Report
Presented by Stacey Hunter
For assurance
1.8a CEO report Nov for Dec
1.8b AHA October November 23 Briefing 281123 V1.0

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:55 - Clinical Governance Committee - 31 October and 28 November
Presented by David Buckle
For assurance
2.1a Clinical Governance Committee Escalation Report 31.10.23
2.1b Clinical Governance Committee Escalation Report 28.11.23

2.2 11:00 - Finance and Performance Committee - 31 October and 28 November
Presented by Debbie Beaven
For assurance
2.2 October 2023 Escalation Report from FPC
2.2 Finance and Performance Escalation Report November 2023

2.2.a 11:05 - Current Financial Position Update
Verbal update presented by Mark Ellis
For assurance

2.3 11:10 - Trust Management Committee - 22 November
Presented by Stacey Hunter
For assurance

2.4 11:15 - People and Culture Committee - 26 October and 30 November
Presented by Eiri Jones
For assurance
2.4a PCC Escalation Report to Trust Board October 2023
2.4b PCC Escalation Report to Trust Board November 2023

2.5 11:20 - Integrated Performance Report to include exception reports
Presented by Judy Dyos
For assurance
2.5a IPR Cover Sheet - TMC 2023-11
2.5b Integrated Performance Report Dec 23 v2

2.5.a 11:45 - Mortality Review Update
Verbal update presented by Peter Collins
For assurance

3 STRATEGY AND DEVELOPMENT

3.1 11:50 - Implications for SFT on Major Conditions Strategy
Presented by Tony Mears
For information
- 3.1a Board Paper Cover Sheet - DHSC Major Conditions Strategy
- 3.1b NHSProviders-Major-Conditions-Strategy-Briefing

3.1.a 12:00 - BREAK

3.2 12:30 - Digital Plan Update
Presented by Naginder Dhanoa
For assurance
- 3.2 Digital Plan Update Nov 2023

4 QUALITY AND RISK

4.1 12:40 - In-Patient Survey Results – deferred from October
Presented by Judy Dyos
For assurance
- 4.1a National Inpatient Survey 2022 Results Cover Sheet
- 4.1b National Inpatient Survey 2022 - Results v3 CGC 31.10.2023

4.2 Patient Experience Report Q2 - deferred to March
Presented by Judy Dyos
For assurance

4.3 Quarterly Risk Report Card - deferred to March 2024

4.4 12:50 - PSIRF Plan and Policy
Presented by Fiona McNeight
For approval
- 4.4a TB cover sheet PSIRF policy and plan
- 4.4b PSIRF update for TB

4.5 13:00 - External Well Led Development Review
Presented by Fiona McNeight
For assurance
- 4.5a TB Coversheet Well Led development themes December 2023
- 4.5b Well-Led Developmental Review Areas for Improvement November 2023

4.6 13:10 - Maternity and Neonatal Quality and Safety Report Quarter 2
Presented by Judy Dyos
For assurance
- 4.6a Front sheet Q and S report Q2 23 24
- 4.6b Quarterly Maternity and Neonatal Quality and Safety Report Q2 2023

4.7 13:15 - Perinatal Quality Surveillance Report October (September data)
Presented by Judy Dyos
For assurance
- 4.7a Front sheet Perinatal quality surveillance October (september Data)
- 4.7b Monthly Perinatal Quality Surveillance report. October - September data

4.8 13:20 - Perinatal Quality Surveillance Report – November (October data)
Presented by Judy Dyos
For assurance
- 4.8a Front sheet Perinatal quality surveillance November (October Data)
- 4.8b Perinatal Surveilance reporting November - October data

4.9 13:25 - ATAIN Action Plan
Presented by Judy Dyos
For assurance
- 4.9a front sheet for CGC ATAIN action plan
- 4.9b ATAIN report and action plan Q1

4.10 13:30 - Maternity and Neonatal Training Needs Analysis (TNA)
Presented by Judy Dyos
For assurance
The embedded documents in 4.10b have been uploaded as separate documents

4.10a Front Sheet TNA
4.10b CCFv2 TNA 2021 onwards

5 CLOSING BUSINESS

5.1 Agreement of Principal Actions and Items for Escalation

5.2 13:35 - Any Other Business

5.3 13:40 - Public Questions

5.4 Date next meeting

6 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 5 October 2023, Boardroom/MS Teams
Salisbury NHS Foundation Trust
Boardroom

Board Members:

Eiri Jones (EJ)	Non-Executive Director (Chair)
Debbie Beaven (DBe)	Non-Executive Director
David Buckle (DBu)	Non-Executive Director
Tania Baker (TB)	Non-Executive Director
Michael von Bertele (MVB)	Non-Executive Director
Stacey Hunter (SH)	Chief Executive Officer
Judy Dyos (JDy)	Chief Nursing Officer
Mark Ellis (ME)	Chief Finance Officer
Peter Collins (PC)	Chief Medical Office
Lisa Thomas (LT)	Chief Operating Officer
Melanie Whitfield (MW)	Chief People Officer

In Attendance:

Kylie Nye (KN)	Head of Corporate Governance (minutes)
Fiona McNeight (FMc)	Director of Integrated Governance
Alex Talbott (AT)	Associate Director of Improvement
Jayne Sheppard (JS)	Lead Governor (observer)
Jane Podkolinski (JP)	Governor (observer)
Frances Owen (FO)	Governor (observer)
Vicky Marston (VM)	Director of Midwifery (for agenda item 5.6)
Sarah Needle (SN)	Divisional Director of Operations Medicine - Shadow Board
Bernie Dunn (BD)	Shadow Board (observer)
Jon Thorne (JT)	Estates Technical Services Officer (for agenda item 1.2)
Elizabeth Swift (ES)	Freedom to Speak Up Guardian (for agenda item 1.2)
Louise Couzens	Clinical Commissioning Group (observer)

ACTION

TB1 05/10/1 **OPENING BUSINESS**

TB1 05/10/1.1 **Presentation of SOX (Sharing Outstanding Excellence) Certificates**

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

September SOX of the month – Isaac Rooney, Lou Figures, Maddie Herridge and Chloe Farley, Spinal Treatment Centre

September Patient Centred SOX – Anne MacRae, Gastroenterology

EJ congratulated all the staff that had been recognised in September on behalf of the Board and also thanked all the staff that had been nominated for their hard work and innovation.

SH noted that the Board had been consistently sighted on the fragility of the Trust's gastroenterology service therefore highlighted how promising it is to hear a good news story about this service.

TB1 05/10/1.2 **Staff Story**

MW introduced Jon Thorne (JT) and Elizabeth Swift (ES) who were in attendance to provide a staff story. MW noted that it is Freedom to Speak Up (FTSU) Month and therefore felt this a pertinent story from JT, Technical Estates Officer, as he had experienced the FTSU service.

JT provided a detailed story of his experience in Estates, which in the past few years has undergone significant change as a result of the concerns raised through FTSU. JT described the fractious culture that had existed in Estates, with episodes of bullying and harassment in the team. The negative behaviours in the team were evident, with staff morale at its lowest and statutory requirements not being met. At the time a number of staff did not feel they were able to speak up to management in the department and therefore they went to ES who JT ended up supporting.

The concerns that were raised resulted in the Trust commissioning an independent review of which the outcome was significant and an operational manager resigned. Several other colleagues have resigned from estates since the concerning issues were raised. The band 5 colleagues in the department had to step up at this point to deliver the service. In the first instance it was acknowledged that the Trust needed effective leadership and they appointed an interim Head of Estates who was determined to invoke positive change. Since then, the Trust appointed has appointed new leadership in terms of a join Director of Estates role between the Trust and Royal United Hospitals Bath NHS Foundation Trust, Brian Johnson and a new Head of Estates, John O'Keefe, who bring a fresh perspective to the department and encourage staff to openly discuss risk without judgement.

There are of course ongoing challenges despite the positive progress made, including issues around the on-call service. Due to the FTSU process Estates has been through a significant transformation and whilst there are challenges in terms of recruitment, the department is on a path to recovery with increased transparency and resilience.

Discussion:
EJ thanked JT for his open and honest account of the issues he had experienced. She noted that she had visited the department following the changes that had been made and noted the how everyone seemed positive and welcoming. EJ noted the positive outcome in members of the team now feeling safe to raise concerns.

MvB referenced that it seemed everyone knew where the underlying problem was but asked JT if he thought the executive team at the time knew about it. JT wasn't aware and noted that at the time it was not known if there were other barriers or if the person in question was being supported by the executive team. He reflected the importance of open communication with staff members when issues like this occur.

LT thanked JT, highlighting his tenacious integrity to continue to fight for the right thing for patients and staff. LT noted that this type of leadership sets the culture of a department. LT added that when there are workforce

constraints it is easy to be blinded by the mediocrity which is sometimes accepted. The Trust have to strive to do better.

SH noted that the culture of the NHS is sometimes focused too much on what external bodies tell us about our own services rather that its own people. Whilst external reports are helpful there needs to be a balance between external and internal perspectives.

DBe commented that to get a sense of what is going on culturally it is important to walk around the site and engage with people. DBe queried if there is enough visibility and engagement to understand some of these issues. SH noted that the Board are undertaking Board Safety Walks and 'Go and Sees' but the team can always do better. The Improving Together programme should be encouraging distributed leadership so staff do not need permission to do the right things. There are always boundaries in an accountability framework but for consistent and good decision-making the Board need to trust the people in these roles.

MW noted that it is important to recognise the improvements in visibility. Other staff, especially the HR business partners, are completing routine review and investment in support is better than it's ever been.

DBe noted that listening is a huge part of understanding concerns but curiosity is needed too.

ES and JT were thanked and they left the meeting.

TB1 05/10/1.3 **Welcome and Apologies**

EJ welcomed everyone to the meeting apologies were received from:

- Rakhee Aggarwal, Non-Executive Director
- Ian Green, Chairman
- Richard Holmes, Non-Executive Director

TB1 05/10/1.4 **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 05/10/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 7th September 2023**

EJ presented the public minutes from 7th September 2023 and the minutes were approved as an accurate record of the meeting.

- Page 6 – The action needs to reflect that it's the impact of industrial action on performance.
- Page 12 - paragraph 2 perinatal mortality review meeting.
- Page 13 - 'where' should be whether.
- Page 17 - 'haha' needs to be deleted.

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

TB1 05/10/1.6 **Matters Arising and Action Log**

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

TB1 07/09/1.8 Chief Executive's Report/ Lucy Letby – This has been added a potential topic for discussion in 2024's Board Development Schedule. Item closed.

TB1 07/09/2.3 Finance and Performance Committee 25th July – This related to the amendment mentioned as part of the minutes. The action relates to the impact of Industrial Action. ME noted that he quantified the financial impact at F&P and had included the number of appointments affected. Item closed.

TB1 07/09/2.6 Integrated Performance Report (IPR) (M4)– The IPR cover sheet has now been updated. Item closed.

TB1 07/09/4.3 Perinatal Quality Surveillance Monthly Report – It was noted that this update would come back to the Board in January. The Board discussed the wording of the action noting that the team were providing an update on sustaining a cultural improvement journey.

It was noted that all other matters arising were either closed or to be considered on a future agenda.

TB1 05/10/1.7 **Register of Attendance**

The register of attendance was noted.

TB1 05/10/1.8 **Chair's Business**

EJ noted the following key points:

- EJ has been covering for IG in her role as Senior Independent Director (SID)
- The Trust has been extremely busy, operating at Opel 4 alongside episodes of Industrial Action (IA).
- There are a number of challenges locally, regionally, and nationally. The Trust's priority is the safety of patients and staff.
- Episodes of Covid-19 have increased and EJ urged staff to book their occupational flu and covid vaccine online.
- The Trust's Annual General Meeting is next week, providing a summary of events during 2022/23. All our welcome to attend.
- In relation to the papers there are a few themes arising around safety and financial responsibility and the quality of some of our data, which will be addressed in the meeting.
- EJ welcomed Shadow Board observers, governor observers and members of the public to the meeting.

TB1 05/10/1.9 **Chief Executive's Report**

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

- Thanks to LT and execs for effectively managing some of the key issues that have arisen whilst SH has been on leave.
- The Trust has been operationally challenged, compounded by the ongoing Industrial Action. Whilst it must be reiterated that the Trust respects colleagues who have a legal right to strike, the Trust urges the British Medical Association (BMA) and government to resolve this dispute to ensure the ongoing safety of patients across the NHS. Thanks to Ian Crowley, Jane Dickinson and Duncan Murray and the executives as they handle the complex issues of IA.
- There is a heightened focus on finance for 2023/24 as the Trust has experienced challenges in delivering the plan. This is also being managed alongside the development of the Trust's mid-long term financial plan.
- SH thanked the Communications team for their input and organisation in 'Thank You Week' in September.

TB1 05/10/2 **FINANCIAL AND OPERATIONAL PERFORMANCE**

TB1 05/10/2.1 **Winter Plan**

LT presented the Winter Plan and noted the following key points:

- The focus remains ion the 10 high-impact interventions for all ICS throughout both documents.
- The focus at SFT will be reducing variation in Same Day Emergency Care (SDEC) provision and providing a robust frailty service with patient pathways designed to recognise those who require the Acute Frailty Unit. Additionally, the Trust is focused on inpatient flow and length of stay and bed productivity and flow.
- One the key risks is around the challenges which are largely outside of the Trust's control. Therefore, work has been ongoing with community colleagues to try and improve the number of patients with No Criteria to Reside (NCTR) which is currently not as developed as we would like. This also includes initiatives in relation to virtual wards where there is scope for improvement.
- Positively, bed escalation plans are widely understood and therefore the level of intervention from executive colleagues has reduced. Improvement requires clinical and operational buy to enhance patient experience.

Discussion:
The Board discussed the positives of Whiteparish opening in Q3, although acknowledging the resource challenges in terms of staff and financial impact.

There is a real ambition to address NCTR but there is a question of challenging our own internal professional standards too. PC explained that work has been ongoing to operationalise the Trust's internal professional standards and progress has been made between ED and other specialities as part of the ED Improvement Project. However, it is

noted that there needs to be a balance between the data and paying attention to the culture within teams.

MvB noted the risk around increased absences over the inter period and suggested reporting staff absence by ward to pinpoint where there might be ongoing issues.

DBe thanked LT for a very good plan, noting she felt assured but queried LT's comment re effective virtual wards and the positive impact they could have on the system-wide approach to NCTR. The Board discussed with SH noting the implementation of such a service and effective execution is currently facing some challenging issues and a set of workforce challenges. It is clear that an improved implementation plan is required, and the two strategic partners at the centre of these plans, Wiltshire Health, and Care (WHC) and Wiltshire Council need to recruit more staff. This is acknowledged by the ICB. It was noted that throughout winter the Board would be seeking assurance through the Board Committees.

TB referenced SDEC and the Frailty service and queried if there were plans to increase this service from 6 days a week to 7. The Board discussed that there are no immediate plans to increase. Further work is required to address workforce models to include not just senior consultants. Additionally, extending the service is not just about the staff to support a 7-day model, acute frailty requires the right people in the community to receive these patients. Inevitably, the Trust is moving in the right direction but full implementation across 7 days will require a level of workforce transformation.

The Board discussed the Frailty Unit, with assurance sought as to when this would become more established. LT explained that the Trust have already experienced a reduction in Length of Stay (LoS) and it is hoped by co-locating and using one space will enhance the staff already in place. The Board noted that this is due to happen in November and Clinical Governance Committee (CGC) have asked for a frailty update in January 2024. SH noted that the improvement in this service is testament to the Improving Together methodology and shows a genuine desire to implement dispersed leadership.

ME noted that when visiting the acute frailty team, he was pleased to observe genuine enthusiasm for how empowered they felt. The ownership of that service was really clear to see.

TB1 05/10/3 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 05/10/3.1 **Clinical Governance Committee – 26 September**

EJ presented the report, providing a summary of escalation points from the meeting held on 26th September 2023. EJ asked for the report to be taken as read and highlighted the key points as follows:

- The Committee noted the standard maternity report required monthly, which was also on the Board agenda.
- Governance progress from divisions has matured well.

- The Committee received a paper around staffing in Maternity, which is also on the Board agenda later.
- There was a concern around gastroenterology raised and there will be an update back to the next meeting.
- There is an ongoing focus on stroke, VTE and mortality. Further reports are expected in relation to VTE and mortality in forthcoming meetings.

Discussion:
PC noted that for clarification, the concern around Gastroenterolgy had been raised by him.

DBu referenced the CAMHS concerns in the report, noting that other parts of the country were in much worse positions than some Trusts in the southwest. JDy explained that SFT have had between 5-8 patients on Sarum with mental health concerns and this is escalated ad discussed with the Chief Nurse in the ICS and other partners. The Trust is providing good care and the team from Oxford Health are doing excellent work to support. There is limited availability for onward care which means these patients get held up in the system. This not only impacts the patient but also staff and has been noted as a cause for turnover.

SH noted the systemic issue, noting the difficulty for local leaders to address as this requires a long-term strategic response. MW noted the small steps taken to help i.e., contributing funds to the ICS to recruit and engage with more mental health nurses. The benefits have yet to be realised but this is a small and positive step in the right direction.

The report was noted.

TB1 05/10/3.2 **Finance and Performance Committee – 26th September**

DBe presented the report, providing a summary of escalation points from the meeting held on 26th September 2023. DBe asked for the report to be taken as read and highlighted the key points as follows:

- Improving together business case received scrutiny and challenge and there was a request to bring back more on the benefits of the programme before approval.
- In terms of performance, the impact of IA is preventing recovery of elective activity in the Trust.
- In terms of data, we had a report on cancer faster diagnosis data which alerted us to a data reporting issue. The Committee took assurance that external reporting was correct and the internal data was incorrect. The matter has been referred to the Audit Committee. RH supported this approach. ME referenced two audits, one starting in November time on data quality for cancer standards and another one focused on the move to the new data warehouse.
- The Committee took assurance from a number of metrics, including stroke performance which has seen an improvement.
- From a financial perspective, the Committee was not assured the Trust will be able to reach the 2023/24 plan. Everyone is doing everything possible to mitigate industrial action. It was

acknowledged that CIPs are performing reasonably well. However, there is a need to increase pace.
- In terms of the Medium-Term Financial Plan (MTFP) which has been signed off and submitted, there were significant challenges in modelling and it was agreed to be a statement of ambition as not every element is planned.

Discussion:
ME noted that in terms of the MTFP modelling there are key components that need to be delivered to underpin that have been discussed as key risks, including, NCTR and improving the cost of caring for people in an acute mental health environment.

The report was noted.

TB1 05/10/3.3 **Trust Management Committee – 27th September**

SH presented the report, providing a summary of escalation points from the meeting held on 27th September 2023. SH asked for the report to be taken as read and highlighted the key points as follows:

- The meeting was focused on a number of business cases, including one which was supported in relation to Gastroenterology and working with primary care. This proposal was driven by the clinical team and the Committee felt it was important to support.
- The New Ward Business Case, which had already been approved 18 months ago, came to the Committee due to the increased costs. The committee approved the amount to the original costings but wanted to scrutinize the additional spend identified namely in Anaesthetics and clinical support functions.
- In relation to the Maternity Care Assistants apprenticeship programme, short term funding identified through national funding was approved. However, there is still a requirement to identify funding to support investment and training in all nursing apprenticeship programs at SFT.

Discussion:
The Board discussed the importance of apprenticeship schemes to sustain future workforce plans. SH noted that this has been discussed with the NHSE Director of Education and the southwest regional CEO. Whilst the issue around funding is recognised, it is also acknowledged that some systems had resolved the issue and therefore there might be learning opportunities from them. DBe noted that whilst systems are under pressure to reduce costs and get back to balance, we must not lose sight of long-term investments and goals. The Board reiterated that whilst it has been difficult to support the apprenticeship business cases and there is currently no resolution to the issue, the strategic intent of the Trust is to support.

DBu referenced the case relation to Gastroenterology working with primary care and asked if any issues of equity of access and sustainability had been discussed. LT noted that the service is starting small with 30 referrals and reiterated that this was instigated by a practice demonstrating capacity and capability.

The report was noted.

TB1 05/10/3.4 **People and Culture Committee – 28th September**

EJ presented the report which provided a summary of escalation points from the meeting held on 28th September 2023. EJ asked for the report to be taken as read and highlighted the following key points:

- The committee is focussing on each chapter of the LTWP in turn and has identified the need to improve the focus on being a learning organisation. There is a continued focus on the turnover rates which remain over target.
- WRES and WDES action plans were received and are on the Board agenda for approval.
- A good dashboard is in place in relation to the operational management of the OD&P service. 36 of the 53 metrics are on target or within 5% of the target.
- Good assurance is now in place in relation to progress against internal audit and counter fraud audit action plans. Where actions have previously been delayed, a clear plan is in place to achieve.

The report was noted.

TB1 05/10/3.5 **Audit Committee 28th September**

ME presented the report which provided a summary of escalation points from the meeting held on 28th September 2023. The points detailed within the report were taken as read.

The report was noted.

TB1 05/10/3.6 **Integrated Performance Report (IPR) (M5)**

ME presented the Integrated Performance Report which provided a summary of August 2023 performance metrics. ME noted that most of the performance challenges had been picked up as part of the Committee escalation report discussions, however highlighted the following key points:

- When considering the Breakthrough Objectives, falls has seen sustained improvement which is reflected in the IPR.
- In terms of bed occupancy, the Trust had not seen a growth in non-elective numbers since Covid but this started in summer.
- Improving time to first outpatient appointment is extremely difficult. However, the Trust is 10% ahead of plan in the context of industrial action.

Discussion:
JDy noted the slight rise in falls in August but noted that action has been taken and September's figures have seen a reduction again.

SH asked for a trajectory for recovery, given we are not where we want to be with cancer performance. LT explained that October F&P is due an update on trajectories.

TB referenced the mortality data and asked for progress in relation to the external review. The Board noted that review had not yet begun and the discussion reiterated the importance of this review and ensuring the terms of reference addressed what was required.

TB1 05/10/4 **STRATEGY AND DEVELOMENT**

TB1 05/10/4.1 **Improving Together Quarterly Update Report Q2**

PC presented the report and welcomed AT to the meeting. SH and PC noted that they had spent some time with peers and reflected on importance of executive leadership to make improving together work. They thanked colleagues who have stuck with the programme. AT highlighted the following key points:

- Training trajectory is on track despite pressure. We are starting to see a learning curve and are looking at how to best prioritise resource and gain assurance that training is directed in the right place.
- Of the maturity assessments undertaken by divisions it is clear that some of the training has started to embed in working practices.
- Teams are starting to see a broader base of benefits demonstrated across the Trust. There is increased confidence going into business planning for 2024/25 to introduce better evidence to planning scenarios.

Discussion:
SH thanked AT and PC for taking this work forward. SH noted the excellent report and that it is clear that patience is helping us to understand how this programme is delivered. This will take a number of years to embed and it will not a be a linear process. This has incurred significant investment but it is positive to see the Trust is a good position.

JDy referenced falls as an example and noted that teams are now able to respond to performance issues without asking for senior leadership. Additionally, people who have not received training yet are also utilising the methodology of working and this has happened organically. DBe commented on this sense of empowerment and hoped this would be reflected in this year's Staff Survey results. It was noted that the Staff Survey asked staff if they know about Improving Together.

The Board discussed sustainability of the programme in condensing the implementation period from 10-5 years. DBe asked how the Trust sustain ongoing training without more investment. The Board discussed having a strong cohort of champions who will train staff and AT noted that it should just become a way of working and self-sustained which is not separated from business as usual.

MvB referred to the conversation has at Shadow Board and it is clear the Trust is still at the start of the process, with some patchy understanding particularly in relation to come of the language. The implementation period had also been discussed with concerns around the reduced timescale, particularly in light of the increasing turnover and continuity in delivery. MvB commented that a degree of patience and realism is required.

PC clarified the position on the reduced timescale, noting that at the start of the work 10 years was what the Trust could afford. However, since starting the programme a lot of learning has made it clear that 10 years is too long to embed cultural change. We are now seeing the benefits by accelerating and are hoping to move into a sustained phase sooner. It is acknowledged that the Trust will have to continue training.

MW explained that the Trust had learnt from RUH Bath NHS Foundation Trust to run an effective Leadership and OD programme alongside implementation and training. This has been supported and has been having a positive impact of Trust leadership.

EJ noted it was good to see departments undertaking self-assessments and looked forward to receiving the feedback.

ACTION: AT/PC
EJ asked if the next report could include who we have trained and how many should we train and the narrative on if we are training the right people.

AT encouraged NEDs to attend the Engine Room. AT left the meeting.

TB1 05/10/4.2 **Review of Trust Strategy Progress Report – deferred to December**

The Trust Board noted this report had been deferred to December.

TB1 05/10/5 **QUALITY AND RISK**

TB1 05/10/5.1 **Board Assurance Framework and Corporate Risk Register**

FMc presented the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR). FMc noted the following key points:

- Included in this BAF and CRR update are the recommendations from the Aqua well led review which were around scrutinising controls and assurances and discussing target dates.
- A further recommendation from the review was to consider target dates for risk mitigation. This has been discussed previously however, the Board are advised to discuss this further and agree the approach to be taken.
- The 5 strategic risks out with tolerance are unchanged since June 2023 although BAF risk 5 has had a third consecutive score decrease. 2 BAF risks have been closed.
- There has been alignment of the Trust BAF with the ICB BAF. The Trust BAF risks 5, 7, 8, 9, 10 and 12 align to the ICB risks in

relation to staff resource, finance, operational performance, and partnership working.
- There is a generic action around Industrial Action which is being worked on.

Discussion
SH noted that the BAF should reflect the realities of the system putting controls of Strategic Oversight Framework (SOF) 3 around finances and recent concerns around WH&C.

EJ noted that in F&P and CGC the risks in the BAF felt real to the risks in the discussion and to the IPR in relation to strategic objectives.

DBe referred to the risk appetite and the description of 'open' and asked where the Board agree its risk appetite. FMc explained that risk appetite had been agreed as part of a facilitated workshop in a Board Development session. SH noted that the Board should align risk appetite to the annual planning process. The risks that are consistently outside of tolerance the Trust have undertaken deep dives on and the Board formally note these 5 risks are accepted as being outside of tolerance but acknowledge that progress is being made. The focus is on controls and assurances.

PC suggested the Board should ask itself through lens of operational excellence are we prioritising resources to those risks that we're not tolerating. SH noted that where we are out with tolerance the Board need to set some parameters or business rules.

The Board discussed the milestones set for risk mitigation and how this is presented for the next round of updates. Therefore, if a risk is not being managed and exceeds the agreed parameters, do we escalate or do we accept. The Board discussed that the risk might be difficult to manage due to financial constraints. LT noted that she is supportive of target dates but noted her concerns about duplicating work. She suggested that the Board need to be pragmatic in holding ourselves and each other to account.

It was agreed that target dates and risk appetite would be discussed at the Board Development session in February.

TB1 05/10/5.2 **Patient Experience Report Q1**

JDy presented the report which had been scrutinised at CGC and referenced in the escalation report. JDy highlighted the following points from the report:

- Complaint response times continue to be challenging. There has been increased support in surgery and medicine. The themes of complaints relate to care, communication, and staff behaviours,
- Friends and Family score has increased with The Trust wide average response rate for Q1 is the highest seen to date with 2,301 responses received.
- There are less complaints and less re-opened complaints.
- The Bereavement survey for Q1 demonstrated improved satisfaction rates when compared to Q4.

Discussion:
The board noted the themes around responsiveness.

TB1 05/10/5.3 **Quarterly Learning from Deaths Report Q1**

PC presented the report which provides the Board with assurance that the Trust is learning from deaths and making improvements.

- PC reminded the Board that assurance regarding mortality is wider than external statistics.
- PC noted the detailed conversations that the Board and CGC had already had around the data, noting there was a heightened national focus around mortality modelling. The SHMI is within the expected range when the hospice data is removed, however the HSMR data, including weekend HSMR, is statistically higher than expected.
- The themes in mortality which the Mortality Steering Group has asked Telstra UK to monitor include acute and unspecified renal failure, pneumonia, non-hypertensive Congestive cardiac failure, acute cerebrovascular disease, fractured neck of femur and Septicaemia.

Discussion:
DBe referenced the coding of comorbidities and asked if the Trust could do a sample data test. PC noted that he has provided some data which he would share. PC explained that coding is measured in two ways, whether the episode has been coded or not and the depth or quality of coding. The Trust's action plan to ensure coding is completed in a timely manner is due to be completed by December '23. The Board discussed the depth of coding and ME noted that he would investigate if the annual audit process was still undertaken.

TB asked if the Board would see the external review terms of reference (ToR) noting her concerns that weekend HSMR remains high. SH noted that the person undertaking this work will be basing his review on the evidence and data sent to him. DBu requested to see the ToR before they're finalised.

LT asked if the Trust had reviewed if there is a disproportionate number of deaths in an area/ward. PC explained as it is coding admission data it will naturally be disproportionate across different the services.

SH noted that the resource to undertake the external review has not yet been secured. PC noted that the Board is seeking further assurance of his understanding and opinion of the data and therefore it is appropriate that he does not entirely influence the ToR. JDy noted that the review needs to be written in a way that our governors will understand.

It was noted that an update on the Trust's coding would come back through Finance and Performance Committee.

TB1 05/10/5.4 **Perinatal Quality Surveillance Maternity and Neonatal Services Monthly Report**

VM joined the meeting and presented the report which 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. VM noted that all three Trusts will be bring the same slide pack for consistency. The following key points were noted:

- Staffing continues to be a challenge although next month, the department is expecting new staff.
- Of the international midwifes, 7 have completed their OSCE. However, 2 have been waiting 7 months for their pin. This has been escalated.
- The midwife to birth ratio 1:30 is and 1: care in labour is achieved at all times.
- The 3 Datix cases related to workforce were for missed breaks.
- Of the incidents reported as moderate 3 related to Post-Partum Haemorrhage and a thematic review is in progress.
- In relation to life support training, a lot of the dates have fallen on Industrial Action and therefore extra dates have been scheduled.

Discussion:
EJ noted that several of the care issues that did not contribute to death related to the lack of access to translation and interpreters.

SH highlighted a recent reputational issue in midwifery. The Trust have a historical process of working with independent midwives. There is one incident that is currently under review which has impacted how the Trust will manage this process going forwards. Some of the actions taken on behalf of the Board have not been well received. However, the Trust is committed to doing the right thing for patients, despite a potential reputational issue. If there is a safety or harm issue this will be fed back through the relevant forum.

TB1 05/10/5.5 **Maternity and Neonatal Bi-Annual Staffing Report**

VM presented the Maternity and Neonatal Bi-Annual Staffing report. The Board were asked to note 5 key points:

- A systematic, evidence-based process to calculate midwifery staffing establishment is completed.
- Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.
- The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.
- All women in active labour receive one-to-one midwifery care.
- Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.

Discussion:
Recruitment is challenging but it is looking to improve in Oct/Nov. There are currently 9.8 WTE on maternity leave in the department.

The Trust acknowledge that continuity of carer is the right thing to do. However, JDy noted that it requires 12 midwives and therefore the Trust is not going to introduce the model at this stage. It is a difficult position but this is reflective of a running a maternity department in a rural setting.

ACTION: JDy. **JDy**
SH requested a documented risk assessment around why the Trust do not have a continuity of carer model.

The Trust Board noted the contents of this report which has been provided for information and assurance processes. The Board noted that CGC had noted the specific expectation in relation to demonstrating effective midwifery workforce planning as detailed in the report.

TB1 05/10/5.6 **Quarterly Risk Report Card**

JDy presented the report which had been through CGC.

A total of 18 reviews were commissioned in Quarter 1. Of these, 8 were Serious incidents and 10 were clinical reviews. In addition, there were 17 SWARMs for falls resulting in moderate and above harm completed. One of these SWARMs progressed to an SII. This is aligned to the new Patient Safety Incident Response Framework (PSIRF).

The team have been working on the implementation of PSIRF, reviewing the governance in the first instance.

The report highlights significantly more incidents on a Thursday and the risk team are trying to understand themes. There has also been an increase in the number of self-harm cases.

Discussion:
FMc noted she had raised concern about divisional utlisation of risk registers and it had been agreed that more assurance was needed.

ACTION: JDy **JDy**
SH suggested that the Board dedicate some development time to discuss and understand implementation of PSIRF.

TB1 05/10/5.7 **In-Patient Survey Results – deferred to December**

The Board noted this report had been deferred to December

TB1 05/10/6 **PEOPLE AND CULTURE**

TB1 05/10/6.1 **Guardian of Safe Working Annual Report – deferred from September**

PC presented the report and noted the following key points:

- This annual report focuses on annual look at gap in terms of what we expect for the junior medical workforce and what the Trust receives and focuses on the rotas in the next year.
- The Trust has 15 WTE gaps. These gaps are filled with locally employed doctors (LEDs).

- Up until now the Guardian of Safe working (GoSw) only focused on training contracts. However, the process of transitioning LEDs to 2016 T&Cs was commenced in spring 2023. This gives LEDs the same access to exception reporting as their deanery appointed peers.

Discussion:
MvB noted the current issues with workforce planning which he noted has failed to keep up with generational differences in gender and the desire to work full time. So many doctors now work less than full time which causes significant problems.

EJ queried whether this has an even more challenging position in 2023/24 due to IA. PC noted that the Trust has not seen increased exception reporting. In terms of fill rate, the deanery does not know ahead of time what each Trust's allocation will be. However, the Trust's fill rate has been better in 2023 than the previous year.

The Board discussed the position of physician associates and if they might have a similar role to the GoSW. PC explained that as the physician associate programme has been developed, dedicated resource has been included to ensure there is the right support. The Board noted that assurance around the correct equity of opportunity for these different staff groups would be taken through People and Culture Committee.

TB1 05/10/6.2 **Nursing Skills Mix Review – deferred from September**

JDY presented the report and noted the following key points:

- This is the 6-monthly report that the team is mandated to bring to the Board to ensure we have the correct level of nursing staff.
- There is positive news in that the Care Hours Per Patient Per Day (CHPPD) has increased.
- Additionally, turnover for nursing is currently at 12% which is below the Trust-wide rate.
- This report does not ask for approval for funding. However, there are indicative costs relating to the recommendations within the report which link to number of developments e.g., SDEC, CAMHS, ED triage.
- Discussions are underway with Avon and Wiltshire Mental Health Trust about booking of mental health nurses as the Trust continues to see an increase in patients presenting with mental health concerns.

Discussion:
SH referenced the categoric financial pressures the Trust is experiencing and noted that the financial funding for consideration details no impact on productivity. The consideration of funding will be handled through business planning. EJ noted the balance of prioritising safety and the difficult financial position.

PC referenced the discussions around disparity between weekend and weekday mortality, noting that it is difficult to take a view as this might

require different staffing models or to have some tasks undertaken by different staffing groups.

The Board discussed international nurse recruitment, noting that there were 70 overseas nurses due to come to SFT. The Board noted that recent cohorts of overseas nurses have not been passing their OSCE first time which takes a lot of mitigation and support. Therefore, teams are looking at reducing overreliance on these members of staff in the first instance to ensure retention.

ME referenced the indicative costs in the paper, noting that the appropriate establishment is never unaffordable. The financial pressure is caused by Length of Stay and therefore the focus should be on using the resource provided to improve efficiency and admission avoidance.

TB noted the usefulness of the report but noted this is a mandatory report which is not replicated for other staff groups. TB therefore queried if it is the Trust's plans to deliver an equivalent report for other staff groups. The Board discussed that there is an equivalent for doctors but plans do not cover other staff groups. JDy noted that there was a piece of work starting, looking at the Allied Health Professional (AHP) staff group.

MvB noted the Trust's aspirations to move towards flexible working and noted that it would be useful to see how many people have successfully recruited to flexible positions. JDy commented that when previously reviewed, most nurses prefer 12-hour shifts as it allows for longer periods of time off.

TB1 05/10/6.3 **Freedom to Speak Up Guardian Board Self-Assessment Tool Kit**

MW presented the report which has been through People and Culture Committee. The Board were asked to confirm if they are both content with the self-assessment and recommendations for action.

- The Trust remains on track to provide strong evidence against all eight principles. The seven areas and actions for improvement over a 6–24-month period is detailed in the report and refer to required training, access and time for Ambassadors and ensuring ongoing cultural development to address any determine when colleagues speak up.
- The Policy has been refreshed and reviewed by the Joint Consultative Committee (JCC) and OD & P management Board (ODPMB).

Discussion:
EJ noted the comprehensive report and that it is positive the Trust is seen as an exemplar. However, there is always more that can be done.

The Board discussed detriment and it was noted that there is some cultural development required to ensure those speaking up feel supported. The Trust's ambition is to support training at all levels and there is work to ensure line managers are allowing the time for FTSU ambassadors to have time to fulfil their roles.

TB1 05/10/6.4 **WRES and WDES Report**

MW noted the report was submitted to People and Culture Committee but the original reports published included a few inaccuracies and therefore a new set of slides have now been added to iBabs. The report sought approval for the recommended action plans, noting it would be formally submitted at the end of October. The following key points were noted:

- The WRES data indicates positive progress. There is a sense of improved fairness around shortlisting and improved recruitment practices.
- There is movement in terms of progression into senior roles for BAME staff. However, the WRES disparity index, which measures the difference in progression rates between BME and white staff, has increased again in 2023.
- It is also acknowledged that whilst the Trust is proud of its diverse workforce this representative of the wider local community.
- The WDES progress made in 2021/22 carried through to 2022/23. A PwC audit resulted in new and improved recruitment practices with six points of the action plan were incorporated.
- In terms of shortlisting, there are similarities in how we treat all people. Where there is improvement to be made is accommodating reasonable adjustments as feedback indicates line managers and senior clinical colleagues are doing this consistently. The Trust is working to complete the Disability Confident Self-Assessment to achieve Level 3 Disability Confident Lead status.

Discussion:
The Board noted that they were due to have an Equality, Diversity, and Inclusion (EDI) strategic session as part of the Board Development programme where some of the themes detailed in the report would be discussed. There are lessons to be learnt from the Chester case re Lucy Letby and acknowledging that alongside data, there are other ways to recognise issues and this is linked to the culture of an organisation.

MvB asked how cultural differences feed into appraisals and the differences in the way this is perceived. MW noted that part of the wider EDI focus is a cultural awareness programme of which the outcome will be fed back.

There was a discussion around the data as RH had sent in some comments about the detail within the first report published. The Board noted that further assurance will be sought re WRES and WDES data in People and Culture Committee.

Decision.
The Board noted the report and recommended action plans and approved for publication by the end of October.

TB1 05/10/7 **GOVERNANCE**

TB1 05/10/7.1 **Register of Seals Q2**

The Board noted no new seals had been added since the last report.

TB1 05/10/7.2 **Approve Board and Committee dates for next year**

FMc presented the report which summarised next year's Committee meeting dates and extended to March 2025.

Discussion and Decision:
There was a detailed discussion and the dates were agreed apart from the dates for F&P Committee and CGC.

ACTION. LT/ ME/KN

It was agreed that they should be 9x a year but LT and ME would look at the months where it would be more appropriate to not have a meeting. It was agreed that dates would be circulated once this had been drafted.	**LT/ ME/ KN**

TB1 05/10/8 **CLOSING BUSINESS**

TB1 05/10/8.1 **Any Other Business**

There was no other business.

TB1 05/10/8.2 **Agreement of Principle Actions and Items for Escalation**

EJ summarised the board's discussion, noting the pertinent topics that had been raised.

EJ thanked the Shadow Board colleagues for their feedback.

TB1 07/09/8.3 **Public Questions**

There were no public questions.

TB1 07/09/8.4 **Date of Next Public Meeting**

The next Public Trust Board meeting will be held on 7th December 2023, in the Board Room, Salisbury NHS Foundation Trust

TB1 07/09/9 **RESOLUTION**

TB1 07/09/9.1 Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

Master Action Log

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

1	Deadline passed, Update
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 07/09/4.3 Perinatal Quality Surveillance Monthly Report	11/01.2024	Vicky Marston, VM	IG asked VM to provide feedback to the board in a few months' time on sustaining a cultural improvement journey in Maternity	**January's meeting**	N	4
Trust Board Public	Sasha Grandfield	TB1 07/09/5.4 Health and Safety Annual Report and Q1	11/01/2024	Melanie Whitfield, MW	IG requested the next report contain more details on the support available to staff and added a trajectory showing if incidents were getting better or worse would also be helpful.	**January's meeting**	N	4
Trust Board Public	Sasha Grandfield	TB1 05/10/4.1 Improving Together Quarterly Update Report Q2	11/01/2024	Alex Talbott, AT Peter Collins, PC	EJ asked if the next report could include who we have trained and how many should we train and the narrative on if we are training the right people	**January's meeting**	N	4
Trust Board Public	Sasha Grandfield	TB1 05/10/5.5 Maternity and Neonatal Bi-Annual Staffing Report	07/12/2023	Judy Dyos, JDy	SH requested a documented risk assessment around why the Trust do not have a continuity of carer model.		N	2
Trust Board Public	Sasha Grandfield	TB1 05/10/5.6 Quarterly Risk Report Card	07/12/2023	Judy Dyos, JDy	SH suggested that the Board dedicate some development time to discuss and understand implementation of PSIRF.	Added as a potential discussion topic for Board development in 2024.	Y	3
Trust Board Public	Sasha Grandfield	TB1 05/10/7.2 Approve Board and Committee dates for next year	07/12/2023	Lisa Thomas, LT Mark Ellis, ME Kylie Nye, KN	It was agreed that F&P and CGC should be 9x a year but LT and ME would look at the months where it would be more appropriate to not have a meeting. It was agreed that dates would be circulated once this had been drafted.	Dates have been confirmed apart from January CGC and F&P dates. Will be circulated once agreed.	Y	3

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	1.8
Date of Meeting:	07 December 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):	Appendix 1 AHA briefing paper			

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 July 2023 The report highlights: • Key national communications for Board awareness and information • Relevant updates from key partnership activities including BSW Integrated Care System and other partnerships • 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 period since the Board met at the beginning of October 2023 and as the Integrated Performance Report details it has been another busy period.

This report alongside the Board committee's escalation report details the progress and highlights to the Board any areas whereby we are not delivering to plan.

Of note is the continued progress across our breakthrough objectives which is supporting reduced length of stay, a sustained reduction in falls and improvements in the number of vacancies and staff availability. This is helping the organisation respond to key challenges and using our Improving Together approach is definitively helping secure ownership of the necessary improvements from the clinical and operational teams who deliver them.

There are also notable improvements in the diagnostic 6-week standard which is excellent and our income and activity is above plan.

The position for cancer waiting times remains cancelled with improvement expected in the coming weeks when the additional capacity for the Dermatology pathway delivers.

There has been no further industrial action in this period . The BMA have agreed to put a revised offer from government to the Consultants which their members will have until mid-Jan to respond too. They have agreed to pause any further strike action for this group until the outcome of this is known.

At the time of authoring the report we are in a critical incident relating to sterile services. This is to ensure that we have appropriate oversight and can mitigate the risks and seek mutual aid until the situation is resolved. This is expected to take circa 5-7 days . I will ask the Chief Nurse to provide a verbal update at Board.

As highlighted previously to the Board and the Clinical Governance committee we have requested support from the regional medical director for an external review of our mortality. This review is due to take place of the 5th of December 2023 and will involve an external team visiting the site, reviewing the data and processes, and having an opportunity to talk to colleagues. The outputs of this will be shared with the Board as soon as they are available.

1.2 Financial sustainability

The financial position remains challenging and is detailed in the financial report . Whilst good progress is being made against the cost improvement plans the adverse position is driven by the costs of industrial action, enhanced care provided to patients with additional mental health needs, residual gaps in the pay award and supernumerary cover for overseas recruits.

The Board will be aware that at our recent extraordinary Board meeting we discussed the latest plans for financial recovery for the second half of the year (H2) . I will ask the Director of Finance to provide a verbal update given this is moving at pace. The details of the requirements have been shared with the Finance and Performance committee . They centre around improving the current forecast whilst ensuring safe services with a particular focus on winter and urgent/emergency care services.

2.0 Our People

2.1 Staffing

As we approach the winter period it is encouraging to note that we have reduced staff vacancy rates to below our 5% target for the last three consecutive months. Not only does this boost staff numbers available to work, but it also has a corresponding positive impact on our staff, who see more colleagues to work alongside. I would like to thank the very hard work of our resourcing team for their efforts to design effective attraction campaigns, improve internal processes and work alongside line managers to ensure onboarding is efficient and a positive experience for new staff. Equally, despite a rise in seasonal illnesses impacting short term absence numbers, we have maintained a lower-than-average absence rate due to illness. Days lost to illness are still higher than we would like, but we have made progress to improve our understanding of the reasonable adjustments process to enable more staff to return to work following sickness absence.

Our people remain our biggest asset and we have continued to introduce a range of new initiatives to support their health and wellbeing. These have included the launch of the new exclusive discount scheme, over and above the Blue Light Card, for businesses and services in Salisbury; a further programme of financial support webinars laid out for 2024 to support financial planning, pension advice and guidance; and streamlining of the emotional health referral process, which now provides a single point of access to triage for in-house counselling and clinical psychology services for staff. Our wellbeing lead has recently conducted a rapid survey of our staff's wellbeing experiences and we will use the results to further improve wellbeing provision and signposting in the New Year. We have achieved good progress in support of staff subject to violence and aggression in the workplace. A six-point plan has been developed to attend to improving staff training, managing patient behaviours (no excuse for abuse campaign), risk assessments and care pathways for patients with dementia and delirium, management responses to identify timely investigations and lessons learned. Finally, as part of our safety management system of audits and inspections we identified an higher incidence of musculo-skeletal injuries in theatres and our spinal unit, which has led to an enhanced training package for these staff seeking to reduce prevalence of injury.

2.2 Education

We are in the middle of further developing our Training Needs Analysis process to support identification of the necessary courses and resource to enable staff to achieve both career and personal development goals. Aligned to this is the publication of a learning and development catalogue which will enable line managers to be better informed of what is available, both mandatory and selective. The appraisal process is a key time when staff can discuss their training needs and then plan future training requirements with their line manager. The refresh of both the appraisal policy and the tools to support it are influencing appraisal completion rates which have gone up by 8% in the last two months, a very encouraging statistic. Elsewhere in the education centre, we have brought back into house training for international nurses to support their OSCE qualification - the first cohort will attend the examination on 1st Dec and we anticipate an improved pass rate. Plans have been put in place to improve the induction training of our Health Care assistants, both in quality and quantity. We aim to be able to train 40 HCAs a month from January, with a broader and more effective training package, all designed to make staff more comfortable for their first weeks on a ward.

3.0 Our Partnerships

3.1 Internal communications and engagement

This time of year, communications and engagement is focussed on the follow up to the Staff Thank You Week, the NHS Staff Survey and plans for Christmas.

It is great to see teams begin to display their certificates, cartoons, and trophies from the Awards night. The feedback from this years thank you week and awards has again been incredibly positive and helps us plan for next year. The NHS annual staff survey always presents a challenge as we seek to get staff to find a few minutes to complete the survey and tell us how it feels to work at the hospital. This year staff have responded incredibly well and we are seeing greatly improved levels of returns. It is especially pleasing to see improved response rates from nurses, midwives, doctors, and dentists as it's important that all professional groups have their voice heard.

Plans for Christmas this year will include the popular free staff and volunteers Christmas Lunch provided by the incredible catering team, the return of lights and trees across the site and an extended programme of seasonal activity with music and storytelling for staff and patients to enjoy.

This past week we have also hosted colleagues from across BSW to discuss our Improving Together programme, seen the Education Centre re-branded with our vison and values and will soon have our facilities Tugs looking smart with new livery.

One of the highlights has been a visit to the Health Service Journal Awards for the team behind our hospital podcast Cake with Joe and Jayne. The podcast series was a finalist and while the team didn't win this time it was a huge honour to have their work celebrated as one of the best communications projects in the country.

3.2 BSW Integrated Care System

3.2.1 Wiltshire Integrated Care Alliance (ICA)

I am pleased to say that greater 'neighbourhood' level working is helping us to integrate services where they matter most to patients. Initiatives like the 'neighbourhood collaboratives' - that brings together a vast array of the public sector from health to police to community groups – are moving toward implementation phase and have secured funding to really start ramping up activity across Wiltshire.

3.2.2 Health Inequalities

A recent AHA 'Clinical Summit' on health inequalities produced lots of opportunities for shared learning on tackling inequity for our population, including in specific conditions as well as across the board i.e., wait lists.
Our health inequalities work, in partnership with colleagues at place, has moved into delivery mode with over £800,000 of grant funding awarded to projects from an under 5s health club on Bemerton Heath, to pan Wiltshire work on mental health.
This work was presented to Wiltshire Council Health Select Committee (https://www.youtube.com/watch?v=XBUn7wR6GYA&list=LL&index=1&t=5994s&pp=gAQBiAQB – from 1h40m).

3.2.3 Community Services

A tender process for community services is now live across BSW for 2025 – 2032. Our team has been working with several our partners on a consortium approach to integrating those services at place. This includes the AHA, our hospice partners, VCSE community colleagues, Primary Care Networks, and internal clinical teams (as part of their strategy responses). Our initial expression of interest is now with commissioners and we expect a more detailed negotiation phase in the new year to establish what delivery would look like ahead of contract award in September 2024 and service provision commencement in April 2025. I would like to thank our Chief Operating Officer (COO) and Associate Director of Strategy who are leading this work on our behalf for their leadership. This is a significant opportunity to design a new community offer that maximises the benefits of integration and care closer to home. The COO may want to provide an additional update in the private board.

3.2.4 Acute Hospital Alliance

Work continues to progress across a range of programmes with a particular focus on the opportunities for further collective action in relation to corporate services. Please see appendix one for the details contained in the AHA report.

Meeting of Board of Directors

Report Summary Sheet

Report Title	Acute Hospital Alliance Briefing, October-November 2023.						Agenda item	
Date of meeting	December 2023							
Purpose	Note X		Agree		Inform		Assure	
Author, contact for enquiries	Ben Irvine, Programme Director (ben.irvine@nhs.net)							
Appendices	Appendix 1. AHA Briefing							
This report was reviewed by	• Stacey Hunter, CEO SFT, Senior Responsible Owner • Cara Charles-Barks, CEO RUH • Kevin McNamara, CEO GWH							
Executive summary	This briefing provides an update on the activities of the Acute Hospital Alliance (AHA) in October and November 2023, as well as a description of priorities for the forthcoming period. The following areas are covered in the briefing: 1. Delivery of Priority Projects 2. Developmental Governance Review 3. National Provider Collaboratives Innovator Programme 4. Programme Resources and Risks The next AHA Board briefing will be issued in February 2024. For further information on the AHA Programme please contact Programme Director Ben Irvine (ben.irvine@nhs.net).							
Equality Impact Assessment	An AHA Programme Equality Impact Assessment [EIA] has been completed. The EIA will be refreshed as the three-year AHA Programme 2023-26 matures.							
Public and patient engagement	The AHA Programme Board approved a Communications and Engagement strategy in Q2 2023-24. Our AHA Clinical Transformation work is closely linked with the BSW Care Model which has been through a significant public engagement exercise. Service users will be involved in service design activities as the AHA Clinical Strategy is implemented.							
Recommendation(s)	To note the AHA briefing.							
Risk (associated with the proposal / recommendation)	High		Medium		Low X		N/A	

Key risks	The development of the BSW AHA is in line with national policy and strategic direction on provider collaboration. The AHA Programme Board, SRO and Programme Director identify and manage risks associated with programme delivery.
Impact on quality	The AHA maintains a strong focus on quality and patient safety and assumes continuous focus on quality improvement – the Improving Together Programme is one of the AHA's core activities. The AHA Clinical Strategy and Staffing Methodology workstreams are designed to improve clinical service effectiveness, patient experience, and quality. The corporate workstreams aim to deliver value for money, quality, and resilience of corporate services.
Resource implications	A cost centre has been established at GWH hosting the core AHA budget. The programme leadership ensures balance in financial contributions between the three Trusts.
Conflicts of interest	None known.
This report supports the delivery of the following BSW System Priorities:	☒ Improving the Health and Wellbeing of Our Population ☒ Developing Sustainable Communities ☒ Sustainable Secondary Care Services ☒ Transforming Care Across BSW ☒ Creating Strong Networks of Health and Care Professionals to Deliver the NHS Long Term Plan and BSW's Operational Plan

Appendix One.

Acute Hospital Alliance, November 2023 Briefing

Introduction

This briefing summarises the activities of the Acute Hospital Alliance (AHA) in October and November 2023, and priorities for the forthcoming period. The following contents are included in each monthly briefing:

1. Committees in Common & Programme Board Activities; Delivering Core Projects
2. AHA Developmental Governance Review
3. National Provider Collaboratives Innovator Programme
4. Programme Resources and Risks

1. Committees in Common & Programme Board Activities

- The Committees in Common (CIC) sets strategic direction for the AHA. At its meeting on 20th October, CIC members were briefed on collaboration opportunities and plans by Trust corporate service leaders. CIC welcomed emerging plans and encouraged leads to pursue opportunities to work at scale where quality, resilience, productivity and financial benefits are identified.
- On 31st October, CIC members and ICB leads, held their latest quarterly meeting. The group discussed a *Compact for the BSW Integrated Care Board & the AHA*. The *Compact*, commissioned at the previous quarterly session, describes how we will work as partners, affirming the AHA's role in BSW ICS as a collaborative delivery partner, with our work being underpinned by a shared understanding of system priorities, objectives, opportunities and expectations. The Compact will be finalised in December and shared widely from January onwards.
- At its meeting on 21st November CIC considered a paper on *decision-making arrangements for the next stages of our single EPR Programme*; it was agreed that a proposal for new governance arrangement would be developed in further detail, for review on 4th December. CIC members also reviewed the *single capital plan* – one of our five priority programmes. The group welcomed the progress made and encouraged the core team to continue as planned. Finally, CIC heard from Trust Strategy, Planning and Partnership leads how the Trusts are working closely together in the ongoing *BSW integrated community services contracting process*. A consortium response to the provider selection questionnaire and Memorandum of Information had been submitted on 17th November. CIC heard that a detailed programme including resourcing and governance arrangements was in development.
- The next CIC meeting planned for 4th December will see discussion focus on the AHA *Clinical Strategy and Transformation Programme*.
- The Programme Board met on 25th November, reviewing the emerging Corporate Services Collaboration programme (further details on page 3 below), and progress of priority projects.

- The All Trust Executives Group, next meets on 15th December. The group will discuss Research & Innovation collaboration, Legal services collaboration and receive detailed briefing on the AHA Clinical Strategy and Transformation Programme.
- *Executive Team Coaching Sessions.* The coaching programme to support our collaborative development continues. Recognising the challenge and ambiguity that system-wide working brings, sessions with Professional Trios of Executive Leads are progressing well, and planning for the next in a series of larger-scale development sessions bringing together the three Executive Teams in early February is underway.
- Updates on the recent activities and next steps for *core AHA activities – Clinical Strategy, Single Capital Plan, EPR Programme and Corporate Services Programme* follow.

Acute Clinical Services Transformation

- *CEO Sponsor:* Cara Charles-Barks, RUH*; Executive Lead*: Peter Collins, Chief Medical Officer, SFT.
- *Recent Activities*: The *Clinical Transformation Programme Board* met on 15th November and saw discussion on the AHA's *Clinical Programme* through which specialty teams from *Orthopaedics, Gastroenterology, Urology and Dermatology* are working together to identify and implement service improvements in response to the Clinical Strategy and BSW Care Model. A standardised framework is being used to support teams to identify opportunities, their vision for services, and improvement measures. Engagement of clinical teams from the three Trusts is good. Discussions with the national GIRFT Specialty Leads have been arranged to support learning or improvement suggestions for each specialty. The *Clinical Transformation Programme Board* noted that it should confirm its resourcing approach, to ensure specialties had sufficient support for collaborative transformation work.
- *Next Steps:* On 20th December the *Clinical Transformation Programme Board* will hold its next session The 2024-2025 quarterly programme of Clinical Summits has been arranged. The next session will be held on 8th February 2024 and will be planned with Local Authority Public Health leads.

Single Capital Priorities Plan

- *CEO Sponsor:* Cara Charles-Barks, RUH*; Executive Lead:* Simon Wade, Chief Finance Officer, GWH.
- *Objective:* Project aims for AHA Trusts: To work together to maximise available capital resources flowing into BSW/ AHA by having a coherent, strategic plan for capital investment within the AHA; to advocate consistently for each-other's schemes and the collective capital development priorities; to establish clear principles guiding how we will collectively respond to national requests to bid for funding. The plan we create will be driven by BSW ICS strategy and population need, using common demand and capacity assumptions.
- *Recent Activities:* October and November saw a core team of leads from each Trust and BSW ICB colleagues complete their initial review of capital investment proposals grouped in five workstreams (Elective Care, Urgent & Emergency Care, Infrastructure, Women & Children's services & Digital). The team reviewed cases reflecting on BSW population need, identifying those schemes where commercial funding routes may be applicable, and those where planning together and with other BSW Partners (Local Authorities, AWP, BSW ICB) would be explored.

- *Next steps.* The core team will establish detailed plan by end December for development of business cases for recommended schemes.

EPR Alignment Programme

- *CEO Sponsor:* Stacey Hunter, SFT*; Executive Lead:* Jon Westbrook, Chief Medical Officer, GWH.
- *Objective:* Procurement and deployment of a single EPR platform.
- *Recent Activities:* Full Business Case detailed review by SW Region in readiness for national EPR Investment Board consideration.
- *Milestones:* NHSE FBC review outcome anticipated mid-December 2023.

Corporate Services Collaboration Programme Development

- *Objective:* Against the background of latest national policy, available benchmarking, and best practice guidance, Executive Teams have begun developing plans for corporate service collaboration over the next five years, identifying opportunities to work at scale to enhance service quality, user experience, career pathways and resilience, and improve efficiency and productivity.
- *Recent activities:* The following services have actively been developing collaboration plans: People, Digital, Finance, Estates & Facilities, Governance & Legal, Communications, Research & Innovation. Executive leads have been identified for each, and those leads have convened a series of workshops / development sessions with their peers, some also harnessing external support to provide expertise and challenge into discussions. As anticipated, services have identified a significant range of opportunities for collaboration between the Trusts, yielding qualitative and quantitative benefits. Leads have also identified a range of opportunities for working at greater scale with other collaborative partners in BSW. These opportunities will be explored further in December and January. Further detail on the AHA corporate collaboration programme will be provided in the February 2024 Briefing. AHA leads are actively seeking examples of successful corporate services collaboration via the Innovation Programme and through our active participation in NHS Confederation and NHS Providers Provider Collaborative networks.
- *Milestones*: End October: Executive Leads presented initial proposals to CIC. November & December detailed plans presented to AHA Programme Board. January 2024 onwards: Implementation begins, plans embedded consistently in core 2024-2026 planning round assumptions.

2. AHA Developmental Governance Review

Following the programme's developmental *governance review* carried out early in 2023, programme leads have continued to work on a series of changes designed to ensure the AHA has strong governance arrangements in place. Recently developments have included further development of a Compact (refer section 1 above) describing how the AHA and ICB will work as partners in BSW ICS. Planning has also begun to streamline decision-making for the next stages of our single EPR Programme. A proposal for new governance arrangements will be considered by the Committees in Common on 4th December. Finally, the Trusts' Improving Together and Strategy leads have been working to embed the Improving Together methodology, with a workshop session bringing together executives and Improving Together leads from the three Trusts planned for early 2024.

3. AHA Participation in National Provider Collaboratives Innovator scheme 2023-2024

Through participation in the Provider Collaboratives Innovator Scheme, the AHA aims to maximise opportunities for collaborative working, enabling delivery of our core programme, and cementing the AHA's role in BSW ICS as a central delivery partner. The programme sees regular Peer Network sessions allowing active sharing of innovation and troubleshooting of issues with the other provider collaboratives in the scheme. In November, the AHA Programme met clinical and transformation leads from the Foundation Group on clinical service improvement. The team also met Birmingham and Black country collaborative leads to learn about their governance approach and legal services collaboration.

Emerging themes from the Innovator Scheme are being collated in Q3 2023-24. On 11th December a BSW AHA team will attend a Provider Collaborative Innovators Scheme Policy Feedback Session hosted by the NHSE Chief Delivery Officer Steve Russell, Director of Provider Development Miranda Carter, and Sir Julian Hartley, Chief Executive of NHS Providers.

4. Programme Resources

The AHA brings together clinical and corporate services experts from across the three Trusts to design and deliver the work programme. CEO sponsors and executive leads are in place for all priority activities. The programme is funded by balanced contributions from the three Trusts. A small core team is in post, with roles being hosted by all three Trusts. The executive leads for our clinical transformation programme are working to ensure sufficient support is available to drive improvements.

5. Risks & Issues

A range of risks and issues continue to be managed by the programme team. A risk register is held centrally, risk management responses are reviewed monthly, with significant items being reported to the Programme Board and Committees in Common. Challenges associated with financial recovery can impact capacity of senior leaders to support collaborative activities. No new and significant risks have emerged in this reporting period.

6. AHA Forward Meeting Cycle

Table one below sets out the dates of our CIC meetings, Programme Board and Clinical Summits for 2023-2024. A detailed meeting planner, providing a clear view of key decision points and milestones has been developed by the programme team and is used by the Programme Board and Committees in Common.

Table 1. 2023-2024-2025 Meeting Cycle: Key Dates

	Q2		Q3			Q4			Q1			Q2	
	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
AHA Programme Board		22nd		24th		26th		22nd		24th		26th	
All Trust Executive Group			27th		15th		23rd		26th		28th		30th
Committee in Common	18th		20th		4th		15th		19th		21st		16th
Clinical Strategy Programme Board	31st	28th	18th	15th	20th	17th	21st	20th	17th	15th	19th	17th	21st
EPR Programme Board	31st	28th	26th	30th	28th	25th	29th	28th	25th	30th	27th	25th	29th
Clinical Summit			TBC			TBC			TBC			TBC	

Finally, the next AHA Board briefing will be issued in February 2023.

Close

Drafted by Programme Director, Ben Irvine

27th November 2023

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board Meeting (Public)	Agenda item:	2.1
Date of meeting:	07/12/23		

Report from (Committee Name):	CGC		Committee Meeting Date:	31/10/23
Status:	Information	Discussion	Assurance	Approval
Prepared by:	David Buckle, Non-Executive Director			
Non-Executive Presenting:	David Buckle, Non-Executive Director			
Appendices (if necessary)	N/A			

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

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

- **Nil**

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

- **Mortality review has been commissioned.**
- **Cancer performance concerns were discussed, and there was recognition of F and P involvement.**

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

- **Sustained improvement in stroke with Q1 being graded as SSNAP B**
- **Increase in FFT uptake.**
- **The governance process for QIAs (particularly around MTFP) was clarified and it was agreed that they would be reported to CGC by exception.**
- **The annual complaints survey was useful, and it was discussed but the number of responses was low.**
- **National Inpatient survey was reviewed.**
- **Quarterly safeguarding reports for children and adults were discussed**

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

- N/A

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 Meeting (Public)	Agenda item:	2.1
Date of meeting:	07/12/23		

Report from (Committee Name):	CGC		Committee Meeting Date:	28/11/23
Status:	Information	Discussion	Assurance	Approval
Prepared by:	David Buckle, Non-Executive Director			
Non-Executive Presenting:	David Buckle, Non-Executive Director			
Appendices (if necessary)	N/A			

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

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

- **Nil**

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

- **Quarterly research report was particularly positive from a user experience perspective, but the numbers of patients participating in trials is lower than expected.**
- **Six monthly GIRFT report demonstrates some excellent work and engagement but overall, the program is slightly behind schedule. This is partly due to regional and national support being reduced during covid.**
- **Maternity was comprehensively discussed. We are not expecting to achieve 10/10 which is required to achieve the incentive scheme. Despite this we are pleased with progress and engagement**

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

- **The medical division report and discussion demonstrated good engagement with governance.**
- **Internal audit program recommendations were complete.**
- **Six monthly medication safety report provided assurance and the antibiotic CQUIN was progressing very well. Aseptic services were still dealing with legacy issues.**
- **The CMO provided written evidence that there were no working Drs without a DBS check. He also confirmed that we didn't have a significant backlog of unreported x-rays and we were tackling those we did have.**
- **The annual cancer survey report showed an above average performance and a good response rate of 63**

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
• **PSIRF policy approved.**

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:	2.2
Date of meeting:	07 December 2023		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	31 October 2023
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Debbie Beaven (NED)			

Recommendation:

The Finance and Performance Committee met on 31 October 2023. The following matters were tabled for approval:

1. **Commercial Off the Shelf (procurement route for software licences) -** The Committee discussed the paper but felt unable to recommend it to Board until the details around the finances and controls were clearer, particularly in the context of the spend to date compared to plan. The paper will be updated and come back to the November meeting.

2. **EPR Agency Recruitment -** The Committee considered the paper proposing the agencies to be used to source specialist digital resources, should there be issues with recruiting into these roles given the high demand for digital skills. ***The Committee recommends the proposal to the Board for approval.***

3. **Pharmacy Wholesalers –** The recommendation made to the Committee aligns SFT pharmacy supply with others in the ICS, within an existing framework. The Committee questioned the lateness of this proposal given the existing contract expired on the day of the meeting and was assured that the new contract is ready to mobilise and that there would be no disruption to pharmaceutical supplies. As the contract exceeds the limits for the Committee and needs Board approval the Committee agreed approval should be sought urgently outside of the Board meeting.

   Post meeting note: approval was obtained on 2 November via email and will be ratified at the next Board meeting.

4. **West of England Imaging Network – OBC progression to FBC** – The Committee, having considered this proposal before, was updated on the progress and the preferred option. Approval to continue with the development of the FBC was given, acknowledging the current risk of a funding gap and the need to ensure that SFT does not take on any additional cost pressure. ***The Committee approved.***

5. **Extension to Partnership with Salutem** – The Committee approved the extension of the arrangement with Salutem, who are supporting SFT with the development of the Campus plans. There are no additional costs although it was flagged that there could be some legal costs in relation to contractual negotiations. ***The Committee approved.***

6. **Improving Together Business Case Assurance** – The Committee was assured that there are benefits in accelerating the program and heard how it underpins SFT's change management process

and culture and is essential for many projects, particularly EPR. Whilst the Committee did not get the level of assurance around the financial quantification of the benefits, it agreed that the cultural embedding was essential and therefore asked that a benefits realisation assessment is presented to F&P in March or April 2024, and that there are periodic updates on benefits to provide the Committee with ongoing assurance of the value of benefits both financial and non-financial.

Executive Summary:

The Board is asked to note the following items from the F&P meeting on 31 October:

Performance and Risk:

1. **Integrated Performance Report, including updates on trajectory, theatre, care co-ordination Service and cancer improvements:**
   a. ***Alert***
      i. **Cancer** - SFT is currently behind on 62+ day trajectory due to capacity issues within the Skin pathways which is having a significant impact on SFT's 28 day and 62-day performance during late Q2 and early Q3. Countermseaures to improve the position include additional workforce resource in Plastics to support Skin capacity, proposal to use insourcing resource (SWAG funded) in November for backlog clearance, improvement in triage and clinical risk assessment process at point of referral to ensure appropriate use of first seen appointments and communication with GPs re referral quality. As a result of our cancer and mortality performance we have been advised that we will move from SOF2 to SOF3, involving more oversight in these particular areas.
      ii. Elective waits over 65 weeks have increased further, with 300 patients waiting over 65 weeks at the end of Q2. Industrial action remains a significant risk to achievement of zero waits by the end of Mar 24, with large volumes of elective activity rescheduled or not booked to allow urgent activity to be safely supported. Current forecast is a backlog of 170 at year end with no further IA, and up to 460 if current level of IA continues.
   b. Assure
      i. **Theatre** utilisation has improved, (with a hope that the drop in M6 is just a blip). Although late starts are stubbornly stable, they are in the upper quartile of performance in the region. Increased visibility using whiteboards will drive continued improvements in reducing late starts. The new Robotic surgery is going well with great feedback from theatre staff. A planned revamp of the theatre timetable and model alignment with specialities with further improve utilisation, the aim being that the theatre timetable drives job plans and not the other way around.
      ii. **Care Co-ordination –** Good assurance around the engagement and impact of the platform, which uses data from disparate systems and creates bespoke dashboards and messaging to support clinicians. The system will be complementary to EPR as is the case in other Trusts where both operate together.
      iii. Diagnostic DM01 achieved its highest performance in 18 months.
      iv. SDEC continues to support reduced LoS and discharges.
   c. Advise
      i. Bed occupancy increased to 100.6% as total monthly discharges slipped by 11, impacting ED which, with demand up, saw a drop in 4-hour performance for a second consecutive month to 72.5%. There is an ambition to get to 80% to give SFT access to capital funding.
      ii. **Trajectory Update** – out of 6 metrics, bed occupancy is the only one we are unable to provide assurance on regarding the reduction in occupancy level, likely to impact elective and non-elective activity.

2. **Finance Report & CIPs**
   a. ***Advise -*** The Committee was asked to note the financial position to M6, which shows a continuing deficit; £6.6m, £4.3m worse than plan. The YTD position is driven by the net costs of Industrial action of £1.7m year to date, the costs of providing enhanced care to patients £1.4m, supernumerary cover for new and overseas staff £1.1m and year to date residual gap on pay award funding c£0.7m.
   b. ***Assure -*** The savings delivered through the CIPs plan total £5.9m and are behind plan, however there is confidence that the divisional performance, which is ahead of plan will compensate for the lack of progress at system level on the community provision to address the NCTR, and the £15.3m target will be achieved. The impact of recurring CIPs into next year will also be reported.
   c. ***Alert -*** There will be a full update on the forecast outturn in next month's meeting, with concerns that the ongoing pressures will mean a further deterioration, as is the case across the entire system.

3. **Digital Update, Cyber and Data Protection –** The Committee took ***assurance*** from the cyber and DP paper and was ***assured*** that digital projects were being effectively managed with the overall trend for the entire digital programme remaining stable with limited status changes. The infrastructure capacity issues are improving with a full move to the new data warehouse on track for completion by the end of the year. The gantt chart provided a good overview of the project plan, noting the completion of projects and reduction in numbers of projects in 2024 to accommodate the EPR project.

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 Public Board	Agenda item:	2.2
Date of meeting:	7 December 2023		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	28 November 2023
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Debbie Beaven – Chair of Finance & Performance Committee			
Non-Executive Presenting:	Debbie Beaven			
Appendices (if necessary)	none			

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

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

- **Sterile Services – critical incident**. On 27 November 2023 a critical incident was declared for sterile services as a result of equipment failure and the resulting timescales for a fully effective repair, which is anticipated to be on or before 5th December. The situation is being managed with support from others in BSW, BOB, and HIOW systems, with trays being sent out for sterilisation on a 48-hour turnaround rather than 24 hours. The impact is on the availability of trays for surgery, which is being managed daily. In the event of having to prioritise a trauma admission there could be a shortfall in supply for other services. At the time of the meeting there had only been 2 procedures cancelled. Management is considering if this is a SI.
- **Financial performance**. At the end of month 7 we are £6.3m off plan; £2.6m relating to industrial action and unfunded element of the pay award, £1.8m relating to continuing levels of NCTR and £1.5m as a result of enhanced needs from demand and conditions presented. There are already enhanced SOPs on agency spend, which are having a positive impact in reducing usage, and there is progress with OSCI nurses getting their pins. However, there is an urgent need for a significant drop in expenditure from next month.
- **Latest financial submission to the ICB** shows a deficit of £8.1m (before additional funding), starting from our best-case position. After funding that deficit is £4.3m. Given the deficit submission across the whole system there has been significant push back to get to a system breakeven. The view of the Committee is that there is already risk in our forecast, and we can't realistically see a way to push it any further. The Committee was alerted to a potential risk of having to repay any shortfall (deficit) next year and the risk of the pressure to pull back from investments, such as EPR and cancer support in-sourcing arrangements, despite the impact on the longer-term efficiency and effective of systems and health outcomes respectively.
- **Estates** – The level of non-compliant PSSR is reducing with plans to clear them all by the end of the quarter.

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

- **Financial briefing for all staff –** there will be a communication to all staff about the financial position, why it is different this year, what is being done and what more can be done. The aim is to sensitively galvanize more hearts and minds around the challenges and actions.

- **Cancer –** performance continues to be a challenge, although there has been some progress as a result of the additional resource invested with the support of the Somerset, Wiltshire, Avon, and Gloucestershire (SWAG) Cancer Alliance; an additional 200 patients have been seen. With breast reconstruction we heard that the support we had hoped for from other trusts was not available, but that we are managing the list and prioritising cases on an ongoing basis.
- **Stroke –** deteriorated again in the month. Weekends are a theme regarding performance and will be subject to further review. Improvement requires more resource and sustained action.
- **The Rapid Assessment Treatment (RAT) in A&E** resulted in positive outcomes. The 1st week went well, the 2nd less so, but a pause and improve response addressed this, with the huge positive impact on morale, which was described as "buzzing".
- **Bed occupancy and management –** again remains challenging with NCTR. The ewhiteboards are being used to monitor and manage beds, although the usage is not, yet, universally embraced.

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

- **DM01 –** Performance continues to improve with good ownership by local leads and additional capacity being key contributing factors to a performance, which is now at 90.96% (comparable to 2 years ago, and above the 85% NHSE standard).
- **Discharge –** at their highest level for 4 months, with triage in dedicated areas making a difference, as are the discharge hubs which are progressing well. SDEC also continues make a significant difference. There are two Registrars leading reviews on the discharge process, which will provide more learnings.
- **CIPs –** we received a confident briefing on the forecast to achieve the target CIPs of £15.3m, despite being short on the £3m saving from the discharge process. When challenged regarding the significant shift in run rate (7 months to last 5 months), there were robust responses around plans, including surgery increasing activity and fill rates, medicine's acute frailty unit (albeit reinvested into elective), and generally the reduction in agency spend with controls, OSCI nurses qualified and recruitment of substantive roles. The Committee acknowledged the significant achievement to date and the determination to drive harder and faster to deliver the forecast, but with a gentle word of risk around the £2m shortfall on recurring CIPs moving into 24/25, based on £8.8m of recurrent this year.
- **Estates Strategy** – work is on track to delivery an Estates Strategy by March 2023, with the Committee asking for assurances around alignment of priority spends with the SFT operational and financial plans for 24/25.

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

- **Revenue Support** – the recommendation accepted by the Committee was to start the process for cash support in March '24 and April '25, with the need driven by the financial deficit position. This was commended to the Board after the meeting with approval given electronically enabling the process to commence. The approval is to be ratified at the Private Board meeting.
- **Capital allocation** – a recommendation was made to use capital slippage on planned projects to bring forward spend on priority medical equipment and other spend, which has already been approved through internal governance structures for spend in 24/25. The Committee supported the recommendations on the basis that these are "no regret" spends and will not add further burden to our capital prioritisation in future years.
- **Commercial Off the Shelf** - The procurement arrangement to bring Microsoft licences into this procurement route was supported by the Committee with a paper going to Private Board for approval.
- **Agency Nursing Preferred Supplier List** – The Committee supported the recommendation of 13 agencies, having taken assurance around the rigorous selection process, benchmarking, commercial benefits and the supplier quality and engagement process The paper is commended to

the Private Board for approval and while the primary drive is to reduce agency volume this also supports the drive to reducing agency cost.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.4
Date of meeting:	7th December 2023		

Report from (Committee Name):	People and Culture Committee		Committee Meeting Date:	26th October 2023
Status:	Information	Discussion	Assurance	Approval
	√		√	
Prepared by:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Non-Executive Presenting:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Appendices (if necessary)	N/A			

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

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

- Accommodation for staff remains a key area of concern in terms of our retention work (Long Term Plan and People Promise)
- Agency staffing costing more per unit therefore more reduction in usage required

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

- Work ongoing to embed the actions required to achieve the retention improvements required
- Improvement in medical appraisal, however still off trajectory
- Freedom to Speak Up report shows good access to the Guardian. Further work required to understand themes and what should be going elsewhere. Patient safety reporting will be forwarded to Clinical Governance Committee
- Remaining vacancies in the people team resulting in delays in meeting KPIs

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

- Good strategic focus on retention as part of the People Promise
- Staff survey responses tracking national average
- Progress reported in all 7 improvement projects underway

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

-

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.4
Date of meeting:	7th December 2023		

Report from (Committee Name):	People and Culture Committee		Committee Meeting Date:	30th November 2023
Status:	Information	Discussion	Assurance	Approval
	√		√	
Prepared by:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Non-Executive Presenting:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Appendices (if necessary)	N/A			

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

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

- Turnover remains over trajectory at > 14%
- Return to work interviews not done routinely. People team are supporting line managers with this
- Mandatory training and appraisal rates require further focus

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

- The CPO is actively involved in several system workstreams and projects - some are taking time to embed and progress
- Challenges in terms of medical education are capacity (space for training, admin and supervisor)
- Review of workforce numbers based on 19/220 baseline. Plan to increase number of bank staff to reduce agency spend

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

- Positive meeting with shift in several metrics e.g reduction in agency spend (nursing and medical staff), increase in recruitment (Vacancy rate below 5.0%) and subsequent increase in right staff in right place and care hours per patient day (CHPPD)
- Very positive report from the Director of Medical Education highlighting positive GMC survey results (top third nationally) and positive visits from Deanery and Foundation Programme teams. Described as 'the envy of others'. Physician's Assistants programme going well with good feedback.
- Positive team working supported by Improving Together methodology
- Good practice noted in relation to Exemplar site for People Promise – visit from NHSE due
- Good response rate to staff survey

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

- N/A

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.5
Date of meeting:	7 December 2023		

Report tile:	Integrated Performance Report			
Status:	Information	Discussion	Assurance	Approval
			Yes	
Approval Process: (where has this paper been reviewed and approved):	Lisa Thomas, Chief Operating Officer			
Prepared by:	Adam Parsons, Operational Performance Lead			
Executive Sponsor: (presenting)	Judy Dyos, Chief Nurse Officer			

Recommendation:

The Trust Board are asked to note the Trust's operational performance for Month 7 (October 2023).

Executive Summary:

October continued the trend of constrained capacity, as *Bed Occupancy* remained high, despite marginal decrease, at 98.7% with average LoS increasing to 8.96 days and No Criteria to Reside (NCTR) patients also persistently high, although slightly reduced, at average of 70 and both contributors to pressure which resulted in all escalation areas being opened at times during the month. ED performance declined in correlation with continuing patient flow issues, with *4-hour* standard decreasing again to 71.6% and *Ambulance Handover* average time increasing to 20 minutes.

However, overall discharges increased to highest level in 4 months at 944 and marginal gains can be attributed to the brilliant service change of SDEC, where appropriate patients are being triaged into dedicated areas for Acute Medical (AMU), Surgery (SAU) and Frailty (AFU), the latter of which moved to their new home in Durrington ward at the end of the October. These pathways are minimising impact on ED and the wider Trust, showing significant improvements in the proportion of patients treated with zero-day LoS: AMU >28% and SAU >65%.

Cancer performance continued to deteriorate, although pertinent to compare Trust position to that of the entire country, where *2ww* sits at 61.1% vs 74% (93% target) and *62-day* is now 48.6% vs 59.3% (85% target) to demonstrate that the Trust is not alone with this national concern. To address this growing backlog, the Trust has insourced additional capacity to run weekend clinics starting from November that will see and treat >400 patients, and improvement in performance is expected from M8.

Diagnostics remain a consistent shining light of performance, with sustained improvement in the *DM01* 6-week standard since the beginning of the year, now reaching 90.96% which is approaching levels of 2 years ago and more significantly, above the expectation by NHSE to recover to 85% by year end.

Breakthrough objective of reducing *Wait Time to 1st OP appointment* saw a reduction of 1 day in October to 131 days average and overall *RTT Waiting List* also reduced to 29,516 patients, although remains above plan and will become increasingly pressured into winter. Other breakthrough objective of *Reducing Falls* dropped to lowest level in 2 years at 5.5 which is a fantastic achievement and testament to focus. Further quality metrics were a contradiction, with *Pressure Ulcers* and *Serious Incidents* improving to 1.89 and 2 respectively, although *Stroke* performance and *Bed Moves* both declined to worst position in months at 31% and 3.28 respectively, with causes being flow, staff sickness and in the case of the latter, ward openings and relocations.

Salisbury NHS Foundation Trust

Workforce breakthrough objective of *Staff Availability* remained static for agency spend at 6.1% of gross pay, with all other related metrics consistent and most notably, Staff Vacancy rate being commendable for exactly this, holding below target of 5% for third month in a row.

Finance recorded an *Income and Expenditure* control total deficit of c£8.0m in M7 against a target of c£1.7m - an adverse variance of c£6.3m. The position is driven by the costs of Industrial Action (IA), enhanced care provided to patients, supernumerary cover for new and overseas staff and the residual gap on pay awards.

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

Integrated Performance Report

NHS
Salisbury
NHS Foundation Trust

October 2023

Summary

October 2023

Salisbury NHS Foundation Trust

October continued the trend of constrained capacity, as *Bed Occupancy* remained high, despite marginal decrease, at 98.7% with average LoS increasing to 8.96 days and No Criteria to Reside (NCTR) patients also persistently high, although slightly reduced, at average of 70 and both contributors to pressure which resulted in all escalation areas being opened at times during the month. ED performance declined in correlation with continuing patient flow issues, with *4-hour* standard decreasing again to 71.6% and *Ambulance Handover* average time increasing to 20 minutes.

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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
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NHS Foundation Trust

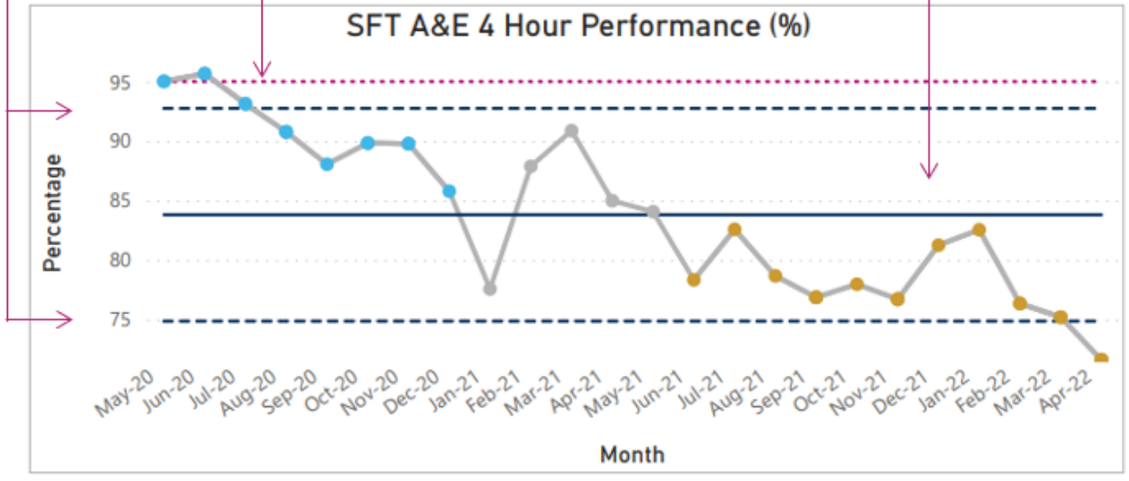
Reading a Statistical Process Control (SPC) Chart

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

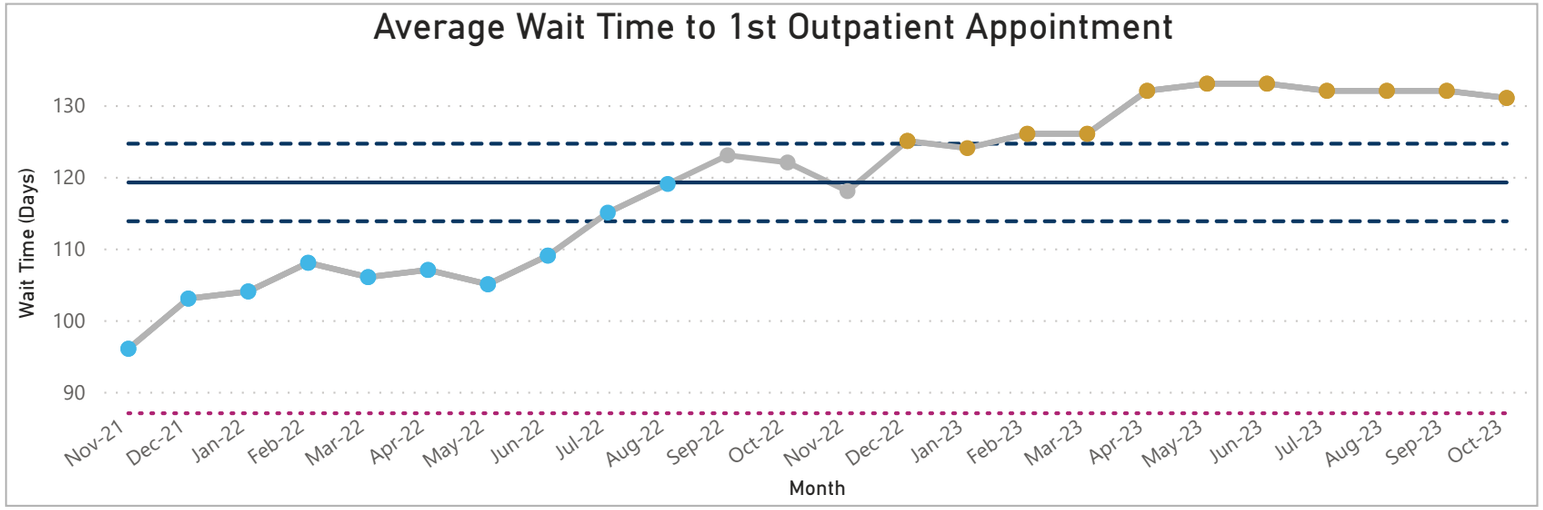
Partnerships

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 marginal improvement in performance at 131 down 1 day from 132 in September. However, the time to 1st OP Appointment has now been broadly static since a peak in July at 133, following a consistent deterioration from Nov 21 to April 23, and has only varied by a single day since. This should be viewed in context given the monthly loss of capacity / activity from the Industrial Action (IA) over the last 10 months. It is highly likely that the consequence of this IA will continue have an effect on performance going forwards as specialties address the resulting increased backlogs.

Whilst there was an improvement in Surgery and W&NB of 1 day, (138.71 and 124.65 days respectively) and 2 days in Medicine (117.86), CSFS experienced a further deterioration from 89 to 91.5 days, driven mainly by Chemical Pathology. However, the numbers compared to other specialities are relatively low and as such the Trusts aggregate position is broadly driven by a small number of key specialties: Oral (177), Gastroenterology (161), General Surgery (142), Gynae (124). ENT (149) and Plastics (147) are also significant contributors but are both seeing significant reductions in the last couple of months.

The Trust's focus remains on seeing patients in line with NHSE requirements. The impact of the IA has affected those patients with less clinical risk and therefore waiting longest. Increased levels of 2ww and Urgent referrals continue to challenge this position further.

Speciality huddles have been running for a number of months with benefits now being realised in a number of areas, including ENT & Plastics (as per above) and Cardiology (5 day reduction in average waiting time in month).

Actions (SMART)

- Changing primary care referral practices escalated to System and ICB colleagues, including commissioners for action.
- Weekly review of undated longest waiting patient by specialty with specific review on those patients awaiting 1st OPA - Progress reported to CEO and COO via summary updates.
- Cardiology Improvement huddles have reviewed clinic structure to enable protection of New patient appointment slots. Focused action is predicted to drive down routine wait times to 4 weeks by Oct 24.
- Plastics and ENT Improvement huddles both have Time to 1st OPA as a driver to focus on reduction of wait times. Their actions include: WL validation, clinically appropriate discharge of long-wait patients and clinic template reviews.
- Further rollout of specialty Improvement huddles (training and support required) to contribute to reduction in Time to 1st OPA.
- Specialty Managers and DDO's of challenged key specialties have been supplied with historic trajectories and booking performance to assist forward planning.
- Demand and Capacity support to Plastics and Gynaecology to be concluded, with further specialties to follow.

Risks and Mitigations

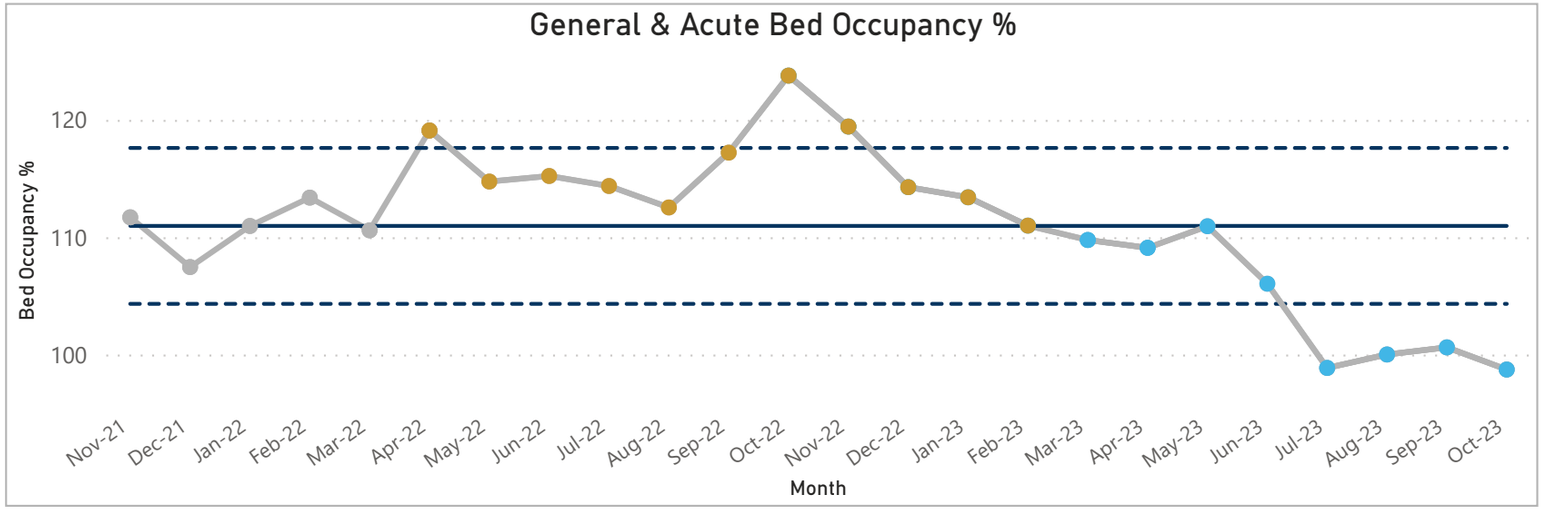
Limitations continue in relation to the Trust's ability to comprehensively map demand and capacity at a subspeciality / pathway level, however the performance team are supporting this work with the Divisions and specialities. Resource limitations at both DMT and Speciality level have been raised and 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. Locum Consultant started in Plastics, and has commenced an insourcing relationship with an external body '18wks' which is addressing the long waits in Dermatology. 18wks have been engaged to support further work across Plastics / Dermatology to improve the Skin cancer pathways.

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

Bed occupancy has decreased slightly this month to 98% from 100% in previous month.
Attendances to ED have remained very static.
Non-Elective (NEL) and Elective LoS increased this month to 9.2 and 4.3 days respectively. However, the number of patients going through SDEC on a zero-day LoS has increased this month to 28.4% for Medicine and is consistently high for General Surgery and Urology.
AFU moved at the end on the month, data will be avaiable in M8.
No Criteria to Reside (NCTR) numbers remain similar to previous months with little progress into reducing.
LoS from admission to being fit to be discharged continues to decrease and has come down from 11 days to 10 in one month.
LoS from patients being made NCTR to discharge on complex pathways remains static from last month.
System partners continue to see an increase in demand for P1 placements.
The time of day that patients are discharged continues to be a challenge with the peak discharge now being 17:00, the overall % discharged before midday increased slightly.
Total number of discharges for the month have risen again this month back up to numbers similar to M5 following the decline in M6.

Actions (SMART)

Work continues with specialist surgical teams to establish SDEC pathways for Trauma and Orthopaedics, Head and Neck etc.
AFU to move (end Oct) into Durrington ward which will support collaborative working with AMU and Medical SDEC.
Ongoing work with Radiology to ensure that NEL pathways are supported with the capacity that is required and all pathways are appropriate.
Discharge Hub - WH&C are recruiting into vacant posts for SFT inreach, Local Authority have completed a restructure to support specific capacity in SFT.
Discharge process working group established. Two forums set up to meet F1 and F2 junior doctors to talk through the challenges they have on a daily basis and try to understand why discharge planning does not have a priority for them.
Reset week being planned for early December, focus again will be discharge, completing tasks that are not usually BAU, such as OOA transport requests being managed by the transport office rather than the ward staff.

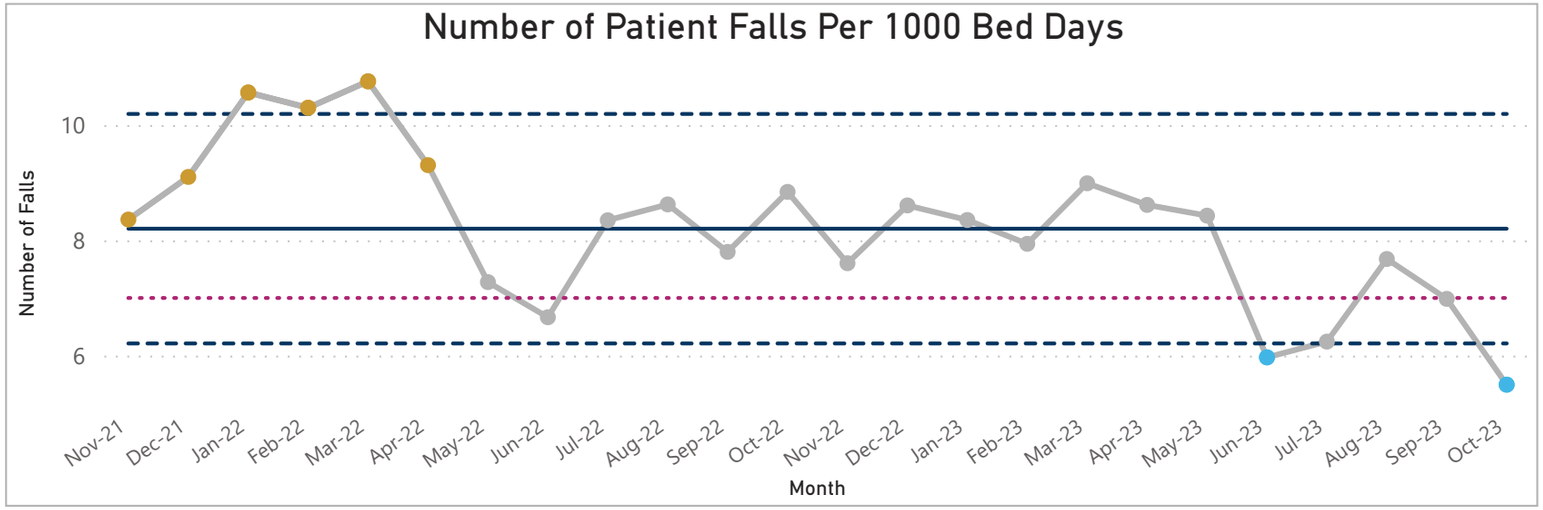
Risks and Mitigations

An increase in Infection Prevention Control (IPC) challenges such
as COVID or other will impact the ability to keep escalation areas closed. IPC will also impact staff available to work.
As winter approaches, operational challenges related to capacity are expected to increase - winter planning is under way.
Ongoing IA from various professional groups and unions reduces staff capacity to focus on the QI work aligned with Improving Together.

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

In October, falls reduced to 5.49 per 1,000 bed days which is a great improvement with a target of 7.

There was 1 inpatient fall with moderate or above harm.
• Subdural haemorrhage
This is a significant improvement compared to 5 falls with moderate harm or above in September.
Falls audit data continues to show improvements, 70% of wards (that have submitted their data) have a 90% and above compliance with falls risk assessments being in date and 90% of wards have a 90% and above compliance with accurate interventions being implemented.

Actions (SMART)

The Falls Workstream met towards the end of October in which we discussed implementation of the 'Hot Debrief' to be performed immediately after every fall.
We are working on improving the Falls risk assessment in ED. We are also bringing in the 'Think Yellow Scheme' which involves providing yellow socks and blankets to patients at high risk of falls to become easily identifiable. This has shown a significant decrease in falls in other settings. We have also begun Falls Reduction Training in ED.
Bay watch continues to be in use on Amesbury Ward, Farley Ward and Spire ward, with other wards beginning to get involved. Farley Ward showed a reduction in falls having had 13 falls in September, followed by 8 in October. We are carrying out Bay Watch training on Spire Ward in December. A bay watch job description has been created, ensuring all staff know what is required of them.
From December we will be rolling out Falls Reduction Training throughout all wards.
We now have a new Falls Reduction Facilitator working Thursdays and Fridays to give us a full week's service. This will enable us to get out onto the wards and deliver more education to staff.
We are working on developing the falls risk assessment to include a bed safety assessment.
Lying and Standing Blood Pressure (L&S BP) compliance is inconsistent, we are carrying out targeted training in M8.

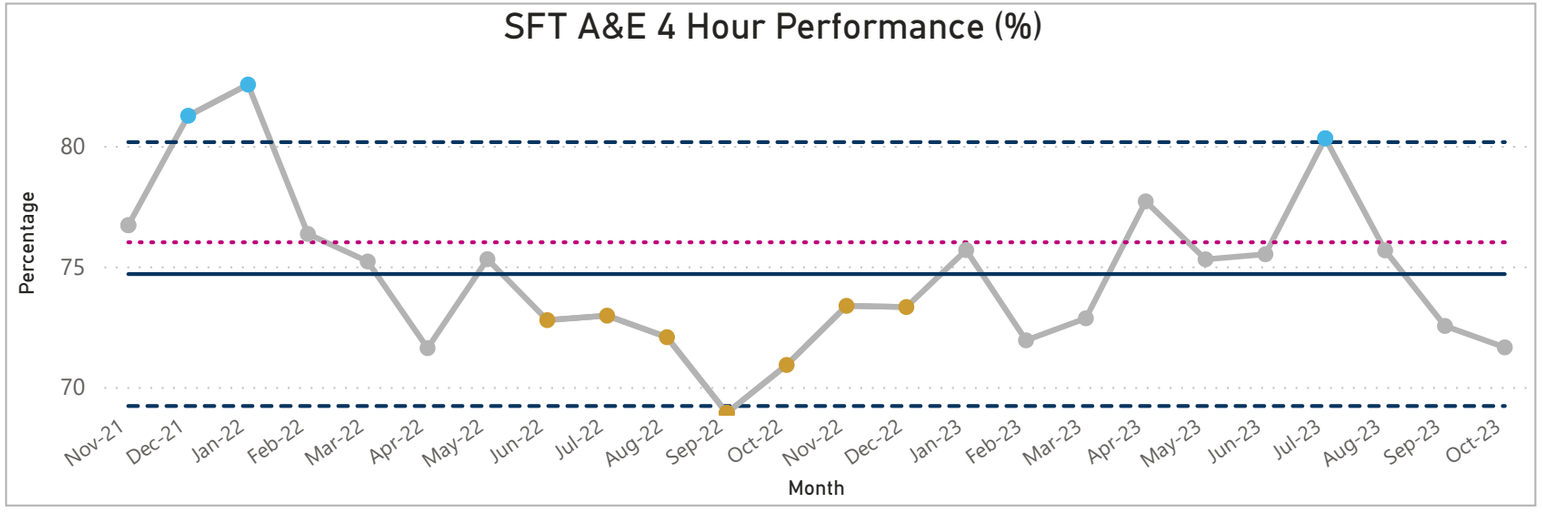
Risks and Mitigations

The winter months have consistently shown a rise in falls, with Falls Reduction Training being rolled out in December, The Think Yellow Scheme and risk assessment improvement we hope to reduce the number of falls over the winter period. There is still work to be done on L&S BP compliance, this will be covered in the Falls Reduction Training.

Emergency Access (4hr) Standard

Target 76%

National Key Performance Indicators



Performance Latest Month:	71.6%
Attendances:	6471
>12 hrs in ED Breaches:	43

Understanding the performance

M7 4-hour standard performance has just slightly decreased in performance by 0.9% to 71.6% compared to M6 of 72.5%. With overall attendances down by just 9 for the month with 6,471 attendances compared to 6,480 in M5.

Acuity of patients in M7 remained much the same as M6 with 52 Category 1 patients against 54 in M6 and a slight increase in Category 2 patients from 438 to 444.

M7 has seen a slight increase in the number of 12-hour breaches, 42 compared to 36 in M6. This is indicative of the difficulties the Trust experienced in M7 relating to Flow with the reopening of all Trust escalation areas at periods of the month. Type 1 4 hr performance saw a slight decrease to 58.4% from 59.6% in M6.

Spaces lost per day to patients with a DTA deteriorated by 0.4 to 5.9. As articulated by this figure, flow out of the department continues to be the biggest contributory factor to the failure of the 4-hour and 12-hour standard performance.

Average time to initial assessment again increased rising to 31 minutes compared with 28 minutes in M6. This remains a high priority on the Emergency Departments objectives.

Actions (SMART)

The Emergency Department have continued to push recruitment and have successfully recruited 0.61 WTE Band 7 and 5.28 WTE Band 6's having previously recruited into all Band 5 positions although over 50% of Band 5 nurses remain with little ED experience. An additional Band 6 practice educator will be in post from 4th December to support the skill deficit.
Band 2/3 vacancies remain at 1.5 WTE. One of the newly recruited Band 6's has transferred from Agency to a substantive position.

On 13th November the pilot to stream and Rapid Assessment and Treatment (RAT) patients at the front door starts which should see an improvement in time to initial assessment and treatment performance.

M7 saw a change in the process for handover for adult patients moving from ED with the introduction of an improved patient handover form. This has been found to be consistent, information is relevant and is a safer handover however it has not seen any impact on flow or bed availability in the Department.

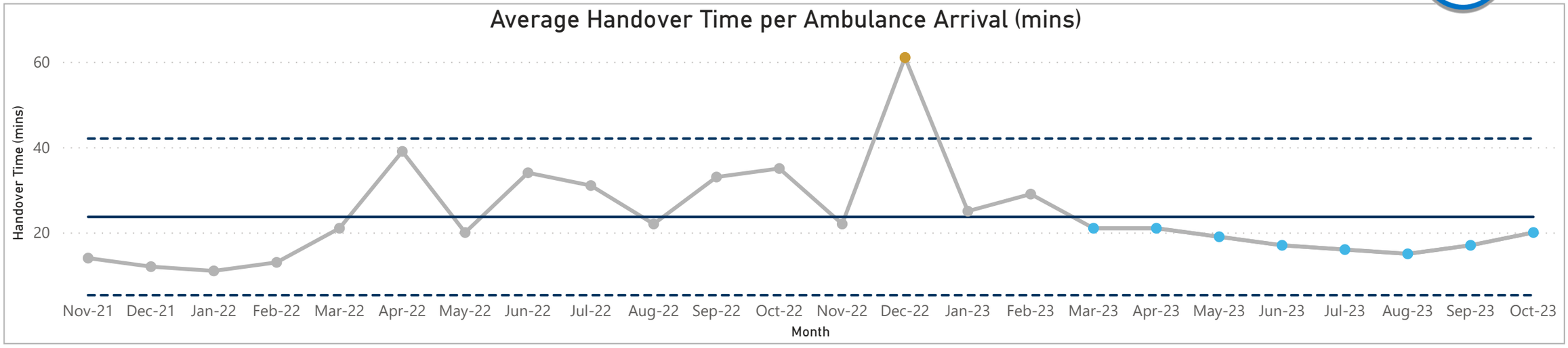
Risks and Mitigations

Timely flow out of the Department continues to impact 4- and 12-hour standard performance targets with high bed occupancy levels across the Trust continuing.
Unfortunately the re-opening of Whiteparish Ward following refurbishment did not have an impact on ED performance.

There remain significant gaps in the medical workforce with 3.2 WTE Consultant Gaps. The Senior Leadership Team continue to work on recruiting into these vacancies with interest from one CESR trainee and a further potential Consultant applicant.

Ambulance Handover Delays

National Key Performance Indicators



Understanding the performance

Patients arriving by ambulance slightly increased to 1,234 in M7 compared to 1,202 in M6 with handover times declining overall as below:

- Patients off loaded <15 minutes decreased to 81% (from 83%)
- Patients off loaded <30 minutes decreased to 81% (from 90%)
- Patients off loaded <60 minutes static at 93%

Delays correlate with NCTR patients and flow issues experienced in M7.

Actions (SMART)

The electronic ambulance service EPR system (Ortivis) was reconnected in M7 and is now fully running, alleviating administration burden and paper risk.

We are restarting our regular ambulance meetings with SWAST in M8 to discuss what has gone well, what has not gone so well and any upcoming changes along with the role of the Halo.

The pilot to stream and Rapid Assement and Treatment (RAT) patients at the front door (launching in M8) is expected to see an improvement in ambulance handover times.

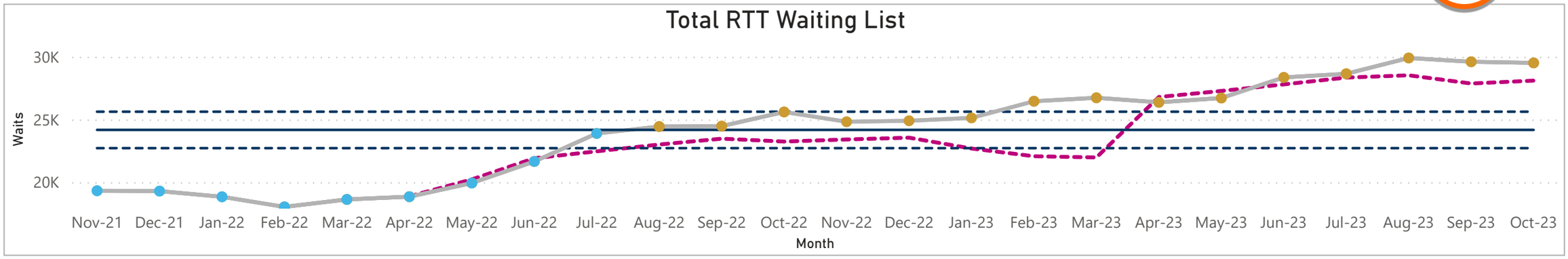
Risks and Mitigations

The HALO service vacancy will be improved in January with the recruitment of 1 WTE HALO provided by SWAST. SWAST continue to provide HALO support at times of surge when there is not a permanent HALO present, and the Emergency Department continues to work collaboratively with SWAST partners.

High bed occupancy levels and staffing challenges across the Trust, continues to result in poor timely flow out of the department, hindering capacity within the Emergency Department, with a loss of an average of 5.9 spaces per day in M7. This continues to be the biggest challenge in being able to offload patients swiftly and safely into the department. 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	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Longest Waiting Patient (Weeks)	87	83	85	73	75	76	75	76	77	243	200	194

Understanding the performance

The Total RTT Waiting List size position at the end of October is 29,516 which is a decrease of 91 from September (29,607), and second monthly reduction, albeit marginal, and remains behind plan.

Despite the second monthly decrease, there continues to be a limited number of specialties that account for a disproportionate percentage of the waiting list increase since April 2022. The top five specialties with the greatest increase in their respective waiting list all are: Urology (1st), Gynaecology (2nd), Plastics (3rd), General Surgery (4th), and ENT (5th). They collectively account for 53.6% of the increase in waiting list size since April 2022.

The Dermatology insourcing initiative continues to reduced pressure on the dermatology service. Plastics recruitment has been successful with a new locum and staff grade in post.

Given the 10 months of industrial action the growth in the waiting list size is not entirely surprising. However, the arresting this increase over the last two months irrespective of the quantum of reduction is broadly encouraging, and the recent announcements that IA will, in the short term be curtailed, augurs well for further reduction in the coming months.

Actions (SMART)

The largest proportion of the waiting lists remains within the non-admitted pathways. There are 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. Plastics.

A number of actions are planned to continue through November including:

- Monitoring of Long Waits to continue with a mirrored process for the 65ww target as was implemented for the 78ww in 2022/23.
- Focused speciality support to the most challenged specialties in the form of weekly huddles supported by the Transformation Team ongoing.
- Breast DIEP waiting list reduction.
- Dermatology insourcing to continue as per business case.
- Commence insourcing to support Skin service.
- Develop plans to improve clinical engagement in OPD Transformation.
- Agree agenda for Planned Care Board's workplan for the remainder of the financial year.

Risks and Mitigations

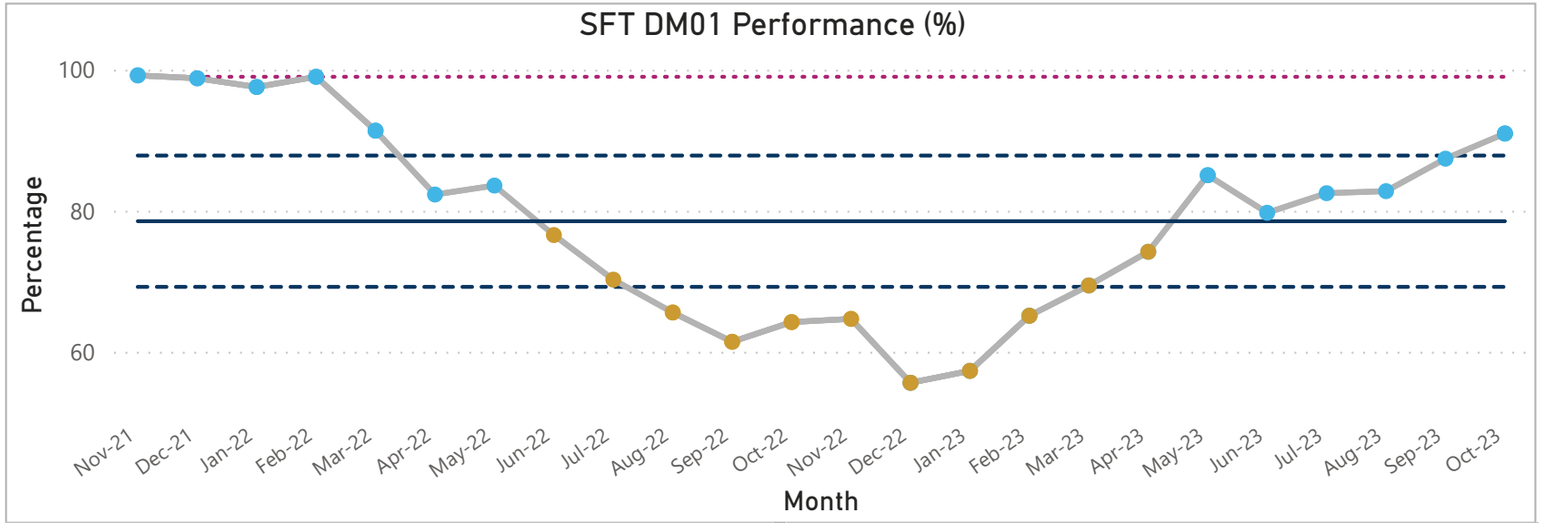
The risk of lost capacity owing to the IA remains and whilst mitigations are in place to support safety for those most clinically urgent patients, the volume of activity affected cannot usually be entirely mitigated, and many plans have now been stretched beyond that for which they were designed.

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 to continue through Q3 and into Q4.

Diagnostic Wait Times Performance (DM01)

Target 99%

National Key Performance Indicators



Performance Latest Month: 91.0%

Diagnostic Activity: 7438

	Performance	Breaches		Performance	Breaches
MRI	88.5%	42	CT	100.0%	0
US	98.7%	20	DEXA	100.0%	0
Audio	76.0%	183	Cardio	83.0%	53
Neuro	100.0%	0	Colon	71.9%	54
Flexi Sig	70.6%	20	Gastro	86.2%	13

Understanding the performance

DM01 performance continues to improve in M7, increasing from 87.39% in M6 to now 90.96% and ahead of Trust improvement trajectory position. Whilst this position represents an increased waiting list size (4,257 patients, increased from 3,932), it does also represent a reduction in the number of patients impacted by 'breach' of waiting time standard with 385 patients impacted in M7 as compared to 496 in M6.

The most significant improvement reported is within Audiology, with a reduction from 286 breaches in M6 to 183 in M7. Neurophysiology also restored there zero breach position following an unusual 'one off' month of reporting 21 breaches in M6 (due to staff absence).

Radiology, Cardiology and Endoscopy positions remain relatively stable although some small increases of breaches in Cardiology and MRI which will need to be closely monitored and understood to not cause future risk to the position (escalated to Divisional Manager for Medicine re Cardiology and DDO for CSFS will investigate the MRI position with Radiology - likely caused by Cardiac MRI capacity concerns).

Actions (SMART)

1) Explore and understand the MRI waiting numbers and confirm actions to reduce numbers waiting (likely to be Cardiac and can be positively impacted with second weekly list due online from January 2024)

2) Explore and understand the increasing Cardiology breaches (likely Transoesophageal Echocardiogram - TOE - related). This has been escalated to the Medicine Division for urgent resolution.

3) Continue with incentivised overtime within Audiology to further continue to restore compliance in this modality. Likely to be required at least until M10 to see complete improvement.

4) As numbers of breaches continue to reduce, ensure that modalities have focus on long waiter positions to ensure no over 13 week waiters by end of March 2024.

Risks and Mitigations

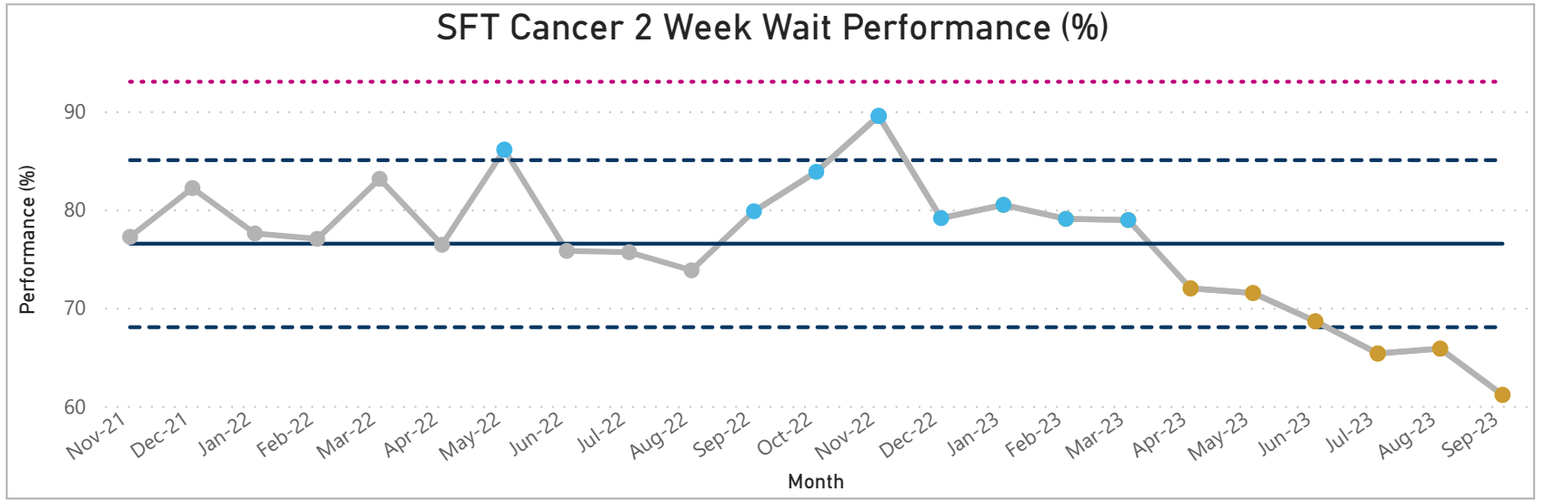
There is risk within Cardiac pathways in Radiology to be able to deliver the DM01 position in Cardiac MRI and Cardiac CT. Data requires review to ensure reporting is correct and capacity increases need to be explored (this will include options for outsourcing).

Continued fragility within the Gastroenterology service is making it challenging to reduce the overall numbers of 6 week breaches. Although, positively, the numbers of long waiters (those patients over 18 weeks) has reduced and has good oversight by the bookings team.

Cancer 2 Week Wait Performance

Target 93%

National Key Performance Indicators



	Performance	Num	Den	Breaches
Two Week Wait Standard:	61.1%	626	1024	398
Two Week Wait Breast Symptomatic Standard:	93.9%	31	33	2

Understanding the performance

The Trust continues to be challenged against the 2ww Performance in September. This position has been steadily decreasing since March as we have had challenges within the 2ww Suspected Skin Cancer Pathway and Suspected Colorectal Cancer Pathway. In September the reported performance for Skin was sat at 7.2% with 192 2ww Breaches. This has seen the Trusts overall performance decrease to 61.13%. The next lowest performing tumour site was Colorectal with a total of 126 2ww Breaches which resulted in their overall performance being 43.0%. The main reasons across both specialites was inadequate outpatient capacity which resulted in a total of 303 breaches.

Actions (SMART)

The Trusts 2ww position is monitored weekly within Cancer Improvement Group. We continue to engage with services to understand their plans for recovery and to gain oversight into the operational challenges.

Skin are currently in the process of booking the planned weekend waiting list initiative which will see 400+ slots become available over 4 weekends in November and December with a plan to recover the backlog position which has built up over the summer.

Colorectal have successfully recruited an additional CNS for Early Diagnosis which will help support the front end of the pathway. This funding is for 2 years and will help support triage of referrals and management of IDA patients. As well as this an Endoscopy pathway navigator which has had agreed funding to support the management of Endoscopy for 2ww patients to increase utilisation and oversight for Suspected Cancer patients. Colorectal have also applied for additional funding for 1 Locum Consultant to help support 2ww Activity. This is currently awaiting sign off but will increase capacity for 2ww Suspected Cancer outpatient activity

Risks and Mitigations

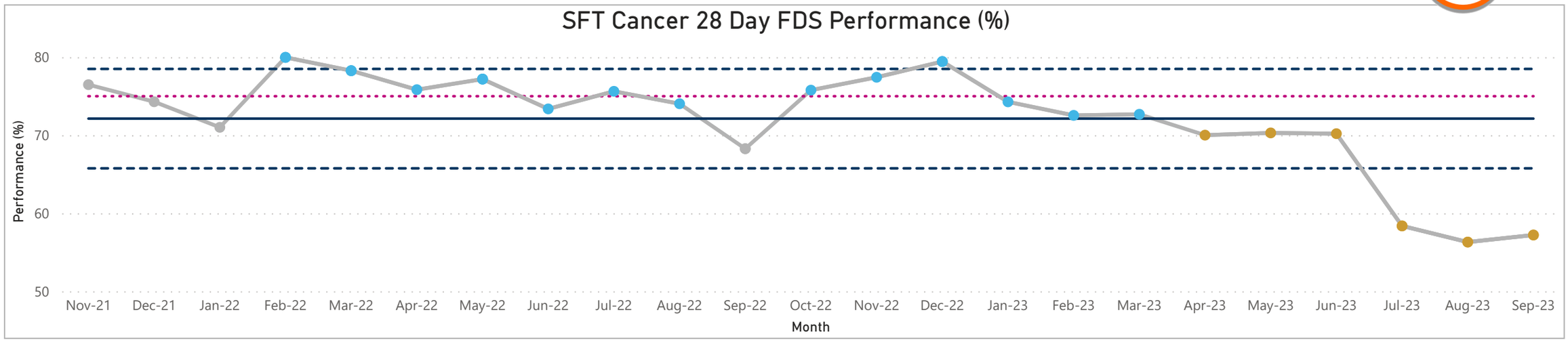
As of October 2023 we will no longer be reporting the 2ww Target externally. We will continue to monitor this target as it has a direct impact on the Trusts ability to succeed against the 28-day faster diagnosis standard.

The Trusts 28-day FDS target has been effected due to the delays in patients being seen for patients within the Suspected Skin Cancer pathway. This has been caused by patients waiting beyond 28 days to be given a decision to treat. The knock on effect of this will continue until the end of the quarter as Skin are regularly one of the tumour sites which are able to meet the FDS standard in previous months. After the waiting list initiative we are likely to see a drop in performance across 2ww and 28-day due to patients coming off the PTL in a failed position but we are anticipating this position to improve early into next year.

Cancer 28 Day Faster Diagnosis Standard Performance

Target 75%

National Key Performance Indicators



Understanding the performance

The Trust did not meet the 28-day FDS Standard in August reporting below the expected 75% at 57.21%. The challenges noted with the current Dermatology / Plastics are having a negative impact on the Trusts overall 28-day performance. Currently Skin is sat at 15.1% Urology continues to have challenges in the diagnostic element with Radiology and Biopsy dates being the main cause for their performance. We have also seen a drop in performance for Lower GI (LGI) - this is likely caused by the impact and loss of 2ww Capacity in July / August which has effected their 28-day performance, we have put an ask into the Cancer Alliance for additional locum funding to help cover the period of sickness within the substantive consultant team.

Actions (SMART)

The FDS Performance is monitored during the weekly cancer improvement group and performance is discussed at the bi-monthly cancer board and SLT, the last one being held in October.

The recruitment of the early diagnosis nurse for LGI will support their ability to ensure patients are sent on the correct pathway and are reassured more timely. Having the Early Diagnosis support the triage protocol for the rapid referral office should see a reduction in the number of investigations ordered which in turn will support the waiting list and capacity.

Risks and Mitigations

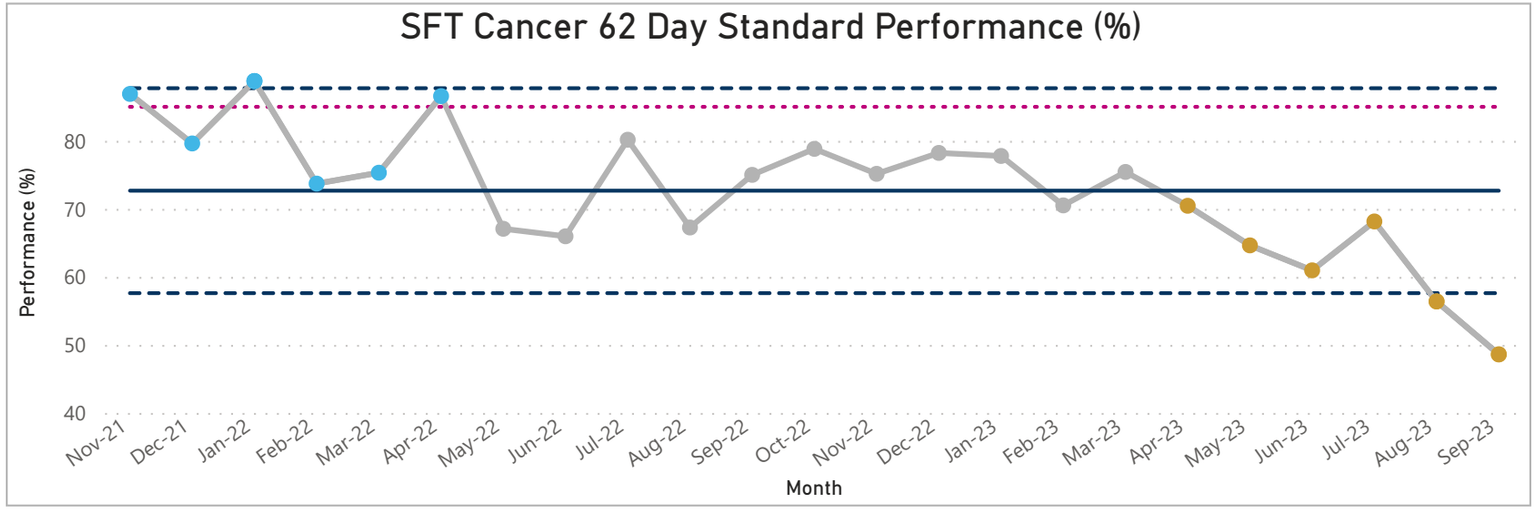
Skin FDS Performance continues to be a risk to the Trusts overall FDS compliance. Skin usually achieve 95% compliance against the faster diagnosis standard, this is due to patients being listed for surgery as a clock stop for faster diagnosis. Due to the capacity challenges within Plastics and the 2ww - the average wait to first seen is exceeding 28 days and slipping week-on-week. This is anticipated to improve from December onwards with the planned 4 weekend lists in November / December.

Colorectal PTL is currently growing due to lack of outpatient slots available for patients not appropriate for STT. We have asked the Cancer Alliance for funding to support a Locum Colorectal Consultant to provide additional cover in November / December.

Cancer 62 Day Standard Performance

Target 85%

National Key Performance Indicators



	Performance	Num	Den
62 Day Standard:	48.6%	35	72
62 Day Screening:	0.0%	0	1

Understanding the performance

The Trusts performance against the 62-day standard was reported at 48.61% the break down of breaches are shown below:

- Skin - 15.0 Breaches
- Urology - 7.0 Breaches
- Colorectal - 5.5 Breaches
- Breast - 3.0 Breaches
- Upper GI - 3.0 Breaches
- Gynaecology -1.0 Breach
- Haematology - 1.0 Breach
- Lung - 1.0 breach
- Head and Neck - 0.5 Breaches

The main themes for breach reasons were:
- Elective Capacity - 17.0 Breaches
- Complex Diagnostic Pathways - 10.0 Breaches
- Healthcare initiated delay - 2.5 breaches

Actions (SMART)

Skin have seen the impact in the drop in performance in June has consequentially impacted September 62 day performance with 15 breaches. This is due to the impact in June / July and we are anticipating a higher than usual number of breaches until the end of the year.

Colorectal's number of breaches has grown due to challenges within consultant availability due to annual leave / unavailability / sickness. The planned recruitment of the endoscopy business pathway navigator and early diagnosis nurse should help support the front end of the pathway which will support the back-end pathway allowing for additional time for clinical follow-up.

We have been sharing the breach reasons with operational teams through the Cancer Improvement Group after the monthly validation, rying to draw themes from the breaches to improve, this is ongoing and we will continue tobe monitored.

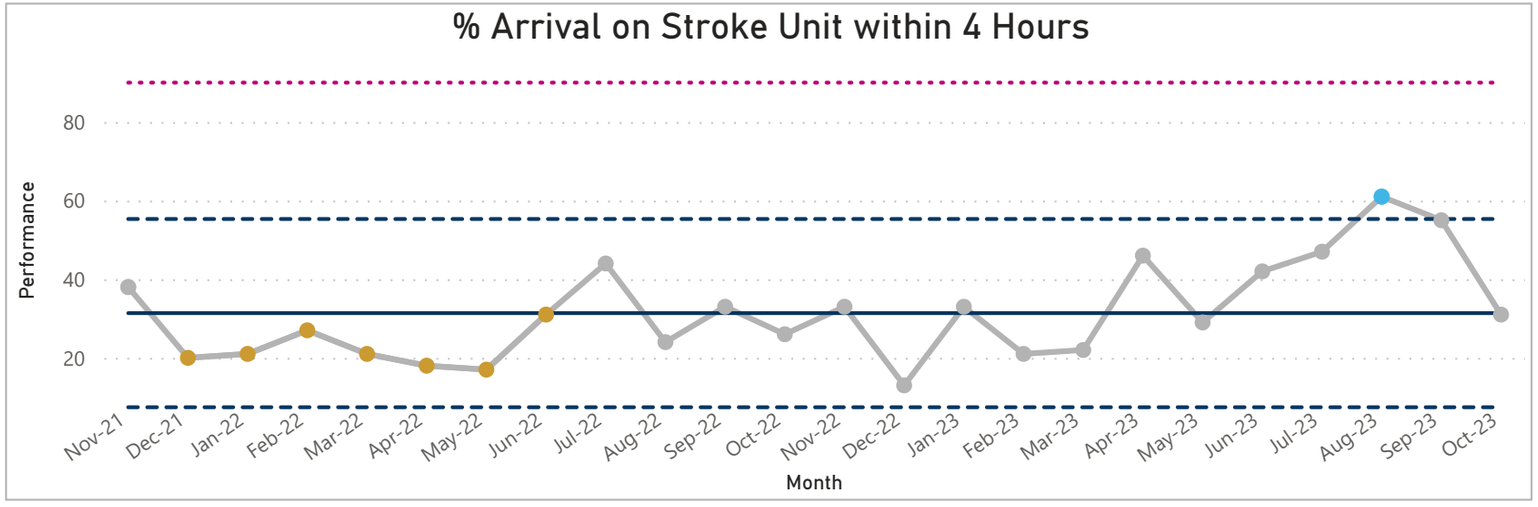
Risks and Mitigations

The Skin challenge continues to be a risk to the Trusts 62-day Performance as per above with the challenges within Skin. Patients are waiting longer for their first OPA which will subsequently delay their ability to provide a treatment within 62 days and put additional burden on MDT and Histopathology. We have seen this in September and from the waiting list initiative in November we are likely to see more patients requiring TCI's which potentially could result in breaches.

Radiology have drafted an escalation process which is currently undergoing review. This will allow us to escalate high risk patients for MDT / Treatments more timely as Radiology have seen increased waits over the summer period with a large cohort of outsourcing continuing. We are anticipating sign off of this process by end of November.

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
2022-2023	D	C	C	C
2023-2024	B			

Understanding the performance

M7 performance for the 4-hour target is at 31%, a significant reduction of 26% from M6. The drop in performance may be contributory to Doctor Strikes that took place in October along with high bed occupancy across the Trust. Staff sickness in M7 was high at 4.8% compared to that of 2.6% in M6.
M7 data identified 18 out of 26 discharged patients in M6 did not arrive to the Unit within target. Out of these 18 patients, 10 patients were awaiting beds when the ward was at full capacity, 5 patients did not meet criteria for boarding and 1 patient falling just 6 minutes out of target. 6 patients were late diagnosis due to Strokes being confirmed following CT / MRI 3 were out of target. There were 2 delayed transfers due to missing notes and late communication.
There were 49 diagnosed Stroke admissions in M7, of which 32 were out of target, consisting of 15 where ED not informing the Stroke Unit, 13 late diagnosis, 6 due to bed capacity, 1 due to staffing issue, 1 awaiting doctors review and 1 missing notes causing delay in diagnosis.

Actions (SMART)

The Stroke Unit is currently undertaking a PDSA (Plan Do Study Act) trial for 3 weeks across M7 and M8 with an additional B6 Nurse who is monitoring admissions through the Emergency department. The Stroke Nurse will follow patients through the Stroke pathway, along with monitoring triage at the Front Door to identify walk in patients presenting with Stroke symptoms. This will allow the Stroke Unit to identify root causes for the 4-hour performance target. Early data has already seen a marked improvement in the 4-hour performance target.
Senior Nursing team members visited the Stroke Unit at Bath Hospital in M8 as they have a continued high performance for the 4-hour target. Findings will be presented to the Stroke Senior Leadership Team.
The Stroke Unit continue with Improving Together methodology to ensure issues and driver metrics are discussed at huddles. A new Stroke Unit Service Manager started in M7 who will assist with continued improvements.
The Stroke Unit continue working on the average LOS, with a significant reduction of 3.9 days in M7 compared to 6.94 days in M6.
The Unit will now have a Band 6 nurse overnight to assist with skill mix and to help improve the 4-hour performance target and to oversee timely admissions out of hours.

Risks and Mitigations

High bed occupancy and operational pressures coming into winter may continue to impact on the 4-hour performance target. The ward will continue to ring fence a bed on the Stroke Unit, or when appropriate, using the GP assessment room whilst awaiting bed availability.
Training and shared learning with ED staff has now been delayed till M10 due to staffing levels and sickness.
The Stroke Unit will continue to monitor staff sickness.
There is still a vacancy for 1.0 wte Stroke Consultant, which is currently being backfilled with Locums.

Maternity

Are We Safe?

01/10/2023 <- Reporting Month (Input the first of the REPORTING month)

	SFT Assurance Dashboard	Guidance	Standard	RAG Target 2021-22 Q4	RAG rating calculation R	Red	RAG rating calculation G	Green	RAG rating Red	RAG rating Green	Improvement Direction	Rolling 6 months May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Rolling 6m average
Perinatal Morbidity and Mortality (M&M)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)			NA	>=	2	=	0	>= 2	= 0	Down	0	0	0	0	1	0	0.1667
	Number of stillbirths (>+ 24 weeks excl TOP)			NA					NA	NA	Down	0	1	0	0	0	0	0
	Number of neonatal deaths : 0-28 days			NA					NA	NA	Down	0.0	1.0	0.0	0.0	0.0	0.0	0.2
	Number of neonatal deaths : 0-28 days per 1,000 Live (Reg) Births	ONS	2.7 per 1000 live births	NA	>=	2.8	<=	2.6	>= 2.8	<= 2.6	Down	0.0	6.3	0.0	0.0	0.0	0.0	1.0
	Medical termination over 24 +0 registered			NA	NA	NA	NA	NA	NA	NA	Down	0	0	0	0	0	0	0
Maternal M&M	Number of Maternal Deaths			NA					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	NA	>=	9.2	<=	9.0	>= 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		NA	>=	2	=	0	>= 2	= 0	Down	0	1	0	1	0	1	0.5
Insight	Datix incidence SII	6 month SFT rolling		1	>=	2	=	0	>= 2	= 0	Down	0	2	0	2	0	0	0.7
	HSIB referrals	6 month SFT rolling		0	>=	1	=	0	>= 1	= 0	Down	0	0	0	1	0	1	0.3
	HSIB/NHSR/CQC or other organisation with a concern or request	6 month SFT rolling		0	>=	1	=	0	>= 1	= 0	Down	0	0	0	0	0	0	0.0
	Coroner Reg 28 made directly to trust	6 month SFT rolling		0	>=	1	=	0	>= 1	= 0	Down	0	0	0	0	0	0	0.0
Workforce	Obstetric cover - labour ward	RCOG guidence		40	<=	39	>=	40	<= 39	>= 40	Up	40	40	40	40	40	40	40
	Midwife to Birth ratio	RCM;NHSR;BR +	1.26	1.29	>=	1.28	<=	1.26	>= 1.28	<= 1.26	Down	1.31	1.29	1.30	1.30	1.29	1.29	NA
	Midwifery vacancy rate (black= over establishment; red =under establishment)			NA	>=	1		NA	>= 1	NA	Down	23.2	23.0	23.9	23.3	22.2	15.7	NA
	Provision of 1 to 1 care in established labour (%)	NICE, RCM, MIS	100%	100	<=	94	>=	100	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Datix relating to workforce	6 month SFT rolling		NA	>=	2	=	0	>= 2	= 0	Down	1	1	2	3	0	0	1.1667
	Compliance with supernumery status of the LW coordinator - %	NICE;RCM;NHSR	100% rostered	100	<=	94	>=	100	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Numbers of times maternity unit on divert	6 month SFT rolling		NA	>=	2	=	0	>= 2	= 0	Down	0	0	0	1	0	0	0.2
Involvement	Service user feedback : Number of Compliments	6 month SFT rolling		1		NA	>=	1	NA	>= 1	Up	22	3	1	0	28	3	10
	Service user feedback : Number of Complaints	6 month SFT rolling		NA	>=	NA	<=	NA	NA	NA	Down	2	0	1	0	1	0	0.7
	Number of SOX	6 month SFT rolling		8		NA	>=	8	NA	>= 8	Up	12	7	9	10	5	6	8

Understanding the performance

0 datix' relating to workforce
Rolling 6-month averages for mortality remain below national average.
Neonatal death of a baby in June* with a congenital abnormality that was incompatible with life (*NB artificially inflated rate as figure per 1,000 births).
Maternity service not diverted since August following the birth of 30 week triplets utilizing all available equipment and maximum capacity.
Nil SII's this month.

Actions (SMART)

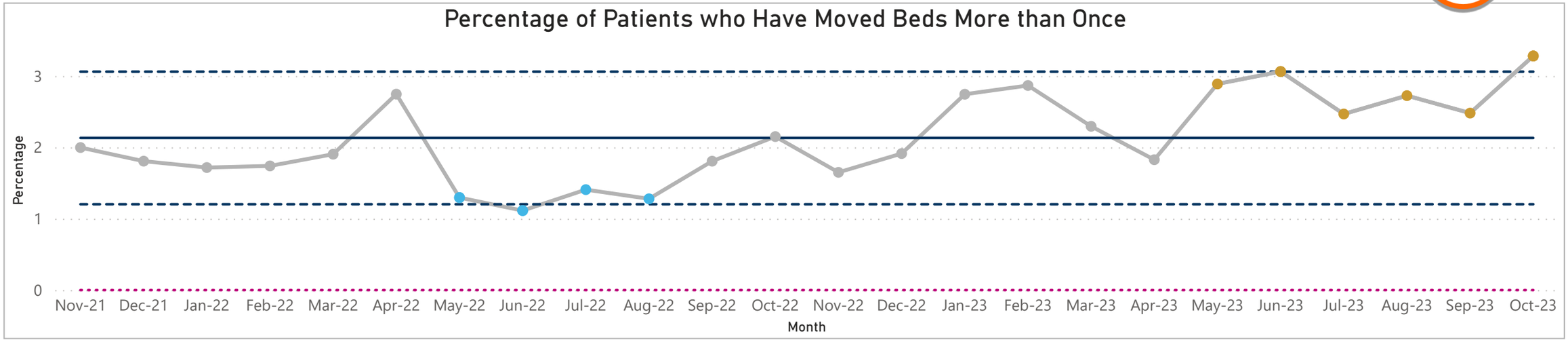
Targeted recruitment drive in place with welcome incentive.
6 Preceptee Midwives started during October 23, 4 pending, starting over the next 3 months
2 band 6 midwives commenced October 23

Risks and Mitigations

Midwifery staffing remains a risk, mitigated by long line agency usage, continuing at present due to vacancy numbers and delays in IA NMC PIN's.
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

The percentage of patients moved more than once has increased once again this month and is significantly higher compared to the same period last year.
Throughout October the sustained pressure on bed occupancy had a direct impact on the number of moves that a patient experiences within their inpatient stay. The use of escalation has a correlation of the number of medical outliers into surgery which then helps to generate acute capacity but results in an increase in number of moves.
October saw the reopening of Whiteparish ward and the ward swaps of Pitton to Durrington and the new location of AFU. To facilitate this, patient's were required to be moved into the right area for their episode of care which has increased the number of moves experienced.
There has been a continued pressure on bedding speciality patients within SSEU for prolonged periods.

Actions (SMART)

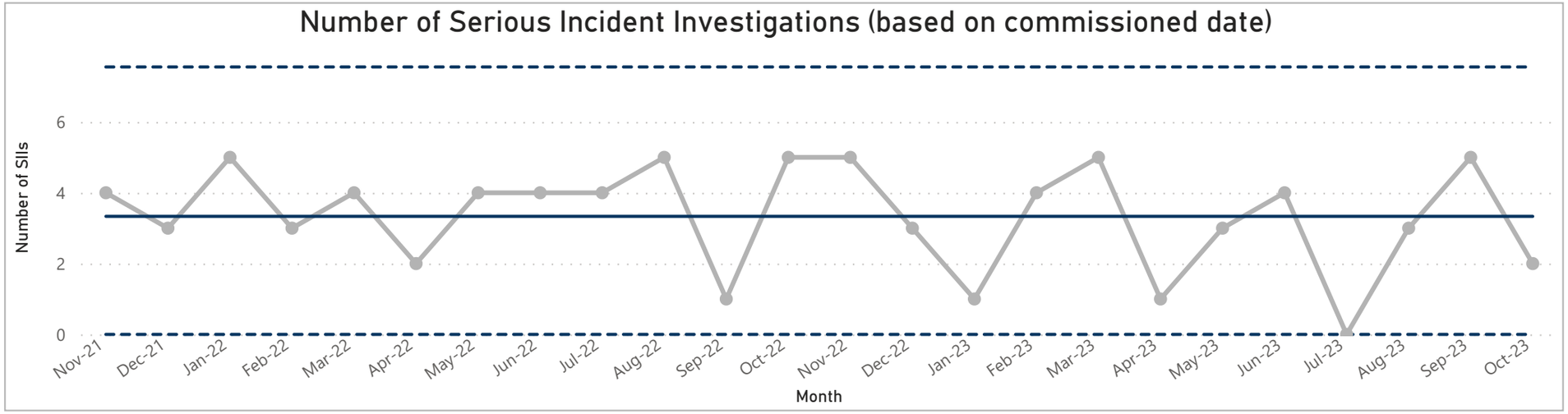
AFU has seen a positive reduction in LoS for frailty patients. This is the result of ongoing work with the teams to ensure that downstream movement of patients after 1-2 days stay on AFU to the most appropriate ward. Involvement with the AFU working group is ongoing, sharing concerns and positive outcomes for the patients.
There is continued work with the early identification and triaging of the patients being admitted via ED/ AMU / SDEC / SAU to ensure patients are transferred to the right ward on the first move.

Risks and Mitigations

To accommodate patients' needs in clinical speciality when the hospital is full requires prioritisation and movement.
Throughout October the Trust saw a rise in escalation beds and medical outlier patients into the surgical division to accommodate the increased operational pressures on the Trust's capacity.
There is a drive to ensure the Trust is in a reduced number of escalation beds and there is a focus on the discharge process and how the Trust can improve flow throughout each division to ensure patient moves are reduced going forward, especially over the winter period.

Incidents

Are We Safe?



Fyear	Never Events
2021-2022	3
2022-2023	0
2023-2024	2

Understanding the performance

There were 2 Serious Incident Investigations (SIIs) commissioned in October:

SII 598 - Discharge process on AMU
SII 603 - Delay to treatment

A reduction from last month (4 with one cluster investigation).

Actions (SMART)

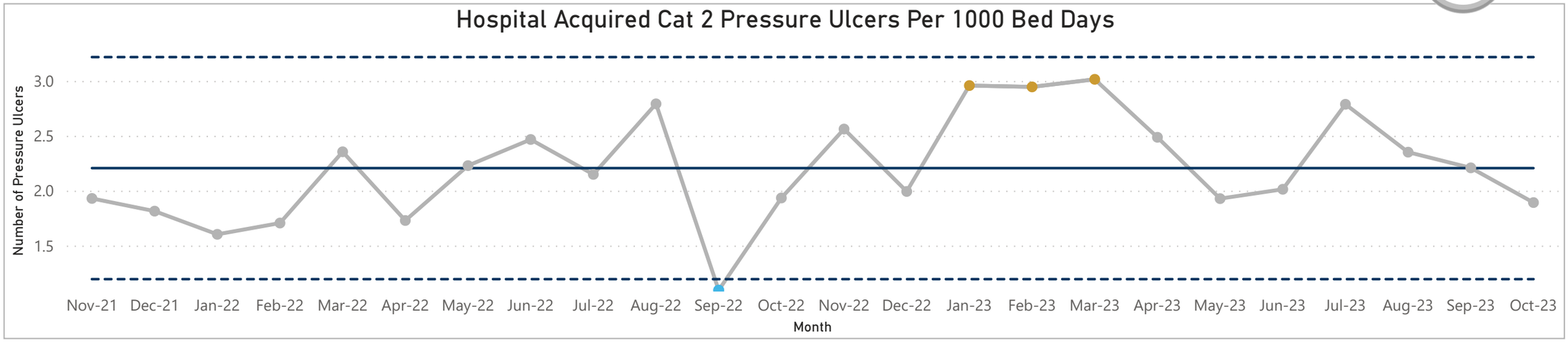
Investigate SIIs as per Trust policy, with those detailed underway and to continue through the month.

Risks and Mitigations

Once an incident has been identified and a 72-hour report completed, it is established whether there are any immediate saftey actions that need to be implemented or escalated straight away. On completion of the report, learning is cascaded through the intranet, Clinical Governance sessions, Patient Safety Steering group and dissemintaion to relevant staff via area leads.

Pressure Ulcers

Are We Safe?



Understanding the performance

35 Hospital acquired PUs in September.

• 27 Cat 2 PUs – Three of these were device related. This is a decrease in PU2 numbers from September.
• We have seen 5 DTI and 3 Unstageable PUs this month which is an increase from September. None of these are device related.
• No hospital acquired PU3 or PU4 in October.
• There was a reduction in pressure ulcers from the medical wards this month. Which also indicates an increase in pressure ulcers on surgical wards. The clinical support wards remained the same as September.
• There is also an increase in patients with hospital acquired MASD this month. This increase in numbers is seen in the surgical wards. There is a reduction in MASD from the Medical wards and a noticeable improvement from the CSFS division who only had 1 hospital acquired MASD reported.

46 Present on admission PUs In October 2023.
27 Present on admission MASD In October 2023.

Actions (SMART)

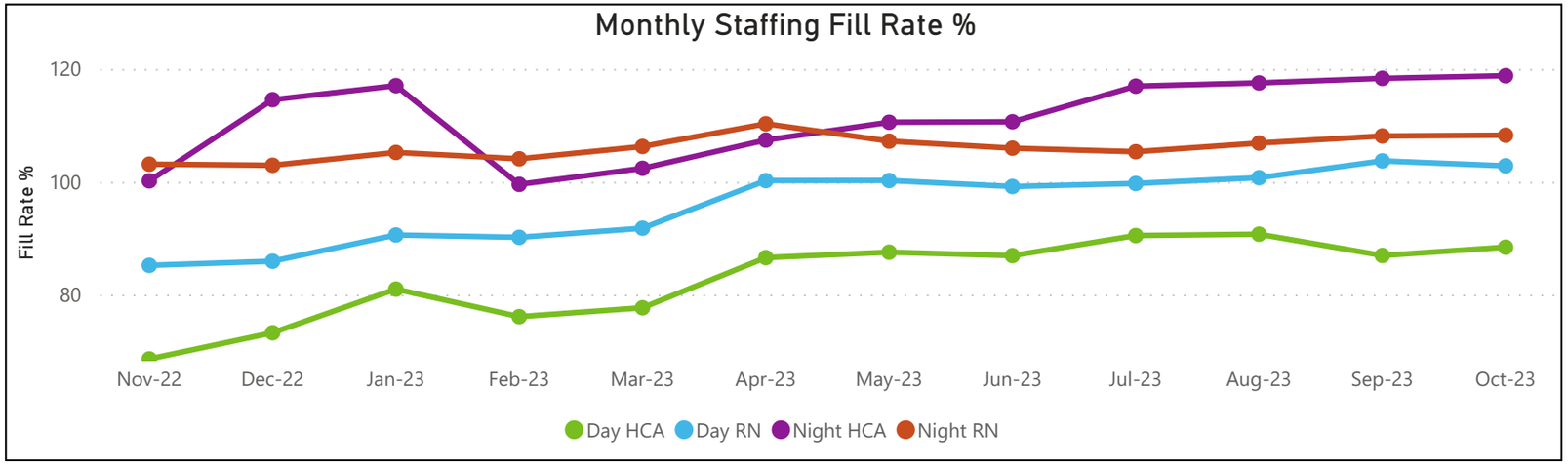
• We are continuing our work with the spinal education team. This is an ongoing project, we have now changed our weekly meetings to every three weeks to allow time for objectives to be worked on. We will continue to discus concerns and develop plans and offer support.
• The TVN team have started taking students on again. This was paused when the staffing levels were reduced due to long term sickness. We are happy to report that we have started taking students on for learning purposes during their training.

Risks and Mitigations

• The Trust will be participating with Worldwide STOP the pressure ulcer day on the 16th November. Directorate Matrons and the TV Team will be visiting the wards to promote additional pressure ulcer prevention using the aSSKINg (assessment, Skin inspection, Surface, Keep moving, Incontinence care, Nutrition, giving information) model.
• The aSSKINg care plan and the aSSKINg patient safety review form are both awaiting ratification. The plan is to start rolling these documents out on the 1st December 2023.
• The new Pressure Ulcer Prevention and Management Policy is waiting for ratification from Patient Safety Steering Group.
• TVN have secured funding from STARs for additional pressure relieving equipment. The off-loading products will be delivered to ED and inpatient wards following education and training, during the STOP the pressure campaign week.

Nurse Staff Fill Rate

Are We Safe?



Ward	Day RN	Night RN	Day HCA	Night HCA
Amesbury	97%	100%	91%	126%
AMU	98%	106%	72%	101%
Breamore	112%	111%	63%	150%
Britford	98%	105%	94%	94%
Chilmark	102%	103%	83%	97%
Downton	110%	132%	103%	139%
Durrington	111%	101%	73%	122%
Farley	106%	113%	101%	161%
Hospice	95%	101%	97%	104%
Laverstock	130%	146%	102%	85%
Longford	110%	108%	78%	90%
Maternity	82%	93%		
NICU	100%	99%	61%	
Odstock	106%	99%	107%	132%
Pitton	116%	121%	94%	142%
Radnor	90%	97%	76%	84%
Redlynch	99%	108%	95%	112%
Sarum	115%	138%	100%	
Spire	118%	117%	100%	162%
Tisbury	95%	100%	72%	95%
Whiteparish	135%	119%	95%	119%

Understanding the performance

All 4 markers continue to remain broadly static, normal variation. HCA day rate fill still under 100% - driven by areas such as critical care who only have 1HCA which they do not replace if unfilled, HCA vacancies and unfilled additional duties added for specials at ward level. If unfilled on roster they remain to demonstrate need was required but shift not filled.

CHPPD 8.1 in month (same as last month) and 7.3 (0.4 down) when excluding critical care and maternity excluded – this shift in CHPPD is then seen in the increased staff costs as less shifts go unfilled.

Actions (SMART)

Ward assistant project – KPIs from matrons awaited (data being collated)

IEN Recruitment – Sri Lanka visit completed, 15 nurses offered posts, ongoing project to establish future partnership working

Business cases for RNDA, Nurse associate to RN business cases approved in principle but being taken to system financial recovery group – remains with exec team with no update. First appointments made under Return to Practice business case.

Trailers obtained to use as training hub to bring OSCE training back in house (saving £800 per candidate) – expected launch in October – still awaiting trailers but change in process commenced.

Work on A3 for enhanced care and RMNs – meeting dates planned for September.

Ongoing work with partners on opportunity for mental health support worker to replace some RMNs – led by AWP.

Risks and Mitigations

Ongoing turnover for HCAs and RNs exceeds starters (risk)

Increase demand for patients requiring RMN support (risk)

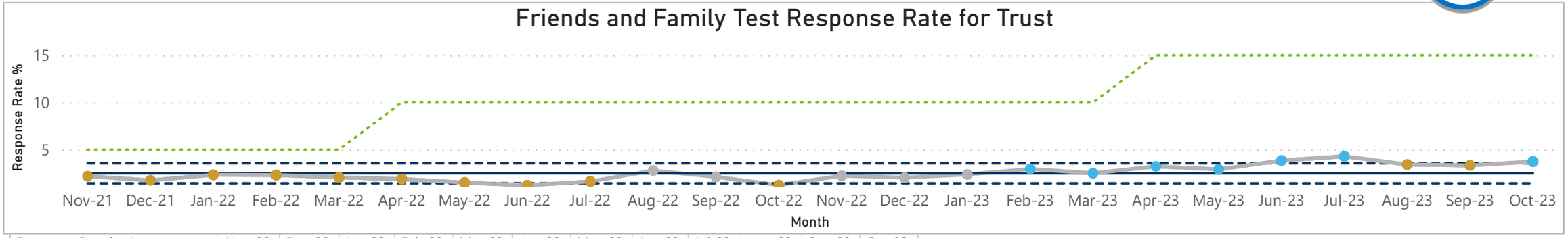
Additional beds utilised which are reliant on temporary workforce and not in establishment (risk)

Domestic and international recruitment campaigns (mitigation)

OD+P led work on retention, turnover and inclusion (mitigation and risk)

Friends and Family Test Response Rate

Our Care



Response Rate by Area	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
FFT Response Rate - A&E	1.1%	0.3%	0.8%	1.6%	1.0%	0.6%	0.6%	0.8%	1.1%	0.8%	0.6%	1.0%
FFT Response Rate - Day Case	2.5%	1.4%	0.3%	2.0%	2.5%	3.4%	4.2%	6.4%	6.6%	3.5%	5.8%	4.1%
FFT Response Rate - Inpatient	10.5%	5.8%	11.5%	13.0%	3.2%	14.5%	12.9%	17.1%	28.4%	20.5%	33.7%	24.0%
FFT Response Rate - Maternity	0.0%	2.6%	2.2%	3.7%	1.4%	0.0%	0.5%	0.0%	0.0%	0.9%	1.0%	2.9%
FFT Response Rate - Outpatient	1.6%	2.0%	2.0%	2.2%	2.1%	2.5%	2.3%	2.6%	2.2%	2.2%	2.1%	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 Areas are encouraged to offer feedback forms to patients at discharge or during their stay. Weekly emails are sent to leads showing feedback received in the previous week, allowing them to pick up any immediate causes for concern and mitigate these where possible.
Negative feedback should be reviewed by the ward / area regularly and formal reporting bi-annual is provided by PALS, to the Patient Experience Steering Group.
FFT response figures have largely increased, and staff are still being encouraged and reminded to offer FFT through the PALS outreach services. This remains the sole method of obtaining responses and this will mean inevitable fluctuations in activity.
Cards have gone to all areas and offer free postage. Gender options have also now been extended in line with national guidance.

Actions (SMART)

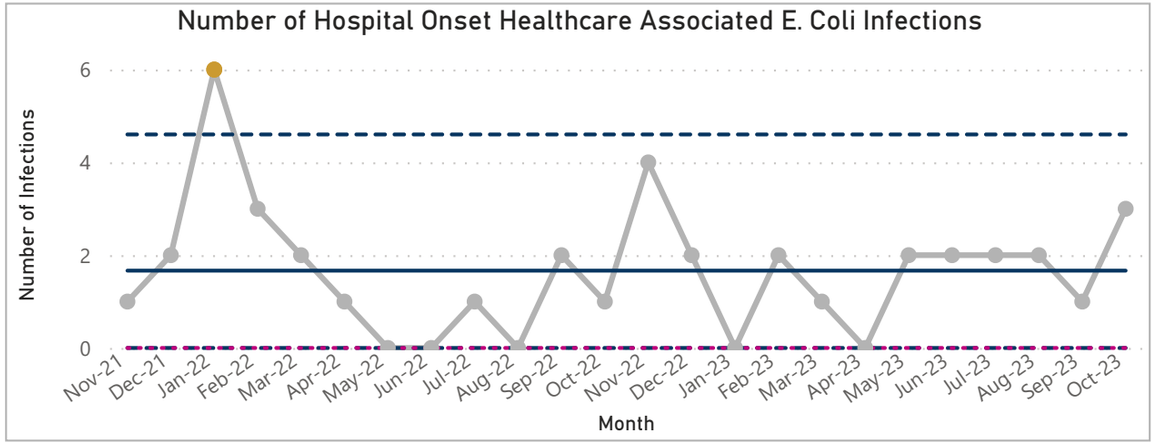
Delay in the rollout of digital provider was taken in November 2022, postponing this until December 2023.
This solution would facilitate an SMS option in a bid to increase responses rates, particularly in Outpatient areas and ED. It would also meet accessibility requirements with a new online form and digital dashboard.
Interim actions were taken to develop the digital dashboard in the interim. This will be loaded with retrospective data to allow insight and analysis of FFT comments. This will not have any impact on response rates. This month we saw a high response rate across Inpatient, Day case and Outpatient areas and hope this will continute to improve monthly.
Concentrated efforts to promote adoption of FFT has been communicated via PALS Outreach visits,
helping to demonstrate to staff the importance of promoting
this to patients as a way to hearing their views and gathering
feedback on their services.

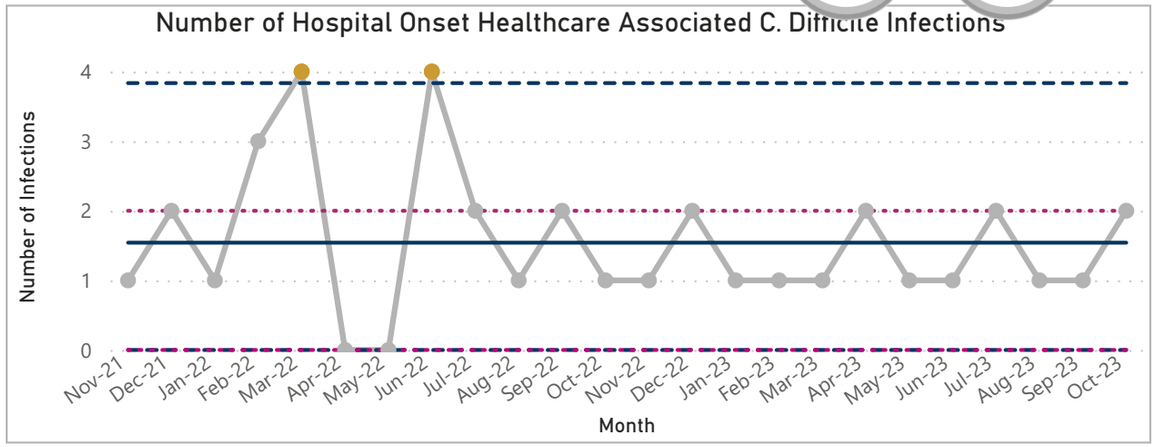
Risks and Mitigations

We anticipate that the new dashboard will further increase this as we will be in a position to draw themes and insights from these comments. We are currently working with the new digital provider on the data analysis dashboard and we hope to be in a position to analyse and theme the comments we collected during Q1 and Q2 showcasing these through the Divisional Governance structures and Patient Experience reports. These mitigations are unlikely to have any impact on response rates but will significantly improve our data quality and therefore the insights we draw from this feedback. We hope to have the dashboard populated and begin extractions from this Autumn, and plan to introduce this reporting within the Patient Experience Reporting from Q3. Response rates are noted to have reduced this month, this could be owed to a delay in collation of the FFT cards owed to volunteering resource not being available for data entry (they were on holiday). This is a known risk to the data collection and entry, this delay in response input cannot be mitigated until the new digital provider is fully adopted where these gaps can be supplemented with a courier service collection and data entry services, which they also provide.

Infection Control

Are We Safe?





Understanding the performance

There has been three hospital onset healthcare associated reportable E.coli bacteraemia infections, and two hospital onset healthcare associated reportable C.difficile cases this month. There has been no hospital onset healthcare associated MSSA bacteraemia infections this month.
A period of increased incidence (PII) of C.difficile was declared for a medical ward during the month.
The Infection Control Nurses (ICNs) continue to undertake 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	5
MRSA Bacteraemia Infections: Hospital Onset	0	0	0

Actions (SMART)

Advancement with an alternative approach for staff in ward areas to complete hand hygiene education and assessments continues within surgery, and has commenced in medicine under the direction of the Operational Matrons.
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. The divisions are monitoring those areas that have produced action plans. 'Share & Learn' meetings continue, using the new divisional format.
Involvement with BSW collaborative workstreams. Feedback communicated from sessions has been shared at the SFT Infection Prevention & Control Working Group as part of a standing agenda item.

Risks and Mitigations

Slow progress with rolling out the alternative hand hygiene assessment method within medicine.
Band 6 nurse started in post at the end of the month, commencing orientation programme.
Ongoing clinical and non-clinical workload for IPC nursing team continues to have an impact on ability to progress other HCAI prevention work e.g. policy reviews / development, and innovation activities.
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 were published in May 2023).

Mortality

Are We Safe?

Metric Name	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-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Crude Mortality	79	94	86	84	84	88	84	77	88	82	73	75	77	102	106	88	95	81	89	51	60	78	55	79
HSMR District Hospital (excludes deaths recorded by Salisbury Hospice)	106.41	105.02	99.28	102.37	104.12	108.04	109.81	110.84	112.65	114.18	114.57	116.02	115.93	115.08	115.20	114.30	115.64	114.45	114.46					
HSMR Trust	116.13	118.21	106.53	108.89	110.50	113.70	114.89	116.37	117.91	119.69	120.07	121.88	121.84	121.67	122.37	121.63	122.44	122.18	123.03					
SHMI District Hospital (excludes deaths recorded by Salisbury Hospice)	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	107.71	108.68	108.40	109.89	111.72					
SHMI Trust	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	112.92	113.77	113.65	115.19	117.05					

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 ending in May 23 for Salisbury District Hospital is 111.72.

The HSMR for the 12 month rolling period ending in May 23 for Salisbury District Hospital is 114.46.

Actions (SMART)

The Trust Board have commissioned a review of our mortality governance processes to ensure that we are taking all reasonable steps to understand and act on the significant and sustained change seen in the Trust's statistical mortality model benchmarking.
Low coding of comorbidities may be resulting in a higher-than-expected number of deaths. We are prioritising coding of patients who die and improving coding of patients' comorbidities.

A data insight report is provided by Dr Foster and reviewed at each Mortality Surveillance Group (MSG) meeting and contains peer comparison data. There have been no obvious patterns or themes suggesting significant deficiencies in care from recent reviews although a general increased in patient frailty at the point of admission has been noted. A regional mortality summit is being established to help provide us with further context in regards to our mortality data. Data suggests that there is a lower overall mortality rate for the region as a whole when compared to national figures.

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
Ambulance Handovers 60+ mins	84	128	133		0		Special Cause Improving - Run Below Mean	X	31
Cancer 31 Day Performance Overall	96.4%	97.3%	90.5%		96%		Common Cause Variation	X	1
Cancer 62 Day Screening Performance	75.0%	88.9%	0.0%		90%		Common Cause Variation	X	13
Complaints Acknowledged within agreed timescale %	24.0%	48.0%	60.0%	90.0%				X	31
ED 12 Hour Breaches (Arrival to Departure)	47	36	43		0		Special Cause Improving - Run Below Mean	X	31
ED Attendances	6320	6480	6471				Special Cause Concerning - Run Above Mean		
Inpatients Undergoing VTE Risk Assessment within 24hrs %	37.1%	33.5%	33.6%		95%			X	31
Mixed Sex Accommodation Breaches	12	19	22	0	0		Special Cause Improving - Run Below Mean	X	14
Number of High Harm Falls in Hospital	4	6	2	0	0		Common Cause Variation	X	14
RTT Incomplete Pathways: Total 52 week waits	1290	1291	1259	810	0		Special Cause Concerning - Above Upper Control Limit	X	10
RTT Incomplete Pathways: Total 65 week waits	225	300	296	120	0		Special Cause Concerning - Above Upper Control Limit	X	2
RTT Incomplete Pathways: Total 78 week waits	15	15	20	0	0		Special Cause Improving - Below Lower Control Limit	X	3
Total Incidents (All Grading) per 1000 Bed Days	60	57	59				Special Cause Concerning - Run Above Mean		
Trust Performance RTT %	61.3%	60.2%	59.1%		92%		Special Cause Concerning - Below Lower Control Limit	X	31

Watch Metrics: Alerting Narrative

Quality of Care, Access and Outcomes

Understanding the performance

Ongoing challenges in reducing the longest waits for elective care continue to alert, with a slight increase in the number of patients waiting over 78 weeks, and only small reductions in the number of patients waiting over 52 and 65 weeks.

Cancer performance remains under pressure, with all metrics except 2ww breast performance alerting. The significant deterioration in the skin performance remains the biggest contributor to overall Trust performance.

There was an increase in the number of ambulance handovers waiting over 1 hour, although this did improve in the second half of the month, with an average handover time under 18 minutes.

There has been consistent improvement over the last 3 months in the percentage of complaints responded to within agreed timescales from 24% to 60%.

Actions (SMART)

Agreement to curtail IA in the short term will provide some opportunity to prevent reductions in elective and outpatient activity with the effect of reducing the number of patients in the long waiting groups.

A skin insourcing arrangement will commence in M8, with the expectation of restoring Trust level performance against the 28-day cancer Faster Diagnosis standard and the number of patients waiting longer than 62 days for treatment to plan levels by M11.

A pilot to stream and rapidly assess all patients arriving in the Emergency Department will commence in M8. This will improve safety and enable ambulances to be offloaded more quickly, ensuring consistent flow out of the department into the hospital will be critical to stop delays occurring.

Risks and Mitigations

With current IA suspended the risk of reduced activity has lessened, however until a formal resolution is agreed ongoing action remains a key risk.

Staffing pressures in areas with small teams remain vulnerable, and areas with particular constraints such as Plastics and Gastroenterology are fragile. Robust oversight of areas affected by this is in place, with external support insourced to support cancer pathways where appropriate.

High occupancy levels in the Trust can cause delays in being able to flow from the Emergency Department into the hospital, with delays offloading ambulances at times as a result of this. Improvement actions such as a new rapid assessment process in ED, and SDEC pathways are helping to mitigate the risk. High levels of patients in the hospital that no longer meet the criteria to reside continue to increase pressure on occupancy and flow.

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
Average Patients with No Criteria to Reside	89	86	83	111		L	Special Cause Improving - Below Lower Control Limit	✓	0
Cancer 2 Week Wait Breast Performance	90.0%	93.5%	93.9%		90%	H	Special Cause Improving - Above Upper Control Limit	✓	0
Diagnostics Activity	7482	7206	7438	6961		H	Special Cause Improving - Run Above Mean	✓	0
Neonatal Deaths Per 1000 Live Births	0	0	0		0		Common Cause Variation	✓	0
Pressure Ulcers Hospital Acquired Cat 2	33	30	27				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 3	0	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	1.1%	0.8%	0.9%			L	Special Cause Improving - Run Below Mean		
Serious Incident Investigations	3	5	2				Common Cause Variation		
Stillbirths Per 1000 Total Births	0	0	0				Common Cause Variation		
Stroke patients receiving a CT scan within one hour of arrival	65.0%	73.0%	62.0%		50%		Common Cause Variation	✓	0
Total Incidents Resulting in High Harm (Mod/Maj/Cat) %	2.5%	2.7%	2.7%				Common Cause Variation		
Total Number of Complaints Received	9	16	17				Common Cause Variation		
Total Number of Compliments Received	86	13	29				Common Cause Variation		

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

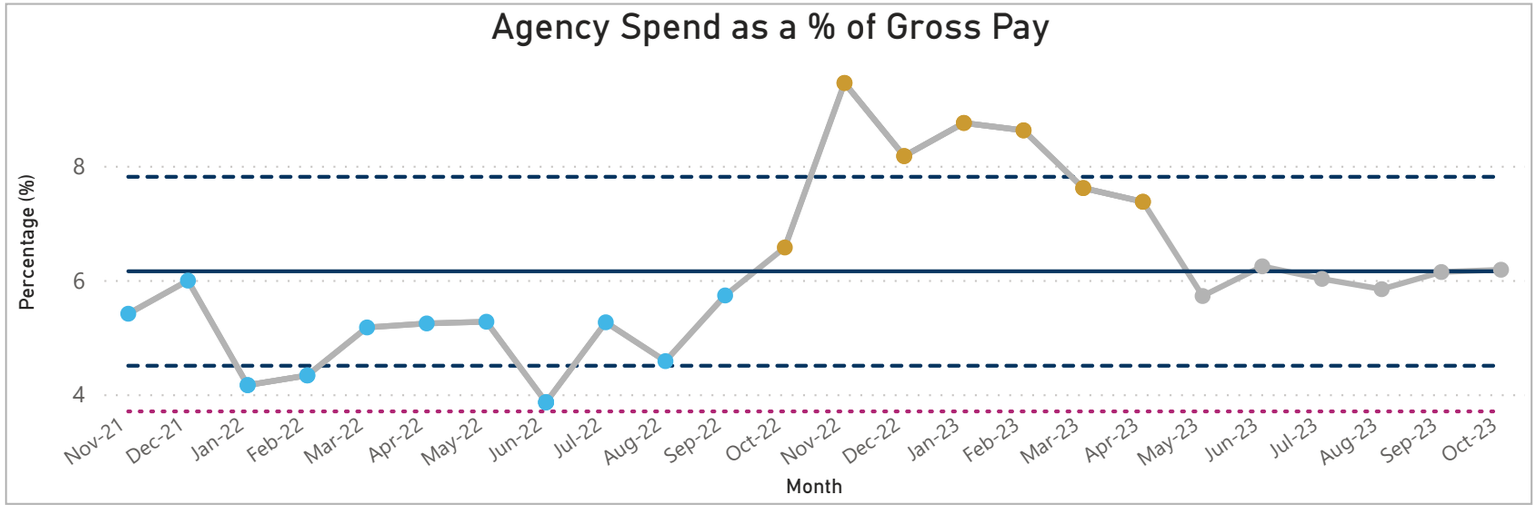
Partnerships

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 reduced from £1.16M in Sep to £1.12M in Oct 23, but this represented an increase in % spend against the total bill from 6.14 to 6.18% because of a c£800k reduction in substantive spend in October. Spend against nursing has again reduced to £522K, the lowest level for 12 months, and now representing c47% of all Agency spend. Medical costs have dropped to 33% of spend at c£375k, still higher than the 6-month average of £267k. A rise of £40k against other clinical staff (a 40% increase) and £40k on Infrastructure staff (a c200% increase) is unwelcome and will be tracked in coming reports. Estates and infomatics provided the greatest spike in the infrastructure staff spend.

W&NB spend has declined to historical levels following last months spike. Medicine is the worst performing division proportionally at 10.1% of their pay bill, but theatres provided the largest spend, accounting for nearly 10% of all Agency spend.

Actions (SMART)

Temp Staffing Grip and Control. The implementation of weekly meetings to generate a forward look on Agency spend in Nursing appears to be having some success in reducing spend. Similar work is being undertaken by the medical staffing team to enable improved control of medical agency spend. Agreement at system level to collaborate on medical bank and agency rates.

Establishment Control: Establishment control work will be aligned with monthly meetings to manage establishment against budget, conducted through Finance and HR Business Partners for each division.

Bank Staff: Recruitment campaign to improve Nurse and HCA staff bank numbers is underway.

Risks and Mitigations

Corporate Risk – Sustainable Workforce
Mitigations:

Line Managers insufficiently trained to support people promise and absence management initiatives – Leaders training now established at 2 levels, with management training interventions designed and in place.

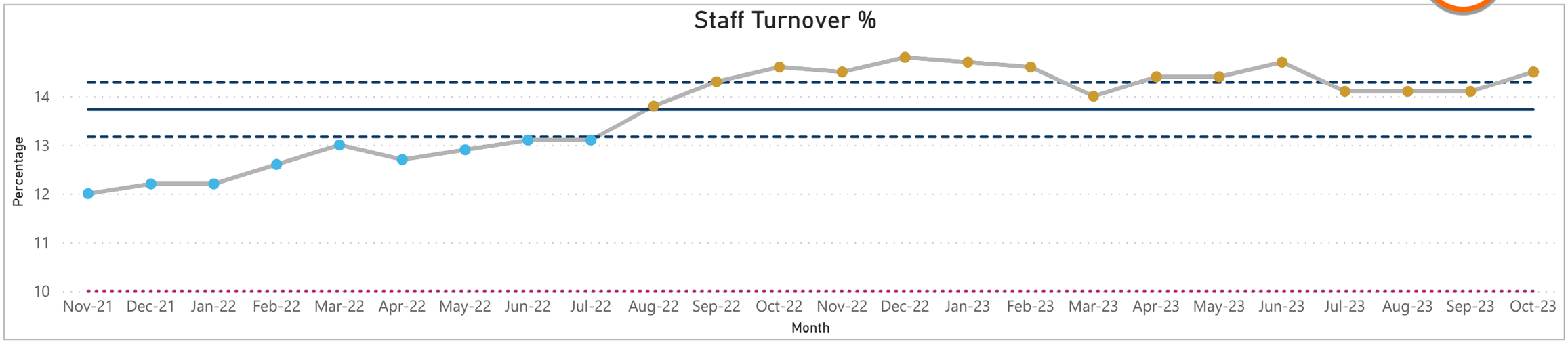
Temp staffing 5 point plan seeks to address weaknesses in the process and controls of temp staffing, as well as managing Agency costs through increasing Bank staff numbers and a negotiation of improved contracts with agency providers.

Estb Control project timelines are tight and require detailed engagement from DMT, Fin BP and HR BP. The new timetable has just been released seeking to establish a reconciled position by Dec 23.

Workforce - Turnover

Target 10%

People



Understanding the performance

Despite another net gain of 30 FTE staff this month Turnover rates have again risen, to 14.18%. Although the Trust has successfully increased the total number of staff in post by 171 FTE since Oct 22, it has lost nearly 488 FTE in the same period, requiring recruitment of these posts to maintain pace, and it is this loss of staff that keeps the turnover rate too high.

All Divisions remain above the Trust target of 10%. Women & New-Born (19.71%) remain the division with the highest proportional turnover for the sixth month. Trust wide Nursing and midwifery turnover has dropped to 11.40% this month, which maintains the downward trend of the last 3 months, whereas Additional clinical services have the highest turnover rate at 22%.

Forty-one FTE left the Trust this month, with nearly a quarter having served less than one year, and 2 thirds 5 years or less.

Actions (SMART)

The national retention toolkit has been released and actions assessed against this toolkit to support line managers with a particular focus on those in their first 2 years of service and under 30. This work is complemented by 100 day and 1-year sessions for staff organised by OD&P. WRES / WDES and Gender pay gap action plans have been released and will be put onto project footing to improve the sense of belonging in the Trust and improve staff experience.

People promise actions, designed to support staff retention and improve welfare and wellbeing continue to be rolled out, with an increased focus on communicating the positive interventions available for all staff. A wellbeing survey has been launched to identify areas of concern amongst staff and baselining against the national NHS wellbeing framework has also been completed. Actions will be discussed at the next Health and Wellbeing Committee in December.

Risks and Mitigations

Corporate Risk – Sustainable Workforce

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

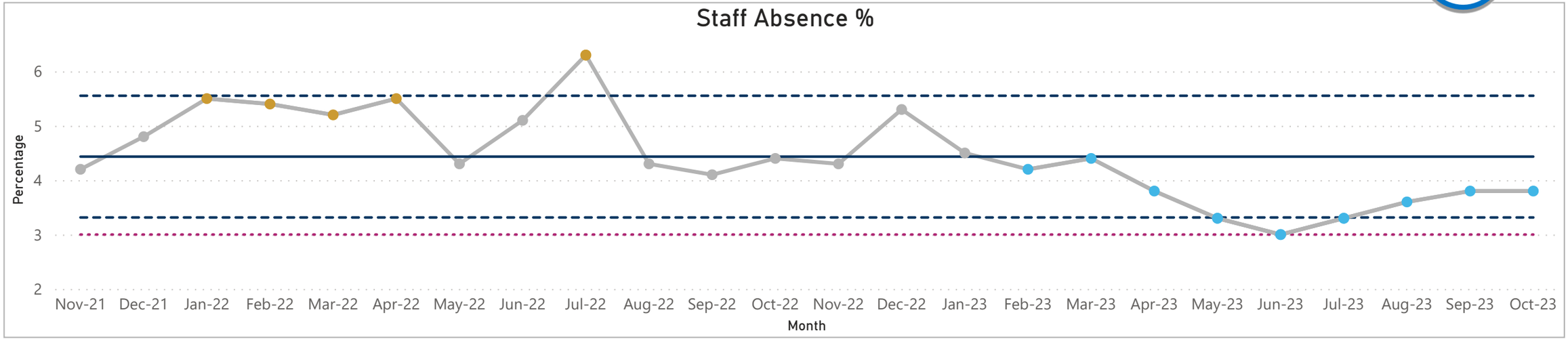
Divisional Staff Survey Action Plans

Line Manager Training interventions

Workforce - Sickness

Target 3%

People



Understanding the performance

Sickness absence stabilised at 3.8% in October against the target of 3%. Short term absences for coughs, cold and infectious diseases remain higher than previous months. Vaccination uptake for C-19 and Flu is progressing well which should help as we enter the winter period.

The corporate division became the worst performing division this month at over 4% with Surgery also above that figure. Staff from Additional Clinical Services remain the staff group with the highest absence rate at 6.46% and Estates teams have seen high rates of absence again this month at 6.46%

Sickness accounted for 4,517 FTE days lost to the Trust, of which 3,077 were for short term absence. Long term absence has been lower for the last 6 months compared to the previous period last year, a positive reflection on efforts to support staff back to work.

Actions (SMART)

Absence Management: Work has been initiated to understand the reasons why a number of staff are unable to return to work with reasonable adjustments following illness. Support for line managers to understand the process and rules around reasonable adaptations in the workplace is being put in place.

Work is underway following publication of the Annual H&S report to develop the Health Intelligence 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. This initial work will report in December 23.

The prevention of violence and aggression within the Trust remains a focus, seeking to prevent physical injury, but also aiming to reduce cases of workplace stress and anxiety for those working in high prevalence situations.

Risks and Mitigations

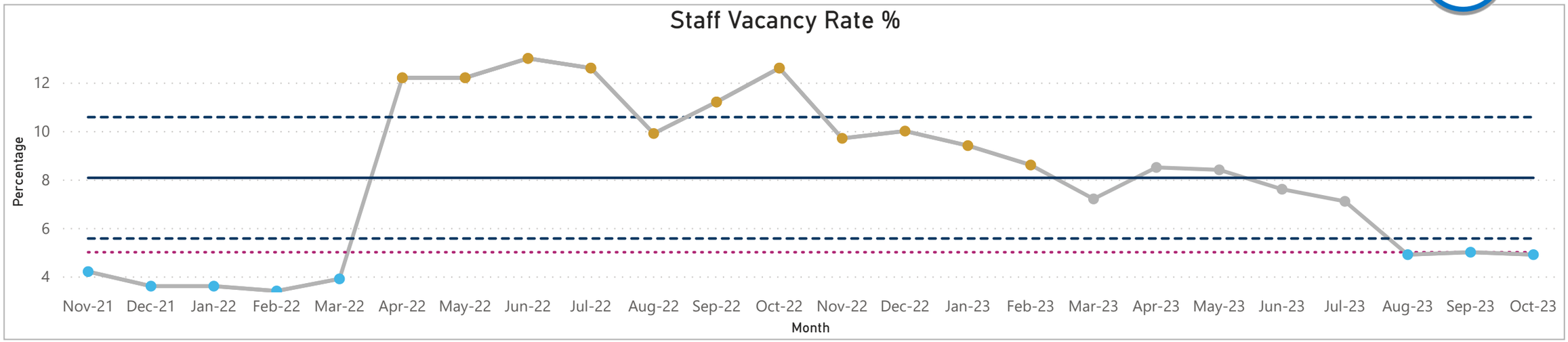
Corporate Risk – Delivery of OH service
Increased counselling and physio hours have been agreed and staff recruited for the counselling post. Delivery of an initial health intelligence capability is planned for Summer 23.

Corporate Risk – Sustainable Workforce
The HRA team has been reduced by 50% (4 FTE) due to promotion, resignation and maternity leave – this will generate a short-term impact on outputs for the Team.

Workforce - Vacancies

Target 5%

People



Understanding the performance

Vacancy rates remain below the 5% target at 4.9% for the third month running, testament to excellent work from Line Managers and the resourcing team.

For the first time in a number of months, nursing vacancies have dropped below 100 to 86 overall. The 88 vacancies within infrastructure staff roles is the highest in the Trust. Theatres remain the service with the highest vacancies, predominately within Nursing staff, and there are campaigns in place to continue to close this gap.

Specialist areas with small numbers of vacancies can create high agency spend because of hard to fill posts. Work is underway to isolate these areas and generate recruitment activity to meet these hard to recruit posts.

Actions (SMART)

The clear identification of vacancies against funded establishment remains the key challenge to management of effective campaigns to deliver new staff. This is ongoing work as part of Workforce trajectory forecasting, seeking to support Divisions and Line Managers with targeted attraction and recruitment campaigns, specifically for hard to fill high value niche posts

The focus of Advertisement campaigns remains Theatres, The Emergency Department, Maternity, HCAs and Housekeeping. Recent activity has also focussed on delivery of additional bank staff for nursing and HCA.

A business case has been agreed to support return to practice for nurses. Business cases to support degree apprenticeships for nursing and to enable additional training to allow those overseas staff with nursing qualifications to practice in the UK are pending decisions at system level.

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 %	88.6%	87.3%	86.8%	90.0%	85%		Common Cause Variation	X	9
Medical Appraisal Rate %	91.5%	86.2%	82.7%	90.0%			Common Cause Variation	X	2
Non-Medical Appraisal Rate %	61.0%	64.5%	70.2%	86.0%		H	Special Cause Improving - Above Upper Control Limit	X	31

Watch Metrics: Alerting Narrative

People

Understanding the performance

Mandatory training activity continues its slight downward trend, now over a four-month period, standing at 86.8%. For the moment this score is above the national target of 85%. Women and New Born and the Corporate area (less facilities) remain the lowest performing divisions at 83 and 82% completion respectively. Both quality and facilities are above the improvement target requirement of 90% completion.
Medical appraisals data has continued to fall for the second month in a row and now needs targeted effort to increase the score from the current low of 82% towards the 90% target.
More positive is the 4.7% increase to non-medical appraisals, seeing that figure rise to above 70% for the first time in over 18 months. The target of 86% remains some way off, but Facilities at 92% demonstrate that the target is achievable with focussed effort. In this area the new appraisal form has been a demonstrable positive.

Actions (SMART)

Mandatory Training: A busy operational period in the hospital has seen training activity reduce – key to maintaining training currency is the ability for line managers to release staff to attend training. 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. The Education team will offer additional support to those corporate areas struggling to complete training, and the HRBP for corporate will continue to remind managers and staff of the requirements.

Medical Appraisals: Further work is required by the HR Staffing team to understand why medical appraisal rates continue to drop for the third month.

Appraisals: Work to identify and support managers with a large number of outstanding appraisals has been conducted. Instructions on how to record appraisals on ESR has been published and training offered to line managers to support data capture.

Risks and Mitigations

Corporate Risk - Sustainable Workforce.

Retention Mitigations – People Promise Projects, 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

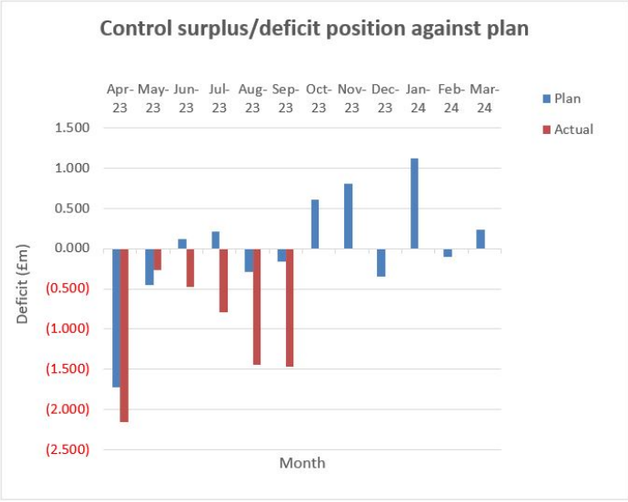
People

Income and Expenditure

Income & Expenditure:

Finance and Use of Resources

	September '23 In Month			September '23 YTD			23-24
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	24,546	25,232	687	147,338	148,529	1,192	275,490
Other Clinical Income	823	258	(566)	4,816	8,200	3,383	9,478
Other Income (excl Donations)	3,313	3,742	429	17,457	20,683	3,226	59,621
Total income	**28,682**	**29,232**	**550**	**169,611**	**177,411**	**7,800**	**344,589**
Operating Expenditure							
Pay	(17,951)	(19,658)	(1,707)	(106,463)	(116,441)	(9,979)	(212,809)
Non Pay	(9,308)	(9,383)	(75)	(55,938)	(57,515)	(1,577)	(112,722)
Total Expenditure	**(27,259)**	**(29,041)**	**(1,782)**	**(162,401)**	**(173,957)**	**(11,556)**	**(325,531)**
EBITDA	**1,423**	**191**	**(1,232)**	**7,210**	**3,454**	**(3,756)**	**19,058**
Financing Costs (incl Depreciation)	(1,589)	(1,664)	(75)	(9,527)	(10,067)	(540)	(19,058)
NHSE Control Total	**(166)**	**(1,473)**	**(1,307)**	**(2,317)**	**(6,613)**	**(4,296)**	**0**



Understanding the performance

The financial plan submitted to NHS England on 4 May shows a break-even 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 7 the Trust recorded a control total deficit of c£8.0m against a target of c£1.7m - an adverse variance of c£6.3m. The position is driven by the costs of IA, enhanced care provided to patients, supernumerary cover for new and overseas staff and the residual gap on pay awards.

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, particularly in relation to continued levels of patients with no clinical right to reside, as the efficiency plan assumes significant length of stay reductions which will not be realised in full without effective system working. Delivery of productivity increases which are contingent on both length of stay reductions and the recruitment of staff. The Trust's forecast of £15.3m efficiency savings includes more than 29% non recurrent delivery and signals a risk if further recurrent efficiencies cannot be identified. Actions are ongoing to identify additional schemes. Impacts of Industrial action which drives the increased costs of cover and constrains the elective programme, introducing risk to income.

Income & Activity Delivered by Point of Delivery

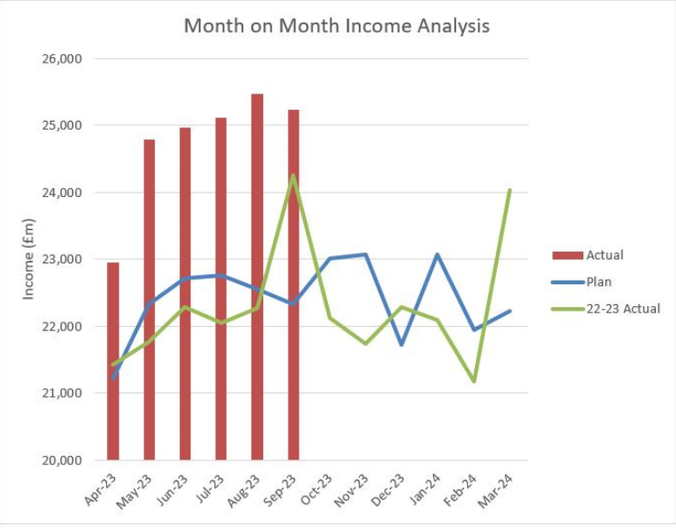
Clinical Income:

Finance and Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Sept 23 Year to Date (YTD) Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	5,473	5,799	326
Day Case	10,869	10,513	(356)
Elective inpatients	6,937	7,215	278
Excluded Drugs & Devices (inc Lucentis)	12,031	12,793	762
Non Elective inpatients	39,566	39,529	(37)
Other	54,331	53,163	(1,168)
Outpatients	18,131	19,517	1,386
TOTAL	**147,338**	**148,529**	**1,192**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	90,752	91,966	1,214
Dorset ICB	14,449	14,068	(381)
Hampshire, Southampton & IOW ICB	12,524	12,271	(253)
Specialist Services	20,106	20,592	486
Other	9,507	9,632	126
TOTAL	**147,338**	**148,529**	**1,192**

	Activity YTD Plan	Actuals	Variance	Activity Last Year Actuals	Variance last year
A&E	36,950	37,009	59	36,876	133
Day case	11,561	11,811	250	11,173	638
Elective	1,599	1,590	(9)	1,684	(94)
Non Elective	13,783	13,813	30	13,247	566
Outpatients	125,356	132,769	7,413	123,356	9,413



Understanding the performance

The Clinical income position is above plan year to date due to BSW ICB overperformance on Outpatient first attendances and procedures, Elective Inpatients, Advice and Guidance and Radiology from the use of independent sector providers for MRI and CT activity and Specialist services overperformance on High cost drugs and devices and Chemotherapy activity.

The level of uncoded day cases and inpatient spells is 32% in September and 95% in October at the time the activity was taken for reporting purposes. August's activity was fully coded at the SUS submission.

Activity was higher in October than September across all points of delivery with the exception of A&E attendances.

Actions (SMART)

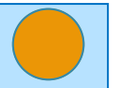
The contracts with ICBs and NHS England remain under negotiation at this stage. Several contract schedules have been agreed with commissioners with discussions progressing on the finance schedules with BSW and Dorset ICBs. Further guidance is anticipated around Dental commissioning arrangements including revised ICB allocations and detailed ERF calculations.

Risks and Mitigations

The impact of industrial action constrains the elective programme, introducing risk to income. Additional guidance has been received which reduces the ERF target by 4% in total across all commissioners and a funding allocation of £2.6m to mitigate the impact of Industrial action to October. All commissioner contracts, excluding BSW ICB, are now required at 99% of 2019/20 Elective activity levels. The Trust is seeking to mitigate the impact by maximising activity recording opportunities and via the contract negotiations.

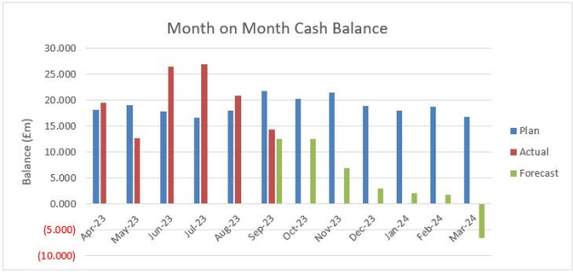
Cash Position & Capital Programme

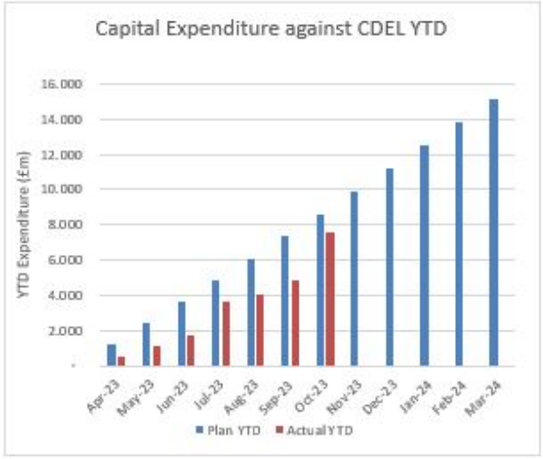
Capital Spend: 

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	8,648	694
Debtors	24,999	25,788	789
Cash	28,891	14,333	(14,558)
TOTAL CURRENT ASSETS	**61,844**	**48,769**	**(13,075)**
Creditors	(58,026)	(50,683)	7,343
Borrowings	(641)	(639)	2
Provisions	(474)	(470)	4
TOTAL CURRENT LIABILITIES	**(59,141)**	**(51,792)**	**7,349**
TOTAL WORKING CAPITAL	**2,703**	**(3,023)**	**(5,726)**





Payables age profile	Total Payables £'000	0-30 days £'000	31-60 days £'000	61-90 days £'000	90+ days £'000
Sep-23	**5,536**	4,514	618	- 52	456
Aug-23	**6,684**	5,666	246	239	533
Jul-23	**9,501**	8,470	238	174	619
Jun-23	**8,446**	7,306	231	379	530
Movement vs prev mth	*(1,148)*	*(1,153)*	*372*	*(290)*	*(77)*

Schemes	Annual Plan £000s	October '23 YTD Plan £000s	October '23 YTD Actual £000s	October '23 YTD Variance £000s
CDEL Schemes				
Building schemes CIR	2,785	1,631	604	1,027
Building projects	6,201	3,631	3,436	195
IM&T	3,432	1,779	1,586	193
Medical Equipment	2,698	1,580	466	1,114
Total CDEL schemes	**15,116**	**8,621**	**6,092**	**2,529**
National Funding				
New Elective Ward TIF	*11,352*	*2,556*	*2,556*	*0*
Salix Decarbonisation	*10,005*	*3,443*	*3,443*	*0*
Shared EPR - national element	*3,760*	*0*	*0*	*0*
Digital Pathology	*1,053*	*489*	*489*	*0*
Pathology LIMS	*310*	*96*	*96*	*0*
SW Imaging (ATVS)	*174*	*2*	*2*	*0*
Total National Funding	**27,254**	**6,586**	**6,586**	**0**
Great Western Hospitals transaction				
Medical Equipment - Surgical robot			**1,431**	**(1,431)**
GRAND TOTAL	**42,370**	**15,207**	**14,109**	**1,098**

Understanding the performance

In M7 there has been significant expenditure on CDEL Schemes of £2.6m of which £1.4m is the transaction for the Surgical robot from Great Western Hospital (GWH) and £0.8m was on the Whiteparish ward refurbishment. Forecast expenditure by capital sub group continues to 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 c£6.2m below plan following the reductions in creditors, increases in debtors and the year to date deficit of c£8.0m which is now c£6.3m adverse to plan.

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 working capital funding is in place as early as possible to mitigate cash requirements.

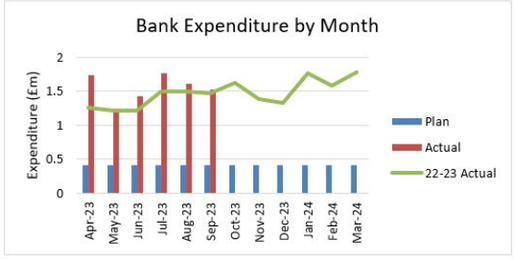
Risks and Mitigations

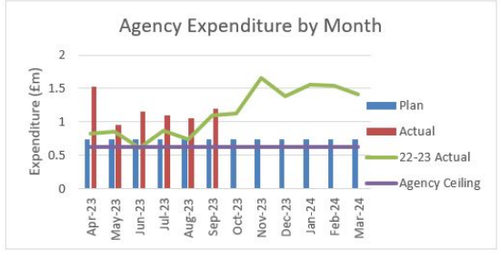
Additional capital pressures are emerging in year and such risks will have to be managed within the overall capital envelope if additional funding cannot be secured. Following the resubmission of financial plans on 4th May 2023 the Trust is awaiting confirmation from NHS England of the Capital leases funding of £5m. This funding is expected to be used to purchase CT scanners and C-arm equipment on a leased basis but has not been confirmed by the Treasury. 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 procurement capacity.

Workforce and Agency Spend

Pay:

Finance and Use of Resources





	September '23 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	99,335	99,764	430
Pay - Bank	2,543	9,305	6,762
Pay - Agency	4,585	6,981	2,396
Other (eg apprenticeship levy)		391	391
TOTAL	**106,463**	**116,441**	**9,979**
Medical Staff	27,989	30,423	2,435
Nursing	27,882	31,323	3,440
Support to Nursing	7,626	10,660	3,034
Other Clinical Staff	15,079	15,221	142
Infrastructure staff	27,887	28,423	536
Other (eg apprenticeship levy)		391	391
TOTAL	**106,463**	**116,441**	**9,979**

	September '23 YTD		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	470.7	533.76	63.1
Nursing	1,148.2	1,170.66	22.5
Support to Nursing	516.6	612.58	96.0
Other Clinical Staff	641.8	636.93	(4.9)
Infrastructure staff	1,452.6	1,427.79	(24.8)
TOTAL	**4,229.9**	**4,381.7**	**151.9**

Understanding the performance

M7 was a marginal change of £55k to the M6 position. Pay costs remain consistently above plan with an adverse variance to plan in month of c£1.8m and c£11.8m YTD. There were modest changes across Substantive, Bank and Agency costs in month. The pay position includes the cumulative pay savings target at month 7 of c£5.4m of which c£3.3m has been delivered to date. Staff availability decreased by a further 6 WTE in October due to a deterioration in sickness (equivalent to 6 WTE) within clinical areas which have to backfill shifts. The average unavailability was 24.9% (23.7% in September) which disproportionately impacts areas delivering clinical activity.

Substantive vacancies across the Trust have increased to 4% from 3% in September with the highest proportion of vacancies remaining within the Consultant and Nursing and midwifery groups. The unfilled rate has remained at 3%, mainly across Consultant and Infrastructure groups.

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, staff availability, 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. Industrial action has driven the increased costs of cover and Time off in lieu (TOIL).

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	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	Tissue Viability 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	Patients moved more than once %	Lorenzo via 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 patients receiving a CT scan within one hour of arrival	Stroke Team	Peter Collins	Medium
Watch	Stroke: % Bedside Swallow Assessment within 4 hours	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	Cancer 31 Day Performance Overall	Cancer Services	Lisa Thomas	High
Watch	Inpatients Undergoing VTE Risk Assessment within 24hrs %	Lorenzo via Trust Data Warehouse	Peter Collins	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	Tissue Viability team	Judy Dyos	High
Watch	Pressure Ulcers Hospital Acquired Cat 3	Tissue Viability team	Judy Dyos	High
Watch	Pressure Ulcers Hospital Acquired Cat 4	Tissue Viability 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 Incidents Resulting in High Harm (Mod/Maj/Cat) %	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

Report to	Trust Board (Public)	Agenda item:	3.1
Date of meeting	7 December 2023		

Report title:	Implications for SFT on Major Conditions Strategy			
Status:	Information	Discussion	Assurance	Approval
	YES			
Approval Process: (Where had this paper been reviewed and approved)				
Prepared by:	Tony Mears			
Executive sponsor: (presenting)	Lisa Thomas			
Appendices	NHS Providers Major Conditions Strategy Briefing (next-day-briefing-major-conditions-strategy-15-8-23-final.pdf (nhsproviders.org)) DHSC Major Conditions Strategy (Major conditions strategy: case for change and our strategic framework - GOV.UK (www.gov.uk))			

Recommendation

Board members to note for information the new Government 'Major Conditions Strategy' and the implications within the executive summary for SFT and our future work.

Executive Summary

Please find attached the NHS Providers Briefing on the new DHSC 'Major Conditions Strategy'.

The Department for Health and Social Care (DHSC) published an interim case for change and strategic framework as part of the Major Conditions Strategy on 14 August 2023.

It covers six conditions:

- Cancers
- Cardiovascular disease (CVD), including stroke and diabetes
- Musculoskeletal disorders (MSK)
- Mental ill-health
- Dementia
- Chronic respiratory disease

It is recognised by the strategy that half of all acute admissions in England are accounted for by patients living with two or more long term conditions. An increasing trend of particular significance given Wiltshire's rural ageing population above and beyond the national mean.

As is also currently, and rightly, the focus of ICS' and national teams, there is a significant focus on 'left shift' on those condition pathways. With SFT's involvement in the future of community services within our geography this has implications for how we shape the future of community and acute integration around these major conditions.

Tackling health inequity and implementing the CORE20PLUS5 approach is a central theme and requirement, dovetailing with our work to influence partners at place on the priorities for health inequality work and drawing on the top contributors for our population (CVD, Cancer, Respiratory).

Much of the strategy aligns to the future ambitions of our services, ambitions from the cardiology team seeking to deliver more secondary prevention so as to prevent readmission and mortality; to integrated respiratory pathways, and the benefits of aligning community and acute paediatrics.

The strategy has several notable elements for our population:

- The strategy sets out a desire to support those at risk, particularly frailer people, and support them prior to a crisis that may place pressure on acute services. This includes how technology might be used to identify earlier opportunistic testing and screening.

- The strategy also recognises the challenges faced by rural ageing populations, particularly around access and socio-economic pressures. As a consequence NHSE has commissioned the Office for Health Improvement and Disparities to develop a resource to support investigation of variation in dementia diagnosis rates including aspects such as rurality.

- For our population the widest health inequity occurs between richest and poorest within outcomes for cardiovascular disease, and cancers. The strategy has much to say on both. There is a nod to existing commitments such as DHSC's aim to ensure a digital NHS Health Check for CVD is available by spring 2024. There is also a nod to the need to improve ED wait times and ambulance handover delays. On Cancer there are nods to upcoming changes in annual operating guidance that will streamline how cancer performance is monitored.

The NHS Providers Briefing is attached but also available here: next-day-briefing-major-conditions-strategy-15-8-23-final.pdf (nhsproviders.org)

The full strategy document is available on the government website here: Major conditions strategy: case for change and our strategic framework - GOV.UK (www.gov.uk)

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	
Other (please describe):	

Major Conditions Strategy: A case for change and strategic framework

Introduction

The Department for Health and Social Care (DHSC) published an interim case for change and strategic framework as part of the Major Conditions Strategy on 14 August 2023. The document sets out the evidence underpinning the strategy and provides an overview of initial plans for action over the next five years. The full strategy document is expected to be published in early 2024, following analysis of responses to DHSC's call for evidence, which closed on 12 July 2023, and further consultation with stakeholders. The strategy is relevant to England only.

This briefing provides an overview of the case for change and strategic framework, the key areas of focus for the final strategy and our view. NHS Providers submitted a written response to the call for evidence in June 2023 and have met regularly with colleagues at DHSC and the Office for Health Improvement and Disparities to discuss the development of the strategy.

Overview of the Major Conditions Strategy

The document clarifies that the Major Conditions Strategy will aim to improve health outcomes and better meet the health and wellbeing needs of local populations. It will contribute to the broader government goal to narrow the gap in healthy life expectancy between local areas where it is highest and lowest by 2030 and to raise healthy life expectancy by 5 years by 2035, as laid out in the Levelling Up White Paper. The strategy will recognise challenges facing society, specifically around multi-morbidity in ageing populations. People with two or more conditions account for around 50% of hospital admissions and over half of NHS costs.

The strategy will focus on six major conditions:

- Cancers
- Cardiovascular disease (CVD), including stroke and diabetes
- Musculoskeletal disorders (MSK)

- Mental ill health
- Dementia
- Chronic respiratory disease

In providing one strategy for a number of different long term conditions, the government aim to remove pre-existing siloes between diseases and increase the provision of holistic, joined up and personalised care for patients. This approach reflects the broader shift towards integrated care and the creation of Integrated Care Systems following the Health and Care Act 2022.

Strategic framework

The strategic framework, which will underpin the final strategy, focuses action on:

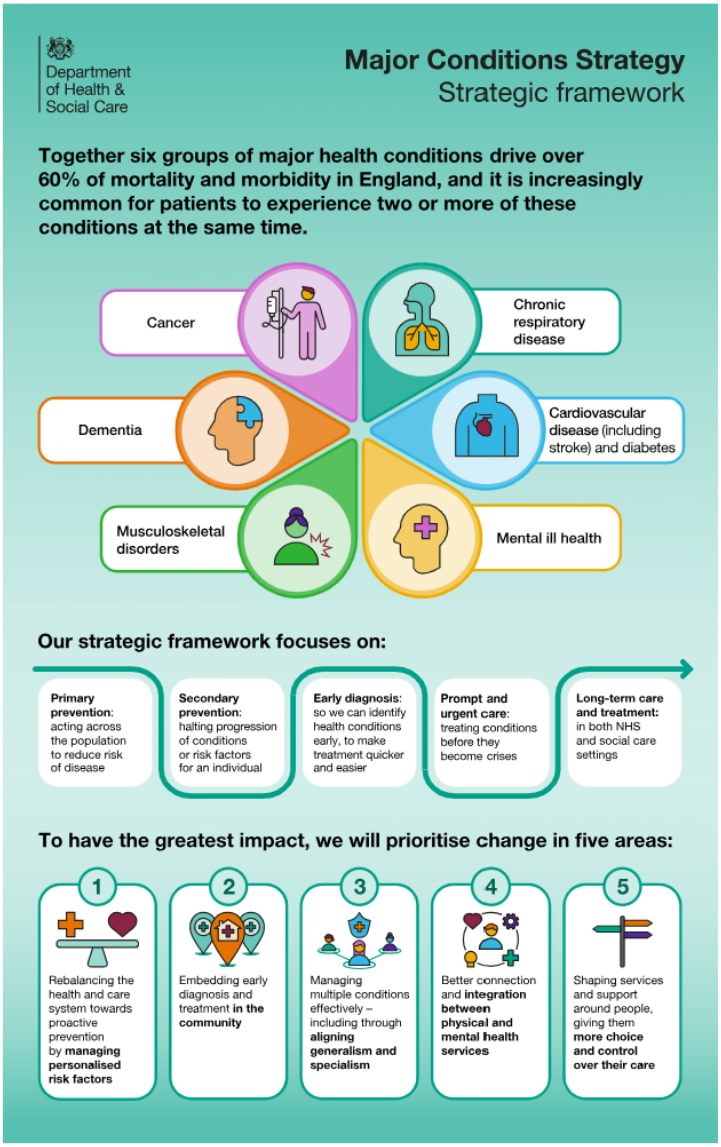
- Primary prevention: acting across the population to reduce risk of disease
- Secondary prevention: halting progression of conditions or risk factors for an individual
- Early diagnosis: to identify health conditions early, to make treatment quicker and easier
- Prompt and urgent care: treating conditions before they become crises
- Long term care and treatment in both NHS and social care settings

Tackling health inequalities is recognised as central to improving health outcomes and will be embedded across the whole strategy. It will include consideration to socioeconomic deprivation, ethnicity, gender and inclusion health in leading to health disparities. Implementation of NHS England's Core20PLUS5 framework for reducing health inequalities will be key.

DHSC has outlined five priority areas where it can make most difference:

1. Rebalancing the health and care system, over time, towards a personalised approach to prevention through the management of risk factors
2. Embedding early diagnosis and treatment in the community
3. Managing multiple conditions effectively – including embedding generalist and specialist skills within teams, organisations and individual clinicians
4. Seeking much closer alignment and integration between physical and mental health services
5. Shaping services and support around the lives of people, giving them greater choice and control where they need and want it and real clarity about their choices and next steps in their care.

The strategic framework has been simplified in the following graphic:



Prevention

The Major Conditions Strategy will focus on preventing ill health by reducing the impact of risk factors on health outcomes. The strategy will empower individuals to lead healthy lives, focusing on smoking, diet, physical activity, and alcohol and drug use, which account for most of the burden of ill health. There are clear disparities among population groups across these healthy behaviours. The strategy refers to existing government commitments in order to advance this agenda, including: achieving a smokefree society by 2030, £780 million investment in drug and alcohol treatment services, creation of Family Hubs / Start for Life programmes and development of a national suicide prevention strategy.

The case for change acknowledges the importance of tackling the wider determinants of health to improve primary prevention. The strategy will also highlight the vital role of integrated care systems (ICSs) in improving population health. It will also recognise the need for broader government action on reformulation of unhealthy foods, increasing rates of physical activity and reducing air pollution.

The case for change clarifies the key role the NHS and NHS trusts in delivering on secondary prevention, through identifying and offering targeted intervention to those most at risk of developing more serious illness. The final strategy will aim to enhance community based services and improve access to diagnoses and treatment.

Early diagnosis, early intervention and quality treatment

The Major Conditions Strategy plans to identify opportunities for earlier diagnosis and treatment, by sharing lessons learned between conditions and ICSs. For example, building on the work of NHS screening programmes. The strategy will explore the role of technology and AI to improve diagnostics and treatment.

The strategy will aim to improve treatment and experiences of patients where care is often siloed by condition, by increasing integration and personalised care. It will specifically outline plans to improve holistic care between mental health and physical health pathways. The strategy will also take a life course approach, recognising the peak onset of conditions and ensuring the right systems are in place to identify and treat conditions for different age groups.

Living with major conditions

The final strategy will provide a plan for patients living with long term conditions that cannot be prevented or fully cured through treatment and will aim to improve care coordination, symptom management and support for families / unpaid carers.

The case for change clarifies that the NHS and NHS trusts should focus on delivery of high quality, integrated and personalised care, including social care. Patients should be empowered to be active partners in their care, for example through shared decision making and choice, by providing accessible information to patients about their care. It also outlines plans to improve 'pre-habilitation', rehabilitation and recovery services for patients.

The final strategy will also explore interventions to improve:

- Pain management

- Medicines management (including polypharmacy)
- End of life care
- The mental health of people with physical conditions
- The physical health of people with mental health conditions.

Enabling systems

The case for change identifies three cross-cutting enablers to achieving success and improving health outcomes: digital technologies and innovation, research and leadership.

The final strategy plans to empower Integrated Care Systems to develop local approaches that best meet the needs of local populations, rather than through centralised solutions and targets.

NHS Providers view

We welcome the initial commitments set out in this case for change and strategic framework and can see that many of the priorities we set out in our written response to the call for evidence are reflected in the document. We look forward to more detail being published in the full version of the final strategy in early 2024 and would welcome more specific information on the role of NHS trusts in delivering the actions outlined. It is important that the final strategy document recognises the operational pressures facing NHS trusts and aligns to other existing guidance and strategies, particularly around backlog recovery.

We welcome the focus on primary prevention, secondary prevention and managing long term conditions. We also welcome the life course approach to major conditions, as we know that the onset of many conditions is in childhood and adolescence and interventions will need to be taken during this period in order to prevent ill health. NHS trusts play a vital role in prevention and care management, as demonstrated in our report *Providers Deliver: New roles in prevention*. As anchor institutions, trusts positively influence the population health and wellbeing of a local area.

In the final Major Conditions Strategy, more detail should be provided on how NHS trust will be supported to overcome the barriers they face in prioritising action on prevention. This includes: improving the accessibility and interoperability of data within systems, increasing dedicated funding for prevention and tackling operational pressures that often divert focus away from prevention.

We support the commitments to improve early diagnosis and treatment of conditions and welcome the plans to bolster community care and invest in digital technologies. The focus on personalised

patient care is particularly welcome, as we know that current care is often narrowly focused on the treatment of specific diseases or organs in the body. The interim report rightly recognises the increasing multi-morbidity of patients, whereby a holistic and integrated approach to care is most beneficial. We also welcome the signals within the document to achieve parity of esteem between physical and mental health conditions. Delivering timely and accurate diagnosis and high-quality treatment relies on a fully resourced NHS workforce. It is therefore crucial that the NHS Long Term Workforce Plan is fully funded and implemented to complement the Major Conditions Strategy.

We welcome the commitment to reducing health inequalities and tackling the wider determinants of health, which underpins the interim strategy. We know that disparities exist across a range of health outcomes and within the six conditions outlined in the strategy. However, actions to reduce disparities and improve prevention cannot be the sole responsibility of NHS services. The final strategy should further outline the role of cross-government departments on this agenda. Poverty drives health inequalities and economic inequalities must be tackled in order to see improvements, requiring action across governmental departments and sectors. The government must be committed to taking centralised decisions to improve health and wellbeing, such as reformulation of unhealthy food products. Cuts to the public health grant in recent years have undermined the efforts of local authorities to improve population health and reduce inequalities. There must be increased support for public services, such as public health and social care, given the crucial role these services play in providing wider care.

Report to:	Trust Board (Public)	Agenda item:	3.2
Date of Meeting:	07 December 2023		

Report Title:	Digital Plan Update – Nov 23			
Status:	Information	Discussion	Assurance	Approval
	x		x	
Approval Process (where has this paper been reviewed and approved)				
Prepared by:	Jon Burwell, Chief Information Officer Russell King, Head of Business Management			
Executive Sponsor	Naginder Dhanoa, Chief Digital Officer			
Appendices (list if applicable):	None			

Recommendation:
Trust Board is asked to note the contents of the report.

Executive Summary:
This report summarises the progress against the Trust's Digital Plan over the last 12 months. All the workstreams expected to commence in 2023/24 are now underway with the exception of RFID which has been deprioritised at this stage. The report highlights a range of wider programmes of work that have completed over the last 6 months and the programmes that are currently in progress. Where possible the Trust is working with ICS partners, in particular Great Western NHS Foundation Trust to standardise solutions and ways of working to help build resilience between the digital teams. All programmes have been prioritised through the Corporate Projects Prioritisation Group which forms part of the wider programme governance set up as part of the emergence of Improving Together. Digital Steering Group still oversees the delivery of Digital Programmes and considers how any new requests fits in with the Digital Plan's priorities and expected outcomes. Alongside the commencement of the Shared EPR Programme, 2024/25 will see a focus on developing plans for improving digital literacy, improving digital inclusion, increasing the use of personal monitoring apps. These plans will be developed in close partnership with peer organisations both at an ICS level and a place based level. The main risks to the plan are available funding and the capacity of staff to engage in the digital agenda, in particular the Shared EPR programme. Where staff need to be released to support priority digital programmes, any associated risks from doing this will be clearly identified and escalated through Trust governance for consideration.

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) -	☐

Digital Plan Update - November 2023

2 Introduction

This report summarises the progress against the Trust's Digital Plan which was signed off in November 2022. The Plan is split into five priorities:

- Our Electronic Patient Record
- Digitally enabled partnership working
- Supporting the people we serve
- Empowering a digital workforce
- Modern and Secure Infrastructure

Plan delivery is overseen through the Digital Steering Group. However, the governance around prioritising new and current programmes of work has changed slightly with the emergence of Improving Together over the last 18 months.

3 Project and Planned Work Progress

The table below outlines the major workstreams within the Digital Plan that were originally expected to be completed up to April 2024. Many programmes of work run over multiple years and have a range of activities and milestones within them as can be seen in the overall plan on a page in Appendix 1.

Workstream	Status	Update
Our Electronic Patient Record		
Shared EPR Programme	In Progress	FBC approved locally, with NHS England for consideration.
Electronic prescribing and Medicines Administration (EPMA) in Lorenzo	Complete	Rollout completed October 2023.
Electronic Discharge Summaries in Lorenzo	In Progress	Expected to be completed by March 2024.
Nursing E documentation – Phases 1 and 2 Digitisation of nursing paper charts and forms	Complete	Rollout completed in July 2023. Optimisation of what has already been rolled out will be completed this financial year.
Digitisation of paper processes for the Gastroenterology service	Complete	Completed in Q1 2023/24. A further five services have also have a level of digitisation of paper processes also undertaken (Trauma Database, Respiratory Service, Cardiac Rehab, Paediatrics, Anaesthetics).
Lorenzo patient context launch of Order Comms (Review) and ICS Shared Care Record	In Progress	ICS Shared Care Record launch complete. Order Comms launch still under development by with the supplier.
Paperless emergency department in Lorenzo	In Progress	This work is being reviewed to agree final activities before focus shifts to the Shared EPR programme.
Digitally enabled partnership working		
Go live of integrated digital care record (ICR)	Complete	
Roll out of advice and guidance software	Complete	

ICS Joint data warehousing pilot	In Progress	ICB has started piloting an approach to warehousing, being monitored through ICS BI Oversight Group
Adoption of PHM analysis tools	In Progress	Initial adoption occurred however current roadmap to enhance use not in place. New executive sponsor looking to increase use of PHM tools.
Expansion of ICR content	Complete	Sharing of Pathology and Radiology Reports into BSW ICR completed in July 2023, roadmap for ICR agreed.
Cloud Power BI	In Progress	Power BI being rolled on, cloud (NHS Tenant) business case being developed for consideration.
Procurement of archiving solution	In Progress	Now being procured jointly across the Acute Hospital Alliance in tandem with the Shared EPR Procurement. Expecting completion by April 2024.
Supporting the people we serve		
Maternity and Cancer PHR pilots	In Progress	The Maternity PHR was paused with a new Maternity EPR being procured. Cancer PHR implemented.
Roll out of virtual consultations solution	Complete	Dr Doctor now used for virtual consultations.
Virtual appointment rebooking	In Progress	Delayed due to supplier capacity to undertaken work. Completion date TBC.
Optional electronic patient letters	In Progress	Expecting go live in Jan 2024.
Expansion of home monitoring apps and telehealth	In Progress	Whilst some elements have been rolled out with virtual wards, there is not a robust plan for extending this at this stage.
Expansion of virtual wards	Complete	Virtual wards have been rolled out and will continue to evolve over the coming year.
Empowering a digital workforce		
Self Service BI for staff	Complete	Self Service BI available to staff, will continue to extend. Next area of focus is upskilling of key staff to support their use of Business Intelligence.
Intranet refresh	Complete	New intranet launched in April 2023 and further enhanced since.
Commencement of RPA programme	Complete	RPA underway, expecting business case to extend resources in Q4 2023/24.
Digital Improvement Network Launched	Complete	Launched and in embedding phase.
Digital Maternity	In Progress	Expecting to complete implementation of new Maternity EPR in 2024/25. Project Manager in place.
Phase 1 of eRostering roll out complete	In Progress	Deployment has commenced.
Online corporate filing structure	In Progress	Analysis underway on the implications of using SharePoint, initial focus is personal drives. Expected to be a programme of work in 2024/25.
RFID pilot	Not Started	Dependant on connectivity programme.

Build up core digital learning resources on the intranet	Complete	Additional training added and will continue to be updated with new content as it is required.
Modern and Secure Infrastructure		
Virtual Smartcards/Authentication	In Progress	National approach to virtual smartcards/authentication have changed. New authentication approach being rolled out (CIS2) nationally, currently two services live at SFT.
Approval of Trust cloud strategy	In Progress	Cloud plan being developed, Digital Steering Group to review in March 2024
Data Warehouse migration complete	In Progress	Expecting go live of SUS/SLAM process in new warehouse in Feb 2024.
Wi-Fi improvements pilot rolled out in Spinal services	In Progress	Expecting completion by March 2024 subject to supplier capacity.
Expansion of secure bandwidth capacity	In Progress	One secure line complete, second secure line to be completed by March 2024.

3.4 Other Project and Planned Work Completed

There are a range of wider projects and planned works in progress across the Trust. Over the last six months the following have also been completed:

Programme	**Completion Date**
Datix Upgrade	July 2023 /Oct 2023
Medilogik – Replacement Endoscopy System Implementation	July 2023
E whiteboard system upgrade – supporting Urgent Emergency Care actions	July 2023
ICVS System Upgrade	July 2023
Text Messaging to VTE patients	June 2023
Roche Blood Gas Analysers	June 2023
Dawn -Anticoagulation System upgrade	August 2023
Medicode 360 – Coding system upgrade	September 2023
Amat – Audit System replacement	September 2023
Bighand – Digital Dictation – System Upgrade and Enhancements	November 2023

3.5 Projects & Planned Work In Progress

The table below summarises the list of planned key activity items/projects that are either already in progress or due to commence in this financial year.

Programme
AMat – Mortality Reporting tool
Blood 360 Upgrade
Electronic Documentation Management System upgrade and enhancements
Extension of Advice and Guidance software to remaining services and EPR integration
Finance system Cloud Migration
Virtual Outpatients – Roll Out to remaining services
Completion of Digital Letters and Assessments

Replacing GP Order Comms – business case being developed
Harlequin System Upgrade
Implementation of SystmOne hospice patient system
Electronic Referrals, Inpatient Bookings and Digitisation of Wessex rehab paper processes through Lorenzo
PACs Active Directory migration
Digital Communication and Signage solution rollout
Teletracking Upgrade – Portering system upgrade
SystmOne Upgrade and read/write access for specialist services
Video Conferencing Upgrade for the Board Room
Pathology MES roll out of managed equipment
Digital Pathology roll out
Implementation of new Pathology LIMS system
Cloud Power BI implementation (subject to business case approval)
Completion of Core Infrastructure migration
Digital literacy assessment roll out

4 New Schemes approved at Digital Steering Group

The Digital Steering Group, chaired by the Chief Medical Officer, has responsibility to review business cases and options appraisals. The following papers were reviewed ahead of submission to other committees or groups and supported:

May 2023

- The movement to digitising ECGs, storing them on PACS as our strategic imaging solution. The direction of travel was approved with the business case now on holding pending identification of funding.

July 2023

- Maternity EPR. The business case was approved and has now also been approved for procurement by the Trust. Procurement underway.

October 2023

- West of England Shared Imaging Platform OBC. The business case was supported and recommended to the Trust for support to Full Business Case.

5 Risks to the Digital Plan

The two main risks to the delivery of the Digital Plan remains funding and the availability of resources to support.

Nationally, funding available continues to be predominantly capital whereas increasingly the requirement is for recurrent revenue funding as solutions move to cloud hosting and/or different licensing models. Further to this, the national funding for digital has been restricted to support finances of wider NHS requirements. The impact on the Trust is yet to be seen and will be reviewed once there is clarity as to what programmes will be reduced/removed.

Whilst 2023/24 has been a successful year for staff engagement in rollouts, in particular EPMA, 2024/25 will see a step change in support required with the planned commencement of the Shared EPR programme. The resource requirements for the Shared EPR programme is being discussed with Divisions to finalise a realistic plan. Where there are wider risks associated with the potential release of staff to support digital programmes, this will be discussed and agreed through Trust governance.

Appendix 1: Digital Plan on a Page

Project	Start Date	End Date	Complexity	Phases
EPMA	Mar-21	Oct-23	High	COMPLETE
				COMPLETE
Paperlite - E Documentation Phase 2/3	Mar-23	Mar-24	High	
				Phase 2 Implementation
				Final Phase scoping
				Final Phase Config/Testing
				Final Phase Implementation
Paperlite - Discharges in Lorenzo	Dec-22	Mar-24	High	
				Testing/Configuration
				Implementation
Paperlite - ED Improvements	Mar-21	Dec-23	Medium	
				Rolling Implementation
Paperlite - Electronic Bookings	Mar-23	Dec-23	Medium	
				Implementation
PAC - CRIS Communicator Options	Jan-23	Dec-23	Medium	
				Approval of options/plan
PACS - AD Migration	Jul-23	Nov-23	Low	
				Planning
				Implementation
BIGHAND/CITO Migration	Apr-20	Nov-23	Low	
		Jan-24		Build Phase (Servers)
				Testing/Implementation
Pathology LIMS	Jun-21	Feb-25	High	
				Preparation/Plannning
				Configuration/Build
				Testing
				Implementation
Digital Pathology	Jul-22	Dec-24	Medium	
				Hardware Install
				Phase 1 validation
Shared EPR	Apr-21	Mar-26	High	
				Business Case Approval
				Engagement/Discovery
				Configuration/Testing
				Implementation
Maternity EPR - Badgernet	Apr-23	Sep-24	Medium	
				Supplier Engagement
				Configuration
				Testing /Training
				Implementation
GP Order Comms Replacement (Business Case)	Jul-23	Jan-24	Medium	
				Business Case Approval
Integrated Care Record - Phase 3	Aug-23	Jan-24	Low	
				Scoping
				Testing /Implementation
Doctor Dr - Letters/Assesments	Jun-23	Mar-24	Medium	
				Configuration
				Testing/Training
				Implementation
Cinapsis - Roll Out & Lorenzo integration	Mar-22	Feb-24	Low	
				Rolling Implementation
E Whiteboard Upgrade	Mar-23	Jul-23		COMPLETE
E Whitebaord feeds- Bi - directional	Jul-23	Oct-23	Medium	De Scoped/Stopped
				Scoping Decision
Teletracking Upgrade	May-23	Jan-24	Low	Supplier dependent
Blood 360 Upgrade	Apr-23	Jan-24	Low	
TPP Viewer Upgrade/Roll out	Jun-22	TBC	Low	
Snapp Comms (Digital Comms)	Mar-23	Nov-23	Low	
Medicode 360 Upgrade	May-23	Sep-23		COMPLETE
DAWN System Upgrade	Sep-22	Aug-23		COMPLETE
My Medical Record Pilot	Apr-22	Apr-25	Low	
NHS MAIL - MFA	Mar-23	Dec-23	Low	Rolling Implementation
AMAT - Audit/Mortality System	Mar-23	Feb-24	Medium	
				Audit Go live
				Mortality Go Live
System One - Hospice System	Feb-23	Feb-24	Medium	
				Configuration and Testing
				Implemenation
RPA - Process Automation Pilots	Dec-22	Mar-24	Medium	
				Intial Pilot Live
				Rolling Automation Processes
				Pilot Review and Proposal
Servers Refresh Programme	Oct-19	Dec-23	High	Rolling Programme
BI Transformation	Apr-19	Mar-24	High	
Connectivity	Dec-20	Ongoing	Medium	
RAPIDS /SAN Replacement	Jun-21	Jul-24	High	
				Migration
				Decommission Old Network
Network Projects	Sep-20	Apr-24	High	Rolling Programme
Video Conferencing Upgrade	Feb-23	Dec-23	Low	
RFID - Med Devices	Apr-21	Oct-23	Low	Replan
VOIP/Telecoms Projects	Nov-20	Oct-23	Medium	Replan

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.1
Date of meeting:	7th December 2023		

Report tile:	National Inpatient Survey Results – 2022			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Presented to Patient Experience Steering Group – 25th October 2023 Clinical Governance Committee – 31 October 2023			
Prepared by:	Victoria Aldridge – Head of Patient Experience			
Executive Sponsor: (presenting)	Judy Dyos – Chief Nursing Officer			

Recommendation:

The Committee are asked to note the following presentation of the Adult Inpatient Survey 2022 Results and comparisons from the 2021 survey.

Executive Summary:

The National Inpatient Survey 2022 is an annual, nationally mandated survey which captures the experiences of patients aged 16years+ who had spent at least one night in hospital and discharged during November 2022. The full CQC benchmark report is now available here: NHS Surveys.

Response rates this year were noted to have increased when compared with 2021 (48% to 51%), a total of 621 responses were received. Demographic spread was largely similar to that seen in 2021 with a fairly equal split of male and female responses (less than 0.5% of participants said their gender was different from the sex they were registered with at birth.) Two thirds of respondents were aged 66 or over and 97% were from a white background. 81% declared to have a physical or mental health condition, disability or illnesses that has lasted or is expected to last 12 months or more.

Overall experience rating was 79.5%, this was noted as a slight decrease when compared with SFT's 2021 results of 79.6%. 3 areas of questioning had improved significantly (by 5% of more) these were related to assistance with feeding and access to meals outside of meal-time, as well as prevention from sleeping due to lighting. 2 areas scored worse by 5%, these related to explanations when changing wards and home situations not being taken into account when planning discharge from hospital.

In 2021 the four key areas for improvement were highlighted as discharge process and follow-up, communication, staffing levels and food/drink, noise and disruption.

Discharge process and follow-up: Improvements were noted in relation to discussions around additional equipment that may be needed post-discharge and follow-up with health and social care. Work is still needed with involving patients with decision making, and more consideration of individual circumstances as part of discharge planning.

Communication: Improvements noted around Doctor's explanations, but there was a small decline in the scoring of the same question for Nurses. Both staff groups had an increase in confidence noted.

Improvements can be seen for patient's feeling including in the conversations about them but conversely not in relation to actual involvement with decision making.

Decreases noted in relation to being able to talk about worries and fears and receiving differing information from staff.

Improvements to how well staff explained and answered questions in relation to procedures (both pre and post) but information regarding ward changes needs further review.

Staffing levels: Slight improvement to responses related to enough help with keeping clean, but patients still felt that there were not enough Nurses on duty and weren't always able to get attention when needed.

Food and drink, noise and disruption, facilities: Improvements across the board noted in relation to experiences of noise at night, assistance with feeding and drinking, quality of food and access to food outside of meal-times.

Comparison across all areas of the inpatient survey were noted to be about the same as other Trusts (indicated in orange on slide 11). Benchmarking against our own results from 2021 the only areas noted to have had a slightly reduced score were in relation to admission to hospital and leaving hospital. Overall patient experience score remains largely the same from last year.

Themes from comments were relatively evenly split (positive vs negative). Staffing made up a majority of the comments (41%), 65% of which were positive. General themes from comments also noted as follows:

Positive:

- Care and general treatment
- Operations/investigations and procedure
- Staff (nurses and doctors primarily)

Negative:

- Wait/access
- Discharge process/information
- Communication
- Staffing levels

Access to food and hydration were a particular area of concern noted in 2021. Taking into account the time lag with reporting the survey results, a selection of real-time feedback obtained between July and September 2023 has been included to reflect the current status of this. Questions related to quality and selection of dietary options available and assistance with feeding was reviewed. There is a slight decline noted in the level of assistance received for basic care (eating, drinking and washing) as we move into September. A total of 79 responses were collected during this period across 14 inpatient wards.

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

National Inpatient Survey Results (2022)

Results Report - Sept 2023

Clinical Governance Committee
31st October 2023

Presented by:
Victoria Aldridge – Head of Patient Experience

Angie Ansell – Deputy Chief Nursing Officer

Salisbury NHS Foundation Trust National Inpatient Survey 2022

Sample: Patients aged 16years+ who had spent at least one night in hospital and discharged during November 2022

Scoring: Each question in the survey that can be scored are converted into scores on a scale of 0 to 10. Scores of 10 are assigned to the most positive and scores of 0 are assigned to the least positive.

Full CQC Benchmark Report:

Survey - NHS Surveys

Summary of comparisons

133 NHS Acute Trusts involved

63, 224 Total responses received return rate of 40.2%
(noted 23% for 2021)

621 Total responses received for SFT

51%* Response rate *noted to be higher by 3% than 2021

No. of questions where SFT scored better than other Trusts = 0

No. of questions where SFT scored about the same as other Trusts = 41

No. of questions where SFT scored worse or somewhat worse than other Trusts = 4*

Demographic breakdown

Salisbury NHS Foundation Trust

Age

5% were aged 16 - 35

7% were aged 36 - 50

22% were aged 51 - 65

66 % were aged 66+

Sex

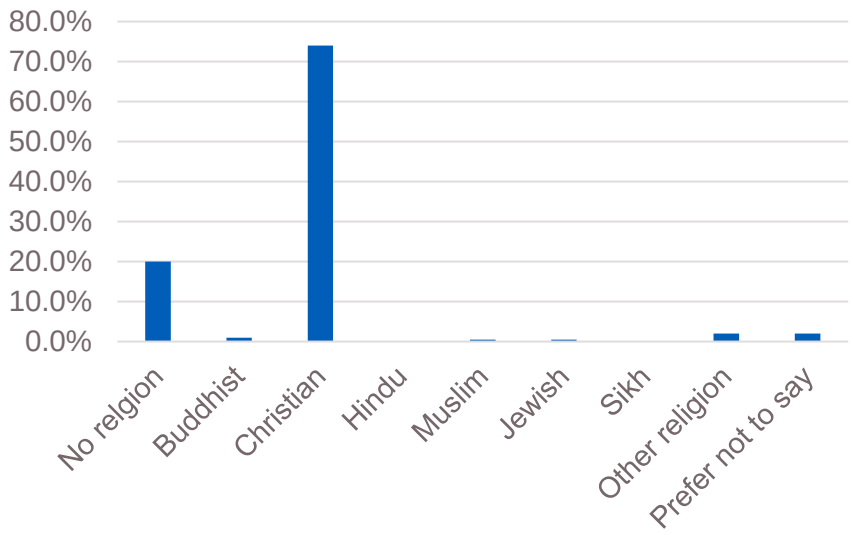
53% of those surveyed identified as female

46% of those surveyed identified as male

0.0% of those surveyed identified as intersex

<0.5% of participants said their gender is different from the sex they were registered with at birth

Religion



Ethnicity

97% of those surveyed were White

1% were Mixed

<0.5% were Asian, Asian British, Arab or other ethnic group

0% were Black or Black British

1% were unknown

81%

of participants said they have physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last 12 months or more

Comparison with SFT's 2021's survey results

2 questions were scored worse by +5%

- Q7 - clear explanation for changing wards
- Q34 - home situation was not taken into account when planning for the patient to leave hospital

3 questions were scored better by +5%

- Q5 - prevention of sleep due to lighting
- Q13 - assistance with meals
- Q14 - access to meals outside of mealtime

Overall experience rating 79.5%

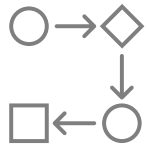
(noted as a slight decrease when compared with SFT's 2021 results of 79.6%, however response rate was higher)

Areas for improvement comparison – how did we do?

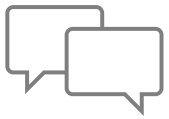
Salisbury NHS Foundation Trust

In response to the 2021 survey results an action plan was put in place to improve in the following highlighted areas:

2021

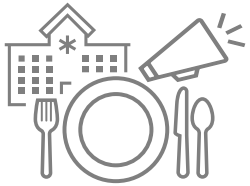


Discharge process and follow-up



Communication

Staffing levels



Food and drink, noise and disruption, facilities

Discharge process and follow-up

Salisbury NHS Foundation Trust

		2021	2022
Q33	To what extent did staff involve you in decisions about you leaving hospital?	68.0%	66.2%
Q34	To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital?	69.7%	52.4%
Q35	Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	85.2%	86.3%
Q36	Were you given enough notice about when you were going to leave hospital?	68.8%	67.6%
Q37	Before you left hospital, were you given any information about what you should or should not do after leaving hospital? This includes any verbal, written or online information.	79.3%	79.7%
Q38	To what extent did you understand the information you were given about what you should or should not do after leaving hospital?	90.6%	88.9%
Q40	Before you left hospital, did you know what would happen next with your care?	66.2%	66.6%
Q41	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	76.6%	74.3%
Q42	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? Please include any services from a physiotherapist, community nurse or GP, or assistance from social services or the voluntary sector.	78.9%	79.7%
Q44	After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?	59.5%	61.6%

Improved response rates to discussions around additional equipment that may be needed post-discharge and follow-up with health and social care.

Work is still needed with involving patients with decision making, and more consideration of individual circumstances as part of discharge planning.

Communication

Salisbury NHS Foundation Trust

		2021	2022
Q7	Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?	74.3%	67.8%
Q16	When you asked doctors questions, did you get answers you could understand?	86.1%	88.1%
Q17	Did you have confidence and trust in the doctors treating you?	89.1%	91.4%
Q18	When doctors spoke about your care in front of you, were you included in the conversation?	84.5%	87.5%
Q19	When you asked nurses questions, did you get answers you could understand?	85.2%	84.5%
Q20	Did you have confidence and trust in the nurses treating you?	87.5%	88.1%
Q21	When nurses spoke about your care in front of you, were you included in the conversation?	84.5%	86.0%
Q23	Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?	78.2%	77.9%
Q24	To what extent did staff looking after you involve you in decisions about your care and treatment?	69.0%	67.3%
Q25	How much information about your condition or treatment was given to you?	87.0%	88.3%
Q26	Did you feel able to talk to members of hospital staff about your worries and fears?	75.4%	73.8%
Q31	Beforehand, how well did hospital staff answer your questions about the operations or procedures?	88.0%	89.0%
Q32	After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone?	77.6%	81.5%

Improved response rates around Doctors explanations, but small decline in Nurses. Both staff groups had an increase in confidence noted.

Improvements to including patients in the conversation about them but not in relation to involvement with decision making.

Decrease noted in relation to being able to talk about worries and fears and receiving differing information from staff.

Improvements to how well staff explained and answered questions in relation to procedures (pre and post).

Information regarding ward changes needs further review.

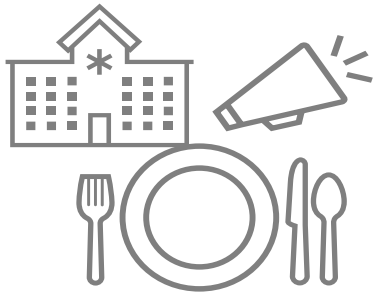
Staffing levels

Salisbury NHS Foundation Trust

		2021	2022
Q9	Did you get enough help from staff to wash or keep yourself clean?	76.3%	76.9%
Q22	In your opinion, were there enough nurses on duty to care for you in hospital?	68.6%	63.7%
Q29	Were you able to get a member of staff to help you when you needed attention?	77.1%	75.3%

Slight improvement to response rates related to enough help with keeping clean, but patients still felt that there were not enough Nurses on duty and weren't always able to get attention when needed.

National decreases noted in both staffing levels and attention from staff when needed (when comparing with 2020): National infographic.pdf



Food and drink, noise and disruption, facilities

Salisbury NHS Foundation Trust

		2021	2022
Q5_1	Were you ever prevented from sleeping at night by any of the following: noise from other patients	53.2%	54.1%
Q5_2	Were you ever prevented from sleeping at night by any of the following: noise from staff	80.7%	83.4%
Q5_3	Were you ever prevented from sleeping at night by any of the following: noise from medical equipment	81.0%	84.0%
Q5_4	Were you ever prevented from sleeping at night by any of the following: hospital lighting	77.9%	83.4%

Q11	Were you offered food that met any dietary needs or requirements you had? This could include religious, medical or allergy requirements, vegetarian/vegan options, or different food formats such as liquified or pureed food.	84.6%	85.0%
Q12	How would you rate the hospital food?	72.1%	73.6%
Q13	Did you get enough help from staff to eat your meals?	68.3%	74.0%
Q14	Were you able to get hospital food outside of set meal times? This could include additional food if you missed set meal times due to operations/procedures or another reason.	55.7%	62.7%
Q15_1	During your time in hospital, did you get enough to drink: Yes	82.8%	84.9%

Improvements across the board noted in relation to experiences of noise at night, assistance with feeding and drinking, quality of food and access to food outside of meal-times.

Comparison with other Trusts and 2021

KEY:
Colour of the patient response represents how this figures compares with that of other Trusts:

- Better than expected
- About the same
- Worse than expected
- The trust's score last year

NHS Salisbury NHS Foundation Trust

	2022	2021
Admission to hospital	Patient Response 7.0	Patient Response 7.1
Hospital and Ward	Patient Response 7.7	Patient Response 7.5
Doctors	Patient Response 9.0	Patient Response 8.7
Nurses	Patient Response 8.1	Patient Response 8.1
Care and treatment	Patient Response 8.1	Patient Response 7.8
Operations and procedures	Patient Response 8.6	Patient Response 8.1
Leaving hospital	Patient Response 7.0	Patient Response 7.1
Feedback on quality of care	Patient Response 1.0	Patient Response 1.0
Respect and dignity	Patient Response 9.0	Patient Response 9.0

2021

Experience overall

Patient Response
8.0

Patient Response
8.0

Salisbury NHS Foundation Trust

Comparison with other trusts within your region

Trusts with the highest scores

Royal Devon University Healthcare NHS Foundation Trust	8.5
Royal United Hospitals Bath NHS Foundation Trust	8.3
Torbay and South Devon NHS Foundation Trust	8.3
North Bristol NHS Trust	8.3
University Hospitals Bristol and Weston NHS Foundation Trust	8.3

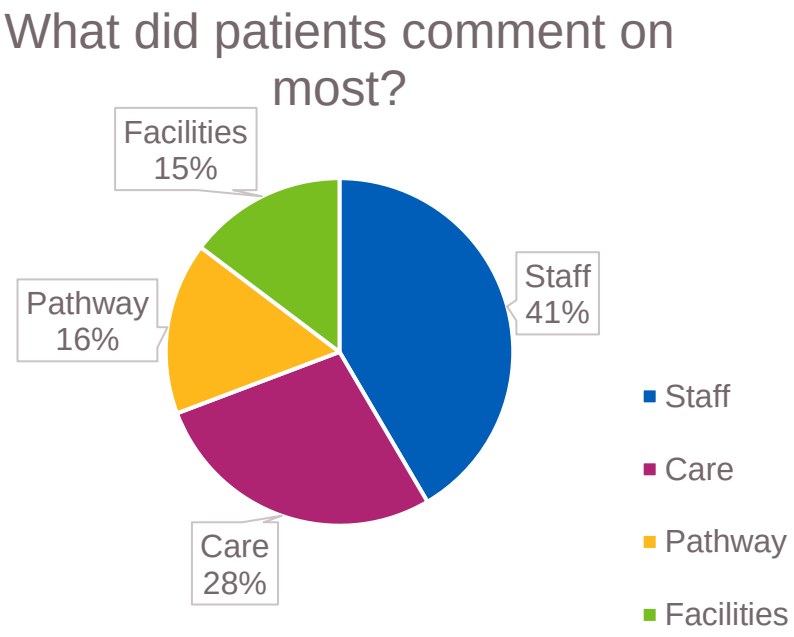
Trusts with the lowest scores

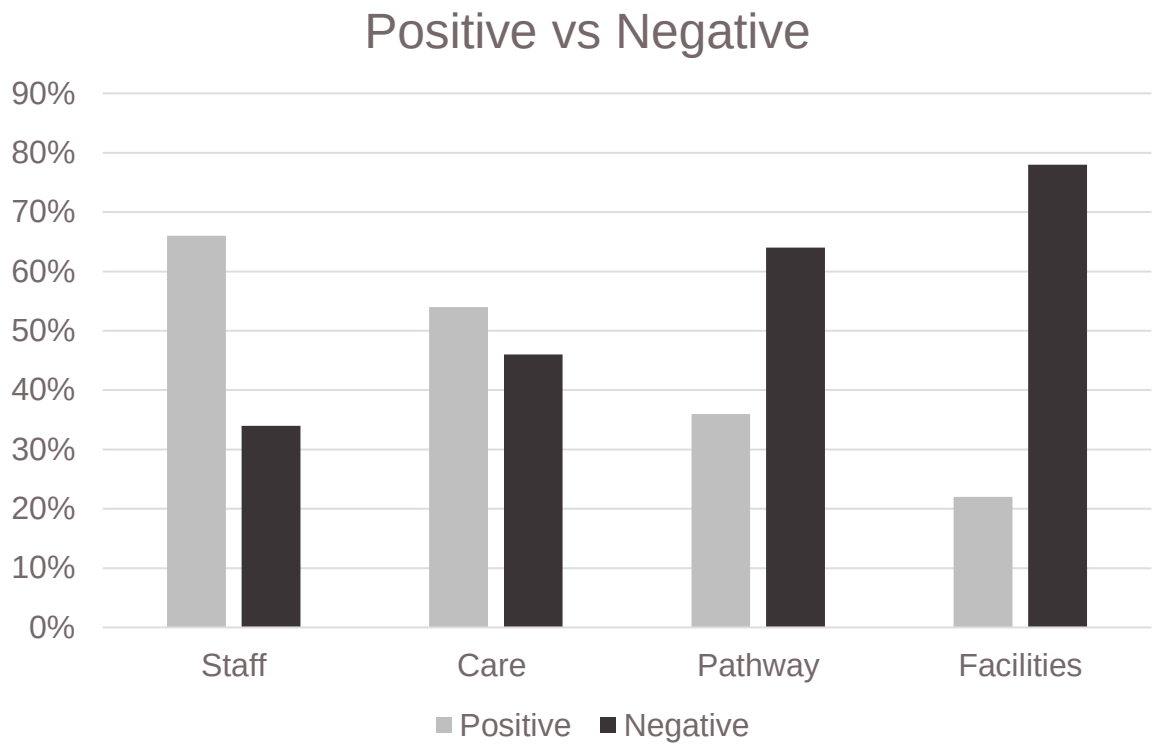
Great Western Hospitals NHS Foundation Trust	7.8
Gloucestershire Hospitals NHS Foundation Trust	7.8
University Hospitals Plymouth NHS Trust	7.9
Yeovil District Hospital NHS Foundation Trust	7.9
Salisbury NHS Foundation Trust	8.0

Themes from comments

Total comments received: 1,509

Overall positive: 51%





Themes from comments

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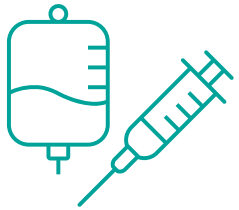
Positives

Care and general treatment

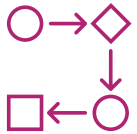


Operations/investigations and procedures

Staff (nurses and doctors primarily)

Negatives

Wait/access



Discharge process/information

Communication

Staffing levels

Assurance against Nutrition and Hydration responses – Real-Time Feedback

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 is usually undertaken by volunteers or governors.

The aim of the feedback to give a "real-time" view of a patient's perspective of their care.

Real-time feedback is currently undertaken in all inpatient areas with the exception of 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

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

Real-Time Feedback – Food and Nutrition Focus Jul – Sept 2023

Salisbury NHS Foundation Trust

July 2023

		Average Score	Number of responses
How would you describe the quality and selection of dietary options available to you?	Hospital and ward	94.1	17
How would you describe the level of assistance you receive for basic care such as eating, drinking and washing?	Hospital and ward	93.8	16

Breamore, Downton, Durrington, Laverstock, Longford Ward

August 2023

		Average Score	Number of responses
How would you describe the level of assistance you receive for basic care such as eating, drinking and washing?	Hospital and ward	95.2	21
How would you describe the quality and selection of dietary options available to you?	Hospital and ward	81.3	24

AMU, Breamore, Britford, Downton, Farley, Pembroke, Farley, Pembroke, Pitton, Redlynch, Spire, Tisbury

September 2023

		Average Score	Number of responses
How would you describe the level of assistance you receive for basic care such as eating, drinking and washing?	Hospital and ward	83.3	33
How would you describe the quality and selection of dietary options available to you?	Hospital and ward	66.7	33

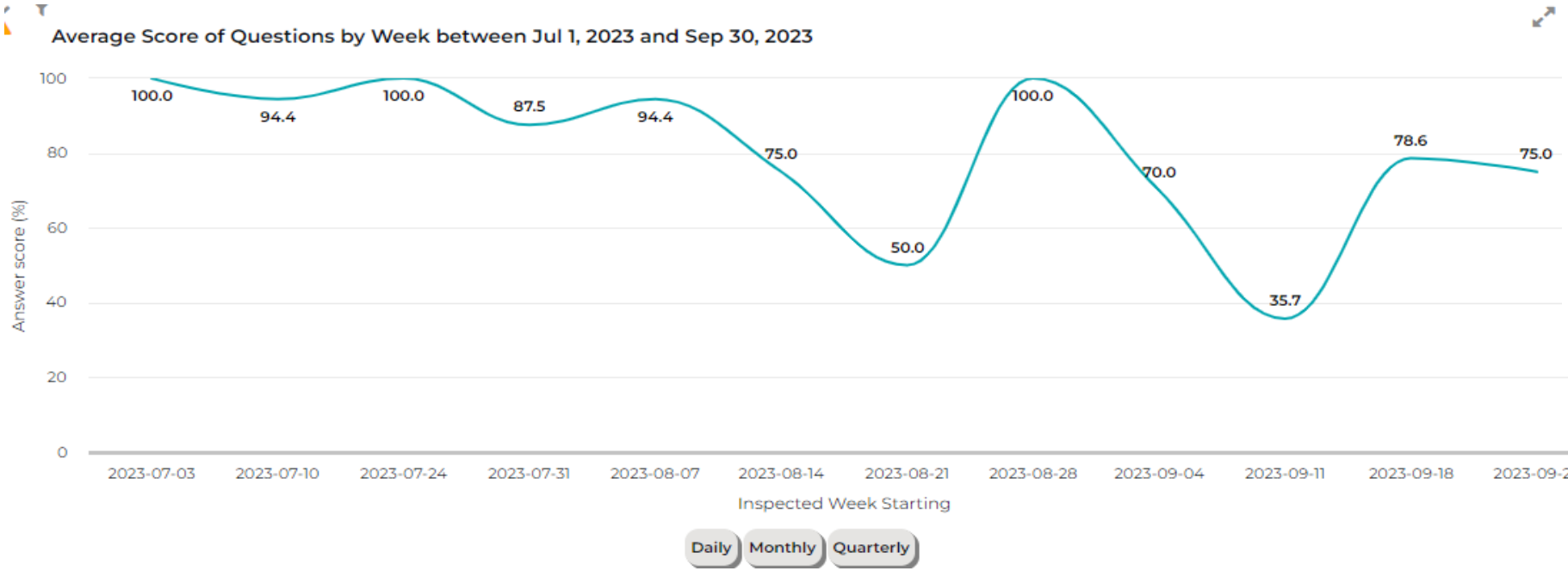
AMU, Breamore, Britford, Downton, Durrington, Laverstock, Longford Ward, Odstock

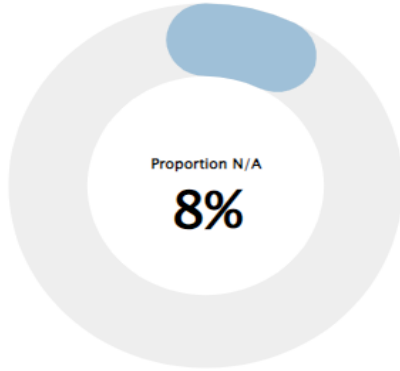
Person Centred & Safe | Professional | Responsive | Friendly | Progressive

Real-Time Feedback – Food and Nutrition Focus Trend

Salisbury NHS Foundation Trust

Question Text	Answer score (%)	Responded Answers
How would you describe the quality and selection of dietary options available to you?	77.7	74



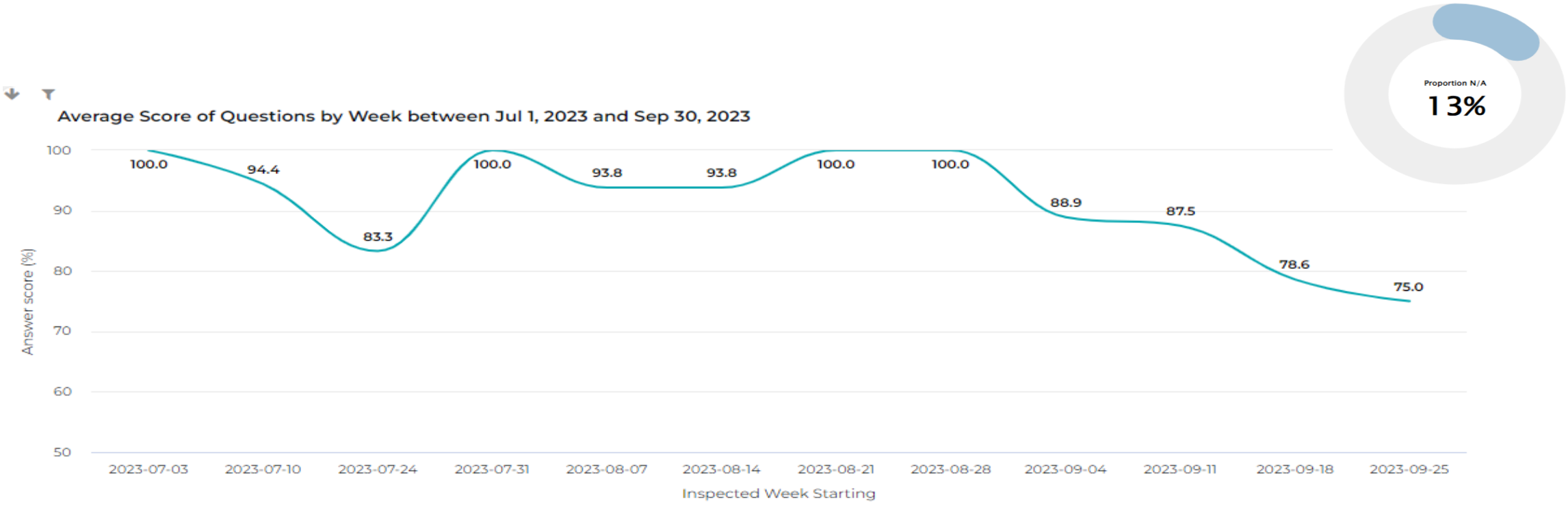


Person Centred & Safe | Professional | Responsive | Friendly | Progressive

Real-Time Feedback – Food and Nutrition Focus Trend

Salisbury NHS Foundation Trust

Question Text	Answer score (%)	Responded Answers
How would you describe the level of assistance you receive for basic care such as eating, drinking and washing?	89.3	70



Next steps for assurance

Salisbury NHS Foundation Trust

1. Consider amendment to Real-Time Feedback questions to be more explicit in their references to "enough to eat and drink"
2. Food and drink audit via Patient Experience Team
3. Update of Categories on Datix to include more robust reporting of food and hydration events
4. Update to F&N Policy ?
5. Ward assistant roles – continue to embed across the Trust and are now present in X inpatient wards.

Proposed new Stage of Care = "Nutrition, Hydration & Swallowing":-

Details (subcategory)	Adverse Events (incident types)
Adherence to SaLT swallow recommendations	Inappropriate consistency drink / fluids
	Inappropriate consistency food / diet
	Not following SaLT swallow strategies or guidance
Clinically Assisted Nutrition & Hydration	Radiologically inserted Gastrostomy issues
	Percutaneous Endoscopically inserted Gastrostomy issues
	Nasogastric tube issues
	Parenteral nutrition issues
	Other feeding tube issues
Delay to assessment / treatment	Prolonged period of NBM (including without ANH/CANH)
	Other
Mouth care / Oral hygiene	Poor mouth care
Nutrition & Hydration monitoring	Insufficient nutrition monitoring (weights, food charts, hydration charts, refeeding bloods)
Other	

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.4
Date of meeting:	7th December 2023		

Report tile:	PSIRF plan and policy			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	October 18th PSIRF Implementation Group November 15th Clinical Management Board November 22nd Trust Management Committee November 28th Clinical Governance Committee			
Prepared by:	Louise Jones and Alison Montgomery			
Executive Sponsor: (presenting)	Judy Dyos			

Recommendation:

Trust Board are asked to review and approve the Patient Safety Incident Response Framework (PSIRF) plan and policy in preparation for its launch and formal implementation on 8 January 2024.

There is a power point presentation in addition to the Policy and Plan to add some context around PSIRF.

Executive Summary:

PSIRF sets out new guidance on how NHS organisations respond to patient safety incidents and ensures compassionate engagement with 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. Key changes are to what and how we investigate, managing other proportionate responses and the engagement and involvement of patient, families and staff in any type of response and the development of actions or improvement plans.

The plan and policy were written using national templates and guidance and associated supporting documents.

The plan identifies local and national mandated patient safety incident investigation (PSII) requirements. It tells a 'story' of how we arrived at our locally-led PSII response priorities and gives an overview of how other types of responses will be used.

The policy supports the requirements of PSIRF and sets out Salisbury NHS Foundation Trust's approach to developing and maintaining effective systems and processes for reporting and responding to patient safety incidents for the purpose of learning and improving patient safety. It details how the plan will be operationalised.

A patient safety incident or event is any unintended or unexpected incident or event which could have or did lead to harm for one or more patient's receiving healthcare and can result in no harm or contribute to a fatal outcome. The policy requires all staff to take responsibility for reporting any incident, adverse event or near miss that they become aware of and review them as detailed within the policy.

The plan and policy will be reviewed every 12 – 18 months as a minimum to ensure it reflects changes in practice, or earlier if there are any significant changes.

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

(Insert Title)

Purpose

1.1 State the purpose of the report.

2 Background

2.1 Provide sufficient background to inform the reader of the history to the content of the paper and prepare them for the recommendation.

3 Use headings to separate the report

3.1 Complete the report using appropriate headings and sections.

3.2 Link your report to the Trust's Strategy or Assurance Framework as appropriate

4 Summary

4.1 Summarise the content and bring report to a close.

5 Recommendations

5.1 State the recommendation to the group [This should mirror the recommendation on the covering paper]

[Insert name of author(s)]
[Insert Job title of author(s)]

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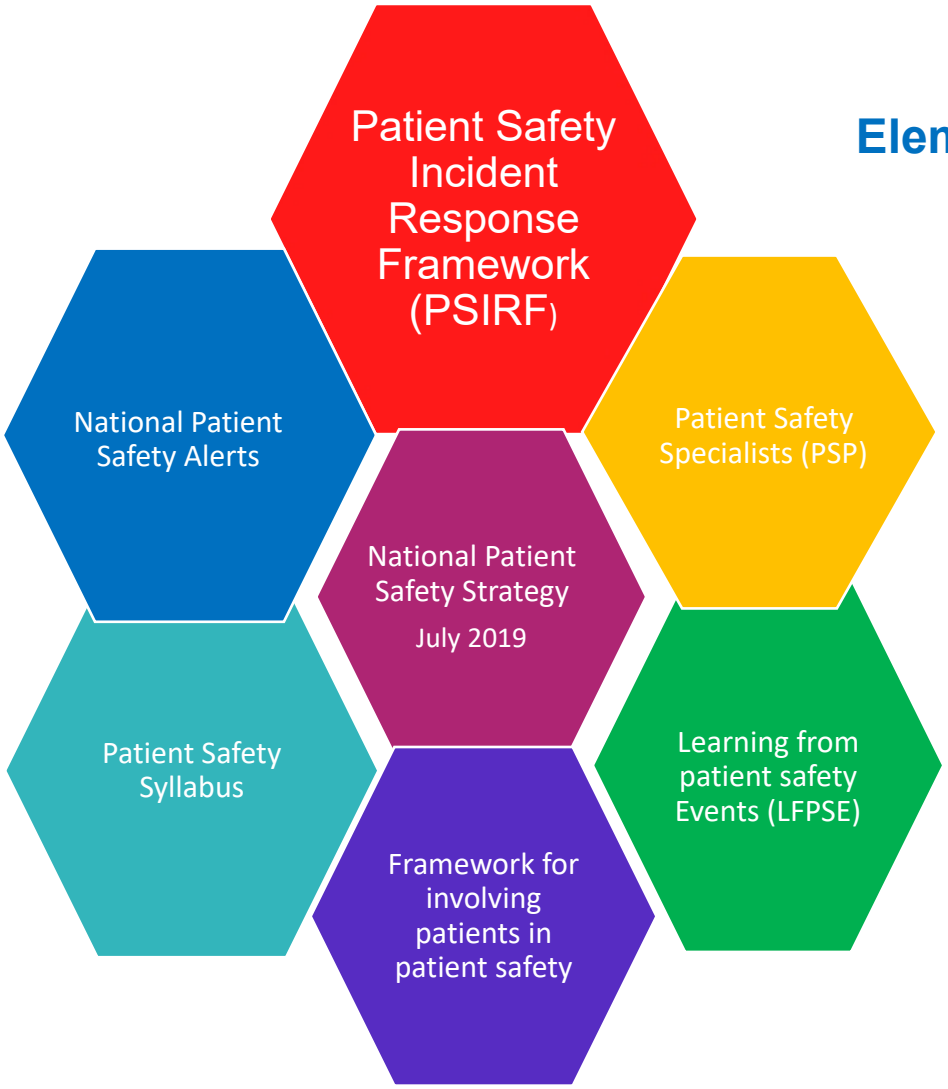
Patient Safety Incident Response Framework

(PSIRF)

Salisbury
NHS Foundation Trust

Elements of the Patient Safety Strategy



PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on patient outcomes and definitions of harm

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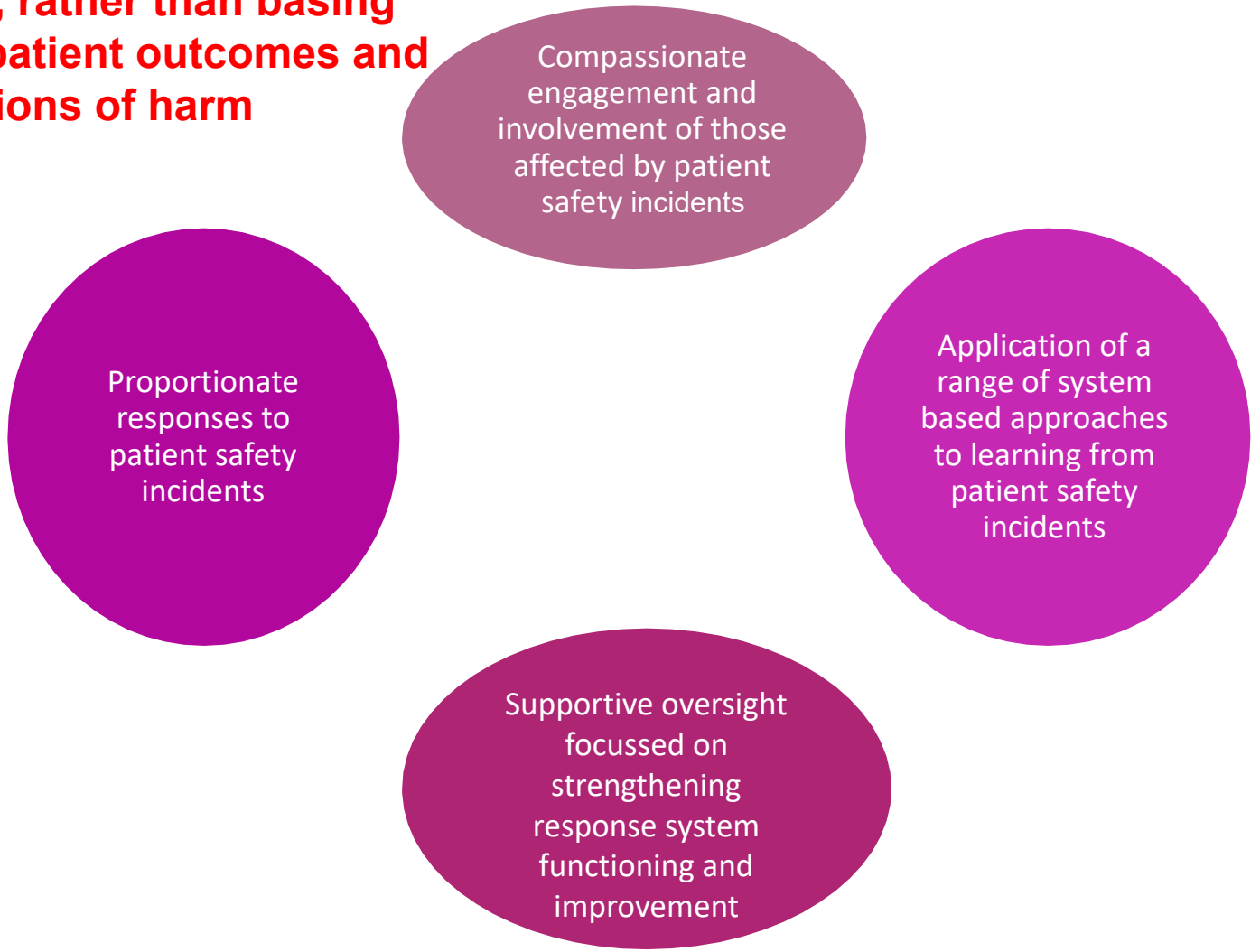


Deliverables to date….

-
- PSIRF implementation group established
- Regional network group
- Review of our current reporting systems and how we support open and honest reporting within our organisation
- Look back at 2 years of data (19,467 incidents) along with other data relating to patient safety to assist with identifying local priorities for the PSIRP
- Identification of resource to focus on PSIRF implementation at pace
- Comms plan underway to start the ‘drip feed approach’ to PSIRF
- Levels 1 and 2 patient safety training launch on MLE for staff to complete
- Successful appointment of 2 Learning Response Leads to support investigations
- Process mapping undertaken to review current reporting systems
  - The Datix journey
  - Complaints
  - Freedom to speak up (FTSU)
  - Mortality
  - Legal
  - Maternity
  - Safeguarding
  - IPC
  -

Local and National Priorities

Salisbury NHS Foundation Trust

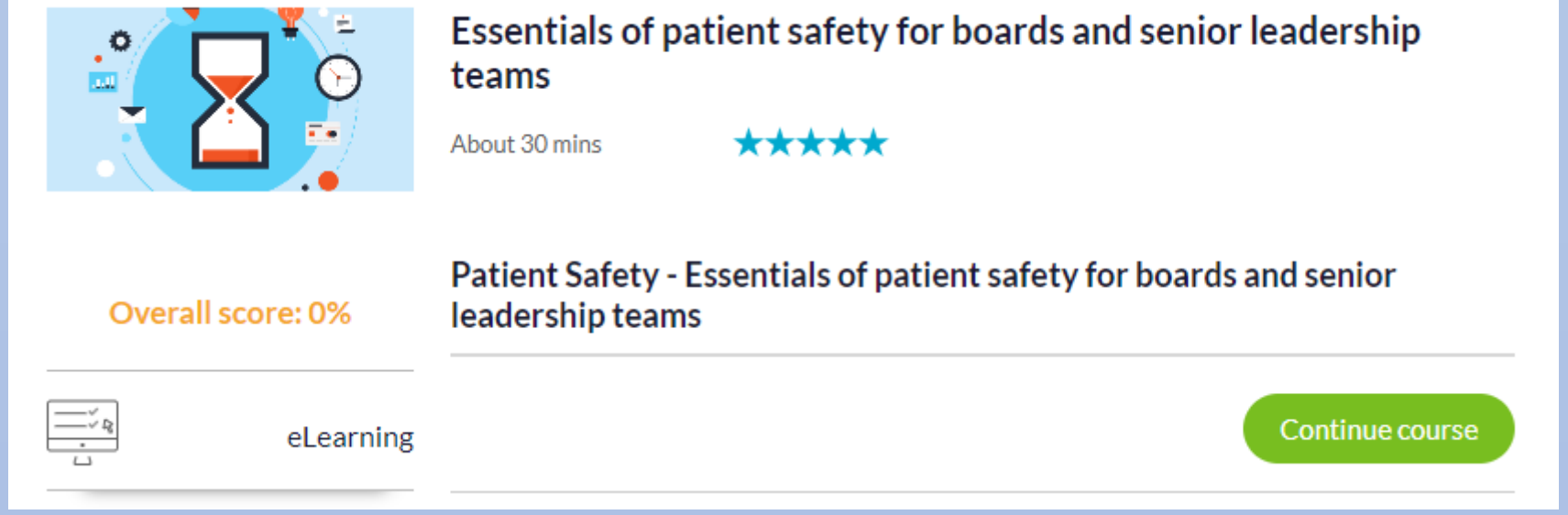
5 local priorities identified through data analysis:

Medication	Any incident relating to the administration of the medication
Clinical Assessment (Investigations, images, and laboratory tests)	Any incident relating to a wrongly identified patient at ward level having a laboratory test
Discharge	Any incident identifying a breakdown in the discharge planning process
Appointments	Any incident identifying a breakdown in the appointment or referral process
Obstetrics	Any incident identifying a failure in undertaking a risk assessment

10 National Priorities:

Incidents that meet the criteria set in the Never Events list 2018
Deaths clinically assessed as more likely than not due to problems in care
Maternity and neonatal incidents meeting HSIB criteria
Child deaths
Deaths of persons with learning disabilities
Safeguarding incidents in which: Babies, child and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse / violence Adults (over 18 years old) are in receipt of care and support needs by their Local Authority The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence
Incidents in screening programmes
Deaths in custody (e.g., police custody, in prison, etc.) where health provision is delivered by the NHS
Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)
Mental health related homicides

Board Training



Training required to be undertaken by Board members

Policy and Plan

- October 18th — PSIRF Implementation Group (approved)
- November 15th — Clinical Management Board (approved)
- November 22nd — Trust Management Committee (approved)
- November 28th — Clinical Governance Committee (supported)
- December 7th — Trust Board (for approval)

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Launch date confirmed
January 8th, 2024

Report to	Trust Board (Public)	Agenda item:	4.5
Date of meeting	07/12/2023		

Report title:	External Well-Led Development Review – key themes for development			
Status:	Information	Discussion	Assurance	Approval
				x
Approval Process: (Where had this paper been reviewed and approved)	• Executive Away Day 14 September 2023 – review of report and identified key areas of improvement. • Board Workshop 10 October 2023 – outcome of review presented by AQUA. • Executive agreement to the key development themes and delivery workstreams 11 November 2023.			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices				

Recommendation

Trust Board to approve the key areas for development. The Board to agree the frequency of progress reports.

Executive Summary

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

Key development themes have been identified for each Key Line of Enquiry (KLOE) from the findings of the review and are outlined in the slides including current workstreams to address improvement. Any further action required has been identified. It has been recognized that there are current programmes of work in place to address the key areas for development without the requirement to create additional workstreams.

Once the areas for development have been approved by the Board, these will be disseminated to the relevant workstreams to implement. Oversight of progress will be through progress reports to Board by the Director of Integrated Governance in addition to information reported through the committee governance structure.

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

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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

Well-Led Developmental Review

Areas for Development

Background

- BSW competitive tender process – AQUA appointed.
- SFT review April – June 2023 (GWH review in progress and RUH to follow early 2024).
- Executive Away Day 14 September 2023 – review of report and identified key areas of improvement.
- Board Workshop 10 October 2023 – outcome of review presented by AQUA.

Key development themes identified for each Key Line of Enquiry (KLOE) are outlined in the following slides including current workstreams addressing improvement and further action required.

KLOE 1: Is there leadership capacity and capability to deliver high quality, sustainable care?

NHS Salisbury NHS Foundation Trust

Key development themes	Current Delivery Workstream (ongoing)	Further action
NED skillset review and consideration of an Associate NED model	Part of current NED recruitment process	
Board Committee escalation process – review of escalation templates	Template revised to include the 3As (Assure, Alert, Advise).	Complete
Talent management & succession planning approach	People Promise workstream	On TMC agenda in December
Strengthen divisional governance	Director of Integrated Governance / COO	
Structured Board Development Programme	Chair – in development	
Board visibility – structured approach	Board safety walk effectiveness review. Go and See's	Go and See process confirmation

KLOE 1 : report findings

NHS Salisbury NHS Foundation Trust

KLOE 1 Leadership, Capacity and Capability

Key Development Themes

↑ Board Stability and Capacity

The underlying narrative behind each of the Board appointments is compelling but the number of changes may prompt a challenge in respect of Board stability. NED preparedness for regulatory questions varied considerably.

Development –

- *There may be value in periodically undertaking a stocktake of priorities, individual portfolios, major change programmes against individual and collective board capacity. Whilst key to this is appointment to interim vacancies, consideration can also be given to Associate NED roles.*
- *Regulatory challenge development is recommended to present the Trust in the best light (for board and divisional leadership). This preparation needs to be underpinned by mentoring and strong Trust-focused evidence base.*
- *Provide a single positive narrative for Board members in respect of recent appointments to ensure a consistent response to this challenge.*
- *Review the balance of executive capacity and engagement with external partnership commitments recognising that partners may be better placed to lead on some external programmes.*

↑ Talent Management and Succession Planning

An environment has been created where talent and succession discussions can take place, but the next step is to build a more cohesive and embedded approach.

Development-

- *Undertake a structured approach to building Trust-wide talent management and succession planning arrangements.*
- *Increased access to NED perspective and board as part of the leadership development programme. Consideration of operating this programme as an AHA to increase perspective and system context.*

↑ Board Visibility

There are some good examples of leadership visibility, but it is variable and there is opportunity for senior leaders to be clearer about their individual and collective approach to visibility.

Development-

- *Progress the Board Safety Walkround review and incorporate consideration of improved clinician engagement, timing and organisation.*
- *Full Board consideration of a more structured approach to visible, sustainable, compassionate, inclusive and effective leadership*
- *Review the totality of executive external partnership commitments.*
- *Enable wider engagement of senior leaders with Non-Executive directors*

↑ Divisional Leadership (refer also to other sections re divisional developments)

There is some variation in respect of having the right blend of capacity, skills, and experience across divisions.

Development-

- *Assessment of divisional capacity (and leadership gaps) aligned to roles, responsibilities, and scale.*
- *Support for divisional tri-team level development recognising their formation as a group.*
- *Continued focus and increase of cross divisional working and engagement, to continue to increase appreciation (and group resolution) of pressures and challenges. In addition, there was stakeholder appetite for more shared peer learning and sharing opportunities at operational level.*
- *Board line of sight to divisional leadership and performance is an area that needs to be kept under review, Including board exposure and NED visibility with divisions.*
- *There is opportunity to increase empowerment of divisional teams through defined earned autonomy (including defined exit criterion from intensive support). This would benefit releasing executive capacity for system work.*
- *Better engagement with the Local Maternity System is required so there is a shared understanding of any concerns. The Maternity Improvement Plan has had a number of iterations and there may be value in the Maternity Improvement Group being more evidently Board-led.*
- *Explore whether there are synergies across CSFS disparate services and whether opportunities of grouping services in such a division have been fully exploited.*
- *Supporting the development of governance maturity and embeddedness across divisions.*

KLOE 2: Is there a clear vision and credible strategy?

Salisbury NHS Foundation Trust

Key development themes	Current Delivery Workstream (ongoing)	Further action
Divisional 5-year plans	Plans under development	
Clinical strategy narrative	We do not have a separate clinical strategy – incorporated within Trust Strategy	
Health inequalities reporting and awareness	Health Inequalities Group work programme	

KLOE 2 : report findings

NHS Salisbury NHS Foundation Trust

KLOE 2
Trust Vision and Strategy

Key Development Themes

↑ Strategy Development

There is a clear strategy, set of priorities, vision and values. Improving Together has helped socialise all these elements.

Development

- *The level of collaboration and engagement in developing strategy was not always seen as positive across the divisions. The engagement approach should be reviewed when the strategy is next refreshed.*
- *Produce a narrative on how all the underpinning strategies and initiatives fit together.*
- *Align the monitoring of strategy delivery to provide transparency.*
- *Application of a structured approach to Divisional annual planning and 5-year planning.*

↑ Business Cases

Board oversight of business cases and the tracking and monitoring of strategic business cases was not well understood.

Development

- *The approach to business cases should be reviewed.*

↑ Clinical Strategy

The lack of a clinical strategy for the Trust is considered to be a gap.

Development

- *A Board focus upon the need for all clinicians to be able to connect with, and exercise influence over, the pan-AHA clinical strategy.*

↑ Health Inequalities

There is good work in train on health inequalities but there was little leadership knowledge of context and strategic intent.

Development

- *Shared narrative is required so leaders (at corporate and divisional levels) can explain what health inequalities are, the data that is being looked at and what action the Trust might be taking alone or with partner agencies.*

KLOE 3: Are there clear roles, responsibilities and systems of accountability to support good governance and management?

NHS Salisbury NHS Foundation Trust

Key development themes	Current Delivery Workstream (ongoing)	Further action
Divisional accountability	Refreshed Integrated Accountability & Governance Framework. Exec Performance reviews. Risk Strategy	
Quality of Board and Board Committee papers and cover sheets	Executive ownership	NHS Providers report writing session for Execs, NEDS and DMTs
Review governor observer in private Board		Completed
Policy compliance	TMC oversight / Corporate Governance	

KLOE 3 : report findings

NHS Salisbury NHS Foundation Trust

KLOE 3 Roles, Responsibilities and System Accountability

Key Development Themes

↑ Board and Committee Developments

Improvements to the consistency of committee papers

Not all papers were clear in terms of their purpose, what the committee was expected to do, where the paper had previously been and where it was going next. Some papers were not in a format that easily enabled holding to account on delivery, risks, mitigations, and timeframes for the impact of those mitigations. On occasion papers are late.

Development

- *Programme of work to improve the format, timeliness and writing of committee papers.*

Strengthen escalation processes

Chairs' reports are discursive and assurance escalation is not easily visible at Board. Referrals across committees could be strengthened.

Development –

- *This could be strengthened by structuring in a triple "A" format: Advise, Alert and Assure*
- *Embed reflection on the need to cross refer to other committees in committee agendas.*

Consistent challenge and contribution

Executive and non-executive contributions were not always evenly spread across attendees leading to some voices not being heard.

Development

- *Consideration of whole-Board development programme incorporating unitary Board principles, appreciative enquiry and effective challenge.*

Policy Compliance

As a key part of governance structures and regulatory oversight, it is important to maintain the focus on addressing the backlog of policies due for update.

Development

- *Ensure Board and committee line of sight on tracking policy compliance.*

↑ Board Openness

Whilst public openness is encouraged, Governor's observation of the private board is not standard practice and due to confidentiality can lead to additional meetings being required.

Development

Another option is to exclude governors from Part 2 of the Board but strictly limit what goes into Part 2 and have as much in the open part of the Board as possible. This helps to allay governor concerns that they are missing key issues and can be supplemented by the Chair providing the agenda and a summary of what has been discussed. Also, this needs to be seen alongside other opportunities the governors have to observe the NEDs e.g. COG, other committees of the Board.

KLOE 4: Is there a culture of high quality, sustainable care?

Salisbury NHS Foundation Trust

Key development themes	Current Delivery Workstream (ongoing)	Further action
Freedom to Speak Up reporting	Board reports. Triangulation with risk and complaints. Discussion on-going re reflecting learning	
Staff survey action	Divisional action plans. TMC oversight. Quarterly Pulse survey	

KLOE 4 : report findings

Salisbury NHS Foundation Trust

KLOE 4
Culture

Key Development Themes

↑ Refer to KLOE 2 Health Inequalities

↑ Staff Feedback

Developments

- *Sustained focus on staff led improvement in Staff Survey results particularly amongst nursing, midwifery and BAME staff*
- *Opportunities for better communicating the improvements that have been made in response to the survey results.*
- *Sustained focus on completion of appraisals and emphasis on their value-add.*

↑ Equality and Diversity

Developments

- *Improved knowledge and use of EDI data to drive change.*

↑ Challenged Services

Developments

- *Working with system partners to assess the viability and ongoing sustainability of challenged services.*

↑ Safety Culture

Developments

- *Embed and sustain changes e.g., theatres consent.*
- *Focus upon learning from incidents and planning e.g., liberty protection standards and PSIRF implementation.*
- *Simplify lengthy and over-engineered processes where possible e.g., incident investigation process.*

↑ Freedom to Speak Up

Developments

- *Investigate and act upon the 50% increase in issues raised with the FTSU Guardian and monitoring of timely feedback to staff (in accordance with internal policy).*
- *Review divisional level access to FTSU.*
- *As part of the review of staff survey performance, review timeliness of FTSU responses.*

↑ Patient, Service User and Family Engagement

Developments

- *Embed coproduction as a norm across the organisation aiming for evidence of consistent codesign and coproduction.*
- *Include service users and carers in Improving Together training and delivery of Trust improvement work. (see KLOE 8)*
- *Consider whether the description of coproduction could be strengthened by reference to health inequalities and EDI and by demonstrating how the Trust will engage and coproduce with different sub-populations.*

KLOE 5: Is there appropriate and accurate information being effectively processed, challenged and acted on?

Salisbury NHS Foundation Trust

Key development themes	Current Delivery Workstream (ongoing)	Further action
Board cyber and digital awareness	Board Development Programme Review of Digital Governance underway	

KLOE 5 : report findings

Salisbury NHS Foundation Trust

KLOE 5 Information

Key Development Themes

↑ Digital Strategy

Development

- Assessment of the capacity of staff to address EPR and other digital priorities, change programmes and alignment to Improving Together
  - *Prioritisation of digital projects/initiatives recognising the impact of the EPR programme (i.e., staffing capacity and capability).*
- Funding, limitations to revenue and capital allocation
- Evidence of lessons learnt from other organisations.

↑ Information Governance

Development

- *Increased board cyber and digital awareness*

KLOE 6: Are there clear effective processes for managing risk, issues and performance?

Salisbury NHS Foundation Trust

Key development themes	Current Delivery Workstream (ongoing)	Further action
BAF – aligned to ICB BAF and clarity on controls and assurances	Changes to BAF template actioned and alignment to the ICB BAF reported to Board Oct 23.	Complete.
QIA process	QIA policy and process revised. Oversight via Clinical Management Board	
Review of risk appetite	Scheduled for Board Development in Feb 24.	

KLOE 6 : report findings

Salisbury NHS Foundation Trust

KLOE 6
Managing Risk and Performance

Key Development Themes

↑ Risk Appetite

Risk appetite is at an early stage of development and needs to become part of the discussions at all levels of governance.

Development-

- *Progress the risk appetite work that has been started and incorporate into committee operation and Board decision-making.*

↑ Board Assurance Framework

The format, content and utilisation of the BAF can be improved particularly with regard to separating controls and assurances, trajectories for improvement and connection to deep dives.

Development-

- *A development programme to refresh the BAF would be timely.*

↑ Top Risks

There is some inconsistency in how the Trust's top risks are described by leaders.

Development-

- *A narrative in advance of any regulatory visit (linked to any BAF development work) should set out key risks for leaders at all levels.*

↑ Quality Impact Assessment

Visibility and consistent understanding of QIA processes needs leadership attention.

Development-

- *Further communication and engagement on QIA arrangements is important.*
-

↑ Performance

There is opportunity to further refine the use of SPC reporting.

- *Consider implementing hybrid SPC aligned to RAG ratings and better utilisation of trajectories, taking account of planned improvements, actions, and investments. Using longer time series where the data is available, helps with seasonal variation. Also suggest the application of the special cause rules could more effectively drive the narrative / analysis / action. Narrative can be observational: if you're using an SPC and the data falls within levels of expected variation then the narrative should conclude levels are as expected, no further analysis is needed and no further actions being undertaken. The trajectories for improvement could be better described and monitored.*
- *There was an appetite for expanding the system to facilitate pathway information (in and out of hospital).*
- *Increased ability for the divisions to interrogate data. The business cases for the EPR and a new maternity system were recognised as opportunities to strengthen information and the ability to share data across providers.*
- *There are concerns that indicators that are not breakthrough measures have a reduced focus which can lead to failure to identify early warnings. This places significant reliance on the operational and divisional teams operating effective governance processes.*

KLOE 7: Are the people who use services, the public, staff and external partners engaged and involved?

Salisbury NHS Foundation Trust

Key development themes	Current Delivery Workstream (ongoing)	Further action
Structured approach to co-production	Patient panels Patient Safety Partners x2 Patient Experience Steering Group	
Staff engagement	People Promise workstream	

KLOE 7 : report findings

Salisbury NHS Foundation Trust

KLOE 7 Engagement

Key Development Themes

System Engagement

Development

- *The Trust were recognised internally and by system partners as having a significant presence across system initiatives. There was in some internal and external courts a perception that this required rebalancing and a reduction in dominance to facilitate an improved internal focus.*
  - *There is an opportunity to redistribute responsibilities across partners e.g., medical leadership.*
- *There was a perception from partners that within a system context the Trust could be more open and inclusive.*

Service Provision Partnerships

Development

- *Wiltshire Health and Care (WH&C) partnership has a contract extension to 2024:*
  - *System based decisions regarding the provision and commissioning approach for community care will be required. It was understood that there were tensions between the organisations regarding the future model.*
  - *It was understood that the partnership would be financially challenged in 2024 regarding pay award funding.*
  - *It was understood by partners that Salisbury saw direct management the community health service delivery as part of their ongoing viability.*
  - *Viability could be compromised subject to the contractual arrangements (i.e., current block arrangements).*
- *Stakeholders noted an opportunity to risk share more equitably particularly between the Trust and Wiltshire Council where relationships 'could be better.'*
- *The provision of mental health services by different adult and CAMHS providers outside the AHA presents some challenges particularly with out of hours responsiveness.*

Staff Engagement and Communication

Development

- *The Communications Team is built on freelance staffing which impacts team and staff development. A business case has been submitted to develop as substantive.*

Service User and Carer Engagement

Development

- *Ensure a robust approach to service user and carer engagement becomes the norm and that there is evidence of coproduction in all innovation and continuous improvement work.*

KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation

NHS Salisbury NHS Foundation Trust

Key development themes	Current Delivery Workstream (ongoing)	Further action
Organisational learning (complaints, incidents, mortality reviews)	PSIRF Mortality Surveillance Group Divisional learning forums	Review of clinical governance half days underway
Growing commercial based research	Research and Innovation Board work programme	
Lived experience into Improving Together	Improving Together Board	Associate Director of Improvement to explore further

KLOE 8 : report findings

Salisbury NHS Foundation Trust

KLOE 8
Learning and Improvement

Key Development Themes

↑ Building Capability

Development

- *Consider how to train lived experience partners in Improving Together as part of the Coach House team. There may be the opportunity to learn from the work of other providers e.g., Leeds Teaching Hospital QI Partner model.*
- *Review involvement of Deputy Directors who feel that with their responsibilities for operational delivery, they are a critical layer to involve as soon as possible.*

↑ Deployment / Operating System

Development

- *Include people with lived experience in Improving Together in a far more intentional way scaled across the Trust, trained in the IT method to participate in operational improvement teams.*
- *It may be possible to strengthen the link between Improving Together and implementation of the NHS Safety Strategy to maximise resource investment.*

↑ Impact

Development

- *The impact narrative could be strengthened and aligned with the Trusts strategic priorities.*
- *The Improving Together work is portrayed as primarily training rather than impactful. Stronger evidence albeit in pockets could be prepared in readiness for regulatory conversations.*

↑ Learning Organisation

Development

- *There is opportunity to strengthen whole organisation learning. It was anticipated that PSIRF will support this improvement.*
- *There needs to be increased understanding of the division's role in sharing learning from deaths across specialties and across divisions.*
- *Mortality surveillance group includes representatives from the divisions. Further clarity is required on attendees' role to ensure consistent sharing of information.*

↑ Clinical Audit and Mortality

Development

- *Align audits to the Improving Together initiative.*
- *There is no easy way to theme (free test field) learning from case note review on the current system.*
- *Increased understanding of the division's role in sharing learning from deaths across specialties and across divisions*
- *Clarify role of attendees at Mortality Surveillance Group to ensure consistent sharing of information across departments/ specialties.*

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Report to:	Trust Board (Public)	Agenda item:	4.6
Date of meeting:	7th December 2023		

Report tile:	Maternity Quality and Safety Report for Quarter 2 2023/24.			
Status:	Information	Discussion	Assurance	Approval
	X	x	X	
Approval Process: (where has this paper been reviewed and approved):	Report approved through Divisional Governance 17.11.23 and Clinical Governance Committee 28th November 2023			
Prepared by:	Vicki Marston- Director of Maternity and Neonatal Services.			
Executive Sponsor: (presenting)	Judy Dyos – Chief Nursing Officer			

Recommendation:

The Committee are asked to note the report, and its content to be minuted as per CNST requirements ensuring that quarterly oversight of the Quality and Safety Agenda is maintained in addition to the monthly Perinatal Quality Surveillance Model that is reported monthly.

CNST requirements board minutes to note the following:

1. PMRT review to be noted in board minutes.
2. Compliance with labour ward coordinator being supernumerary and women receiving 1:1 care =100%

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 and 2022 recommendations and work towards the 2023 publication of the Three Year Delivery plan. 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 2 23/24.

Positive points to note:

- Patient experience

- Stillbirth and Neonatal death rate- nil reported in Q2 23/24
- Ockenden 2020 compliance – all actions expected to be closed by Q3
- Progress towards CNST – MIS year 5 requirements

Points needing to focus on

- Progress on the Maternity safety support programme as work continues towards exit fomr the plan.
- Challenges with training compliance for PROMPT and NLS
- Challenges with meeting compliance and full implementation with Saving babies lives care bundle.

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

Maternity and Neonatal Services Quality and Safety Report Q2 2023

Women and Newborn Division

Maternity Quality and Safety Report to Board Quarter 2 2023/24

Trust: Salisbury Foundation Trust

CQC Maternity Ratings Inspection 2021	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:
	Requires Improvement	Requires Improvement	Inspected but not rated		Inadequate	

Maternity Safety Support Programme	Select Y / N	Yes

	2023/24											
	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1.Findings of review of all perinatal deaths using the real time data monitoring tool	✓	✓	✓	✓	✓	✓						
2. Findings of review of all cases eligible for referral to HSIB	✓	✓	✓	✓	✓	✓						
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	✓	✓	✓	✓	✓	✓						
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	✓	✓	✓	On track for required MIS compliance targets	On track for required MIS compliance targets	On track for required MIS compliance targets						
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	✓	✓	✓	✓	✓	✓						
3.Service User Voice Feedback	✓	✓	✓	✓	✓	✓						
4.Staff feedback from frontline champion and walk-abouts	✓	✓	✓	✓	✓	✓						
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	✓	✓	✓	✓	✓	✓						
6.Coroner Reg 28 made directly to Trust	n/a	n/a	n/a	n/a	n/a	n/a						
7.Progress in achievement of CNST 10	✓	✓	✓	✓	✓	✓						

8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	Reported annually
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (Reported annually)	Reported annually

Contents

1.Executive summary

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the Salisbury Foundation Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. The information within the report reflects actions in line with Ockenden and progress made in response to any identified concerns at provider level.

2.Good news stories

During this quarter Maternity services have successfully implemented the pertussis vaccine in Antenatal Clinic. The Neonatal unit successfully achieved Baby Friendly Initiative (BFI) Level 2 award. The Trusts new audit system AMaT has been successfully launched in Maternity during September and October.

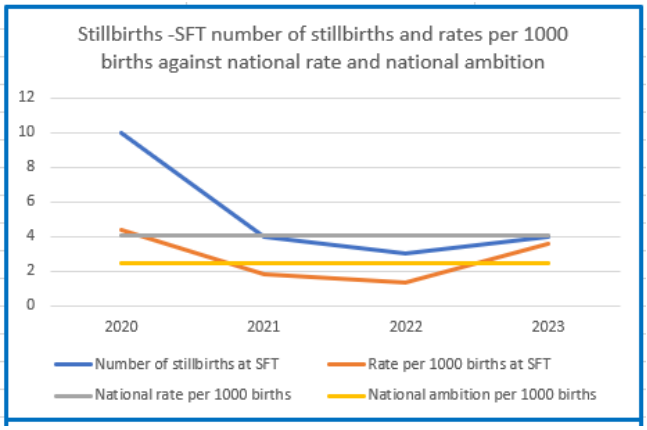
Recruitment successes: We have now recruited a substantive Director of Midwifery and Neonatal Services. Five new Specialist Trainee Obstetric Registrars are also starting on 4/10/23. We have 6 new Band 5 Midwives starting in October, with 4 more starting once they have completed their course. We also have successfully recruited four Band 6 Midwives. The advert is currently out for the Midwifery apprenticeship course starting in January 2024. We have 7 international Midwives, and all have passed their OSCE's. Five have received their registration and have been employed as Band 5 Midwives. We have successfully recruited a Named Midwife for Safeguarding and, an Audit and Guidelines Midwife.

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.

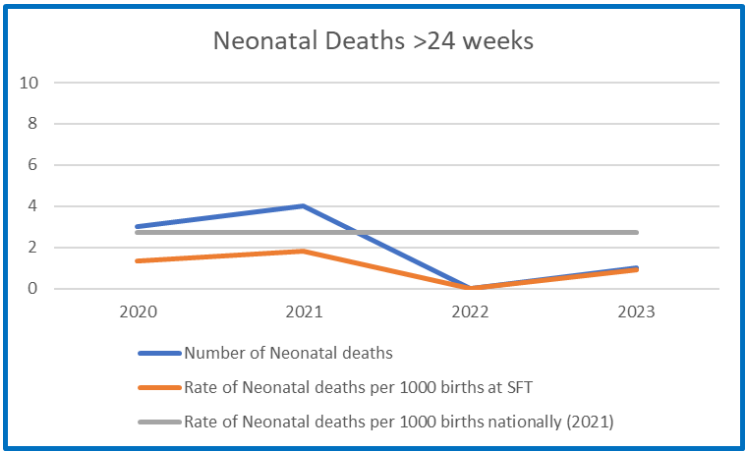
In Q2 we have had 0 stillbirth as detailed in Figure 1, this makes a total of 4 in 2023 so far, which equates to 1.8 per 1000. The national rate per 1000 births is 4.1 per 1000 with a national ambition to reduce to 2.5 per 1000 births.

Figure 1. Stillbirth rate (by number and, per 1000 births) for Salisbury compared with national rate and ambition



In Q2 Salisbury Foundation Trust had zero (0) reportable neonatal deaths. Annual local trends by number and rate per 1000 are compared with national rates between 2020-2023 in figure 2. This shows positive progress towards national targets.

Figure 2. Number of neonatal deaths and rate per 1000 at Salisbury compared with national rate per 1000



Perinatal Mortality Review Tool (PMRT) Summary Quarter 2 2023/24

PMRT was designed and will be developed further 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'.

Maternity 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 eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.
b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions sought from 30 May 2023 onwards.
c) For deaths of babies who were born and died in your Trust, multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.
d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023

Please note within the new year 5 MIS scheme the lettered points of this standard for safety action 1 have been changed and will be different to previous reports.

During Q2 23/24 1 Medical Termination of Pregnancy met the criteria for MBRRACE notification, 0 met the criteria for MBRRACE surveillance and 0 met the criteria for PMRT review.

Figure 3. Table showing the number of PMRT reportable perinatal deaths in Q1 and Q2

23/24 (excluding terminations for abnormalities)	**Q1**	**Q2**
Stillbirths (>37^{+0} weeks)	0	0
Stillbirths (>24^{+0} weeks - 36^{+6}weeks)	1	0
Late miscarriage (22^{+0} weeks - 23^{+6}weeks)	0	0
Neonatal deaths	1	0
Total	**2**	**0**

During Q2 2023/24 figure 4 (below) highlights that there were two outstanding cases to be reviewed by the PMRT group from previous quarters and that they were compliant with the MIS Year 5 CNST standards except for one case which was with UHS and outside of our control.

Figure 4. Table showing the MBRRACE reportable cases. There were two cases in Q1 which were reviewed using the PMRT tool in Q2. There is one MBRRACE reportable case in Q2, and their compliance with the MIS (CNST) standards. Green represents the standards being completed. Red signifies standard not completed.

Gest at del	Type of loss	CNST SA 1ai) MBRACCE notification	CNST SA 1ai) Surveillance	CNST SA 1c) Parental engagement sought	CNST SA 1aii) PMRT factual info	CNST SA 1b) PMRT review meeting	CNST SA 1b) PMRT draft report	CNST SA 1b) PMRT report	Grading of care:
27+3	SB	Yes-21/6/23	Yes 26/6/2023	Yes- sent to	Completed 7/8/23	23/09/2023	03/10/2023	03/10/2023	1: C, 2: B
37+	NND	Yes- 3/7/2023	Yes 11/07/2023	Yes- none given at time of report/ letter sent/ no feedback given with phone call	Completed 14/7/23	28/08/2023	03/10/2023	27/12/2023	1:B, 2:A, 3:A
22+3	MTOP	Yes 22/09/2023	NA- MTOP	NA- MTOP	NA- MTOP	NA-MTOP	NA-MTOP	NA-MTOP	NA-MTOP

Key: Grading of care

- A- No issues identified
- B- Issues identified that would not have had an impact on the outcome
- C- Issues identified that may have made a difference on the outcome
- D- Issues identified that would likely have made a difference to the outcome

From the reviews, care issues, process and systems changes are identified. Individual action plans are then developed and agreed for cases.

Figure 5: Table showing PMRT action plans for each case review of deaths in quarter 2

Action	Implementation plan
Robust processes within the Trust need to be put in place to ensure language needs are managed from first access to maternity services.	To talk to staff to discuss the barriers around this and then decide an action plan. NED present at review will take this to the Executive Team for the Trust. Issue of community care at booking to be taken to the antenatal quality meeting for further discussion
Robust processes are required by the trust to ensure women who need aspirin are provided with it.	To talk to staff to discuss the barriers around this and then decide an action plan. To be discussed at the antenatal quality meeting for a plan. NED present at review will take this to the Executive Team for the Trust.
The baby was small for gestational age at birth, but appropriate growth surveillance had not been carried out.	Review local guidance against national guidance and LMNS and take to MDT for confirmation, communicate to staff- clarify SFH vs serial growth USS and the 26-28 weeks gap if on serial USS
Continue auditing CO monitoring Laser, theme of the week communications	Review equipment checking and escalate process of CO monitors

The Year 5 Maternity Incentive Scheme (MIS) requirements from NHS Resolution (NHSR) recommend using the PMRT tool reporting function to generate reports to share with Trust boards. This report is required to achieve compliance with standard d and will be submitted to the board on a quarterly basis. A PMRT report covering Q1 and Q2 23/24 is embedded below for this purpose:

PMRT_BoardReport_
Salisbury NHS Found

4.Maternity and Newborn Safety Investigation (MNSI, formerly HSIB) and Maternity SI's

Background

The aim of the National Maternity Safety Ambition launched in November 2015 was to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur soon after birth, by 2025. This strategy was updated in November 2017 with a new national action plan called Safer Maternity Care, which set out additional measures to improve the rigour and quality of investigations into term stillbirths, serious brain injuries to babies and deaths of mothers and babies. The Secretary of State for Health asked HSIB to carry out the work around maternity safety investigations outlined in the Safer Maternity Care action plan. However, in October 2023 HSIB was transformed into two bodies the MNSI and Health Services Safety Investigations Body (HSSIB). As part of this transformation the health and social care regulator the Care Quality Commission (CQC) have taken over the HSIB maternity investigations under the newly formed MNSI.

MNSI will continue to 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: Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy

Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.

Early neonatal death: when the baby died within the first week of life (0-6 days) of any cause.

Severe brain injury diagnosed in the first seven days of life, when the baby:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or
- Was therapeutically cooled (active cooling only) or
- Had decreased central tone and was comatose and had seizures of any kind

To meet the requirements against the 7 Immediate and Essential Actions (IEAs) in the Ockenden report all SI's concerning maternity services adhere to the Trusts Incident management Policy. There is also a robust process for reporting cases that meet the criteria for MNSI.

At Salisbury Foundation Trust Hospital there was one case of a term baby being transferred to a tertiary unit for active cooling; which qualified for notification to MNSI during Quarter 2 2023/2024. This case is currently being investigated by MNSI. As part of this SFT's legal department have notified the NHS Resolution Early Notification Scheme (as a requirement of our membership to CNST and current Year 5 MIS requirements) to support improved timeliness of incident to claims decisions thus supporting families and reducing associated costs to all parties. This case is noted in the next section.

5.Investigation progress update

During this section of the report there is an update on the progress of all ongoing external MNSI/HSIB investigations, any Coroner Regulation 28 notifications and Maternity SI's commissioned during quarter 2. There will also be an update on the compliance tracker used by the Trust to monitor and close actions identified during investigations. Figure 6 (below) summarises the progress of MNSI (formerly HSIB) external investigations and notifications.

Figure 6. Progress of HSIB (now MNSI) investigations including any external notifications

Ref	HSIB Reference	Confirmed level of investigation	Date confirmed Investigation	External Notifications and Other Investigations
SII 555	MI-024309	HSIB Investigation	21/03/2023	This was a case involving a full-term stillbirth that occurred during labour. It was reported via STEIS. HSIB have shared the final report with the Trust and family. Parents have declined tripartite meeting. DoC stage 3 letter from CEO sent on 4.10.23. Actions added to Risk team compliance tracker. Evidence being sent to newly formed MNSI and risk team for closure.
DATIX 158202 SII587	MI-031767	MNSI Investigation (formerly HSIB)	22/08/23	This case involved a term baby being transferred to a tertiary unit for active cooling. HSIB (now MNSI) have agreed to investigate. Early Notification Scheme completed. MNSI interviewed staff on 2.10.23.

Coroner Regulation 28 made directly to Trust

A Coroner Regulation 28 report (prevention of future death) is something that can be issued to an organisation by a coroner following investigation of a death whereby concerns have been identified. It sets out these concerns and requests action to be taken by an organisation. An organisation has 56 days to provide the coroner with a response that includes details of actions taken.
There are no Coroner Regulation 28 Reports in this reporting period.

Maternity Serious Incident Investigations (SII's)

During quarter 2 2023/24 there was one maternity Serious Incident investigations commissioned

(see figure 7).

Figure 7. Maternity SII's commissioned in Q2

SI number	Incident	Panel	Immediate Learning
SII586 Datix 158202	Transferred to SFT following eclamptic fit at home. Received a General Anaesthetic	External Panel Chair identified, panel date 2.11.23	All emergency eclampsia kit to be checked thoroughly to ensure complete (including algorithms). Completed 8.9.23

Investigation Actions

At the end of Q2 in September 2023, 14 investigations were open containing a total of 64 actions. 7 remain unresolved and a further 4 are in progress. In early September there were 27 unresolved actions, demonstrating the Divisions' ongoing management of compliance. Figure 8 shows the RAG rated compliance tracker as of 13th October.

Figure 8. Compliance Tracker demonstrating progress on Investigation Actions (13.10.23)

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
CR 454	Click	W&NB	December 2021	Q2 23-24	Q2 23-24	Oct 22	Q4 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	Q2 23-24	Jan 23	Q4 22-23	Q4 22-23	Q4 22-23	Q3 22-23	Q4 22-23	Q1 23-24		
SII 489	Click	W&NB	May 2022	Q1 22-23	Dec 22	Q4 22-23	Q4 22-23	Q3 22-23	Q3 22-23					
SII 497	Click	Surgery	July 2022	Surg	Q1 23-24	Q2 23-24	Med	Apr 23						
SII 506	Click	W&NB	March 2021	CSFS	Jun 23	Q1 23-24	CSFS							
CR 509	Click	W&NB	July 2022	Q2 22-23	Oct 23	Aug 23	Oct 23	Aug 23						
SII 510	Click	W&NB	August 2022	Q1 23-24	Q1 23-24	Feb 23	Q2 23-34	Feb 23	Jan 23	Jan 23	Q1 23-24	Jan 23		
CR 512	Click	W&NB	September 2022	Sept 23	Jul 23									
CR 514	Click	W&NB	September 2022	Q3 22-23	Jan 23	Q1 23-24	Dec 22	Feb 23	Q2 23-24	Q1 23-24				
CR 527	Click	W&NB	October 2022	Q1 23-24	Q1 23-24	Jun 23	Q2 23-24							
SII 537	Click	W&NB	December 22	Jul 23	Jul 23	Jul 23								
CR 540	Click	W&NB	November 2022	Jul 23	Q1 23-24	Sep 23	Jul 23	Jun 24						
SII 555	Click	W&NB	March 2023	Nov 23	Nov 23	Nov 23	Nov 23							

Colour Code		
No Evidence	Evidence of Progress	Evidence of Completion

6.Continuity of Care

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. The Maternity service have applied for the Wiltshire Health Inequalities Bid. If successful, this funding would support the set-up of two dedicated antenatal continuity roles to improve care and outcomes for our BAME population of service users. This would use QI methodology as part of our improving together commitment and will target improving engagement.

7.Ockenden Report 2020 and 2022 Immediate and Essential Action (IEA) updates

For Ockenden 2020 there are seven IEAs, separated into 22 local actions. There has been positive progress with compliance being assured for 17/22 actions now. IAE 4 is now complete following the completion of the Maternal Mental Health guideline which is now linked to the Maternal Medicine SOP. Evidence for IAE 3, 6 and 7 will be presented at the next Ockenden meeting in November for closure which will result in the completion of all Ockenden 2020 actions. For the Ockenden Final Actions 2022, there are 15 essential actions, separated into 84 actions. Compliance has been assured for 19/84. Three further actions have been closed in the last month. Figures 9 and 10 below demonstrate current progress with both 2020 and 2022 IEAs.

Figure 9. Current progress with Ockenden 2020 IEAs

	Current Rag Status /Action No	Immediate & Essential Action	Number of actions under each heading rated		
			RED	AMBER	GREEN
Oct-23	1	Enhanced Safety	0=	0=	3=
	2	Listening to Women & Families	0=	0=	1=
	3	Staff Training & Working Together	0=	1=	2=
	4	Managing Complex Pregnancy	0=	0=	3 ↑
	5	Risk Assessment Through Pregnancy	0=	0=	2=
	6	Monitoring Fetal Wellbeing	0=	1=	6=
	7	Informed Consent	0=	3=	0=
		TOTAL	0	5	17↑

As of October 2023, there were 5 actions remaining in process for Ockenden 2020. There is anticipation that 4 will be closed off in November, with the last remaining action awaiting confirmation of completion from the LMNS.

Figure 10. Current progress with Ockenden 2022 IEAs

	Current Rag Status /Action No	Immediate & Essential Action	Number of actions under each heading rated		
			RED	AMBER	GREEN
Oct-23	1	Workforce Planning & Sustainability	0=	3=	4=
	2	Safe Staffing	0=	6=	4=
	3	Escalation & Accountability	0=	3=	2=
	4	Clinical Governance - Leadership	0=	3=	4=
	5	Clinical Governance - Incident Investigation & Complaints	0=	4=	2=
	6	Learning From Maternal Deaths	0=	2=	0=
	7	Multidisciplinary Training	0=	6=	1=
	8	Complex Antenatal Care	2=	2=	1=
	9	Preterm Birth	2=	2=	0=
	10	Labour & Birth	4=	2=	0=
	11	Obstetric Anaesthesia	0=	3=	0=
	12	Postnatal Care	0=	4=	0=
	13	Bereavement Care	0=	4=	0=
	14	Neonatal Care	3=	2=	1=
	15	Supporting Families	0=	3=	0=
		TOTAL	11	48	19

Working parties are in progress to continue the actions in progress and to commence actions not yet started. Ockenden work in progress is discussed at the monthly board level safety champions meetings and maternity governance. The Ockenden Working Group meets regularly to drive progress on the immediate and essential actions.

We continue to work with the Local Maternity and Neonatal Systems (LMNS) to ensure joined up working, this includes the establishment of a LMNS dashboard to ensure data is benchmarked across all three service providers.

8. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

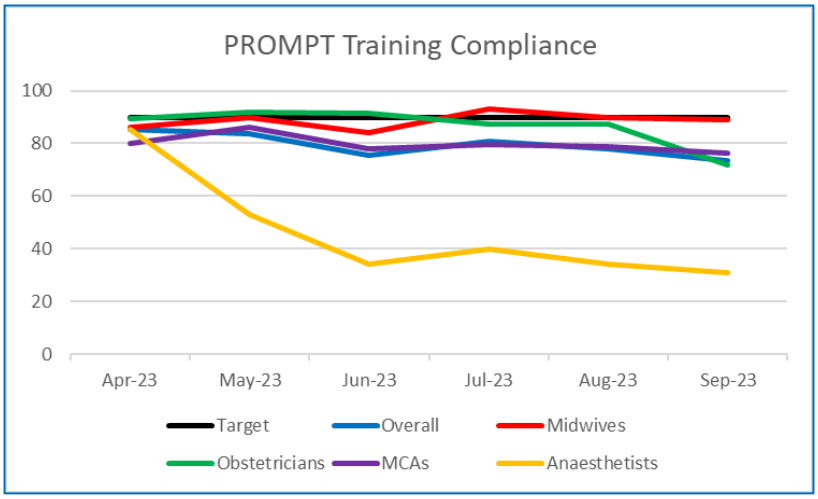
As part of the Maternity Incentive Scheme and the Core Competency framework, work has been on going to achieve compliance for all our staff groups in key specified training. Training is currently a divisional driver for Improving Together due to recognition of concerns around meeting targeted outcomes for numbers of staff trained. We will continue to focus on compliance with 6 key training programmes locally that are particularly relevant to both obstetricians and midwives which include the 3 MIS key areas.

Within the MIS, 3 key areas are identified to achieve training compliance of over 90%:

- PROMPT – Multidisciplinary Obstetric Emergencies
- Newborn Life Support
- Fetal Monitoring

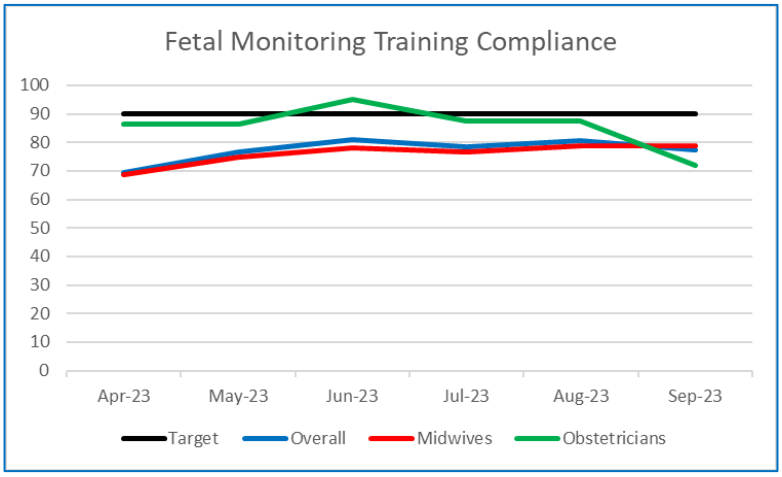
In Maternity Incentive Scheme year 5, the data needs to be further stratified to be compliant with safety standard 8. This includes staff groups and grades individual compliance with above training modules. We have included this data to continue monitoring compliance during MIS year 5. In quarter 2, there is the rotation of junior doctors which has influenced compliance rates in all training elements as shown below.

Figure 11. PROMPT training compliance by staff group as of 01/09/2023



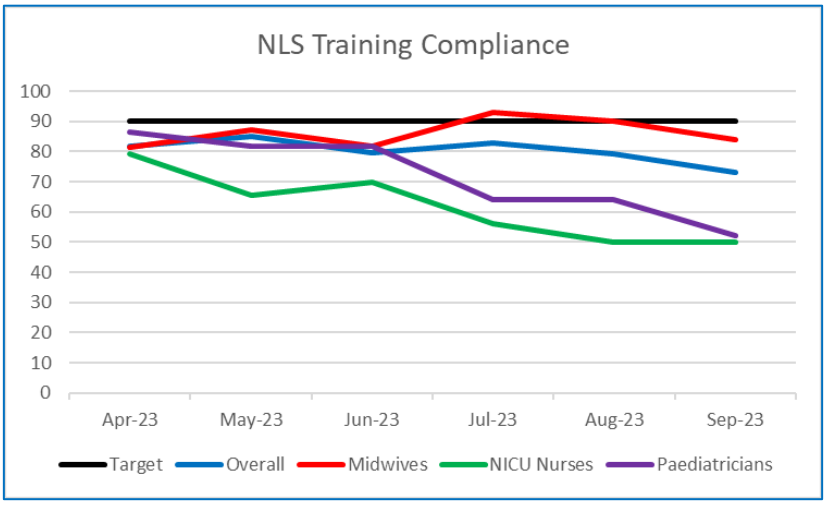
Anaesthetic attendance at PROMPT training has been a challenge this year due to conflicting demands of the surgical services versus training attendance. This has been escalated to Surgery and Women and Newborn Divisional Leadership Teams and an action plan has been commenced to ensure compliance by December 2023. This includes additional PROMPT training dates in October and November.

Figure 12. Fetal Monitoring training compliance by staff group as of 1.9.23.



Obstetric compliance with fetal monitoring training has fallen due to the rotation of junior doctors during this quarter. To ensure compliance by December, additional training dates have been created in October and November.

Figure 13. NLS training compliance by staff group as of 1.9.23.



An overall decrease in training compliance for NLS in this quarter mainly due to the lack of training dates throughout the summer and the rotation of junior doctors. An action plan in place and additional dates have been created in October and November.

The Maternity Incentive Scheme now require NLS to be delivered by Resuscitation Council (RC)-trained instructors only (July 2023). Within our department, we only have 2 instructors currently working – both with limited capacity to teach. We have a further 2 midwives who will commence RC training in 2024 and 2 instructors returning from Maternity Leave to enable this in the future. However, due to the challenges of not being able to meet the MIS requirements this year, this has been escalated to our Divisional Management Team to be escalated to Trust board and our LMNS. Due to a lack of RC instructors in the LMNS also, as a minimum, our NLS training is delivered by staff who have attended RC NLS course in the last 4 years, as requested in the FAQ from MIS. This has been included in the escalation report to DMT.

9.Maternity and Neonatal Safety Champions meetings

In Quarter 2 bimonthly meetings for the Safety Champions continued in accordance with Safety action 9 of the Maternity Incentive Scheme.

Minutes and action tracker can be accessed below:

Safety Champion minutes July 2023.do

Master Copy of Maternity Safety Char

10.Saving Babies Lives V3

The Saving Babies Lives Care Bundle version 3 (SBLCBv3) was published on 31st May 2023. The

SBLCBv3 represents Safety Action 6 of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme. NHS England have produced an Implementation Tool to assist Trusts in reporting progress to Board and LMNS/ICB. This was published on 5th July 2023. In addition to the five Elements of the previous care bundle, version three contains an extra element relating to pregnant women with pre-existing diabetes. Saving Babies Lives Version 3 has been challenging to achieve with the new set of requirements (see below). The implementation tool provides detailed minimum requirements and stretch targets for compliance and evidence required. SFT are working towards the minimum evidence and compliance required.

Figure 14. SBLv3 compliance as of 10th August 2023 **LMNS progress notification received by SFT on 31.10.23.*

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	30%	Partially implemented	10%
Element 2	Fetal growth restriction	Partially implemented	55%	Partially implemented	5%
Element 3	Reduced fetal movements	Not implemented	0%	Not implemented	0%
Element 4	Fetal monitoring in labour	Not implemented	0%	Not implemented	0%
Element 5	Preterm birth	Partially implemented	44%	Partially implemented	11%
Element 6	Diabetes	Partially implemented	33%	Not implemented	0%
All Elements	TOTAL	Partially implemented	40%	Partially implemented	7%

Since 10th August several guidelines have been updated in line with the SBL requirements and the leads are working through the recent LMNS response and their requests. For SFT identifying compliance levels through audit and providing evidence of this assurance has been a challenge due to current IT systems impacting on audit arrangements and carrying a vacancy for an Audit and Guidelines Midwife and Assurance Midwife roles. We have now successfully recruited to the Audit and Guidelines Midwife role (November start). A SBL dashboard is currently being built by informatics to support this. It is recognised that Badgernet will improve the ability to extract live data and SBL reports for audit as opposed to the current process of manual auditing and its resource implications. It is hoped that ongoing job planning work will support this ongoing national requirement.

11. NHS Resolution Maternity Incentive Scheme (MIS) Year 5 progress as of end Q2.

SFT self-declared that they were compliant with 5 out of the 10-safety action as defined in the Maternity Incentive Scheme year 4 2022/23. Following publication of year 5 on 31st May 2023 we are benchmarking current position and have an improvement plan in place to move towards compliance of the standards. Regular meetings and review are supporting our expectation of improved compliance for 2024 submission. As noted in the previous Saving Babies Lives section this is currently a challenge to achieve and a risk to achieving NHS Resolution (CNST) MIS year 5. The Figure below shows current progress and projections for this which is an improvement on year 4.

Figure 15. Current progress towards MIS 5 requirements

NHSR Maternity Incentive Scheme- Year 5 Submission by 1st February 2024					
Are we well led?		Description	Yr 4 Submission	Comment	Current Assessment
	1	**Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Compliant	No issues identified or anticipated	
	2	**Maternity Services Data Set** submission to required standard	Compliant	No issues identified or anticipated	
	3	**Transitional Care Data Set** minimise separation to mothers and babies	Non Compliant	Plan in place to achieve compliance	
	4	**Clinical Workforce Planning** effective system	Non Compliant	Work in progress. Compliance is achievable.	
	5	**Midwifery Workforce Planning**	Compliant	No issues identified or anticipated	
	6	**Saving Babies Lives Care Bundle V3** compliance with all elements	Non Compliant	New bundle published 31/5/23- Extra element for women with pre pregnancy diabetes. Work in progress. Several barriers to achieving compliance. Compliance is achievable.	
	7	**Service User Involvement and co-Production**	Compliant	No issues identified or anticipated	
	8	**Multidisciplinary Training**	Non Compliant	Work in progress. Compliance is achievable.	
	9	**Board Assurance** Board to Ward to Board	Non Compliant	Awaiting ratification of new Maternity Governance Framework. Proposed changes to trust policy *Accountability and Integrated Governance Framework* Compliance is achievable.	
	10	**HSIB and EN Reporting**	Non Compliant	Awaiting ratification of new Maternity Governance Framework. Compliance is achievable.	
Person Centred & Safe		Professional	Responsive	Friendly	Progressive

12.The number of incidents logged graded as moderate or above

During Q2 there were 12 incidents recorded as moderate or above. Figure 16 shows a summary and Figure 17 provides further description.

Figure 16. Summary of Moderate or above incidents in Q2 2023/24

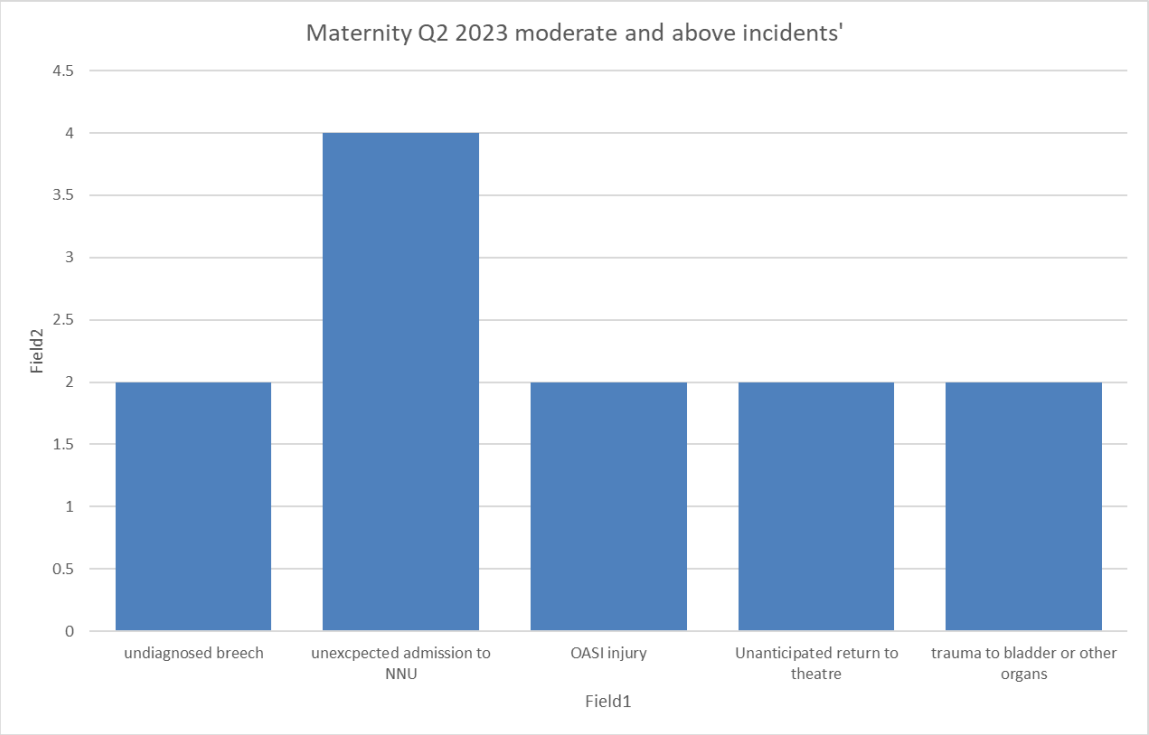


Figure 17. Description of Moderate or above incidents in Q2 2023/24

Incident category	Outcome/learning/actions
Unexpected admission to NNU	These are reviewed through the MDT ATAIN process where both the mother and baby's care are reviewed and where necessary escalated for further review. The reviews of all these cases are awaited due to effects of annual leave and industrial action.
Undiagnosed Breach	These cases are under review
OASI injury	Local review as part of ongoing rolling audit
Unanticpated return to theatre	These cases are in the stage of 72hr review
Trauma to bladder or other organs	These have been escalated to the college tutors of the individual trainees and are also due 72hr reviews

13.Safe Maternity Staffing

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to provide safe care at all times to women and babies in all settings. Midwifery staffing is reported separately to the Clinical Governance Committee and Trust Board biannually.

Midwifery Staffing
A bi-annual staffing review paper was submitted to clinical governance committee as per Maternity Incentive Scheme Safety Action 5 in Quarter 2 2024/23, a further report will be submitted in March 2024 as per requirement. Midwifery vacancies are monitored monthly through IPR and highlighted at Executive performance review monthly.

To ensure continued focus on the staff vacancies across the division remains one of our drivers for improving together, with midwifery vacancies the highest vacancy rate in the division. This staffing 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 measure are in place to maintain a safe service and ensure 1:1 care is maintained for all labouring women. Figure 18 shows a summary of workforce safety metrics.

Figure 18. Current workforce safety metrics.

Measure	Aim	June 23	July 23	Aug 23	Sept 23
Midwife to Birth Ratio	1:26	1:29	1:30	1:30	1:29
Supernumerary labour ward coordinator status	100%	100%	100%	100%	100%
1:1 care in labour	100%	100%	100%	100%	100%

Whilst midwifery vacancies remain an ongoing challenge, several initiatives have been employed to maintain a safe service as detailed below:

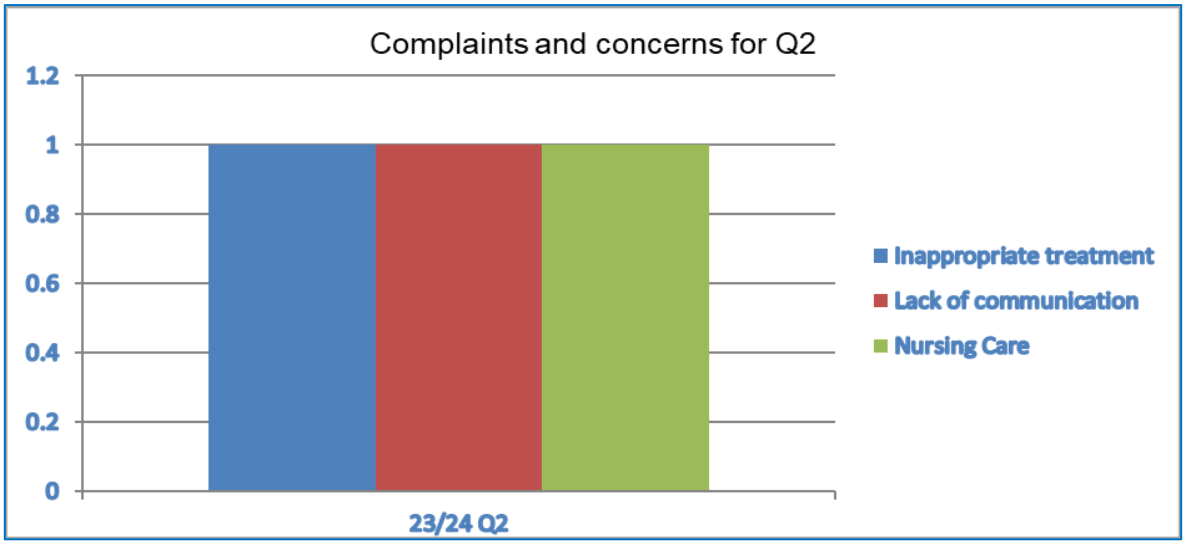
- A robust maternity escalation plan
- Registered General Nurse employed in clinical areas.
- Over recruitment of maternity care assistants
- Engaged in collaboration to recruit International Midwives- we have 7 within the service, all 7 have passed OSCEs, 5 of the 7 midwives have NMC Pin and 2 are awaiting them.
- Use of agency midwives
- Recruitment campaign to include executive agreed incentivised payment once in post.
- Relocation package promoted.
- Flexible working party to review working patterns.

We have an ongoing recruitment campaign and have 14.6 WTE midwives who have accepted posts to commence work at SFT in the coming months, with further interviews in the coming weeks.
We continue to closely monitor staffing daily to ensure a safe service is maintained at all times.

14.Insights from service users and Maternity Voices Partnership Co-production

Themes have been identified from complaints and are summarised in figure 19.

Figure 19. Identified themes from complaints



- Postnatal patient experience, Self-discharge (Trust wide action)

Complaints logged and closures within target times.

There were 11 compliant closures in Q2. 6 were responded to within time scale, offering compliance rate of 54%. The graphs in figures 20 and 21 illustrate a direct correlation between the number of complaints received over time to the number comments and enquiries reported. The results demonstrate a downward trajectory of complaints logged formally, with an increase in real-time resolutions to comments and concerns.

Figure 20. Complaints formally logged in Q2 – downward trajectory.

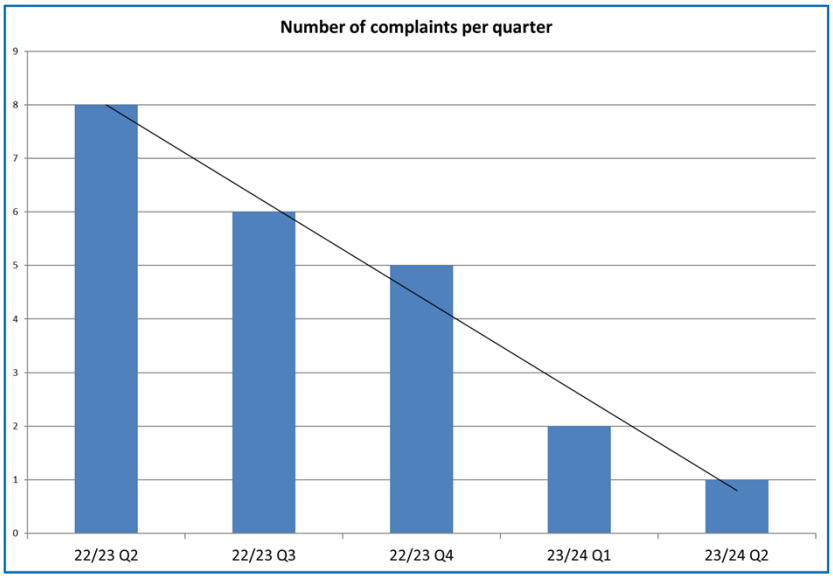
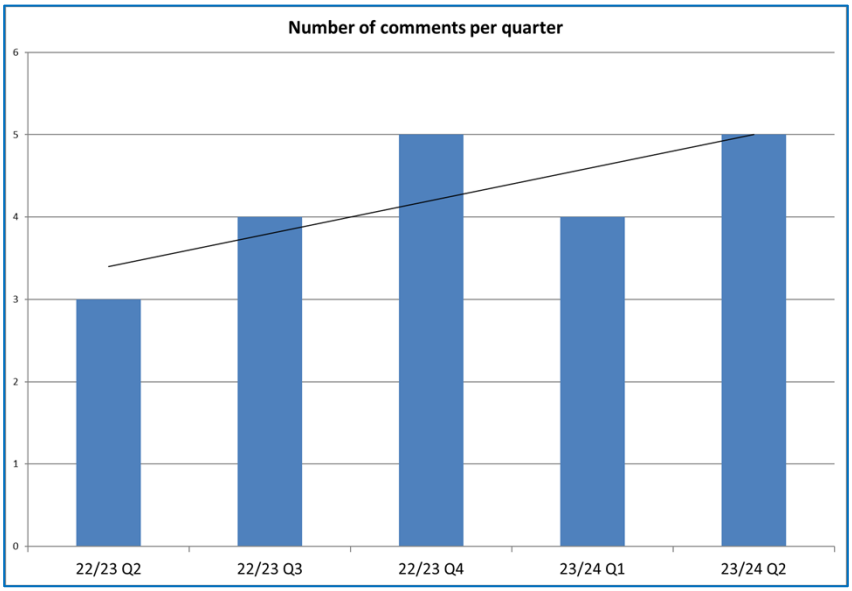


Figure 21. Complaints closure times increasing



We are working in collaboration with the PALS teams to ensure where complainant's concerns are response to promptly.

Agreed actions form closed complaints and concerns in Q2.

- Feedback to be utilized as a tool for learning. Development plan to be agreed and discussed with the midwife.
- Patient participation in the development of the postnatal ward patient experience survey
- Revise the current patient information leaflet in regard to VQ scans.
- Development of a Standard Operational Procedure (SOP) RE booking a VQ scan, with consideration given to, discussion with the woman and forward planning.

- Discussion with the DAU lead RE facilities available for postnatal women on the DAU and escalation to senior obstetrician if the acuity is high, to reduce the time women and their babies are on the unit.
- Clarity is needed surrounding what stage (in the postnatal period) the Gynaecology Department takes over the ongoing care of a patient.
- Patient experience agenda to be included in Junior doctors' induction day.

Comments and enquiries

- 5 comments have been logged with PALS:
    - The patient felt 'judged' during a consultation in ANC.
    - Lack of birth options
    - Management of a wound infection
    - Delay in receiving a Birth Reflection appointment.
    - Care provided in DAU

  One comment was escalated to a concern.

- Comments resolved at departmental level
    - Concern RE induction of labour
    - Communication by a member of the DAU staff
    - Delay in communication RE the arrangements around provision of providing a patient story.
    - Concern RE a member of staff's communication whilst in ANC.

  Enquiries
    - Wave of light event
    - Donation to the NNU

Patient feedback and Family Test (FFT)

We are undertaking a relaunch of the FFT within maternity following the implementation of the new FFT cards. Regrettably, we have received a minimal response to the FFT, this quarter. However, all responses received in this quarter were rated as good or very good.

Neonatal Unit Parent Questionnaire results headlines

96.9% of parents asked felt that their baby's admission to the unit went smoothly. 100% of parents said they were made to feel welcomed. 60% of women were given any information about the neonatal unit prior to your baby's/ babies' admission. Overall parents rated their experience as 9/10 and this is a comment received this quarter:

"We were very involved by staff at every stage of our babies' stay and their condition. If we had a question or queries someone always had the time to talk to us about it."

Action

- Increase awareness that parents are entitled to free parking.
- Own meal trolley for the NNU
- Availability of a microwave in the family accommodation

Priorities for Patient Experience:

1. Working in collaboration with the MNVP in prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.
2. Submission of the application for the Health Inequalities Project Funding (if successful will help support a continuity programme for Black, Asian and Minority Ethnic women)
3. Coproduction of a patient experience survey (Realtime audit)
4. Monitor and report on the ongoing bereavement audit.
5. Re-launch FFT
6. Support learning from woman's lived experience of our service
7. Focus on learning form positive patient experience.

Staff feedback

Q2 SOX themes and are highlighted in figure 22 and 23.

Figure 22. SOX themes for Q2

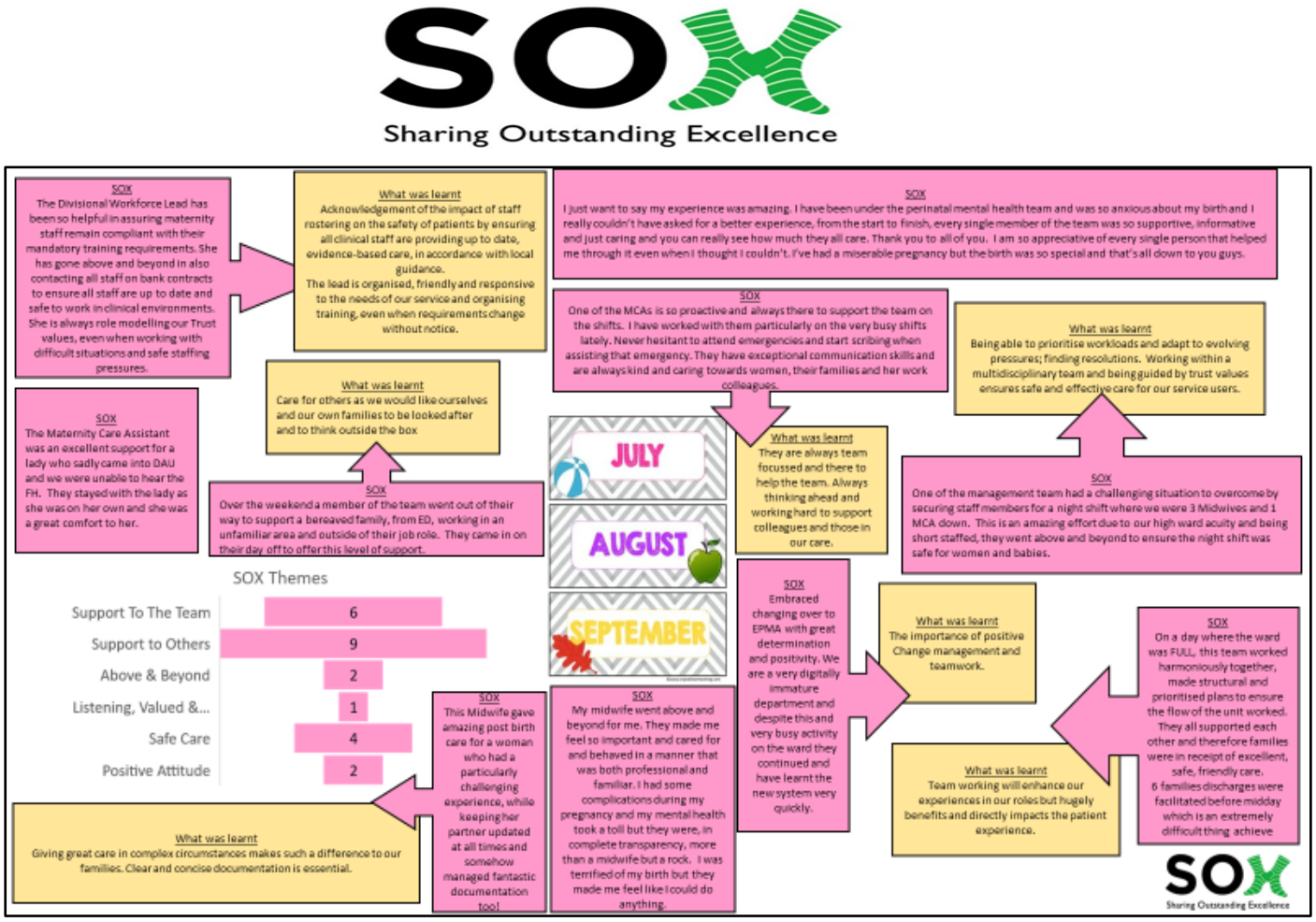
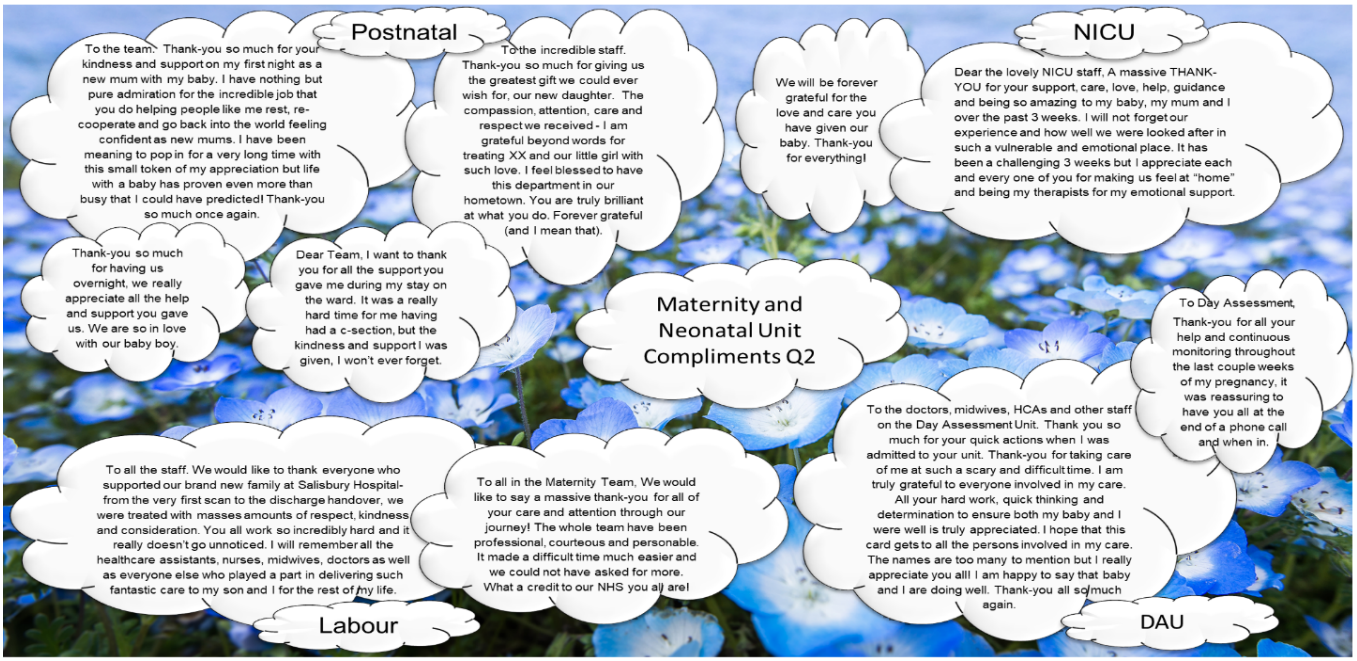


Figure 23. Staff compliments during Q2



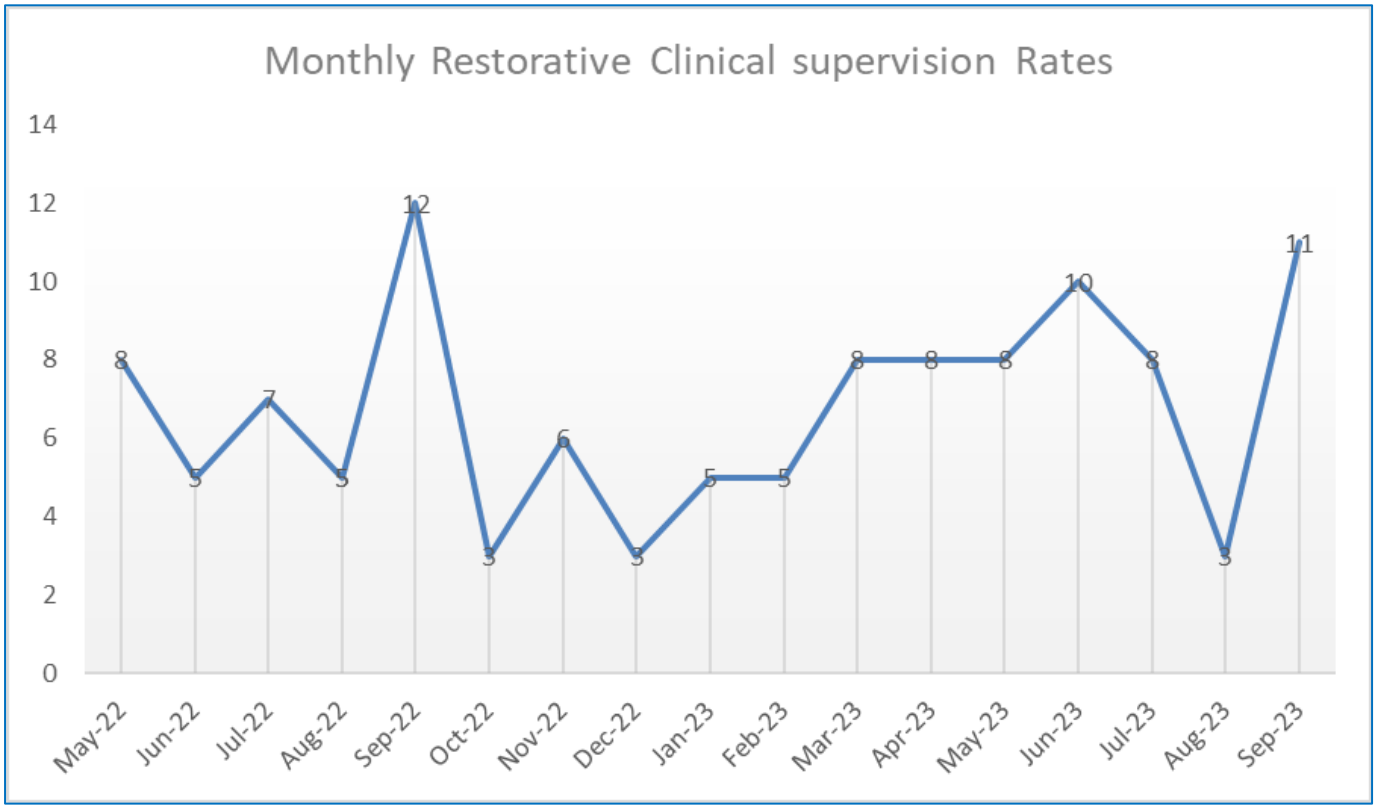
15.Implementation of the A-EQUIP model

The Professional Midwifery Advocate (PMA) team are responsible for implementing and deploying the A-EQUIP model (Advocating for Education and Quality Improvement) which supports a continuous improvement process that aims to build personal and professional resilience, enhance quality of care and support preparedness for appraisal and professional revalidation.

PMA Restorative Clinical Supervision (RCS) update

RCS supports the Restorative element of the A-equip model. Through Q2, all Midwives returning from long term sick or Maternity leave, and all new starters have received a RCS session. Additional RCS support for all NQMW and international midwives has continued through Q2. Secure data is kept on the number of RCS sessions taking place, and themes are collected (whilst ensuring confidentiality is maintained). 22 RCS sessions were carried out in Q2, a reduction from 26 in Q1. 2 of these were Midwives returning to work after long term sickness,2 were returning to work from maternity leave, 3 were new members of staff and the other 14 were Midwives who had a work-related issue they needed support with.

Figure 24. Monthly restorative clinical supervision rates



PMA activity

- Teaching continues around Civility and respect and our Divisional Behaviour Charter, with all our new Midwifery/MCA and Medical staff.
- Active Bystander Training has been launched to support the growth of a positive culture within maternity and neonatal. Plans are in progress to make this available to all staff through inclusion in PROMPT study day.
- The lead PMA is supporting the role out and analysis of the SCORE cultural survey (part of the Perinatal Culture and Leadership programme)

PMA Training

No further new PMA's qualified.

PNA/PMA collaborative working.

The Lead PMA has written a 'PMA/PNA plan to deliver the a-equip model at Salisbury NHS Trust'. 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.

16.Avoidable Admission into the Neonatal Unit (ATAIN)

The National Ambition

In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on:

- Reducing harm through learning from serious incidents and litigation claims
- Improving culture, teamwork and improvement capability within maternity units.

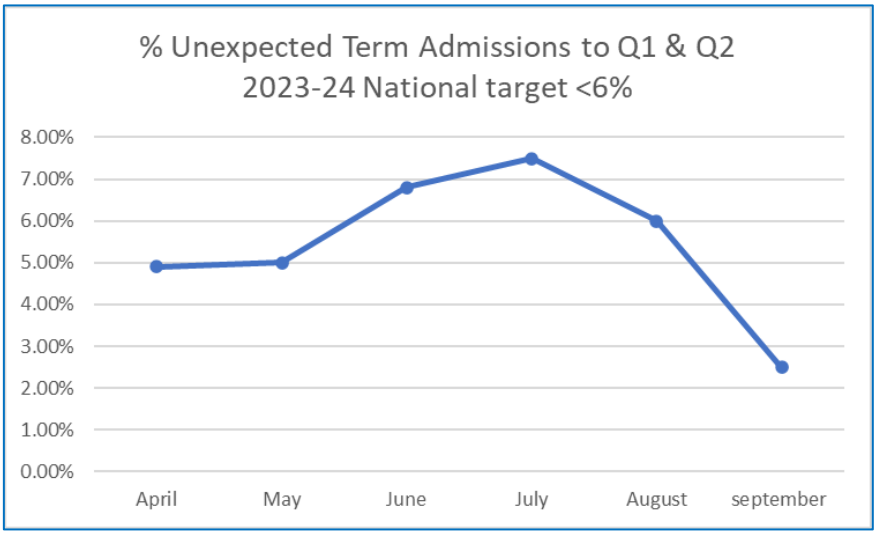
Why is it important?

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

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 term babies admitted to NICU to be <6%, however our local Operational Delivery Network aims for a rate of <5%. The Q2 rate in Salisbury is 4.83% which is compliant with the local neonatal network goal. See figure below. We continue to see that the majority of these admissions are due to respiratory complications associated with birth (Transient Tachypnea of the Newborn TTN).

Figure 25. % of avoidable term admissions against national target.



Due to new research into complications caused by antenatal steroids the obstetric team have decided that they will not be prepared to give antenatal steroids to infants ≥37/40 weeks' gestation Infants as this is out of national guidance. In response to this the paediatric and neonatal team are starting a QI project 'Think 45' this will ensure that the medical/nursing team will monitor infants for a 45-minute period providing respiratory support on the labour ward to try and avoid excess TTN admissions to the neonatal unit. The progress and success of this QI project will become clear through the ATAIN meeting and ongoing data collection and audit.

17.Maternity Safety Support Programme (NHSE)

Formal support from the NHSE programme continues and work remains ongoing with SFTs allocated Maternity Improvement Advisor from NHSE.

Maternity Improvement Plan (MIP)
The Maternity improvement plan continues to be worked on with input from the MDT, DMT and our NHS Maternity Improvement Advisor from NHS England. Monthly meetings to monitor progress against the identified actions and feed into the divisional governance process are ensuring progress and improvements are ongoing.

The Director of Midwifery, Clinical Director and Divisional Director of Operations are planning to meet with LMNS lead Midwife, Regional Chief Midwife and MIA in October 2023 to reset priorities, agree timelines and the exit plan from the programme.

18.Care Quality Commission

Following the CQC inspection in 2021 we continue to measure our performance against the points raised in the report. These topics include pool cleaning, emergency equipment checking and fluid balance and bladder care. Figure 26 shows audit compliance for bladder care in Q2 and figure 27 shows audit compliance for pool cleaning. These topics all continue to be audited and actions are ongoing. A postnatal lead midwife has been appointed, included within the education programme and a continued Improving Together project.

Figure 26. audit compliance for the bladder care (covering the last quarter)

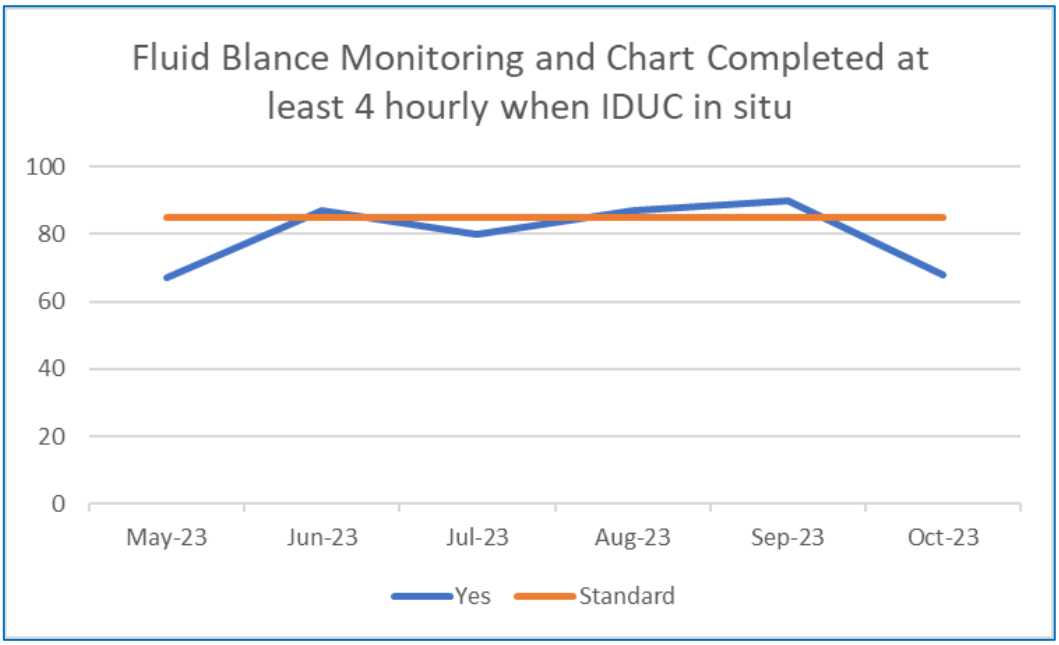
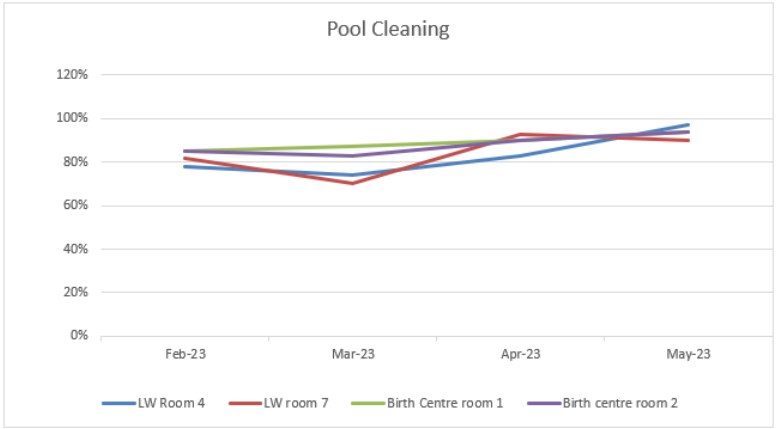
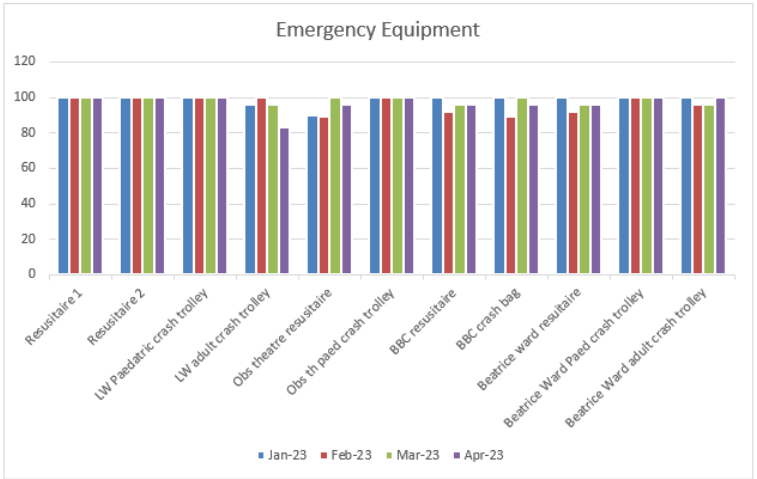


Figure 27. audit compliance for the pool cleaning





W&N have been early implementers of AMAT the new audit system which is being rolled out across the Trust. The implementation is early but showing success with several audits being uploaded so far with a plan to transfer all audits centrally to AMAT.

There has been a vacancy in Audit Midwife position. This is now recruited to; starting November 2023. This work will be prioritised once in place. In the meantime, support has been provided by the Trust's Clinical Audit Facilitator and she now has an agreed 1 day per week to assist.

Two thematic reviews will take place looking into massive obstetric haemorrhage and babies who were born with Apgar scores of less than 7. This was identified from the clinical dashboard and a review is planned in November and will be shared with the Division and the LMNS.

Learning from governance activities including investigations is ongoing and innovations have been brought forward in terms of how learning is shared across the division. This includes the implementation of learning vignettes being shared electronically and in hard copy across the clinical areas, sharing action plans being shared in the form of LASERS.

The Quality and Safety team maintain good compliance with statutory Duty of Candour.

19.Risk register highlights

A new bi-monthly 'Risk Register Review Meeting' has been set up. Named leads with risks on the register will be invited to this meeting and be asked to provide an update. Current risk register highlights are identified below.

Figure 28. New Risks, awaiting DMT review as of 13.10.23

7693	Obstetric and Paediatric teams have no job plans for antenatal and postnatal screening programmes	15/05/2023	Clinical Risk	8
7858	Lack of specialist antenatal clinic dedicated to multifetal pregnancy	30/09/2023	Clinical Risk	6

Figure 29. Top Open Risk register items as of 13.10.23

ID	Title	Opened	Risk Type	Rating (current)
7812	Inadequate labour ward building	17/08/2023	Clinical Risk	15
7733	Lack of Service for Abnormal Placentation	15/06/2023	Clinical Risk	15
7709	Divisional Guideline management currently not functional	29/05/2023	Clinical Risk	15
7185	There is a risk to patient safety because the anaesthetic room equipment for 2nd case not fit for purpose	20/01/2022	Clinical Risk	9
7860	Neonatal ventilators	04/10/2023	Clinical Risk	12
7221	There is a risk of cases with harm not being escalated due to the large backlog of Datix	14/02/2022	Clinical Risk	10
5713	shortage of midwives which may pose a risk to deliver safe care thoughout the maternity care pathway	07/02/2019	Clinical Risk	10
6773	transfusion training competencies do not meet the minimum requirements of the blood policy of 85%	24/12/2020	Clinical Risk	12

20.Safeguarding

SAFEGUARDING SUPERVISION:

- Safeguarding supervision for CMWs = 100%.
- Safeguarding supervision for Unit MWs = 49%. This is not a true reflection as unit MWs are only required to complete 3 sessions/year.
- Unit MWs who have completed 3 sessions = 10%.
- Unit midwives who have completed 2 sessions = 32%
- Unit midwives who have completed 1 session = 37%.
- Midwives who have completed 0 sessions = 20%.

As an action Safeguarding supervision sessions are being held weekly by the supervision team at differing times to support midwives to attend. The team are also regularly holding ad hoc sessions when acuity allows.

CP PLANS:

- There are 10 unborn babies on Child protection plans.
- 5 of these Child protection plans are also subject to legal proceedings due to the severity of concern.
- Themes for legal proceedings include neglect, severe Mental Health, Domestic Abuse, substance misuse and learning difficulties.

Level 3 Safeguarding Children training:

- Midwives' compliance = 89%. This % includes newly registered international midwives and new starters who may be booked onto training.
- Obstetricians' compliance is 20% The Obstetric lead is encouraging and supporting the obstetrician to attend the training and attend safeguarding supervision sessions
- L3 Safeguarding children training is fully booked until January 24.
- All staff who need to complete this training are encouraged to get booked on as there is plenty of time to request on allocate.

L3 Adult Safeguarding training:

- This is for B7 and B8 midwives only at present.
- Part 1 is online training and part 2 is face to face ½ day training.
- Compliance for this is poor. All midwives recorded as out of date or needing to complete this have been contacted to provide their certificates as evidence or to book onto the training. This will be monitored, and any further action plans developed.

21.Beatrice Birthing Unit

During 1st May-30th September 23 women have utilised the Beatrice Birth Centre.

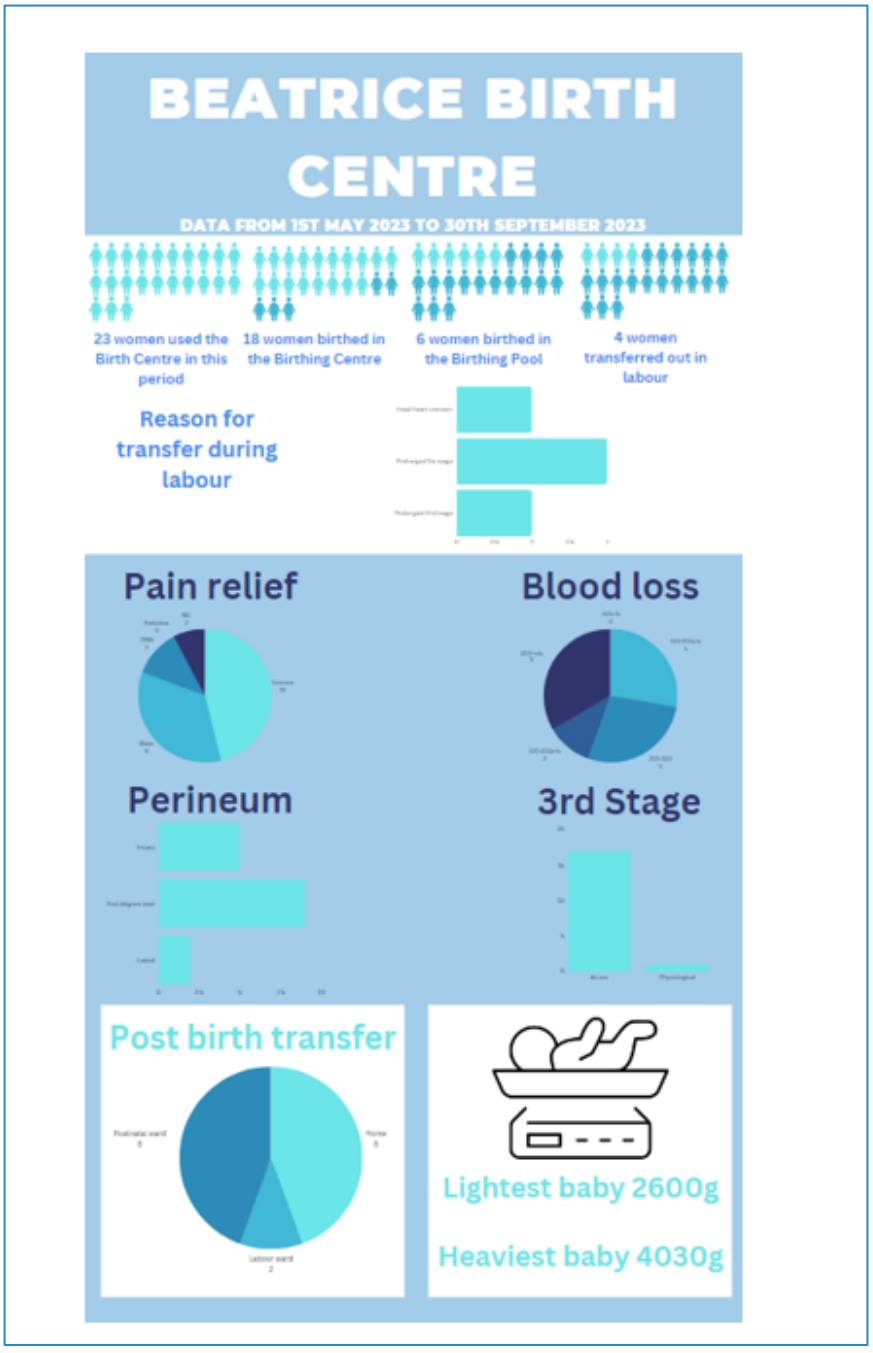
Of these 23 women 18 had their baby in the birth centre. The 5 women were transferred during their labour. 1 for fetal monitoring concerns, 3 for a prolonged 2nd stage and 1 who required pain relief not available in the Birth Centre. Two women were transferred to labour ward immediately following birth, one for perineal repair in theatre and one for close observation following a PPH hf 800mls as per guideline. This is summarised in the infographic in figure 30.

Of the 18 women who birthed their baby in the Birth Centre 7 had a water birth.

During this period the criteria has been extended to support women wishing to use pethidine for analgesia and for women who are recommended to have IV antibiotics in labour for group B strep.

Feedback from women who have used the birth centre continues to be very positive.

Figure 30. Beatrice Birth Centre infographic summary May-September 2023



22. Screening Services

Six Screening programmes are offered at SDH

- Sickle cell and thalassaemia Screening
- Infectious Diseases in pregnant screening
- Fetal Anomaly Screening
- New-born Hearing Screening
- Newborn and Infant physical examination
- Newborn blood spot screening

There was a second QA visit to the antenatal and newborn screening services at SDH following an initial visit on September 13th, 2022. 44 recommendations were identified following the first visit, with a deadline of May 2023 for a specified proportion of the actions and November 2023 for the remaining actions. All the 18 actions which were due for closure in May are now closed with several more awaiting confirmation of closure from the QA team. The remaining actions have a deadline of November 2023. Good progress and feedback has been received from QA team who have provided face to face monthly support since January 2023.
All screening guidelines have now been updated and are all available on microguide.

Incidents / Risks / Screening Incident Assessment Form (SIAF)

All providers of local NHS screening services have a duty to report and manage screening safety incidents in line with 'Managing safety incident in NHS screening programmes' screening safety incidents include;

- Any unintended or unexpected incident(s), acts of commission or acts of omission that occur in the delivery of an NHS screening programme that could have or did lead to harm to one or more persons participating in the screening programme, or to staff working in the screening programme.
- Harm or a risk of harm because one or more persons eligible for screening are not offered screening.

For Q2 SDH has had 3 SIAFS 1 x Postnatal and 1 x Antenatal.

Postnatal SIAF 12205 – Missed hip USS referral baby was breech presentation after 36 weeks' gestation. This SIAF was investigated, and an RCA was submitted and subsequently closed by the teams within NHSE.

Antenatal SIAF 012572 – Missed booking due to possible electronic self-referral malfunction. Woman not seen until 24+5 thereby missing antenatal screening and receiving no antenatal care until that point. SIAF investigated 72hr review completed, RCA sent to NHSE awaiting closure.

Q1&Q2 KPI's

KPI's are used to measure how the 6 antenatal and postnatal screening programmes are performing and give a high-level overview of their quality. They contribute to the quality assurance of the screening programmes.

Figure 29. Q4 (2022) and Q1 (2023) Antenatal and Postnatal screening KPI improvement areas highlighted in yellow **Q2 KPI's are not published until December.*

KPI Standards	Q4 (2022) Jan-March	Q1 (2023) April-June	Acceptable threshold	Achievable threshold
ST1: Antenatal screening Coverage	99.8%	99.6%	>95.0%	>99.0%
ST2: timeliness of antenatal screening	76.8%	76.1%	>50.0%	>75.0%
ST3: completion of FOQ	93.9%	95.6%	>95.0%	>99.0%
ST4a: timely offer of PND to women at risk of having an infant with SCD or thalassaemia	NO CASES	100%	To be set	To be set
ST4b: timely offer of PND to couples at risk of having an infant with SCD of thalassaemia	NO CASES	100%	To be set	To be set
NB2: Avoidable newborn blood spot repeat tests	3.0%	1.4%	<2.0%	<1.0%
ID1: HIV Coverage	99.8%	99.6%	>95.0%	>99.0%
ID3: Hepatitis B coverage	99.8%	99.6%	>95.0%	>99.0%
ID4: Syphilis Coverage	99.8%	99.6%	>95.0%	>99.0%
FA2: Coverage 20- week screening scan	99.8%	99.8%	>95.0%	>99.0%

SO4: referral timeliness of information and support	100%	100%	>97.0%	>99.0%
NH1: The proportion of babies eligible for newborn hearing screening for whom the screening process is complete < 4 weeks (28 days) corrected age (in services which provide a hospital model – well babies) and neonatal intensive care unit (NICU) babies or by < 5 weeks (35 days) corrected age (in services which provide a community model – well babies). (NH1)	100%	100%	>98.0%	>99.5%
NH2: The proportion of babies requiring immediate referral who are brought for an audiological assessment appointment in the required timescale. (NH2)	100%	100%	>90.0%	>95.0%
NP1: the proportion of babies eligible for the newborn physical examination who are tested for all 4 components (3 components in female infants) of the newborn examination at ≤ 72 hours of age and have a conclusive result on the day of the report	95.6%	96.6%	>95.0%	>97.5%
NP3: the proportion of babies with a screen positive newborn hip result who attend for ultrasound scan of the hips within the designated timescale.	84%	86.2%	>90%	>95%

During Q4 there was a decline in ST3 (The proportion of antenatal SCT samples submitted to the laboratory accompanied by a completed family origin questionnaire.), NB2 (The proportion of first blood spot samples that require repeating due to an avoidable failure in the sampling process.) and NP3 (The proportion of babies with a screen positive newborn hip result who attend for ultrasound of the hips within the designated timescale) measures were put in place to bring the KPI's back to the acceptable threshold and improvements have been seen in Q1.

23.Three Year Maternity & Neonatal Single Delivery Plan

On 30th March 2023 NHS England published its three-year delivery plan for Maternity and Neonatal Services.

The plan sets out how the NHS will make maternity and neonatal care safer, more personalized, and more equitable for women, babies, and families.

There are clear actions and objectives defining responsibility for trusts, ICB and NHS England around four themes:

1. ***Listening to Women and Families with compassion***
2. ***Supporting the Workforce***
3. ***Developing and sustaining a culture of safety.***
4. ***Meeting and improving standards and structures.***

We are aiming to assess ourselves against the themes and formulate a plan to work towards compliance and assurance, and plan to bring a separate report to board to share early in 2024.

24.Recommendation and next steps

The Committee and Board are asked to receive and discuss the content of the report noting the links to NHSR Maternity Incentive Scheme and the below next steps:

- CNST, Ockenden and Maternity Improvement Plan working group meetings continue to ensure traction and movement with ongoing actions.

- Head of Midwifery role to go out to advert in Q3

- To pilot the co-designed system wide LMNS Perinatal Quality Surveillance dashboard across BSW to provide robust assurances.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board Public	Agenda item:	4.7
Date of meeting:	7th December 2023		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services - September			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Approved by DMT remotely on 21.11.23 following Divisional Governance on 17.1.23 and Clinical Governance Committee 28th November 2023			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos			

Recommendation:

The committee are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 5 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

Executive Summary:

The Maternity Incentive Scheme (safety action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly. The perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance report for SFT for September 2023.

The report comprises of an new slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW

Summary:

Staffing:

- Staffing noted as a challenge and remains a driver for improving together.
- Midwifery vacancies and maternity leave mitigated by bank and long line agency usage.

- Midwife to birth ratio 1:29
- 1:1 care in labour achieved at all times
- Supernumerary status of labour ward maintained 100% time

PMRT

- 1 Review in September
- 4 actions from PMRT review – all in progress

Incidences reported as moderate

- 6 – No themes with other 3

Training

- Compliance shows slight decrease in PROMPT and NLS training, Plan in place to address this and improve compliance.
- Specific plan for Anaesthetic attendance at PROMPT to ensure CNST compliance by December and safety maintained with staff appropriately trained.

Service user and staff feedback

- Co-produced survey with MNVP and service user around postnatal care in progress
  Detailed and actions taken forward to address any concerns or areas for improvement as detailed in slides

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

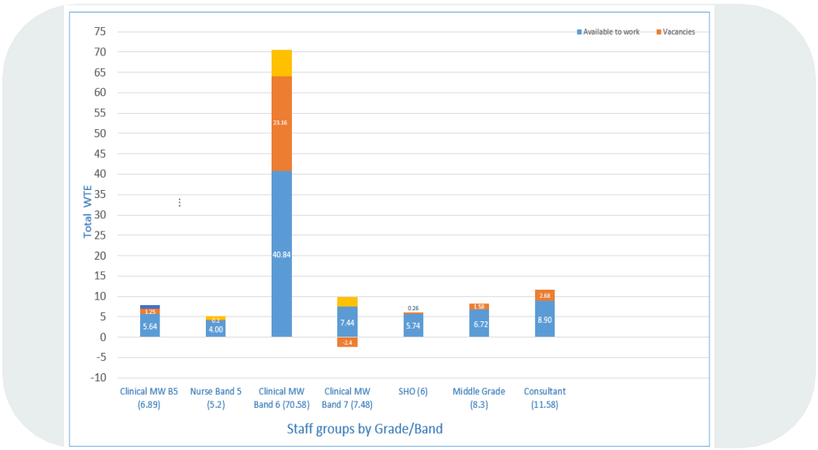
Perinatal Quality Surveillance Integrated Performance Report

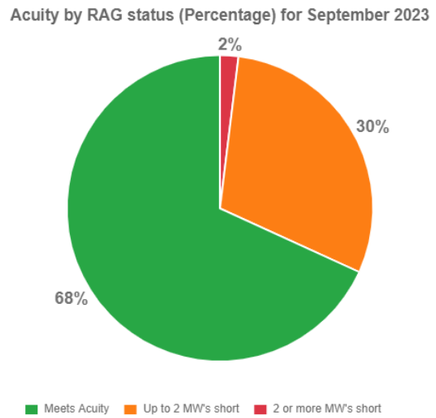
September Data 2023

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

Maternity & Neonatal Workforce

	Target	Threshold		June 23	Jul 23	Aug 23	Sep 23	Comment
Midwife to Birth Ratio	1:26	=<1:26	>1:26	1:29	1:30	1:30	1:29	
1:1 Care	100%	100%	100%	100%	100%	100%	100%	
Consultant Presence in Delivery Suite (Hrs per week)	40	=>40	<40	40	40	40	40	
Supernumerary Status of Delivery Suite Coordinator	100 %	100 %	100 %	100 %	100 %	100 %	100 %	
Confidence factor in BirthRate+ recording								Audit be commenced November 2023
Daily multidisciplinary team ward round								Audit to be commenced Nov 23
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0			0	0	0	0	To be monitored via datix reporting





- **OVERVIEW**

Key Achievements:

- Out of 7 international midwives who have joined the trust all have now passed their OSCE. 2 have received NMC pin and 5 are awaiting this and to start.
- Supernumerary status of coordinator maintained and achieved 100% of time
- 1:1 care achieved 100% of time

Next Steps for Progression:

- Continue with targeted recruitment campaign
- 2 x places secured on Nurse to Midwife conversion course. Commencing Jan '24, training funded by HEE.
- 2 x places secured for Midwifery apprenticeship which will be open to current MSW

Key Risks:

- Vacancy rate of 23 WTE Midwives leading to challenges in maintaining fill rates
- Challenge in supporting well-being of staff whilst staffing levels are low but mitigating this and ensuring safety by use of escalation policy and ensuring midwives are rostered where acuity dictates the need is.

Perinatal Mortality Review Tool (PMRT)

Background Narrative & Identified Issues:

- *Figure 1: Shows live data for perinatal losses reportable to MBRRACE 1/9/2022- 30/9/23 form MBRRACE data tool. (Excluding MTOP's, data only given up to last loss)*
- *Figure 2: Shows PMRT reviews completed in September 2023*
- *Table 2:Shows actions generated from PMRT reviews completed in September 2023*

Number of babies who died in September that meet PMRT review criteria:

0

Improvement Actions & Timescales:

Development patient information and access to services in different languages is an ongoing project.

Themes in issues:

Issues around mothers receiving aspirin have been highlighted in previous reviews.

Figure 1. Live data for perinatal losses reportable to MBRRACE

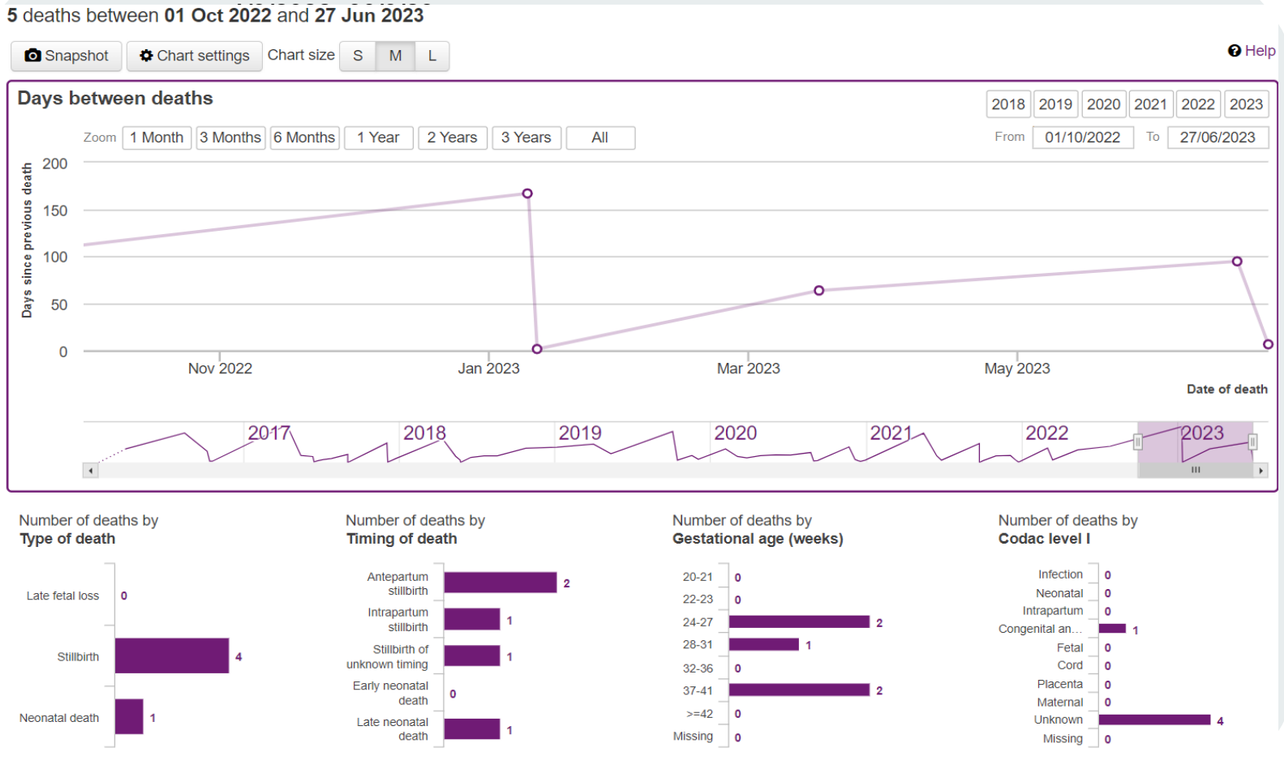


Table 2- PMRT Actions from case review in September 2023

Action	Implementation plan
Robust processes within the Trust need to be put in place to ensure language needs are managed from first access to maternity services.	To talk to staff to discuss the barriers around this and then decide an action plan. NED present at review will take this to the Executive Team for the Trust. Issue of community care at booking to be taken to the antenatal quality meeting for further discussion
Robust processes are required by the trust to ensure women who need aspirin are provided with it.	To talk to staff to discuss the barriers around this and then decide an action plan. To be discussed at the antenatal quality meeting for a plan. NED present at review will take this to the Executive Team for the Trust.
The baby was small for gestational age at birth, but appropriate growth surveillance had not been carried out.	Review local guidance against national guidance and LMNS and take to MDT for confirmation, communicate to staff- clarify SFH vs serial growth USS and the 26-28 weeks gap if on serial USS
Continue auditing CO monitoring Laser, theme of the week communications	Review equipment checking and escalate process of CO monitors

Table 1: PMRT reviews completed in September 2023

Date of delivery	Gestation at delivery	Type of loss	MBRRACE ID	PMRT multidisiplinary review date	Grading of care
20/06/2023	27+3	Stillbirth	88068	23/09/2023	Upto the point the baby had died- C- issues may have made a difference to the outcome
					After the baby had died- B- issues identified would have made no difference to the outcome of the mother.

Incidents & Investigations
DATIX SUMMARY

New Moderate Harm Incidents (September 2023)

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI Reference
158956	05.09.2023	Moderate	EMLSCS for breech and abruption at 35+4	Gases of 6.9. Baby to NICU. 72hr review due to low gases. Presented at PSS, decision for local review. For discussion at Perinatal at a later date.	NA	NA
159690	09.09.2023	Moderate	Term admission and went to Soton for cooling	Referred to HSIB and awaiting triage decision	Possible	Possible
159341	19.09.2023	Moderate	Local guidance around PPH and documentation not followed on multiple occasions	Presented at PSS and decision for CCR. Panel arrangements ongoing.	NA	NA CRR n TBC
159332	19.09.2023	Moderate	Mother did not receive a Consultant obstetrician review antenatally. This birth would have been her second subsequent both post LSCS. This was not reviewed.	Awaiting presentation at PSS	NA	NA
159523	28.09.2023	Moderate	2.2L urinary retention post LSCS.	Awaiting presentation at PSS	NA	NA
159505	27.09.2023	Moderate	MMR vaccine given in early pregnancy. No referral to FMU.	Awaiting presentation at PSS		

Following recommendations made in the Ockenden Report all cases referred to HSIB will be reported as a Serious Incident (SI).

New Serious Incidents (September 2023)

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI Reference
NO NEW SI/HSIB CASES REPORTED DURING SEPTEMBER						

72-hour Incident Reviews

Completed Maternity & Neonatal 72-hour Reviews (Sept 2023)

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI Reference
158629	Incident Date 23.08.2023 Presented 12.09.2023	Minor	Missed antenatal booking. Patient filled out online form however system down so never received.	Case referred to SIAF. SIAF happy with internal investigation and case closed.	NA	NA
158557	Incident date 18.08.2023 Presented 19.09.2023	Moderate	MOH after triplet EMLSCS birth of 2.3L. Blood transfusion and return to theatre for EUA under GA.	Case presented at PSS, kept at local review level.	NA	NA
159008	Incident Date 07.09.2023 Presented 26.09.2023	No harm	Multiple pulls used during ventouse delivery (6).	Kept at local review. Local guidance reviewed and 3 pulls to bring head to perineum, 3 more gentle pulls allowed to assist delivery of head. Supported refection by Reg with Consultant.	NA	NA
159204	Incident Date 14.09.2023 Presented 26.09.223	No harm	MOH of 3L. Possible abruption and GA.	72 hr review panel agreed that the incident was well recognised, escalated and managed. Presented at PSS, kept at local review.	NA	MA
158956	Incident Date 05.09.2023 Presented 26.09.2023	Moderate	Baby born with low cord gases. Pre-term spont. Labour at 35/40 with APH.	Presented at PSS-agreed to take to Perinatal meeting at later date for learning. The Quality and Safety Team have recently introduced a 72-hour review tracker for identifying themes	NA	NA

Maternity Safety Support Programme	Ongoing MIP	**CQC Ratings**	TBC	**Maternal Deaths**	Nil	**Concerns or requests from national bodies**	Nil	**Coroners Regulation 28**	Nil

Ongoing Investigations

Maternity & Neonatal Investigations (September)

SIIs, CRs and LRs In Progress								
ID	Directorate / Ward / Dept	Summary of incident	Incident date	Date commissioned	CRG	Date Due to CCG / 60 days target	Within 60 day target?	Progress Notes
SII 554	w and NB/Gynae	Delayed Ca Diagnosis	25/11/2022	21/03/2023		**08/06/2023**		Report in writing
CR 565	Maternity/W&NB	Uexpected admission to neonatal unit	18/05/2023	30/05/2023		**22/08/2023**		Report in writing
CR 569	Maternity	Uncrossmatchable Blood	02/06/2023	13/06/2023		**08/09/2023**		Report in Writing
SII 570	Maternity	Retained Swab	09/06/2023	13/06/2023		**08/09/2023**		Panel rearranged for 16.10.23 (originally 5.9.23) External chair
SII 571	Maternity	Placenta Acreta	25/05/2023	20/06/2023		**14/09/2023**		Panel chair identified, awaiting panel date and panel selection
SII 574	Maternity	Stillbirth		27/06/2023		**21/09/2023**		Panel held 14/8 - report in writing
CR 578	W and NB/Gynae	Delay in diagnosis (Ca)		11/07/2023		**02/10/2023**		PANEL 06/09
CR 579	WNB	Term admission to NICU	20/04/2023	18/07/2023		**09/10/2023**		Draft report sent to staff 7.9.23 - minor amendments then to send to DMT and CRG
CR 580	WNB	Term admission to NICU	16/07/2023	01/08/2023		**23/10/2023**		Panel date 16.10.23, arranging panel selection
CR 584	Maternity	OASI	3.7.23	8.8.23		**30/10/2023**		Panel date 16.10.23, arranging panel selection
SII586	Maternity	Eclampsia and GA	8.8.23	22.8.23		**13/11/2023**		Panel chair identified (external to Maternity), awaiting panel date.
SII 587 (HSIB)	Maternity/W&NB	Term baby admitted to NICU and transferred to tertiary unit for cooling	12.8.23	22.8.23		**13/11/2023**		HSIB have attended SFT and met with parents. Face to face staff interviews 2.10.23
CR 588	Maternity	Antenatal Pulmonary Embolism at 15 weeks pregnant	31.7.23	29.08.23		**20/11/2023**		Panel date 11.10.23, arranging panel
SII 591	WNB/Gyane	Failure to carry out test		12/09/2023		**05/12/2023**		
CR 592	WNB	SIAF		12/09/2023		**05/12/2023**		

Reports for EXIT								
ID	Directorate / Ward / Dept	Summary of incident	Date commissioned	CRG	Date Due to CCG	Within 60 day target?	Progress notes	
SII 548	Maternity/W&NB	Term admission to NICU	23/02/2023	28/02/2023		**26/05/2023**		Went to exit 21/8, for resubmission by email

SIIs, CRs and LRs Signed off - share (Stage 3) duty of candour								
ID	Directorate / Ward / Dept	Summary of incident	Incident date	Date Signed Off	Duty of Candour Update	Report share		
SII 492	Maternity/W&NB	baby fitted in first 24 hrs - not HSIB - fitting was due to metabolic disorder	13/07/2022	19/07/2022		**12/10/2022**		Report shared & letter inviting to meet sent 8.9.23. For DoC L3 letter from Chief Exec.
SII 555 (HSIB)	Maternity/W&NB	Intrapartum stillbirth - HSIB	16/03/2023	21/03/2023		**08/06/2023**		Declined tripartite meeting with HSIB (25.9.23). DOC Letter 3 letter from Chief Exec sent for signature.

Following recommendations made in the Ockenden Report all cases referred to HSIB will be reported as a Serious Incident (SI).

Data correct as of 3rd October 2023 (finalised with Trust PSS group). The data in the preceding month may have changed due to this being reported weekly via Trust Risk team and being updated and agreed locally

Investigation Actions

Compliance Tracker (September)

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				
CR 454	Click	W&NB	December 2021	Q2 23-24	Q2 23-24	Oct 22	Q4 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	Q2 23-24	Jan 23	Q4 22-23	Q4 22-23	Q4 22-23	Q3 22-23	Q4 22-23	Q1 23-24		
SII 489	Click	W&NB	May 2022	Q1 22-23	Dec 22	Q4 22-23	Q4 22-23	Q3 22-23	Q3 22-23					
SII 497	Click	Surgery	July 2022	Surg	Q1 23-24	Q2 23-24	Med	Apr 23						
SII 506	Click	W&NB	March 2021	CSFS	Jun 23	Q1 23-24	CSFS							
CR 509	Click	W&NB	July 2022	Q2 22-23	Oct 23	Aug 23	Oct 23	Aug 23						
SII 510	Click	W&NB	August 2022	Q1 23-24	Q1 23-24	Feb 23	Feb 23	Feb 23	Jan 23	Jan 23	Q1 23-24	Jan 23		
CR 512	Click	W&NB	September 2022	Sept 23	Jul 23									
CR 514	Click	W&NB	September 2022	Q3 22-23	Jan 23	Q1 23-24	Dec 22	Feb 23	Q2 23-24	Q1 23-24				
CR 527	Click	W&NB	October 2022	Q1 23-24	Q1 23-24	Jun 23	Q2 23-24							
SII 537	Click	W&NB	December 22	Jul 23	Jul 23	Jul 23								
CR 540	Click	W&NB	November 2022	Jul 23	Jun 23	Sep 23	Jul 23	Jun 24						

** Action tracker held corporately and reported via Trust Risk Team. Data in preceding and current month maybe the same or have changed due to Trust reporting mechanisms and due to cases being removed once all actions completed.

Feedback – Staff & Service Users

MNVP Service User Feedback

Key Achievements & Positive Feedback:

No formal feedback from the MNVP – awaiting on recent survey results.

- **Identified Areas of Improvements:**

Postnatal care / community visits

Next Steps for Progressions:

- Postnatal patient experience survey commenced in September 23. The questions were co-produced by a women who raised a concerns about her postnatal care together with the MNVP
- To co-produce the action plan in response to the 2023 National Patient Experience Survey.
- MNVP are scheduled to undertake '15 steps' exercise on 10th October 23.
- Following a transformation workstream with the focus on the community model, it is hoped by the end of Q3 we will be able to deliver a continuity model for the AN and PN care provision. We have reintroduced face to face booking appointments.

Safety Champions Staff Feedback

Key Achievements & Positive Feedback:

Neonatal Unit Parent Questionnaire results:

Headlines:

96.9% of parents asked felt that their baby's admission to the unit went smoothly. 100% of parent said they were made to feel welcomed.

Overall parents rated their experience as 9/10

Identified Areas of Improvements:

Action following NNU patient feedback:

- *Ensuring that Parents are aware that they are entitled to free parking*
- *Own meal trolley for the NNU*
- *Availability of a microwave in the family accommodation*

Action plan to be devised following the 23 National Patient Experience Survey.

Next Steps for Progressions:

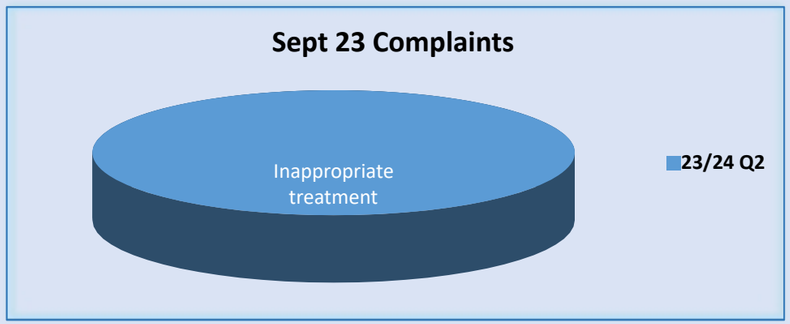
NNU Manager to continue discussion RE NNU's dedicated meal trolley.

Compliments & Complaints

Themes & Trends:

Ongoing themes from concerns and complaints:

- Postnatal care provision
- Self-discharge



Compliments	**28**	**PALS Contacts**	**1**
Online Compliments	**none**	**Complaints**	**1**

Friends & Family Survey

Key Achievements:

Only 3 responses logged in Q1, however 100% of women rated their experience as very good

"Staff have always been friendly, professional and non-judgmental."

"A lot of checks after birth which is good. Great information given and help with tongue tie"

"The staff are great and abundance of breast-feeding support".

Identified Areas of Improvements:

Actively promote FFT

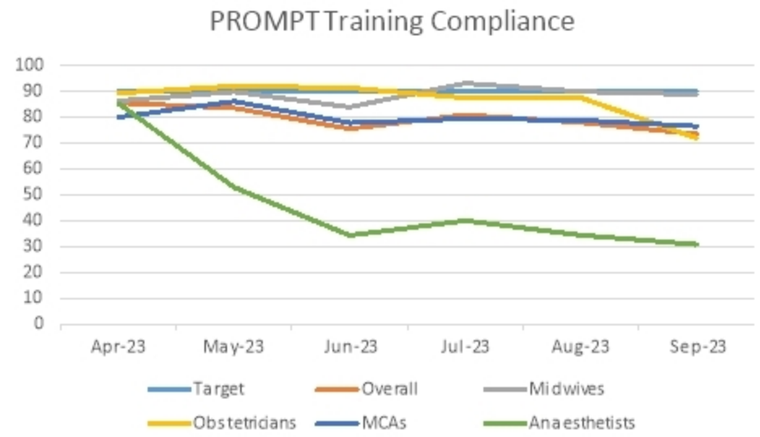
Next Steps for Progressions:

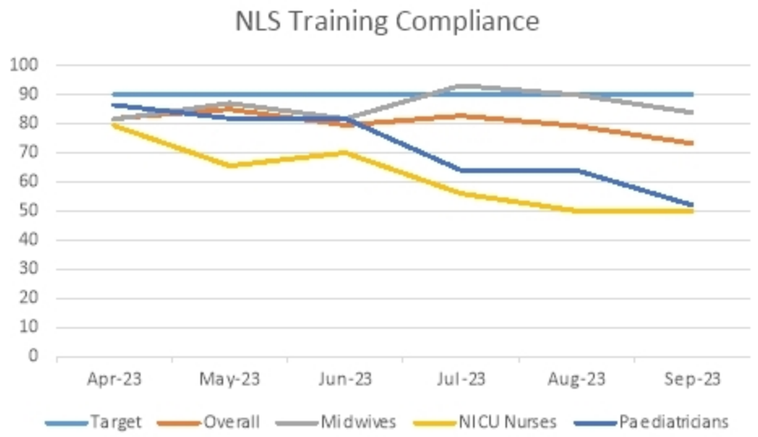
The Maternity Unit only has old FFT cards on display in a few areas. Investigation is underway to establish the location of the new FFT cards.

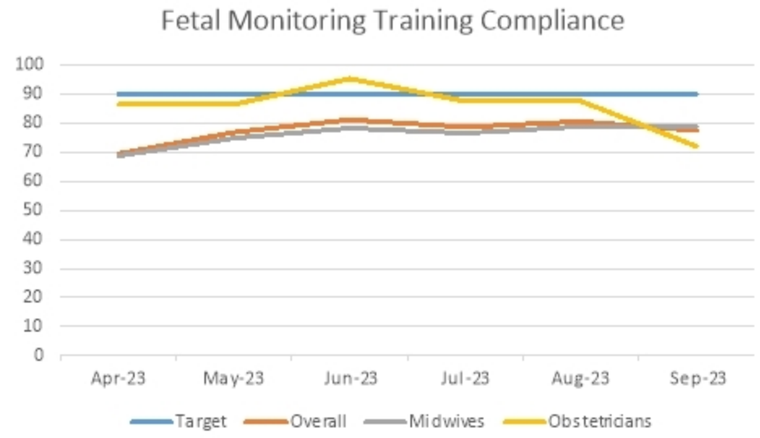
Current Local patient surveys ongoing :

- Postnatal care
- AN and PN screening service survey
- Maternity's new website (launched Oct 23)
- NNU family experience.
- Bereavement survey
- Pregnancy journey survey- with the focus on women in low social economic groups, Black, Asian and ethnic minority groups.

Training & Education







Background Narrative & Identified Issues:

Within the MIS, 3 key areas are identified to achieve training compliance of over 90%:

•PROMPT – Multidisciplinary Obstetric Emergencies

•Newborn Life Support

•Fetal Monitoring

In Maternity Incentive Scheme year 5, the data needs to be further stratified to be compliant with safety standard 8. This includes staff groups and grades individual compliance with above training modules. We have included this data to continue monitoring compliance during MIS year 5.

Improvement Actions & Timescales:

- Additional dates for PROMPT and fetal monitoring created in October and November.
- Plan in place for anaesthetic attendance at PROMPT – cancelling of elective work to ensure attendance.

Risks:

- Doctor strike dates in October fall onto training dates - ?attendance.
- Lack of RC-trained instructors for NLS updates – mitigated as provided by RC attenders.

Compliance across National Guidelines

OCKENDEN 2020 Report

	Current Rag Status /Action No	Immediate & Essential Action	Number of actions under each heading rated		
			RED	AMBER	GREEN
Oct-23	1	Enhanced Safety	0=	0=	3=
	2	Listening to Women & Families	0=	0=	1=
	3	Staff Training & Working Together	0=	1=	2=
	4	Managing Complex Pregnancy	0=	0=	3 ↑
	5	Risk Assessment Through Pregnancy	0=	0=	2=
	6	Monitoring Fetal Wellbeing	0=	1=	6=
	7	Informed Consent	0=	3=	0=
		TOTAL	0	5	18↑

Ockenden 2020 Report

Key Achievements:

- Publishing of maternal mental health guideline
- Writing of informed consent information for website and updating of guidelines

Next Steps for Progressions:

- Publishing of updated guidelines and updating of website – expected this month

Key Risks to Full Compliance:

requested

OCKENDEN 2022 Report

	Current Rag Status /Action No	Immediate & Essential Action	Number of actions under each heading rated		
			RED	AMBER	GREEN
Oct-23	1	Workforce Planning & Sustainability	0=	3=	4=
	2	Safe Staffing	0=	6=	4=
	3	Escalation & Accountability	0=	3=	2=
	4	Clinical Governance - Leadership	0=	3=	4=
	5	Clinical Governance - Incident Investigation & Complaints	0=	4=	2=
	6	Learning From Maternal Deaths	0=	2=	0=
	7	Multidisciplinary Training	0=	6=	1=
	8	Complex Antenatal Care	2=	2=	1=
	9	Preterm Birth	2=	2=	0=
	10	Labour & Birth	4=	2=	0=
	11	Obstetric Anaesthesia	0=	3=	0=
	12	Postnatal Care	0=	4=	0=
	13	Bereavement Care	0=	4=	0=
	14	Neonatal Care	3=	2=	1=
	15	Supporting Families	0=	3=	0=
		TOTAL	11	48	19

Ockenden 2022 Report

Key Achievements:

- Nearly all actions are in progress

Next Steps for Progressions:

- Working groups for actions to begin progress

Key Risks to Full Compliance:

- None

Compliance across National Guidelines

CNST/Maternity Incentive Scheme (MIS)

	NHSR Maternity Incentive Scheme- Year 5 Submission by 1st February 2024				
Are we well led?		Description	Yr 4 Submission	Comment	Current Assessment
	1	**Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Compliant	No issues identified or anticipated	
	2	**Maternity Services Data Set** submission to required standard	Compliant	No issues identified or anticipated	
	3	**Transitional Care Data Set** minimise separation to mothers and babies	Non Compliant	Plan in place to achieve compliance	
	4	**Clinical Workforce Planning** effective system	Non Compliant	Work in progress. Compliance is achievable.	
	5	**Midwifery Workforce Planning**	Compliant	No issues identified or anticipated	
	6	**Saving Babies Lives Care Bundle V3** compliance with all elements	Non Compliant	New bundle published 31/5/23- Extra element for women with pre pregnancy diabetes. Work in progress. Several barriers to achieving compliance. Compliance is achievable.	
	7	**Service User Involvement and co-Production**	Compliant	No issues identified or anticipated	
	8	**Multidisciplinary Training**	Non Compliant	Work in progress. Compliance is achievable.	
	9	**Board Assurance** Board to Ward to Board	Non Compliant	Awaiting ratification of new Maternity Governance Framework. Proposed changes to trust policy *Accountability and Integrated Governance Framework* Compliance is achievable.	
	10	**HSIB and EN Reporting**	Non Compliant	Awaiting ratification of new Maternity Governance Framework. Compliance is achievable.	

CNST / Maternity Incentive Scheme (MIS)

Key Achievements:

- Good progress with all actions

Key Risks to Full Compliance:

- Saving Babies Lives version 3 was launched on 31st May 2023 with a detailed implementation tool in July 2023. For SFT this has been a challenge due to current IT systems impacting on audit arrangements (Badgernet will improve the ability to extract live data for audit as opposed to current arrangements of manual auditing and its resource implications). Also impacting is the unsuccessful recruitment to an Assurance Midwife lead role (despite recurrent advertising). There is also job planning work ongoing to enable dedicated obstetric PA time to support this intervention.

Maternity Three Year Delivery Plan

Maternity 3 Three Year Delivery Plan

Key Achievements:

- Action plan created for Three year delivery plan

Next Steps for Progressions:

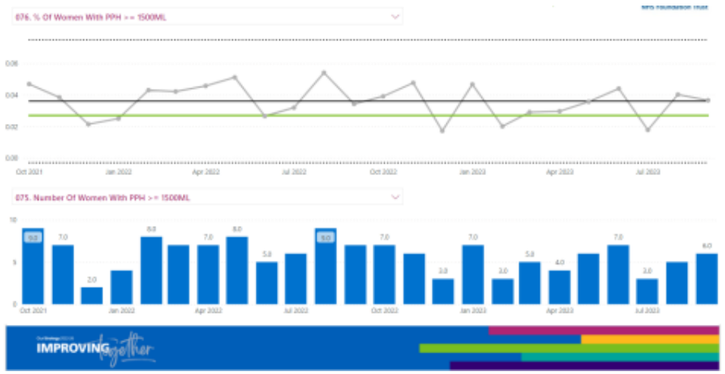
- Job matching and advertising for an inclusion midwife to support with improving equity
- Allocation of actions

Key Risks to Full Compliance:

- None identified at present

Themes

% and number of women with PPH >1500ml



Theme – PPH rate above national rate

Key Achievements:

- Recognition that SFT has a consistently high PPH rate above national target and that this is mirrored across the LMNS.

Next Steps for Progressions:
- Conduct a thematic review of PPH >1500mls cases

Countermeasures:
- To await thematic review and to include use of PPH Risk assessment tool.

% and number of babies born at term with APGAR of less than 7 at 5 mins

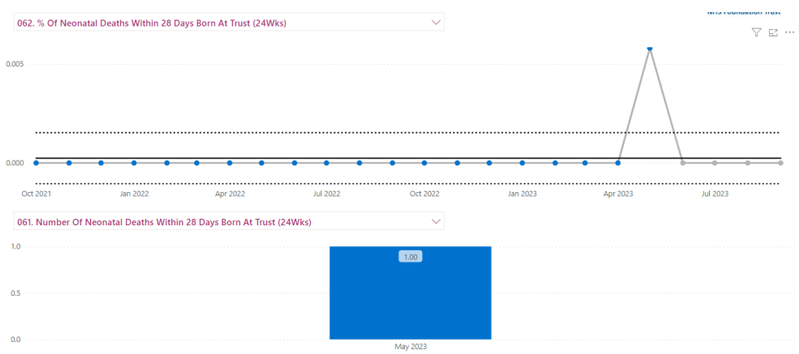
Theme - % and number of babies born at term with APGAR of less than 7 at 5 minutes

Key Achievements:
- Recognition that SFT has a higher % of term babies with low APGARS than national target.

Next Steps for Progressions:
- Conduct a thematic review of cases

Countermeasures:
- To await thematic review results and to include use of PPH Risk assessment tool

% and number of neonatal deaths within 28 days Born at Trust



Theme - % and number of neonatal deaths over 24 weeks gestation within 28 days Born at Trust

Key Achievements:
- This chart represents 1 neonatal death which was a baby born with known abnormalities and planned palliative care. This slide is to offer assurances re neonatal death rate at SFT in light of the national media coverage of the high-profile Lucy Letby media case

Next Steps for Progressions:
- To continue to monitor all quality and safety markers.

Countermeasures:
- To ensure staff are aware re escalating concerns and whistleblowing. Neonatal unit have posters around the unit about this process.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.8
Date of meeting:	7th December 2023		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services – October 2023			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Approved by DMT remotely on 21.11.23 following Divisional Governance on 17.1.23 and Clinical Governance Committee 28th November 2023			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos			

Recommendation:

The committee are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 5 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

Executive Summary:

The Maternity Incentive Scheme (safety action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly. The perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance report for SFT for October 2023.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW

Summary:

Staffing:

- Staffing noted as a challenge and remains a driver for improving together, however x8 new starters in October.

- Midwifery vacancies and maternity leave mitigated by bank and long line agency usage.
- Midwife to birth ratio 1:30
- 1:1 care in labour achieved at all times
- Supernumerary status of labour ward maintained 100% time.

PMRT

- No review in October

Incidences reported as moderate.

- 4– 3 are around Obstetric anal sphincter injury. Quality and Safety team to review previous months to consider if this is a theme.

Training

- Compliance shows slight increase in PROMPT, CTG and NLS training, Plan in place throughout November training to continue to improve compliance and reach 90% target.
- Specific plan for Anaesthetic attendance at PROMPT to ensure CNST compliance by December and safety maintained with staff appropriately trained. Current trajectory in place to support this.

Service user and staff feedback

Current Local patient surveys ongoing:

- Postnatal care
- AN and PN screening service survey
- Maternity's new website (launched Oct 23)
- NNU family experience.
- Bereavement survey

- 15 Steps in Maternity' completed by MNVP and service users in October, feedback received and action plan codesign.

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

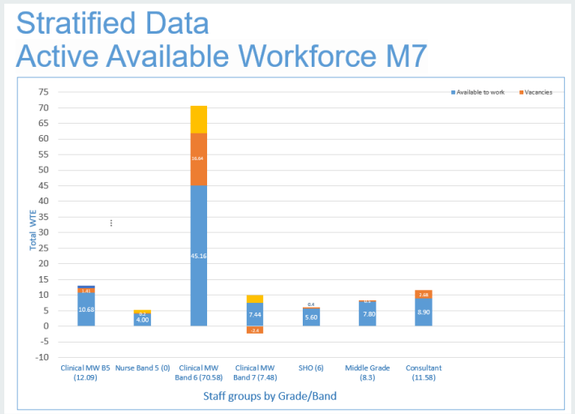
Perinatal Quality Surveillance Integrated Performance Report

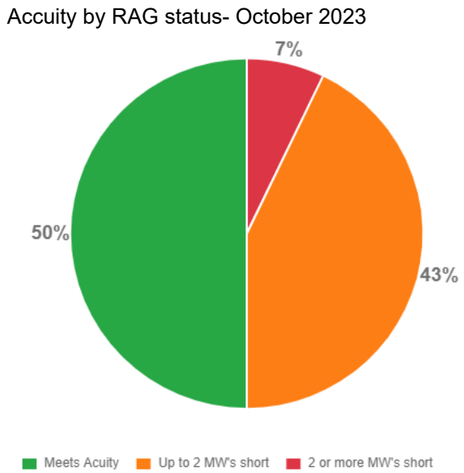
October Data 2023

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

Maternity & Neonatal Workforce

	Target	Threshold		July 23	Aug 23	Sep 23	Oct 23	Comment
Midwife to Birth Ratio	1:26	=<1:26	>1:26	1:30	1:30	1:29	1:30	
1:1 Care	100%	100%	100%	100%	100%	100%	100%	
Consultant Presence in Delivery Suite (Hrs per week)	40	=>40	<40	40	40	40	40	
Supernumerary Status of Delivery Suite Coordinator	100 %	100 %	100 %	100 %	100 %	100 %	100 %	
Confidence factor in Birthrate+ recording								Audit be commenced November 2023
Daily multidisciplinary team ward round								Audit to be commenced Nov 23
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0			0	0	0	0	To be monitored via datix reporting





- **OVERVIEW**

Key Achievements:

- Out of 7 international midwives who have joined the trust all have now passed their OSCE. 5 have received NMC pin and 2 are awaiting this and to start.
- Supernumerary status of coordinator maintained and achieved 100% of time
- 1:1 care achieved 100% of time
- Reduction in Midwifery vacancies, further reduction anticipated in November

Next Steps for Progression:

- Continue with targeted recruitment campaign
- 2 x places secured on Nurse to Midwife conversion course. Commencing Jan ’24, training funded by HEE.
- 2 x places secured for Midwifery apprenticeship which will be open to current MSW

Key Risks:

- Vacancy rate of 15.65 WTE Midwives leading to challenges in maintaining fill rates
- Challenge in supporting well-being of staff whilst staffing levels are low but mitigating this and ensuring safety by use of escalation policy and ensuring midwives are rostered where acuity dictates the need is.

Perinatal Mortality Review Tool (PMRT)

Background Narrative & Identified Issues:

- *Figure 1: Shows live data for perinatal losses reportable to MBRRACE 1/10/2022- 31/10/23 form MBRRACE data tool. To show the trend of the year. (Excluding MTOP's, data only given up to last loss)*
- *Table 1: Shows PMRT reviews completed in October 2023*
- *Table 2:Shows actions generated from PMRT reviews completed in October 2023*

Number of babies who died in October that meet PMRT review criteria:

0

Improvement Actions & Timescales:

No cases reviewed

Themes in issues:

No cases reviewed

Figure 1. Live data for perinatal losses reportable to MBRRACE 1/10/2022- 31/10/23

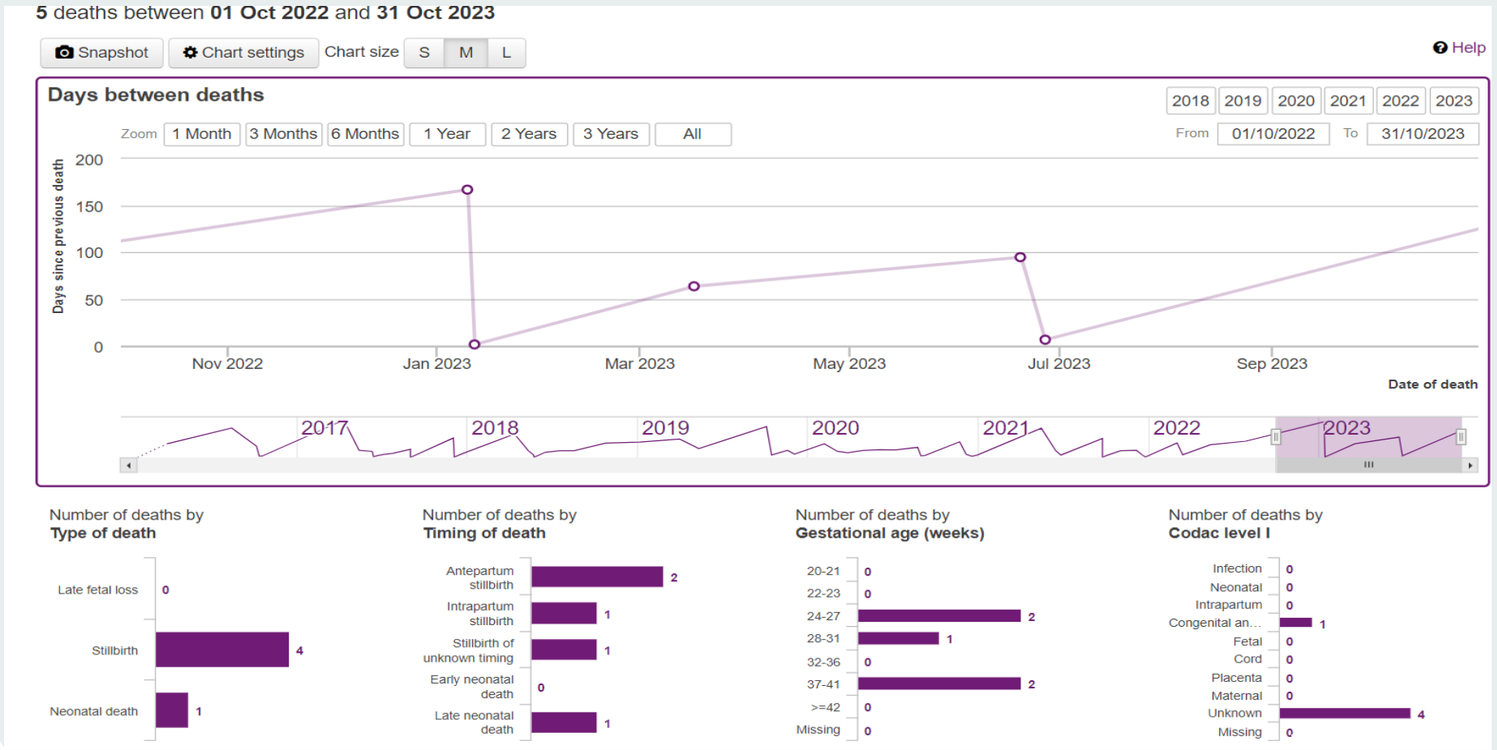


Table 2- PMRT Actions from review the reporting month 2023

There were no cases to be reviewed by the PMRT group in October therefore there were no actions generated.

Table 1: PMRT reviews completed during the reporting month

There were no cases reviewed by the PMRT group in October.

Incidents & Investigations
DATIX SUMMARY

New Moderate Harm Incidents (October 2023)

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI Reference
160280	25.10.2023	Moderate	Instrumental delivery for delay in second stage- reported as pushing for 2hrs but had only been approx. 45 minutes. CTG NAD. 3a tear sustained.	Awaiting review at patient safety summit 14.11.2023.	NA	NA
160332	27.10.2023	Moderate	Precipitate birth in the pool of 4kg baby. 3b tear sustained.	Initial thoughts that there had been a missed opportunity to refer for a growth USS. However upon further review this would not have made an impact/changed the outcome of this case. To take to PSS for presentation as part of a cluster.	NA	NA
160367	29.10.2023	Moderate	3c tear-delay going to theatre for suturing. Has experienced foot drop and walking with crutch at home at present.	For presentation at PSS 14.11.23	NA	NA
160407	30.10.2023	Moderate	MOH following instrumental delivery and shoulder dystocia. Received blood products	For presentation at PSS 14.11.23	NA	NA

New Serious Incidents (September 2023)

Following recommendations made in the Ockenden Report all cases referred to HSIB will be reported as a Serious Incident (SI).

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI Reference
NO NEW SI/HSIB CASES REPORTED DURING SEPTEMBER						

72-hour Incident Reviews

Completed Maternity & Neonatal 72-hour Reviews (Oct 23)

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI Reference
147126	07.07.2023-incident	Moderate downgraded to minor	Mother experienced a BBA and MOH of 1.9L and received blood products.	This incident was over a year ago, but the woman has recently lodged a complaint that she may not have required a blood transfusion if she had had an earlier attendance in theatre. A 72-hour review was not carried out at the time of the incident. Panel felt overall good care provided and to feedback to patient experience midwife for ongoing liaison with patient.	NA	NA
159341	19.09.2023-incident	Moderate	Mother experienced MOH at home following planned homebirth with independent midwives. Concerns re documentation and management around PPH.	Clinical review commissioned and currently being arranged.	NA	NA
159690	09.09.2023-incident	Moderate downgraded to minor	Twin delivered by ELLSCS. Working diagnosis of stroke and was cooled for 72hrs. Referred to HSIB-rejected as did not meet criteria. MRI NAD on day 8.	Presented at PSS and was awaiting HSIB decision. HSIB have since rejected. BH would like to review notes further and take back to PSS. Will aim to do this by PSS on 21.11.23	NA	NA
159355	21.09.2023-incident	Moderate downgraded to minor	Mother experienced MOH of 2.2L and received 2 units of RBC's.	Presented at PSS and downgraded to minor. Noted that there was lots of good care provided in difficult circumstances.	NA	NA
159447	16.09.2023-incident	Moderate downgraded to minor	Possible ureter damage at LSCS. Necessitated further investigation which ruled out damage, however needed 2nd GA for procedure.	Good care identified with prompt referral to specialist teams.	NA	NA
159776	06.10.2023-incident	Moderate downgraded to minor	ELLSCS for low lying placenta. MOH of 1.6L. Received RBC's. Had low platelts.	Good care, no omissions-good MDT working. Downgraded to minor.	NA	NA
159951	25.09.2023-incident	Moderate	Bladder injury during elective caesarean under spinal	Presented at PSS. Panel felt the matter was swiftly recognised and escalated with excellent MDT working.	NA	NA
159169	13.09.2023-incident	Moderate	Epidural bag ran out and then switched off by mw in second stage of labour.	Presented at PSS-for local discussion and learning.	NA	NA
159523	28.09.2023-incident	Moderate	2.2L urinary retention.	Catheterised and referred to continence service for TWOC and residual bladder scanning etc. Has sensation and is now pu'ing normally. For local learning.	NA	NA
159332	19.09.2023-incident Presented at PSS 31.10.2023	Minor	No obstetric review in antenatal clinic for VBAC.	Panel agreed that no harm had been caused. Although local guidance of course should have been followed, this did not have an impact on the outcome for this mother. For local review and learning.	NA	NA
159505	27.09.2023-incident	Minor	Mother received MMR vaccine at 5-6 weeks pregnancy before she was aware of her pregnancy. Came to light during her booking appt.	Ideally the patient should have had a more detailed 20/40 USS via FMU. Obs Cons discussed case with FMU and they were reassured that she had had multiple USS and growth USS at SDH and reassured that the were normal. Added to the vaccine surveillance programme and advised that senior paed should do NIPE. NIPE NAD.	NA	NA

Maternity Safety Support Programme	Yes	**CQC Ratings**	TBC	**Maternal Deaths**	Nil	**Concerns or requests from national bodies**	Nil	**Coroners Regulation 28**	Nil

Ongoing Investigations

Maternity & Neonatal Investigations (September)

SIIs, CRs and LRs In Progress								
ID	Directorate / Ward /	Summary of incident	Incident date	Date commissioned	CRG	Date Due to CCG / 60	Within 60 day	Progress Notes
CR 565	Maternity/W&NB	Uexpected admission to neonatal unit	18/05/2023	30/05/2023		22/08/2023		Draft report received minor formatting by Q&S team. To send to panel and staff for factual accuracy
CR 569	Maternity	Uncrossmatchable Blood - Antibodies	02/06/2023	13/06/2023		08/09/2023		Draft report received minor formatting by Q&S team. To send to panel and staff for factual accuracy
SII 570	Maternity	Retained Swab	09/06/2023	13/06/2023		08/09/2023		Report in writing. (Panel date 16.10.23, rescheduled from 5.9.23).
SII 571	Maternity	Placenta Acreta	25/05/2023	20/06/2023		14/09/2023		Panel on 16.11.23 9.30-11.30am. Difficulty organising panel availability.
SII 574	Maternity	Stillbirth		27/06/2023		21/09/2023		Draft report received minor formatting by Q&S team. To send to panel and staff for factual accuracy. Panel 14.8.23
CR 579	WNB	Term admission to NICU	20/04/2023	18/07/2023		09/10/2023		Draft report sent to DMT, has been to panel and staff. To finalised post comments and send to CRG for presentation.
CR 580	WNB	Term admission to NICU	16/07/2023	01/08/2023		23/10/2023		Report in writing. (Panel date 16.10.23).
CR 584	Maternity	OASI	3.7.23	8.8.23		30/10/2023		Panel date rescheduled. Panel TBC.
SII586	Maternity	Eclampsia and GA	8.8.23	22.8.23		13/11/2023		External chair. Panel date 9.11.23.
SII 587 (HSIB)	Maternity/W&NB	Term baby admitted to NICU and transferred to tertiary unit for cooling	12.8.23	22.8.23		13/11/2023		HSIB have attended SFT and met with parents. Face to face staff interviews 2.10.23.
CR 588	Maternity	Antenatal Pulmonary Embolism at 15 weeks pregnant	31.7.23	29.08.23		20/11/2023		Panel date 31.10.23 (moved from 11.10.23). Report will be in writing.
159341 CCR:	Maternity	PPH at Home, did not follow guidelines. C/O IDM	19.9.23	3.10.23				Awaiting decision from DMT re external panel chair (external to maternity)

Reports for EXIT							
ID	Directorate / Ward / Dept	Summary of incident	Date commissioned	CRG	Date Due to CCG	Within 60 day target?	Progress notes

SIIs, CRs and LRs Signed off - share (Stage 3) duty of candour								
ID	Directorate / Ward / Dept	Summary of incident	Incident date	Date Signed Off	Duty of Candour Update	Report share		
SII 548	Maternity/W&NB	Term admission to NICU	23/02/2023	28/02/2023		26/05/2023		Report shared 25.9.23. Meeting parents 9.11.23 2-3pm. To then draft DOC 3 letter from CEO.
SII 492	Maternity/W&NB	baby fitted in first 24 hrs - not HSIB - fitting was thought to be due to metabolic disorder, now excluded.	13/07/2022	19/07/2022		12/10/2022		Report shared 7.9.23. Joint DOC 3 from CEO (investigation and compliant close) 10.10.23 DOC 3 CEO letter 10.10.23. Datix updated. Report to risk inc action

Following recommendations made in the Ockenden Report all cases referred to HSIB will be reported as a Serious Incident (SI).

Data correct as of 31st October 2023 (finalised with Trust PSS group). The data in the preceding month may have changed due to this being reported weekly via Trust Risk team and being updated and agreed locally

Investigation Actions

Compliance Tracker (September)

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
CR 454	Click	W&NB	December 2021	Q2 23-24	Q2 23-24	Oct 22	Q4 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	Q2 23-24	Jan 23	Q4 22-23	Q4 22-23	Q4 22-23	Q3 22-23	Q4 22-23	Q1 23-24		
SII 489	Click	W&NB	May 2022	Q1 22-23	Dec 22	Q4 22-23	Q4 22-23	Q3 22-23	Q3 22-23					
SII 497	Click	Surgery	July 2022	Surg	Q1 23-24	Q2 23-24	Med	Apr 23						
SII 506	Click	W&NB	March 2021	CSFS	Jun 23	Q1 23-24	CSFS							
CR 509	Click	W&NB	July 2022	Q2 22-23	Oct 23	Aug 23	Oct 23	Aug 23						
SII 510	Click	W&NB	August 2022	Q1 23-24	Q1 23-24	Feb 23	Q2 23-34	Feb 23	Jan 23	Jan 23	Q1 23-24	Jan 23		
CR 512	Click	W&NB	September 2022	Sept 23	Jul 23									
CR 514	Click	W&NB	September 2022	Q3 22-23	Jan 23	Q1 23-24	Dec 22	Feb 23	Q2 23-24	Q1 23-24				
CR 527	Click	W&NB	October 2022	Q1 23-24	Q1 23-24	Jun 23	Q2 23-24							
SII 537	Click	W&NB	December 22	Jul 23	Jul 23	Jul 23								
CR 540	Click	W&NB	November 2022	Jul 23	Q1 23-24	Sep 23	Jul 23	Jun 24						
SII 555	Click	W&NB	March 2023	Nov 23	Nov 23	Nov 23	Nov 23							

Colour Code		
No Evidence	Evidence of Progress	Evidence of Completion

** Action tracker held corporately and reported via Trust Risk Team. Data in preceding and current month maybe the same or have changed due to Trust reporting mechanisms and due to cases being removed once all actions completed. Current tracker received on 13th October **(above)**

Feedback – Staff & Service Users

MNVP Service User Feedback

Key Achievements & Positive Feedback:

15 step was undertaken on 2nd October 23

Identified Areas of Improvements:

Review of Postnatal and Antenatal care in response to the above review, together with recent comments and concerns and the local pregnancy journey survey.

Next Steps for Progressions:

- Completion of the action plan for both 15 steps and National Maternity survey
- Continue to promote FFT
- Provision of evidence in support of Ockendon

Safety Champions Staff Feedback

Key Achievements & Positive Feedback:

The health inequalities funding application was unsuccessful. Suggested actions was to work in collaboration with the LNMS for submission in 2024
We welcomed the newly appointed Maternity and Neonatal Independent Senior Advocate (MN ISA) working across BSW, hosted by the ICB.

Identified Areas of Improvements:

Action plan to be devised following the 23 National Patient Experience Survey.

Next Steps for Progressions:

AL to notify the clinical director should our health inequalities bid be successful

Compliments & Complaints

Themes & Trends: Oct 23

C**omplaints :0**
Compliment:3
Concern:3
Comments:11
Themes of concerns :

- **Women feeling not listened to.**
- **perceived incorrect documentation and access to their personal details**

Friends & Family Survey

Key Achievements: Q2 SOX =24 main theme being 'support to others'.

FFT feedback 16/9/23-20/10/23 3 responses**, all rated good or very good.**
Antenatal feedback:
Rated very good: "Team were always friendly and kind. Always did the best for me and my baby. Always cared for my mental health first".

Identified Areas of Improvements:

Continue to promote FFT

Next Steps for Progressions:

All leads have been asked to locate the current FFT cards are offer them to women who access their department/ inpatient aeras

Current Local patient surveys ongoing :

- Postnatal care
- AN and PN screening service survey
- Maternity's new website (launched Oct 23)
- NNU family experience.
- Bereavement survey

Completed National /local surveys:

- Pregnancy journey survey- with the focus on women in low social economic groups, Black, Asian and ethnic minority groups. – analysis of the result is being undertaken.
- National Maternity Patient experince survey – action plan in in development, analysis of the free text is in progress.

Compliance across National Guidelines – Ockenden

OCKENDEN 2020 Report

	Current Rag Status /Action No	Immediate & Essential Action	Number of actions under each heading rated		
			RED	AMBER	GREEN
Oct-23	1	Enhanced Safety	0=	0=	3=
	2	Listening to Women & Families	0=	0=	1=
	3	Staff Training & Working Together	0=	1=	2=
	4	Managing Complex Pregnancy	0=	0=	3↑
	5	Risk Assessment Through Pregnancy	0=	0=	2=
	6	Monitoring Fetal Wellbeing	0=	1=	6=
	7	Informed Consent	0=	3=	0=
		TOTAL	0	5	18↑

Ockenden 2020 Report

Key Achievements:
- Publishing of maternal mental health guideline
- Writing of informed consent information for website and updating of guidelines

Next Steps for Progressions:
- Work towards closing amber actions

Key Risks to Full Compliance:

OCKENDEN 2022 Report

	Current Rag Status /Action No	Immediate & Essential Action	Number of actions under each heading rated		
			RED	AMBER	GREEN
Oct-23	1	Workforce Planning & Sustainability	0=	3=	4=
	2	Safe Staffing	0=	6=	4=
	3	Escalation & Accountability	0=	3=	2=
	4	Clinical Governance - Leadership	0=	3=	4=
	5	Clinical Governance - Incident Investigation & Complaints	0=	4=	2=
	6	Learning From Maternal Deaths	0=	2=	0=
	7	Multidisciplinary Training	0=	6=	1=
	8	Complex Antenatal Care	2=	2=	1=
	9	Preterm Birth	2=	2=	0=
	10	Labour & Birth	4=	2=	0=
	11	Obstetric Anaesthesia	0=	3=	0=
	12	Postnatal Care	0=	4=	0=
	13	Bereavement Care	0=	4=	0=
	14	Neonatal Care	3=	2=	1=
	15	Supporting Families	0=	3=	0=
		TOTAL	11	48	19

Ockenden 2022 Report

Key Achievements:
- Nearly all actions are in progress

Next Steps for Progressions:
- Working groups for actions to begin progress

Key Risks to Full Compliance:
- None

Compliance across National Guidelines – MIS

CNST/Maternity Incentive Scheme (MIS)

	NHSR Maternity Incentive Scheme- Year 5 Submission by 1st February 2024			
	Description	Yr 4 Submission	Comment	Current Assessment
Are we well led?	1 **Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Compliant	No issues identified or anticipated	
	2 **Maternity Services Data Set** submission to required standard	Compliant	No issues identified or anticipated	
	3 **Transitional Care Data Set** minimise separation to mothers and babies	Non Compliant	Plan in place to achieve compliance	
	4 **Clinical Workforce Planning** effective system	Non Compliant	Work in progress. Compliance is achievable.	
	5 **Midwifery Workforce Planning**	Compliant	No issues identified or anticipated	
	6 **Saving Babies Lives Care Bundle V3** compliance with all elements	Non Compliant	New bundle published 31/5/23- Extra element for women with pre pregnancy diabetes. Work in progress. Several barriers to achieving compliance. Compliance is achievable.	
	7 **Service User Involvement and co-Production**	Compliant	No issues identified or anticipated	
	8 **Multidisciplinary Training**	Non Compliant	Work in progress. Compliance is achievable.	
	9 **Board Assurance** Board to Ward to Board	Non Compliant	Awaiting ratification of new Maternity Governance Framework. Proposed changes to trust policy *Accountability and Integrated Governance Framework* Compliance is	
	10 **HSIB and EN Reporting**	Non Compliant	Awaiting ratification of new Maternity Governance Framework. Compliance is achievable.	
	Person Centred & Safe	Professional	Responsive	Friendly	Progressive

CNST / Maternity Incentive Scheme (MIS)

Key Achievements:
- Nearly all actions are nearing completion
- CNST meeting on 11/10/23 confirmed good progress with all actions

Key Risks to Full Compliance:
- Progress continues with all actions at steady pace with continual review of guidance for any new evidence required

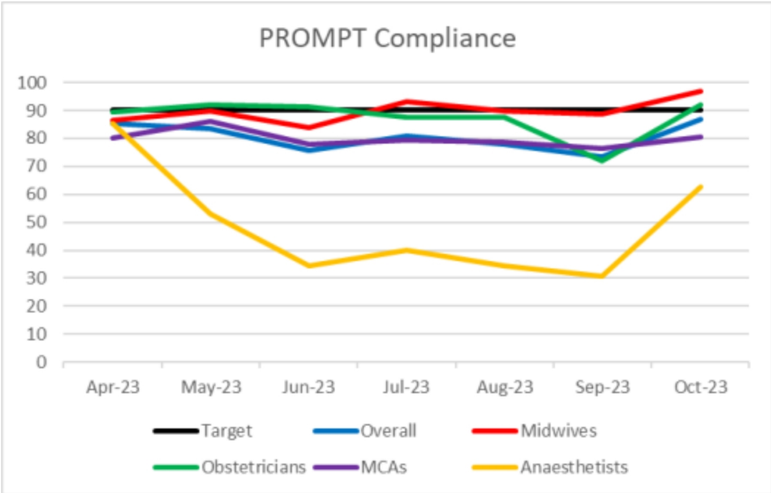
Maternity 3 Year Single Delivery Plan

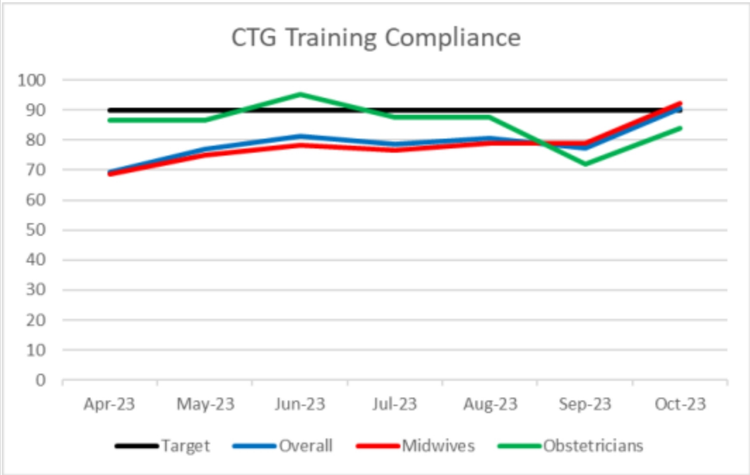
Maternity 3 Year Single Delivery Plan

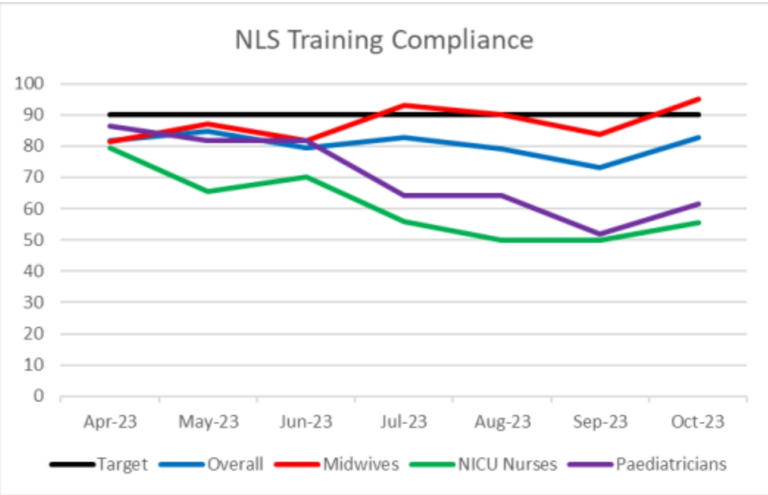
Plan reviewed by Divisional Triumvirate, some actions already in progress following staff survey and already being progressed through Improving together methodology.

Plan to utilise Improving together methodology to focus and prioritise actions from the plan.

Training & Education







Background Narrative & Identified Issues:

Within the MIS, 3 key areas are identified to achieve training compliance of over 90%:

•PROMPT – Multidisciplinary Obstetric Emergencies

•Newborn Life Support

•Fetal Monitoring - New Obstetric trainees have started at the trust and are non-complaint as have not yet had their training but are all allocated for training in November so we will reach 90% by 1st December

In Maternity Incentive Scheme year 5, the data needs to be further stratified to be compliant with safety standard 8. This includes staff groups and grades individual compliance with above training modules. We have included this data to continue monitoring compliance during MIS year 5.

Improvement Actions & Timescales:

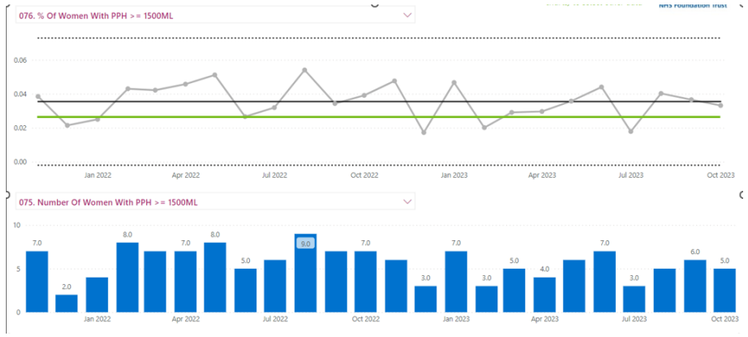
- Additional dates for PROMPT and fetal monitoring created in October and November – plan ensures >90% for each staff group for CTG and PROMPT.
- Plan in place for anaesthetic attendance at PROMPT – cancelling of elective work to ensure attendance.
- NLS compliance for Neonatal and Paediatric staff escalated to each department for plan – awaiting feedback.

Risks:

- Lack of RC-trained instructors for NLS updates – mitigated as provided by RC attenders.

Ongoing Themes

% and number of women with PPH >1500ml



Theme – PPH rate above national rate

Key Achievements:

- Recognition that SFT maintains as consistently high PPH rate above national target and that this is mirrored across the LMNS.

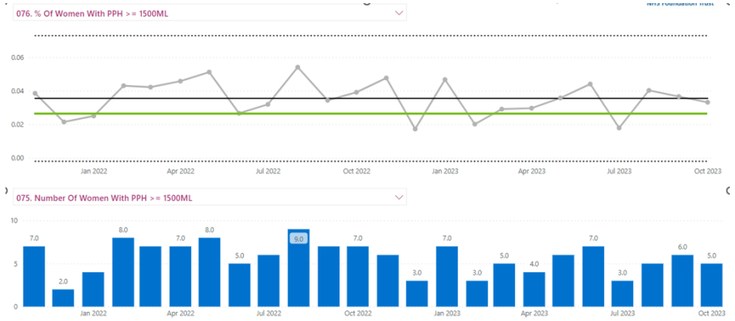
Next Steps for Progressions:

- Conduct a thematic review (November) of PPH >1500mls cases

Countermeasures:

- To await thematic review and to include use of PPH Risk assessment tool.

% and number of babies born at term with APGAR of less than 7 at 5 mins



Theme - % and number of babies born at term with APGAR of less than 7 at 5 minutes

Key Achievements:

- Recognition that SFT maintains a higher % of term babies with low APGARS than national target.

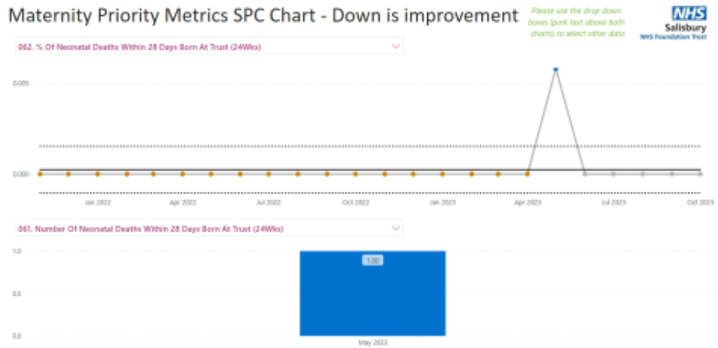
Next Steps for Progressions:

- Conduct a thematic review of cases (November)

Countermeasures:

- To await thematic review results and to include use of PPH Risk assessment tool

% and number of neonatal deaths within 28 days Born at Trust



Theme - % and number of neonatal deaths within 28 days Born at Trust

Key Achievements:

- This chart represents 1 neonatal death in May 2023 which was a baby born with known abnormalities and planned palliative care. This slide is to offer assurances re neonatal death rate at SFT in light of the national media coverage of the high-profile Lucy Letby media case

Next Steps for Progressions:

- To continue to monitor all quality and safety markers.

Countermeasures:

- To continue education and awareness re escalating concerns and whistleblowing. Neonatal unit have posters around the unit..

Health Inequalities

Maternity 3 Year Delivery Plan covers Health Inequalities

Action plan has been drafted

Next steps:
- Job matching and advertising for an inclusion midwife to support with improving equity –LMNS funded fixed term post
- Allocation of actions

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.9
Date of meeting:	7 December 2023		

Report tile:	CNST safety action 3. ATAIN action plan			
Status:	Information	Discussion	Assurance	Approval
Approval Process: (where has this paper been reviewed and approved):	Neonatal governance Women & Newborn Divisional governance committee Sign off by CD, DOM, DDO and NN CL Clinical Governance 28th November 2023			
Prepared by:	Abigail Kingston			
Executive Sponsor: (presenting)	Judy Dyos			

Recommendation:

The Committee are asked to;
Sign off the ATAIN action plan as per CNST safety action 3, note progress of actions and provide any challenge for ATAIN process.

Executive Summary:

The Trust has a monthly meeting to review all unexpected term admissions into the neonatal unit with a view to identifying whether separation of primary carer and baby could have been avoided. Thematic review of the causes of admission is used to create an action plan to address the findings of the review. The action plan allows assurance of progress.

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	
Other (please describe):	

NHS
Salisbury
NHS Foundation Trust

ATAIN report and action plan Q1 & Q2

Salisbury NHSFT Neonatal Unit.

Introduction

Reducing admissions at term is a national NHS improvement driver to reduce potentially avoidable harm to babies born over 37 weeks gestation who are admitted to neonatal units unexpectedly within the first 28 days of birth.
The secretary of state for health has made four key priorities which include reducing the stillbirth, neonatal brain injury and neonatal death rate by 50% by 2031, reducing harm from learning from serious incidents, improving culture and teamwork and implementing the recommendations from better births.
There are four key areas relating to term admissions within the NHS improvement ATAIN document (2017) which are:

- • Hypoglycaemia
- • Jaundice
- • Respiratory conditions
- • Hypoxic-ischaemic encephalopathy

Avoiding term admissions is incredibly important for several reasons. The first is the impact of long-term health of these babies in having attended a neonatal unit, and the long-term consequences of the above conditions: particularly relating to HIE. The second biggest impact is the effect of separation on the family, and the influence early separation can have upon the mother-child relationship (Crenshaw 2007; 2014 Bigelow et al 2012). A baby entering a neonatal intensive care unit can impact on long term breastfeeding rates, maternal or paternal mental health and in addition there are also potential impacts on the infant microbiome which can have long term health implications. Finally, there is the financial cost to the NHS with every baby admitted to the neonatal intensive care unit unexpectedly.

SFT Strategic priorities ; **Population**, reducing harm.

CQC Domains:

Effective: E2 - How are people's care and treatment outcomes monitored and how do they compare with other services?

Well-Led: W2 - Does the governance framework ensures that responsibilities are clear, and that quality, performance and risks are understood and managed?

Audit Aims

To review with multi-disciplinary team, the causes of unexpected term admission to the neonatal unit.

To use the data collected and the review to identify themes.

To produce an action plan addressing the themes in an effort to reduce admission rates.

To escalate themes through the departmental, divisional and Trust governance framework.

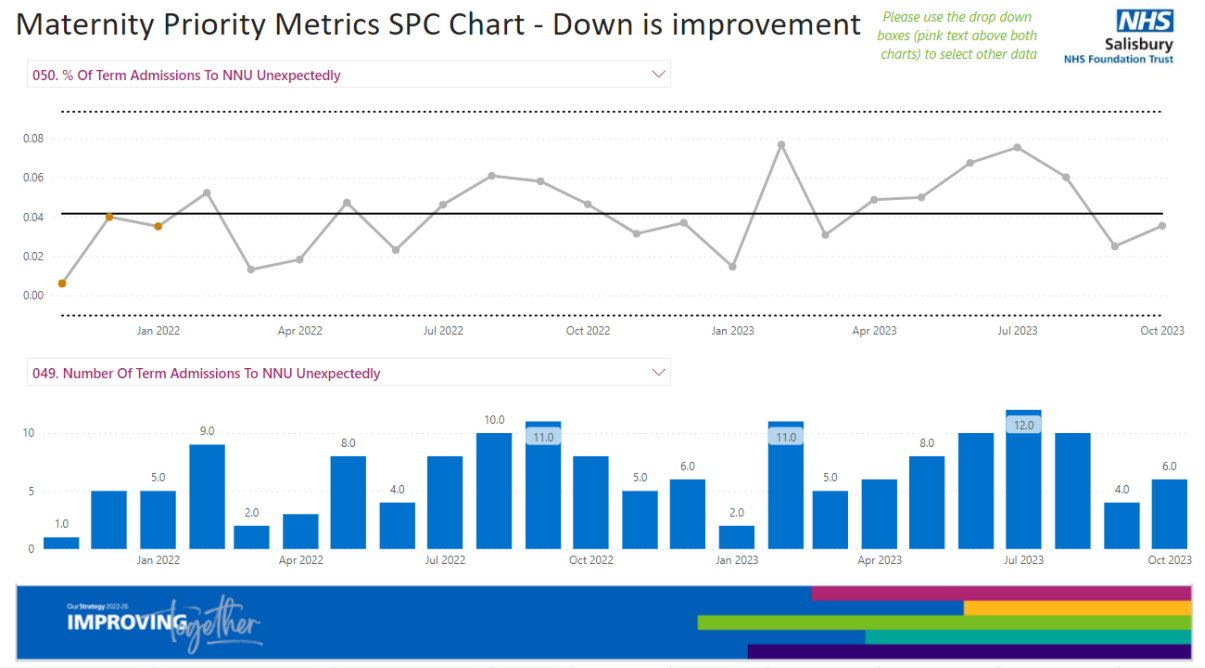
DATA

In quarter 1 there were 24 unexpected term admissions to NNU

In quarter 2 there were 26 unexpected term admissions to NNU

The National aim is to keep term admissions <6%, the Thames valley & Wessex aim is to keep term admissions below 5%.

With small numbers our data is best analysed using an SPC chart.



This shows that the level is not alerting and the run mean from Jan 2022 is 4%.

<u>Reasons for admission identified through MDT review;</u>

Please note that some babies have more than one reason for admission.

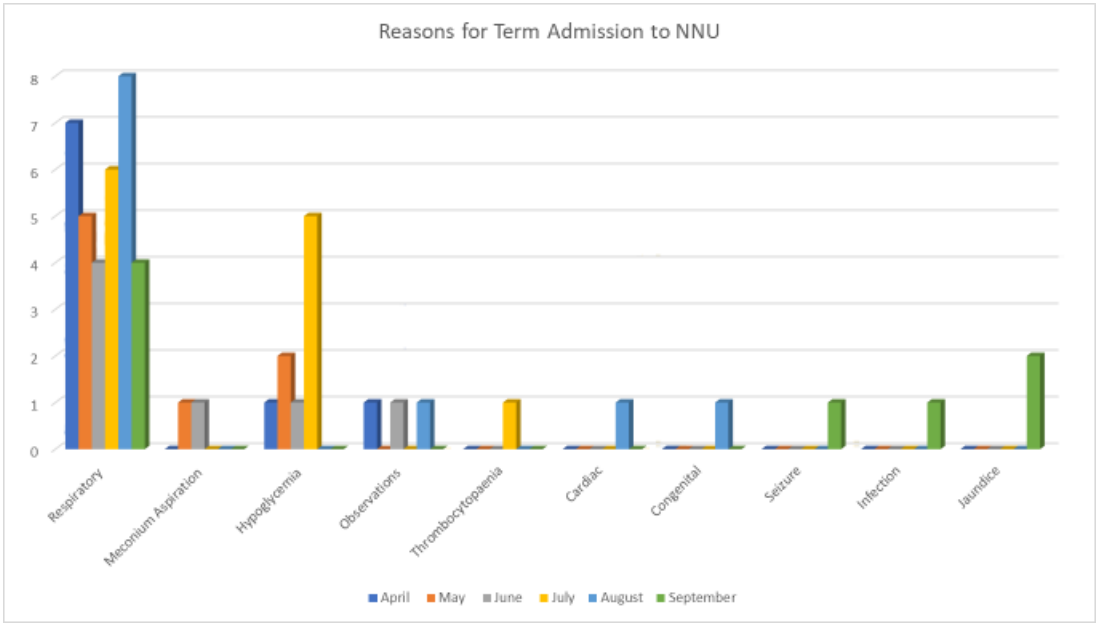
Respiratory admission has been the primary reason for the last two quarters and this is the same across BSW and bench marking done by a recent ATAIN visit to Winchester hospital.

As part of the action plan, a deep dive into early CS (37 weeks) was undertaken by the maternity and obstetric teams to understand the contribution of this to the ATAIN data.

Please see Appendix 1 for action plan

Reasons for Term admissions to NICU

NHS Salisbury NHS Foundation Trust



Summary of deep dive into ‘early’ CS:

Summary of Review of 37 week Elective C/S

NHS Salisbury NHS Foundation Trust

- Declining trend of 37/40 ELCS
- No concerns with obstetric management
- 3 x cases where decisions made on USS findings. Awaiting review of images. Review of images shows 2 OK, 1 with issues of measurement
- Good evidence of counselling for decision for delivery
- In summary: No evidence of increasing trend for ELCS at 37 weeks or deficiencies in management

Appendix 1

ATAIN action tracker Nov 23

Action Tracker

Deadline passed. Completed Status = N	1					
Deadline in future. Current progress made is updated. Completed status = N	2			Please RAG rate all actions, see to the left the suitable numbers for each action.		
Completed status = Y	3					
No update at this time	4					

Agenda Item	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
Audit past sticker use as have now been running for 2 months	retrospective audit but then moving towards real time audit as stickers now being used	GD	31/07/23	Sticker being filled in much more now - not 100% will do spot audit for next month when reviewing notes	Y	3
To introduce 'Think 45' inititive	Attending team to offer upto 45mins of PEEP to aid transition and hopfully reduce the number of term infants admitted for respiratory (transition) issues.	HH	01/06/24	Started to train staff launch Q1 2024	N	2
Theatre Trolly provided to be able to get post section mums into NICU room. Ward beds don't fit	Martons QI project to move this forward and embed withinmaternity. CB LW lead to join the team to help push this forward	GD/BR/CB	31/06/2024	relauch as imporving together project with 'Think 45' in Q1 2024. To involve all MDT to roll out next year	N	2
Obsetrics to review reasons for LSCS at 37 weeks and review process about false positives due to GROW recording	Sophie & risk lead to raise this with wider maternity service and sonograhpy	SMG/AB	Aug-23	AB has drawn data this shows no disproposinate amount of admissions in the 37 week category. AB meet with SD to go through GROW data and trust not outlying for incosistancies.	Y	3

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.10
Date of meeting:	7th December 2023		

Report tile:	Maternity and Neonatal Training Needs Analysis (TNA)			
Status:	Information	Discussion	Assurance	Approval
	Yes		Yes	
Approval Process: (where has this paper been reviewed and approved):	Approved by Women and Newborn Divisional Management Team Divisional Governance 17.11.23 and Clinical Governance Committee 28th November 2023			
Prepared by:	Vicki Marston - Director of Maternity and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing officer			

Recommendation:

The committee are asked to note the contents of the Training Needs Analysis which has been provided for information and assurance processes.

To demonstrate compliance with the Maternity Incentive scheme the committee is asked to note the specific expectations in relation CNST – Safety Action 8 of implementing version 2 of the core competency framework.

Executive Summary:

As per Safety action 8 the TNA is in place and evidences a plan that implements the requirements of the Core Competency Framework version 2.

The committee is asked to note and minute the following required standards as set out in the report that a training plan should be in place to implement all six core modules of the Core Competency Framework over a 3-year period, starting from MIS year 4 in August 2021 and up to July 202:

Required standard and minimum evidential requirement:

1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.

2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.

3. The plan is developed based on the “How to” Guide developed by NHS England.

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

Core Competency Framwework Version 2 Training Needs Analysis

Salisbury NHS Foundation Trust

Core Competency Framework v2 TNA

Date of agreement by LMNS each year:

Save new TNA each year, or as per any changes to show any developments

	INSERT DATE: (Can attach meeting minutes here)	**INSERT DATE:** (Can attach meeting minutes here)	**INSERT DATE** (Can attach meeting minutes here)
	Year 1 (2022)	**Year 2 (2023)**	**Year 3 (2024)**

Core Competency Module	Minimum standard	Stretch Target - Ambition/Aspiration	Training details			Monitoring system	Trust Compliance %	Mitigation/Action Plan	Predicted staff expenditure perinatal team (WTE/Annum)									
			Year 1	Year 2	Year 3				Attend (Y/N)	Midwives	Attend (Y/N)	Maternity Care Assistants	Attend (Y/N)	Obstetricians	Attend (Y/N)	Anaesthetists	Attend (Y/N)	Maternity Nurses
										Total cost/year								
										WTE								
1. Saving babies Lives care bundle	90% attendance – annually for each element with eLfH module every 3 years Training must include learning from incidents, service user feedback and local learning Training must include local guidelines and care pathways E-learning can be appropriate for some elements. Learning must be responsive to local clinical incidents and service user feedback	≥95% attendance Shared learning from incidents across LMS and Buddy LMNS relating to morbidity & mortality. Benchmarking against other organisations with similar clinical profile and national programmes Staff evaluation on quality of training in place with evidence of improvement Service users share their experiences as part of training day Use of positive case examples to learn from Training to be tailored to role and place of work for each element.			Half Taught Day: Multiple Pregnancy Preterm Birth Diabetes in Pregnancy eLearning for: GROW Smoking	Trusts to document monitoring system used		Trusts to document mitigation/action plan if not compliant	Please record data against module elements								
Smoking in Pregnancy	Training must include:- All multidisciplinary staff trained to deliver Very Brief Advice to women and their partners NCSCT e-learning Local opt-out pathways/protocols, advice to give to women and actions to be taken. CO monitoring & discussion of result. Individuals delivering tobacco dependence treatment interventions should be fully trained to NCSCT standards	Smoke-free advisors have evidence-based behavioural training (i.e. CBT/Risk perception) Use of service user case study Every Contact Counts training Evidence of Specialist smoke-free advisors sharing briefings and national publications i.e. Maternal and Neonatal Health Safety Collaborative. Action on Smoking and Health (ASH) briefings for Integrated Care Systems	Included on Maternity Study Day Evidence of eLearning via eLfH Midwives Study day 24th May..docx; Bea's 2022 mandatory presentation.pptx	Included on Maternity Study Day Evidence of eLearning via eLfH 16.5.23 Timetable Study Day.docx; Bea's PIMS presentation 23.pptx	Completion of eLearning (eLfH)	Education Dashboard		Trusts to document mitigation/action plan if not compliant	Y	£2,657 0.06	Y	£484 0.02	Y	£1,110 0.01	N	£0 0.00	N	£0 0.00
Fetal Growth Restriction	Training must include:- local referral pathways, identification of risk factors and actions to be taken. Evidence of learning from local Trust detection rates and actions implemented Include symphysis fundal height measuring, plotting & interpreting results practical training and assessment, and case reviews from examples of missed cases locally	Use of service user case study Review of trust's detection rates, compared to other similar organisations and national data Audit of compliance against training action plan developed as a result of incidents related to fetal growth restriction	Completion of eLearning (eLfH)	Included on Maternity Study Day Completion of eLearning (eLfH) 16.5.23 Timetable Study Day.docx; Gap and Grow.pptx	Completion of eLearning (eLfH)	Education Dashboard		Trusts to document mitigation/action plan if not compliant	Y	£2,657 0.06	N	£0 0.00	Y	£1,110 0.01	N	£0 0.00	N	£0 0.00
Reduced fetal movements	Training must include:- Local pathways/protocols, and advice to give to women and actions to be taken. Evidence of learning from case histories, service user feedback, complaints and local audits	Use of service user case study Audit of compliance against training action plan developed as a result of incidents related to fetal movements	Included on Fetal Monitoring Study Day CTG Training Day Plan NO TIMINGS.docx	Included on Maternity Study Day BSOTs care pathways included 16.5.23 Timetable Study Day.docx; BSOTS_Short Presentation 2022.pptx	Included on Fetal Monitoring Study Day	Trusts to document monitoring system used		Trusts to document mitigation/action plan if not compliant	Y	£2,657 0.06	N	£0 0.00	Y	£1,110 0.01	N	£0 0.00	N	£0 0.00
Fetal monitoring in labour	See Module 2	See Module 2							Please record data in Module 2. Fetal Surveillance in labour (Below)									
Preterm birth	Training must include:- Identification of risk factors, local referral pathways, All elements in alignment with the BAPM/MatNeoSIP optimisation and stabilisation of the preterm infant pathway of care A team-based shared approach to implementation as per local unit policy Risk assessment and management in multiple pregnancy	Evidence of impact using the improvement strategies to optimise preterm birth outcomes Use of clinical simulations Review of outcomes in relation to multiple births & identified improvement(s) Use of service user case study	Not included	Not included	SBLCBv3 half day	Trusts to document monitoring system used		Trusts to document mitigation/action plan if not compliant	Y	£3,986 0.09	Y	£727 0.03	Y	£1,665 0.02	Y	£1,854 0.02	N	£159 0.00
Diabetes in pregnancy	Training must include:- identification of risk factors and actions to be taken referral through local multidisciplinary pathways including Maternal Medicine Networks and escalation to endocrinology teams Intensified focus on glucose management in line with NHS Long Term Plan & NICE guidance, including Continuous Glucose Monitoring Care of the diabetic woman in labour	Learning from local and national case reviews are disseminated Use of service user case study with diabetes in pregnancy	Not in CCFv1 Not in CCFv1	Included on Maternity Study Day - delivered by Diabetic Specialist Nurse 16.5.23 Timetable Study Day.docx; GDM Mandy March 23.pptx	SBLCBv3 half day	Trusts to document monitoring system used		Trusts to document mitigation/action plan if not compliant	Y	£2,657 0.06	Y	£484 0.02	Y	£1,110 0.01	N	£1,854 0.02	Y	£106 0.00
2. Fetal monitoring and surveillance (in the antenatal and intrapartum period)	90% attendance Annual Update. All staff will have to pass an annual competency assessment that has been agreed by the local commissioner (CCG) based on the advice of the Clinical Network. Trusts should agree a procedure with their CCG for how to manage staff who fail this assessment. (Pass mark of 85%) 1 full day training in addition to the local emergencies training day Fetal monitoring lead trainers must attend annual specialist training updates outside of their unit Training must:- Be responsive to local clinical incidents, service user feedback and local learning, utilising local case histories. Include use of risk assessment at start of and throughout labour complying with fetal monitoring guidelines. Include antenatal fetal monitoring, intermittent auscultation and electronic fetal monitoring. Be tailored for specific staff groups e.g. Homebirth or birth centre teams Be multi-disciplinary & scenario-based. Include information about using the equipment that is available Include the fetal surveillance of multiple pregnancies Include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMNS.	≥95% attendance ≥95% pass mark/evaluation Use of positive case examples to learn from Shared learning across LMNS & Buddy LMNS. Benchmarking against other organisations with similar clinical profile and national programmes. Evidence of MDT case scenario discussions & shared with wider team to increase accessibility Evidence of improvement following staff evaluation on training when ≥95% feedback is evaluated as good or excellent Lead specialists are in collaboration with the national network of fetal monitoring specialists to support own learning, practice developments & evidence based care Wider training i.e. on neonatal HIE & nervous system physiology Intrapartum midwives attend additional high level training to support fetal monitoring knowledge on the ABC programme when available Independent external evaluation of local training	As per CCFv1 Included: Risk assessment throughout labour IA and EFM Local case studies Reduced fetal movements CTG Training Day Plan NO TIMINGS.docx; 3. PHYSIOLOGY.pptx; 5. APPLICATION TO PRACTICE.pptx	As per CCFv1 Fetal Monitoring Study Day Human Factors Risk Assessments Local Case Studies AN, IIA and Intrapartum CTG Machine Competency Assessment Document; 6. 2023_CTG training day RP.pptx	As per CCFv2 Fetal Monitoring Study Day Local case studies Risk assessments AN, IIA and Intrapartum Equipment Multiple Pregnancies Human Factors	Education Dashboard		Trusts to document mitigation/action plan if not compliant	Y	£21,259 0.48	N	£0.00 0.00	Y	£4,438.70 0.05	N	£0.00 0.00	N	£0 0.00

3. Maternity Emergencies and multiprofessional training	90% of each relevant maternity unit staff group has attended an "in-house" MDT training day & include a minimum of 4 maternity emergencies with all scenarios covered over a 3-year period and priorities based on locally identified training needs Antepartum and postpartum haemorrhage Shoulder dystocia Cord prolapse Maternal collapse, escalation and resuscitation Pre-eclampsia/eclampsia severe hypertension Impacted fetal head Uterine rupture Vaginal breech birth Care of the critically ill patient Annual update Training should be face to face (unless in exceptional circumstances such as the Covid Pandemic) Training must:- Include the identification of deteriorating mother/baby and use of MEWS/MEOWS/NEWTT charts as locally relevant Include communication, escalation of care & use of tools such as SBARD Be sensitive and responsive to local safety insights, near misses or HSIB cases. Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan Use service user comments or feedback from investigations Maternal & Neonatal outcomes using exemplars from national programmes i.e. National Maternity Perinatal Audit (NMPA); Getting it Right First Time (GIRFT); Healthcare Safety Investigation Branch (HSIB) Include at least one scenario from a learning from excellence case study. Be tailored for specific staff groups e.g. Homebirth or birth centre teams/ maternity support worker (MSW). Include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. Include human factors training. Include at least one of the emergency scenarios to be conducted in the clinical area, ensuring full attendance from the relevant wider multi-professional team. This will enable local system and environmental factors within the clinical setting to be considered, any risks and issues identified and an action plan developed to address these.	≥95% attendance Shared learning across LMNS or network Use of positive case examples to learn from Programme of clinical simulations at point of care in variety of settings including community and evidence of learning, actions, feedback & debrief Staff evaluation on quality of training in place with evidence of improvement if ≤95% feedback is evaluated as good or excellent	As per CCFv1: COVID-19 specific training Antepartum Haemorrhage Sepsis and care of the critically ill patient Annual Update Vaginal Breech birth Shoulder dystocia Eclampsia	Included: Uterine Inversion and MOH Shoulder Dystocia Vaginal Breech Birth Pre-Eclampsia/Eclampsia Sepsis and care of critically ill patient Impacted Fetal Head Human Factors Training (delivered by Sim Suite Lead)	To include: Cord prolapse LA Toxicity Maternal collapse, escalation and resuscitation APH Uterine rupture and VBAC	Education Dashboard		Trusts to document mitigation/action plan if not compliant	Y	£21,259 0.48	Y	£3,876 0.14	Y	£8,877 0.10	Y	£7,414 0.07	Y	£846 0.02
4. Equality, Equity and Personalised Care	90% attendance (3 yearly programme of all topics) Training should cover local pathways and key contacts when supporting women & families. Training must include learning from incidents, service user feedback and local learning Must include local guidance, referral procedures and 'red flags' One topic from each list must be covered as a minimum, identified from unit priorities, audit report findings and locally identified learning, involving aspects of care which require reinforcing and national guidance:- List A Ongoing antenatal and intrapartum risk assessment and risk communication Maternal mental health Bereavement Care List B Personalised Care and Support Planning (including plans when in use locally) Informed decision making, enabling choice, consent & human rights Equality & Diversity with cultural competence	≥95% attendance Involving MNVPs/Service Users in coproducing and/or delivering training based on lived experiences. Service user feedback gained from Personalised Care and Support Plans (PCSP) audits are embedded into training Use of positive case examples to learn from Benchmarking against other organisations with similar clinical profile and national programmes Training on learning disabilities & Autism that is maternity specific is embedded in personalised care training Equality & diversity training includes unconscious bias; LGBTQ Risk assessment & risk communication includes genetic risk Staff evaluation on quality of training in place with evidence of improvement where ≤95% feedback is evaluated as good or excellent Yearly training on any subject Stakeholder support i.e. SANDS involved in supporting delivery of training	As per CCFv1: Included on Maternity Study Day: Maternal Mental Health Families with babies on NICU / transitional care	Maternal Mental Health on Maternity Study Day	Maternity Study Day To include: Bereavement Care Personalised Care and Support Planning	Education Dashboard		Trusts to document mitigation/action plan if not compliant	Y	£5,315 0.12	Y	£969 0.14	Y	£2,219 0.02	Y	£3,707 0.04	Y	£212 0.01
5. Care during Labour and Immediate Postnatal Period	90% attendance (3 yearly programme of all topics) Training must:- Include learning from incidents, audit reviews and investigations, service user feedback and local learning Learning from themes identified in national investigations e.g. HSIB Have a focus on deviation from the norm and escalating concerns Include national training resources within local training e.g., OASI Care Bundle (obstetric anal sphincter injuries), RoBUST Operative Simulation Birth Course, prevention and optimisation of premature birth. . Be tailored for specific staff groups depending on their work location and role e.g. Homebirth or birth centre teams/ MSW Subjects must include:- Management of labour including latent phase VBAC (vaginal birth after caesarean) and uterine rupture GBS (Group B Streptococcis) in labour Management of epidural analgesia and recovery care after general anaesthetic Operative vaginal birth Pelvic Health & Perineal Trauma – prevention of & OASI pathway and PFMT Multiple Pregnancy Infant Feeding ATAIN (Avoiding Term Admissions into Neonatal Units).	>95% attendance of relevant staff group Shared learning across LMNS Use of positive case examples to learn from Benchmarking against other organisations with similar clinical profile and national programmes Staff evaluation on quality of training in place with evidence of improvement where ≤95% feedback is evaluated as good or excellent Use of service user case studies & service users to share their experiences	As per CCFv1: MaternityStudy Day included: Learning from themes / Governance update Management of epidural anaesthesia and recovery care after general anaesthesia	Maternity Study Day included: OASI Care Bundle and Pelvic Health Infant Feeding	Maternity Study Day to include: Latent phase of labour GBS in labour ATAIN Operative Vaginal Birth Multiple Pregnancy on SBL day	Education Dashboard		Trusts to document mitigation/action plan if not compliant	Y	£7,972 0.18	Y	£1,453 0.05	Y	£2,219 0.02	N	£3,707 0.04	Y	£317 0.01
6. Neonatal Basic Life Support	90% attendance at a neonatal basic life support annual update either as an in-house neonatal basic life support training or Newborn Life Support (NLS) Only registered RC trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates Training must:- Be 'hands-on' and scenario based and tailored to learning from incidents, service user feedback and local learning priorities. Include knowledge and understanding of NLS algorithm. Include recognition of the deterioration of black and brown babies Include recognition of deteriorating newborn, action to be taken and local escalation procedures, and the use of SBARD tool for handovers (or local equivalent). Include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. Include human factors. Be tailored for specific staff groups depending on their work location and role, e.g. Homebirth or birth centre teams/ MSW. Cover scenarios in different environments and must include training on use of the equipment available in those environments to ensure staff are familiar.	≥95% attendance Attendance on separate certified NLS training for maternity staff should be locally decided but this would be the gold standard with updates every 4 years. Evidence of MDT point of care simulation programme, attendance records and learning from them with innovative practices to ensure wide attendance from all staff groups/unsocial shifts/community staff Learning from national investigations & programmes e.g. HSIB & ATAIN Benchmarking against other organisations with similar clinical profile and national programmes Staff evaluation on quality of training in place with evidence of improvement plans where ≤95% feedback is evaluated as good or excellent Use of service user case studies and parents sharing their experiences including the use of positive case examples to learn from.	Neonatal Basic Life Support included on Emergency Skills day for Midwives and taught in the inpatient settings (labour ward, birth centre on PN ward)	Neonatal Basic Life Support included on Emergency Skills day for Midwives and taught in the inpatient settings (labour ward, birth centre on PN ward)	Neonatal Basic Life Support included on Emergency Skills day for Midwives and taught in the inpatient settings (labour ward, birth centre on PN ward)	Education Dashboard		Trusts to document mitigation/action plan if not compliant	Y	£3,986 0.09	N	£0 0.00	N	£0 0.00	N	£0 0.00	Y	£159 0.00

Department inputs (table 1)		
	Annual Head Count	Annual Mid Point Salary
Midwives	116	£44,671.00
Maternity Care Assistants	33	£28,628.00
Obstetricians	24	£90,161.00
Anaesthetists	35	£103,269.00
Maternity Nurses	5	£41,257.00

Table 3				
Training Module	**Groups**	**Input Data**	**Outputs**	
		Training Hour(s) per staff member per year (all blended learning to be added as a total)	**Total Annual Cost**	**Annual WTE**
1. Saving babies Lives				
Smoking in Pregnancy	Midwives	1	**£2,657**	**0.06**
	Maternity Care Assistants	1	**£484**	**0.02**
	Obstetricians	1	**£1,110**	**0.01**
	Anaesthetists	0	**£0**	**0.00**
	Maternity Nurses	0	**£0**	**0.00**
Fetal Growth Restriction	Midwives	1	**£2,657**	**0.06**
	Maternity Care Assistants	0	**£0**	**0.00**
	Obstetricians	1	**£1,110**	**0.01**
	Anaesthetists	0	**£0**	**0.00**
	Maternity Nurses	0	**£0**	**0.00**
Reduced fetal movements	Midwives	1	**£2,657**	**0.06**
	Maternity Care Assistants	0	**£0**	**0.00**
	Obstetricians	1	**£1,110**	**0.01**
	Anaesthetists	0	**£0**	**0.00**
	Maternity Nurses	0	**£0**	**0.00**
Fetal monitoring in labour (this will be the same as below)	**Please record data in Module 2. Fetal Surveillance in labour (Below)**			

will be the same as below)				
Pre-term birth.	Midwives	1.5	**£3,986**	**0.09**
	Maternity Care Assistants	1.5	**£727**	**0.03**
	Obstetricians	1.5	**£1,665**	**0.02**
	Anaesthetists	1	**£1,854**	**0.02**
	Maternity Nurses	1.5	**£159**	**0.00**
Diabetes in pregnancy	Midwives	1	**£2,657**	**0.06**
	Maternity Care Assistants	1	**£484**	**0.02**
	Obstetricians	1	**£1,110**	**0.01**
	Anaesthetists	1	**£1,854**	**0.02**
	Maternity Nurses	1	**£106**	**0.00**
2. Fetal surveillance in labour	Midwives	8	**£21,259**	**0.48**
	Maternity Care Assistants	0	**£0**	**0.00**
	Obstetricians	4	**£4,439**	**0.05**
	Anaesthetists	0	**£0**	**0.00**
	Maternity Nurses	0	**£0**	**0.00**
3. Maternity emergencies	Midwives	8	**£21,259**	**0.48**
	Maternity Care Assistants	8	**£3,876**	**0.14**
	Obstetricians	8	**£8,877**	**0.10**
	Anaesthetists	4	**£7,414**	**0.07**
	Maternity Nurses	8	**£846**	**0.02**
4. Personalised Care	Midwives	2	**£5,315**	**0.12**
	Maternity Care Assistants	2	**£969**	**0.03**
	Obstetricians	2	**£2,219**	**0.02**
	Anaesthetists	2	**£3,707**	**0.04**
	Maternity Nurses	2	**£212**	**0.01**
5. Care during Labour and Immediate PN Period	Midwives	3	**£7,972**	**0.18**
	Maternity Care Assistants	3	**£1,453**	**0.05**
	Obstetricians	2	**£2,219**	**0.02**
	Anaesthetists	2	**£3,707**	**0.04**
	Maternity Nurses	3	**£317**	**0.01**
	Midwives	1.5	**£3,986**	**0.09**

6. Neonatal life support	Maternity Care Assistants	0	**£0**	**0.00**
	Obstetricians	0	**£0**	**0.00**
	Anaesthetists	0	**£0**	**0.00**
	Maternity Nurses	1.5	**£159**	**0.00**

Department Outputs (table 2)			
	Total AnnualCost	Total Annual WTE	Total hours training
Midwives	£74,406	2	28
Maternity Care Assistants	£7,994	0	17
Obstetricians	£23,858	0	22
Anaesthetists	£18,535	0	10
Theatre staff	£1,798	0	17
Total	£126,592		

Workbook and Sheet Passwords All = CCF

28.00

Department inputs (table 1)		
	Annual Head Count	Annual Mid Point Salary
Neonatologists	25	£44,671.00
Neonatal Nurses	25	£28,628.00

Department Outputs (table 2)			
	Total AnnualCost	Total Annual WTE	Total hours training
Neonatologists	£859	0.02	1.5
Neonatal Nurses	£551	0.02	1.5
Total	£1,410		

Table 3				
Training Module	Groups	Input Data	Outputs	
		Training Hour(s) per staff member per year (all blended learning to be added as a total)	Total Annual Cost	Annual WTE
3. Maternity emergencies	Neonatologists	0	£0	0.00
	Neonatal Nurses	0	£0	0.00
6. Neonatal life support	Neonatologists	1.5	£859	0.02
	Neonatal Nurses	1.5	£551	0.02