Bundle Trust Board Public 7 March 2024

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates
January SOX of the month – Amanda Chinnock, Whiteparish Ward and Oliver Sohan, Will Knibbs and Mathew Hill, AMU
January Patient Centred SOX – Urology Department
February SOX of the month –
February Patient Centred SOX –

1.2 10:10 - Patient Story
Presented by Victoria Aldridge

1.3 10:30 - Welcome and Apologies
Apologies received from -
Jon Burwell

1.4 Declaration of Interests, Fit & Proper / Good Character

1.5 10:35 - Minutes of the previous meeting
Minutes attached from meeting held on 11th Janauary 2024
For approval
1.5 Draft Public Board mins 11 January 2024

1.6 Matters Arising and Action Log
1.6 Public Board Action Log

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

1.8 10:45 - Chief Executive Report
Presented by Lisa Thomas
For information
1.8 CEO report Feb 24

1.9 Register of Attendance
1.9 Register of Attendance - Public Board 2023-24

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:55 - Integrated Performance Report to include exception reports
Presented by Melanie Whitfield
For assurance
2.1a IPR Cover Sheet - Trust Board 2024-02
2.1b Integrated Performance Report March_24_Final

2.2 11:20 - Clinical Governance Committee – 30 January and 27 February
Presented by David Buckle
For assurance
2.2a CGC Escalation Report to Trust Board March 2024 from January 2024 CGC
2.2b CGC Escalation Report February
2.2c IA SBAR V2

2.3 11:25 - Finance and Performance Committee – 30 January and 27 February
Presented by Debbie Beaven
For assurance
2.3a Finance and Performance Escalation Report January 2024 (002)
2.3b Finance and Performance Escalation Report February 2024

2.4 11:30 - People and Culture Committee – 25 January and 29 February
Presented by Eiri Jones
For assurance
2.4a PCC Escalation Report to Trust Board January 2024 to March 2024 Board. Final
2.4b PCC Escalation Report to Trust Board from PCC February 2024 to Board March 2024.

2.5 11:35 - Trust Management Committee – 24 January and 28 February (to include Annual Green Plan Report)

Presented by Lisa Thomas
For assurance

2.5 TMC esclation report

3 FINANCIAL AND OPERATIONAL PERFORMANCE

3.1 Standing Financial Instructions (changed to May on cycle of business)

4 GOVERNANCE

4.1 11:40 - Register of Seals
Presented by Fiona McNeight
For information

4.1 Register of Seals

5 PEOPLE AND CULTURE

5.1 11:45 - National Staff Survey Results
Presentation by Melanie Whitfield on the day

5.2 11:55 - BREAK

5.2 Health and Safety Report - deferred to May

6 QUALITY AND RISK

6.1 12:25 - Board Assurance Framework and Corporate Risk Register
Presented by Fiona McNeight
For assurance

6.1a Trust Board BAF report March 2024
6.1b Board Assurance Framework January 2024 V1
6.1c Corporate Risk Register January 2024
6.1d CRR tracker v1_January Board Committees 2024

6.2.1 12:35 - Patient Experience Report Q2 (deferred from December)
Presented by Judy Dyos
For assurance

6.2.1a Patient Experience - Patient Feedback Report Q2 23-24 v3.0
6.2.1b Appendix 1 - B7 Development Day - August 2023 v2 Distribution Version
6.2.1c Appendix 2 - HWW Action Plan - Working Document - v6
6.2.1d Appendix 2a - HWW_yousaidwedid
6.2.1e Appendix 3 SFT 23-24 Patient Complaints Audit ToR FINAL
6.2.1f APPENDIX 4 Friends and Family Feedback Britford Aug-Sep 2023
6.2.1g APPENDIX 4 Friends and Family Feedback AMU Aug-Sep 2023
6.2.1h APPENDIX 4 Friends and Family Feedback Pembroke Aug-Sep 2023
6.2.1i APPENDIX 4 Friends and Family Feedback Pitton Aug-Sep 2023
6.2.1j Appendix 5 National Inpatient Survey 2022 - Results v2 PESG
6.2.1k Appendix 6 CPES 2022

6.2.2 Patient Experience Report Q3
Presented by Judy Dyos
For assurance

6.2.2a Patient Experience - Patient Feedback Report Q3 23-24 v2.0
6.2.2b Appendix 1 - Leadership Programme - Apologies and Liabilities Oct 2023 v2
6.2.2c Appendix 2 - SDH Spinal Patient Panel - Trust Board Patient Story 06.12.23
6.2.2d Appendix 3 - SFT 23-24 Patient Complaints Report FINAL
6.2.2e Appendix 3a - SFT Audit - Management Actions 120224 v1.3
6.2.2f Appendix 4 - Examples of FFT Comments for Q3
6.2.2g Appendix 5 - Disharge and Patient Flow Project - Patient Feedback Jan 24 v1
6.2.2h Appendix 6 - Complaints Process Survey Feedack Report 2023 v2 CGC
6.2.2i Appendix 7 - Real-Time Feedback RTF Comments Q3 23-24

6.3.1 12:45 - Quarterly Learning from Deaths Report Q3
Presented by Peter Collins
For assurance

6.3.1a Q3 Learning from Death Report

6.3.1b 202402 Q3 LFD Report 2023-24v1.2

6.3.2 12:55 - Mortality Insight Visit
Presented by Peter Collins
For assurance

6.3.2a 202402 Mortality Insight Visit Proposed Action Plan
6.3.2b Salisbury NHSFT Mortality Insights Visit 05 December 2023 Feedback v1.1
6.3.2c Salisbury Mortality Insight Visit December 2023 - cover letter

6.4 13:05 - Quarterly Risk Report Card Q2 (deferred from Dec) Q3 deferred to May
Presented by Judy Dyos
For assurance

6.4 RMRC and risk report Q2 DRAFT2 (002)

6.5 13:15 - Maternity & Neonatal Quality and Safety Report Q3
Presented by Judy Dyos/Abi Kingston
For assurance

6.5a Front sheet Q and S report Q3 23 24
6.5b Quarterly Maternity and Neonatal Quality and Safety Report Q3 (Sept-Dec) 2023

6.6 13:25 - Perinatal Quality Surveillance Report January (December data)
Presented by Judy Dyos/Abi Kingston
For assurance

6.6a Front sheet Perinatal quality surveillance Jan (Dec data)
6.6b Perinatal Surveilance JAN report - Dec data

6.7 13:30 - Perinatal Quality Surveillance Report February (January data)
Presented by Judy Dyos/Abi Kingston
For assurance

6.7a Front sheet Perinatal quality surveillance February (January data)
6.7b Peri Qual Surv - Feb report (Jan data) FINAL

6.8 13:35 - Salisbury NHS Foundation Trust review of Neonatal Death in the Neonatal Unit between 2018-2023
Presented by Judy Dyos/Abi Kingston
For assurance

6.8a Neonatal Death Front Sheet
6.8b Neonatal deaths in Salisbury 2018-2023_

6.9 Annual Maternity Survey - deferred to May

7 CLOSING BUSINESS

7.1 13:40 - Any Other Business

7.2 Agreement of Principal Actions and Items for Escalation

7.3 13:45 - Public Questions

7.4 13:55 - Date next meeting
2 May 2024

8 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)

Draft
Minutes of the Public Trust Board meeting
held at 10:00am on Thursday 11 January 2024, Boardroom/MS Teams
Salisbury NHS Foundation Trust
Boardroom

Board Members:	
Ian Green (IG)	Chair
Eiri Jones (EJ)	Non-Executive Director
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
Richard Holmes (RH)	Non-Executive Director
Rakhee Aggarwal (RA)	Non-Executive Director (Via Teams)
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
Jayne Sheppard (JS)	Lead Governor (observer)
Jane Podkolinski (JP)	Governor (observer)
Frances Owen (FO)	Governor (observer via Teams)
Vicky Marston (VM)	Director of Midwifery (TB1 11/1/7.3-7.4)
Hannah Boyd (HB)	Divisional Director of Operations for Women (TB1 11/1/7.3-7.4)
Abigail Kingston (AK)	Clinical Director Women and Newborn (TB1 11/1/7.3-7.4)
Aazzalrahman Alghoul (AA)	F1 Doctor Elderly Medicine (TB1 11/1/1.2)
Clare Page (CP)	Elderly Care Consultant (TB1 11/1/1.2)
Brian Johnson (BJ)	Director of Estates (TB1 11/1/3.2)
Tony Mears (TM)	Associate Director of Strategy (TB1 11/1/3.1)
Alex Talbott (AT)	Associate Director of Improvement (TB1 11/1/4.1)

222		**ACTION**
TB1 07/12/1	**OPENING BUSINESS**	
TB1 11/1/1.1	**Presentation of SOX (Sharing Outstanding Excellence) Certificates**	
	IG noted the following members of staff had been awarded a SOX Certificate and details of the nominations were given: **December SOX of the month** – Will Bayliss, Wessex Rehab **December Patient Centred SOX** – Emergency Department and Security Team IG congratulated all the staff that had been recognised in December on behalf of the Board and also thanked all the staff that had been nominated for their hard work and innovation. These staff will receive a SOX award in person.	

TB1 11/1/1.2	**Staff Story**	
	PC welcomed Aazzalrahman Alghoul (AA) and Clare Page (CP) to the meeting. PC hoped this story would help the Board reflect upon Trust attitudes towards staff, particularly those who come from overseas to work with us. AA shared his story of joining the Trust as a Health Care Assistant (HCA) despite being a trained junior doctor from Gaza and explained how he had persevered to become registered to practice medicine in the UK. AA discussed the challenges he faced as a Palestinian from Gaza in obtaining work permits, sitting exams, securing training positions, and managing perceptions due to the gaps in his CV. He highlighted the challenges he faced in paying for the required exams, describing some of the sacrifices he had to make to ensure he could sit them, including taking unpaid leave. He described the education team as welcoming and friendly but unfortunately unable to help trainee doctors when trying to organise exams. He thanked the Elderly Care Team, CP and PC for their support at work but noted that he had found it difficult joining the team in a supernumerary role. AA highlighted the great care the elderly and palliative care team deliver in the Trust, noting that medicine in his own country is very different as people do not live as long. He sadly described how his father had recently passed away due to the lack of care available, particularly due to the current crisis in Gaza. He noted that it was a privilege to be able to care for patients here and thanked the Board for the opportunity to tell his story. **Discussion:** The Board thanked AA for sharing some of his experiences and reflected on the learning from this story, particularly regarding attitudes and hurdles faced by overseas doctors and the need for more systematic support in areas like education, training, leave approval and supernumerary time. PC thanked AA for highlighting some of the challenges which have indicated the additional support overseas employees might require. The group acknowledged the need for positive, ongoing relationships with trainees and respect for different contributions to help avoid obstacles to teamwork. PC thanked CP for her support to AA. She noted that whilst AA did not enjoy being supernumerary, this is the right thing to do and it can be quickly gauged if this is required. Whilst there is a cost implication, it is an important step to ensure new trainees have the best experience when starting in these positions. MvB offered to connect AA with relevant charities who can offer support. The Board acknowledged AA's determination in becoming an F1 at the Trust and IG thanked him for his time and candour and for the commitment he demonstrates in caring for patients. CP and AA left the meeting.	
TB1 11/1/1.3	**Welcome and Apologies**	
	IG welcomed everyone to the meeting. No apologies were noted.	

TB1 11/1/1.4	**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 11/1/1.5	**Minutes of the Part 1 (Public) Trust Board meeting held on 7th December 2023**	
	IG presented the public minutes from 7th December 2023 and the following was noted: • RH noted that he had not joined via Teams. It was RA. • JDy referenced the minutes re CNST on p.11, noting that they required amendment. JDy will speak to KN outside of the meeting. • DBe had sent some amendments via email which had been made. Subject to these amendments, the minutes were agreed as a correct record of the meeting.	
TB1 11/1/1.6	**Matters Arising and Action Log**	
	FMc presented the action log and noted the following key updates: **TB1 07/09/4.3 Perinatal Quality Surveillance Monthly Report:** It was noted that maternity reports were on the agenda and the team had been asked to update the Board on their cultural improvement journey**. Item closed.** **TB1 07/09/5.4 Health and Safety Annual Report and Q1:** MW noted that she would raise this as part of the report later on the agenda. **TB1 05/10/5.5 Maternity and Neonatal Bi-Annual Staffing Report:** JDy noted that the risk around continuity of carer has been included in the risk around staffing for maternity and the team are completing a QIA. EJ noted that risk assessing is the right thing to do, however, Ockenden is clear that the continuity of carer requirements should not take precedent over other areas of care. The Board noted that the Trust is not an outlier when compared with similar sized maternity departments. Item closed. It was noted that all other matters arising were either closed or to be considered on a future agenda.	
TB1 11/1/1.7	**Chair's Business**	
	IG noted the following key points: • This is SH's last meeting as CEO as she leaves at the end of January to join North Tees. IG thanked SH for her hard work and support in the Trust over the last 3 ½ years. IG noted that there will be further opportunities to say goodbye to SH before she left but wished her well in her new role. • In terms of wider conversations regarding future leadership models there have been ongoing conversations and a meeting is planned on 12th January to consider an agreed way forward.	

	The update was noted.	
TB1 11/1/1.8	**Chief Executive's Report**	
	SH presented her CEO report and highlighted the following key points: • Key focus has been expected operational challenges from winter pressure and Industrial Action (IA). There have been pressures and the plan has been maintained which staff should be proud of. • Thanks to JDi and IC for their preparation and planning of IA. The personal commitment of some staff has been really positive to see. SH conveyed her thanks to Dr Paul Stephens who has come in to work every night to support the handover and ensure this has gone smoothly. SH also thanked PC for his support during this period too. • There is an expectation that we're not at the peak of Flu or Covid yet, so there could be further challenges to come. • No Operational Planning guidance has been received yet. **Discussion:** EJ noted the positive atmosphere in the hospital when visiting different departments and she thanked all staff for their hard work during these challenging times. IG reiterated the thanks to all of those who have supported during IA noting it requires perseverance and careful planning, particularly the longer it continues for. In terms of IA, it is the Trust's hope that this can be resolved soon. SH noted that SAS doctors have secured a mandate to strike. The update was noted.	
TB1 11/1/2	**ASSURANCE AND REPORTS OF COMMITTEES**	
TB1 11/1/2.1	**Integrated Performance Report (IPR) (M8)**	
	PC presented the Integrated Performance Report which provided a summary of November 2023 performance metrics and is used to monitor progress towards the Trust's overall vision. PC noted that following key points: • Of the four breakthrough objectives there has been positive progess with Falls, which is below the target of 7 falls with harm per 1000 bed days and has been tracking this way for several months. Additionally, there has been progress in managing bed occupancy. For 5 months the Trust has been tracking towards the lower target. The target has not yet been achieved it but it continues to improve despite the operational and IA challenges. • Staff availability continues to be difficult to manage, although there are some positives to take from some of the metrics. • Reducing the time to first Out-Patient (OP) appointment has not been achieved. There is further work underway to understand the top contributors to this underperformance. • There has been a deterioration regarding cancer performance targets although diagnostics has improved. The key contributor to this reduced performance is Dermatology and, in particular, skin cancer. Actions have been put in place to improve this trajectory.	

- There are positive areas of performance in terms of the reduction in absence and in the vacancy rate.
- The Trust is not on target in terms of financial planning. However, the grip on bank and agency has started to improve.
- The success of the Stroke team should be acknowledged as they have achieved a SSNAP (Sentinel Stroke National Audit Programme) A rating for the last quarter. PC extended thanks to the Stroke team who have been using Improving Together to improve process in the speciality.

Discussion:
DBe was encouraged to observe several metrics moving in the right direction but asked about the executive's level of confidence in terms of sustained improvement. PC noted that teams are observing a reduction in variability which is a strong indication of embedding effective processes. It is about shifting focus and embracing continuous improvement which means there will be more emphasis on areas of poor performance. The watch metrics have clear escalation route if there is deterioration.

DBe asked what additional initiatives are required to ensure an improved turnover trajectory. MW noted that whilst there is further work to utilise Improving Together tools to identify the key issues around turnover, it is clear that the Trust do not receive sufficient data about why people leave. The feedback loop from leavers needs to be clearer. DBe acknowledged that turnover is not an easy metric to solve but it was clear that enhanced discipline is needed regarding exit interviews. SH agreed, noting that the lessons learnt through the outpatient waiting list work is that improvement needs to be more granular to initiate the change.

DBu congratulated the Stroke team on achieving the SNNAP score of A, particularly considering the challenges that had been reported back through CGC and the Board in the last year. EJ noted that CGC had sought assurance and escalated when they were not assured. She was happy to observe this improvement and hoped for sustained improvement.

TB referenced the time to first OP appointment metric, noting it has improved in some areas and other areas have seen challenges. TB asked if the Trust are aware of the changes/ process that work and if so is this related to culture and changing attitudes. The Board discussed and comparisons in relation to the Urgent and Emergency Care Board and Elective Care Board were noted. LT explained that the initial OP improvement programme was too broad and it is now acknowledged that there is a need for more specific interventions.

IG asked for further assurance in relation to cancer performance, asking for more information on the balance between backlog and new referrals in Dermatology and the actions taken to mitigate. LT noted that the demand and capacity issue around skin was identified in October 2023. The Trust has enough capacity to treat the referrals received now. However, there is an urgent need to address the backlog. The one challenge we have had in our response to outsourcing is that the department has a higher conversion rate. However, the Trust have received cancer funding to mitigate this.

In terms of the issues in gynaecology, the teams are working through the demand and capacity data. The department requires a locum. IG queried oversight and leadership of Trust performance. LT noted that performance sat

	within the COO's remit, noting that there was work within the team to build upon, standard leader work and how performance is managed. This is also being relayed to new service managers to standardise how performance is managed across the Trust. There is clinical oversight of cancer performance through the Cancer Board. DBu asked if the skin cancer list included a large number of Basal Cell Carcinomas (BCC). PC confirmed it did not, it is mostly melanoma. RH queried if the Trust will always have new patients on long waiting lists. LT explained that they would if we additional capacity had not been scheduled but noted that patients are seen in order. IG noted that the NEDs should reflect on what further assurance is needed around cancer performance. The report was noted.	
TB1 11/1/2.1a	**Outcome of Mortality Review**	
	PC verbally updated the Board that the formal response was still awaited. The initial feedback provided from the Mortality Review identified a number of improvements but there was no evidence that harm is being cased. However, variation in data is real and is impacted from the quality of coding. PC noted that a number of actions have already been put in place from the verbal feedback receive. A formal response to the recommendations with come back through CGC and the Board. **Discussion:** PC noted that the clinical actions were around strengthening of assurance e.g., ensuring we joined system wide mortality meetings run by the ICB. And strengthening buy-in into mortality in the Trust. The other recommendations around improving the Trust's coding position will be more challenging. SH queried the consistent attendance at the Mortality Steering group. PC noted that this has been picked up and attendance has improved. TB and the Board discussed the issues around coding and encouraging clinical ownership of data and holding to account to ensure the data is correct. JDy highlighted that mortality and the coding issue is a multidisciplinary one and nurses should be taking more responsibility too. Therefore, this has been raised at the Nursing Forum. IG noted that once received the outcome of this review will also be reported to the Council of Governors. The update was noted.	
TB1 11/1/2.2	**Audit Committee – 12 December 2023**	
	RH presented his escalation report which highlighted the key points from the meeting held on 12th December. RH asked the Board to take the report as read and noted: • The Trust's new external and internal auditors and counter fraud teams attended the Committee. The approach they all use work well.	

	• The Committee took the opportunity, with its new external partners, to reflect on how the Audit Committee could add real practical value to the Executive team, as well as providing assurance on the systems of internal control to the Board. • The Committee received and recommended to the Board the approval of a paper that proposes short term changes to Standing Financial Instructions (SFIs) for the procurement of capital items up to a value of £350k during the period between 1 January 2024 and 31 March 2024. KPMG observed that it was not usual practice for organisations temporarily to amend SFIs, and challenged the Trust to consider whether or not this agile approach should be integrated into the SFIs permanently. This will be considered by the Executive.	
TB1 11/1/2.2a	**Standing Financial Instructions (SFIs)**	
	ME presented further to the above recommendation from the Audit Committee highlighted in item TB1 11/1/2.2. **Discussion:** SH urged the Board to support this change as ultimately patients will be impacted if not approved. The Trust has an aging estate and, as there is insufficient capital to address this, it is always disappointing when the Trust is unable to spend last-minute funding. SH noted that this approach was taken in 2022/23. DBe noted that she was content with this approach but was concerned that capital spend sometimes incurs operating costs and it should be clear if the costs are aligned to budgets and/or plans. ME noted that as part of capital spend, the Trust always include approval of revenue plans. DBe asked ME to check that this was explicit in the SFIs. **ACTION: ME** EJ asked why this is not a permanent approach and what the risks and mitigations are. ME explained that this is requested as an interim solution due to the volume of work at this time of year. The risk is very low and using this approach means that the Director of Procurement or his deputy is still able undertake all the necessary checks. **Decision:** The Board approved the proposed interim amendments to the SFIs.	**ME**
TB1 11/1/2.3	**Charitable Funds Committee – 12 December 2023**	
	IG presented the report which provided a summary of escalation points from the meeting held on 12 December 2023. The report was noted.	
TB1 11/1/3	**FINANCIAL AND OPERATIONAL PERFORMANCE**	
TB1 11/1/3.1	**Quarterly Strategy Update**	
	LT introduced TM who presented the report which asked the Board to note the progress against the Trust's priorities and associated vision metrics, including the allocation of project support and resource. Additionally, the	

	paper asked the Board to note the completion of response submission by all clinical specialties to the main Trust strategy, the structure of those responses, and the next steps. **Discussion**: TM presented the slides and the following key discussion points were raised: DBe noted that the report did not indicate if the progress made was at the expected pace. TM noted that this is hard to gauge over a decade long horizon, with some goals less quantifiable than others. Some of the timescales are being recalibrated. The Board discussed how the Trust can demonstrate progress against the actions supporting delivery of the Trust Strategy. LT noted that this can be included in the next update. **ACTION: LT/ TM** The Board discussed the strategy response structure where each speciality had produced a service-level analysis to contribute towards a broader strategic analysis of how this work is taken forward. The Board noted that the Trust wanted to showcase some of this work and SH urged the Board to attend once this had been scheduled in. DBe queried if this will include correlation across disciplines, highlighting themes and interdependencies. TM confirmed it would, noting that the broader analysis does focus on themes. SH thanked TM and noted that the Trust will only deliver transformational change at a granular level.. The report was noted.	**LT/ TM**
TB1 11/1/3.2	**Estates Technical Service Update**	
	IG welcomed BJ to the meeting, noting that this was his last report before he moves to his new role at the end of February. IG thanked BJ for his strategic leadership in estates, noting the great improvement that had been made since he joined the Trust. BJ noted he was proud of the work the teams have done to improve in the last two years. BJ highlighted the following key items from his report: • The Trust is now reporting three extreme risks and two will close in the next month. Mitigations are detailed within the report. • One relates to CAFM system which has expired and is no longer supported. BJ noted that with procurement support the team is annexing the RUH Bath system which will hopefully support better utlisation. • The capital team are now entering the final quarter of a very challenging year, delivering more than £30m of construction works, including £22m of external funding with the additional pressure to ensure all monies are drawn down. With the BSW commitment to invest in the EPR system over the next 3-years, as previously reported capital availability will become highly constrained. Some difficult decisions lay ahead regarding allocation of capital and our ability to maintain a safe estate. **Discussion:** DBe referenced the constraints on capital and how we will keep track of the impact of decisions around risk as there will be significant trade-offs.	

	Additionally, DBe referenced the geothermal feasibility study and asked when the Trust would likely receive results. BJ noted that the results will be available in summer. This is because not all landowners have given permission to undertake the relevant testing on the surround land. IG noted that he has written to landowners. BJ explained that in terms of risks in relation to capital, planning lists and the estates backlog are prioritised utilising a risk matrix. DBe noted that if a decision is taken around capital spend that increases spend or risk elsewhere, this should be highlighted. EJ thanked BJ for his leadership in Estates. EJ noted that a number of the challenges highlighted through the Health and Safety Report are Estates based. Therefore, for further assurance, EJ suggested that there might be triangulation between the two. JDy noted that hand hygiene training levels were low in Estates and offered support to the team to help improve this. SH also thanked BJ, who she described as being extremely approachable and effective in this joint role. The Board wished BJ well in his new role in Cornwall. The report was noted and BJ left the meeting.	
TB1 11/1/3.3	**Planning Update**	
	LT noted that in the absence of national planning guidance the Trust continues to work on the 2024/25 plan. Once it has been published it will go through F&P and Board. It was noted that the timescales might be considerably tighter than previous years. An extraordinary Board has already been added to diaries to mitigate this. The update was noted.	
TB1 11/1/4	**STRATEGY AND DEVELOPMENT**	
TB1 11/1/4.1	**Improving Together Quarterly Update Report Q3**	
	PC introduced AT who presented the report which was provided to assure the Board of the Trust's progress in developing the Improving Together programme. AT provided an update on current progress, noting that currently only one workstream was off track. The three key points to highlight to the Board were related to training, maturity and investment which were summarised in the report. AT explained that the Trust is very much into 'phase two' of the programme, with teams now experiencing benefits being delivered and sustained in places, for example in falls performance and ED pathways. AT highlighted the good conversations at the Urgent and Emergency Care Group meetings around identifying and understanding the problem better. **Discussion:** IG noted that through interaction with staff across the Trust it is clear how important and impactful Improving Together is.	

	IG asked how Improving Together is aligned to the Trust induction. AT noted that the Trust is currently reliant on local leadership to deliver the message to new staff but there are plans to develop an induction pack introducing the Improving Together methodology. MW also referenced the 90-day improvement project led by People Promise manager which picks up any initial feedback regarding staff induction. PC noted that there is a module for clinicians which is aligned to Improving Together, recognising that doctors play an important role in delivering continuous improvement. DBe referenced the maturity assessment table and asked what the table should look like for 2024/25. DBe noted this would be useful to understand, particularly as the Board agreed to invest to accelerate the programme. DBe also asked if there is correlation data to show us the teams that have had training and the initiatives/ outcomes that have happened as a result. RA noted that the initial focus has been implementing this across clinical teams and asked when the focus would be moving to non-clinical teams and enable the approach across the whole organisation. TB reflected on the fact that the KPMG contract is ending and asked if there is any risk that the Trust will drift away from the core rational and if so, how this is prevented. The Board discussed the expected level of risk with these programmes of work and that it is important as a board to own Improving Together and how we operate. There was a suggestion of the Board revisiting the principles every 6-12 months but also exploring other mechanisms to hold each other to account. AT answered DBe's first query, noting that there needs to be an understanding of what is happening at speciality level and staff members need to complete the maturity assessment. However, AT explained that with the number of initiatives underway there is a danger that providing this level of detail becomes an industry. DBe acknowledged this and asked for further information/context around the impact of training and sustained motivation. AT referenced RA's query, noting that corporate and non-clinical staff were in the pipeline for training. The report was noted and AT left the meeting.	
TB1 11/1/5	**PEOPLE AND CULTURE**	
TB1 11/1/5.1	**Health and Safety Quarterly Report**	
	MW presented the report which had been produced by Troy Ready, Health and Safety Manager. The following key points were highlighted. • There has been an increase in violence and aggression cases against staff. There is focused work on this and to ensure there is a consistent process and the Trust is responding to these incidents in the correct way. There will be more information around where this has occurred and the subsequent work to ensure our staff feel safe and supported at work. • The Trust had documented a risk regarding the lack of a Health and Safety Management System. The response during 2023 was to	

	implement a system supported by agreed objectives, performance reports, an understanding of consequence and frequency of injuries, a standard response to injuries, a program of audit and risk activity, strategies to manage the risk of violence and aggression and greater consultation with clinical and non-clinical areas. Whilst there has been considerable progress in the implementation of the H&S management system and recognised benefits of this work, there is further work to do to fully embed across the Trust. . **Discussion:** IG referred to the 'no excuse for abuse' campaign noting that the Board fully supports this. SH noted that feedback from some individuals that have experienced violence or aggression in the workplace is that the Trust does not have a systematic response for these situations and it is important that colleagues feel supported. RH queried the training staff receive in relation to violence and aggression. SH explained that there is clear guidance and conflict resolution training and an escalation process. JDy advised staff are trained to deescalate and one of the reasons for additional shift requests is because the Trust is receiving and caring for more and more patients who require enhanced care. The Trust's security team is very good but one concern is how the Trust supports and cares for challenging patients, particularly those with poor mental health as the police do not always have to support in these situations. There is further work required to mitigate this. EJ noted that some areas of the H&S report links to the issues highlighted in the Estates report. It was agreed that MW would review how the information in each report could be triangulated and picked up via People and Culture Committee. **ACTION: MW**	**MW**
TB1 11/1/5.2	**Medical Education Performance Annual Report**	
	PC presented the report on behalf of the Director of Medical Education, Emma Halliwell (EH), who had given her apologies. PC took the report as read, noting the huge amount of work that had gone into the comprehensive report. He highlighted that: • The Trust's first cohort of Physician Associates have graduated and there will be four in post by autumn. It has been confirmed that these posts will be regulated by the General Medical Council (GMC). • It is important to highlight that the team is working with Heath Education England Wessex to support training, education, and wellbeing of doctors alongside the prolonged industrial action. **Discussion:** The Board discussed the Physician Associate positions, noting that they were unable to join the British Medical Association (BMA). It was noted that the Trust need to ensure patients and other staff understand how these roles fit into the clinical equation in terms of delivering care. It was further discussed that generally these roles are well received, despite some unwarranted animosity that had been reported via social media channels. SH reflected that when introducing new roles, there needs to be an understanding from all	

	perspectives. It was suggested that the standards in terms of staff introducing themselves to patients should be refreshed. It was noted that there had been a detailed discussion at People and Culture Committee and EJ had conveyed her thanks to EH and the team for their hard work. The report was noted.	
TB1 11/1/6	**GOVERNANCE**	
TB1 11/1/6.1	**Emergency Preparedness, Resilience and Response Annual Assurance Statement and Compliance**	
	LT presented the report, which had been prepared by the Trust's Head of Emergency Preparedness, Resilience and Response (EPRR). LT reported that the Trust's rating for EPRR compliance is 'Substantive' compliant meaning the arrangements in place appropriately address all but one of the core standards expected. The only core standard which has been identified as partially compliant is Domain 10, Standard 10, which requires having trained staff for Chemical, Biological, Radiological & Nuclear (CBRN) on each roster within ED or available from other departments so there is cover 24/7, 365 days a year. Enhanced training for ED staff and the site team is planned to the Trust can be compliant against this standard. **Discussion**: DBe noted that the number of total incidents seemed high. The Board discussed the strict criteria around what is defined as an incident. LT noted that the focus should be on the structure and the robust processes in place to manage incidents. The Board discussed incidents relating to leaks and power issues and how this related to the ageing estate of the Trust. It was noted that the Trust's maintenance backlog is large and therefore more incidents like these are expected. IG asked if the Trust was affected by the cyber-attack on SWAST. It was confirmed that we were not impacted. RH queried if each division had its own business continuity plan. LT confirmed that they all do. Not all will be up to date but there is a regular cycle of challenge and refresh for the continuity plans. The report was noted.	
TB1 11/1/6.2	**Register of Seals**	
	The Board noted no new seals had been entered in the register.	
TB1 11/1/7	**QUALITY AND RISK**	
TB1 11/1/7.1	**Director of Infection Prevention & Control (DIPC) Report**	

	JDy presented the 6 monthly report which asked the Board to note the performance against Infection Prevention and Control requirements for the year and to acknowledge their collective responsibility as outlined in the report, confirming receipt of appropriate assurance. The following was noted: • A good report, with no outbreaks of common infections reported. The Trust continues to benchmark well against a number of infections that are commonly encountered. • There were 5 COVID outbreaks which are difficult to manage being so contagious. • There was a reported CPE (*Carbapenemase Producing Enterobacteriaceae*) outbreak. This patient was transferred from another hospital but this was not identified. As a result, there was cross contaminated in surgery but both patients are fine. Procedural guidance is being re-reviewed to see if any further action can be taken to avoid this in the future. • The Trust is an outlier for surgical site infection surveillance (SSIS) for repair of neck of femur (FNoF). A deep dive has been completed and there are no themes. • In relation to the IPC Board Assurance Framework (BAF) 54/64 KLOE are compliant with 7 being partially compliant. Work is ongoing to achieve full compliance in all areas, all of which that have full processes in place but adherence remains ongoing work. • JDy reported a challenge in delivering anti-microbial ward rounds twice weekly dur to staffing pressures. **Discussion:** IG queried what pseudomonas was. This is an infection picked up in water. To avoid it taps and showers need to be flushed regularly to stop this building up. This has been an issue on Sarum in the past but it has been mitigated. EJ noted that she had completed a Board Safety Walk with the IPC team and observed really positive team working and noted that they had recently recruited to a long-term vacancy. They had been transparent regarding their successes and challenges. EJ queried the challenges regarding antimicrobial stewardship and if this linked to increased C-Difficile cases. JDy noted that this would be reviewed. The Board discussed the Trust's position in relation to SSIS and EJ asked PC if there is good surgical leadership. PC noted that there has been significant work to strengthen leadership and he was confidence in the heightened oversight going forward. TB noted that the increase in delay of surgery could also contribute to risk of SSIS. PC confirmed this was true but this had not been identified when reviewing the FNoF pathway.	
TB1 11/1/7.2	**Quarterly Learning from Deaths Report**	
	PC presented the report, prepared by Ben Browne, which provides assurance that the Trust is learning from deaths and making improvements. • PC noted that this was a 2023/24 Q2 report but noted the action taken since the report to review out of hours provision and medical care. It is acknowledged that understanding mortality figures in relation to the days of the week is difficult to measure and interpret but this is the right thing to do.	

	• As discussed earlier in the meeting the Trust had commissioned an external mortality review. The Trust is awaiting a formal outcome from that review. **Discussion:** IG suggested that whilst this was an historical report, there has been a lot of work done since Q2 and it is important this is recorded. From a governance perspective it might be useful to include an updated appendix on recent progress for future reports. **ACTION: PC** RH referenced the death of patients with serious mental health needs and asked if this was a cluster. PC explained that these had not been identified as a cluster of deaths but further investigation outside the meeting was required to understand if these deaths all happened in this period. PC noted he would feedback outside of the meeting. **ACTION: PC** RH noted that the glossary included in the paper was useful and asked if this could be considered for future Board/Committee papers. It was further suggested that this report should be appended to the governors' papers for information as they had raised mortality as an issue previously. **ACTION: PC.** The Board noted that the Trust's new Mortality Lead was Dr Charles Ranabaldo who will take up this position from next month.	**PC** **PC**
TB1 11/1/7.3	**CNST Declaration sign-off**	
	VM, HB and AK joined the meeting to present the report which asked the Board to note the requirements set out by NHSE CNST Maternity Incentive Scheme Year 5 and consider the report evidencing compliance with 9 out of the 10 safety actions. IG noted the broad documentation received and the steer given in terms of key points to highlight which had been gratefully received. VM went through the report in detail providing evidence of, and compliance against the following: • Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team at a minimum of quarterly and that any support required of the Board has been identified and is being implemented. • Compliance to short term locum usage • Compliance to Long term locum guidance (ROCG) and action plan to address gap in compliance. • Action plan to address shortfall in compliance to the RCOG guidance on compensatory rest. • Compliance of consultant attendance for the clinical situations listed in the RCOG workforce document. • Availability of Obstetric anaesthetic cover in line with ACSA standard 1.7.2.1 • Action plan to address lack of compliance to (British Association of Perinatal Medicine (BAPM) standards for Neonatal Medical workforce. • Action plan to address lack of compliance to BAPM standards for Neonatal Nursing workforce. Using the CNST NHSR Safety Action Board Notification template, Salisbury NHS Trust can demonstrate compliance to Safety Action 4 as per Appendix 7.	

	Discussion: JDy thanked the team for the report and noted that all evidence has been reviewed by two independent people and they agreed our position is a true one The Board discussed the Saving Babies Lives care bundle (safety action 6), noting that it had not been fully implemented yet. AK noted that the Trust continues to work towards compliance with support and oversight from the ICM and LMNS. However, as SFT is a small DGH it will require collecting all evidence manually which is complex and challenging. VM noted that Section B of the declaration form requested £184,844 from the incentive scheme to increase capacity and achieve some of these targets. DBu recognised how much work goes into evidencing this work. Looking ahead DBu recognised the difficulties in delivering some of these standards and asked if the team were hopeful to achieve safety action 6 and if there were any other areas of concern. The team noted that safety action 4 has more risk attached to it but noted that the parameters around these safety actions sometimes change. Medical staffing has been challenging, for example in relation to compensatory rest. This has been raised with the LMNS. It is unknown what will be requested next. JDy advised the Board that other Trusts are also struggling to comply with the Saving Babies Lives care bundle. However, for SFT this will be made easier with BadgerNet. JDy highlighted the challenges around headcount in maternity whilst being asked by NHSE to deliver more standards. The MIP has described the work done at SFT as transformational and it was agreed that the Board has had more than sufficient oversight of this journey. EJ referenced her role as Maternity Safety Champion and noted that it had been a privilege to be involved and suggested other NEDs to take on the role. There is a significant ask for assurance from NHSE and EJ noted that she and DBu discussed CGC and how it is ensured that due diligence is done at that forum to make this report easier to digest Board. Additionally, whilst it is important to receive this information and feel assured, there are other services that require the Board's attention. It was noted that there had been an action relating to the improving cultural journey in Maternity. JDy noted that a cultural survey had been completed with feedback to staff groups with external facilitators involved. When the formal feedback is received this will be reported. VM noted that the Freedom to Speak Up concerns had reduced. The management team do collate themes. Additionally, when reviewing the department's retention, we are not currently forecasting any midwifery leavers. The department now received the Safety Champion walkabouts and feedback is acted upon. Additionally, there are now listening events which have proved insightful and is another method of staff feedback. It was agreed the action could be closed. **Decision:** The Board approved the CEO to sign the Board declaration form prior to submission to NHS Resolution. It was noted that it was SH's responsibility on behalf of the Board to ensure that the Accountable Officer (AO) for the Integrated Care System (ICB) is apprised of the MIS safety actions' evidence	

	and declaration form. SH thanked the team for their hard work and the demonstrated improvement.	
TB1 11/1/7.4	**Perinatal Quality Surveillance Report October (December data)**	
	VM presented the monthly report which demonstrates assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme - year 5 - Safety Action 9. VM provided a detailed update on 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 Board noted the report.	
TB1 11/1/8	**CLOSING BUSINESS**	
TB1 11/1/8.1	**Any Other Business**	
	There was no other business.	
TB1 11/1/8.2	**Agreement of Principle Actions and Items for Escalation**	
	IG summarised the board's discussion, noting the pertinent topics that had been raised. • The Board had been particularly impacted by the Staff Story and asked PC to provide colleagues with thanks for the way this was presented and for AA's honesty and transparency. The Board will reflect what more we can do as a Trust for our overseas staff. • The operational challenges continue but planning processes are working to mitigate. • The emerging consistent approach to presenting the IPR is assisting the NEDs to think about assurance and key areas of focus. • The Medical Education performance report was received and indicated a high-quality medical education team in the Trust.	
TB1 11/1/8.3	**Public Questions**	
	It was noted that a member of public had arrived at the Board during the meeting. During the break they had raised an issue with SH and IG of a of a personal nature about the care of a relative. This will be followed up with a specific action via the Patient Advice and Liaison Service (PALS).	
	Feedback and reflection of the meeting.	
	IG noted that as part of aligning to the Improving Together methodology and to support an effective meeting process he had implemented a reflective agenda item, providing the opportunity for members to comment on the meeting. The Board reflected and discussed how the meeting had gone.	
TB1 11/1/8.4	**Date of Next Public Meeting**	

	The next Public Trust Board meeting will be held on 7th March 2024, in the Board Room, Salisbury NHS Foundation Trust	
TB1 11/1/9	**RESOLUTION**	
TB1 11/1/9.1	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

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

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

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Grandfield	TB1 07/12/3.2 Digital Plan Update	26/03/2024	Jon Burwell, JB	IG referenced the 'project and planned work progress', noting that some have dates and some do not. IG asked for all to have dates for consistency.	**To be incorporate into the digital updates which go to F&P Committee in March**	N	4
Trust Board Public	Sasha Grandfield	TB1 11/1/2.2a Standing Financial Instructions (SFIs)	07/03/2024	Mark Ellis, ME	ME noted that as part of capital spend, the Trust always include approval of revenue plans. DBe asked ME to check that this was explicit in the SFIs.		N	2
Trust Board Public	Sasha Grandfield	TB1 11/1/3.1 Quarterly Strategy Update	06/06/2024	Lisa Thomas, LT Tony Mears, TM	The Board discussed how the Trust can demonstrate progress against the actions supporting delivery of the Trust Strategy. LT noted that this can be included in the next update.	**June**	N	4
Trust Board Public	Sasha Grandfield	TB1 11/1/5.1 Health and Safety Quarterly Report	04/07/2024	Melanie Whitfield, MW	EJ noted that some areas of the H&S report links to the issues highlighted in the Estates report. It was agreed that MW would review how the information in each report could be triangulated and picked up via People and Culture Committee.	**July**	N	4
Trust Board Public	Sasha Grandfield	TB1 11/1/7.2 Quarterly Learning from Deaths Report	07/03/2024	Peter Collins, PC	1) From a governance perspective it might be useful to include an updated appendix on recent progress for future reports. 2) PC to feedback to RH and TB otuside of the meeting re deaths of patients with serious mental health. 3) It was further suggested that this report should be appended to the governors' papers for information as they had raised mortality as an issue previously.	**On agenda 7 March**	N	2

Report to:	Trust Board (Public)	Agenda item:	1.8
Date of meeting:	7th March 2024		

Report title:	Chief Executive Report			
Status:	Information	Discussion	Assurance	Approval
	x			
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Lisa Thomas, Chief Executive			
Executive Sponsor: (presenting)				
Appendices	N/A			

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.

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):	

In my first report I wanted to thank colleagues across the organisation and system for how much support I have received stepping into the Chief Executive role. January was a month for acknowledging Stacey for her strong leadership and reflecting on the legacy she left for us to collectively build on.

1. Population

Operational Context

The detailed performance is shared in the Integrated Performance Report, but key messages focused for January highlight the sustained pressure on services across the organisation. Both Emergency Department performance, the number of escalation beds open and the numbers of patients waiting for onward care (NCTR) increased resulting in the Trust being in the highest level of escalation (OPEL 4) for twelve days. Despite this challenge the teams worked hard to ensure ambulance handover delays remained low.

Our clinical, operational and EPRR colleagues once again did a fantastic job in the oversight of the industrial action by junior doctors in January. I continue to be grateful to all colleagues who are involved, both recognising the significant time requirement placed on leadership teams who plan to mitigate the action and those colleagues who cover during the striking periods.

This month we went live with Patient Safety Incident Response Framework (PSIRF) the new NHS England mandated process for patient safety incidents and how they are investigated. The process prioritises compassionate engagement with all those affected, the Framework focusses on analysing trends and themes across all patient safety incidents, to identify learning and improvement opportunities that have the potential to bring the biggest benefit to our patients.

2. Our People

We were delighted to announce that people looking to start a rewarding career in healthcare can now apply to study a direct-entry Nursing Associate Foundation Degree in Salisbury, thanks to a new collaboration between ourselves, Coventry University Group and Wiltshire College and University Centre. The course is a positive step towards our wider aspirations of serving and supporting the local community with high quality education and employment, and we look forward to welcoming the intake of new students for their work placements in the next academic year. Thank you to the ward sisters, trainee and nursing associates and the Practice Education Team for all their input at the validation event.

We continue to focus on finding different solutions to addressing car parking concerns across the site. We launched the free hopper bus for staff in January, where staff can park at Britford Park and Ride and jump on a free hopper bus to the Trust to mitigate car parking challenges particularly at peak times. The Trust has started this as a pilot and further evaluation will follow based on feedback from staff.

3 Our Partnerships

The focus of discussions in the last month have centred around the planning picture for the year ahead. Whilst the planning guidance has yet to be released both the system and SFT have been working to develop our priorities and plans for next year.

BSW system is under significant financial pressure and the need to work differently and collaboratively with all system partners is never greater. Conversations are likely to continue over the coming weeks on the scale of the challenge and the pace of change balancing the need to reduce the deficit with the capacity to deliver such significant change.

Register of Attendance – Public Board 2023/24

	6 April	4 May	6 July	7 September	5 October	7 December	11 January	7 March	attendance rate
Tania Baker	✓	✓	✓	✓	✓	✓	✓		7/7
Michael von Bertele	✓	✓	✓	✓	✓	✓	✓		7/7
Stacey Hunter	✓	✓	✓	✓	✓	✓	✓		7/7
Lisa Thomas	x	✓	✓	✓	✓	✓	✓		6/7
Judy Dyos	✓	✓	✓	✓	✓	✓	✓		7/7
Melanie Whitfield	✓	✓	✓	✓	✓	✓	✓		7/7
Eiri Jones	✓	✓	✓	✓	✓	✓	✓		7/7
Rakhee Aggarwal	✓	✓	✓	✓	x	✓	✓		6/7
David Buckle	✓	✓	✓	✓	✓	✓	✓		7/7
Peter Collins	✓	✓	✓	✓	✓	✓	✓		7/7
Mark Ellis	✓	✓	✓	✓	✓	✓	✓		7/7
Debbie Beaven	✓	✓	✓	✓	✓	✓	✓		7/7
Richard Holmes	✓	✓	✓	✓	x	✓	✓		6/7
Ian Green	✓	✓	✓	✓	x	✓	✓		6/7

Governor Observer								
Lucinda Herklots		✓						
Jane Podkolinski	✓		✓	✓	✓	✓	✓	
Jayne Sheppard			✓	✓	✓	✓	✓	
Frances Owen			✓		✓	✓	✓	
William Holmes				✓				

Attended - ✓

Apologies – X

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	2.1
Date of meeting:	07th March 2024		

Report tile:	Integrated Performance Report			
Status:	Information	Discussion	Assurance	Approval
			Yes	
Approval Process: (where has this paper been reviewed and approved):	Niall Prosser, Chief Operating Officer			
Prepared by:	Adam Parsons, Operational Performance Lead			
Executive Sponsor: (presenting)	Melanie Whitfield, Chief People Officer			

Recommendation:

The Trust Management Committee are asked to note the Trust's operational performance for Month 10 (January 2024).

Executive Summary:

Breakthrough Objectives

- *Wait to First OP Appointment* returned from Christmas increase to last year's consistent position, with a reduction from 136 to 132 days and a focus to drive down further to target this year.
- *Bed Occupancy* increased from 97% to 104% due largely to the number of No Criteria to Reside (NCTR) patients increasing sharply from 75 to 88 average and indicative of the pressure on flow the Trust felt in month, where 12 days were spent in OPEL 4 escalation status.
- Reducing patient harm measured through *Falls* decreased to 6.2 and is now back below the target of 7 for the 6th time in the last 8 months.
- Staff Availability measured by *Agency Spend* increased slightly from 3.7% to 4% although remains close to target for second month in a row.

Deteriorating Performance

- Cancer remains an area of concern, with internal watch metrics of *2ww* and overall backlog *>62 days* both worsening to 48.9% and 158 patients respectively. The Trust remains in tier 2 Cancer oversight for our current 62-day backlog position. Skin, Colorectal and Breast are key contributors, who all now have additional capacity in place to improve. This position was expected and remains projected to reduce in line with trajectory by the end of financial year, projecting end position of 78 patients. Positively, all nationally reportable metrics continued to improve and show impact of additional insourced capacity:
  - *28-day Faster Diagnosis Standard (FDS)* from 58.7% to 70%
  - *31-day Standard* from 89.5% to 93%
  - *62-day Standard* from 59.5% to 60%

  Note: Cancer data is one month behind, reporting December in this IPR.
- As also expected, Diagnostics *6-week standard (DM01)* further declined in performance, from 84.5% to a reported 79.2%. Contributing modalities of Ultrasound (USS) and Echocardiogram (Echo) have additional capacity secured to rectify position from M11 (doubled existing insourcing support for former and new insourcing contract starting for latter), with improvement expected in M12 with the Trust still forecasting meeting the 85% national target by the end of the year.

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Alerting Metrics

- Total *Incidents resulting in High Harm* increased from 3.2% to 5.8% with reasons varying as per incident and all moderate and above patient safety incidents have executive oversight at the weekly patient safety summit.
- *Mixed Sex Accommodation Breaches* doubled from 10 to 20 and is evidence of pressured flow across the Trust, where escalation areas are used out of necessity.
- The Emergency Department (ED) saw a reduction in *Ambulance Handovers >60mins* from 112 to 94 and a relative hold on *12-hour Breaches* at 42, despite attendances being 686 higher than the same month last year, the equivalent to 22 per day and making wider maintained performance even more commendable.

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

January 2024

Summary

January 2024

This month saw a return to levels of pressure experienced regularly last year, with capacity and flow both stretched to the point of highest levels of reportable escalation (OPEL 4), where the Trust held this status for 12 days. Industrial Action (IA) held for the longest period to date was a key contributor and the impact of which will be detailed throughout this pack. Causes of pressure beyond IA were a combination of an increase of patients with No Criteria to Reside (NCTR) from 75 to a daily average of 88 - which naturally had a negative impact on the breakthrough objective of Bed Occupancy, causing this to rise to 104% - and the volume of patients attending the Emergency Department (ED), with 6,549 total compared to 5,839 the previous year. This is the equivalent of 22 additional attendances per day and with ED performance against the *4-hour standard* and *Ambulance Handover* maintained at 70% and 23 minutes respectively, this again emphasises the impact the Rapid Assessment Treat and Triage (RATT) service model introduction is making.

Waiting list related metrics showed recovery from the Christmas seasonal reduction in activity, with the breakthrough objective of reducing *Wait Time to 1st Appointment* improving from 136 to 132 days as standard capacity returned, and the *Total RTT Waiting List* increasing slightly from 29,270 to 29,682 as a result of this reduction. Both are anticipated to improve throughout the year as an outcome of a new Access Meeting focused on reducing patient long waits, with significant improvements already seen across all weeks waiting categories: over 78 weeks from 33 to 21, over 65 weeks from 255 to 195 and over 52 weeks from 1022 to 919.

Cancer performance remains under the national spotlight, with the Trust remaining in Tier 2 Cancer oversight for our current 62-day backlog position. Performance in month was mixed although generally positive. Despite a growing backlog of patients waiting more than *62 days* up to 158 other reportable metrics all continued to show improvement: *28-day Faster Diagnosis Standard (FDS)* from 58.7% to 70%, *31-day Standard* from 89.5% to 93% and *62-day Standard* from 59.5% to 60% highlighting the impact of additional insourced capacity and indicating that the backlog will reduce in line with trajectory before the end of the financial year, projecting end position of 78 patients.

Diagnostics, as expected until additional capacity is fully mobilised, saw a further deterioration in performance against the *6-week Standard (DM01)* from 84.5% to 79.2% which is the lowest level in almost a year. The activity decrease is mainly driven by Ultrasound (USS) and Cardiac Echo, with increased capacity plans being implemented for both and expecting to show improved performance in M12 with the Trust still forecasting meeting the 85% national target by the end of the year.

Quality related metrics were contrasting, with positive performance seen in the breakthrough objective of *Reducing Falls* as it dropped below target again for the 6th time in the last 8 months down to 6.2 per 1,000 bed days, the number of patients who *Moved Bed more than Once* decreasing to 3.2% and the number of *Serious Incidents* also reducing to 1 in Month. Whereas negative performance was reported in the Stroke *4-hour performance* dropping from 56% to 44% and *Pressure Ulcers* increasing from 1.89 to 2.46 per 1,000 bed days.

The Workforce breakthrough objective of staffing availability measured by *Agency Spend* increased slightly from 3.73% to 4% although remains close to the target of 3.7% for the second month in succession and is emerging evidence of a sustained improvement for the first time since recording.

Finance recorded an *Income and Expenditure* control total deficit of £2.1m against a target of £0.3m - an adverse variance of £1.8m. The year-to-date position of £7.5m deficit is driven by supernumerary cover for new and overseas staff, the residual gap on pay awards, impact of Industrial Action (IA) and staff unavailability.

Vision

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

People working for us	Population our patients and their families	Partnerships working with us

Vision metrics 7 – 10 years

People			Population			Partnerships		
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)?

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

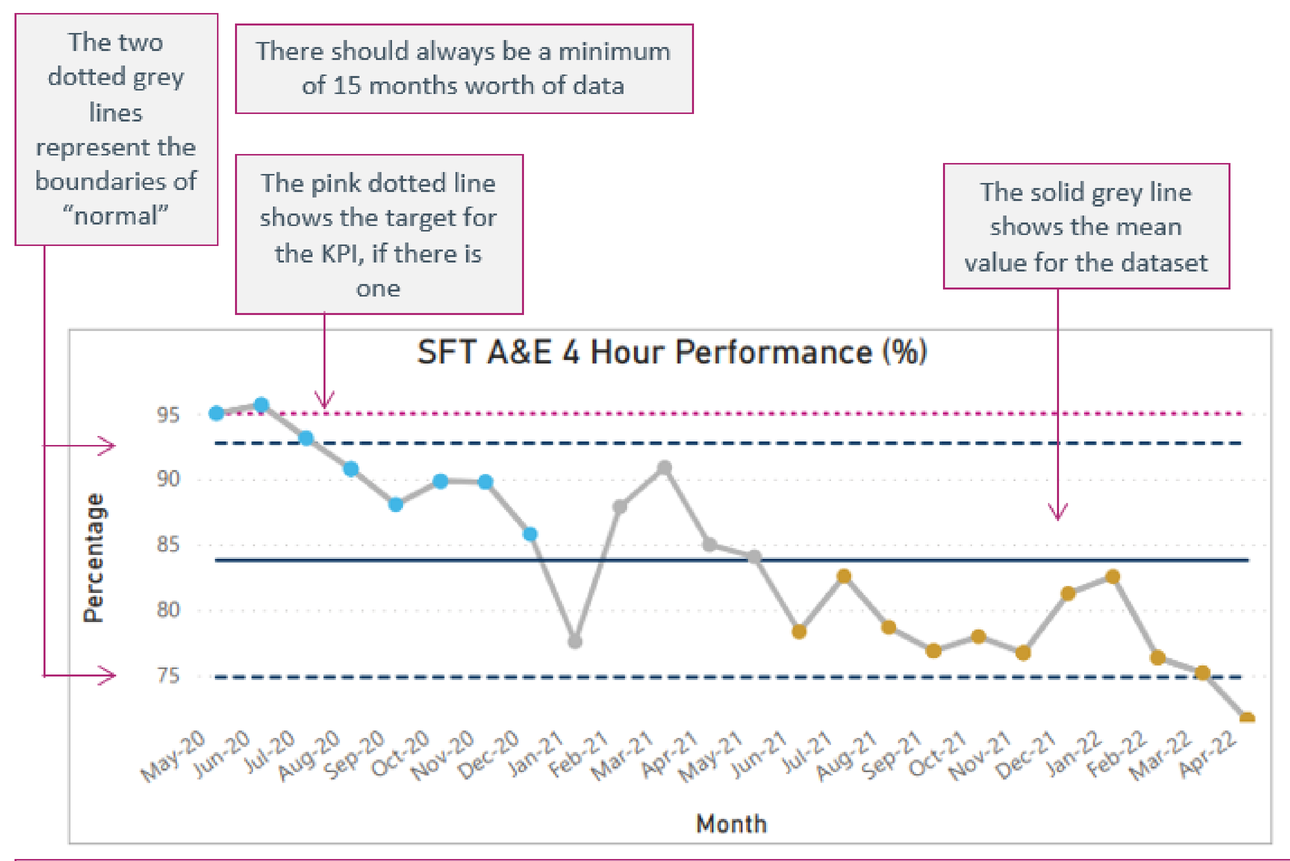
Reading a Statistical Process Control (SPC) Chart

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

Population

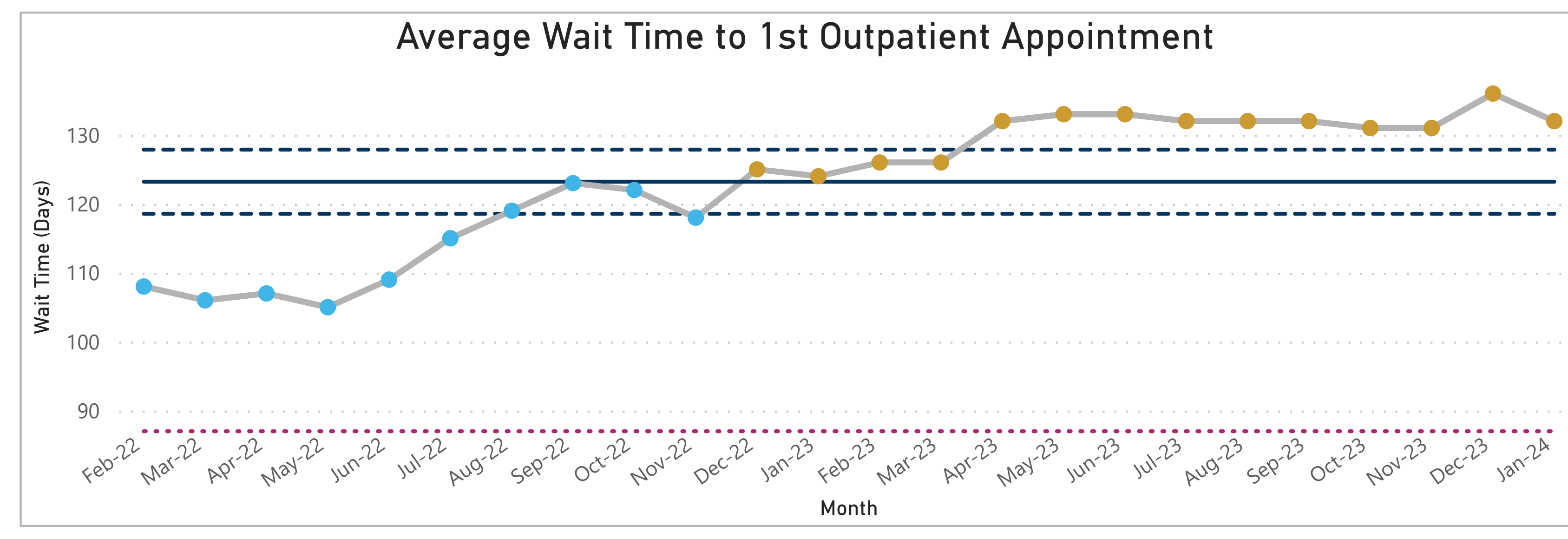
Partnerships

People

Reduced 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 an improvement of 4 days between December and January at 132 days, despite the Industrial Action (IA) at the start of the month (and almost reversing the previous months deterioration of 5 days). All divisions bar Women & New-Born (W&NB) improved their respective performance in month. This is not entirely surprising given that W&NB are disproportionately affected by Industrial Action (IA). Clinical Support and Family Services (CSFS) had a marginal improvement of circa 0.5 days, with Surgery and Medicine both improving by circa 4 days each.

Of the six greatest contributors only Gynaecology failed to reduce their average waits, with a marginal increase of 1 day. Oral (18days), Gastroenterology (21days), General Surgery (3days), ENT (4days) and Plastics (9days), all returned improving positions.

The Trust's focus remains on seeing patients in line with clinical need, referral type, e.g. Cancer 2 week wait (2ww) and Urgent referrals, and by longest wait, in line with NHSE requirements. During the IA the Trust prioritised the patients with greatest clinical need, which delayed the continued recovery of the long waiters.

Increased levels of 2ww and urgent referrals have been reported across a number of specialities with a review of the pre covid and post covid rates confirming some significant shifts in proportion of 2ww and Urgent referrals as a percentage of the total referrals seen. This change in referral patterns (as much as 20% in some specialties) has compounded the usual tension between clinical priority and longest waits.

Actions (SMART)

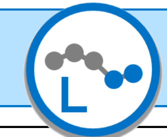
- Internal analysis has been undertaken identifying variation in individual practice referral behaviours – comms plan and targeted practice visits to be arranged.
- Planned Care Board to focus on a further three specialities Gen Surgery, Gynaecology and Respiratory from January 2024, adopting and following the clinically developed, speciality specific, GIRFT Further/Faster guidance.
- Trust progress against long waiting patients including those awaiting 1st Appointment to continue to be monitored weekly and to be reported to the CEO and COO via weekly summary updates.
- 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 October 2024.
- Plastics and ENT Improvement huddles both have Time to 1st OP Appointment as a driver to focus on reduction of wait times. Their actions include: Waiting List validation, clinically appropriate discharge of long-wait patients and clinic template reviews.
- Further rollout of specialty huddles (training and support required) to contribute to reduction in Time to 1st OP Appointment in align with Improving Together approach.
- Demand and Capacity support to Gynaecology concluded, with Respiratory and Plastics to be finalised.

Risks and Mitigations

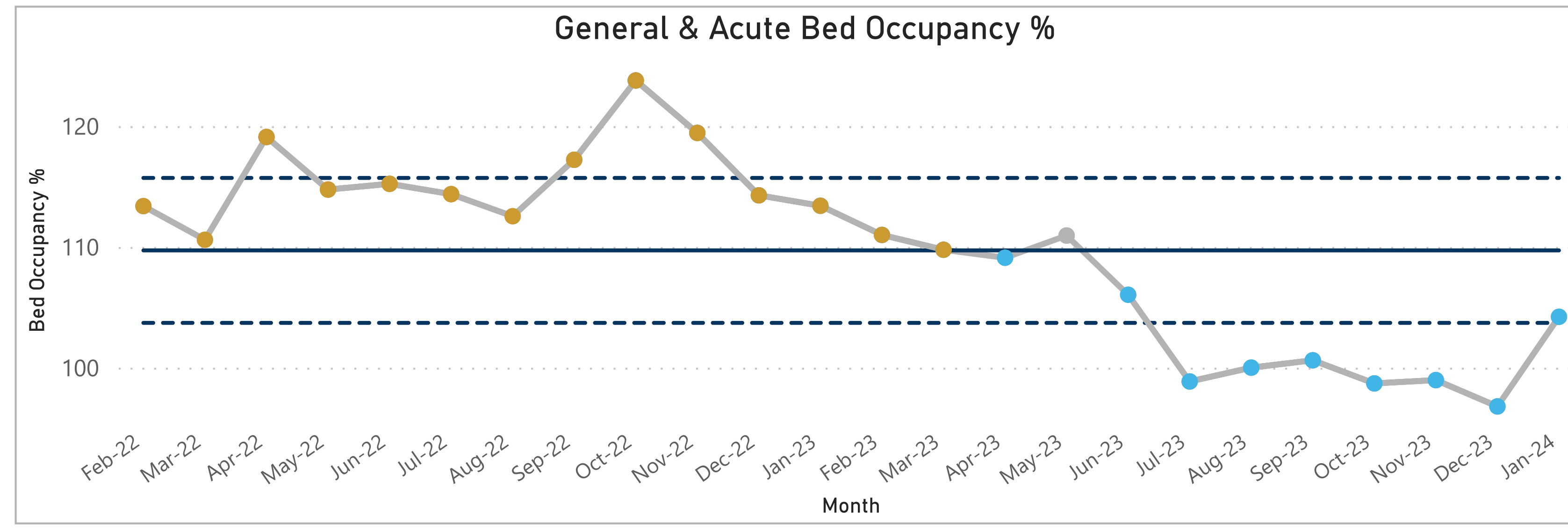
- Continued growth in demand against challenges to recruit to some positions is a risk.
- Limitations continue in relation to the Trust's ability to comprehensively map demand and capacity at a subspeciality / pathway level, however the performance team are supporting this work with the Divisions and specialities.
- Risk of ongoing IA and impact.
- Weekly Access Meeting now in place with performance team and operational managers to review waiting list and drive towards national reduction targets.
- Staffing pressures exist across a number of specialities which present potential individual speciality pressure into next financial year.
- Patients to continue to be booked in line with NHSE recommendations, with weekly validation of long waiting patients.

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 risen sharply during the month of January. Whilst ED attendances remain static for the Month, compared to January 2023 they are considerably higher. Admission rate was slightly higher than the previous month and significantly higher than January 2023, readmission rates remain static.

Length of Stay (LoS) has seen a decrease across Medicine and Surgical divisons, most significantly in surgery. LoS from admission to being fit to be discharged has increased this month, with a decrease in delayed discharge LoS, however LoS to No Criteria to Reside (NCTR) has decreased. Overall NCTR lost bed days increased slightly during January.

Acute Frailty Unit (AFU) is showing a slight decrease in LoS, however the number of patients being seen on a zero LoS pathway has increased giving an indication of higher acuity in this group of patients. The number of readmissions has increased slignificantly to 16% compared to 9% in December.

The discharge pattern across 24 hours is unchanged at just over 10% being before midday, with weekend numbers dissapointingly low at 20%. Overall number of discharges for the month have decreased in January compared to December as would be expected with seasonal variation.

Actions (SMART)

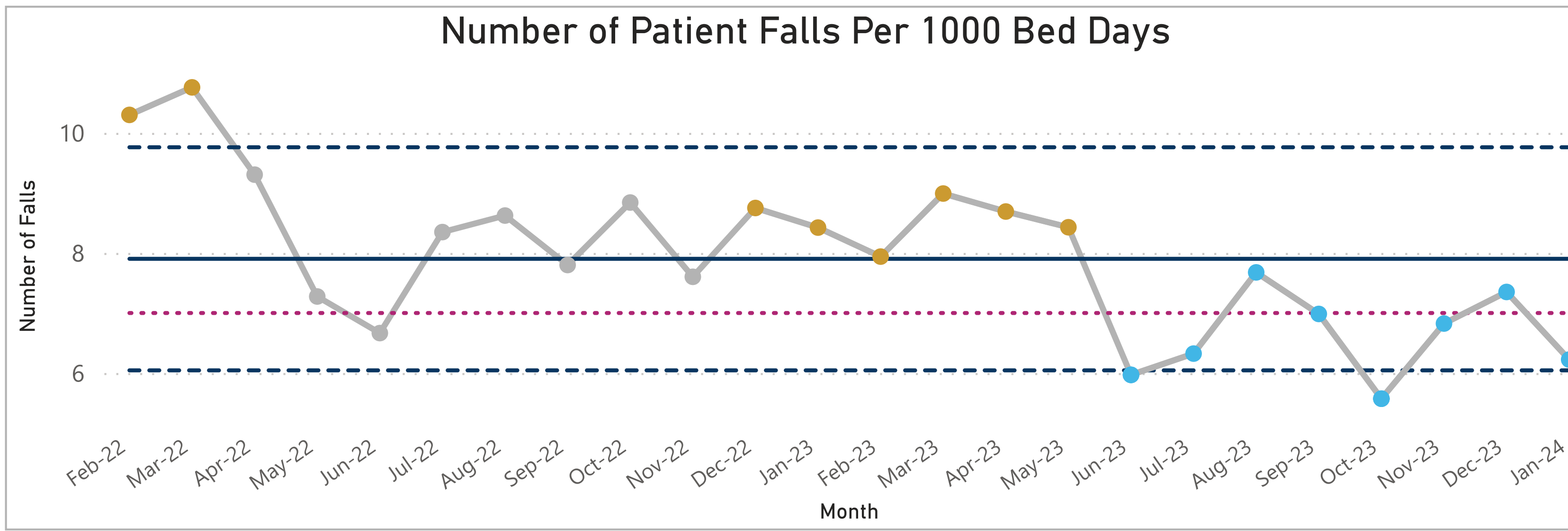
- Improving Together work continues across the divisions. Surgery have identified a focus on Trauma and Orthopaedic pathways for LoS reduction for Non-Elective (NEL) and elective patients.
- Improvement huddle has been started on Laverstock ward. Tisbury ward to explore potential for LoS improvements (A3 to be worked through) in patients waiting for Cardiology procedures.
- 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 - this is planned for January.
- Reset week will lead to some changes in how Non-Urgent Patient Transport (NUPT) is managed between the wards and the transport office, which will decrease the burden on the wards.

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.
- Ongoing operational challenges related to capacity are expected to vary over the winter months.
- Ongoing Industrial Action (IA) from various professional groups and unions reduces staff capacity to focus on the Quality Improvment (QI) work.

Reducing Patient Harm

Target 7



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 January falls decreased from 7.35 to 6.22 per 1000 bed days, which is below the target of 7. This is a huge improvement from 8.35 in January 2023.

There were x6 inpatient falls with moderate or above harm:
- 2 Neck of Femur (NoF) fractures.
- 1 New cortical bleeds and bilateral tiny Subdural Haematoma (SDH).
- 1 Laceration to the head requiring sutures and a blood transfusion.
- 1 Scalp Haematoma - the patient passed away therefore upgraded to moderate. Death certificate states heart attack, awaiting coroner's report, can possibly be downgraded.
- 1 Suspicion of small amount of acute bleed on top of known SDH - Can possibly be downgraded.

This has decreased from 7 moderate or above harm falls in December. Falls audit data identified 90% of wards (that have submitted their data) have a 95% and above compliance with risk assessments being in date, with 80% of wards having a 100% compliance rate, this has improved from December. 90% of wards have a 95% and above rate of implementing accurate interventions. Which has increased from 71% last month.

Actions (SMART)

- The Emergency Department (ED) has been provided with the falls training power point and ED specific falls risk assessment to publish amongst staff, this will allow the think yellow scheme to be launched within the coming weeks. The scheme involves providing yellow socks and blankets to patients at high risk of falls, to become easily identifiable.
- Plan on delivering education beyond ED to Portering, X-ray staff etc to ensure all areas are aware of what this yellow scheme entails. The ED matron has pushed for the falls audits to be completed within ED / SSEU this will give us more insight to what improvements can be made in these areas.
- Bay watch continues to be in use throughout the hospital, with more wards implementing. Falls on Pitton have decreased from 4 falls in December to 3 in January. Spire has shown some improvement with a decrease from 13 to 11 in January. An action log has also been designed with target dates to try and get these numbers down.
- Improvement in Laying and Standing Blood Pressure (L&SBP) compliance by 40% of wards in January, a tiny increase from 36% in December. However, Redlynch has shown significant improvement from 70% in December to 94% in January. We are considering ideas to improve L&SBP compliance throughout all wards.
- We are in discussion with the Pharmacy team to carry out falls training with staff this year.
- There is a national target that all patients who have a falls risk assessment as an inpatient should have an eye test, we have plans to trial a new multifactorial falls risk assessment which incorporates a visual check.

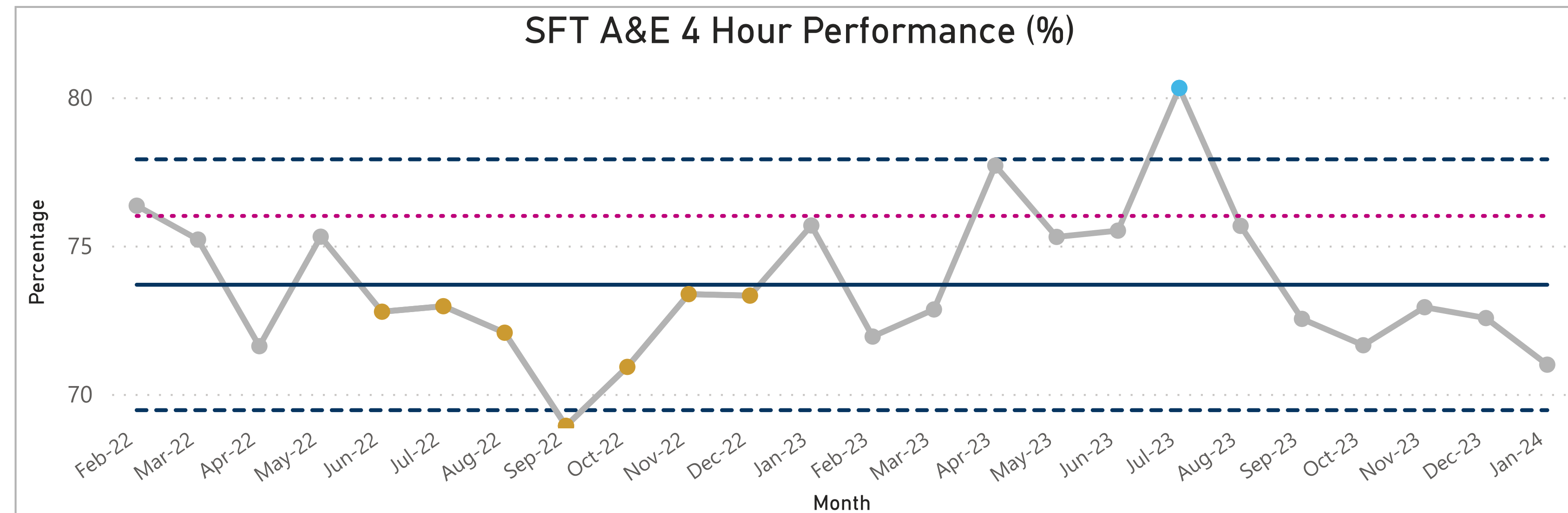
Risks and Mitigations

- January has been a long month; however, improvements have still been made, we hope to continue to see improvements and a reduction in falls in the coming months. Falls reduction training has now been delivered on seven wards and will continue to be delivered throughout the hospital.
- L&SBP compliance is at a standstill and improvement is still required. Falls reduction training being delivered to see an improvement. L&SBP lanyard cards have been shared amongst staff to prompt action. Doctors have been prescribing L&SBP checks in some areas, we are in discussion to see if this can become a regular prescription for all patients aged over 65 years.
- Need for patients to mobilise as much as possible to assist reducing Length of Stay (LoS) continues to risk potential falls.

Emergency Access (4hr) Standard

Target 76%

National Key Performance Indicators



Performance Latest Month: 71.0%

Attendances: 6549

>12 hrs in ED Breaches: 42

Understanding the performance

Attendances in M10 remained slightly up at 6,549 (all types), this is a 2% year to date increase in comparison to last year. However, within this type 1 attendances remain up by 4% year to date and type 3 (walk in centre) attendance are down by 6%.

Performance against the 4 hour standard has reduced in the last 5 months, with M10 reducing further to 70.99%, the lowest month year so far this year. Year to date performance does remain 2% higher than 2022/23 despite the increase in attendances.

12-hour breaches remained static at 43 compared with 41 in M9. Flow out of the department into the hospital remains the biggest contributor to both the 4-hour and 12-hour standards. High levels of occupancy in the Trust continue to put pressure on flow with patients waiting longer in the Emergency Department (ED) as a result.

Spaces lost per day to patients with a Decision to Admit (DTA) further deteriorated to 6.2 and this loss of space amounts to the capacity to see 89 patients. This further illustrates the difficulties the Trust is facing regarding flow, with patients remaining in ED for an average of 9 hours after they are referred and accepted for an inpatient bed, of which 104% were occupied in month.

Actions (SMART)

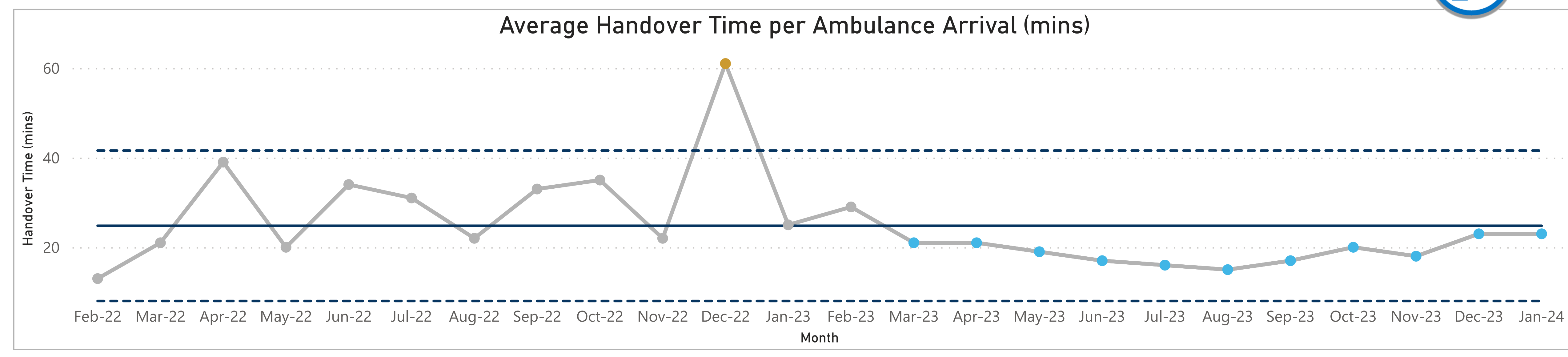
• New weekly performance huddles started to monitor performance and identify any potential areas of improvement.
• A work force review is planned to review current medical staffing levels comparing weekdays and weekends.
• The 23/24 skill mix review is awaiting formal confirmation of funding to ensure there are adequate staff with the correct skills, staffing the correct areas.
• Business Case in development to support increase in Advanced Clinical Practitioners (ACP) numbers.
Investment secured for an additional 2 junior doctor posts next year.
• Rapid Assessment Treatment and Triage / Rapid Ambulatory (RATT / RAMBO) is continually under review.

Risks and Mitigations

• Timely flow out of the Department continues to impact 4-hour and 12-hour standard performance targets with high bed occupancy levels across the Trust. Improving Together A3 creation under way to explore reasons for delayed moves out of ED.
• Large focus remains on staff training which has led to improved staff retention and addresses skill mix.
• A3 also under development to explore reasons for non-Admitted breaches. There is increased focus as these breaches should be within ED's ability to reduce.
• Patients with No Criteria to Reside (NCTR) and number of ED attendances both increasing is a risk to performance and will continue to present flow challenges.

Ambulance Handover Delays

National Key Performance Indicators



Understanding the performance

Attendances by ambulance in M10 reduced to 1,276 compared to 1,611 in M9 however this is an increase of 20% from M10 in 2023, which is the equivalent of 8 ambulances a day.

Handover times dropped slightly with 82% of patients handed over in less than 15 minutes compared with 85% in M9, 11% handed over >30 minutes and > 60 minutes remained at 7%.

The ability to maintain the ambulance performance well above the national average is as a direct result of Rapid Assessment Treatment and Triage (RATT) being embedded within the department. Without RATT in place performance is likely to have deteriorated further due to the lack of space and delayed flow out of the department.

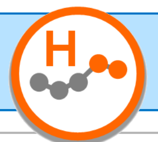
Actions (SMART)

- New ambulance handover software was introduced to ED in M9 by South Western Ambulance Service (SWAST) to capture more accurate 'live' data which is still embedding.
- Monthly meetings with the SWAST team are taking place improving collaborative working between teams.
- Weekly performance huddles will also cover Ambulance Handover data with a view to highlight any potential areas of improvement.

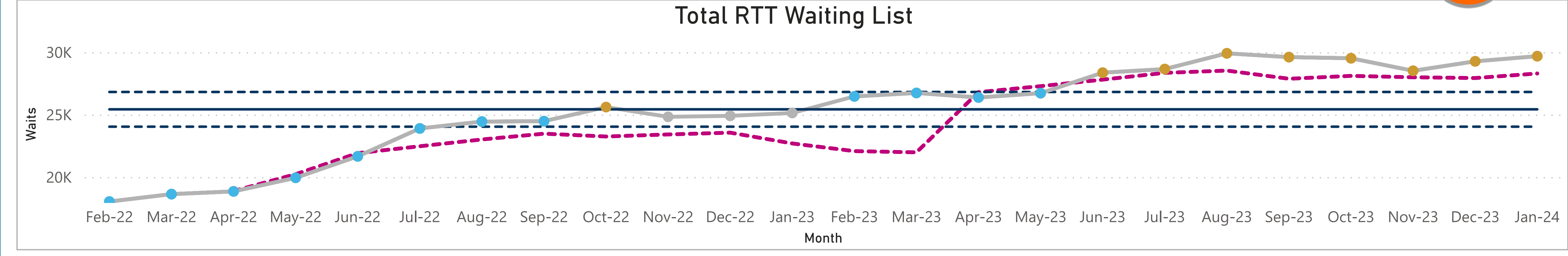
Risks and Mitigations

- The RATT process continues to provide positive impact and sustain performance.
- There is currently ongoing work with Informatics looking into the validity of ambulance data as not all data sources match. Informatics are hoping to work with SWAST on using their data set from the new XCAD handover software.

Total Elective Waiting List (Referral to Treatment)



National Key Performance Indicators



Month	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Longest Waiting Patient (Weeks)	73	75	76	75	76	77	243	200	194	153	139	110

Understanding the performance

The Total RTT Waiting List size position at the end of January showed a deterioration of 412 from 29,270 to 29,682 and remains behind plan, by a total of 1,387 patients. This is the second month of deterioration following three months of improvement but should be set in the context of reduced activity across Christmas and successive Industrial Action (IA) in both December and January.

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 are: Urology (1st), Gynaecology (2nd), ENT (3rd), Plastics (4th), and General Surgery (5th). They collectively account for 59.16% of the increase in waiting list size since April 2022. Gynaecology and General Surgery are two of the three focus specialties for Planned Care Board to adopt the GIRFT Further / Faster principles of efficient Outpatient Department (OPD) operations.

Work to reduce the number of Breast DIEP long waiters has continued with longest waits now being 110 weeks. All breast DIEPs at risk of breaching 65ww now have a plan to been seen before the end of March and for this cohort of patients, it is expected SFT will meet the 65ww target.

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 and Gynaecology.

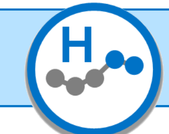
A number of actions are planned to continue through February including:
• Adoption of GIRFT Further/Faster Principles for three key specialties via Planned Care Board, General Surgery, Respiratory and Gynae, to include clinical engagement.
• Ongoing Breast DIEP waiting list reduction, with trajectory for clearance to NHS target level by March 31st – on target.
• Plastics insourcing inplace to support both Cancer performance and 65ww clearance and to continue into February.
• Completion of the RTT module for CCS tool to allow for enhanced validation and waiting list data quality.
• Transition of the CCS tool to BAU for both RTT and OPD Module planned for early Feb
• New ward (Imber) opening and expanded Theatre timetable from April will support increase of surgical activity and in turn reduce waiting list.

Risks and Mitigations

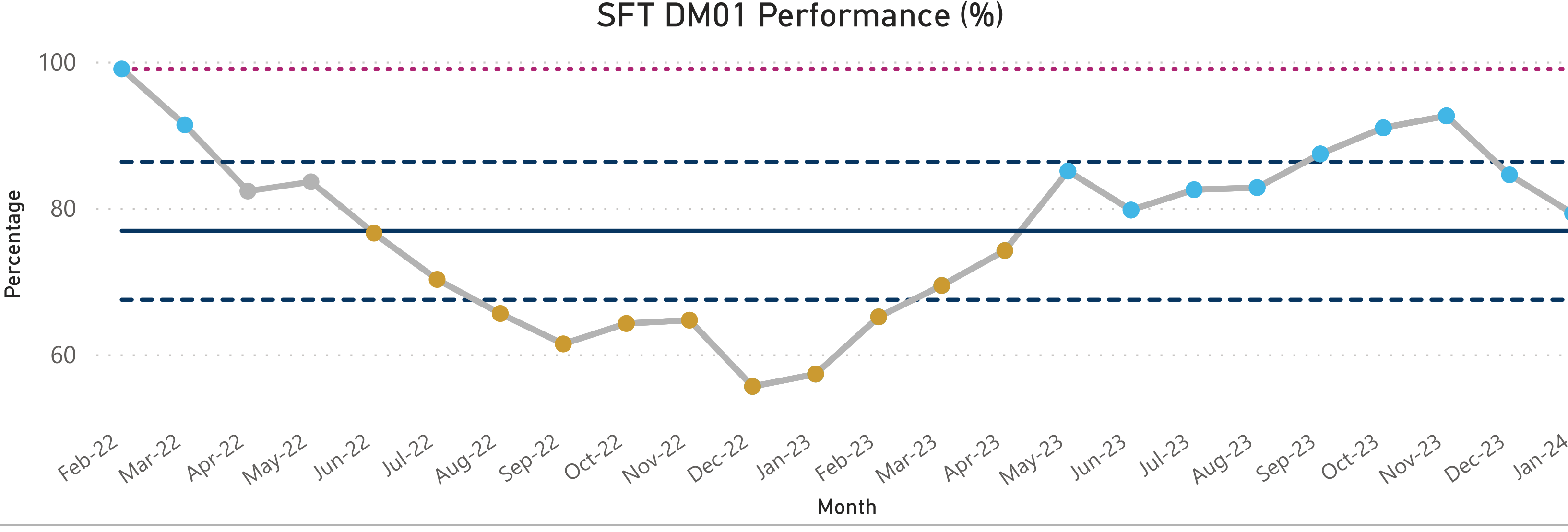
• The risk of lost capacity owing to IA remains, with February dates now announced by the BMA. Whilst mitigations are in place to support safety for those most clinically urgent patients, it is unlikely that the volume of activity affected cannot be entirely mitigated.
• Weekly Access Meeting now in place with performance team and operational managers to review waiting list and drive towards national reduction targets.
• Support into operational teams to enhance level of focus on the non-admitted pathways, through further OPD workshops and weekly huddles in line with Improving Together methodology to continue through the remainder of Quarter 3 and into 4.
• Planned mitigation of new ward and theatre timetable to support increased activity.

Diagnostic Wait Times Performance (DM01)

Target 99%



National Key Performance Indicators



Performance Latest Month: 79.3%

Diagnostic Activity: 7978

	Performance	Breaches		Performance	Breaches
MRI	83.3%	115	CT	98.7%	8
US	76.8%	504	DEXA	100.0%	0
Audio	75.0%	128	Cardio	53.9%	317
Neuro	99.0%	2	Colon	78.2%	41
Flexi Sig	69.6%	28	Gastro	91.5%	16

Understanding the performance

DM01 performance reduced in M10 to 79.62% vs the M9 performance of 84.53%. This represents a total of 1,159 patients impacted by a wait time of greater than 6 weeks for a diagnostic test in M10, compared to 825 patients impacted in M9. Overall waiting list size increased from 5,332 in M9 to 5,588 in M10.

The modalities influencing the position with the highest number of breaches remain as Ultrasound (USS) and Cardiology Echo although there were also increased breach numbers in MRI and in Endoscopy. Audiology reported an improved position, reducing total breaches to 128 from 156.

MRI reported 115 breaches (59 in M9) with the majority of these are related to Cardiac MRI, although also circa 30 patients due to specific Musculoskeletal (MSK) related scan. Overall average wait time for MRI is < 4 weeks.

Summary Breaches as follows:
- CT - 8 breaches (2 in M9)
- USS - 504 breaches (372 in M9)
- Audiology - 128 breaches (156 in M9)
- Cardiology Echo - 317 breaches (174 in M9)
- Endoscopy - 85 breaches (62 in M9)

The Trust is forecasting to achieve 85% target by the end of march 2024.

Actions (SMART)

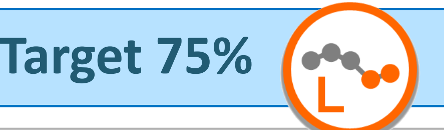
- Increase insource provision and maximise overtime capacity in USS for M11 to improve position and aim for 85% restoration by end of M12.
- Commence insourcing within Cardiology Echo to increase capacity with a view to restore to 85% by M1 of 2024/25.
- Review root causes of non Cardiac MRI breaches to ascertain actions required to prevent increases in MRI breaches.

Risks and Mitigations

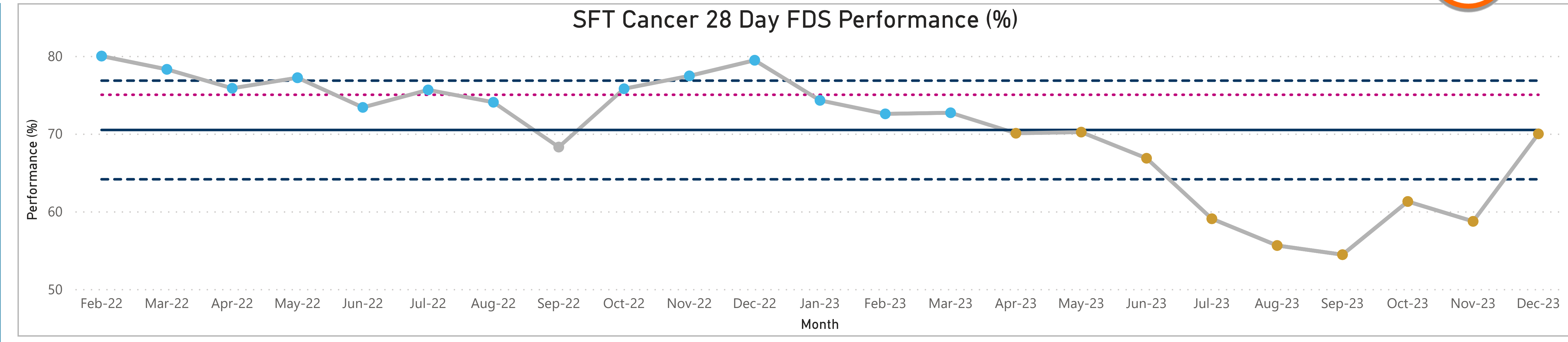
- USS and Cardiology Echo remain dependent on temporary staffing or insourcing arrangements to maintain capacity. USS workforce is improving but vacancies will remain until student pipeline is fully qualified at end of 2024.
- CT replacement project commences for the first scanner from M11. Provision of a mobile scanner is planned to ensure routine elective capacity can be maintained and that there is business continuity for acute pathways if remaining CT was to have a fault.
- Cardiac MRI does not have sufficient capacity to manage current waiting list and the referral numbers. Currently two lists per week, need at least a third and possible fourth. Some outsourcing to UHS currently occurs although this is likely to cease imminently.
- New Cardiology Consultant with Imaging sub specialty due to start in April.
- Radiology and Cardiology to work together regarding opportunities for third weekly in-house list.

Cancer 28 Day Faster Diagnosis Standard Performance

Target 75%



National Key Performance Indicators



Understanding the performance

28d performance for the December submission improved to 70.8% from the November position of 56.7%.

The number of patients impacted by not receiving their diagnois (or non-diagnosis) within 28 days in December was 323 of a total of 1,108 as compared to 559 patients impacted of a total of 1,291 in November.

The largest contributor to this improvement was restoration of compliance against the standard in the Skin pathway, reporting 78.1% compliance vs 24.8% in November. This was as a result of the planned insourcing capacity that commenced in November, restoring first seen waits to less than 28 days.

Improvements when comparing November with December performance were also noted in Haematology, Gynaecology and Lung, although only Lung above 75% in this cohort.

Risk areas to compliance include Colorectal, where performance declined from 48.2% in November to 37.8% in December and Urology, which declined slightly from 46.3% to 45.6% but known capacity risk and likely to decrease in M10.

Actions (SMART)

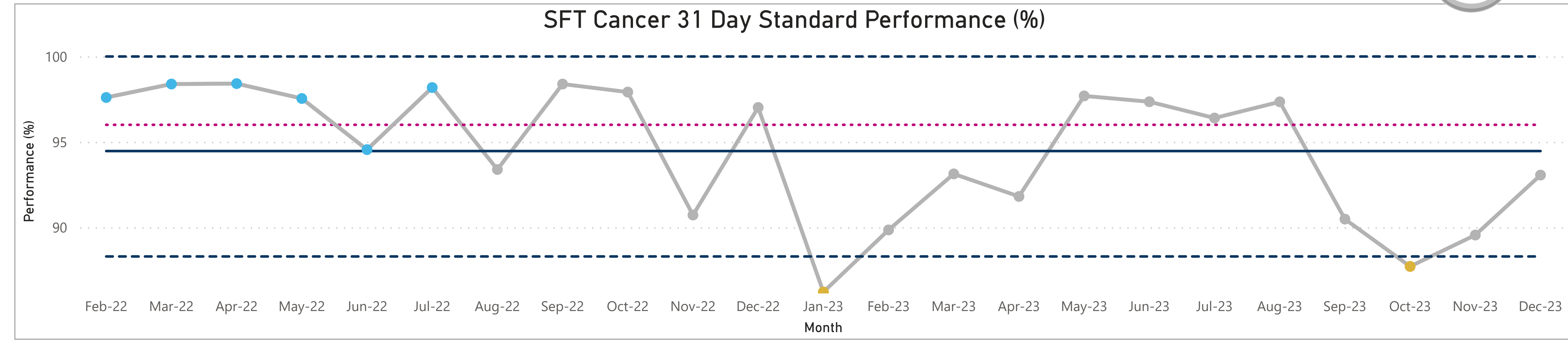
- Continuation of insourcing capacity within the skin pathway to provide resilience to the first seen wait through Q4.
- Attendance and engagement from Colorectal Multidisciplinary Team (MDT) to attend PTL (Waiting List) meetings, working on proactive actions for pathway management.
- Locum provided (cancer alliance funded) clinics within Colorectal to restore first seen waits to < 14 days during M10.
- Refresh / relaunch of cancer improvement group with operational teams from late M10 to focus on explicit countermeasures to improved 28-day performance longer term.
- Engagement with Tiering oversight with NHSE and pursue funding opportunities for increased capacity to restore KPIs at SFT.

Risks and Mitigations

- Prolonged first seen waits in Colorectal during Q3 will result in lengthening diagnostic pathways, likely beyond 28 days in a patient's pathway that will take some time to recover for there to be a noticeable improvement in 28-day performance. Mitigated with increased oversight and focus through PTL meetings and Cancer Improvement Group.
- Sustainability of capacity within Skin pathway - options to mitigate with further cancer alliance or NHSE funded insourcing and medium terms plans for workforce improvement at SFT.
- Short term absences of CNS workforce in Urology resulting in Lead Nurse having less lead/administration time to support PTL actions and pathway management. Mitigated in part by navigator and MDTC team tracking actions and raising escalations.

Cancer 31 Day Standard Performance

National Key Performance Indicators



Understanding the performance

31-day performance in December improved to 93.1% compared to 89.5% in November.

This performance represents 10 patients breaching the standard, of a total of 145 recorded. For November 16 patients breached the standard of a total of 153 recorded.

As anticipated, the majority of breaches were recorded within the Skin pathway (6 of the 10 patients impacted) due to the constrained capacity for minor ops treatments.

The other reportable breaches were 2 within Breast services, where the longest wait was 49 days to Decision to Treat (DTT), 1 for Haematology at 37 days and 1 for Gynaecology at 35 days.

Actions (SMART)

- Further minor ops capacity required in the skin pathway in M10 and likely M11 to sustain appropriate wait times for the 31-day DTT target.
- Escalations of potential breaches, to limit the possiblity of patients breaching the standard by only a few days to be brought to Cancer Improvement Group for resolution by operational management team.
- Core list of 31-day applicable procedures to be shared with central bookings to ensure To Come In (TCI) dates booked appropriately.
- Breach dates for patients pending Oncology / Chemotherapy planning to be shared with booking team to ensure patients a) not booked to breach or b) escalation of breach is made before booking is completed.

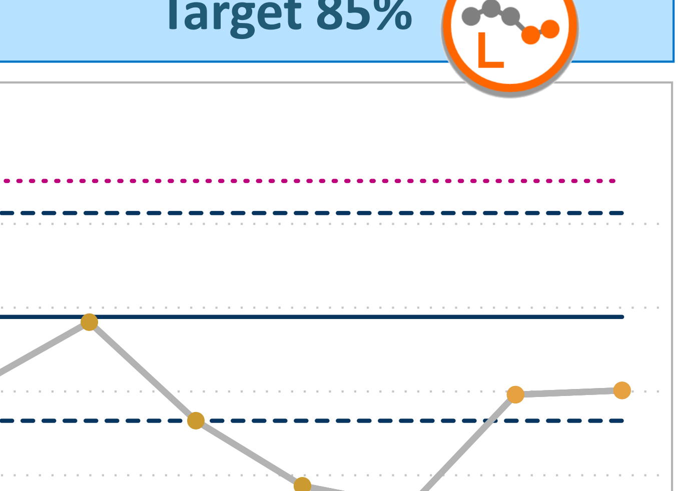
Risks and Mitigations

- Performance against the 31-day standard at SFT is generally good and not often at risk - the actions underway will support further improvement of this compliance and ensure escalations occur before patients are booked to breach.
- A reduction of capacity in minor ops within skin or an increased referral and conversion rate could put at risk the 31-day standard but this is currently mitigated by insourcing capacity funded by cancer alliance and / or NHSE.

National Key Performance Indicators

Cancer 62 Day Standard Performance

Target 85%



Understanding the performance

There was a small improvement in the 62-day performance in December, increasing to 60% from 59.5% in November.

This represents 29 breaches in December of a total of 72.5 treatments recorded vs 32 breaches in November against 79 treatments recorded.

Highlight summary breaches as follows:

- Skin - 9 patients
- Colorectal - 8 patients
- Urology - 4.5 patients
- Lung - 3 patients

With smaller numbers impacted throughout other specialties.

Whilst there was a significant number of patients impacted in the Skin pathway, this is an improvement compared with November where 16 patients breached the 62-day target.

Backlog position >62 days also increased to 158 patients as expected, although remains projected to reduce in line with trajectory by the end of financial year.

Actions (SMART)

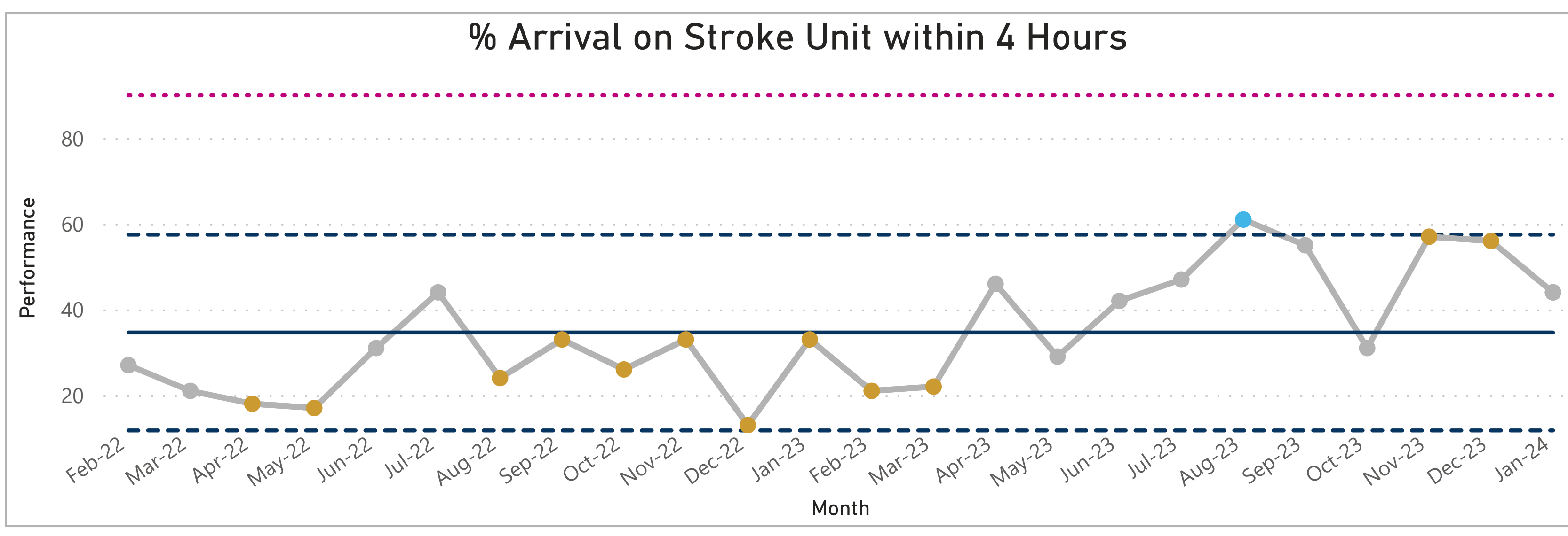
- Minor ops capacity within the Skin pathway will also support improvement of the 62-day performance. Capacity is planned across Q4.
- Escalations of potential breaches, to limit the possiblity of patients breaching the standard by only a few days to be brought to Cancer Improvement Group for resolution by operational management team.
- Breach dates for patients pending Oncology / Chemotherapy planning to be shared with booking team to ensure patients a) not booked to breach or b) escalation of breach is made before booking is completed.

Risks and Mitigations

- Whilst there is a continued focus on reducing 62-day backlog back to within trajectory, there will be more recorded 62-day breaches per month as patients are progressed along their pathway and removed from backlog. Resolution of backlog to trajectory and below should then allow for a marked improvement in 62-day performance assuming that all the key pathway management mechanisms remain in place (i.e. PTL management etc.)

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
2022-2023	D	C	C	C
2023-2024	B	A		

Understanding the performance

The national target for patients admitted to the stroke unit within 4 hours is 90%. M10 end performance (based on discharged patients) was 44%, down 12% from 56% in M9.

Summary M10 discharged patients.
Out of the 27 patients discharged in M10, 15 did not make it to the unit within target and were admitted outside of the 4-hour window. Of these, 3 were inpatient strokes, 10 brought in via ambulance and 2 walked into ED. Of the 15 who did not make it to the unit, 3 patients had nonspecific stroke symptoms whilst 11 were suspected strokes/ obvious symptoms. January's data identified that 9 out of the 15 were out of hours. Main contributing factors were:

• 4 patients diagnosed after CT x1? TIA however CT showed bleed the other 3 had nonspecific symptoms.
• 3 patients waiting >4 hrs to be seen by 1st Doc in ED all with obvious stroke symptoms, 3 of these pts were OOH. 2 of these were pts that had walked into ED
• 4 patients out of target due to bed capacity 2 boarding spaces already occupied and 2 unsuitable to board.

Improving together 4-hour performance metric.
Our monthly admission target is 70% of patients to be admitted within 4 hours. M10 end performance for admissions was 52% which is 18% off our overall target. Of the 23 admissions to the stroke unit, 11 did not make it to the unit within 4 hours. 3 x ED did not inform stroke unit, 5 late diagnosis, 1 other reason and 2 x issues with bed capacity.

Actions (SMART)

The main contributing factors affecting the 4-hour performance in M10 were due to high occupancy in the stroke unit and communication between ED and the stroke unit and delayed diagnosis of stroke.

Countermeasures include:

• The stroke unit continue to monitor and identify possible strokes coming through the front door to enable early intervention and admission to the stroke unit within the 4-hour performance target.
• A business case to be written to ensure appropriate Psychology support is given to the stroke unit, this has been proven to provide better patient outcomes and overall reduction in LOS.
• Driver metric to facilitate patients being discharged before 12pm, is driven through regular Farley Huddle board meetings, to ensure we have early flow through the stroke unit and helping reduction in LOS.
• Continued targeted education and training in ED to ensure SOP is being used effectively and on early recognition symptoms of stroke.

Risks and Mitigations

• M10 has seen high acuity across the Trust with the need for additional side rooms with regards to infection control, impacting on the stroke units bed capacity. The stroke unit has continually boarded patients in M10 to minimise the impact of this.

Maternity

Are We Safe?

01/01/2024 <- Reporting Month (Input the first of the REPORTING month)

	SFT Assurance Dashboard	Guidance	Standard	RAG Target 2021-22 Q4	RAG rating calculation: R	RAG rating calculation: Red	RAG rating calculation: G	RAG rating calculation: Green	RAG rating: Red	RAG rating: Green	Improvement Direction	Rolling 6 months: Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
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	1	0	0	0	0
	Number of stillbirths (>+ 24 weeks excl TOP)			NA					NA	NA	Down	0	0	0	2	1	0
	Number of neonatal deaths : 0-28 days			NA					NA	NA	Down	0.0	0.0	0.0	0.0	0.0	2.0
	Number of neonatal deaths : 0-28 days per 1,000 Live (Reg) Births	ONS	2.7 per 1000 live births	NA	>=	2.8	<=	2.6	>= 2.8	<= 2.6	Down	0.0	0.0	0.0	0.0	0.0	13.5
	Medical termination over 24 +0 registered			NA	NA	NA	NA	NA	NA	NA	Down	0	0	0	0	1	0
Maternal M&M	Number of Maternal Deaths			NA					NA	NA	Down	0	0	0	0	0	0
	Number of Maternal Deaths per 100,000 Maternal Deaths	ONS	9.1 per 100,000 women who delivered	NA	>=	9.2	<=	9.0	>= 9.2	<= 9	Down	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	1	0	1	0	0	0
Insight	Datix incidence SII	6 month SFT rolling		0	>=	1	=	0	>= 1	= 0	Down	2	0	0	0	0	0
	HSIB referrals	6 month SFT rolling		0	>=	1	=	0	>= 1	= 0	Down	1	0	1	0	0	0
	HSIB/NHSR/CQC or other organisation with a concern or request	6 month SFT rolling		0	>=	1	=	0	>= 1	= 0	Down	1	0	0	1	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
Workforce	Obstetric cover - labour ward	RCOG guidence		40	<=	39	>=	40	<= 39	>= 40	Up	40	40	40	40	40	40
	Midwife to Birth ratio	RCM;NHSR;BR+	1.26	1.30	>=	1.28	<=	1.26	>= 1.28	<= 1.26	Down	1.30	1.29	1.35	1.28	1.32	1.25
	Midwifery vacancy rate (black= over establishment; red = under establishment)			NA	>=	1		NA	>= 1	NA	Down	23.3	22.2	15.7	13.9	14.0	12.0
	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
	Datix relating to workforce	6 month SFT rolling		NA	>=	2	=	0	>= 2	= 0	Down	3	0	0	0	1	0
	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
	Numbers of times maternity unit on divert	6 month SFT rolling		NA	>=	2	=	0	>= 2	= 0	Down	1	0	0	0	0	0
Involvement	Service user feedback : Number of Compliments	6 month SFT rolling		10		NA	>=	10	NA	>= 10	Up	0	28	3	1	0	35
	Service user feedback : Number of Complaints	6 month SFT rolling		NA	>=	NA	<=	NA	NA	NA	Down	0	1	0	2	0	0
	Number of SOX	6 month SFT rolling		3		NA	>=	3	NA	>= 3	Up	10	5	6	0	4	9

Understanding the performance

In January Maternity reported:

• Two neonatal deaths of extremely premature 21+5 week twins in January. This data includes live registerable births of any gestation.

Note: National programme, Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) record neonatal deaths from 22 weeks gestation for Perinatal Mortality Review (PMRT). The two neonatal deaths when calculated at the national rate of per 1000 live births provides a figure of 13.5 per 1000.

Midwife to birth ratio remains above SFT individualised recommended rate of 1:26 , despite this 1:1 care in labour maintained.

0 datix' relating to workforce.

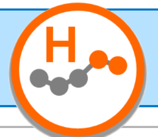
Actions (SMART)

• Neonatal deaths: Patient Safety Review has taken place.
• Targeted recruitment drive in place with welcome incentive.
• One new Band 6 midwife commenced in post in January.
• Three Band 6 and two Band 5 midwives have conditional offers, awaiting start dates.
• Two International midwives are still awaiting NMC PINs .

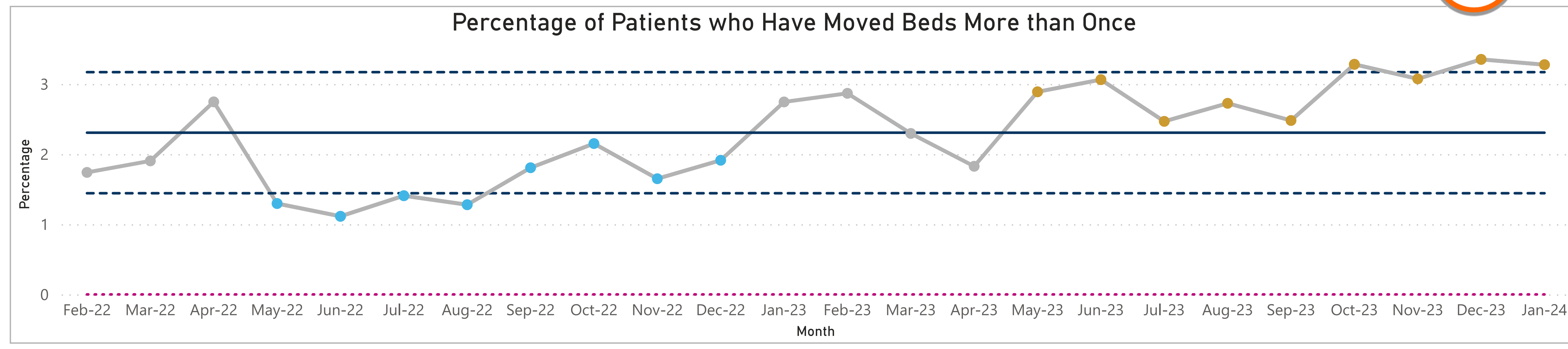
Risks and Mitigations

• Midwifery staffing remains a risk and active recruitment is seeing an ongoing reduction in vacancy rate.
• Escalation policy followed to ensure 1:1 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

Throughout M10 there has been a slight improvement in the percentage of patients moved more than once in comparison to M9. There has been a drive to ensure that patients who have been moved more than once are highlighted to ward leads to prevent any further moves during their journey.

M10 saw sustained pressure on the escalation beds which are being used within the Trust. Day Surgery (DSU) has remained open as escalation during this period, along with the regular use of Interventional Radiology as a bedding down area, which has seen the number of moves remain extremely high. The use of escalation has a correlation of the number of medical patients into the surgical footprint which then helps to generate acute medical capacity but results in an increase in number of moves.

Ongoing work with community partners to increase discharges into the system to ensure that our No Criteria to Reside (NCTR) patients are reducing, which ultimately drives the number of escalation beds and moves per patient, impacting patient experience and their length of stay.

Actions (SMART)

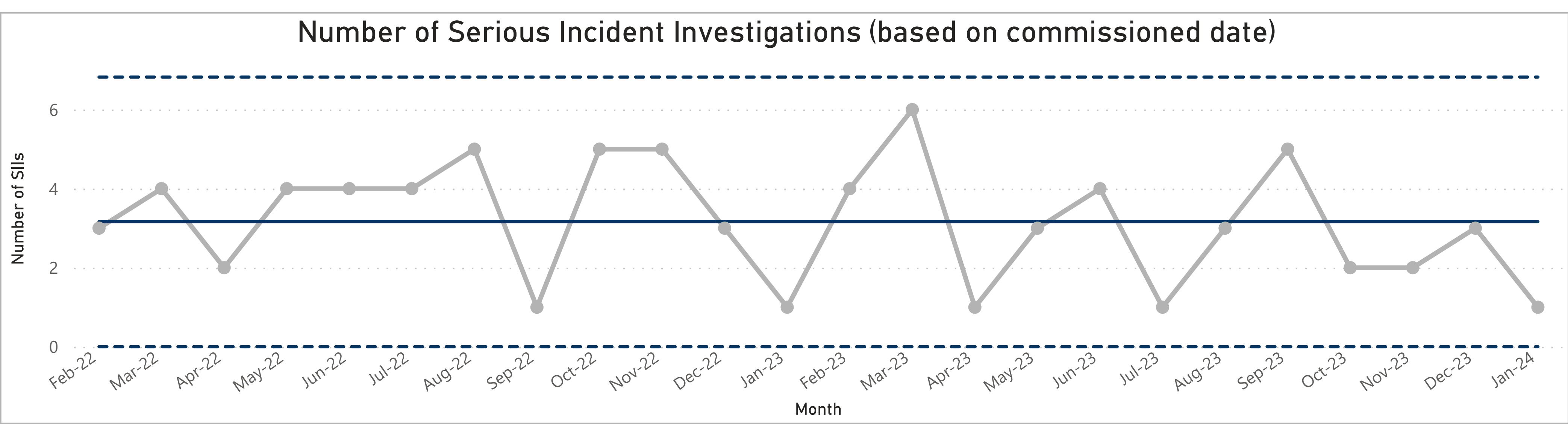
- Ongoing work with the ward leads over the Medical and Surgical divisions and the site team to ensure the information regarding the patient journey is readily available and considered when identifying names to backfill escalation areas.
- Continued discussions with informatics to ensure that the data collection and reporting is an accurate reflection on the percentage of patients moved.
- Close work with the AMU / AFU nursing and medical teams to promote the right patient placement on admission to help prevent multiple moves.

Risks and Mitigations

- Ward leads and Site team trying to mitigate the increase in number of moves per patient through identification and awareness of patient journey and remains the focus of teams.
- Use of escalation areas to reduce ambulance handover delays within our Emergency Department generates an increased risk of moves per patient.
- There are mitigations in place to ensure that each division have a list of appropriate names to move to the escalation areas. This continues to be an area that we need to reduce the number of escalation beds in use.
- Continued focus with system partners to improve onward flow into community services.
- Increased demand for side rooms for IPC measures to prevent outbreaks of infections and not inhibit flow throughout the Trust, resulting in moves from patient that are no longer requiring side room occupancy.

Incidents

Are We Safe?



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

Understanding the performance

One serious incident (SII) commissioned in January:

SII617 - Medication error

Note: Due to a change in the national patient safety policy, as of 8th January, SIIs will cease to be commissioned. This is due to the introduction of the Patient Safety Incident Response Framework (PSIRF) which has been discussed through the Trust Clinical Management Board.

Actions (SMART)

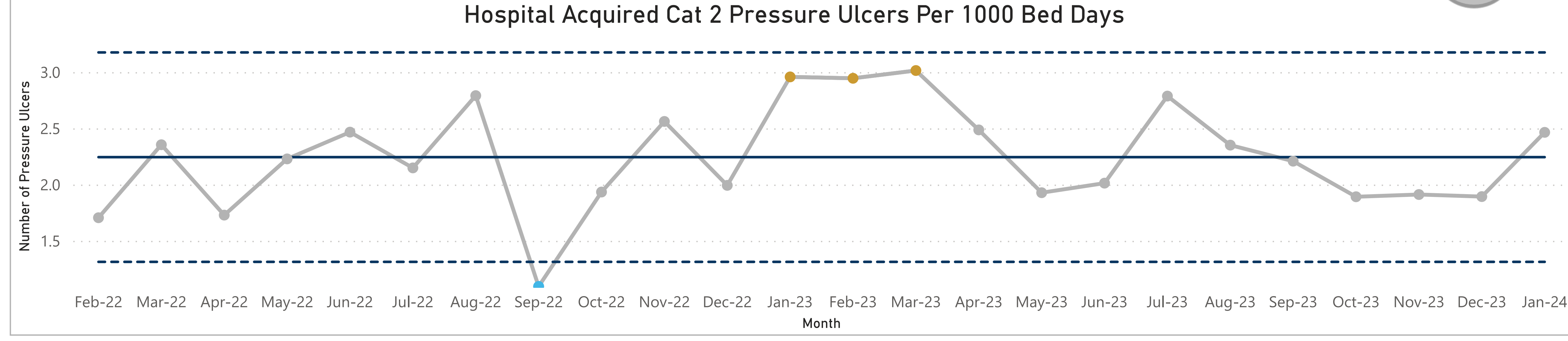
• Investigate SIIs as per Trust policy, with those detailed underway and to continue through the month.
• Establish how new PSIRF process will impact performance reporting.

Risks and Mitigations

• Once an incident has been identified and a 72-hour report completed, it is established whether there are any immediate safety 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 dissemination to relevant staff via area leads.

Pressure Ulcers

Are We Safe?



Understanding the performance

58 Hospital acquired Pressure Ulcers (PUs) in January. This is an increase in numbers from December. There is also a noticeable increase in the number of patients seen with hospital acquired PU injury in January. 48 patients in January compared to the 32 that were seen in December.

- 37 Cat 2 PUs – two of these were device related. This is an increase in numbers of PU2s from December.
- We have seen 16 hospital acquired Deep Tissue Injuries (DTIs) this month which is double the number of wounds seen in December.
- There have been 3 hospital acquired unstageable PUs this month which is an increase from December.
- We have seen 2 hospital acquired PU3s this month, which is an increase from December.
- 0 Hospital acquired PU4s this month.
- The number of PUs between the divisions shows a significate increase in patients seen on the Medical wards, with their number of patients sustaining a pressure injury increasing from 14 patients in December to 31 patients in January.
- Surgical and Clinical Support and Family Services (CSFS) numbers remain the same as December with no significant increase.
- The number of hospital acquired Moisture Associated Skin Damage (MASD) this month remains similar to December.

57 Present on admission PUs In January 2024
34 Present on admission MASD In January 2024.

Actions (SMART)

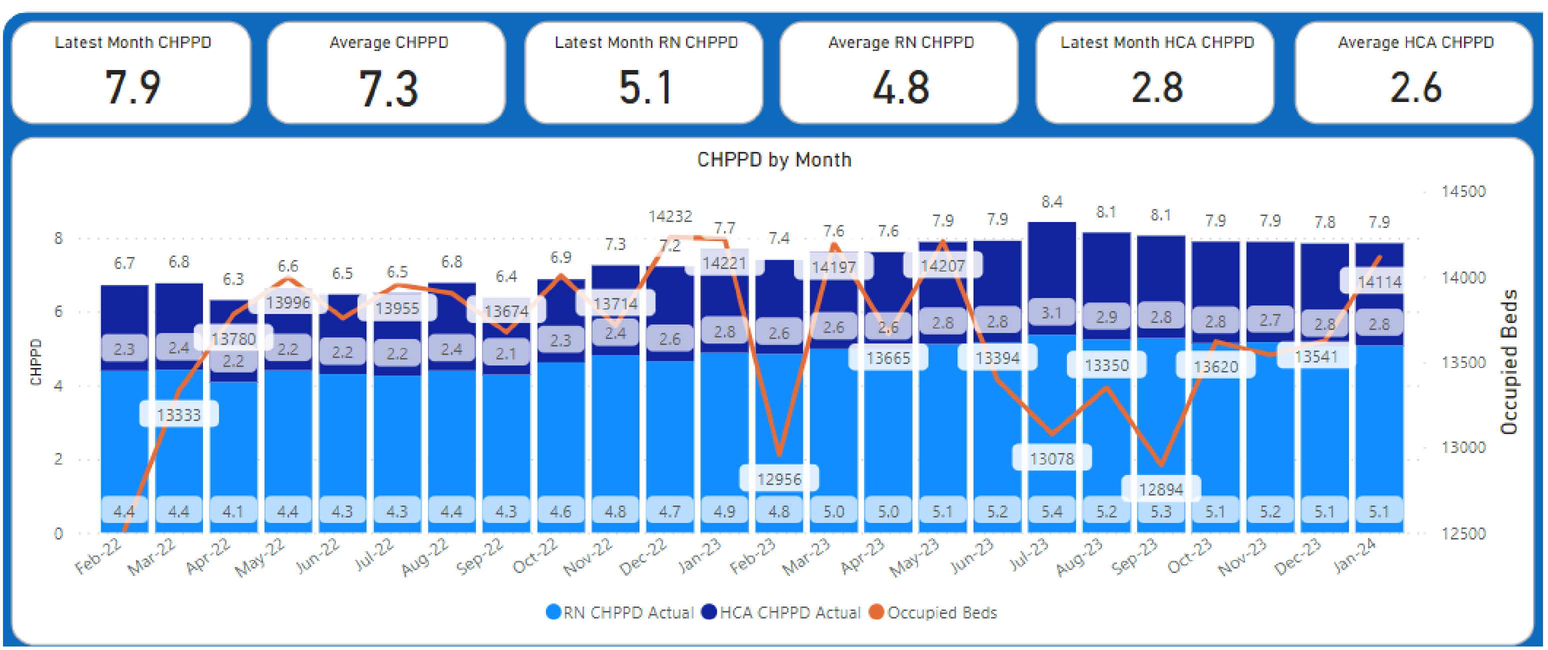
- Tissue Viability (TV) staff have provided ward training for all staff for the new aSSKINg paperwork that will be replacing SKIN bundles, training 168 members of staff.
- The new Repose wedges have all been distributed to the wards and are available for use. 150 members of staff have been trained in how to use these.
- The Repose reps have been providing additional training to all the ward staff for the wedge throughout January.
- The Repose reps have been going around the wards offering training for the new heel up boots that are now available to all wards once training has been completed. 44 staff members across the wards have received training.
- TV staff are continuing to deliver teaching to all new Healthcare Assistant (HCA) members of staff and to the overseas nurses that join us.
- TV staff have rolled out the new aSSKINg PSR 72 hour review to all the wards.
- Work continues with local trusts around pressure ulcer bench marking.
- Continuation of the SEQUIN audit for each ward, which TV will review.
- TV have rolled out a new online pressure ulcer audit tool.
- TV lead has started the national evaluation tool PURPOSE T work.

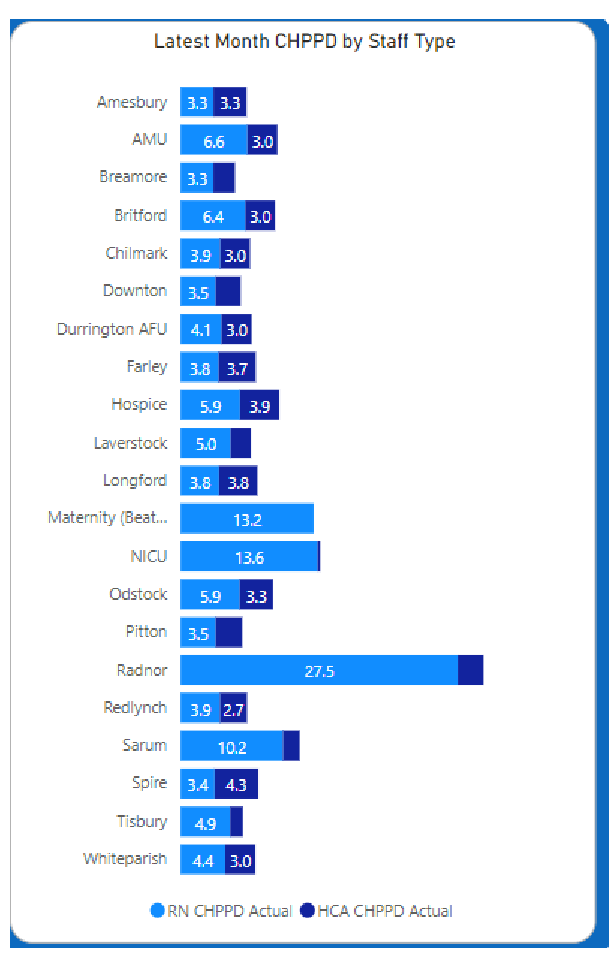
Risks and Mitigations

- TVN are still without a consultant, meaning our consultant led outpatient pressure ulcer clinics are still unavailable this month. This has therefore seen an increase in waiting times for patients in the community to be reviewed for potential surgery.
- The wards that have received the training for the new Repose heel up equipment are awaiting supply of the new boots.
- TV are currently waiting for confirmation of change on the updated version of the new aSSKINg documentation. This needs to be approved before we can roll it out to the wards to replace the old SKIN bundles.

Nurse Staff Fill Rate

Are We Safe?





Understanding the performance

The data presented has switched this month to show CHPPD (Care Hours per Patient Day) which measures the total hours worked by Registered Nurses (RNs) and Healthcare Assistants (HCAs) divided by the average number of patients at midnight, and is nationally reported.

CHPPD of 7.9 in month (slight increase of 0.1) and 7.2 when excluding Critical Care and Maternity. Of note, in month Sarum CHPPD remains high at 10, reflective of number of empty beds in January in Paediatrics.

CHPPD has continued to show steady improvement over time which is reflective of the improvement in staff vacancies.

When comparing nationally we are in the lowest quarter, with a range from 5 - 18 hours.

Actions (SMART)

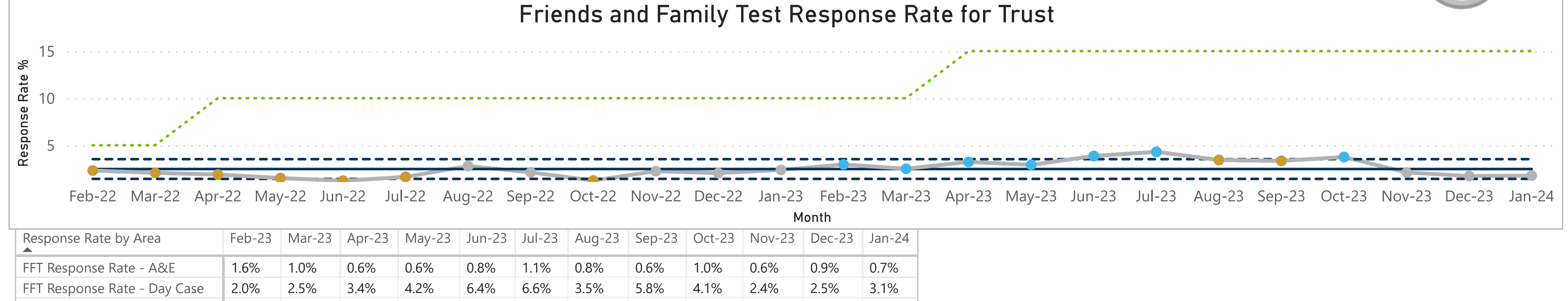
• Safer Nursing Care Tool (SNCT) completed in 6 wards in November - dashboards being created, rollout of training to remaining wards.
Ward assistant project - KPIs from matrons awaited (data being collated).
• IEN Recruitment - work undertaken to improve pass rate now showing much higher success rate of first time passes.
• Business cases for RNDA, Nurse associate to RN business cases approved in principle but being taken to system financial recovery group - remains with executive team to update.
• 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 - continue to await outcome being chased by region. Training hub temporarily set up.
• Weekly forward review of staffing meeting implemented and Safe Staffing SOP being updated in line with partner organisations.

Risks and Mitigations

• Ongoing turnover for HCAs and RNs exceeds starters (risk).
• Increase demand for patients requiring Mental Health Nurse (RMN) support (risk).
• Additional beds utilised which are reliant on temporary workforce and not in establishment - increased risk in winter months (risk).
• Increased demand for additional nursing in ED to provide corridor nurse for ED - additional 5.5 WTE per week (risk).
• Increased demand for nursing due to high numbers of escalation bed areas open means that there has been increase in bank and agency expenditure (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	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
FFT Response Rate - A&E	1.6%	1.0%	0.6%	0.6%	0.8%	1.1%	0.8%	0.6%	1.0%	0.6%	0.9%	0.7%
FFT Response Rate - Day Case	2.0%	2.5%	3.4%	4.2%	6.4%	6.6%	3.5%	5.8%	4.1%	2.4%	2.5%	3.1%
FFT Response Rate - Inpatient	13.0%	3.2%	14.5%	12.9%	17.1%	28.4%	20.5%	33.7%	24.0%	17.2%	10.2%	19.1%
FFT Response Rate - Maternity	3.7%	1.4%	0.0%	0.5%	0.0%	0.0%	0.9%	1.0%	2.9%	0.9%	0.5%	3.8%
FFT Response Rate - Outpatient	2.2%	2.1%	2.5%	2.3%	2.6%	2.2%	2.2%	2.1%	2.3%	1.3%	1.1%	0.9%

Understanding the performance

January saw a static response rate of 1.77%. 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)

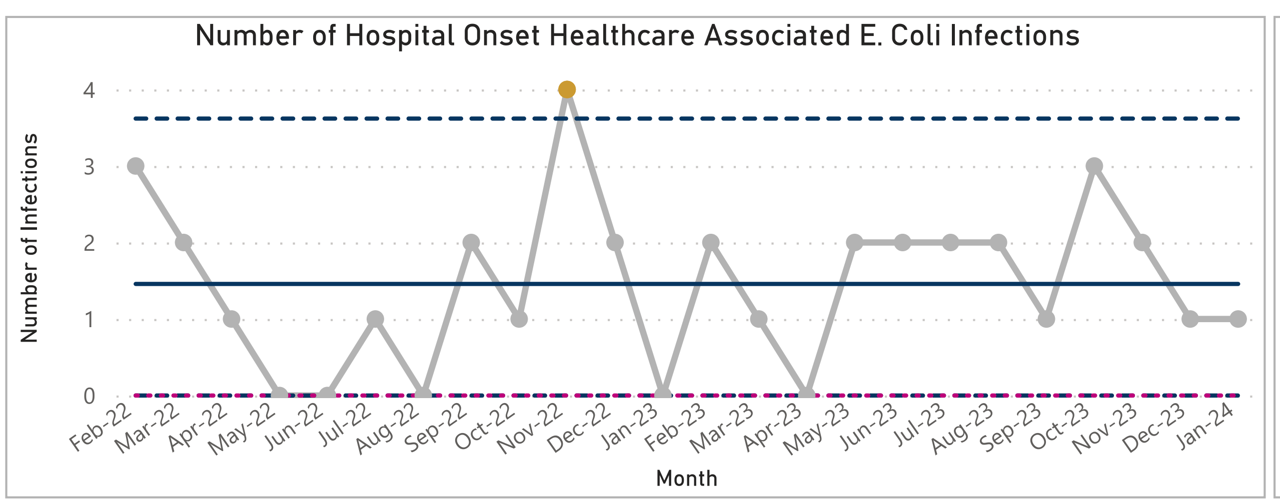
• Delay in the rollout of digital provider was taken in November 2022, postponing this until early 2024. This solution would facilitate an SMS option in a bid to increase responses rates, particularly in Outpatient areas and ED. It would also meet accessibility requirements with a new online form and 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.
• 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.

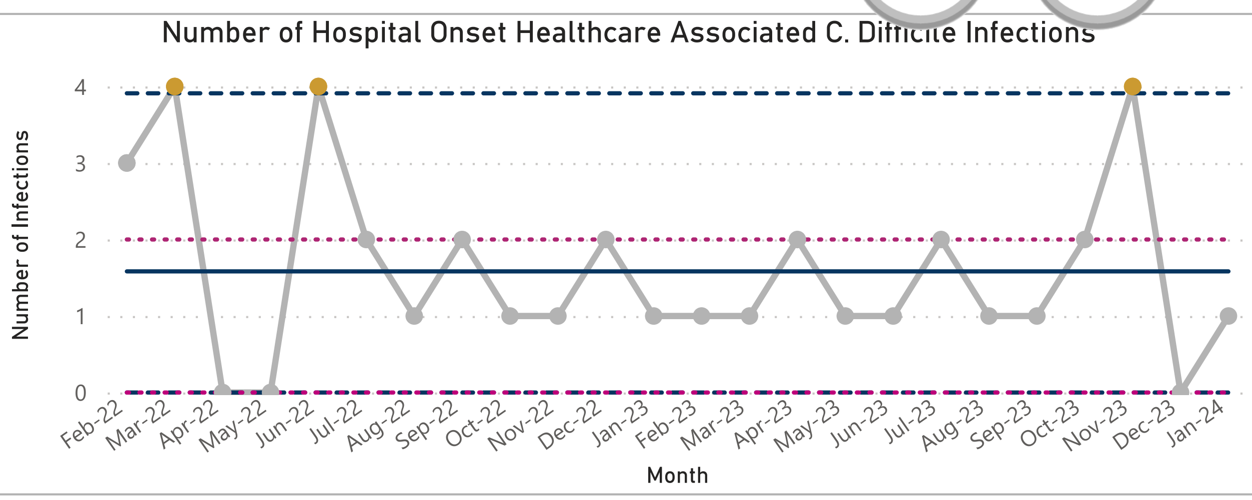
Risks and Mitigations

• 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 comments 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 soon, we then plan to introduce this reporting within the Patient Experience Reporting.
• Response rates have started to increase again this month. Manual entering of data 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 one hospital onset healthcare associated reportable E.coli bacteraemia infection, and one hospital onset healthcare associated reportable C.difficile case this month. There have been no hospital onset healthcare associated MSSA bacteraemia infections this month.

Three of the previously reported periods of increased incidence (PII) of C.difficile declared during quarter 3 of 2023/24 for Pembroke, Spire and Pitton Wards were declared over by the Infection Prevention & Control Working Group (IPCWG).

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	6
MRSA Bacteraemia Infections: Hospital Onset	0	0	0

Actions (SMART)

- 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 for quarterly reporting, with delays in receiving feedback.
- Involvement with the newly formed BSW ICS HCAI and IP&M collaborative workstream. Feedback from the sessions will be shared at the SFT IPCWG as part of a standing agenda item. SFT representation was planned at a BSW IPC meeting in January to review Klebsiella bacteraemia cases, however this meeting was cancelled (revised date not yet arranged).

Risks and Mitigations

- No progress reported by the Medical division for roll out of alternative hand hygiene assessment method.
- New Band 6 nurse continues to require intensive support progressing through their orientation programme.
- Increased 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	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	Nov-23	Dec-23	Jan-24
Crude Mortality	84	84	88	84	77	88	82	73	75	77	102	106	88	95	81	89	51	60	78	55	79	80	95	93
HSMR District Hospital (excludes deaths recorded by Salisbury Hospice)	102.37	104.12	108.04	109.81	110.84	112.65	114.18	113.71	115.72	116.02	115.68	116.20	115.67	117.48	116.69	116.92	114.56	110.51	108.67					
HSMR Trust	108.89	110.50	113.70	114.89	116.37	117.91	119.69	119.20	121.56	121.91	122.25	123.37	123.02	124.29	124.43	125.41	122.56	118.87	117.15					
SHMI District Hospital (excludes deaths recorded by Salisbury Hospice)	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	107.89	107.66	107.22					
SHMI Trust	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	113.48	112.83	112.56					

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 national Summary Hospital-level Mortality Indicator (SHMI) for the 12 month rolling period ending in August 2023 for Salisbury District Hospital is 107.22.

The national Hospital Standardised Mortality Ratio (HSMR) for the 12 month rolling period ending in August 2023 for Salisbury District Hospital is 108.67.

Actions (SMART)

- A mortality insight visit took place on 5th December 2023 at the request of the Trust Board due to concerns about SFT being a statistical outlier for their reported mortality statistics (SHMI / HSMR). The Trust formally received written feedback from this visit on 2nd February 2024, and this included some positive feedback and also areas for further development and learning. A proposed list of assigned actions have been developed and these will be discussed at the Trust's Mortality Surveillance Group in February.

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	95	112	94		0		Special Cause Improving - Run Below Mean	✗	34
Cancer 2 Week Wait Performance	70.0%	56.3%	48.9%		93%		Special Cause Concerning - Below Lower Control Limit	✗	34
Cancer Patients waiting > 62 days	119	87	158	90			Special Cause Concerning - Above Upper Control Limit	✗	1
Complaints Closed within agreed timescale %	35.0%	41.0%	48.0%	90.0%				✗	34
ED 12 Hour Breaches (Arrival to Departure)	52	40	42		0		Special Cause Improving - Run Below Mean	✗	34
ED Attendances	6323	6574	6549				Special Cause Concerning - Run Above Mean		
Inpatients Undergoing VTE Risk Assessment within 24hrs %	32.8%	30.6%	26.6%		95%			✗	34
Mixed Sex Accommodation Breaches	29	10	20	0	0		Special Cause Improving - Run Below Mean	✗	17
Number of High Harm Falls in Hospital	3	6	6	0	0		Common Cause Variation	✗	17
Pressure Ulcers Hospital Acquired Cat 3	0	0	2				Special Cause Concerning - Above Upper Control Limit		
RTT Incomplete Pathways: Total 52 week waits	1155	1022	919	735	0		Special Cause Concerning - Run Above Mean	✗	13
RTT Incomplete Pathways: Total 65 week waits	258	255	195	45	0		Special Cause Concerning - Run Above Mean	✗	5
RTT Incomplete Pathways: Total 78 week waits	33	33	21	0	0		Special Cause Improving - Run Below Mean	✗	6
Total Incidents Resulting in High Harm (Mod/Maj/Cat) %	3.4%	3.2%	5.8%				Special Cause Concerning - Above Upper Control Limit		

Watch Metrics: Alerting Narrative

Quality of Care, Access and Outcomes

Understanding the performance

A number of watch metrics are alerting this month in response to positive change – ambulance handovers over 60 minutes, the number of patients spending over 12 hours in the Emergency Department (ED), the number of patients waiting over 78 weeks for elective treatment and mixed sex breaches continue to show an improving trend. The focused work in ED to implement the Rapid Triage (RATT) trial continues to show improved ambulance handover times. The number of attendances to ED are trending above the mean, which further highlights the impact of the improvement work the department are sustained despite an increased level of attendances.

Watch metrics in relation to Cancer 2 Week Wait and the number of patients waiting over 62 days for Cancer treatment remain alerting, the top contributors for this are challenges in the Skin and Lower GI pathways which is affecting all the reported milestones along the pathway.

Progress was made against reducing the longest waiting patients for elective treatment, with a reduction to 21. Reductions were also seen in the 65 and 52 weeks groups, although these remain behind plan, with the ongoing Industrial Action (IA) and the disruption to elective services the biggest contributor to this.

Actions (SMART)

• Focused work continues on the Cancer pathway with an improvement trajectory in place, with performance expected to return to plan levels by the end of the March 2024. Improvement is evident against the 28-day and 62-day standards, with the 2 Week Wait and over 62-day expected to improve in M10 (Cancer data in this report is one month behind due to reporting timeframes, latest data is this report is M9). Skin and Lower GI continue to be the biggest contributors, an insourcing arrangement has been mobilised for Skin to provide minor ops capacity in M10. Lower GI has an increasing workforce in terms of nursing and medical support from M10 with improvement also expected in M10.

• Weekly monitoring of longest elective waits has been implemented with the introduction of an Access meeting and new performance management framework. The expectation from NHS England is that all waits over 65 weeks are eliminated by the end of March 2024, and the Trust has made good progress against this despite activity lost during IA, but there remains a risk that a small number of patients will remain waiting over 65 weeks beyond March.

Risks and Mitigations

• Risk of ongoing IA and impact on elective activity. Weekly Access Meeting now in place with performance team and operational managers to review waiting list and drive towards national reduction targets. Staffing pressures exist across a number of specialities which present potential individual speciality pressure into next financial year. Patients to continue to be booked in line with NHSE recommendations, with weekly validation of long waiting patients.
• Flow out of ED continues to impact 4-hour and 12-hour standards with high bed occupancy levels across the Trust. Improving Together A3 creation under way to explore reasons for delayed moves out of ED.

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	79	74	88	113			Special Cause Improving - Run Below Mean	✓	0
Diagnostics Activity	7438	6757	7978	7046			Common Cause Variation	✓	0
Neonatal Deaths Per 1000 Live Births	0	0	0		0		Special Cause Improving - Run Below Mean	✓	0
Pressure Ulcers Hospital Acquired Cat 2	27	27	37				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 4	2	0	0				Common Cause Variation		
Proportion of patients spending more than 12 hours in an emergency department	1.2%	0.9%	0.9%				Special Cause Improving - Run Below Mean		
Serious Incident Investigations	2	3	1				Common Cause Variation		
Stillbirths Per 1000 Total Births	11	11	0				Common Cause Variation		
Stroke patients receiving a CT scan within one hour of arrival	57.0%	66.0%	56.0%		50%		Special Cause Improving - Run Above Mean	✓	0
Total Incidents (All Grading) per 1000 Bed Days	64	52	57				Common Cause Variation		
Total Number of Complaints Received	22	7	14				Common Cause Variation		
Total Number of Compliments Received	66	34	43				Common Cause Variation		

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

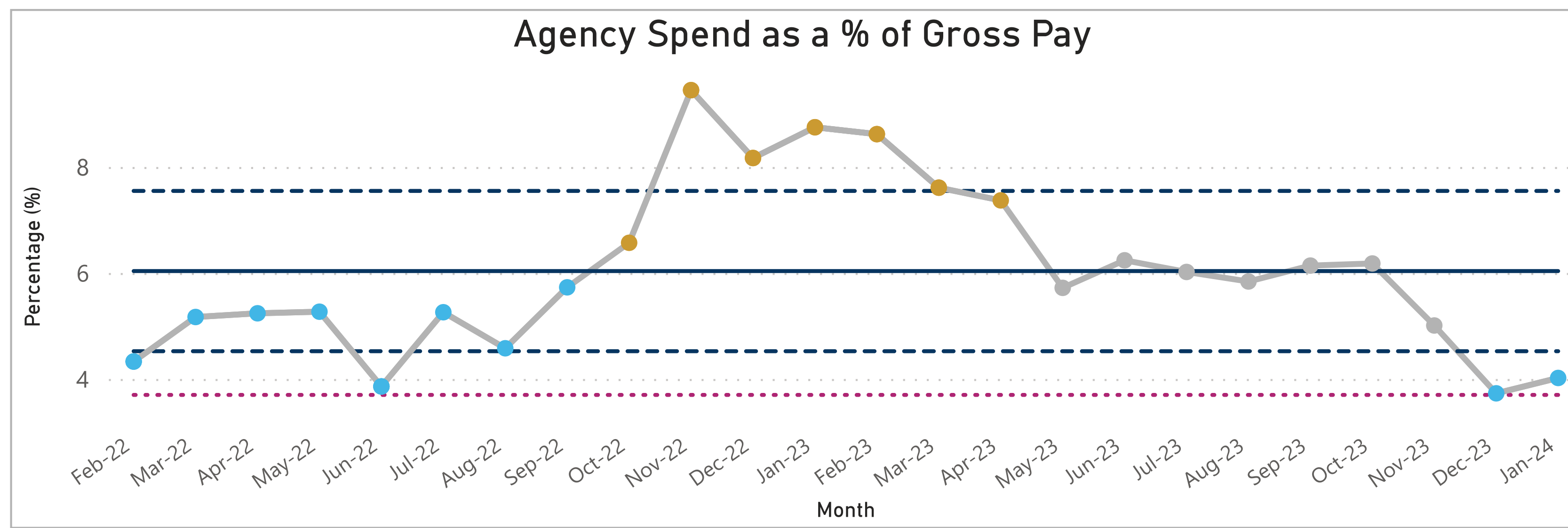
Population

Partnerships

People

Staffing Availability

Target 3.7%



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 is measured at 4.02% of total spend this month, a slight rise against last month's year low of 3.73%. This represents a spend of £641K, noting that the corporate area accrued £44K of agency spend refund against previous expenditure. Given the impact of post-Christmas leave, seasonal illness and strike action at the start of January, this represents a solid performance and compares well with Jan 23 which saw a spend of c£1.56M representing 7.3 % of total pay.

Nursing spend rose to £374K from £317K, proportionally 54% of total agency cost. Medical spend was £193K a reduction of £29K this month and the lowest level this financial year, helped by the recruitment of substantive staff to replace locums.

Theatres remained the highest spending speciality this month at £84K, an in-month reduction of £38K.

Actions (SMART)

- Temp Staffing Grip and Control. Grip and control of Temp staffing appears to be influencing temporary spend, despite moving into the winter period, cost has reduced. Further work is being developed to manage medical spend and to align agency rates across the region.
- Bank Staff recruitment campaign to improve Nurse and HCA staff bank numbers remains live.
- Temp Staffing Preferred Supplier List (PSL) Contract. The new PSL contract and DE contracts go live on 5th February. This should provide further opportunity to control off framework and above cap agency spend.

Risks and Mitigations

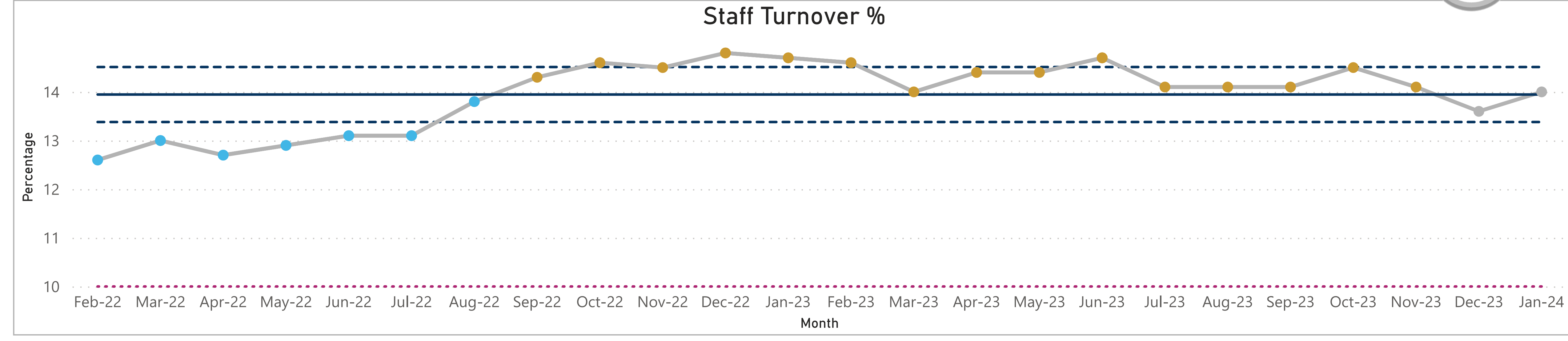
Corporate Risk – Sustainable Workforce.

- 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.
- Establishment Control project timelines are tight and require detailed engagement from DMT, Finance BP and Human Resources BP.

Workforce - Turnover

Target 10%

People



Understanding the performance

Turnover has risen slightly this month to 13.95%, returning to the mean over the last 16 month period. Staff numbers increased this month by 45.87 FTE overall, which will impact the 12 month rolling average for turnover in future months. 39.08 (FTE) staff left the Trust in January.

All Divisions remain above the Trust target of 10%, with Women & New-Born the worst performing, although it is noted that their turnover has reduced by a further 1.5% this month to 15.34%. Across the various staff groups, Nursing stabilised close to target at 10.4%, and additional clinical services remain the highest area of turnover at 21.69%.

46 individuals left the Trust in Jan 24 of which 9 left to another role in the NHS. Of the 46 leavers, 13 left for positive reasons, 9 did not state a reason and the remaining 24 left for negative reasons including work/life balance, re-location lack of opportunities and health.

Actions (SMART)

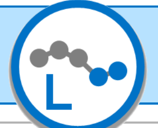
- The Action plan to address issues identified in WRES/WDES and Gender Pay Gap reports is being developed. This will include looking at areas to improve performance at interview and improve the upwards trends against reporting of incidences of bullying harassment and discrimination for those staff with protected characteristics.
- 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. Specific actions against the Additional Clinical Services cohort are being developed
- Wellbeing survey data is being analysed and actions will be discussed at the next Health and Wellbeing Committee in December.

Risks and Mitigations

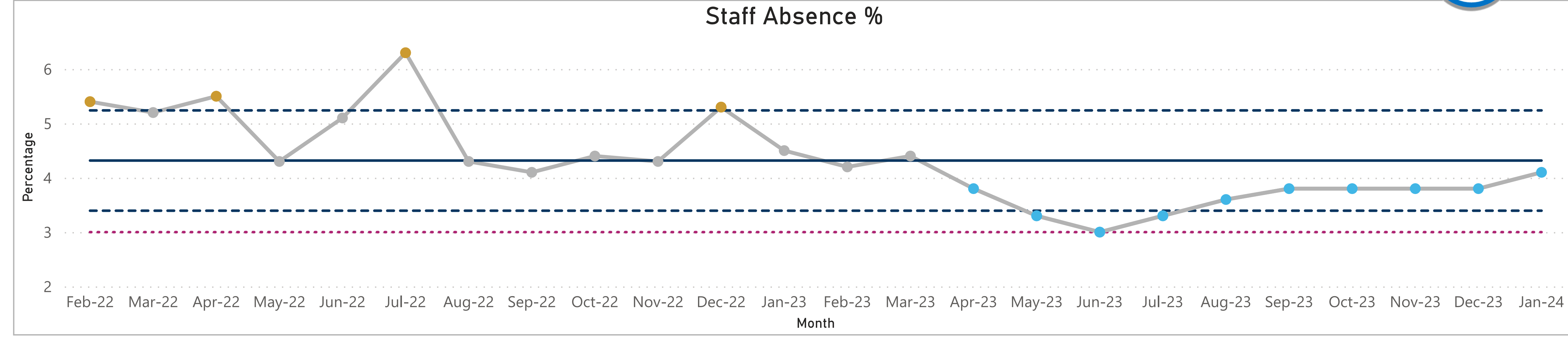
Corporate Risk – Sustainable Workforce.

- 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



People



Understanding the performance

Sickness absence has risen to 4.1%, above the 4% mark for the first time in since Mar 23. It remains below the Jan 23 level of 4.5%. The key contributor to this rise has been a jump in gastro-intestinal illnesses, and an increase in anxiety and stress conditions. A positive story is a reduction by 25% of days lost to back problems.

No division has hit the 3% target, although Clinical Support and Family Services (CSFS) are at 3.29%. Women and New-Born (W&NB) and Estates remains the worst performing groups at 6.18% and 5.11% respectively. Additional clinical services (5.88%) remain the staff group with the highest absence rates, some 5.5% higher than the best performing staff group, Allied Health Practitioners (AHPs).

Sickness accounted for 5,040 FTE days lost to the Trust, of which 3,211 were for short term absence. Long term absence has jumped by 25% this month to 1,829 lost days.

Actions (SMART)

- Absence Management: A second round of staff briefings is underway to explain the implementation and policy relating to reasonable adjustments, aimed at getting staff with long term sickness back to work.
- The first data triangulation working group met in Jan 24, seeking to bring together various data sources to identify hotspots, which will trigger action plans to support managers improve retention.
- 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.

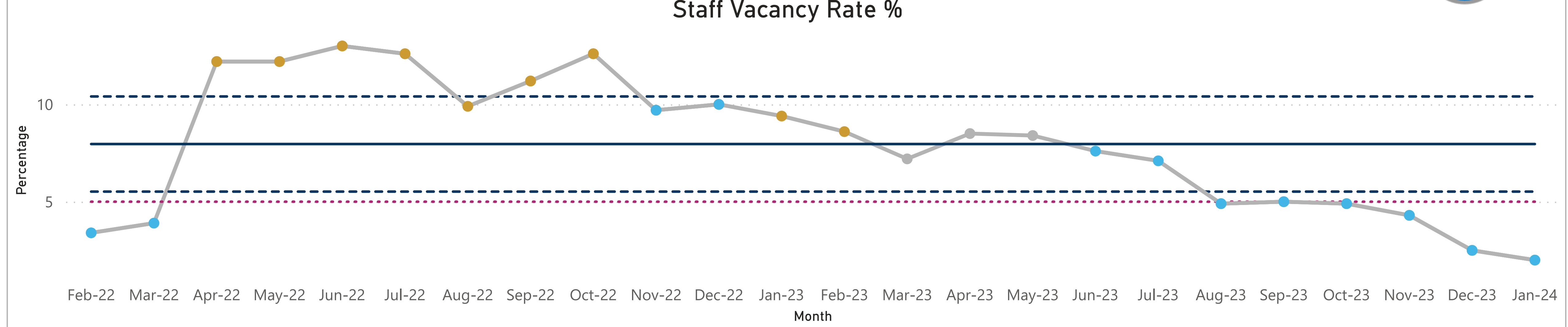
Risks and Mitigations

Corporate Risk – 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%



Understanding the performance

Trust wide vacancy rates continue to drop well below the vacancy target of 5% to 2%. There are 80 identified vacancies against the Trust establishment of 4007 funded FTE.

Vacancy numbers continue to fall across all staff groups, less Infrastructure Staff which rose to 72 this month.

Theatres remain the service with the highest vacancies, predominately within Nursing staff, and there are campaigns in place to continue to close this gap.

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 campaign has also been launched to attract consultant staff in hard to recruit posts.

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 %	86.5%	86.6%	86.2%	90.0%	85%		Special Cause Concerning - Two Out of Three Low	✗	12
Medical Appraisal Rate %	85.9%	86.7%	86.5%	90.0%			Common Cause Variation	✗	5
Non-Medical Appraisal Rate %	75.1%	78.0%	80.3%	86.0%			Special Cause Improving - Above Upper Control Limit	✗	34

Watch Metrics: Alerting Narrative

People

Understanding the performance

Mandatory training activity remains above national target at 86.2%, but below the Trust improvement target of 90%. Facilities continue to be the standard bearer in this area at 96% completion and Quality meet the 90% improvement target. CSFS slipped to 89% this month. Corporate and Women and New-Born remain below the national 85% target.

Medical appraisal rates measure 86.5% this month. 47 medical appraisals are showing as out of date for greater than 3 months.

Non-Medical appraisals rose for the 5th month in a row to 80.3%, as close to the improvement target as figures show for the last 21 months. Further efforts to embed this good practice are essential to ensure that the rate continues to improve against those more difficult areas – medicine, corporate and surgery all sit below the 85% compliance rate.

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.
• Non-Medical Appraisals: Instructions on how to record appraisals on ESR have been published and training offered to line managers to support data capture. The ESR support team remain available to support line managers with uploading appraisal data into ESR. Monthly reconciliation of appraisals with line managers by business partners is also having a positive effect.

Risks and Mitigations

Corporate Risk - Sustainable Workforce.
Corporate Risk – MLE accuracy.
• Ongoing work to identify and establish accuracy within compliance rates on the Trust MLE system.
• 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

Our Priorities

Population

Partnerships

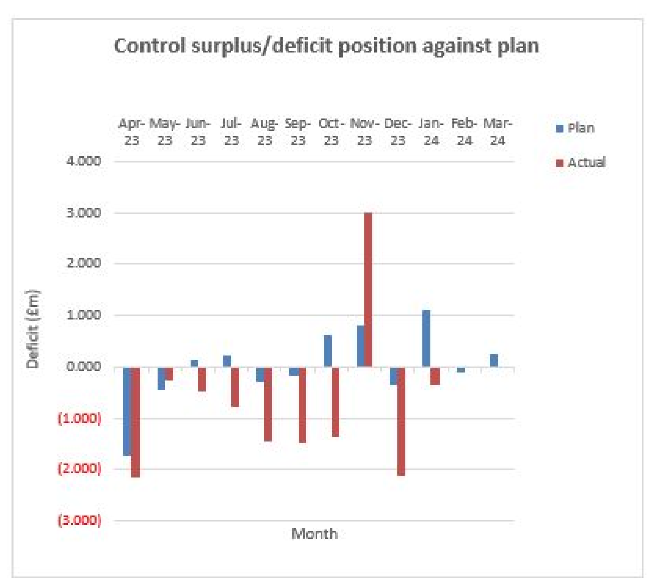
People

Income and Expenditure

Income & Expenditure:

Finance and Use of Resources

	January '24 In Month			January '24 YTD			23-24
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	23,862	25,267	1,405	244,947	253,898	8,951	275,490
Other Clinical Income	550	1,450	900	7,877	12,721	4,844	9,478
Other Income (excl Donations)	5,439	1,423	(4,016)	34,240	32,735	(1,505)	59,621
Total income	**29,851**	**28,140**	**(1,711)**	**287,064**	**299,354**	**12,291**	**344,589**
Operating Expenditure							
Pay	(17,580)	(19,438)	(1,858)	(177,492)	(194,794)	(17,303)	(212,809)
Non Pay	(9,564)	(7,352)	2,212	(93,831)	(95,137)	(1,306)	(112,722)
Total Expenditure	**(27,144)**	**(26,790)**	**354**	**(271,323)**	**(289,932)**	**(18,609)**	**(325,531)**
EBITDA	**2,707**	**1,351**	**(1,356)**	**15,741**	**9,423**	**(6,318)**	**19,058**
Financing Costs (incl Depreciation)	(1,587)	(1,709)	(122)	(15,879)	(16,877)	(998)	(19,058)
NHSE Control Total	**1,120**	**(358)**	**(1,478)**	**(138)**	**(7,454)**	**(7,316)**	**0**



Understanding the performance

The financial plan submitted to NHS England on 4th May shows a breakeven control total position for the year. This has been revised to £6.3m following the Month 9 forecast and H2 submission on 22nd November 2023.

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 10 the Trust recorded a control total deficit of £2.1m against a target of £0.3m - an adverse variance of £1.8m. The year to date position of £7.5m deficit is driven by supernumerary cover for new and overseas staff, the residual gap on pay awards, impact of Industrial Action (IA) and staff unavailability.

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 31% non recurrent delivery and signals a risk if further recurrent efficiencies cannot be identified. Actions are ongoing to identify additional schemes.

Income & Activity Delivered by Point of Delivery

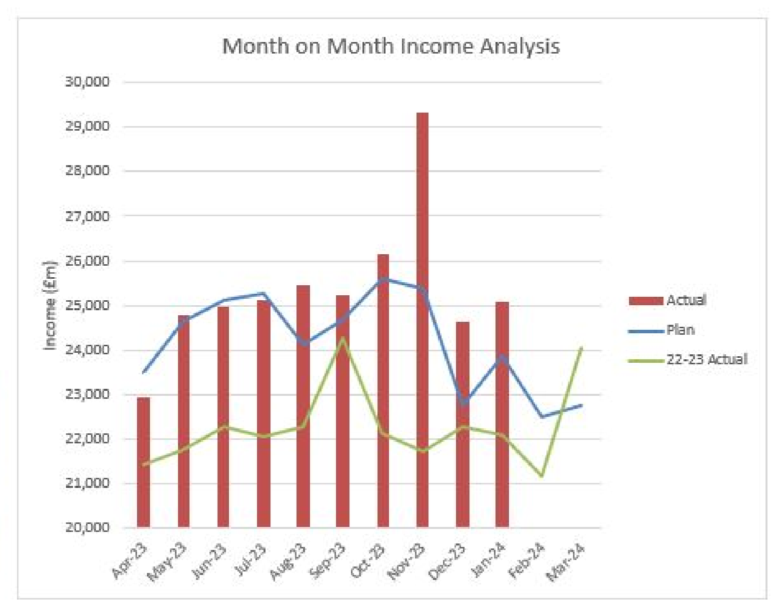
Clinical Income:

Finance and Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Jan Year to Date (YTD) Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	8,956	9,872	916
Day Case	18,583	17,842	(741)
Elective inpatients	11,832	12,126	294
Excluded Drugs & Devices (inc Lucentis)	20,117	22,561	2,444
Non Elective inpatients	66,160	63,300	(2,860)
Other	88,760	94,125	5,365
Outpatients	30,539	33,885	3,346
TOTAL	244,947	253,711	8,764

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	149,809	157,474	7,665
Dorset ICB	24,541	24,734	193
Hampshire, Southampton & IOW ICB	21,026	20,871	(155)
Specialist Services	33,753	35,484	1,731
Other	15,818	15,148	(670)
TOTAL	244,947	253,711	8,764

	Activity YTD Plan	Actuals	Variance	Activity Last Year Actuals	Variance last year
A&E	61,785	61,991	206	61,082	909
Day case	19,765	19,991	226	18,513	1,478
Elective	2,728	2,671	(57)	2,749	(78)
Non Elective	23,047	23,472	425	22,237	1,235
Outpatients	210,838	230,650	19,812	211,292	19,358



Understanding the performance

The Clinical income position is above plan year to date due to BSW ICB overperformance which includes Industrial action funding, funding for the financing charges of nationally funded capital schemes and overperformance on Outpatient first attendances and procedures, Elective Inpatients, Advice and Guidance and Radiology. Specialist services overperformance on High cost drugs and devices and Chemotherapy activity. This is offset by underperformance on the Dorset and Hampshire ICB contracts and other NHS England contracts.

The level of uncoded day cases and inpatient spells is 25% in December and 94% in January at the time the activity was taken for reporting purposes which is an improvement on the prior month but a deterioration on the January position by 2%. November's activity was fully coded at the SUS submission.

Activity was higher in January than December across all the main points of delivery with the exception of Non Elective activity.

Actions (SMART)

• The contracts with ICBs and NHS England remain under negotiation at this stage with both contracts expected to be signed in February.

Risks and Mitigations

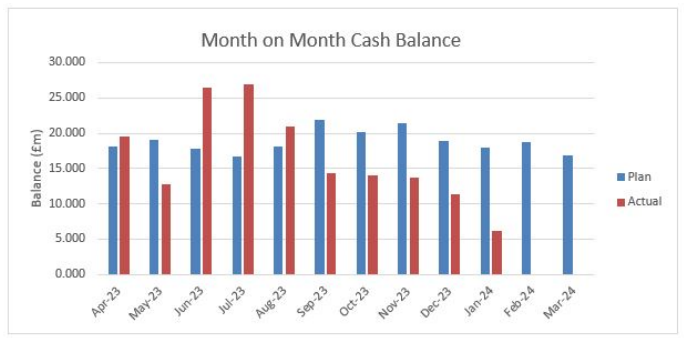
• The impact of industrial action has constrained the elective programme and management capacity to improve productivity. Industrial action is now expected from 24-29 February. • All commissioner contracts, excluding BSW ICB, now require 99% of 2019/20 Elective activity levels.
• The Trust is seeking to mitigate the impact by maximising activity recording opportunities and via contract negotiations.

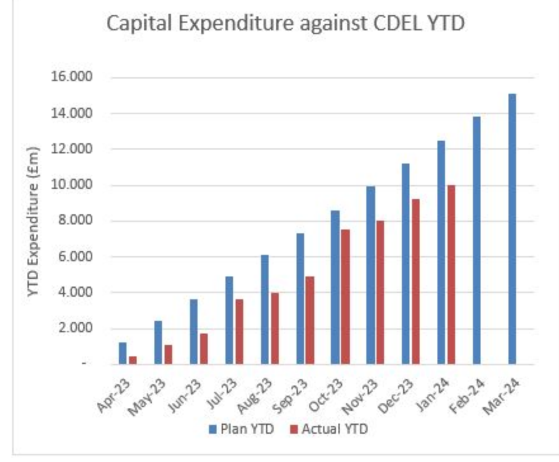
Cash Position & Capital Programme

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	8,790	836
Debtors	24,999	26,192	1,193
Cash	28,891	6,168	(22,723)
TOTAL CURRENT ASSETS	**61,844**	**41,150**	**(20,694)**
Creditors	(58,026)	(45,484)	12,542
Borrowings	(641)	(632)	9
Provisions	(474)	(458)	16
TOTAL CURRENT LIABILITIES	**(59,141)**	**(46,574)**	**12,567**
TOTAL WORKING CAPITAL	**2,703**	**(5,424)**	**(8,127)**





Schemes	Annual Plan £000s	January '24 YTD Plan £000s	January '24 YTD Actual £000s	January '24 YTD Variance £000s
CDEL Schemes				
Building schemes CIR	2,785	2,323	1,593	730
Building projects	6,201	5,173	3,804	1,369
IM&T	3,432	2,771	2,109	662
Medical Equipment	2,698	2,251	1,056	1,195
Total CDEL schemes	**15,116**	**12,518**	**8,562**	**3,956**
National Funding				
New Elective Ward TIF	11,952	7,394	7,394	0
Salix Decarbonisation	10,005	5,858	5,858	0
Shared EPR - national element	3,760	0	0	0
Digital Pathology	1,053	753	753	0
Pathology LIMS	310	88	88	0
SW Imaging (ATVS)	174	2	2	0
Cyber Improvement	16	16	16	
Total National Funding	**27,254**	**14,095**	**14,111**	**0**
Great Western Hospitals transaction				
Medical Equipment - Surgical robot			**1,431**	**(1,431)**
GRAND TOTAL	**42,370**	**26,613**	**24,104**	**2,525**

Payables age profile	Total Payables £'000	0-30 days £'000	31-60 days £'000	61-90 days £'000	90+ days £'000
Jan-24	**8,523**	7,017	849	190	467
Dec-23	**8,680**	7,562	478	197	442
Nov-23	**10,204**	8,882	224	542	556
Movement vs prev mth	*(156)*	*(545)*	*371*	*(8)*	*25*

Understanding the performance

In month 10 there has been Capital expenditure of £0.8m CDEL and £2.4m on the Salix project.

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. Slippage on BIG projects in year has resulted in MDMC projects being brought forward to 2023/24.

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.
Cash reserves are now c£12m below plan following the reductions in creditors, increases in debtors and the year to date deficit of c£7m.

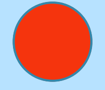
Actions (SMART)

• The Trust will be actively seeking opportunities for additional capital funds and mitigating any slippage as this arises. • 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.
• NHS England has confirmed that revenue support of £4.3m will be provided in March. This is on the basis that the Trust will maintain the NHSE approved minimum cash balance of £1.1m for the remainder of 2023/24.

Risks and Mitigations

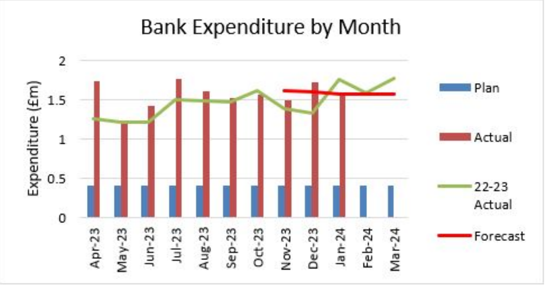
• Additional capital pressures are emerging in year and such risks will have to be managed within the overall capital envelope if additional funding cannot be secured. • The Trust received confirmation of the BSW ICB Capital leases allocation of £6.1m on 30/11/23 against a plan of £12.5m. SFT had anticipated £5m for 2023/24. The Trust has submitted a request against a provider contingency allocation for Capital leases funding to purchase C-arm equipment and Anaesthetic machines on a leased basis.
• The constraint of both available cash and system capital expenditure limits gives rise to both a mid and long term risk to the Trust.
• The context of digital modernisation programmes, along with an aging estate and medical equipment means the Trust's five year capital requirement is well in excess of available resources. The Trust seeks to in part mitigate this risk through the proactive bidding for national funds where available. • Supply chain disruption and inflationary pressures remain a significant draw of time on the procurement team. This gives rise to a risk in both lead times and overall procurement capacity.

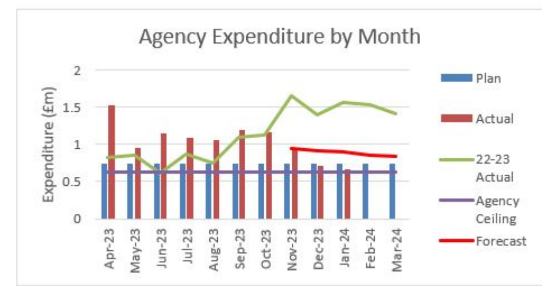
Workforce and Agency Spend

Pay: 

Finance and Use of Resources

Total Pay against Plan





	January '24 YTD Plan £000s	Actual £000s	Variance £000s
Pay - In Post	165,601	167,997	(2,396)
Pay - Bank	4,247	15,629	(11,382)
Pay - Agency	7,644	10,471	(2,828)
Other (eg apprenticeship levy)		696	(696)
TOTAL	**177,492**	**194,794**	**(17,303)**
Medical Staff	46,661	51,744	(5,083)
Nursing	46,475	51,996	(5,521)
Support to Nursing	12,710	17,709	(4,999)
Other Clinical Staff	25,139	25,628	(489)
Infrastructure staff	46,508	47,022	(514)
Other (eg apprenticeship levy)		696	(696)
TOTAL	**177,492**	**194,794**	**(17,303)**

	January '24 YTD Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	459.4	533.07	(73.7)
Nursing	1,149.9	1,214.35	(64.5)
Support to Nursing	521.4	635.36	(114.0)
Other Clinical Staff	642.9	635.20	7.7
Infrastructure staff	1,497.1	1,440.40	56.7
TOTAL	**4,270.7**	**4,458.4**	**(187.7)**

Understanding the performance

Month 10 costs reduced by £0.1m in month with an adverse variance to plan in month of £1.9m and £17.3m YTD. There was an increase in Substantive costs offset by reductions in Bank and Agency costs in month.

The pay position includes the cumulative pay savings target at month 10 of £6.9m of which £4.5m has been delivered to date.
Staff unavailability reduced by 33 WTE in January with a reduction of 90 WTE linked to Bank holidays, but sickness increased by 20 WTE and study leave increased by 36 WTE.

Substantive vacancies across the Trust have remained at 2% in January with the highest proportion of vacancies remaining within the Consultant, Nursing and midwifery and NHS Infrastructure groups. The unfilled rate increased to 2% in January, 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 (IA) 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	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 28 Day Faster Diagnosis Standard	Cancer Services	Lisa Thomas	High
Narrative	Cancer 31 Day Performance Overall	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 Handovers 60+ mins	SWAST AR119 report	Lisa Thomas	High
Watch	Average Patients with No Criteria to Reside	e-whiteboards via Trust Data Warehouse	Lisa Thomas	Medium
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 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

Data Sources: Watch Metrics (2)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
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 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

Data Sources: Other Metrics (1)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
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
Other	Night HCA	Health Roster	Melanie Whitfield	High
Other	Night RN	Health Roster	Melanie Whitfield	High

Data Sources: Other Metrics (2)

Understand the Data

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

Data Sources: Other Metrics (3)

Understand the Data

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

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	2.2
Date of meeting:	7th March 2024		

Report from (Committee Name):	Clinical Governance Committee		Committee Meeting Date:	31st January 2024
Status:	Information	Discussion	Assurance	Approval
	√		√	
Prepared by:	Miss Eiri Jones, NED, for Dr D Buckle			
Non-Executive Presenting:	Miss Eiri Jones, NED, for Dr D Buckle			
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.

- Ongoing impact of the child and adolescent mental health demand on the ward and staff (see assurance section for good practice and mitigations)
- Midwife vacancies continue to be a challenge
- Response timelines for formal complaints
- PALS continue to receive concerns re parking
- The gap identified in the Mental Health Act audit has an action in place to address
- Safeguarding training data remains a concern. HR and OD team working with the safeguarding team to verify data

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 following items were presented and discussed at the meeting:
  - DVT (verbal report with full report to come to February meeting)
  - Deep Dive – Children and Young People update including mental health workload
  - Mental Health Steering Group
  - Governance presentation from Women and Newborn Division
  - December and January Perinatal Surveillance Reports
  - Clinical Negligence Scheme for Trusts (CNST) report
  - Neonatal deaths in Salisbury NHS Foundation Trust (due diligence for assurance following on from the baby deaths in the Countess of Chester Hospital)
  - Integrated Performance Report (IPR)
  - Board Assurance Framework (BAF)
  - Quarterly reports for risk and PSIRF compliance, patient experience, safeguarding children and adults
  - Clinical Audit 6 month report
  - National Patient Safety programme update
  - Clinical Management Board (CMB) escalation report

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

- To support the increasing demand for child and adolescent mental health care, the team on Sarum are working in partnership with the mental health provider. There has been progress over the last 12 months and the risk scores have reduced. Visibility of senior managers to support the service has been noted as positive and the locum consultant has played a key role in the improvement work
- Maternity continue to maintain 1:1 in labour and supernumerary status for labour ward coordinator
- Compliance in relation to CNST maternity incentive scheme has improved from last year with 9 out of 10 actions compliant
- The review of neonatal deaths on the neonatal unit over a five year period showed that there was a small number of deaths and all were expected due to their clinical conditions. Report is provided for the March Board
- The stroke service has achieved a SNAPP audit score of A. This is excellent news and down to a multi-professional team approach
- Positive work in the audit department to support clinical teams. A new audit system is proving beneficial and user friendly. The team are using Improving Together methodology

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):	

Report to:	Trust Board (Public)	Agenda item:	2.2
Date of meeting:	7 March 2024		

Report from (Committee Name):	Clinical Governance Committee		Committee Meeting Date:	27 February 2024
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	David Buckle			
Non-Executive Presenting:	David Buckle			
Appendices (if necessary)				

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

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

- 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.

- CGC reviewed Q3 Quarterly maternity Q and S report.
- CGC reviewed monthly perinatal surveillance report.
- VTE assessments remain low but the number of patients affected is much the same suggesting this is a data collection problem. We will review again.
- Attached is a report on the affects of industrial action
- The external report on our mortality review process was discussed and the action plan reviewed.
- 7 day service standards were reported. The Trust continues to progress this ambition wherever possible but full implementation will not be possible for some time.

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

- Surgical divisional governance report
- Q3 patient experience report provided a clear picture of the patient experience

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

- Nil

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

Report to:	Trust Board (Public)	**Agenda item:**	2.2
Date of Meeting:	07 March 2024		

Report Title:	SBAR Quality impact review of Industrial Action (IA)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	CNO Judy Dyos, CMO Dr Peter Collins			
Executive Sponsor (presenting):	CNO Judy Dyos, CMO Dr Peter Collins			
Appendices (list if applicable):	Appendix 1 Rescheduled OPD and theatre activity table			

Recommendation:
This paper aims to assure the Committee of the processes of oversight that have been in place for quality and safety oversight for days when IA have been undertaken in the past 12 months .

Executive Summary:

During this financial year there has been a total of 38 days of Industrial Action. 30 days of this have been weekday doctor strikes, which have the biggest impact on elective activity.

Assure- All incidents moderate and above have been reviewed in full by the CMO and CNO and further investigations have been undertaken in all cases of incidents of concern. Only 1 is case of failure to recognize a deteriorating patient can be directly linked to staffing issues as a result of IA.

There was a concern that IA may affect the running of anti-natal clinics and pose a risk for pregnant patients however there one rescheduled clinic and all patients were seen within expected timeframes.

Alert - The numbers of rescheduled theaters and outpatient cases has been very significant but the impact physical or safety is difficult to quantify. It is important to acknowledge that RTT and long waits for outpatient's appointments are not solely due to IA but a number of wider factors including the impact of COVID on waiting lists Any cases that come to light of harm will be managed through the PSIRF process. Divisional teams have waiting list oversight processes in place for all patents on the surgical waiting list.

Advise – The CNO and CMO will maintain the continued oversight of incidents and focus on days of IA in the weekly patient safety summit. The Divisional teams will maintain the oversight of waiting lists and datix report any safety issues that arise.

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 Situation

Since December 2022 there has been increased Industrial Action (IA) undertaken across the NHS. Salisbury Foundation Trust was not affected by the IA by the Royal College of Nursing (RCN) until January 2023 which resulted in 3 walkouts up to March 2023. The British Medical Association (BMA) commenced IA in March 2023 and this remains an ongoing campaign with Junior doctors striking on 8 occasions and Consultants on 4 occasions. Additionally, the Royal College of Physiotherapists undertook a one-day strike action in July 2023, this had less impact of a safety risk they as therapists do not provide a 24/7 service so risk mitigation was easily managed. All IA dates are captured in table 1.

Externally to the Salisbury NHS trust the Ambulance service also undertook a number of episodes of IA, this did impact the running of the ED and concerns accessibility to the trusts in cases of homebirths that were problematic as results home births were suspended on these days.

2 Background

For each strike episode the trust ran an incident response approach with executive gold meetings three times daily to ensure mitigation, safety oversight and correct governance has been in place. Significant planning was required to manage rotas, theatres, outpatient and clinic activities in all the strike sessions. This planning was led by the deputy directors in OD&P, Operations, Medical leadership and Nursing.

2.1 Impact of the nurse's strike

In the first two episodes of strike activity the Chief Nurse and senior nursing team worked closely with the RCN to ensure agreed levels of cover in line with Sunday/bank holidays staffing across the site. Critical Care and the Emergency Department were exempt from derogations and full staffing was nationally agreed for these areas. The CNO was able to make appeals for additional derogations if there were safety concerns for other areas if required but this was not always agreed by the RCN. Services that would not run on Sundays were stopped from having nursing cover such as out-patients departments however a number ran with HCAS and Consultants.

In the third and final episode of strike activity for the RCN, an all-out walk was sought and no derogations agreed.

On all three occasions a basic staffing numbers were achieved through the running of a redeployment hub but this did require movement of staff across the Trust including redeployment of Clinical Nurses specialist and advanced practitioners. This did impact on continuity of care and safety due to staff working in unfamiliar environments, but oversight was provide by Matrons and Divisional Heads of Nursing through the course of the day and night.

2.2 Impact of the Doctors industrial action

In each round of junior doctor action, the Trust has relied on clinical care being maintained with a combination of Consultants, non-consultant grade medical staff not eligible to strike and junior doctors who have chosen not to take industrial action. Divisional operational and clinical leadership have maximised the use of normal scheduled work and extra contractual work by existing staff to maintain services prioritising urgent and emergency pathways and patients awaiting elective admitted and non-admitted care for time dependant conditions such as cancer or suspected cancer.

Minimum staffing levels have allowed safe care for all inpatients with the maximum potential risks being to:

- the ability to respond to deterioration in a timely way (1 potential harm reported)
- a failure to carry out routine tasks normally undertaken by junior staff due to a lack of capacity or familiarity with process (1 potential harm reported)
- the ability to maintain adequate patient flow and discharge (negligible measurable impact)
- the ability to detect harm in undifferentiated or low risk patients (as yet no significant incidents reported)

During the action taken by consultants there were national agreed derogations to ensure levels of service akin to Christmas day meaning that urgent and emergency care pathways functioned relatively normally. The relative low percentage of consultants taking action allowed a minimal impact to elective care.

Longer term impacts of continued industrial action are to the morale of the medical workforce, the ability to effectively train and be trained, and an erosion of trust both within the profession and between clinical professions. The Trust has attempted to mitigate this by transparent honest dialogue with medial staff and the BMA and continues recognition of the additional work and resilience required of all staff during this time.

There was a concern that IA may affect the running of anti-natal clinics and pose a risk for pregnant patients however there one rescheduled clinic and all patients were seen within expected timeframes.

3 Actions
Quality and safety review processes

The Chief Nursing officer and Chief Medical Officer undertook a review of 53 reported incidents that occurred during strike episodes. The incidents reviewed were all raised as moderate or above harm by staff across the hospital in the IA time frames. Additionally, the risk team also undertake quality checks on incident classified as low or no harm to ensure they have correctly assessed against an approved standard operating procedure. To note there were several incidents that were reported by different staff but related to the same incident. The weekly patient safety summit continues to provide weekly oversight of all moderate incidents by the CMO and CNO or one of their deputies, we have been identifying if any of this falling on days of IA .

3.1 Incidents that occurred during the Nursing IA
There was one incident with a failure to recognise a deteriorating patient by a staff member that was redeployed due to the strike. This was declared a serious incident due to it being attributable to redeployment during IA. This was the only incident that was clearly linked, all others were issues that are commonly seen across the course of the year, there may have been a higher risk with the reduced staffing levels, but it is not possible to form a direct link it to the IA.

3.2 Incidents that occurred during the Doctors IA
Two incidents were possibly linked to the lower numbers of doctors available during industrial action (failure to prescribe pre-op VTE prophylaxis, failure to escalate a patient). As of December 2023, The Chief Medical Officer has reviewed all urgent treatment in-patients and 2 week wait outpatients cancelled or not booked due to industrial action to ensure that the postponement is unlikely to cause harm and that timely rebooking has occurred.

The knock-on risk to patients whose 1st appointments have been delayed or those with undetected or unexpected pathology with cancelled follow up appointments is harder to quantify but no harms of this type have been reported yet.

It has been observed during periods of junior doctor industrial action (in the UK and internationally) that urgent and emergency care pathways often function more efficiently due to higher number of senior decision makers being present and a reduction in the handover or deferment of clinical decisions mad by more junior staff.
Whilst this points to a long term strategic operational benefit of more senior decision makers (from medical and other professions) on the wards, current staffing levels mean that the apparent benefit is off set by the cancelation of outpatient and elective activity.

Professional group	Dates	Incidents review for harm	Themes of note	Action
RCN	18th -19th Jan 2023	6 (4 related to the same incident)	One failed recognition of deteriorating patient due unfamiliar staff member covering in strike.	SI commissioned
RCN	6th-7th Feb 2023	0		
RCN	1st-3rd Mar 2023	3		
BMA Junior Drs	13th-16th Mar 2023	3		
BMA Junior Drs	11th-15th Apr 2023	5		
BMA Junior Drs	14th-17th Jun 2023	8	Patient self-discharged and overdosed in bathroom. waited for review for some time	CR commissioned
BMA Junior Drs	13th-18th July 2023	8		
BMA Consultants	20th-22nd July 2023	0		
BMA Junior Drs	11th-15th Aug 2023	7	Failure to escalate a patient. Term baby admitted to NICU DVT no prophylaxis pre op	Local review SI commissioned Local review
BMA Consultants	24th-25th Aug 2023	0		
BMA Consultants	19th-20th Sep 2023	3		
BMA Junior Drs	20th-22nd Sep 2023	3		
BMA Consultants	2nd-4th Oct 2023	0		
BMA Junior Drs	20th-23rd Dec 2023	1		
BMA Junior Drs	3rd-9th Jan 2024	6	Pre term birth of twins. I neonatal death due to congenital condition Hypoxic patient poorly managed for high Flow Nasal O2. Junior Dr not familiar with the management of these patients – PSR in progress	PSR PSR /case note review

Table 1

4 Rescheduled operations and outpatients' appointments

4.1 Impact on Outpatient Appointments and Surgical Activity

During this financial year (as at 8/1/24) there has been a total of 38 days of Industrial Action. 30 days of this have been weekday doctor strikes, which have the biggest impact on elective activity. Actual impact varies but we have seen approximately 40-50% of outpatient activity and 60-70% of elective theatre and day case lost due to strike action on these weekdays.

The actual number of reported rescheduled procedures can be seen in appendix A, this is the data submitted to NHSE . However, the true impact is far greater due to the fact that no activity was scheduled once IA dates were announced.

To better understanding of the true impact the surgical division undertook an exercise based on the activity completed year to date. This aimed to use the data of normal activity and understand the potential loss of activity. They projected a conservative estimate of the surgery divisions activity lost due to industrial action up to 8/1/24 is 1092 new outpatient appointments, 2040 follow up outpatients' appointments, 1170 outpatient procedures, 94 in patient procedures and 688-day cases. Given cancer and urgent appointments would have been prioritised during the IA it is likely that the least clinically urgent, and therefore longest waiting patients, would have been disproportionately affected by this loss of activity.

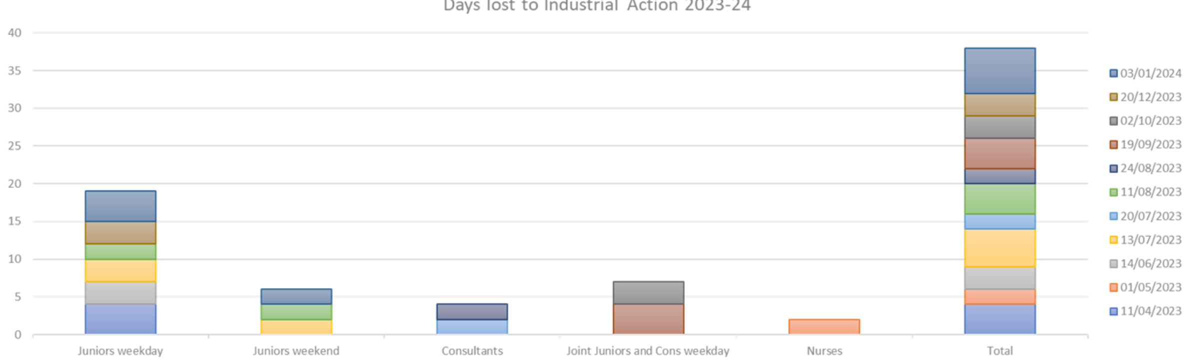


Table 2

4.2 Actions to mitigate risk to patients affected by long waiting times

It is important to acknowledge that RTT and long waits for outpatient's appointments are not solely due to IA but a number of wider factors including the impact of COVID on waiting lists.

To mitigate the risk for patients that have been rescheduled or delayed weekly access meetings are undertaken, these are chaired by the Access Manager with attendance from Operational / Service managers from all divisions to report on RTT long waiters. The Operational managers provide patient level detail, escalate any blockers to booking and the risk of harm. Patient Tracking List(PTL) reviews are being undertaken by the Operational Team on a weekly basis with Central Booking, supporting the reduction in long waits and therefore identifying any patients at risk of harm. Currently both are focusing on RTT patients, with a view to include active, inactive and non RTT from April 2024 onwards.

Weekly Cancer PTL meetings discuss all patients on cancer pathways, at tumour site level, ensuring any patient impacted by IA is rebooked at the earliest possible opportunity to mitigate against potential harm.

Outpatient, Inpatients and RTT modules are now live in care coordination and improving elective care coordination tools which provide enhanced visibility to clinicians in relation to their waiting list, which also enables escalation to DMT.

Time to first outpatients is a trust breakthrough objective and the only one of the three breakthrough objectives that has not moved in a positive direction, as such it is the only one that will remain in place for the coming year with focus on utilising stratified data and demand/ capacity analysis to drive targeted improvement that is reported the planned care board.

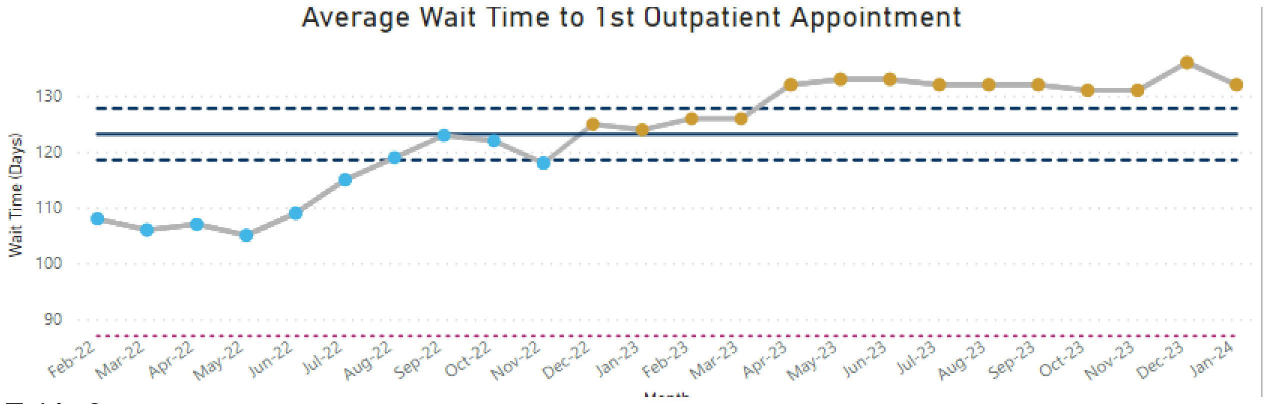


Table 3

Focused work on theatre utilisation and the plan for an increased number of theatres is a high priority with a go live planned for 16 theatres from April 2024

Focused work is on progress on the the nationally mandated target is to ensure no patient has waited over 65 weeks for treatment after the 31st March 2024. Overall, the surgery division has been trending positively throughout last year to achieving a clearance rate of 96.95% of 65-week waiters despite the challenges presented, including but not limited to repeated episodes of industrial action. However, as the numbers decrease the complexity of the remaining patients increases and as we work through winter pressures our ability to influence the wait list decreases. We anticipate a worse-case scenario of 23 65-week breaches at year end, split between General Surgery, Plastic Surgery and Ear, Nose and throat (ENT).

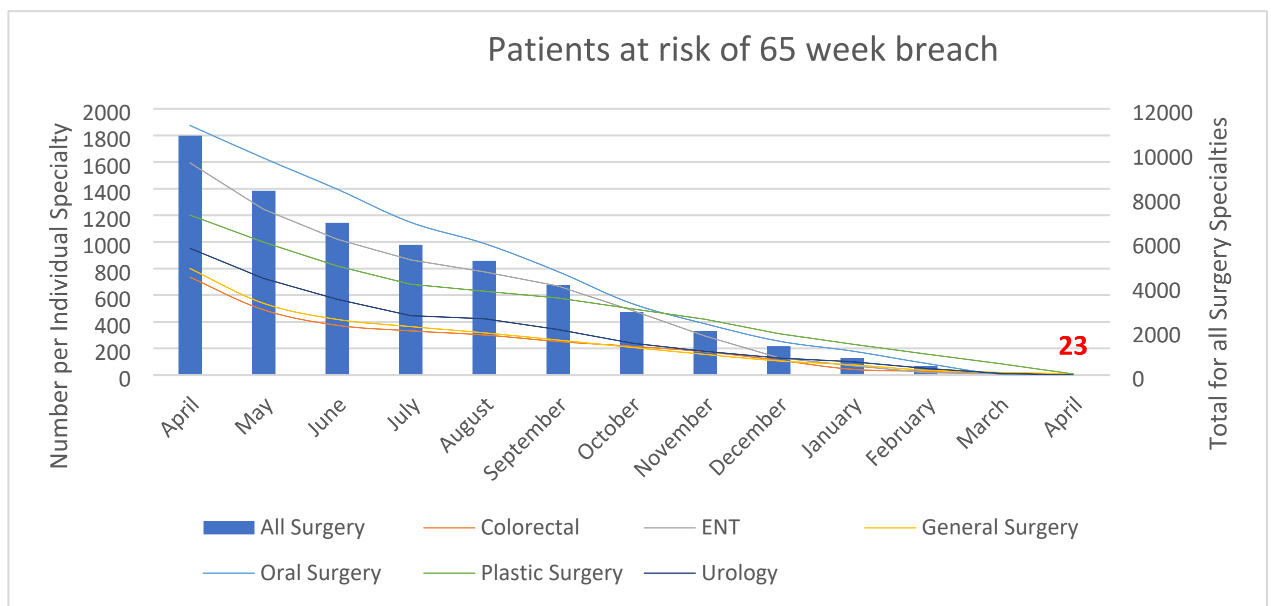


Table 4

Additionally, the opening of Imber ward in late spring 2024 will facilitate the management of outlying medical patients and positively impacts the ability of the organisation to undertake elective in-patient surgery.

5 Financial impacts

So far in 2023/24 we have incurred £1.7m in direct backfill costs and lost the opportunity to deliver £2.2m in additional activity, adding further delays to patient pathways. While NHSE have established mechanisms to financially compensate Trusts for this impact, this has generally come from within departmental budgets at the expense of often transformative programmes of work such as digital. In addition, management capacity consumed by managing the impact of the industrial action (such as validating rosters and rebooking patients) mean we have been unable to move at the desired pace in our own transformation programmes, potential constraining our ability to invest in future quality initiatives.

			Rescheduled activity			Direct costs						
Staff group	Dates	Number of staff absent from work as a result of IA	Day cases	Elective Inpatients	Outpatients	Salary deductions £'000	Backfill costs £'000	Other costs £'000	Total Direct costs £'000	Lost ERF income £'000	Lost Efficiency costs £'000	Total costs £'000
Junior Doctors	3-9 January					(55)	250	40	235	490	550	1,275
Junior Doctors	20-23 December	174		29	246	(40)	200	20	180	285	250	715
						December - January Forecast costs			415	775	800	1,990
Junior Doctors & Consultants	2-4 October	225	2		135	(42)	189		147	137		284
Junior Doctors & Consultants	19-22 September	261	16	2	289	(60)	263		203	317		520
Consultants	24-25 August	43	14		128	(19)	76		57	79		136
Junior Doctors	11-15 August	210	38	8	107	(39)	176	10	147	173		320
Radiographers	25-26 July											
Consultants	20-21 July	56	28	3	198	(24)	99	108	183	147		330
Junior Doctors	13-17 July	209	21	9	151	(39)	176		137	132		269
Junior Doctors	14-17 June	222		6	205	(41)	186	7	152	189		341
Nurses	30-3 May	28				(4)	9		6			6
Junior Doctors	11-14 April	296		22	544	(55)	249	20	213	238		451
							April - October costs		1,245	1,412		2,657
						Total Industrial Action Forecast costs			1,660	2,187	800	4,647

Table 5

6 Recommendations

This report details the processes followed to review the quality impact of industrial action.

This includes a detailed review of the any incidents that occurred in any episodes of IA and the oversight processes. The work undertaken at divisional levels to review and oversee patients on waiting lists. Finally, the planned work of the trust to increase capacity in coming year to address the back log .
This work will be overseen as part of the Improving Together methodology.

The CMO and CNO feel a report in 6 months on the further disruption of IA and mitigating actions should come to CGC to update the committee on the ongoing impact.

Current oversight processes will be maintained and upwardly reported.

Appendix 1
NHSE Reported rescheduled activity.

	All Inpatient	All Day Cases	All Outpatient
Tues 11 April	2	6	110
Weds 12 April	0	2	107
Thurs 13 April	2	6	140
Fri 14 April	0	4	187
Sat 15 April	0	0	0
April Total	**4**	**18**	**544**
Weds 14 June	3	1	62
Thurs 15 June	2	0	79
Fri 16 June	0	0	64
Sat 17 June	0	0	0
June Total	**5**	**1**	**205**
Thurs 13 Jul	2	10	94
Fri 14 Jul	2	6	22
Sat 15 Jul	0	0	0
Sun 16 Jul	0	0	0
Mon 17 Jul	5	5	35
Tues 18 Jul	0	0	15
July Total	**9**	**21**	**166**
Fri 11 Aug	4	17	50
Sat 12 Aug	0	0	0
Sun 13 Aug	0	0	0
Mon 14 Aug	4	21	57
Tues 15 Aug	0	0	0
August Total	**8**	**38**	**107**
Weds 20 Sept	0	2	84
Thurs 21 Sept	2	3	115
Fri 22 Sept	0	0	57
September Total	**2**	**5**	**256**
Weds 20 Dec	8	0	112
Thurs 21 Dec	13	0	62
Fri 22 Dec	8	0	72
Sat 23 Dec	0	0	0
December Total	**29**	**0**	**246**
Weds 03 Jan	0	1	71
Thurs 04 Jan	6	3	74
Fri 05 Jan	5	9	55
Sat 06 Jan	0	0	0
Mon 07 Jan	0	1	0
Tues 08 Jan	3	7	51
Weds 09 Jan	0	0	0
January Total	**14**	**21**	**251**

TOTAL 71	104	1775

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Public Board (Public)	Agenda item:	2.3
Date of meeting:	7 March 2024		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	30 January 2024
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Debbie Beaven – Chair of Finance & Performance Committee			
Non-Executive Presenting:	Debbie Beaven			
Appendices (if necessary)	none			

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

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

- **Cancer –** performance deteriorated further in the 28-day FDS. We heard that "skin" performance has a significant detrimental impact on all cancer metrics - we asked for some evidence of the performance without skin, and an assurance paper will come to the committee next month with a breakdown. We are an outlier and under regional monitoring.
- **Financial outturn and CIP performance –** Our performance and run rate has been impacted by IA and our elective capacity, which has a knock-on impact on our CIPs. We are £5.8m off target ytd, with the majority of the shortfall arising in Medicine and Surgery. We are £1m adverse to the H2 forecast, which made no allowance for IA. There is a risk that we will end the year with a deficit in the range of £6m best case to £10m most likely, with a shortfall of £1-2m on CIPs contributing to a worse position, remembering there is no system solution to NCTR, which as a £3m reduction target, although SFT are covering some of that shortfall with overperformance on divisional CIPs.

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.

- **Carbon –** We received an update on the progress with the contract, which will be a 17-year commitment, with the primary aim of reducing our carbon footprint. A comprehensive summary will come to the next meeting, with a reminder of the key features of the business case, details of the responsibilities of the 3 parties involved, highlighting the key contractual conditions, carbon and financial savings, and annual maintenance and other costs, including potential insurance costs (if any) and key KPIs, ahead of the contract going to Board for final approval.
- **Subsidiary –** WHA financial performance continues to be a challenge for this year and next, with uncertainty on how the system will "account" for the deficit next year. STS has suffered from delays in NHS procurement, adding financial pressure, but there is confidence on some contractual wins, given its good reputation and a closing of the market pricing differentials.
- **Planning –** has commenced, but without any guidance from NHSE. At a top level the numbers have not significantly improved but it is important to show what positive shifts there have been and what factors are consuming the cost and efficiency improvements. The team emphasised the need to get NCTR down which requires system collaboration. More can be done to improve LoS and we will drive harder on elective aiming to open more theatres.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.
• **Frailty –** a deep dive presentation gave us substantial assurance of a speciality that was making significant improvements in processes and performance using Improving Together methodology. We heard that they started from a point of the service "not as good as we want", and the knowledge that early consultation with a geriatrician and access to a frailty unit improved outcomes and life expectancy. Through a proof of concept exercise starting in August 2023 length of stay reduced significantly (16.8 days to 5.5) and readmissions down by 4.7% (ppts) to 12.9%. The capacity created is estimated to be saving £2m pa, although this will not hit the bottom line as it has been consumed by sustained increase in demand volumes. The team are confident they can improve further, some of which may need investment. • **Cardiology –** another example of Improving Together Methodology being adopted to drive improvement. Starting with huddles in the summer the team described learning each other's language and terminology to improve understanding. A3 thinking resulted in a better and simpler structure for clinics. By clearing the 2long waiters" (those with less urgent and complex needs), they have seen a significant improvement in performance data. Next is the valve clinic and taking these successes out to other clinician forums for clinicians to inspire other clinicians to build momentum and advocacy for Improving together. • **Breast reconstruction waits –** following a deep dive last year and an action to get an update on the performance we were assured that waits > 78 weeks have nearly been eliminated, with >65 weeks expected to be eliminated by the end of March.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
• No cases were presented for recommendation or approval

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):	

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Public Board	Agenda item:	2.3
Date of meeting:	7 March 2024		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	27 February 2024
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Debbie Beaven – Chair of Finance & Performance Committee			
Non-Executive Presenting:	Debbie Beaven			
Appendices (if necessary)	none			

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

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

- **Cancer –** the trust remains in tier 2 Cancer oversight for our current 62-day backlog position with performance remaining an area of concern> Internal watch metrics of 2ww and overall backlog >62 days both worsened in December (data is one month behind other performance metrics) to 48.9% and 158 patients respectively. Volumes are higher than expected for this time of year, which may be attributed to public awareness resulting for high profile media stories. Skin, Colorectal and Breast, who are the main contributors to the poor performance, all now have additional capacity in place to improve and all nationally reportable metrics continued to improve and show impact of additional insourced capacity, however there is still some way to go. The cancer delivery group is looking at target pathways. The Committee agreed a deep dive into Cancer in the March meeting would be valuable, particularly in the context of the operational plan for next year, which assumes SFT achieves and sustains targets by M5.
- **Financial outturn –** As a result of ongoing IA our outturn forecast has worsened and looked like it was heading to £10m deficit as operational pressures continue, however with M10 improved performance that has been mitigated down to approx. £9m. Some additional funding for IA is expected, but SFT won't be fully compensated for IA as our size and level of safe staffing is disproportionately impacted by IA, which is not recognised in the funding allocation.
- **Operational Planning 24/25 –** the current position is a significant deficit, which we fully anticipate will not be palatable to the ICB and NHS England. There may be consequences impacting our level of oversight, capital allocations and key project funding. The Committee feels that there needs to be more distinction between efficiency gains and increases in volume/demand. It is important to show the progress made and how this is supporting increased volume, some of which is not funded, but essential for to support the health of our population.

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.

- **Cyber Security** – overall the Committee was assured of the effectiveness of our cyber and security controls, there was one serious incident involving the police (details of which are confidential). There is, also, a red risk around mobile devices, which is being mitigated by manual workarounds. Consideration is being given to replacing Zebra devices. Multi-Factor Authentication (for anyone with NHS email account) will be mandatory at the end of March.

- **Estates CAFM system** – the need for a new system Estates CAFM system is life expired and no longer supported. Current database content is insufficient for comprehensive planned maintenance of assets and procurement activity for a replacement system has commenced, but without any guidance from NHSE. These has been rated an extreme risk as no solution has been identified yet, although there are mitigations in place.
- **Coding** – An audit on coding gave assurance that SFT meets standards, but did highlight, based on a sample test, that the quality of coding had gone down year on year, and there was potential for more income to be earned if improved. There are a number of challenges around time taken to train coders, the use of agency and the manual nature of the work, and it was proposed that the Improving Together A3 thinking with clinical engagement, might create some "different thinking" to break through some of these challenges and improve the process and quality. The Committee will hear back on the results in April.
- **Bank Costs** – whilst agency costs (breakthrough objective) are improving, bank costs remain high, with much related to the IA. We were advised that Medical and Surgery having addressed agency spend will now focus on bank, providing the greatest opportunity for financial savings.
- **Inter-Committee referral** – the Committee asked that an evaluation of the cost and effectiveness of supernumerary posts versus investing in apprentices, be referred to People and OD committee, with apprenticeships potentially a more sustainable approach for the mid to long term.

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

- **CIPs –**the £3m for the discharge process will not be delivered as there is no system supported solution on the table yet, however the divisional targets will be achieved and some exceeded, resulting in the highest ever level of CIPs delivered in any year – totalling approx. £12.9m. There is a target of 5% for 24/25 which equates to £16.1m, with £11.5m of this year's savings being recurrent. Overall the governance and ownership has been strong this year, but with increasing need to drive efficiency and innovation of processes, the Financial Recovery Board will move meetings from monthly to fortnightly focusing on deep dives and driving sustainable delivery.
- **Cardiology –** although performance is not where it should be, as a result of team absences, the Committee was assured that with insourcing it will recover.
- **RTT –** there are 195 patients over 65 weeks, with an expectation that it will be below 50 by the end of the year and >104 weeks will be cleared. The Operational Plan for 24/25 assumes zero >52 weeks by March 2025.
- **Deep dives –** The Committee will continue with deep dives, which provide valuable insight and assurance at a divisional or operational level. March – Cancer, April – Bed Planning and Gynae.
- Ambulance handover times one of the best in the country.
- Many metrics improving despite continuing and, at times, increasing operational challenges.

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

- No cases were presented for recommendation or approval

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

Other (please describe):	

Report to:	Trust Board (Public)	Agenda item:	2.4
Date of meeting:	7th March 2024		

Report from (Committee Name):	People and Culture Committee		Committee Meeting Date:	25 January 2024
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.

- 40 service areas are being reviewed in relation to the Strategic Workforce Planning. This is a significant piece of work and the resources to complete are limited therefore there is a risk to the timeline for completion.
- Whilst a lot of positive work is being undertaken through the FTSU office, inappropriate attitudes and behaviours remains a key theme. The Just and Restorative Culture work is being developed to support this.
- A large locum spend was flagged in the GOSW report. The Committee requested further information on this for the next report. High sickness amongst junior doctors was also noted

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 following subjects were discussed at the meeting:
  - Board Assurance Framework (BAF)
  - Terms of Reference
  - People Promise –Increasing Staff Engagement, Inclusive Employer, Increasing Retention and Reducing turnover, We are Safe and Healthy
  - Strategic Workforce Planning, workforce plan and winter plan
  - Integrated Performance Report (IPR) People and OD
  - Freedom to Speak Up Report
  - Guardian of Safe Working
  - Upward Report from OD&P Management Board

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

- A site visit has been undertaken by the national team in relation to the Trust being an exemplar site for the People Promise. The feedback was positive from the visit.
- The BAF was reviewed and detailed evidence of good progress. The committee were well sighted on the contents and there were no surprises.
- The People Promise update outlined good progress on advocacy in the Pulse surveys though the national staff survey results are still awaited in relation to this.

- Good progress continues to be made in relation to the people and OD metrics in the IPR with reduction in all four key metrics – agency spend, vacancies, staff sickness and turnover

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
• The FTSU strategy was approved for submission

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):	

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	2.4
Date of meeting:	7th March 2024		

Report from (Committee Name):	People and Culture Committee		Committee Meeting Date:	29th February 2024
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.

- The ICS is currently undertaking its 30% workforce reduction work.
- The increasing dependence and need for digital infrastructure and knowledge is a recognised risk for the Trust. It emerged as a theme in several items in this meeting.
- Challenges in meeting SLA's and KPIs relate to staff absences and vacancies within the OD and P team.
- Information has been sought re mitigations for key areas of work e.g., strategic workforce plan and e-roster. The audit relating to the strategic workforce plan has overdue actions and this will be discussed further at the next Audit Committee.

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

- The following items were presented and discussed at this month's meeting:
  - Future annual workplan and Terms of Reference (ToR). These are being reviewed in preparation for 2024-5 workplan and reflection on committee effectiveness.
  - Update on BSW system working in relation to people and culture. There is a re-focus on aligning AHA and ICS work on financial recovery/ cost control, reducing variation realising the EPR programme and benefits and completing the joint community services collaboration -
  - Coventry Partnership
  - The first four topics of the final chapter of the Long-Term Workforce Plan, Reform was presented and discussed in detail with particular reference to shift to care in the community, improvement in use of digital and the ageing population and workforce.
  - OD and People service level agreement and key performance indicators performance report
  - Audit and fraud report
  - Integrated Performance Report (IPR)
  - Staff Survey high level results (embargoed till March). Noting the results for areas of the staff survey and Gender Pay Gap that require further improvement, plans will be developed to address these. Learning from where there has been improvement over the last year will be considered in planning for further improvements.
  - Gender Pay Gap report.
  - OD&P Management Board escalation report

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.
• The work with the Coventry partnership is progressing well, noting that there are further opportunities to be gained. • Of the 5 audit reports for the department, four are now closed with actions completed. • The breakthrough objective for workforce and people is at a lower level that 12 months ago (this is positive). All four metrics measured in the IPR are at their best performance levels. • Both the staff survey and the Gender Pay Gap reports show positive shifts in results. For the staff survey the internal progress shows 'significant' improvements in many areas (55 questions). Whilst many of the metrics remain on, just above or just below the national average, the Trust is one of the most improved (3rd most improved)

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
• Gender Pay Gap report • The annual workplan and ToR will come to Board in due course as part of the annual governance review

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

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

Report title:	Trust Management Committee escalation report			
Status:	Information	Discussion	Assurance	Approval
	x		x	
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Lisa Thomas, Chief Executive			
Executive Sponsor: (presenting)				
Appendices	N/A			

Recommendation:
The Board is asked to note the report

Executive Summary:

The Trust management Committee was held on the 24th January the key points to note were

Assure

- The committee noted the green plan and recognised the level of work underway to address the sustainability agenda. The report was a positive step in meeting the Trust strategic aspirations.

- The committee considered a number of business cases – all of which are subject to the ICS approval triple lock process. The Committee approved a case for service transfer between UHS and SFT for Autologous peripheral blood stem cell transplantation services. This would help support the Trust seeing additional patients mitigating the need for patients to transfer to Southampton. This would be referred through the ICS process for consideration.

- The Committee had a briefing on the new CQC assessment framework as it moves to a single assessment framework.

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Alert

- A recognition that violence and aggression towards staff was concerning with a key focus on actions required to support staff. This was a high priority of the health and safety committee with an ongoing action plan.

- The escalated position of the hospital was discussed with high numbers of additional beds in use, both safety and patient experience was considered with some additional measures to be implemented to improve care.

Advise

- Cancer performance remained a focus with the need to continue to focus on the 62 day target for patient particularly in the Skin and Lower Gastro pathways.

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):	

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	4.1
Date of meeting:	07 March 2024		

Report title:	Register of Seals			
Status:	Information	Discussion	Assurance	Approval
	✓			
Approval Process: (where has this paper been reviewed and approved):	Approved by Lisa Thomas, Chief Executive and Mark Ellis, Chief Finance Officer			
Prepared by:	Sasha Godfrey, EA and Board Support Officer			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			

Recommendation:

The Board is asked to note the entries to the Trust's Register of Seals which, while not formally authorised by resolution of the Trust Board, have been authorised through powers delegated by the Trust Board.

Executive Summary:

To report entries in the Trust's Register of Seals since the last report to Board in November 2022.

None of the signatories who witnessed the fixing of the seal of Salisbury NHS Foundation Trust had an interest in the transactions they witnessed.

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

No.	Date signed in Register	Approval Details	Held on file with:	Signature one:	Signature Two:
372	January 2024	Lease relating to rooms 11 and 12, Black 26 SFT	Laurence Arnold	Lisa Thomas	Mark Ellis
373	February 2024	Lease relating to part of Salisbury Central Health Clinic, Avon Approach, Salisbury SP1 3SL	Laurence Arnold	Lisa Thomas	Not required

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	6.1
Date of meeting:	07 March 2024		

Report title:	Board Assurance Framework (BAF) and Corporate Risk Register (CRR) Report			
Status:	Information	Discussion	Assurance	Approval
		Yes		
Approval Process: (where has this paper been reviewed and approved):	Presented at: Clinical Governance Committee 30/01/2024 Finance and Performance Committee 30/01/2024 People and Culture Committee 25/01/2024 Trust Management Committee 24/01/2024			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices:	Board Assurance Framework January 2024 Summary CRR Tracker v1 January 2024 Corporate Risk Register January 2024			

Recommendation:

Trust Board are asked to review, discuss and make any recommendations to the following:

- Board Assurance Framework (BAF)
- Corporate Risk Register
- The Corporate Risk Tracker

Specifically, the Board is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current and future risks.
- Review the risks out with tolerance and request any further assurance required in respect of risk mitigation.
- Review the principle strategic risks (BAF) and any associated gaps in control or assurance.

Executive Summary:

The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance.

There are 3 strategic risks out with tolerance which is a positive shift since September 2023. Workforce related risks 5 and 7 have both moved within risk tolerance.

There are 18 risks on the CRR which is comparable to September 2023 (2 risks removed and 2 new risks added). The corporate risk profile has also seen some improvement with reduction in risk scores for 5 risks together with risk 508 relating to health and safety and risk 7809 relating to HSMR both moving to target score.

There are 8 risks out with tolerance comparable to the last report. Risk 7573 relating to sustained use of escalation bed capacity and risk 7472 relating to staff absence are now within tolerance.

There has been an ongoing positive shift in the overall risk profile since June 2023. A notable improvement in the workforce related risks can be seen since September 2023 and a number of risk scores have reduced following further mitigation.

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

Board Assurance Framework (BAF) and Corporate Risk Register (CRR) Report

Purpose

1.1 The purpose of the report is to provide an updated BAF and CRR providing all relevant information to the Board and Board Committees on the risks to achievement of the strategic objectives and their management.

2 Background

2.1 The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance. The provision of healthcare involves risks and being assured is a major factor in successfully controlling risk.

3 Summary Strategic Risk Profile

3.1 BAF summary

There has been a positive shift in the risk profile predominantly related to the improvement in the workforce metrics which has resulted in both risks 5 and 7 moving within tolerance.

3.2 BAF Risks Out with Tolerance

There are 3 strategic risks out with tolerance compared to 5 reported in September 2023:

- BAF 4 - Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery. Score unchanged at 16.
- BAF 8 - Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care. Score unchanged at 16.
- BAF 9 - An irreversible inability to reduce the scale of financial deficit. Score unchanged at 16.

All of the above risks have a score greater than 15. These all fall within an open risk appetite and therefore any score over 12 is out with tolerance. The risk tolerance has not identified any unexpected risks out with tolerance and reflect the challenges discussed at Board and Board Committees and evidenced through the Integrated Performance Report metrics and individual reports.

3.3 BAF Risk Profile Changes

Both workforce BAF risks (5 and 7) have reduced their scores from 16 to 12 and moved within risk tolerance.

BAF risk 2 has increased in score from 10 to 12 as a result of the dermatology demand and capacity mis-match which is impacting on statutory cancer targets.

3.4 **Board Committee feedback**

There was suggestion to review BAF risk 9 in relation to the wording of the risk regarding the financial deficit. This will be addressed for the next report. There was discussion regarding whether the risk score for BAF risk 4 relating to critical plant and building infrastructure should be higher than 16 despite progress against the critical risks reported at Finance and Performance Committee. This will be considered and reported in the next report. There was discussion and agreement to consider increasing the Corporate risk score for risk 7734 regarding capital funding from 15.

3.5 **CRR summary**

The risk type, risk appetite and risk tolerance is now applied to all CRR risks. There are 18 risks on the CRR which is comparable to September 2023 (2 risks removed and 2 new risks added). The corporate risk profile has also seen some improvement with reduction in risk scores for 5 risks together with risk 508 relating to health and safety and risk 7809 relating to HSMR both moving to target score.

There are 8 risks out with tolerance comparable to the last report. Risk 7573 relating to sustained use of escalation bed capacity is now within tolerance.

Risks outwith tolerance:

- Risk 5704 (Population): Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce. Score 15. There has been ongoing oversight of this service through Clinical Governance Committee and upward reporting to Board.
- Risk 7807 (Population): As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff. Score 15 but reduced from 20.
- Risk 7955 (Population): There is a risk that ongoing industrial action compromises the quality and timeliness of patient care, compromises operational effectiveness and impacts on the workforce morale. **New risk.** Score 16.
- Risk 5751: Risk of patient harm caused by a delayed discharge from hospital. The score has reduced to 15 from 20.
- Risk 7574 (Population): The continued pressure from urgent care flow alongside the increases in length of stay, compromises the ability for the Trust to undertake planned care. Score unchanged at 15.
- Risk 7308 (Partnership): The financial plan for 2022/23 is a deficit plan with assumed 2.2% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Therefore, there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures. Score unchanged at 20.
- Risk 7734 (Partnership): Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services. Score 15.
- Risk 6229 (Population) - The DSU building is 'end of life' and has been identified as priority for replacement. Score is unchanged at 20.

New risks since September 2023

There are 2 new risks:

- 7946 (Population): As a result of competing priorities, shifting resource plans and sub-optimal scoping of projects there is a risk that transformation programmes and projects will not be delivered to time which may result in the Trust not realising the benefits of the work. This risk replaces risk 5972. Score 12.
- 7955 (Population): There is a risk that ongoing industrial action compromises the quality and timeliness of patient care, compromises operational effectiveness and impacts on the workforce morale. Score 16.

Risks removed:

- Risk 5972 (Population): Risk that improvement and transformation is not delivered in a timely manner. This risk has been revised and a new risk created (7946).
- Risk 6836 (Population): There is a risk that the re-designation of the Neonatal Intensive Care Unit (NICU) will result in restricted access to neonatal intensive care for women in Wiltshire with the impact on quality and safety. This risk has been transferred to the Women and Newborn Divisional risk register.
- Risk 6143 (Population): Risk that inadequate medical staffing in the organisation will impact on the ability of the Trust to maintain safe and effective services across 7 days. Data on frequency of inadequate weekend service provision suggests the risk score is low and within tolerance.

Risks with an increased score:

- Nil to note

Risks with a decreased score:

- Risk 508 (Population): The absence of a comprehensive Health and Safety Management System for the Trust runs the risk that legislative requirements will not be embedded into the Trust standards to which departments are expected to work. Without those standards, we cannot expect the Trust be compliant, so the consequences of non-compliance with health and safety law results in Staff and all persons on site at risk of harm and the Trust at risk of prosecution and claims. Score 9 to 6. The Trust now has a formal H&S management system in place.
- Risk 7573 (Population): The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services. Score 15 to 12. Bed occupancy has started to reduce and the number of patient in ED waiting for a bed overnight is reducing.
- Risk 7809 (Population): There is a risk that the Trust has an unidentified gap in effective clinical care may be the cause of the sustained deterioration in HSMR and SMR. There is a current failure to provide adequate assurance that the change in statistics is not a result of avoidable harm. Score 8 to 4 therefore now at target score. This is based on the outcome of the external review which has not identified evidence of avoidable harm.
- Risk 7472 (People): As a result of unmanageable staff absences, poor retention of existing staff and ineffective recruitment activity to fill vacancies, there is a risk that SFT is unable to manage service provision and operate in a safe hospital. Score 16 to 12. This is as a result of improvement in overall workforce metrics.
- Risk 7807 (Population): As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-

optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff. Score 20 to 15.

4 Summary

4.1 There has been an ongoing positive shift in the overall risk profile since June 2023. A notable improvement in the workforce related risks can be seen since September 2023 and a number of risk scores have reduced following further mitigation. The changes noted to the BAF and CRR demonstrate that this is a dynamic process and one of continuous improvement.

5 Recommendations

5.1 The Board Committees are asked to review, discuss and make any recommendations to the following:

- Board Assurance Framework (BAF)
- Corporate Risk Register
- The Corporate Risk Tracker

Specifically, the Committee is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current and future risks.
- Review the risks out with tolerance and request any further assurance required in respect of risk mitigation.
- Review the principle strategic risks (BAF) and any associated gaps in control or assurance.
- Discuss how target dates can be incorporated
- Discuss alignment with the BSW ICB Board Assurance Framework.
- Agree escalation points for the Trust Board, to include any emerging risk/s or control concerns.

Fiona McNeight
Director of Integrated Governance

Board Assurance Framework

V1 January 2024

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

An outstanding experience for every patient

Board Assurance Framework

The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance.

Trust Values

The core values and behaviours to support the achievement of the Trust vision:

Person Centred & Safe
Our focus is on delivering high quality, safe and person focussed care through teamwork and continuous improvement.

Professional
We will be open and honest, efficient and act as role models for our teams and our communities.

Responsive
We will be action oriented, and respond positively to feedback.

Friendly
We will be welcoming to all, treat people with respect and dignity and value others as individuals.

Progressive
We will constantly seek to improve and transform the way we work, to ensure that our services respond to the changing needs of our communities.

Strategic Priorities

Improving the health and well being of the Population we serve

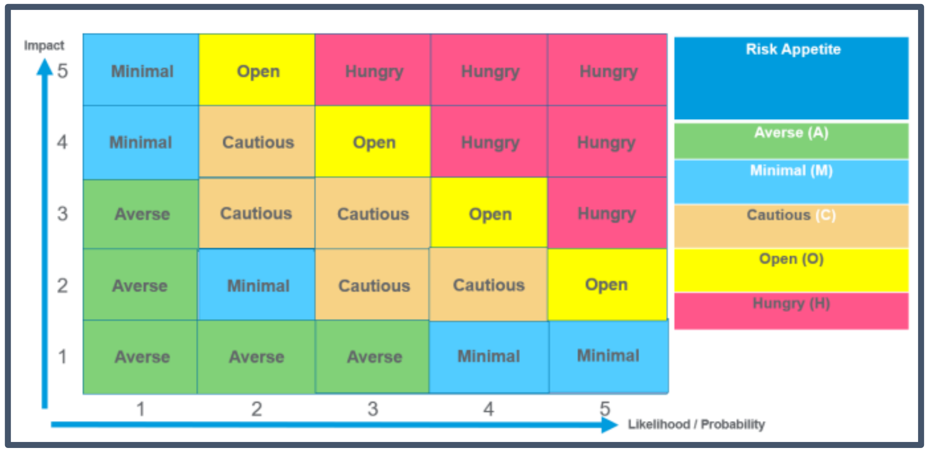
Working through Partnerships to transform and integrate our services

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

Risk Matrix

Risk Matrix					
Likelihood/ Frequency ↓	**Consequence/Impact →**				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
5 Almost Certain	**Moderate 5**	**High 10**	**Significant 15**	**Significant 20**	**Significant 25**
4 Likely	**Moderate 4**	**High 8**	**High 12**	**Significant 16**	**Significant 20**
3 Possible	**Low 3**	**Moderate 6**	**High 9**	**High 12**	**Significant 15**
2 Unlikely	**Low 2**	**Moderate 4**	**Moderate 6**	**High 8**	**High 10**
1 Rare	**Low 1**	**Low 2**	**Low 3**	**Moderate 4**	**Moderate 5**

Risk Appetite



Averse – Avoidance of any risk exposure.

Minimal – Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.

Cautious – Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.

Open – Willing to consider all potential options, subject to continued application and / or establishment of controls: recognising that there could be a high-risk exposure.

Hungry – Eager to be innovative and take on a very high level of risk but only in the right circumstances.

Risk Scores	Risk Appetite Level
15+	Hungry
10-12	Open
6-9	Cautious
4-5	Minimal
1-3	Averse

Risk Tolerance	
within tolerance	
outwith tolerance	

Board Assurance Framework Dashboard

Strategic Risk	Risk Title	Exec Lead	Initial Score	Jan-22	Apr-22	Jul-22	Oct-22	Jan-23	Jun-23	Sep-23	Jan-24	Target
POPULATION - Improving the health and wellbeing of the population we serve												
BAF 2	The scale of and demand for certain Specialist or Sub-Specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service.	Chief Medical Officer	15	10	10	10	10	10	10	10	12	8
BAF 3	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.	Chief Digital Officer	16	12	12	12	12	12	12	12	12	9
BAF 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.	Chief Executive Officer / Director of estates	12	16	16	16	16	16	16	16	16	8
BAF 8	Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.	Chief Operating Officer	20			20	20	20	16	16	16	9

Risk Score Key

Low Risk 1-3
Moderate Risk 4-6
High Risk 8-12
Extreme Risk 15-25

Board Assurance Framework Dashboard Cont.

Strategic Risk	Risk Title	Exec Lead	Initial Score	Jan-22	Apr-22	Jul-22	Oct-22	Jan-23	Jun-23	Sep-23	Jan-24	Target
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work												
BAF 5	As a result of inadequate nursing staff and additional open capacity there is a risk of poor quality of care and poor patient experience.	Chief Nursing Officer	20			20	20	25	20	16	12	9
BAF 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.	Chief People Officer	20			20	20	20	16	16	12	9
PARTNERSHIPS - Working through partnerships to transform and integrate our services												
BAF 9	An irreversible inability to reduce the scale of financial deficit	Chief Finance Officer	12			12	16	16	16	16	16	9
BAF 10	Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.	Chief executive Officer/ Chief Operating Officer	9			9	9	9	9	9	9	6
BAF 11	Significant failure of supply chain which could result in substantial or prolonged disruption to services.	Chief Finance Officer	12			12	12	12	12	12	12	9
BAF 12	Risk of sustained deterioration across key performance metrics (new risk)	Chief Operating Officer	16				16	16	12	12	12	9

Risk Score Key

Low Risk 1-3
Moderate Risk 4-6
High Risk 8-12
Extreme Risk 15-25

BAF Risk 2	The scale of and demand for certain Specialist or Sub-Specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service.
Strategic Priority	Population
Linked Corporate Risks	5704
Executive Lead	Chief Medical Officer
Lead Committee	Finance and Performance
Risk Type	Innovation
Risk Appetite / tolerance	Open

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	Target Score
15	10	10	10	10	10	10	10	10	12	8

Context

Increasing public professional and regulatory requirements resulting in sub-specialisation which is resource intensive and difficult to provide in a Trust of this size.

The 3 most vulnerable specialties include GI, dermatology and the sleep service.

Controls

Trust contribution into the AHA clinical strategy with set up of oversight Board chaired by the CMO.
Dermatology mutual aid agreement with RUH
GI bleed service being managed in partnership with Bournemouth (UHD)
Reconfiguration of sleep services across BSW – agreed clinical model presented to the AHA Programme Executive. Agreement to proceed to full business case.
External Medical workforce and model of care commissioned work completed- workforce model now feeding into divisional operational planning

Assurance

Internal assurance through service performance and outcome measures.

External assurance through GIRFT and the AHA clinical strategy review monitoring

Progress

What is going well/ Future Opportunities?

Acute Hospital Alliance clinical strategy is developed specifically looking at small for scale services and the opportunity for cross organisational working or service reconfiguration to support sustainability

Sleep service contract notice served to Dorset to reduce demand for SFT

What are the current challenges including future risks?

Pace of change required for large scale reconfiguration
Current fragile services could be at risk of regulatory enforcement action.
Risk that patients will not have access to state of the art services
Current substantive workforce gap in GI Medicine precludes on site GI bleed service.
Lack of capacity in the sleep service to meet demand.
Dermatology demand capacity mis-match is impacting on statutory cancer targets

How are these challenges being managed?

Clinical governance processes ensure minimum safe standards are maintained.
AHA clinical strategy work being led by Chief Medical Officer.
GI bleed service being managed in partnership with UHD.
Trust leading on reconfiguration of sleep services across BSW.
Dermatology and sleep services are subject to working groups as part of the AHA clinical strategy implementation.
Commissioned Deputy CMO to undertake review of a sustainable partnership model for GI services (6 month delivery).
Successful recruitment to plastics service (subspecialism in skin).
Insourcing to allow timely diagnosis in skin cancer pathway

BAF Risk 3	Non delivery of programmes within the Digital Plan could result in poor quality services, reputational damage and inability to attract and retain high quality staff
Strategic Priority	Population
Linked Corporate Risks	5360 (Cyber)
Executive Lead	Chief Financial Officer
Lead Committee	Finance and Performance
Risk Type	Infrastructure
Risk Appetite / tolerance	**Open**

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	Target Score
16	12	12	12	12	12	12	12	12	12	9

Context

The Trust is digitally immature when benchmarked nationally. The Trust's digital plan sets out a significant agenda to improve integration of systems, maximise the existing Electronic Patient Record (EPR) whilst working towards a more sustainable longer term joint approach across the ICS, expanding the use of data and ensuring we have infrastructure that enables us to effective use technology and stay safe.

As technology touches on most transformation programmes, there is insufficient capacity and funding to deliver all that is asked with our appropriate prioritisation. This constraint risks the Trust not being able to maintain all desired level of improvements alongside participating in all local and regional initiatives with peers. Anticipated to meet the target score of 9 from March 2024 once FBC funding approved and improvement in staff recruitment.

Controls

Digital Steering Group in place with robust digital governance below this, including programme governance.
BSW shared EPR programme board in place.
Clinical digital leadership in place including CCIO, CNIO, MIOs and Digital Midwife.
Digital Innovation Launched to increase digital profile including digital champions and digital superusers to support change and ownership.
Cyber security team set up within IT Operational to manage cyber risk mitigation activities.
Joint CDO, CIO and Deputy CIO roles across SFT & GWH.

Assurance

Digital Steering Group minutes.
Prioritised digital plan for the year agreed
Regular Digital Plan updates to Board committees.
Regular minutes from BSW shared EPR programme board.
Rolling cyber desktop exercises results

Progress

What is going well/ Future Opportunities?

Refreshed Digital Plan approved at Trust Board in November 2022.
Shared EPR OBC approved, Preferred Bidder selected in December 2022. FBC approved by Trusts and ICB, submitted for national approval Aug 2023.
Digital Services Review roadmap developed as part of AHA corporate services review. Next actions being a) to agree whether ICS is within scope of joint CDO role, b) joint CDO recruitment and consideration of alignment quick wins.

What are the current challenges including future risks?

1. Some infrastructure hardware procurement delays remain globally.
2. Funding for new shared EPR not confirmed until Full Business Case approved.
3. There remains a large agenda of projects with a digital component which are not resourced, funded or prioritised.
4. Some digital programmes are behind original plans.
5. Lack of funding to deliver full Digital Plan including removing all unsupported technologies.
6. Clinical engagement is limited due to operational pressures.
7. Recruitment and retention of Business Intelligence skills

How are these challenges being managed?

1. Reprioritisation of existing infrastructure stock usage to help deliver programmes as quickly as possible.
2. Informal funding commitment from NHSE/I. Business case with national team for approval, decision expected in Jan 2024.
3. Prioritisation of programmes through Corporate Projects Prioritisation Group. Discussion planned to consider impact EPR programme will have on wider transformation plans.
4. Programmes are rebased as part of existing programme governance & strong PMB challenge on delivering against this rebased targets in place. Risk mitigations put in place where appropriate.
5. Seeking opportunities for national funding to support programmes
6. Clinical leads supporting identifying champions for key activities (Shared EPR, implementation activities). Implementing new communication software to support different digital communication methods.
7. Plan being finalised to build resilience with GWH, and change some role focus to make it easier to recruit. Working with ICS to consider opportunities to reduce duplication.

BAF Risk 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.		
Strategic Priority	Population		
Linked Corporate Risks	6229, 7734		
Executive Lead	CEO/ Director of Estates		
Lead Committee	Finance and Performance		
Risk Type	Infrastructure	**Risk Appetite/Tolerance**	**Open**

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	Target Score
12	16	16	16	16	16	16	16	16	16	8

Context

SFT has a substantial estates backlog (£75.2m – 2023) which impacts service delivery, quality of estate and public/patient experience. Limitations via CDEL and lack of investment capital impact the Trust ability to reduce the estates backlog and creates a corresponding increase in Trust risks; costs to operate and maintain the existing estate, likelihood of future infrastructure and estate failures, compromised service delivery and patient care. Equally environmental sustainability investment is limited reducing the Trust ability to achieve net carbon zero.

Whilst National and/or targeted funding may become available, careful planning and prioritisation of requirements is essential yet remains consistently insufficient to make any marked progress in the reduction of long term risks, or exceed the inflationary rate of change to the backlog value. The clinical strategy and the estates strategy are key long term plans for the Trust evolution and delivery of effective and reliable services over the next 10 years (and beyond), but require significant investment to achieve.

Controls

6 Facet survey of the whole site completed in 2022, providing an up to date and independent assessment of the campus in accordance with National guidance (NHS Estate Code).

The 6-facet data reviewed annually and adjusted to reflect capital investment made in year and increases due to inflation. Last annual update May 2023 Quarterly estates reporting to Trust Board. Annual capital plan reviewed via Strategic Capital committee.

Internal audit on management of backlog maintenance completed in 2023 and recommendations being followed through.

Assurance

Significant improvements in estates governance and risk management introduced in last 12 months, including the 10 year capital programme compiled, with investment forecasts for estates backlog.

Estates compliance status clearly recorded. 2022-23 targets achieved. Continued progress to mitigate and conclude compliance actions for 2023-24 year end.

Progress

What is going well /Future Opportunities?

- 10 year capital programme compiled, includes investment forecast for estates backlog. Program subject to annual prioritisation process
- Additional elective ward mobilised (replaces poor condition estate)
- Estates strategy renewal, mobilised with procurement underway, Target completion May 2024.
- Estates strategy update will incorporate Campus project for long term development
- Successful bid for national investment to begin decarbonisation of energy infrastructure, £10m for 2023/24, further bids to be submitted for future years.

What are the current challenges including future risks?

- Insufficient capital. Inflation pressures alone continue to significantly increase backlog value year-on-year
- Competing demands for Trust capital each year.
- Estates backlog value (£75.2m) is not actual cost to deliver Likely value £120.3m
- Limited electrical infrastructure on campus impacting future redevelopment opportunities
- Current decarbonisation (Salix) investment does not encompass whole site. Further investment required to realise decarbonisation. Decarbonisation strategy reduces fossil fuel use but increases electrical demand which is a higher cost, Trust utility costs will rise as we become more environmentally sustainable.
- Lack of adequate investment means infrastructure continues to degrade – level of backlog maintenance increases. Cost to maintain Trust estates and infrastructure increases. Infrastructure failure risk increases
- Day surgery unit remains Trust highest priority, with no funding source available.
- Aged areas of the Estate are not fit for purpose or occupation (SFT South and central) but require investment for continued use and are at higher risk of failure.
- Trust 'space' is in high demand and appetite to remove poor quality buildings challenged with space use.
- Clinical strategy limitations inhibit the estates strategy.
- National targeted resources do not address key resilience issues
- Patient environment quality being compromised e.g., spinal unit
- Quality of on-site residential accommodation poor with little investment
- Director of Estates leaving the Trust

How are these challenges being managed?

- Categorisation & prioritisation of Trust capital. Review and prioritisation within Trust framework (alongside digital, medical equipment etc)
- Continued lobbying for major service developments – DSU
- Funding applications made for environmental sustainability and energy decarbonisation (e.g. Salix)
- Estate's strategy procurement documents mobilised
- Board paper planned to present options for on-site residential accommodation
- Investigations into strategic partnership models to allow development and investment of the estate.
- Monthly meetings with regional NHSEI colleagues to highlight priorities and risks
- Continued review of poor quality accommodation use, identifying opportunities to vacate (e.g remove and dispose archive material) with potential to demolish and remove risk
- Increased scrutiny of estate requests via space allocation committee. Management of space utilisation 'creep'.
- Existing team with Trust support to backfill Director of Estates until permanent solution implemented

BAF Risk 5	**As a result of inadequate nursing staff and additional open capacity there is a risk of poor quality of care and poor patient experience.**
Strategic Priority	People
Linked Corporate Risks	5704, 7039,7573, 7472, 7574,7955
Executive Lead	Chief Nursing Officer
Lead Committee	People and Culture Committee
Risk Type	Capability and skills
Risk Appetite / tolerance	**Open**

Risk Score 2023/24

Initial Score	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	Target score
20			20	20	25	20	16	12	9

Context

There has been an improving picture over the last 6 months in addition to no industrial action for the nursing workforce.
Overall, CHPPD has improved however, there are ongoing challenges within Medicine Division.
Maternity leave is high due to predominant female workforce.
Retention of HCA workforce continues to be challenging.
Heavy reliance on RMN due to MH needs and unavailability of specialised MH beds. In addition, use of additional staff for enhanced care for complex patients.
Agency spend remains a financial challenge in relation to RMN and RN usage although agency hours has reduced.
OSCE nurses taking longer to convert since the change to external training provider (from internal provision) although position has improved.

Controls

3 x daily staffing meetings and early escalation to agency
Monthly safer staffing meeting
Recruitment events
Block booking and use of bank staff
Apprenticeship to Registered Nurse in place (limited funding)
Successful overseas and HCA recruitment
HCA away days to boost retention
Revised HCA induction and competencies
Risk assessments and SOP in place for boarding
Weekly nursing workforce control meeting chaired by Deputy CNO.

Assurance

CHPPD – good levels in all areas with exception of Medicine.
RN vacancy for wards reduced from 14.5% in May, 10% in July and now 4.5% in November
Sickness reduction from 9% in December to 6.5% in November.
Reduction in agency hours from 12,300 in August to 8,000 in November.
Reduction in staff redeployment

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Registered nurse recruitment ongoing. HCA Apprenticeships including Maths and English to attract staff with low educational attainment. HCA support workers in place to support wellbeing and education Partnership working to review future workforce requirements and further opportunities	Overall vacancy rate for HCAs Sickness absence rate across RN and HCA. Staffing demand is likely to increase based on levels of NCTR and Bed capacity modelling which will increase required number of HCA and RN's Retention of current staff Deterioration in key quality metrics Inability to release staff for training Recruiting to cover new ward	Recruitment events ongoing Revised induction for RNs Utilising Improving Together methodology to focus on improvement areas. Ongoing focus on tissue viability, recognition of deteriorating patients and falls prevention management New to Care HCA Programme Medicine Division managing plans for new ward including recruitment

BAF Risk 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.
Strategic Priority	**People**
Linked Corporate Risks	5704, 7039, 6143, 7573, 7472
Executive Lead	Chief People Officer
Lead Committee	People and Culture Committee
Risk Type	Capability and Skills — **Risk Appetite / tolerance**: **Open**

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	Target Score
20				20	20	20	16	16	12	12

Context

October '23: turnover is 14.18% (target 10% and is the highest in BSW). A month on month improving vacancy position, reducing to 4.9% (target 5%). Sickness absence stabilised at 3.8% against a Trust target of 3%.
Maintaining Trust compliance for staff mandatory training with 86.8% (target 85%).
Improving compliance with non-medical appraisal rates – 70.2% (target 86%)
On-going industrial action for medical workforce when other professional groups have agreed a National settlement
Quarterly pulse survey is indicating an improving perception from staff against all People Promise elements
Exemplar site for the People Promise
There is a National shortage of workforce across a range of professions and BSW mirror the National picture. Attraction to geographical area through recruitment and retention premia, Golden Handshake welcome payment, offer of relocation payment and re-launched 'Refer a friend scheme'.
Looking at significant staffing requirement for opening of the new ward and 3 additional theatres.

Controls

Workforce Control Panel overseeing vacancies
Financial recovery programme includes 6 workforce interventions including establishment control
International RN and Midwife recruitment
HCA recruitment and retention facilitator in post
Staff availability now a breakthrough objective with clear focus
Active update and review of all people policies which are being written and implemented in support of a just and restorative culture.
Workstreams for all 7 elements of the People Promise benchmarked against staff survey
Newly established leadership development programme plus a proposed people management skills modular programme
Overhaul of recruitment process with emphasis on high impact actions

Assurance

Improving vacancy position – as a result of attraction incentives
Improving pulse survey responses
Maximum take up on the leadership development, wellbeing and appraisal training courses
Time to hire recruitment process – significant reduction in days.
Sickness absence within target through monthly monitoring

Progress

What is going well/ Future Opportunities?

Recruitment & attraction process and practices overhaul in conjunction with PWC – implementation phase completed and imminent launch
Student reservist campaign
Reviewing approach to training needs analysis – appointed to Head of Clinical Learning
Launched wellbeing survey – awaiting results
Development of a strategic workforce plan

What are the current challenges including future risks?

1. Increasing retention and reducing turnover
2. Line managers capacity to manage exit interviews and complete appraisals
3. Non-Medical Appraisal compliance – slow improvement
4. Manager's capacity to manage staff wellbeing and career development due to operational pressures.
5. Lack of Strategic workforce planner

How are these challenges being managed?

1. A comprehensive improvement programme against all 7 elements of the People Promise
2. Review of exit interview approach – focus on top contributors identified from A3. Ongoing listening to staff at first 90 days and 1 year anniversary. Hearing it campaign launched
3. Design and partial implementation of people management skills for line managers
4. Line managers training course to be launched 2024
5. Interim in post – ongoing substantive recruitment challenges

BAF Risk 8	Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.

Strategic Priority	Population
Linked Corporate Risks	5751, 6143, 7573, 7574,7039
Executive Lead	Chief Operating Officer
Lead Committee	Finance and Performance
Risk Type	Capacity
Risk Appetite / tolerance	Open

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	Target score
20				20	20	20	16	16	16	9

Context

Our operational context remains challenging with escalation beds , demand for urgent services consistently pressurised, the on-going need to reduce length of time patients are waiting for planned care and staff availability day to day creating significant pressure for the teams. The continued use of escalation capacity compromises efficiency and effectiveness of the operational flow and compromises patient care.

The underlying constraint is insufficient capacity in respect of the skilled workforce required alongside system wide change to respond to an aging population . The ongoing level of patients in the hospital who are medically fit for discharge impact on available beds to see and treat planned care patients.

Controls

SFT Urgent Care Board
SFT Planned Care Board
BSW Urgent Care Board
BSW Urgent Care Tactical
Wiltshire Alliance meetings

Assurance

BSW Virtual ward and care co-ordination centre in place reducing demand on SFT beds and admissions
SDEC model reducing bed occupancy requirements for SFT
Acute Frailty model started August 23 – decreased LOS
Overall bed escalation and bed occupancy has decreased since Q42022/23.

Progress

What is going well/ Future Opportunities?

Trust internal programme to reduce bed occupancy including implementation of SDEC, Acute frailty Unit now moved to Durrington and Rambo in ED has had an impact with length of stay for emergency admissions reducing compared to last year by 1 day.

Discharge Hub integration improved NCTR reducing the average by 15 patients since July 2023.

What are the current challenges including future risks?

The time it takes for Patients to flow out of ED due to bed occupancy remaining higher than national target of 92%.

Relatively high NCTR bed occupancy as a result of insufficient community care provision and pathway reconfiguration.

Continued escalation into DSU compromising surgery rates and recovery of 2019/20 activity levels

How are these challenges being managed?

Recruitment into vacant nursing, medical and admin posts in ED ongoing.

Daily focus on site flow to maximise bed efficiency

Urgent care Board to oversee transformation programme

Winter plan including UEC Recovery plan to manage flow being developed.

New chair area in DSU to go live in Q4 to help mitigate escalation on planned care activity.

BAF Risk 9	An irreversible inability to reduce the scale of financial deficit		
Strategic Priority	Partnership		
Linked Corporate Risks	6857, 7308,7734		
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Finance	Risk Appetite / tolerance	Open

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	Target Score
12				12	16	16	16	16	16	9

Context	Controls	Assurance
The Trust has had an underlying deficit greater than 5% of turnover for a number of years. This has led the Trust to be disadvantaged in terms of capital spend due to managing cash flows. Restricted capital expenditure limit is compounded by GWH PFI impact on system allocation. The financial position emerging from Covid remains with SFT being in material deficit. This position has deteriorated and despite increased funding, SFT remains challenged particularly due to high numbers of patients waiting for onward packages of care. The Trust is not alone with BSW ICS reporting an underlying deficit relative to allocation funding. The inability to deliver a breakeven position risks the ability to deliver safe and effective care and or regulatory action associated with breach of license conditions.	Ongoing discussions to agree the distribution of centrally held ICB funding by system Directors of Finance People workstreams are focusing on retention of staff, with planned interventions ranging from the onboarding process through to retire and return conversations. The BSW-wide procurement workplan levies the ICS spending power to mitigate the impact of inflation. Breakthrough objective initiatives focus on patients no longer clinically requiring an acute hospital bed, as well as fall reduction, in order to reduce the demand on the Trust's bed base.	3 year financial plan will act as assurance mechanism Staff availability breakthrough measurement Monthly reporting on performance and forecast Breakthrough objective measurement via Engine Room

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Focus on increase in productivity to mitigate further decline in financial position and maximise opportunities for ERF. Acute Alliance programme of benchmarking to identify opportunities. LOS reductions having favourable impact on bed base. Work on longer stays on-going.	Identifying CIP plans in context of significant operational challenges. Increasing proportion of savings programme will have to be delivered through clinical service transformation. Adequate cash reserves to service capital programme Medium term financial outlook is uncertain Long term capital programme needs to be assessed against available CDEL and additional funding sources. BSW transformation programme immature and not fully	Improving together programme improving a structured approach to change. Working with ICS to develop BSW sustainability programme. Development of CIP teams within corporate and divisional teams Oversight on delivery of CIP through the Financial Recovery Group Cash flow monitoring and NHSE support in place if

BAF Risk 10	Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.
Strategic Priority	**Partnership**
Linked Corporate Risks	6858
Executive Lead	Chief Executive Officer/ Chief Operating Officer
Lead Committee	Finance and Performance
Risk Type	Integration & Partnership
Risk Appetite / tolerance	Open

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	Target Score
9				9	9	9	9	9	9	6

Context

The Integrated Care Alliance continues to develop and respond to changing national guidance on role and functions. In turn this places risk to how quickly trusted successful partnership working can enable service integration and delivery.

Without partnership working one of SFT's strategic aims of integrating care and partnership working is compromised leading to disjointed services for patients.

The community services contract has now gone live which offers both an opportunity and presents a challenge to the integration of services for SFT.

Controls

ICB and Wiltshire PLACE with SFT representation
Established AHA with SFT representation
SFT executive representation within ICS workstreams

Assurance

Community services delivery plan published

Progress

What is going well/ Future Opportunities?

Work with the Acute Hospital Alliance continues to develop and gather momentum.
Acute Alliance Clinical strategy
Elective and Urgent care well established forums
New Community services implementation plan group
Executive Planning

What are the current challenges including future risks?

Place based working still in infancy, further work to progress placed based strategy for integrated care, particularly with community services.
Challenge to develop relationships across multiple partners at place, including the capacity to influence and support the wide range of groups.
Community services tender is 18 month timescale across BSW which impacts on resources and will in the short term potentially slow down integration and change.

How are these challenges being managed?

The Trust is represented at appropriate meetings at PLACE, Acute Providers and the ICS.

Exec team members developing relationships with professional colleagues, attending stakeholder events.

BAF Risk 11	Significant failure of supply chain which could result in substantial or prolonged disruption to services.		
Strategic Priority	Population		
Linked Corporate Risks	Nil		
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Covid Recovery	Risk Appetite / tolerance	Open

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	Target score
12				12	12	12	12	12	12	9

Context

The Supply Chain service at SFT has been disrupted from global supply issues which have led to considerable challenges across various product ranges over the past 2 years. These global issues of supply are against a back drop of the UK exiting from the EU and commodity pricing increasing and global economic challenges with currency.

There are significant risks to service delivery due to a shortage and/or distribution challenges, with a large number of clinical and digital supplies. This currently is manifesting through a global shortage of digital component parts impacting digital project lead in times of over six months. This is impacting services like sleep apnoea where distribution of machines is severely disrupted leaving longer patient waiting times.

Controls

Focus on inventory management
Reallocation of procurement staff to work on supply disruption
Investment in niche solutions to digitise aspects of the supply chain increasing resilience

Assurance

Use of Datix to track risks and use of Trello to track ongoing issues and updates. Lead times of certain products in excess of the normal

Supply chain monitoring through procurement systems – current supply issues with Stryker products (although improving)

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Supply Disruption meeting 3 times a week with NHS Supply chain to give early warning of issues Clinical procurement Specialists building comprehensive list of alternatives. Clinical teams working with procurement to approve and support finding alternatives Management of key issues via Datix to track risk	Non availability on areas where we do not dual source and are predominantly reliant on one supplier (i.e. Stryker trauma and elective Hip and knee) – currently supply issues with Stryker products but availability is now improving. Lead times of certain products being far in excess of the normal and poor communication from suppliers when there is a shortage of supply	Procurement managing product substitutions and maintaining a list of alternatives Use of Datix to track risks and use of Trello to track ongoing issues and updates 3 times per week meeting of supply chain teams across region to share intel and meet Supply Chain Introduction of dual sourcing where appropriate to mitigate risk Regular Supplier review meetings with high risk suppliers Supply chain monitoring through procurement systems Appropriate communication to staff where supply chain is disrupted

Strategic Priority	Population		
Linked Corporate Risks	5751, 7573, 7574, 7039, 7807,7955		
Executive Lead	Lisa Thomas, Chief operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Covid Recovery	Risk Appetite / tolerance	Open

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	Target score
16					16	16	12	12	12	9

Context	Controls	Assurance
There is a risk that all performance targets (Cancer, planned Care, Diagnostic targets) are not improving due to significant gaps in workforce and ongoing industrial action. Due to significant gaps in workforce across a number of functions (e.g Theatres, Diagnostics, central booking) alongside demand being greater than capacity, key performance and quality metrics are showing sustained deterioration. The ongoing impact of industrial action is a significant risk to meeting performance targets due to the level of cancellations.	Planned care and urgent Care boards for transformation BSW Planned Care Board and Elective Recovery group Delivery group monitors performance weekly Cancer improvement group	52/78 week performance is on trajectory although there are emerging risks following further Industrial Action Outsourcing arrangement for additional capacity in Radiology which has improved DMO1 performance significantly in Ultrasound, MRI and CT.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
DM01 improved during Q2& Q3 with additional capacity and focused recovery. Some recovery of long waits for Breast Reconstruction activity reducing the number waiting over 78 weeks. Cancer backlog for skin has reduced with focused funding from Cancer alliance and increased outsourcing.	Number of Patients waiting for planned treatment is increasing Industrial action impacting. Significant issue with Plastic breast reconstruction services due to Consultant capacity. Outpatient waits not reducing in line with expectations – further improvement work targeted to reduce follow up's increase PIFU and improve pathways for patients	Improved governance processes for oversight of performance (delivery group. Cancer improvement group). New process standard work in place from January 2024 Planned Care and Urgent Care SFT Boards in place to support transformation – focus on outpatient in Q4 BSW Urgent care and Planned care boards well established to help support delivery.

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due Date	Action Done Date	Action Lead	Source of Review	Review Date	Rating (target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk	Controls in Place	Gaps in Control	Assurance on Controls	Gaps in Assurance
7809	Quality Directorate	Trustwide	17/08/2023	Clinical Governance	8	There is a risk that the Trust has an unidentified gap in effective clinical care may be the cause of the sustained deterioration in HSMR and SMR. There is a current failure to provide adequate assurance that the change in statistics is not a result of avoidable harm. This may result in reputational risk if unresolved	Cannot believe that this will ever happen again	Major	4	Chair and CEO have requested external review from Regional CMO to provide further assurance of mortality oversight	30/11/2023	29/12/2023	Collins, Peter	Trust Board	29/02/2024	4	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Collins, Peter	17/08/2023	Internal mortality surveillance group External reporting and scrutiny by Telstra (Dr Foster) Mortality data reported monthly through IPR Learning from Deaths Report to Board quarterly. Further assurance papers through CGC and Board, shared with Governors	Nil to note	No consistent concerns in any one diagnostic group. No consistent themes of inadequacy of clinical care from structured judgment mortality reviews All cause mortality (from public health data) suggests a low rate of mortality in SFT catchment area. Recent NHSE led external review did not identify significant concerns around clinical care but identified a number of	Unexplained deterioration in HSMR and HSR which whilst in keeping with a National picture of lack of confidence in current statistical modelling, does not fully explain the sustained SFT trend
										SFT mortality lead to lead work to set up BSW wide mortality meeting to provide further peer learning and assurance	30/11/2023	29/12/2023	Browne, Ben												
										Action plan to be created once formal feedback from NHSE external review on 5th December.	27/02/2024		Collins, Peter												
508	Organisational Development and People	Trustwide	21/11/2002	Other assurance not listed	8	The absence of a comprehensive Health and Safety Management System for the Trust runs the risk that legislative requirements will not be embedded into the Trust standards to which departments are expected to work. Without those standards, we cannot expect the Trust be be compliant, so the consequences of non-compliance with health and safety law results in Staff and all persons on site at risk of harm and the Trust at risk of prosecution and claims.	Do not expect it to happen again but it is possible	Moderate	4	Trust compliance is assessed on an add hoc basis by Health & Safety. Yearly corporate and self assessment audits are conducted in 2 clinical and 2 non-clinical areas. Compliance results are reported to the H&S Committee, the Workforce Committee and then onto the board.	01/10/2019	08/02/2021	Knight, Paul	Health and Safety Committee	31/03/2024	4	Population	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Ready, Troy	06/04/2022	Adequate Health & Safety management system is now in place, with an appropriate system of audit & inspection. Policies and standards are in place with a work programme to ensure they are updated where required by the end of the financial year. All staff trained at induction and further training is in place. Individual department specialist training. A process that requires health and safety risk assessments is in place. Health and Safety Manager and Adviser are in place, plus a Manual Handling Adviser. A mechanism of governance is in place through the H&S Committee, which receives reports from relevant officers plus 19 sub-committees. Interim actions are being taken by the Interim H&S Manager to highlight priorities against this risk and to undertake a small number of activity audits to assess compliance. Adverse event reporting and subsequent analysis/investigation. Health and Safety Committee meetings reporting to board. Health and Safety sub-committees reporting to the Health and safety Committee. Controls Assurance. Health and Safety inspections. Union Health and Safety reps in place.	Some policies not yet up-to-date with current legislation, work programme in place as identified in the H&S management system programme of work. At Oct 23 - a list of outstanding policies has been identified, updated and presented to the H&S Committee for approval. Outstanding policies will be updated by the end of November 2023.	Observations of behaviours and standards across the publicly accessible parts of the site indicate a H&S culture that is in need of improvement. Independent reports have highlighted areas for improvement which are being addressed at a senior level. An agreed programme of audit and inspection overseen by the H&S committee. october 23 - An internal audit program is implemented against a published audit program, task analysis are completed against a published schedule and reporting of performance against H&S targets identifies injury trends and allows for action to manage identified risks to the H&S of staff.	Absence of assurance from divisions and departments giving visibility of H&S issues via the H&S committee. Insufficient near-miss reporting on Datix, for example, multiple examples across the campus of lack of control of premises (e.g. loading bay gates left open, fire doors propped open, safety equipment obstructed by inappropriate storage, trip hazards & obstacles in public areas etc). Ensuring compliance with policy & procedures.
										Trust compliance is assessed on an add hoc basis by Health & Safety. Yearly corporate and self assessment audits are conducted in 2 clinical and 2 non-clinical areas. Compliance results are reported to the H&S Committee, the Workforce Committee and then onto the board.	01/10/2019	08/02/2021	Knight, Paul												
										Reviewed the scope of the risk assessment and have not found any significant gaps in our provision of health & safety instruction, training and baseline support.	20/07/2022	06/10/2022	Adams, Peter												
										Reviewed the scope of the risk assessment and have not found any significant gaps in our provision of health & safety instruction, training and baseline support.	20/07/2022	06/10/2022	Adams, Peter												
										5/5/22 Recruit permanent H&S Manager. Transparent escalation and communication of the risk in the first instance is intended to draw attention to the work required to create a comprehensive H&S Management System. Recruitment of a permanent H&S Manager is underway whose task it will be to determine the long-term resources required to deliver and maintain (i) the polices and standards that define how the Trust will address H&S compliance, and (ii) the form of the audit system that will measure the gaps between the legal requirements and the Trust's policies and standards; and the gaps between those policies & standards and their implementation by divisions and directorates. In addition the H&S Management system requires support of divisions and directorates in activities such as: H&S Training; risk assessment; and accident investigation; and the administration and contribution to corporate governance activity through the provision of data dashboards, performance reports, attendance and contribution to H&S committee & sub-committees and escalation reports	01/08/2022	07/09/2022	Adams, Peter												
										5/5/22 Recruit permanent H&S Manager. Transparent escalation and communication of the risk in the first instance is intended to draw attention to the work required to create a comprehensive H&S Management System. Recruitment of a permanent H&S Manager is underway whose task it will be to determine the long-term resources required to deliver and maintain (i) the polices and standards that define how the Trust will address H&S compliance, and (ii) the form of the audit system that will measure the gaps between the legal requirements and the Trust's policies and standards; and the gaps between those policies & standards and their implementation by divisions and directorates. In addition the H&S Management system requires support of divisions and directorates in activities such as: H&S Training; risk assessment; and accident investigation; and the administration and contribution to corporate governance activity through the provision of data dashboards, performance reports, attendance and contribution to H&S committee & sub-committees and escalation reports	01/08/2022	07/09/2022	Adams, Peter												
										The polices and standards required by H&S legislation have been identified and a plan of work is being drawn up to resource their implementation, estimated 47 documents requiring 70 days' work. Auditing of activities to assess implementation of legislative requirements is underway and upon the arrival of the new H&S Manager on 1/8/22 a long-term scheme of audit will be devised. Recruitment of a H&S Adviser is underway and consideration of how to resource policy and audit workload in the long term will be led by the H&S Manager.	30/12/2022	06/10/2022	Adams, Peter												
										The polices and standards required by H&S legislation have been identified and a plan of work is being drawn up to resource their implementation, estimated 47 documents requiring 70 days' work. Auditing of activities to assess implementation of legislative requirements is underway and upon the arrival of the new H&S Manager on 1/8/22 a long-term scheme of audit will be devised. Recruitment of a H&S Adviser is underway and consideration of how to resource policy and audit workload in the long term will be led by the H&S Manager.	30/12/2022	06/10/2022	Adams, Peter												
										7 policies approved by OMB 19/7/22	19/07/2022	19/07/2022	Adams, Peter												
										7 policies approved by OMB 19/7/22	19/07/2022	19/07/2022	Adams, Peter												
										Create a H&SMS that provides measurement, audit and assurance to the Trust Board	30/12/2022	07/06/2023	Ready, Troy												
										Create a H&SMS that provides measurement, audit and assurance to the Trust Board	30/12/2022	07/06/2023	Ready, Troy												
										Review gaps in current H&S procedures and policies and update where required	30/11/2023	29/12/2023	Ready, Troy												
										Review gaps in current H&S procedures and policies and update where required	30/11/2023	29/12/2023	Ready, Troy												
6857	Finance and Procuremen	twide	12/03/2021	Financial		There is a risk that weaknesses in controls give rise to an opportunity for fraud, in	ably r, but ot a istent ue	nor	8	continue programme of fraud awareness and prevention with Counter Fraud team	31/03/2022	13/04/2022	Thomas, Lisa	rtmen 'eam eting	30/08/2024	8	ership s	Board orate isk ister)	tor of ance	Mark	12/03/2021	budgetary controls internal control procedures in built into financial systems	Standard operating procedures across the Whole Trust	Counter Fraud reports budget monitoring reports	investigative fraud allegations show sporadic gaps in

	t			management		turn meaning the Trust incurs financial losses.				Address the drivers of fraud- financial wellbeing of staff	30/06/2022	21/06/2022	Thomas, Lisa									between purchasing and paying training to all staff on induction	inconsistently applied	fraud investigations low level reporting	procedures.
6858	Finance and Procurement	Trustwide	12/03/2021	Trusts Objectives	9	There is a risk as new guidance and models of working emerge the immaturity of partnerships between SFT and wider BSW organisations will impact on progress to achieve key objectives. With the delay to the ICS formal start date and a double running with ICB's this may delay progress in system transformation.	May recur occasionally	Moderate	9	Executive team participate in Place based leadership development within the ICS to help shape collaborative arrangements. workshop 13th July	31/08/2021	12/10/2021	Thomas, Lisa	Trust Board	30/11/2023	6	Partnerships	Trust Board (Corporate Risk Register)	Chief Operating Officer	Thomas, Lisa	12/03/2021	Pulse newsletters Wiltshire alliance attendance key members on ICS development groups (population health, SALSA) white paper published Acute Alliance member	ICB leading the system development work therefore not always sighted on national or regional development.	System working reported to Board Transformation programme aligned with ICA in Wiltshire Acute Alliance work programme and reporting to Board.	Speed in which changes to patient pathways and models of care is currently slow.
										Trust developing committee in common with Acute Alliance - progress towards provider collaborative in line with national guidance	31/12/2021	11/01/2022	Thomas, Lisa												
										Trust to work in partnership with new emerging leadership structure to develop transformation plans to meet national operating targets.	31/03/2023	13/06/2023	Thomas, Lisa												
5955	Finance and Procurement	Trustwide	13/08/2019	Trustwide risk assessment	15	Insufficiently robust management control procedures across the organisation which pose a financial, reputational, legal and operational/clinical risk.	May recur occasionally	Moderate	9	Reviewing Trust wide risk training, aiming to roll out programme to all middle managers	31/03/2020	17/06/2020	Thomas, Lisa	Trust Board	31/03/2024	6	Population	Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	13/08/2019	SFI's standard operating procedures corporate policies (e.g. HR) Governance assurance map risk register Leadership development programme in place Regular finance training provided for budget holders	-Education and training on management of risk across the organisation.	-Low levels of reported Fraud -low volume of litigation -head of internal audit opinion -Infrequent high risk audit findings	-Internal audit reports highlighting weaknesses in controls and processes.
										Process mapping underway for business critical controls	31/12/2019	16/12/2019	Thomas, Lisa												
										Trust identifying additional procurement training for those areas of non compliance across the organisation. New process targeting individuals starts in November 2019.	29/03/2020	17/06/2020	Willoughby, Kelly												
										Trust developed draft risk training specification for additional support for directorates- view to tender and award before December 2019.	31/12/2020	07/01/2021	Thomas, Lisa												
										Introduce a monthly informatics department management committee that feeds into monthly executive performance reviews	31/10/2019	18/10/2019	Burwell, Jonathan												
										Approval of IT General Controls plan at Informatics DMC and ratify at exec performance review	31/01/2020	02/03/2020	Scott, Andy												
										Approach to testing of backups agreed	20/03/2020	02/03/2020	Cowling, Andrew												
										All IT system contracts reviewed with IAA and IAO confirmed and delivery of duties being monitored	31/12/2020	15/12/2020	Burwell, Jonathan												
										Full review of informatics standard operating procedures including putting in place monitoring processes	30/06/2022	06/01/2023	Scott, Andy												
										Full implementation of IT general controls framework	31/12/2021	12/03/2021	Scott, Andy												
										Complete a stocktake of all IT operational infrastructure	31/01/2020	02/03/2020	Burwell, Jonathan												
										Implement a robust asset management system	30/10/2020	01/07/2020	Burwell, Jonathan												
										Implement a centralised rolling replacement programme for computers, laptops and iPads	01/04/2020	28/04/2020	Burwell, Jonathan												
										Complete review of IT security policies	30/10/2021	09/12/2021	Burwell, Jonathan												
										Review of existing storage locations of Informatics SOPs to centralise and improve searchability though using modern software such as CITO or Sharepoint	31/08/2021	16/08/2021	Burwell, Jonathan												
										Embed improving together methodology in performance review reporting structure.	31/01/2023	04/05/2023	Ellis, Mark												
										Development of a standard budgetary management and control training pack for leaders and managers	29/12/2023	29/12/2023	Ellis, Mark												
										Financial management responsibilities reflected in managers 'appraisal process	30/06/2024		Ellis, Mark												
7078	Transformation & IM&T	Trust Offices	12/10/2021	Trusts Objectives	12	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together work programme deadlines. The impact of this would be a delay in the pace and scale of the rollout of our shared continuous improvement approach across the Trust and within the AHA. This could result in the Trust not being able to improve performance as far as it could have if the programme had stayed on track.	May recur occasionally	Moderate	9	Use of existing PMB groups to address issues on A3 content	22/11/2021	14/01/2022	Cox, Emma	Executive Director Meeting	29/02/2024	6	People	Trust Board (Corporate Risk Register)	Chief Medical Officer	Talbott, Alex	13/10/2021	Responsibility for delivery sitting with Associate Director of Improvement. Executive oversight of delivery through the monthly Improving Together Board chaired by CEO. Reporting includes progress against the April 2023 to September 2024 roadmap and case studies from across the organisation on the benefit and impact of Improving Together. The Trust Board receive a quarterly board report from the programme board. In preparation for the monthly programme board report and quarterly Trust Board report each of the nine workstreams are reviewed and update by each of the workstream leads (Exec and manager leads). Risks relating to the programme are reviewed on a monthly basis by the Associate Director of Improvement and the Head of the Coach House. This generates new and refresh mitigations as the risk and resultant issues develop month-by-month. E.g. Coach House staffing changes.	None.	- Monthly reviews in preparation for the Improving Together Programme Board between the Associate Director of Improvement and the Head of the Coach House. - Reviews of the workstreams against the overall roadmap at the monthly Improving Together Programme Board and the programme board minutes. - Quarterly reports to Trust Board. - Monthly Engine Room reviews led by the Executives, including quarterly Engine Rooms taking in progress across the four boards: vision metrics, strategic initiatives, breakthrough objectives and corporate projects. -Training continues to be on-trajectory with the Coach House team prioritising training delivery while staffing capacity is constrained. - Of off-track workstreams (OMS Frontline, Leadership Behaviours and Coach House) the actions to bring them back on-track are known as detailed in the programme board papers.	Behind trajectory of Improver Advanced training
										SRO leads to prioritise the work and engage with specific task and finish groups	30/11/2021	14/01/2022	Cox, Emma												
										Executive to agree new road map by end of July.	31/07/2022	31/10/2022	Provins, Esther												
										Commence recruitment for Programme Director.	30/08/2022	29/12/2022	Collins, Peter												
										Sustainability workshop completed with Execs and KPMG. Produced roadmap and key area of priorities and assumption in the next 18 months. Detailed roadmaps and requirements to be presented to the Improving Together Programme Board in March 2023.	20/03/2023	09/06/2023	Cox, Emma												
										Recruitment to coach house to cover maternity leave (B6 improvement practitioner) for 6 months	29/09/2023	06/10/2023	Cox, Emma												
										Recruitment of the three B7 rotational Senior Improvement Practitioner roles into the Coach House. Await final approval of the business case at F&P on 26th September 2023.	31/10/2023	02/01/2024	Cox, Emma												
										Review of training delivery approach and programme in order to bring the Trust back on trajectory. This includes learning from the past year of training delivery within current structure	29/02/2024		Cox, Emma												
5360	Transformation & IM&T	Information Technology	28/02/2018	Data Protection	15	Risk of a cyber or ransomware attack, resulting in the potential loss of IT systems, compromised patient care and financial loss.	Do not expect it to happen again but it is possible	Catastrophic	10	02/10/18 IT Technical group on 8/10/18 to discuss what Anti virus software should be purchased	10/10/2018	14/12/2018	Noble, Bob	Information Governance Steering Group	31/03/2024	8	Population	Trust Board (Corporate Risk Register)	Director of Finance	Burwell, Jonathan	11/02/2020	- Information Security Team in place to proactively manage CareCERT compliance - Microsoft Defender Endpoint (MDE) is installed to monitor the Microsoft Windows operating system on a PC or laptop to identify any abnormalities and take immediate action to stop issues identified spreading - NESSUS vulnerability scanning in place - Industry standard firewalls have been installed (Watchguard) - Trust compliant with DSPT which is Cyber essentials equivalent - IT Health Assurance Dashboard (ITHAD) provides compliance monitoring, in particular CareCERT compliance. - SIEM, Password monitoring solution and PAM products implemented. - All devices on supported version of Windows (windows 10 version 21H2).	- Three Windows 7 devices remain, being migrated to UHS (Genetic) - A number of outstanding devices for Critical CareCERT. Log4j critical careCERT is a significant wide ranging risk that is considered. - A number of MDE alerts in last 12 months related to staff clicking on phishing emails	SFT Informatics CareCERT Alert Dashboard in place as part of ITHAD. Informatics Tech Group oversees progress in CareCERT compliance, patching monitored and wider cyber activities. IT Health dashboard in place and reviewed Tech Group using this operationally Quarterly digital update to F&P. Board agreed moderate risk appetite for cyber security risk in 2021. IG, DP and Cyber related Policies in place and up to date. Rolling progress of desktop exercises to test business continuity plans and preparedness	cc.
										Technical Group made decision to extend current product. Quotes being obtained for 1, 2 and 3 year extension.	28/02/2019	20/02/2019	Noble, Bob												
										Review of practicalities of getting ransomware with financial controller.	24/07/2019	09/09/2019	Burwell, Jonathan												
										Development of Cyber Essentials plus plan to support achievement of the standard by 2021	17/01/2020	03/02/2020	Carman, Mr Stephen												
										Review of options for SIEM automated logging and impact of this on resource	31/03/2020	28/04/2020	Carman, Mr Stephen												
										Business case to TMC for agreement of option, associated resources an risk management	18/03/2020	28/04/2020	Carman, Mr Stephen												
										Windows 10 migration complete	31/03/2022	13/04/2022	Arnold, Jon												
										Cyber essentials plus accreditation achieved	30/06/2021	09/07/2021	Carman, Mr Stephen												
										Completion of outstanding penetration test actions prior to moving into cyber essentials plus plan	28/02/2020	17/03/2020	Burwell, Jonathan												
										Implementation of SIEM solution with regional leads	30/06/2020	10/07/2020	Carman, Mr Stephen												
										ATP to be installed on Servers	31/12/2020	08/01/2021	Gibson, Richard												
										External CORS review to be undertake to support progress review	31/01/2021	24/02/2021	Burwell, Jonathan												
										Test implementation of IT Health Assurance Dashboard	31/05/2021	09/07/2021	Burwell, Jonathan												
										Review of proposed actions outlined by NHSD cyber team and CORS assessment to develop a 2021/22 updated cyber plan.	30/07/2021	12/10/2021	Gibson, Richard												
										Implementation of offline backup storage	21/12/2021	12/01/2022	Gibson, Richard												
										Completion of KPI report for Cyber	17/09/2021	12/10/2021	Badham, Gareth												
										Completion Log4j Critical CareCERT mitigations that are currently available.	30/03/2023	22/05/2023	Gibson, Richard												
										Implement Privileged Access Management solution	30/03/2024		Gibson, Richard												
										Rollout of SpecOps	16/12/2022	16/12/2022	Gibson, Richard												
										Procure a solution to monitor networked medical devices	31/03/2023	22/05/2023	Gibson, Richard												
										Undertaken awareness of Metacompliance training, focusing on Phishing	30/10/2023	30/10/2023	Gibson, Richard												
										Communication and reporting of red flag for staffing regionally to NHSI/E	02/08/2021	02/08/2021	Merrifield, Tracey												
										Explore use of agencies (including off cap) to support block booking	09/08/2021	09/08/2021	Wilding, Mr Henry												

7039	Trustwide	Trustwide	13/09/2021	Bed meeting, Departmental risk assessment, Incident reports, Trustwide risk assessment	15	The Trust is currently experiencing increased demand and patient acuity across all in patient services, at a time of increased nursing sickness, maternity leave, leavers and retirements, and reduced recruitment. This increases risk for patient harm, increases risk of burnout for remaining staff, causes delay to flow and discharges, and inability to provide the required care for all patients. Due to national shortfall in nursing and midwifery hours, there is an ongoing risk to recruitment and retention.	Will probably recur, but is not a persistent issue	Moderate	12	Explore use of agency HCAs to support wards	20/09/2021	13/12/2021	Wilding, Mr Henry	Directorate Management Team Meeting	31/03/2024	4	Population	Trust Board (Corporate Risk Register)	Director of Nursing	Hyett, Fiona	01/07/2022	Thrice daily staffing meeting to review allocation of resources and escalation to off cap agencies Rotas completed at six weeks with automatic access to nurse bank and subsequent escalation to nursing agencies at 3 weeks (Tier A) and 3 days (Tier B). Use of nurse bank and temporary staffing Use of supervisory time to support wards Use of RAG safe staffing to guide and inform staffing deployments Availability of matron until 20.00 to support and manage staffing deployments/late sickness calls Use of specialist nurses to support wards	Reduced training and development opportunities. Safe staffing RAG does not account for enhanced care needs. Unpredictable demand for mental health or CAMHS enhanced care leading to use of high cost agency. OSCE nurses are taking a longer time to pass leading to extended supernumerary periods. Ability to maintain HCA retention.	Reduction in RN vacancy for ward areas. Reduction in Falls with Harm. Improving position in relation to tissue damage. Maintenance of Allocate and safecare data. Use of red flags and professional judgement to escalate and capture concerns and mitigations. Daily staffing summaries shared with operational team Datix reporting	Complaints received regarding to care provision. Sickness above target of 3%. Agency spend (although reducing significantly). Failure to escalate deteriorating patients.
										Establish HCA recruitment event - webinar and associated interview dates	30/09/2021	13/09/2021	Holt, Sharon												
										Use of Specialist Nurses/Out patient Nursing to support ward areas	01/11/2021	04/03/2022	Dyos, Judy												
										Development of B2 non-clinical support worker role (housekeeper) to support wards	13/12/2021	13/12/2021	Wilding, Mr Henry												
										Request for use of volunteers from non-patient facing teams to support wards with delivery of meals, answering phone, runner, drink round	01/01/2022	04/03/2022	Wilding, Mr Henry												
										Develop winter incentive scheme for bank workers	01/01/2022	13/12/2021	Ashley, Simon												
										Explore of use of short, fixed term use of over time payments for part time staff.	27/12/2021	04/03/2022	Wilding, Mr Henry												
										Extension of winter incentive scheme until 02/04/22 to support ongoing escalation and acuity	04/03/2022	04/03/2022	Wilding, Mr Henry												
										Develop specific Easter holiday incentive scheme to support and encourage additional shift coverage	08/04/2022	08/04/2022	Wilding, Mr Henry												
										Ongoing use of golden incentive to support short notice sickness/gap	01/09/2022	05/10/2022	Wilding, Mr Henry												
										Revise incentive scheme framework with established triggers and values, and process of sign off	01/08/2022	05/07/2022	Ashley, Simon												
										Review action card/BCP regarding deployment of available resources in times of extemis	31/10/2022	05/10/2022	Cox, Emma												
										Commission task and finish group to explore all options and opportunities to recruit, retain and incentivise additional nursing hours and support	28/10/2022	13/12/2022	Wilding, Mr Henry												
										Recruit substantively to 'allocation on arrival' team to support wards/areas as required	30/11/2022	10/10/2022	Ashley, Simon												
										Develop and recruit to non-clinical support worker role	06/01/2023	14/06/2023	Hyett, Fiona												
										Commission development of and recruitment to the use of a discharge lounge, supporting earlier discharge on the day and release of current nursing hours on wards facilitating TTOs, transport, collections	06/01/2023	13/12/2022	Osman, Laura												
										Recruitment of discharge coordinators to support specific wards, releasing nursing time and availability	30/06/2023	14/08/2023	Dickinson, Jane												
										Temporary staffing winter incentive scheme approved by execs. To go live from 30/12/22	30/12/2022	21/12/2022	Ashley, Simon												
										Implement counter measures that came from the A3 on enhanced care management.	31/10/2023	15/01/2024	Hyett, Fiona												
										Work in partnership with AWP to reduce the use of Mental Health RMNs and improve continuity of care.	31/12/2023	15/01/2024	Hyett, Fiona												
7946	Transformation & IM&T	Trustwide	02/01/2024	Departmental risk assessment	12	As a result of competing priorities, shifting resource plans and sub-optimal scoping of projects there is a risk that transformation programmes and projects will not be delivered to time which may result in the Trust not realising the benefits of the work.	Will probably recur, but is not a persistent issue	Moderate	12	Training refresher on project documentation in the transformation team	29/03/2024		Arnett, Louise	Directorate Management Team Meeting	30/04/2024	9	Population	Trust Board (Corporate Risk Register)	Director of Transformation	Talbott, Alex	02/01/2024	Transformation programme Boards Resource scheduling bi-weekly meeting Urgent and Emergency Care and Planned Care Boards Small projects Board Corporate Projects Prioritisation Group feeding into the Engine Room Project documentation to support delivery	Capacity and capability to deliver to time	Good knowledge of transformation programmes and projects underway	Programme slippage Incomplete and sub-standard documentation
										Track project delivery via transformation senior leadership team meeting	29/03/2024		Talbott, Alex												
										Continue to strengthen the role of Corporate Project Prioritisation Group (CPPG) by ensuring it runs monthly and routing resource requests and major resourcing changes via CPPG.	29/03/2024		Talbott, Alex												
7472	Organisational Development and People	Organisational Development & People Department	12/10/2022	Trustwide risk assessment	16	As a result of staff absences, continued poor retention of existing staff and ineffective & inefficient recruitment activity to fill vacancies in a timely manner, there is a risk that SFT is unable to manage service provision and operate a safe hospital. This is compounded by the need to staff the new ward and additional theatre capacity.	May recur occasionally	Major	12	Staff resource plans identified and agreed with Divisional Management Teams.	31/03/2024		Crowley, Ian	Trust Board	31/03/2024	9	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Whitfield, Melanie	12/10/2022	Monthly analysis of Workforce Data against Staffing Availability levels People Promise elements delivered to improve retention Targeted attraction and recruitment campaigns against identified priority vacancies. Line management training to support delivery of Career and well being conversations. Divisional and trust workforce control panels. First 90 day and 1 year anniversary feedback events. Hearing it campaign. We have a specialist interim involved in resource planning and strategic workforce management. AHA clinical strategy to meet long term NHS workforce plan targets Quarterly nursing safe staffing meetings. Nursing skills mix bi-annual reviews.	Resources to deliver the NHS Widening participation agenda. Line management confidence to manage absence and grievance procedures. Insufficient wellbeing and career conversations. Further review of exit process and appraisals are required	Improving KPIs for vacancy rate, time to hire, and sickness absence control - maintaining though not improving staff retention. Turnover remains at 14%. Positive trend on quarterly pulse survey.	Lack of alignment between budgeted FTE and the establishment recorded per service function and/or division - this is one of six improvement projects in our financial recovery. Number of days absence/time lost due to short intermittent periods of absence being effectively managed. Control and effective management of temporary staffing numbers.
										Mechanism to manage career pathways and career conversations delivered.	14/01/2023	07/06/2023	Crowley, Ian												
										Delivery of the widening participation initiative.	31/03/2024		Crowley, Ian												
										Recruitment processes optimised (pwc recommendations implemented).	30/04/2023	07/06/2023	Crowley, Ian												
										Movers and leavers project delivered.	31/03/2024		Crowley, Ian												
										People Promise actions for this year to be delivered.	31/03/2024		Crowley, Ian												
										Health and Well-being plan delivered.	30/09/2023	17/09/2023	Crowley, Ian												
										Exit and appraisal policy review and application.	31/03/2024		Whitfield, Melanie												
7573	Operations Directorate	Trustwide	16/01/2023	Bed meeting	20	The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services.	Will probably recur, but is not a persistent issue	Moderate	12	Urgent and Emergency Care Board established to hold transformation programmes to reduce bed occupancy	29/09/2023	07/09/2023	Thomas, Lisa	Trust Board	29/03/2024	12	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	Thomas, Lisa	16/01/2023	site report, clinical safety huddle patient safety meeting nurse staffing meetings x2 daily urgent care board	system plans for reduction in NCTR including use of additional bedded capacity	Bed occupancy has started to reduce whiteparish ward closed to enable refurbishment Number of patients in ED waiting for bed overnight reducing	Number of beds open still higher than core bed footprint NCTR remains higher than expected Turnover of staff increasing
										expansion of SDEC to surgery and Gynae specialities to further prevent admissions and need for beds	29/12/2023	15/01/2024	Thomas, Lisa												
										work with BSW on NCTR reduction plan - particularly those waiting for care Act assessment in beds	29/12/2023	15/01/2024	Thomas, Lisa												
										finalise winter plan to optimise flow, including OPEL levels, escalation protocols	31/10/2023	15/01/2024	Thomas, Lisa												
7574	Operations Directorate	Trustwide	16/01/2023	Service Delivery Plan	15	The continued pressure from urgent care flow alongside the increases in length of stay, compromises the ability for the Trust to undertake planned care.	Will undoubtedly recur, possibly frequently	Moderate	15	Outpatient transformation programme request for additional support - to ensure progress in reducing patients waiting, reduction in follow ups and increased in PIFU	29/09/2023	07/09/2023	Thomas, Lisa	Weekly Delivery Group	29/12/2023	12	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	Thomas, Lisa		delivery Group IPR EPR meetings with Divisions Planned care board Theatre productivity programme BSW Elective Care Board	New ward being built- lead time to completed (23/24) Impact of NCTR patients on available bed capacity no real reduction in time to first outpatient appointment risking 78 WW	Longer waits over 78 weeks 104 week waits on trajectory growth in waiting list fairly stable	some specialities under pressure for 52 benchmark lower for productivity that comparable Trusts can't achieve 2019/20 levels of activity due to bed capacity
										Work with Wiltshire Alliance to reduce NCTR impacting on elective beds through the development of virtual wards, discharge hub and pathway changes for non bedded capacity.	29/09/2023	07/09/2023	Thomas, Lisa												
										planned care board to focus on outpatients for the next three months in line with NHS letter 2/8	30/12/2023	15/01/2024	Thomas, Lisa												
										winter plan includes expansion within DSU for chairs to mitigate against winter escalation	29/12/2023	15/01/2024	Thomas, Lisa												
										New ward opens with new timetable for April/May 2024 to increase planned care capacity	30/04/2024		Thomas, Lisa												
7734	Finance and Procurement	Finance Department	16/06/2023	Financial management	15	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Will undoubtedly recur, possibly frequently	Moderate	15	2024/25 medical equipment brought into 2023/24 as backfill against estates program slippage.	31/03/2024		Ellis, Mark	Finance and Performance Committee	31/03/2024	8	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	21/09/2023	- capital control group priorities capital programme - monitor Datix incident reporting related to infrastructure and equipment.	- financial constraints on ability to address whole scale estate risk. - unclear regional/national process for emergency capital bids	- incident reporting highlighting areas of concern - sub groups maintain 5 year capital plans providing visibility of programme deliverables and gaps	- increasing level of maintenance required - increasing number of incidents of operational disruption particularly in day surgery
7807		Trustwide	16/08/2023	Incident reports, Trustwide risk assessment, Violence and Aggression	20	As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff. This also impacts on staff morale	Will undoubtedly recur, possibly frequently	Moderate	15	Agree an approval algorithm for mental health 1 to 1 support with AWP.	28/02/2024		Osman, Laura	Trust Board	31/03/2024	12	Population	Trust Board (Corporate Risk Register)	Director of Nursing	Murray, Dr Duncan	16/08/2023	Daily review of mental health needs across the organisation and identify staffing requirements. Use of agency RMNs.	Availability of adult mental health beds and tier 4 CAMHS beds. Inconsistent standards of agency RMN skills and knowledge.	Improved partnership working leading to better therapeutic input.	Long length of stay for mental health patients requiring community or MH inpatient facilities. Increase number of incidents reported in relation to mental health patients.
										Ongoing collaboration with partners at ICS and regional level related to Mental Health Provision.	31/12/2023		Murray, Dr Duncan												
						A risk that the current lack of substantive Gastroenterology medical and nursing workforce will impact on the ability of the service to deliver sustainable	...bly frequently			Ongoing recruitment drive.	30/09/2019	25/04/2019	Clarke, Lisa	...eting				...k Register)	...cer			Sustainable provision of service through use of long-term locums provided by ID Medical. Ongoing recruitment efforts for specialist nursing and unfilled medical posts. May 2023 - New Fixed term gastroenterologist starting end of	Unsuccessful recruitment to specialist Nurse roles, which has a particular impact on Hepatology and IBD service provision. Until substantive recruitment is complete, off site provision of GI Bleed on-call service will continue.	Regular contract monitoring meetings with ID Medical. Monitoring of Key Quality Indicators demonstrating a safe service. 3 new substantive GI Consultants in post and providing oversight and assessment of current service performance.	Service is not meeting all required performance standards but this is understood and related to post-Covid elective recovery challenges. No service specific concerns identified currently. New consultants are uncovering new risks as they explore the
										Continual clinical prioritisation to ensure that high risk areas are covered.	01/04/2019	17/04/2019	Clarke, Lisa												
										Continuing insourcing of private provider to endoscopy.	30/06/2019	25/04/2019	Vandyken, Mrs Ali												
										Quantification and mitigation of the risk to bowel scope.	01/04/2019	17/04/2019	Vandyken, Mrs Ali												
										Tender for elements of the Gastroenterology service.	01/04/2019	17/04/2019	Stagg, Andrew												
										Monthly update to F&P Committee and CGC.	10/05/2019	25/04/2019	Hyett, Andy												
										Presentation of gastro strategy to Finance and Performance Committee.	31/05/2019	12/06/2019	Hyett, Andy												
										Put together a workshop with CDs and Clinical Leads to discuss options for service provision.	01/10/2019	22/10/2019	Hyett, Andy												
										Continue conversations and meetings with alternative NHS providers for likely future joint partnership for delivery of service	30/09/2019	29/08/2019	Henderson, Dr Stuart												
										Medical Director to link with other STP partners around system wide solution.	31/12/2019	21/02/2020	Blanshard, Dr Christine												

5704	Surgery	Trustwide	31/01/2019	Directorate risk assessment	16	workforce will impact on the ability of the service to deliver sustainable comprehensive safe and effective care to patients.	Will undoubtedly recur, possi	Moderate	15	Case for change to develop a GI unit to be completed	31/12/2019	04/03/2020	Hyett, Andy	Intensive Support Me	31/01/2024	6	Population	Trust Board (Corporate Ris	Chief Medical Offi	Collins, Peter	31/01/2019	May 2023 - New Fixed term gastroenterologist starting end of May 23 August 23 - Deputy CMO commissioned to provide oversight of the service and to describe road map to sustainability through partnership with neighbouring acute Trusts. External support from senior gastroenterologist providing elements of IBD service October 23 - continued support from executive team for improvements with fortnightly assurance meetings. Partnerships with local GP in place and due to commence Nov 23 supporting with specific clinical pathways.	May 2023 - Substantive consultant has handed in notice - leaving end of July 2023. Fixed term consultant going on Mat leave in mid June 2023. Clinical leadership of GI Unit changing hands. June 23 - Resignation of substantive consultant. August 23 - long term capacity and demand planning remains challenging due to non substantive medical workforce October 23 - business case in progress with Southampton hospital to increase support for ERCP / IBD services	Additional service development time has been job planned for the new consultants to support development of the service and increased governance May 2023 - Reduction in Endoscopy long waiters. August 23 - endoscopy performance remains above peer average in BSW. external quality data does not suggest the Trust is an outlier. October 23 - Reduction in long waiters for both gastro and endoscopy through focussed attention on waiting lists	service but action plans are being developed and will be raised as new specific risks. May 2023 - With fluctuation in staffing levels in endoscopy and gastro over the last 6 months there has been an impact on waiting list levels. Mitigations are in place to regain control June 23 - Risk to service provision around ERCP, inflammatory bowel disease, and nutrition. August 23 - as June update. All subject to ongoing work overseen by Deputy CMO
										New GI unit to be launched on 1st April	01/04/2020	07/05/2020	Hyett, Andy												
										To recruit medical and nursing staff for the GI Unit.	31/01/2024		Rowell, Hayley												
										Confirm Southampton will be able to take over full responsibility for the GI Bleed out of hours service.	23/04/2021	23/04/2021	Branagan, Mr Graham												
										Secure support for existing junior doctors	30/07/2021	31/08/2021	Branagan, Mr Graham												
										Ongoing regular review of workforce strategy in GI unit	01/12/2021	20/12/2021	East, Rachael												
										Recruitment to Nutrition Service Vacancy required.	31/01/2022	28/03/2022	East, Rachael												
										Develop joint governance meeting between medicine and surgery	31/08/2023	20/11/2023	East, Rachael												
										Recruitment of new clinical lead for GI Unit	31/05/2023	22/06/2023	Stephens, Mr Paul												
										CMO to report outcome of GI services review once complete.	29/02/2024		Murray, Dr Duncan												
										Surgical division to provide assurance report on oversight of operational delivery and any impacts to quality to CGC on 27th June 2023.	27/06/2023	13/07/2023	East, Rachael												
										Intensive support meetings to commence fortnightly from 24th July.	24/07/2023	17/08/2023	East, Rachael												
5751	Operations Directorate	Discharge Team	11/03/2019	Directorate risk assessment	16	Risk of patient harm caused by patients remaining in hospital when their clinical need does not require this (no right to reside). This risk is caused by capacity/resource constraints in out of hospital care.	Will undoubtedly recur, possibly frequently	Moderate	15	Winter director managing Trustwide ECIST actions.	01/05/2019	12/06/2019	Hyett, Andy	Trust Board	31/03/2024	12	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	Thomas, Lisa	11/03/2019	Daily discharge meeting. Daily reporting and monitoring. System escalation plan revised and approved. Patient flow score card monitoring delivery of KPIs. Expert panel which reviews stranded patients recommencing from July. Weekly system discharge meeting which our head of integrated discharge is now joining. Monthly urgent care board which the COO attends. A system wide winter plan including council and community providers. The BSW system appointed a Director of Urgent Care. Targeting of patient for review by the Medical Director has been implemented as an ongoing process. Discharge Project Team meeting weekly to drive forward improvements. Improved dataset for daily monitoring. Development of Transformation programme for 2021/22. Project Initiation Document has been developed for Patient Flow including KPIs. Weekly system flow meetings attended by new Head of Flow role. Deputy Chief Operating Officer role in place. No right to reside is an approved breakthrough objective as part of the Improving Together Programme Improved data quality	- system trajectory for reduction in NCTR patients not met - capacity gap in Council for domiciliary care which means significant shortage of available care hours -	There is currently increased system visibility. Good visibility of patients waiting on different pathways which is recognised by all across the system. Wiltshire flow hub to manage all patients waiting care new care co-ordination hub being put in place for winter	The number of patients without a right to reside is not reducing. Bed occupancy is high - with escalation areas in use flow through the hospital is poor with delays in ambulance handovers increasing and patient care/quality metrics have deteriorated. Bed capacity mitigation plans identified at BSW level did not materialise as planned - therefore increasing pressure on bed occupancy at SFT.
										Winter Director coordinating trajectory for delivery of DTOC target.	01/05/2019	12/06/2019	Hyett, Andy												
										Trust actions being led by COO and Medicine CD and managed through weekly delivery meeting and monthly PMB.	01/05/2019	12/06/2019	Hyett, Andy												
										Weekly expert panel meeting to challenge discharge pathways chaired by CCG director of quality.	01/05/2019	12/06/2019	Hyett, Andy												
										Trust implementing discharge PTL	01/07/2019	04/09/2019	Hyett, Andy												
										Escalation to EDLDB non delivery of trajectory	01/07/2019	04/09/2019	Hyett, Andy												
										Mitigation actions being prepared to mitigate lack of capacity in the community.	01/08/2019	04/09/2019	Hyett, Andy												
										All providers required to present their winter plans to EDLDB in September.	30/09/2019	22/10/2019	Hyett, Andy												
										Business case to expand ESD service going to TMC in September and COO and DoF meeting Wiltshire Health and Care to align services	30/11/2019	10/12/2019	Hyett, Andy												
										CEO DOF and COO representing SFT at system wide winter summit on 25th October 2019.	31/10/2019	10/12/2019	Hyett, Andy												
										COO representing Trust at Regional Workshop w/b 9th December	14/12/2019	04/03/2020	Hyett, Andy												
										System wide actions to be monitored through the ED local delivery board.	01/04/2020	28/04/2020	Hyett, Andy												
										COO escalating the need for an ED LDB risk log reflecting the risks carried by each provider organisation.	19/12/2019	04/03/2020	Hyett, Andy												
										Risk to be captured on newly developed ED Local Delivery Board Risk Register.	31/03/2020	28/04/2020	Hyett, Andy												
										Action plan to be developed for 2021 by Urgent Care Board.	31/03/2021	04/05/2021	Hyett, Andy												
										Reinstate the challenge of stranded patients by the Medical Director by the end of October.	01/11/2020	20/10/2020	Hyett, Andy												
										Development of Transformation Programme for improved Discharge processes.	31/05/2021	28/06/2021	Hyett, Andy												
										Agreement of system escalation triggers.	31/05/2021	28/06/2021	Hyett, Andy												
										Review of bed modelling in light of increased urgent and elective activity.	31/05/2021	30/06/2021	Humphrey, Kieran												
										Agreement of Improvement Trajectory with system partners.	30/07/2021	08/10/2021	Hyett, Andy												
										Delivery of the Transformation Improvement Plan.	30/11/2021	30/12/2021	Wood, Paul												
										Delivery of the BSW Urgent Care Board discharge improvement plan which the Trust is contributing to	31/10/2022	11/10/2022	Thomas, Lisa												
										Trust working with BSW on delivery of 57 additional community beds at South newton from November.	30/11/2022	28/12/2022	Thomas, Lisa												
										Trust developing winter plan for implementation focusing on pathway 0 patients to maximise available bed capacity	31/10/2022	28/12/2022	Thomas, Lisa												
										Discharge Hub being established at SFT to support efficient and effective discharge process and improve partner working	29/09/2023	14/08/2023	Cavill, Emma												
										SFT to complete bed modelling and potential pathway improvements with Wiltshire Place colleagues	30/11/2023	15/01/2024	Thomas, Lisa												
7955		Trustwide	01/01/2024	Waiting times	16	There is a risk that ongoing industrial action compromises the quality and timeliness of patient care, compromises operational effectiveness and impacts on the workforce morale.	Will probably recur, but is not a persistent issue	Major	16					Trust Board	29/03/2024	8		Trust Board (Corporate Risk Register), Joint Board of Directors	Chief Operating Officer	Thomas, Lisa	15/01/2024	EPRR infrastructure IA planning CGC oversight People and Culture committee TMC Pulse survey	Not able to look at longitudinal impact of patients receiving care during strike periods where staffing levels may be different. Minimum staffing levels means cancelling planned patient care due to availability.	Harm related incident reporting low during strike periods sickness levels static and not deteriorating	Patient waiting times increasing in planned care cancelled procedures during strike period cancer performance compromised
7308	Finance and Procurement	Trustwide	19/04/2022	Trusts Objectives, Trustwide risk assessment	15	The financial plan for 2023/24 is for an underlying deficit plan with assumed 5% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Ongoing industrial action is affecting both activity levels and management capacity to deliver required improvement programmes. Therefore there is a risk that the financial plan will not be delivered and cash balances will deplete during 2023.	Will undoubtedly recur, possibly frequently	Major	20	Grip and Control processes reviewed in all Divisions to ensure robust financial governance	29/07/2022	11/10/2022	Thomas, Lisa	Finance and Performance Committee	30/11/2023	9	Partnerships	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	19/04/2022	Cash flow forecasting -- monitoring reports to F&P - SFI's ensuring strong financial governance - budget signed off for April 2023/24 based on internal assumptions - ICB surplus distribution to providers agreed. - Weekly agency usage monitoring - Monthly financial recovery group chaired by CEO - Enhanced vacancy control and temporary staffing process - System investment triple lock	- Delivery of 5% CIP dependent on external action - Uncertain impact of winter pressures, staffing gaps, and effects of industrial action	Gaining traction on key improvement programmes leading to closure of beds and reduced agency costs but run rate remains higher than planned Activity is ahead of plan	Ongoing agency bookings Pay overspend Forecasted £4.3 million deficit.
										Divisions asked to identify full CIP and or productivity plans to ensure they manage within Budget for 2022/23	29/07/2022	11/10/2022	Thomas, Lisa												
										Deployment of winter plans.	30/11/2022	15/12/2022	Ellis, Mark												
										Seeking support for unfunded pressures from the ICB and SpecCom.	31/01/2023	31/03/2023	Ellis, Mark												
										Review of agency booking process.	31/01/2023	31/03/2023	Whitfield, Melanie												
										3-year forecast being undertaken in Q1, including risks and impact on cash flow.	29/09/2023	29/12/2023	Ellis, Mark												
										Identification of additional savings opportunities managed through Divisions with oversight from FRG.	31/03/2024		Ellis, Mark												
										Organisation wide communications strategy for financial recovery	31/01/2024		Ellis, Mark												

6229	Surgery	Day Surgery Unit	04/03/2020	Access targets, Complaints, Departmental risk assessment, External audit reports, Incident reports, Other assurance not listed, Service Delivery Plan, Waiting times	12	[07/07/2023 12:00:42 Laurence Arnold] The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures. Failure of the air handling unit is becoming a regular occurrence, this in turn affects the overall environment, prevents activity from taking place owing to infection control policies and results in cancellations of elective procedures. Incidents relating to the building condition are increasing and impacting on patient safety, care and experience. Regular problems with maintaining temperatures safely - theatre F particularly difficult. Air handling plant is sub-optimal for the needs of the facilities. Poor environment for staff - lack of wellbeing facilities. Results in inconvenience for patients - cancellations, and being moved to main theatres. The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures. Failure of the air handling unit is becoming a regular occurrence, this in turn affects the overall environment, prevents activity from taking place owing to infection control policies and results in cancellations of elective procedures. Incidents relating to the building condition are increasing and impacting on patient safety, care and experience	Will undoubtedly recur, possibly frequently	Major	20	DSU risk escalated to wider stakeholders to ensure remains priority scheme for BSW and South West Region	13/06/2023	13/06/2023	Arnold, Laurence	Trust Board	31/10/2023	4	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	O'Keeffe, John	13/01/2023	[07/07/2023 12:00:42 Laurence Arnold] None ad hoc nature of issues results in limitations around mitigations. Staff manage individual cases and issues None ad hoc nature of issues results in limitations around mitigations.	[07/07/2023 12:00:42 Laurence Arnold] Substantial capital investment is required - the whole facility needs to replacing, necessitating national capital funding. Funding for new DSU.	None Constant lobbying being undertaken to attempt to secure funding.	[07/07/2023 12:00:42 Laurence Arnold] Problems persist - Roof leaks, heating failures and significant investment identified in the critical plant survey (2020). Regular failure in AHU's resulting in patient cancellations Roof leaks, heating failures and significant investment identified in the critical plant survey (2020). Regular failure in AHU's resulting in patient cancellations

Corporate Risk Register Summary - January 2024 v1

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Oct-22	Jan-23	Jun-23	Sep-23	Jan-24	Target
Risk Detail				Score Trend						
POPULATION - Improving the health and wellbeing of the population we serve										
5704	Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce	Chief Medical Officer	31-Jan-19	16	9	9	15	15	15	6
5751	Risk of patient harm caused by a delayed discharge from hospital.	Chief Operating Officer	11-Mar-19	16	20	20	20	15	15	12
7039	The Trust is currently experiencing increased demand and patient acuity across all in-patient areas, at a time of increased nursing sickness, maternity leave, leavers and retirement and reduced recruitment. This causes a shortfall in Care Hours per Patient day (CHPPD), increases risk of burnout for remaining staff, causes delay to flow and discharges and inability to provide required care for all patients	Chief Nursing Officer	01-Jul-22	15	20	15	15	12	12	4
5360	Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss	Chief Finance Officer	11-Feb-20	15	10	10	10	10	10	8
5955	Insufficient organisation wide robust management control procedures	Chief Finance Officer	13-Aug-19	15	9	9	9	9	9	6

7946	As a result of competing priorities, shifting resource plans and sub-optimal scoping of projects there is a risk that transformation programmes and projects will not be delivered to time which may result in the Trust not realising the benefits of the work. **New risk**	Chief Medical Officer/Director of Transformation	02-Jan-24	12					12	9
508	The absence of a comprehensive Health and Safety Management System for the Trust runs the risk that legislative requirements will not be embedded into the Trust standards to which departments are expected to work. Without those standards, we cannot expect the Trust be compliant, so the consequences of non-compliance with health and safety law results in Staff and all persons on site at risk of harm and the Trust at risk of prosecution and claims.	Chief People Officer	30-Jun-21	16	12	12	9	9	6	6
6229	The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures. Failure of the air handling unit is becoming a regular occurrence, this in turn affects the overall environment, prevents activity from taking place owing to infection control policies and results in cancellations of elective procedures. Incidents relating to the building condition are increasing and impacting on patient safety, care and experience	Chief Operating Officer	02-Jan-23	12		20	20	20	20	4

7573	The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services.	Chief Operating Officer	16-Jan-23	20		20	20	15	12	12
7574	The continued pressure from urgent care flow alongside the increases in length of stay, compromises the ability for the Trust to undertake planned care.	Chief Operating Officer	16-Jan-23	15		15	15	15	15	12
7807	As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff.	Chief Nursing Officer	16-Aug-23	20				20	15	12
7955	There is a risk that ongoing industrial action compromises the quality and timeliness of patient care, compromises operational effectiveness and impacts on the workforce morale. **New Risk**	Chief Operating Officer	01-Jan-24	16					16	8

7809	There is a risk that the Trust has an unidentified gap in effective clinical care may be the cause of the sustained deterioration in HSMR and SMR. There is a current failure to provide adequate assurance that the change in statistics is not a result of avoidable harm.	Chief Medical Officer	17-Aug-23	8				8	4	4
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work										
7472	As a result of unmanageable staff absences, poor retention of existing staff and ineffective recruitment activity to fill vacancies, there is a risk that SFT is unable to manage service provision and operate in a safe hospital	Chief People Officer	12-Oct-22	16	16	16	16	16	12	6
7078	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together Programme deadlines	Chief Medical Officer	13-Oct-21	12	12	9	6	9	9	6
PARTNERSHIPS - Working through partnerships to transform and integrate our services										
6857	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn resulting in the Trust incurring financial losses **Risk tolerated**	Chief Finance Officer	12-Mar-21	6	8	8	8	8	8	8
6858	There is a risk as new guidance and models of working emerge, the immaturity of partnerships between the Trust and wider BSW organisations will impact on progress to achieve key objectives	Chief Operating Officer	12-Mar-21	9	9	9	9	9	9	6
7734	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Chief Finance Officer	16-Jun-23	15			15	15	15	8

7308	The financial plan for 2022/23 is a deficit plan with assumed 2.2% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Therefore there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures.	Chief Finance Officer	12-Mar-21	15	12	16	20	20	20	9

Risk Score Key

Low Risk 1-3
Moderate Risk 4-6
High Risk 8-12
Extreme Risk 15-25

Risk Appetite

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board Meeting (Public)	Agenda item:	6.2
Date of meeting:	07 March 2024		

Report tile:	Patient Feedback Report – Q2 2023/24			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Patient Experience Steering Group – 24th January 2024. Clinical Governance Committee – 30th January 2024			
Prepared by:	Victoria Aldridge - Head of Patient Experience			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			
Appendices (list if applicable):	APPENDIX 1: B7 Development Day - August 2023 v2 Distribution Version APPENDIX 2: Complaints Process Review – Action Plan Progress v6 APPENDIX 2a: HWW – You Said, We Did Update APPENDIX 3 KPMG Complaints Internal Audit Terms of Reference APPENDIX 4: Friends and Family Test Comments – Q2 2023/24 APPENDIX 5: National Inpatient Survey Results (2022) APPENDIX 6: National Cancer Patient Experience Survey Results (2022)			

Recommendation:
This report is for assurance and noting by the Committee.

Executive Summary:

This report provides summary and insights drawn from the various methods by which our patients feedback on our services. This includes analysis of complaints, concerns, compliments, Friends and Family Testing and National surveys reported during Q2 of 2023/24. To summarise the contents of this paper:

Complaints/concerns/compliments and enquiries:

The number of formal complaints made in Q2 has increased (n~40) when compared with the previous quarter. 35 complaints were formally logged in Q1, however these figures are still significantly lower than those logged in Q4 (n~57) and Q3 of 2022/23 (n~56).

There were 56 concerns logged in Q2, an increase again on Q1 (41), but significantly lower than what has been seen in Q2 & Q3 2022/23 (n~68 and 60 respectively). New reporting capabilities have been able to demonstrate where early resolution and descalation of complaints/concerns are occurring, the early data around this continues to be positive and could suggest a contributory factor to the reductions in numbers of logged complaints being seen overall.

A total of 375 comments/enquiries were logged by the PALS team in Q2, a significant increase to the 277 seen in Q1 and also in Q4 (n~354) which was the last noted peak.

A total of 173 compliments were recorded on Datix this quarter across the Trust (6 more than last quarter). We are now able to breakdown this reporting down to show which areas are receiving these

compliments. Work is still needed with individual areas to ensure all compliments are sent to PALS for formal recording.

For Q2 the most common high-level theme for complaints across the Trust were the same as those seen in Q1. These were in relation to Patient Care (40%) and Communication at (23%) and Values and Behaviours of Staff (10%) – this was noted to be a common theme for all four clinical divisions.

Overdue complaints continue to be a challenge for the Trust as a whole, continuing to fall short of the 90% Improving Together target set. PALS continue to work closely with the divisions on closing this gap, focusing on early resolution and de-escalation in anticipation that this will help to reduce the overall backlog in some areas over time.

The number of reopened complaints/concerns in Q2 has increased this quarter, reasons for this are varied but largely due to new questions being asked or being unhappy with the outcome. There were also an indication that lack of accountability or the information contained in the response was not correct were also reasons for complaints reopening.

New report section to note for this quarter: This section summarises the learning and areas of focus for each Division which have been determined thorough patient experience presentations at DMT and clinical governance sessions. This learning is then brought back to the Patient Experience Steering Group at a later as an opportunity to share learning across divisions (see Learning from Patient Experience).

Friends and Family Test: The Trust wide average response rate for Q2 is now the highest seen to date with 2,529 responses received. The response rate has also peaked at 3.6% (of eligible population), and although this is below the Improving Together target for 2023/24 of 15%, we continue on a positive upward trajectory towards this. Friends and Family Test experience ratings have decreased slightly going down to 97% from 98%. Digital provider rollout has now been reinstated and project implementation will be taking place during Q4 of 23/24. Theming of comments from the digital dashboard has been delayed until Q3 reporting due to issues with the data set being uploaded to the new platform.

Local Surveys:

Real-time feedback (RTF) has had more consistency throughout Q2 and is now a standing item for discussion at the PESG. Overall good satisfaction rates, though some issues noted around noise at night and involvement with discharge plans.

The Bereavement Survey for Q2 is usually summarised within this report and appendixed, however this report is still pending finalisation with the End of Life Care Leads owed to vacant posts. This will be included in later reports once these can be signed off through tehh End of Life Care Steering Group.

National Surveys:

National Inpatient Survey 2022: Comparison across all areas of the inpatient survey were noted to be about the same as other Trusts. Benchmarking against our own results from 2021 showed that 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.

Cancer Patient Experience Survey 2022: Overall positive survey, with patient experience rating out performing the national average and the performance of our BSW peers.

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

Patient Experience Report - Patient Feedback Q2 2023/24

Purpose of paper

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

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

Background

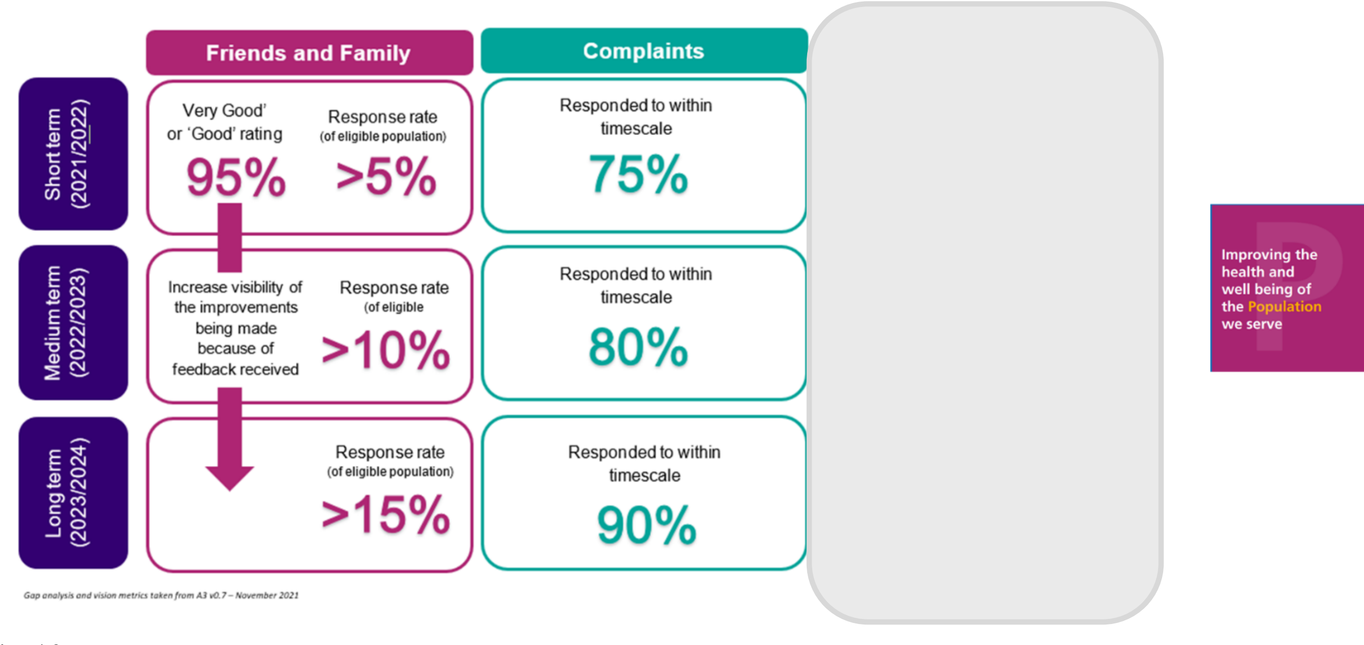
Patient experience is defined as “the sum of all interactions, shaped by an organisation’s culture that influence patient perceptions across the continuum of care”. Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and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

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

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

These metrics are currently under review and will be produced under a new A3 “Patient Engagement Score”. This will be introduced through the annual patient engagement report in Q1 of 2024/25.

Patient Experience – Improving Together Summary



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1. Complaints, Concerns and Compliments - Trust Overview

There were a total of 4 items of feedback posted on the NHS Website* in Q2.

Average rating on responses:

	Positive	Negative	Average star rating
Q2 23/24	2	2	★★★
Q1 23/24	4	0	★★★★★
Q4 22/23	2	2	★★★
Q3 22/23	4	0	★★★★★

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

Summary of these comments are depicted in this wordcloud:

friendly
outpatients
appalling
contact service
gynae professional
department
hard care
experience

Patient Activity

Table 1.1 shows the breakdown for patient activity across the Divisions and total for the Trust. This is used to calculate this feedback on a per 1,000 basis (see Figure 1.1). The Trust is seeing a similar level of patient activity compared with last quarter.

Table 1.1 – Patient activity

Patient Activity by Division / Quarter	Clinical Support and Family Services	Medicine	Surgery	Women & Newborn	Total
Q2 2023 - 24	33,871	34, 921	39, 997	4,330	113,119
Q1 2023 - 24	35,540	34, 554	40, 495	4, 206	114, 795
Q4 2022-23	34,107	28,406	35,310	3,795	101,618
Q3 2022-23	31,906	29,040	35,374	4,802	101,122

Compliments

Compliments are sent directly to the Chief Executive, PALS or via the SOX inbox and are acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment the PALS team complete a SOX which is sent to the SOX administrator for forwarding onto the individual and their line manager. Whilst compliments in some areas continue to be retained locally within the departments/wards, the PALS team continue to work with the Divisions to ensure that all compliments are logged with PALS and recorded as a Datix entry. This ensures for more robust reporting and future changes to the Datix system will allow for theming of compliments to enable reporting alongside complaints and FFT.

Further analysis of compliments is included within individual divisional reports.

Complaints and Concerns

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

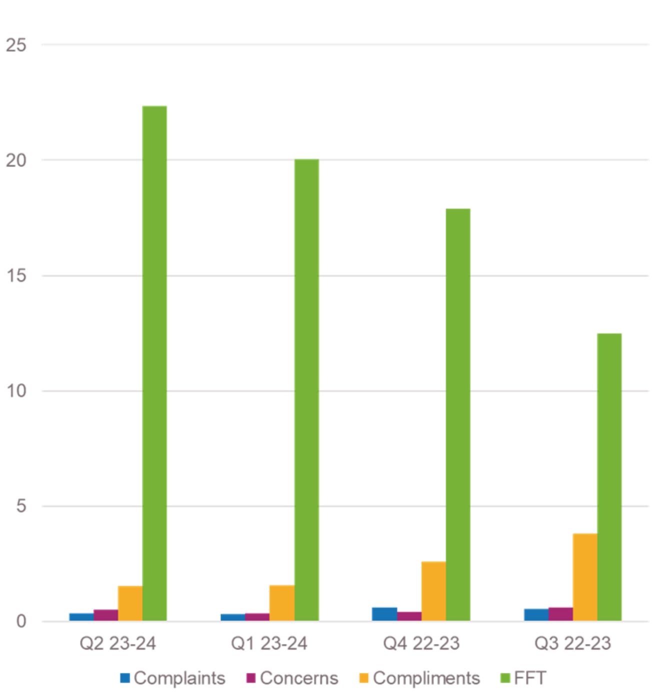
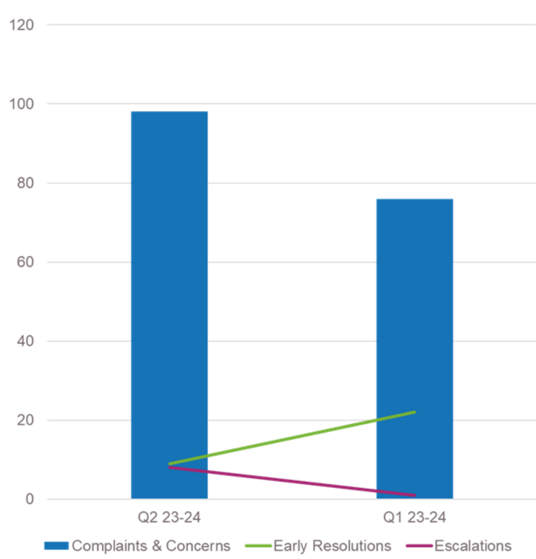


Figure 1.1 shows a slight increase in the total number of both complaints and concerns for Q2, this is against the landscape of a similar total patient activity seen in Q1. FFT feedback also continues to increase, though it is noted that compliment numbers have reduced again slightly. We do continue to believe that this is still a consequence of the transition to formally recording compliments on Datix, which relies on wards and departments to remember to send these through to PALS. We continue to promote the importance of this through divisional and departmental patient experience presentations as well as our PALS outreach visits.

In Q2 the PALS department logged 375 comments/enquiries. This was a 102 more than in Q1. This equates to an average of 3.3 contacts per 1,000 patient activity across the Trust.

During Q2 there were a total of 96 complaints and concerns logged (76 in Q1). Changes to the complaints process over the past 6-12months coupled with targeted work through PALS to adopt the PHSO principles on **early resolution** and **de-escalation** of complaints continues to be emphasised.

Figure 1.1a Total Number of Complaints & Concerns, Early resolutions, and Escalations



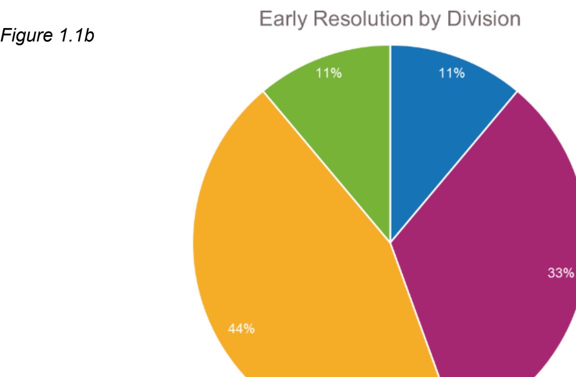
Changes to the Datix system implemented in Q1 now enables reporting on the number of complaints/concerns that have been de-escalated following early intervention and/or resolution. 9 of these were considered to have achieved an early resolution in Q2.

8 of the 96 total above, were noted to have escalated from a comment or enquiry into a concern or complaint.

Figure 1.1a shows how these correlate with Q1.

Figure 1.1b shows how the de-escalated complaints/concerns were distributed across the Trust.

Figure 1.1b



Surgery continue to work hard this quarter to adopt the principles around early resolution and de-escalation, and this is evidenced by having the highest proportion of the 9 resolved early.

Table 1.2 shows the themes for complaints received in Q2. Highlighted are the top three most prevalent themes. All three of these themes are consistent with Q1, these top three themes are further broken down into sub-categories for deeper analysis in Tables 1.2a-1.2c.

Table 1.2 Raw data - Themes from Q2 Complaints/concerns

	CSFS	Medicine	Surgery	Women & Newborn	% of total by theme
Access to treatment or drugs		1	6	1	7%
Admissions, discharge and transfers excluding delayed discharge due to absence of care package	1	2			4%
Appointments including delays and cancellations	1		5	1	7%
Clinical Treatment		2	1	1	4%
Communications	2	15	3	2	23%
End of Life Care					0%
Facilities Services			1		1%
Other					0%
Patient Care including Nutrition / Hydration	2	11	20	5	40%
Prescribing errors		2	1		3%
Values and behaviours (Staff)	1	5	2	2	10%
Total by Division	7	38	39	12	
Divisions Total	96				

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

Unsatisfied with treatment and **further complications** came out as the highest sub-category for **Patient Care** (see Table 1.2a).

Insensitive and **lack of communication** came out again as the highest cause for complaints under **Communications** (see Table 1.2b)

Values and Behvaiours of staff was a new theme for Q1 (not previously seen since Q2 of 22/23, but it has now continued into this quarter. **Medical staff** have the highest proportion of these complaints (see Table 1.2c)

Table 1.2a

Patient Care including Nutrition / Hydration	38	40%
Unsatisfactory treatment	11	29%
Further complications	7	18%
Inappropriate treatment	5	13%
Nursing Care	4	11%
Correct diagnosis not made	3	8%
Pain management	3	8%
Harm	2	5%
Falls	1	3%
Learning Disability	1	3%
Nightcare	1	3%

Table 1.2b

Communications	22	23%
Insensitive communication	8	36%
Lack of communication	7	32%
Information not given to family	4	18%
Call bell	1	5%
Delay in receiving/sending information	1	5%
Opening times	1	5%

Table 1.2c

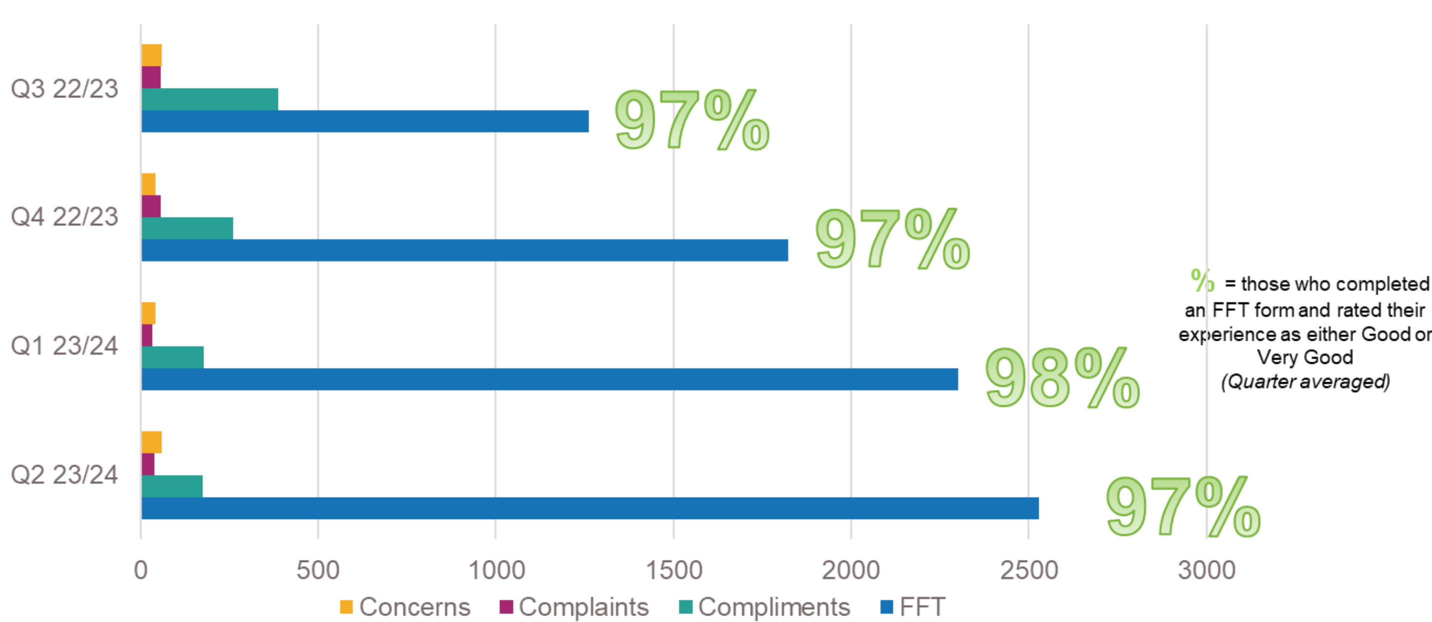
Values and behaviours (staff)	10	10%
Attitude of staff - medical	5	50%
Attitude of nursing staff	3	30%
Attitude of staff - admin	1	10%
Discrimination on the grounds of weight	1	10%

Complaints and concerns continue to be small in number when compared with the number of Friends and Family Test (FFT) feedback received across the Trust. The response rate to FFT continues to increase with only a minor reduction in the overall satisfaction rating.

This comparison is demonstrated in Figure 1.2.

The proprortion of good or very good experiences (as rated by our service users) and how vast this is in comparison to the number who have raised a complaint or concern helps to contextualise the overall expereince our patients are reflecting.

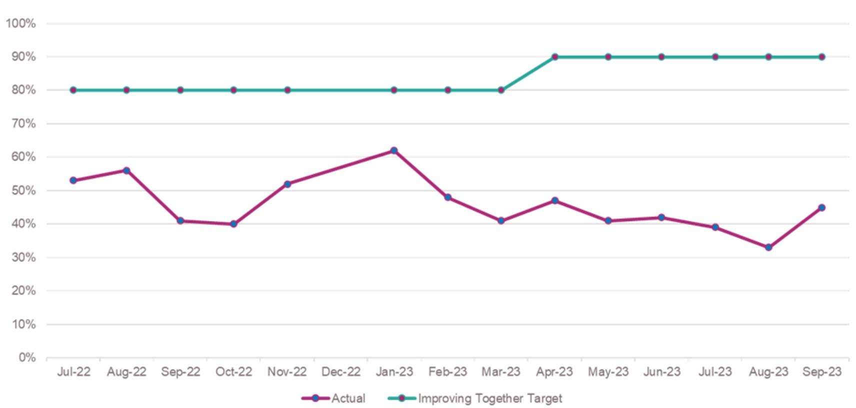
Figure 1.2 – Reiterates the FFT feedback rates compared with complaints, concerns and compliments (based on a per 1,000 patient activity) but also demonstrates the patient experiences rates obtained from these.



Overdue Complaints

As a Trust average, we continue to struggle to achieve the 90% Improving Together target.

Figure 1.3 – Percetage of complaints closed within target (Trust-wide average) as reported through PESG.



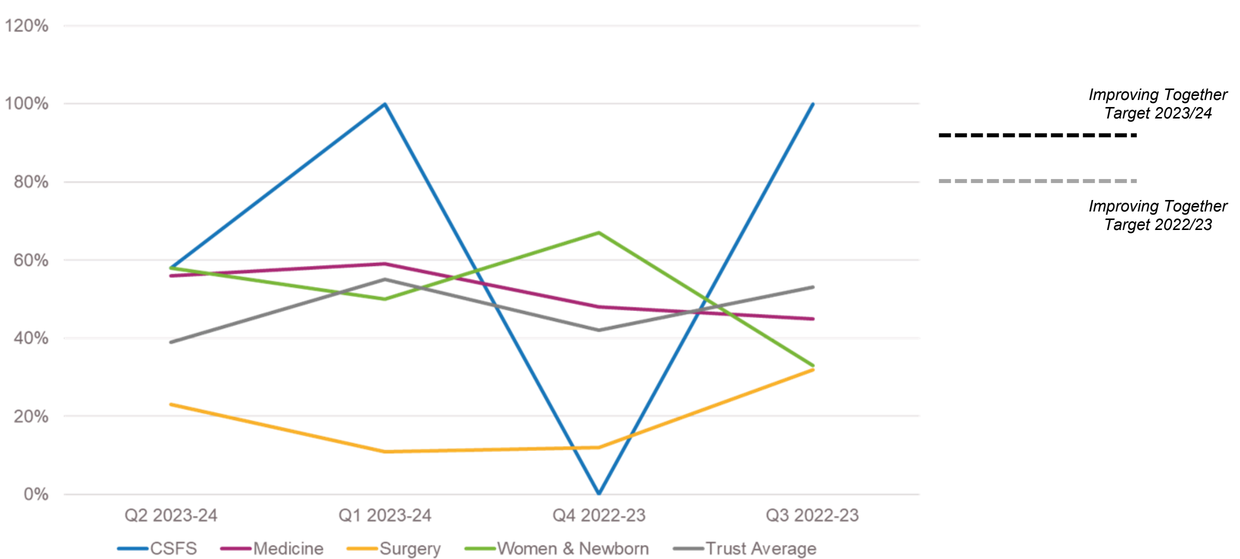
This target continues to be monitored via the Integrated Performance Report (IPR) as a watch metric.

Live data is also monitored via the Patient Experience Steering Group (PESG) and the tracking of this is demonstrated in Figure 1.3.

At Division level, we are seeing varied compliance to this target. This is largely impacted by operational pressures, there are also challenges to timely response associated with the complexity and volume of complaints requiring responses within similar timeframes.

From Q4 the Patient Experience Steering Group will be also be reviewing hot spot areas within the Divisions which may be contributing to the Division's overall average.

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



Surgery and Women & Newborn are continuing on an overall upward trajectory from Q1 going into Q2 with this target.

Medicine continue to work hard to maintain a steady compliance towards the Improving Together target of 90%, however, as explained above, this continues to be an area of challenge across the Trust.

Note: CSFS's data indicates a 0% target achievement in Q4, however, for context, no complaints during that period were due response, therefore target was *"not applicable"*.

The has been huge efforts from all Divisions to work more closely with the PALS team in responding to complaints and exploring opportunities for early resolution to avoid breaching this target where possible. PALS continues to hold fortnightly meetings to review outstanding complaints and in offering additional support to the Divisions where there may be hot spots.

(see Section 5 Division Summaries – Complaints, Concerns and Compliments) for more detailed breakdowns for each Division.

Figure 1.5 – Number of re-opened complaints or concerns

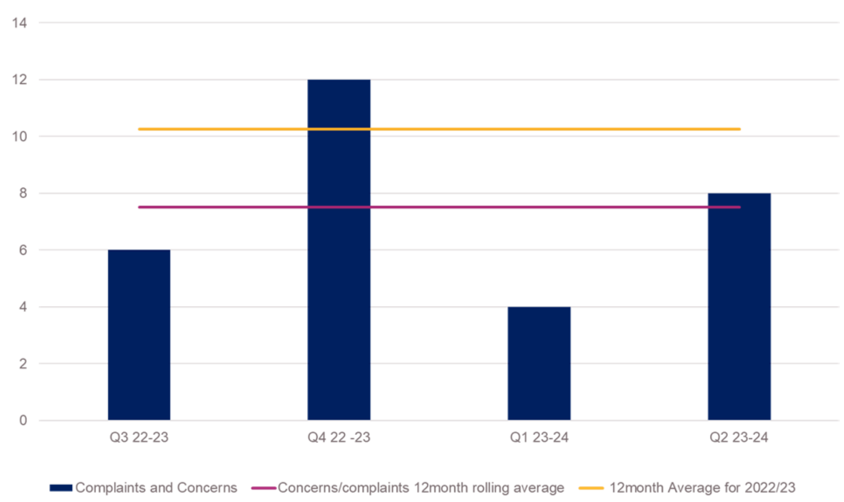


Figure 1.5 shows the number of re-opened complaints and concerns (in total), compared with previous quarters.

The yellow lines show the average for 2022/23 acting as a benchmark.

The pink line calculates a rolling average for the 12month period shown.

The number of reopened complaints and concerns have increased this quarter from Q1, driving up the pink line average, however this remains lower than the 2022/23 period, indicating a more successful overall first time resolution of complaints and concerns.

For those which have reopened, the reasons were varied and in some cases unavoidable as the complainant had further or new questions. However, for many it was due to the complainant being unhappy with the outcome, a perceived lack of accountability or the information was not correct.

The PALS team and the Division Leads continue to work hard to realise the benefits of concluding investigations with complaint meetings to avoid reopening for reasons like these and where written responses are required ensuring these address all the points, contain empathetic apologies, are factually accurate and demonstrate lessons learnt.

2. Learning from Patient Experience

Patient Stories

For August's Patient Experience Steering Group (PESG) a patient was invited to attended in person to tell her story of her experiences on Pembroke Suite.The story comes following a complaint to the PALS team where the patient described having to attend the suite for a few days at a time every few weeks for cycles of treatment. This was a very impactful story, with detailed descriptions of the environment and how this impacted on her stay and recovery.

Observations on the experience of shared bays, the atmosphere created by lack of windows and low natural light (making it hard to differentiate between night and day) were shared. Poor lighting also made for comparisons like *"it felt like a dungeon"*. The trolley ramp outside is noisy at all times of the day and night and causes issues with sleeping, impacting on well-being and recovery. Sharing a room also raises issues with privacy and dignity, particularly when patients are struggling with sickness and diarrhoea as a result of their treatment. Temperature is difficult to control and is not within control of the staff on the ward. It's either freezing or too hot and little means of fresh air.

Lots of discussions generated at PESG and summarised as: Challenges with an ageing environment, no options to relocate and any refurbishment would need to be extensive. The Cancer team continue to use patient stories and experiences through the Your Views Matter (YVM) survey to highlight these issues and evidence the need for longer term investment and improvements.

Patient Experience Presentations

The Head of Patient Experience continues to explore how to maximise opportunities for sharing patient experiences through DMT's and Clinical Governance Sessions. Throughout Q2, complaints and FFT data from Q1 was shared at Divisional Governance sessions as an opportunity to share patient experience data with front-line teams and encourage reflections on what mitigations could be considered to change poor experiences and replicate those things which are being done well.

In return, Divisions are now regularly attending the Patient Experience Steering Group (PESG) to reflect on this data and also provide updates on any areas of focus which they are pursuing informed in part, by some of this data.

Table 1.3 – Q1 Patient Experience data presented to Divisions during this quarter

Division	Data presented to Division	Division update to PESG
Surgery	19th July 2023	30th August 2023
CSFS	*20th December 2023**	28th June 2023
Medicine	29th August 2023	26th July 2023
Women & Newborn	19th October 2023*	25th October 2023
Facilities (Food & Nutrition /PLACE)	*18th October 2023** (Food & Nutrition)	27th September 2023

**For F&N, PLACE, CSFS and Women & Newborn Q1 and Q2 data were combined and presented together at a later date than planned due to agenda items of meetings having to be rescheduled. Raw data was provided to the area leads in advance to allow update for PESG as scheduled.*

Surgery Update to PESG (30th August 2023):

Historic issue with large numbers of open complaints and failure to meet response timescales. Work is now being concentrated to close that gap. Improvements in the last quarter had been noted in relation to complaints closure, with focus on early resolutions where possible. The Division has been working closely with PALS and Complaints Coordinators within the Division.

The DMT now have fortnightly meetings to review outstanding complaints and operational teams are realigning their structures to work within specialties which is hoped to improve ownership of complaints.

Key themes in the most recent quarter include patient care, access to clinical treatment and communications. These themes are reflected in the Division's driver metrics under the Improving Together initiative. The impact of industrial actions this year were noted to be a contributory factor to the access to treatment theme.

Communication, sub-themes of either lack of or inappropriate communications. Nursing staff were being encouraged to attend the Advanced Communiations Course (in-house) along with additional training on complaints.

Noted highest areas for complaints was Orthopedics and Gastroenterology. Department was noted to be going through a period of intensive support at the point of this update. Gaps in ward assistant roles across the Division, could be indicative of the themes for complaints seen in Q1.

The division were able to celebrate efforts within intensive care - volunteers knitting blankets for end-of-life patients, and patient diaries were being completed on ITU. Focused work within the ops teams was underway to ensure "wardable" patients are relocated as quickly as possible.

CSFS Update to PESG (28th June 2023):

Summary of achievements through 2022/23 including refurbishment of patient areas, launch and implementation of the What Matters to You programme in the hospital (soon to be followed by Paediatrics and Spinal).

Changes to Division to now include Dietetics, End of Life Care, Spinal Unit, Specialist Palliative Care Services and Therapies.

Challenges noted from patient feedback sources to be predominately around signage and parking.

Focuses on embedding improving together methodology for complaint response timescales, DNA rates, staff engagement and embedding of wellbeing and career conversations.

FFT feedback for May was averaging 5% for the Division, with a 99% satisfaction rate. 6month data shows Outpatient and Daycase to be contributing to the vast majority of these response rates.

Medicine Update to PESG (26th July 2023):

Summary of achievements:

- Dedicated governance time and robust structure to divisional governance meetings
- Clear focus given to patient experience
- Deep dives into RISKs and outstanding actions with improved compliance
- Continual focuse on reducing complaints/concerns, through descalation and early resolution.
- Follow up of complaint actions and review of themes ongoing. Encouraging more face to face meetings, and phone calls. Trialing invitations for ex patients/relatives to share experiences within the division's governance meetings
- Learning from incidents forum is well established for widespread learning across the division

Challenges within the division relating to communication, making up a large proportion of all complaints and concerns. Specific focus areas include:

- "feeling understood"

- "to be treated with dignity and respect"
- "being involved in decisions"
- "simple explanations"
- "being open and honest"

The current barriers were summarised as:

- Changing the mindset of the staff
- Job roles and responsibilities
- Prioritising work load
- Building on skills and confidence of junior members of staff
- Managing high level of violence and aggression towards staff

Women & Newborn Update to PESG (25th October 2023):
This update will be provided in the Q3 report.

Facilities Update to PESG (27th September 2023):
Various SOX nominations and 8 of 36 shortlisted for SOX of the year were from Facilities services. 6 of 8 non-clinical compliments received were for Facilities. Outline of current workplans:

- Catering – Implement National Standards (funding to be confirmed)
- Laundry – Tender (to be awarded), spec includes changes
- Car Parking (Patients and Visitors) ANPR – monitor and adjust
- Housekeeping – Implement New Standards - year 2 of 3
- Portering – Additional £110k investment approved – developing new staffing rotas
- Helipad replacement – 31/03/24
- Catering - Gold Tray Replacement/re-launch 6/11/23
- Catering – Single use plastic ban – 1/10/23
- Catering/Sustainability Teams – Foodie Sunday (1/10/23)

3. Training & Development for Staff

The Patient Experience Team and PALS continue to work with Division leads to explore opportunities to share learning from complaints with ward and area leads.

Training on complaints for the new Band 6's and Band 7 nursing staff took placed in July and August 2023 and were targeted with the Surgical Division initially. (see Appendix 1). The Head of Patient Experience is currently working with the Surgery DMT to look at inclusion of complaints training in the new operational manager post inductions in the Autumn.

Further complaints training is scheduled as part of the Consultants Leadership programme in October 2023 and there is also Division wide training session scheduled for Women & Newborn in November 2023.

4. External Complaints Process Reviews

HWW Complaints Project Action Plan progress update

The PALS and Patient Experience team have now largely completed the Action Plan (see Appendix 2) developed following the outcomes of the HWW complaints process project (here).

Many of these actions now form business as usual and there are no concerns raised by the Head of Patient Experience around the progress of these or any inability to complete those partially complete.

HWW continue to provide representation at the Patient Experience Steering Group and are kept up to date with the action plan progress.

HWW have also now published their “You Said, We Did” response to this project (see Appendix 2a).

No further updates on this project will be included in these reports unless by specific request from the Board.

KMPG Internal Complaints Audit 2023

In September 2023 the complaints process was subject to an internal audit with KPMG. The terms of reference for this audit can be found in Appendix 3. The outcome of the audit including recommendations and subsequent action plan will be included in the Patient Experience Q3 report.

5. Division Summaries – Complaints, Concerns and Compliments

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

0 Complaints/concerns were recorded for **non-clinical** divisions in Q2.

There were a total of 32 comments/enquiries logged in Q2 (one more than in Q1) of which 50% were related to the car parking charges (36% were related to the car park in Q1). 9% were related to a lack of car parking spaces.

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

There were a total of 6 compliments recorded on Datix for non-clinical divisions across Q2. This is the same number received in Q1, with catering, PALS and the chapel being consistent in both quarters. Housekeeping is new for Q2.

Figure 5.0 shows a breakdown of where the compliments were received:

Figure 5.0 – Non-clinical Compliments breakdown by location

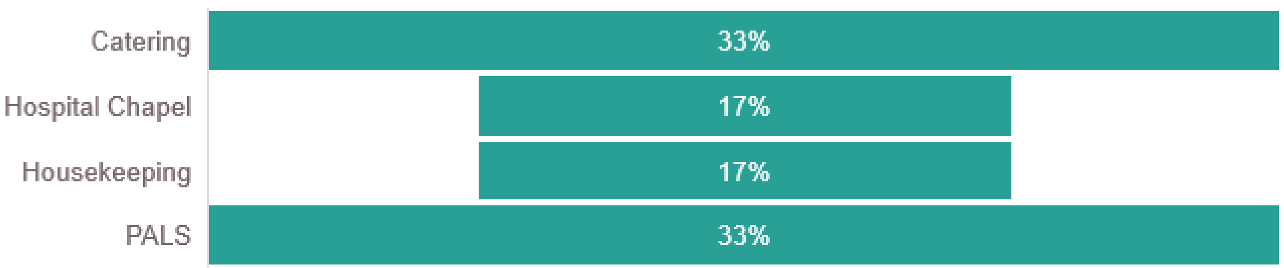


Figure 5.0a shows the location of complaints, concerns and compliments by area:

Figure 5.0a – Location of complaints, concerns and compliments by area

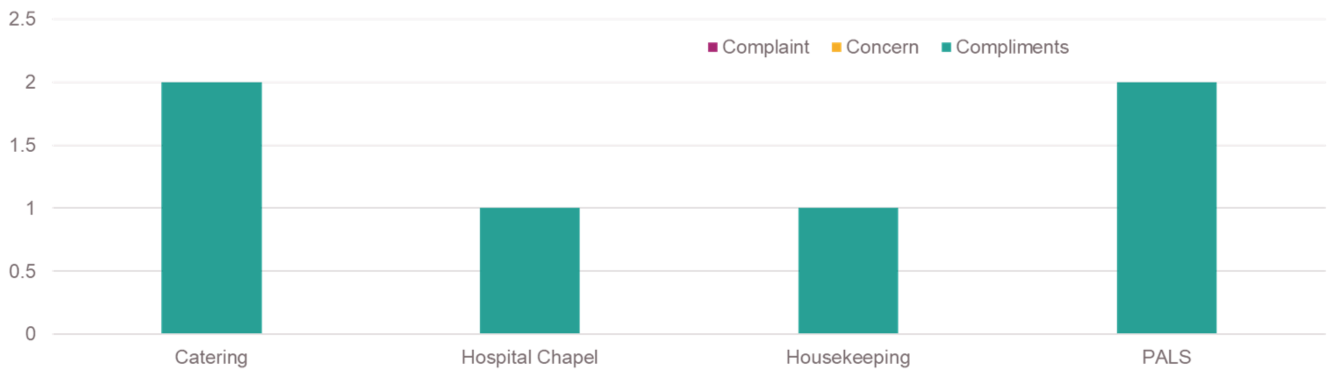


Figure 5.0b is a word cloud to summarise these compliments

Clinical Support and Family Services (CSFS)

- There were a total of 7 complaints and concerns received during Q2
- The division was able to achieve a 67% response rate within target
- 0 complaints/concerns were reopened.
- 5 compliments were formally logged on Datix.

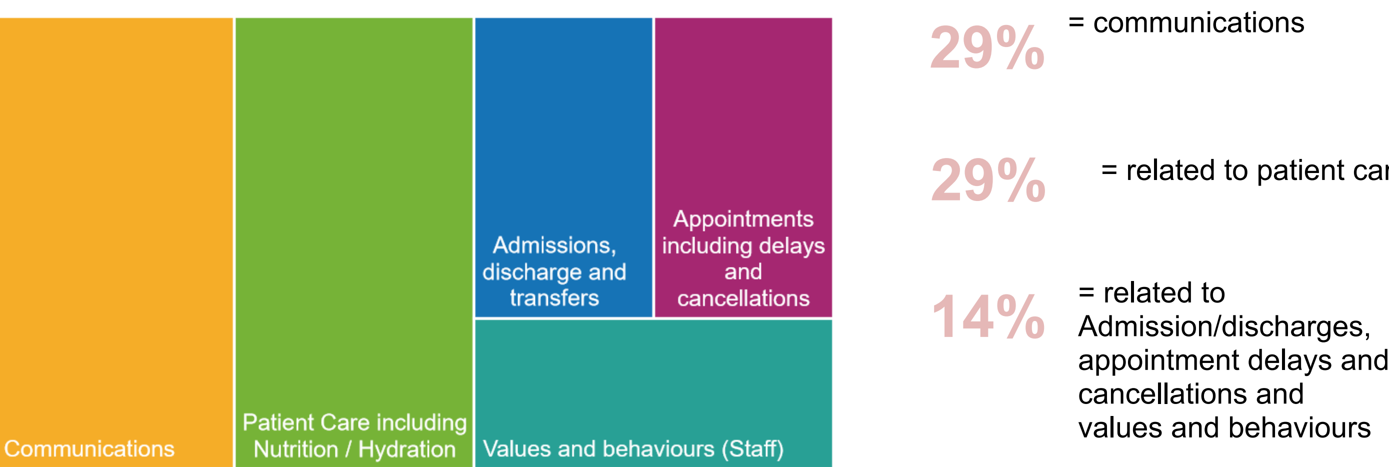
Table 5.1 Summary of patient expereince data with quarterly comparisons

- ▼ Positive downward trajectory on previous quarter
- ▼ Negative downward trajectory on previous quarter
- ▶ No change on previous quarter
- ▲ Positive upward trajectory on previous quarter
- ▲ Negative upward trajectory on previous quarter

	Q3 22-23	Q4 22-23	Q1 23-24	Q2 23-24
Complaints	▲ 5	▼ 1	▲ 2	▶ 2
Concerns	▼ 5	▶ 5	▼ 2	▲ 5
Compliments	▲ 6	▲ 21	▼ 8	▼ 5
FFT Responses	▲ 206	▲ 349	▲ 403	▼ 315
Re-opened complaints/concerns	▲ 1	▼ 0	▶ 0	▶ 0
% closed complaints responded to within agreed timescale	▲ 100%	▼ 0%	▲ 100%	▼ 67%
Complaints closed in this quarter	4	2	1	3
Complaints by Division activity (per 1,000)	▲ 0.2 (31,906)	▼ 0.0 (34,107)	▼ 0.06 (35,540)	▶ 0.06 (33,871)
Concerns by Division activity (per 1,000)	▶ 0.2 (31,906)	▼ 0.1 (34,107)	▼ 0.06 (35,540)	▶ 0.15 (33,871)
Compliments by Division activity (per 1,000)	▲ 0.2 (31,906)	▲ 0.6 (34,107)	▲ 0.23 (35,540)	▼ 0.15 (33,871)

Figure 5.1 demonstrates the most prevalent high-level themes for opened complaints during Q2.

Figure 5.1 – Summary of themes for CSFS Complaints and Concerns – Q2 2023/24



There are some clear changes this quarter compared with Q1, with 50% of the complaints in Q1 being related to **values and behaviours of staff**, and 25% (respectively) owed to **clinical treatment** and **prescribing errors**.

Within the top two themes for Q2, the following shows a sub-category breakdown for further context of these complaints:

Table 5.1a

Communications	**2**	**29%**
Insensitive communication	1	50%
Opening times	1	50%

Table 5.1b

Patient Care	**2**	**29%**
Further complications	1	50%
Unsatifactory treatment	1	50%

Compliments – Clinical Support and Family Services

Figure 5.2 – CSFS Compliments breakdown

There were a total of 5 compliments for CSFS across Q2. This is fewer than previous quarters and all have been logged on Datix. Figure 5.2 shows a breakdown of where the compliments were received:

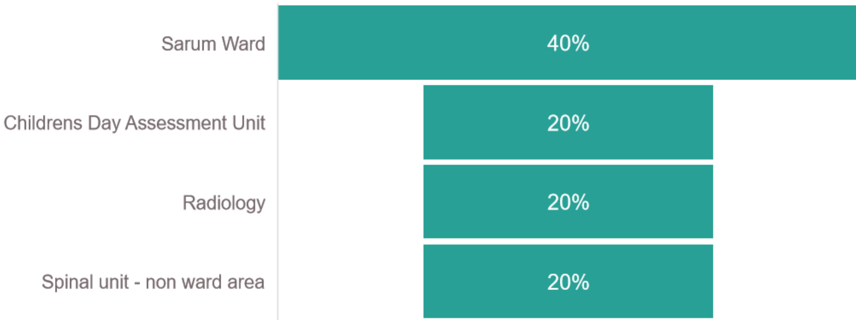
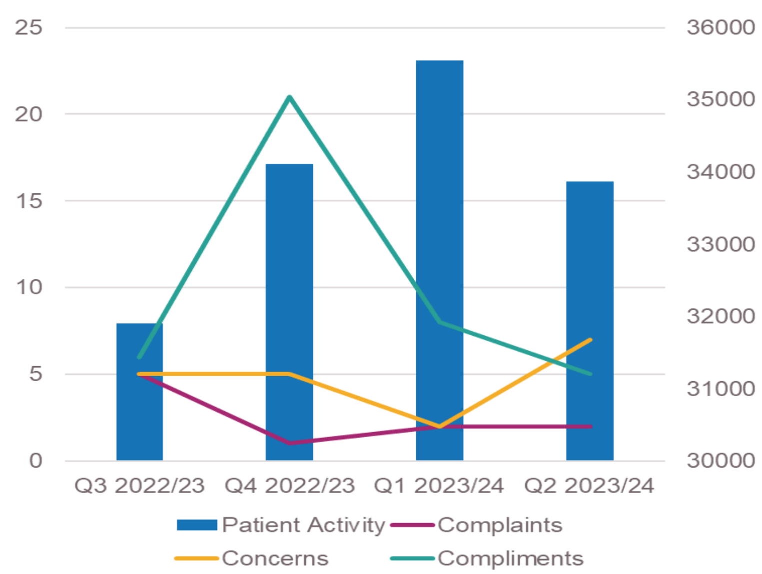


Figure 5.2a is a word cloud to summarise these compliments

Figure 5.3 shows correlation of number of complaints, concerns and compliments by patient activity for Clinical Support & Family Services**.**

Figure 5.3 – CSFS patient activity correlation with feedback

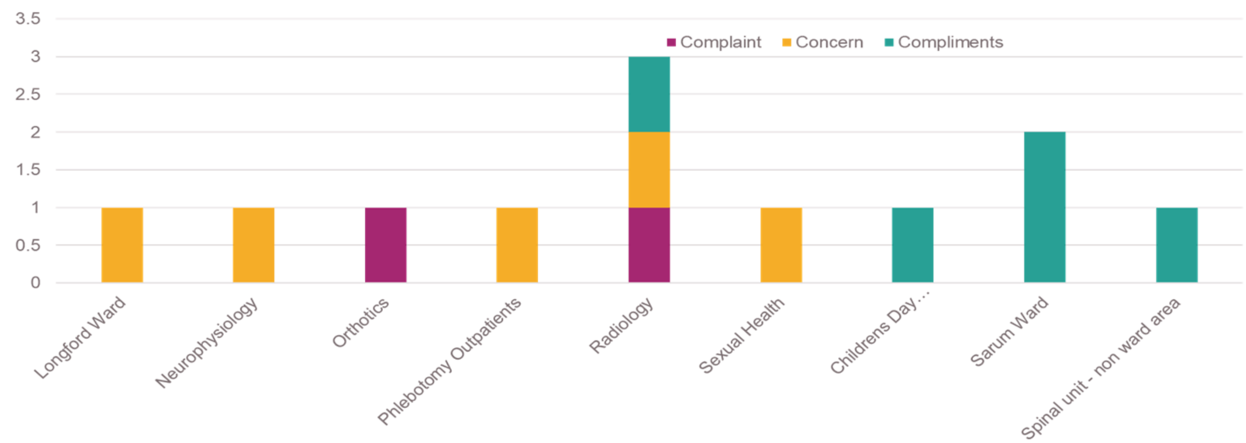


The Division has seen a slight increase in the number of logged concerns. Complaints however appear to remain on a downward trajectory.

Compliments recorded this quarter are significantly lower than the previous quarter and further work continues to ensure departments are sharing these with the PALS team for recording on Datix.

Figure 5.4 shows the location of complaints, concerns and compliments by area:

Figure 5.4 – Location of complaints, concerns and compliments by area



Women and Newborn

- There were a total of 12 complaints and concerns for Q2 – this has doubled on Q1.
- 11 complaints were closed in Q2; with 55% being responded to within the agreed timescale. This is a slight increase on the 50% compliance achieved in the previous quarter.
- 1 complaint was reopened.
- 16 compliments were formally logged on Datix.

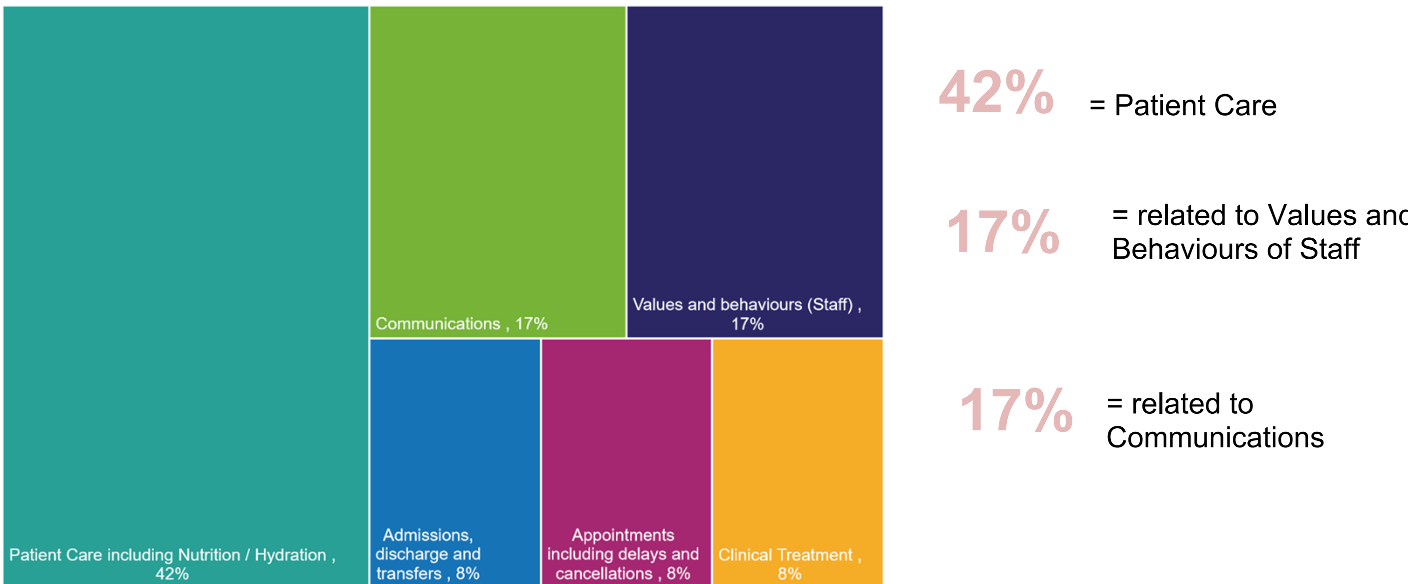
Key:
- ▼ Positive downward trajectory on previous quarter (green)
- ▼ Negative downward trajectory on previous quarter (red)
- ▶ No change on previous quarter (amber)
- ▲ Positive upward trajectory on previous quarter (green)
- ▲ Negative upward trajectory on previous quarter (red)

Table 5.2 Summary of patient expereince data with quarterly comparisons

	Q3 22-23	Q4 22-23	Q1 23-24	Q2 23-24
Complaints	▼ 7	▲ 8	▼ 3	▲ 4
Concerns	▶ 5	▼ 3	▶ 3	▲ 8
Compliments	▼ 19	▲ 34	▲ 68	▼ 16
FFT Responses	▼ 19	▲ 114	▼ 50	▼ 18
Re-opened complaints/concerns	▼ 0	▲ 1	▼ 0	▲ 1
% closed complaints responded to within agreed timescale	▲ 33%	▲ 67%	▼ 50%	▲ 0.55%
Complaints closed in this quarter	9	6	4	11
Complaints by Division activity (per 1,000)	▼ 1.5 (4,802)	▲ 2.1 (3,795)	▼ 0.71 (4, 206)	▲ 0.92 (4, 330)
Concerns by Division activity (per 1,000)	▼ 1.0 (4,802)	▼ 0.8 (3,795)	▼ 0.71 (4, 206)	▲ 1.85 (4, 330)
Compliments by Division activity (per 1,000)	▼ 4.0 (4,802)	▲ 9.0 (3,795)	▲ 13.7 (4, 206)	▼ 3.70 (4, 330)

Figure 5.5 – Summary of themes for W&N Complaints and Concerns – Q2 2023/24

Patient care remains the highest theme for complaints this quarter, consistent with Q1. **Values and Behaviours of staff** is also a consistent theme carried through from Q1.



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

Table 5.2a

Patient Care	**5**	**42%**
Correct diagnosis not made	2	40%
Further complications	1	20%
Inappropriate treatment	1	20%
Nursing Care	1	20%

Table 5.2b

Values and Behaviours (staff)	**2**	**17%**
Discrimination on the grounds of weight	1	50%
Attitude of medical staff	1	50%

Table 5.2c

Communications	**2**	**17%**
Insensitive communication	1	50%
Lack of communication	1	50%

Compliments – Women & Newborn

Figure 5.6 – W&NB Compliments breakdown

There was a total of 16 recorded compliments for W&N across Q2, these were all formally recorded on Datix. Figure 5.6 shows a breakdown of where the compliments were received, and consistencies with Q1 were noted on the labour ward, gynae outpatients and postnatal:

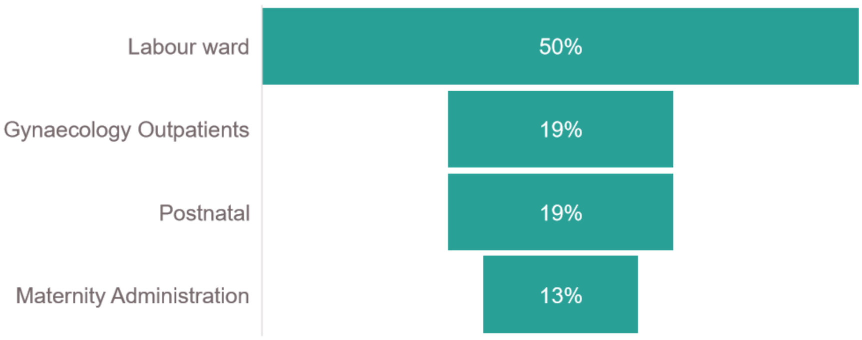
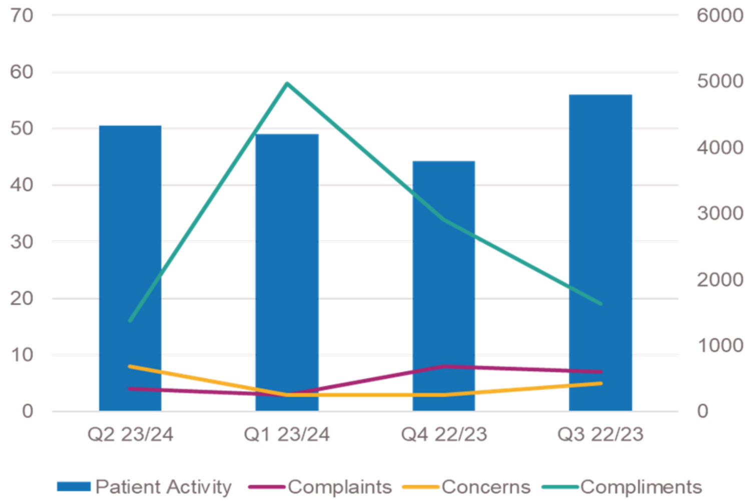


Figure 5.6a is a word cloud to summarise these compliments

Figure 5.7 shows correlation of number of complaints, concerns and compliments by patient activity for Clinical Support & Family Services**.**

Figure 5.7 – W&NB patient activity correlation with feedback

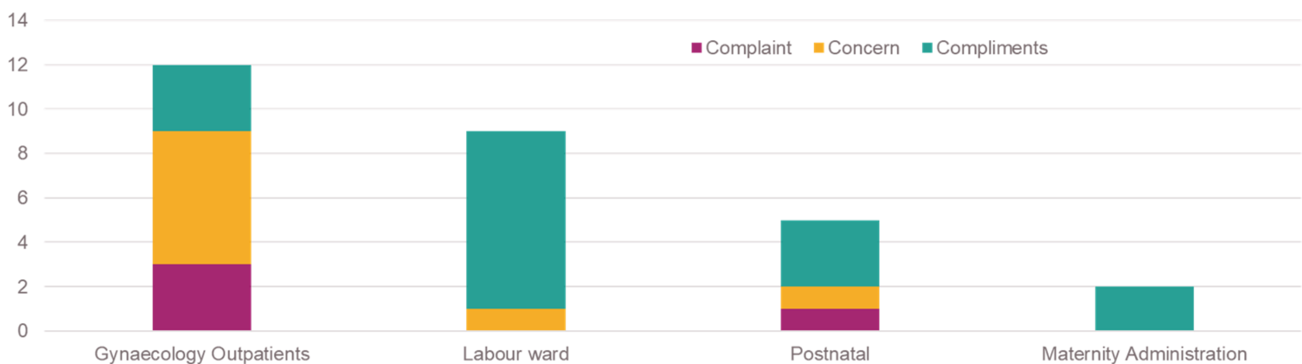


The Division saw an increased number of patients this quarter compared with Q1. The number of logged concerns and complaints also increased this quarter.

Compliments recorded this quarter has reduced compared with the previous quarters, but this is likely owed to a lack of recording.

Figure 5.8 shows the location of complaints, concerns and compliments by area:

Figure 5.8 – Location of complaints, concerns and compliments by area



Medicine

- There were a total of 38 complaints and concerns for Q2, this is an increase on the total number seen for Q1 (n~29).
- 101 compliments were formally logged on Datix.
- 15 complaints were closed in Q2; with 67% being responded to within the agreed timescale. This is a notable continued move towards the 90% Improving Together Target.
- 2 complaints were re-opened this quarter, same number as Q1.

▼ Positive downward trajectory on previous quarter
▼ Negative downward trajectory on previous quarter
► No change on previous quarter
▲ Positive upward trajectory on previous quarter
▲ Negative upward trajectory on previous quarter

Table 5.3 Summary of patient expereince data with quarterly comparisons

	Q3 22-23	Q4 22-23	Q1 23-24	Q2 23-24
Complaints	▼ 18	▲ 31	▼ 12	▲ 18
Concerns	▼ 24	▼ 18	▼ 17	▲ 20
Compliments	▲ 251	▼ 134	▼ 51	▲ 101
FFT Responses	▼ 383	▲ 482	▲ 573	▲ 935
Re-opened complaints/concerns	▼ 2	▲ 5	▼ 2	► 2
% closed complaints responded to within agreed timescale	▲ 45%	▲ 58%	▲ 59%	▲ 67%
Complaints closed in this quarter	29	19	22	15
Complaints by Division activity (per 1,000)	▼ 0.6 (29,040)	▲ 1.1 (28,406)	▼ 0.35 (34, 554)	▲ 0.52 (34, 921)
Concerns by Division activity (per 1,000)	▼ 0.8 (29,040)	▼ 0.6 (28,406)	▼ 0.49 (34, 554)	▲ 0.57 (34, 921)
Compliments by Division activity (per 1,000)	▲ 8.6 (29,040)	▼ 4.7 (28,406)	▼ 1.45 (34, 554)	▲ 2.89 (34, 921)

Figure 5.9 – Summary of themes for Medicine Complaints and Concerns – Q2 2023/24

For comparison, the three top themes common for Q1 remain consistent this quarter. **Communication** has increased in prevalence, replacing **Patient care** as the most common theme.

Lack of and **insensitive communication** are prevalent sub-themes again this quarter. Patients being **unsatisfied with treatment** was noted to be a significant proportion of the sub-themes under **patient care**.

The theme for **staff values and behaviours**, was equally split in the previous quarter, however this is demonstrating more prevalently amongst medical staff this quarter.

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

Table 5.3a

Communications	15	39%
Insensitive communication	5	33%
Lack of communication	5	33%
Information not given to family	3	20%
Call bell	1	7%
Delay in receiving/sending information	1	7%

Table 5.3b

Patient Care (inc. Nutrition/Hydration)	11	29%
Unsatisfactory treatment	5	45%
Inappropriate treatment	2	18%
Falls	1	9%
Harm	1	9%
Nightcare	1	9%
Pain management	1	9%

Table 5.3c

Values and Behaviours of Staff	5	13%
Attitude of staff - medical	3	60%
Attitude of nursing staff	2	40%

Compliments - Medicine

There was a total of 101 compliments logged for Medicine on Datix for Q2, this was noted to be significantly higher than previous quarters, the Division have worked hard to include PALS in sharing of their compliments.

Figure 5.10 shows a breakdown of where the compliments were received:

Figure 5.10 – Medicine Compliments breakdown

Farley have had the most compliments logged on Datix this quarter, followed by ED. Redlynch, Pembroke and AMU remain areas for consistent compliments this quarter compared with last quarter.

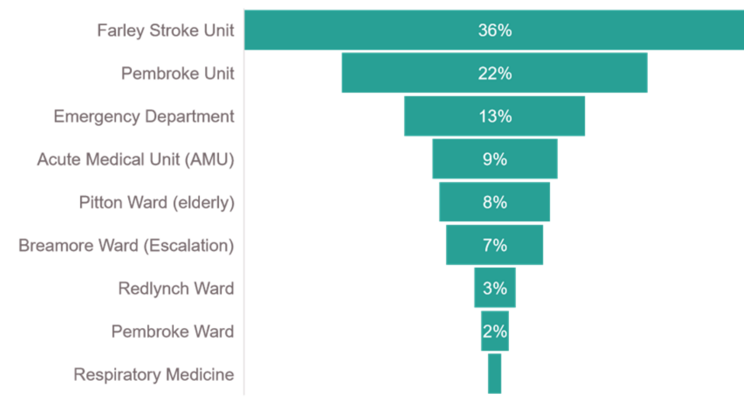


Figure 5.10a is a word cloud to summarise these compliments

Figure 5.11 shows correlation of number of complaints, concerns and compliments by patient activity for Medicine.

Figure 5.11 – Complaints, concerns and compliments correlation with patient activity

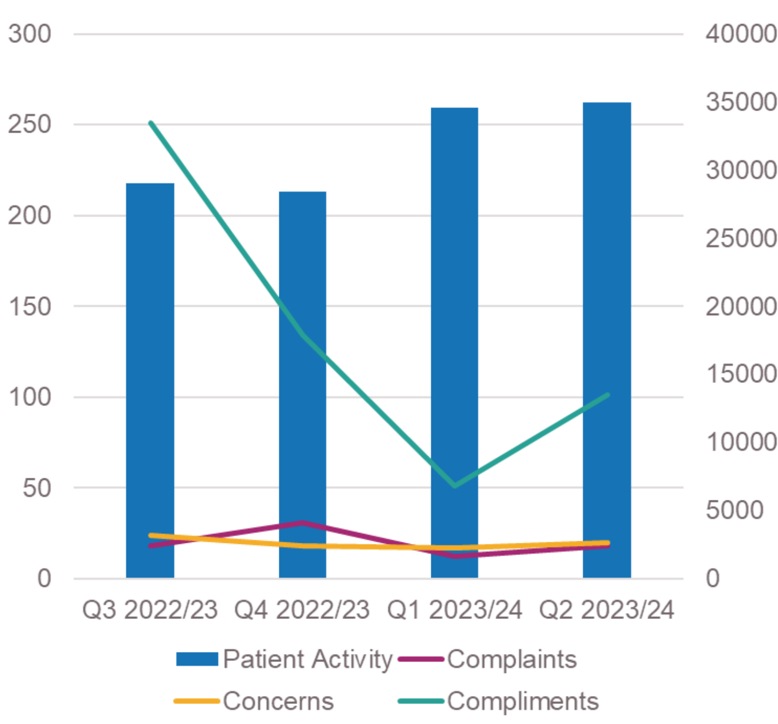
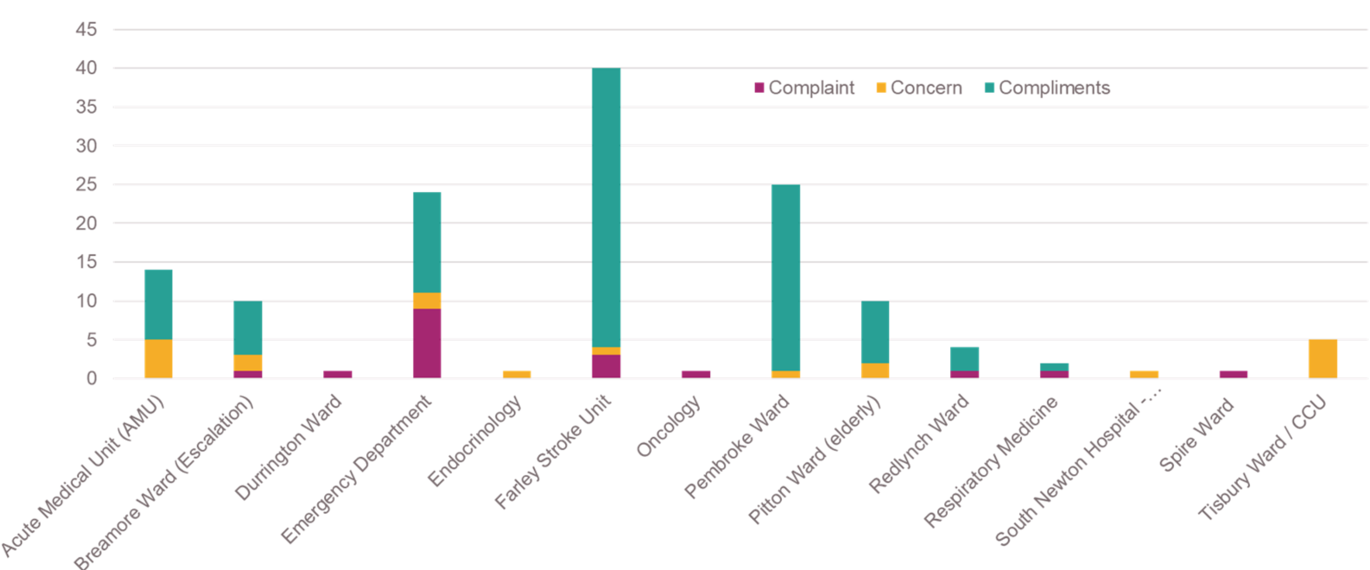


Figure 5.11 is demonstrating a small increase in the number of concerns and complaints this quarter but this is against a landscape of increased patient activity.

These numbers however remain lower than in Q4, where the lowest number of patient activity was also seen for the Division.

Figure 5.12 shows the location of complaints, concerns and compliments by area:

Figure 5.12 – Location of complaints, concerns and compliments by area



Surgery

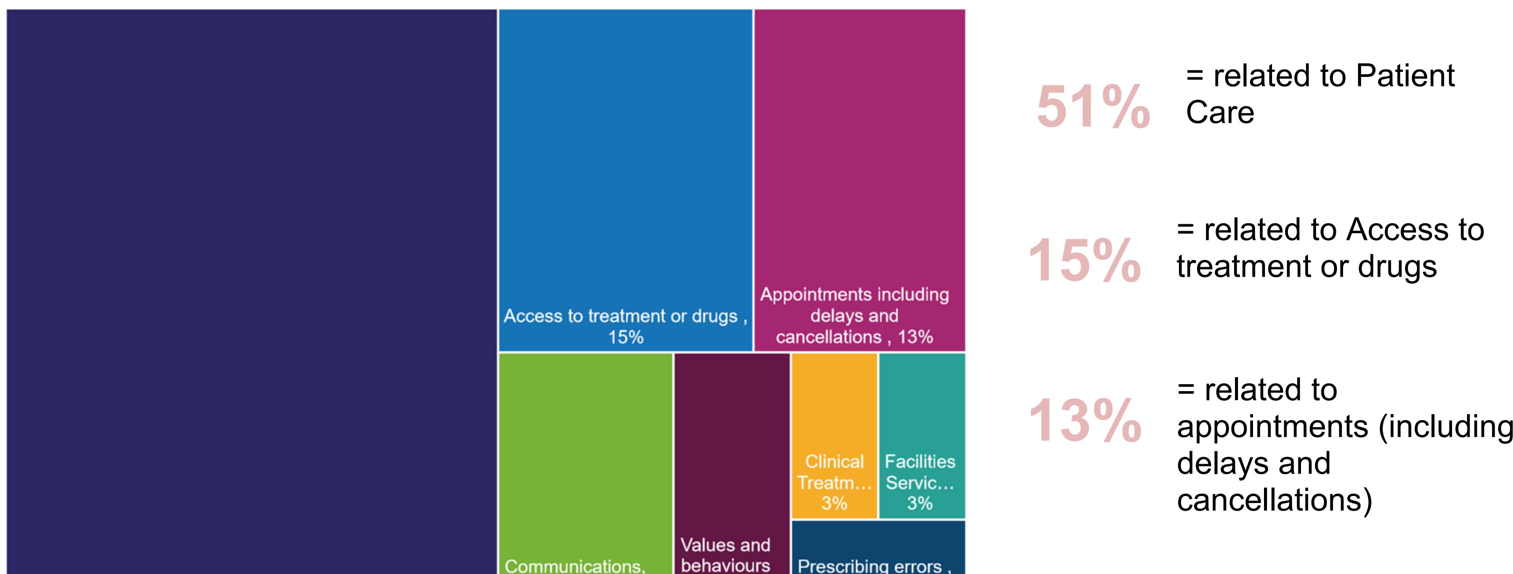
- There were a total of 39 complaints and concerns for Q2, an increase of 2 from Q1.
- 27 complaints were closed in Q2, same as Q1. 22% of these were on target compared with 11% in Q1.
- 5 were reopened this quarter, an increase of 3 from the previous quarter.
- 51 compliments were logged this quarter.

Table 5.4 Summary of patient expereince data with quarterly comparisons

- ▼ Positive downward trajectory on previous quarter
- ▼ Negative downward trajectory on previous quarter
- ▶ No change on previous quarter
- ▲ Positive upward trajectory on previous quarter
- ▲ Negative upward trajectory on previous quarter

	Q3 22-23	Q4 22-23	Q1 23-24	Q2 23-24
Complaints	▲ 26	▼ 17	▲ 18	▼ 16
Concerns	▶ 26	▼ 16	▲ 19	▲ 23
Compliments	▲ 112	▼ 72	▼ 62	▼ 51
FFT Responses	▼ 661	▲ 877	▲ 1,275	▼ 1,261
Re-opened complaints/concerns	▼ 3	▲ 6	▼ 2	▲ 5
% closed complaints responded to within agreed timescale	▲ 32%	▼ 12%	▼ 11%	▲ 22%
Complaints closed in this quarter	19	17	27	27
Complaints by Division activity (per 1,000)	▶ 0.7 (35,374)	▼ 0.5 (35,310)	▼ 0.44 (40,495)	▼ 0.40 (39,997)
Concerns by Division activity (per 1,000)	▼ 0.7 (35,374)	▼ 0.5 (35,310)	▼ 0.47 (40,495)	▲ 0.58 (39,997)
Compliments by Division activity (per 1,000)	▲ 3.2 (35,374)	▼ 2.0 (35,310)	▼ 1.53 (40,495)	▼ 1.28 (39,997)

Figure 5.13 – Summary of themes for Surgery Complaints and Concerns – Q2 2023/24



For comparison, the only common theme for Q2 is **Patient Care**, previous themes were related to **Communications** and **Clinical Treatment.** The prevelant sub-themes for **patient care** were **further complications** and **dissatisfaction with treatment. Delay in receiving treatment** or **treatment being unavailable** were also a key theme for complaints.

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

Table 5.4a

Patient Care	**20**	**51%**
Unsatisfactory treatment	5	25%
Further complications	5	25%
Nursing Care	3	15%
Pain management	2	10%
Inappropriate treatment	2	10%
Correct diagnosis not made	1	5%
Harm	1	5%
Learning Disability	1	5%

Table 5.4b

Access to Treatment or Drugs	**6**	**15%**
Delay in receiving treatment	2	33%
Treatment unavailable	2	33%
Operation delayed	1	17%
Operation delayed following admission	1	17%

Table 5.4c

Appointments	5	13%
Appointment system - procedures	2	40%
Appointment date required	1	20%
Delay in receiving appointment	1	20%
Unsatisfactory Outcome	1	20%

Compliments – Surgery

Figure 5.14 – Surgery Compliments breakdown

There were a total of 51 compliments for Surgery for Q2, this was noted to be slightly lower than last quarter and may indicate that further work could be needed to ensure these are being logged with PALS.

Figure 5.14 shows a breakdown of where the compliments were received, there are consistencies noted this quarter from Odstock and Radnor wards.

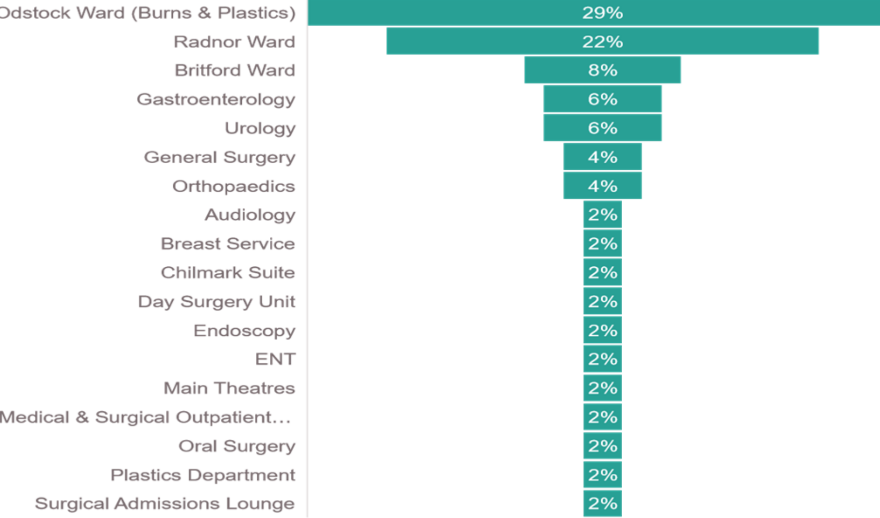


Figure 5.14a is a word cloud to summarise these compliments

Figure 5.15 shows correlation of number of complaints, concerns and compliments by patient activity for Surgery. Fig 5.15 Activity compared with Complaints, Concerns and compliments

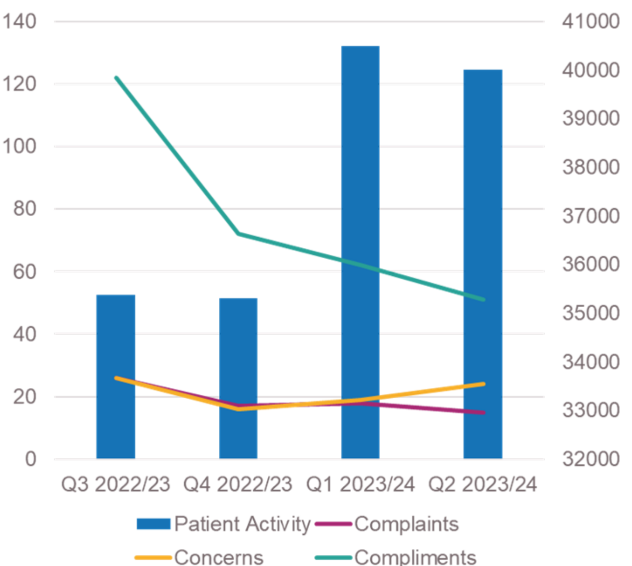


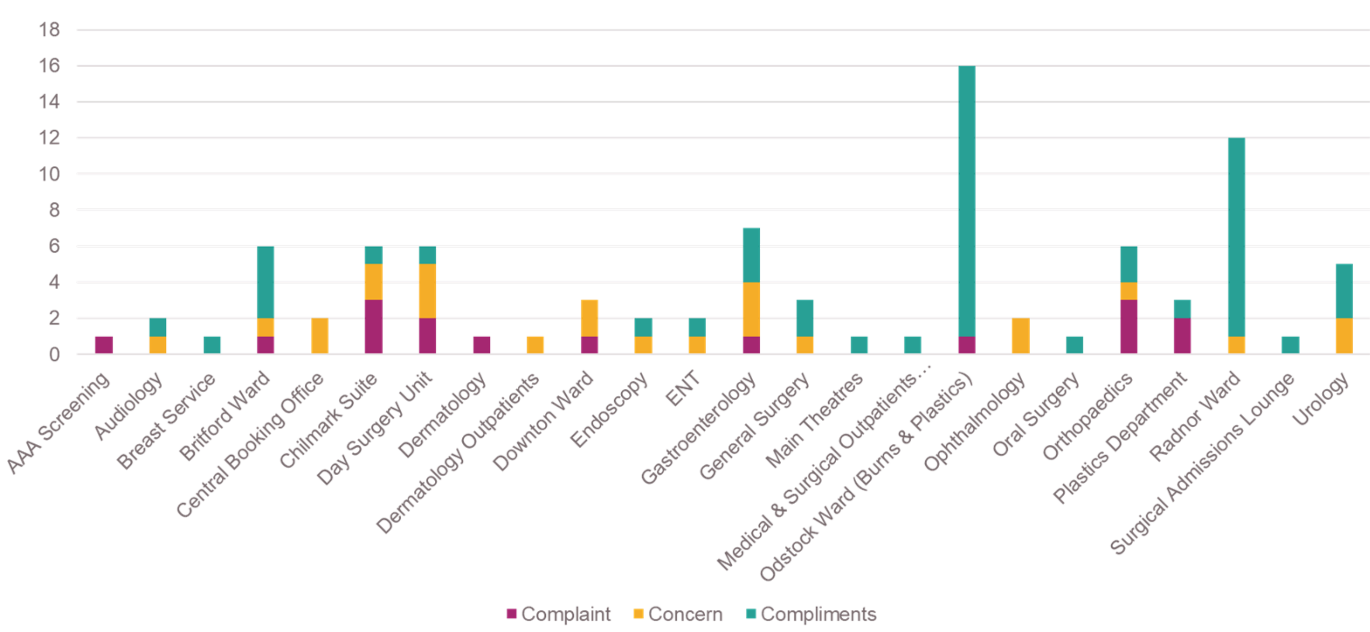
Figure 5.15 is demonstrating an overall decline in the number of recorded complaints. Concerns however have increased slightly.

This division has been actively engaged in adopting the principles for de-escalation of complaints and utilising opportunities for earlier resolution.

This work will continue with an aim that these approaches will eventually impact on the response with timescale challenges that the Division currently faces.

Figure 5.16 shows the location of complaints, concerns and compliments by area:

Figure 5.16 – Location of complaints, concerns and compliments by area

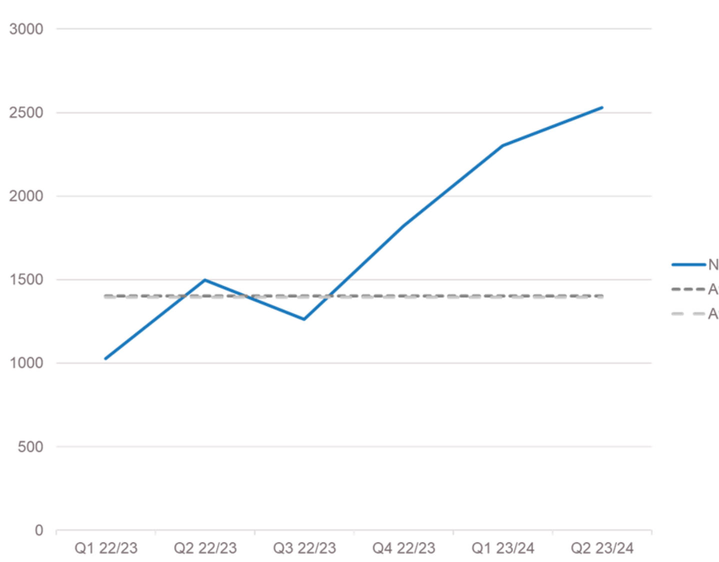


Person Centred & Safe Professional Responsive Friendly Progressive

6. Friends and Family (FFT)

Response Rates

Fig 6.1 Number of FFT responses, broken down by quarter with historic averages



A total of **2,529** patients provided feedback through the paper Friends and Family Test (FFT) in Q2 of 23/24. This continues to be the highest number of responses we have seen to date.

The grey dotted lines show the calculated quarter averages for the last 2 years.

Themes and insights

Development of the digital dashboard to allow for comment theming has experienced some data complications during the initial trial uploads. Data for Q1 and Q2 were attempted for upload, but the team continue to experience issues with the CSV file formatting, we continue to trial different versions of these templates. This is currently being worked through with the provider and regrettably inclusion of this data will be delayed until Q3 reporting as a result.

97% Of those surveyed rated their experience of our hospital as Good or Very Good (average for Q2 2023-24)

3.6%* Response rate (*of eligible population and averaged for Q2 2023-24)

FFT display posters are now created on a bi-monthly basis and displayed in inpatient areas, a selection of these are included in Appendix 4. This is a new iniative and will look to be extended to outpatient areas and ED in due course.

The target response rate continues to be significantly below our Improving Together target of >15% of eligible patients for 2023/24, however this is increasing despite the increased patient activity and therefore subsequent eligible population. We have seen a small decrease in the overall satisfaction rating as the response rate increases, which was anticipated.

There continues to be a primary reliance on the use of the FFT cards and this subsequently means that inpatient areas tend to perform better with response rates compared with outpatients or ED. This will continue to be a challenge until the full rollout of the SMS digital solution, which has been scheduled for implementation during Q4 of 2023/24.

Table 6.1 summarises the response rates in accordance with patient activity.

Table 6.1 Response rate across the Trust by per 1,000 patient activity – rolling annual comparison

	Q2 22-23	Q3 22-23	Q4 22-23	Q1 23-24	Q2 23-24
Across all Directorates	▲ 15.4 (97,212)	▼ 12.5 (101,122)	▲ 17.9 (101,618)	▲ 20.0 (114, 795)	▲ 22.36 (113, 119)

Benchmarking against Improving Together Targets

As Figure 6.2 demonstrates, we continue to be far from our **Improving Together** targets but we are on an overall continued upward trajectory and this is without any radical changes to the accessibility of the feedback forms.

Figure 6.2 – Response rate (based on eligible population) – Trust wide

15%

Response rate target

(2023/24)

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

NHS Salisbury NHS Foundation Trust

Urology

PATIENT FEEDBACK

The Stars Appeal clothing initiative & PALS

PATIENT FEEDBACK

Your efforts today in providing some clothing, put a smile on the face of a very distressed patient.
It restored her dignity and faith that people can be kind, so a BIG THANK YOU!

7. Patient and Public Feedback – Local Surveys

Annual Complaints Process Feedback

These results are still being collated and will be included in the Q3 report.

Managing Staff and Patient Expectations Working Group – (Discharge Project)

This is a new project aimed at improving discharge planning, the initial findings from this will be included in the Q3 report.

Real-Time Feedback (RTF)

The aim of RTF is to give a "real-time" view of a patients perspective of their care.

Real-time feedback is not currently undertaken within the maternity inpatient areas or on Sarum ward. Survey results are sent to ward leads within one week of these being completed for their reflection.

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 & dignity and overall experience.

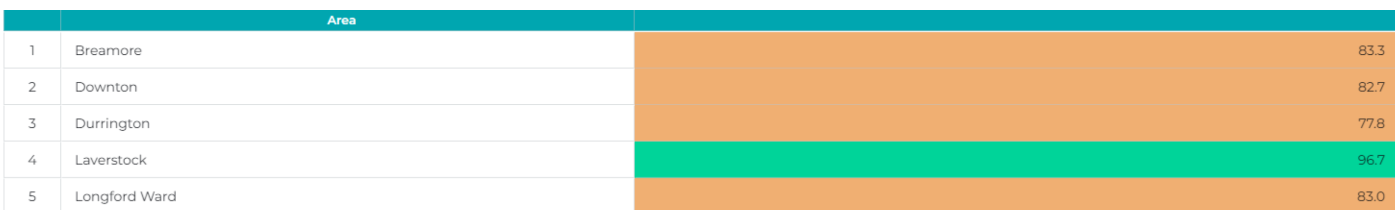
RTF has been much more consistent throughout Q2 owed to the efforts of volunteers, governors and work experience students.

RTF is now regularly presented to the Patient Experience Steering Group, reflecting on the data from the previous month. Summary of analysis to date:

Table 7.1 Number of inspections and locations visited

Month	Total number of surveys	Number of inpatient areas visited	Wards surveyed	Average Score
July	**18**	**5**	Breamore, Downton, Durringon, Laverstock, Longford,	82.9%
August	**26**	**10**	AMU, Breamore, Britford, Downton, Farley, Pemrboke, Pitton,Redlynch, Spire, Tisbury	88.0%
September	**36**	**8**	AMU, Breamore, Britford, Downton, Durringon, Laverstock, Longford, Odstock	81.3%

July 2023 Summary:



	Area	
1	Breamore	83.3
2	Downton	82.7
3	Durrington	77.8
4	Laverstock	96.7
5	Longford Ward	83.0

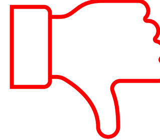
August 2023 Summary:

	Area	
1	AMU	83.1
2	Breamore	93.8
3	Britford	92.8
4	Downton	96.7
5	Farley	82.5
6	Pembroke	91.5
7	Pitton	96.7
8	Redlynch	96.4
9	Spire	89.3
10	Tisbury	78.2

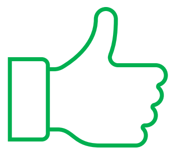
September 2023 Summary:

	Area	
1	AMU	73.2
2	Breamore	84.0
3	Britford	91.8
4	Downton	70.0
5	Durrington	77.3
6	Laverstock	87.7
7	Longford Ward	77.1
8	Odstock	79.3

Key themes noted:



Noise at night and understanding and involvement with discharge planning are the two areas which scored the lowest during this quarter.



Patients feeling treated with privacy and dignity and the overall cleanliness of the ward environments were the main questions which received the most consistently positive responses.

8. Patient and Public Feedback – National Surveys

National Inpatient Survey 2022

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.

Summary data slides presented to PESG and Clinical Governance Committee can be found in Appendix 5.

National Cancer Patient Experience Survey 2022 (CPES)

Fieldwork commenced Oct -22 and Feb 23 with published report received in July 2023. SFT achieved over the national average for response rate (63% vs 53%). 90% of sample submitted were from a white British background, therefore unsurprised by the majority proportion of response coming from this group.

Key messages:

53 of of 61 questions were within the expected range and there were 8 positive outliers (above expectation). There were no negative outliers.

Overall care rating out of 10 came in at 9.0. This was higher than our peers within the BSW region. This was also slightly higher than the national average of 8.9.

Next steps outlined including working with SWAG Cancer Alliance to embed “What Matters to Me”, focuses on information resources and consideration of two site-specific groups to inform action planning. Full results can be found in Appendix 6.

Scheduled Reporting of Surveys

Maternity Survey 2023 – will be reported in Q4 2023/24

Children and Young People Survey 2023 – will be reported in (TBC) 24/25

National Inpatient Survey 2023 – will be reported in (TBC) 24/25

APPENDIX 1: Patient Experience - B7 Development Day - August 2023 v2 Distribution Version

See attachement.

APPENDIX 2: Complaints Process Review – Action Plan Progress – v6

See attachement.

APPENDIX 2a: HWW – You Said, We Did Update

See attachement.

APPENDIX 3: KPMG Governance, Risk & Compliance Services – Complaints Internal Audit Terms of Reference

See attachement.

APPENDIX 4: Friends and Family Test Comments Sample – Q2 2023/24

See attachement.

APPENDIX 5: National Inpatient Survey Results (2022) – Results Report

See attachement.

APPENDIX 6: National Cancer Patient Experience Survey 2022 (CPES)

See attachement.

9th August 2023

Band 7 Development Day

Introduction to Complaints

Victoria Aldridge - Head of Patient Experience

Session key points

- ✓ Complaints – the NHS pledge, the process and our priorities
- ✓ What we have learnt from complaints
- ✓ Reflection on a complaint you have received
- ✓ What happens when a complainant is unsatisfied with the outcome
- ✓ Saying sorry… Do’s and Don'ts!
- ✓ Tips for managing a complaint
- ✓ PALS – we are more than just complaints!
- ✓ Questions and PALS contact details

The NHS pledge to complaint and redress

Source: NHS Constitution for England

Complainants are treated with courtesy and receive appropriate support throughout the handling of a complaint; and that the fact that they have complained will not adversely affect their future treatment

When mistakes happen or if patients are harmed while receiving health care they receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma they have experienced, and know that lessons will be learned to help avoid a similar incident occurring again

The organisation learns lessons from complaints and claims and uses these to improve NHS services

Complaints are exempt from the investigation process when they are…

- Complaints about private treatment;
- Complaints that have already been investigated;
- Complaints where legal action has already been started;
- Complaints about data subject requests under the Data Protection Act 2018;
- Complaints relating to requests under the Freedom of Information Act 2000;
- Complaints over 12months old**

Resolution first.
We encourage complainants to…

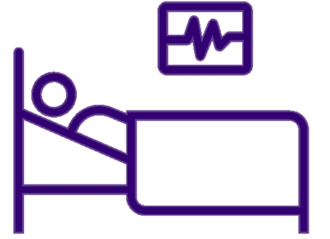
Raise their concern as soon as possible after the event has occurred

Talk it through with those involved with their care in the first instance

If raising a concern on behalf of someone else, ensure they have the appropriate consent in place

Be clear about what they want as an outcome

Historically, what are our most common themes for complaints?



Access to treatment

The Trust's most common cause for complaints so far in 2022/23

Patient Care – (unsatisfied with quality of care or outcome of treatment)

Communication (insensitive and/or lack of)

Access to Treatment (delays, cancellations)

Source: Complaints theme data Q1 - Q4 2022/23 (trust wide)

What have we learnt about complaints?

1. Communication will probably always be our greatest challenge
2. Reality does not always meet expectations
   Fawlty Towers: An Interesting View
3. Right process, but right communication?
4. Relationships are key – *patients don't want to complain about people they like!*
5. Early resolution of the small things can make a huge difference to the big things
6. Empathy – try to understand someone else's point of view Empathy: The Human Connection to Patient Care - YouTube

Reflect on a complaint you or your service/dept may have received …

NHS
Salisbury
NHS Foundation Trust

How was it communicated?

What was your first reaction on receiving it?

What was the support like for you when being informed of this?

How did it make you feel?

What did you do first?

What are our priorities?

Current Complaint Process

Complaint comes in

Record of discussion taken, key points and defining of outcomes

Allegation against staff member

Litigation

Serious Incident / Clinical Review

48hr template sent to Division leads.

Template is returned with RAG response, next actions for investigation and identification of early resolution

Investigations and statements are undertaken, learning identified and response drafted/ meeting arranged

Holding letter may be sent with extended timeframe if RAG response time is exceeded

Actions and responses are revied by PALS and response has second review with the Quality Team

Response is send to complainant

Meeting may be arranged instead of response letter to discuss and address the points of the complaint

RAG Status	
Green	25 w/days
Amber	40 w/days
Red	60 w/days

Our pledge to complainants

They experience:

- An accessible, supportive and easy to use complaints process

They receive:

- A clear explanation of what happened and why
- A full and thorough investigation
- Acknowledgement, accountability and apology where appropriate

They are reassured:

- That clear actions and learning have come from their complaint to ensure that the issues raised are learnt from and steps are taken to prevent recurrence.

Writing a witness statement

Here are some tips of what to include in your statement -

- The date, place, and time of any relevant issues, use chronological order.
- What you saw, heard or know – stick to the facts.
- How you have recalled these events (i.e. from memory, from the medical records or from your recollection of your standard practice at that time)
- If you wish to support the reasons for a decision made, give reference to the protocol, research or Trust policy. Explain the reasons for deviating from these guidelines if appropriate.
- Identify other staff involved.
- Explain any medical terms or abbreviations
- If tests or investigations are referenced include details of normal ranges
- Aim to respond to the specific issues of the concern/complaint.
- Write your statement as though you are explaining it to the complaint – talk to them in the first person and where appropriate – apologise.
- Saying sorry is **NOT** an admission of guilt.

Saying sorry…

- ✓ Is always the right thing to do
- ✓ Is not an admission of liability
- ✓ Acknowledges that something could have gone better
- ✓ Is the first step to learning from what happened and preventing it recurring

Source: NHS Resolutions – publication 2018

Do’s and Dont’s

Source: NHS Resolutions – publication 2018

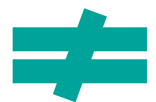
Do say:

- ✓ I’m sorry … happened
- ✓ We’re truly sorry for the distress caused
- ✓ I’m sorry, we have learned that…

Don’t say:

- ✗ I’m sorry you feel like that
- ✗ We’re sorry if you’re offended
- ✗ I’m sorry you took it that way
- ✗ We’re sorry, BUT...

An apology vs accepting liability



One does not equate to the other

Do not let the fear of litigation prevent an apology

Duty of candour is a statutory and regulatory requirement

The complainant is not satisfied
What happens next?

Further meeting may be offered

Referral to the Parliamentary and Health Service Ombudsman

Complainant may wish to take legal action and would be advised to seek independent representation.
The SFT legal team would be informed of the complaint details at this stage

Managing a complaint

Top Tips from our Complaints Handlers

- **Listen, understand and value** – listen with empathy, understand what the issues are. What do they want the outcome to be? Thank them for raising their issue.
- **Early resolution** – what information can we find out easily now? What actions can we take now? What method of response is the most appropriate?
- **Communication** – keep in touch. Don't make promises you cant keep. Stick to timescales and keep the complainant informed, ***especially*** when timescales may not be met. Join up internal communications where possible for the benefit of the complainant
- **Meaningful apology** – saying sorry **is not** an admission of error or guilt. A meaningful apology is also about demonstrating we have taken actions to prevent this from happening again.
- **Comprehensive and comprehensible** – Ensure you have addressed all of the concerns. Be clear with your language and avoid using jargon or acronyms.

Ask for help – if you're struggling with how to respond to a complaint then talk to us – we're here to help!

PALS Services

we are so much more than just complaints !

- Patient clothing & TV cards – provided by the Stars Appeal
- Friends and Family Tests (FFT)
- Message to a loved one
- Virtual visiting
- Accessibility and Interpreting Services
- PALS Outreach Services
- Patient engagement initiatives
- Lost property
- Real-time Feedback (RTF)
- Hearing Aid Batteries
- Insurance forms
- Your Views Matter Bereavement survey
- Patient Stories
- Compliments on Datix
- Local and National Surveys

Any questions?

Victoria Aldridge

PALS Office - Block 62, SDH North
Green Entrance

Telephone: 01722 336262
Extension - 5246

Victoria.aldridge3@nhs.net

PALS:

PALS Office - Block 62, SDH North
Green Entrance

Direct dial: 01722 429044
Extension - 5244

sft.pals@nhs.net

Action Plan from HWW survey report – version 6

Recommendation	Actions taken	Responsibility	By when	Status	Evidence to demonstrate actions have been completed
Disseminate information about the complaints process across all Trust departments and ensure all staff can explain the role of PALS.	PALS Outreach Service	PALS team	Ongoing since August 2022 – make BAU	**Complete**	Now business as usual, fully embedded with the PALS team. Each member has 3-4 inpatient wards they visit on a recurring 6weekly basis. These visits review complaints, FFT, and general discussions related to patients experiences i.e. lost property etc. (example attached) PALS Outreach Ward Visit Tisbury W Friends and Family Feedback February 2
	Regular attendance at DMT meetings	PALS Lead / Head of Patient Experience	Ongoing since August 2022	**Complete**	Now business as usual, quarterly presentations at all divisional governance meetings (patient experience focus, covering complaints, compliments and FFT) Surgical Governance - Patien W&N - Patient Experience Update 1 CSFS - Patient Experience Update - Medicine DMT - Patient Experience U
	PALS leaflet currently being developed Posters to be designed and audit undertaken as where these need to be located	PALS Lead / Head of Patient Experience	~~March 2023~~ ~~June 2023~~ October 2023	**Partial completion**	New PALS leaflet now approved via PESG. Launched on the 9th October 2023. Poster currently in draft design phase, requires patient engagement.
	Opportunities for shadowing PALS enquiries	PALS Lead	Ongoing since November 2022 – make BAU	**Complete**	Now business as usual, so far 8 staff members have shadowed the PALS team since November 2022. This shadowing has been undertaken by a mixture of clinical and non-clinical colleagues from Radiology, information governance, catering, clinical psychology, and ward clerks. We will continue to facilitate this as part of our business as usual. We have developed a feedback form

					to help us to continue to maximise the benefit of what staff can get from this exposure
	Staff development – F2 doctor training, B7 development days, Admin Training Collaboration with Mentor4Leaders. Consideration with standard Trust Induction timetable	Head of Patient Experience	January 2023 March 2023 *TBC*	**Complete** **Complete** **Close action.**	PALS Services - Admin Presentation Consultants Programme - Commu Patient Experience - F2 Core Teaching Pr Patient Experience - Staff Development F Discussed with education leads, no room currently on the Trust induction timetable, instead to consider local inductions for specific roles, trial with Surgery Operational Managers Autumn 2023. **Remove action.**
Provide regular updates to complainants and inform them of revised timescales as appropriate.	Weekly meetings between PALS Lead and complaints co-ordinators for escalation and ensure regular communications	PALS Lead and complaints co-ordinators	January 2023	**Complete**	Cycle of meetings added – format continues to develop with focuses on overdue and complex complaints, escalation and communication/update to complainants
	Review of holding letter timescales. Change to acknowledgement letters to be clearer on timescales, reference numbers and who is overseeing their complaint.	PALS Lead / Head of Patient Experience	January 2023	**Complete**	Updated acknowledgement letters. Acknowledgement letter 25 working da
Identify potential communication barriers with complainant at first contact.	Record of discussion re-designed to include: Summary of the key points to address	PALS Lead / Head of Patient Experience	January – March 2023 ~~January – March 2023~~	**Complete**	Updated Record of Discussion template to incorporate 48hour review process – and launched with Divisions. Changes to Complaints Processi Division 48-hour Initial Complaints Re Record of discussion v2 Dec 2(

	Accessibility needs i.e. larger font letters or translation services etc.		Extended to Summer 2023 to coincide with other accessibility workstreams	Partial completion	Input on the new PALS leaflet has been requested from the RNIB (Royal National Institute for the Blind) to help develop guidance alongside use of the Trusts branding. Successful bid with Cancer Services for health inequalities funds to purchase widget software to expand communications for those with learning disabilities. Widget has now been purchased, online training to be scheduled for key staff in the New Year. Easy read training now completed by Patient Experience team and Cancer Services Information coordinator. First leaflet for review/amends will be the new PALS leaflet.
	Embedding the 48hr review template to highlight challenges from department/divisions	PALS Lead / Head of Patient Experience	January – March 2023	Complete	As above.
Improve signposting to additional support e.g., advocacy services.	Acknowledgement letters, leaflets amendments Building links with local advocacy services	PALS Lead / Head of Patient Experience	~~January – March 2023~~ Extended to Summer 2023	Complete	Talk from Local Advocacy Services – PALS Team Meeting – February 2023. Talk postponed as speaker is currently unwell. Rescheduled talk date to be confirmed. Talk at team meeting 14th June 2023.
Publicise and celebrate improvements made to services as a direct result of complaints raised e.g., you said, we did.	Review of FFT Boards (location, information etc.) Implementation of new digital provider to allow for insightful analysis of feedback and meaningful triangulation with complaints.	PALS Lead / Head of Patient Experience / Engagement Lead	January – March 2023 ~~April 2023~~ December 2023 October 2023	Complete In Progress Partial completion	Orders for new and replacement FFT boards currently underway. Requirements presented to PESG on March 2023. Bi-Annual FFT Update - PESG Marc Digital provider rollout delayed until December 2023. Interim actions to continue to drive response rates included in the above presentation. Project received IT and informatics resourcing in December 2023, implementation plan now underway, scheduled for first SMS trials in Q4 of 2023/24. Digital dashboard now in place, historic FFT data for Q1 (and Q2 once finalised) is planned to begin development of the theming and analysis of comments in the interim. This is planned to be operational by end of Q2. Initial teething issues with data extracts, but data is now available and dashboard is now actively being utilised.
	Reporting on outputs and learning from complaints – exploring the use of the actions recording and reporting function on Datix	PALS Lead / Head of Patient Experience	Ongoing	Partial completion	Limited with exploration due to changes to Datix being limited as new system is anticipated under the PSIRF project. Additional reporting via PESG and patient experience presentations at Divisional DMTs and Clinical Governance meetings. Reporting to be summarised through quarterly patient experience report.

	Introduction of a new standard to response letters which bullet point/summarise actions being taken Embedding cultures for following up closed complaints with "you said, we did".	PALS Lead / Head of Patient Experience	January 2023 March 2023	**Complete** **In Progress**	Updated process with Divisions and use of examples. FW_ Changes to complaint response Example letter.pdf Wider comms to be included, task group (Civic Engagement) is being considered as a key group to help mobilise this action.
Continued monitoring	Complaints process feedback, survey to be updated to reflect this project and continued monitoring. Use of survey monkey and SOP for completion will also be drafted.	PALS Lead / Complaints Coordinators	May 2023	**Complete**	Survey monkey created and draft SOP due to be approved at PESG in May 2023. New feedback survey will be launched with all closed complaints from the 9th May 2023. Presentation of analysis scheduled for CGC in September 2023.

Improving Salisbury District Hospital's complaints handling process

In autumn 2022 we carried out a piece of work to hear your views on making a complaint at Salisbury District Hospital, which made several recommendations to make information about the complaints process easier to understand.

Following on from this report, the hospital has introduced a new Complaints Handling Policy and created a new Guide to Complaints, Concerns, Comments and Compliments.

You said

Make it easier for people to make a complaint and give them confidence in the complaints process.

What's changed?

Our volunteers, as well as the hospital's Patient Experience Steering Group, have been involved in the development of the new leaflet to ensure that it's patient friendly. Their suggestions included:

- A clear, Plain English guide to the process with a reassuring, friendly tone
- An emphasis on who the PALS team are and what they do
- Map and photos of where the team is based

There will be digital and printed versions of the guide available, an accessible version compatible with screen readers, and an Easy Read version.

PALS – who we are and how we can help you

As the Patient Advice and Liaison Service (PALS), we act as the "customer service" for our hospital. We can advise and support you, your family, visitors and carers with:

- Listening to your suggestions, queries and concerns.
- Helping to sort out problems on your behalf.
- Giving information about NHS services.
- Facilitating access needs including arranging interpreters or other accessible information (see page 6).

Meet our PALS team

We can also give you information about the NHS complaints procedure (see page 9 of this booklet), including details of Advocacy services if you want to make a complaint. A member of our team can take the details of your complaint and will work with the relevant department(s) to investigate your concerns.

Additionally, we are able to help you get involved with the hospital through our various engagement initiatives.

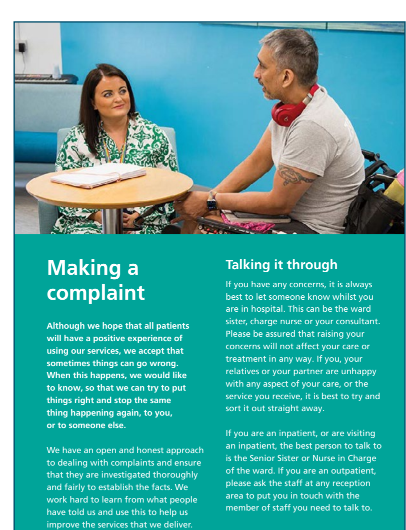
How to find us

The Patient Advice and Liaison Service (PALS) office is located in the Central part of the hospital. We are most easily accessible via Entrance B on Odstock Road, then 'The Green' Entrance (Entrance I on the map).

Through 'The Green' Entrance (see below) the office is the second door on the left.

If you are accessing PALS from the Main Entrance in the North building (Entrance F on the Map), you will need to go up to level 4 and follow the signs for the link bridge.

There is a short stay designated PALS parking space (30 minutes max.) for visitors to the PALS office. This is located just outside the Green Entrance. Alternatively, there is parking in Car Parks 7 and 8.



Making a complaint

Although we hope that all patients will have a positive experience of using our services, we accept that sometimes things can go wrong. When this happens, we would like to know, so that we can try to put things right and stop the same thing happening again, to you, or to someone else.

We have an open and honest approach to dealing with complaints and ensure that they are investigated thoroughly and fairly to establish the facts. We work hard to learn from what people have told us and use this to help us improve the services that we deliver.

Talking it through

If you have any concerns, it is always best to let someone know whilst you are in hospital. This can be the ward sister, charge nurse or your consultant. Please be assured that raising your concerns will not affect your care or treatment in any way. If you, your relatives or your partner are unhappy with any aspect of your care, or the service you receive, it is best to try and sort it out straight away.

If you are an inpatient, or are visiting an inpatient, the best person to talk to is the Senior Sister or Nurse in Charge of the ward. If you are an outpatient, please ask the staff at any reception area to put you in touch with the member of staff you need to talk to.

What's next?

Kate Barber, Volunteering and Partnerships Lead at Healthwatch Wiltshire, explains:

"We're delighted that public feedback has helped shape improvements to the complaints process at Salisbury District Hospital. It's great to see how committed staff are to ensuring the patient voice is heard.

"Our readers' panel of volunteers have been instrumental in providing constuctive feedback on the new leaflet. We're pleased that the volunteers' comments have been taken on board and it's lovely they've been recognised for their work.

"Being part of the Patient Experience Steering Group means we can continue to see how the hospital engages with patients and the different ways it gathers their experiences."

"Healthwatch Wilsthire continue to work in collaboration with the Patient Experience team here at Salisbury Hospital. They are a regular and valued presence within our monthly Patient Experience Steering Group (PESG) and continue to support our service improvement plans related to our Complaints process.

"A key milestone for this improvement project was the redevelopment of the Trust's complaints leaflet. This underwent a vigorous review with colleagues at Healthwatch Wiltshire and further reviews by the Trust's patient readership groups. This was formally launched in October 2023 and is the first Hospital publication to carry its new 'patient reviewed' stamp to indicate these various collaborations.

"Since May 2023, the complaints process review survey originally developed with Healthwatch Wiltshire has also become an integral part of the follow-up for all closed complaints and concerns. Surveys are digitally accessible via a QR code and paper copies are also sent via post for those who require this format. Regular analysis of these results continues to act as a benchmark for these improvements.

"I would like to extend my thanks to our colleagues at Healthwatch Wiltshire who continue to work with us to improve our services for the benefit of our patients."

Victoria Alridge, Head of Patient Experience at Salisbury District Hospital

Find out more

Your experiences of making a complaint at Salisbury District Hospital highlights the findings from a survey that gathered the views of people on the complaints handling process at Salisbury District Hospital.

Our report reveals that people found it difficult to find information on how to make a complaint and didn't fully understand the role of the Patient Advice and Liaison Service (PALS).

Visit our website to read the report.

Terms of Reference: Patient Complaints

Salisbury NHS Foundation Trust

KPMG Governance, Risk & Compliance Services

—

August 2023

Patient Complaints

01

Background

Formal complaints provide an important mechanism by which management can assess the quality of services provided. Effective complaints handling is a foundation of the patient experience and can also provide enhancements to patient safety and clinical effectiveness if lessons are learned and necessary action taken. This review will evaluate the Trust's processes for managing and responding to complaints, including a review of the policy and procedures and sample testing of individual complaints received and associated correspondence, to provide assurance that the Trust's policies are being complied with.

Complaints can span multiple clinical divisions. Therefore, it is important that effective mechanisms are in place for monitoring the response times of complaints and sharing lessons learnt with all areas of the Trust that are affected, and that these lessons are cascaded to the wider Trust where appropriate. We will review governance arrangements surrounding the management and reporting of complaints across the Trust and consider how lessons learnt are captured and shared. We will also review the Trust's approach to complaints management and backlog reduction, looking for process improvement as part of that work.

Scope of internal audit

The scope of this review will include the consideration of:

- Policies and procedures relating to patient complaints and the extent to which they are adhered to in a timely manner in different divisions (Key Risks 1 & 2);
- Analysis of the number of complaints which are re-opened, and how this varies across divisions (Key Risk 3);
- Monitoring and reporting of complaints activity through governance structures (Key Risk 4); and
- How lessons learnt are captured and shared across the Trust (Key Risk 5).

Our Approach

Our work will involve the following activities:

- Meetings with the key staff involved in patient complaints processes;
- Walkthroughs of key patient complaints processes;
- Consideration of alignment of the Trust's policy and procedures with the NHS Complaints Standards and best practice where appropriate;
- Desktop review of documentation supporting the internal controls; and
- Sample testing where appropriate.

The approach will include sample checks to determine whether the key controls are being effectively and consistently operated. In cases where we note controls do not exist, we will raise this as a finding.

An escalation process will be agreed with Management for instances where documentation, meetings or interview note confirmations are not provided in a timely manner.

Out of scope

We will not provide an assessment on the quality of the responses for the complaints sampled. Our work does not provide an absolute assurance that material error, loss or fraud does not exist.

Key risks identified	
1	**Policies and procedures** Policies and procedures for patient complaints are not sufficiently documented or communicated to staff which may result in inconsistent and/or inappropriate practices being applied throughout the Trust.

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Patient Complaints

Key risks identified	
2	**Timeliness of responses** There is no mechanism for identifying complaints at risk of breaching set targets and complaints are not handled with in a timely manner, negatively impacting patient experience.
3	**Re-opened complaints** Patient complaints are not responded to effectively, increasing the workload for staff involved through the re-opening of complaints, and negatively impacting patient experience.
4	**Monitoring and reporting** There is insufficient oversight at a senior level of complaint trends and complaint handling performance, reducing accountability for those involved and impacting the ability for informed decisions to be made.
5	**Lessons Learnt** Emerging themes and lessons learnt from patient complaints are not shared widely across the Trust, preventing learning opportunities.

Anticipated assurance

Management anticipates that this review will be given a 'partial assurance with improvements required' (AMBER-RED) rating, recognising that the control environment is well designed but improvements are likely to be required in the operation of controls across the Trust.

Assistance required

We require assistance to deliver this review on time, in particular we need: prompt agreement of these terms of reference; staff required for interview to ensure their reasonable availability; and access to relevant records.

Key contacts

In order to undertake this work we will require meetings with:

- Judy Dyos, Chief Nursing Officer (Executive Sponsor);
- Angie Ansell, Deputy Chief Nursing Officer;
- Victoria Aldridge, Head of Patient Experience; and
- Sophie Brookes, PALS Lead.

This list is not exhaustive and we may require additional meetings as our work progresses.

Documentation request

We provide below details of documentation we would like to review if available. This list is not exhaustive and if there are other documents that we feel would be useful to review we will request these whilst onsite. Similarly if you feel there are other documents that would assist us which are not listed please provide them.

- Policies and procedures relating to patient complaints;
- Organisation structure;
- Training material provided on complaints processes;
- A list from Datix of all complaints received since 1 January 2023, detailing timestamps for all key actions in the complaint handling process;
- A list from Datix all re-opened complaints since 1 January 2023;
- Relevant papers on patient complaints activity and/or compliance that have been reported to Board/Sub-Committees/Executive in the last 12 months; and
- Evidence to demonstrate the capturing and sharing of lessons learnt from complaints in the last 12 months.

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Patient Complaints

Outputs

We will present our findings in a report. The report will be agreed with Judy Dyos, as the Executive sponsor for this review, before it is presented to the Audit Committee for approval.

Timetable

The timetable for this review is shown below

Due date	Task	Responsibility	
		SFT	KPMG
August 2023	Prepare and agree terms of reference	✓	✓
Fieldwork			
06 September 2023	Start fieldwork	✓	✓
19 September 2023	Complete fieldwork		✓
22 September 2023	Closure meeting	✓	✓
Reporting			
06 October 2023	Issue draft report		✓
20 October 2023	Provide management responses	✓	
27 October 2023	Final report issued		✓
14 December 2023	Presentation to Audit Committee		✓

Resourcing

This review forms part of our 2023/24 internal audit plan. Staff will be drawn from your core audit team as follows

Name	Position
Neil Thomas	Partner
Tiffany Irwin	Manager
Kallie Beasley	Internal Auditor

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This report has been prepared solely for Salisbury NHS Foundation Trust in accordance with the terms and conditions set out in our engagement letter dated April 2023. We do not accept or assume any liability or duty of care for any other purpose or to any other party. This report should not be disclosed to any third party, quoted or referred to without our prior written consent.

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Friends and Family Feedback

Britford Ward – Aug – Sep 2032

The care night and day was good. God bless and thank you.

Everyone was brilliant. I was looked after as one would expect to. All the staff have been professional and courteous

Everyone had a smile and were very helpful and friendly. Thank you all.

The friendliness of everyone, and that they smile so easily.

Attentive staff even when put under pressure. Happy faces and always helpful. Listened and responded.

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

Friends and Family Feedback

AMU Ward – Aug – Sep 2023

The whole team were attentive, responsible and approachable at all times.

A superb team giving care not only to patients but to one another. A lovely happy and informative atmosphere.

Managed to make me feel comfortable and safe.

Prompt and efficient action. Friendly and understanding staff. Cleanliness and hygiene.

Tests done quickly and very efficiently. Seemed to be plenty of staff so no long waits. Staff seemed happy and worked well with each other.

Friends and Family Feedback
Pembroke Ward – Aug- Sep 2023

Excellent! Everything, especially the kind dedicated staff.

Medical care was efficient, prompt and effective, plus it was served with a smile. Choice of vegan food on menu is very good, essential for me.

Kindness, care and general attention.

Excellent level of care and kindness.

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

Friends and Family Feedback

Pitton Ward – Aug- Sep 2023

The hard working, amazing cheerful care staff, therapists and other professionals.

Mum was pleased it was a clean place to be. All the staff were nice to deal with.

Helpful all the time. Kind and caring.

The hard working, amazing cheerful care staff, therapists and other professionals.

Quiet. Enjoyed my experience.

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

National Inpatient Survey Results (2022)

Results Report - Sept 2023

Patient Experience Steering Group 25th 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

Age

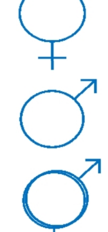
5% were aged 16 - 35

7% were aged 36 - 50

22% were aged 51 - 65

66 % were aged 66+

Sex



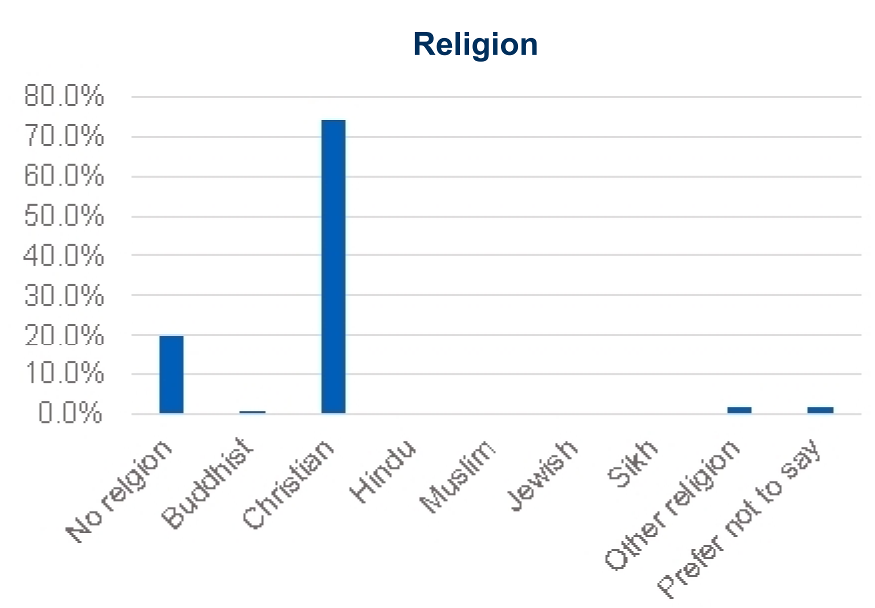
53% of those surveyed identified as female

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

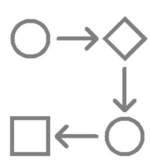
Overall experience rating 79.5%

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

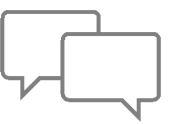
Areas for improvement comparison – how did we do?

2021

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

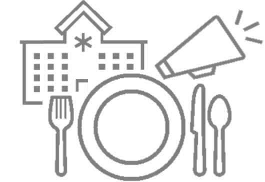


Discharge process and follow-up

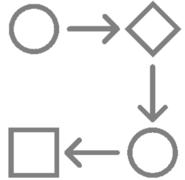


Communication

Staffing levels



Food and drink, noise and disruption, facilities



Discharge process and follow-up

		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.

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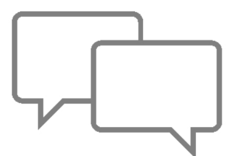


Communication

		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).

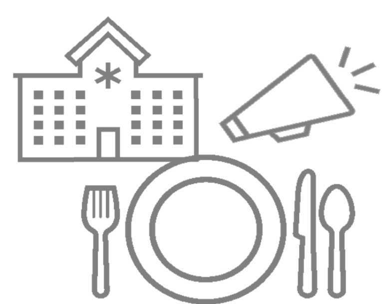
Information regarding ward changes needs further review.

Staffing levels

		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

		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%

		2021	2022
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

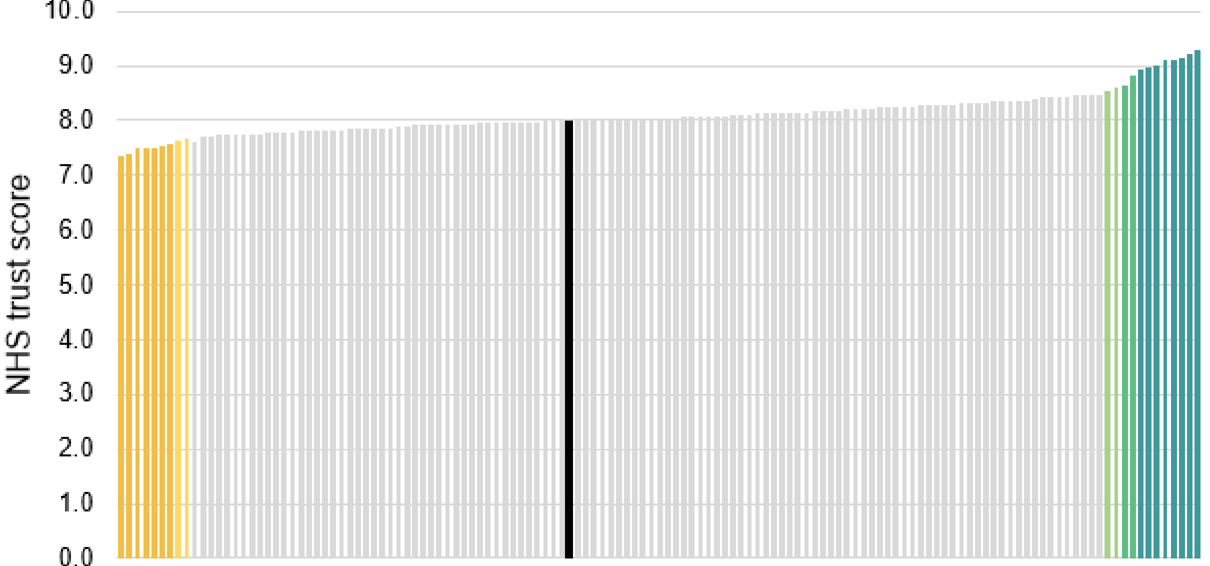
	2022 Patient Response	2021 Patient Response
Admission to hospital	7.0	7.1
Hospital and Ward	7.7	7.5
Doctors	9.0	8.7
Nurses	8.1	8.1
Care and treatment	8.1	7.8
Operations and procedures	8.6	8.1
Leaving hospital	7.0	7.1
Feedback on quality of care	1.0	1.0
Respect and dignity	9.0	9.0

2021

Experience overall

Patient Response **8.0**

Patient Response **8.0**



Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores

Trust	Score
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

Trust	Score
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

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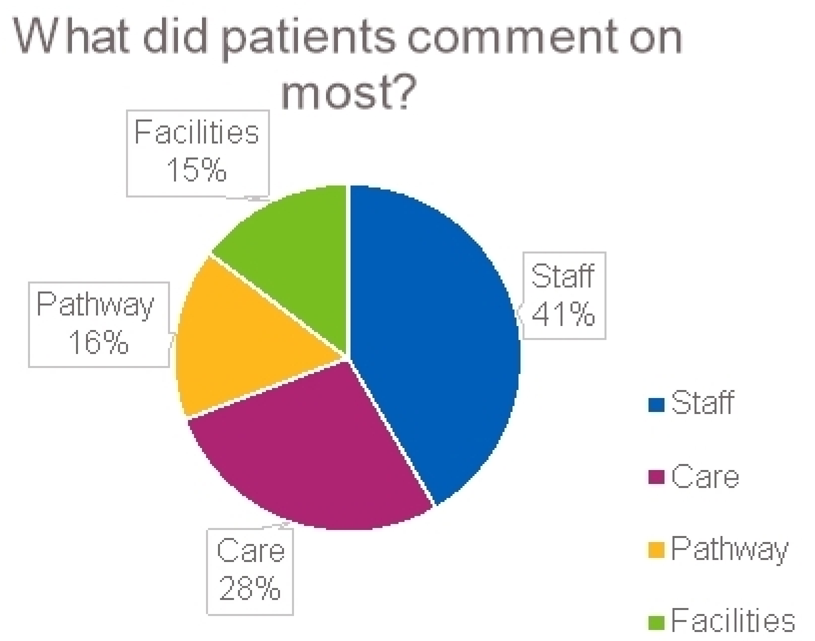
Themes from comments

Total comments received: 1,509

Overall positive: 51%



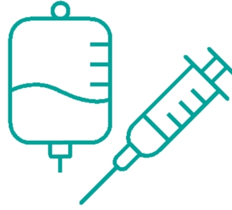
Positive vs Negative

90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Staff
Care
Pathway
Facilities
Positive
Negative

Themes from comments

Positives

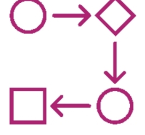
Care and general treatment


Operations/investigations and procedures

Staff (nurses and doctors primarily)

Negatives

Wait/access


Discharge process/information

Communication

Staffing levels

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

July 2023

Question		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

Question		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

Question		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		

Real-Time Feedback – Food and Nutrition Focus Trend

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

Average Score of Questions by Week between Jul 1, 2023 and Sep 30, 2023

Inspected Week Starting	Answer score (%)
2023-07-03	100.0
2023-07-10	94.4
2023-07-24	100.0
2023-07-31	87.5
2023-08-07	94.4
2023-08-14	75.0
2023-08-21	50.0
2023-08-28	100.0
2023-09-04	70.0
2023-09-11	35.7
2023-09-18	78.6
2023-09-25	75.0

Daily Monthly Quarterly

Proportion N/A
8%

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Real-Time Feedback – Food and Nutrition Focus Trend

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

Average Score of Questions by Week between Jul 1, 2023 and Sep 30, 2023

Inspected Week Starting	Answer score (%)
2023-07-03	100.0
2023-07-10	94.4
2023-07-24	83.3
2023-07-31	100.0
2023-08-07	93.8
2023-08-14	93.8
2023-08-21	100.0
2023-08-28	100.0
2023-09-04	88.9
2023-09-11	87.5
2023-09-18	78.6
2023-09-25	75.0

Proportion N/A
13%

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

National Cancer Patient Experience Survey 2022

(Published July 2023)

Luke Curtis

Lead Cancer Nurse

NCPES Introduction

- Annual survey, commissioned & managed by NHS England (since 2010)
  - ➢ New design from 2021, therefore break in series data & limited comparison

- Picker - responsible for designing, running & analysing the survey

Designed to

- Monitor progress in cancer care
- Provide information to drive local quality improvements
- Assist commissioners and providers of cancer care
- Inform the work various charities and stakeholder groups, supporting cancer patients

NCPES Methodology

- Provider survey samples
  - Adults (16 and over), with a confirmed diagnosis of cancer
  - Discharged from SFT (after an inpatient or day-case attendance for cancer related treatment) in April, May and June 2022

- Trusts submitted sample of patients September 2022

- Survey fieldwork Oct. 2022 – Feb. 2023

- Reports published July 2023 (National, Alliance, ICS, Trust)

Respondent Breakdown

- **298** patients responded out of **476**
- SFT **63%** response rate compared to national average **53%**

Respondents by Tumour Group

	Number of Respondents
Brain / CNS	0
Breast	46
Colorectal / LGT	46
Gynaecological	11
Haematological	44
Head and Neck	*
Lung	14
Prostate	35
Sarcoma	*
Skin	14
Upper Gastro	6
Urological	34
Other	39
Total	**298**

Respondents by Survey Type

	Number of Respondents
Paper	239
Online	59
Phone	0
Translation Service	0
Total	**298**

Response by Ethnicity

	Number of Respondents
White	
English / Welsh / Scottish / Northern Irish / British	266
Irish	*
Gypsy or Irish Traveller	*
Any other White background	*
Mixed / Multiple Ethnicity	
White and Black Caribbean	*
White and Black African	*
White and Asian	*
Any other Mixed / multiple ethnic background	*
Asian or Asian British	
Indian	*
Pakistani	*
Bangladeshi	*
Chinese	*
Any other Asian background	*
Black / African / Caribbean / Black British	
African	*
Caribbean	*
Any other Black / African / Caribbean background	*
Other Ethnicity	
Arab	*
Any other ethnic group	*
Not given	
Not given	20
Total	**298**

Key Messages

- The report scores 61 questions at Trust level, which are compared to the national average, expected lower and upper ranges.
- **53** questions were within the **expected range**. There were **8 positive** outliers and **0 negative** outlier.
- **Positive outliers**

	Case Mix Adjusted Scores			National Score
	2022 Score	Lower Expected Range	Upper Expected Range	
Q3. Referral for diagnosis was explained in a way the patient could completely understand	74%	59%	72%	**65%**
Q8. Diagnostic test results were explained in a way the patient could completely understand	83%	73%	83%	**78%**
Q15. Patient was definitely told about their diagnosis in an appropriate place	90%	81%	89%	**85%**
Q21. Patient was definitely involved as much as they wanted to be in decisions about their treatment	85%	75%	84%	**79%**
Q22. Family and/or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	86%	75%	85%	**80%**
Q50. During treatment, the patient definitely got enough care and support at home from community or voluntary services	63%	42%	61%	**51%**
Q51. Patient definitely received the right amount of support from their GP practice during treatment	58%	36%	53%	**45%**
Q56. The whole care team worked well together	94%	86%	93%	**90%**

Negative Outliers

SWAG Cancer Alliance

Trust Expected Range Summary

Data labels relate to the number of scores that fell below, within and above the expected range

- Number of scores below the Lower Expected Range
- Number of scores between the Upper and Lower Expected Ranges
- Number of scores above the Upper Expected Range

Trust		Expected Range Classification (below)	(within)	(above)
RD1	Royal United Hospitals Bath NHS Foundation Trust	1	43	17
RTE	Gloucestershire Hospitals NHS Foundation Trust		52	9
RNZ	Salisbury NHS Foundation Trust		53	8
RH5	Somerset NHS Foundation Trust	2	54	5
RA7	University Hospitals Bristol and Weston NHS Foundation Trust	1	57	3
RA4	Yeovil District Hospital NHS Foundation Trust	3	55	3
RVJ	North Bristol NHS Trust	7	53	1

Integrated Care Boards

ICB Expected Range Summary

Data labels relate to the number of scores that fell below, within and above the expected range

- Number of scores below the Lower Expected Range
- Number of scores between the Upper and Lower Expected Ranges
- Number of scores above the Upper Expected Range

ICB		Below	Within	Above
QR1	NHS Gloucestershire Integrated Care Board		52	9
QSL	NHS Somerset Integrated Care Board	1	54	6
QOX	NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board	2	54	5
QUY	NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board	4	56	1

Overall Care

- Patients are asked to rate their care from very poor (0) to very good (10). The Trust score was **9.0** compared to a national average of **8.9**, lower expected of 8.7 and upper of 9.1. An **improvement** from 8.9 in 2021!

- **Our Peers in BSW**

	2021	2022
Royal United Hospitals Bath	8.8	9.0
Great Western Hospitals	8.8	8.9

- **Our Peers in SWAG Cancer Alliance**

Yeovil Foundation Trust	9.1	8.8
Somerset Foundation Trust	9.1	8.8
North Bristol NHS	9.0	8.8
University Hospital Bristol and Weston	9.0	8.9
Gloucestershire Hospitals	9.1	9.0

Overall Care by Site Specific Team

Site	2021	2022
Breast	9.0	8.7
Colorectal	8.7	9.2
Gynaecology		8.6
Haematology	9.2	8.9
Lung		9.0
Prostate	9.0	8.6
Skin		9.6
Urology	9.0	8.8
Other		9.2

Comparison to 2021 Results

Negative Outliers progress 2021-2022

			2021		2022		
Section	**Question Number**	**Scored Question Text**	**Responses**	**Score**	**Responses**	**Score**	**Significant Change 2021-2022**
08. Hospital care	Q34	Patient was always able to get help from ward staff when needed	87	67%	109	72%	5%

Positive Outliers progress 2021-2022

			2021		2022		
Section	**Question Number**	**Scored Question Text**	**Responses**	**Score**	**Responses**	**Score**	**Significant Change 2021-2022**
05. Deciding on the best treatment	Q22	Family and/or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	187	83%	261	86%	3%
07. Support from hospital staff	Q29	Patient was offered information about how to get financial help or benefits	98	87%	132	72%	15%
09. Your treatment	Q42_2	Patient completely had enough understandable information about progress with chemotherapy	122	86%	156	80%	6%
09. Your treatment	Q42_4	Patient completely had enough understandable information about progress with hormone therapy	61	84%	58	69%	15%
11. Support while at home	Q50	During treatment, the patient definitely got enough care and support at home from community or voluntary services	86	66%	109	63%	3%

Comparison to 2021 Results

2 Questions % increase by 6% or more

			2021		2022		
Section	Question Number	Scored Question Text	Responses	Score	Responses	Score	Significant Change 2021-2022
08. Hospital care	Q32	Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	71	58%	88	64%	6%
12. Care from your GP practice	Q51	Patient definitely received the right amount of support from their GP practice during treatment	131	49%	165	58%	9%

7 Questions % changed by 0%

			2021		2022		
Section	Question Number	Scored Question Text	Responses	Score	Responses	Score	Significant Change 2021-2022
02. Diagnostic tests	Q08	Diagnostic test results were explained in a way the patient could completely understand	171	83%	257	83%	0%
02. Diagnostic tests	Q09	Enough privacy was always given to the patient when receiving diagnostic test results	172	95%	261	95%	0%
08. Hospital care	Q33	Patient was always involved in decisions about their care and treatment whilst in hospital	89	69%	108	69%	0%
08. Hospital care	Q39	Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case	181	81%	261	81%	0%
09. Your treatment	Q42_3	Patient completely had enough understandable information about progress with radiotherapy	51	82%	77	82%	0%
10. Immediate and long term side effects	Q47	Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment	184	58%	261	58%	0%
13. Living with and beyond cancer	Q55	Patient was given enough information about the possibility and signs of cancer coming back or spreading	164	63%	242	63%	0%

Comparison to 2021 Results

12 questions % increased by 3-5%

Section	Question Number	Scored Question Text	2021		2022		
			Responses	Score	Responses	Score	Significant Change 2021-2022
01. Support from your GP practice	Q03	Referral for diagnosis was explained in a way the patient could completely understand	159	72%	220	75%	3%
04. Support from a main contact person	Q17	Patient had a main point of contact within the care team	204	89%	280	93%	4%
05. Deciding on the best treatment	Q22	Family and/or carers were definitely involved as much as the patient wanted them to be in decisions about treatment options	187	83%	261	86%	3%
05. Deciding on the best treatment	Q23	Patient could get further advice or a second opinion before making decisions about their treatment options	81	54%	122	59%	5%
07. Support from hospital staff	Q27	Staff provided the patient with relevant information on available support	179	88%	237	92%	4%
08. Hospital care	Q31	Patient had confidence and trust in all of the team looking after them during their stay in hospital	89	73%	110	77%	4%
08. Hospital care	Q34	Patient was always able to get help from ward staff when needed	87	67%	109	72%	5%
08. Hospital care	Q35	Patient was always able to discuss worries and fears with hospital staff	82	63%	104	67%	4%
08. Hospital care	Q36	Hospital staff always did everything they could to help the patient control pain	75	83%	93	88%	5%
10. Immediate and long term side effects	Q44	Possible side effects from treatment were definitely explained in a way the patient could understand	203	74%	284	77%	3%
12. Care from your GP practice	Q52	Patient has had a review of cancer care by GP practice	202	17%	277	22%	5%
14. Your overall NHS care	Q58	Cancer research opportunities were discussed with patient	127	36%	171	40%	4%

Comparison to 2021 Results

11 questions % increased by less than 3%

Section	Question Number	Scored Question Text	2021		2022		
			Responses	Score	Responses	Score	Significant Change 2021-2022
02. Diagnostic tests	Q05	Patient received all the information needed about the diagnostic test in advance	160	93%	245	95%	2%
02. Diagnostic tests	Q07	Patient felt the length of time waiting for diagnostic test results was about right	171	81%	257	82%	1%
03. Finding out you had cancer	Q15	Patient was definitely told about their diagnosis in an appropriate place	206	87%	295	89%	2%
05. Deciding on the best treatment	Q21	Patient was definitely involved as much as they wanted to be in decisions about their treatment	208	84%	291	85%	1%
06. Care Planning	Q26	Care team reviewed the patient's care plan with them to ensure it was up to date	91	97%	115	99%	2%
07. Support from hospital staff	Q28	Patient definitely got the right level of support for their overall health and well being from hospital staff	208	78%	290	80%	2%
08. Hospital care	Q38	Patient received easily understandable information about what they should or should not do after leaving hospital	87	85%	109	87%	2%
09. Your treatment	Q42_1	Patient completely had enough understandable information about progress with surgery	109	85%	155	86%	1%
10. Immediate and long term side effects	Q46	Patient was given information that they could access about support in dealing with immediate side effects from treatment	143	86%	211	87%	1%
14. Your overall NHS care	Q56	The whole care team worked well together	200	92%	283	94%	2%
14. Your overall NHS care	Q57	Administration of care was very good or good	209	89%	289	90%	1%

Comparison to 2021 Results

9 Questions % Decreased by 3-5%

			2021		2022		
Section	Question Number	Scored Question Text	Responses	Score	Responses	Score	Significant Change 2021-2022
05. Deciding on the best treatment	Q20	Treatment options were explained in a way the patient could completely understand	193	87%	275	84%	3%
06. Care Planning	Q24	Patient was definitely able to have a discussion about their needs or concerns prior to treatment	185	77%	262	72%	5%
09. Your treatment	Q41_1	Beforehand patient completely had enough understandable information about surgery	108	92%	155	89%	3%
09. Your treatment	Q41_5	Beforehand patient completely had enough understandable information about immunotherapy	25	88%	36	83%	5%
09. Your treatment	Q42_5	Patient completely had enough understandable information about progress with immunotherapy	26	81%	36	78%	3%
10. Immediate and long term side effects	Q45	Patient was always offered practical advice on dealing with any immediate side effects from treatment	184	73%	260	68%	4%
10. Immediate and long term side effects	Q48	Patient was definitely able to discuss options for managing the impact of any long-term side effects	156	55%	229	52%	3%
11. Support while at home	Q49	Care team gave family, or someone close, all the information needed to help care for the patient at home	139	62%	186	59%	3%
11. Support while at home	Q50	During treatment, the patient definitely got enough care and support at home from community or voluntary services	86	66%	109	63%	3%

Comparison to 2021 Results

14 Questions % Decreased by less than 3%

Section	Question Number	Scored Question Text	2021		2022		
			Responses	Score	Responses	Score	Significant Change 2021-2022
01. Support from your GP practice	Q02	Patient only spoke to primary care professional once or twice before cancer diagnosis	123	83%	154	81%	2%
02. Diagnostic tests	Q06	Diagnostic test staff appeared to completely have all the information they needed about the patient	168	85%	258	84%	1%
03. Finding out you had cancer	Q12	Patient was told they could have a family member, carer or friend with them when told diagnosis	192	78%	279	77%	1%
03. Finding out you had cancer	Q13	Patient was definitely told sensitively that they had cancer	207	79%	290	77%	2%
03. Finding out you had cancer	Q14	Cancer diagnosis explained in a way the patient could completely understand	208	82%	294	81%	1%
03. Finding out you had cancer	Q16	Patient was told they could go back later for more information about their diagnosis	187	88%	268	86%	2%
04. Support from a main contact person	Q18	Patient found it very or quite easy to contact their main contact person	163	88%	242	86%	2%
04. Support from a main contact person	Q19	Patient found advice from main contact person was very or quite helpful	170	98%	249	97%	1%
06. Care Planning	Q25	A member of their care team helped the patient create a care plan to address any needs or concerns	110	96%	149	95%	1%
08. Hospital care	Q37	Patient was always treated with respect and dignity while in hospital	90	84%	109	83%	1%
09. Your treatment	Q41_2	Beforehand patient completely had enough understandable information about chemotherapy	122	89%	155	88%	1%
09. Your treatment	Q43	Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right	210	85%	290	83%	2%
13. Living with and beyond cancer	Q53	After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	45	38%	49	37%	1%
13. Living with and beyond cancer	Q54	The right amount of information and support was offered to the patient between final treatment and the follow up appointment	93	83%	124	81%	2%

Comparison to 2021 Results- Areas of focus

5 Questions % Decreased by 6% or more

Section	Question Number	Scored Question Text	2021 Responses	2021 Score	2022 Responses	2022 Score	Significant Change 2021-2022
07. Support from hospital staff	Q29	Patient was offered information about how to get financial help or benefits	98	87%	132	72%	15%
09. Your treatment	Q41_3	Beforehand patient completely had enough understandable information about radiotherapy	48	90%	78	82%	8%
09. Your treatment	Q41_4	Beforehand patient completely had enough understandable information about hormone therapy	60	82%	60	73%	9%
09. Your treatment	Q42_2	Patient completely had enough understandable information about progress with chemotherapy	122	86%	156	80%	6%
09. Your treatment	Q42_4	Patient completely had enough understandable information about progress with hormone therapy	61	84%	58	69%	15%

Lowest results for 2022- Area of Focus

Question Number	Scored Question Text	No. of responses	Unadjusted Trust Score	National
Q52	Patient has had a review of cancer care by GP practice	277	22.4%	20.6%
Q53	After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	49	36.7%	31.1%
Q58	Cancer research opportunities were discussed with patient	171	40.4%	43.1%
Q48	Patient was definitely able to discuss options for managing the impact of any long-term side effects	229	52.0%	53.2%
Q51	Patient definitely received the right amount of support from their GP practice during treatment	165	58.2%	44.7%
Q47	Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment	261	58.2%	59.0%
Q23	Patient could get further advice or a second opinion before making decisions about their treatment options	122	59.0%	52.0%
Q49	Care team gave family, or someone close, all the information needed to help care for the patient at home	186	59.1%	57.9%

Lowest results for 2022

Question Number	Scored Question Text	No. of responses	Unadjusted Trust Score	National
Q55	Patient was given enough information about the possibility and signs of cancer coming back or spreading	242	63.2%	62.4%
Q50	During treatment, the patient definitely got enough care and support at home from community or voluntary services	109	63.3%	51.3%
Q32	Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	88	63.6%	65.7%
Q35	Patient was always able to discuss worries and fears with hospital staff	104	67.3%	64.2%
Q45	Patient was always offered practical advice on dealing with any immediate side effects from treatment	260	68.1%	69.3%
Q33	Patient was always involved in decisions about their care and treatment whilst in hospital	108	68.5%	69.5%
Q42_4	Patient completely had enough understandable information about progress with hormone therapy	58	69.0%	72.5%
Q29	Patient was offered information about how to get financial help or benefits	132	72.0%	67.5%
Q24	Patient was definitely able to have a discussion about their needs or concerns prior to treatment	262	72.1%	71.1%
Q34	Patient was always able to get help from ward staff when needed	109	72.5%	72.6%
Q41_4	Beforehand patient completely had enough understandable information about hormone therapy	60	73.3%	78.8%

Patients Comments- to be Celebrated

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Patients Comments- Learning

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Initial Observations

Overwhelmingly positive results

Our low scores themes are all related to:-

- Communication
- Information giving (including side effects, immunotherapy, recurrence, late effects)
- Holistic support
- Research opportunities
- Cancer care reviews in community

These can all be solved by taking the time to understand what matters to the patient and there preferences, treating people as equal partners in their care.

Next Steps

- Continue to offer personalised care interventions, focus on Personalised Care and Support Plans
- Work with SWAG Cancer Alliance to embed What Matters to Me
- Late effects- what else can we do
- Focus on information resources
- Introduce a Macmillan Information Hub and Info points
- Introduce information pack at diagnosis
- CNS review- present at diagnosis and treatment planning
- Site specific groups to identify 2 areas of focus to form action plan

The full report can be found by following this link (comments are not nationally published) Latest local results - National Cancer Patient Experience Survey (ncpes.co.uk) and search Salisbury.

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	6.2
Date of meeting:	07 March 2024		

Report tile:	Patient Feedback Report – Q3 2023/24			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee – 27th February 2024 Patient Expereince Steering Group – 28th February 2024			
Prepared by:	Victoria Aldridge - Head of Patient Experience			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			
Appendices (list if applicable):	APPENDIX 1: Leadership Training Programme - Apologies and Liabilities Oct 2023 v2 APPENDIX 2: SDH Spinal Patient Panel - Trust Board Patient Story 06.12.23 APPENDIX 3 - KMPG SFT 23-24 Patient Complaints Report FINAL APPENDIX 3a Audit Management actions 120224 v1.0 APPENDIX 4: Friends and Family Test Comments – Q3 2023/24 APPENDIX 5: Disharge and Patient Flow Project - Patient Feedback Jan 24 v1 APPENDIX 6: Annual Complaints Process Survey Report – October 2023 APPENDIX 7: Real-Time Feedback RTF Comments Q3 23-24			

Recommendation:
This report is for assurance and noting by the Committee.

Executive Summary:

This report provides summary and insights drawn from the various methods by which our patients feedback on our services. This includes analysis of complaints, concerns, compliments, Friends and Family Testing and any National surveys reported during Q3 of 2023-24.

To summarise the contents of this paper:

Complaints/concerns/compliments and enquiries:

The number of formal complaints made in Q3 has increased slightly (n~45) when compared with Q2 (n~40).

There were 60 concerns logged in Q3, an increase on Q2 (n~56).

Comparing the totality of both complaints and concerns to the numbers seen in the same quarter last year these have overall reduced, this is against a landscape of increased patient activity.

A total of 395 comments/enquiries were logged by the PALS team in Q3, a continued increase on previous quarters, this is new noted peak when comparing both 23/24 and 22/23 reporting.

314 compliments were recorded on Datix this quarter across the Trust (141 more than last quarter), there were 44 compliments not logged by PALS in time for this reporting, these will therefore be included with the Q4 report.

For Q3 the two most common high-level themes for complaints across the Trust were the same as those seen in Q2. These were in relation to **Patient Care** (40%) and **Communication** (26%). The third most prevalent theme was new, 10% accounting for **Admissions, discharges and transfers**. Within this theme **early discharge** and **discharge procedures** came out as the highest sub-categories (see Table 1.2c). This data is noted to have some correlation with the discharge themes highlighted in the Q2 report for Real-Time Feedback (RTF). Suggesting a possible pre-indication of this as an emerging theme.

Overdue complaints continue to be a challenge for the Trust as a whole, we continue to fall short of the 90% Improving Together target set. PALS have targeted support to individual departments and specialities where challenges are being recognised. Focuses on early intervention and resolution continue to be promoted.

The number of reopened complaints/concerns in Q3 has decreased slightly this quarter, reasons for this had no clear themes.

Friends and Family Test (FFT) Trust wide average response rate for Q3 has dropped slightly with 2,141 responses received. This reduced the response rate to 2.5% (of eligible population). This was anticipated based on historic peaks and drops in activity. Factors associated with Christmas and New Year periods and availability of volunteers to input the cards (only current collection method) have impacted this. FFT experience ratings however have increased slightly to 98%. The project to launch a digital provider is scheduled for Go Live in January 2024, with anticipated completion in April 2024.

Local Surveys:

Annual complaints process survey was presented to CGC in December 2023. Overall shows good compliance with the PHSO complaints standards framework and significant improvement against the previous feedback which was taken as part of the Healthwartch Wiltshire and SFT co-produced project. Response rate was a respectable 30.9%.

Real-time feedback (RTF) remains a standing item for discussion at the PESG. Overall good satisfaction rates, though some issues noted around noise at night and involvement with discharge plans and quality of written information. High levels of satisfaction related to being treated with dignity and respect and cleanliness of the ward areas. A total of 70 surveys were completed during this quarter.

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

Patient Experience - Patient Feedback
Q3 Report 2023/24

Purpose of paper

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

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

Background

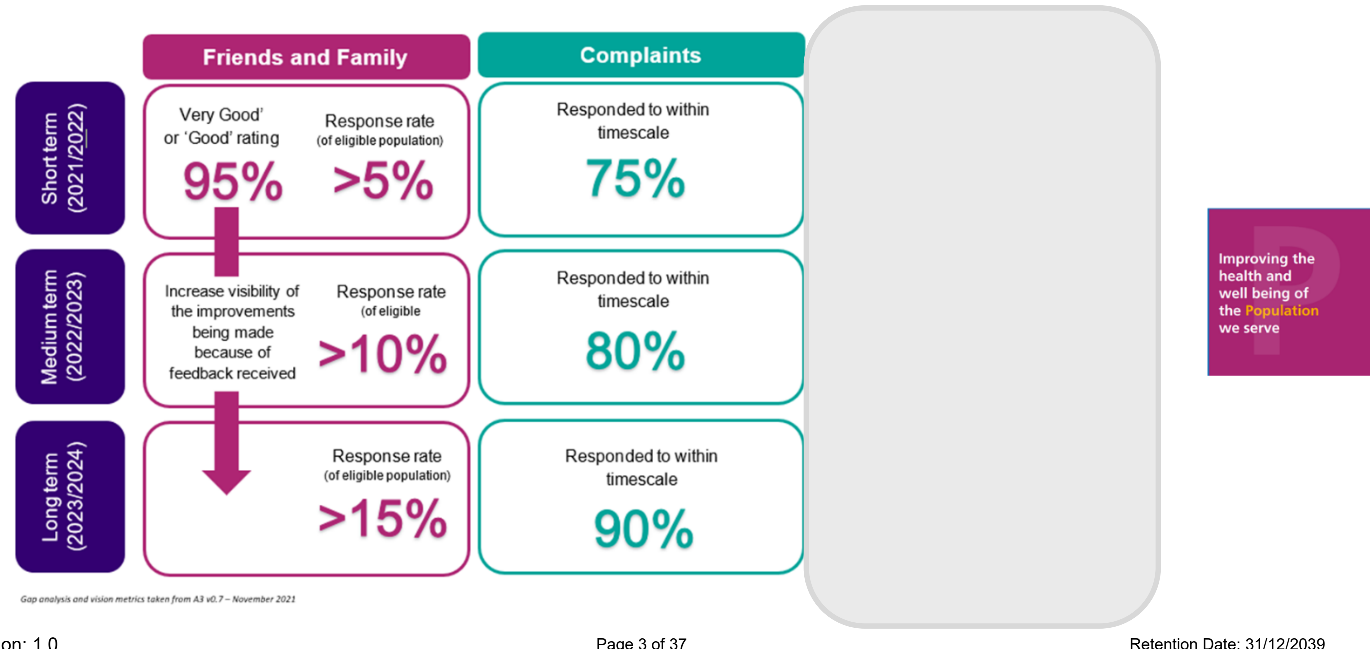
Patient experience is defined as "the sum of all interactions, shaped by an organisation's culture that influence patient perceptions across the continuum of care". Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and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

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

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

These metrics are currently under review and will be produced under a new A3 "Patient Engagement Score". This will be introduced through the annual patient engagement report in Q1 of 2024/25.

Patient Experience – Improving Together Summary



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1. Complaints, Concerns and Compliments - Trust Overview

There were a total of 7 items of feedback posted on the NHS Website* in Q3.

Average rating on responses:

	Positive	Neutral	Negative	Average star rating
Q3 23/24	6	1	0	★★★★★
Q2 23/24	2	0	2	★★★
Q1 23/24	4	0	0	★★★★★
Q4 22/23	2	0	2	★★★

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

Summary of these comments are depicted in this wordcloud:

Patient Activity

Table 1.1 shows the breakdown for patient activity across the Divisions and total for the Trust. This is used to calculate this feedback on a per 1,000 basis (see Figure 1.1). The Trust is seeing a similar level of patient activity compared with last quarter, but significantly higher than this same period last year.

Table 1.1 – Patient activity

Patient Activity by Division / Quarter	Clinical Support and Family Services	Medicine	Surgery	Women & Newborn	Total
Q3 2023 - 24	33,495	35,002	41,789	4,471	114,757
Q2 2023 - 24	33,871	34, 921	39, 997	4,330	113,119
Q1 2023 - 24	35,540	34, 554	40, 495	4, 206	114, 795
Q4 2022-23	34,107	28,406	35,310	3,795	101,618
Q3 2022-23	*31,906*	*29,040*	*35,374*	*4,802*	*101,122*

Compliments

Compliments are sent directly to the Chief Executive, PALS or via the SOX inbox and are acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment the PALS team complete a SOX which is sent to the SOX administrator for formal recognition. Whilst compliments continue to be retained locally within the department areas, the

PALS team continue to promote the importance of sharing these with PALS so these can be given equal weighting with formal reporting. This ensures for more robust reporting and future changes to the Datix system will allow for theming of compliments to enable reporting alongside complaints and FFT.

Further analysis of compliments is included within each Division's individual reports.

Complaints and Concerns

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

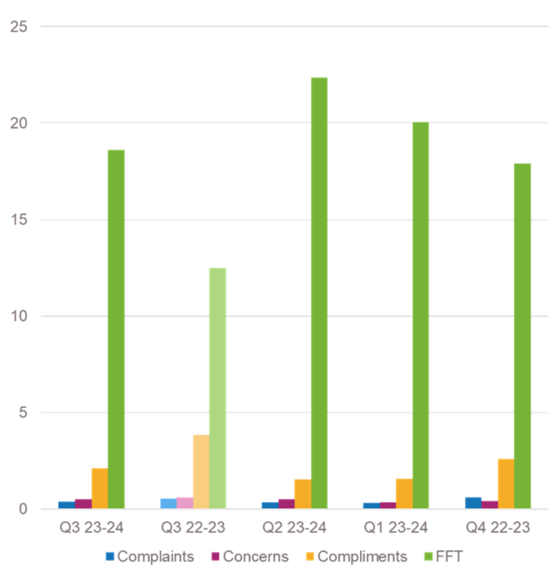


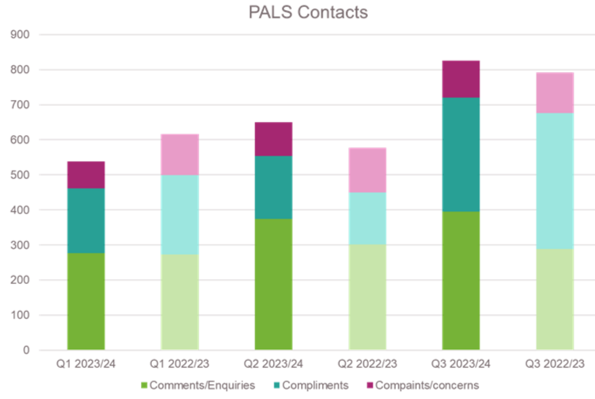
Figure 1.1 shows a continued increase in the total number of both complaints and concerns received for Q3, in comparison with Q1 + Q2. However, this is less than the same period last year *(opaque graphs)*. FFT feedback has decreased this quarter, which was anticipated given the limited method of data collection, which is usually impacted at this time of year. However for context, this is still significantly higher than this time last year.

Compliment numbers have increased, as we continue to promote recording with PALS for reporting. It is noted that at the time of writing this report that there were **44** compliments outstanding for logging, these will be carried over into Q4.

In Q3 the PALS department logged 395 comments/enquiries. This is a 20 more than in Q2.

This equates to an average of 3.4 contacts per 1,000 patient activity across the Trust.

Figure 1.1a Total Number of Complaints & Concerns, Comments/enquiries, and Compliments logged by PALS with quarter comparisons 2022/23 – 2023/24



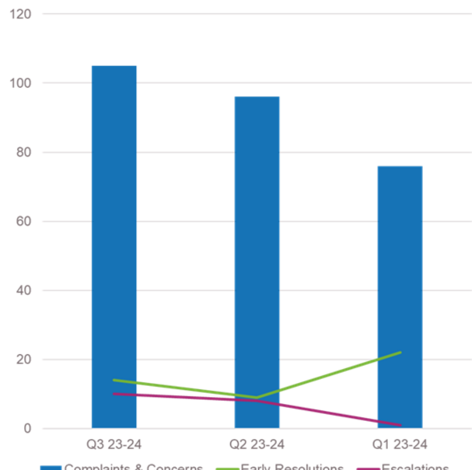
During Q3 there were a total of 105 complaints and concerns logged (96 in Q2).

Figure 1.1a demonstrates the steady increase in contacts for the PALS department, particularly noted for comments and enquiries.

Complaints and concerns have been comparatively lower when compared with the same time periods last year (pink opaqe graphs).

Changes to the complaints process over the past 6-12months coupled with targeted work through PALS to adopt the PHSO principles on **early resolution** of complaints continues to be emphasised.

Figure 1.1b Total Number of Complaints & Concerns, Early resolutions, and Escalations

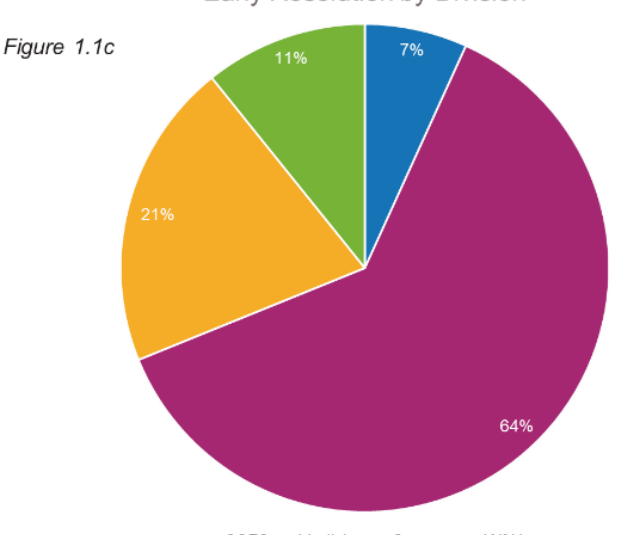


Changes to the Datix system implemented in Q1 now enables reporting on the number of complaints/concerns that have been deescalated following early intervention and/or resolution. 14 of the 105 were considered to achieve an earlier resolution than anticipated in Q3.

10 of the total above, were noted to have escalated from a comment or enquiry into a concern or complaint.

Figure 1.1b shows how this correlates with previous quarters.

Figure 1.1c shows how the de-escalated complaints/concerns were distributed across the Trust.



Both Surgery and Medicine continue to work hard this quarter to adopt the principles around early resolution and de-escalation, and this is evidenced by the highest proportion of the 14 resolved early this quarter coming from these Divisions.

Table 1.2 below shows the themes for complaints received in Q3. Highlighted are the top three most prevalent themes. **Communication** and **Patient Care** are consistent themes with the previous quarter, however **admissions, discharge and transfers** is a new theme so far this year. These top three themes are further broken down into sub-categories for deeper analysis in Tables 1.2a-1.2c.

Table 1.2 Raw data - Themes from Q2 Complaints/concerns

	CSFS	Medicine	Surgery	Women & Newborn	Non-clinical	% of total by theme
Access to treatment or drugs		1	3			4%
Admissions, discharge and transfers		5	6			10%
Appointments including delays and cancellations	2		7			9%
Clinical Treatment						
Commissioning Services			1			1%
Communications	2	13	5	6	1	26%
End of Life Care						
Facilities Services			1		2	3%
Other		1				1%
Patient Care including Nutrition / Hydration	2	16	18	6		40%
Prescribing errors						
Privacy, dignity & wellbeing			1		1	2%
Values and behaviours (Staff)	2		3			5%
Total by Division	**8**	**36**	**45**	**12**	**4**	
Divisions Total	**105**					

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

Unsatisfied with treatment came out as the highest sub-category for **Patient Care** (see Table 1.2a).

Insensitive or **lack of communication** came out again as the highest causes for complaints under the **Communications** category (see Table 1.2b)

Admissions, discharge and transfer is a new theme for Q3. With **Early discharge** and **discharge procedures** coming out as the highest causes (see Table 1.2c).

Table 1.2a

Patient Care including Nutrition / Hydration	**42**	**40%**
Correct diagnosis not made	6	14%
Delay in making diagnosis	4	10%
Falls	1	2%
Further complications	8	19%
Inappropriate treatment	5	12%
Lack of equipment/aids/appliances	1	2%
Nursing Care	4	10%
Unsatisfactory treatment	**13**	**31%**

Table 1.2b

Communications	27	26%
Delay in receiving/sending information	1	4%
Information not given to family	3	11%
Information not given to patient	2	7%
Insensitive communication	**9**	**33%**
Lack of communication	**9**	**33%**
Wrong information	3	11%

Table 1.2c

Admissions, discharge and transfers	11	10%
Discharge procedures	**4**	**36%**
Discharge summary incomplete / not sent	1	9%
Early discharge	**4**	**36%**
Unsatisfactory arrangements	2	18%

It was noted in the Q2 report within real-time feedback (RTF) that the patient's understanding of their *discharge plan* was an area of low scoring.

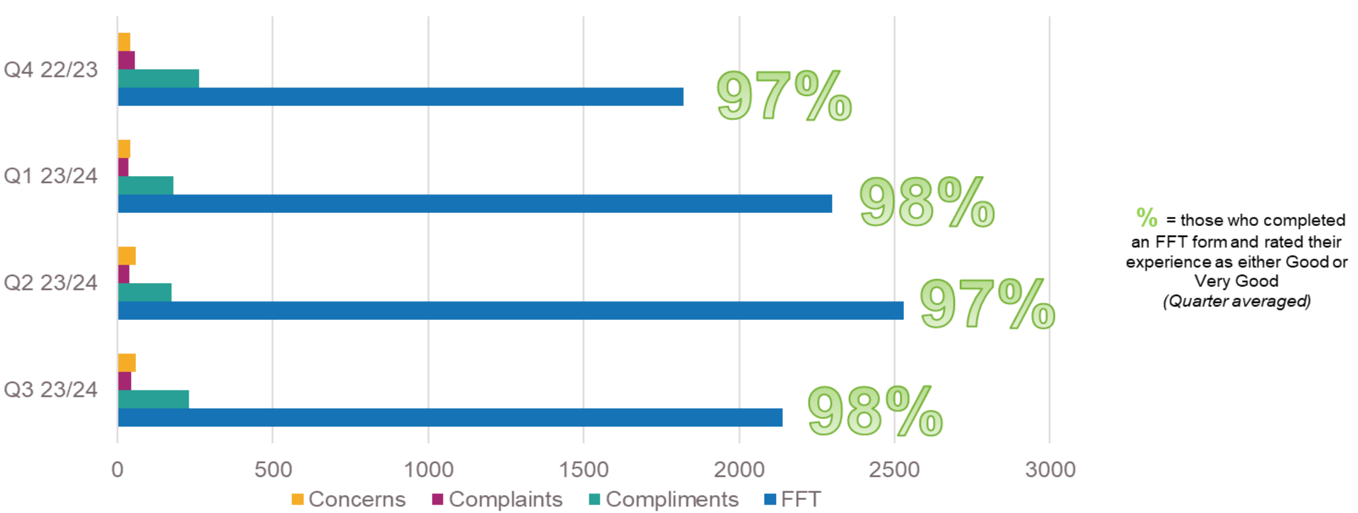
This could suggest that feedback from RTF could be a means of anticipating themes for complaints before they are formally logged. This was highlighted to the Managing Staff and Patient Expectations Working Group.

Further analysis of these themes is reported within the Division's reports.

Complaints and concerns continue to be small in number when compared with the number of Friends and Family Test (FFT) feedback received across the Trust and satisfaction rates associated with these. This comparison is demonstrated in Figure 1.2.

This demonstration represents the proprortion of good or very good experiences (as rated by our service users) and how vast this is in comparison to the number who have raised a complaint or concern. This has however seen a slight increase in satisfaction. This data is significant in demonstrating (by the proportions of feedback) that overall patient experience is positive.

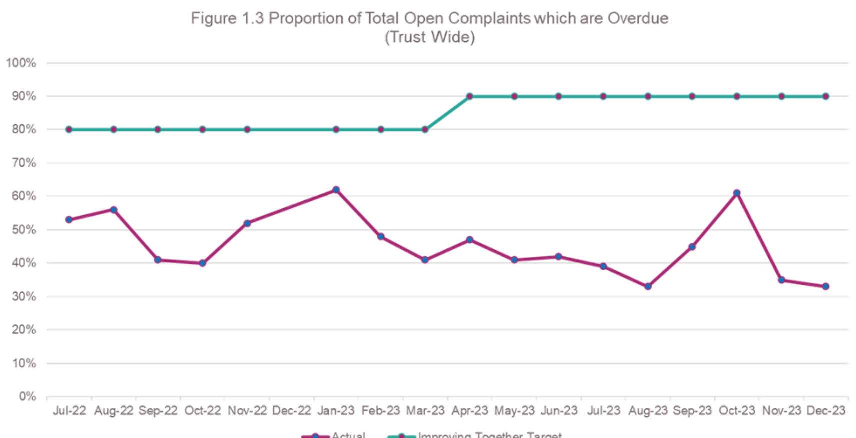
Figure 1.2 – Reiterates the FFT feedback rates compared with complaints, concerns and compliments (based on a per 1,000 patient activity) but also demonstrates the patient experiences rates obtained from these.



Overdue Complaints

The Trusts Improving Together Target for response to complaints within their agreed timescale is set at 90%. As a Trust we continue to struggle to achieve this, despite individual areas regularly achieving this.

There are various factors that can influence this, but focused work continues within individual areas to improve processes in order to help mitigate these extenuating factors are being trialled.



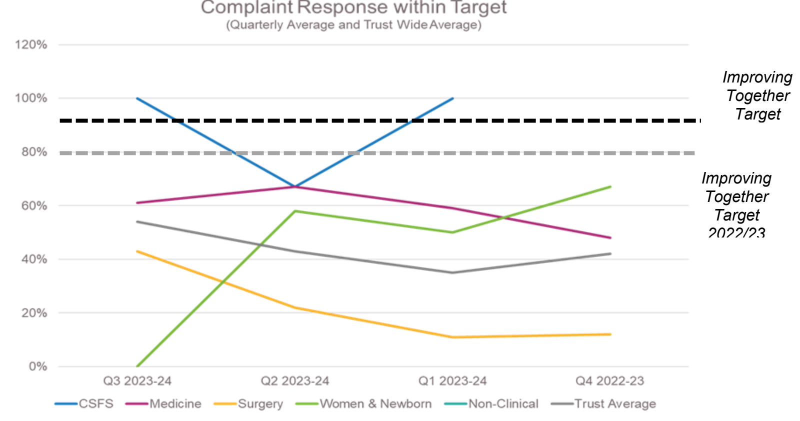
This target continues to be monitored via the Integrated Performance Report (IPR) as a watch metric.

Monthly live data is also monitored via the Patient Experience Steering Group, the tracking of this target through this forum is demonstrated in Figure 1.3.

At Division level, we are seeing varied compliance to this target. This is largely impacted by operational pressures, along with complexity and the number of complaints requiring response within similar timeframes. There is a strong drive within the Divisions to change their complaints handling structures to ensure clearer ownership of these within the relevant areas.

PESG overdue complaints reporting from December 2023 started to focus on which areas were struggling the most with overdue responses, this was to help highlight their need for more support or escalate if needed. In addition, PALS continue to work closely with individual areas supporting with response writing where this is also causing delay. To date, additional support has been provided to Day Surgery Unit, ED and Ophthalmology.

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



Surgery and CSFS are continuing on an small upward trajectory going into Q3 with this target.
Medicine continue to work hard to maintain a steady compliance towards the Improving Together target of 90%, however, as demonstrated in Figure 1.4 this continues to be an area of challenge across the Trust.

Women & Newborn's data indicates a 0% target achievement in Q3, this is because zero complaints were responded to within timescale during this period.

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PALS continues to hold fortnightly meetings to review outstanding complaints and offer additional support to the Divisions where there are noted hot spots.

(see Section 3 Division Summaries – Complaints, Concerns and Compliments) for more detailed breakdowns for each Division.

Reopened Complaints

Figure 1.5 – Number of re-opened complaints or concerns

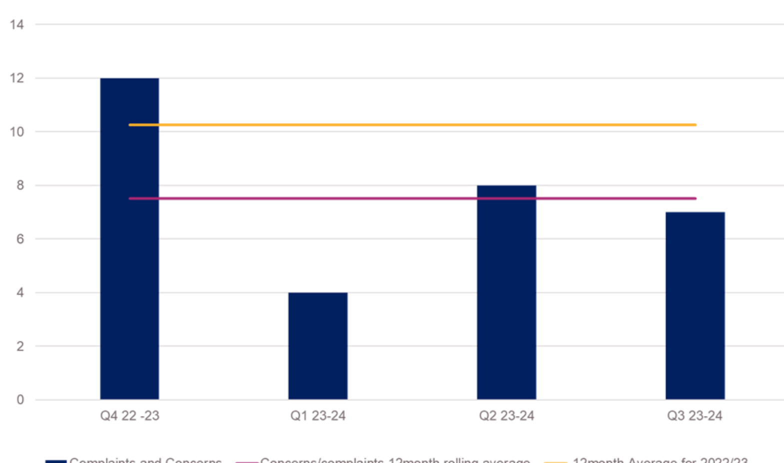


Figure 1.5 shows the number of reopened complaints and concerns (in total), compared with previous quarters.

The yellow lines shows the average for 2022/23 acting as a benchmark.

The pink line calculates a rolling average for the 12month period shown.

The number of reopened complaints and concerns has decreased this quarter compared with Q2, and falls below the rolling 12month average indicating a higher success rate of first time resolution.

For those which have reopened the reasons were varied with no clear themes. The PALS team and the Division Leads continue to work hard to realise the benefits of concluding investigations with complaint meetings. Where written responses are required ensuring these address all the points raised, contain empathetic apologies, are factually accurate and demonstrate lessons learnt are emphasised as the key principles.

2. Learning from Patient Experience

Patient Stories

For September's Patient Experience Steering Group (PESG) the patient chair for the Spinal Patient Panel*1 was invited to attend in person to talk about the successes and challenges the patient panel have had since their formation in April 2023.

The Spinal Unit wanted a dedicated Patient's Forum to ensure ways of getting patient feedback into regional oversight groups but also to inform changes and service improvements based on real patient experience.

The group's chair helped to form the initial group contacting previous service users who had been discharged and also came up with some of the initial areas of focus (based on his experience as a patient) in order to help kick start the discussions. Since then, the group continues to evolve, meeting bi-monthly and has 5-6 regular attendees. They also have a Terms of Reference, formal minutes and action log. To date there has been successful installation of additional toilet equipment, which had previously thought to not be viable given the set-up of the area. There are also two other active workstreams related to the trialling of a gait walking (to aid self-rehab) and another helping to improve patient/family information. The group also now provides patient voices at the regional oversight group.

This story prompted an action to review the Trust's funding application for an Accessibility Audit, which remains under review with the Patient Experience Steering Group.

This story was also invited to present to Trust Board on the 6th December 2023 – see Appendix 2.

**1~(this reference has been included in the Q3 report as this was unreported in the Patient Experience Q2 report.)*

Managing Staff and Patient Expectations Working Group – (Discharge Project)

This is a new project aimed at improving discharge planning and ultimately improving patient flow. The key stakeholders in this project to date have been the Associate Director for Community Engagement, Head of Patient Flow and Head of Patient Experience.

The group have been scoping ideas for improving how the Trust communicates discharge planning, looking at creative ways to engage the patient in this as well staff. The concept is to *"think discharge"* as early as possible after the patient is admitted. Initial findings from the project indicate that some patients often don't understand what is meant by "discharge" often limiting this to *"how I will get home from the hospital"* and staff are not always considering these plans early enough when additional elements may be needed in order to complete this timely and successfully. This is an ongoing piece of work. Data from RTF in Q2 and themes from Complaints in Q3 are indicating that patients are not being actively included in the discharge planning or attempts to improve patient flow are resulting in patients feeling unclear or not in agreement with their discharge plans.

See Appendix 5.

Patient Experience Division Presentations

The Head of Patient Experience continues to explore how to maximise opportunities for sharing patient experiences through DMT's and Clinical Governance Sessions. Throughout Q3, complaints and FFT data from Q2 was shared at Divisional Governance sessions as an opportunity to share patient experience data with front-line teams and encourage reflections on

what mitigations could be considered to change poor experiences and replicate those things which are being done well.

In return, Divisions are now regularly attending the Patient Experience Steering Group to reflect on this data and also provide updates on any areas of focus which they are pursuing informed in part, by this data.

Table 1.3 – Q1 Patient Experience data presented to Divisions during this quarter

Division	Data presented to Division	Division update to PESG
Surgery	15th November 2023	*Scheduled for January 2024*
CSFS	*20th December 2023*	25th October 2023
Medicine	19th December 2023	22nd November 2023
Women & Newborn	19th October 2023	25th October 2023
Facilities (Food & Nutrition /PLACE)	*18th October 2023* (Food & Nutrition)	*Scheduled for January 2024*

In addition, individual specialities have also started to ask for this data in a presentation format to help inform local improvements. An overview of FFT, complaints and compliments was provided to Fracture and Orthopadics for their speciality meeting held on the 14th December 2023.

CSFS Update to PESG (25th October 2023):

Themes for complaints were largely in relation to Communication and Treatment. The division has now undertaken Improving Together training and have highlighted their priorities around child health DNA rates and ensuring staff voices are heard, recognising the links between patient experience and staff satisfaction.

Radiology are reinstating their patient communication group, utilising service specific feedback boxes. CSFS had recognised a single point of failure in relation to their complaints process and work is underway to identify complaint leads for each department.

Significant difficulties were highlighted in relation to the management of complex and challenging Mental Health patients on Sarum, this is a consequence of various factors, partly related to reduced resources for child and adolescent mental health in the community. The division are planning a staff story to demonstrate the alternative resources that have been utilised such as the Volunteering PAT (Pets As Therapy) services, and how this worked successfully alongside security to maintain the safety and wellbeing of the patient, but also the other patients and staff around them.

Medicine Update to PESG (22nd November 2023):

Medicine are focusing on celebrating staff and sharing good practice, this is through various means including awards and recognitions within the Division and having their own awards ceremony in December. Current themes for complaints are mainly around communication. The Division is actively promoting early interventions for complaints and are having more face-to-face complaints meetings, which have been positively embraced by the teams. They are also trialing complaint follow-ups. This can involve inviting complainants back into wards/areas to see the changes made as a result of their complaint or following up in writing changes that have been made as a formal update. This good practice is recognised for being patient centred and its subsequent effectiveness, but there are challenges associated as it is time consuming and takes planning, its therefore not practical for every complaint. Feedback from the families where this has been achieved however, has been really positive.

Women & Newborn Update to PESG (25th October 2023):

The division is continuing to actively adopt early resolution to concerns raised where possible and striving for improvements to response within timescale. The PALS developed a training package for staff (delivered in November 2023) to aid this further. Themes noted were in relation to staff communication, postnatal care and self-discharge. 24 SOX's were received the majority of which were themed as "support to others". FFT is currently being actively relaunched as response rates have significantly reduced over recent months.

The 15 Steps Maternity Voice Partners independent report is currently awaiting final publication, this will come back to PESG for presentation and reflection.

Preliminary report for the 2023 National Maternity Survey was presented. Achieving an above average response rate of 59% and increased averaged mean experience rating of 79.4% (0.8% higher than 2022). The Trust were in the top 20% for six questions around the following areas:

- Choice and being listened too antenatally
- Not being left alone when worried during labour
- Confidence and trust in midwives after going home

The Trust were in the bottom 20% for seven questions around the following areas:

- Feeding in Hospital
- Mental Health and changes that might be experienced
- Visiting times
- Being treated with kindness and being given information on the ward after birth

3. Training & Development for Staff

The Patient Experience Team and PALS continue to work with Division leads to explore opportunities to share learning from complaints with ward and area leads.

A new programme was developed for the Senior Clinicians Leadership Development Programme and presented to a group of Consultants in October 2023. This training prackage was co-developed by the Head of Patient Expereince and Head of Legal Services to focus on "apologising and liability" as this was an area of interest for this group (see Appendix 1).

An introduction to complaints and themes from complaints package was developed and presented to the Women & Newborn Division as part of a focused learning event on the 8th November 2023.

4. Process reviews, audits and policies

KMPG Internal Complaints Audit 2023

In September 2023 the complaints process was subject to an internal audit with KPMG. A random sample of 15 complaints received between 1st January 2023 - 30th September 2023 were reviewed in detail by external auditors KPMG throughout October and November 2023. The complaints process was scrutinised through a series of interviews with key staff including the Head of Patient Experience, PALS Lead and Complaints Coordinators. In addition, interviews with the Leads for Medicine, Women & Newborn and Surgery were also conducted.

In conjunction with these interviews the following were also reviewed:

- The Trust's complaints policy and any associated procedural templates active at that time
- The Healthwatch Wiltshire complaints process improvement project (2022/23)

- Training materials developed for staff
- Terms or Reference and escalation reports for relevant committees (PESG, CMB etc.)
- Patient Experience quarterly reports and Divisional Governance Presentations

Overall, the findings from this audit were very positive, claiming an AMBER/GREEN rating describing *"a well-designed complaints management process at corporate level with improvement opportunities identified at the Divisional level"*. No actions for improvement that were identified were given a high priority rating.

In summary, the following were considered to be areas of good practice:

- The complaints policy is in date, comprehensive and clearly sets out timescales for patient complaint management which is available to all staff and the public.
- Complaints are managed in the Datix system which allows for easy and appropriate oversight of all open complaints.
- There is a well designed governance structure in place which regularly reports patient complaint figures on at least a quarterly basis, including figures and overarching themes.
- Regular discussions on open complaints are held between the PALS Lead and the complaints coordinators, with a focus on overdue complaints.
- Written responses require review and sign off from the Chief Executive before they are sent to the complainant.
- Discussions with Divisional management found that the complaints co-ordinators are seen as a positive addition to the complaints management process.

The main areas for improvements were centred around:

- Further development of the mechanisms to ensure sharing lessons are learnt at divisional, cross-division and trust-wide level to prevent repeat complaints with the same root cause.
- Reducing single points of failure by having clearer processes at division level and in particularly clearer guidance around timescales
- Clearer process for re-opened complaints
- Provide greater assurance that all complaints (yet to be formally processed) are formally documented on Datix.

The full report and action plan progress can be found in Appendicies 3 & 3a.

5. Division Summaries – Complaints, Concerns and Compliments

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

4 complaints/concerns were recorded for **non-clinical** divisions in Q3.

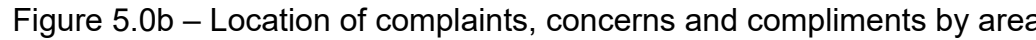
There were a total of 26 comments/enquiries logged in Q3 (6 less than in Q2) of which 38% were related to requests for further information, the vast majority of which were pertaining to medical records. Car parking enquiries had been a notable theme for enquiries in Q2, however this was noted to have signficantly reduced in Q3.

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

There were a total of 10 compliments recorded on Datix for non-clinical divisions across Q3. This is an increase of 4 on Q2, with PALS being consistent in both quarters.

Figure 5.0 shows a breakdown of where the compliments were received and Figure 5.0a is Word cloud summary of the common words used in these compliments:

Figure 5.0 – Non-clinical Compliments breakdown by location



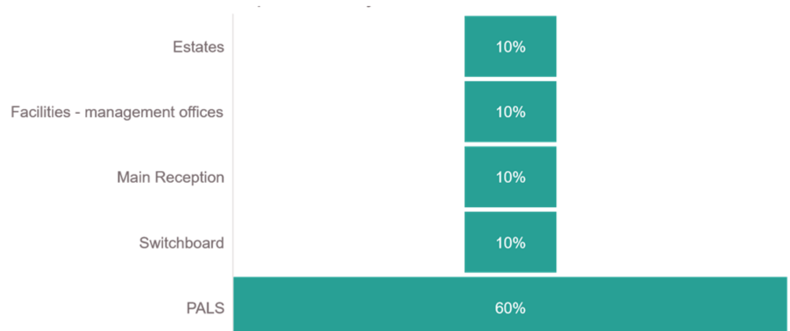
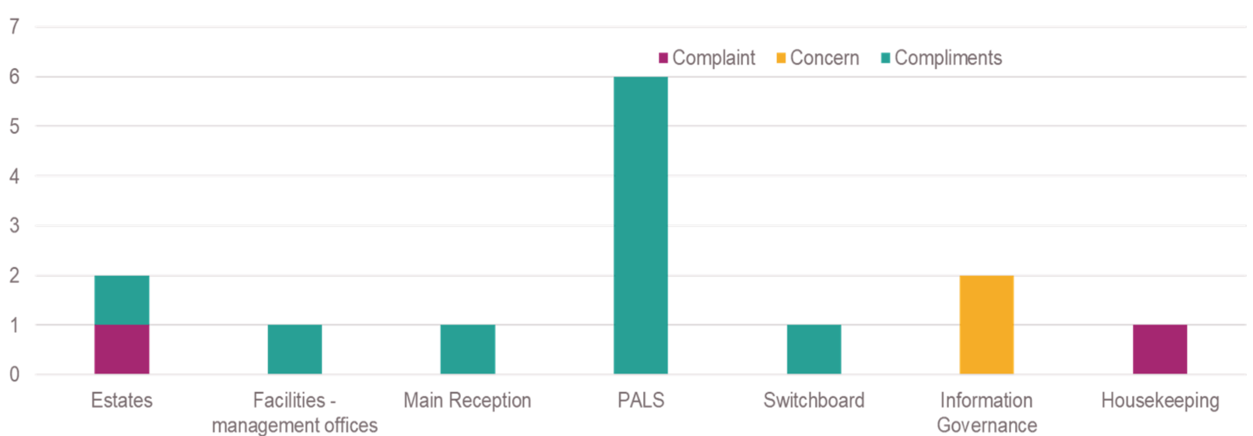


Figure 5.0b shows the location of complaints, concerns and compliments by area:

Figure 5.0b – Location of complaints, concerns and compliments by area



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Clinical Support and Family Services (CSFS)

- There were a total of 7 complaints and concerns received during Q3
- The division was able to achieve a 100% response rate within target for complaints and concerns during this period
- 0 complaints/concerns were reopened.
- 19 compliments were formally logged on Datix.

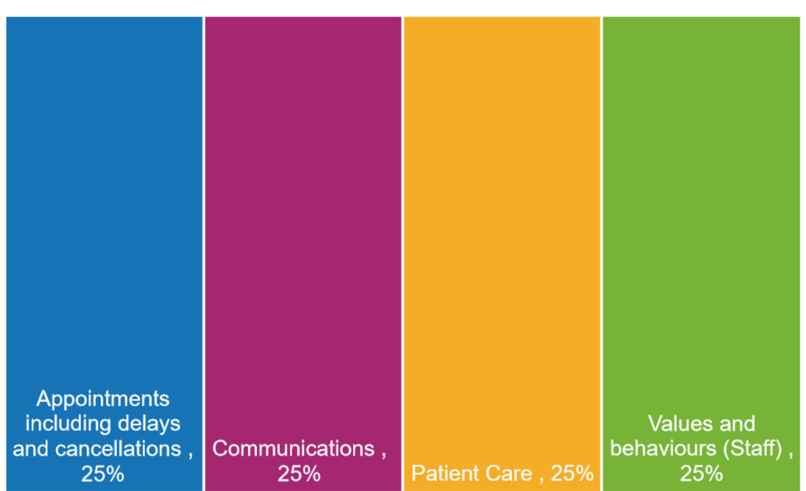
Table 5.1 Summary of number of received, reopened and response within timeframe – annual comparison and quarterly averages.

- ▼ Positive downward trajectory on previous quarter
- ▼ Negative downward trajectory on previous quarter
- ▶ No change on previous quarter
- ▲ Positive upward trajectory on previous quarter
- ▲ Negative upward trajectory on previous quarter

	Q3 22-23	Q4 22-23	Q1 23-24	Q2 23-24	Q3 23-24
Complaints	▲ 5	▼ 1	▲ 2	▶ 2	▲ 5
Concerns	▼ 5	▶ 5	▼ 2	▲ 5	▼ 2
Compliments	▲ 6	▲ 21	▼ 8	▼ 5	▲ 19
FFT Responses	▲ 206	▲ 349	▲ 403	▼ 315	▼ 241
Re-opened complaints/concerns	▲ 1	▼ 0	▶ 0	▶ 0	▶ 0
% closed complaints responded to within agreed timescale	▲ 100%	▼ 0%	▲ 100%	▼ 67%	▲ 100%
Complaints closed in this quarter	4	2	1	3	3
Complaints by Division activity (per 1,000)	▲ 0.2 (31,906)	▼ 0.0 (34,107)	▼ 0.06 (35,540)	▶ 0.06 (33,871)	▲ 0.15 (33,495)
Concerns by Division activity (per 1,000)	▶ 0.2 (31,906)	▼ 0.1 (34,107)	▼ 0.06 (35,540)	▶ 0.15 (33,871)	▼ 0.06 (33,495)
Compliments by Division activity (per 1,000)	▲ 0.2 (31,906)	▲ 0.6 (34,107)	▲ 0.23 (35,540)	▼ 0.15 (33,871)	▲ 0.57 (33,495)

Figure 5.1 demonstrates the most prevalent high-level themes for opened complaints during Q3.

Figure 5.1 – Summary of themes for CSFS Complaints and Concerns – Q3 2023/24



25% = Communications, Patient Care, Appointments and Values and Behaviours of staff *(respectively)*

This quarter there is an equal split of themes, therefore noprevalence of note. **Communication**, **patient care** and **appointments** are consistent themes from Q2.

Within these themes the following tables shows a sub-category breakdown for further context of these complaints:

Table 5.1a

Appointments including delays and cancellations	2	25%
Appointment system procedures	2	100%

Table 5.1b

Communications	2	25%
Delay in receiving/sending information	1	50%
Lack of communication	1	50%

Table 5.1c

Patient Care	2	25%
Correct diagnosis not made	1	50%
Delay in making diagnosis	1	50%

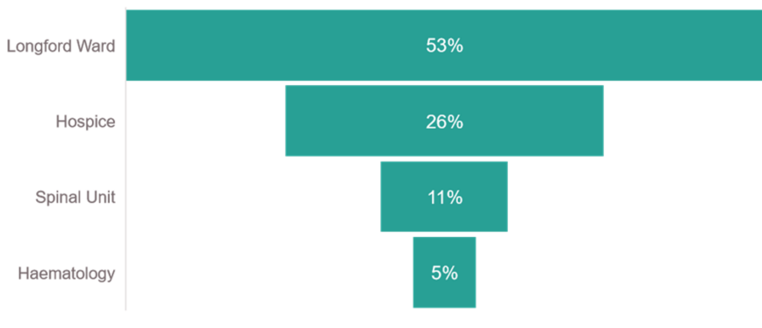
Table 5.1d

Staff Values and Behaviours	2	25%
Attitude of staff - admin	1	50%
Attitude of staff - medical	1	50%

Compliments – Clinical Support and Family Services

Figure 5.2 – CSFS Compliments breakdown

There were a total of 19 compliments for CSFS across Q3. This is fewer than previous quarters and all have been logged on Datix. Figure 5.2 shows a breakdown of where the compliments were received:



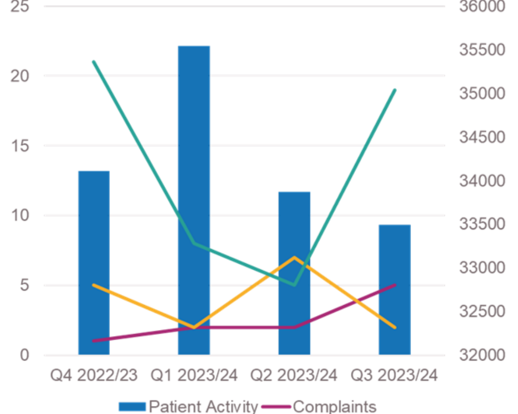
Radiology and Spinal Unit were noted to be consistent with compliments this quarter compared with Q2. Longford Ward achieved the highest proportion of complaints for the Division.

Figure 5.2a is a word clou summarising key themes from this compliments.

Figure 5.2a word cloud

Figure 5.3 shows correlation of number of complaints, concerns and compliments by patient activity for Clinical Support & Family Services.

Figure 5.3 – CSFS patient activity correlation with feedback

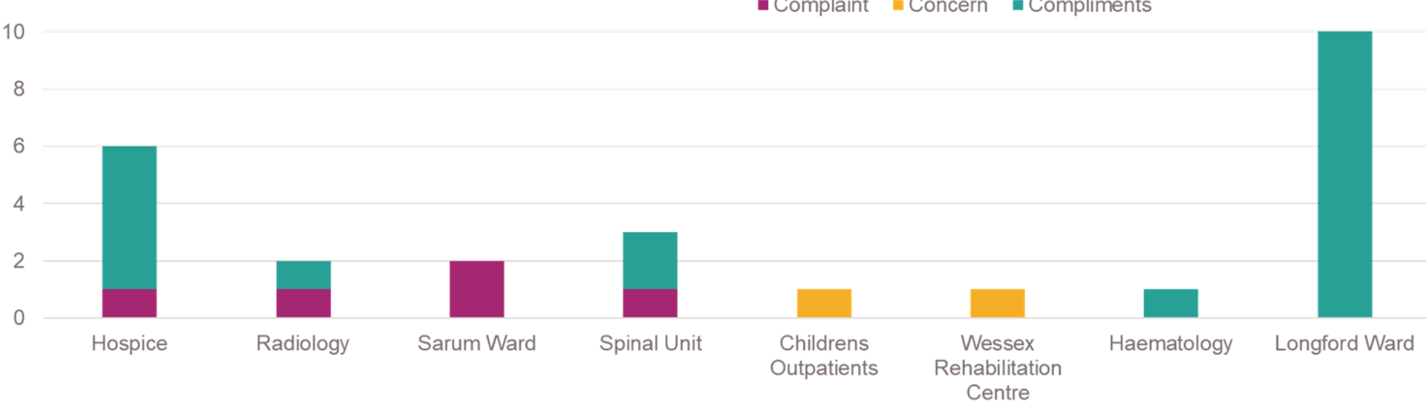


The Division has seen a slight increase in the number of logged complaints, but concerns have reduced.

Compliments recorded this quarter have significantly increased but further work continues to ensure all departments within the Division are sharing these with PALS for recording on Datix.

Figure 5.4 shows the location of complaints, concerns and compliments by area:

Figure 5.4 – Location of complaints, concerns and compliments by area



Women and Newborn

- There were a total of 12 complaints and concerns for Q3 – this is the same as Q2.
- 2 complaints were closed in Q3; 0% of these were within the agreed timescale. This is a significant reduction on the 50% achieved in the previous quarter.
- 2 complaints were reopened.
- 16 compliments were formally logged on Datix. However, due to a delay in reporting by PALS there were a further 4 for this period not logged at time of writing this report.

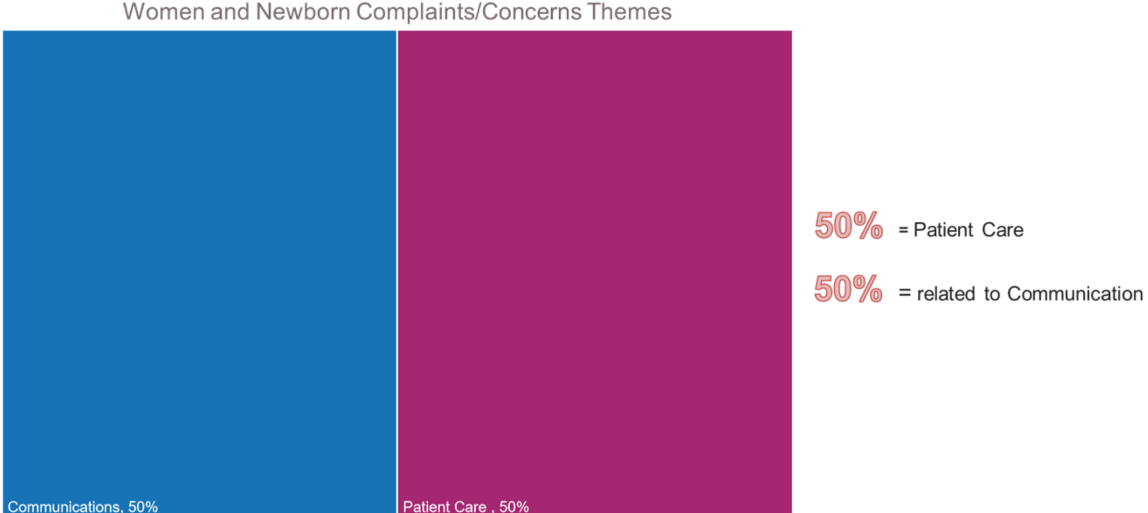
Table 5.2 Summary of number of received, reopened and response within timeframe – annual comparison and quarterly averages.

- ▼ Positive downward trajectory on previous quarter
- ▼ Negative downward trajectory on previous quarter
- ▶ No change on previous quarter
- ▲ Positive upward trajectory on previous quarter
- ▲ Negative upward trajectory on previous quarter

	Q3 22-23	Q4 22-23	Q1 23-24	Q2 23-24	Q3 23-24
Complaints	▼7	▲8	▼3	▲4	▲6
Concerns	▶5	▼3	▶3	▲8	▼6
Compliments	▼19	▲34	▲68	▼16	▼4
FFT Responses	▼19	▲114	▼50	▼18	▲38
Re-opened complaints/concerns	▼0	▲1	▼0	▲1	▲2
% closed complaints responded to within agreed timescale	▲33%	▲67%	▼60%	▼55%	▼0%
Complaints closed in this quarter	9	6	4	11	2
Complaints by Division activity (per 1,000)	▼1.5 (4,802)	▲2.1 (3,795)	▼0.71 (4, 206)	▲0.92 (4, 330)	▲1.34 (4, 471)
Concerns by Division activity (per 1,000)	▼1.0 (4,802)	▼0.8 (3,795)	▼0.71 (4, 206)	▲1.85 (4, 330)	▼1.34 (4, 471)
Compliments by Division activity (per 1,000)	▼4.0 (4,802)	▲9.0 (3,795)	▲13.7 (4, 206)	▼3.70 (4, 330)	▼0.89 (4, 471)

Figure 5.5 – Summary of themes for W&N Complaints and Concerns – Q3 2023/24

Patient care and **Communication** remain the highest themes for complaints this quarter, consistent with Q2. **Values and Behaviours of staff** was a theme carried through from Q1 to Q2, but was not recorded at all for Q3.



Within these themes, **unsatisfied with treatment** made up 33% of those caterogised under **patient care**. Whilst **insensitive or lack of communication** made up 33% (respectively) of those categorised under **communication**. Tables 5.2a and 5.2b show the following sub-category breakdowns for further context of these themes:

Table 5.2a

Patient Care	6	50%
Further complications	1	17%
Inappropriate treatment	1	17%
Lack of equipment/aids/appliances	1	17%
Nursing Care	1	17%
Unsatisfactory treatment	2	33%

Table 5.2b

Communications	6	50%
Information not given to family	1	17%
Insensitive communication	2	33%
Lack of communication	2	33%
Wrong information	1	17%

Compliments – Women & Newborn

Figure 5.6 – W&NB Compliments breakdown

There was a total of 4 recorded compliments for W&N across Q3, that were all formally recorded on Datix.

Figure 5.6 shows a breakdown of where the compliments were received, and consistencies with Q2 were noted with postnatal.

Figure 5.6a is a word cloud to summarise these compliments

Figure 5.6 – W&NB compliments location

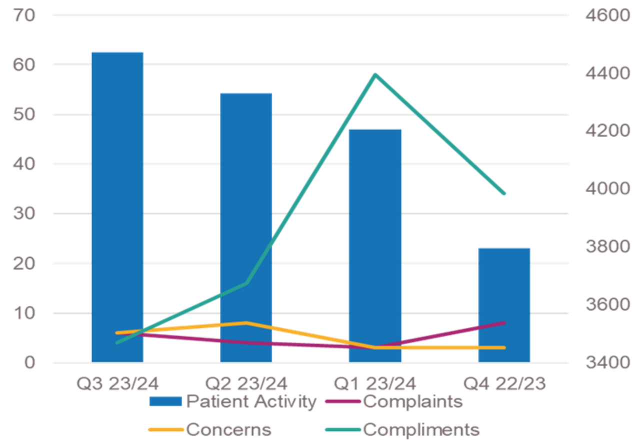
Location	%
Postnatal	75%
Maternity Day Assessment Unit	25%

feedback supported thank baby husband say one please every support infant care exceptional following midwives ongoing emergency amazing feeding compassion hospital midwife pre team c-section email eclampsia incredible provided journey

Figure 5.6a – W&NB compliments word cloud

Figure 5.7 shows correlation of number of complaints, concerns and compliments by patient activity for Women and Newborn

Figure 5.7 – W&NB patient activity correlation with feedback



The Division saw an increased number of patients this quarter compared with Q2. The number of logged concerns and complaints was static despite this.

Compliments recorded this quarter has reduced compared with the previous quarters, partly due to delays with recording by PALS.

Figure 5.8 shows the location of complaints, concerns and compliments by area:

Figure 5.8 – Location of complaints, concerns and compliments by area

Complaint Concern Compliments

5 4 3 2 1 0

Beatrice Birth Centre | Fertility Centre | Gynaecology Outpatients | Postnatal | Maternity Day Assessment Unit | Labour ward

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Medicine

- There were a total of 36 complaints and concerns for Q3, this is a slight decrease on the total number seen for Q2 (n~38).
- 169 compliments were formally logged on Datix. However, due to a delay in reporting by PALS there were a further 30 for this period not logged at time of writing this report.
- 18 complaints were closed in Q3; with 61% being responded to within the agreed timescale. This is a slight reduction on Q2 however, the division continues to demonstrate a commitment to meet the 90% Improving Together Target.
- 1 complaint reopened this quarter, one less than Q2.

Table 5.3 Summary of number of received, reopened and response within timeframe – annual comparison and quarterly averages.

▼ Positive downward trajectory on previous quarter (green)
▼ Negative downward trajectory on previous quarter (red)
► No change on previous quarter (amber)
▲ Positive upward trajectory on previous quarter (green)
▲ Negative upward trajectory on previous quarter (red)

	Q3 22-23	Q4 22-23	Q1 23-24	Q2 23-24	Q3 23-24
Complaints	▼ 18	▲ 31	▼ 12	▲ 18	▼ 15
Concerns	▼ 24	▼ 18	▼ 17	▲ 20	▲ 21
Compliments	▲ 251	▼ 134	▼ 51	▲ 101	▲ 169
FFT Responses	▼ 383	▲ 482	▲ 573	▲ 935	▼ 799
Re-opened complaints/concerns	▼ 2	▲ 5	▼ 2	► 2	▼ 1
% closed complaints responded to within agreed timescale	▲ 45%	▲ 58%	▲ 59%	▲ 67%	▼ 61%
Complaints closed in this quarter	29	19	22	15	18
Complaints by Division activity (per 1,000)	▼ 0.6 (29,040)	▲ 1.1 (28,406)	▼ 0.35 (34, 554)	▲ 0.52 (34, 921)	▼ 0.43 (35, 002)
Concerns by Division activity (per 1,000)	▼ 0.8 (29,040)	▼ 0.6 (28,406)	▼ 0.49 (34, 554)	▲ 0.57 (34, 921)	▲ 0.60 (35, 002)
Compliments by Division activity (per 1,000)	▲ 8.6 (29,040)	▼ 4.7 (28,406)	▼ 1.45 (34, 554)	▲ 2.89 (34, 921)	▲ 4.83 (35, 002)

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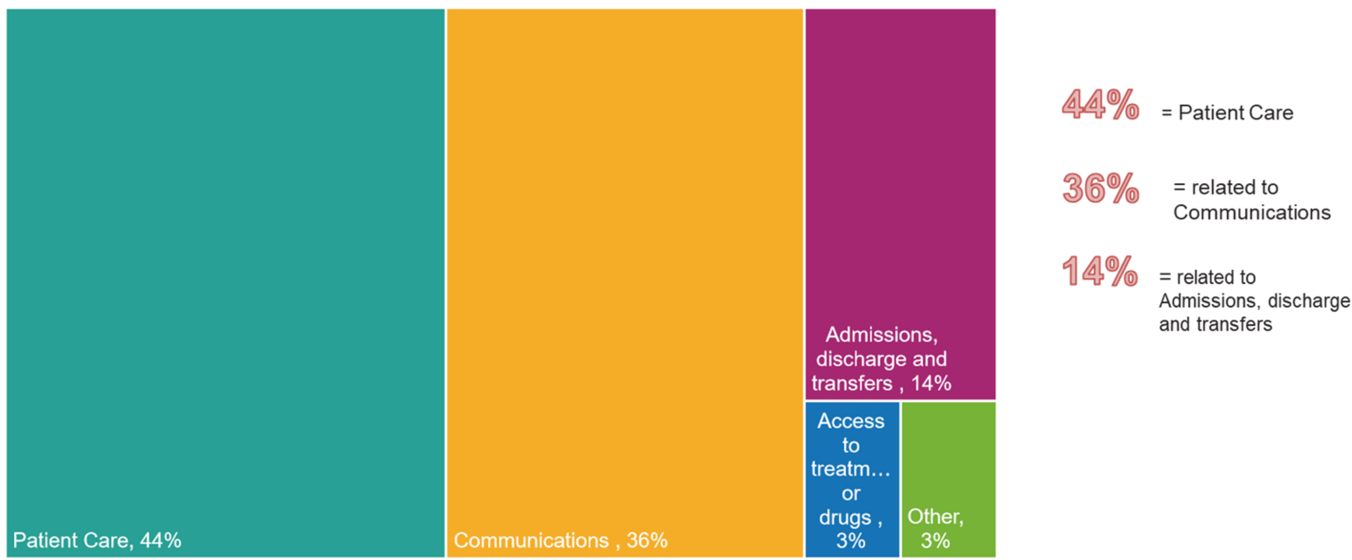
Figure 5.9 – Summary of themes for Medicine Complaints and Concerns – Q3 2023/24



For comparison, two of the top themes common for Q2 remained consistent this quarter. **Patient Care** has replaced **Communication** as the most prevalent theme. However, Values and Behaviours of staff is no longer a theme of note, and we have seen a new emgerging theme related to **admission, discharge and transfers** in Q3.

Lack of communication was the most prevalent sub-theme under **Communication** accounting for 38% of these complaints. Patients being **unsatisfied with treatment** remained the most significant sub-theme under **Patient Care** accounting for 50%. **Discharge procedures** had the most significant proportion of those categorised under **admission, discharge and transfers**, accounting for 60% of these.

Tables 5.3a, b and c show a breakdown of all the sub-categories for further context of the themes from these complaints:

Table 5.3a

Patient Care	16	44%
Correct diagnosis not made	3	19%
Delay in making diagnosis	2	13%
Falls	1	6%
Further complications	1	6%
Inappropriate treatment	1	6%
Unsatisfactory treatment	8	50%

Table 5.3b

Commnications	13	36%
Information not given to family	2	15%
Information not given to patient	2	15%
Insensitive communication	3	23%
Lack of communication	5	38%

Wrong information	1	8%

Table 5.3c

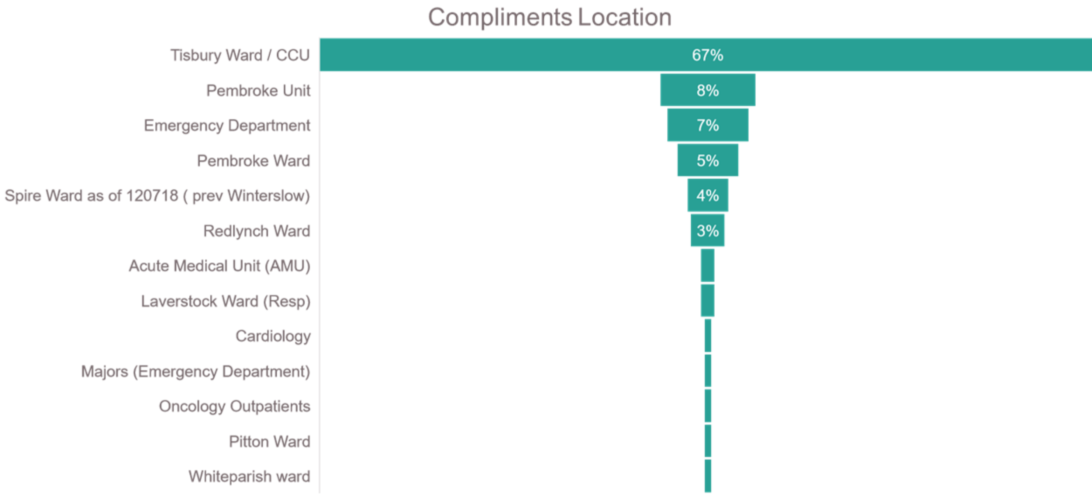
Admissions, discharges & transfers	**5**	**14%**
Discharge procedures	3	60%
Early discharge	1	20%
Unsatisfactory arrangements	1	20%

Compliments - Medicine

There was a total of 169 compliments logged for Medicine on Datix for Q3, this was noted to be significantly higher than previous quarters, the Division have worked hard to include PALS in sharing of their compliments.

Figure 5.10 shows a breakdown of where the compliments were received:

Figure 5.10 – Medicine Compliments breakdown



ED, Pemrboke and Redlynch are consistent areas this quarter with compliments received in Q2.

Figure 5.10a is a word cloud to summarise these compliments

Figure 5.10a – Word cloud

Figure 5.11 shows correlation of number of complaints, concerns and compliments by patient activity for Medicine.

Figure 5.11 – Complaints, concerns and compliments correlation with patient activity

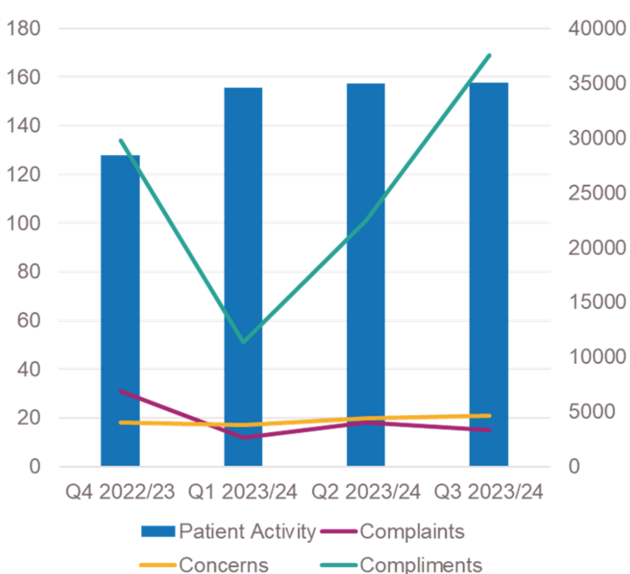
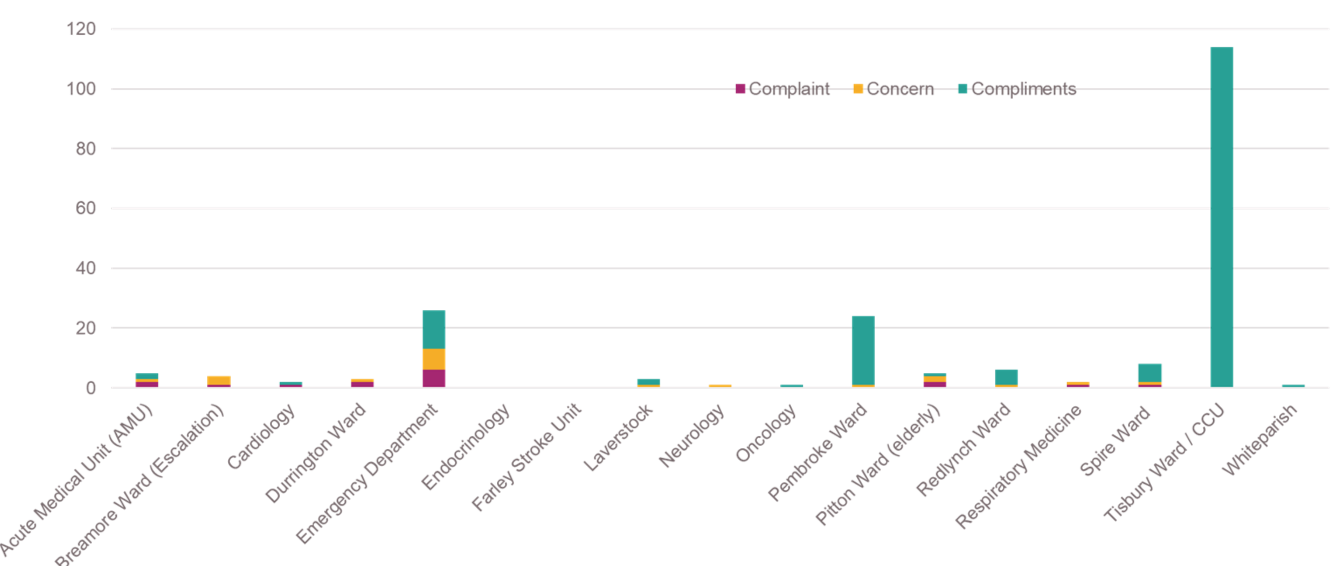


Figure 5.11 is demonstrating a very small increase in the number of concerns and complaints this quarter compared with previous quarters, however these appear to continue to be on a downward trajectory against a landscape of increased patient activity.

These numbers however remain lower than in Q4, where the lowest number of patient activity was also seen for the Division.

Figure 5.12 shows the location of complaints, concerns and compliments by area:

Figure 5.12 – Location of complaints, concerns and compliments by area



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Surgery

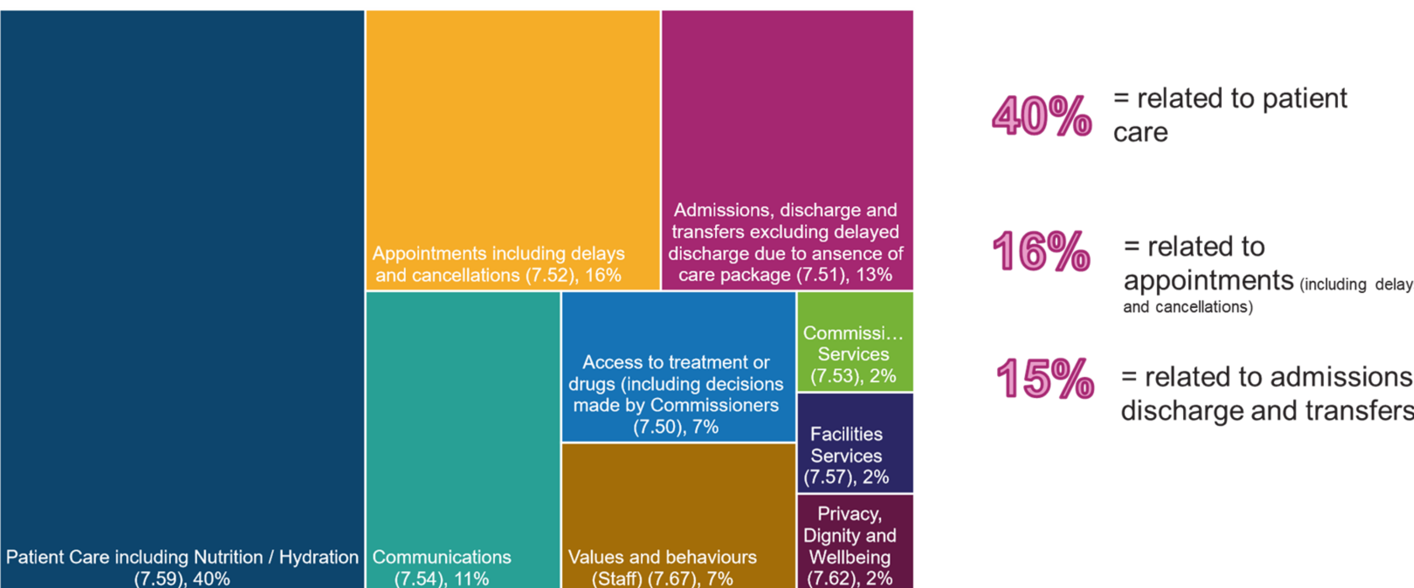
- There were a total of 46 complaints and concerns for Q3, an increase of 7 from Q2.
- 14 complaints were closed in Q3, 13 less than Q2. 43% of these were on target compared with 22% in Q2.
- 4 were reopened this quarter, a decrease of 1 from the previous quarter.
- 111 compliments were logged this quarter. However, due to a delay in reporting by PALS there were a further 10 for this period which were not logged at time of writing this report.

Table 5.4 Summary of number of received, reopened and response within timeframe – annual comparison and quarterly averages.

- ▼ Positive downward trajectory on previous quarter
- ▼ Negative downward trajectory on previous quarter
- ▶ No change on previous quarter
- ▲ Positive upward trajectory on previous quarter
- ▲ Negative upward trajectory on previous quarter

	Q3 22-23	Q4 22-23	Q1 23-24	Q2 23-24	Q3 23-24
Complaints	▲ 26	▼ 17	▲ 18	▼ 16	▲ 17
Concerns	▶ 26	▼ 16	▲ 19	▲ 23	▲ 29
Compliments	▲ 112	▼ 72	▼ 62	▼ 51	▲ 111
FFT Responses	▼ 661	▲ 877	▲ 1,275	▼ 1,261	▼ 1,057
Re-opened complaints/concerns	▼ 3	▲ 6	▼ 2	▲ 5	▼ 4
% closed complaints responded to within agreed timescale	▲ 32%	▼ 12%	▼ 11%	▲ 22%	▲ 43%
Complaints closed in this quarter	19	17	27	27	14
Complaints by Division activity (per 1,000)	▶ 0.7 (35,374)	▼ 0.5 (35,310)	▼ 0.44 (40,495)	▼ 0.40 (39,997)	▲ 0.41 (41,789)
Concerns by Division activity (per 1,000)	▼ 0.7 (35,374)	▼ 0.5 (35,310)	▼ 0.47 (40,495)	▲ 0.58 (39,997)	▲ 0.69 (41,789)
Compliments by Division activity (per 1,000)	▲ 3.2 (35,374)	▼ 2.0 (35,310)	▼ 1.53 (40,495)	▼ 1.28 (39,997)	▲ 2.66 (41,789)

Figure **5.13 –** Summary of themes for Surgery Complaints and Concerns – Q3 2023/24



For comparison, two of the top themes common for Q2 remained consistent this quarter. **Patient care** and **Appoiintments** as the most prevalent themes. However, **Access to treatment or drugs** is no longer a theme of note, and we have seen a new emgerging theme related to **admission, discharge and transfers** in Q3.

Further complications was the most prevalent sub-theme under **Patient Care** accounting for 33% of these complaints. **Appointment system - procedures** was the most significant sub-theme under **Appointments** accounting for 71%. **Early discharge** had the most significant proportion of those categorised under **admission, discharge and transfers**, accounting for 50% of these.

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

Table 5.4a

Patient Care	18	40%
Correct diagnosis not made	2	11%
Delay in making diagnosis	1	6%
Further complications	6	33%
Inappropriate treatment	3	17%
Nursing Care	3	17%
Unsatisfactory treatment	3	17%

Table 5.4b

Appointments	7	16%
Appointment system - procedures	5	71%
Delay in receiving appointment	1	14%
Unsatisfactory Outcome	1	14%

Table 5.4c

Admissions, discharge and transfers	6	15%
Discharge procedures	1	17%
Discharge summary incomplete / not sent	1	17%
Early discharge	3	50%
Unsatisfactory arrangements	1	17%

Compliments – Surgery

Figure 5.14 – Surgery Compliments breakdown

There was a total of 111 compliments for Surgery for Q3, significantly higher than last quarter.

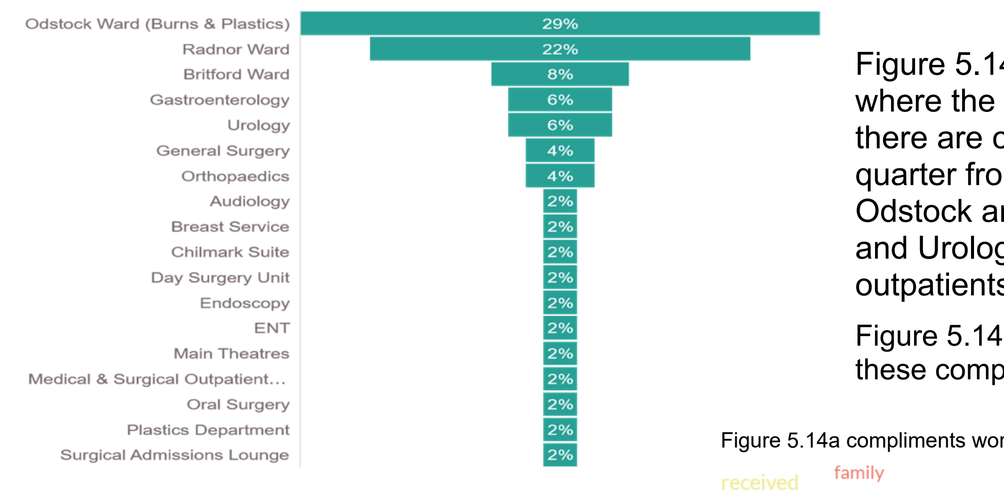


Figure 5.14 shows a breakdown of where the compliments were received, there are consistencies noted this quarter from the previous quarter with Odstock and Britford for inpatinet areas and Urology and Breast Services for outpatients.

Figure 5.14a is a word cloud to summarise these compliments

Figure 5.14a compliments word cloud

Figure 5.15 shows correlation of number of complaints, concerns and compliments by patient activity for Surgery.

Fig 5.15 Activity compared with Complaints, Concerns and compliments

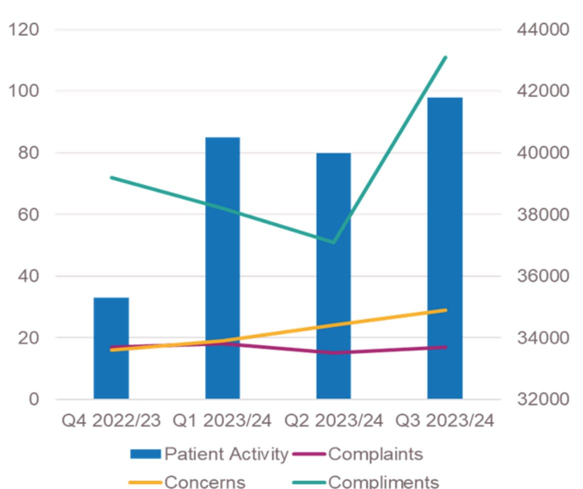


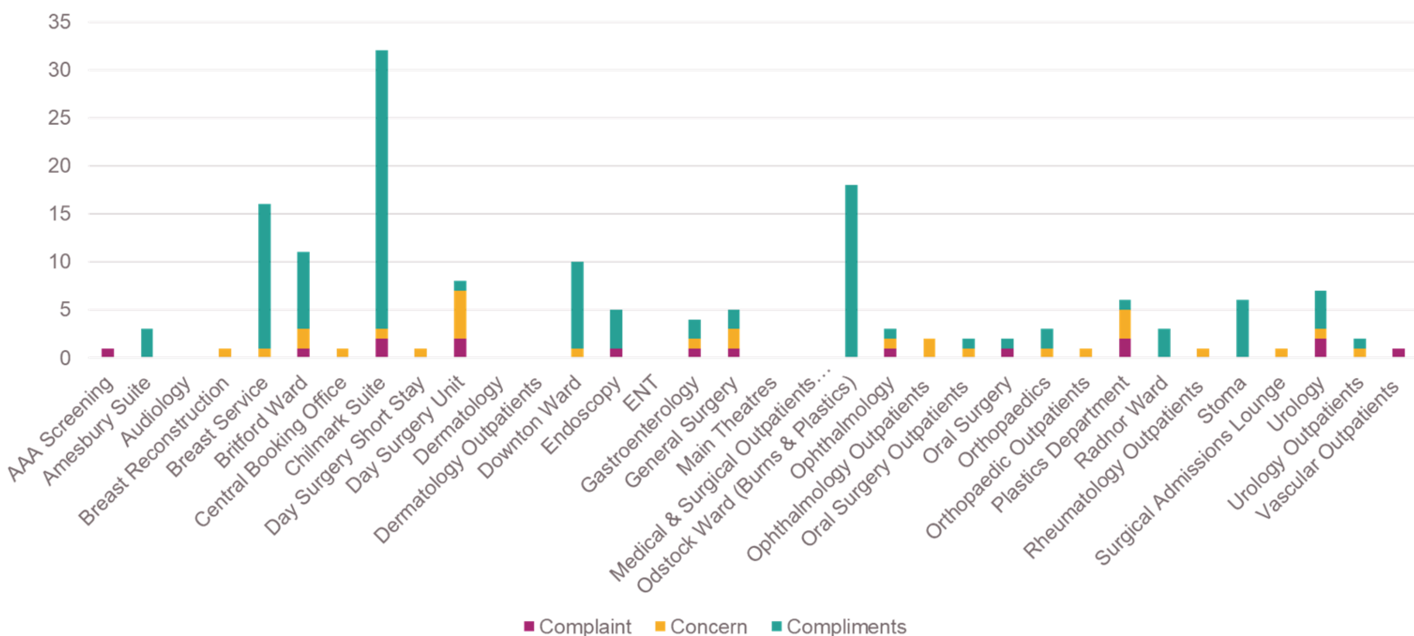
Figure 5.15 is demonstrating an overall decline in the number of recorded complaints, concerns however have increased slightly.

This division has been actively engaged in adopting the principles for descalation of complaints and utilising opportunities for earlier resolution.

Compliments have increased significantly, this is owed to the efforts of the individual areas sharing these compliments with PALS for recording.

Figure 5.16 shows the location of complaints, concerns and compliments by area:

Figure 5.16 – Location of complaints, concerns and compliments by area



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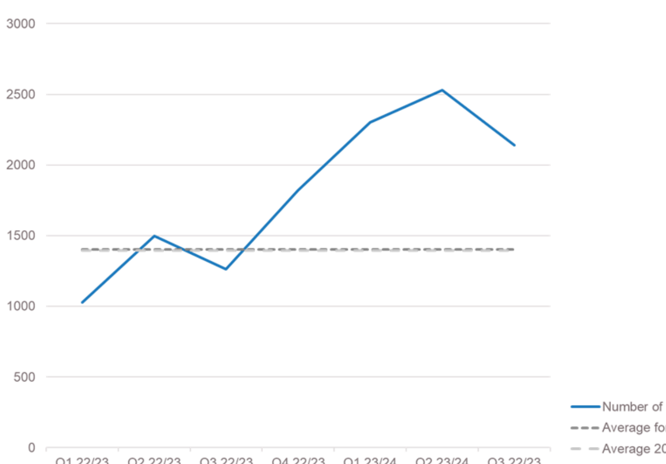
6. Friends and Family (FFT)

Response Rates

Fig 6.1 Number of FFT responses, broken down by quarter with historic averages



A total of **2,141** patients provided feedback through the paper Friends and Family Test (FFT) in Q2 of 23/24. This is drop on Q2 and Q1, but was anticipated due to the limited means by which this is currently collected.

This response rate however continues to be higher than the calculated quarter averages for the last 2 years (as demonstrated by the the grey dotted lines in Fig 6.1)

The digital FFT project is set to resume in January 2024 following the Boards decision to delay this back in December 2022. This project has a dual aim of increasing response rates as well as providing theming of comments for trends and analysis insights. The digital tool will provide alternative methods of obtaining responses (SMS and QR codes), which should help to mitigate the drop in activity we've tended to see historically in Q3 as well.

This project is scheduled for completion by the end of Q4 2023/24.

98% Of those surveyed rated their experience of our hospital as Good or Very Good (average for Q3 2023-24)

2.5%* Response rate (*of eligible population and averaged for Q3 2023-24)

A selection of the comments received from both inpatient and outpatient areas across the Trust can be found in Appendix 4.

The target response rate continues to be significantly below our Improving Together target of >15% of eligible patients for 2023/24, however the Trust remains consistent in accomplishing its other target of achieving a >95% satisfaction rate.

Table 6.1 summarises the response rates in accordance with patient activity.

Table 6.1 Response rate across the Trust by per 1,000 patient activity – rolling annual comparison

	Q3 22-23	Q4 22-23	Q1 23-24	Q2 23-24	Q3 23-24
Across all Directorates	▼12.5 (101,122)	▲17.9 (101,618)	▲20.0 (114, 795)	▲22.36 (113, 119)	▼18.59 (114, 757)

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Benchmarking against Improving Together Targets

As Figure 6.2 demonstrates - we continue to be far from our **Improving Together** targets as we go into 2023/24.

Figure 6.2 – Response rate (based on eligible population) – Trust wide

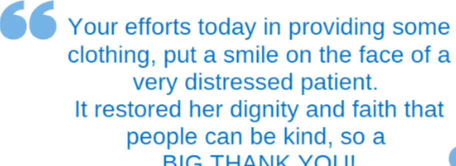
15%

Response rate target

(2023/24)

November and December response rates significantly impacted the quarterly performance. December historically is a difficult month to maintain response rates due to the reduced staffing caused by the Christmas and New Year periods. The only collection method the Trust has relies heavily on staff reminding to complete these, subsequently many areas also rely on volunteers for this which can also see a drop in resourcing at this time of year.

We continue to regularly promote positive feedback received via FFT through weekly social media plugs under "*#ThankyouThursday*" and "*#FeedbackFriday*" hashtags. Examples take from October 2023:



Your efforts today in providing some clothing, put a smile on the face of a very distressed patient.
It restored her dignity and faith that people can be kind, so a BIG THANK YOU!

7. Patient and Public Feedback – Local Surveys

Annual Complaints Process Feedback

This annual report is a measure of the Trust's compliance against the PHSO complaints standards, as perceived by the complainant. This survey was relaunched in May 2023 following the HWW process review project and responses are based on those who had a closed complaint with the Trust between the 1st May 2023 and the 1st September 2023.

Response rate was a respectable 30.7%, however only 63% of closed complaints during this period had a record of being sent the survey. Response rates and process for collecting this feedback were one of the key areas of development identified within this report.

Overall, the results indicate improvements to the complaints process, when compared with the outcomes from the HWW project in 2022. Some of the results received between May and September 2023 were anticipated as part of the local improvements that were already in place and still embedding.

Full report was shared at Clinical Governance Committee on the 31st October 2023 and can be found in Appendix 6.

Real-Time Feedback (RTF)

The aim of RTF is to give a "real-time" view of a patients perspective of their care.

Real-time feedback is not currently undertaken within the maternity inpatient areas or on Sarum ward. Surveys are taken at the patients bedside and results are sent to ward leads within one week of these being completed for reflection.

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 & dignity and overall experience.

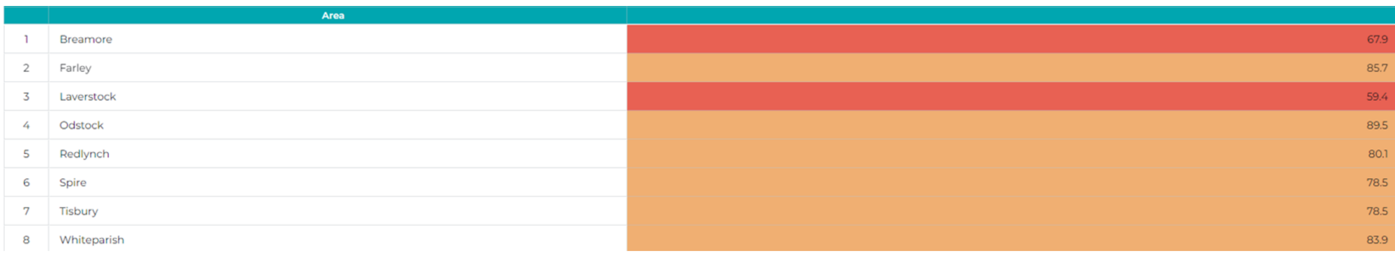
Real-time feedback (RTF) has maintained consistency throughout Q3 owed to the efforts of volunteers, governors and work experience students.

RTF is now regularly presented to the Patient Experience Steering Group, reflecting on the data from the previous month. Summary of analysis to date:

Table 7.1 Number of inspections and locations visited

Month	Total number of surveys	Number of inpatient areas visited	Wards surveyed	Average Score
October	36	8	Breamore, Fairly, Laverstock, Odstock, Redlynch, Spire, Tisbury, Whiteparish	81.1%
November	28	7	AMU, Breamore, Downton, Durrington, Longford, Pembroke, Whiteparish	86.9%
December	6	4	Britford, Farley, Odstock, Spire	82.3%

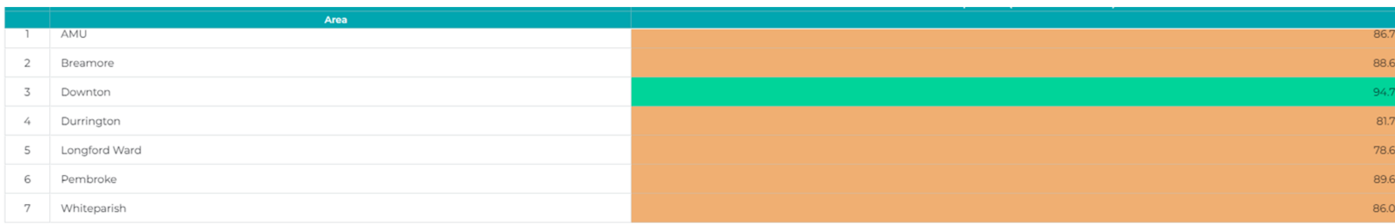
Table 7.1a October 2023 Summary:



	Area	
1	Breamore	67.9
2	Farley	85.7
3	Laverstock	59.4
4	Odstock	89.5
5	Redlynch	80.1
6	Spire	78.5
7	Tisbury	78.5
8	Whiteparish	83.9

Cleanliness of the ward and being treated with dignity & respect are areas which continue to score the highest. Patients are rating cleanliness at 97% on average. Noise levels at night and the understanding (or involvement) with discharge plans are continuing to score lowest. Noise level satisfaction ratings averaging at 47%.

Table 7.1b November 2023 Summary:



	Area	
1	AMU	86.7
2	Breamore	88.6
3	Downton	94.7
4	Durrington	81.7
5	Longford Ward	78.6
6	Pembroke	89.6
7	Whiteparish	86.0

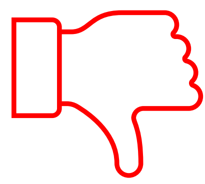
Table 7.1c December 2023 Summary:

	Area	
1	Britford	90.0
2	Farley	78.6
3	Odstock	95.3
4	Spire	67.2

Looking at the data for November and December combined, the highest and lowest scoring themes remain the same around noise at night, which continues to be reducing month on month in comparison to 63.5% back in August. Noise at night was rated as poor for all patients who gave feedback.

9 patients who had had operations, felt the quality of written information provided regarding these was poor.

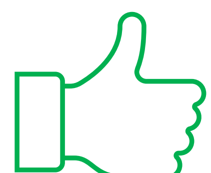
Key themes noted and mitigations:



Noise at night is a common theme this quarter and was prevalent last quarter. This is noted to be a historical issue, which has been difficult to tackle. Understanding the causes for the noise has been identified as a necessary addition to RTF feedback so that mitigations can be given due consideration. This is being followed up as an action through PESG. Bluetooth noise cancelling headphones are also currently being researched by the Spinal Patient Panel as one of their projects.

Quality of written information given to patients and understanding and involvement with discharge planning scored the lowest during this quarter. This has been fed back to the Managing Staff and Patient Expectations Working Group.

The readership group managed by the Patient Experience Team continues to grow with more and more patient-facing material being reviewed through this forum and approved at PESG. Material approved through this group now carry the "patient reviewed" indicator. This is a developing process for which the vision will be that all patient facing material is reviewed and approved through this forum.



Patients feeling treated with privacy and dignity and the overall cleanliness of the ward environments were the main areas which received a consistently positive response.

The Trust is currently in its second year of a three year plan to achieve the National Cleaning Standards, this has required significant investment and vast recruitment, training and resourcing in order to achieve.

See Appendix 7 for summary of comments taken from Real-time Feedback during Q3.

8. Patient and Public Feedback – National Surveys

No surveys scheduled for reporting in this quarterly report.

Scheduled Reporting of Surveys

Maternity Survey 2023 – will be reported in Q4 2023/24

Children and Young People Survey 2023 – will be reported in (TBC) 24/25

National Inpatient Survey 2023 – will be reported in (TBC) 24/25

APPENDIX 1: Leadership Training Programme - Apologies and Liabilities Oct 2023 v2

See attachment.

APPENDIX 2: SDH Spinal Patient Panel - Trust Board Patient Story 06.12.23

See attachment.

APPENDIX 3 - KMPG SFT 23-24 Patient Complaints Report FINAL

See attachment.

APPENDIX 3a Audit Management actions 120224 v1.0

See attachment.

APPENDIX 4: Friends and Family Test Comments – Q3 2023/24

See attachment.

APPENDIX 5: Disharge and Patient Flow Project - Patient Feedback Jan 24 v1

See attachment.

APPENDIX 6: Annual Complaints Process Survey Report – October 2023

See attachment.

APPENDIX 7: Real-Time Feedback RTF Comments Q3 23-24

See attachment.

12th October 2023

Distribution version.

Senior Clinician Leadership Development Programme

Apologies and Liabilities

An Introduction to Complaints and Litigation

Victoria Aldridge - Head of Patient Experience
Judith Leach – Head of Legal Services (Barrister)

Session key points

- ✓ Complaints - exemptions, our pledge and resolution first
- ✓ Common themes for complaints
- ✓ What have we learnt?
- ✓ SFTs current complaints process
- ✓ Reflecting on your experience with complaints
- ✓ Reopened complaints
- ✓ Saying sorry, Do’s and Don'ts!
- ✓ What if we didn’t make a mistake?
- ✓ Apologies do not mean liability
- ✓ Tips for managing a complaint
- ✓ PALS – we are more than just complaints!
- ✓ Key contacts

The NHS pledge to complaint and redress

Source: NHS Constitution for England

Complainants are treated with courtesy and receive appropriate support throughout the handling of a complaint; and that the fact that they have complained will not adversely affect their future treatment

When mistakes happen or if patients are harmed while receiving health care they receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma they have experienced, and know that lessons will be learned to help avoid a similar incident occurring again

The organisation learns lessons from complaints and claims and uses these to improve NHS services

Our pledge to complainants

They experience:

- An accessible, supportive and easy to use complaints process

They receive:

- A clear explanation of what happened and why
- A full and thorough investigation
- Acknowledgement, accountability and apology where appropriate

They are reassured:

- That clear actions and learning have come from their complaint to ensure that the issues raised are learnt from and steps are taken to prevent recurrence.

Complaints are exempt from the investigation process when they are…

- about private treatment;
- have already been investigated;
- where legal action has already been started;
- about data subject requests under the Data Protection Act 2018;
- relating to requests under the Freedom of Information Act 2000;
- Complaints over 12months old*

Resolution first.
We encourage complainants to…

Raise their concern as soon as possible after the event has occurred

Talk it through with those involved with their care in the first instance

If raising a concern on behalf of someone else, ensure they have the appropriate consent in place

Be clear about what they want as an outcome

What are the most common themes for complaints?

Access to treatment

What have we learnt from complaints?

Communication will probably always be our greatest challenge and theme for complaints

Empathy – our ability to understand someone else's point of view

Relationships are key – people don't want to complain about people they like!

Early resolution of the small things can make a huge difference

Reality does not always meet expectations

Current Complaint Process

Complaint comes in

Record of discussion taken, key points and defining of outcomes

Allegation against staff member

Litigation

Serious Incident / Clinical Review

48hr template sent to Division leads.

Template is returned with RAG response, next actions for investigation and identification of early resolution

Investigations and statements are undertaken, learning identified and response drafted/ meeting arranged

Holding letter may be sent with extended timeframe if RAG response time is exceeded

Actions and responses are reviewed by PALS and response has second review with the Quality Team

Outcome of investigation and a response is provided to complainant

Meeting may be arranged instead of response letter to discuss and address the points of the complaint

RAG Status	
Green	25 w/days
Amber	40 w/days
Red	60 w/days

Reflect on a complaint you or your service/dept may have received …

The complainant is not satisfied
What happens next?

Further meeting may be offered

Referral to the Parliamentary and Health Service Ombudsman

Complainant may wish to take legal action and would be advised to seek independent representation.
The SFT legal team would be informed of the complaint details at this stage

Saying sorry…

- ✓ Is always the right thing to do
- ✓ Is not an admission of liability
- ✓ Acknowledges that something could have gone better
- ✓ Is the first step to learning from what happened and preventing it recurring

Source: NHS Resolutions – publication 2018

Do’s and Don’t’s

Source: NHS Resolutions – publication 2018

Do say:

- ✓ I’m sorry … happened
- ✓ We’re truly sorry for the distress caused
- ✓ I’m sorry, we have learned that…

Don’t say:

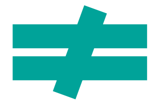
- ✗ I’m sorry you feel like that
- ✗ We’re sorry if you’re offended
- ✗ I’m sorry you took it that way
- ✗ We’re sorry, but...

“Dad, that’s not what the doctor meant!”

“Yes, but that’s what they said…. And it hurt.”

What if we didn’t make a mistake – why are we apologising?

An apology vs accepting liability



Liability

One does not equate to the other

Do not let the fear of litigation prevent an apology

Duty of candour is a statutory and regulatory requirement

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Some caveats…

Apology with admissions of **causation** should have evidential backing

When it is not clear an error has caused the damage either:

Obtain specialist view to confirm

Advise if the short term and long term effect is unclear.

Should a claim be pursued – The Trust's acceptance of causation can be used by a claimant and is more difficult to address.

This can send a patient down the litigation route unnecessarily.

Principles for successful complaints management

Listen, understand and value

Early resolution

Communication

Meaningful apology

Comprehensive and comprehensible

Ask for help!

PALS Services
we are so much more than just complaints !

- Patient clothing & TV cards – provided by the Stars Appeal
- Friends and Family Tests (FFT)
- Message to a loved one
- Virtual visiting
- Accessibility and Interpreting Services
- PALS Outreach Services
- Patient engagement initiatives
- Lost property
- Real-time Feedback (RTF)
- Your Views Matter Bereavement survey
- Hearing Aid Batteries
- Insurance forms
- Patient Stories
- Compliments
- Local and National Surveys

Any questions?

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Extension – 2169 / 2030

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SDH Spinal Rehalibation Centre Patients Forum

Setup, Objective, Aims & Progress.

Chris Prentice

Ex-Service User/Volunteer and Chair of the Spinal Patient Panel

Background:
External Consultant Review

In response to the CQC reports 0f 2018 & 2020/1. An external consultant was brought in with various observations and recommendations, of which, a 'Patients Forum' was proposed.

As a former patient volunteering for Engage on the unit, I was approached by the Clinical Lead to help set up the forum which would be the first of its type at SDH and a possible forerunner for other specialist units.

The agreed approach was that this was not to be a complaints unit but an action group to take onboard generic issues highlighted by patients and staff and, using their experience and ideas, to provide suggestions and solutions that may not be readily apparent to the unit management.

A pre-requisite of setting up the group was that it would need to be taken seriously and have the backing of senior service staff to be effective.

At the time of writing, projects are on track and progressing well… we are optimistic that the forum will prove to be a great asset for the unit and the hospital.

Activity to date

- 5 meetings held since the first meeting in April 2023.
  - Mixture of face to face and teams meetings (combination of off site and within the hospital)
  - 6 regular attendees, all ex-service users (including Chair)
  - Chair and led by a patient and ex-service user
  - Spinal Service team representation at all 5 meetings
- Current projects were selected based on the common experiences of the group and themed as:
  - Improving patient information (pre and post admission)
  - Maximising opportunities for self-rehabilitation
  - Patient experience of facilities (i.e. noise, toilets)
- The group have developed:
  - An action log
  - Formal minutes
  - Terms of Reference
- The group also recently provided two patient representatives for the new Regional Oversight Committee

The first forum was held in April 2023

A 10 point plan was put forward to get the forum off and running & many of these proposals, along with other suggestions from the panel are now up and running and reaching maturity in terms of action or being closed down as considered either not worthwhile, practical or achievable.

Examples: For reasons of brevity, three headline projects listed below:

GAIT WALKER

Trials have been held and more are planned. The Head of Physiotherapy has said that there is optimism that a viable unit can be found and deployed. Further trials due in the next few weeks

TOILET SAFETY GRAB RAILS

Project currently about to enter trials

BONE CONDUCTION HEARING AIDS

Currently under test in the Ophthalmic Unit at SDH

Gait Walker

This concept a been put forward to help 'incomplete' patients self rehabilitate. Identified potential benefits:

- Allows patient to self rehabilitate and reduce load on Physiotherapy and support staff as current standard wheeled Zimmer frames are not stable and require staff supervision whilst in use.
- Relief of posterior discomfort from long sessions sitting in a wheelchair and reduce risk of Pressure Ulcers.
- Increased patient welfare benefits.
- Use it or Lose it benefits
- Potential for faster recovery times, increasing unit throughput and decreasing the unit waiting list time.

Toilet Safety Grab Rails

The toilets at the unit mostly do not meet current safety standards due to the walls not having sufficient strength to support grab rails. The status quo is… is that met the standards at the time of install!

- A high number of falls (probably the highest of all) are generated as patients try to manage transfers from chair to toilet unsupervised.
- £40m estimated to bring them up to standard, If this floor mounted idea works (trial about to start) then this will potentially achieve compliance for more like £40K!

Benefits include:

- Increased patient safety
- Reduced complaints and potential claims
- Greater independence and patient welfare
- Compliance with current standards
- Relatively low Capital Cost

Bone Conduction Hearing Aids

This is an area that is not spinal unit only related but hospital wide. This proposal was brought about by the common issue of patients with reduced hearing capacity not being able to hear because they have left hearing aids at home, mislaid them, batteries exhausted etc.

The bone conduction method with a Bluetooth microphone link or similar provide NHS staff/volunteers with a portable and hygienic method of establishing a rapport.

Benefits include:

- Decreased patient isolation & increase in welfare
- Reduced staff/volunteer time required with effective communication
- Reduced risk of miscommunication and potentially dangerous misdiagnosis/treatment
- Patient confidentiality more easily maintained
- Non intrusive wear and easy to clean greatly reducing risk of transmitted infection

Thank you for your time

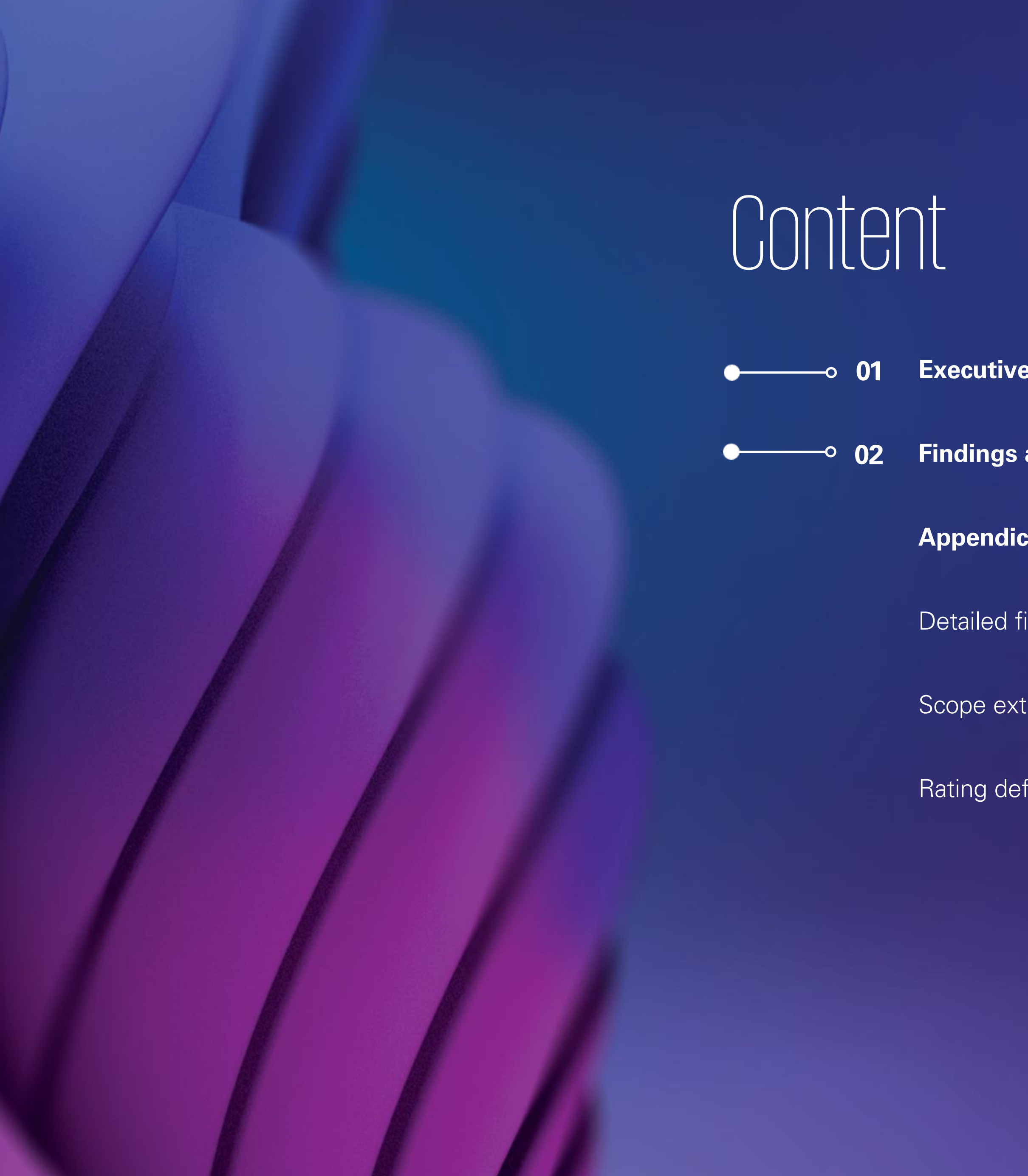
Patient Complaints

Salisbury NHS Foundation Trust

KPMG Governance, Risk & Compliance Services

December 2023

Overall rating:	
	Significant assurance
>	Significant assurance with minor improvement opportunities
	Partial assurance with improvements required
	No assurance



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Detailed findings

Scope extract

Rating definitions

Distribution list

For action:

Victoria Aldridge, Head of Patient Experience

Sophie Brookes, PALS Lead

For information:

Judy Dyos, Chief Nursing Officer (Executive Sponsor)

Report status

Closing meeting: 12 October 2023

Draft report issued: 06 November 2023

Final report issued: 01 December 2023

Presented to Audit Committee: 12 December 2023

Executive summary

01

Conclusion

We reviewed processes and controls relating to the management of patient complaints and provide a rating of 'significant assurance with minor improvement opportunities' (AMBER GREEN). Our rating is driven by a well designed complaints management process at corporate level with improvement opportunities identified at the Divisional level.

The Handling Comments, Concerns, Complaints and Compliments Policy appropriately and clearly documents the process for managing complaints received, including defining responsibilities for both the Patient Advice and Liaison Service (PALS) and Divisions. Flowcharts included in the policy capture timeframes for each stage of the process depending on the rating assigned to the complaint. The policy does not capture the process for managing re-opened complaints. The process for managing and investigating complaints at a Divisional level varies driven by local structures, only one division (Surgery) has a guidance document to capture expected steps in the process.

Target response times are clearly defined in the policy. Sample testing of 15 complaints found that target response times were exceeded for ten, largely caused by capacity and workload of staff. The response time for complaints is currently calculated from the date the complaint is entered into Datix, and our sample testing found 10/15 complaints were entered at a later date than when the complaint was made, ranging from two to 17 working days. Recorded response times and related compliance metrics reported may not accurately reflect the time taken to respond to complaints.

There is an appropriate governance structure in place for the regular reporting of complaints data, including overdue complaints and common complaints themes, at all levels of the Trust at least quarterly via a quarterly patient experience report.

We identified actions regarding the sharing of lessons learned at a Divisional, cross-Divisional, and Trust-wide level. Whilst common complaint themes are reported via governance groups, lessons learned are only reported by exception on an undefined basis. Discussions with divisional management identified that wider sharing of lessons learned and good practice would be beneficial to improving complaints management.

Summary

Overall rating:	Significant assurance with minor improvement opportunities

Priority rating:	Control design	Operating effectiveness
High	0	0
Medium	3	1
Low	1	1

Acknowledgements

We would like to thank the following individuals for their contribution during this internal audit:

- Judy Dyos , Chief Nursing Officer (Executive Sponsor);
- Victoria Aldridge, Head of Patient Experience;
- Sophie Brookes, PALS Lead;
- Kirsty Benfield, Deputy Head of Nursing (Medicine);
- Helen Hammond, Business Support Manager (Surgery);
- Alison Lambert, Family Experience Midwife (Women and Newborn); and
- Complaints coordinators.

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Executive summary

Areas of good practice

- ✓ The complaints policy is in date, comprehensive and clearly sets out timescales for patient complaint management which is available to all staff and the public.
- ✓ Complaints are managed in the Datix system which allows for easy and appropriate oversight of all open complaints.
- ✓ There is a well designed governance structure in place which regularly reports patient complaint figures on at least a quarterly basis, including figures and overarching themes.
- ✓ Regular discussions on open complaints are held between the PALS Lead and the complaints coordinators, with a focus on overdue complaints.
- ✓ Written responses require review and sign off from the Chief Executive before they are sent to the complainant.
- ✓ Discussions with Divisional management found that the complaints co-ordinators are seen as a positive addition to the complaints management process.

Out of scope

We will not provide an assessment on the quality of the responses for the complaints sampled. Our work does not provide an absolute assurance that material error, loss or fraud does not exist.

Summary of key findings

Area	Finding
Divisional guidance documents	**2.1** Currently there is no requirement for Divisions to produce complaints management guidance for division-specific procedures.
Sharing lessons learned and good practice	**2.2** There are limited forums for formally sharing lessons learned from complaints at a Trust level.
Re-opened complaints	**2.3** The complaints policy does not include the process for managing re-opened complaints.
Accuracy of response times	**2.4** Complaints response times are being calculated from the date of entry to Datix, instead of the date of receipt.
Completeness of meeting records	**2.5** Records are not retained for all meetings used to resolve complaints.
Record of joint investigations	**2.6** There is no requirement to retain evidence of each stage of the complaint management process when a joint-Trust complaint is being led by the other Trust.

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Findings and management actions

02

2.1 Divisional guidance documents

Medium

Currently there is no requirement for Divisions to produce complaints management guidance for division-specific procedures.

The process for managing complaints is clear and standardised at a corporate level, however this is not always extended at a Division level. Discussions with Divisions identified that only Surgery has developed a guidance document for processing complaints forwarded from PALS. Most Divisions only have one contact responsible for managing responses to complaints, including ensuring responses are received in time to meet timelines. Our sample testing of 15 complaints between January and August 2023 found that 10 exceeded the target response time.

Through discussions with Divisions it was acknowledged that many set internal deadlines for investigations to help ensure deadlines are met, however these are not formally recorded and expectations are not always expressed and understood by individuals involved.

The frequency of complaints data monitoring by Divisional governance varies. A minimum expectation has not been determined.

Risk: Single points of failure exist if processes are not documented. There is a risk of timelines being exceeded due to Division-level expectations not being set.

Agreed management action:

1. Produce a template for Division level guidance for managing complaints, including key areas such as allocating investigating managers, internal timelines, and Division-level reporting requirements.
2. Communicate deadlines for responding to complaints within divisions to those involved.
3. Set a minimum expectation for monitoring of complaints data within divisions.

Evidence to confirm implementation:

1. Division guidance document template.
2. Communication of deadlines: guidance to be included with the Divisional guidance and complaints policy.
3. Agreed minimum reporting at divisional level governance.

Responsible person/title:

Victoria Aldridge – Head of Patient Experience

Target date:

29 February 2024

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Findings and management actions

2.2 Sharing lessons learned and good practice

Medium

There are limited forums for sharing lessons learned and/or good practice from complaints.

Whilst actions associated with specific complaints are captured within Datix, there are limited forums for sharing wider lessons learned which may be cross-divisional or Trust-wide. Work on this is being completed but it is currently undefined due to system limitations.

It is acknowledged that Medicine have recently introduced a 'Learning from incidents' forum which plans on sharing complaints themes and topics for discussion. However, there are no similar forums in other Directorates and/or at a Trust level.

Each Division manages their complaints slightly differently due to different divisional structures. Medicine and surgery, the divisions with the highest volume of complaints, have separate trackers for monitoring complaints and their relevant timelines to meet trust wide deadlines. There is no regular forum to share good practice and for discussing the management and admin of complaints management across Divisions.

Risk: There is a risk of repeat complaints with the same root cause, causing reputational damage and reducing the quality of patient service.

Agreed management action:

1. Publish trust-wide lessons learned on the intranet on a regular basis.
2. Include trust-wide lessons learned from complaints within the quarterly patient experience report.
3. Include discussion of lessons learned from complaints across the Trust, and sharing of best practice, within divisional forums.

Evidence to confirm implementation:

1. Trust-wide lessons learned from complaints published in a newsletter on the intranet.
2. Lessons learned included in the quarterly patient experience report.
3. Evidence of discussion of lessons learned and best practice in divisional forums.

Responsible person/title:

Victoria Aldridge – Head of Patient Experience

Target date:

30 June 2024

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Findings and management actions

2.3 Re-opened complaints

Medium

The complaints policy does not include the process for managing re-opened complaints.

The Handling Comments, Concerns, Complaints and Compliments Policy does not include the procedure for managing re-opened complaints. Management have explained that the Trust should respond within 25 working days and it is preferable to organise a meeting to discuss the gaps in the initial response.

This is not formally recorded as an expected process to be followed. There are inconsistent records maintained for resolution of re-opened complaints. Two of the five re-opened complaints sampled did not have evidence of response and/or resolution retained.

Risk: There is a risk that re-opened complaints aren't addressed in the expected timeline due to a lack of awareness.

Agreed management action:

Update the Handling Comments, Concerns, Complaints and Compliments Policy to include a section on managing re-opened complaints.

Evidence to confirm implementation:

Updated Handling Comments, Concerns, Complaints and Compliments Policy including re-opened complaints.

Responsible person/title:

Victoria Aldridge – Head of Patient Experience

Target date:

29 February 2024

2.4 Accuracy of response times

Medium

Complaints response times are being calculated from the date of entry to Datix, instead of the date of receipt.

The Datix system records the date of complaint as the date the complaint is entered into the system. Due to workload pressures and delays it is not always possible to enter complaints into Datix as they arrive. Our sample testing of 15 complaints identified that ten were recorded at a later date than received, ranging from two to 17 working days later.

Days to acknowledge and respond to complaints are calculated based on the date entered into Datix therefore impact the accuracy of target response dates and reported performance against related metrics. Five complaints in our sample were found to have been acknowledged outside of the three day timeframe due to this process.

Risk: There is a risk that more complaints are overdue than known due to delays in entering the complaint into the Datix system.

Agreed management action:

Add a section into the Datix complaints record to record the date of receipt and use this to calculate deadlines.

Evidence to confirm implementation:

Dates of receipt are recorded for complaints in Datix.

Responsible person/title:

Sophie Brookes – PALS Lead

Target date:

31 January 2024

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Findings and management actions

2.5 Completeness of meeting records

Low

Records are not retained for all meetings used to resolve complaints.

Out of the 15 complaints tested during this review, two were resolved via meetings. One did not have PALS present and emailed PALS to confirm that the complainant was happy to close the meeting but nothing was formally recorded. The second was resolved via an informal conversation and PALS communicated on reflection this should not have been logged as a complaint.

It is acknowledged that the normal process requires meeting minutes reviewed by the Chief Executive, however when PALS are not directly involved in the meeting this can be missed.

Risk: There is a risk that a complaint is deemed closed after a meeting when there are further expectations from the complainant, causing an increase in re-opened complaints.

Agreed management action:

Review the template for recording outputs from meeting-based complaint resolutions, and include this as an appendix to the policy.

Evidence to confirm implementation:

Meeting record template used for patient complaints included within the new policy.

Responsible person/title:

Sophie Brookes – PALS Lead

Target date:

29 February 2024

2.6 Record of joint investigations

Low

There is currently no requirement to retain evidence of each stage of the complaint management process when a joint-Trust complaint is being led by the other Trust.

One of the 15 complaints sampled was a joint complaint for which the investigation was being led by the other Trust involved. Record of approval from the PALS lead is recorded via email however Salisbury did not have awareness or retain evidence of when the response was sent to the complainant and/or when the complaint was deemed closed.

Risk: There is a risk that complaints data and information held in Datix in inaccurate or incomplete, which may be required if complaints are re-opened.

Agreed management action:

Add guidance and templates to the main complaints policy and retain evidence of the response to complaints where these are being led by another Trust.

Evidence to confirm implementation:

Cross-Trust complaints responses are recorded; guidance and templates added to the Trust's main complaints policy .

Responsible person/title:

Sophie Brookes – PALS Lead

Target date:

31 March 2024

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Detailed findings - system design

Assessment of process design of patient complaints received by the Trust is captured in the table below;

Process	Controls	KPMG Commentary
Complaints procedure Patient complaints are acknowledged by the Patient Advice and Liaison Service (PALS) within three working days and logged on Datix web. Key complaints data is populated by PALS and sent with the complaint letter to the relevant Directorate Manager (DM). Divisions must populate the remainder of the form and return it to PALS within 48 hours. The DM assigns an investigating manager who, together with the PALS complaint coordinator, will agree upon a response RAG rating to determine the expected time to complete a full investigation; • GREEN: Response within 25 working days, a non-complex complaint involving one or two Services with no adverse outcome or injury (e.g. delayed appointment). • AMBER: Response within 40 working days. A complex complaint involving multiple services, where an adverse outcome or minor injury was noted, media contact suggested or completed, or the complaint suggests neglect or significant failings in care. The investigating team may require additional time due to absence in the relevant clinical team. A statement may be required from an ex-employee of the Trust. • RED: Response within 60 working days where an adverse outcome was noted. Involving multiple services, there is confirmed or suggested media contact and/or the complaint suggests neglect or abuse of a vulnerable patient.	1. Complaints are logged on the Datix web tracker by PALS. 2. The 48 hour form is completed by Divisions and returned within 48 hours after the complaint is received. 3. There is a defined timeline of three working days to acknowledge patient complaints. 4. Complaints are RAG rated to determine the timeline to be followed, workflow timelines are defined per rating.	✓ Having complaints logged on Datix helps maintain a record of the complaints received, the category or underlying theme, and a record of time taken to respond. ✓ The 48 hour form captures the complaint details, including a brief description and key points for actions, and provides guidance to the Divisions on what their response needs to include and if there can be early resolution. ✓ There are defined timescales dependent on the complexity of the complaint investigation require, allowing the timeliness of responses to be monitored. ✓ Each RAG rating has defined criteria and guidance to prevent, or minimise, incorrect allocation.

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Appendix A

Detailed findings - system design

Process	Controls	KPMG Commentary
Each pathway has set timelines, an overview of which is included as a flowchart within the policy. The investigating manager is responsible for completing the investigation and determining whether a letter or meeting response is required. Written responses and meeting notes require sign off from the Chief Executive. Individuals who re-open a complaint are invited for a meeting to discuss what issues remain. The trust has set a 25 day timeline for responding to re-opened complaints. Actions arising from complaints are allocated to the complaint within Datix with allocated responsible individuals and expected due dates. Automated emails are sent to responsible individuals as they fall due. Overarching lessons learned are reported via quarterly patient experience reports which are presented to all Trust level governance groups. Complaints training is provided to different staff groups on an adhoc basis.	5. Complaint responses require review and sign off from the Chief Executive before they are sent to the complainant. 6. Actions arising from complaints are recorded within Datix with allocated responsible individuals and deadlines. 7. Re-opened complaints are responded to within 25 working days. 8. Complaints training is provided and tailored to different staff levels on an adhoc basis.	✓ Re-opened complaints have a separate timescale and recommend a meeting which helps mitigate any further misunderstanding which may lead to referrals to the ombudsman. ✓ Actions arising from complaints are recorded in Datix with allocated individuals and expected completion dates. The system automatically sends reminders when actions are falling due, helping to ensure actions are implemented in a timely manner. ✓ Lessons learned are captured via reporting key themes to governance groups, showing awareness of key issues causing complaints. • The procedure for re-opened complaints is not captured in the complaints policy. See **Finding 2.3**.
Policies and Procedures There is a Handling Comments, Concerns, Complaints and Compliments Policy which is accessible through the Trust's guide repository accessible by the public. The policy captures the processes for responding to feedback from patients, including complaints. The Head of Patient Experience and Complaints Lead is responsible for the document which was last updated in June 2022 and due for review in October 2023.	9. The Handling Comments, Concerns, Complaints and Compliments Policy is owned by the Head of Patient Experience and Complaints Lead and has set review dates.	✓ The complaints policy requires review in the near future but is currently in date. Management are aware of the upcoming review required. ✓ The Head of Patient Experience and Complaints Lead is responsible for ensuring the document is up to date and accurate.

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Appendix A

Detailed findings - system design

Process	Controls	KPMG Commentary
Governance – Monitoring and Reporting Weekly meetings are held between the PALS Lead and the two patient complaint coordinators during which a spreadsheet recording details of open, overdue, and re-opened complaints is reviewed and updated. This meeting is to update the status of complaints and flag any issues which may require escalation with the relevant investigating manager. The Patient Experience Steering Group (PESG) meet at least 10 times a year with a standing agenda item to review overdue complaints and discuss challenges to meeting set timelines. Patient stories and updates from each Division are also reported on a rotational basis, including compliments and complaints and their associated themes with next steps to address them. The PESG escalate issues and report complaints data to the Clinical Management Board (CMB). The CMB meet monthly, reviewing the PESG Escalation report with a focus on overdue complaints which are included as a separate appendix. The CMB report to the Clinical Governance Committee (CGC) which has delegated responsibility to assure the Trust Board that a high quality care level is provided to patients. CGC meet monthly with patient experience reports reviewed quarterly. The Trust Board and Council of Governors (CoG) review the quarterly patient experience reports, including complaints KPI's, at the following meeting.	10. Weekly meeting between PALS and the complaints coordinators to review complaints. 11. PESG meet at least 10 times a year, including review of overdue complaints, escalating issues to CMB. 12. CMB meet monthly to review complaints, escalating issues to the CGC. 13. CGC meet monthly and review patient complaints on a quarterly basis via quarterly Patient Experience Feedback reports. 14. The Board reviews complaints by exception and via the quarterly Patient Experience Feedback reports. 15. The CoG monitors complaints via the quarterly Patient Experience Feedback reports.	✓ There is a defined governance structure in place with clears lines for escalation of complaints. ✓ There is a focus on overdue complaints which provide a higher risk of reputational damage due to slow responses to patients. ✓ The composition of each governance group is appropriate to ensure Trust-wide awareness of patient complaints and their underlying themes, including next steps to address these. ✓ Weekly meetings between PALS and the complaints coordinators helps address any potential delays on a timely basis and allows the PALS Lead to directly follow up on any delays or issues.

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Appendix A

Detailed findings - divisional design

At the request of management we gained a high-level understanding of the processes within three Divisions at the Trust; Medicine, Surgery, and Women's & Newborn. Due to the nature of their roles, Medicine and Surgery receive the highest volume of complaints. Our findings and analysis of each approach are captured in the table below.

Process	Medicine	Surgery	Women & Newborn	KPMG Commentary
Guidance	Follows the Trust-wide complaints policy.	Follows the Trust-wide complaints policy. An informal, Surgery-specific complaints guidance document has been produced by the complaints lead.	Follows the Trust-wide complaints policy.	• There's no requirement for division-level complaints procedure documents. See **Finding 2.1**.
Complaint management	Led by the Deputy Divisional Head of Nursing for Medicine ('complaints lead'). A separate, Medicine-specific, complaints tracker is in place to record the complaints received, relevant due dates and responsible individuals. Responsible individuals (RI) are determined by the complaints lead and the relevant service lead. The responsible individuals and teams populate the 48 hour form, reviewed by the complaints lead before it is returned to PALS. The RI populates the complaints letter in the Trust-wide template. This is reviewed for completeness and tone by the complaints lead before it is submitted to PALS to formalise.	There are two complaints leads in the department, a Support Manager and a PA for the Surgery Management Team. The Support Manager role is solely focused on complaints and is unique to Surgery. Complaints are forwarded from PALS to the Surgery Admin shared mailbox. These are recorded on a separate Surgery-specific complaints log. The complaints leads forward the complaint with an action plan template to the lead clinician and relevant individuals involved to be populated and returned in 2 weeks. Communications are saved in a separate electronic folder on a shared drive. Teams are requested to call complainants and attempt early resolution.	Led by the Family Experience Midwife. Complainants are contacted within a week to get a first hand account and to give assurance the issues raised are being reviewed. First hand account statements and complaint details are forwarded to the relevant individual(s) for investigation, including contact details for the Professional Midwife Advocates (PMA) if related to midwifery who provide support to staff.	✓ The two largest divisions monitor their complaints using trackers. ✓ Surgery has an admin shared mailbox to ensure complaints are reviewed in a timely manner. ✓ Surgery have a specific role which focuses on complaints management. ✓ Trust-wide templates are used across the Divisions. • The responsibility for managing complaints falls to one individual in all divisions apart from Surgery, providing the risk of single point of failure. See **Finding 2.1**.

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Appendix A

Detailed findings - divisional design

Process	Medicine	Surgery	Women & Newborn	KPMG Commentary
Complaint management **(continued)**		Once the information and action plan template is received from the responsible team the complaint leads draft the written response and return it to PALS for formalisation.	A meeting is encouraged over a written response. Meeting minutes are signed off by the chief executive before they are sent as a formal response to complainants.	• Not all divisions have set target timelines for internal responses to complaints. See **Finding 2.1**.
Re-opened complaints	PALS provide the reasons behind the complaint being re-opened. The tracker is updated for re-opened complaints and the relevant team(s) are contacted. A meeting is offered to resolve and address the remaining queries or complaints. This can then be followed up with a written response if requested.	Reopened complaints are entered onto the complaints log and the subsequent communication is recorded in a sub-folder of the original complaints folder.	There is a 2 week target response timeframe. A meeting is encouraged to discuss the issue and identify a resolution.	✓ All divisions encourage a meeting to resolve re-opened complaints and address remaining issues.
Lessons learned	A learning from incidents forum is held after the monthly divisional governance meeting to share updates on lessons learned from complaints received. Medicine invite complainants back to the hospital to demonstrate the changes made since their complaints were received.	Lessons learned are shared informally at ward level via the matrons who had oversight of the complaints process. There are no formal processes for identifying and sharing lessons learned at a wider Divisional level.	There are quarterly newsletters capturing lessons learned. Due to the smaller size of the Division, most lessons learned are shared informally at a service line level.	✓ Each division has a form of informal lessons learned sharing. • There is no formalised expectation for sharing lessons learned or good practice at a divisional or cross-divisional level. See **Finding 2.2**.

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Appendix A

Detailed findings - divisional design

Process	Medicine	Surgery	Women & Newborn	KPMG Commentary
Monitoring and reporting	There are informal weekly meetings between the complaints lead and the complaints coordinator for the Division. There are weekly senior leadership team meetings where the complaints lead provides an update on the status of complaints, escalating where there are delays. There is a monthly divisional governance meeting where PALS provide a detailed update.	Overdue cases are flagged to the Division Management Team (DMT) for Surgery via a monthly report from the complaints leads. PALS are copied into the report for awareness. DMT meet weekly but review complaints on a monthly basis.	There are monthly meetings for each service line where complaints can be discussed and escalated.	✓ Both Medicine and Surgery, the largest divisions regarding complaints, have regular, formal meetings where complaints are reviewed and escalated at a Division level. • The frequency of review of complaints varies between divisions. See **Finding 2.1**.

We reviewed the trackers produced by Medicine and Surgery, and a sample of the Divisional-level meeting minutes to compare the divisional level processes for the two largest divisions. We found that the approach to monitoring was largely consistent regarding a tracker and Divisional management meetings to review the numbers of complaints with a focus on overdue complaints. However, there are inconsistencies in the details in both the trackers and the detail of discussions within the meetings. The Medicine Division has recently introduced a learning from incidents forum for which a record of attendees, discussions and SMART actions arising is maintained, Surgery does not have a similar forum.

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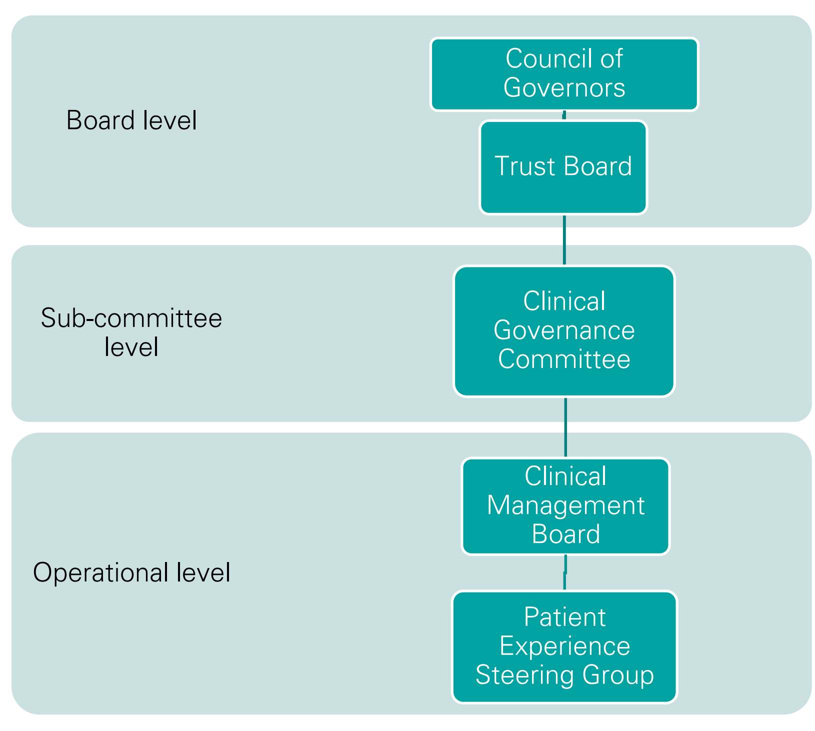
Appendix B

Detailed findings - governance

A review of the governance structure was completed, including analysing terms of references, meeting minutes, and relevant papers. Our findings are summarised in the table below. This review tested the operating effectiveness of **Controls 10 to 15**.

Group	KPMG Commentary
Council of Governors (CoG)	✓ The CoG has overarching responsibility for monitoring performance of the Trust and ensuring the local community and staff have a greater say in how services are developed. Quarterly Patient Experience Feedback Reports are reported and reviewed.
Trust Board	✓ The Trust Board monitor patient complaints via review of quarterly Patient Experience Feedback reports, patient stories which have resulted in complaints, and any escalated items from the CGC.
Clinical Governance Committee (CGC)	✓ The CGC is reportable to the Trust Board and Chief Executive, responsible for ensuring a high quality of care is provided to patients throughout the Trust. Updates are provided via patient feedback reports, reported up through the PESG and CMB. CBC reports to Trust Board.
Clinical Management Board (CMB)	✓ The CMB meet monthly to monitor the quality-of-care provision. CMB review complaints escalated from the PESG via the PESG escalation report and review current patient complaint statistics. The CMB reports to CGC.
Patient Experience Steering Group (PESG)	✓ The PESG meet at least 10 times a year with a purpose to provide assurance to the Trust Board that the Trust is listening to patients about their experiences and taking action to improve the experience of those using its services. Review of overdue complaints is a standing agenda item. Each Division provides patient complaint updates on a rotational basis. PESG reports to CMB.



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Appendix C

Detailed findings - control testing

We have tested operation of the **controls 1 to 9** identified in **Appendix A,** and set out our findings below. Note: controls 10 to 15 were covered in the governance testing in Appendix B.

Control	KPMG Commentary
We obtained a listing of the patient complaints received between January and August 2023 and selected a sample of 15 complaints from a total of 106.	
Control 1 Complaints are logged on the Datix web tracker by PALS	✓ All 15/15 complaints sampled were logged in Datix. • 10/15 of the sampled complaints were delayed in being added to Datix, ranging from two to 17 days after the date the complaint was received. Reported response times are calculated from the date the complaint added to Datix and therefore do not reflect the actual time taken to respond. We reviewed the impact of this on compliance with target dates and found that none of the 15 had been incorrectly recorded to as responded to within the allocated time. See **Finding 2.4**.
Control 2 The 48 hour form is completed by Divisions and returned within 48 hours after the complaint is received.	A 48 hour form had not been completed for 11/15 sampled complaints. See **Finding 2.1**.
Control 3 There is a defined timeline of three working days to acknowledge patient complaints.	✓ 13/15 sampled complaints were acknowledged within the three day timeframe based on the date of entry to Datix. • One sampled complaint was acknowledged in six working days. Discussions with management identified that this complaint was originally going to be resolved via a telephone call to the complainant, in line with the early resolution approach adopted by the Trust. The call was not completed by the responsible team, resulting in the complaint acknowledgement being delayed. See **Finding 2.5**. • One sampled complaint was managed via a joint investigation led by the other Trust involved, a copy of the complaint acknowledgement was not retained by Salisbury. See **Finding 2.6**. • A further five complaints in our sample were found to have been acknowledged outside of the three day timeframe due to the delays in recording complaints in Datix. See **Finding 2.4**.

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Appendix C

Detailed findings - control testing

Control	KPMG Commentary
Control 4 Complaints are RAG rated to determine the timeline to be followed, workflow timelines are defined per rating.	• 10/15 sampled complaints exceeded their defined timescales, exceeding from between 4 to 105 days. See **Finding 2.1**. • One complaint was a joint complaint managed by the other Trust involved. There was no record available of when the complaint response was sent by the other Trust to the complainant. See **Finding 2.6**.
Control 5 Complaint responses require review and sign off from the Chief Executive before they are sent to the complainant.	✓ 13/15 of the complaints sampled had appropriate evidence of sign off. • Two complaints were resolved via informal meetings with no record of review or oversight available See **Finding 2.5**.
Control 6 Actions arising from complaints are recorded within Datix with allocated responsible individuals and deadlines.	✓ Where applicable actions arising from complaints were recorded in Datix. Only two of the complaints sampled had actions arising. These actions had assigned responsible individuals and due dates allocated in Datix.
Control 7 Re-opened complaints are responded to within 25 working days.	• We selected a sample of five re-opened complaints from the last 12 months and found that insufficient evidence was retained for two samples to assess the timeliness of managing re-opened complaints. See **Finding 2.3**. • Analysis of re-opened complaints in the 12 months to August 2023 identified that Medicine had the highest volume (6, 46%), closely followed by Surgery (5, 38%). Women and Newborn had the fewest (2, 15%). It is acknowledged that Surgery and Medicine receive the highest volume of complaints. ✓ Of the 106 complaints raised across the Trust between January and August 2023, only 7 (6.6%) were reopened.
Control 8 Complaints training is provided and tailored to different staff levels on an adhoc basis.	✓ We reviewed training materials for six sessions provided to various staff levels and found that appropriate content was provided to inform staff of the complaints process, key complaint themes, top tips for managing complaints, and PALS services.

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Appendix C

Detailed findings - control testing

Control	KPMG Commentary
Control 9 The Complaints Policy is owned by the Head of Patient Experience and Complaints Lead and has set review dates.	✓ The policy in place is in-date, comprehensive and widely accessible to staff and patients with a defined owner minimising the risk of an out of date policy. ✓ The policy has appendices including the timelines for different RAG ratings, and templates for a record of discussion, action plan, and statements. • The policy does not cover the process for re-opened complaints and how these should be addressed. See **Finding 2.3**.

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Appendix D

Scope extract

Background of the internal audit

Formal complaints provide an important mechanism by which management can assess the quality of services provided. Effective complaints handling is a foundation of the patient experience and can also provide enhancements to patient safety and clinical effectiveness if lessons are learned and necessary action taken. This review will evaluate the Trust's processes for managing and responding to complaints, including a review of the policy and procedures and sample testing of individual complaints received and associated correspondence, to provide assurance that the Trust's policies are being complied with.

Complaints can span multiple clinical divisions. Therefore, it is important that effective mechanisms are in place for monitoring the response times of complaints and sharing lessons learnt with all areas of the Trust that are affected, and that these lessons are cascaded to the wider Trust where appropriate. We will review governance arrangements surrounding the management and reporting of complaints across the Trust and consider how lessons learnt are captured and shared. We will also review the Trust's approach to complaints management and backlog reduction, looking for process improvement as part of that work.

Scope of internal audit

The scope of this review included consideration of:

- Policies and procedures relating to patient complaints and the extent to which they are adhered to in a timely manner in different divisions (Key Risks 1 & 2);
- Analysis of the number of complaints which are reopened, and how this varies across divisions (Key Risk 3);
- Monitoring and reporting of complaints activity through governance structures (Key Risk 4); and
- How lessons learnt are captured and shared across the Trust (Key Risk 5).

Our approach

Our work involved the following activities:

- Meetings with the key staff involved in patient complaints processes;
- Walkthroughs of key patient complaints processes;
- Consideration of alignment of the Trust's policy and procedures with the NHS Complaints Standards and best practice where appropriate;
- Desktop review of documentation supporting the internal controls; and
- Sample testing where appropriate.

The approach included sample checks to determine whether the key controls are being effectively and consistently operated. In cases where we noted controls do not exist, have raised this as a finding.

Key risks identified

1. **Policies and procedures:** Policies and procedures for patient complaints are not sufficiently documented or communicated to staff which may result in inconsistent and/or inappropriate practices.
2. **Timeliness of responses:** There is no mechanism for identifying complaints at risk of breaching set targets and complaints are not handled with in a timely manner, negatively impacting patient experience.
3. **Reopened complaints:** Patient complaints are not responded to effectively, increasing the workload for staff involved through the re opening of complaints, and negatively impacting patient experience.
4. **Monitoring and reporting:** There is insufficient oversight at a senior level of complaint trends and complaint handling performance, reducing accountability for those involved and impacting the ability for informed decisions to be made.
5. **Lessons Learnt:** Emerging themes and lessons learnt from patient complaints are not shared widely across the Trust, preventing learning opportunities.

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Appendix E

Ratings definitions

We have set out below the overall report grading criteria and priority ratings used to assess each individual finding.

Overall report rating	Definition
Significant assurance	The system is well designed and only minor low priority management actions have been identified related to its operation. Might be indicated by priority three only, or no management actions (i.e. any weaknesses identified relate only to issues of good practice which could improve the efficiency and effectiveness of the system or process).
Significant assurance with minor improvement opportunities	The systems is generally well designed however minor improvements could be made and some exceptions in its operation have been identified. Might be indicated by one or more priority two management actions. (i.e. there are weaknesses requiring improvement but these are not vital to the achievement of strategic aims and objectives - however, if not addressed the weaknesses could increase the likelihood of strategic risks occurring).
Partial assurance with improvements required	Both the design of the system and its effective operation need to be addressed by management. Might be indicated by one or more priority one, or a high number of priority two management actions that taken cumulatively suggest a weak control environment. (i.e. the weakness or weaknesses identified have a significant impact preventing achievement of strategic aims and/or objectives; or result in an unacceptable exposure to reputation or other strategic risks).
No assurance	The system has not been designed effectively and is not operating effectively. Audit work has been limited by ineffective system design and significant attention is needed to address the controls. Might be indicated by one or more priority one management actions and fundamental design or operational weaknesses in the area under review. (i.e. the weakness or weaknesses identified have a fundamental and immediate impact preventing achievement of strategic aims and/or objectives; or result in an unacceptable exposure to reputation or other strategic risks).

Finding priority rating	Definition
Low	Issues arising that would, if corrected, improve internal control in general but are not management actions which could improve the efficiency and / or effectiveness of the system or process but which are not vital to achieving your strategic aims and objectives. These are generally issues of good practice that the auditors consider would achieve better outcomes.
Medium	A potentially significant or medium level weakness in the system or process which could put you at risk of not achieving its strategic aims and objectives. In particular, having the potential for adverse impact on your reputation or for raising the likelihood of your strategic risks occurring.
High	A significant weakness in the system or process which is putting you at serious risk of not achieving its strategic aims and objectives. In particular: significant adverse impact on reputation; non-compliance with key statutory requirements; or substantially raising the likelihood that any of your strategic risks will occur. Any management action in this category would require immediate attention.

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2023-24 KPMG Internal Complaints Report – Management Actions Tracker

Associated file(s) location: W:\Chief-Executive-Directorate\Customer Care\Complaints Internal Audit\2023

Finding	Management Action	Evidence to confirm implementation	Owner and Due date	Progress update and RAG Status
2.1 Divisional Guidance documents (Medium) Currently there is no requirement for Divisions to produce complaints management guidance for division-specific procedures.	1. Produce a template for Division level guidance for managing complaints, including key areas such as allocating investigating managers, internal timelines, and Division-level reporting requirements. 2. Communicate deadlines for responding to complaints within divisions to those involved. 3. Set a minimum expectation for monitoring of complaints data within divisions.	1. Division guidance document template. 2. Communication of deadlines: guidance to be included with the Divisional guidance and complaints policy. 3. Agreed minimum reporting at divisional level governance.	Victoria Aldridge – Head of Patient Experience 29/02/2024	**Largely complete** Sections added as follows to the updated complaints policy. Policy awaiting first sign-off with PESG (28th Feb 2024). 1.Work continues with the Divisions to develop guidance documents to outline their individual processes. These will be added as appendices to the new complaints policy once finalised. 2.Communication of deadlines explicitly referenced in the new policy “Complaints pathway and investigation process”. 3. New section added to the complaints policy – “learning from complaints”.

2.2 Sharing lessons learned and good practice (Medium) There are limited forums for sharing lessons learned and/or good practice from complaints.	1. Publish trust-wide lessons learned on the intranet on a regular basis. 2. Include trust-wide lessons learned from complaints within the quarterly patient experience report. 3. Include discussion of lessons learned from complaints across the Trust, and sharing of best practice, within divisional forums.	1. Trust-wide lessons learned from complaints published in a newsletter on the intranet. 2. Lessons learned included in the quarterly patient experience report. 3. Evidence of discussion of lessons learned and best practice in divisional forums.	Victoria Aldridge – Head of Patient Experience 30/06/2024	**In progress** New section added to the Patient Experience quarterly reports (starting from Q2 2023/24) – "learning from Patient Experience". Evidence of Patient Experience presentations for Divisional forums (quarterly basis)- template developed Further work needed to develop a digital format (i.e. newsletter or intranet) for sharing Trust-wide lessons learnt. Currently included in complaints training for B7's, F2's and consultants.
2.3 Re-opened complaints (Medium) The complaints policy does not include the process for managing re-opened complaints.	Update the Handling Comments, Concerns, Complaints and Compliments Policy to include a section on managing re-opened complaints.	1. Updated Handling Comments, Concerns, Complaints and Compliments Policy including re-opened complaints	Victoria Aldridge – Head of Patient Experience 29/02/2024	**Completed** "Reopened complaints" section added to the updated complaints policy. Policy awaiting first sign-off with PESG (28th Feb 2024).
2.4 Accuracy of response times (Medium) Complaints response times are being calculated from the date	Add a section into the Datix complaints record to record the date of receipt and use this to calculate deadlines.	1. Dates of receipt are recorded for complaints in Datix.	Sophie Brookes – PALS Lead 31/01/2024	**Completed** Additional field added to Datix . This is referenced for completion in the

of entry to Datix, instead of the date of receipt.				new policy under "record keeping" and is now business as usual.
2.5 Completeness of meeting records (Low) Records are not retained for all meetings used to resolve complaints.	Produce a template for recording outputs from meeting-based complaint resolutions, include this as an appendix to the policy and circulate to Divisions.	1. Meeting record template used for patient complaints.	Sophie Brookes – PALS Lead 29/02/2024	**Completed** Appendix added to the updated complaints policy. Policy awaiting first sign-off with PESG (28th Feb 2024).
2.6 Record of joint investigations (Low) There is currently no requirement to retain evidence of each stage of the complaint management process when a joint-Trust complaint is being led by the other Trust.	Retain evidence of the response to complaints where these are being led by another Trust.	1. Cross-Trust complaints responses are recorded, guidance and templates to be added to the Trusts main complaints policy .	Sophie Brookes – PALS Lead 31/03/2024	**Completed** Section added to the updated complaints policy. Policy awaiting first sign-off with PESG (28th Feb 2024). Archive of separate policy that was previously in place to prevent missed information.

Friends and Family Feedback
Medicine Comments Q3

Breamore
Friendly, helpful staff and a nice cuppa!

Cardiac Suite
Wonderful, attentive care. I was always treated as an individual and never as just another patient. A truly wonderful team.

Farley
Everyone worked as a team and provided excellent care with many going above and beyond.

Durrington
Most nurses were utterly caring, 2 or 3 certainly weren't!

Pitton
All the clinical care and attention. Made to feel looked after.

Tisbury
All of the staff were excellent, I couldn't have asked for better care. The food was excellent. The best hospital food I have ever had.

Endoscopy
Medical staff made me feel very relaxed. I was very unsettled after last appt. Dr Hasson was very caring putting me at ease from the start, thank you.

Laverstock
Caring staff, although overworked and understaffed they always made time for you especially if you had a problem. They were jolly and kind.

Respiratory Department
Prompt reception. Courteous and efficient tester.

Cardiac Rehabilitation
The sessions were informative, inclusive and enjoyable. I felt welcome and took great reassurance that I could do physical activity without being concerned.

AMU
Outstanding run ward. Everyone cared. Nothing was too much for them. Although they were very busy they looked after my partner as if she was their only patient.

Nunton Day
Great long term care. Personal Good tea! Superb staff.

Cardiac Investigations
Came on the wrong day, but they managed to fit me in so I did not have to come back! Thank you to the lovely young Mangho who did my EGG.

ED
Scene quickly in as pleasant environment with very nice and kind staff. As always a great hospital.

Whiteparish
The attention to detail. All staff were pleasant and efficient. The wards are light and airy.

Redlynch
Ian Morgan is sincere, so caring and happy to go that extra mile for myself and the other patients. Please ensure Ian gets recognition for his care and thank you. SDH has always cared for me very well, thank you again.

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

Friends and Family Feedback

CSFS Comments Q3

NHS Salisbury NHS Foundation Trust

Sexual Health

Everything was explained thoroughly and simply. Helen and Bella were very friendly.

Orthotics

Warm welcome on arrival by receptionist. Seen before time with very friendly staff. Highly recommend.

DEXA Clinic

Easy dept to find. No fuss. Scan very quick. Staff wonderful, patient and kind.

CT/MRI

Informative, relaxing, professional, excellent in every way.

Wessex – Lower Limb

Focused attention and knowledgeable physios. Everyone very helpful and clear programs to follow.

Pathology Reception

Perfect, prompt and friendly service

Early Supported Discharge

The team listened to concerns and were able to give constructive answers. The support given was excellent.

Moire Fringe

Reliable. Very approachable and friendly, and still remaining professional.

Sarum

Clean rooms. Majority of staff were welcoming and friendly. Given own room/space.

Neurophysiology

All staff were incredibly friendly and welcoming which made my visit easier as I was anxious about my appt.

Wessex – Chronic Pain

I was given the space to voice my concerns and I have never felt more heard! I am so grateful to be believed.

Wessex – Upper Limb

The rehabilitation has put me on the road to repair and restore confidence.

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

Friends and Family Feedback
Surgery Comments Q3

Amesbury
Excellent care by staff from arrival in A&E to op in theatre. Very fast.

Burns
Super good!!! Emily and Amy were amazingly friendly, welcoming and knowledgeable. Thank you.

Audiology
My appt was on time. All instructions were very clear. I felt comfortable enough to ask questions without feeling rushed. Many thanks

Dermatology
Very helpful and insightful. Made me feel more confident in the fact that we know what the issues are.

Rheumatology
I always feel so very well looked after by all the team, especially Dr Bartram and nurse R Lowey. I did have one appt with Dr Clynes and could not fault him. He was extremely caring, professional and empathetic. An absolutely credit to the team. Thank you, you make such a difference.

Odstock
All the staff on Odstock ward were truly amazing, from Christina the ward cleaner who has a very positive outlook on her job and life in general, I really looked forward to chatting to her every morning she is full of amazing attributes, the physiotherapists were so full of motivation with a touch of fun albeit I think they found me a bit of a handful, but nothing their patients could not handle, the nurses and student nurses were highly skilled and are definitely dedicated to their profession, all the student nurses will sail through any exams they have to take, the entire ward was so full of positivity and is a credit to the NHS

Chilmark
I was amazed that all the nurses were so kind without exception. The nursing was sensitive. I was warmly received by Donna Roberts who was caring. Also Abbi, Shelli, Gisha and Mary. All very smiley, gentle and kind.

Fracture & Orthopaedics
Friendly staff, outstanding empathy. Hayley organised so much for me and looked after me so very well. You can tell she takes pride in what she does and really cares about the comfort of her patients.

Med/Surg OP
All of it. I had to wait a little while but that didn't matter. Staff all lovely and professional and very thorough. I felt very well looked after

Oral Surgery
Efficient, friendly, professional, kept me in the picture. Thank you

Laser
Friendly, relaxed atmosphere with a professional service.

Plastic Surgery
Brilliant! Punctual, lovely staff. Sylvia had a great manner. I have been here many times with my 95yrs old mother in law. Fantastic service and wonderful staff. I was so impressed.

Main Theatres
Very efficient, lovely caring staff who explained the whole procedure in detail. I felt very cared for.

Downton
All the staff in Downton, you are brilliant, amazing people. A credit to humanity. Thank you so much for your kindness and care.

Britford
Everyone was very lovely and extremely good at reassuring me. Worked so quick to helping me get better

DSU
Children's - The staff here are amazing, from the reception smiling to the wonderful nurse who is a warm lovely human, to the surgeon. Just wow! A special thanks to Domini, my nurse! She is so attentive and calming. Lovely to see people who love their work and are so passionate about patients and their families.

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

Friends and Family Feedback
Women & Newborn Comments Q3

NHS
Salisbury
NHS Foundation Trust

Community Postnatal
Lovely individuals, provided assurance to me as a new time mum and signposted me to lots of helpful areas.

Early Pregnancy Unit
I felt very poorly and was dehydrated when I came. Everyone as friendly and attentive.

Postnatal
Excellent care from all midwives and care assistants, including infant feeding team. In particular Eunace was excellent.

Gynaecology
Friendly smiling staff. Procedure well explained. Very professional and reassuring. Very clean facility.

Community Postnatal
Great support throughout my 2 pregnancies from everyone, but mainly RM Ellen Pizzey. Thank you so much

Labour Ward
Outstanding care received during our stay.

Antenatal
Laura Ollington was absolutely lovely. Her cheery disposition put us all at ease. We are tempted to adopt her!

Early Pregnancy Unit
The person doing the scan was gentle and empathetic.

Gynaecology
Excellent. Everything from start to finish. Amazing staff. Wonderful, happy and reassuring. Thank you

Antenatal
Very efficient and really friendly staff! I felt very well cared for!

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

Patient Feedback

Managing Staff and Patient Expectations Working Group

Victoria Aldridge
Head of Patient Experience
18th Jan 2024

January 2024 update

Trust Wide Themes
Q3

Sub themes of Top three
Q3

Top sub-themes (within top three prevalent themes)
- Unsatisfied with treatment
- Insensitive or lack of communication
- **Early discharge and discharge procedures**

January 2024 update

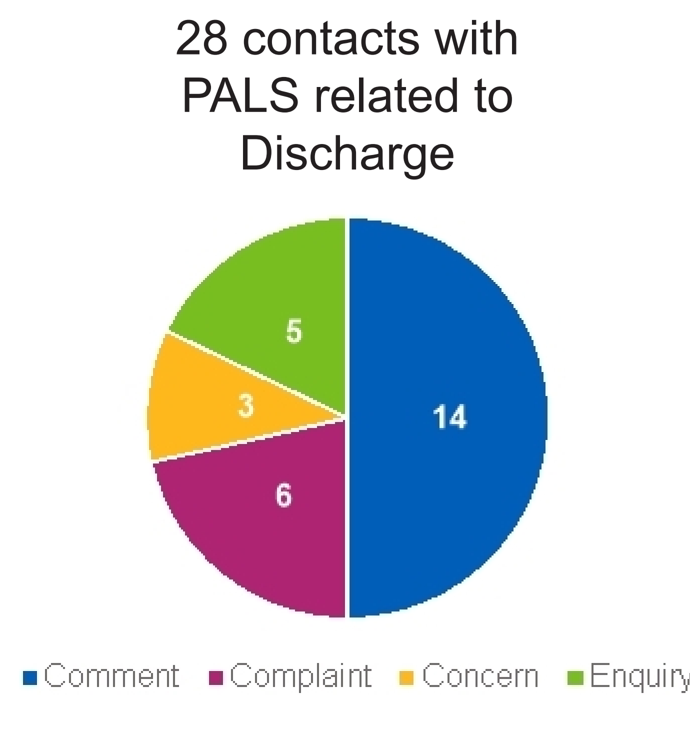
Summary of insights from RTF collected July/August/September 2023

- In July, 18 patients were surveyed across 5 wards
- The overall experience was rated at 75%
- All wards scored 100% for cleanliness and patients being treated with dignity and respect
- All wards also scored the lowest around noise levels at night and a patients understanding or involvement with discharge plans

- In August, 26 patients were surveyed across 6 wards.
- Overall experience was rated at 98%
- Wards still rated 100% for cleanliness and being treated with dignity and respect.
- Lowest scoring were still noise and level of understanding, but it had improved.

- So far in September, 35 patients were surveyed across 8 wards and total surveyed was 36
- Overall experience was down at 88.9%
- Being treated with dignity and respect is still being reported at 100%
- Noise levels at night and understanding discharge are still the lowest scoring along with numbers of medical staff on duty this month.

Review of PALS enquiries related to discharge 01.04.2023 – 13.11.2023



Summary of reason for contact

Reason	Count
Discharged delayed - due to care, equipment or living situation	6
Discharged too soon	2
Discharged without equipment	1
Unclear discharge plan	3
Unhappy with discharge plan	9
Unsafe discharge	6

Real-Time Feedback – Background and Scoring

Real-Time Feedback is a face-to-face opportunistic survey undertaken by the patient's bedside whilst they are in hospital. This can be undertaken by staff, volunteers or governors.

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

Real-time feedback is not currently undertaken within the maternity inpatient areas or on Sarum ward.

The survey mirrors the focuses of the National Inpatient survey and includes questions to assess the following areas:

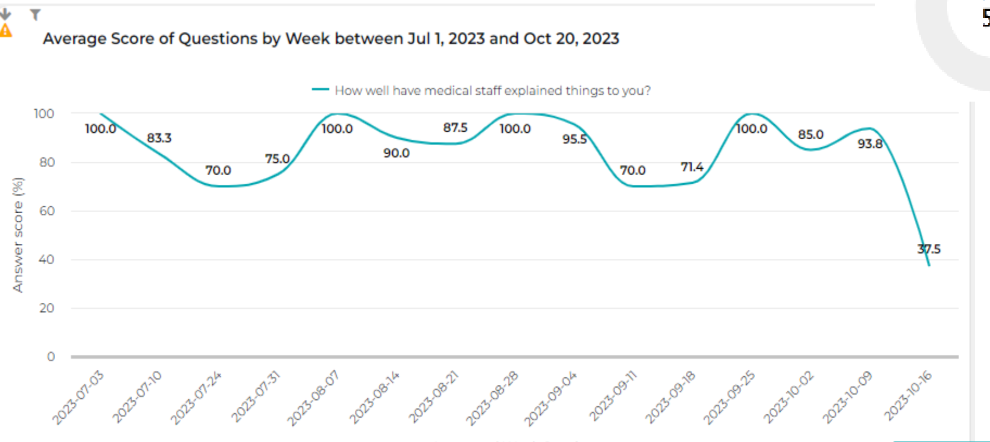
- Admission to hospital
- The ward environment
- Doctors
- Nurses
- Care and treatment
- Operations and procedures
- Leaving hospital
- Respect and Dignity
- Overall experience

Questions are rated 1 - 5 (1 = very poor and 5 = very good)

Questions are weighted and averaged to present an overall performance score %

November 2023 update

Real Time Feedback
Jul – Oct 2023



5%

How well have medical staff explained things to you?

Answer score (%)	Responded Answers
85.6	97

77.8 Jul 2023 · 94.2 Aug 2023 · 87.1 Sep 2023 · 79.5 Oct 2023

Area	Answer score (%)	Responded Answers
Britford	100.0	9
Laverstock	100.0	7
Pembroke	100.0	2
Pitton	100.0	1
Farley	91.7	6
Odstock	90.0	5
Tisbury	85.7	7
Breamore	83.3	12
Downton	83.3	9
AMU	83.3	6
Redlynch	82.1	14
Spire	75.0	6
Durrington	75.0	4
Longford Ward	72.2	9

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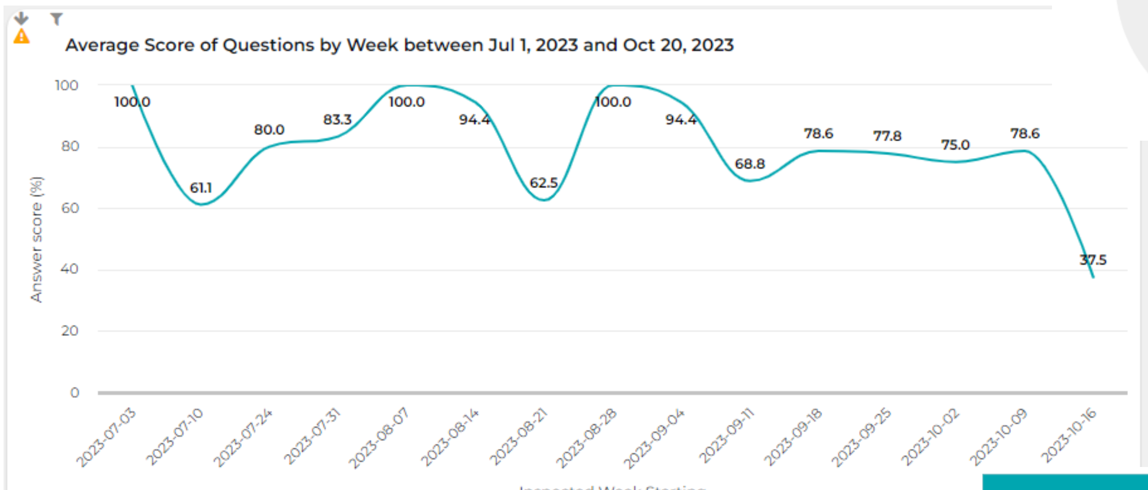
November 2023 update

Real Time Feedback Jul – Oct 2023

Proportion N/A

5%



How would you describe your involvement with decisions around your care and treatment?

Answer score (%)	Responded Answers
79.4	97

	Jul 2023	Aug 2023	Sep 2023	Oct 2023
Answer score (%)	70.6	92.0	80.9	69.0

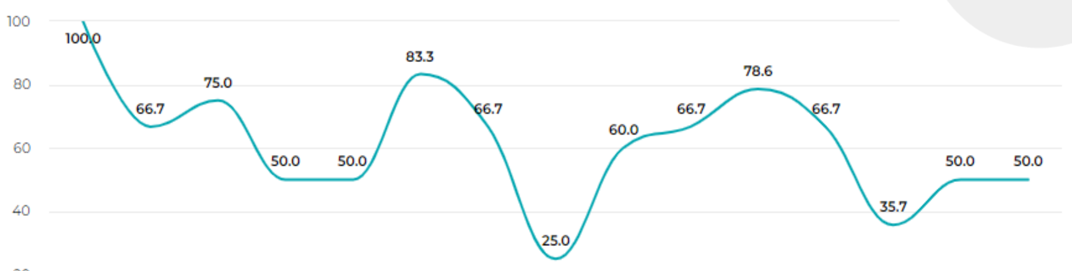
Area	Answer score (%)	Responded Answers
Laverstock	100.0	5
Pembroke	100.0	2
Pitton	100.0	1
Britford	95.0	10
Odstock	90.0	5
Spire	83.3	6
AMU	83.3	6
Redlynch	75.0	12
Breamore	75.0	12
Downton	75.0	10
Farley	75.0	6
Durrington	75.0	4
Tisbury	71.4	7
Longford Ward	63.6	11

November 2023 update

Real Time Feedback Jul – Oct 2023

Proportion N/A 33%

How would you describe your understanding or involvement with your discharge plan?



Answer score (%)	Responded Answers
61.8	68

65.4 (Jul 2023), 67.6 (Aug 2023), 66.0 (Sep 2023), 42.3 (Oct 2023)

Area	Answer score (%)	Responded Answers
Tisbury	87.5	4
Laverstock	80.0	5
Britford	75.0	8
Farley	70.0	5
Breamore	68.2	11
Downton	66.7	6
Redlynch	66.7	6
Longford Ward	62.5	8
Durrington	50.0	3
Pembroke	50.0	2
Pitton	50.0	1
AMU	33.3	3
Spire	10.0	5
Odstock	0.0	1

October 2023 update

Informal interviews – Summary of Conversations

5 interviews undertaken, random sampling across Britford, Downton and Tisbury (September 2023)

3 males & 2 females

Oldest = 90years & Youngest = 59 years

Average ward stay = 6.5 days

5/5 understood why they were in hospital today

3/5 knew what the plans were for them today

2/5 knew when they were planned for discharge home

1 of the 2 however, did not understand their discharge plan

3 of the 5 who did not have a planned discharge understood the reasons for this

Summary of findings

- Explanations from medical staff are improving. 2 of the 5 informal interviews noted they had received an update from their medical team that same day.
  - Longford, Durrington and Spire were amongst the lowest scores in relation to this question on RTF, although this scoring was ranked Adequate to Good.

- Feelings of involvement with decisions and treatment indicate a gradual reduction (monthly comparison on RTF).
  - Longford and Tisbury were amongst the lowest scores for this question on RTF, although this ranked as Adequate.

- Understanding and involvement with discharge plan has seen a significant reduction (monthly average on RTF).
  - AMU, Spire and Odstock had the lowest rating to this question on RTF, ranking as Poor and Very Poor.
  - In contrast, only 1 of the 5 interviewed felt that they could have been better involved with their discharge plan.

Patient Experience Team information:

PALS Office - Block 62
Green Entrance

Direct dial: 01722 429044
Extension – 5246/5248

sft.patientexpereince@nhs.net

CLASSIFICATION: please select

Report to:	Clinical Governance Committee	Agenda item:	5.2
Date of meeting:	31st October 2023		

Report tile:	Patient Experience – Complaints Process Survey Report			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Patient Experience Steering Group – 27th September 2023			
Prepared by:	Sophie Brookes – PALS Lead			
Executive Sponsor: (presenting)	Judy Dyos – Chief Nursing Officer			

Recommendation:
This report is for assurance and noting by the Committee.

Executive Summary:
This report provides summary and insights drawn from the feedback received from complainants who have had a closed complaint between 1st May 2023 and the 1st September 2023. This includes comparison to the feedback from the Healthwatch Wiltshire Project undertaken in 2022 and further actions planned in response to this feedback. Response rate was a respectable 30.7%, however only 63% of closed complaints during this period have a record of being sent this survey. Response rates and process are one of the mitigation actions outlined in this report. The results received have improved since the HWW project results received in 2022. Some of the results received between May and September 2023 were expected and mitigations have already been put in place to improve these.

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

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Patient Experience – Complaints Process Survey Report
May 2023 – September 2023

Purpose of paper

To provide the necessary Boards and Committees with assurance that Salisbury Hospital's complaints process is being actively monitored and continually adapted to improve the experiences of service users who find themselves in the difficult position of having to raise a complaint or concern.

This paper will seek to measure the effectiveness of the improvement actions put in place following the process review which took place in partnership with Healthwatch Wiltshire in 2022.

Background

This report is produced annually and enables us to consider how effectively we deal with complaints from people who have had a first-hand experience of our complaints processes.

In 2022 Salisbury undertook a co-produced project with Healthwatch Wiltshire sampling the experiences of 89 closed complaints between the 1st of January 2022 and 30th June 2022. The results of this survey informed a service and process improvement plan which was presented to the Patient Experience Steering Group and Clinical Governance Committee in December 2022.

We amended historic survey questions in April 2023 to match the complaints survey undertaken in 2022 so measure the impact of these changes. This was reinstated from the 1st May 2023.

The Process

The Complaints Co-ordinators send the surveys out at the time the signed response letters are sent out and the complaint or concern is closed. There are two options to complete the survey: via paper with return envelope to PALS or via a QR code link to an online survey.

Response rate

Between 1st May 2023 and 1st September 2023, 26 surveys were sent out, however it was noted that there have been a total of 41 closures of concerns and complaints during this time. This data is pulled from a Datix report and is feasible that the appropriate drop down was not completed on all of this occasion, but survey still sent out. The Complaints Co-ordinators have been reminded to ensure that they complete the questionnaire field on Datix so it is clear that this process has been completed.

During this period, we have received 8 completed surveys back. We have had recent discussions in the PALS Department whether sending the surveys out at the time of response is the correct period in which to send this, or whether these should be delayed. In the interim it was agreed to continue to send them out at the time of the response letter and review in 3 months' time.

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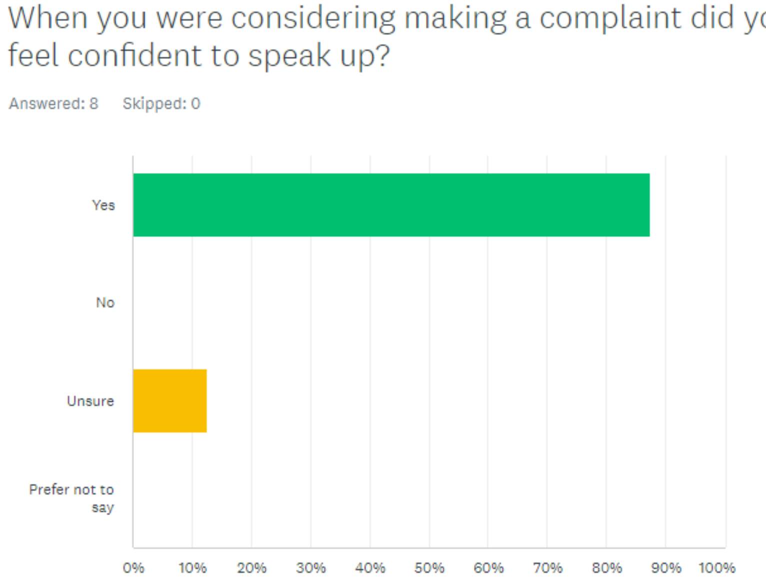
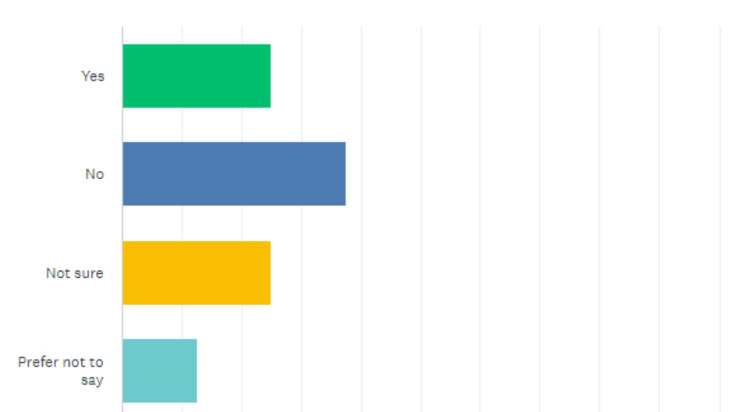
Survey results and insights

Below are the survey results received between the 1st May 2023 – 1st September 2023. We have acknowledged a gap in the reporting, where we are unable to distinguish which division the results relate to and is something that the PALS team will continue to discuss as to how we can mitigate this.

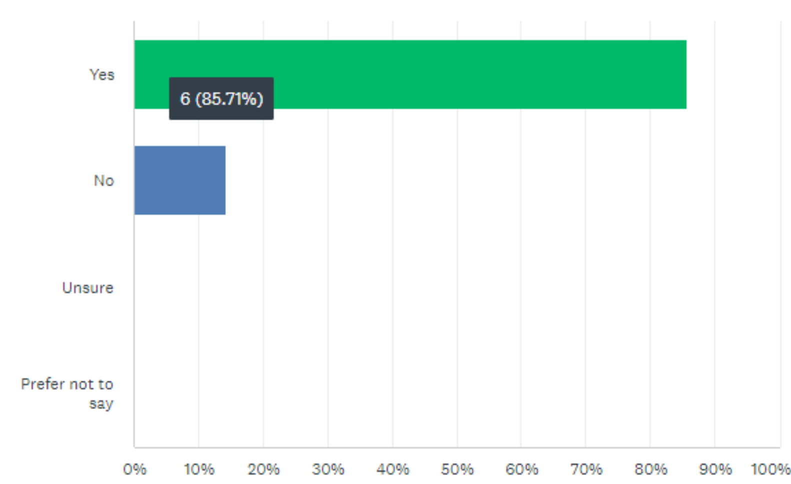


7 people were confident in speaking up when raising their complaint. One person was unsure.



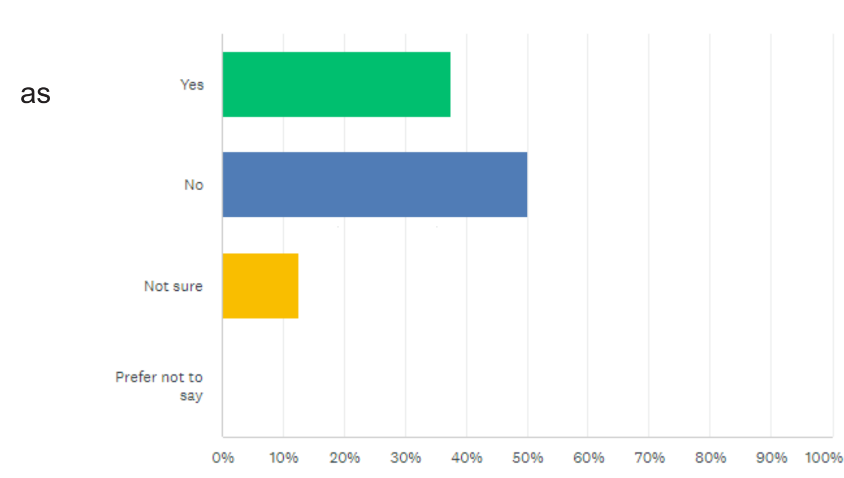
2 people felt that making a complaint may adversely affect their care, 3 people felt it wouldn't affect their care, 2 people were unsure and 1 person did not want to say.

We ensure it is highlighted in the complaint acknowledgement emails and letters that raising a complaint/concern will not prejudice the patients care and treatment in any way. However, we acknowledge that as the investigation is undertaken by those involved with the patient's care (as they are often the best placed to respond) it is understandable how the complainant may not feel there is a clear distinction between these.



6 people felt making a complaint was a simple process; 1 person did not feel making a complaint was a simple process and 1 person skipped this question.

We received similar results from the HWW results but did make some changes at the time to make the process more efficient such as introducing a 48hr review form, changes made to the acknowledgement letters, getting a clearer understanding of what the complainants want as an outcome to raising their concerns and trying to get an early resolution where possible.

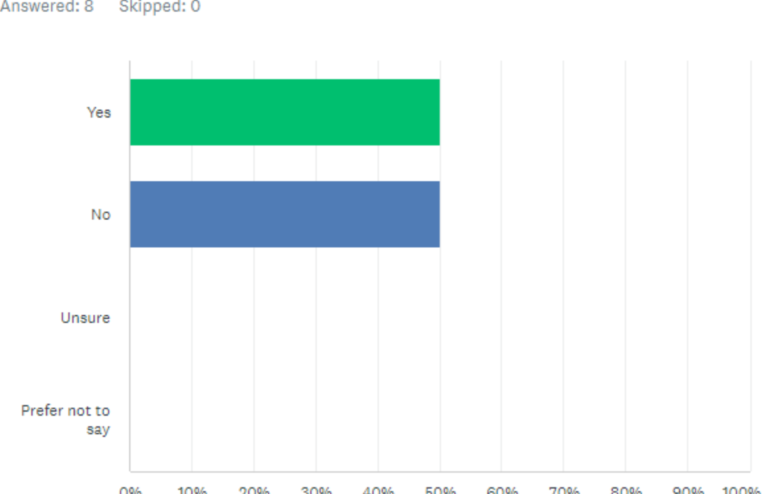


4 people answered no to this question, 3 people answered yes and 1 person was unsure.

This was also raised as being an issue when we received the HWW results and as a result, we ensured that the Advocacy details were more prominent on the acknowledgement letters and made clearer in our new PALS complaints leaflet which is anticipated to be finalised by end of September 2023.

The PALS team are also incorporating signposting to these services at first point of contact to PALS. The team are

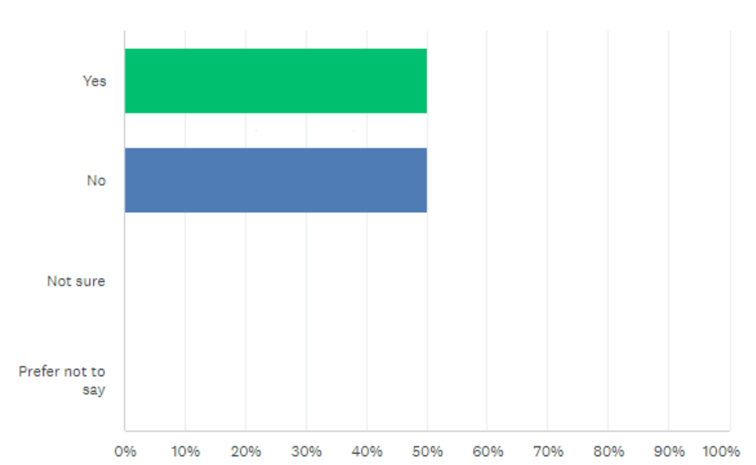
considering whether changes to the Record of Discussion template maybe helpful in prompting this as part of a wider conversation around any other support and accessibility considerations they may need (i.e., interpretation, large print, reading difficulties etc.) as this may also impact how their complaint is communicated to them.



This question had a 50/50 response rate.

The Complaints Co-ordinators try and keep the complainants updated when possible, however, it is not always straightforward getting updates from the divisions due to pressures and capacity issues.

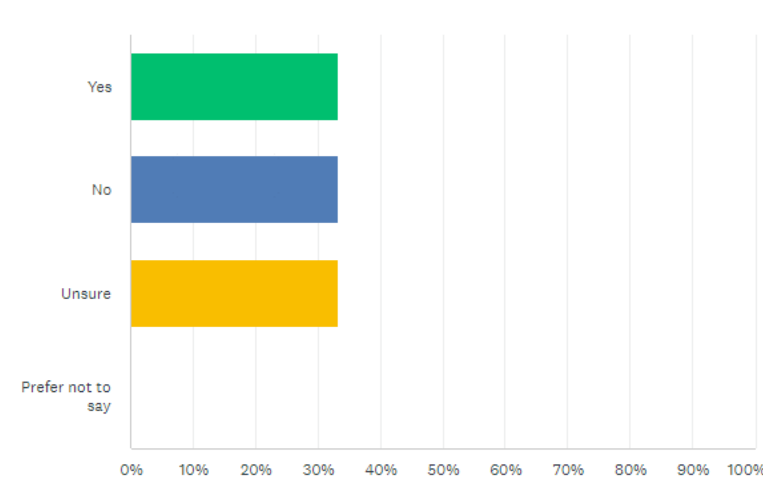
The Complaints Co-ordinators have a weekly catch-up meeting with the PALS Lead where overdue cases are discussed and holding letters are sent to the complainants to inform them that their responses are taking longer than expected and the reason why. These weekly meetings also help with escalating those complaints or concerns where the reason for the delay in response is unclear.



This question also had a 50/50 response rate, which was unanticipated. In response to the previous feedback through HWW, acknowledgement letters were amended to contain a clear date of when a response should be expected by (See appendix 1) .

Acknowledgement letters are sent out the same day as the complaint/concern is logged on Datix. Every complainant receives acknowledgement in writing, either by letter or by email.

The Trust currently works to one of three response timescales, 25 working days, 40 working days and 60 working days.



6 people answered this question and 2 people skipped.

2 people felt their complaint timescale was not kept to. This is an ongoing issue within the Divisions, and for some this is more of a challenge than others. We recognise that responses can be delayed due to operational pressures and capacity issues especially when responses require input from clinical staff as part of the investigation.

We continue to work with the Divisions on promoting the importance of responding within timescale, alongside the importance of early resolution where possible for the mutual benefit of both the complainant and the staff involved with the complaint.

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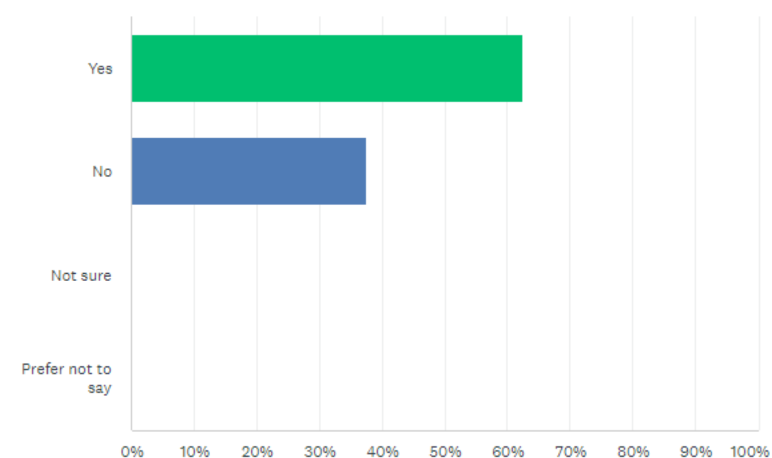


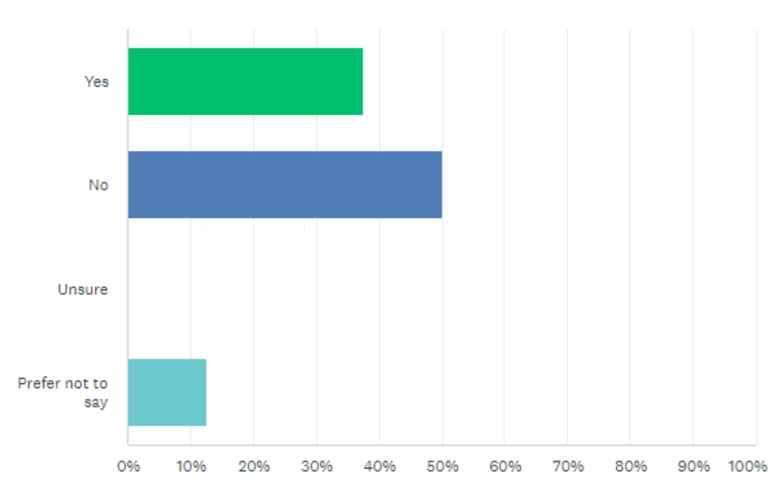
5 people felt their concerns/questions were properly addressed, however 3 people felt they weren't.

Complainants are able to re-open their concerns and complaints if they feel that the matters remain unresolved.

They will be offered further investigation and a subsequent written response or alternatively, we would encourage a meeting be arranged with a view to move towards full closure.

If we are unable to resolve their complaint, we would signpost them to the Parliamentary Health Service Ombudsman for support with resolution. If the complainant is seeking a legal claim, we would advise they seek independent advice. We would alert the legal team and advise the complainant that compensation cannot be obtained through the complaints process.

The PALS Lead has weekly catch-up meetings with the Complaints Co-ordinators which includes looking at the re-opened concerns and complaints and the reasons for re-opening. The main themes were the complainant feeling not all their concerns/questions were answered sufficiently in the response, the response left the complainant with further questions and complainants feeling there were inaccuracies in the hospitals account of events.



4 people felt that their response did not contain a meaningful apology.

The Head of Patient Experience and PALS Lead have been delivering complaints training to departments and teams which includes the importance of a meaningful apology, further work is still needed as for many staff apologies are still heavily associated with an admission of guilt, error or liability.

Targeted training for senior staff (Consultants) is planned for October 2023 and plans to be co-delivered by both PALS and Legal Services to help address this specific issue.

Training packages delivered since January 2023:

17th January 2023 – Band 7 Ward Leads Development Day

24th January 2023 - PALS Services and Complaints – Admin Governance

24th January – F2 Doctors Training

27th January 2023 – Band 7 Ward Leads Development Day

24th March 2023 - Consultants Programme - Communication Skills and Intro to Complaints

12th July 2023 – Band 6 Development Day

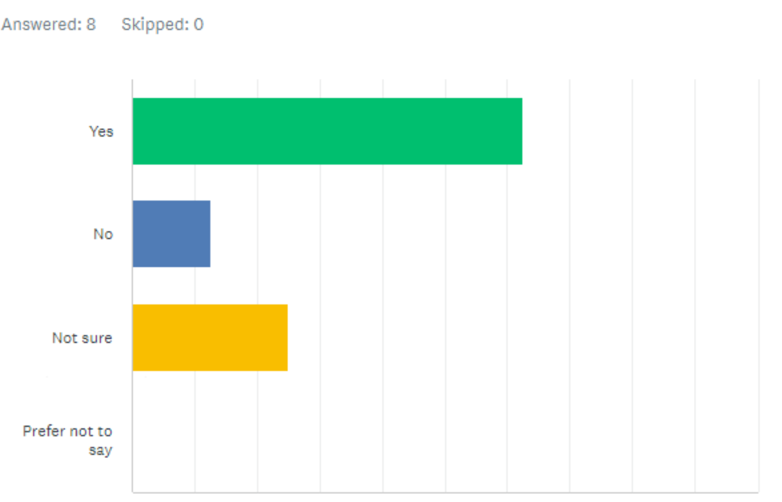
9th August 2023 – Band 7 Ward Leads Development Day

14th September 2023 – Introduction to Complaints and PALS – Maternity

Q10

On receiving the final outcomes of your complaint, did you feel reassured that learning had taken place, and that your complaint had made a difference to how the service will be run in future?

Answered: 8 Skipped: 0



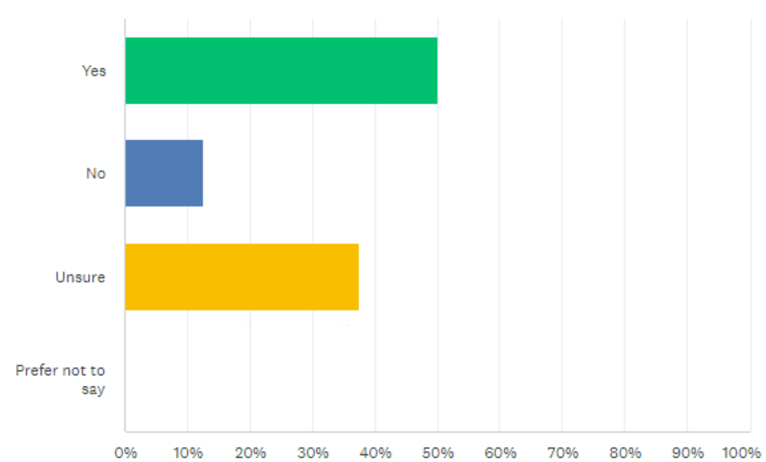
5 people felt that learning had taken place following raising their complaint. 2 people were unsure and one person did not feel reassured learning had taken place.

The PALS team are working closely with the divisions to ensure that learning is shared with the relevant staff and teams. Some divisions are currently working on ideas to follow up with complainants on the learning and actions that have taken place as a result of their complaint. This has been very successful with a couple of families who have come back to visit the wards to see what improvements had been implemented.

Q11

Do you feel the time taken to respond to your complaint was in keeping with the severity and/or complexity of the complaint?

Answered: 8 Skipped: 0

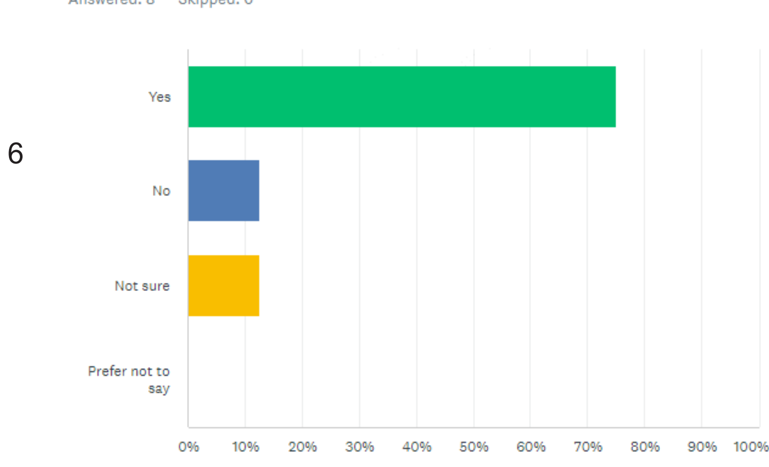


4 people felt the time taken to respond to their complaint was in keeping with the severity/complexity of their complaint. 1 person disagreed with this and 3 were unsure.

Q12

Do you feel that the time and effort involved in making your complaint was properly acknowledged and valued by relevant staff?

Answered: 8 Skipped: 0

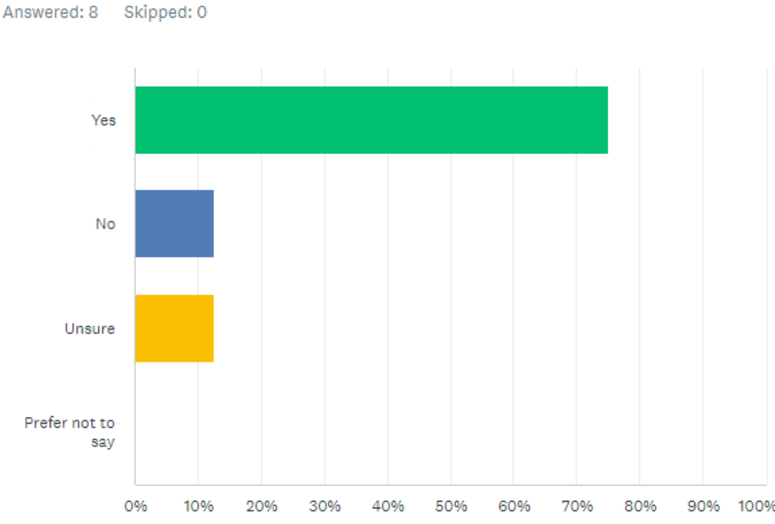


6 people felt that the time and effort involved in their complaint was properly acknowledged and valued by relevant staff.

Q13

Was this response sufficiently personal to you and specific to the nature of your complaint?

Answered: 8 Skipped: 0



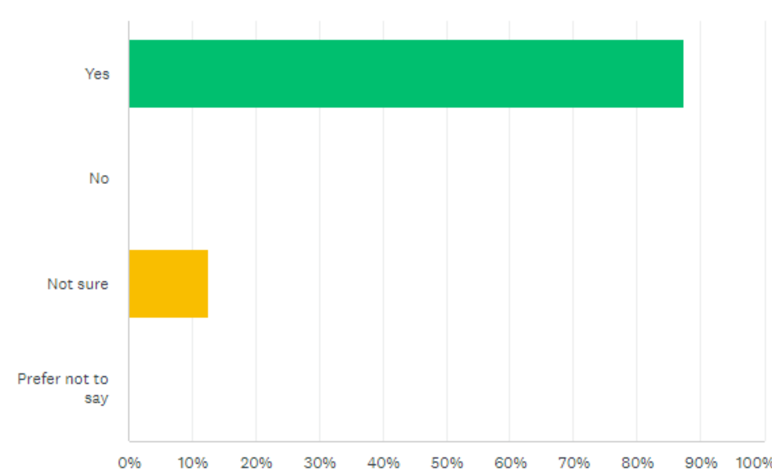
Linking in with question 12 above, 6 people also felt their response was sufficiently detailed and personal to them in regard to the nature of their complaint.

This is a positive response to this question as this is a key feature within the complaints training packages. Emphasis is placed on the importance of compiling a meaningful, personal, and sufficiently detailed response to any complaint or concern.

Q14

Reflecting on your overall experience, would you feel confident in making a complaint in the future if you needed to?

Answered: 8 Skipped: 0

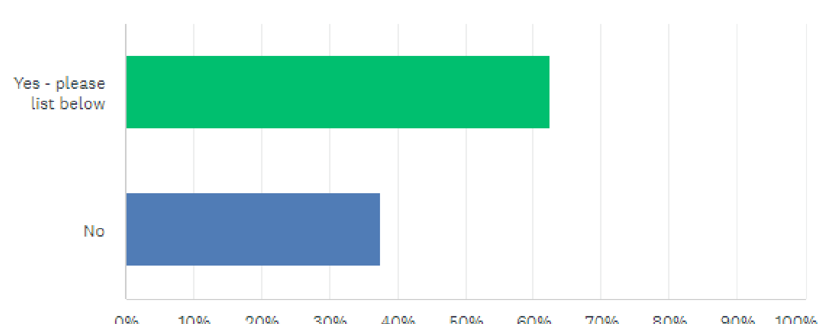


7 people feel confident in making a complaint in the future if they need to.

Q15

Do you have any suggestions about how the complaints process could be improved? (Please do not include any personally identifiable information.)

Answered: 8 Skipped: 0



Below are the suggestions made and it is evident that the main proposal is for better communication throughout the complaints journey and keeping the complainant updated with regards to timescales.

This is something we are already aware of as being a key area for improvement and are working closely with the divisions to improve the timeliness of responses and for better communication regarding any delays so we can cascade this back to the complainant.

I was not kept informed during the process. I constantly had to chase for an update on my complaint. My suggestion is to keep grieving families informed as promised. An email update every 2 weeks. Sending chase emails is not what you want to do when you are grieving.

Maybe use email in the future.

Could be much faster in contacting me with the results of my complaint. It took months.

Better communication but the majority of my complaint was related to poor communication so I am not surprised my complaint was dealt with as it was.

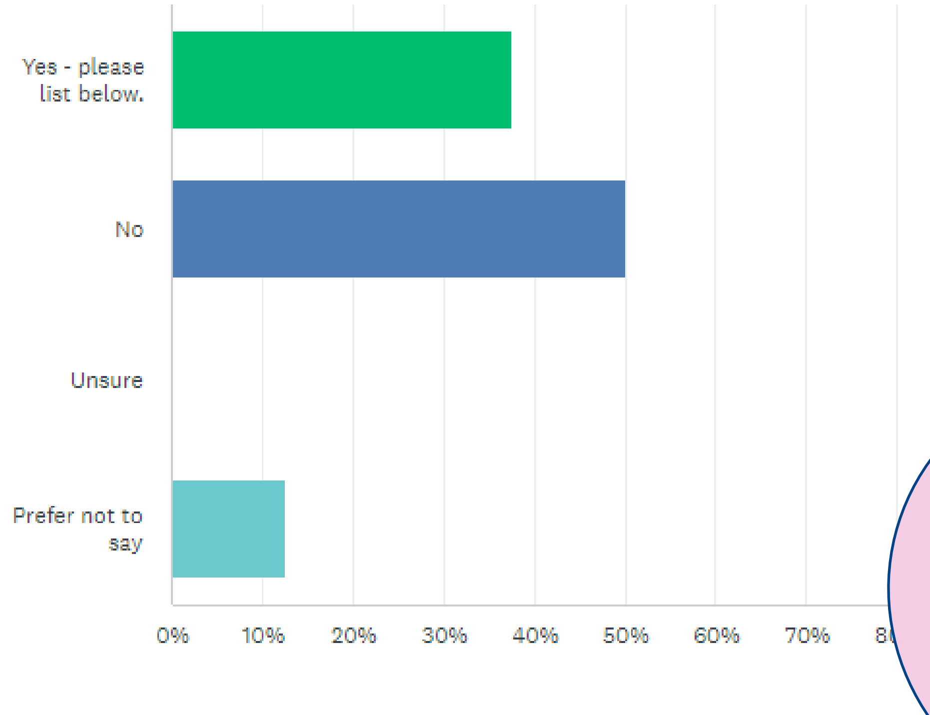
More frequent updates on when the complaint would be finalised.

1. Look at the bigger picture. 2. Acknowledge the failing of putting people at risk still under treatment into such groups. 3. Make the point to the group that where possible?? will help continue to improve facilities and that the NHS cannot pay for everything! 4. Inspect any changed facilities well before starting a new course on the day it is supposed to happen.

Q16

Are there any other comments you would like to make in relation to your experience of the complaints process? (Please do not include any personally identifiable information.)

Answered: 8 Skipped: 0



At this time my complaint is still ongoing and I am awaiting further communication so feel I cannot comment on the whole process at this present time

I think I should have been told who my consultant was and should have been given a choice. Please make sure that all personnel look straight at my face when speaking. I am deaf and looking at a wall or paper or? I can't hear.

My family and I have a long relationship with Salisbury Hospital. I was born there; I was diagnosed with Diabetes when I was a child and received good care and treatment. My Dad, in his later years had several procedures at Salisbury hospital. Cardiology, Audiology, Dementia Care. He was always well looked after. I feel he was let down when he needed Salisbury hospital the most. I do appreciate the outcome letter I received; however, it will take time for me to rebuild my trust with the hospital.

Demographic breakdown

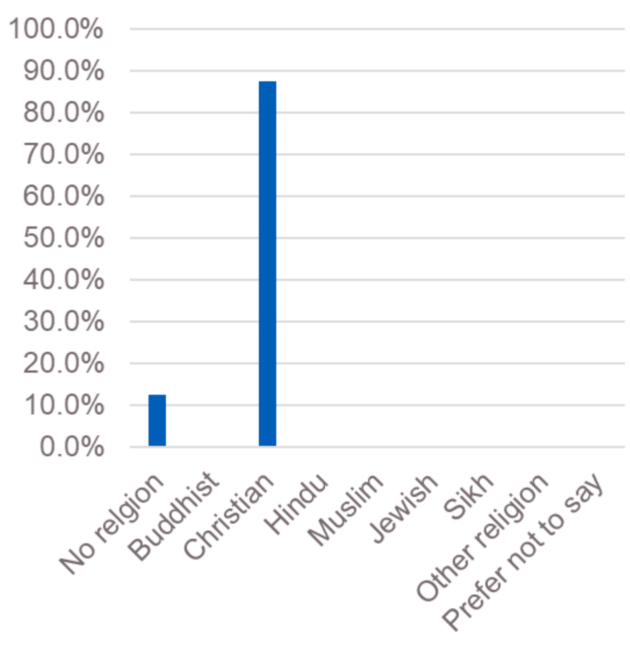
Age

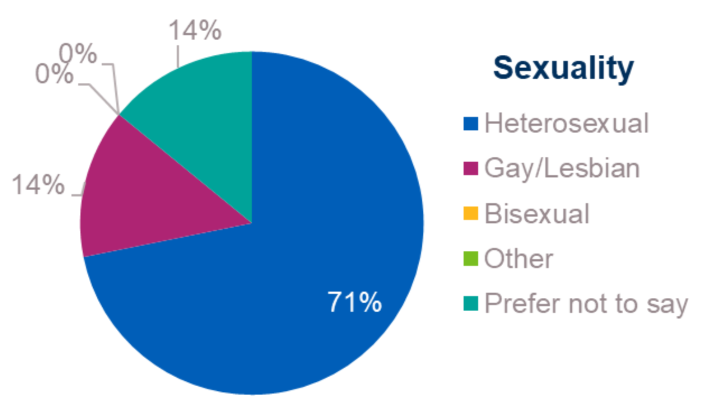
12.5% were aged 35-44
37.5% were aged 45-54
12.5% were aged 65-74
25.0 % were aged 75-84
12.5% were aged 85+

Ethnicity

25% of those surveyed were British
75% were English

Religion





Gender

0.0%
25.0%
75.0%

- Male
- Female
- Prefer not to say

Long term health condition or learning disability

62.5% said yes
37.5% said no

Next steps / report recommendation

After reviewing the survey results and comments, the main issues identified were the lack of signposting to additional support such as Advocacy services, timescales of responses not being adhered to and updates not being provided throughout the complaints process.

With regards to accessing additional support, we have highlighted this more thoroughly in our new PALS leaflet and also include all advocacy services in the acknowledgement letter which every complainant receives.

Action: The PALS Team to discuss additional support options at first point of contact.

Timescales of responses not being kept to is an ongoing issue, however, the PALS Lead and Complaints Co-ordinators are working closely with the respective divisions to support where necessary and help them move towards the Improving Together Target of 90% . The PALS Lead and Complaints Co-ordinators have weekly catch-up meetings to identify any cases that are overdue that are causing concern and these are then highlighted with the Investigating Manager for a response to be shared as soon as possible or an update to be shared regarding the reason for the delay so that proactive contact can be made to the complainant.

Keeping the complainant informed and actively involved in their complaints journey is also something the PALS team are working hard to improve. We have already made changes to the acknowledgement letters, clearly allocating the reference number and the name of the Complaints Co-ordinator handling their case so there is continuity throughout the process. Holding letters and phone calls are communicated to the complainant once PALS have been notified of any change/delay to their response and the reasons why. It can sometimes be challenging getting updates from the divisions making it difficult to update the complainant accordingly, however, this does seem to be improving.

Moving forward, the PALS team need to look at ways of getting better engagement regarding the complaints surveys so we have more data to analyse. We also need to consider modification of the survey to allow correlation of experience by division so we can better target feedback and improvements.

Action: Look at different ways of sending the surveys out and being able to determine which division they relate to.

Sophie Brookes – PALS Lead

Appendix 1 – Acknowledgement letters

Acknowledgement letter 25 working da

Acknowledgement letter 40 working da

Acknowledgement letter 60 working da

Realtime Feedback Comments – Q3

Sometimes conversations of a confidential nature can be overheard

Very appreciative of the staff and the hospital.

Doesn't feel she is listened to as an individual.

Really appreciated the benefit of the stars appeal.

Wonderful in this particular ward - the staff are amazing across the whole trust.

Disturbed by moving patients at night.

My overall experience has been very poor

Not my first time in this hospital but have always had a very good experience

The nurses are lovely- wonderful and cheery

Sometimes there is a communication problem or difficulty in understanding.

Patient thinks Salisbury is an excellent hospital. Has been a patient in Salisbury on and off for 6 years and always treated well.

The staff work jolly hard

Whiteparish has been refurbished, but there are no TV's – why?

The staff have been very kind and friendly

Things are not so good at the weekends

TV's can be loud at night. There are not enough headphones available

I would welcome Asian options. As an Asian I prefer noodles and rice

Appreciate choice of fruit and salad

The night staff seem less able than the day shift

I have to walk to the other ward for bathroom facilities

I used meditation for my MRI procedure. This should be an option for all patients

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	6.3.1
Date of meeting:	7 March 2024		

Report tile:	Q3 Learning from Deaths Report 2023-24			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	Mortality Surveillance Group Clinical Governance Committee 27 February 2024			
Prepared by:	Dr Ben Browne, Associate Medical Director			
Executive Sponsor: (presenting)	Dr Peter Collins, Chief Medical Officer			

Recommendation:

The paper is to provide assurance that the Trust is learning from deaths and making improvements.

Executive Summary:

The Trust MSG met on 14th November 2023 in Quarter 3 (Q3), where learning, improvement themes and actions arising from mortality diagnosis group alerts and individual case reviews were discussed.

There were 254 inpatient deaths during Q3, which was an increase on the relatively lower numbers that had been observed across the Trust during Q2 (193 inpatient deaths). This figure is inclusive of patients who died in either the Emergency Department or Hospice.
38 of these deaths occurred in the hospice, and this compares to 45 during Q2.

During Quarter 3 there was/were:

- 7 deaths where COVID-19 was the primary cause of death (recorded as 1a on the death certificate).
- 3 stillbirths.
- 0 maternal deaths.
- 2 deaths reported in a patient with a learning disability.
- 4 deaths in patients considered to have a serious mental illness.

The full breakdown of these figures is shown in the mortality overview table show on page 4 of the main report.

- A total of 248/254 deaths were scrutinised by the Medical Examiners (MEs) in Quarter 3. There has been a consistent increase in the case numbers being reviewed by the ME when compared to previous quarters:
- Q1: 92%
- Q2: 97%
- Q3: 98%

- 20 Structured Judgement Reviews (SJRs) were requested by the MEs in Q3 (approximately 8% of all inpatient deaths). This is comparable to the national average of around 10%.

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Other:

- A BSW join mortality group was established during Q3 and was attended by staff from SFT.
- A mortality insight visit was requested by the Trust Board and took place during Q3.
- Progress has continued to be made with the development of our new electronic mortality reporting tool (AMaT), which remains on track to be launched in March 2024.

End of Life Care

The Your Views Matter Bereavement survey aims to capture the views and experience of bereaved families.

During Quarter 3:

- 135 families gave consent for the Trust's Your Views Matter bereavement survey to be posted (an increase from 88 in Q2).
- A response rate of 36% (n~ 48) was achieved.
- 81% of respondents rated the overall end of life care as good or very good (up from 76% in Q2).

National Benchmarks

Latest SHMI (as reported by NHS Digital at the time of publication):

- The SHMI is within the expected range for both the Trust (inclusive of hospice) and District Hospice (excludes hospice).

HSMR:

- A two-month time lag continues to be applied to the HSMR data to improve the accuracy of data for the 12-month period. This is due to a potential coding backlog for the two most recent months of discharge data. ***Therefore, the latest HSMR is for the 12-month rolling period ending in August 2023.***

  - The HSMR for the Trust (includes hospice data) and District Hospital (excludes hospice data) are both statistically higher than expected.
  - Weekday and weekend HSMR for the Trust are both statistically higher than expected. However, weekday figures fall to within the expected range with the hospice data excluded.

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

QUARTER 3 2023/24 LEARNING FROM DEATHS REPORT

February 2024

A summary document outlining the learning from deaths at Salisbury NHS Foundation Trust during the third financial quarter of 2023/24. Data correct as of 07.02.202 [unless otherwise stated in the report]

GLOSSARY OF TERMS

CHARLSON COMORBIDITY INDEX (CCI) SCORE
The Charlson Comorbidity Score is a method of measuring comorbidity. It is a weighted index that predicts the risk of death based on the number and severity of 19 comorbid conditions.

CUSUM
A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues. The CQC monitor CUSUM's at a 99.9% threshold to determine outliers.

HSMR
The Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity.

ME
Medical examiners (MEs) are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. The purpose of the medical examiner system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths, ensure the appropriate direction of deaths to the coroner, provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased, improve the quality of death certification, and improve the quality of mortality data. The Medical Examiner (ME) system was introduced in April 2020 and was established in the Trust by August 2020.

MSG
The Mortality Surveillance Group (MSG) meets bi-monthly and is responsible for reviewing deaths to identify problems in care and commissioning improvement work, to reduce unwarranted variation and improve patient outcomes. To identify the learning arising from reviews and improvements needed.

PALS
The Patient Advice and Liasion Service (PALS) offers confidential advice, support and information on health-related matters and they provide a point of contact for patients, their families and their carers. A complaint is an expression of dissatisfaction made to an organisation, either written or spoken, and whether justified or not, which requires a formal response from the Chief Executive. A concern is a problem raised that can be resolved/responded to by the clinical or non-clinical teams concerned. Concerns include issues where the patient/family member has said that they don't want to make a formal complaint.

RESPECT
The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) provides a personalised recommendation for an individual's clinical care in emergency situations whether they are not able to make decisions or express their wishes.

SFT
Salisbury NHS Foundation Trust.

SHMI
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. It covers in-hospital deaths and deaths that occur up to 30 days post discharge for all diagnoses excluding still births. The SHMI is an indicator which reports on mortality at trust level across the NHS in England and it is produced and published as an official statistic by NHS Digital.

SII
Serious Incident requiring Investigation.

SJR
The Structured Judgement Review (SJR) is a process for undertaking a review of the care received by patients who have died.

SMR
A calculation used to monitor death rates. The Standardised Mortality Ratio (SMR) is the ratio of observed deaths to expected deaths, where expected deaths are calculated for a typical area with the same case-mix adjustment. The SMR may be quoted as either a ratio or a percentage. If the SMR is quoted as a percentage and is equal to 100, then this means the number of observed deaths equals that of expected. If higher than 100, then there is a higher reported mortality ratio.

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SOX

Sharing Outstanding Excellence (SOX) is a method of paying a compliment to a team or a member of staff. It is a way of learning from when things go well.

Learning from Deaths Report – Quarter 3

1. Purpose

To comply with the national requirements of the Learning from Deaths framework, Trust Boards must publish information on deaths, reviews, and investigations via a quarterly report to a public board meeting.

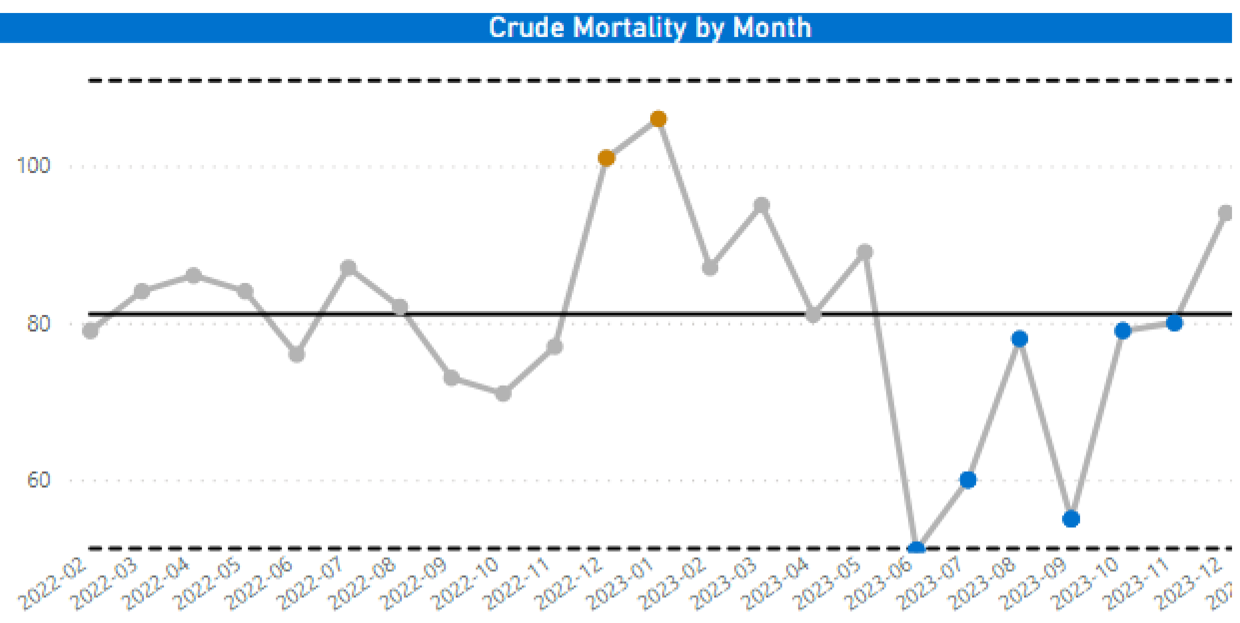
2. Background

The Learning from Deaths initiative aims to promote learning and improve how Trusts support and engage bereaved families and carers of those who die in our care.

3. Learning from Deaths in Q3

The hospital mortality group (MSG) met on 14th November 2023 in Quarter 3 (Q3), where learning, improvement themes and actions arising from mortality diagnosis group alerts and individual case reviews were discussed. The learning outlined in this report reflects a summary of the key highlights during this period and the information reviewed and discussed at the MSG.

3.1. Data Overview



The graph above has been obtained from our newly developed Power-Bi data dashboard. It shows the number of deaths occurring in SFT as reported monthly.

Below average numbers were observed between June to December 2023. The mortality rate increased during quarter 3 (Q3) and during the month of December, but these numbers remain comparable/lower than the figures seen in 2022/23. The graph and table on the next page provide a further breakdown of these figures.

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Mortality Overview

Total Deaths as Reported by the Medical Examiner: Apr-22 - Dec-23

Number of Deaths

100
80
60

2022-04 2022-05 2022-06 2022-07 2022-08 2022-09 2022-10 2022-11 2022-12 2023-01 2023-02 2023-03 2023-04 2023-05 2023-06 2023-07 2023-08 2023-09 2023-10 2023-11 2023-

Mortality Overview: Apr-22 - Dec-23

Year-Month	Total Deaths as Reported by the ME	Deaths Reviewed by the ME	SJRs Requested by the ME	ED Deaths	Hospice Deaths	Covid19 as Primary Cause of Death (1a)	Total Stillbirth Deaths	Late Miscarriage 22 - 23+6 Weeks	Stillbirths >24+0 - 36+6	Stillbirths >37+0	Total Neonatal Deaths	Total Maternal Deaths	Total Learning Disability Deaths	Total Serious Mental Illness Deaths
2023-12	95	92	4	7	16	0	1	0	1	0	0	0	0	0
2023-11	80	78	10	4	10	4	2	0	2	0	0	0	1	1
2023-10	79	78	6	3	12	3	0	0	0	0	0	0	1	3
2023-09	55	54	1	2	15	1	0	0	0	0	0	0	0	1
2023-08	78	75	6	2	17	1	0	0	0	0	0	0	0	2
2023-07	60	58	5	1	13	0	0	0	0	0	0	0	1	1
2023-06	51	49	1	0	9	0	1	0	1	0	1	0	0	0
2023-05	89	80	8	3	15	2	0	0	0	0	0	0	4	0
2023-04	81	74	6	3	17	3	0	0	0	0	0	0	0	0

Learning Continued:

Summary of Learning in Q3

3.1.1. A **BSW joint mortality group** was established in Q3 (chaired by the Deputy Chief Medical Officer of the local Care Board (ICB)), and the first meeting took place in October 2023. The shared objectives for the group were agreed, and processes for learning (across each of our local hospitals) were discussed to help identify areas for greater alignment. It is anticipated that future agenda items will include the review of more population data and mortality statistics from across the region, thus enabling the hospital to better understand how the provision of care across the system (in and outside of hospital) may impact on place of death.

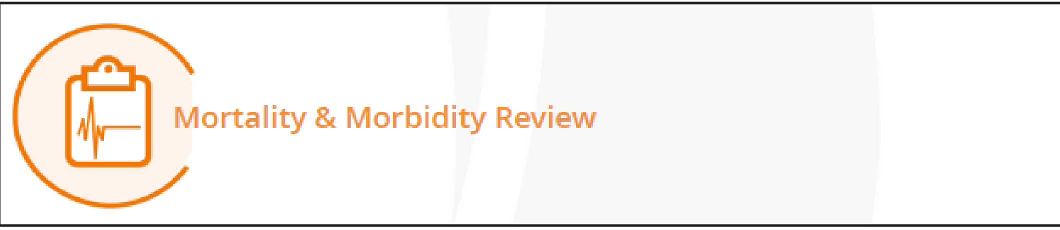
3.1.2. The hospital board had recently requested for NHS England to undertake an **external review of the hospital's mortality governance processes**. The purpose being to ensure that the hospital is taking all reasonable steps to understand and act on the significant and sustained change seen in the hospital mortality benchmarking statistics. This review took place in December 2023 and some verbal feedback was received at the time of the review. The full report is expected to be received during quarter 4 (Q4). The feedback suggested that no significant clinical risk to patients cared for in Salisbury hospital had been identified. However, several recommendations were made; for instance, the need for our clinical and coding teams to work more closely to ensure that data quality is improved. An action plan has been developed and will be reviewed at the hospital's next mortality meeting. It is expected that the full report from NHS England will have been formally received by this time and will also be discussed at this meeting.

3.1.3. Mr Richard Cole's term as **Trust Mortality Lead** ended in September 2023. However, he has continued to provide leadership and support for the roll out of the hospital's new mortality reporting tool whilst ensuring that there is continuity until a new clinical lead is appointed. Mr Cole has been integral to supporting the hospital's learning from deaths process over the past year, and we thank him for the tremendous support that he has given to the organisation and in helping to improve the quality of care for our patients and staff.

3.1.4. Using data from our partners (Telstra U.K.), **alerts** are sometimes generated when the observed numbers of deaths exceed expected numbers for a particular group of patients, and these alerts are routinely reviewed at the Trust mortality meeting. An alert was recently generated for patients admitted with syncope (a temporary loss of consciousness caused by a fall in blood pressure) and a review of each of the patient's inpatient record was undertaken during Q3 to help identify any areas for learning. Overall, the number of patients triggering the alert was small and patients appeared to receive good overall care during their inpatient stay. There were regular reviews undertaken by the medical team with evidence of good decision-making. There was also good recognition of patient deterioration, timely escalation, and prompt actions, with good evidence of shared decisions being made with families and carers of these patients. One patient was noted to have a particularly long inpatient stay and potential areas of learning and improvement related to this have were discussed.

3.1.5. Three new 'alert' reviews were commissioned in quarter 3 and have been assigned to various reviewers with specialist knowledge in these areas. The learning from these reviews will be presented and discussed in a subsequent mortality meeting ('aspiration pneumonitis,' 'leukaemias,' and 'septicaemia (except in labour')).

3.1.6. Our **new mortality reporting tool** (using a system called Audit Management and Tracking (AMaT)) is on schedule to be formally launched in March 2024.



3.1.7. As part of the development of the mortality system, 50 consecutive mortality reviews from quarter 3 were analysed in depth to check the functionality of its proposed categories for documentation of learning content. This analysis enabled an evaluation of learning recorded during this period and of how effective the design might be for the move to online collection of information relating to this important component of mortality reviewing. The results are shown in table 1. Below, according to each defined learning category:

Table 1. Categorisation of learning points

Category (with *examples* of typical comments)	Positive comments	Negative comments
1. Assessment, investigation or diagnosis	3	0
2. Medication/IV fluids/electrolytes/oxygen/ VTE prophylaxis *"Early focus on symptom control"*	2	0
3. Treatment and [ongoing] management plan *"Early involvement of palliative care team"* *"Good involvement of other clinical specialties"* *"Earlier palliative care input"*	8	5
4. Infection control management	1	0
5. Operation/invasive procedure	0	0
6. Clinical monitoring incl charts; deteriorating patient *"Appropriate responses to changing clinical picture"*	6	3
7. Resuscitation following a cardiac or respiratory arrest	0	0
8. EoLC support/delivery *"Good end of life practice"* *"Non-completion of Respect form"* *"Earlier Advanced care planning*	16	5
9. Falls	0	0
10. Pressure ulcer	0	0
11. Transfers (internal/external)	0	2
12. Mental illness or Learning disability	1	0
13. Other problem not fitting in the categories above:		
Blood Transfusion	0	0

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Communication -between teams	7	1
-with patient	3	1
-with relatives/carers *"Good communications with family"* *"More regular updates to family"* *"Good discussions with family"*	20	5
Consent	0	0
Dementia / Delirium	0	0
Documentation *"Documentation of investigations suggesting potential deterioration"*	1	1
Medical Device or Equipment Mortality or Morbidity Nutrition Patient Flow Patient Safety & Safeguarding Staffing	}0	}0

3.1.8. An assessment of the learning documented in more reviews has been made possible because of the introduction of a ‘checklist’ proforma for mortality cases. These are reviews which have not been triggered because of specific concerns raised by the Medical Examiners and are therefore in most cases being done routinely. This is enabling the Trust to now collate learning (in a standardised way) from a greater number of cases, thus presenting a more balanced report on overall patient care across the organisation.

There was a total of 69 positive learning comments and 23 negative ones identified. As there were often several comments on each review template in the learning/actions section, including a mixture of both positive and negative learning, the total number of comments exceeds the number of mortality reviews undertaken.

3.1.9. An example of quality improvement arising from these learning points includes one about communications relating to end-of-life care (EoLC) where, despite many positive comments which help to keep an overall perspective on the Trust's good standards, there may be scope for change. At a previous Trust mortality meeting it was suggested that ward staff should be more proactive in contacting relatives or carers. This would mean that a member of staff who knows the patient's clinical and background situation could make the call to the relative or carer, as opposed to the usual situation when a staff member not so familiar with the case might receive an incoming call when a more familiar colleague is otherwise occupied or not present on the ward. The evidence from our mortality reviews has supported this change in approach and for a pilot to now be developed.

3.1.10. With all learning and actions accessible to analysis in the new online platform, it will become easier to identify specific clinical areas or wards, for example, where a problem is occurring, enabling more targeted improvements to be made. Clinical areas with low or absent negative comments can be identified and approached for indicators of best practice which can then be shared more widely. It is important to capture evidence of good practice via these positive comments and not just focus on problems with care (which is a significant component of Structured Judgement Reviews) because the Trust can then obtain a balanced view of overall patient care and safety, as well as of good practice relating to EoLC. It also gives encouragement to staff by acknowledging and documenting when they are delivering good or excellent care. An additional benefit of standardisation of our learning

and action categories is that they have been designed to be aligned with the Trust's current adverse event subtypes and future Patient Safety Incident Response Framework (PSIRF) themes. This allows analysis across both datasets (mortality review and PSIRF) for specific clinical or service delivery issues to the benefit of patient safety and care. The same structures and categories could be adopted across neighbouring cooperating Trusts to add to the pool of data collected within the same standardised framework. This creates the potential to increase the opportunities for shared learning and quality improvement across wider health care systems.

3.2. End of Life Care

3.2.1. The Your Views Matter Bereavement survey was established in 2020 and was created to capture the views and experiences of bereaved relatives. This is an opportunity for families to feedback their experiences about the support they themselves received and the end of life care their loved one was given during their last days of life in Salisbury Hospital. Whilst the feedback is anonymous, relatives can name individuals they would like to acknowledge and thank for making a difference. Likewise, where the experience was less than satisfactory those completing the survey also have the option to enclose their contact details and be followed up by the PALS team.

3.2.2. Your Views Matter Bereavement survey was posted to 135 families in Q3 with their consent, 48 (36%) responding. This is a significant increase on Q2, with more than double the responses. Responses this quarter are noted to be higher than the average response rate seen for 2022-2023 (28%) and much closer to the average response rates previously seen for 2021/22 (39%).

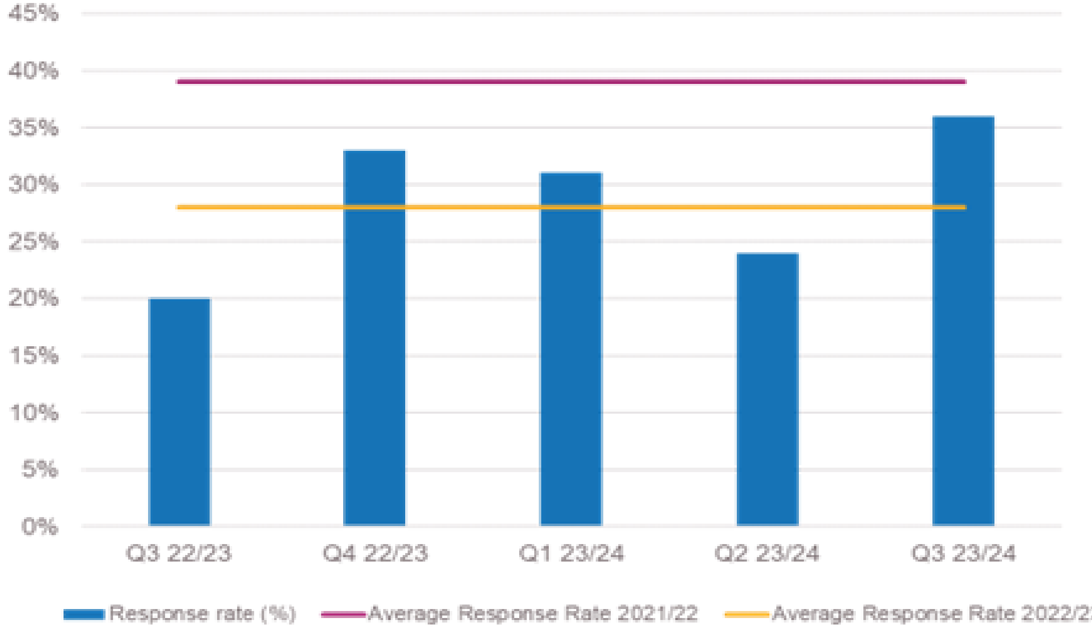

Figure 1.1 Response rates

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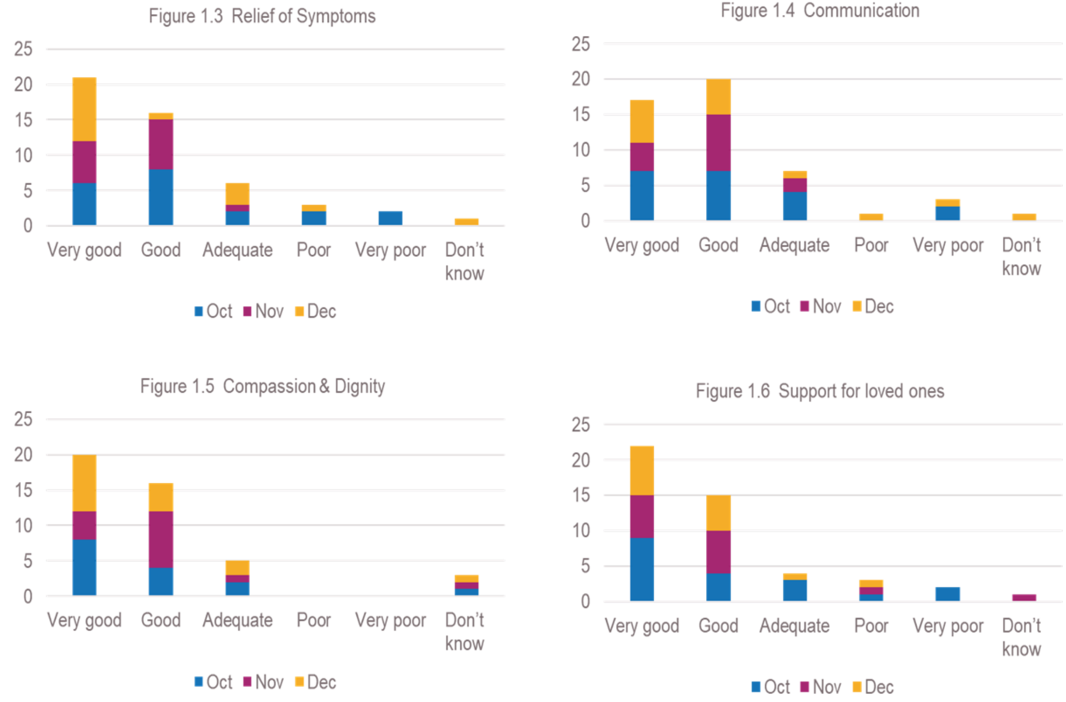
3.2.3. 81% of respondents rated the overall end of life care as good or very good. This is the highest proportion we have seen since reporting began in Q2 21/22. Poor/Very Poor ratings were also noted to be at their lowest since reporting began.

2 survey participants requested a call-back from PALS, 1 of these was logged as a formal complaint with letter to CEO. This is a reduction by half for Q2 for the number of call-backs made by PALS.

Figures 1.3 to 1.6 show the overall ratings in the key areas of patient experience.



3.2.4. Overall, all four focus areas are rated as good or very good. Compassion and dignity continue to be an area of positive patient experience.

3.2.5. There continue to be some negative themes around facilities and appropriateness of the room or ward where someone dies. The key themes were lack of privacy, and noise. There was a noted decrease in those who felt that the room/ward in which their loved spent their last days was appropriate (83% in Q2 compared to 69% in Q3). There was a total of 25 comments made about the bereavement office (compared to 8 in Q2). These continue to be largely positive comments.

The able below shows the overall satisfaction rating from the bereavement survey results

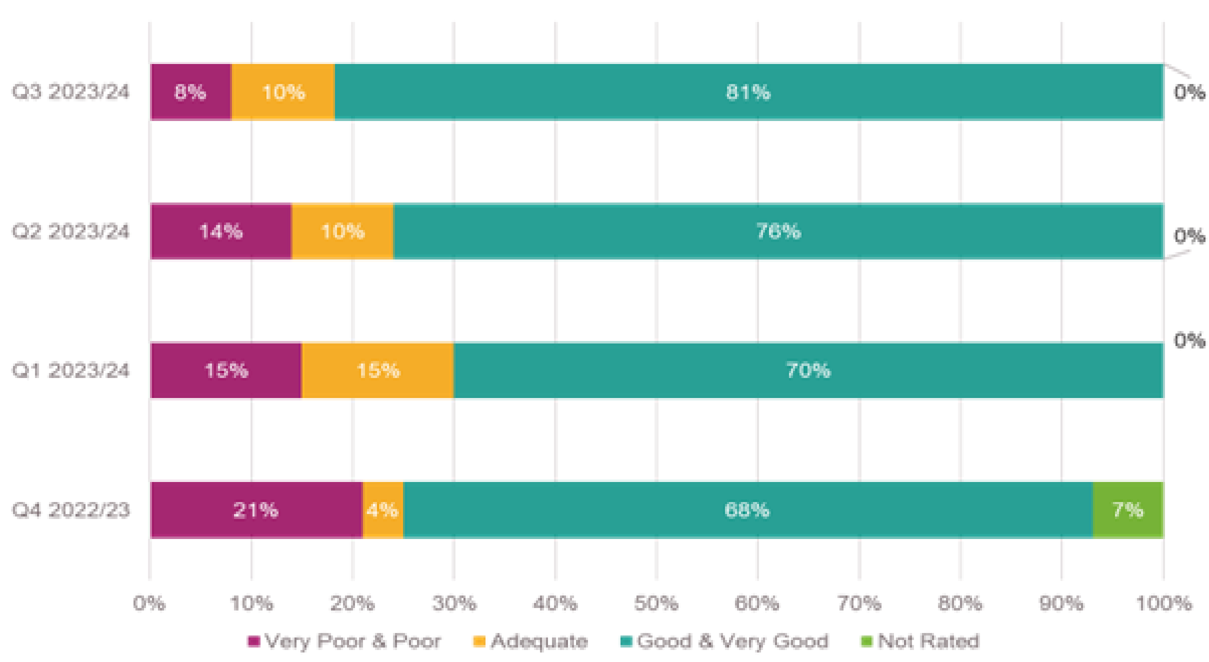


Figure 1.2 Satisfaction rating

3.3. Medical Examiners (MEs)

3.3.1. The ME system was introduced to ensure excellence in care for the bereaved and learning from deaths to drive improvement. The Medical Examiners aim to scrutinise all acute hospital deaths, and a local network of MEs exists to share learning and provide an independent review facility if needed.

3.3.2. 20 Structured Judgement Reviews were requested by the Medical Examiners in Q3 out of a total of 248 patients cases reviewed. Overall 98% of all patients who died whilst under the care of SFT were subject to a Medical Examiner review during Q3.

3.3.3. A small number of reviews were requested under our mandated categories of patients with a learning disability/autism (2) and/or serious mental illness (4) in Q3. As per recent changes (to improve scrutiny and learning from these case types), these cases will be subject to a mortality review (using the validated SJR method) and will also be reviewed by our learning disability/autism nurse and/or shared with our mental health steering group for further triangulation and specialist review for learning. This is in addition to the learning disability /autism cases being submitted to the national LeDer programme (NHS England » Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) .

3.3.4. The requests (identified through ME screening) continue to be categorised into problem themes and stage of care (see table below). Some requests can fall into multiple categories. Where requests do not fit into any of the categories below, this may be because the ME has requested a review for a specific group of patients, e.g., where a serious mental illness or learning disability has been identified but no obvious problems in care were identified during their initial screening. This process of tracking and reviewing the learning and actions will improve significantly once the online mortality platform goes live in March 2024.

Type of problem	*Stage of Care* →								
	Admission and initial assessment (first 24 hours)	Ongoing care	Care during a procedure	Perioperative/procedure care	End of life care (or discharge care)	Concerns about over all care	**2023/24 YTD**	**2022/23 YEAR TOTAL**	***2021/22 YEAR TOTAL***
Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)							*1*	*7*	*17*
Problem with medication / IV fluids / electrolytes / oxygen		*1*	*1*				*3*	*5*	*3*
Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)		1				2	*6*	*8*	*7*
Problem with infection control						*1*	*1*	*0*	*0*
Problem related to operation/invasive procedure (other than infection control)							*2*	*2*	*4*
Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)						*4*	*6*	*7*	*13*
Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR))							*0*	*0*	*0*
Problem of any other type not fitting the categories above						10	*28*	*26*	*24*
2023/24 YTD	*1*	*5*	*1*	*1*	1	38			
2022/23 YEAR TOTAL	*6*	*15*	*0*	*0*	*5*	*30*			
2021/22 YEAR TOTAL	*9*	*24*	*3*	*3*	*4*	*25*			

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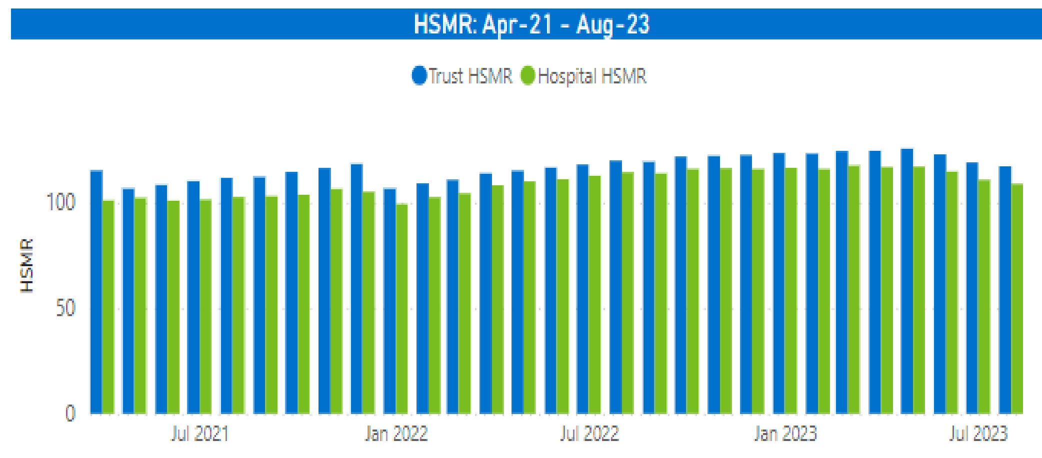
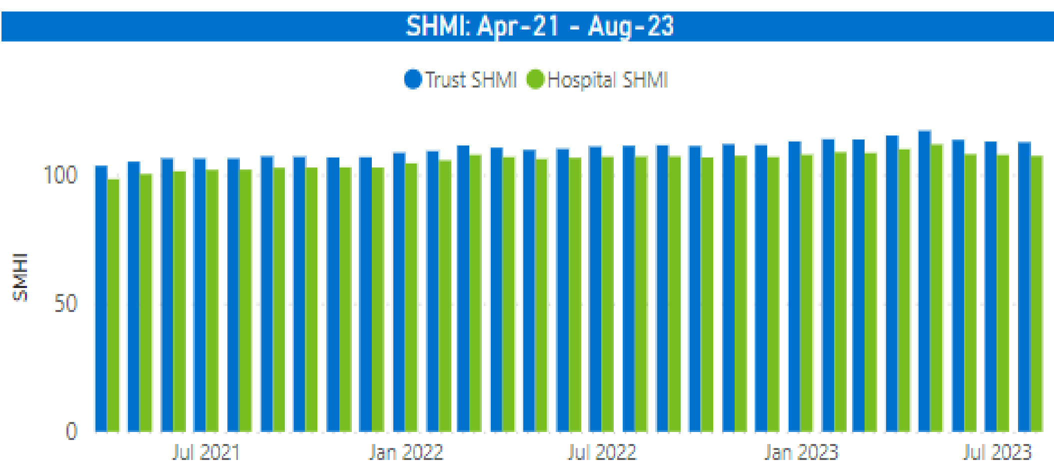
APPENDICES – Mortality Supplementary Data

1. HSMR and SHMI rolling 12-month trend to August '23

1.1. A two-month time lag has been applied to the HSMR data to improve the accuracy of data for the 12-month period. This is due to a potential coding backlog for the two most recent months of discharge data. Therefore, the latest HSMR is for the 12-month rolling period ending in August 2023. Both the HSMR and SHMI have seen a positive decline in the past three months, which is likely to be linked to the lower crude mortality figures observed during this period.





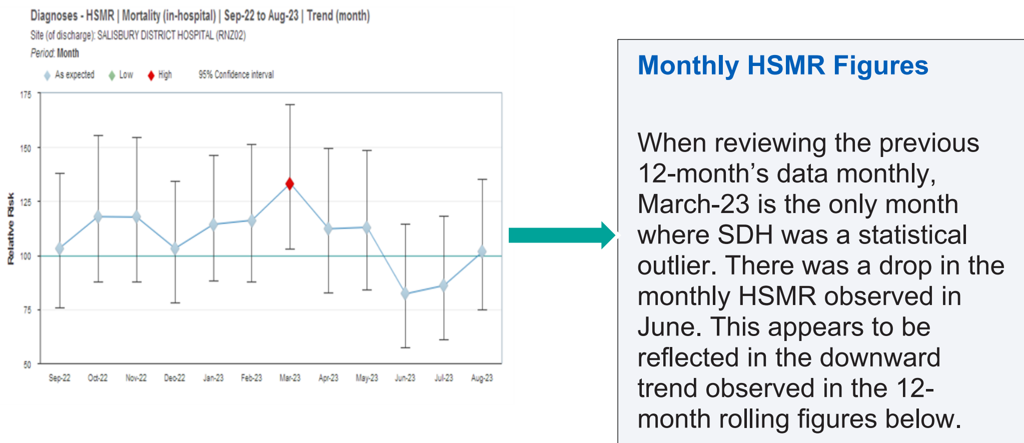
2. HSMR rolling 12-month trend to August '23

2.1. The HSMR (relative risk) for the Trust (includes hospice data) for the twelve-month period ending in August 2023 is **117.1** and is statistically higher than expected (108.9 – 125.9, 95% confidence limits).

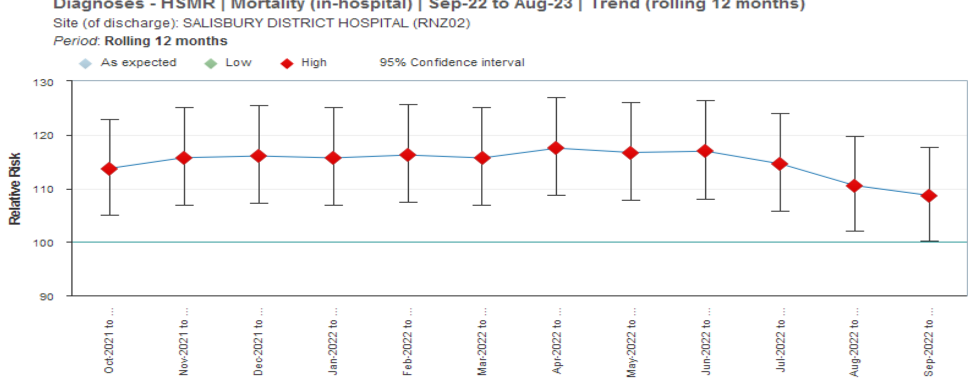
2.2. The HSMR (relative risk) for Salisbury District Hospital (excludes hospice data) for the twelve-month period ending in August 2023 is **108.7** and is statistically higher than expected (100.2 – 117.7).

2.3. Weekday HSMR is **110.4** and weekend HSMR is **134.0**. Both are statistically higher than expected. For Salisbury District Hospital (excludes hospice data) this is **102.9** and **127.3** respectively. Weekend HSMR is statistically higher than expected. Weekday figures fall to within the expected range with the hospice figures excluded.

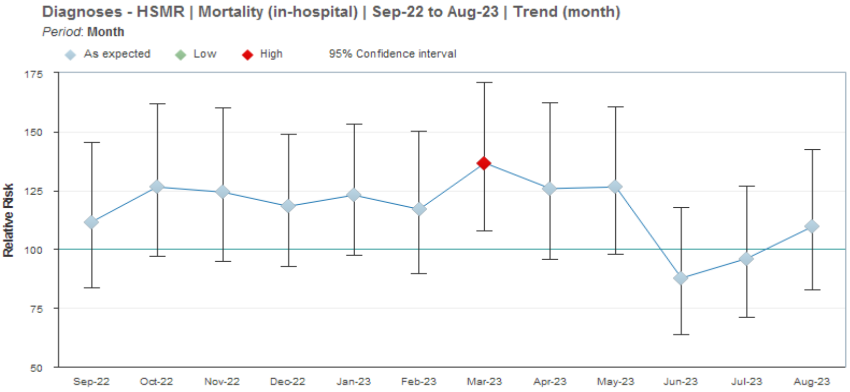
Salisbury District Hospital HSMR [Excludes Hospice Data] – Monthly Trend



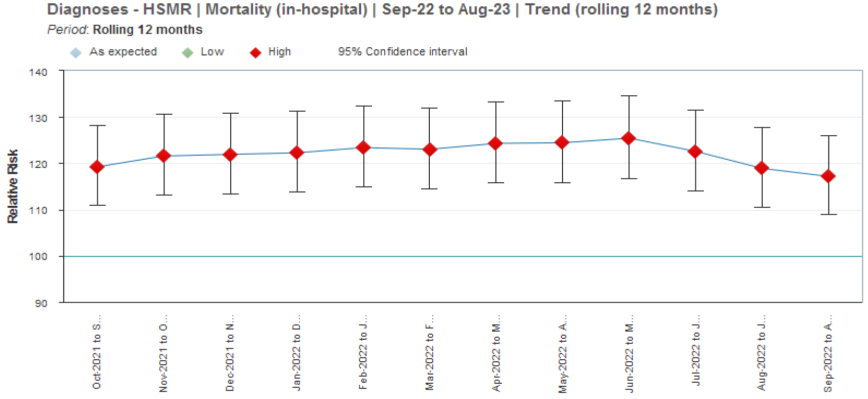
Salisbury District Hospital HSMR [Excludes Hospice Data] – Rolling 12-Month Trend



Trust HSMR [Includes Hospice Data] – Monthly Trend



Trust HSMR [Includes Hospice Data] – Rolling 12-month Trend



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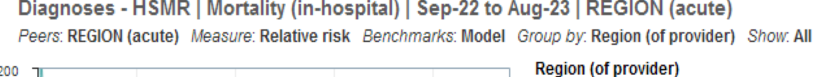
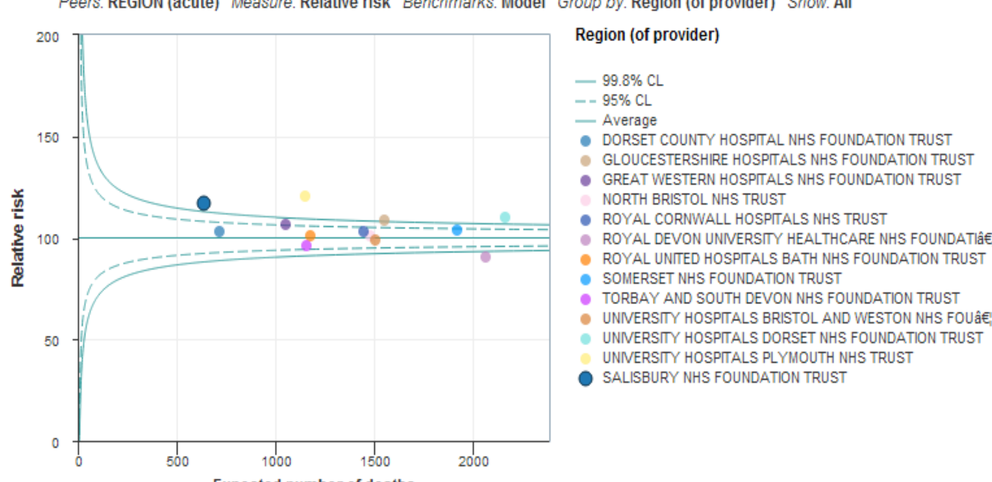
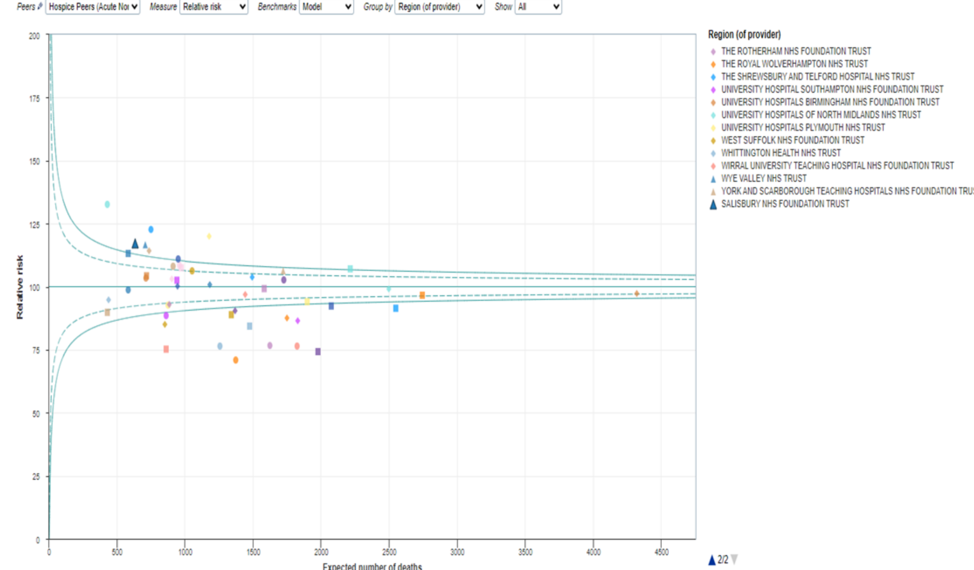
Trust HSMR [Includes Hospice Data] Peer Comparison Rolling 12-month Trend.

Regional Acute Trusts





Hospice Peers



3. Summary Hospital-Level Mortality Indicator (SHMI) for September 2022 – August 2023

3.1. The SHMI (includes hospice data) is an indicator which reports on mortality at Trust level across the NHS in England and it is published as an official statistic by NHS Digital. The latest available data is published in this report.

3.2. The Trust SHMI is **1.1256** for the twelve-month period ending in August 2023 and is within the expected range (NHS Digital Data). When comparing SHMI by site, Salisbury District Hospital is **1.0722** and Salisbury Hospice is **2.4757.**

3.3. The SHMI is also within the expected range when our hospice data is removed.

Site level breakdown (experimental statistics)

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value
RNZ02	Salisbury District Hospital	31,000	995	930	1.0722
RNZ78	Salisbury Hospice	125	90	35	2.4757

3.4. The tables at the end of this report show additional data for SFT as a breakdown for specific conditions for the twelve-month period ending in August 2023.

SHMI data for the 12 Month Period Ending in August 2023

SHMI - Summary Hospital Mortality Indicator

Period: Sep 22 - Aug 23

Provider: RNZ - SALISBURY NHS FOUNDATION TRUST

Region: NHS ENGLAND SOUTH WEST (SOUTH WEST NORTH)

☐ Click to enable bespoke peer

SHMI - Published (With Over Dispersion)

* click group name to filter; click header title to clear

	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RTE	Gloucestershire Hospitals NHS Foundation Trust	95,080	2,560	2,335	225	109.49	89.22	112.09
RN3	Great Western Hospitals NHS Foundation Trust	57,190	1,745	1,665	80	104.85	88.96	112.41
RVJ	North Bristol NHS Trust	93,250	2,335	2,410	-75	96.88	89.24	112.06
RD1	Royal United Hospitals Bath NHS Foundation Trust	57,410	1,835	1,895	-60	96.95	89.07	112.27
RNZ	Salisbury NHS Foundation Trust	31,130	1,085	965	120	112.56	88.35	113.19
RA7	University Hospitals Bristol And Weston NHS Foundation Trust	97,025	2,305	2,455	-150	93.87	89.25	112.05
Group		431,085	11,865	11,725	140	101.19		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
SALISBURY DISTRICT HOSPITAL	31,000	995	930	107.22	85.04	117.59
SALISBURY HOSPICE	125	90	35	247.57	70.06	142.74

300.0
200.0
100.0
0.0
RNZ02
RNZ78

SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	55	40.00	131.89	73.10 136.79
Cancer of bronchus, lung	30	25.00	125.15	66.55 150.25
Secondary malignancies	30	30.00	101.61	70.13 142.59
Fluid and electrolyte disorders	15	15.00	106.53	55.17 181.25
Acute myocardial infarction	15	20.00	63.32	65.16 153.47
Pneumonia	125	135.00	94.00	81.36 122.91
Acute bronchitis	10	10.00	72.07	56.90 175.75
Gastrointestinal haemorrhage	10	15.00	80.03	58.94 169.67
Urinary tract infections	10	20.00	65.62	59.76 167.33
Fracture of neck of femur (hip)	25	25.00	84.02	68.64 145.69

Deaths: In / Out Hospital

In Hospital | Out of Hospital

	In Hospital	Out of Hospital
RA7	1,705	595
RNZ	845	245
RD1	1,230	605
RVJ	1,790	545
RN3	1,235	510
RTE	1,780	780

0% 20% 40% 60% 80% 100%

% Palliative Care Coding

% Provider Spells with Palliative Care Coding

RTE	RN3	RVJ	RD1	RNZ	RA7
1.7	2.1	1.5	1.9	2.4	1.7

% Deaths with Palliative Care Coding

RTE	RN3	RVJ	RD1	RNZ	RA7
45.0	46.0	43.0	38.0	48.0	41.0

Trend / Rate

12 Months to

	May 23	Jun 23	Jul 23	Aug 23
SHMI	117.05	113.48	112.83	112.56
Crude Rate	3.5%	3.4%	3.4%	3.5%

RA7
RNZ
RD1
RVJ
RN3
RTE
0.0 50.0 100.0 150.0

SHMI Group - With 95% CI (Dr Foster)

SHMI Group	Obs	Exp	SHMI	Low / High
(113) Other connective tissue disease	20	10	200.00	122.11 308.90
(75) Chronic obstructive pulmonary disease and bronchiectasis	40	25	160.00	114.29 217.88
(65) Congestive heart failure, nonhypertensive	45	30	150.00	109.40 200.72
(42) Mental retardation, Senility and organic mental disorders	25	15	166.67	107.83 246.04
(124) Intracranial injury	15	10	150.00	83.89 247.42
(92) Biliary tract disease	15	10	150.00	83.89 247.42
(81) Cystic fibrosis, Other lower respiratory disease	15	10	150.00	83.89 247.42
(89) Intestinal obstruction without hernia	20	15	133.33	81.41 205.93

* Dr Foster "SHMI Group" values based on published, rounded values with 95% CI's

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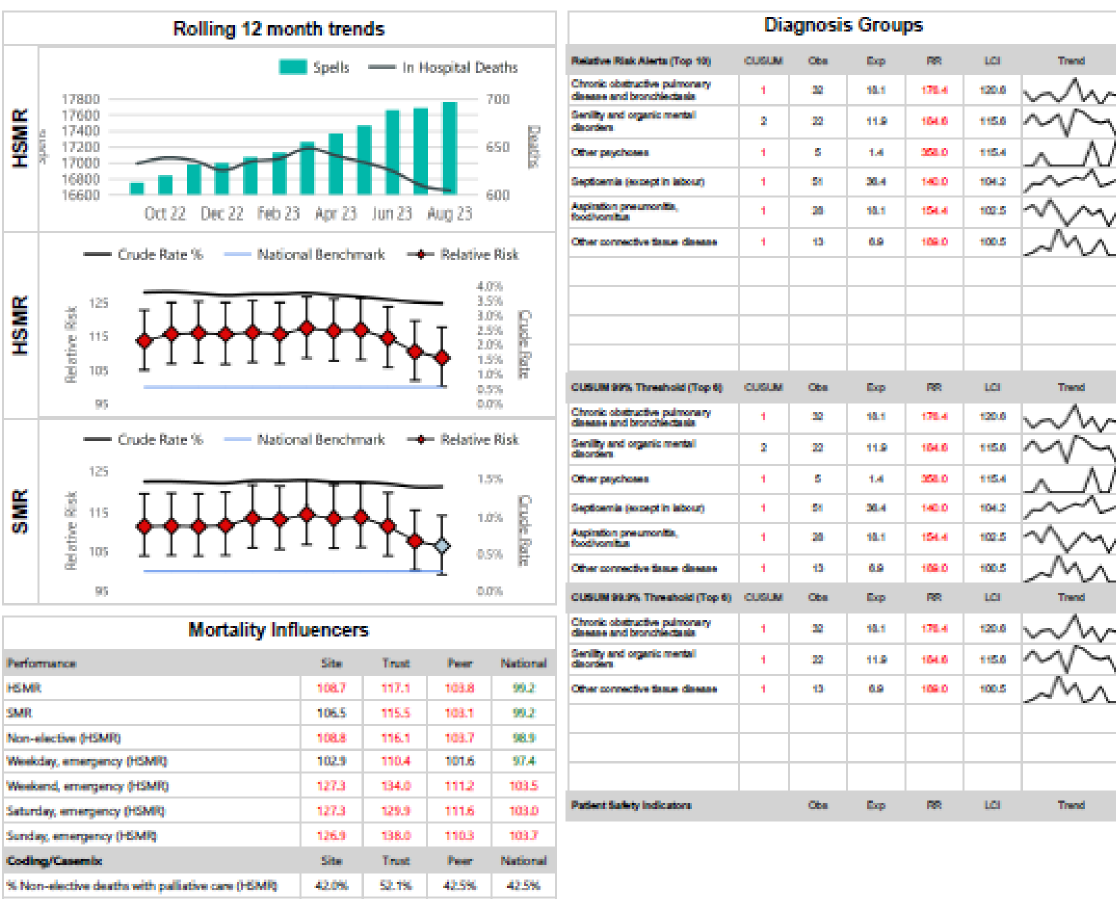
HSMR for the 12 Month Period Ending in August 2023 for Salisbury District Hospital [Excludes Hospice Data]

Mortality Summary for 12 months to Aug-2023 as at 22/01/2024

SALISBURY NHS FOUNDATION TRUST - SALISBURY DISTRICT HOSPITAL (RNZ02)



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	1	32	18.1	176.4	120.6	
Senility and organic mental disorders	2	22	11.9	184.6	115.6	
Other psychoses	1	5	1.4	358.0	115.4	
Septicemia (except in labour)	1	51	36.4	140.0	104.2	
Aspiration pneumonitis, food/vomitus	1	28	18.1	154.4	102.5	
Other connective tissue disease	1	13	6.9	188.0	100.5	

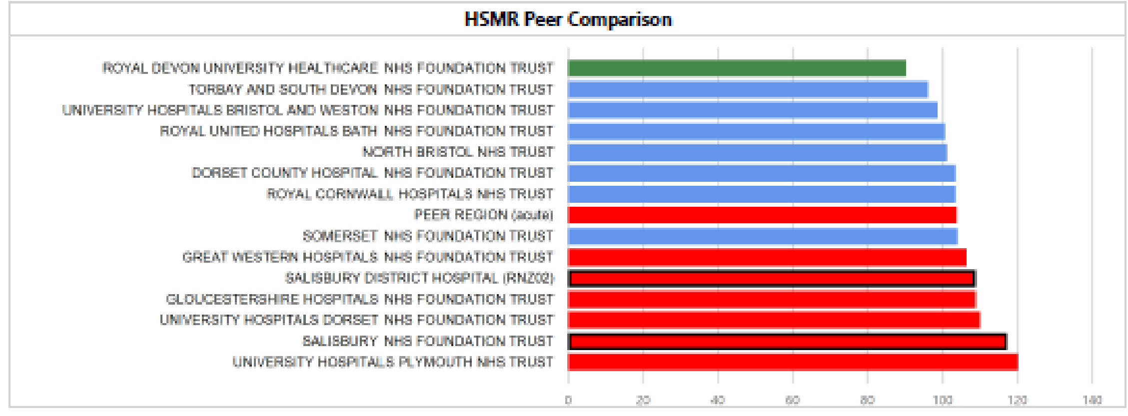
CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	1	32	18.1	176.4	120.6	
Senility and organic mental disorders	2	22	11.9	184.6	115.6	
Other psychoses	1	5	1.4	358.0	115.4	
Septicemia (except in labour)	1	51	36.4	140.0	104.2	
Aspiration pneumonitis, food/vomitus	1	28	18.1	154.4	102.5	
Other connective tissue disease	1	13	6.9	188.0	100.5	

CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	1	32	18.1	176.4	120.6	
Senility and organic mental disorders	1	22	11.9	184.6	115.6	
Other connective tissue disease	1	13	6.9	188.0	100.5	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR	108.7	117.1	103.8	99.2
SMR	106.5	115.5	103.1	99.2
Non-elective (HSMR)	108.8	116.1	103.7	98.9
Weekday, emergency (HSMR)	102.9	110.4	101.6	97.4
Weekend, emergency (HSMR)	127.3	134.0	111.2	103.5
Saturday, emergency (HSMR)	127.3	129.9	111.6	103.0
Sunday, emergency (HSMR)	126.9	138.0	110.3	103.7
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)	42.0%	52.1%	42.5%	42.5%
% Non-elective spells with palliative care (HSMR)	4.2%	5.8%	4.8%	5.0%
% Spells in Symptoms & Signs chapter	7.7%	7.6%	6.6%	6.3%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	48.9%	48.2%	42.6%	41.6%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	12.2%	12.6%	15.2%	16.0%
% Non-elective spells in Risk Band (0-10%) (HSMR)	87.2%	85.7%	85.0%	84.4%



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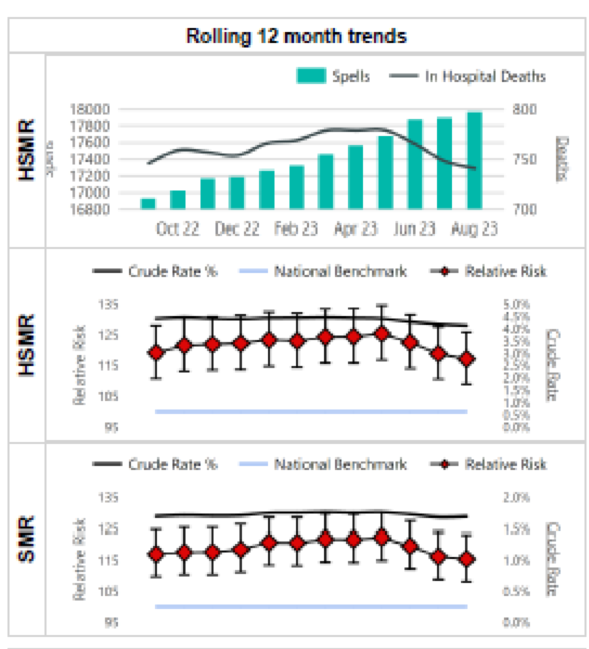
**** Data suppressed in accordance with the HSCIC HES Analysis Guide 2014

HSMR for the 12 Month Period Ending in August 2023 for SFT [Includes Hospice Data]

Mortality Summary for 12 months to Aug-2023 as at 22/01/2024

SALISBURY NHS FOUNDATION TRUST - All Sites



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	1	30	19.0	173.5	119.4	
Nonspecific chest pain	0	3	0.5	590.5	118.7	
Other psychoses	1	5	1.4	358.0	115.4	
Senility and organic mental disorders	2	22	12.0	183.2	114.7	
Other connective tissue disease	1	15	7.7	195.3	109.2	
Septicemia (except in labour)	1	54	38.4	140.7	105.7	
Aspiration pneumonitis, food/vomitus	1	28	18.1	154.4	102.5	

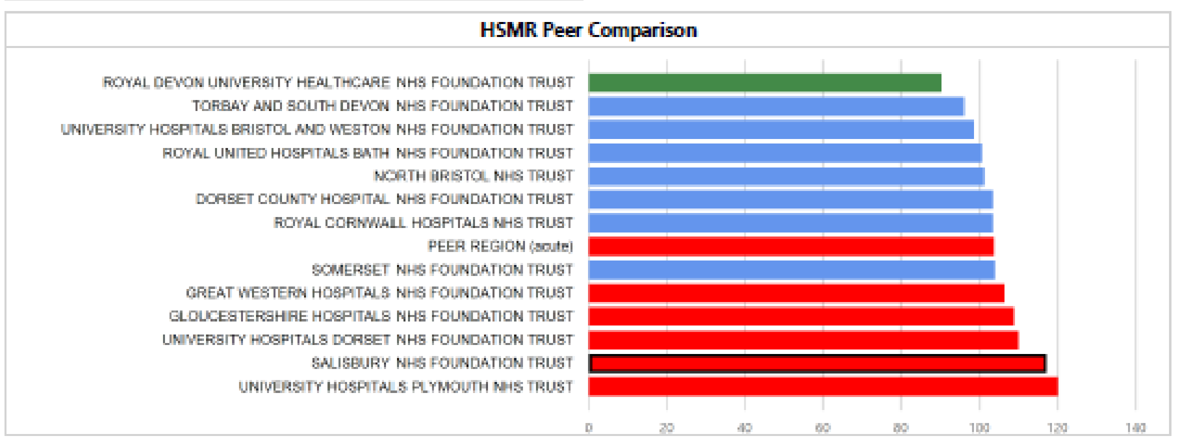
CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	1	30	19.0	173.5	119.4	
Senility and organic mental disorders	2	22	12.0	183.2	114.7	
Other connective tissue disease	1	15	7.7	195.3	109.2	
Septicemia (except in labour)	1	54	38.4	140.7	105.7	
Aspiration pneumonitis, food/vomitus	1	28	18.1	154.4	102.5	
Secondary malignancies	1	26	17.3	150.6	98.4	

CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	1	30	19.0	173.5	119.4	
Senility and organic mental disorders	1	22	12.0	183.2	114.7	
Secondary malignancies	1	26	17.3	150.6	98.4	

Patient Safety Indicators		Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR		117.1	103.8	99.2
SMR		115.5	103.1	99.2
Non-elective (HSMR)		116.1	103.7	98.9
Weekday, emergency (HSMR)		110.4	101.6	97.4
Weekend, emergency (HSMR)		134.0	111.2	103.5
Saturday, emergency (HSMR)		129.9	111.6	103.0
Sunday, emergency (HSMR)		138.0	110.3	103.7
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)		52.1%	42.5%	42.5%
% Non-elective spells with palliative care (HSMR)		5.8%	4.8%	5.0%
% Spells in Symptoms & Signs chapter		7.6%	6.6%	6.3%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)		48.2%	42.6%	41.6%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)		12.6%	15.2%	16.0%
% Non-elective spells in Risk Band (0-10%) (HSMR)		85.7%	85.0%	84.4%



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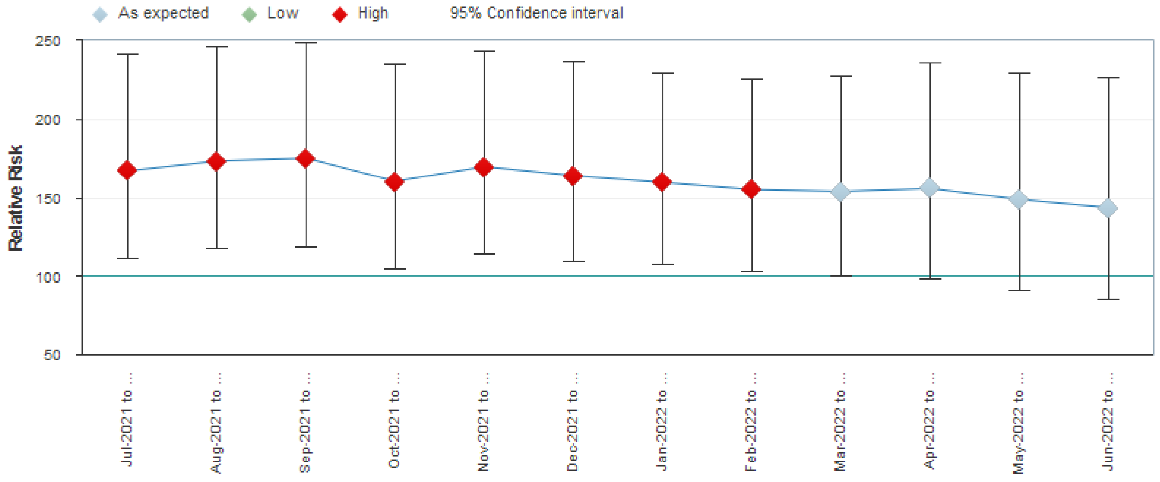
12-Month Trends in Relative Risk for High-Risk Diagnosis Groups

Acute and unspecified renal failure | Mortality (in-hospital) | Jun-22 to May-23 | Trend (rolling 12 months)

Diagnosis group: Acute and unspecified renal failure

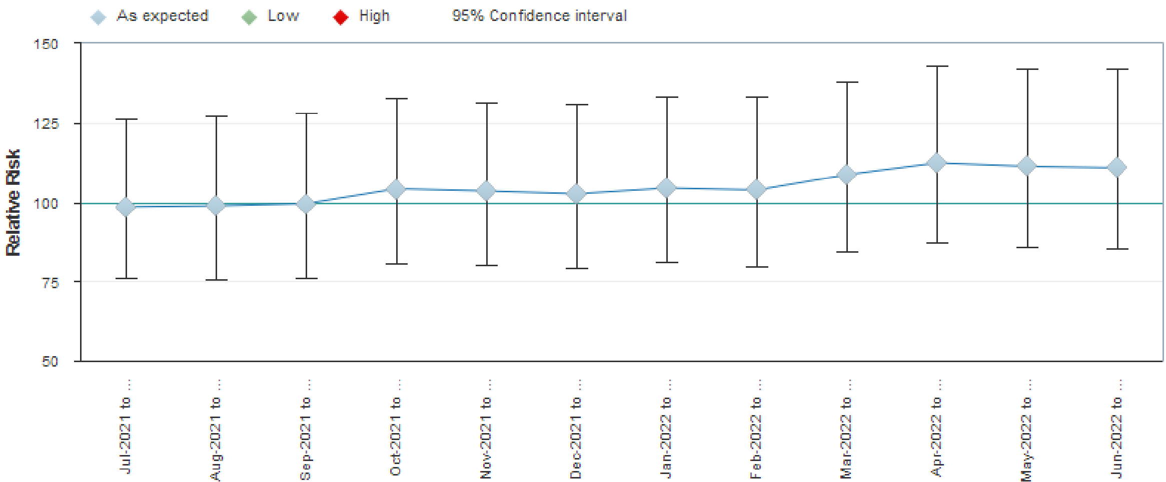
Period: **Rolling 12 months**

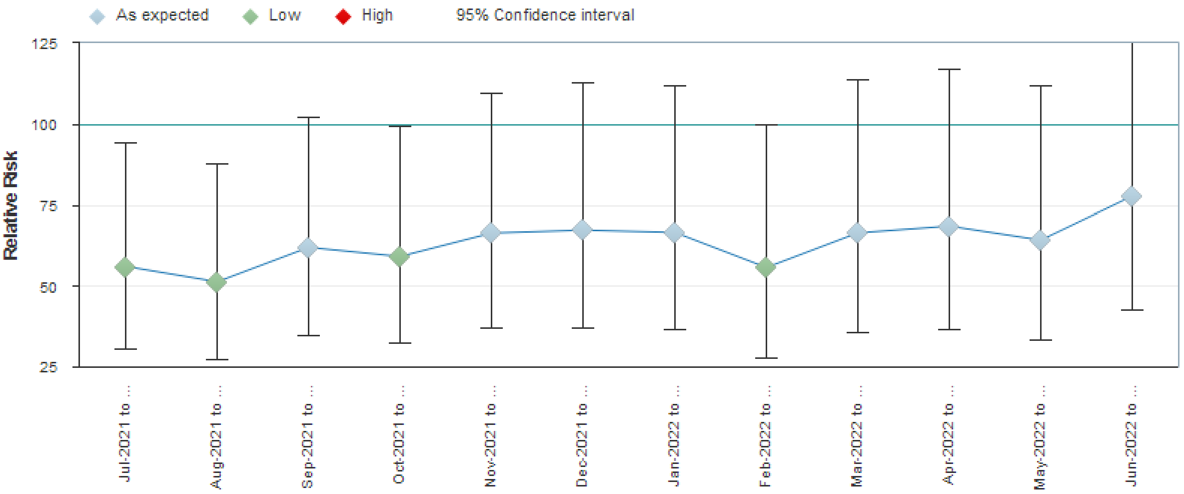


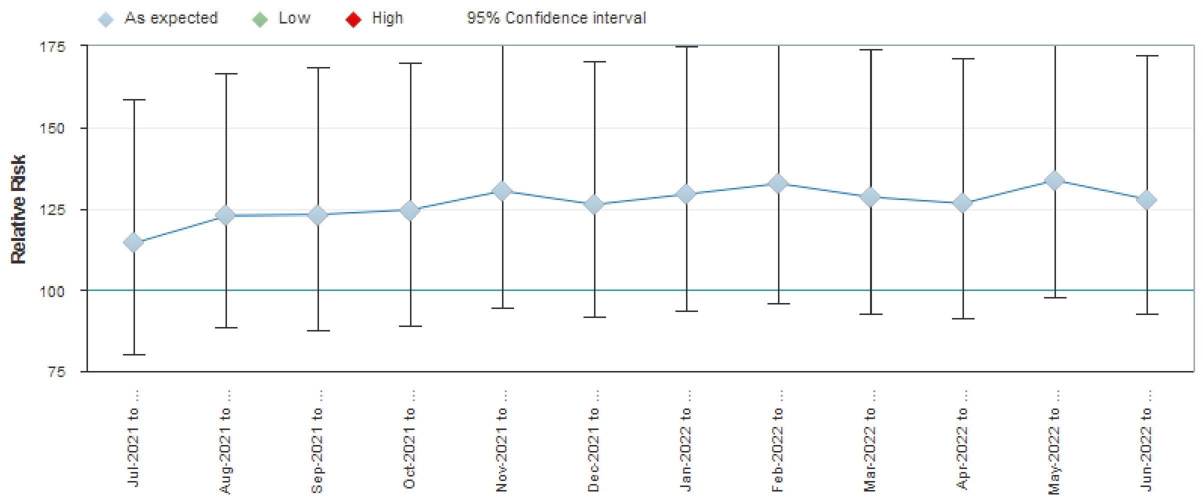
Acute cerebrovascular disease | Mortality (in-hospital) | Jun-22 to May-23 | Trend (rolling 12 months)

Diagnosis group: Acute cerebrovascular disease

Period: **Rolling 12 months**




Acute myocardial infarction | Mortality (in-hospital) | Jun-22 to May-23 | Trend (rolling 12 months)
Diagnosis group: Acute myocardial infarction
Period: Rolling 12 months
As expected
Low
High
95% Confidence interval
Relative Risk
125
100
75
50
25
Jul-2021 to ...
Aug-2021 to ...
Sep-2021 to ...
Oct-2021 to ...
Nov-2021 to ...
Dec-2021 to ...
Jan-2022 to ...
Feb-2022 to ...
Mar-2022 to ...
Apr-2022 to ...
May-2022 to ...
Jun-2022 to ...


Congestive heart failure, nonhypertensive | Mortality (in-hospital) | Jun-22 to May-23 | Trend (rolling 12 months)
Diagnosis group: Congestive heart failure, nonhypertensive
Period: Rolling 12 months
As expected
Low
High
95% Confidence interval
Relative Risk
175
150
125
100
75
Jul-2021 to ...
Aug-2021 to ...
Sep-2021 to ...
Oct-2021 to ...
Nov-2021 to ...
Dec-2021 to ...
Jan-2022 to ...
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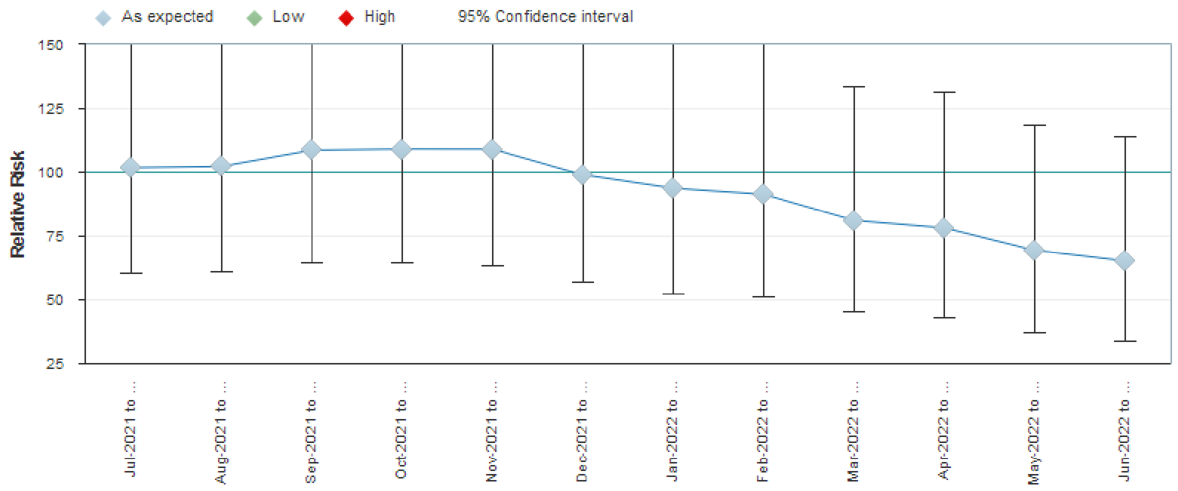
NHS
Salisbury
NHS Foundation Trust


Fracture of neck of femur (hip) | Mortality (in-hospital) | Jun-22 to May-23 | Trend (rolling 12 months)
Diagnosis group: Fracture of neck of femur (hip)
Period: Rolling 12 months
As expected
Low
High
95% Confidence interval
Relative Risk
150
125
100
75
50
25
Jul-2021 to ...
Aug-2021 to ...
Sep-2021 to ...
Oct-2021 to ...
Nov-2021 to ...
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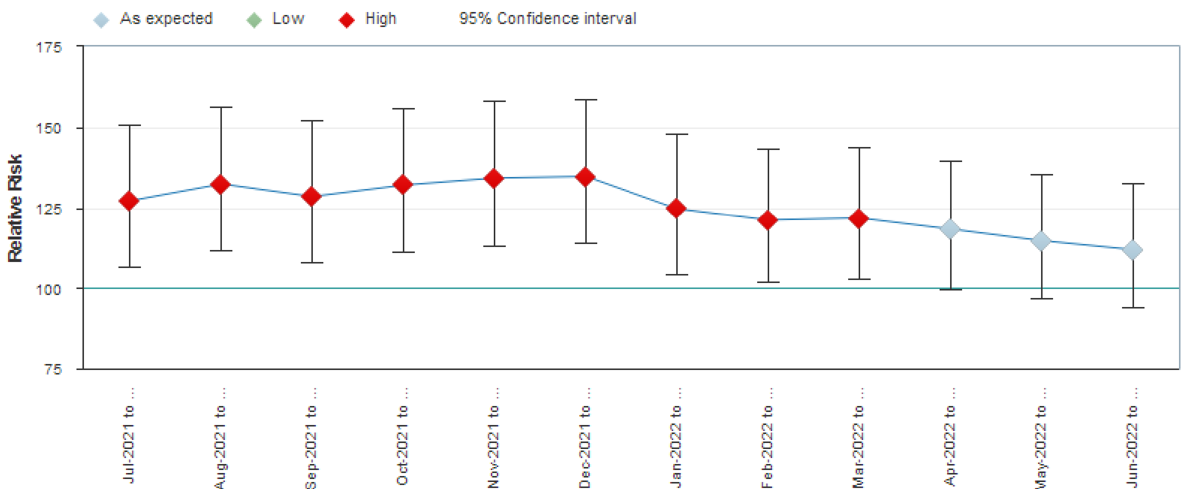
Pneumonia | Mortality (in-hospital) | Jun-22 to May-23 | Trend (rolling 12 months)
Diagnosis group: Pneumonia
Period: Rolling 12 months
As expected
Low
High
95% Confidence interval
Relative Risk
175
150
125
100
75
Jul-2021 to ...
Aug-2021 to ...
Sep-2021 to ...
Oct-2021 to ...
Nov-2021 to ...
Dec-2021 to ...
Jan-2022 to ...
Feb-2022 to ...
Mar-2022 to ...
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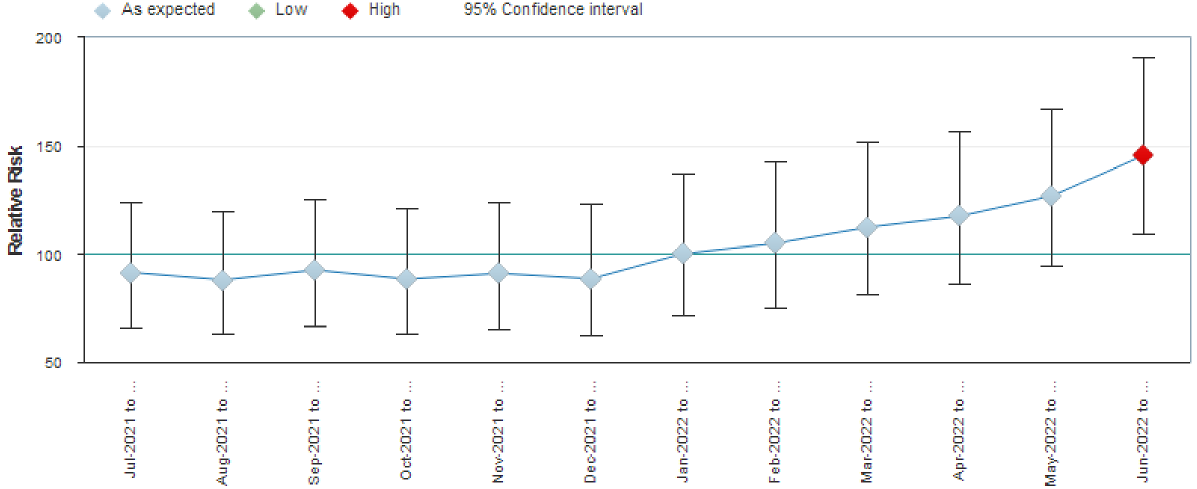
May-2022 to ...
Jun-2022 to ...



* * * * * *** END OF REPORT*** * * * * *

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	6.3.2
Date of meeting:	7 March 2024		

Report tile:	Mortality Insight Visit - Proposed Action Plan			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee 27 February 2024			
Prepared by:	Dr Ben Browne, Associate Medical Director Dr Peter Collins, Chief Medical Officer			
Executive Sponsor: (presenting)	N/A			

Recommendation:

The Board/Committee are asked to review and discuss the proposed list of actions in the context of the outcomes of the mortality insight visit which was undertaken by NHSE on 05 December 2023.

Executive Summary:

A mortality insight visit took place on 05 December 2023 at the request of the Trust Board, due to concerns about SFT being a statistical outlier for their reported mortality statistics (SHMI / HSMR). The Trust formally received recommendations from this visit on 2 February 2024 outlining areas for improvement. A copy of the feedback received has been attached along with the cover letter and a list of the proposed actions. The feedback has been annotated to reference the specific action it relates to.

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

DRAFT

Proposed Actions – Mortality Insight Visit
05 December 2023

Ref.	ACTION	Proposed Owner	COMPLETED
1	To discuss at clinical directors meeting the divisional representation required at MSG and agree attendances	PC	Dec 2023
2	Agreed the role and responsibilities for the divisional rep./lead (including how learning is disseminated back to staff), and approve /include in mortality policy	BB/CDs/PC	Agree at Feb 2024 MSG
3	Recruit to vacant Trust Mortality Lead (TML) post	PC	Pending
4	To consider amending the current mortality Power-Bi dashboard (removal of more sensitive SJR/Review data) so it can be published for all staff access via the Trust intranet – rather than being restricted to only a few staff members.	BB	Discuss at Feb 2024 MSG
5	Digitalise & improve the SJR process through the launch of AMaT	BB/RC/TML	Due 11 March 2024
6	Approve new SOP & Policy for AMaT – This should include expectations to use AMaT for recording mortality reviews in both commissioned / non-commissioned reviews (thus ensuring that the outcomes of reviews are completed/captured across a broader range of specialties).	BB	Approve at Feb 2024 MSG
7	A member of the patient experience team to provide a regular report/ update in relation to complaints related to deceased patients and any learning	VA	Discuss/agree at Feb 2024 MSG
8	Ensure SFT representation at system-wide BSW mortality meetings – to use this forum to also align future insights (including / not limited to review of Dr Foster reports). Community care provision to be a topic of discussion	BB/PC	Completed – 2nd meeting held Jan 2024
9	Update M&M policy	BB	To approve at Feb 2024 MSG
10	Update SJR template questions and/or training materials to ensure the reviewer consistently considers whether the patient was in the right place of care, e.g., ward, to meet their needs. Does the structured judgement review specifically identify if a patient was cared for on the correct ward to ascertain if further mitigations could be put in place to prevent deterioration on outlier wards. Preferred place of death is also an area the Trust may wish to explore for inclusion within their structured judgement review processes.	RC/BB	In progress – To be in completed by AMaT launch, March 2024
11	The Trust should review its structured judgement review training policy to ensure that all staff who undertake a structured judgement reviews are competent to undertake this analysis.	RC/BB	
12	Consider/discuss how audit data is reviewed at MSG and/or included in our learning from deaths reports	BB	Discuss at Feb 2024 MSG
13	Ensuring broader wider representation (including chair) at M&M meetings. Review the attendees at the Mortality Surveillance Group to ensure the right people are represented in the meetings including promoting patient/family/carers voice in this group. Also, the inclusion of an Allied Health Professional may assist with enriching the discussion. It is suggested that Allied Health Professional are included as structured judgement reviewers, and as member of the Mortality Surveillance Group. This will enhance discussion and conversation. *The Trust should consider if the palliative care teams can attend Morbidity & Mortality meetings to discuss their perspective of care and potential improvements.*	TML/BB/PC	Discuss at MSG Feb 2024
14	Better align our quality improvement drive with mortality – Improving Together consideration/link	PC/JD	
15	CODING actions - including link to coding and improving relationship between coders and the clinical team. The Trust would benefit from reviewing the coding team skill mix, potentially increasing capacity/modifying ways of working to enable them to work alongside clinicians with the aim of improving the quality of the clinical records. It would be helpful to the Trust if coding team detailed the actions that clinical staff could take that will make them more able to best reflect the clinical conditions that affect their patients. This will then inform what further work can be undertaken in this area. Dorset County Hospital have done some useful work in this area.	CODING	

16	Depth of coding for both the emergency and elective pathways together with a review of the use of signs and symptoms (rather than diagnosis) coding should also be undertaken. The Integrated Care Board has access to the Regional Mortality Comparator Dashboard which will help the Trust in this endeavour.	**CODING**	
17	An update on coding should be a standing agenda item on the Trust Mortality Surveillance Group meeting.	**RH**	Added as standard agenda Feb 2024
18	Develop a single overall action plan on how the Trust intends to reduce mortality indicators with realistic trajectories.	**PC/BB**	
19	The Trust should ensure that activity is captured accurately from SystmOne to inform mortality and Quality Improvement metric	**[action to be clarified with NHSE]**	
20	The Trust should establish a Standard Operating Procedure for logging end of life decisions to enable clinical teams to follow established wishes.	**EOL**	
21	The Trust should consider a deep dive to review the pathways into the hospice beds as well as the associated coding that is applied to better understand the impact on overall Trust mortality profile.	**CSSF Division**	
22	The Trust should develop induction training on importance and standards of records keeping.	**CODING**	
23	The Trust should use the Mortality Surveillance Group feedback and learning to steer the agenda for Clinical Governance half-days	**BB/EC/CA**	Governance half-days under review
24	Consider how litigation data is reviewed at MSG and included in the learning from death reports	**JL/BB**	
25	Review the Terms of Reference (ToR) for the Trusts EoL steering group and Mortality Surveillance group to ensure that the core purpose, membership, standing and agenda items and reporting support the mortality and learning from deaths experience	**PC**	
26	The Trust must review whether they are receiving what they require from the Telstra contract	**PC**	
27	Review the impact of rotas in out of hours provision of care	**UC Board**	
28	Introduce quarterly focus for non-mandated Structured Judgment Reviews to ensure that emergent risks and issues can be explored (e.g CUSUM alerts or themes from Medical Examiner or patient safety reviews)	**BB**	

COMPLETE

PENDING NEEDS DISCUSSION

DRAFT

Feedback on the Salisbury NHSFT Mortality Insights Visit 05 December 2023

Heading	Observations	Suggested Considerations / Improvements
Strategy	• The Chief Medical Officer outlined a clear strategy to assure that the Trust is providing a good quality of care while work is ongoing to understand the mortality metrics. • The Team heard from all interviews that there was good executive focus and attention on the right things. Staff voiced that they are paying attention and that they have confidence in escalation. • Across interviews there was a consistent theme of the lack of availability of community and domiciliary care with a sense that this may be influencing place of death, hence impact on mortality statistics. • The Team heard consistent messages about a lack of capacity to manage patients out of hospital whether in community/intermediate care or nursing homes. This is impacting significantly on the No Criteria To Reside (NCTR) numbers and experience of care with very high bed occupancy. • The Team heard there was a lack of focus on frailty services at Integrated Care Board level, and that care home admissions for End of Life care were coming to the acute hospital via the Emergency Department. • The team heard that a gap analysis against the national Fuller Inquiry of mortuary services is in process; however, staff were unclear about where this would be reported.	• The Trust reported that work was already underway to review the impact of rotas in out of hours provision. Due to the significantly raised weekend mortality this should be prioritised. This is not an issue that the Trust can solve in isolation and must be included in system work.27 • The Trust should work with the Integrated Care Board to understand care pathways as well as the impacts of crude mortality. A particular focus on the frailty and end of life pathways would be useful.8 • The Trust could develop an single overall action plan to detail how it intends to reduce mortality indicators with realistic trajectories.18 • The Trust should ensure that activity is captured accurately from SystmOne to inform mortality and Quality Improvement metrics.19 • The Trust should establish a Standard Operating Procedure for logging end of life decisions to enable clinical teams to follow established wishes. 20

Heading	Observations	Suggested Considerations / Improvements
	• The Team heard that Discharge to Assess was the preferred means of “Fast-track” discharge but was hampered by lack of Continuing Healthcare clarity. • There appeared to be a lack of clarity about when the discharge process begins (for example should this start as soon as the patient arrives?). • The team heard that palliative care services were moving to SystmOne to align with the community. • There appears to be a lack of integrated end of life decision care planning.	
Systems & Processes	• There are a fewer number of Structured Judgement Reviews being undertaken than expected and it appear many are being suggested by the Medical Examiner from ‘statutory’ criteria (for example Learning Disabilities Mortality Review (LeDeR). • Learning from individual cases appears to be noted but it is not clear if these are collated into themes either within directorates or across the Trust. As a result, there is no evidence that learning from mortality is feeding into Quality Improvement priorities for the Trust. • Divisional leads are not involved in the Mortality Surveillance Group. • Mortality data is not readily available to clinicians • Outcomes feed up to the Board bypassing Divisions, however it is not clear that messages return or spread more widely to the front line. • An extract from the patient experience report is shared at the Mortality Surveillance Group; however, this was reported as performance focused and did not include other sources such as the bereavement survey information.	• The number of structured judgement reviews may be insufficient to identify system learning; there is a need to increase number of structured judgement reviews undertaken that are not just triggered by those mandated in the Learning from Deaths Policy (random selection). Consideration should be given to aligning structured judgement review findings with the Trust Patient Safety Incident Response Framework (PSIRF) implementation plans 28 • Preferred place of death is an area the Trust may wish to explore for inclusion within their structured judgement review processes. 10 • It would improve shared learning to identify themes to feed into quality improvement priorities. This is important as problems may not be visible in individual areas until a wider review takes place. This is often a missed opportunity to prevent future problems/harm.14, 23 • The Trust should discuss the inclusion of Divisional leads on the Trust Mortality Surveillance Group. It was acknowledged that there was further work to be undertaken regarding engaging with divisional teams and attendance at the Mortality Surveillance Group. 1 • Power BI is a useful information tool. It would be helpful to improve engagement with this by broadening access to mortality data for speciality leads.4 • The Trust should ensure learning is spread effectively across the organisation and that Board messages feed back down to front line staff.2 23

Heading	Observations	Suggested Considerations / Improvements
	• It is not clear how the "patient voice" from Patient Advice & Liaison Service (PALS) influences the mortality review process.	• Whilst learning from deaths reviews meet current guidance and focus on identifying any lapses in care, consideration should be given to patient choice and best practice pathways to identify opportunities for service redesign / transformation. 14 • The Trust should review the attendees at the Mortality Surveillance Group to ensure the right people are represented in the meetings including promoting patient/family/carers voice in this group. Also, the inclusion of an Allied Health Professional may assist with enriching the discussion. 2, 7, 13 • The Trust should explore if a deep dive of patients who die on an outlying ward could be undertaken. Alternatively, could the structured judgement reviews specifically identify if a patient was cared for on the correct ward to ascertain if further mitigations could be put in place to prevent deterioration on outlier wards.10, 14, 28 • A feedback mechanism should be developed to the Patient Advice & Liaison Service (PALS) team about what has changed because of the "patient voice". 7
Training & Resources	• There was no evidence of training being provided to support coding for either consultant or junior medical staff. • There was no evidence of training of clinical leadership teams to help them understand mortality metrics. This manifested itself as clinicians not appearing to understand the relationship between record keeping, coding, performance, and patient safety systems. • It was reported that some junior doctors are less confident at listing a diagnosis as opposed to describing symptoms. • The Team heard Matrons, Heads of Nursing and Ward Sisters have had intensive safety training and development packages. • The Team heard that Critical Care Outreach Service was well resourced and available 24/7.	• Whilst the focus should be on accuracy of clinical records, there are some quick wins on coding which could address several of the issues contributing to the elevated Summary Hospital-level Mortality Indicator (SHMI). This will include training that should be offered to junior medical staff and consultants (and potentially nursing and Allied Health Professionals) to explain the impacts on quality of care and opportunities for improvement of poor clinical notes for coding purposes.15 • The Trust should review its structured judgement review training policy to ensure that all staff who undertake a structured judgement reviews are competent to undertake this analysis.11 • The Trust should develop induction training on importance and standards of records keeping. 15, 22

Heading	Observations	Suggested Considerations / Improvements
	Any deteriorating patients could be referred into this team by ward staff. • There does not appear to be any training on record keeping standards (to enable accurate records and coding).	
Data and information support learning from deaths	• Poor clinical documentation is having an impact on coding. This particularly relates to the number of spells coded as a signs or symptoms (R codes). Given the demographics of the Salisbury population there are opportunities to improve depth of coding. • The Team heard that the coding team, whilst having sufficient whole-time equivalent staff, were struggling to meet their requirements due to several of their staff not being fully trained. This skill mix issue was hampering their ability to be outwardly facing with very little time for interaction with clinical teams. The Team heard that the coding team were inward facing and did not have the capacity to meet with clinical staff to explain their issues. • The Medical Examiner System is well established and providing regular reports. The Lead Medical Examiner is conscious of his independence from the clinical governance aspects of the organisation but is willing to share information with the aim to improve the quality of care to patients. The reports provided were largely data on numbers of cases reviewed. There is potentially a missed opportunity for information from the Medical Examiner to identify rapidly emerging issues and to aid the Mortality Surveillance Group to identify themes across directorates. • The Team heard that papers often focus on Summary Hospital-level Mortality Indicator (SHMI) metrics and splitting out general hospital and	• The Trust would benefit from reviewing the coding team skill mix, potentially increasing capacity/modifying ways of working to enable them to work alongside clinicians with the aim of improving the quality of the clinical records. It would be helpful to the Trust if coding team detailed the actions that clinical staff could take that will make them more able to best reflect the clinical conditions that affect their patients. This will then inform what further work can be undertaken in this area. Dorset County Hospital have done some useful work in this area. 15 • A review of the Trust's coding data shows that work is needed to understand how the on-site Hospice mortality data is affecting the Summary Hospital-level Mortality Indicator (SHMI) for the whole Trust. Depth of coding for both the emergency and elective pathways together with a review of the use of signs and symptoms (rather than diagnosis) coding should also be undertaken. The Integrated Care Board has access to the Regional Mortality Comparator Dashboard which will help the Trust in this endeavour. 15, 8 • The Trust should consider a deep dive to review the pathways into the hospice beds as well as the associated coding that is applied to better understand the impact on overall Trust mortality profile. 15, 21 • The Trust has one of the highest numbers of deaths occurring in hospital setting in the country. This will affect the crude mortality rate. The Trust will want to explore community care provision within the Integrated Care System. 17 • The Trust should discuss with the Medical Examiner the possibility for feedback and escalation of emerging themes as and when they occur. 25 28 • Whilst the Medical Examiner service provides quarterly updates into the Trust's Learning from Deaths report, there is merit in the Medical Examiner providing an annual report on their work. This could coincide with the Trust's Learning from Deaths annual report. 25

Heading	Observations	Suggested Considerations / Improvements
	hospice deaths to explain the difference. There appears to be lost opportunities to provide more narrative (particularly in assuring the public) which make the learning and actions more accessible. • Weekly patient safety meeting focusing on reviewing moderate harm and above incidents are in place. This meeting has been established for three years and has Chief Nursing Officer/Chief Medical Officer attendance. • Thematic improvement work is in place, focusing on identified priorities which impact on mortality, for example falls, deteriorating patient, acute kidney injury, and documentation. • Clinicians interviewed reported that they are currently working in a 'hybrid' model with some patient records paper and other electronic, which at time did not assist with timely clinical decision making. • The Team heard that the Trust had not been issued with any Prevention of Future Death (Regulation 28) reports from the Coroner for a number of years. • The palliative care team are not routinely involved in Morbidity & Mortality meetings, even if they were active in the case. • Morbidity & Mortality meetings complete mortality checklists and submit this information to Senior Leadership; they do not however receive feedback on the overall outcomes of this data collection (trends, insights). • There was an excellent quality improvement focus; however, this requires a significant steer from clinical teams to focus on enhanced patient outcomes through the agreed quality improvement methodology.	• The Trust would benefit from a review of the Telstra reports to the Mortality Surveillance Group, which could include a focus on emerging or changing relative risks (CUSUM alerts) as early warnings of future alerts. 25, 26, 28 • The Trust must review whether they are receiving what they require from the Telstra contract. This could be linked to a wider review across the BSW system.26 • The Chief Medical Officer should discuss with the Medical Examiner whether they would consider supporting trust risk and governance processes with information from the Medical Examiner Service. 25 • The Trust should consider adapting Board papers to ensure the implications of learning are clear to members of the public. Clarity about learning and what has been done with it is paramount. 12, 24 14 • The Trust should consider an overarching mortality action plan with associated monitoring.18 • The Trust should review how it promotes, via various methods and forums, the dissemination of learning throughout the organisation as part of a wider communication strategy. 14, 23 • Consideration should be given to including complaints and litigation data in the Learning from Deaths quarterly report. 7, 24 • The Trust could reflect on why it has not received any Prevention of Future Deaths reports. It may be the result of good clinical and corporate governance as well as a positive relationships with the coroner. 24 • The Trust should consider if the palliative care teams can attend Morbidity & Mortality meetings to discuss their perspective of care and potential improvements. 25 • The Trust should strengthen the link between learning from structured judgment reviews and clinical quality improvement. The Quality Improvement workstreams should be informed by the findings of the mortality reviews. 14

Heading	Observations	Suggested Considerations / Improvements
Governance	• The Team saw clear governance structures relating to mortality with good clinical engagement. There is however a risk that key information and reports are bypassing directorates on the way to the Board, especially divisional clinical directors. • The Trust has an extensive improvement programme in place with clear priorities identified. Many of these priorities will align to mortality improvement, however it was not clear that these links had been identified. • The Trust's Learning from Deaths quarterly report is received by the public Board on a quarterly basis, meeting National Quality Board guidelines. The Trust was willing to adapt the report to meet best practice. • Clinical governance half days are valued but are described as not having a strategic overview / steer from the Trust Mortality Surveillance Group. • Morbidity & Mortality meetings appear to exist in isolation from wider mortality program. Where mortality is being considered by departments, the view is very localised. There was an expectation that "someone has the overview". This "overview" is not shared.	• The Trust should ensure directorate leads are engaged and clear on their accountabilities. 1, 2 • The Trust should ensure learning is not just received by the Board but is shared with the front line teams. Divisions should be accountable for delivery of this process. 2, 4, 14, 23 • The Trust should consider prioritising quality improvement training for those leading on mortality. 14 • It is suggested that Allied Health Professional are included as structured judgement reviewers, and as member of the Mortality Surveillance Group. This will enhance discussion and conversation (although it is recognised that opinions may already be asked for if deemed appropriate). 13 • The Trust may wish to consider an annual report on Learning from Deaths, reviewing what has been undertaken in the past year and looking to the work planned for the next. 25 • The quarterly Learning from Deaths report would benefit from including national audit data that reflects the Trust's position in relation to mortality. Dorset County Hospital NHSFT are an example of a Trust that includes this in their reporting. The Learning from Deaths report would also benefit from being reviewed by a patient group with the aim of making it a report that not only meets national requitements but is also written for the public. The SW Regional Team, via the Integrated Care Board would be willing to work with the Trust to develop the report that could then be shared with other South West Integrated Care Boards. The South West Regional team are also willing to share a checklist that will help the Trust to ensure that it has met all the requirements of the National Quality Board guidance. 25 • The Trust should review its support for the local Morbidity & Mortality meetings to ensure that they meet Royal College standards and feed back into the Morbidity & Mortality learning system. A clear feedback mechanism for Morbidity & Mortality meetings to encourage ongoing engagement is also needed. 2, 9 • An update on coding should be a standing agenda item on the Trust Mortality Surveillance Group meeting. 15,25 • The Trust should use the Mortality Surveillance Group feedback and learning to steer the agenda for Clinical Governance half-days. This

Heading	Observations	Suggested Considerations / Improvements
		will bring all colleagues to be aligned and enable collective thinking and energy to the process. 23

To: Salisbury District Hospital NHS Foundation Trust

South West House
Blackbrook Park Avenue
Taunton
TA1 2PX

2 February 2024

Dear Peter,

Mortality Insight Visit by NHSE SW Regional Team 05 December 2023

Firstly, I would like to take this opportunity to thank you, and your team for making the visit function so efficiently, and for providing the data needed for analysis in a timely manner to allow the insight team time to review prior to our visit.

I would also like to thank you for your invitation to visit, and provide you with our observations, in addition to some areas where we suggest improvements that could be made.

The insight team consisted of:

- Dr Michael Marsh – NHSE SW Regional Chief Medical Officer
- Dr Alyson O'Donnell – Deputy Chief Medical Officer- Dorset ICB
- Dr Barry Coakley – Deputy Chief Medical Officer - BSW ICB
- Ben Roe – NHSE SW Clinical Quality Director
- Neal Cleaver – NHSE SW Deputy Clinical Quality Director
- Sue Little – NHSE SW Assistant Clinical Quality Director
- Paul Smith – NHSE SW Senior Clinical Quality Manager
- Bryony Quick – NHSE SW Quality Improvement Officer

The full details of our observations, findings and suggested improvements are available in the appendix attached to this letter.

If there is anything that you do not feel reflects what was observed during the day or does not appear to correlate with feedback provided verbally, please contact us on the details below and we would be happy to arrange a discussion to explore further.

During our visit, we asked if there were any specific areas you would like us to comment on and you were able to identify the following 2 areas:

1. **The Reporting of Mortality statistics in the Integrated Performance Report, with a focus on the effectiveness of Trust Board papers.**

The NHSE Regional team have commented within the attached report on the good quality of the Board papers in this regard, with the recognition that the statistics are compared to country averages and should not be used for ranking of hospitals.

The NHSE Regional team would be willing to support any review of Board papers to support with this further if it would be helpful.

2. **The assurance gained by the regional team on the use of palliative care coding and the splitting out of hospice and hospital coding of data.**

   This was highlighted at the feedback meeting provided at the end of the visit as a potential area of coding discrepancy, and this is also reflected in the full feedback report.

   The NHSE Regional team have offered to work with your Deputy Chief Medical Officer and Head of Clinical Effectiveness (Dr Ben Browne) to support understanding and improvement of this and seek resolution.

In essence, I believe that there a few key areas that both the Trust and ICB should focus efforts to achieve improvements, alongside the additional considerations provided in the full report:

No.	Area	Detail	Action
1.	Frailty Pathways	To consider the ICB/System approach to the provision of (and commissioning of) frailty pathway alternatives to the acute hospital and implement rapid improvements	The Trust should work with the ICB to review the provision of frailty alternative pathways within the system
2.	End of Life Care	To consider the alternatives to palliative care patients being admitted through the Emergency Department at the acute Trust. It would currently appear that with a lack of alternatives, EoLC patients are being admitted through an emergency route, then waiting for Hospice admission from the Trust.	The Trust may wish to consider a deep dive to review the pathways into the hospice beds as well as the associated coding that is applied to better understand the impact on overall Trust mortality profile.
3.	Coding	A lack of robust clinical documentation is having an impact on coding. This particularly relates to the number of spells coded as a signs or symptoms (R codes). Given the demographics of the Salisbury population there are opportunities to improve depth of coding.	A review of the Trust's coding data shows that work is needed to understand how the on-site Hospice mortality data is affecting the Summary Hospital-level Mortality Indicator (SHMI) for the whole Trust.

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No.	Area	Detail	Action
		There was no evidence of training being provided to support coding for either consultant or junior medical staff	Depth of coding for both the emergency and elective pathways together with a review of the use of signs and symptoms (rather than diagnosis) coding should also be undertaken.

If a more detailed conversation would be helpful, or you feel that there is more that the regional team could do to support you with any of these areas of improvement, please feel free to contact us on the details below:

Clinical Quality Team, NHS England - South West
england.swqualityhub@nhs.net

Yours sincerely,

Dr Michael J Marsh

Regional Medical Director & CCIO
Higher Level Responsible Officer
South West Region
NHS England

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CLASSIFICATION:

Report to:	Trust Board (Public)	Agenda item:	6.4
Date of meeting:	7 March 2024		

Report tile:	Quarter 2 2023/24 Risk Management Report			
Status:	Information	Discussion	Assurance	Approval
			X	
Approval Process: (where has this paper been reviewed and approved):	Clinical Management Board Clinical Governance Committee 30 January 2024			
Prepared by:	Kim Melbourne Deputy Risk Manager			
Executive Sponsor: (presenting)	Judy Dyos Chief Nurse			

Recommendation:
To note the report and to inform the committee that the reporting will develop over the coming months in line with the outputs of PSIRF.

Executive Summary:

Given the implementation of PSIRF this report is in a transitional phase and will be developed further in line with the outputs of PSIRF.

This report, will focus on the following:

1. Incident reporting
2. Commissioned CR/SII
3. Compliance Reports and Duty of Candour
4. Deep Dives
5. Risk Registers.
6. Learning from Reviews

1. Incident reporting

From Q1 23/24 (2519) to Q2 23/24 (2411) there is a 7.8% decrease in the reporting rate. In November 2023, the National Reporting and Learning System (NRLS) was replaced by the Learning from Patient Safety Events (LFPSE). Leading up to this, testing was required which meant staff were unable to access Datix and this may therefore have impacted on the decreased reporting. The Risk Management Team will continue to monitor this trend.

The largest reporting group continues to be nursing and allied health professionals with no harm incidents being the highest category. In quarter 2, moderate and above incidents account for 3.3% of the total reported incidents.

Comment: Under the Serious Incident Framework (SIF) no harm risk data is not currently analysed however with the move to the Patient Safety Incident Response Framework (PSIRF), the process for monitoring trends in patient safety incidents will change to include all reported incidents.

2. **Commissioned Clinical reviews/Serious Incident Investigations**

Through the Patient Safety Summit (PSS), 21 reviews were commissioned in quarter 2 2023/24. Of these, 6 were commissioned as Serious Incidents inquiries (SII) and 15 as clinical reviews.

19 ongoing SII/CRs have been completed and closed during quarter 2. None of these were completed within the 60-day time frame however as planned the Integrated Care Board (ICB) is working collaboratively with the Trust monitoring whether progress is being consistently made rather than a strict adherence to the previously recommended 60 days.

At the time of this report, 46 SII/CRs remain open. 15 of these are within the original 60-day timeframe, the other 31 have breached the 60-day timeframe.

Comment: On 8th January 2024, the Trust transitioned from using the Serious Incident Framework (SIF) to the Patient Safety Incident Response Framework (PSIRF) and therefore no further clinical reviews or serious incident inquires will be commissioned. Unlike the SIF, the PSIRF promotes a proportionate approach to responding to patient safety incidents and therefore moving forward investigation timeframes will be set differently as it is not an investigation framework that prescribes what to investigate. The Risk Management Team estimate that all open clinical reviews and serious incident inquiries will be completed by May 2024.

3. **Ensure compliance of 'duty of candour' reports.**

As part of our ongoing commitment to promoting a learning culture we continue to monitor Duty of Candour compliance when patients suffer moderate, major or serious harm and report it weekly to the Patient Safety Summit to drive and monitor further improvement. Reporting of this data is complex and the risk management team are looking at ways to present meaningful data that is current and demonstrates trends. Compliance however is discussed at the weekly Patient Safety Summit where the executive team have the opportunity to explore any barriers with the divisional teams. Current compliance for stage 1 is 78%, stage 2 is 58% and stage 3 is 20%.

Comment: Stage 2 compliance data from Datix regarding Duty of Candour compliance is low however the divisional leads have identified incomplete Datix documentation as the main root cause. The delays in the completion of SIIs does have an impact on compliance at stage 3.

4. **Compliance Reports and Deep Dives**

Recommendations and learning continue to be extrapolated from review action plans. There are currently 190 open actions which have breached their specified time frame. As well as monthly reminders being sent to the divisions and action owners, these compliance reports are addressed in the divisional deep dive meetings that are held with the

executives. 50% of the divisions are within the recommended time frame of a deep dive, held every 3-6 months. Barriers lie with the availability of quorate members to attend.

Comment: Moving forward the Risk Management Team will be working collaboratively with the divisional teams to thematically cluster all the 190 open actions and consider closure if an improvement workstream is already in place.

5. Risk Registers.

Each Department and Division continues to maintain a risk register. Divisional risk registers are formally reviewed in Divisional Governance Meetings and through Executive Performance reviews, in addition to a risk deep dive as described above.

6. Learning from incidents forum (LFIF)

The LFIF (Medicine Division) was developed in March 2023 in collaboration with the Risk Management Team following review of themes and trends specifically within medicine. It was identified that there was a gap in disseminating the learning, from local reviews, complaint feedback and Datix investigations. In preparation for PSIRF, all local learning identified through PSS, complaint actions and ward safety huddles will be shared for widespread learning. Although this is a pilot within the Medicine division, the vision is to roll this out to the other three clinical divisions.

Comment: Following positive evaluations and in line with the PSIRF plan, this model will be used in the remaining divisions.

<u>**Quarter 2 2023/24 Risk Management Report**</u>

Introduction

The Trust recognises that risk management must be fully embedded for the organisation to function safely and effectively. Robust risk management processes must be in place for the Trust Board to be assured on performance and standards. To achieve this, the Trust Board needs to be confident that the systems, policies and staff it has put in place are operating in a way that is effective, focused on key risks, and driving the delivery of the corporate objectives. To monitor the effectiveness of the risk management processes and policies the following strategic objectives have been set:

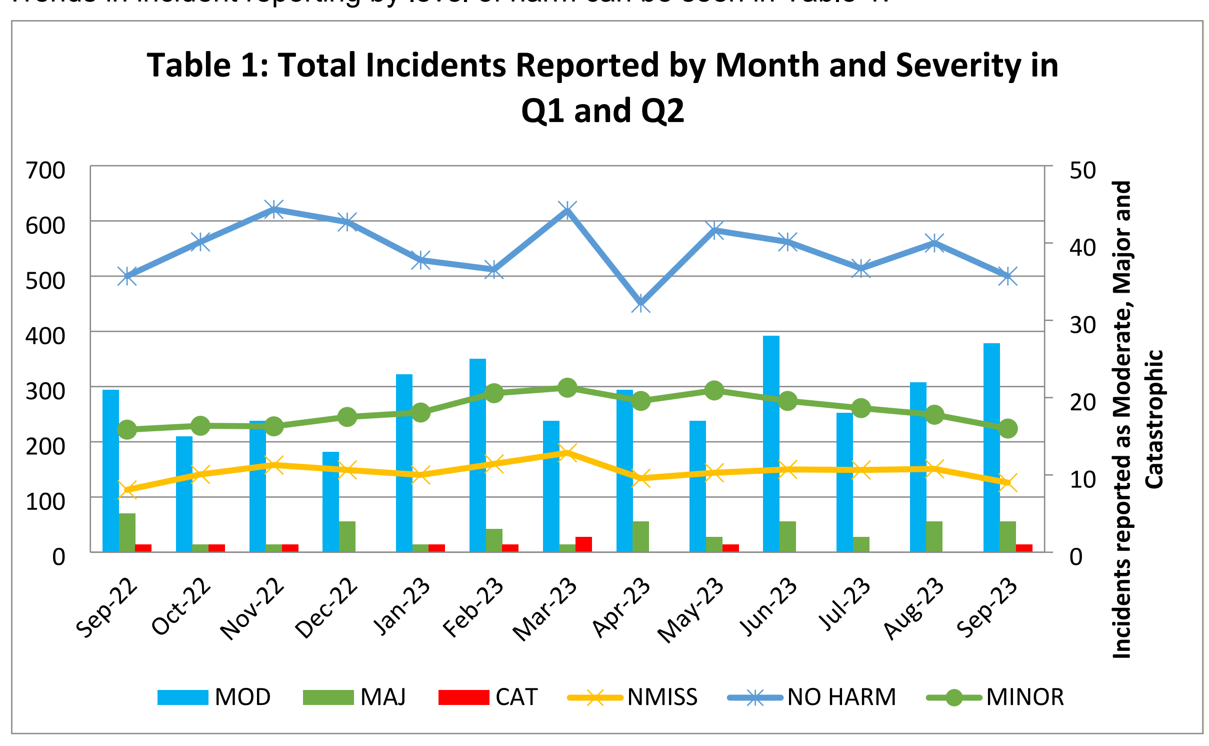
- Monitoring of incidents to highlight trends and areas requiring further investigation/action.
- Embedding risk management at all levels of the organisation and promoting a culture of fairness, openness and learning. Promoting and encouraging reporting
- Ensuring there is appropriate provision of datix incident training.
- Monitor compliance of 'Duty of Candour' and provide reports.

This report will focus on the following areas:

1. Incident reporting
2. Commissioned CR/SII
3. Compliance Reports and Duty of Candour
4. Deep Dives
5. Risk Registers.
6. Learning from Reviews

1. Incident Reporting

From Q1 23/24 (2519) to Q2 23/24 (2411) there is a 7.8% decrease in the reporting rate. Trends in incident reporting by level of harm can be seen in Table 1.



Comment: Highest reporting continues to be no harm incidents. The data suggests that moderate and above incidents have increased in quarter 2 however the team will continue to monitor and report trends.

In November 2023, the National Reporting and Learning System (NRLS) was replaced by the Learning from Patient Safety Events (LFPSE). During the testing and transition period leading up to this, staff were unable to access Datix and this may therefore have impacted on the decreased reporting.

2. Commissioned CR/SII.

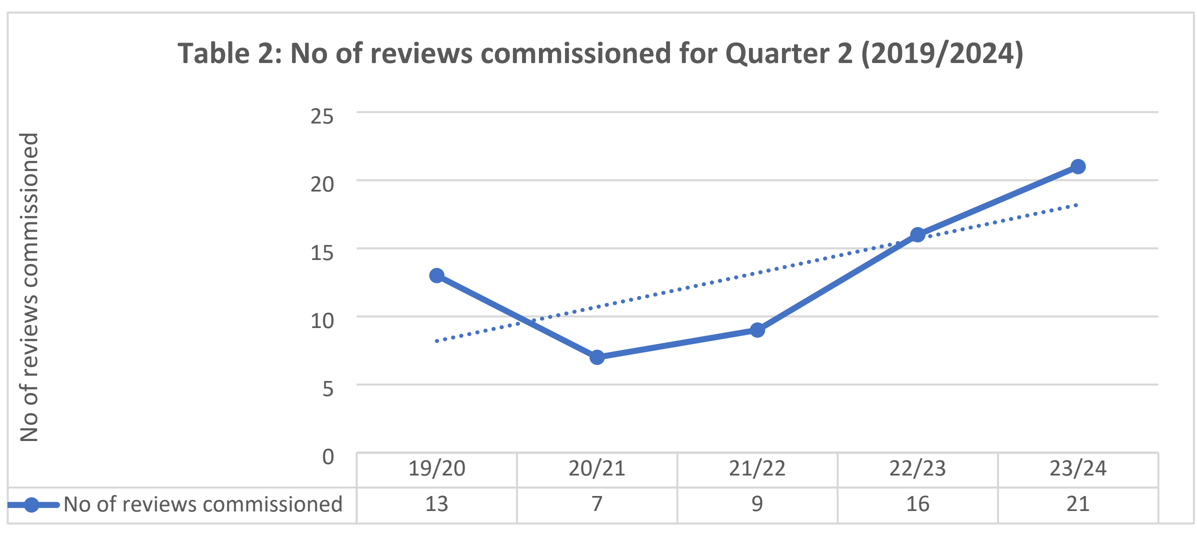
The weekly executive led Patient Safety Summit (PSS) provides a means of systematically reviewing and managing responses to patient safety incidents within the organisation. The main purpose of the group is to ensure incidents are managed effectively and consistently, and any quality or safety themes can be identified and escalated to the required governance channels as appropriate. This also includes the sharing and communication of best practice. Assurance is sought to understand what has been put in place to mitigate a repeated incident and what learning for the team involved and wider learning can be drawn upon. Prior to the meeting the Head of Nursing / Divisional Matron will have arranged for a 72-hour report to have been completed. Using the Serious Incident / Adverse Incident reporting guidance, the meeting will agree whether the incident is:

- A Serious Incident, requiring external reporting to our commissioners and an investigation with delivery of a report within 60 working days
- A high-risk incident requiring a clinical review and a report presented to CRG.
- An incident requiring local investigation and management which is recorded on Datix
- For an external agency/organisation to undertake the review
- A potential joint investigation with another organisation

Through the PSS, 21 reviews were commissioned in quarter 2 2023/24. Of these, 6 were Serious Incidents and 15 were clinical reviews. Details of the types of incidents are detailed below, table 2

Comment:

- Whilst the themes of the reviews commissioned this quarter are broad there are several where the overarching themes have been raised in previous SII/CRs such as delayed recognition of patient deterioration and a failure to escalate and/or failure to respond. These themes have been fed back to the *Escalation Workstream* which is a subgroup of the *Deteriorating and Sepsis Steering Group*.
- There has been one Never Event in Quarter two which involved a mouth prop being left in a child following dental surgery. No harm was caused to the patient.
- Table 2 compares quarter 2 data over the last 5 financial years of commissioned reviews. Following the introduction of the weekly patient safety summit (PSS), in December 2020, there has been a steady increase in the number of reviews commissioned.



Compliance against SI/CR KPI timeframes

Examining the SII/CR data for Quarter 2:

- 19 SII/CRs have been completed and closed during Quarter 2. 4 of these were reviews completed by the HSIB for maternity cases.
- The ICS are now looking at whether progress is being consistently made rather than a strict adherence to the previously recommended 60 days.

46 SII/CRs remain open.

- 15 of these are within the original 60-day timeframe, the other 31 have breached .but are being monitored in conjunction with the ICS team.
- Members of the Quality Team within the ICS have attended the weekly PSS and are in receipt of timely progress updates of SII's.
- Processes are constantly being reviewed to identify and address where the delays are and how these can be minimised. The main challenge reported by the divisional teams is securing a clinical chair for the panel meetings.

Actions: The Trust has now transitioned over to Patient Safety Incident Response Framework (PSIRF) and it is predicted that all outstanding reviews commissioned under the Serious Incident Framework will be closed by May 2024.

3. Ensuring compliance with 'Duty of Candour' requirements

As part of our ongoing commitment to promoting a learning culture we continue to monitor Duty of Candour compliance when patients suffer moderate, major or serious harm and report it weekly to the Patient Safety Summit to drive and monitor further improvement. Whilst our staff have complied with their professional duty of candour, the statutory duty requires clear documentation of our explanation and an apology followed up by a letter. This requirement is now embedded within the Datix web reporting form so that compliance can be monitored at all 3 stages of the incident process. Following this change the Risk Management Team are able to provide more detailed information to assist divisional teams to identify any gaps.

Table 3 outlines the Trusts current position with duty of candour across the four divisional groups. Compliance in stage 2 is notably low and after discussion with divisional leads, they feel confident that the required letters have been sent to patients and families but have not been uploaded to Datix. The 60-day timeframe and subsequent delays in the completion of SIIs being completed and consequently being able to share with families, does have an impact on compliance at stage 3.

Quarter	Incidents of Patient Harm, Moderate+	Duty of Candour Stage 1: Has the Patient and/or relative been informed?			Duty of Candour Stage 2: Date Duty of Candour Letter Sent				Duty of Candour Stage 3: Date contact made with patient / family to offer to share report			
		No	Yes	% Compliance	No date on Datix - being chased	Date entered on Datix	% Compliance	No date on Datix - being chased	SII/CR not yet complete so Stage 3 N/A	Patient / family declined to see report	Date entered on Datix	% Compliance
Q1 23/24	66	17	49	**74.2**	32	34	**51.5**	46	0	1	19	**29.2**
Q2 23/24	50	11	39	**78.0**	21	29	**58.0**	37	3	1	9	**19.6**

Table 3

Comment: The Duty of Candour data changes on a daily basis therefore this should be considered when considering the table above. The data was correct at the time of writing this report.

4. Compliance report for SII/CR open actions – deep dives

Following a patient safety investigation an action plan is agreed which aims to mitigate the risk of the incident reoccurring. The purpose of the deep dive is to provide assurance that teams understand the key problems around open actions and duty of candour. Collaboratively with the executive team, divisions have an opportunity to discuss solutions and barriers to closing outstanding actions. Table 4 illustrates the number of actions within the reviews that remain open and have breached their completion date. Alongside the risk registers, the compliance reports are discussed within the deep dives that are held between the divisional leads and the executive team. The table below also demonstrates when each division last had their deep dive meeting.

Directorate	Breached (Red)	Breached but work in progress (Amber)	Total breached	last deep dive
Medicine	72	36	**108**	22/06/2023
Surgery	19	26	**45**	27/11/2023
CSFS	3	7	**10**	03/08/2023
W and NB	13	11	**24**	16/06/2023

Table 4: SII/CR Action Plan compliance

Learning from completed reviews.

The following are examples of areas of learning that have been extrapolated from SII/CRs.

- Importance of early discussions with patients and their families to ensure patients are receiving the most appropriate level of care and that ReSPECT decisions are acknowledged.
- Patients over 55 attending ED with certain presentation (heart failure, abdominal pain) an ECG should be performed. Clearer documentation and communication should be also ensured at all stages to prevent missing investigations.
- Review of patients if pre-alerted and unable to offload in person and/or within 30 minutes of arrival and remain outside of the ED environment.
- In addition, details of handover and escalation conversations between ambulance crews and ED clinicians should be documented, for instance using an SBAR structure.
- The importance of discarding used IVI drips immediately once detached from the patient.
- The importance of recognising and escalating the deteriorating patient and adherence to Trust escalation policy.
- The importance of having an MRI prior to referring a patient for a capsule endoscopy, this case has reinforced the importance of requesting tests you have knowledge about and asking for help if this is not the case.
- The importance of specialty patients to be under the care of the specialty team and not a general medical team

Shared learning Forums

Learning from Incidents forum

Background:

- LFIF (Medicine Division) was developed in March 2023 in collaboration with The Risk Management team following review of themes and trends specifically within medicine.
- It was identified that there was a gap in disseminating the learning, from local reviews, complaint feedback and Datix investigations.
- In preparation for PSIRF, all local learning identified through PSS, complaint actions and ward safety huddles to be shared for widespread learning.
- Monthly meeting established post medicine governance meeting for all levels of staff to attend and share learning and discuss ward incidents.
- Informal presentation style but formal requirement to feedback.
- All levels of staff invited. Currently only nursing staff attend this meeting however Medics, Therapy and Pharmacy who work within Medicine have now been invited to target all staff groups.
- SIM sessions to be introduced when staffing allows.

- The LFIF is in the process of being embedded into each division, ultimately the plan is for a quarterly trust wide LFIF in which all divisions will feed back the learning from the divisional LFIF meetings.

Example discussions and presentations:

Acute Medical Unit (AMU) - missing morphine (since found to be a documentation error)

- Understanding of local policies and procedures with regards to student nurses and their involvement with administering CD drugs.
- Evidence of miscommunication and identified learning and gaps in Documentation.

Breamore – allegations against staff

- Identified learning involved particularly around staff attitudes and behaviour and different cultures and experiences.
- The team shared their experiences which generated a group discussion.

Laverstock – high risk medications

- Discussed the importance of not meeting those for any of our patients on the wards and understanding why some staff don't escalate the need to give these medications on a regular basis and go out and find these medications.

Redlynch – misplaced NG Tube

- This incident was discussed at length at Patient Safety summit and there was a lot of good practice.
- The local review was quite in depth from the Redlynch team to be able to share the use of NG tubes on all the wards.

AMU – 4 minute briefing

- Sharing good practice that was taken from a clinical review and learning from incidents around the ward areas which was shared for 4 minutes at the end of the safety brief.

Documentation

- The retrospective entry and keeping that information as up to date as possible which generate that group discussion around staff members completing their documentation in a timely manner.

Barriers noticed:

1. Staff engagement
2. Staff availability

3. Limited SIM resource
4. Timely completion of reports
5. Feedback

Next steps:
1. MDT approach, all have now been invited to attend.
2. Trust wide engagement
3. PSIRF preparation
4. Ward posters/ LFIF Newsletter
5. Patient, Family and staff experiences discussed.
6. SIM sessions to be introduced.

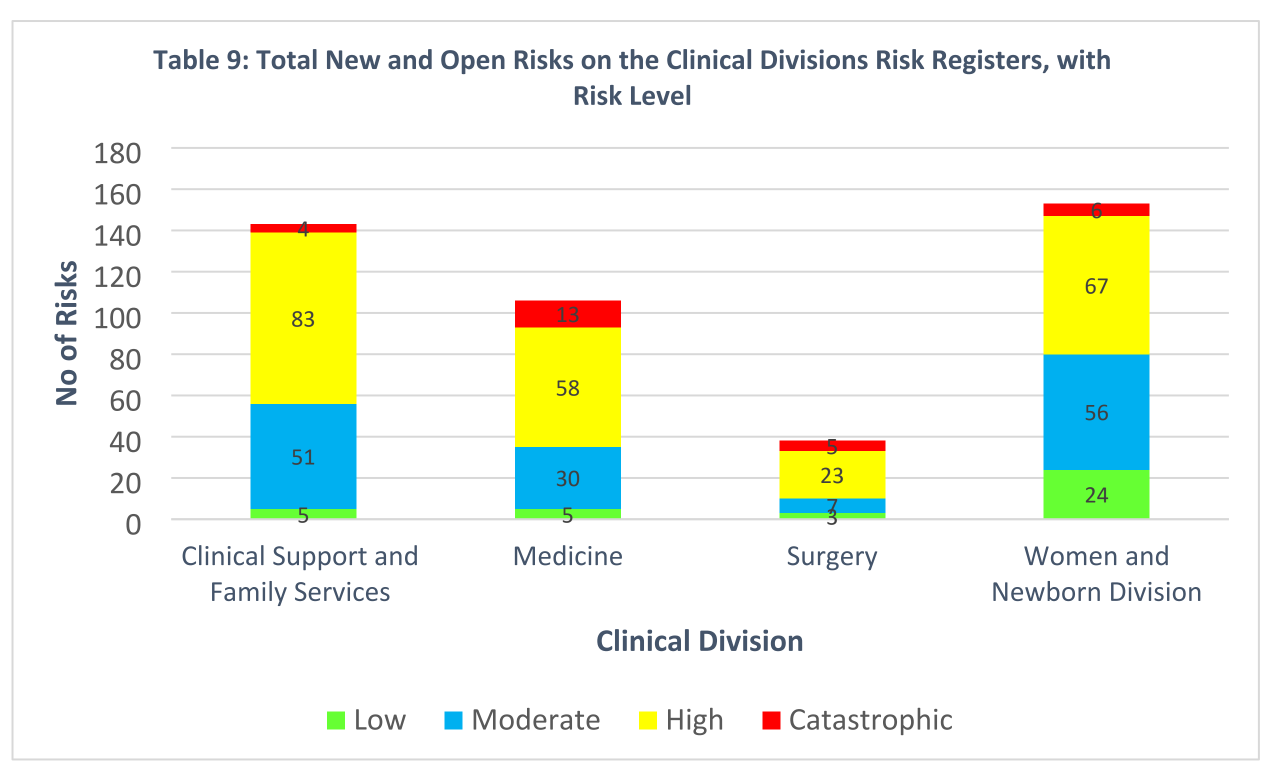
In support of the need to roll LFIF out into the other divisions, LIFI has been incorporated into the PSIRF policy so there will be expectation that it will happen in other divisions.

5. Risk registers

As of 29/09/2023 the trust has a total of 686 open risks, 288 of these have expired their review date. Table 9 details the current open risks for each division, alongside the grading. There are a total of 440 risks open between the four divisions.

Additionally, divisionally held risks of 15 or above, new risk or risks being closed are discussed at the monthly Executive Performance Reviews.

Divisional Management Team are being asked to replicate the deep dive undertaken by the CNO and CMO with them into all their specialty services levels.



Comment: Due to competing pressures and introducing the new LFPSE system and PSIRF within the trust the risk team have not been able to manage the risk register as closely as it would like. A review of the risk team and some additional appointments for the PSIRF oversight will allow the risk team to undertake a focused piece of work to clear the backlog over the next quarter.

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):	

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	6.5
Date of meeting:	7th March 2024		

Report tile:	Maternity Quality and Safety Report for Quarter 3 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 22.2.24. Clinical Governance Committee 27 February 2024			
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 for 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 3 23/24 with detail highlighted below:

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

- In Q3 – 3 Stillbirths – thematic review completed with no themes identified. All 3 to be reviewed via PMRT with external oversight at the reviews to provide additional scrutiny. Overall rate for 2023 3.5/1000 for SFT National rate 4.1/1000
- No reportable Neonatal Deaths
- No Maternity Serious Incident investigations in Q3
- Focus on Ockenden IEA 2022 to be progressed through Maternity Improvement group
- All CNST Training reached 90% compliance in Q3, however this impacted on other mandatory training rates which will be focussed on during Q4.
- Good attendance at Safety Champions meetings and continuation of these bi-monthly
- CNST compliance 9 out of 10 safety actions
- Challenge with compliance with Saving Babies Lives vs 3 – action plan submitted for extra resource to support the roles and actions that would need to be taken and put into place to move forwards towards compliance.
- Midwifery Staffing – reviewed monthly via perinatal quality surveillance slides to Trust board monthly. Escalation policy followed to ensure safe staffing levels maintained and escalated appropriately.
- 1:1 labour care and supernumerary stays of labour ward coordinator maintained 100% of the time.
- Feedback received via safety champions, FFT, MNVP and complaints concerned actioned and feedback to staff and service users.
- Atain rates for SFT for Q3 are 3% against a national ambition of <6% and a network ambition of <5%.
- Good progress made with the Maternity Safety Support Programme – 1 action remains on the exit criteria with an aim to move to sustainability in March 2024 subject to NHSE approval.
- Screening services continue to progress actions following QA visit in September 2022. Out of 44 actions 34 are now closed.
- Targeted focus on safeguarding supervision, obstetricians expected to be at 100% in April. Work continues to improve midwifery compliance which is currently at 89%

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 Q3 2023

Women and Newborn Division

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

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 Quality and Safety Report to Board Quarter 3 2023/24

	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 (CCF)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	On track for required MIS compliance targets	On track for required MIS compliance targets	Compliant for required MIS compliance targets not CCF			
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	n/a	n/a	n/a			
7.Progress in achievement of CNST 10	✓	✓	✓	✓	✓	✓	✓	✓	✓			

Trust: Salisbury Foundation Trust

Maternity Safety Support Programme	Select Y / N	Yes

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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

Recruitment successes: We have now recruited a substantive Head of Midwifery and Neonatal Services, commencing in post March 2024. We have also recruited an Antenatal Clinic Lead Midwife and Day Assessment lead Midwife both commencing in post in the Spring.

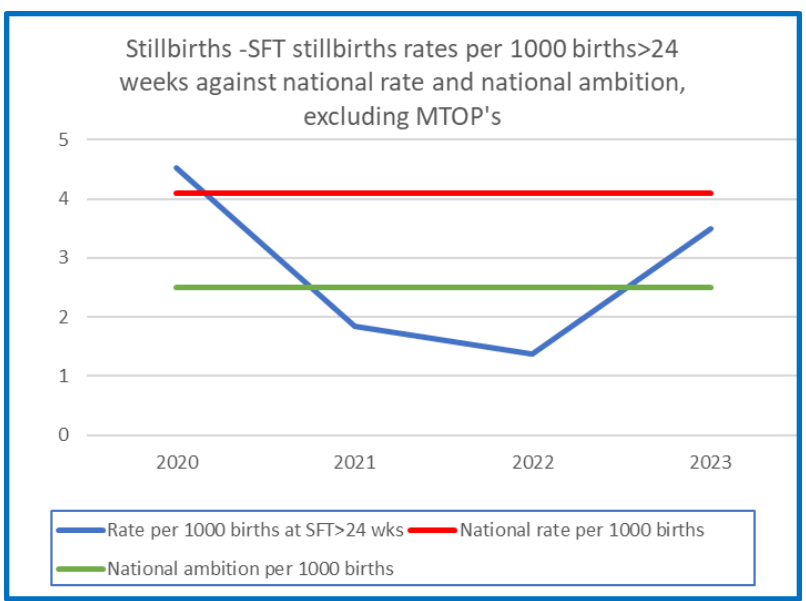
We made excellent progress with CNST Maternity Incentive Scheme and will be declaring that we have met 9 out of 10 of the requirements when we present to Board in January.

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.

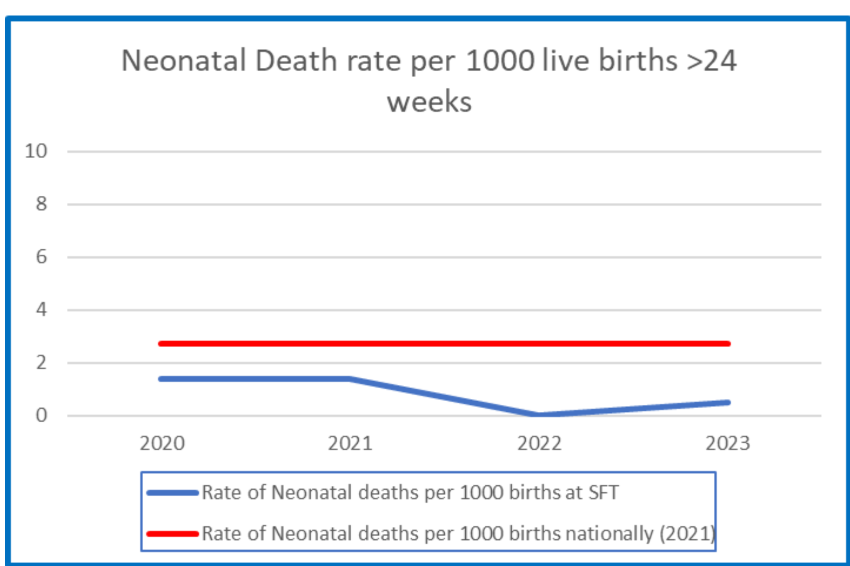
In Q3 we have had 3 stillbirths (Excluding MTOP's) as detailed in Figure 1, this makes a total of 7 in 2023, which equates to 3.5 per 1000 births. The national rate per 1000 births is 4.1 per 1000 with a national ambition to reduce to 2.5 per 1000 births. All three stillbirths were reviewed by our 72-hour review panel and presented to Patient Safety Summit. All three were eligible for PMRT for review as part of this and this includes external scrutiny. We anticipate that these will all reviewed within the stipulated MBRRACE time frames.

Figure 1. Stillbirth rate (per 1000 births excluding MTOP's) for Salisbury compared with national rate and ambition**.**



In Q3 Salisbury Foundation Trust had 0 reportable neonatal deaths. This makes a total of 1 in 2023 which equates to 0.50 per 1000 births. The national neonatal death rate is 2.7 per 1000 live births. 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. Neonatal death rate per 1000 live births > 24 weeks at Salisbury compared with national rate



Perinatal Mortality Review Tool (PMRT) Summary Quarter 3 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: (The time period for MIS year 5 has now ended however we are still working towards these requirements whilst we await the next MIS set of standards.)

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 Q3 23/24 4 cases met the criteria for MBRRACE notification (one case was of a MTOP at 29 weeks), 3 of these cases met the criteria for MBRRACE surveillance and 3 of these cases met the criteria for PMRT review.

Figure 3. Table showing the number of PMRT reportable perinatal deaths in Q1, Q2 and Q3

23/24 (excluding terminations for abnormalities)	Q1	Q2	Q3
Stillbirths (>37^{+0} weeks)	0	0	0
Stillbirths (>24^{+0} weeks - 36^{+6}weeks)	1	0	3
Late miscarriage (22^{+0} weeks - 23^{+6}weeks)	0	0	0
Neonatal deaths	1	0	0
Total	**2**	**0**	**3**

Q3 2023/24 figure 4 (below) highlights outstanding cases to be reviewed by the PMRT group and that they were compliant with the MIS Year 5 CNST standards. The compliance with the MIS (CNST) standards is highlighted as follows: Green represents the standards being completed. Red signifies standard not completed within the reporting time of this quarterly report however, the planned completion dates will meet MIS standards.

Figure 4. Table showing the MBRRACE reportable cases.

MBRRACE ID	Gest at del	Type of loss	CNST Safety action 1ai) MBRACCE	CNST Safety action 1ai)Survaillanc	CNST Safety action 1b) Parental engament sought	CNST Safety action 1c) PMRT Factual info	CNST Safety action 1c) PMRT review meeting	CNST Safety action 1c) PMRT draft report	CNST Safety action 1c) PMRT report	Grading of care:
90169	26+4	SB	Yes-2/11/2023	Yes-20/11/2023	Yes-20/11/2023	Yes 15/12/2023	Planned 12/1/24			
90642	34+4	SB	Yes 30/11/2023	Yes-15/12/2023	Yes- 1/12/2023	Yes 15/12/2023	Planned 9/2/24			
90990	28+6	MTOP-SB	Yes 21/12/2023	NA-MTOP	NA-MTOP	NA-MTOP	NA-MTOP	NA-MTOP	NA-MTOP	NA-MTOP
91012	25+5	SB	Yes-22/12/2023	Planned 2/1/24	Planned 5/1/24	Planned 23/1/24	Planned 8/3/24			
86616	39+3	SB	Yes-21/03/2023	Yes-06/04/2023	Sought by HSIB	HSIB-09/05/2023	HSIB 10/11/23	29/11/2023	29/11/2023	1:C 2:B

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

In summary of the above, during Q3 there were 4 MBRRACE reportable cases. Of the 4 cases that met criteria for MBRRACE notification, 3 met criteria for PMRT review (one was a medical termination of pregnancy (MTOP) at 29 weeks). Of note, in Q3 23/24 the PMRT review was undertaken for one case from Q4 22/23, this was an intrapartum stillbirth and under review by MNSI (formally HSIB). This case was reviewed using the PMR tool in Q3 following the completion of the HSIB final report, HSIB were present at the PMRT meeting as external reviewers. The MIS timeframes are not applied to HSIB cases.

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 3

Action	Implementation plan
The fetal heart monitoring in the latent phase of labour was not carried out correctly	This action is embedded in the HSIB final report and recommendations- and will be implemented from the report
During this mother's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out	This action is embedded in the HSIB final report and recommendations- and will be implemented from the report
Appropriate action was not taken when fetal heart rate abnormalities were identified during the latent phase of labour	This action is embedded in the HSIB final report and recommendations- and will be implemented from the report
Although indicated this mother was not offered a Kleihauer test	Bereavement checklist to be reviewed. Staff training via Bereavement Workshops
Although indicated this mother was not offered infection screening for herself and her baby	To discuss with Microbiology Bereavement checklist to be reviewed. Staff training via Bereavement Workshops

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 Board report covering Q1, Q2 and Q3 23/24 is embedded below for this purpose:

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 one baby was presented to MNSI for triage following an elective caesarian section, and subsequent admission to a tertiary unit, however this case did not meet MNSI criteria.

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 3. 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. As of 22.01.2024, the final report has been received and action planning following safety recommendations from MNSI is ongoing. A tripartite meeting has been welcomed by the family and availability for all parties is being sought to arrange this.

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 3 2023/24 there were no Maternity Serious Incident Investigations (SII's) commissioned.

Investigation Actions

At the end of Q3 in December, 14 investigations were open containing a total of 67 actions. 34 are RAG scored as 'green' with evidence completed. 24 remain unresolved and are RAG scored as 'red' with 9 RAG scored as 'amber' with ongoing evidence. Figure 8 shows the compliance tracker matrix, accurate as of the 1st of January 2024. The Obstetric Risk lead and Quality and Safety team are meeting regularly to identify barriers to action holders completing their actions in a timely way. All action holders have been contacted with a request for their action evidence in order to close this. A thematic review of all closed SII and CCR's in planned in February 2024 as part of the Maternity Improvement Program (MIP) exit requirement.

Figure 8. Compliance Tracker demonstrating progress on Investigation Actions (01.01.24)

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 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 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							
SII 548	Click	W&NB/Surgery	February 2023	Nov 23	Nov 23	Nov 23	Nov 23	Surg	Nov 23	Nov 23				
SII 578	Click	W&NB	June 2023	Feb 24	Q4 23-24	Jan 24								

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.

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

For Ockenden 2020 quarter 3 has seen the closure of all outstanding actions. For the Ockenden Final Actions 2022, there are 15 essential actions, separated into 84 actions. Compliance has been assured for 20/84. 9 are awaiting closure, 8 not started and 47 in progress.

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
Nov-23	1	Enhanced Safety	0=	0=	3=
	2	Listening to Women & Families	0=	0=	1=
	3	Staff Training & Working Together	0=	0=	3= ↑
	4	Managing Complex Pregnancy	0=	0=	3=
	5	Risk Assessment Through Pregnancy	0=	0=	2=
	6	Monitoring Fetal Wellbeing	0=	0=	8= ↑
	7	Informed Consent	0=	0=	3= ↑
		TOTAL	0	0	23=↑

Figure 10. Current progress with Ockenden 2022 IEAs

	Current Rag Status	Immediate & Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
Dec-23	1	Workforce Planning & Sustainability	0=	2=	1=↑	4=
	2	Safe Staffing	0=	4=↓	1=↑	5= ↑
	3	Escalation & Accountability	0=	2=↓	1=↑	2=
	4	Clinical Governance - Leadership	0=	3=	0=	4=
	5	Clinical Governance - Incident Investigation & Complaints	0=	3=↓	2=↑	2=
	6	Learning From Maternal Deaths	0=	2=	0=	0=
	7	Multidisciplinary Training	0=	3=↓	3=	1=
	8	Complex Antenatal Care	0=↓	4=↑	0=	1=
	9	Preterm Birth	2=	2=	0=	0=
	10	Labour & Birth	2=↓	3=↑	1=↑	0=
	11	Obstetric Anaesthesia	0=	7=	0=	0=
	12	Postnatal Care	1=	3=	0=	0=
	13	Bereavement Care	0=	4=	0=	0=
	14	Neonatal Care	3=	2=	0=	1=
	15	Supporting Families	0=	3=	0=	0=
		TOTAL	8	47	9	20

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. There are nine actions with evidence awaiting closure at the January 2024 Ockenden meeting.

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. The deadline for the MIS year was 1st December 2024. We were able to achieve the required compliance in all 3 areas of training as below.

Figure 11. PROMPT training compliance by staff group as of 01.12.24

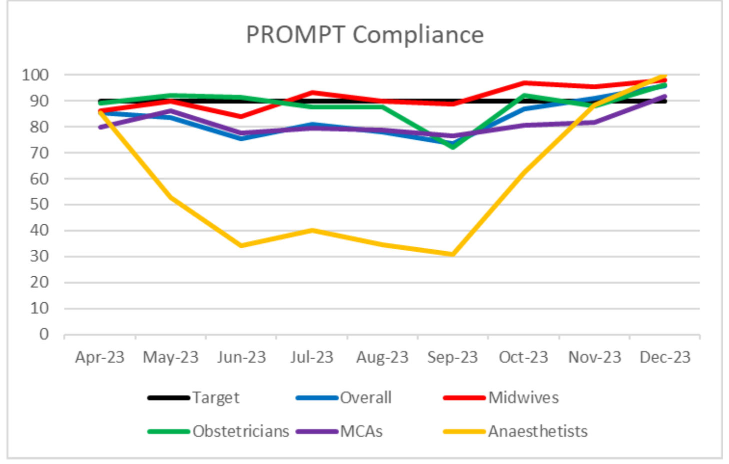


Figure 12. Fetal Monitoring training compliance by staff group as of 01.12.23

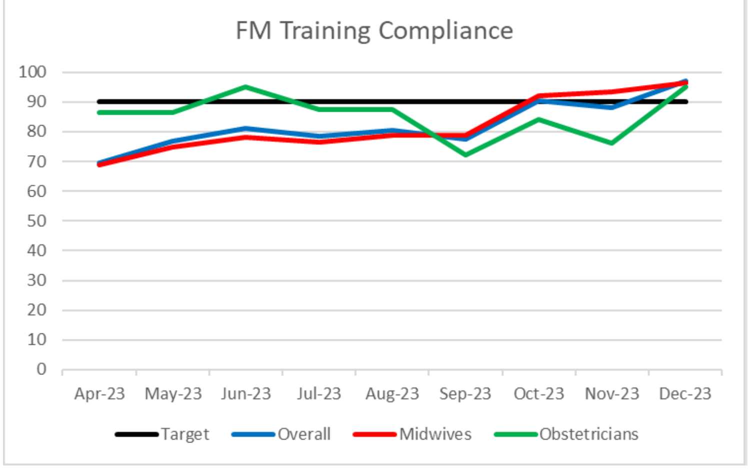


Figure 13. NLS training compliance by staff group as of 01.12.23

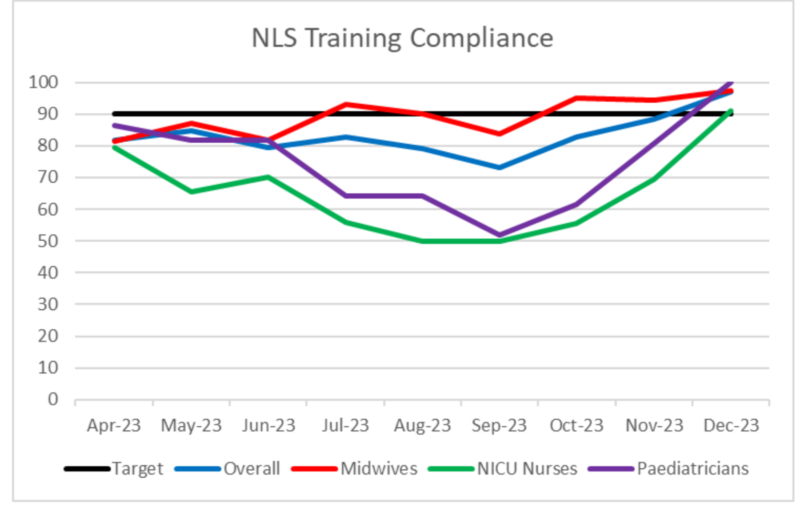
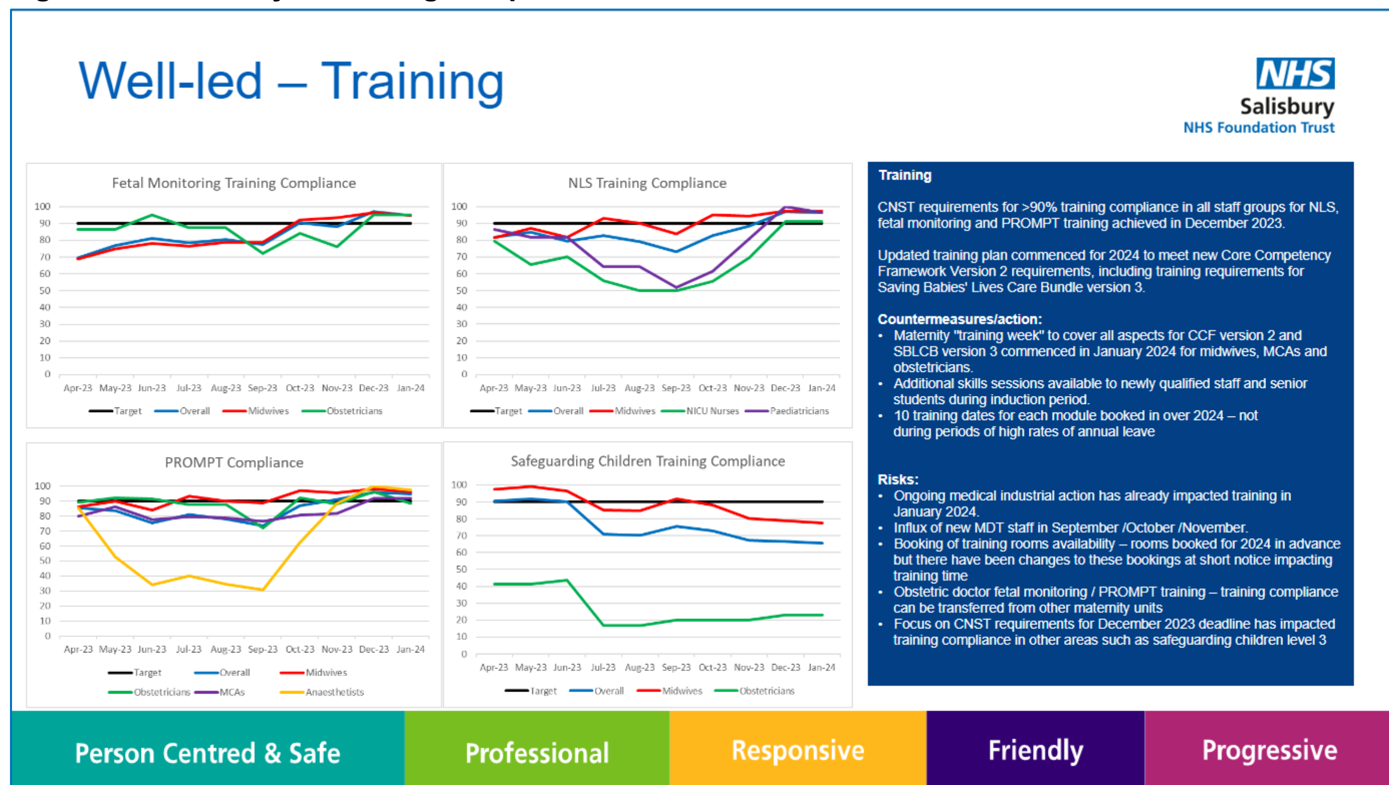


Figure 14. Summary of training compliance



Although all training compliance was met for the CNST deadline in December, this impacted other rates of compliance for Trust mandatory training, including Safeguarding Children Level 3, negatively. The focus was away from this for the last quarter of the year, so moving forwards, we will be improving Trust-required training compliance alongside the maternity-specific requirements.

The plan for 2024 is to front-load attendance at the CNST required training as above. This will ensure good quality training attended by the multi-disciplinary team at each session and allow availability for junior doctors and rotating or new staff to attend later in the year as required.

The Core Competency Framework Version 2 includes more required maternity-specific training in 2024, including covering the Saving Babies' Lives Care bundle Version 3 for obstetricians, midwives and MCAs. This will be introduced for midwives and MCAs to attend a "training week" to cover all maternity-specific required training in the CCF within a week to support compliance figures and individual development. 10 "weeks" have been booked throughout 2024 to facilitate this, with midwives and MCAs being booked over 3 months in advance to attend.

9.Maternity and Neonatal Safety Champions meetings

In Quarter 3 bimonthly meetings for the Safety Champions continued in accordance with Safety action 9 of the Maternity Incentive Scheme.

Recent meeting notes and action tracker can be accessed below:

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 have been working towards the minimum evidence and compliance required with current compliance noted in the figures below.

Figure 15. SBLv3 Board report noting 41% self-assessed compliance on 1.12.23 (2nd submission)

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)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	20%	Partially implemented	20%	CNST Not Met
Element 2	Fetal growth restriction	Partially implemented	55%	Partially implemented	50%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	40%	Not implemented	0%	CNST Not Met
Element 5	Preterm birth	Partially implemented	33%	Partially implemented	37%	CNST Not Met
Element 6	Diabetes	Partially implemented	67%	Partially implemented	33%	CNST Not Met
All Elements	TOTAL	Partially implemented	41%	Partially implemented	37%	CNST Not Met

SBLCBv3 Interventions Partially or Not Implemented - self assessment vs validated assessment

0% 20% 40% 60% 80% 100% 120%

Smoking in pregnancy, Fetal growth restriction, Reduced fetal movements, Fetal monitoring in labour, Preterm birth, Diabetes in pregnancy, All Elements

Self assessment % (Not fully implemented) | Validated assessment % (Not fully implemented)

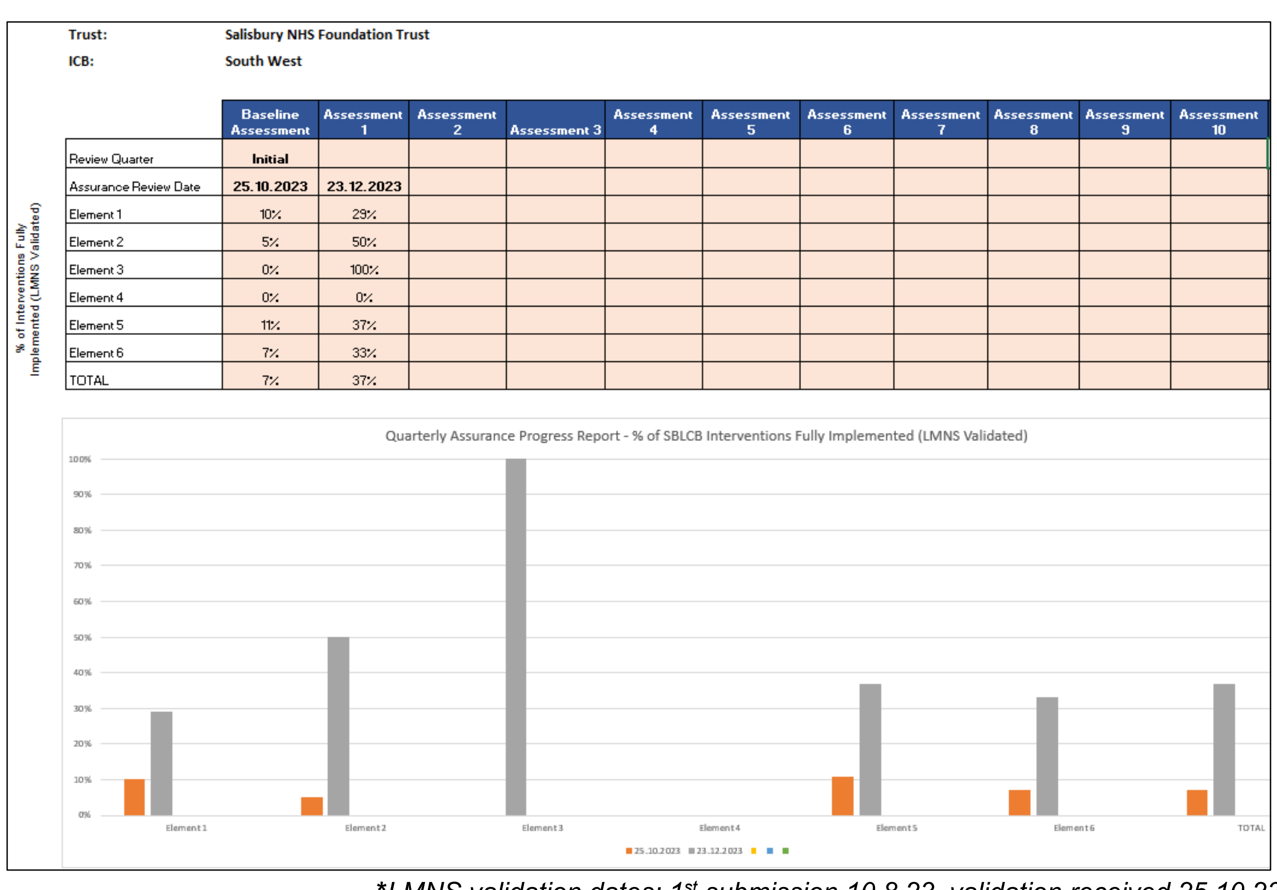
SBLCBv3 Interventions Fully Implemented - self assessment vs validated assessment

0% 20% 40% 60% 80% 100% 120%

Smoking in pregnancy, Fetal growth restriction, Reduced fetal movements, Fetal monitoring in labour, Preterm birth, Diabetes in pregnancy, All Elements

Self assessment % (Fully implemented) | Validated assessment % (Fully implemented)

Figure 16. SBLv3 Progress at SFT and LMNS review record (2nd submission on 1.12.24)



Trust: Salisbury NHS Foundation Trust

ICB: South West

% of Interventions Fully Implemented (LMNS Validated)

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5	Assessment 6	Assessment 7	Assessment 8	Assessment 9	Assessment 10
Review Quarter	Initial										
Assurance Review Date	25.10.2023	23.12.2023									
Element 1	10%	29%									
Element 2	5%	50%									
Element 3	0%	100%									
Element 4	0%	0%									
Element 5	11%	37%									
Element 6	7%	33%									
TOTAL	7%	37%									

**LMNS validation dates: 1st submission 10.8.23, validation received 25.10.23. 2nd submission 1.12.23 LMNS validation received 19.1.24. (dated 23.12.23)*

On 10th August SFT declared self-assessed compliance as 40%. BSW LMNS provided feedback on this on 31.10.23 with an external assessment of 7% compliance with SBLv3 care bundle. Since this time a significant amount of work has taken place around guidelines, developing an SBL dashboard and audits. The draft dashboard (SBL Dashboard - Power BI Report Server (salisbury.nhs.uk) with named leads being responsible for supporting data entry. Audit currently remains a challenge due to the nature of audits being predominantly manual in the absence of a fully digitalised clinical information system and is acknowledged that it will improve when Clevermed Badgernet is fully implemented. Resourcing support for SBL leads has also been a challenge. Work continues to identify ongoing leads, job plan for this and ensure mechanisms and processes are in place to work towards achieving SBL and becoming fully compliant as part of SFT's commitment to achieving the national ambition of reducing stillbirth and improving perinatal outcomes.

On 1st December 2023 SFT declared 41% compliance and on 19.1.24 received notification of the LMNS validated assessment of 37%. This is a significant improvement and work continues with identifying ongoing leads, developing clear action plans and the continuance of monthly SBL meetings for leads.

11. NHS Resolution Maternity Incentive Scheme (MIS) Year 5 progress as of end Q3.

SFT previously self-declared that they were compliant with 5 out of the 10-safety action as defined in the Maternity Incentive Scheme (MIS) year 4 2022/23. Following regular meetings and review we are pleased to report improved compliance for MIS year 5 2023/24 submission and have declared 9 out of 10 safety actions as compliant.

We are non-compliant for Safety Action 6 Saving Babies Lives but have detailed in the action plan submitted to NHSE the roles and actions that would need to be taken and put into place to move forwards towards compliance. The Figure below shows current progress and projections for this which is an improvement on the previous year 4 submission.

Figure 17. Current progress towards MIS 5 requirements

Are we well led?	NHSR Maternity Incentive Scheme- Year 5 Submission by 1st February 2024			
	Description	Yr 5 Submission	Comment	Current Assessment
1	**Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Compliant	All Standards Met	
2	**Maternity Services Data Set** submission to required standard	Compliant	All Standards Met	
3	**Transitional Care Data Set** minimise separation to mothers and babies	Compliant	All Standards Met	
4	**Clinical Workforce Planning** effective system	Compliant	All Standards Met	
5	**Midwifery Workforce Planning**	Compliant	All Standards Met	
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	All Standards Met	
8	**Multidisciplinary Training**	Compliant	All Standards Met	
9	**Board Assurance** Board to Ward to Board	Compliant	All Standards Met	
10	**HSIB and EN Reporting**	Compliant	All Standards Met	

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

12.The number of incidents logged graded as moderate or above

During Q3 there were 11 incidents recorded as moderate or above. Figure below shows a summary description.

Figure 18. 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. These ATAIN reviews are ongoing, however the initial reviews by the Q&S team showed no omissions in care in 2 of the cases, with one case receiving a PSIRF PSR review at the time of writing.
Local PPH guidance not followed at homebirth	Escalated to clinical review.
OASI injury	Local review as part of ongoing rolling audit. Where there are no concerns or omissions in care, local rolling audit continues and if anything is of

	concerns these are then escalated to PSR and presented to the Patient Safety Summit.
Eclamptic fit	Escalated to clinical review.
Trauma to bladder or other organs and scar dehiscence.	72hr reviews (now known as PSR) completed and no omissions in care or concerns found.

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 always provide safe care to women and babies in all settings. Midwifery staffing is reported separately to the Clinical Governance Committee and Trust Board biannually as well as via monthly perinatal quality slide set report to both committees.

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 2023/24, 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 19. Current workforce safety metrics for Q3

Measure	Aim	Oct 23	Nov 23	Dec 23
Midwife to Birth Ratio	1:26	1:30	1:28	1:32
Supernumerary labour ward coordinator status	100%	100%	100%	100%
1:1 care in labour	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.
- Recruitment campaign to include executive agreed incentivised payment once in post.
- Relocation package promoted.
- Flexible working party have reviewed working patterns. Actions identified and instigated to improve work life balance.

We have an ongoing recruitment campaign and continue to receive targeted support from the central recruitment team to support us and recruitment is reviewed weekly with the team to ensure timely appointments. We continue to closely monitor staffing daily to ensure a safe service is maintained at all times.

14. Service users and Maternity Voices Partnership Co-production

Summary of complaint, concerns and enquiries

Maternity Services have observed a downward trend in formal complaints logged over the past

year. However, there was a slight increase in Q3, although due to the small numbers of complaints reported this may not be a significant finding, but this is an area of continued monitoring.

Figure 20. Trajectory of complaints per quarter

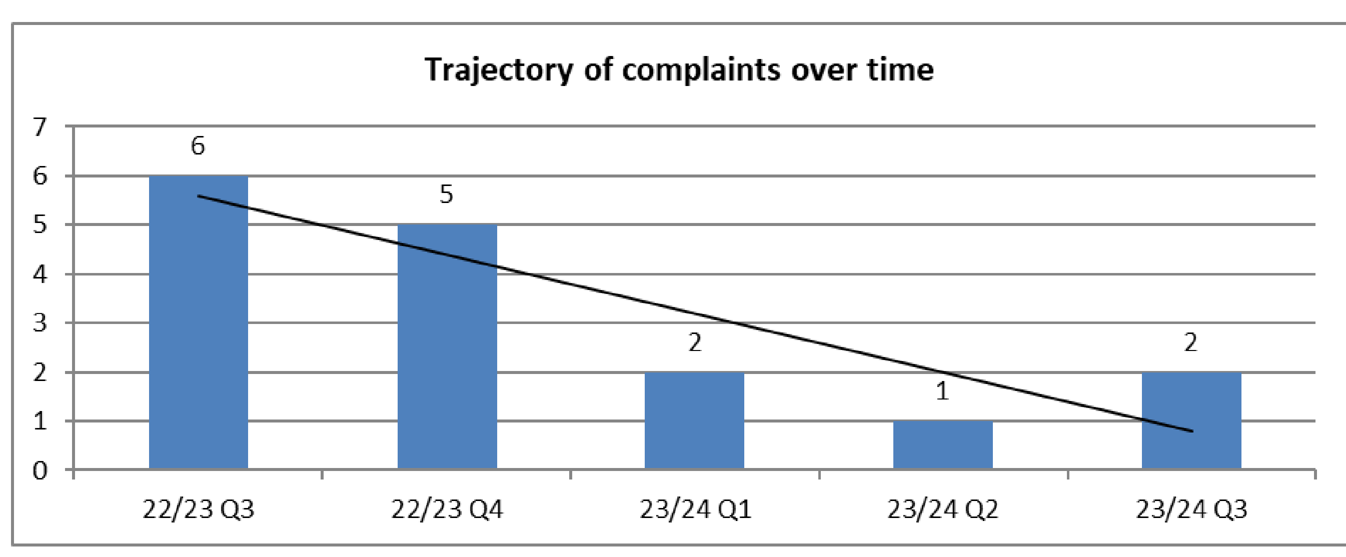


Figure 21. Themes of complains in Q3.

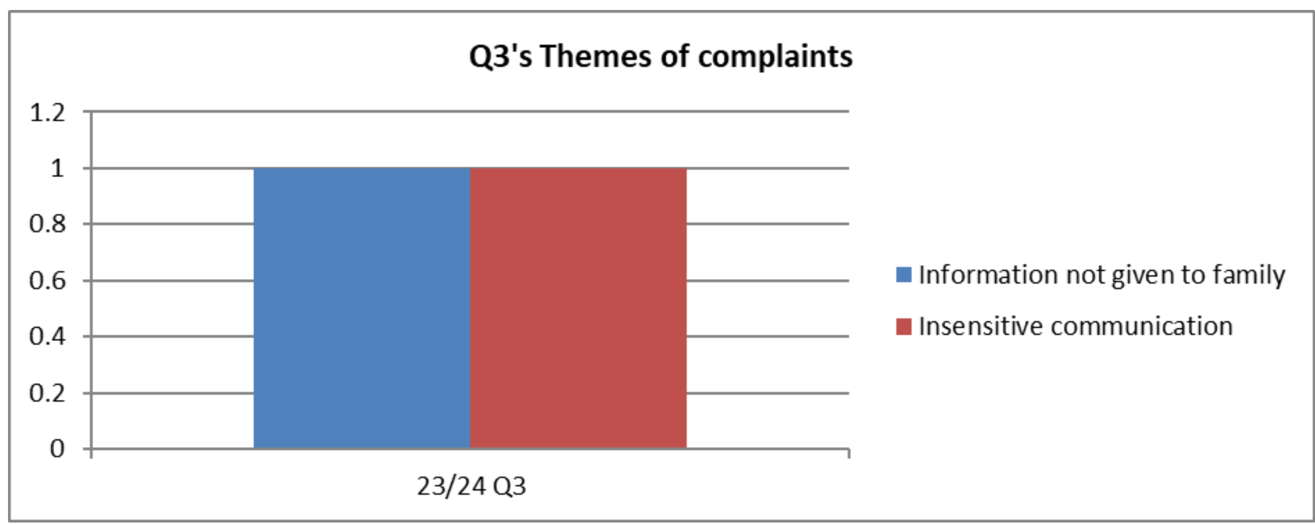
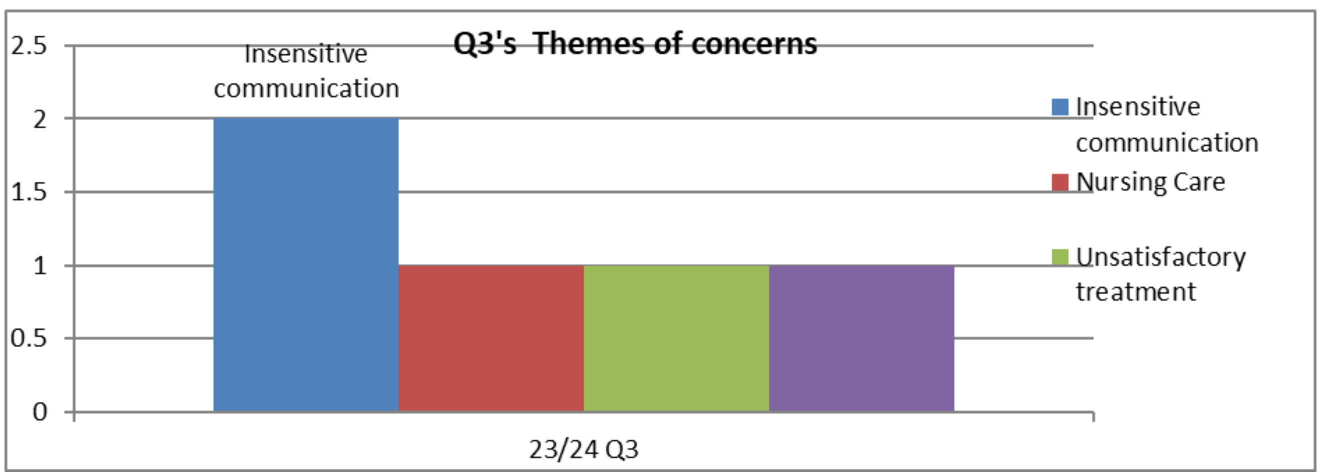


Figure 22. Themes of concerns in Q3.



Communication, the lack of information - how it has been delivered or the way this information is shared was a theme from complaints and concerns in Q3.

Personalised care plan is a subject discussed at the annual training days. Within these sessions the use of language and professional communication is addressed.

Q3's Comments and Enquiries

Main themes of comments and enquiries in Q3 were 'unsatisfactory treatment'. Enquiries were raised in regard to the Birth Reflection Service and local guidance around the screening policy.

Figure 23. Comments and enquires received in Q3

Area	Case opened	Description	outcome	Theme
Postnatal	11/12/2023	Pt would like to have a birth reflections meeting following the birth of her 3rd baby and some postnatal complaints she wants to discuss. Asked for her email to be fwd to AL	PALS fwd pt email to the Family Experience Midwife to arrange a birth reflections meeting.	Unsatisfactory treatment
Beatrice Birth Centre	20/11/2023	Feedback has been shared from their experiences on the maternity unit.	Birth Reflection appointment offered.	Unsatisfactory treatment
Maternity Day Assessment Unit	04/10/2023	Patient has been into DAU - maternity 5 or 6 times now and they are not reassured about what is happening or being investigated. They have been told by the consultant this week that it is just one of those things.	Outpatient Matron has spoken to the patient and discussed any actions. Patient has asked for case to be kept open in case any other issues arise.	Unsatisfactory treatment
Maternity Administration	27/10/2023	Patient has had a copy of maternity records and there is a lot of incorrect information in them and patient would like to speak to someone about them.	Family Experience Midwife has spoken to patient and is meeting with her in reflections clinic	Information required
Maternity Administration	07/11/2023	Challenging the 12 week scan policy Enquiry being looked into by Ultrasound Service Lead	Mgr has passed it on	Lack of communication
Antenatal Clinic	16/11/2023	Pt has questioned the policy around not allowing children to attend for growth scans. She has a pregnancy growth scan booked and is a military wife, her husband is away on duty and she has no family living locally to support her.	Pt contacted by the Lead sonographer	Appointment system - procedures

There were 3 concerns closed in Q3, none were closed within the agreed target times.

Actions:

- The DAMA (discharge against medical advice) policy is under review from a Trust perspective. **Action on going.**
- Care of the woman in the latent phase of labour to be reviewed – **Action completed - Guidelines approved and available on Microguide as from November 23**

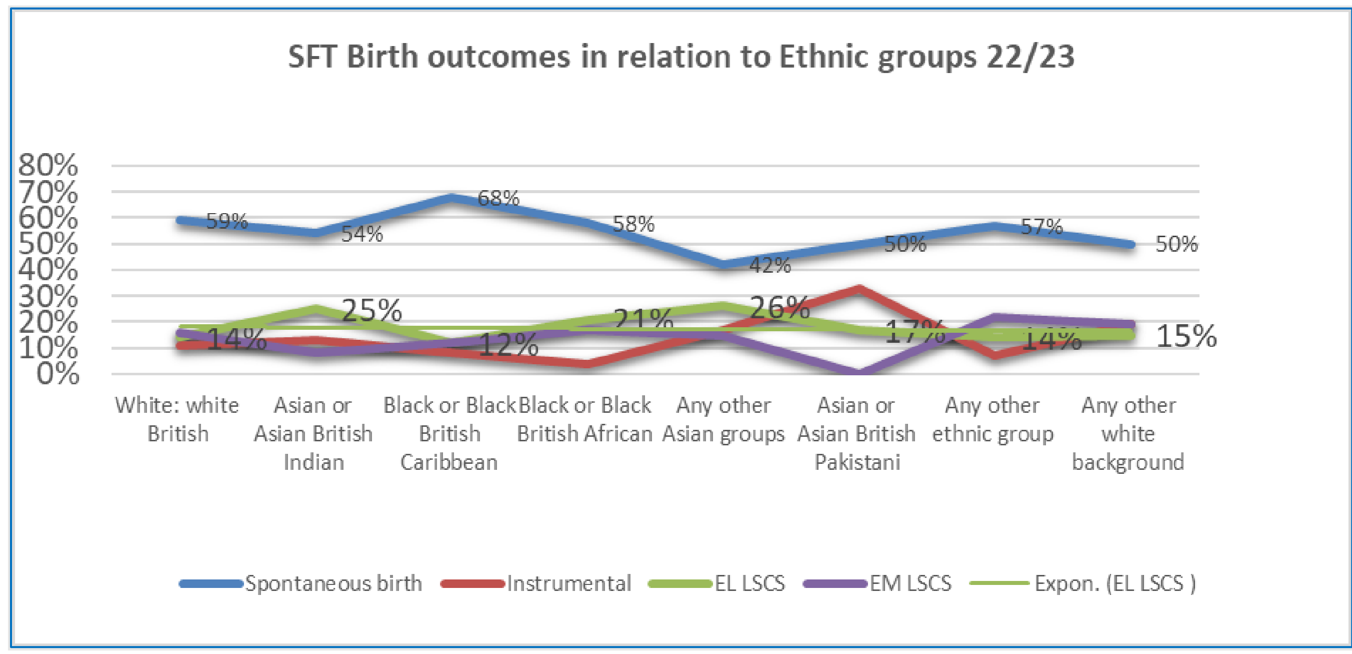
Local Surveys

Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Purpose of the survey: MIS Year 5 requires evidence that the MNVP is 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.

This document evidences feedback from service users which captures voices of those from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation.

Figure 24. Local birth outcome figures by ethnicity



- Nearly all service users did not feel that their care was impacted due to their ethnicity
- Most service users reported positive feedback
- Some service users felt they weren't able to make fully informed decisions
- Translation services were not offered to those applicable during their antenatal appointments
- Some service users have experienced a lack of continuity of care
- Some service users felt they weren't listened to or had to repeat themselves
- Lack of digital records

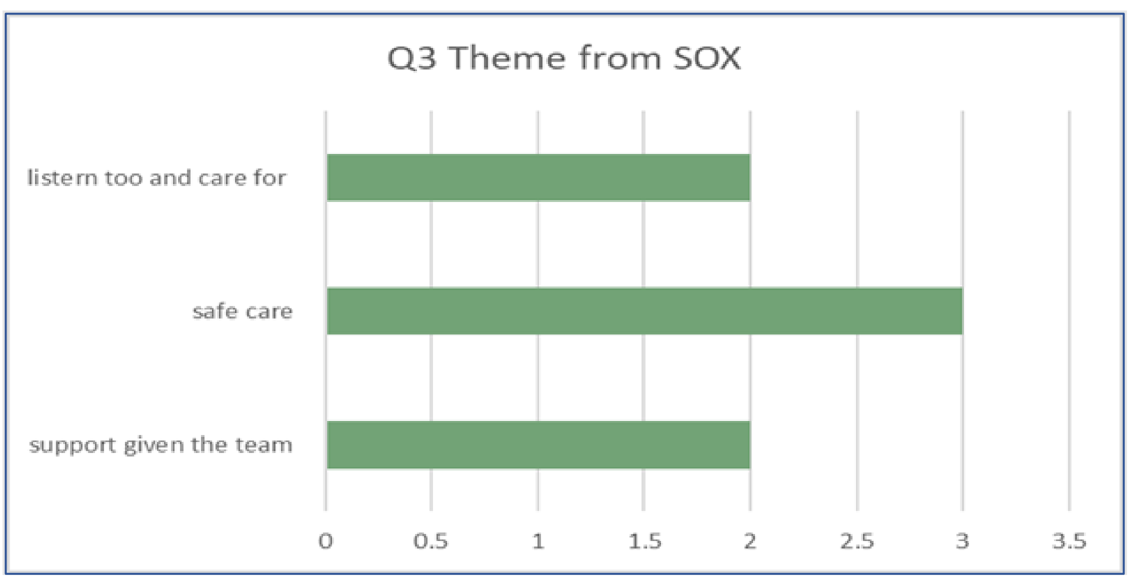
Figure 25. Actions taken in response to local surveys and birth outcome data

Action
Feedback results of this survey with relevant teams
Personalised care training to include service user feedback and informed consent
Review current translation services, consider SOP and communication with teams about translation services
Improve continuity of care in community and antenatal clinic – prioritise areas of deprivation and those with higher ethnic minorities
Implement end-to-end digital system which will improve communication between departments
Submit this evidence to NHSR
Working in collaboration with the MNVP to describe a poster to encourage women to seek support if they are need to translation services.
Undertake a real time survey on women's experience of their ANC appointment.
Provide better information to women on the expectation RE seeing their named consultant at each ANC appointment

Compliments and SOX

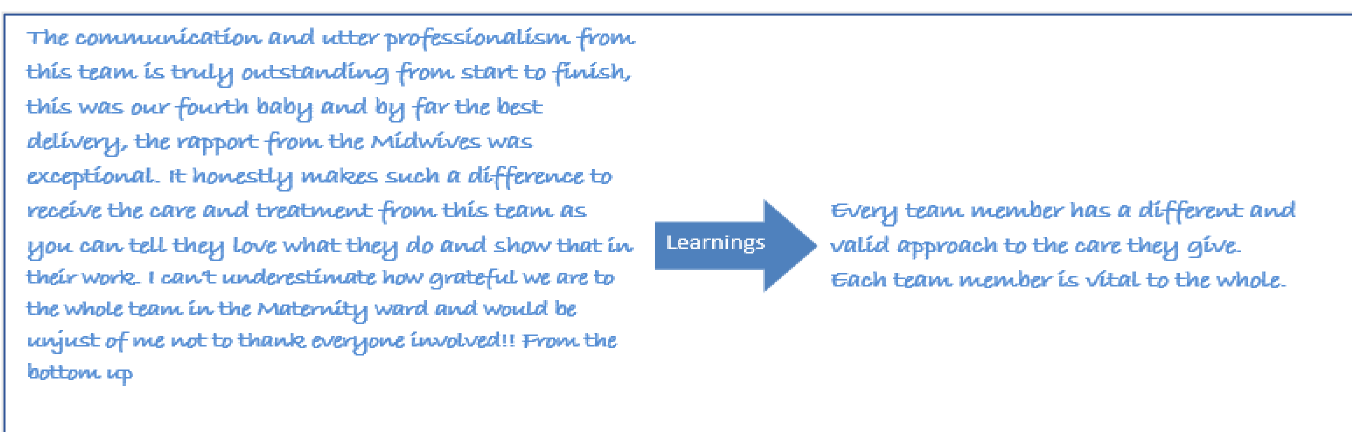
4 compliments in Q4 3 in regard to PN and 1 in respect to Maternity DAU. SOX: 7 SOX recorded in Q3

Figure 26. Themes from SOX in Q3



The provision of safe care appears to be the main theme of SOX in Q3. Below in an example of a comment received and the learning.

Figure 27. example of a comment received and the learning.



FFT (Friends and Family Test)

- **Labour care:**

Rating: VERY GOOD "Outstanding care received during our stay"

- **Community Postnatal care:**

Rating: GOOD: "XX and student midwife were loving and caring. Great after a bad hospital experience"

Rating: VERY GOOD :"All staff very helpful and wiling to share knowledge which can be calming"

Rating: VERY GOOD: "Great support throughout my 2 pregnancies from everyone- Thank you so much".

- **Antenatal Care:**

Rating: VERY GOOD "Team were always friendly and kind. Always did the best   for me and baby. Always cared for my mental health first".

Rating: VERY POOR: "We are a military family who have recently moved to the area. We called and explained we have an 8yr and 1yr. We were told the 8yr can not stay but the 1yr can. Wed suffered bleeding prior to the scan and fear the worst. My wife was then made to go in alone, with out help or support".

Rating: GOOD "I feel like the level of care was good but only from selective staff. I felt I was being left out of the loop about time scales and situation updates. When staff were questioned by me or my husband we were being avoided and left for hours with no care

Response taken: Feedback has been shared with the relevant Matron for consideration and action.

MNVP update

The MNVP together with 2 services users conducted a 15 steps assessment of the Maternity and Neonatal unit on 2nd October 23.

Summary of the findings:

Welcoming & Informative

- Positive signage to the maternity unit is very clear and the new entrance makes it very easy to navigate between the separate areas. The uniform posters are helpful.

Safe and Clean

- The labour ward looked and smelt very clinical whereas the birth centre was a much less overpowering smell. One parent felt reassured seeing all the equipment on display in labour ward whereas the other said it made her feel really anxious

Friendly & Personal

- We were welcomed and acknowledged by most staff members. There is lots of diversity on the posters around the unit, “I didn’t feel alienated as a brown skinned woman”. We really enjoyed the positive affirmation poster on labour ward but wish there were more! The refreshments table and reading materials in DAU is a really lovely touch.

Organised & Calm

- Service users reported the whole unit, particularly labour ward felt much calmer and less chaotic than they expected it to be. Service users still felt a huge contrast between labour ward and the birth centre due to the amount of equipment on view around labour ward. There is also some really lovely artwork on the walls in the birth centre but nothing nice to look at around the labour ward. Kitchen on NICU was very well stocked and accessible and information on walls was relevant and well organised, overall a really nice calm and organised environment.

Areas for improvement:

- Car parking
- Entrance to the labour ward was considered dark due to a broken light.
- No information on how to use the lighting in the birth centre.
- Partner/’s lounge was considered unwelcoming.
- Clear expectation RE who may access the kitchen areas.
- Improved signage on the treatment room doors.
- Review of posters in the inpatient and outpatient areas.
- Inconsistency of artwork.

Action plan has been developed.

We have been involved in various activities around user engagement and feedback as noted below.

Figure 28. Outreach engagement group sessions offered on TEAMS in January

Out- reach engagement groups.

After a very productive MNVP Conversation 15 with a focus on military families, the patient experince midwife/ community midwife situated in the Med Centres will work collaboratively with the MNVP on a new Padlet full of resources for the Military Families.

MNVP survey reports embedded below:

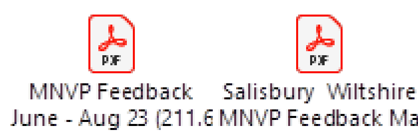


Figure 29. Focus on Personalised Care:

Personalised Care

Key Praise

Parents reported all risks and benefits were explained at their level of understanding and their wishes were listened to.

Areas of Concern

- Confusion and poor communication between Midwives and Consultants
- Parents felt risks and benefits weren't explained clearly or could have been better

Opportunities for Action

To ensure risks & benefits are being explained clearly

PERSONALISED CARE

KEY PRAISE

Parents felt incredibly well supported by Midwives for their birth choices and were pleased with how Midwives listened to, respected and actioned their birth preferences.

AREAS OF CONCERN

- Parents planning homebirths feel they aren't receiving personalised care (Midwives not supporting them through complexities) to give them the very best chance of having a homebirth.
- Parents feeling upset and scared by Doctors – not given the opportunity to make informed decisions or being pressured to go with a different option.

OPPORTUNITIES FOR ACTION

Share the MNVP Making Informed Decisions About Your Care leaflet to ensure all care providers are opening and engaging in two way conversations with parents.

Personalised care planning has been the subject of the recent clinical governance session and is discussed at the annual study days.

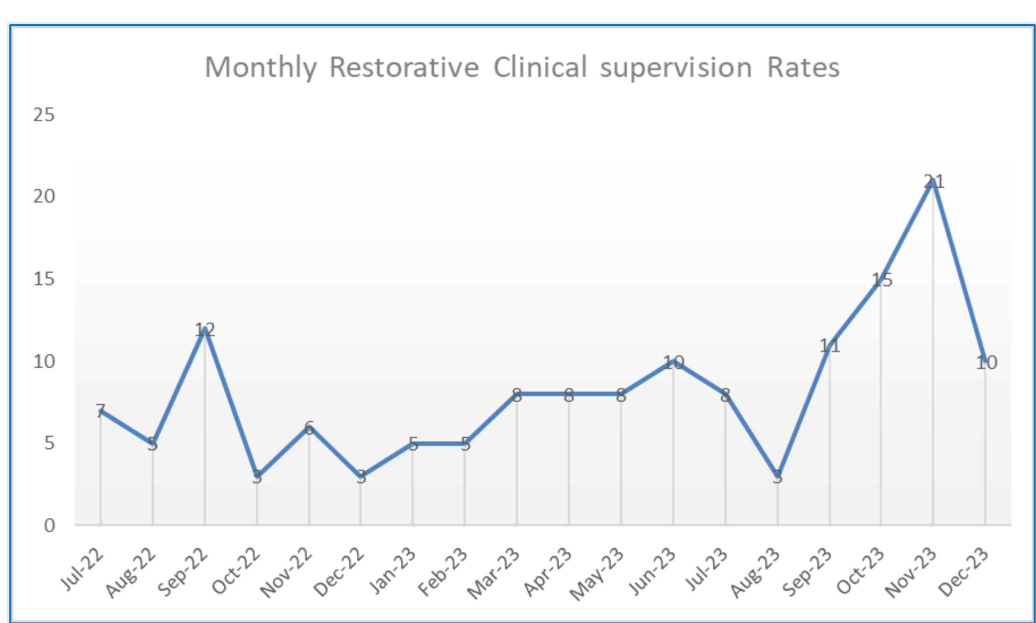
15. A-EQUIP model

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 Q3, all Midwives returning from maternity leave and all new starters have received an RCS session. Additional RCS support for all NQMW and international midwives has continued through Q3. Secure data is kept on the number of RCS sessions taking place, and themes are collected (whilst ensuring confidentiality is maintained). 46 RCS sessions were carried out in Q3, an increase from 22 in Q2 which is an increase of **111%** . The were no Midwives returning to work after long term sickness in Q3,3 were returning to work from maternity leave, 4 were new members of staff, 12 were Preceptees receiving RCS as part of their individual preceptee support package and the remaining 27 were Midwives who had a work-related issue they needed support with.

Figure 30. 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. This is included on induction and within our PROMPT study day.
- Active Bystander Training has been launched to support the growth of a positive culture within maternity and neonatal. This training will be included in the PROMT mandatory study day, as part of a wider session around Civility from January 2024.
- The lead PMA is supporting the role out and analysis of the SCORE cultural survey (part of the Perinatal Culture and Leadership programme), undertaking deeper Cultural conversation debrief with staff through Q4.
- PMA input remains a large part of our Preceptorship support package, and includes quarterly 1:1 restorative supervision and teaching on preceptee study days. Topics covered include creating a positive work place culture, civility and respect, and a session on increasing awareness around psychological health in the workplace, and how to maintain and protect it.
- Production of Wellbeing folders for staff for all staff rest rooms, with information and signposting around physical health, psychological health and the menopause.

PMA Training

There are 2 Midwives starting PMA training in January (funded through NHS England).

PNA/PMA collaborative working.
With 2 nurses from NICU starting PNA training, discussions are underway about how the PMA's and PNA's within Women and Newborn can work together collaboratively to form a larger PMNA team, in support of all maternity and NICU staff.

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.

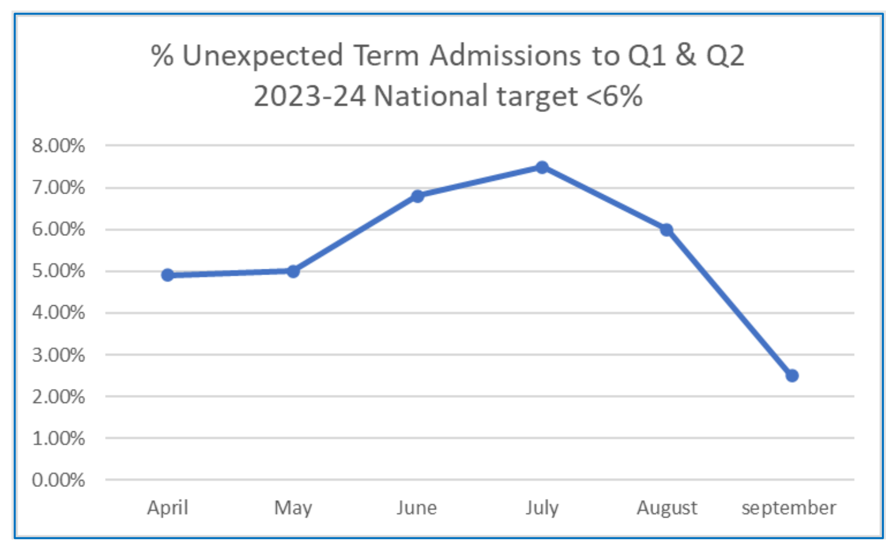
The national ambition is for the percentage of term babies admitted to NICU to be **<6%**, however our local Operational Delivery Network aims for a rate of **<5%**. The Q3 rate in Salisbury is **5%** so remains red (see TVW ODN ATAIN Dashboard embedded below).

A data collection error has been identified locally and the neonatal team are working with the TV&W data analyst and maternity digital lead to resolve this. Current local data below shows a local ATAIN rate of **4.6%**

Figure 31. Local ATAIN rates per month for Q1, 2 & 3

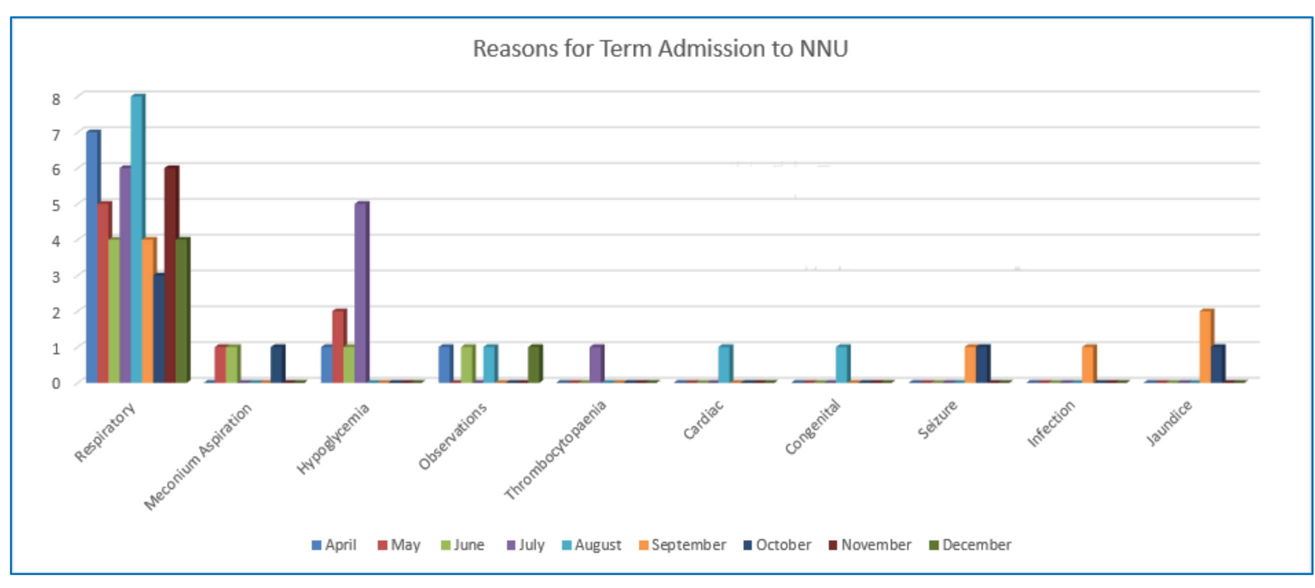
Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
123	160	148	159	166	160	169	161	165
135	172	162	170	179	166	186	179	180
9	11	11	16	16	8	8	9	5
6	8	10	12	10	4	6	6	3
4.9%	5.0%	6.8%	7.5%	6.0%	2.5%	3.6%	3.7%	1.8%

Figure 32. % of avoidable term admissions against national target for Q1 & Q2.



The majority of ATAIN admissions are due to respiratory complications associated with birth (Transient Tachypnea of the Newborn TTN). Please see the below CNST data from April – December this year pertaining to ATAIN.

Figure 33. ATAIN admission categories for Q1, Q2 & Q3.



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.

Below is the ATAIN meeting action tracker that has been embedded:

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.

Dedicated Project Management support has been provided from the SFT Transformation Team resource for the 6-month period until the end of April 2024. The aim of this introduction is to co-ordinate the delivery of the Maternity Safety Support Programme with an objective to exit the MSSP by March 2024.

The benefits will be demonstrated through action progress tracking within the Maternity Improvement Plan.

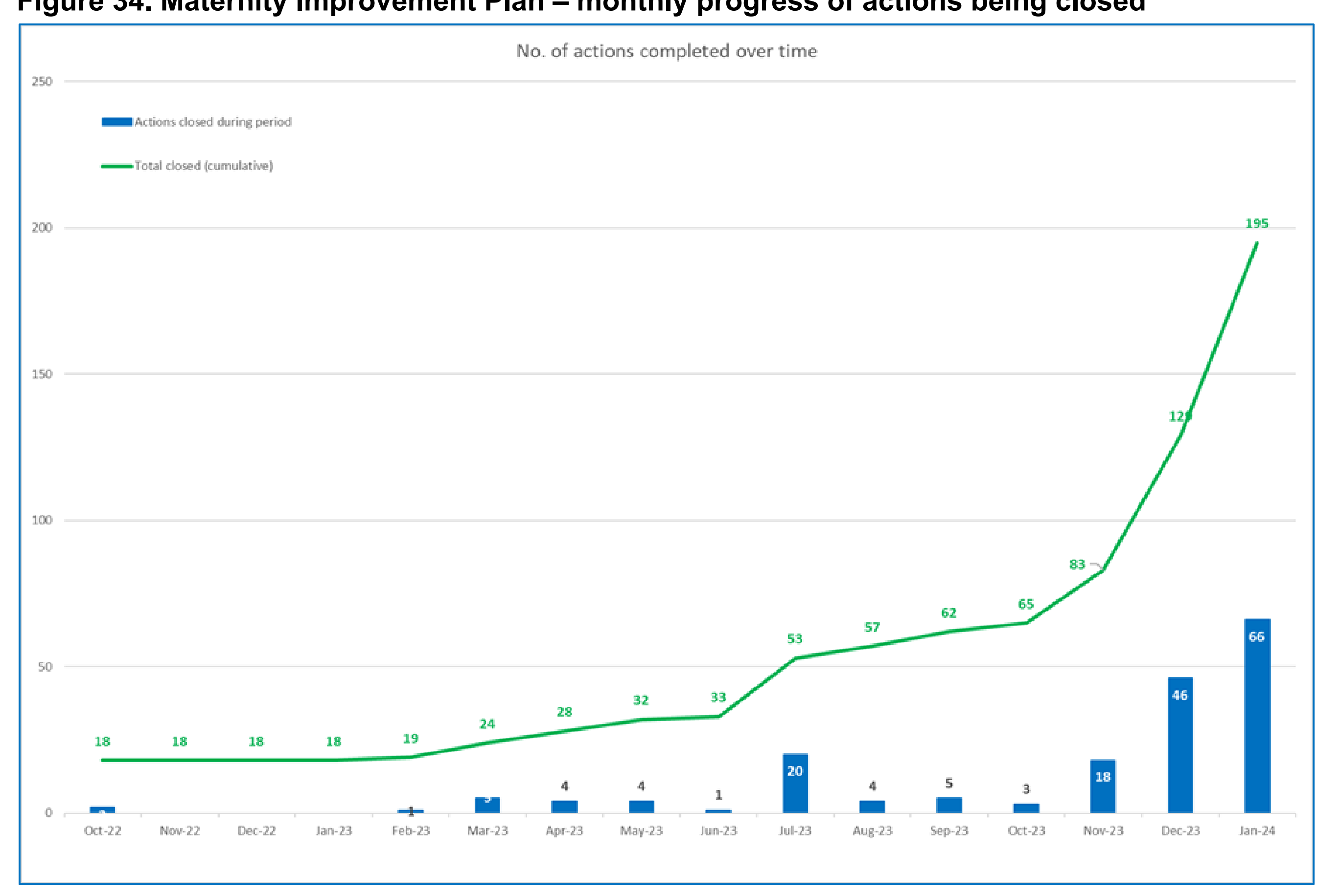
Maternity Improvement Plan (MIP)

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 met with LMNS lead Midwife, Regional Chief Midwife and MIA in October 2023 to reset priorities, agree timelines and the exit plan from the programme.

The Maternity Improvement Plan provides both a high-level overview of the current situation,and demonstrates where focussed resource would deliver value.

Figure 34. Maternity Improvement Plan – monthly progress of actions being closed



18.Audit and progress on Care Quality Commission audit feedback

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.

The figure below shows audit compliance for bladder care in Q3 and 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 program and a continued Improving Together project.

Figure 35. audit compliance for the bladder care (covering the last quarter)

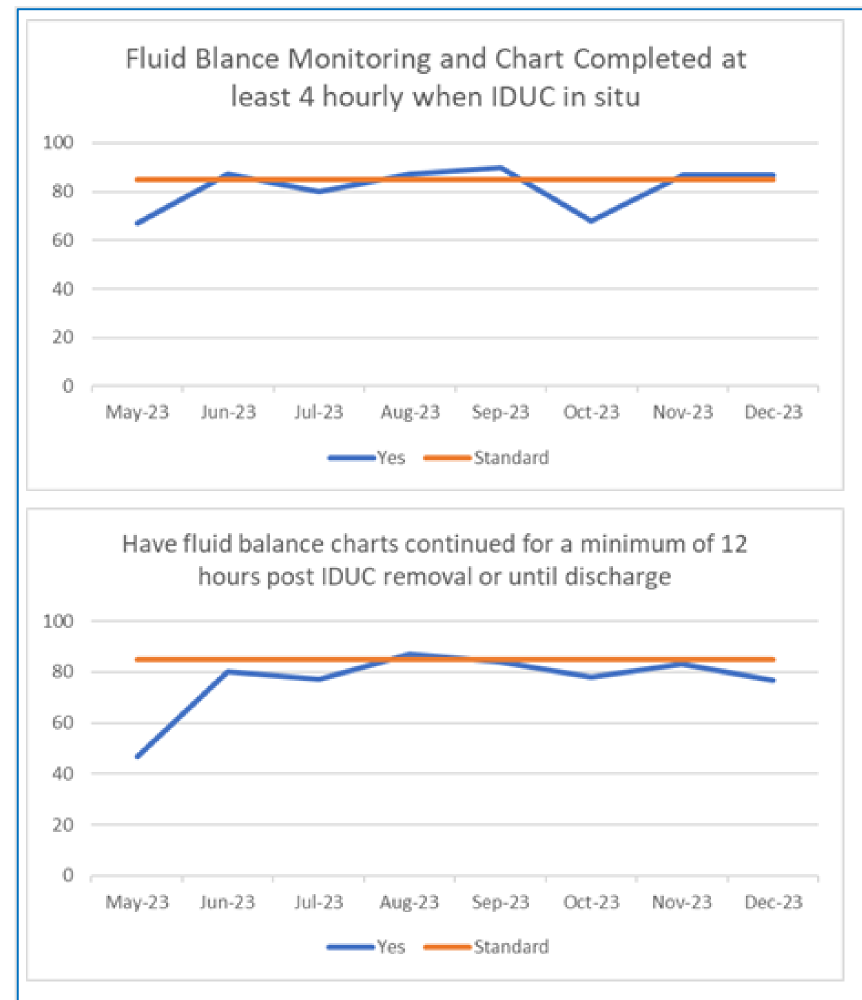
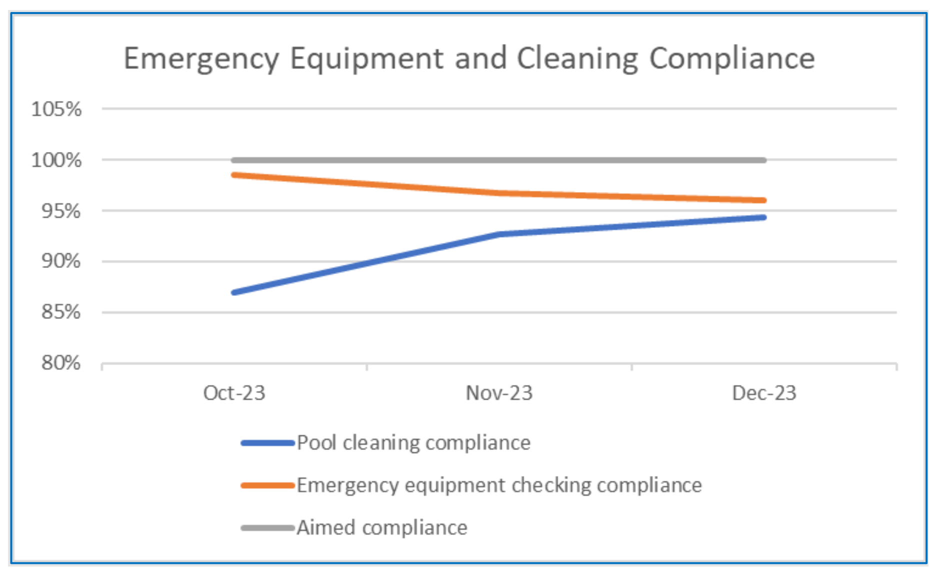


Figure 36. audit compliance for the pool cleaning



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 have taken 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 presented at Maternity Governance meeting in January 2024 and will be shared with 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 bi-monthly 'Risk Register Review Meeting' has been set up. Named leads with risks on the register are reminded to review and update their risk and, are invited to the meeting or provide an update. Current risk register highlights are identified below.

Figure 37. Risk register summary on 30.1.24

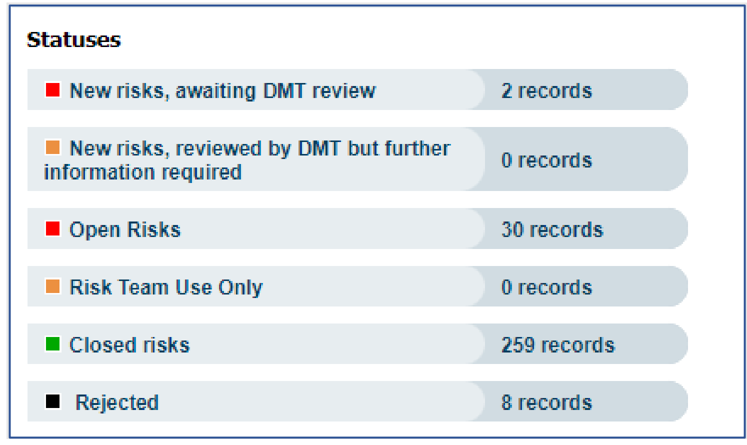


Figure 38. New Risks, awaiting DMT review as of 30.1.24

ID	Title	Opened	Risk Type	Rating (current)
7923	Neonatal unit heating	08/12/2023	Corporate Risk	10
7858	Lack of specialist antenatal clinic dedicated to multifetal pregnancy	30/09/2023	Clinical Risk	10

Figure 39. Current Open Risk register items as of 30.1.24

ID	Title	Opened	Risk Type	Rating (current)
7894	Delay in first trimester screening bloods reaching the lab in Portsmouth	14/11/2023	Clinical Risk	12
7812	Inadequate labour ward building	17/08/2023	Clinical Risk	15
7733	Lack of Service for Abnormal Placentation	15/06/2023	Clinical Risk	15
7700	Independent Midwifery Local Guidance	19/05/2023	Clinical Risk	8
7913	W&N Division not vaccinating babies within 28 days who require it	28/11/2023	Clinical Risk	12
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
6836	Risk of re-designation of neonatal intensive care service	24/02/2021	Clinical Risk	5
6412	Lack of 2nd Obstetric theatre	28/04/2020	Clinical Risk	9
7860	Neonatal ventilators	04/10/2023	Clinical Risk	12
7222	Number of Administration roles across division do not meet service need	14/02/2022	Organisational Risk	8
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
7014	Paper maternity records posing an IG issue and safety issue if information lost	16/08/2021	Clinical Risk	15
5713	shortage of midwives which may pose a risk to deliver safe care thoughout the maternity care pathway	07/02/2019	Clinical Risk	10
7047	No access to maternal records for women out of area as trusts moved to digital maternity records	13/09/2021	Clinical Risk	9
6773	transfusion training competencies do not meet the minimum requirements of the blood policy of 85%	24/12/2020	Clinical Risk	12
7693	Obstetric and Paediatric teams have no job plans for antenatal and postnatal screening programmes	15/05/2023	Clinical Risk	8
7623	Neonatal ROP	02/03/2023	Organisational Risk	5
7109	There is a theorectical risk of infection to women and babies as the Labour Ward birthing pools are over recommended manufactu	15/11/2021	Clinical Risk	5
7891	No separate consultant rotas for obstetrics and gynaecology	13/11/2023	Clinical Risk	4
7634	Maternity Information system (E3)	14/03/2023	Corporate Risk	12

20.Safeguarding

SAFEGUARDING SUPERVISION

- Safeguarding supervision for CMWs = 89%
- Safeguarding supervision for Unit MWs = 56% . Midwives are required to complete 3 sessions/year. The plan is to increase the number of sessions available and roster staff from April. One of the supervisors is currently off sick.
- Midwives who have completed 0 sessions = 10. Plan as above and staff will be emailed and line managers copied in. Line managers to discuss the those non-complaint to ensure protected time is prioritised to compete this training.
- Only 3 midwives currently trained in children's safeguarding supervision, designated nurse for safeguarding ICB has suggested this should be 5 to support with organisational resilience. We have a large majority of midwives who are less experienced and require more supervision to support in the development of their safeguarding knowledge. Plan to be agreed.

CP PLANS- The quality of data is limited as we are awaiting outcomes for several cases

- 3 Unborns on CP plans.
- 3 on CIN
- 3 level 2B
- 3 single assessments in progress
- Themes for legal proceedings include neglect, severe MH, DA, substance misuse and learning difficulties.

Good news: We have had 2 recent cases which have required involvement from adult safeguarding due to concerns regarding capacity. We used a multidisplinary approach and we met regularly to ensure actions had been completed in a timely manner, adult safeguarding was able to advise the appropriate support for the women. This included the nurse for learning disabilities and autism, who was able to support and meet the women in the obstetric antenatal clinic.

One of the cases involved working closely with the perinatal health team and the appropriate care was able to be implemented within a timely manner.

Level 3 Safeguarding Children training:

- Midwives' compliance = 71%. All non-compliant midwives have been rostered for training throughout the year and this will continue in the future.
- Obstetricians' compliance is currently 82% and will be 100% by the end of April
- Plan for Junior doctors to link with Shelley King and Hannah Rickard to roster the training within their work plan.
- L3 Safeguarding children training is fully booked until April 2024 but additional places were provided for the January training.

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 is 33% and improving. We are required to provide adult safeguarding supervision and a plan for adult safeguarding supervision training is in development.

21.Beatrice Birthing Unit

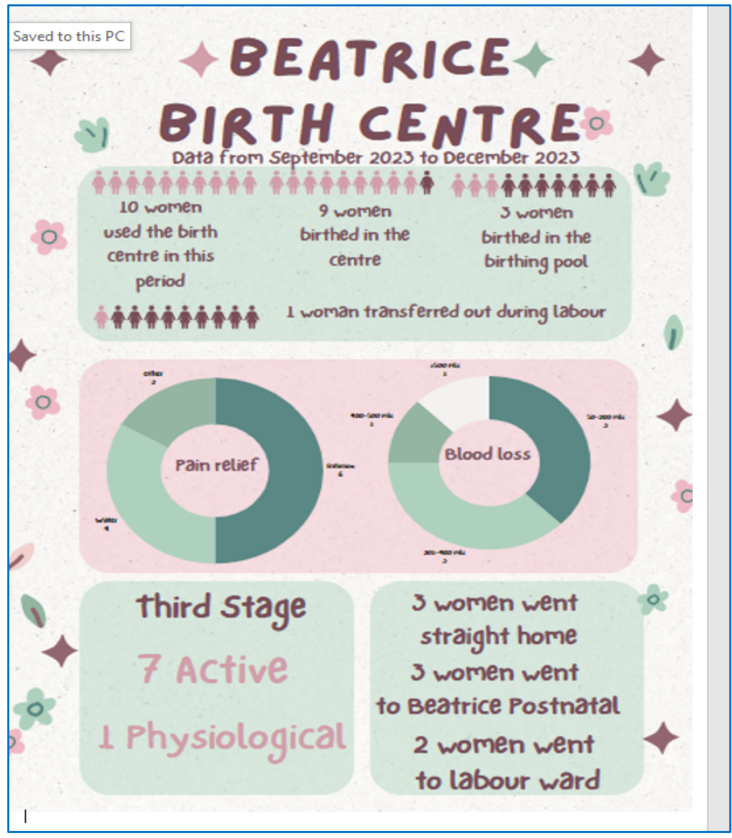
During 1st October 2023 – 31st December 2023 11 women have utilised the Beatrice Birth Centre, which equates to 2% of service users

Of these 11 women, 90.9% birthed their baby in the birth centre. The 1 woman who was transferred during their labour for a prolonged 2nd stage. This is summarised in the infographic in figure 30.

During this period the inpatient matron has attended information sharing sessions hosted by the MNVP to promote and showcase the Beatrice Birth Centre

Feedback from women who have used the birth centre continues to be very positive.

Figure 40. Beatrice Birth Centre infographic summary September 2023 - December 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. 34 of the recommendations have now been confirmed as closed by NHS England quality assurance team the remaining 10 recommendations have been handed to the Screening and immunisations team to continue to monitor. QA have recently sent a letter to the directors outlining the remaining open recommendations. There is a plan that is being worked towards for the remaining recommendations to be closed. QA had a positive response to the number of recommendations the screening team have closed to date.

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 Q3 SDH has had 1 Antenatal SIAF.

Antenatal SIAF 12086 - A lady who had booked her pregnancy with SDH contacted as she had not received her First trimester screening results and was 17 weeks pregnant. Results had not been sent or reported as the patient had only had a dating scan and not first trimester screening as she had requested. The investigation found that the out of area process for women booking to deliver at Salisbury (OOA) had fallen short of the expected standard.
1. The OOA team had emailed the Antenatal clinic midwives who had past the booking form on to the administration team. The booking form had not been completed correctly and therefore it was not clear if the patient had opted for screening. When the patient called to ask for an appointment date, she was given a dating scan appointment only.
2. Sonographer did not clarify with the patient if she had declined screening.
3. Failsafe check by MCA and screening team highlighted improvements required to ensure patients who have a dating scan are rebooked for NT scan or contacted to discuss screening options.
4. Quad test was not offered instead the patient was offered NIPT as senior DMT felt it was more appropriate to screen the women for all three conditions as she had wanted combined testing.

Q2&Q3 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 41. Q1 (2023) and Q2 (2023) Antenatal and Postnatal screening KPI improvement areas highlighted in yellow **Q3 KPI's are not published until March.*

KPI Standards	Q1 (2023) April-June	Q2 (2023) July-Sep	Acceptable threshold	Achievable threshold
ST1: Antenatal screening Coverage	99.6%	100%	>95.0%	>99.0%
ST2: timeliness of antenatal screening	76.1%	74.8%	>50.0%	>75.0%
ST3: completion of FOQ	95.6%	92.7%	>95.0%	>99.0%
ST4a: timely offer of PND to women at risk of having an infant with SCD or thalassaemia	100%	0 cases	To be set	To be set
ST4b: timely offer of PND to couples at risk of having an infant with SCD of thalassaemia	100%	0 cases	To be set	To be set
NB2: Avoidable newborn blood spot repeat tests	1.4%	0.8%	<2.0%	<1.0%
ID1: HIV Coverage	99.6%	100%	>95.0%	>99.0%
ID3: Hepatitis B coverage	99.6%	100%	>95.0%	>99.0%
ID4: Syphilis Coverage	99.6%	100%	>95.0%	>99.0%
FA2: Coverage 20- week screening scan	99.8%	99.0%	>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%	87.5%	>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	96.6%	97.7%	>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.	86.2%	89.0%	>90%	>95%

During Q2 there was a decline in the following KPI's, ST2 (The proportion of pregnant women having antenatal sickle cell and thalassaemia screening for whom a screening result is available

before or at 10 weeks plus 0 days gestation.), NH2 (The proportion of babies requiring immediate referral who are brought for an audiological assessment appointment in the required timescale.) The acceptable standard was not met 1 Baby missed the NH2 KPI due to parents cancelling 2x appointments offered within the NH2 window. They attended a 3rd appointment made which breeched NH2. NP3 (The proportion of babies with a screen positive newborn hip result who attend for ultrasound of the hips within the designated timescale) measures have been put in place to bring the KPI's back to the acceptable threshold and improvements have been seen in Q2 in some of the KPI's that were not meeting the acceptable and achievable thresholds during Q4 & 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.***

Focus within the last quarter has been around working towards achieving CNST MIS year 5 compliance. We are now 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 in Spring 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.
- Working towards SBL compliance and resource to support this.
- Focus on working towards three-year delivery requirements and mapping the additional resources identified to deliver on the plan.

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	6.6
Date of meeting:	7th March 2024		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services – January (December data)			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Approved by DMT on 11.01.24 Divisional Governance on 19.01.24 Clinical Governance Committee 30th January 2024			
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 December 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.
- Midwifery vacancies and maternity leave mitigated by bank usage.

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

- Midwife to birth ratio 1:32
- 1:1 care in labour achieved at all times
- Supernumerary status of labour ward maintained 100% time

PMRT

- No cases scheduled for review in December
- 4 actions from PMRT review – all in progress

Incidences reported as moderate

- 5 –
  - 1 stillbirth at 25.5. No omissions in care noted at initial review, for PMRT review.
  - 2 third degree tears – no themes noted.

Ongoing investigations

- Deep dive into delays in completing within 60 day target and actions taken to improve compliance

CNST

- Compliance of 9 out of 0 safety actions achieved – increase from 5 achieved last year

Service user and staff feedback

- 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):	

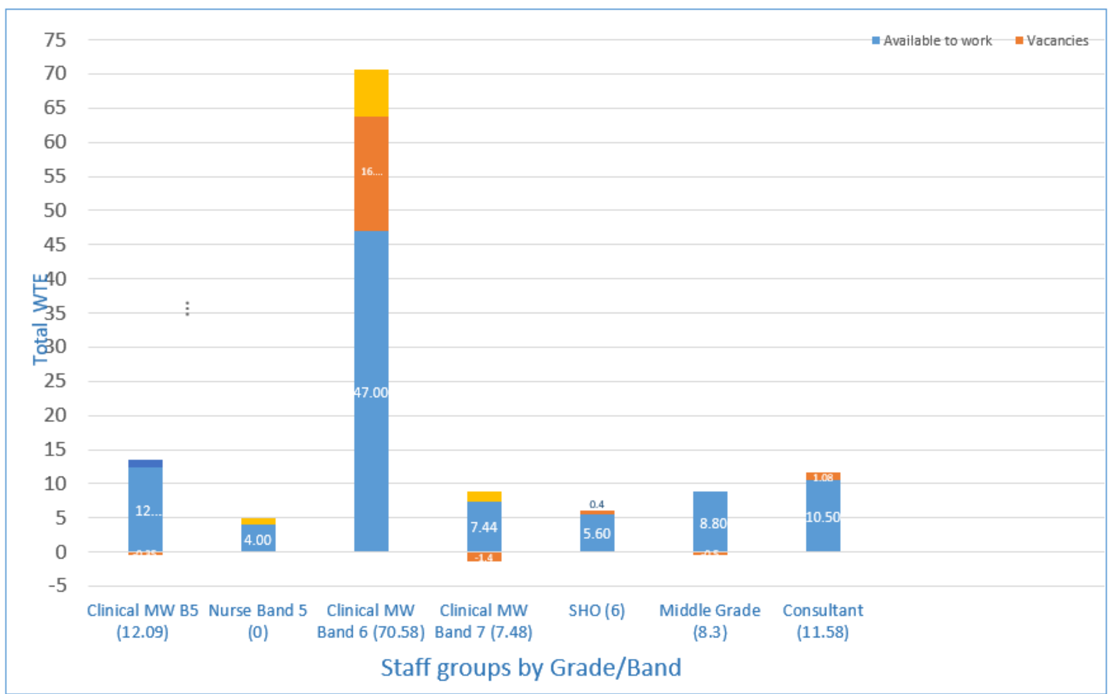
Perinatal Quality Surveillance Integrated Performance – Monthly Report

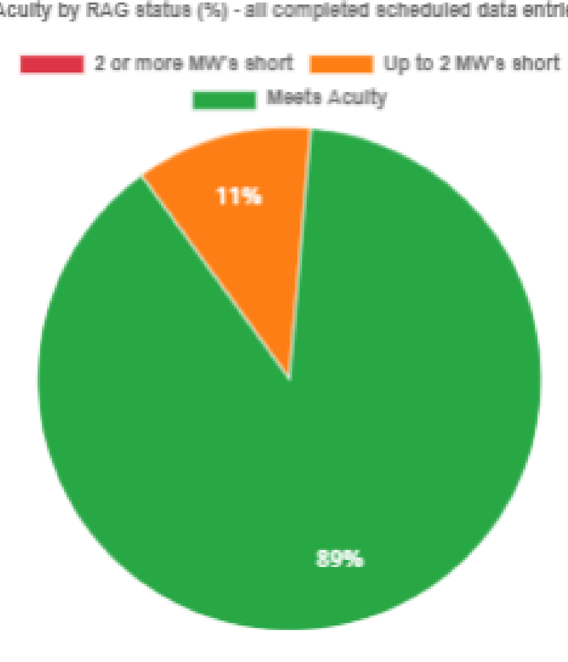
December Data 2023

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

Maternity & Neonatal Workforce

	Target	Threshold (green)	Threshold (red)	Oct 23	Nov 23	Dec 23	Comment
Midwife to Birth Ratio	1:26	=<1:26	>1:26	1:30	1:28	1:32	
1:1 Care	100%	100%	100%	100%	100%	100%	
Consultant Presence in Delivery Suite (Hrs per week)	40	=>40	<40	40	40	40	
Supernumerary Status of Delivery Suite Coordinator	100 %	100 %	100 %	100 %	100%	100	
Confidence factor in Birthrate+ recording						Yes	Audit commenced November 2023
Daily multidisciplinary team ward round					100%	100%	Audit commenced November 2023
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0			0 Datix received	0 Datix received	0 Datix received	To be monitored via datix reporting





- **OVERVIEW**

Key Achievements:

- Out of seven international midwives who have joined the trust all have now passed their OSCE. Two are awaiting NMC PINS.
- Supernumerary status of coordinator maintained and achieved 100% of time
- 1:1 care achieved 100% of time
- Two Band 5 Preceptee Midwives commenced in post in Dec. A further two have conditional offers. Awaiting start dates.
- One Band 6 started 2/1/24 3 further have conditional offers.

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 MSW candidates confirmed for Midwifery apprentice course in January

Key Risks:

- Vacancy rate of 14 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 1/1/2023-22/12/2023 form MBRRACE data tool. To show the trend of the year. (Excluding MTOP's, data only given up to last loss)*
- *Table 1: There were no cases reviewed by the PMRT review group in December 2023*
- *Table 2:There were no cases reviewed by the PMRT review group in December 2023*

Number of babies who died in December that meet PMRT review criteria:

1- Stillbirth at 25 weeks

Improvement Actions & Timescales:

To review action tracker and gather updates on outstanding actions.

Themes in issues:

None

Figure 1. Live data for perinatal losses reportable to MBRRACE 01/01/2023- 22/12/2023

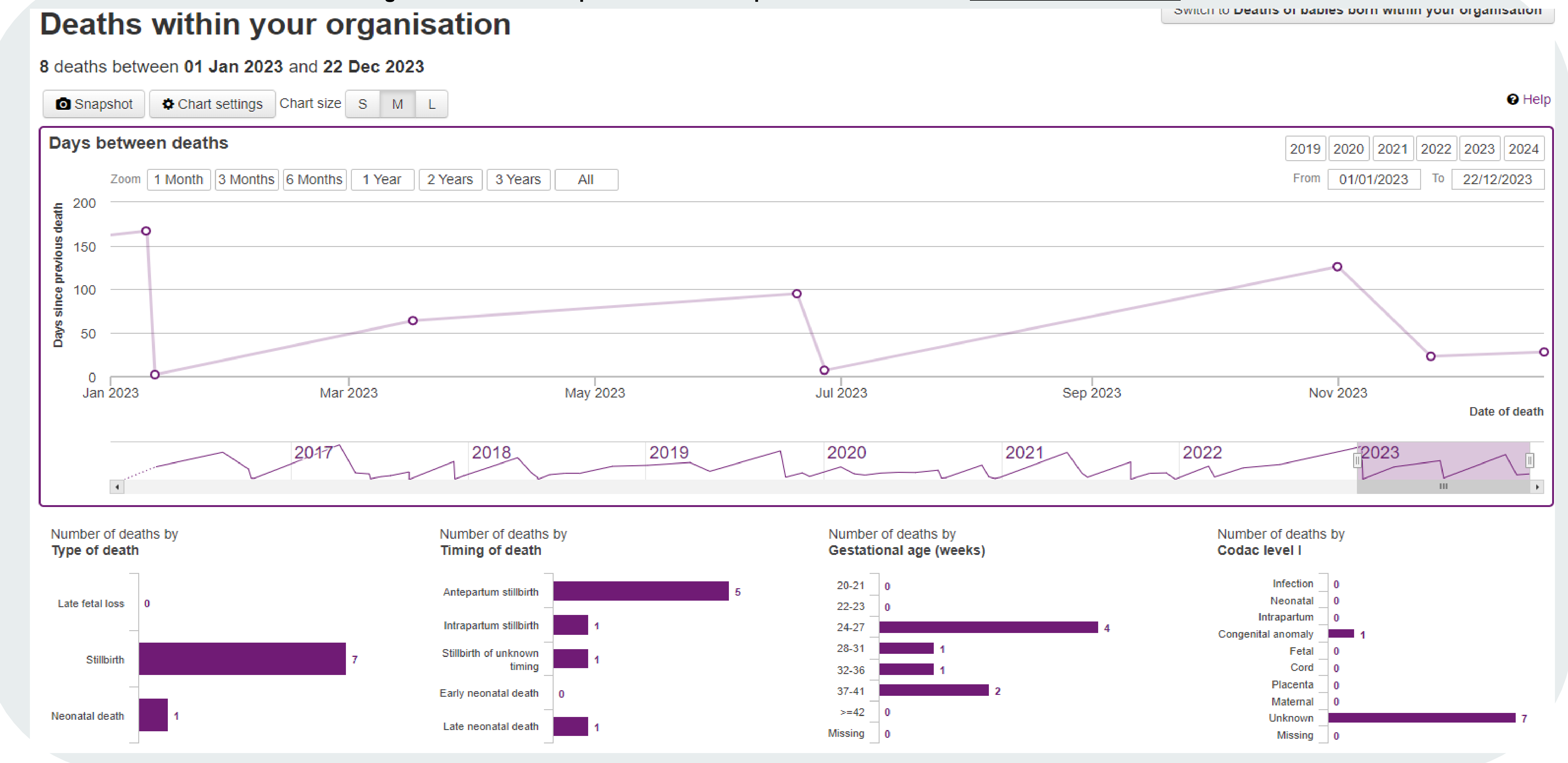


Table 1: PMRT reviews completed during the reporting month

No cases were eligible for review using the PMRT tool in December 2023

Table 2- PMRT Actions from reviews in the reporting

No cases were eligible for review using the PMRT tool in December 2023

Incidents & Investigations
DATIX SUMMARY

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI Reference
161613	01.12.2023	Moderate	3c tear	No omissions in care noted. OASI measures used at the time of birth. To ensure staff are counselling for OASI antenatally. Added to rolling audit and presented as part of fixed agenda update at Patient Safety Summit.	N/A	N/A
161648	10.12.2023	Moderate	3rd degree tear	No omissions in care noted	N/A	N/A
162239	16.12.2023	Moderate	2L MOH with blood products.	2L MOH following forceps delivery. Found through failsafe report on 5th January 2024-for 72hr review and will update Datix accordingly.	N/A	TBC post review
161983	22.12.2023	Moderate	Attended DAU with reduced fetal movements at 25+5. IUD diagnosed.	72hr report delayed due to quoracy of panel. Panel met and case to be presented at Patient Safety Summit 09.01.2024.	N/A	TBC post review.
162016	26.12.2023	Moderate	Term admission to NICU from labour ward for temperature instability and low blood sugars.	Appropriate care provided on labour ward-no omissions in care. Review of term admission to go through the ATAIN process.	N/A	N/A

New Serious Incidents (November 2023)

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI Reference
NO NEW SII						

** Following recommendations made in the Ockenden Report all cases referred to MNSI (formerly HSIB) will be reported as a Serious Incident (SI).

72-hour Incident Reviews

Completed Maternity & Neonatal 72-hour Reviews (Nov 23)

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI Reference
161461	04.12.2023 To be presented at PSS after external opinion.	No harm	Mother presented with puerperal psychosis.	Review requested as it was felt that there were some cross-department learning points that needed to be addressed. Helpful meeting between maternity and mental health teams. BH and LW to create flowchart for presentation on the clinical wards to assist with information around presentation and what to do/who to contact re: puerperal psychosis.	N/A	N/A
160280	14.11.2023 Presented at PSS 05.12.2023	No harm	3rd degree tear	Delay in presentation of this case as extra information requested from attending midwife who only has a bank contract therefore difficult to get hold of. Information gathered and circulated to the panel-no concerns. Taken to PSS as part of rolling update.	N/A	N/A
160870	01.08.2023 Reviewed 12.12.2023	No harm	Complaint case flagged through Family Experience Midwife	Mother raised complaint that induction of labour process was prolonged by the use of prostaglandins, rather than using oxytocin straightaway. Care reviewed by panel-no omissions in care noted and fed back to Family Experience Midwife.	N/A	N/A
160856	14.11.2023 Presented at PSS 02.01.24	No harm	Collapse in ANC	Patient was found to be not pregnant and was attending for pre-conception care. Immediate safety actions were identified such as out of date signage and issues with the buzzer system which were rectified the same day.	N/A	N/A
161099	23.11.2023 Reviewed 7.12.2023	No harm	Scar dehiscence noted at ELLSCS	Reviewed by panel-although noted at ELLSCS not through to serosa layer. Liquor noted to be clear at delivery and not bloodstained.	N/A	N/A
161392	30.11.2023 Reviewed 13.12.2023	No harm	Term admission to NICU. Apgar scores did not reflect the gases and condition of the baby	No omissions in care.	N/A	N/A

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

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
CR 565	Maternity/W&NB	Uexpected admission to neonatal unit	18/05/2023	30/05/2023		22/08/2023		CRG 11.1.24
CR 569	Maternity	Uncrossmatchable Blood - Antibodies	02/06/2023	13/06/2023		08/09/2023		CRG 11.1.24
SII 570	Maternity	Retained Swab	09/06/2023	13/06/2023		08/09/2023		External chair. Panel 16.10.23 (originally 5.9.23). Report in writing. Escalated to Risk Management for support. Planned for CRG 15.2.23
SII 571	Maternity	Placenta Acreta	25/05/2023	20/06/2023		14/09/2023		Panel 16.11.23. Report in writing. CRG 15.2.24
SII 574	Maternity	Stillbirth		27/06/2023		21/09/2023		Panel 14/8/23. Awaiting draft report ETA 5.2.24. CRG 15.2.24.
CR 580	WNB	Term admission to NICU	16/07/2023	01/08/2023		23/10/2023		Panel on 16.10.23. Awaiting amended draft. Chair out of country.
CR 584	Maternity	OASI	3.7.23	8.8.23		30/10/2023		Rescheduled panel successfully sat on 8.1.23. Report in writing. Additional info required.
SII586	Maternity	Eclampsia and GA	8.8.23	22.8.23		13/11/2023		External chair. Panel on 2.11.23. Draft Report received 5.1.23.
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		Final report received. To organise Tripartite meeting and action plan. Draft action plan and present to CRG for sign-off. CRG on 8.2.24
CR 588	Maternity	Antenatal Pulmonary Embolism at 15 weeks pregnant	31.7.23	29.08.23		20/11/2023		Panel 31.10.23 (moved from 11.10.23). Report in writing - support with draft.
CR 599	Maternity	PPH at Home, did not follow guidelines. C/O IDM	19.9.23	3.10.23		28/12/2023		Panel 12.1.23
CR 613	Maternity/W&NB	Eclampsia	19/11/2023	28/11/2023		26/02/2024		Panel date TBC - awaiting further availability. Escalation to Risk lead.

Reports for EXIT								
ID	Directorate / Ward / Dept	Summary of incident	Date commissioned	CRG	Date Due to CCG	Within 60 day target?	Progress notes	
CR 579	WNB	Term admission to NICU	20/04/2023	18/07/2023		09/10/2023		CRG Dec. Awaiting EXIT meeting date.

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		

Following recommendations made in the Ockenden Report all cases referred to HSIB will be reported as a Serious Incident (SI).

Data correct as of 9.1.24 (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 – Open and Completed

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 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 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							
SII 548	Click	W&NB/Surgery	February 2023	Nov 23	Nov 23	Nov 23	Nov 23	Surg	Nov 23	Nov 23				

W&NB SII / CR Completed 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 425	Click	W&NB	September 2021	Q1 23-24	Q1 23-24	Q1 23-24	Q1 23-24							
SII 432	Click	W&NB	September 2021	Q3 21-22	Q3 21-22	Q2 22-23	Q2 22-23	Q2 22-23	Q2 22-23	Q2 22-23				
SII 437	Click	W&NB	October 2021	Q2 22-23	Q3 22-23	Q3 22-23	Q3 22-23	Q1 23-24						
SII 442	Click	W&NB	October 2021	Q4 21-22	Q3 22-23	Q3 22-23	Q4 22-23	Q3 22-23	Q1 22-23	Q2 22-23	Q4 21-22	Q1 22-23	Q1 22-23	
CR 453	Click	W&NB	October 2021	Q3 21-22	Q1 23-24	Q3 22-23	Q3 22-23	Q3 22-23						
CR 462 (PA)	Click	W&NB	January 2022	Q1 23-24	Q1 23-24	Q3 22-23	Q2 22-23	Q1 23-24						
CR 462 (PB)	Click	W&NB / Medicine	March 2022	Q1 23-24	Med.	Q2 22-23	Q2 22-23							
CR 466	Click	W&NB	February 2022	Q1 22-23	Q3 22-23	Q3 22-23	Q3 22-23							
CR 462 (PC)	Click	W&NB	January 2022	Q3 22-23										
CR 451	Click	W&NB	October 2021	Q3 21-22	Q3 21-22	Q4 21-22	Q1 22-23	Q3 22-23	Q2 22-23	Q3 22-23				
SII 460	Click	W&NB / Surgery	January 2022	Q4 22-23	Q4 22-23	Q3 22-23								
SII 484	Click	W&NB	May 2022	Q4 22-23	Q1 23-24	Q1 23-24	Q1 23-24	Q1 23-24	Q2 23-24					
CR 492	Click	W&NB	July 2023											
CR 505	Click	W&NB	August 2022	Q2 22-23	Q1 23-24	Q4 22-23	Q1 23-24							
SII 497	Click	Surgery	July 2022	Surg	Q1 23-24	Q2 23-24	Med	Apr 23						
SII 472	Click	W&NB	February 2022	Q1 22-23	Oct 22	Oct 22	Q3 22-23	Q3 22-23						

** 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 11th December.

Feedback – Staff & Service Users

MNVP Service User Feedback	Safety Champions Staff Feedback
Key Achievements & Positive Feedback: **No new feedback received.** **Identified Areas of Improvements:** **Next Steps for Progressions:** collaborative working with the relevant leads of departments and the MNVP on the development of a service improvement action plan.	**Key achievements & positive Feedback:** No additional feedback this month **Identified Areas of Improvements:** **Next Steps for Progressions:** .
Compliments & Complaints	**Friends & Family Survey**
Themes & Trends: Dec 23 **No new maternity complaints** **Themes from comments**: **Only one comment and enquiry logged on Datix, in regard to the Birth Reflection Service.**	**Key Achievements:** **Identified Areas of Improvements:** **Next Steps for Progressions:** **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:** 2023 National Maternity Survey action plan to be finalized by the DMT,

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
Nov-23	1	Enhanced Safety	0=	0=	3=
	2	Listening to Women & Families	0=	0=	1=
	3	Staff Training & Working Together	0=	0=	3= ↑
	4	Managing Complex Pregnancy	0=	0=	3=
	5	Risk Assessment Through Pregnancy	0=	0=	2=
	6	Monitoring Fetal Wellbeing	0=	0=	8= ↑
	7	Informed Consent	0=	0=	3= ↑
		TOTAL	0	0	5↑

Ockenden 2020 Report

Key Achievements:
Now fully compliant with Ockenden 2020
Can now be removed

OCKENDEN 2022 Report

	Current Rag Status	Immediate & Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
Dec-23	1	Workforce Planning & Sustainability	0=	2=	1=↑	4=
	2	Safe Staffing	0=	4=↓	1=↑	5= ↑
	3	Escalation & Accountability	0=	2=↓	1=↑	2=
	4	Clinical Governance - Leadership	0=	3=	0=	4=
	5	Clinical Governance - Incident Investigation & Complaints	0=	3=↓	2=↑	2=
	6	Learning From Maternal Deaths	0=	2=	0=	0=
	7	Multidisciplinary Training	0=	3=↓	3=	1=
	8	Complex Antenatal Care	0=↓	4=↑	0=	1=
	9	Preterm Birth	2=	2=	0=	0=
	10	Labour & Birth	2=↓	3=↑	1=↑	0=
	11	Obstetric Anaesthesia	0=	7=	0=	0=
	12	Postnatal Care	1=	3=	0=	0=
	13	Bereavement Care	0=	4=	0=	0=
	14	Neonatal Care	3=	2=	0=	1=
	15	Supporting Families	0=	3=	0=	0=
		TOTAL	8	47	9	20

Ockenden 2022 Report

Key Achievements:
- Nearly all actions are in progress
- Nine actions for closure at next Ockenden meeting

Next Steps for Progressions:
- Working groups are continuing to be established
- Neonatal team working on neonatal and preterm birth guidance
- Anaesthetists working on guidance in relation to anaesthetic staffing

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 5 Submission	Comment	Current Assessment
1	**Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Compliant	All Standards Met	
2	**Maternity Services Data Set** submission to required standard	Compliant	All Standards Met	
3	**Transitional Care Data Set** minimise separation to mothers and babies	Compliant	All Standards Met	
4	**Clinical Workforce Planning** effective system	Compliant	All Standards Met	
5	**Midwifery Workforce Planning**	Compliant	All Standards Met	
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	All Standards Met	
8	**Multidisciplinary Training**	Compliant	All Standards Met	
9	**Board Assurance** Board to Ward to Board	Compliant	All Standards Met	
10	**HSIB and EN Reporting**	Compliant	All Standards Met	

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

CNST / Maternity Incentive Scheme (MIS)

Key Achievements:
- Compliance with 9 out of 10 Safety Actions achieved

Key Risks to Full Compliance:
- Challenge with progress against SA 6

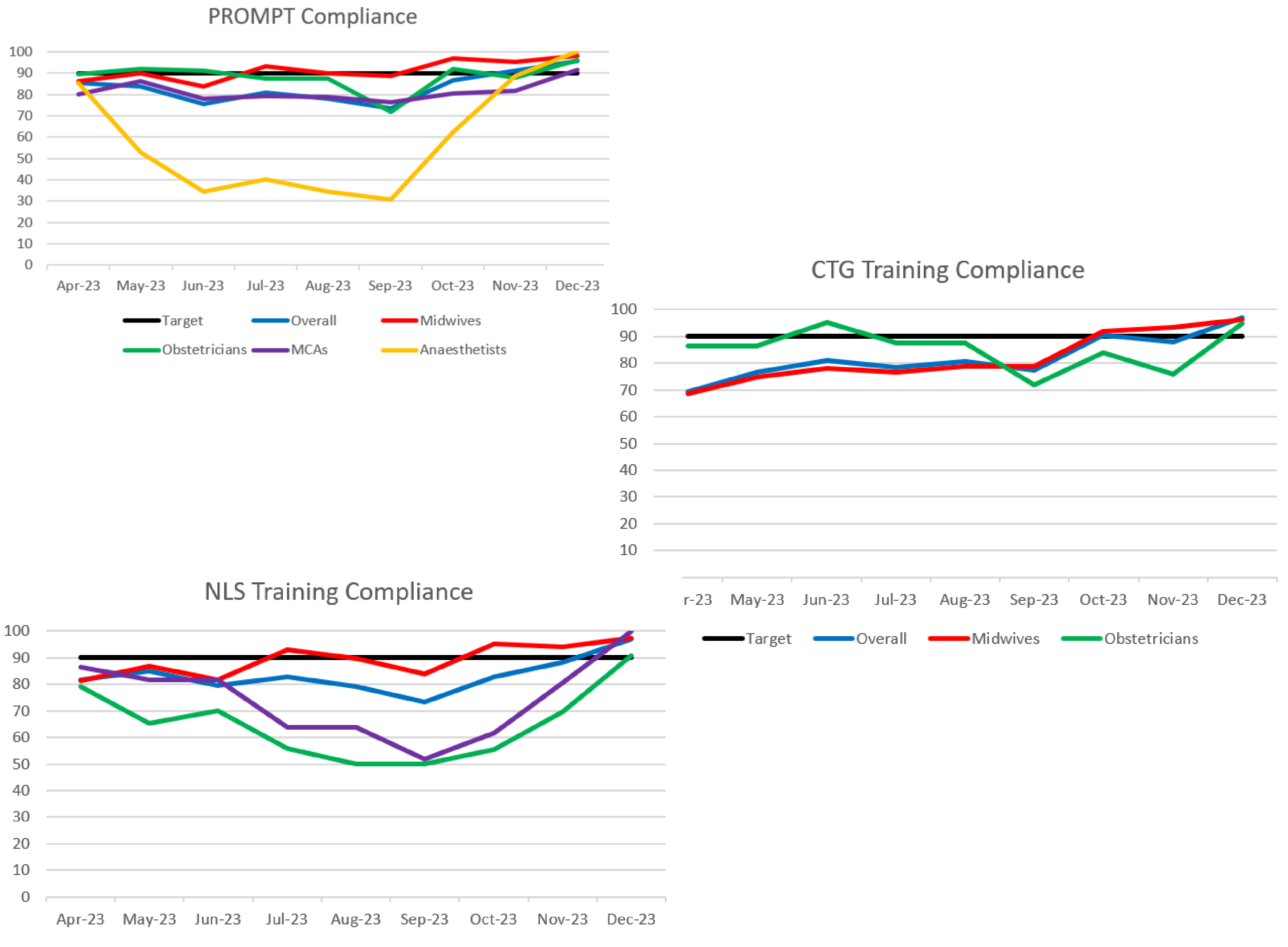
Maternity 3 Year Single Delivery Plan

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 / CTG Training

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:

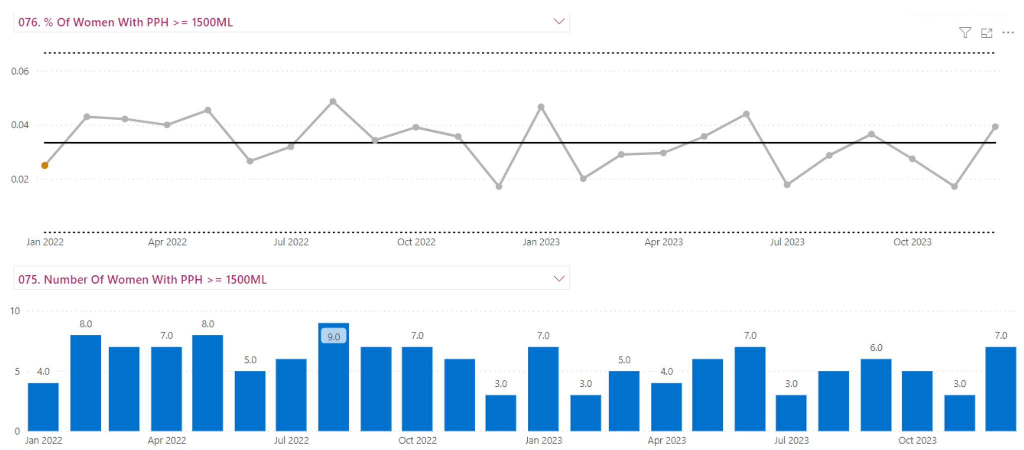
- Deadline for MIS compliance 1st December – met compliance target of >90% for all staff groups in all training areas.

Risks:

- Lack of RC-trained instructors for NLS updates – mitigated as provided by RC attenders (plan in place to achieve this)
- Focus of MIS training requirements has now meant that Trust required training complaince has fallen (Adult BLS and Safeguarding Children Level 3) - plan to now drive these forward.

Ongoing Themes

% and number of women with PPH >1500ml



Theme – PPH rate above national rate

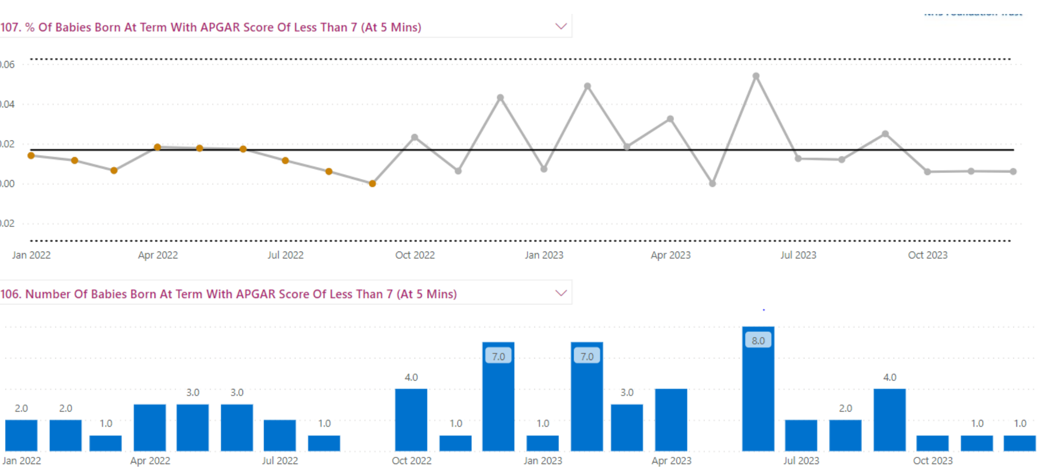
Key Achievements:

- SFT had a higher PPH rate (above national target) which is mirrored across the LMNS. This is being monitored and has seen a reduction in rate over the last two reporting months.

Next Steps for Progressions:

- Small cohort thematic review in December 2023 identified good management but often poor documentation. Fluid balance remains an issue. To re-review every quarter and develop action plan for presentation at next Maternity Governance meeting.

% 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:

- SFT did have a persistently higher % of term babies with low APGARS than national target. This is being monitored and has seen a reduction in rate over the last two reporting months.

Next Steps for Progressions:

- Small cohort thematic review in December 2023 identified documentation and fetal monitoring and classification as initial themes. To re-review every quarter and develop action plan for presentation at next Maternity Governance meeting.

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

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	6.7
Date of meeting:	7th March 2024		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services –January 2023			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Agreed by DMT 15.02.2024 Divisional Governance 22.02.2023 Clinical Governance Committee 27 February 2024			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

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 November 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:

- Reduction in Midwifery vacancies, although still significant gap in clinical Midwives.
- Vacancies and maternity leave mitigated by bank usage.
- Midwife to birth ratio 1:25, lower acuity in January contributing to more favourable figure.

- 1:1 care in labour achieved at all times
- Supernumerary status of labour ward maintained 100% time.

Incidences reported as moderate.

- 3 Incidences reported as moderate.
  - Neonatal Deaths of twins after birth at 21.5 weeks pregnant. Classed as NND as per guidance, below viable gestation.
  - Term admission to NICU
  - Category 1 LSCS, baby transferred to tertiary centre for cooling.

Training

- Compliance in PROMPT, CTG and NLS training. Target of 90% reached and compliance met as of 1st December. Work in January to improve compliance with other mandatory training.

Service user and staff feedback

- Feedback received from varying sources including MNVP, safety champions, friends, and family survey and PALS

National Guidance

- CNST compliance 9 out of 10
- Work ongoing to improve compliance with Ockenden 2022 IEA, new meetings set up monthly to provide targeted support and improve compliance with the actions.

Thematic Reviews

- Reviews undertaken for low apgars and PPH – actions in place following findings and continued monitoring to ensure improvement.

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

NHS
Salisbury
NHS Foundation Trust

Perinatal Quality Surveillance January 2024

Maternity and Neonatal Unit

Salisbury Foundation Hospital

• Safe – Maternity& Neonatal Workforce

NHS
Salisbury
NHS Foundation Trust

	Target	Threshold			Nov 23	Dec 23	Jan 24	Comment
		Green	Amber	Red				
Midwife to birth ratio	1:28	1:28		>1:26	1:28	1:32	1:25	Active recruitment continues
Compliance with supernumerary Status of LW Coordinator %	0	0		>1	100%	100%	100%	
1:1 care not provided	0	0		>1	0	0	0	
Confidence factor in BirthRate+ recording	60%	>60%		<50%			80%	Percentage of possible episodes for which data was recorded. Audit commended December 23
Consultant presence on LW (hours/week)	98	>97						
Daily multidisciplinary team ward round	90%	>90%		<80%	100	100%	100%	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0		>1	0	0	0	

Table 3. Workforce concerns and countermeasures

Impact (biggest > smallest)	Concern	Cause	Countermeasure
1	Lack of band 6 Midwives nationally leading to difficulty in recruitment of experienced midwives	National shortage and unit size not attractive to midwives already in post elsewhere	Grow our own – early interviews for student midwives to recruit as band 5's with recognition that after 12 months they will move to band 6 and over time will contribute to a more stable workforce.
2.	Recruitment of MW's	Multifaceted however focus on lack of development opportunities due to Unit size	Introduction of a rotational development programme to specialist roles
3.	Recruitment of consultants	Not enough sub-speciality Obstetrics due to unit size	AJK to hold meeting with Maternal Medicine Network to discuss options for Obstetric consultant opportunities.

Table 1. Total WTE vacancy and availability to work - by role

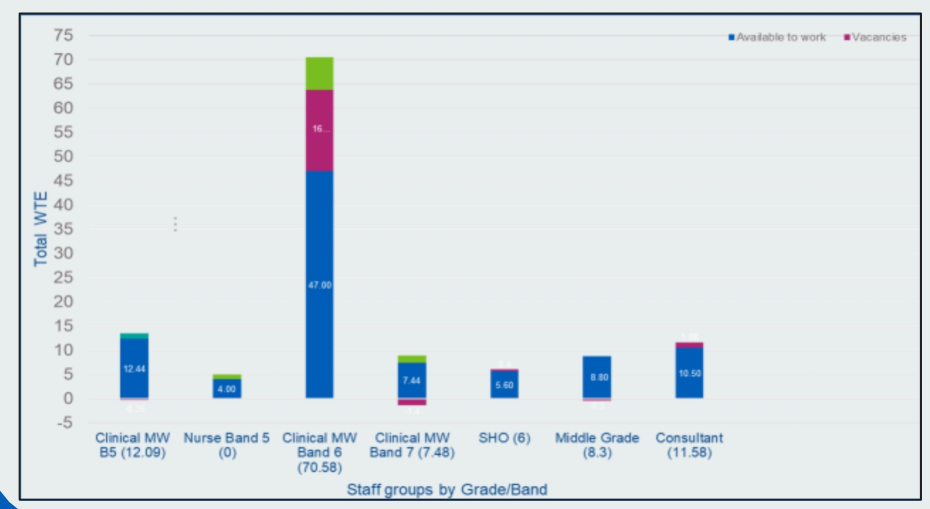
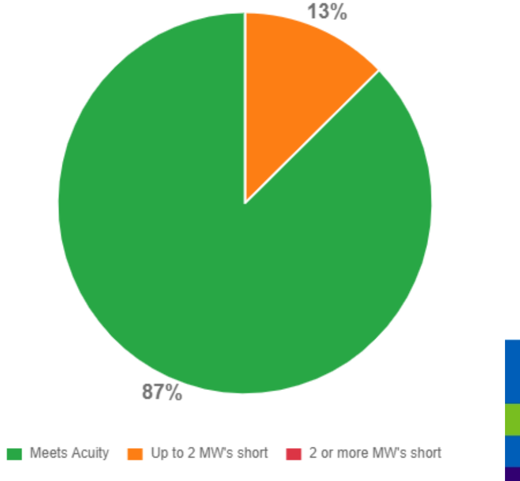


Table 2 represents Acuity vs staffing data for January 2024



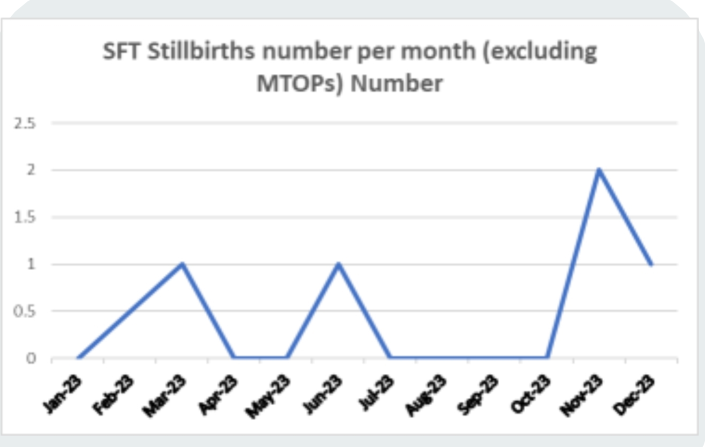
Is the standard of care being delivered?

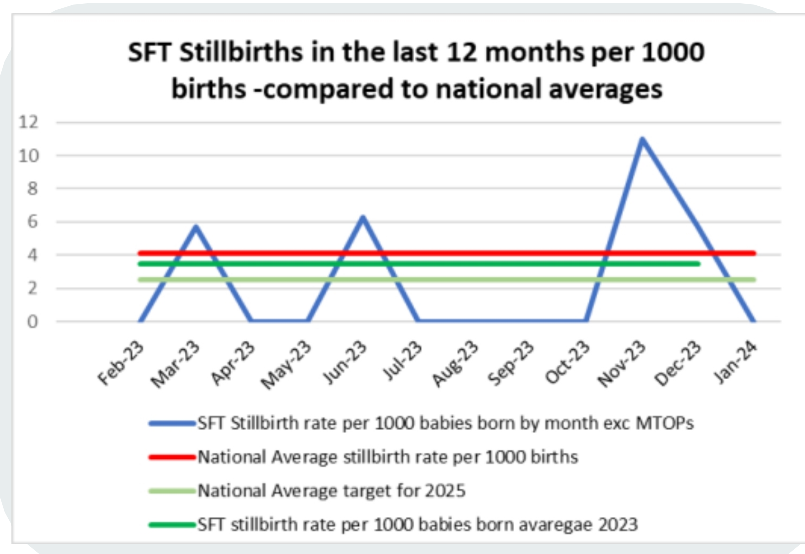
- Supernumerary Labour Ward coordinator status achieved 100% time
- The Midwife to Birth ratio improved due to lower acuity in January.

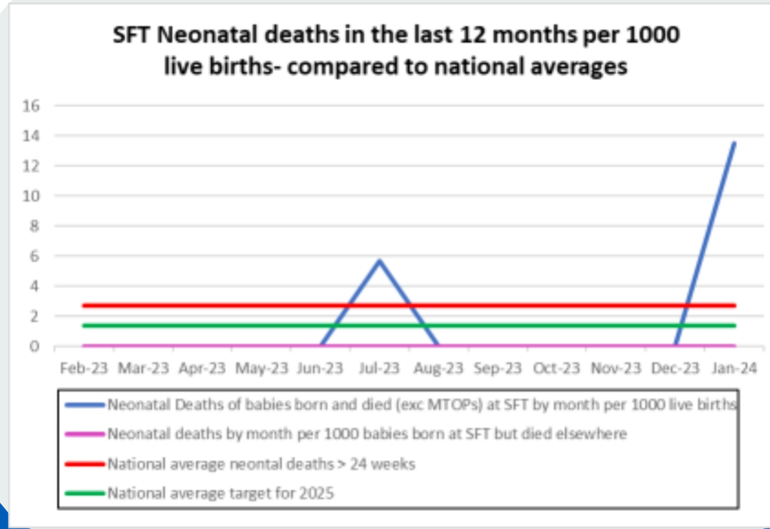
What are the top contributors for under/over-achievement?

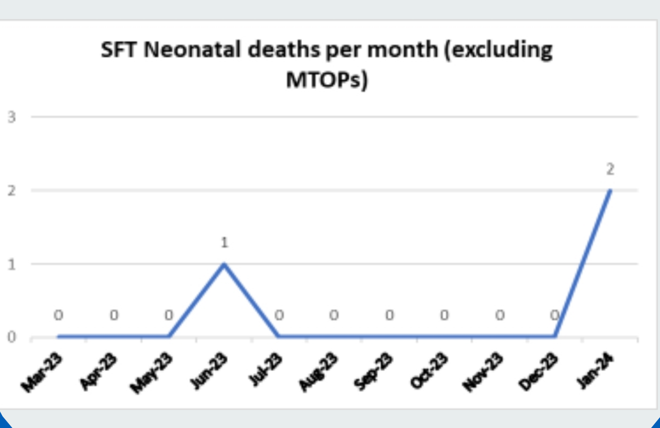
- Vacancy rate
- Maternity leave
- Challenges in recruiting midwives

Safe- Perinatal Mortality Review Tool (PMRT)









- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is MIS Safety Action 1 for year 5. A quarterly update paper is shared with the board.
- Stillbirth and neonatal death rates are excluding MTOP's
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers.
- Still birth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.
- Perinatal deaths for January 2024 :
  2 neonatal deaths- twins at 21+5 weeks
  1 late miscarriage at 21+3 weeks

PMRT Action Plans for Salisbury Foundation Trust – January 2024 reviews

PMRT case ID	Issue text	Action plan text	Person responsible	Target date
90169	This mother presented with reduced fetal movements and scan was indicated but not carried out This mother presented with reduced fetal movements, scans and and/or other investigations were indicated but were not caried out This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance This mother had a growth restricted baby (defined by estimated fetal weight <10th centile or reduced growth velocity on ultrasound) during her pregnancy and there was a delay in the diagnosis This mother had oligohydramnios or polyhydramnios during her pregnancy and there was a delay in the diagnosis	Disseminate the learning to ensure pathway for reduced movements at 24-26 weeks is adhered too as per local guideline- Laser, communications to staff, training and education	Q and S team	30/2/24
90169	This mother's progress in labour was not monitored on a partogram	To discuss with staff at Bereavement workshops	Bereavement MW	01/04/24

PMRT grading of care – Key

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
PMRT: 90169 Datix: 234292	1/11/2023	Unavoidable death	Stillbirth of baby at 26+4 weeks. Baby known to have severe IUGR	Cause of death-Severe IUGR and maternal muscular malperfusion PMRT grading of care- B and B **Actions** Disseminate the learning to ensure pathway for reduced movements at 24-26 weeks is adhered too as per local guideline- Laser, communications to staff, training and education Educate staff on using partograms on bereavement workshops	**NA**	**NA**

Incidents

New Cases for January 24

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	SI? Reference
162915	19/1/24	Moderate	Cat 1 section in anaesthetic room after BAME woman attended for scheduled care - fetal bradycardia at 36+4. Significant fetal resus and baby transferred to PAH for cooling.	MDT review - weekly blood testing for OC, guidance not in alignment with RCOG in term of peak levels and timing of birth. Recommended at PSS in early Feb as PSII.		
162614	19/1/24	Moderate	Term admission following forceps, bradycardia, low gases, inadequate spinal and loss of situational awareness	MDT review – difficult case in pressured circumstances, human factors involved.		
162181	3/1/24	Unavoidable death	Preterm birth of twins at 21+5 weeks resulting in a neonatal death. T1 signs of life witnessed by midwife and Obstetric Registrar Death	This case was referred to the medical examiner (as per all neonatal deaths despite extreme prematurity below viability gestation). Medical examiner advised that this does not require referral to coroner. Pathologist notified that the placenta identified acute chorioamnionitis		

Ongoing Maternity and Neonatal Reviews

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions
155892	18/5/23	Moderate Harm	Unexpected admission to neonatal unit	Shared decision making and escalation training, as well as introduction of updated CTG stickers that give improved information on appropriate actions required
156305	2/6/23	Moderate	Uncrossmatchable blood - antibodies	Draft: Develop a system for handover of care for high-risk women expected on LW. Improve communication between lab and community midwife and add antibodies as risk factor on PPH risk assessment tool
156497	9/6/23	Never event	Retained swab	Draft: Options to be explored around possibility of purchasing swabs that enable a physical barrier to prevent swabs being left in a cavity. a)Revise the Accountable Items, Swab, Instrument and Sharps Count Policy to ensure this is clearly articulated and the associated flow chart is amended in line with this. b)When revising the policy strengthen action 5.2.2 to reiterate the expectation for clear and timely communication of the swab count prior to closure of a body cavity c)Ensure these changes are communicated to all staff within the operating and 'pseudo' operating departments where this policy has relevance. To review and revise the SOP for Opening a Second Obstetric Theatre and link it to the Obstetric Theatre Operational Policy To include into the current maternity records audit a question on whether there is documented evidence that the need for translation services has been considered on the Delivery Suite for women for whom English is not their first language. The Trust should use a second WHO checklist when a separate and distinct operation is required even if the patient has not left the operating room To support junior medical, midwifery nursing staff by anticipating where unusually pressured situations may arise for example in situations of family conflict, personal / professional boundaries / knowledge / power dynamics

Ongoing maternity and neonatal reviews (continued)

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions
156424	25/5/23	Moderate	Undiagnosed placenta accreta	Draft: Create a pathway for the identification and investigation of those with risk factors for PAS and for onward referral for those who are found to have signs suggestive of the condition. Deliver training to sonographers on the ultrasound appearances of PAS and what to do if present Perinatal meeting teaching, SOP to feature at the safety briefing when it launches.
156876	27/6/23	Moderate	Stillbirth at 27/40	Draft: All women should be monitored for CO levels at each antenatal contact Clarification as to when SFH should be measured - wording to be changed
157076	20/4/23	Moderate	Term admission to NICU	Draft: Missed opportunities to correctly classify and respond to CTG. If concerns exist with fetal monitoring, the CTG should not be discontinued for woman to visit toilet. Obstetricians to attend woman in person where there are concerns with CTG. Staff to have the abiity to escalate their concerns around an abnormal CTG and other differing expert opinions. Laser to be completed re advice if a woman wishes to self discharge against advice. High risk women must be cannulated as a priority SBAR to be completed for all handovers. To link this case with the risk register entry need for 2nd theatre

Ongoing maternity and neonatal reviews (continued)

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions
157595	8/8/23	Moderate Harm	3B tear, tailing growth and mode of birth	Not ready
157555	8/1/23	Moderate Harm	Term admission	Amend induction of labour guideline AND fetal monitoring guidelines such that both unequivocally state to continue fetal monitoring at minimum 6 hourly intervals. Clarification of whether women partway through induction need evening Obs ward round review as only intrapartum are currently mandated for this
158301	8/12/23	Moderate harm	Term Admission, required cooling at tertiary unit	Actions currently being discussed
158202	8/8/23	Moderate harm	Eclamptic seizure at home, admitted to ED - GA	Draft actions: Update pathway and explore options for documentation of administration and escalation. Implementation of case huddles in complex patients with clear SBAR handovers. Clinical teams to be notified and included in future sim scenarios
158066	31/7/23	Moderate Harm	PE at 15/40, missed opportunity for LMWH	A failsafe should be introduced to be implemented between appointments with different clinics/specialties to avoid missed appointments and to aid follow up. Appojntment letters should be clearer and terminolgy changed to make it more obvious if a woman is required to see a doctor. High risk VTE women where VTE prophylaxis should br prescribed before 12 weeks should have a timely obstetric consultant appointment in clinic
159341	19/9/23	Moderate harm	PPH at home, guidance not followed	Not ready
161025	19/11/23	Moderate Harm	Eclamptic seizure	Not ready

Responsive

NHS ...ury ...Trust

MNVP Service User Feedback (Dec 23- Jan 24)

Key Achievements & Positive Feedback:
Compliment logged with the MNVP :

I really felt like she gave me all the time and support needed, nothing was too much. She made me feel so comfortable and safe as a pregnant woman, I was really nervous after finding out I was pregnant and every appointment I had she was great.
My MIL came with me to our discharge/ 10 day post birth check up and she said when I came back to the waiting room that it sounded like friends talking and laughing from the otherside of the door which to me says it all about her and her mannerisms. She really is a joy to have in your team of midwives and I am sad that we no longer have to see her for any appointments.

Identified Areas of Improvements:

The MNVP together with 2 services users conducted a 15 steps assessment of the Maternity and Neonatal unit on 2nd October 23.

Next Steps for Progressions:
- Continue roll out of personalised care plan training
- Complete actions from 15 steps.

Safety Champions Staff Feedback

Key points raised:
- Staff shortages on Sarum ward
- CAMHS capacity to support children with eating disorders to be discussed at the next Quality Committee meeting and Children's Safety Board
- Key feedback from 15 steps was discussed and update provided on progress made to date on the suggested actions.
- Themes from complaints discussed, in feedback received via the MNVP that women feel their voices are not being heard in the intrapartum period. Several reports of women birthing in the triage rooms.
- NICU have received support from ITU Radnor ward with ventilators, whilst seeking replacements.

Items for escalation:
- As of Monday 22nd January the PN ward will be changed to the Beatrice Maternity Ward.
- NICU ward temperature and ventilators noted as items for escalation.

Next Steps for Progressions:
- Undertake safety champion walk around.
- Themes from complaints and concerns is an agenda item on the annual study days.

Compliments & Complaints

35 compliment logged in Jan 24 . SOX:9

Only one concern logged in Jan24 in regard to the management of preterm labour.

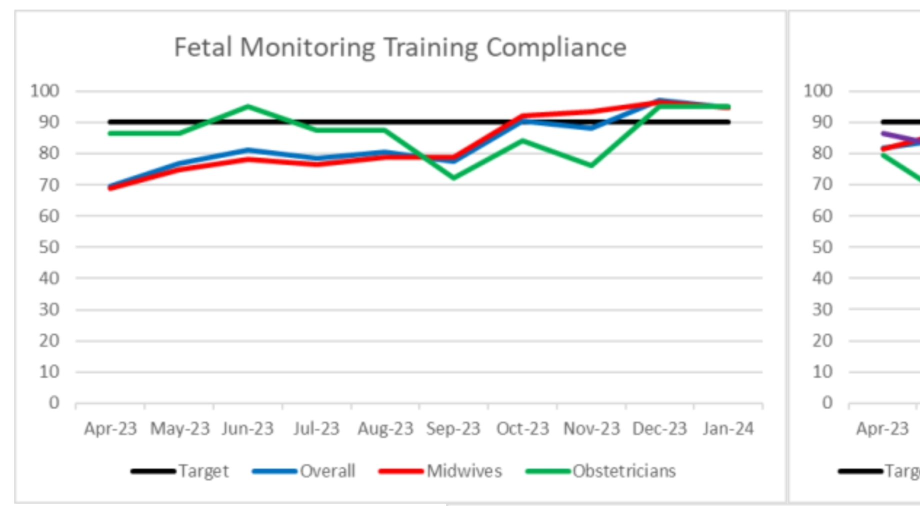
Friends & Family Survey

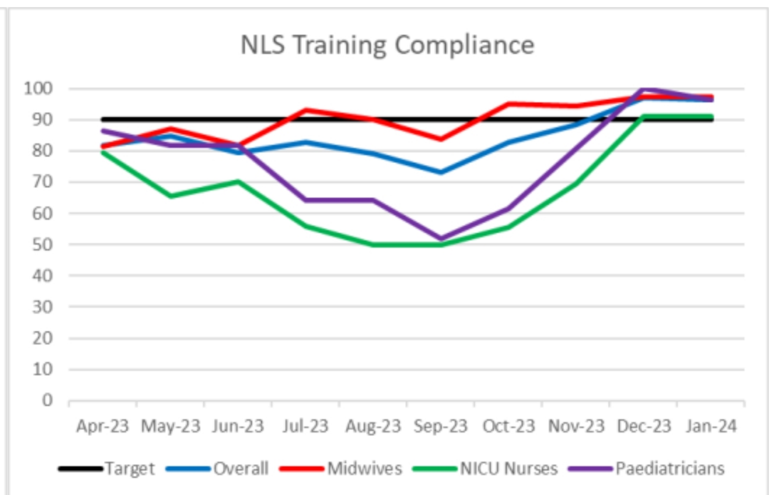
Key Achievements:

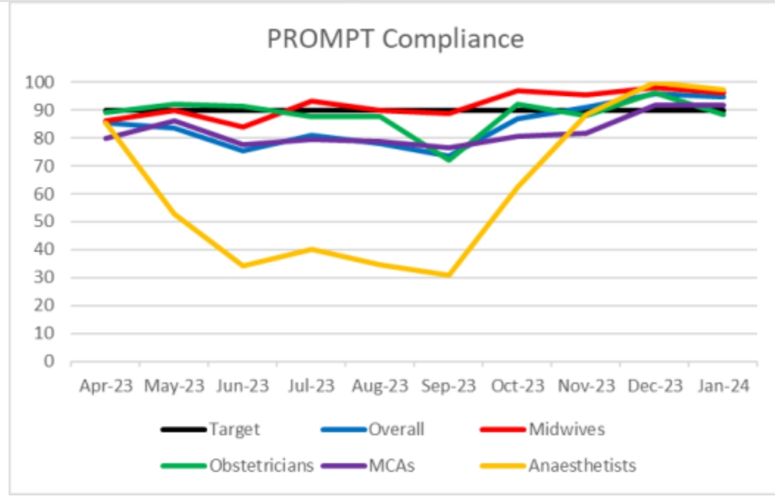
Antenatal care: very good. *Very efficient and really friendly staff! I felt well cared for.*
100% of responses rated their overall patient experience as 'Very Good' demonstrating a 6% increase since Dec 23

Identified Areas of Improvements:
- . Further exploration is required to support military families (who have limited access to childcare) to attend their USS appointments.

Well-led – Training







Training

CNST requirements for >90% training compliance in all staff groups for NLS, fetal monitoring and PROMPT training achieved in December 2023.

Updated training plan commenced for 2024 to meet new Core Competency Framework Version 2 requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

Countermeasures/action:

- Maternity "training week" to cover all aspects for CCF version 2 and SBLCB version 3 commenced in January 2024 for midwives, MCAs and obstetricians.
- Additional skills sessions available to newly qualified staff and senior students during induction period.
- 10 training dates for each module booked in over 2024 – not during periods of high rates of annual leave

Risks:

- Ongoing medical industrial action has already impacted training in January 2024.
- Influx of new MDT staff in September /October /November.
- Booking of training rooms availability – rooms booked for 2024 in advance but there have been changes to these bookings at short notice impacting training time
- Obstetric doctor fetal monitoring / PROMPT training – training compliance can be transferred from other maternity units

Compliance to National Guidance

Table 1. Ockenden 2022

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Ockenden Report

Key Achievements:

- Review of meetings and actions.

Next Steps for Progressions:

- Adopting new methodology to ensure progress of actions

Table 2. CNST Maternity Incentive Scheme – Year 5 submission

Are we well led?	NHSR Maternity Incentive Scheme- Year 5 Submission by 1st February 2024				
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	10	HSIB and EN Reporting	Compliant	All Standards Met	

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

Maternity Incentive Scheme (CNST) Year 5

Key Achievements:

- 9/10 declared for CNST

Next Steps for Progressions:

- Action plan created and submitted to NHSR to secure roles to support compliance for SBL

Themes

NHS
Salisbury
NHS Foundation Trust

Figure 1. Apgars less than 7 at 5 mins of age

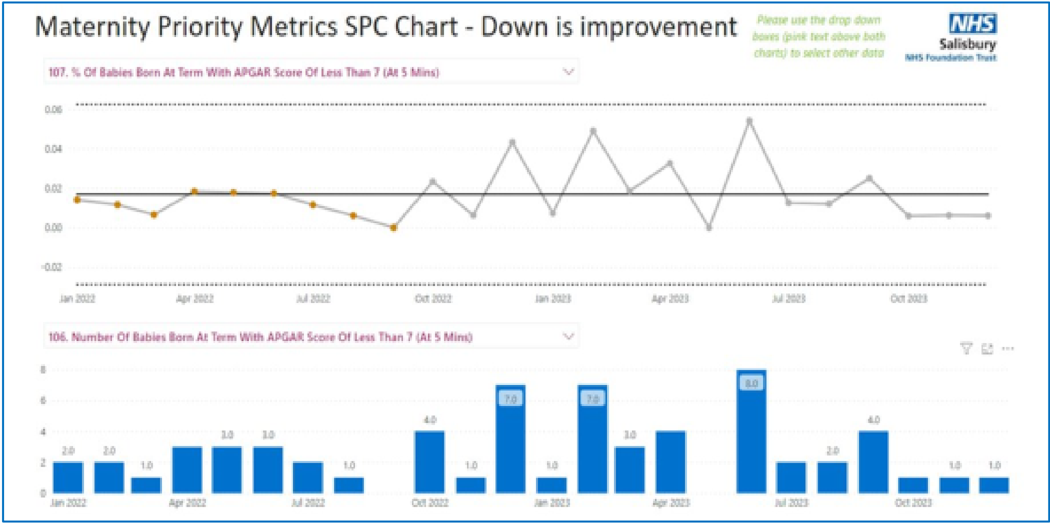
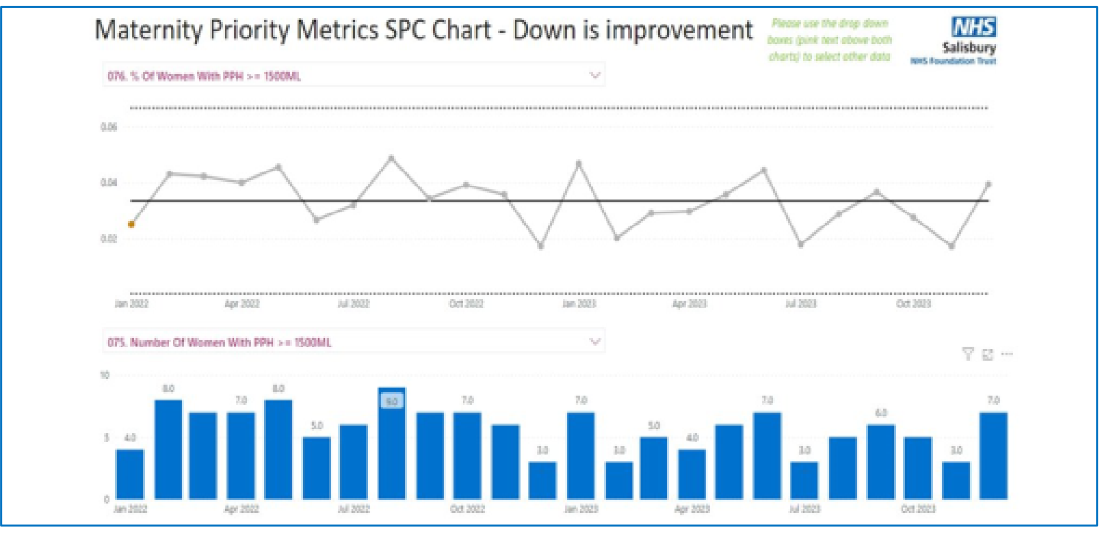


Figure 2. Post Partum Haemorrhage (PPH) >1500mls



Theme – Previously identified rise in babies born with Apgars less than 7 at 5 mins of age

Countermeasures following thematic review in December 2023:

- Thematic review yet to be repeated, however this is planned to identify if any previous themes are recurring trends.
- Two case reviews are in progress (Feb 24) involving low 5 minute Apgar score One such case has been escalated to a PSII under the new PSIRF plan. The other will be reviewed as a PSR. Documentation was identified as a theme in the previous thematic review, and it is evident that this remains an issue. Q & S Team plan to circulate communication within the unit to remind staff of the importance of clear, specific documentation.

Theme – Previously identified rise in PPH rates

Countermeasures following thematic review in December 2023:

- As a continuation of the previous theme, we have identified further cases where fluid balance documentation has been inconsistent. Both thematic reviews were re-presented at February's Maternity Risk & Governance meeting, with good MDT attendance. Different strategies for encouraging consistent use of fluid balance charts were explored, such as encouraging women to feel empowered to record their fluid intake, and more interesting innovative communication for the Q & S Team to circulate.
- Another possible action around labour ward co-ordinators holding a bleep to ensure they have notification of a 2222 MOH call is being explored, in addition to the use of the emergency buzzer.

CLASSIFICATION: UNRESTRICTED

Report to:	Trust Board (Public)	Agenda item:	6.8
Date of meeting:	7 March 2024		

Report title:	Salisbury NHS Foundation Trust review of Neonatal Deaths in the Neonatal Unit between 2018-2023			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes		Yes
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee 30 January 2024			
Prepared by:	Vicki Marston – Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos – Chief Nursing Officer			

Recommendation:

The Committee is asked to note the contents of the report that has been provided in response to the Lucy Letby trial and shows our review of all Neonatal Deaths on the Neonatal Unit over the five years from 2018-2023.

Executive Summary:

In this period (1.1.18-31.10.23) there were a total of 4 deaths in the Neonatal unit. Of the 4 deaths none were associated with an unexpected collapse, and as detailed below all four babies had experienced a neonatal journey and diagnosis that meant that deaths were sadly not unexpected.

1. 2020- This baby was born with Thrombocytopenia due to incompatibility issues with maternal platelets, causing a haemorrhage into the baby's brain which could not be predicted pre-birth. The condition has now been recognised in the mother and care tailored accordingly.

2. 2020 – A category 1 caesarean section was carried out when the mother reported reduced fetal movements at a hospital appointment and difficulty was had locating the fetal heart rate. Following resuscitation, the baby was transferred to a tertiary unit for cooling but returned to Salisbury for palliative care. Baby died of grade 3 neonatal encephalopathy.

3. Twin birth with one twin having known Stenosis of the Pulmonary artery. Stenosis not compatible with life therefore palliative care received by this baby, prior to neonatal death.

4. Baby born with Edwards syndrome and congenital hypoplastic aortic arch, therefore palliative care received by this baby, prior to neonatal death.

All deaths have been appropriately reviewed. There were no themes identified between the deaths, and they have been investigated via appropriate agencies as indicated by individual criteria i.e. PMRT, HSIB where appropriate.

In conclusion, the trust has seen a level of neonatal deaths that is within expected parameters for the number of annual births within the trust.

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Appropriate review of those deaths took place in line with local and national guidance after each death to ensure scrutiny and that any learning was identified and embedded.

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

Salisbury NHS Foundation Trust review of Neonatal Deaths in the Neonatal Unit between 2018-2023.

Executive Summary

In response to the Lucy Letby trial, a review has been undertaken of all neonatal deaths that have occurred within Salisbury Local Neonatal Unit (LNU) over the past 5 years.
This review covers the timeframe of 1st of January 2018 until the 31st of October 2023.
All deaths have been reviewed and reported as required. Of the 4 deaths none were associated with an unexpected collapse, and as detailed below all four babies had experienced a neonatal journey and diagnosis that meant that deaths were not unexpected.

Background

In response to the aforementioned trial and conviction a review has been undertaken to review and provide assurance to the board around numbers of neonatal deaths and the process of review following any neonatal death.

In this period (1.1.18-31.10.23) there were a total of 4 deaths in the Neonatal unit. They consisted of the following:

1. **2020**

   AS (2117942) – This infant was born with thrombocytopenia (NAIT) due to incompatibility issues with maternal platelets. This caused a fatal haemorrhage into the infant's brain which could not be predicted pre-birth. This condition has now been recognised in this mother and care tailored accordingly. Mother has since had a healthy baby born. PMRT process were followed appropriately, and all learning has been shared widely.

2. **2020**

   RW (2123602) – This infant was born at term. Reduced fetal movements were reported when attending a routine midwifery appointment. Nil fetal heartbeat was detected and therefore proceeded to CAT1 C-section. Infant resuscitated and sent to Southampton for cooling but returned to Salisbury for palliative care post 72hrs of

cooling. Infant died of grade 3 neonatal encephalopathy. HSiB conducted their investigation into this case and learning was disseminated widely. PMRT process was also completed.

3. 2021

TW (2135407) – Premature twin with known stenosis of the pulmonary artery. Mother reviewed by Fetal Medicine Unit in Southampton in pregnancy, stenosis not compatible with life so twins delivered in Salisbury. Palliative care given to TW and surviving twin was cared for on the neonatal unit until they were discharged home. PMRT process followed but due to recent inception of this process genetic cause was not ticked (in error) for this infant.

4. 2023

BM (2190326) – This Infant was born prematurely with undiagnosed Edwards syndrome and a congenital hypoplastic aortic arch. This infant was transferred to Southampton NICU for diagnosis but was repatriated to Salisbury for palliative care post diagnosis. National PMRT process followed and learning from the case circulated.

Actions

Trust wide:

1. To continue to support the Neonatal Unit to comply with all national and local systems to support reporting and scrutiny of neonatal deaths inc. PMRT, HSiB, Patient Safety Summits, perinatal process etc.

Neonatal Unit

1. To Continue to comply with all the above.
2. Ensure learning from these events is shared at local level but also shared with the ODN, LMNS etc. and that learning from other Units and the ODN is shared via education and training locally.

Summary

The trust has seen a level of neonatal deaths that is within expected parameters for the number of annual births within the trust.

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Appropriate review of those deaths took place in line with local and national guidance after each death to ensure scrutiny and that any learning was identified and embedded.