Bundle Trust Board Public 7 September 2023

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates
July SOX of the month – Richard Pearce, Facilities
July Patient Centred SOX – Jenny Smith, PALS and Andrea Pearson and Jordon Beresford, Hospice
August SOX of the month –
August Patient Centred SOX –

1.2 10:10 - Patient Story

1.3 Welcome and Apologies
Apologies received from -
Fiona McNeight

1.4 10:30 - Declaration of Interests, Fit & Proper / Good Character

1.5 10:35 - Minutes of the previous meeting
Minutes attached from meeting held on 6 July 2023
For approval
1.5 Draft Public Board mins 6 July 2023 V2

1.6 10:40 - Matters Arising and Action Log
1.6 Public Trust Board Action Log Sept 2023

1.7 10:45 - Chair's Business
Presented by Ian Green
For information
Fit and Proper Persons Guidance Summary
Developmental well-led external review
NED champion roles - Doctors Disciplinary / Security Management

1.8 11:00 - Chief Executive Report
Presented by Stacey Hunter
For Information
1.8a CEO report August for Sep final
1.8b PRN00719 Letter re Verdict in the trial of Lucy Letby 180823
1.8c 090823 Governance Proposals - Update

2 ASSURANCE AND REPORTS OF COMMITTEES BY EXCEPTION

2.1 11:10 - Audit Committee - 20 July
Presented by Richard Holmes
For assurance
2.1 230720 Audit Committee Escalation Report

2.2 11:15 - Clinical Governance Committee – 25 July
Presented by Eiri Jones
For assurance
2.2 Upward Report from July 2023 CGC to September 2023 Trust Board

2.3 11:20 - Finance and Performance Committee – 25 July
Presented by Debbie Beaven
For assurance
2.3 July Escalation Report from F^0P

2.4 11:25 - Trust Management Committee – 26 July
Presented by Stacey Hunter
For assurance
2.4 TMC Escalation Report August v2 SH 2023

2.5 11:30 - People and Culture Committee – 27 July
Verbal presentation by Michael von Bertele
For assurance

2.6 11:35 - Integrated Performance Report to include exception reports - month 4
Presented by Melanie Whitfield
For assurance
2.6a IPR cover sheet - Trust Board 2023-09

2.6b Integrated Performance Report Sep_23

3 FINANCIAL AND OPERATIONAL PERFORMANCE

3.1 11:55 - SIRO Annual Data Security & Protection Assurance Report (includes Toolkit Self-Assessment and Data Protection Annual Report and GDPR) – deferred from July
Presented by Naginder Dhanoa
For assurance

3.1 SIRO Annual DSP Assurance Report Sept 2023

3.2 12:05 - Protecting and expanding elective capacity
Verbal presentation by Lisa Thomas
For assurance

3.2a Protecting and expanding elective capacity assurance

3.2b Board Assurance PRN00673_Protecting and expanding elective capacity letter_040823 (002) - INITIAL DRAFT RESPONSES

4 QUALITY AND RISK

4.1 12:15 - Risk Management Strategy 3 yearly report – deferred from May - to follow
Presented by Judy Dyos
For approval

4.1a cover sheet Risk Management Strategy TB

4.1b DRAFT Risk Management Strategy 2023-26

4.2.1 12:30 - BREAK 30 MINS

4.3 13:00 - Quarterly Maternity Quality and Safety Report
Presented by Judy Dyos
For assurance

4.3a Front sheet Q and S report Q1 trust board (002)

4.3b Maternity and Neonatal Quality and Safety Report Q1 2023 24 Final (002)

4.4 13:10 - Perinatal Quality Surveillance Monthly Report (from July CGC)
Presented by Judy Dyos
For assurance

4.4a Front sheet Perinatal quality surveillance August (July data)

4.4b Perinatal Quality Surveillance monthly report to board Aug 2023

5 PEOPLE AND CULTURE

5.1 Nursing Skills Mix Review - deferred to October

5.2 Guardian of Safe Working Annual Report – deferred to October

5.3 13:20 - Freedom to Speak Up Guardian Annual Report
Presented by Melanie Whitfield
For assurance

5.3 FTSU Trust Board_AR 2022-2023 (V3)

5.4 13:30 - Health and Safety Q1 Report
Presented by Melanie Whitfield
For assurance

5.4a Public Board Cover Sheet - H&S Report Sept

5.4b H&S Report Q1

6 GOVERNANCE

6.1 13:40 - Remuneration Committee Terms of Reference Review
Presented by Rakhee Aggarwal / Ian Green
For approval

6.1a Cover sheet Remuneration Committee terms of reference

6.1b Remuneration Committee Terms of Reference May 2023_Approved Remcom

6.2 13:45 - Annual Report and Accounts (to note)
Presented by Kylie Nye
For noting

6.2a Annual Report and Accounts Cover sheet

6.2b Salisbury NHS Foundation Trust 2022_23 Annual Report and Accounts

6.3 13:50 - Annual Review of Board and Committee Effectiveness

Presented by Kylie Nye
For assurance

6.3 Board and Committee Effectiveness Report 2023

7 CLOSING BUSINESS

7.1 14:00 - Agreement of Principal Actions and Items for Escalation

7.2 Any Other Business

7.3 14:05 - Public Questions

7.4 Date next meeting - 5 October 2023

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)

Salisbury NHS Foundation Trust

Draft
Minutes of the Public Trust Board meeting held at 11:00am on Thursday 6 July 2023, MS Teams
Salisbury NHS Foundation Trust
Boardroom

Board Members:

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

In Attendance:

Georgina Morris (GM)	Consultant in Sexual Health (for agenda item 1.2)
Fiona McNeight (FMc)	Director of Integrated Governance
Sasha Grandfield (SG)	Board Support Officer (minutes)
Jayne Sheppard (JS)	Lead Governor (observer)
Jane Podkolinski (JP)	Governor (observer)
Alex Talbott (AT)	Associate Director for Improvement (for agenda item 3.2)
Cath Hill (CH)	Aqua (observer)
Frances Owen (FO)	Governor (observer)
Simon Harrod (SH)	Public (observer)
Abi Kingston (AK)	Clinical Director, Women and Newborn (for agenda item 5.6)
Vicky Marston (VM)	Interim Director of Midwifery (for agenda item 5.6)

ACTION

TB1 06/07/1 **OPENING BUSINESS**

TB1 06/07/1.1 **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:

May SOX of the month – Laura Lawes, HCA Durrington Ward and Endoscopy Nursing Team

June SOX of the month – Hannah England, Recruitment and the Estates team.

May Patient Centred SOX – Tina Dickenson, Pitton Ward Clerk and Harrie Hudson, Switchboard

June Patient Centred SOX – Leanne Mitchell HCA and Holly Jarvis, HCA – Downton Ward

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

RH noted how wonderful it was to have the Board meeting prefaced by the good work recognised in the SOX winners but added it would be nice to try to recognise some of the winners regionally and nationally too perhaps in the Kings birthday honours list. SH suggested discussing the different ways to acknowledge staff at a future Board Development Day.
ACTION KN/SG **KN/SG**

SH noted how the SOX nominations brought the good work of non-clinical departments to the attention of the Board.

IG noted nominations for the Staff Awards in September were now open and encouraged those present to recognise the good work of staff by nominating them.

TB1 06/07/1.2 **Staff Story**

MW introduced Georgina Morris (GM), consultant in Sexual Health and also the Foundation Programme Director. GM presented a video featuring a foundation doctor with neurodiversity who had overcome some significant challenges to finish his F2 training at the Trust.

GM explained there was no data on the numbers of staff in the NHS with neurodiversity but it was estimated between 10% and 30%. GM noted the doctor featured in the video had developed significantly since joining the trust and was sure to go on to have a successful career.

Discussion:

- JD noted the doctor in the video had a positive experience but that was not necessarily the case for all staff, some staff found it really challenging to access the support they needed.
- DBu noted his experience of general practice was very isolating but wondered if there was an opportunity to explore the careers advice available to junior doctors as the range of careers in medicine was diverse. GM agreed and added the doctor in the video had used the education support network in the Trust to have career discussions and had tried different placements.
- SH noted trainee staff had more flexibility in their role but the same opportunities should be available to substantive staff. SH added the trust should be able to demonstrate to our local population that it is a place that everyone can work in with over 330 different careers to offer.
- RA shared with the Board her diagnoses of dyspraxia and noted the challenges she faced. RA added that it was the law for employers to provide reasonable adjustments to enable staff to be successful regardless of their abilities.
- MvB noted this was an example of diversity in action, traditionally all staff were managed in the same way but now people were more aware and starting to understand the value of getting to know their staff and to really understand their problems.

- DBe questioned how many staff that left the NHS workforce had neurodiversity and the cost of recruitment compared to the cost of the support and technology necessary to retain these staff.
- IG noted the Board had spent some time at a recent development day discussing their EDI responsibilities but there needed to be a further discussion on the Trust's approach to diversity.

IG thanked GM and the Education Team for their leadership and support. IG asked GM to pass on the Boards thanks to the doctor for sharing his story.

GM left meeting.

TB1 06/07/1.3 **Welcome and Apologies**

There were no apologies.

TB1 06/07/1.4 **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 06/07/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 4 May 2023**

IG presented the public minutes from 4th May 2023 and the minutes were approved as an accurate record of the meeting.

TB1 06/07/1.6 **Matters Arising and Action Log**

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

- **TB1 9/3/5.3 Maternity Quality and Safety Report Q3 22/23** – EJ noted this item could be closed, EJ and JD would continue to work on it and report back to Trust Board if necessary.
- **TB1 6/4/3.6 IPR and TB1 4/5/2.5 IPR** – LT confirmed an assurance report would be going to both F&P and CGC in July.
- **TB1 4/5/2.1 Clinical Governance Committee (CGC) 25th April 2023/Maternity** – The Board noted the Badger Net paper was going to July F&P
- **TB1 4/5/6.3 Integrated Accountability and Governance Framework** – FMc confirmed the wording had been updated – item closed.

There were no matters arising.

TB1 06/07/1.7 **Shadow Board Feedback**

RA presented the feedback from the previous days Shadow Board and noted the board had discussed:

- 3 papers were presented, Infection Control, Health and Safety and Patient Experience.
- Accessibility to training and development came out as a theme across all the papers presented.
- Violence and aggression and how to prevent it in.
- How to measure learning from experiences and patient feedback to show lessons have been learned and practices are changing.
- Discussion regarding improving the environment that end-of-life conversations take place in.
- Are the friends and family forms fit for purpose and can the content be influenced.
- Complaints seem to be revisited as people aren't satisfied with the conclusion, the complaints process needed to clarify the question asked before the investigation to get the right outcome for the complainant.
- Distributing the good practice that comes from compliments.
- Asking patients to contribute to the Health and Safety policy.

IG noted he and SH had discussed asking members of the shadow board to attend Trust Board to feedback in future. SH noted there were some recommendations made by the last shadow board cohort which had been agreed in full, SH added in future members of the shadow board will be asked to give their feedback on the agenda item they presented when the same item is presented to the Trust Board to try to make the experience as real as possible. IG noted this would bring a different perspective to the Trust Board.

RA noted the presentations had been slick, the discussion was rich and questions were answered as investigatory work had been done before hand by Shadow Board members. IG thanked RA and the Shadow Board for their feedback and asked RA to provide further shadow board feedback during the discussion of agenda items.

TB1 06/07/1.8 **Chair's Business**

IG noted he had recently spent time with the surgery and medicine divisions and attended their team meetings. IG added he was reassured that the issues being discussed at divisional level were the same issues being discussed at the committees and Board.

IG congratulated LT on her appointment as substantive Chief Operating Officer.

TB1 06/07/1.9 **Chief Executive's Report**

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

- Progress with recovery had been sustained over the last few months, SH thanked the teams involved.

- The organisation had dealt with the last round of industrial action well, SH noted her apologies to any patients who had their appointments rearranged.
- Planning had now started for the forthcoming industrial action by junior doctors next week.
- Confirmation has just been received from the BMA that consultants have also supported strike action on 20th and 21st July. SH noted the fine line between respecting people's legal right to strike and the responsibility of the executive team on behalf of the board to ensure delivery of safe, acute emergency services.
- SH thanked PC and his deputy Duncan Murray for their help with coordinating cover on rotas and for dealing with challenging situations. SH noted that if there were any concerns regarding the service the hospital was able to provide communication would take place off-line to escalate to the Board.
- The Trust was in a period of financial and performance recovery but at month 2 the Trust was on plan.
- Events had taken place to celebrate the NHS 75th anniversary.
- Work experience placements had been welcomed back to the hospital after the pause during COVID.

Discussion:
IG reflected on the impact of the industrial action and the significant amount of activity and planning involved to maintain patient safety. IG added, whilst respecting people's right to strike, the strikes were not sustainable in the long term and the disputes needed to be resolved in the interests of both the patients and staff.

TB noted the RCN action was now over, but the underlying elements had not been resolved so the issues still remained. TB asked if there were any lasting impacts from tensions between groups of staff striking and not striking. SH noted it was too early to determine but reflected on the number of nurses who voted as a way of showing their dissatisfaction. SH added there had been relatively little backlash due to the tone of communications and engagements had been handled well.

JD noted there was a sense of dissatisfaction from nurses but this was aimed mainly at the union.
EJ reflected that the consultants had stepped up during the previous junior doctors strikes to cover rotas but the junior doctors were unable to provide the same cover to consultant posts during the consultant strikes, EJ asked for assurance that there would still be focus on patient safety during the consultant strikes.

PC noted the BMA had guaranteed to provide the same service as emergency Christmas day cover. PC added some consultants would choose not to strike and some of the more senior junior doctors could cover consultants work such as outpatients. PC noted there may be an impact on the willingness of staff to cover if the strikes continue for a significant amount of time.
DBu reflected on the new perspective of the next strikes involving consultants and that there may be subtle issues regarding supervision,

DBu requested that the board be kept informed if the arrangements don't go as planned.

SH noted gold meetings would take place every day in the lead up and during the strikes to make sure the rotas have been populated to keep the Trust's emergency and urgent care services safe, SH confirmed the Board would be kept informed of any concerns. SH added the same level of attention and assurance would be used during the consultants strikes. SH noted cover during the consultants strikes needed to be paid for and PC had been liaising with medical director colleagues in BSW regarding the rate the BMA think should be paid, this offer had to be increased to secure the best opportunities across BSW.

TB1 06/07/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 06/07/2.1 **Clinical Governance Committee (CGC)**

EJ presented the report, providing a summary of escalation points from the meeting held on 27th June 2023. EJ noted the report was very detailed and asked for it to be taken as read and highlighted the key points as follows:

- The year 5 Maternity Incentive Scheme had been received.
- There was good assurance provided regarding the national patient safety work and the preparation of PSIRF.
- There was good alignment and assurance provided by the Board Assurance Framework, the Integrated Performance Report and the quarterly and annual reports.

Discussion:
IG noted the detailed escalation reports from the committees provided the Board with a huge amount of assurance and highlighted the areas that the committees had been focusing on.

SH asked what assurance the committee had received regarding the continued HMSR revalidation. PC offered to circulate a paper to the Board which would give more detail regarding the modelling triangulation work, mortality data and changes in coding practice.

EJ confirmed the mortality lead for the trust would review any flags in detail and there would be an enhanced focus on the learning outcomes in future reports. EJ noted the South West region was reporting lower death rates than other parts of the country and post pandemic people were presenting later. EJ noted the committee was assured that due diligence had been done on HMSR.

DBu noted the Trust was an outlier due to how the measurements were made, a clinical issue or combination of both, there was no evidence but the committee would continue to try to understand why the figure was high. TB asked for PC's update to be circulated to the Board. **ACTION: PC** **PC**

TB1 06/07/2.2 **Finance and Performance Committee**

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

- The EPR business case had been discussed earlier in the Private Trust Board meeting.
- There had been a deep dive into breast reconstruction with a very open and honest report from the surgical team which detailed the change in reporting that will impact the numbers of patients waiting for breast reconstruction. The Committee had received assurance that the Trust's reputational risk would be mitigated through a strong communications plan and patients would be supported with counselling.
- An inspiring testimony on Improving Together had been received with data from SDEC already showing improvements and cost savings.
- Pressures and potential risks to the Quarter 1 forecast were noted.
- The industrial action was attributed as the main cause of the variance against the plan in the Month 2 Finance Report.
- The Committee received assurance on the progress already made on cost savings and were encouraged while noting there were still challenges.

Discussion:
ME noted the BSW was significantly off plan in month 2 and the ICB may make the decision to voluntarily go into financial recovery protocols. ME added for this reason NHSE oversight would be keeping an eye on how the Trust manages its finances.SH suggested continuing this conversation in a tactical discussion in the private session. SH added this had been escalated to the system financial recovery group and LT and her team were working hard to mitigate. IG agreed to continue the discussion in the Private session.

TB1 06/07/2.3 **Trust Management Committee**

SH presented the report which provided a summary of escalation points from the meeting held on 28th June 2023. SH asked for the report to be taken as read and noted this month the committee had received a number of business cases from divisions and corporate services.

TB1 06/07/2.4 **People and Culture Committee**

RA gave a verbal update from the meeting held on 27th June 2023. RA highlighted the following key points:

- The committee had discussed recruitment and retention and how to attract health care assistants.
- There had been a bigger willingness to speak up from staff with protected characteristics.
- The WRES and WDES and Medical Workforce data had been uploaded to the national system.

SH reminded Board colleagues to complete their characteristics on ESR in the next few days.

TB106/07/2.5 **Audit Committee – 22 June 2023**

RH presented the report, providing a summary of escalation points from the meeting held on 22nd June 2023. RH asked for the report to be taken as read and highlighted the following key points:

- There had been an additional audit committee in June to approve the accounts. The financial statement had been submitted to NHSE by the 30th June and had been laid before parliament before the deadline of 7th July. All statutory obligations relating to the annual report and financial statements had been satisfactorily completed this year.
- There had been a changeover of auditors recently and the outgoing auditors had left positive feedback regarding the Trust's capability and achievements which was a reflection on all the hard work that had taken place.
- The Committee had discussed an internal audit report which had picked up some challenges in the Organisational Development and People department, the committee acknowledged there had been lots of hard work already with more work still to do.

IG confirmed the Board had delegated its authority to the Audit Committee to approve the accounts and the Board noted the accounts had been filed appropriately and laid before parliament. DBe asked if internal audit reports get presented at the board committees. RH confirmed that the internal audit reports go to board committees.
MW thanked RH for acknowledging the improvement in OD&P and noted the internal audit report related not only to her department but also to work that all line managers in the Trust needed to do.

TB106/07/2.6 **Integrated Performance Report (IPR) (M2)**

LT presented the Integrated Performance Report which provided a summary of May 2023 performance metrics. LT noted that May had been an interesting month with three bank holidays, strike action taking place and the closure of Whiteparish Ward for maintenance, LT highlighted the following points:

- Use of agencies and sickness had both gone down significantly.
- Cancer targets had been met and it had been a very busy elective month.
- High bed occupancy levels had affected overall performance.
- Concerns regarding cancer dermatology and Stroke and additional support needed in Urology.

Discussion:
IG asked if the Board could be confident that the building blocks were in place to achieve the breakthrough objectives.
LT explained urgent care was in good place, there were some opportunities to explore in planned care, particularly outpatients but there

were problems due to workforce capacity and work was ongoing to understand what mitigations were necessary. LT added she was happy with processes and governance which had been strengthened.

IG noted the discharge lounge had opened since the report had been produced and asked if this had an impact on bed capacity.
LT confirmed the discharge hub had gone live on 3rd July and already had an big impact, the aim of the hub was to try to get elderly patients sent home as soon as possible with social and community care in place, triage of patients already admitted to support their needs beyond their time in hospital and to identify and support patients with complex needs.

TB reflected on patient falls and noted a comment made by the therapy team regarding conservative management of patients who are kept in hospital beyond when they should be discharged. PC noted the continuous improvement methodology trained staff but it was a balance, the quality impact assessment process would focus people's minds on unintended consequences. TB added if patients weren't mobilised quickly, it could have an impact on length of stay. JD noted the falls rate had been fairly static for the last few months but falls with harm had been significantly reduced, there was a risk that mobilisation had been reduced but JD confirmed wards were getting back into initiatives like PJ paralysis which had been lost during the COVID period. JD added there was a balance between patients deconditioning in bed and falling and breaking their neck of femur.

EJ noted the Clinical Governance Committee had discussed the risks of moving elderly frail patients more than once as they can become disoriented and fall. EJ noted Stuart Henderson had attended the meeting to give a presentation on SDEC and as part of the improving together programme had been looking at which patients were being moved multiple times, EJ noted SHe had been asked to come back to Clinical Governance Committee to see if this had an impact on reducing falls. ME noted it would be good to discuss this further to see where the opportunities are when more data was available.
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TB1 06/07/3 **STRATEGY AND DEVELOPMENT**

TB1 06/07/3.1 **Review of Trust Strategy Progress Report**

LT presented the report and noted it was the first report since Improving Together had been adopted and used vision metrics as a way of measuring strategy deployment. LT added she would take the report as read but that there was a strategy session at the Trust Board Development Day in August to discuss this further. LT suggested the Board feedback outside of meeting their thoughts on what would be useful in future quarterly reports.

Discussion:
IG added the report gave a helpful snapshot of where we are and how the improving together methodology fits in but there would be greater insight following the Development Day in August in terms of what the board would like to see on a quarterly basis. EJ referred to item 3.1 in the report and noted it was a great step forward to have one strategy for the

organisation. FMc noted the strategy report had been aligned with the Board Assurance Framework which was why the BAF was now slightly out of sync.

SH noted the new duty to collaborate required being much more explicit about the triple aims. SH added the board could give more thought at the August development day as to how we link back to the triple aims explicitly within the priorities and strategy.

TB1 06/07/3.2 **Improving Together Quarterly Update Report**

PC introduced Alex Talbot (AT) the Associate Director of improvement. AT presented the report and noted the following points:

- Since the last report NHS England had introduced the NHS Impact Report, the Trust already had all the components in place and there was an opportunity for the board to use these to lead with humility.
- The training trajectory was slightly behind due to attendance and capacity in the Coach House.
- The Improving Together language was really starting to grip across the Trust with staff regularly using A3 thinking for problem solving and undertaking 'go and sees'.

Discussion:
IG confirmed he had witnessed the improving together language being used at meetings he had attended. DBe noted a presentation on SDEC had been given at Finance and Performance Committee which had been really inspiring, DBe reflected how more teams could be encouraged to set the right priorities and focus to then be able to find the head space to move forward, DBe suggested making videos of case studies of those who have done it and how they did it to inspire others.

SH noted management posts in the divisions had been increased to develop a triumvirate approach at speciality level on a consistent basis to provide extra opportunity to work with frontline teams using coaching and the operational management system. PC reminded the Board that at the next board development day in August there would be an item focusing on leadership behaviours, in preparation for this PC asked the Board to complete the online survey. IG noted the Board's leadership in this process was crucial to its success.

TB1 06/07/4 **FINANCIAL AND OPERATIONAL PERFORMANCE**

TB1 06/07/4.1 **SIRO Annual Data Security & Protection Assurance Report (includes Toolkit Self-Assessment and Data Protection Annual Report and GDPR) – deferred to September.**

The Board noted the SIRO report had been deferred to September.

TB1 06/07/5 **QUALITY AND RISK**

TB1 06/07/5.1 **Risk Management Strategy 3 yearly report – deferred to September**

The Board noted the Risk Management report had been deferred to September.

TB1 06/07/5.2 **Patient Experience Report – Q4/Annual Report**

JD presented the report and noted the following key points:

- The Trust continued to struggle to get complaints resolved in a timely manner and there had been an increase in complaints being reopened.
- The friends and family test continues to be very positive but the response rate could be better so an online solution was being worked on.
- The Trust had performed well in the National Maternity Survey.
- The Bereavement survey showed a reduction in satisfaction with the management of care of individuals at the point of bereavement. The PALs team were working with divisions to try to improve the patient experience.
- Work on triangulating feedback from patient groups and real time patient feedback to understand the patient experience.

Discussion:
IG asked if there had been any shift in complaints about nutrition and hydration. JD noted the report implied all complaints were about nutrition and hydration, JD added the next report would be clear how many complaints were about nutrition and hydration.

MW referred to insensitive communications and asked for more information. JD explained there had been an issue with consultant's communication in the past and PALS were working on an education piece to try to show consultants the impact of how they say things but there was a challenge due to the complex information they were trying to explain. PC noted there was more to do to support staff to communicate better. PC added the consistent theme with communication complaints was it is often a message that people didn't want to receive. SH noted there was more work to do to get a grip on how long it takes to respond to complaints, as it did not give a good impression of how much this feedback is valued.

EJ noted this report had previously been well received at Clinical Governance Committee and added the softer skills like compassion and kindness were harder to deliver when one was feeling challenged.
DBu asked when complaints could be expected to achieve the Improving Together target. SH noted the shortfall was due to capacity issues in the divisions.

The Board noted the report and appendices.

TB1 06/07/5.3 **Learning from Deaths Report – Q4/Annual Report**

IG asked the Board if they had any further questions on this paper as the content had already been covered in previous reports.

Discussion:
EJ noted this report had previously been received at Clinical Governance Committee where learning from deaths for people with learning disabilities had been discussed. EJ added now there was a lead nurse for learning disabilities in post it would be good to focus on this and strengthen the learning. PC confirmed he had discussed this with the Head of Clinical Effectiveness and it had been agreed to include the additional input from the lead nurse for learning difficulties.

SH noted it may be hard for members of the public to understand why the hospital currently had high Hospital Standard Mortality Ratios (HSMR) and asked if there was a way to explain without being too technical.
PC agreed the paper was complicated and referred to the summary that had been circulated as an action from agenda item 2.1 which was an attempt to respond to these concerns.

IG noted the information needed to be clear and transparent but added this had been reviewed at a regional level which provided a broad level of assurance. RH suggested using the in-house communications team to translate the information into language that could be understood by laypersons. The board noted the report acknowledging that there were ongoing issues.

TB1 06/07/5.4 **Annual DIPC Report**

This item was taken after agenda item 5.6.

JD presented the annual report and highlighted the following points:

- The Trust had declared outbreaks for covid 19 which continued to be easily transmittable across the hospital but with less impact.
- An outbreak of norovirus had been declared which had been closed down quickly.
- The Trust benchmarks well against the rest of the South-West for the key infections that are monitored.
- There had been 4 surgical site infections related to orthopaedic surgeries, a deep dive had been arranged with the surgical team to understand what was driving this and what could be done differently.

Discussion:
RA noted improving hand hygiene training had been discussed at shadow board, RA added during the pandemic hand hygiene had been managed to a high level but had seemed to have slipped back.

JD referred to a pilot scheme recently undertaken on Pitton Ward which was being rolled out across the Trust, the scheme focused on ward managers assessing staff on key measures of compliance but audits show results are largely unchanged, JD confirmed the issue would continue to be challenged and persevere with communications about appropriate uniform and decontamination.
SH noted the report was very positive and the Trust had benchmarked well despite some challenges, SH acknowledged the good work of colleagues to keep patients as free from infection as our counterparts.

The Board noted the report.

TB1 06/07/5.5 **Risk Management Annual Report**

This item was taken after agenda item 5.4.

JD presented the report and highlighted the following points:

- Managing serious incidents and critical incidents in the 60-day time frame had been an ongoing issue, the investigations were very time consuming and the Trust had recently moved to a new system PSIRF which focused on shared learning and would reduce the amount of work.
- There had been 38 falls with harm last year which was a reduction from 54 the previous year.
- Deep dives into divisional risk registers on a quarterly basis, divisional teams to do the same in each speciality and area.
- Training in the correct way to detect and report incidents so that they can be properly managed and are useful.

Discussion:
IG referred to the number of medication incidents and asked if the Board should be concerned about the increase. JD noted when EPMA was fully integrated there would be a much better picture of the Trust's medication issues.
PC confirmed he had discussed this with the Chief Pharmacist. EPMA is now reporting better data and a change to processes has meant the figures are changing. PC has started to triangulate this information.

EJ noted the Pharmacy team had been very open and transparent about their challenges, the Pharmacy team had a 60% vacancy rate but had now recruited 5 new members of staff to start in August. The Clinical Governance Committee had asked for more assurance in their next report and to triangulate with the incident report.

DBe referred to the number of catastrophic rated risks in the report and asked what the definition of catastrophic was. FMc noted any incident rated moderate or above would go to the weekly safety summit where it would be decided if they were truly catastrophic. PC explained sometimes there was a misunderstanding on how to score risks and suggested there needed to be more attention to the consistency of approach by non-clinical and clinical divisions. JD noted there were very few Serious Incidents that were related to medication. JD confirmed there had been issues where a patient had been transferred to a ward using EPMA from a ward that didn't as the roll out had been ward by ward.

SH referred to the non-clinical risks and explained there was a separate report covering Estates. LT asked if future reports could contain a conclusion and if there were any themes which could indicate if there were barriers. IG noted he had recently had to read a clinical review to report back to a family, IG noted the report was very thorough and must have taken a huge amount of work to compile. JD noted the reports were

written by clinical staff. JD added the themes from the report were failure to escalate, failure to diagnose and failure to get treatment.

LT explained her concern was regarding process weaknesses and if the divisions required extra support. JD noted it had been agreed to give clarity on incidents and risks at a future cascade brief.

FMc noted there had been a cultural shift from PSIRF, the Board would no longer need to discuss individual high harm events as the focus would be on the learning from high volume low harm events, FMc added the Board had developed its thinking and focus and the improvements and learning on patient safety.
The Board noted the report.

TB1 06/07/5.6 **Q4 Maternity Quality and Safety Report**

This item was taken after agenda item 5.3.

JD welcomed Abi Kingston (AK), Clinical Director, Women and Newborn Division and Vicky Marston (VM), Interim Director of Midwifery.

VM asked the Board to note the Q4 report and highlighted the following points:

- The Perinatal Mortality Review Tool findings.
- The Trust remained compliant with the labour ward coordinator being supernumerary.
- Women received 100% 1:1 care in Q4.

Discussion:
EJ noted the Care Quality Commission had visited some maternity units in the South West recently and published their reports, EJ added it may be useful to reflect on these reports for learning. EJ noted the strong leadership team now in place in the division and added the Clinical Governance Committee were not complacent. EJ expressed a concern that as a small unit Salisbury did not have a second Obstetric Theatre staffed 24/7 and if it was worth keeping a 2nd theatre open for 1 or 2 cases a year.

IG asked AK to give a general overview as the clinical director.
AK noted there had been a lack of staffing capacity in governance but there was now a quality and safety matron in place. A new governance framework had just been completed and would soon be going to Clinical Governance Committee. AK added the 2nd theatre issue had been added to the risk register.

IG referred to a recent visit to maternity with EJ and commented on the positive feedback received from patients. SH referred to the patient experience indicators and gave her congratulations on having so many in the top 20%. SH referred to a Freedom to Speak Up report and commented that more requests were received from Maternity.
JD noted 2nd theatres were a challenge for smaller hospitals but the aseptic? room was used as mitigation. JD added the Freedom to speak Up concerns had come from a particular group of staff; two meetings had taken place and some positive progress made.

FMc noted Maternity's governance framework had been formally appended to the Integrated Governance Framework. JD noted there were two things that would allow the Trust to move out of the Maternity Improvement Programme – the integrated governance framework and the imbedded maternity improvement meetings.

EJ asked if the right number of obstetric staff were currently in post. AK noted there were a couple of gaps that had recently been appointed to but as a small unit the Trust had struggled to appoint an Obstetrician. RH noted Maternity were now regular visitors to Trust Board and felt welcomed and less isolated because of that, RH noted the Board had not heard from the other divisions. SH noted there was a statutory requirement for Maternity to attend Trust Board but agreed the Non-Executive Directors needed to hear from the people doing the work. SH added that the Board Committees hear from a variety of teams but there was balance between Trust Board business and the connection with staff.

The board approved the report. AK and VM left the meeting.

TB1 06/07/5.7 **Research Q4 Report**

This item was taken after agenda item 5.5.

PC presented the report which was taken as read and highlighted the following points:

- The Trust had performed well against its peers of the same size.
- A new Head of Research had been appointed.
- Plan to expand research portfolio to include research boards and widen participation of the population.

Discussion:
DBe referred to child research and noted there were few volunteers, DBe asked if there were research opportunities in this area. PC noted the research projects available were often niche and not suitable. PC added larger studies were not as frequent and doctors were less inclined to take part in large volume studies as they were qualitative rather than quantitative.

RH asked if clinicians were being asked to focus on research projects rather than taking care of patients. DBu noted research was not part of the hospital's core business but research could attract funding and income. DBu added patients wanted to be part of trials and research should be prioritised against our core responsibilities.

RA noted research needed to be at the core of services to improve the health of our patients and patients nationally. RA added there were untapped talent resources in the workforce with nurses involved in education and research anyway.
SH noted the hospital was not a major research hospital but research was fundamental to improving outcomes for our patients. JD noted research was fundamental to personal development in the organisation

and the Research Board was focused on finding funding to enable specialists to undertake research.

TB1 06/07/5.8 **Board Assurance Framework and Corporate Risk Register**

1:01 FMc presented the report and noted the Board Assurance Framework and Corporate Risk Register had been through all the board committees. FMc gave a summary of the report and noted the following points:

- The Integrated Performance report had been cross referenced with the Board Assurance Register and Corporate Risk Register which had not identified any further risks but had been a useful process and would continue.
- There had been a positive shift in risk profile, 5 of the strategic risks had a reduced score, one of those moved back within tolerance.
- There were 5 strategic risks out with tolerance, additional reports specific to those risks were being provided to give sufficient oversight.
- The Trust's external auditors had suggested we consider how we feed into the ICS risk register, FMc added this would be included in the next report following a discussion with IG and SH.
- The impact of resourcing BAF Risk 4 - backlog on maintenance.
- The corporate risk in relation to urgent care and the impact on planned care.

Discussion:
IG noted the Board Assurance Framework reflected the key risks of the organisation and added the amount of detail gave good assurance and provided a sense of the work being done and limitations in place.

DBe referred to the due date for achieving the target score and asked what the key enablers in place were to achieve that score. FMc noted some of the risks had been updated to include progress made but it was harder to do this for the longer-term risks. DBe noted some of the risks had target dates in the next few years and added this gave an expectation of a longer journey.

LT noted there was a risk of using the Board Assurance Framework as an action plan. SH referred to the risk appetite which helped the board decide what it was least able to tolerate.
EJ asked if the corporate risk register was aligned from Board to ward. FMc noted the critical risks would be raised at Executive Performance Reviews and they would be escalated from there.

TB1 06/07/6 **PEOPLE AND CULTURE**

TB1 06/07/6.1 **Equality and Diversity Annual Report (Deferred to Oct new reporting schedule)**

The Board noted this report has been deferred to October.

TB1 06/07/6.2 **Health and Safety Annual Report 22/23**

MW presented the Health and Safety Report. MW took the report as read and highlighted the following points:

- The permanent Health and Safety Manager had been in post for a year and the Health and Safety Management system was now in the best shape for some time.
- A letter had been received from the Health and Safety Commissioners regarding violence and aggression towards staff, which required work on the causes and the support required.
- Task analysis and more structure introduced with a divisional task calendar to draw attention to senior management their responsibilities and requirements.
- Health and Safety now aligned with estates and working collaboratively on the large number of highly rated risks.

Discussion:
IG noted the disappointingly large number of issues relating to violence and aggression towards staff, IG added violence and aggression towards staff was unfortunate but never acceptable and the board took a zero-tolerance approach.

RA noted the shadow board had discussed incidents of violence on adult wards being higher due to patients with dementia and cognitive issues, RA noted there was a particular skill set required to deal with dementia patients and asked how staff were supported in de-escalating violent situations. RA added the working environment and culture needed to be conducive to reducing violence and aggression. RA added staff turnover was higher on adult wards with age groups 20 to 30 less likely to put up with violence and aggression.

EJ noted the lone working policy required revision as violence often escalated when working individually, EJ added staff aged 21 to 30 were less experienced in dealing with challenging situations.

SH noted the Trust served an aging population and recruiting staff was challenging, SH added there had been an increase in the number of mental health illnesses since the pandemic, particularly in children and young adults. SH noted the Trust needed to make sure staff felt as equipped as possible to respond but that demand and challenges had changed significantly in the last 3 to 4 years.

RH noted an incident was something that happened after everything else has failed but asked if the Trust monitored near misses, RH suggested the Health and Safety report include near misses in future for the Board to review. **ACTION: MW/TR** **MW/ TR**

JD noted some of the Trust's elderly wards faced environmental challenges with no access to outside spaces and freedom to wander which was important to the management of these patients.
MW referred to near misses reporting and noted this was something that senior managers should pick up.
The board noted the report and the statutory responsibilities in relation to health and safety.

TB1 06/07/6.3 **Modern Slavery Statement**

MW confirmed the Modern Slavery Statement was now on the Trust's website as required.
The Board noted and approved the Modern Slavery Statement.

TB1 06/07/6.4 **Medical Revalidation and Assurance Appraisal Annual Report Including Statement of Compliance**

PC presented the report and highlighted the following points:

- The Chief Medical Officer was required to report to the Trust Board that they were satisfied with the amount of resource given to doctors to revalidate and have annual appraisals. PC confirmed he was satisfied.
- There are 233 doctors with a prescribed connection to the responsible officer.
- 51 doctors had been recommended for revalidation during the last financial year, 42 were recommended and 9 deferred due to insufficient evidence.
- These results were just above the national average.

Discussion:
The Board discussed the reasons why a doctor maybe deferred.
EJ asked if there were any concerns with doctors and if so that the appropriate action was being taken. PC referred to the report and assured the Board that there was nobody the Board should be concerned about.

DBu noted he had no concerns regarding the report and reflected the Trust's ambition should be 100% of those doctors that can be appraised should be appraised as there were always reasons why they may be unable to such as sickness.

MvB noted there was scope within the appraisal to look for health problems and asked if any had been picked up in the last year.
PC provided assurance that there were no concerns regarding fitness to practise due to health, but noted health issues that affected work were not captured statistically.

Decision
The Board approved the annual assurance documents and approved the sign off of the statement of compliance.

TB1 06/07/7 **GOVERNANCE**

TB1 06/07/7.1 **Non-Executive Director Responsibilities and Committee Composition**

FMc noted the report looked at Non-Executive Director responsibilities and champion roles and highlighted the following changes that would take effect from 1st September:

- EJ would take over as the Senior Independent Director.
- EJ will chair the People and Culture Committee.

- DBu will chair the Clinical Governance Committee.
- RA will chair the Remuneration Committee.

FMc noted the NHS guidance recommended Non-Exec Directors undertake five champion roles, FMc added the recommended roles were all covered apart from Doctors Disciplinary Advisor and Security Management. FMc noted it was for individual organisations to agree which roles to have, Bristol, RUH and GWH all have these roles covered, RUH also have a Sustainability Champion and a Digital Champion. FMc asked the Board to acknowledge the changes, agree the number of champion roles and consider any new roles.

Discussion:
IG noted MvB would be leaving next year and recruitment planning had started for a new NED to replace him, if there were five champions recommended, they should all be covered but asked the Board if anyone had any contrary views.

EJ noted she had been the Maternity Safety NED since the role was created and felt some fresh eyes in that role may be timely, EJ added she was happy to swap with the Doctors Discipline role as had done that before. FMc noted the NHS review indicated champion roles could be the responsibility of a board committee to give oversight through the governance arrangements of the committee. The Board discussed the champion roles in the report and agreed champion roles were valued. The Board noted the additional work this could create and agreed the board committees could help with the governance.

IG summarised the discussion and noted the board should try to ensure that NED responsibility is provided throughout the committee structure. IG added the five statutory responsibilities should be filled and then assess how best for Non-Exec Directors to engage in particular areas using the Improving Together approach and review on an annual basis. IG agreed to discuss the doctor's disciplinary role and digital role with NED colleagues and bring back to the next meeting. **ACTION IG** **IG**

Decision:
The Board agreed the recommendations in the report.

TB1 06/07/7.2 **Register of Seals**

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

TB1 06/07/8 **CLOSING BUSINESS**

TB1 06/07/8.1 **Any Other Business**

There was no other business.

TB1 06/07/8.2 **Agreement of Principle Actions and Items for Escalation**

IG summarised the board's discussion.

TB1 06/07/8.3 **Public Questions**

There were no questions from the public.

TB1 06/07/8.4 **Date of Next Public Meeting**

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

TB1 06/07/9 **RESOLUTION**

TB1 06/07/9.1 Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

Master Action Log

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

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

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Grandfield	TB1 6/4/3.6 Integrated Performance Report (IPR) (M10)/ Stroke TB1 4/5/2.5 Integrated Performance Report (IPR) (M11)	~~04/05/2023~~ ~~06/07/2023~~ 07/09/2023	Lisa Thomas, LT Peter Collins, PC	Concerns around the operational response around protecting Stroke Beds is clear in the report. This needs to be revisited. PC noted that he would support JDi as the action discussed earlier was to improve the narrative that has been produced by the team. SH noted that further work is required to better represent the improvement in an objective way.	- May Update - SH noted that further to the action around the Stroke narrative in the IPR, there was still further work to ensure the message was explicit to provide the correct level of assurance that beds are being protected for Stroke patients. - July Update - LT confirmed an assurance report would be going to both F&P and CGC. **- Stroke Improvement Slides reported to F&P in July, deferred to allow enough time to discuss. On sept F&P agenda.**	N	2
Trust Board Public	Sasha Grandfield	TB1 06/07/1.1 Presentation of SOX	07/09/2023	Kylie Nye, KN	Board to discuss ways to thank and acknowledge staff at a future Board Development Day	**Added to the development day schedule. Item closed.**	Y	3
Trust Board Public	Sasha Grandfield	TB1 06/07/2.1 Clinical Governance Committee 27th June 2023/HMSR	07/09/2023	Peter Collins, PC	PC to circulate to the Board his update paper giving more detail on mortality data and changes in coding	**Completed. Item closed.**	Y	3
Trust Board Public	Sasha Grandfield	TB1 06/07/6.2 Health and Safety Annual Report 22/23	07/09/2023	Melanie Whitfield, MW Troy Ready, TR	Health and Safety report to include near misses data in future	**Q1 report on September's agenda. This action to be considered for Q2 report onwards.**	N	4
Trust Board Public	Sasha Grandfield	TB1 06/07/7.1 Non-Executive Responsibilities and Committee Composition	07/09/2023	Ian Green, IG	Discuss the doctor's disciplinary and digital champion roles with NED colleagues		N	2

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	1.8
Date of Meeting:	07 September 2023		

Report Title:	Chief Executive's Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X		
Approval Process (where has this paper been reviewed and approved)	N/A			
Prepared by:	Stacey Hunter, Chief Executive Officer			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive Officer			
Appendices (list if applicable):	Appendix 1 LL communication from NHSE Appendix 2 BSW ICB governance proposals			

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

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

Board Assurance Framework – Strategic Priorities	Select as applicable
Population: Improving the health and well-being of the population we serve	☒

Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒
Other (please describe) -	☐

1.0 Our Population

1.1 Operational Context

This report covers the period since the Board met at the beginning of July 2023 which has continued to be impacted by medical staff industrial action, financial and performance recovery alongside progressing our improvements efforts via our Improving Together breakthrough objectives .

The detailed performance is shared in the Integrated Performance Report which demonstrates sustained progress in some of the urgent care improvements and positive progress in two out of our four breakthrough objectives (Falls and LOS). There are continued pressures on the elective and cancer standards which are a combination of capacity challenges and the impact of lost activity due to the recurrent strikes.

As Board members will be aware there has been x 4 further strikes over the last 6 weeks with junior doctors striking continuously from 7am on the 11th of July to 7am on the 15th of July and from 7am on the 13th of August to 7am on the 18th of August . In addition to this Consultant Medical staff have had x 2 periods of Strike action the first from 7am on the 20th of July to 7am on the 22nd of July and latterly from am on the 24th of August to 7am on the 26th of August.

Our clinical, operational and EPRR colleagues once again did a fantastic job in both preparing for the strikes and oversight of activities during that week. As Board members will appreciate this takes a considerable amount of time for our leadership teams. I would like to offer my thanks and appreciation to them and to all our colleagues who stepped in to cover during this period. Whilst we managed well colleagues found securing cover during the August strikes much more difficult than previously . This is likely to be due to the persistent nature of the strikes and the sense from medical colleagues that it is difficult to see an end in sight.

The cumulative impact of the strikes is now putting the delivery of 78-weeks and 65-weeks waiting time standard at risk which we will keep the board appraised of via the Finance and Performance committee. It is also challenging to recover the overall activity numbers given the recurrent nature of the medical staff dispute.

The BMA have announced further dates for consultant strikes in September and October and the outcome of the current BMA ballot for junior doctors is expected on the 31st of August .

1.2 Financial sustainability

Delivery against our financial plan remains a challenge with the Trust £2.4m off plan at the end of July; costs of back fill for gaps in rosters continue to be compounded by the impact of industrial action, the latter accounting for half the deficit against our plan. We are anticipating significant improvements moving into the Autumn with strong a recruitment pipeline, but the costs being incurred to support the needs of patients with complex mental health needs are forecast to continue for the foreseeable future.

Despite the on-going challenge, the Trust has shown significant improvement in underlying productivity in planned care, as well as length of stay reductions in emergency care, particularly due to new same day emergency care pathways.

From a capital expenditure perspective, the Trust has submitted a business case to NHS England for a new electronic patient record system, and progress continues to be made on the building of a new ward.

Work has commenced on the 3–5-year financial recovery plan at an organisation and system level which will require significant focus from Board colleagues over the coming weeks and months. There is a session on our private board agenda today in which the Chief Finance Officer will outline the progress to date and discuss the next steps.

1.3 Bed Capacity Risk

Colleagues will recall I raised the challenge of the South Newton beds closing (41 beds in total) in respect of the impact on our bed occupancy and the numbers of people with No Criteria to Reside . To help mitigate this risk the Wiltshire Integrated Care Alliance developed a recovery plan which was supported by the system including an additional 0.5m for out of hospital capacity.
There has also been a recent Emergency Care Intensive Support Team(ECIST) visit to Wiltshire which has identified further opportunities to reduce the number of people who have a delayed discharge from hospital.
Whilst the recovery plan and ECIST recommendations offer some mitigation I remain concerned about our overall bed capacity.
The Chief Operating Officer may want to provide a verbal update on the position at our Board meeting.

2.0 Our People

2.1 Staffing

The release on 30th June of the much-awaited NHS Long Term Workforce plan is welcomed. We have started to analyse the key requirements under the three focus areas of Train (to grow workforce numbers), Retain (improving Career development options and flexible working opportunities), and Reform (working differently using new technology). Our analysis will in turn inform our Strategic Workforce Plans for the next 5 years. I am encouraged that we have recently already explored ways of supporting nurses to return to practice, improving our numbers of degree apprenticeships for aspiring nurses and offering nurse associates with the opportunity to use the apprenticeship route to qualify as Registered nurses. This focus on offering routes into the nursing profession for those not attracted to traditional university options meets the intent of the plan and supports our strategy in offering opportunities within our local communities, with the likelihood of improved retention for these local staff members.

A continued focus on recruiting and absence management has continued to realise modest benefits against our staff availability target. Our average Agency spend in the last 3 months is down just under 2% on the previous 7 months average at 5.7% of total pay, despite the impact of industrial action and a busy operational tempo in the hospital. Our improving together methodologies are allowing more informed use of data and better targeting of recruitment campaigns and areas for management support. I am encouraged that our absence rates in the last 2 months have been on target at 3%. Finally on staff availability, I am pleased to report that following the increase to establishment numbers in the new financial year from April, vacancies have immediately begun to fall, by way of comparison in FY 22/23, vacancies did not start to fall until October. The efforts of those involved in planning and delivering the recruitment activity to make this improvement are appreciated.

2.2 People Promise

People promise initiatives to have remained a focus for our OD&P team and under the compassionate and inclusive element there has been good progress in the development of our leadership behaviours framework, which seeks to define the behaviours expected of all leaders in the Trust. The arrival of a new wellbeing lead has enabled us to commence baseline our wellbeing offer through the NHS diagnostic framework, with the clear intent to improve the offer and better inform staff of what is available. To support financial wellbeing,

we have agreed a programme of staff discounts with local chamber of commerce member organisations and commissioned a further series of financial briefings covering pension issues.

2.3 Well Led Review

As Board colleagues will be aware we have now received our report from Aqua who we invited to do a well led review on behalf of the Board. Colleagues will have had opportunity to reflect on the reports' findings and we will have an opportunity to do this collectively with the report's author .
The report gives a good sense of the areas where we have strengths under the well led framework and gives us excellent insight into some areas we will want to improve. I look forward to discussing the report in more detail with Board colleagues in the coming weeks.

3.0 Our Partnerships

3.1 National Communications

In addition to communications and assurance about the Industrial Action by doctors in this period , the following material items have been communicated from NHS England.

3.11 New measures for Winter

To supplement the preparations for winter set out in the NHS Urgent and Emergency Care Recovery plan this publication set out the requirements for Care traffic control centres and acute respiratory hubs to build on the investment in additional ambulances and community capacity (virtual wards) . From a BSW perspective the Urgent Care Board have a transformation programme focused on Care Co-ordination which delivers the requirements that are set out .
There is more work to do across Wiltshire to maximum the benefits of both care co-ordination and virtual wards which our clinical and operational teams are supporting.

3.12 New Standards for NHS board members

The NHS published a new framework to help senior board member strengthen board governance and leadership which includes a revised Fit and Proper Person Test (FPPT) . NHS England have done this in response to the one of the five recommendations from the Kark review and will introduce:

- A new standard reference for people leaving NHS Board roles will be held on file until the person turns 75 . This will include details on any ongoing or discontinued complaints and disciplinary issues.
- Data fields on the Electronic Staff Record to record Board members FPPT.
- An extension of FPPT to all commissioners and arm's length bodies, Care Quality Commission and NHS England

I know this is something our Chair will review and ensure we are able to respond too.

3.13 Lucy Letby conviction

I know the conviction for murdering seven babies and attempting to kill another six has sent understandable shock waves through the NHS and the communities we serve. It is difficult to reflect on the impact of these hideous crimes and unimaginable for the parents and families of her victims.

As Board colleagues will know the government have ordered an independent inquiry into the wider circumstances surrounding the deaths including how concerns that were raised were dealt with,
I attach a letter we received from NHS England for Board members information (see appendix 1).

3.2 BSW Integrated Care System

The focus for the ICB on oversight and delivery of the BSW financial recovery plan for 23/24 continues with ongoing pressures in delivery of the plan . I will ask the CFO to detail in our private session.
The ICB have developed updated governance proposals which I share in detail at appendix 2 .

3.3 Wiltshire Integrated Care Alliance (ICA)

The Integrated Care Alliance did not meet in August 2023 as planned; however, work has continued at pace across several areas in recent months, principally around:

- Urgent Care & Flow
- Mental Health
- No Criteria to Reside Recovery
- Health Inequalities
- Delivering the Community Investment Fund
- Neighbourhood Collaboratives

On **mental health** a system workshop was held and some key themes fell out of that for Wiltshire as a 'Place,' these reflected the challenges on prescribing, timelines of diagnosis, where to seek support, and the challenge of flow through acute mental health services. A mental health strategy draft is due by the end of the calendar year.

Health inequalities work proceeds on several fronts with the ICB devolving £860,000 to Wiltshire. Joint Strategic Needs Assessment data and the CORE20PLUS5 approach is directing this work. We have resourced this work clinically and strategically.

The NHS South West **Community Investment Fund** sought to support, develop, and invest in programmes of work that would be effective in local communities. £100,000 was allocated for investment in Wiltshire. This was invested into Wiltshire's local voluntary sector through expansion of existing programmes: Surviving Winter, Cost of Living Response Programme, and Community Grant Cost of Living Uplift Grants.

The '**Neighbourhood Collaboratives**' programme of community led initiatives is also ramping up and exploring a programme of work in the South of Wiltshire, following successes in the North.

3.4 Other partnerships, communications, and engagements

3.4.1 Staff Thank You Week

The Thank You Week includes the annual awards, Long Service Awards, Volunteers lunch, Family Fun and Sports Day and staff and friends live music night. All being held in The Close between Thursday 7th and Saturday 9th September. The events are generously supported by the Stars Appeal and the League of Friends.

The Awards received over four hundred nominations and seats are fully booked for the night with a waiting list of over one hundred. The music night has two hundred prebooked and the Family Fun Day over 400 - 100 volunteers are booked to attend the lunch.

3.4.2 SFT Podcasts *The Cake*

The new series now has three episodes live and they have already been downloaded 150 times. A recording in front of a live audience took place during the inaugural Tent Talks – this episode had two external speakers plus our Chair Ian Green the Trust Chair discussing the challenge of delivering inclusive public services during a time of division and debate.

The first Cake series is a finalist for the HSJ communications award and the CommsHero award for equality and diversity.

3.4.4 Anniversary activity

The hospital held its first in a generation **Open Day** on 22nd July. The event was supported by departments and teams across the hospital plus colleagues from emergency services, partner organisations and charities. While it rained a lot the event had approx. seven hundred attendees and lots of smiles. Highlights can be seen here https://www.youtube.com/watch?v=LRGm42zu2cw&t=6s

Tent Talks took place over two days, 24th and 25th July, in the Seacole and Nightingale tents on The Green - these had been used for the Open Day – the event was generously supported by the Stars Appeal. There were thirty-two separate learning, development, and wellbeing events for staff over 2 days and 750 pre-bookings. These included sessions on inclusion, leadership under pressure and civility plus aromatherapy and sleep workshops and a comedy night to which staff were able to invite friends and partners. Highlights can be viewed here https://www.youtube.com/watch?v=t3pDQj_8pRc&t=4s

I know the Board will want to join me in thanking everyone who worked alongside our communications team in delivering these wonderful events. By the time we meet for our next Board meeting we will be only hours away from our staff awards event which are a brilliant chance to reflect on the contributions our colleagues make to our local communities .

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

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

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

NHS
Bath and North East Somerset,
Swindon and Wiltshire
Integrated Care Board

Approach to delivery governance

Aug-23

Context

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

The NHS Operating Framework assigns the system specific responsibilities in terms of delivery and oversight. As part of this, the ICB needs to have arrangements in place to take assurance over our system commitments, and wants to enact this according to our agreed principles of subsidiarity and mutual accountability.

In order to ensure we are on track with delivery of our key system commitments, we need to have a way of understanding how well we are progressing across five key planning areas:

- Operating plan delivery
- System oversight commitments (closely related to operating plan delivery for 23/24)
- Implementation plan delivery
- Financial Recovery
- Delivery of inequalities and outcomes commitments

We have a number of workstreams and programmes underway, and have discussed with SROs how best to bring these together and achieve greater consistency. This slide deck proposes a way forward for discussion focussing on two areas: delivery of our planning commitments and oversight of NHS organsiations.

Principles

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- We want to continue working in a way that respects our agreed commitments to mutual accountability and collective oversight
- We need to establish mechanisms that operate effectively across system partners, and are based on a high trust, high transparency approach.
- We need clear delivery governance and decision-making routes that are easy to understand and collectively owned, are effective at ensuring that we have the right groups set up to carry out delivery, and that delivery is on track.
- By delivery, we mean putting in place the actions to deliver our agreed strategy, and our implementation plan and operating plan
- We need to recognise the interdependencies and the differences between oversight of 'business as usual' activities and transformation work and ensure the mechanisms we put in place are capable of overseeing both.
- We need to be clear that the ICB risk management framework applies to delivery groups
- There is a desire to have a consistent programme and project methodology using initiation, gateways, milestones, evaluation, closedown etc
- We want to be clear on what decision-making powers / authorisations sit at different forums
- System partners will, as business as usual ensure that their own organisations are delivering against their plans. However, there is benefit in partners carrying out oversight together, in the understanding that under current legislation, performance / delivery oversight cannot be delegated from / by sovereign organisations.
- To ensure efficient and effective ways of working, we should not set up new forums if another group

Proposed approach

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We propose to put in place a governance structure that allows for subsidiarity and also for collective oversight of delivery.

The structure would:

- Enable delivery groups/programmes to have day to day responsibility for implementing our plans, first line response to resolve issues and delays to delivery
- Have consistent terms of reference so that all delivery groups are clear on what is in their remit and authority
- Have a clear escalation framework to ensure issues can be escalated to the appropriate forum
- Establish a planning and delivery oversight forum with representatives from system partners (directors of performance, transformation directors, other nominated reps) to:

  A) twice a quarter, review progress against delivery of our transformation priorities as set out in our implementation plan

  B) on a quarterly basis undertake a collective review of our performance against the NHS oversight framework metrics

- Be clear on the relationship of the delivery and oversight forum with the individual delivery groups, to the financial recovery board, BSW ICB assurance committees, BSW ICB Executive Group, and BSW ICB Board and other relevant forums within organisations
- Be responsible for producing summary highlight and assurance reports to provider and ICB boards as required
- Be respectful to partners' time – utilising different approaches for NHS oversight framework/operating plan vs implementation plan

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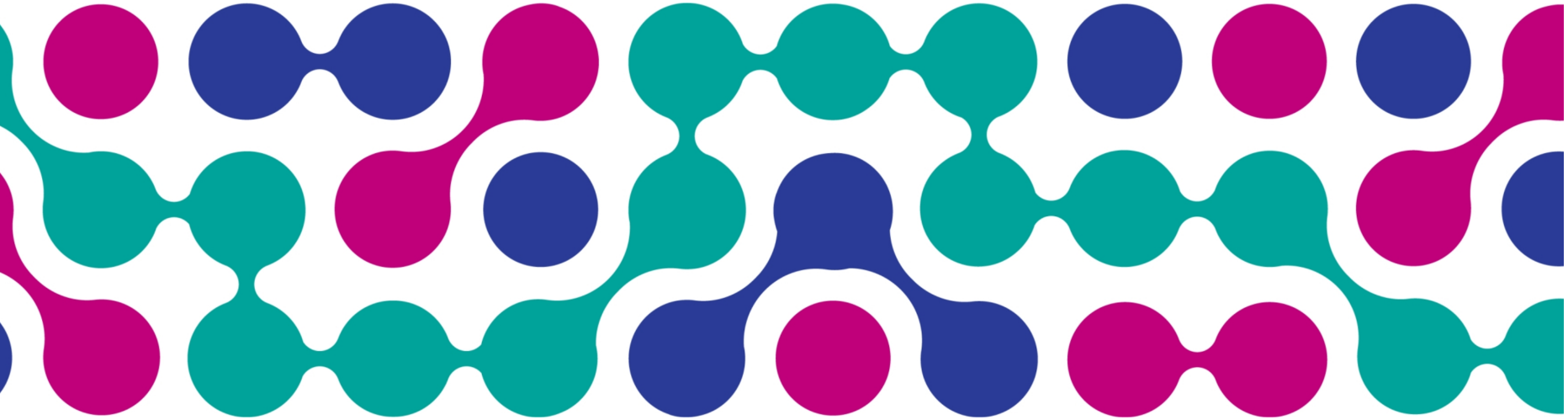
Delivery of our collective plans



Definition of delivery groups

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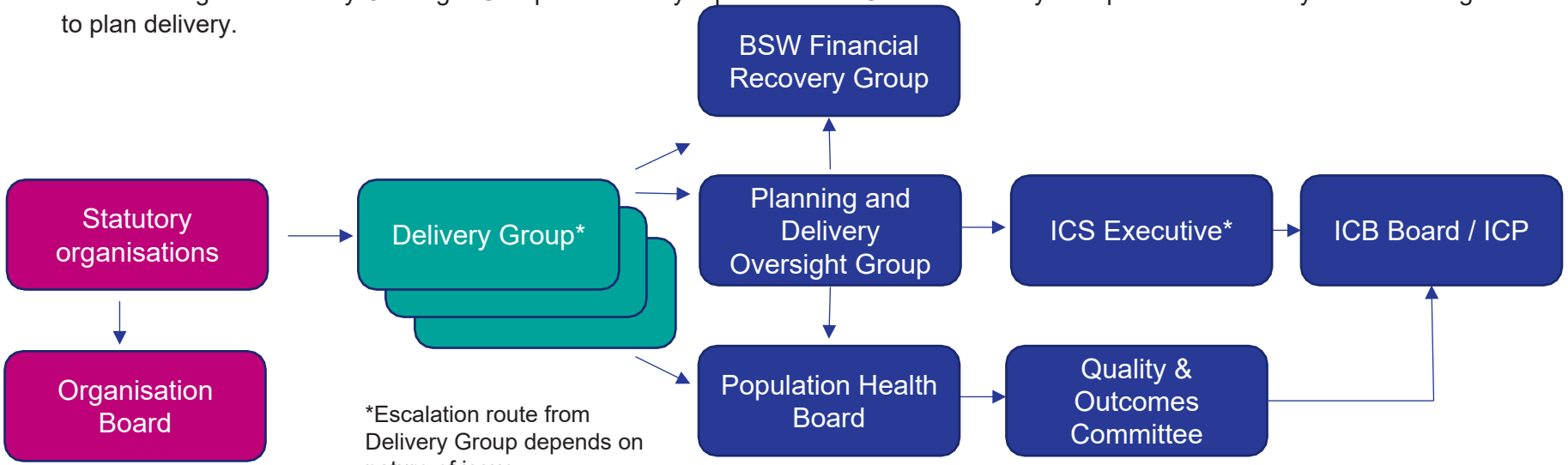
- In this context, delivery groups refers to any group of partner organisations that come together to deliver our operating plan and implementation plan commitments.
- These groups may be existing forums that have other key responsibilities in our system governance e.g. ICAs, but they are also responsible for delivering our plans.
- The main delivery groups as currently identified are listed below – however, we may need to establish other delivery groups as we evolve our implementation plan.
- Approach also allows all parties to be clear on scale of issue and which group is responsible for resolving at any point in time

Clinical transformation delivery groups	Enabling delivery groups	Other forums charged with delivery
Urgent Care & Flow	Digital	B&NES ICA
Elective	Estates	Swindon ICA
Mental Health	Finance	Wiltshire ICA
LD&A	Green	AHA
CYP	Workforce	
LMNS		
Primary and Community Care		

Subsidiarity and authority of delivery groups

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

- Purpose is to enact principle of subsidiary – working assumption that issues are resolved at earliest possible opportunity by those closest to the issue. Each Delivery Group is empowered to take decisions to enable delivery of agreed transformation commitments as set out in the implementation plan and delivery of operating plan commitments. These are shared priorities that all partners have committed to deliver.
- The aim is to have a clear, shared mandate for each delivery group so there is clarity on between system partners on the purpose for each delivery group and what they are aiming to deliver. Delivery groups are formally established by the ICB, to ensure consistency of approach, clarity of applicable governance framework, and the ICB's ability to discharge its responsibilities as system convenor and delivery of system plans.
- Issues can only be escalated where opportunities to resolve at an earlier point through Delivery Groups have been fully explored. Issues will be escalated by the Delivery Group Director.
- The Planning and Delivery Oversight Group will formally report into the ICS Executive by exception on a monthly basis with regards to plan delivery.



*Escalation route from Delivery Group depends on nature of issue

*In time, the Planning and Delivery Group could report into a more formal meeting of the ICS Executive

Escalation levels

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- Aim is to agree an approach allows all parties to be clear on scale of issue and which group is responsible for resolving at any point in time.
- Where any issue has an impact on the overall provider segmentation under the NHS oversight framework, the BSW oversight framework would also apply (see later in document), but would be carried out in a complementary way

Level	Description
Business as usual	Statutory organisations responsible for co-ordinating activities, monitoring and identifying risks / issues for escalation to the relevant delivery group
Advise	Responsible delivery group discussing emerging issue, oversees production and assurance of recovery plan, co-ordinates any support required from other system partners, monitors / assesses effectiveness of support actions, notifies oversight forum via the respective delivery group director
Assure	Delivery and oversight forum reviews issue, provides briefing to ICB Executive/ ICB Board / NHSE as required, agrees any additional support required
Alert	ICS may ask for external support, and undertakes any further actions agreed. In this level of escalation, regulatory action may apply if this relates to an NHS oversight related commitment or quality issue.

Delivery Group roles

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- As discussed at the SRO meeting, there was clear feedback during the programme review that clarity on roles would be helpful, with more consistency across programmes / delivery groups.

Title	Scope of role
Delivery Group Director	The Delivery Group Director is the senior (director-level or equivalent) individual responsible for ensuring that a programme meets its objectives, delivers the projected outcomes and realises the required benefits. and is the overall owner of the change. directs the programme of work. They provide the interface between programme ownership and delivery. They are responsible for planning and designing the programme and proactively monitoring progress, resolving issues and/or taking the decision to escalate issues.
Delivery Group Sponsor	The Delivery Group Sponsor is the Executive or equivalent responsible for championing the programme of work and supporting the Director to carry out his/her role in ensuring the programme is delivering.

- In this set-up, the delivery group sponsors could rotate on an annual basis in order to ensure varied engagement across our major programmes of work. We can also open up sponsorship to our wider ICS executive partners.

Additional considerations

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- We will reflect on the operation of this governance at the end of this financial year to ensure it is fit for purpose
- We will consider and incorporate findings from well-led reviews as they conclude
- The planning and delivery forum will also act as the parent group for the ICB/ICS planning meetings and take overall responsibility for delivery of the key NHS planning submissions

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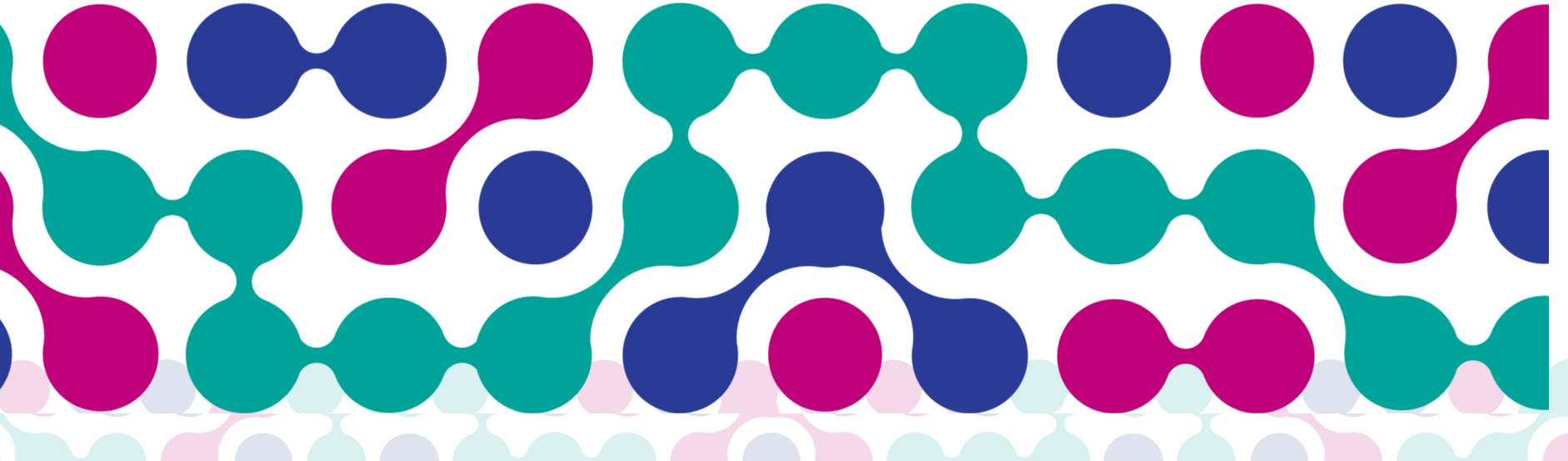
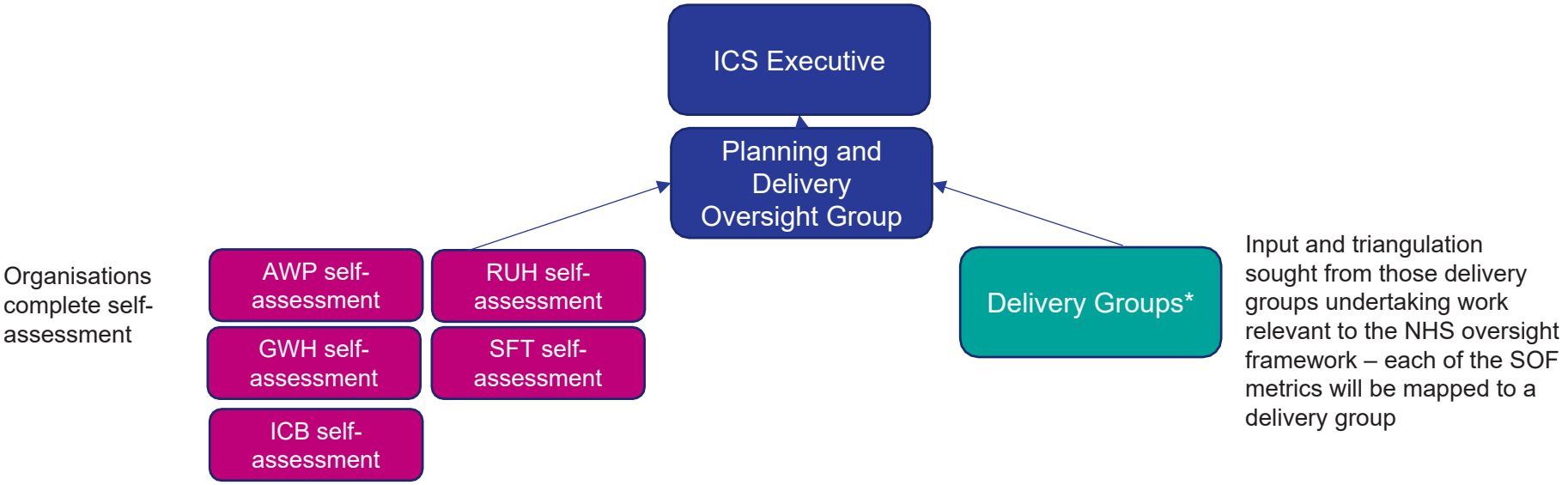
NHS oversight framework



NHS oversight framework (NHS OF)

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

- The ICB has a responsibility to provide first line oversight of NHS providers – this was delegated to ICBs in the NHS operating framework published in November.
- The Planning and Delivery Oversight Group will enable this responsibility to be carried out in our established working principles of mutual accountability and subsidiarity.
- Once a quarter, the NHS partners on the group will meet to review organisation's self-assessment against the NHS OF, and propose a segmentation to NHSE. The segmentation proposals will be shared with the ICS Executive along with any issues or points of escalation. The NHS OF metrics are shown in Appendix 1.
- We are also developing a BSW oversight framework (more overleaf) so that we are clear on what happens if any organisation moves into a segmentation 3 or 4 and/or any particular points of concern result in the need for escalation.



NHS oversight framework

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

- NHS oversight framework sets out the role and responsibilities of NHSE, ICBs and providers in relation to performance oversight.
- Extract below sets out the different segments and the metrics are shown in the appendix, – we are required to carry out a segmentation analysis against the metrics on a quarterly basis.
- Currently, we are carrying out our local responsibilities in a less formal way – but we know that in light of the NHS operating model and changes to ways of working, that we need to move to a more standardised arrangement and codify some of the processes we have established, as well as streamlining other arrangements e.g. CRMs.

Extract from NHS Oversight Framework

Segment	Segment description	Scale and nature of support needs
1	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required
4	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme

BSW oversight framework

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Integrated Care Board

- Aim is to agree and document a local approach to implementation of the NHS oversight framework so that we all understand the principles and mechanisms for overseeing and resolving performance challenges in relation to the domains covered in the NHS oversight framework: quality of care, access and outcomes; preventing ill-health and reducing inequalities, people, use of resources and leadership and capability.
- Principle of mutual accountability and subsidiary will still apply, with the aim of having proportionate oversight allowing for assurance and improvement to take place.
- The full oversight framework will be co-produced by the Planning and delivery oversight group.
- The below table sets out the likely role of different forums within our oversight framework taking into account our delivery group model and principles of mutual accountability.

Organisation/group	Role
Statutory organisations	• Carrying out self-assessment against oversight metrics on a quarterly basis • Putting in place recovery actions to address any segment 3/4 flags
Relevant delivery groups	• Inputting into overall segmentation on a quarterly basis • Monitoring and overseeing recovery actions
Planning and delivery oversight group	Collectively review self-assessments, agree overall segmentation proposals to NHSE on a quarterly basis Triangulate inputs from delivery groups Agree enhanced support arrangements and commission recovery plans where individual metrics or segments flag for segment 3 e.g. enhanced oversight arrangements Take an overall view of impact of recovery actions and recommend any proposals for overall segment changes to ICS executive
ICS Executive	Receive exception reports Agree proposals where an organisation is recommended to move segment
Enhanced oversight arrangements	May be set up in response to a segment 3 flag or another regulatory issue. Will be agreed either by Planning and delivery oversight group or ICS Executive depending on nature and scale of issue e.g. Quality Improvement Group, Finance Oversight Group. Arrangements will be for an interim period whilst issues are resolved.

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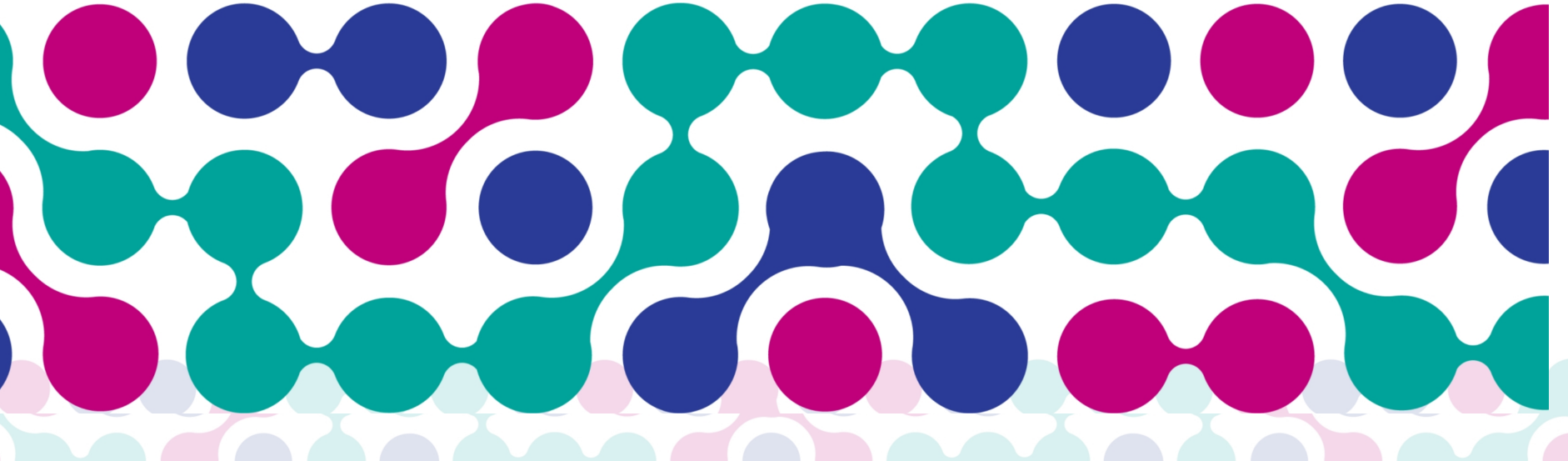
Worked example



Worked example

NHS
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Example	Overall approach	Escalation / SOF status
Diagnostic performance meeting operating plan targets and performing well, albeit with some variation in individual modalities month on month.	BAU performance monitoring via individual trust processes and Elective Care Delivery Group	BAU escalation level. No change to SOF rating
Issue identified regarding operational performance, recovery plan put in place. Trust and Elective Care Delivery Group agree to escalate	1. Modality lead / Trust lead develops recovery plan 2. Trust Board and Elective Care Delivery Group oversees delivery of recovery plan 3. Support mobilised from other partners as appropriate. 4. Oversight group made aware of issues and actions.	Assure escalation level. SOF rating likely unchanged although may have flagged for Segment 3.
Material under-delivery of diagnostic performance, recovery plan not resulting in desired actions. Trust, Elective Care Delivery Group and Oversight Group agree to escalate	1. Delivery Group Director escalates to Oversight Group 2. Further mitigating actions and any further support identified. 3. Issue reported via ICB governance to ICS Exec and ICB Board.	Advise escalation level. SOF flag may result in 3 rating for diagnostics and enhanced provider oversight processes.
Delays to treatment resulting in patient harm and/or significant breach of operating plan commitments regarding operating performance. ICB formally notifies NHSE	1. Ongoing escalation and exception reporting. 2. NHSE made formally aware of issues, and invited to join enhanced oversight as appropriate. 3. Specific briefing made to ICB Board.	Alert escalation level. SOF likely to be 3 or 4. Enhanced provider oversight processes. NHSE may take action e.g. change to tiering status and support offered.

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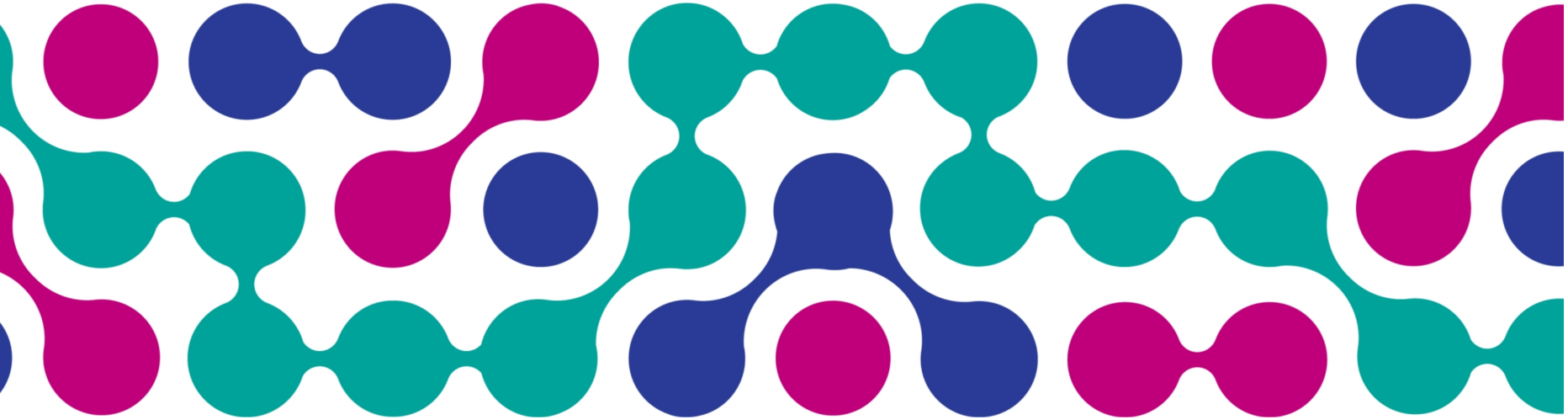
Appendix 1 – NHS Oversight Framework Metrics



Quality of Care, Access & Outcomes

sub-categories: Elective

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

NHS OF Metric Name Full	Period	Target or Standard	National Value	Great Western Hospital		Royal United Hospital		Salisbury FT		BSW ICB ICB or provider aggregate		BSW sub ICB -population	
S007a: Total elective activity undertaken compared with 2019/20 baseline	2023 01	104%		97.5% 101/137	I	105.8% 38/137	I	86.6% 129/137	L	98.5% 21/42	I		
S007b: Elective Activity : Completed pathway elective activity growth	2023 03	110%		107.3% 46/137	I	116.3% 30/137	H	92% 100/137	I	111.7% 11/42	H		
S009a: Total patients waiting more than 52 weeks to start consultant led treatment	2023 04		356,212	2,238 82/136	I	1,695 71/136	I	918 45/136	I	4,851 9/42	H	4,680 9/42	H
S009b: Total patients waiting more than 78 weeks to start consultant led treatment	2023 04		10,979	1 30/136	H	8 60/136	I	0 1/137	H	9 4/42	H	35 4/42	H
S009c: Total patients waiting more than 104 weeks to start consultant led treatment	2023 04	0	441	0 1/136	H	0 1/136	H	0 1/136	H	0 1/42	H	3 17/42	I
S013a: Diagnostic activity levels: Imaging	2023 03	120%	22/42	97.1% 108/135	L	102.7% 81/135	I	117% 30/135	H	104.6% 22/42	I	104.8% 22/42	I
S013b: Diagnostic activity levels: Physiological measurement	2023 03	120%	103.8%	110.8% 51/136	I	111.2% 50/136	I	199.8% 8/136	H	122.2% 9/42	H	122.7% 12/42	I
S013c: Diagnostic activity levels: Endoscopy	2023 03	120%	94%	96.8% 60/136	I	167.3% 10/136	H	22.5% 122/136	L	95.4% 21/42	I	91.5% 23/42	I
S013d: Diagnostic activity levels: Total	2023 03 2023 02	120%	104.7%	98.30% 100/136	I	106.4% 55/136	I	114.1% 29/136	H	105.6% 14/42	I	105.5% 19/42	I

Ranking by quartile

- H — highest quartile
- I — interquartile range
- L — lowest quartile

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Quality of Care, Access & Outcomes

sub-categories: Cancer and Outpatients

NHS OF Metric Name Full	Period	Target or Standard	National Value	Great Western Hospital		Royal United Hospital		Salisbury FT		BSW ICB ICB or provider aggregate	
S010a: Total patients treated for cancer compared with the same point in 2019/20	2023 03	100%		71.2% 126/130	L	118.7% 46/130	I	145.2% 11/130	H	110.8% 14/42	I
S011a: Cancer - percentage of patients on the waiting list who have been waiting more than 62 days	w/e 04/06/ 2023		9.53%	8.91% 74/133	I	9.66% 83/133	I	11.1% 96/133	I	9.63% 24/42	I
S012a: Proportion of patients meeting the faster cancer diagnosis standard	2023 04	75%	71.2%	73.6% 59/134	I	67% 100/134	I	70% 80/134	I	70.3% 21/42	I
S101a: Outpatient follow up activity levels compared with 2019/20 baseline	2023 03	75%								118.3% 31/42	I

Ranking by quartile
H highest quartile
I interquartile range
L lowest quartile

Quality of Care, Access & Outcomes

sub-categories: Urgent and Emergency Care

NHS OF Metric Name Full	Period	Target or Standard	National Value	Great Western Hospital		Royal United Hospital		Salisbury FT		BSW ICB ICB or provider aggregate	
S123a: Adult general and acute type 1 bed occupancy (adjusted for void beds)	2023 05		94.8%	98.4% 109/123	L	96.9% 88/123	I	98.2% 105/123	L	97.8% 39/42	L
S124a: Percentage of beds occupied by patients who no longer meet the criteria to reside	2023 05		14.2%	16.7% 82/133	I	21.6% 117/133	L	26.2% 130/133	L	21.3% 41/42	L

Quality of Care, Access & Outcomes

sub-category: Safe, high-quality care

NHS OF Metric Name Full	Period	Target or Standard	National Value	Great Western Hospital		Royal United Hospital		Salisbury FT		AWP (benchmarked with MH providers)		BSW ICB ICB or provider aggregate		BSW sub ICB -population	
S034a: Summary Hospital level Mortality Indicator	2022 12			2 - as expected 15/120	H	2 - as expected 15/120	H	2 - as expected 15/120	H						
S035a: Overall CQC rating	2023 05			2 - Requires Improvement 73/135	I	3 - Good 11/135	H	3 - Good 11/135	H	2 - Requires Improvement 53/69	L				
S037a: Percentage of patients describing their overall experience of making a GP appointment as good	2022		56.2%									62.5% 6/42	H		
S038a: Consistency of reporting patient safety incidents (% last 6 months data reported)	Apr 2022 - Sep 2022	100%		83.3% 115/137	L	100% 1/137	H	100% 1/137	H	100% 1/71	H				
S040a: Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infection rate (12 mth rolling)	2023 04	0	294	3 95/137	I	1 33/136	H	0 1/136	H			4 16/42	H	11 14/42	I
S041a: Clostridium difficile infection rate (12 mth rolling / 22-23 threshold)	2023 04	100%	129.1%	106.5% 24/136	H	180.5% 122/136	L	140.9% 97/136	I			141.3% 32/42	L	115.3% 21/42	I
S042a: E. coli bloodstream infection rate (12 mth rolling / 22-23 threshold)	2023 04	100%	122.1%	157.6% 121/136	L	130.6% 95/136	I	87.9% 7/136	H			132.7% 34/42	L	118.8% 31/42	I
S044a: Antimicrobial resistance: total prescribing of antibiotics in primary care	Apr 2022 - Mar 2023	87.1%	98.4%											89.9% 9/42	H
S044b: Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Apr 2022 - Mar 2023	10%	7.76%											8.95% 36/42	L
S121a: NHS Staff Survey compassionate culture people promise element sub-score	2022		6.98/10	6.82/10 93/136	I	7.08/10 52/136	I	6.69/10 105/136	L	6.84/10 66/71	L	6.87/10 29/42	I		
S121b: NHS Staff Survey raising concerns people promise element sub-score	2022		6.43/10	6.42/10 69/136	I	6.46/10 61/136	I	6.15/10 108/136	L	6.56/10	L	6.41/10 26/42	I		

Ranking by quartile
- H highest quartile
- I interquartile range
- L lowest quartile

Quality of Care, Access & Outcomes
sub-categories: Personalised Care

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Integrated Care Board

There are no updates on the SOF this month for these metrics

NHS OF Metric Name Full	Period	Target or Standard	National Value	Great Western Hospital		Royal United Hospital		Salisbury FT		BSW ICB ICB or provider aggregate	
S031a: Rate of personalised care interventions	22-23 Q4		115.14 per 1,000							140.9 per 1,000 11/42	H
S032a: Personal health budgets	22-23 Q3		2.33 per 1,000							1.5 per 1,000 32/42	L

Ranking by quartile
H highest quartile
I interquartile range
L lowest quartile

Quality of Care, Access & Outcomes
sub-categories: Maternity and Children's Health

NHS OF Metric Name Full	Period	Target or Standard	National Value	Great Western Hospital		Royal United Hospital		Salisbury FT		BSW ICB ICB or provider aggregate	
S022a: Stillbirths per 1,000 total births	2021		3.52 per 1,000	2.81 per 1,000 34/119	I	2.89 per 1,000 41/119	I	1.85 per 1,000 8/119	H	2.65 per 1,000 7/42	H
S104a: Neonatal deaths per 1,000 total live births	2021		1.6 per 1,000	1.28 per 1,000 64/119	I	0.89 per 1,000 37/119	I	1.39 per 1,000 68/119	I	1.55 per 1,000 24/42	I

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

Quality of Care, Access & Outcomes

sub-categories: Primary and Community Care

Exec Lead : Fiona Slevin-Brown
Richard Smale

NHS OF Metric Name Full	Period	Target or Standard	National Value	Great Western Hospital		Royal United Hospital		Salisbury FT		BSW ICB ICB or provider aggregate		BSW sub ICB -population	
S001a: Number of general practice appointments per 10,000 weighted patients	2023 03		5127.79 per 10,000							5445.03 per 10,000 20/42	I		
S105a: Proportion of patients discharged from hospital to their usual place of residence	2023 03		92.5%	88% 129/136	L	90.4% 104/136	L	95.1% 26/136	H			89.8% 91/106	I
S106a: Available virtual ward capacity per 100k head of population	2023 04	40 per 100,000	17 per 100,000							12.6 per 100,000 28/42	I		
S107a: Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	2023 03	70%	82.2%							66.1% 40/42	L		
S108a: Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a general practice	2023 02		86.3 per 100,000							303.6 per 100,000 3/42	H		
S108b: Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from NHS111 per 100,000 population	2023 02		87.5 per 100,000							70.3 per 100,000 30/42	I		
S109a: Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	2023 05	100%	76.8%							67.5% 33/42	L		

Ranking by quartile
- H highest quartile
- I interquartile range
- L lowest quartile

UPDATED

BSW ICB has moved to the interquartile in this period

UPDATED

BSW ICB has improved to the interquartile in this period

UPDATED

UPDATED

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Quality of Care, Access & Outcomes

sub-categories: MH and LD

	NHS OF Metric Name Full	Period	Target or Standard	National Value	AWP (benchmarked with MH providers)		BSW ICB ICB or provider aggregate	
Learning disabilities and autism	S029a: Inpatients with a learning disability and/or autism per million head of population	22-23 Q4	30 per 1,000,000	42 per 1,000,000			42 per 1,000,000 24/42	I
	S030a: Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check	22-23 Q3	100%	78.1%			71% 38/42	L
Mental health services	S081a: Access rate for IAPT services	2023 03	100%				43.7% 39/42	L
	S084a: Number of children and young people accessing mental health services as a % of population	2023 03	100%				59.6% 41/42	L
	S085a: People with severe mental illness receiving a full annual physical health check and follow-up interventions as a % of LTP indicative trajectory	2023 03	100%	91.3%			82.7% 29/42	I
	S086a: Inappropriate adult acute mental health placement out of area placement bed days	Jan 2023 - Mar 2023	0		305 21/56	I	10 2/42	H
	S110a: Access rates to community mental health services for adult and older adults with severe mental illness	2023 03	100%				506.8% 2/42	H
	S125a: Adult Acute LoS Over 60 Days % of total discharges (MH)	2023 02		22.5%	26.8% 33/52	I		
	S125b: Older Adult Acute LoS Over 90 Days % of total discharges (MH)	2023 03		37.3%	51.9% 46/54	L		

Ranking by quartile
H highest quartile
I interquartile range
L lowest quartile

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Preventing Ill Health and Reducing Inequalities

sub-categories: Screening, Vaccs and Imms

Ranking by quartile	
H	highest quartile
I	interquartile range
L	lowest quartile

NHS OF Metric Name Full	Period	Target or Standard	National Value	BSW ICB ICB or provider aggregate		BSW sub ICB -population	
S046a: Population vaccination coverage: MMR for two doses (5 year olds)	22-23 Q3	95%	85.2%			92.3% 1/42	H
S047a: Proportion of people over 65 receiving a seasonal flu vaccinatio	2023 02	85%	79.9%			84.6% 7/106	H
S050a: Cervical screening coverage : % females aged 25 : 64 attending screening within the target period	22-23 Q3	75%	69.2%			72.9% 12/42	I

Preventing Ill Health and Reducing Inequalities

sub-categories: Prevention and Long-Term Conditions

NHS OF Metric Name Full	Period	Target or Standard	National Value	BSW ICB ICB or provider aggregate		BSW sub ICB -population	
S051a: Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled	22-23 Q4		46.1%	91.4% 3/42	H		
S053a: % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	2021-22	90%	89%			89.8% 15/42	I
S053b: % of hypertension patients who are treated to target as per NICE guidance	2021-22	80%	60.4%			62.4% 13/42	I
S053c: % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	22-23 Q3	45%	58.6%			50.3% 42/42	L
S055a: Number GP referrals to NHS Digital weight management services per 100k population	22-23 Q4		54.8 per 100,000			51.5 per 100,000 19/42	I
S115a: Proportion of diabetes patients that have received all eight diabetes care processes	21-22 Q4		46.7%	52.5% 5/42	H		
S116a: Proportion of adult inpatient settings offering tobacco dependence services	2023 03	100%	28.1%	33.3% 14/42	I		
S116b: Proportion of maternity settings offering tobacco dependence services	2023 03	100%	26%	33.3% 13/42	I		

Ranking by quartile
H highest quartile
I interquartile range
L lowest quartile

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Finance and Use of Resources

sub-categories: Finance

NHS OF Metric Name Full	Period	Target or Standard	National Value	Great Western Hospital		Royal United Hospital		Salisbury FT		BSW ICB ICB or provider aggregate	
S027a: Achievement of Mental Health Investment	2023 03									Yes by £133k	
S118a: Financial stability - variance from break-even (£m YTD)	2023 03			£1k		£10k		£39k		£18k	
S119a: Financial efficiency - variance from efficiency (£m YTD)	2023 03			£2.3m		£0m		£5m		£8.2m	
S120a: Agency Spend vs agency ceiling (% over plan YTD)	2022 02			202%		73%		73%			
S120b: Agency spend price cap compliance	2022 02			No		No		No			

Ranking by quartile
H highest quartile
I interquartile range
L lowest quartile

Leadership

sub-categories: Leadership

NHS OF Metric Name Full	Period	Target or Standard	National Value	Great Western Hospital		Royal United Hospital		Salisbury FT		AWP (benchmarked with MH providers)		BSW ICB ICB or provider aggregate	
S059a: CQC well: led rating	2023 05			3 - Good 14/135	H	3 - Good 14/135	H	3 - Good 14/135	H	3 - Good 13/69	H		
S060a: Aggregate score for NHS staff survey questions that measure perception of leadership culture	2022		6.94/10	6.84/10 74/137	I	7.05/10 30/137	H	6.75/10 104/137	L	7.52/10 21/71	I	7.03/10 13/42	I

Ranking by quartile
H highest quartile
I interquartile range
L lowest quartile

People

sub-categories: belonging in the NHS, growing for the future

	NHS OF Metric Name Full	Period	Target or Standard	National Value	Great Western Hospital		Royal United Hospital		Salisbury FT		AWP (benchmarked with MH providers)		BSW ICB ICB or provider aggregate	
Belonging in the NHS	S071a: Proportion of staff in senior leadership roles who are from a BME background	2022	12%		8.7% 59/137	I	7.14% 65/137	I	0% 132/137	L	6.02% 44/69	I		
	S071b: Proportion of staff in senior leadership roles who are women	2023 04	62%		55.7% 103/135	L	60.3% 84/135	I	56% 100/135	I	66.6% 19/47	I		
	S071c: Proportion of staff in senior leadership roles who are disabled	2022	3.2%		0% 117/137	L	4.2% 29/137	H	0% 117/137	L				
	S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	2022		56%	56.4% 64/137	I	57.9% 46/137	I	53.2% 99/137	I	55.9% 57/71	I	56% 23/42	I
Growing for the Future	S074a: FTE doctors in General Practice per 10,000 weighted patients	2023 04		5.74 per 10,000									6.12 per 10,000 15/42	I
	S075a: Direct patient care staff in GP practices and PCNs per 10,000 weighted patients	22-23 Q3		5.95 per 10,000									7.64 per 10,000 7/42	H

Ranking by quartile

- H highest quartile
- I interquartile range
- L lowest quartile

People

sub-categories: looking after our people

NHS OF Metric Name Full	Period	Target or Standard	National Value	Great Western Hospital		Royal United Hospital		Salisbury FT		AWP (benchmarked with MH providers)		BSW ICB ICB or provider aggregate	
S063a: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	2022		11.1%	10.3% 44/136	I	10.2% 43/136	I	9.83% 37/136	I	10% 52/71	I	10% 14/42	I
S063b: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	2022		20%	20% 73/137	I	20.1% 74/137	I	20% 72/137	I	15.9% 54/71	L	19.2% 26/42	I
S063c: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	2022		27.8%	29% 89/136	I	28.9% 88/136	I	27.9% 71/136	I	28.6% 55/71	L	28.7% 29/42	I
S067a: Leaver rate	2023 03		8.55%	10.2% 130/136	L	9.33% 113/136	L	9.65% 120/136	L	10.2% 62/71	L	9.72% 40/42	L
S068a: Sickness absence rate	2023 01		5.4%	4.89% 47/136	I	4.86% 44/136	I	4.46% 30/136	H	5.55% 33/71	I	4.91% 15/42	I
S069a: Staff survey engagement theme score	2022		6.79/10	6.7/10 92/136	I	6.94/10 40/136	I	6.7/10 91/136	I	6.88/10 62/71	L	6.81/10 25/42	I

Ranking by quartile
H highest quartile
I interquartile range
L lowest quartile

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.1
Date of meeting:	07/09/2023		

Report from (Committee Name):	Audit Committee		Committee Meeting Date:	20 July 2023
Status:	Information	Discussion	Assurance	Approval
	X		X	
Prepared by:	Richard Holmes (Audit Committee Chair)			
Executive Sponsor: (presenting)	Richard Holmes			
Appendices				

Recommendation:

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

Executive Summary:

Key Items for Escalation:

Deep Dive plan for 23/24 – presented and agreed, with flexibility for Executive to raise areas for reactive Deep Dive to Audit Committee should circumstances dictate.

Deep Dive – International Nurse Recruitment. OD&P – Recruitment presented this deep dive.

SFT has been employing IENs since 2017 and currently employs 380. International Education Nurse (IEN) costs in the 2023/24 budget total £1.9m, offset by NHSE funding of £1.1m, a net revenue cost of £0.8m. This represents a 2% premium on top of the SFT Nursing budget of £54m .

On recruitment and relocation to the UK each IEN is required to undertake OSCE training. First time pass rates at SFT have been falling, to a current level of 5%, compared to c40-50% regionally and nationally. Turnover is similar to non-IEN nurses, at around 14%. Each IEN costs c£10k to recruit, relocate and train. Recruitment changed during COVID away from in-country face-to-face selection to online interviews, resulting in an adverse change to the quality of candidates recruited.

Quality of Recruitment and Quality of Training appear to be areas for significant focus.

Substantive actions are underway to improve the quality of recruitment by re-introducing face-to-face in-country recruitment. Currently IENs are principally recruited from India, Nigeria, Kenya and the Philippines; it is intended to open up another channel of IEN recruitment through Sri Lanka. Further, OSCE training will be enhanced with the appointment of four (2wte) Internal Practice Educators at SFT to oversee and guide the development of the IENs. IEN training will be improved to mirror the CLiP training model currently operational for non-IEN nurses.

The Audit Committee requested an assurance update on the effectiveness of these improvements in a year's time.

Internal Audit and Counter Fraud Audit – KPMG, the Trust's newly appointed Internal and Counter Fraud Auditors, attended the meeting for the first time to present their Audit Plans for the Year, and their proposed Audit Strategies and Plans for the future 5 years. The Plans for this year have been proposed by the Executive in conjunction with the KPMG Auditors, and with reference to the Trust's Risk Register. This will see a total of 12 Internal Audits completed between now and the end of the year and cover the full range of operational departments. The Audit Committee accepted the proposals for this year; final 5-year strategic audit plans will be brough back to the September Audit Committee for discussion and approval, but Committee urged consideration of the inclusion of Respect, Safeguarding and Freedom to Speak Up audits to the 5 year plans.

The handover and transition from the previous incumbents is going well. Evidence from the meeting suggests that their interface with SFT is working well, and that their approach to auditing and planning is entirely appropriate so far.

Given that the appointment of KPMG is now System-wide and includes BSW, GWH and RUH as entities, there will be the opportunity through KPMG to benefit from inter-organisation audit efficiencies, knowledge-sharing and best practice.

The Transition programme will also see the completion of the SFT Audit Action Tracker to give sight of the status of Internal Audit Actions; this will be submitted to the next Audit Committee.

Reports for noting – the Committee noted the Annual DPST report, the Reference Cost Assurance report plan, and the Register of Attendance with no issues.

The Committee noted the Register of Losses and Compensation, which demonstrated that losses through waste and stock write-offs were disappointingly high at £45k in the last 3 months. This was due in substantial part to a slower than expected change in supply chain provision from owned to consignment stock, completion of full stock takes in Endoscopy and higher than expected levels of out-of-life stock in Cardiology. All will improve over the coming periods; the Committee will review performance quarterly.

John Parker and Barry Bull, Governors, observed the meeting.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.2
Date of meeting:	7th September 2023		

Report from (Committee Name):	Clinical Governance Committee		Committee Meeting Date:	25th July 2023
Status:	Information	Discussion	Assurance	Approval
	X	X	X	
Prepared by:	Miss Eiri Jones, Chair CGC			
Executive Sponsor: (presenting)	Miss Eiri Jones, Chair CGC			
Appendices	Nil			

Recommendation:

Trust Board members are asked to note and where relevant, discuss the items escalated from the Clinical Governance Committee (CGC) meeting held on the 25th July 2023. The report both provides assurance and identifies areas where further assurance has been sought and / or is required.

The Board is also asked to note the change of Chair of this committee from the next meeting. Dr David Buckle takes over from Miss Eiri Jones.

Executive Summary:

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - The following subjects were discussed on the agenda:
    - Mental Health Liaison
    - 5 steps to safer surgery
    - Integrated Performance Report
    - Dementia annual report
    - Maternity report
    - Clinical Audits, NICE guidance, new technology
    - Patient Engagement and update on strategy
    - Clinical Management Board
    - Mortality
- Areas for noting or requiring further assurance include:
  - Ongoing assurance was sought in relation to veno-thrombo embolus performance and any impact on care. This will come back to the committee in September
  - The theatre team have made good progress in relation to the processes around safer surgery though further assurance is required in relation to the debrief phase of the checklist
  - As part of the discussion on the integrated performance report, a detailed conversation was held in relation to mortality and stroke. The committee will maintain a focus on both these areas and the next steps in gaining strong assurance in these areas

- A good presentation was provided by the dementia lead with the committee seeking further information relating to performance data. The Trust has taken part in the recent survey and the results will come back to the committee when they are available. These will further inform the plans for the ongoing improvement of the service
- The never event in maternity was noted. A regional event was taking place in relation to never events and this would be fed back in the next report. The year 5 maternity incentive scheme has commenced and the new report structure is now in place. This will also come to the Board
- As part of the patient engagement workstream, a new PALS outreach service has been established. Feedback in relation to outcomes will be reported in the next quarter

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

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.3
Date of meeting:	14 August 2023		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	25 July 2023
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Debbie Beaven (NED)			

Recommendation:

The Finance and Performance Committee met on 25th July 2023 with just one contract award for approval:

1. **External Audit -** The Committee was asked to support the recommendation to appoint Deloitte for the provision of External Audit Services via NHS SBS Internal and External Audit, Counter Fraud, and Financial Assurance Services Framework. The contract will remain in place for a period of Three (3) of years, with the option to extend two (2) periods of twelve (12) months.

   The proposal was supported by the Audit Committee, with both Committees mindful of the significant cost increase and the expectation that the contract across the 3 BSW Trusts will provide synergies and shared learnings that will enable audit days to be reduced over the period of the contract. The Committee suggested a target reduction in days each year.

   We were assured that the proposed RPI of 10% would be negotiable each year with this captured in the contractual documentation.

The Committee supports the recommendation to appoint Deloitte as External Auditor for the Trust.

Executive Summary:

The Board is asked to note the following items from the F&P meeting on 25th July:

1. **Integrated Performance Report** – There are a few key performance metrics to highlight in this report:
   a. Bed occupancy has reduced again following an increase last month, and at 106% is lowest is has been since September 2021. The development of Same Day Emergency Care pathways in AMU continue to show improvement in bed utilisation, with 28% of patients admitted to Medicine staying less than one day (an average of 20% in 22/23).
   b. Flow from the Emergency Department to the Stroke unit remains challenging, with 42% of patients arriving on the Stroke unit within 4 hours, this is an improvement in May, but within common cause and not consistent improvement.
   c. The Breakthrough Objective relating to reducing 1st Outpatient waits has remained static at around 133 days for three months now, which given the ongoing impact of Industrial Action on planned services is not overly surprising.

d. The number of patients waiting longer than 52 weeks has increased again, along with a small increase in the number of patients waiting over 65 weeks. The elimination of zero waits of over 78 weeks continues to be achieved.
e. Performance against the cancer standards remains under pressure with 2 weeks wait and 62 Day continuing to be below the standards, and this month 28 Day Faster Diagnosis reduced to 71% against the target of 75%.

2. **Trajectories –** The committee heard of the challenges on the trajectories presented and that the situation could be detrimentally impacted given the ongoing industrial action, which had not yet featured in the trajectories (created in February and following national guidelines not to include industrial action). The trust submitted trajectories to achieve 5 out of the 6 metrics, with Bed occupancy being the only metric where assurance was not provided, on the basis that bed occupancy levels could not reduce enough, whilst still managing the required elective and non-elective activity levels within the bed base.

   The Committee was assured there has been some solid progress in delivering against most performance trajectories, in particular reducing the number of patients waiting over 62 days for cancer treatment, ED performance and Diagnostic waiting times, all of which offer a much-improved service to our patients. The Committee acknowledged that there are some specific challenges, which require further focus to ensure that performance against the 28 Day Faster Diagnosis standard is restored, in particular the Skin and Lower GI services in reducing the first appointment wait.

3. **Breast Reconstruction Update –** the Committee received a verbal update following last month's report. We heard that the Region is helping with actions to reduce waiting lists and we now have 58 women waiting, with 24 of those over 104 weeks. Discussions with Portsmouth to take 10 are ongoing, with Plastics possibly taking 8 of those waiting.

4. **Internal Audit – Waiting List Management –** the Committee received the report by PwC (internal auditors) which they undertook with the key objectives of reviewing policies and procedures in line with national guidance, to understand the governance structure in place and to consider whether effective processes and controls are in place to manage patients through waiting lists. The report was completed in June 2023 and classified as low risk, with 1 medium risk and 2 low risk findings. The Committee took good assurance from the progress and closure of audit actions, particularly given the operational circumstances.

5. **Finance Report** – The Committee was asked to note the financial position for June 2023. In month 3 the Trust recorded a control total deficit position of £2.901m against a target deficit of £2.069m – an adverse variance of £0.832m. Pay costs totalled c£18.8m in Month 3, an adverse variance to plan of c£1.2m. All clinical divisions exceeded planned levels of pay expenditure in month, except for Women and Newborn, although in month costs have slightly reduced. Trust wide bank and agency costs have both increased in month, which is driven by staff availability, specifically for vacancy cover and increased sickness in month within Plastics and Surgical Inpatients, supernumerary cover for newly recruited staff (particularly within Theatres), and increasing enhanced care requirements in month due to the numbers of long stay complex patients being admitted.

   Risks to our Financial and Operational performance remain high with pressure on the emergency care pathways, particularly in relation to continued levels of patients with no clinical right to reside, inflation, delivery of CIPs, and the impact of ongoing industrial action. There could be some upside from the ERF given the adjustment to targets (in recognition of the impact of industrial action) and our teams will work to ensure we get our fair share of the additional fund. As we heard last month, more detail is being worked through to establish an updated forecast for the year.

6. **CIPs –** The Committee received the latest report which highlights the Trust's forecast of £15.3m efficiency savings, of which c27% is non-recurrent delivery and signals a risk if further recurrent efficiencies cannot be identified. The savings delivered up to 30 June total £2.5m, against a target of £3.4m. Corporate vacancies and reductions in utilities costs are offsetting the shortfalls in CIPs in other areas. Reductions in LOS though the implementation of SDEC pathways continue to be sustained, with the closure of Whiteparish contributing just short of £0.1m per month until reopening in the Autumn in line with the bed plan.

   Key risks to CIPs delivery continue to be (1) temporary staffing savings, which are yet to be delivered, despite significant favourable run rate movements. A key pillar of this workstream is the integration of overseas recruits into the workforce, but this is being delayed by a lower than expected first time pass rate. In addition, financial benefits associated with the management of RMN requirements are being offset by sustained high acuity of demand and (2) patients waiting for onward care packages remains in excess of 20% of the acute bed base, meaning that the trust remains in escalated spaces. This is resulting in non-delivery of discharge processes savings as at month 3, with projected benefits of virtual wards not expected to facilitate the closure of further beds.

   Actions are ongoing to identify additional schemes and the Committee takes reasonable assurance of the progress in identifying, tracking and delivery of savings, acknowledging the risks and need for systems interventions to the bed occupancy of NCTR patients.

7. **Long Term Financial Strategy -** The committee received some draft financial projections for the next 3 years. Although BSW have submitted a breakeven plan for 2023/24, this was underpinned by significant non-recurrent support and mitigations. System work has quantified the full underlying opening position for BSW as a deficit of £182m, with in-year recovery plans aiming to deliver an exit run rate of an £86m deficit. High level assumptions at a system level set out a year on year £30m efficiency requirement just to 'stand still' and it is clear financial recovery at this scale cannot be delivered within a single year, and as such a stretching trajectory to reduce this deficit to £8m at a system level by the end of 2025/26.

   The next steps are to (1) map the proposed workstreams against cost pools to refresh understanding of influenceable spend. (2) review proposed contribution of step change in capacity (e.g., new ward) based on latest assumptions. (3) update desk top model with agreed operational assumptions and review the revised gap to trajectory. (4) seek clarification on external trajectories that will support SFT in sustainable improvement in financial run rate, for example NC2R trajectories, Primary Care prescribing.

   NHSE have requested system submissions on the three-year plan, with final submissions due on 27th September, with a draft submission on 8th September. The view of our Executives is that a requirement for SFT to deliver a recurrent £47m in savings and elective productivity increases over that three-year period is not doable, and that a 5-year period is more realistic. An update on this workstream will be included in the Trust Board papers on 7th September and NEDs will be invited to an Executive session to hear of the updates before the draft comes to Board.

8. **Subsidiary Performance and Governance -** The Committee received assurances that OML, STL and SSL are reporting marginal profits and in line with expected plans. The key strategic challenge for OML and SSL remains workforce gaps with both continuing recruitment campaigns.

   Wiltshire Health and Care is the most financial challenged subsidiary. The challenges highlighted to us are material and require increased oversight and controls. SFT are involved in strengthening the plans to mitigate the financial risks. It remains a risk for SFT as 33% joint owner.

We received assurances that there were no nasty surprises with any other subsidiaries given that subsidiaries have just had accounts audited, monthly board meetings taken place and managers meeting in place.

9. **Estates Update –** The Committee received a comprehensive update on the significant volume of estates activity, including £9m of capital projects. One of the most significant risks remains the backlog maintenance which now exceeds £75m. We were assured that the team continues to work through the estate's compliance action plan for 2023-24 with a target to close extreme and high risks and return remaining risks to estates business as usual.

10. **Quarterly Digital Progress Report and SIRO report -** The Committee was given assurance that the overall trend for the entire digital programme remains stable with limited status changes. The programme to implement a new core infrastructure is on track to complete by the end of this year with data migration to the new environment starting from August 2023. The existing infrastructure environment is creating increasing challenges with programmes now being delayed due to speed issues, these are being closely monitored and where possible mitigations are being put in place. There are continued risks on Pathology LIMS, with "go-live" likely to be delayed until February 2025. The Committee received a helpful summary of all the projects and asked for the addition of timing of each major phase and estimated user numbers, so we can see from the one image the likely scale of change and potential risk.

    The new NHS Digital Maturity Assessment (DMA) has been submitted for the Trust, with peer benchmarking completed and the DMA ready for analysing. The first year is a baselining developmental submission to help evolve the DMA into a more accurate benchmarking tool for the 2023/24 return. The intent is to provide insights into the Trust's position in the next report to F&P Committee.

    SIRO - The Trust has submitted a 'Standards Met' DSPT self-assessment for 2022/23 with a much-improved associated audit report. The penetration test which is a mandatory requirement for the DSPT was completed in June 2023. The findings and assurance on actions taken will be provided in the next quarterly report.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board Public	Agenda item:	2.4
Date of meeting:	7th September 2023		

Report title:	Trust Management Committee Escalation Report			
Status:	Information	Discussion	Assurance	Approval
	x		x	
Approval Process: (where has this paper been reviewed and approved):	Reviewed and signed off by Stacey Hunter Chief Executive Officer.			
Prepared by:	Gemma O'Brien and Stacey Hunter Chief Executive Officer			
Executive Sponsor: (presenting)	Stacey Hunter Chief Executive Officer			

Recommendation:

The Board is asked to note the report from the Trust Management Committee held on Wednesday 26th August 2023.

Executive Summary:

The Trust Management Committee was held on the 26th of August and was a full committee this month following a decision taken at last month's committee to revert to having a full TMC meeting with a maximum of 4 Business Cases to be presented each month to allow sufficient discussion.

In addition to the standard escalation reports the Committee received assurance via the IPR and received 5 business cases. All these business cases are being considered within the provision we have agreed within our Operational and Financial Plan for 23/24.

Following review from the Trust Investment Group (TIG) TMC members had the opportunity to review the following 4 cases and support decisions and approvals which are detailed in this report:

1. **Pathology Leadership Structure Business Case**
   This case relates to a proposal for investment in the Pathology Leadership Structure with the approval of one new post which would allow for some restructuring leading to the formation of a Deputy Head of Pathology (8b) and a dedicated Blood Transfusion Manager (8a). The net ask of the case is for approval of the 1 WTE 8a role (£63,576) as the 8b role exists in structure currently and recognises £38,146 within the current run rate.

   TMC discussed the need to signal future efficiencies and reduce unit costs within the service and asked that consideration is given to how these costs are mitigated in the future.

   TMC recognised the regulatory issues that were described in the Business Case as they had been escalated previously through Clinical Management Board.

   TMC noted that they would expect to see a higher appraisal rate (above the 85% compliance rate referred to in the paper) with the addition of an additional leadership capacity in the structure.

TMC approved this case.

1. Increased Cardiac Investigations Unit (CIU) Establishment

This business case outlines the need to fund 4.77 WTE cardiac physiologist posts for Cardiac Investigations Unit. The CIU requires 21.86 WTE Cardiac Physiologists to provide our current level of service provision, not including echocardiograms provided through WLIs and agency, which is a shortfall of 2.77 WTEs (£134,102 annually) against the current staffing establishment budget. To remove WLI and agency spending for echocardiography, recover the projected backlog by November 2026 and maintain required capacity beyond 2026, a further 2.0 WTE Band 7s are required (£108,832 annually).

The case proposes to fund the current budget shortfall plus additional 2.0 WTE Band 7s (total £242,934 annually) which is currently offset by increased achievable outpatient activity income (£259,200 annually). This case is therefore not requesting additional funding and offers an annual contribution of £16,266.

TMC suggested that they would usually expect to see a return of at least 40% on this activity instead of the 5-10% proposed, noting that it's difficult to determine from the Business Case whether this margin could be improved. Feedback was also offered that the business case may be better separated as it was trying to reflect current running costs via a more sustainable solution and account for future growth.

The overall discussion reflected that there was significant work to be done on this business case before it could be considered fit for purpose.

TMC did not approve this case and agreed that further work is required before it comes back to TMC.

2. Recognition of Prior Experience & Learning Associate to Registered Nurse Apprenticeship Programme (RPEL to RN)

This case was previously discussed as one case combined with the Registered Nurse Degree Apprenticeship Programme (RNDA) but was split out for the purposes of TMC in order to make the assessment easier.

Whilst the case sets out that it is income generating, it is unclear if this is statement is correct due to the backfill time not being funded by the apprenticeship income levy which has been partly mitigated by making the apprenticeship part-time. It was noted that the total remaining envelope of SFT funding would not cover the expenditure proposed and will therefore, the shortfall will be escalated through the BSW recovery Group.

TMC noted that further work is required in terms of the banding uplift of these roles and agreed that whilst this case is supported in principle it is difficult to approve it given the absence of a funding stream to cover the costs. The CFO and CEO will raise this at the system financial recovery group.

3. **Registered Nurse Degree Apprenticeship Programme (RNDA)**

TMC reviewed this case which looks to establish funding for a rolling programme of minimum of 5 RNDA apprentices every year.

The preferred option enables the continuation of the apprenticeship for the future, creating a complementary pipeline to current recruitment of Registered Nurses that will deliver up to 5 new RNs per year. TMC heard

that due to delays in the approval of this Business Case, the Trust is unable to run a programme for academic year 23/24 and were therefore seeking approval from TMC to run a cohort from September 2025.

The Nursing Associate Programme has been running since 2017 and the preferred option delivers a complimentary solution for staff to complete an alternative apprenticeship route to Registered Nurse.

TMC supported the case in principle but noted that further work was needed with finance business partners to clarify the multi-year profiling for the case. This is another case whereby it is the right thing to do to increase the domestic supply for registered nurses but there is no clear funding source. The CFO and CEO will raise this at the system financial recovery group.

4. Return To Practice

TMC were asked to approve a 12-month fixed term band 4 contract for 5 returnees to attend Bournemouth University RTP course and 6-month fixed term band 4 contract for 12 returnees to complete the OSCE Computer Based Test (CBT) and Test of Competence (ToC) route per year.

This option would deliver a rolling recruitment programme of RTP nurses every 3 months. By having at 2-3 RTP nursing students per cohort every 3 months, plus a cohort of 5 RTP students on the University route, the number of staff nurses within the Trust would increase by 17 per year. TMC heard how this option would allow for a rolling programme throughout the year, capturing interested parties earlier and reducing the potential of losing them to other organisations.

TMC supported and approved this business case with a minor adjustment of supporting 5 colleagues via Bournemouth University and 5 via the OSCE route. TMC would be keen to understand the learning from the first 5 via the new OSCE route prior to approving further expansion.

TMC received the Integrated Performance Report for July and the Finance Report for July, and their contents were noted.

TMC received an update on the Trust's response to national concerns regarding maternity staff exposure to nitrous oxide which informed that Risk Assessments have been completed and are available from the Trust's Intranet, SALI which detail steps to reduce the exposure risk, provide visual information and instruction particularly where to position the patient in relation to the window.

TMC were informed of plans to review the Trust's existing helipad by March 2024 following a previous incident at another Trust where a patient was knocked to the ground and died from their injuries when an air ambulance was attempting to land. The current helipad does not meet the Civil Aviation CAP1264 which addresses various aspects such as helipad dimensions, approach, and departure paths.

A grant application is being made to cover the cost of the renovation, but TMC were asked to note that the VAT is not supported by the charity. This proposal responds to the Health and Safety Executive notice issued in Jan of this year.

TMC accepted the recommendations in the paper.

TMC received a Policy Update which confirmed that 500 out of 900 trust policies are currently out of date. Policy Authors have been identified and TMC discussed the importance of this backlog being sorted. The paper proposed a trajectory for clearing this backlog over the rest of the calendar year which was supported. Progress against this trajectory will be monitored at TMC every month.

TMC were asked to approve the Business Case Template which was revised following comments from TIG and focused on highlighting benefits realisation and aligning to improving together. The new template also requires that information on the strategic filter and longer financial effects over 5 years are completed.

TMC agreed and approved the new Business Case Template with a view to it being launched from October 1st and uploaded onto Microguide.

TMC received the Risk Management Strategy for 2023-2026 for approval prior to it going to Board for final approvement. The strategy had been updated to set out roles and responsibilities for Risk Management across the organisation, addressing risk appetite and Just Culture and how risks are managed through Datix.

TMC supported the paper to go forward to Board .

TMC received an update to the Elective Patient Access, Booking and Choice of Date Policy which had been refreshed post COVID and reinstates what the rules are in terms of managing access and aligning RTT guidance. TMC supported the paper and requested that it's taken through all divisional EPR's, circulated to the DMT and then comes back to TMC in September.

TMC were informed via Any Other Business that the Trust was looking to implement an Exec rota for twilight shifts given the rise in employee concerns in the out of hours period. This will be providing the opportunity for colleagues get a sense of the culture in these periods and connect with colleagues who may not work during the day time. Some colleagues have expressed concern about this ask and TMC agreed the CNO would lead a session to explore this in Sep. The CEO asked colleagues to focus on what would need to be on place to make this viable for everyone who is being asked to commit to x 1 twilight session per year.

TMC were informed that the Well-Led Review Report has been received from Aqua and that it will be circulated once it has been discussed with Board colleagues.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)		Agenda item:	2.6
Date of meeting:	7th September 2023			
Report tile:	Integrated Performance Report			
Status:	Information	Discussion	Assurance	Approval
			Yes	
Approval Process: (where has this paper been reviewed and approved):	Sections approved by responsible committee: - Operational performance and resources: Finance and Performance Committee - Quality and care: Clinical Governance Committee - Workforce: People and Culture Committee			
Prepared by:	Louise Drayton, Head of Performance and Capacity			
Executive Sponsor: (presenting)	Mark Ellis, Chief Finance Officer			

Recommendation:

The Trust Board are asked to note the Trust's performance for Month 4 (July 2023)

Executive Summary:

There continues to be improvement in flow across the urgent and emergency care pathways, with bed occupancy levels falling below 100% for the first time in the 2-year reporting period. The development of Same Day Emergency Care services in Medicine has been pivotal to this, with the percentage of patients on zero-day pathway rising to 31% (28% in M3, and an average of 20% across 22/23). The benefit of improved flow was evident in the Emergency Department with 80% of patients receiving treatment and admitted or discharged within 4 hours, similarly this is the highest performance since Jan 22. Ambulance handover delays remained low, with an average handover time of 16 minutes, a significant and consistent improvement since the waits of 61 minutes in December 22.

There are number of related quality metrics that are favourable and likely to be at least partly associated with more effective flow; the number of falls was below target at 6.2 per 1000 bed days, this is the second consecutive month below target. The proportion of patients experiencing more than one move reduced to 2.5%. There remains challenge in ensuring Stroke patients reach the Stroke unit within 4 hours, however, there has been two consecutive months of improvement and the standard was achieved for 47% of patients in M4, the highest level in the last 2 years.

The Care Hours Per Patient Day (CHPPD) increased in month to 8.4 reflecting improved nurse staffing levels. Day HCA fill is the only marker now below 100% and work continues to increase fill rate further. Agency spend as a % of gross pay remains above plan at 5.86% (target 3.7%) but in the last 3 months this has reduced and plateaued. The overall vacancy rate continues to trend down and reduced to 7.1% in M4. Although still above target of 5% this represents a significant and largely consistent reduction over the last 16 months.

In Month 4 the Trust recorded a YTD control total deficit of £0.798m against a surplus target of £0.211m - an adverse variance of £1.009m. In month, the position has been driven by the costs of Industrial action, c£1.4m year to date, and providing enhanced care to patients, partially offset by additional income. Non pay is adverse to plan but is fully offset by income to date.

Progress against the elective care standards has been limited and the ongoing industrial action with junior and consultant medical staff is providing prolonged disruption. The Trust maintained zero pathways over 78 weeks, but this is becoming more challenging in some specific areas. The number of pathways over 52 and 65 weeks are both higher

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than plan, and there remains limited progress against the time to first outpatient Breakthrough Objective. Performance against the cancer standards has further deteriorated with the Two Week Wait suspected cancer referral, 28 Day Faster Diagnosis and 62 Day Treatment standard all failing to meet the standard levels. Pressure related to staffing challenges in the Skin pathway is the biggest contributor to Two Week Wait with 201 of the 316 breaches associated with this pathway, and 62 related to capacity in Colorectal. Improvement work in Urology has resulted in many benign patients being clock stopped beyond 28 days which has affected performance but is the right thing to do for the patients. The challenges in the skin pathway are also affecting the 28- and 62-Day standards, although to a lesser level currently.

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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

Integrated Performance Report

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NHS Foundation Trust

July 2023

Summary

July 2023

Salisbury NHS Foundation Trust

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Vision

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

NHS Salisbury NHS Foundation Trust

People
working for us

Population
our patients and their families

Partnerships
working with us

Vision metrics 7 – 10 years

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

Strategic initiatives 3-5 years

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

Corporate Projects

Breakthrough Objectives 12-18 months

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

What is an Integrated Performance Report (IPR)?

NHS Salisbury NHS Foundation Trust

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

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

Business Rules - Driver Metrics

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

Business Rules - Watch Metrics

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

Business Rules - Statutory/Mandatory Metrics

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

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

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

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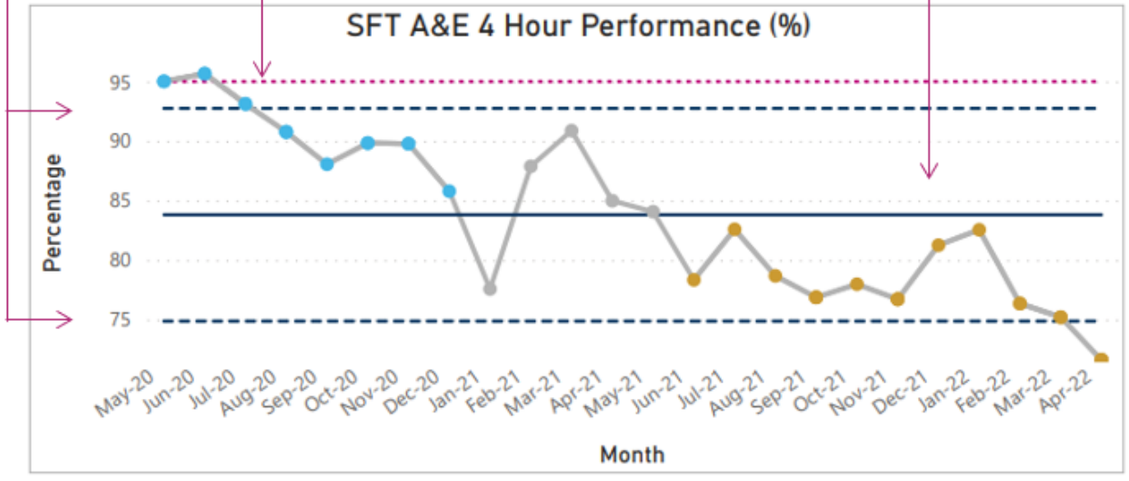
Reading a Statistical Process Control (SPC) Chart

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

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

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

The solid grey line shows the mean value for the dataset



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

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

Grey markers show normal behaviour with no significant cause for variation

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

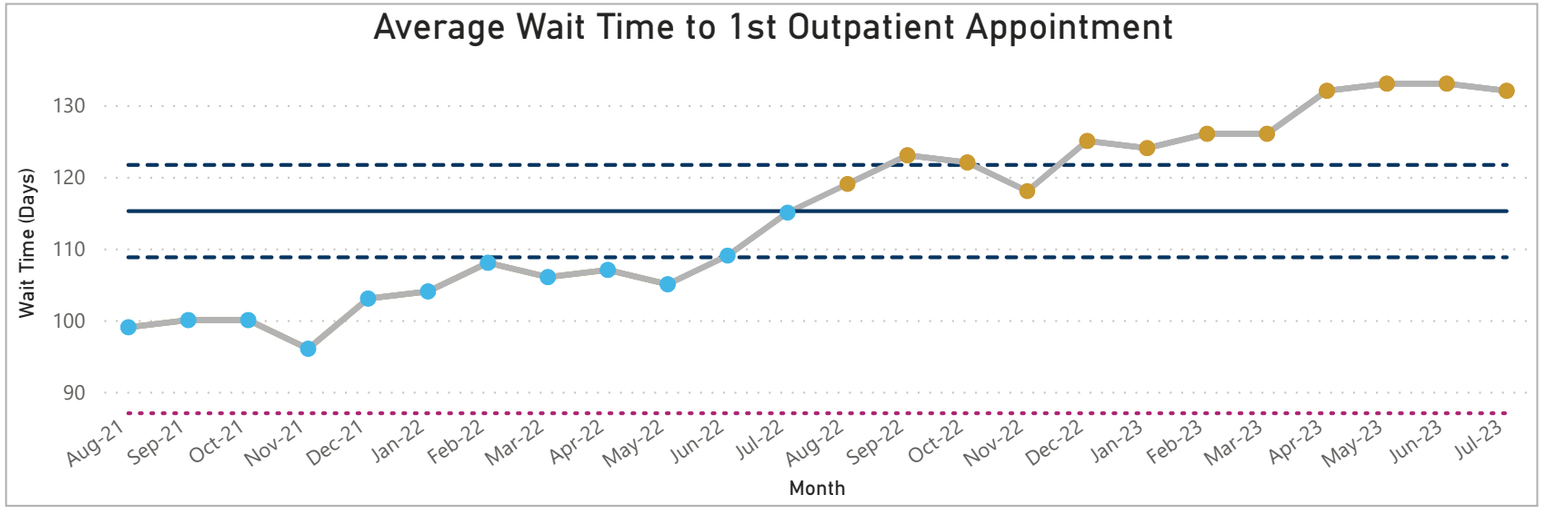
Partnerships

People

Reducing Patient Waiting Times

Target 87 days

Breakthrough Objective



We are driving this measure because…

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

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

Understanding the performance

The performance data shows a slight improvement in performance between June and July's position, at 132, an improvement in 1 day. Given the monthly loss of capacity/activity from the ongoing industrial action this is somewhat positive on the back on a static performance between May and June. This remains, however, significantly behind the local target of 87 days.
There are pockets of improvement at a speciality level, and indeed all Division's demonstrated a slight reduction in month in time to 1st Appoint: Surgery reducing from a peak of 144.59 in May to 142.91 for July, Medicine 114.58 in April, to 112.69 for July, CSFS, 82.63 to 79.08 in month to July, and W&NB seeing a marginal reduction from 110.96 to 110.07 days in month. However, the requirement to consistently re-provide capacity to priority patients on both non-admitted and admitted pathways, resulting from the industrial action, is precluding any material improvement across the board. The Trust continues to focus on seeing patients in line with clinical need, referral type, e.g. Cancer 2week wait and Urgent referrals, and by longest wait, in line with NHSE requirements. The impact of the reduced capacity owing to the Jnr Dr IA and now compounded by Consultant action, affects those patients carrying the least clinical risk and therefore most significantly the longest waiting patients. Increased levels of 2ww and urgent referrals in some areas is compounding the tension between clinical priority and longest waits.

As a result the Trust continues to see the numbers of >52week waits continue to grow.

Actions (SMART)

As part of an overall review of performance management introduce a stand-alone PTL meeting out with of Delivery Group to ensure sufficient oversight and escalation is available for both Trust and Divisions.

Planned go live for the dermatology insourcing remains 19th August.

ICB to investigate disparity of waiting times profile of IS activity to ensure equity of access for patients across both IS and NHS providers – awaiting outcome.

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

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

Risks and Mitigations

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

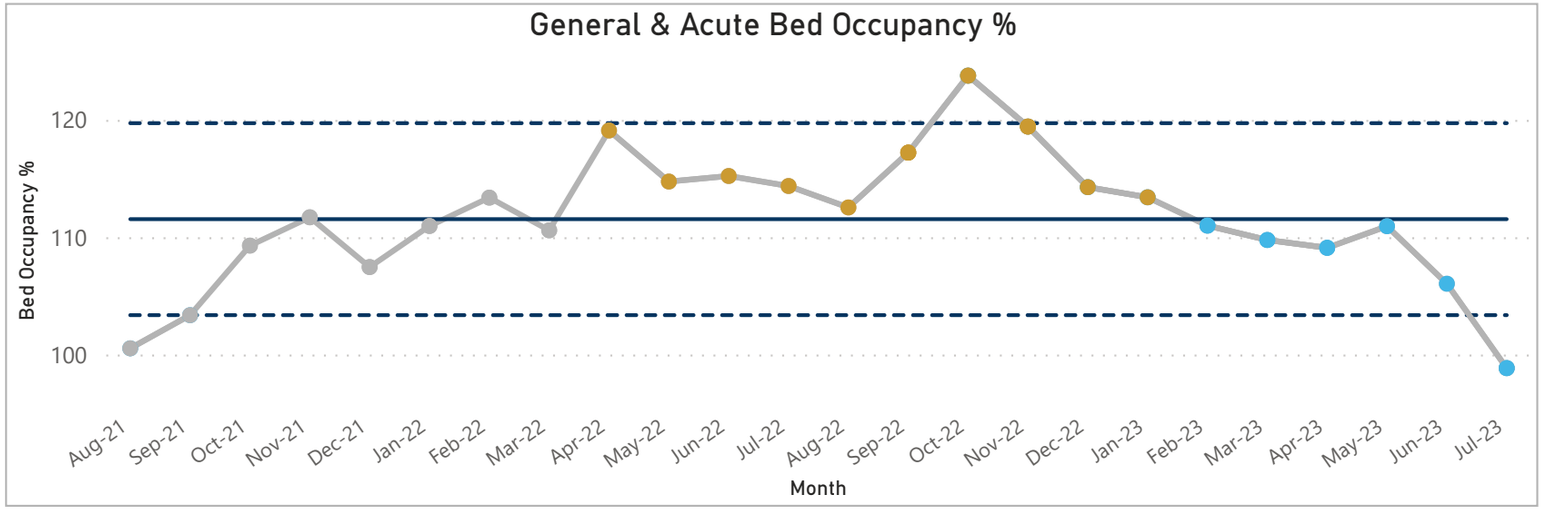
Staffing pressures exist across a number of specialities not least Dermatology and Plastics which present a potential individual speciality pressure into next financial year. The Division of Surgery has an approved business case currently under mobilisation to provide insourcing support. Plastics have recruited in the interim to a Micro Plastics Fellow and Locum Consultant post.

Ongoing Jnr Doctor IA, present significant risk to maintaining levels of capacity, with mitigations options limited.

Optimising Beds

Target 92%

Breakthrough Objective



We are driving this measure because…

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

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

Understanding the performance

Bed occupancy continues to decline thus demonstrating an improving picture; which is an expected seasonal pattern. This is being driven by a reduction in overall length of stay, a number of patients with very high lengths of stay going to another place of care or home. The number of patients being seen in medicine on a 0 day LoS pathway through SDEC has risen once again to 31%. The new frailty pathway seeing over 65 yrs patients has seen 21% on a zero LoS pathway.

Actions (SMART)

- SDEC methodology and process to be rolled out across other surgery specialities by September, A3 completed. Cinapsis needs to be rolled out across surgery to facilitate this.
- Meeting with radiology regarding increasing need for appointments to align with SDEC.
- Full roll out of new ewhiteboard software delayed until early August due to technical challenges but will ensure visibility and ability to audit patient flow management.
- Frailty working group set up,the pilot launched mid july, focusing on LoS, discharges by pathway, % readmissions. It is too early to make any judgements.
- Discharge Hub and Integrated Discharge team- This has now gone live and turn around times for pathway allocation should now start to reduce, BI dashboard yet to be agreed as measurement is proving challenging. Number of P3 patients has greatly reduced.
- LoS and Bed occupancy workstreams set up focusing on ward discharge process; Managing staff and patients expectations and support services, this is looking at setting up a robust standardised vascular access pathway that will reduce the LoS for patients needing a PICC line etc.

Risks and Mitigations

- An increase in Infection Prevention Control challenges such as COVID or other will impact the ability to keep escalation areas closed.

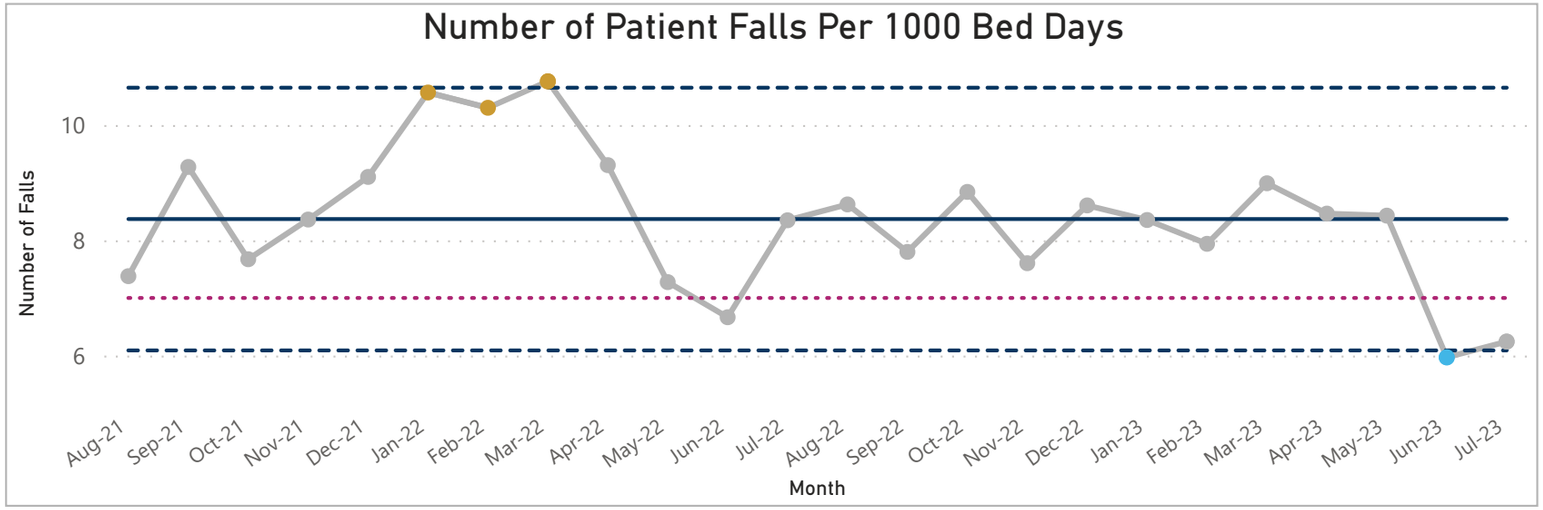
As winter approaches, operational challenges related to capacity are expected to increase - winter planning is under way.

On going industrail action from various professional groups and unions reduces staff capacity to focus on the QI work

Reducing Patient Harm

Target 7

Breakthrough Objective



We are driving this measure because...

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

Understanding the performance

In July the overall falls rate for adult inpatients per 1000 bed days was 6.24 against the target of 7.
This is comparatively lower to last July where the number per 1000 bed days was 11.8
The reason for the fall is multifactorial, but continuing education for new starters and the increase in acknowledgement and focus by senior nursing teams is positively influencing.
Staffing levels on the ward have improved to a more reliable level which is likely to have made a difference. Wards that have established Bay Watch have also seen a decrease in their falls level, most noticably Amesbury Ward who were reporting an average of 13 falls per month and for the past 2 months their reported falls have decreased an average of 6.

Actions (SMART)

The workstream had their first meeting at the end of June. Actions from the meeting are as follows:
Costings for new equipment with Medical Devices team
Terms of reference have been re-written and these will be approved at the next meeting
Adjustments to the monthly ward audit will be fed back to the workstream next month to improve the compliance with Bay Watch, the falls reduction lead is investgating of wearing yellow tabards
A modified risk assessment including an eye test to be trialled on Amesbury and Chilmark wards once approval by the EPR team.
Intentional rounding documentation has been circulated to the group for alteration and approval in August.
Falls Awareness week commences the 18th of September, Chief Executive to be invited to complete 30 minutes of Bay Watch on Amesbury Ward.
Target dates were not set at this meeting, these will be finalised at the next meeing at the end of August:

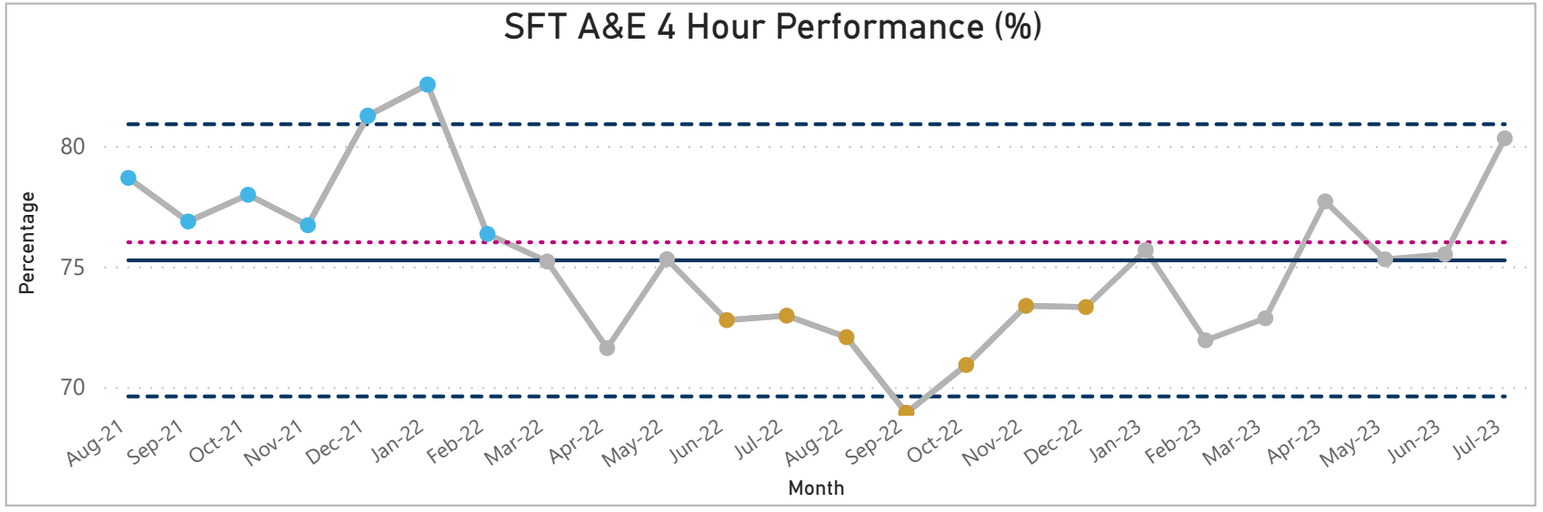
Risks and Mitigations

A Band 6 assistant Falls Practitioner has been advertised with interviews in September. Plan to recruit to 15 hours post so that formal teaching can re-commence for staff as well as ward based teaching.

Emergency Access (4hr) Standard

Target 76%

National Key Performance Indicators



Performance Latest Month: 80.3%

Attendances: 6527

>12 hrs in ED Breaches: 16

Understanding the performance

M4 4-hour standard performance has seen a big increase in performance of 80.3%. Overall attendances remained broadly static, but conversion rates increased by 4.7% to 29.2% in M4 compared to that of 24.6% in M3. This increase is support by the increase in Category 1 & 2 attendances in month.

M4 has seen a sustained decrease in the number of 12-hour breaches, 16 in M4 compared to 28 in M3 and 60 in M2. There was an increase in the proportion of patients requiring admission that were admitted within 4 hours of decision to admit at 68.18% (65.81 % in M3).

The equivalent of 4.3 spaces were lost per day to patients with a DTA in M3 compared to 4.7 spaces in M2, whilst this is a positive reduction, flow out of the department continues to be the biggest contributory factor to the treating and discharging patients within four hours.

Average time to initial assessment has improved to 22 minutes in M4 compared to 35 minutes in M3. This remains a high priority on the Emergency Departments breakthrough objectives. This work is being supported by ECIST who are due to reattend the Trust in M6 to support some pathway redesign.

Actions (SMART)

The Emergency Department continue to push recruitment and in M4 have successfully recruited to all vacant B3&5 posts from M7.

Working group ongoing to help improve handover times out of the Emergency Department and generate faster flow. This has now been allocated project management time to support the delivery.

Risks and Mitigations

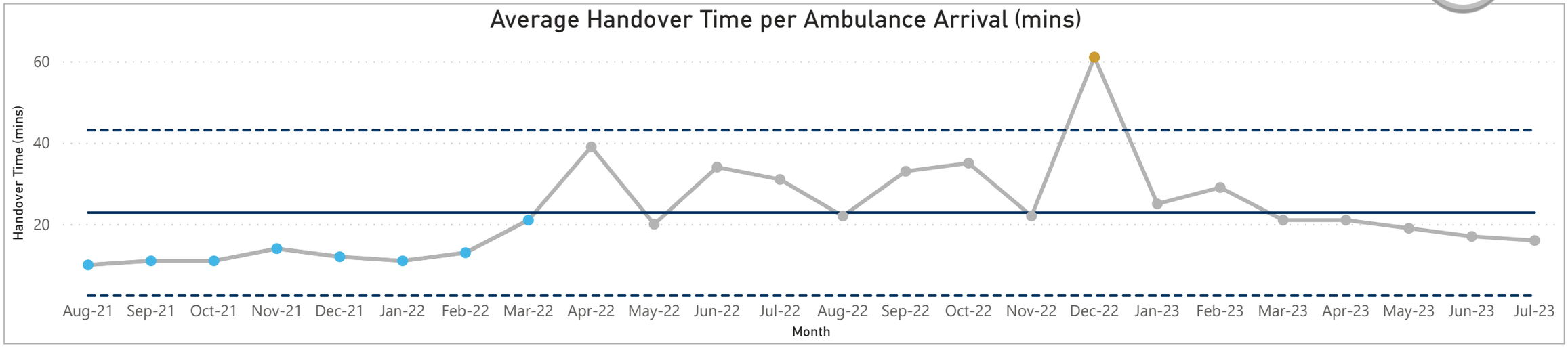
Timely flow out of the Department continues to impact 4- and 12-hour standard performance targets with high bed occupancy levels across the Trust continuing.

There are significant gaps in the medical workforce also with 3.2 WTE Consultant and 4 WTE Middle Grade vacancies. The Senior Leadership Team continue to work on recruiting into these vacancies with proposed National Advert for Nursing Workforce gaps and in reach to the Deanery with upcoming newly qualified Consultants. Physician Associate to start in M4 and Paediatric SHO to commence in M5.

Further planned Junior Doctor and Consultant Strikes are planned for M5 and alternative rota planning are ongoing to support the Department through the planned Industrial Action.

Ambulance Handover Delays

National Key Performance Indicators



Understanding the performance

The number of ambulance arrivals remained fairly static. The agreement to protect Medicine SDEC from escalation which started in M12 continues to have a positive impact, enabling fewer medical patients being diverted to ED, minimising delays to offload at the Front Door. The Emergency Department has seen a continuous improvement for Ambulance Handover for the 6th consecutive month.

- 63.1% of patients off loaded <15 minutes in M3 compared to that of 59.3% in M3
- 90.5% of patients off loaded <30 minutes in M3 compared to that of 85.3% in M3
- 98.2% of patients off loaded < 60 minutes in M3 compared to that of 94.9% in M3

Actions (SMART)

The Emergency Department Matron and senior nursing staff have been making continuous improvement to the Ambulance Handover and have developed a new Ambulance Handover process to be initiated at the end of M4, to continue to make improvements for Ambulances presenting to SFT.

Risks and Mitigations

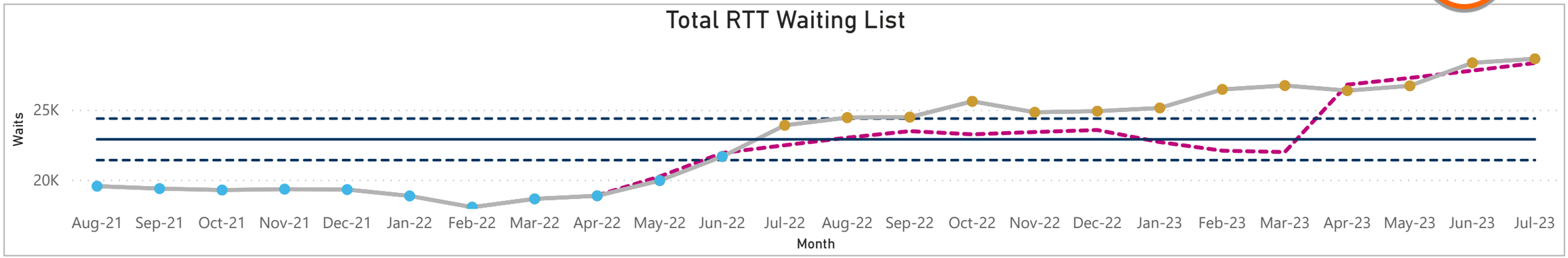
As reported in M1 the HALO service is currently compromised at SFT with a 70% vacancy with only 1 WTE permanent HALO currently provided by SWAST. SWAST continue to work through alternative ways to recruit into this position. SWAST will provide HALO support at times of surge when there is not a permanent HALO present, and the Emergency Department continues to work collaboratively with SWAST partners.

ECIST visit took place in M3 assisting with a workforce review and Streaming processes.

When bed occupancy levels are high or there are staffing challenges across the Trust this can result in poor timely flow out of the department, hindering capacity within the Emergency Department, with a loss of an average of 4.3 spaces per day in M4. This continues to be the biggest challenge in being able to offload patients swiftly and safely into the department. Medicine SDEC remains beneficial in generating earlier flow out of the department and enabling SWAST to convey patients to the most appropriate area.

Total Elective Waiting List (Referral to Treatment)

National Key Performance Indicators



Month	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Longest Waiting Patient (Weeks)	98	94	95	87	83	85	73	75	76	75	76	77

Understanding the performance

The Total RTT Waiting List size position at the end of July stood at 28,649 an increase of 289 from June (28,360). Whilst remaining behind plan, the Trust's position has improved relative to plan from June, from 556 behind plan to 302 behind plan. The variance continues to be driven by a disparity between the clock starts and clock stops with in-month percentage being only 77%, 4508 clock stops vs 5836 clock starts, albeit a slight improvement on 76% in June.

There continues to be a small number of specialties that account for a disproportionate percentage of the waiting list increase since April 2022. The top five specialties with the greatest increase in their respective waiting list all are: Urology (1st), ENT (2nd), Gastroenterology (3rd), General Surgery (4th) and Gynaecology (5th). They collectively account for 53% of the increase in waiting list size since April 2022, up from 51% in month.

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 Dermatology.

A number of actions planned for July onwards are either planned or to continue including: -

- The Dermatology business case approved at TMC and TIG in May has a provisional go live date of 19th August.
- Monitoring of Long Waits to continue with a mirrored process for the 65ww target as was implemented for the 78ww in 2022/23, with the Trust's clearance rate remaining ahead of plan.
- Focussed speciality support to the most challenged specialties in the form of weekly huddles supported by the Transformation Team ongoing, with good progress and engagement in Cardiology and Gynaecology.
- Ongoing recruitment in Plastics, following commencement in post of Micro Plastics Fellow and locum consultant.
- Explore opportunities with BSW partners for Super Saturday Paeds lists and options for introducing HIT lists with assistance from Opteamise – currently ongoing.

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

Risks and Mitigations

The risk of lost capacity owing to the industrial action remains, not least that lost to ongoing monthly Jnr Doctor strikes, now being compounded by consultant IA. Whilst mitigations are in place to support safety for those most clinically urgent patients, the volume of activity affected cannot usually be entirely mitigated, and many plans have now been stretched beyond that for which they were designed.

Whilst >78ww were maintained in July there will be a number of in month breaches, and increase risks of month end breaches to this target. Specifics and actual numbers to be detailed in August IPR

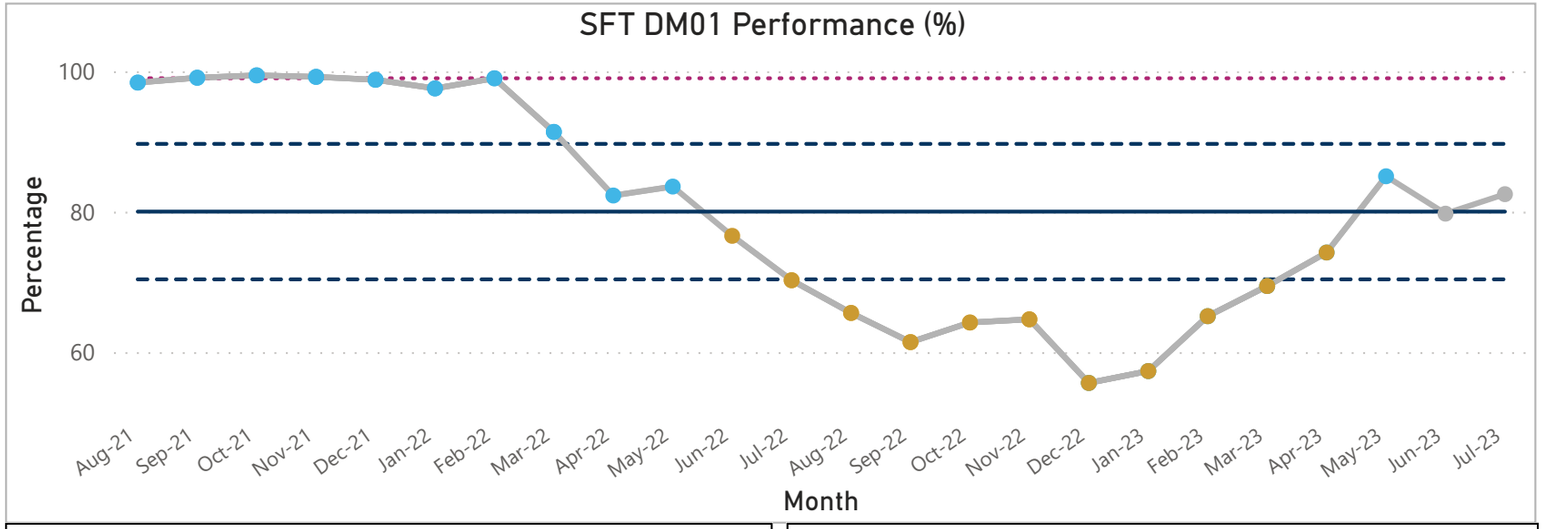
Support into operational teams to enhance level of focus on the non-admitted pathways, through further OPD workshop and weekly huddles in line with Improving Together Methodology throughout to continue through Quarter 2.

The ICB is to begin analysis of workload currently being undertaken by the IS to ensure there is equity across both IS and NHS provider delivery.

Diagnostic Wait Times Performance (DM01)

Target 99%

National Key Performance Indicators



Performance Latest Month: 82.5%

Diagnostic Activity: 7673

	Performance	Breaches		Performance	Breaches
MRI	91.0%	34	CT	99.0%	6
US	95.0%	51	DEXA	100.0%	0
Audio	51.6%	576	Cardio	100.0%	0
Neuro	100.0%	0	Colon	81.9%	34
Flexi Sig	71.7%	28	Gastro	90.3%	14

Understanding the performance

DM01 performance improved in M4 as compared to M3, reporting a position of 82.49% vs 79.72% in M3. Against SFT's trajectory position this is 82.49% vs 84.1%.

This position continues to recognise the adjustment made in Audiology reporting with Audiology now reporting 576 breaches in M4 as compared to 614 in M3 but 96 in M2.

Performance across all other modalities continues to improve (MRI reduced to 34 breaches from 45, USS to 51 from 128 and endoscopy to 78 from 113). Cardiology Echo continue to report 0 breaches.

Radiology, audiology and endoscopy anticipate reporting a similar or improved position in M5.

Actions (SMART)

1) Continue with incentivised overtime rate in August within Audiology to continue decreasing backlog
2) Continue with USS insourcing arrangement Aug-Dec with current contract of work to retain steady state
3) Write business case proposal for continued long term insourcing arrangement for USS recognising workforce position is not improving in Sonography
4) Rotate MRI mobile scanner with GWH for CT for 2 weeks of September to improve utilisation of CDC resource

Risks and Mitigations

USS, Cardiology Echo, Audiology and Endoscopy remain heavily reliant on either overtime, agency or insourcing arrangements

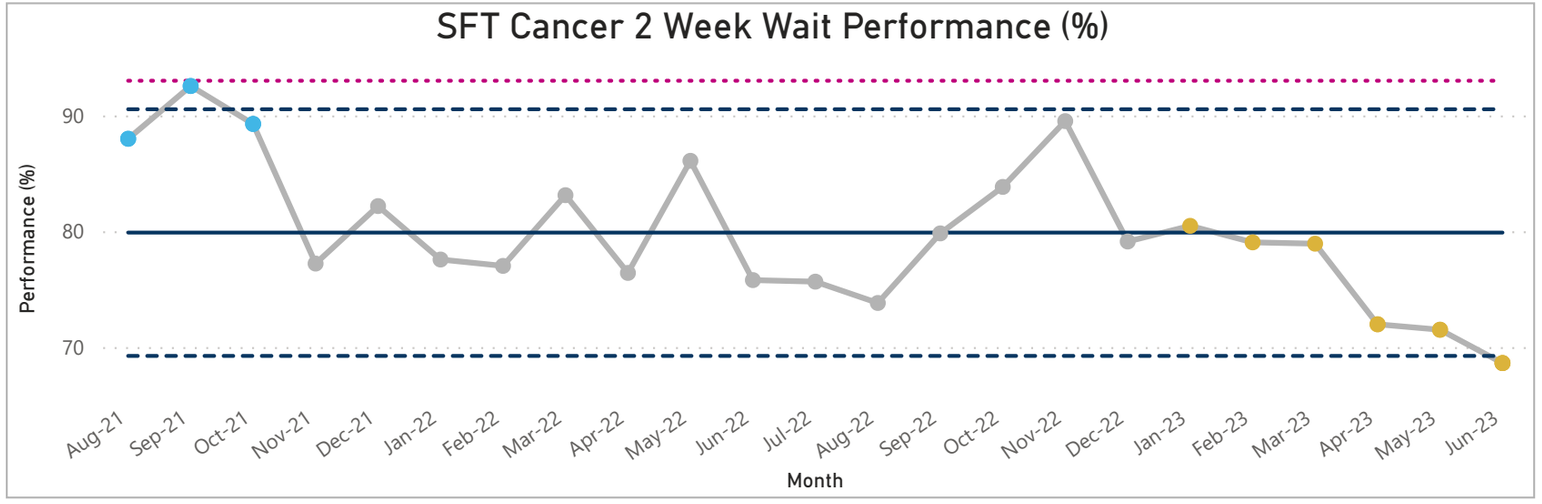
Checking data re sub modalities within Cardiology Echo to ensure all types of scans are being reported as part of DM01 - may cause similar issue as Audiology and may see a reduction in performance

Future (i.e. Q4) CT replacement project will constrain CT capacity but it should be mostly possible to mitigate this by utilising the CDC CT mobile resource

Cancer 2 Week Wait Performance

Target 93%

National Key Performance Indicators



	Performance	Num	Den	Breaches
Two Week Wait Standard:	68.6%	691	1007	316
Two Week Wait Breast Symptomatic Standard:	97.6%	40	41	1

Understanding the performance

The trust continues to be challenged against the 2 week wait standard in June. This position has been steadily decreasing since March with challenges within the 2WW Suspected Skin Cancer Pathway being a big contributor to the decline. In June the reported performance for Skin was sat at 6.5% with 201 2WW Breaches. This has seen the trusts overall performance drop to 68.6%.

The next lowest performing tumour site was Colorectal with a total of 62 breaches which resulted in their overall performance being sat at 59.7%.

The main reasons across both specialites was inadequate outpatient capacity which resulted in a total of 233 breaches.

Actions (SMART)

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

Skin are currently in the process of appointing additional clinical staff to help support the 2WW challenges. However this is not anticipated until later this year. This has been escalated to the Surgical DMT and they are in the process of discussing a way forward to address the capacity challenges within the 2WW. This includes, community dermatology, the SLA with UHS and insourcing of an external company to manage the routine workload to release capacity within Plastics.

Colorectal have had funding agreed for an additional CNS for Early Diagnosis which will help support the front end of the pathway. This funding is for 2 years and will help support triage of referrals and management of IDA patients. As well as this an Endoscopy business manager has had agreed funding to support the management of Endoscopy for 2WW patients to increase utilisation and oversight for Suspected Cancer patients.

Risks and Mitigations

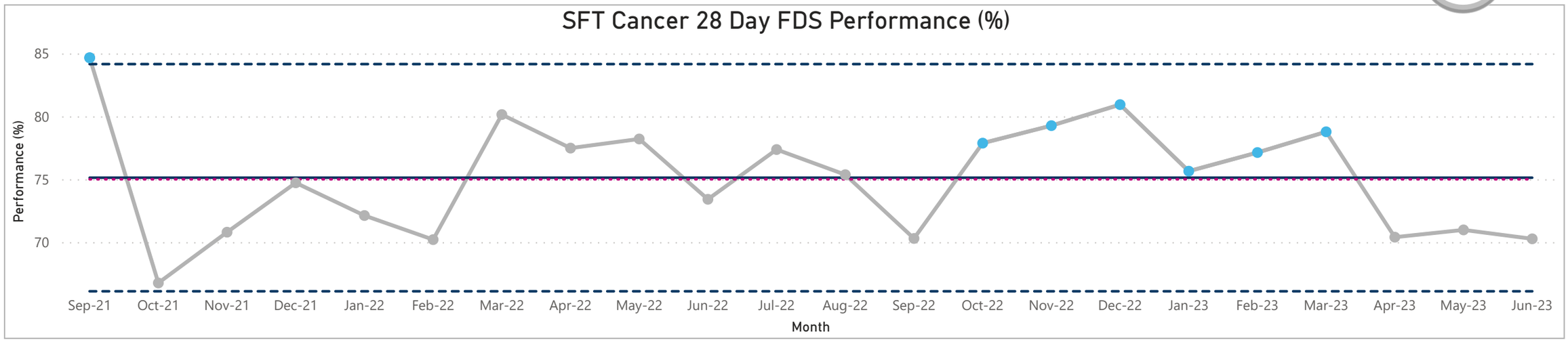
There is a risk to the trusts 28d FDS Target due to the delays in patients being seen for patients within the Suspected Skin Cancer pathway. This has been caused by patients waiting beyond 28 days to be given a decision to treat. The knock on effect of this will be shown in July and August performance as Skin were one of the tumour sites which were able to meet the FDS standard in previous months. Escalation through Delivery group for actions to improve first wait to under 28 days.

There is a risk to the vetting protocol for Colorectal patients due to the ERMA admin-led triage process coming to an end due to a member of staff leaving and the trust are unable to train any further administrators. This has been raised as a DATIX and we have some short term provision in place after the member of staff leaves but the recruitment of the early diagnosis nurse is essential to the process.

Cancer 28 Day Faster Diagnosis Standard Performance

Target 75%

National Key Performance Indicators



Understanding the performance

The trust did not meet the 28d FDS Standard in June reporting just below the expected 75% at 70.27%. The trusts position had dipped in June due to the overhaul of the Urology Cancer PTL which had seen a large proportion of patients removed which took their overall performance to 20.1% this is due to a number of patients sat on the PTL being removed during the validation of the Urology PTL which is now being clinically led. We also saw a small drop in the Gynaecology performance against the FDS Standard due to the implementation of the FDS Benign template letter which saw a large cohort of patients coming off of the PTL.
Skin's FDS Performance has dropped from the regular performance of 95% to 84% which is a large proportion of the trusts FDS performance. This drop is anticipated to fall to around 5% in July / August due to the their inability to provide a decision to treat within 28 days

Actions (SMART)

Both the Urology and Gynaecology performance against FDS are anticipated to improve into July / August due to the service improvements of both the roll-out of template letters for benign patients and the implementation of the clinical PTL for Urology. We are currently in the process of rolling out a clinically led PTL within Gynaecology with support of the CNS / Consultant, this will enable us to have clinical support when making decisions on patients during the PTL and enable us to progress next steps at an expedited timeframe. We are expecting to have the Gynaecology clinical PTL rolled out by the end of August.

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

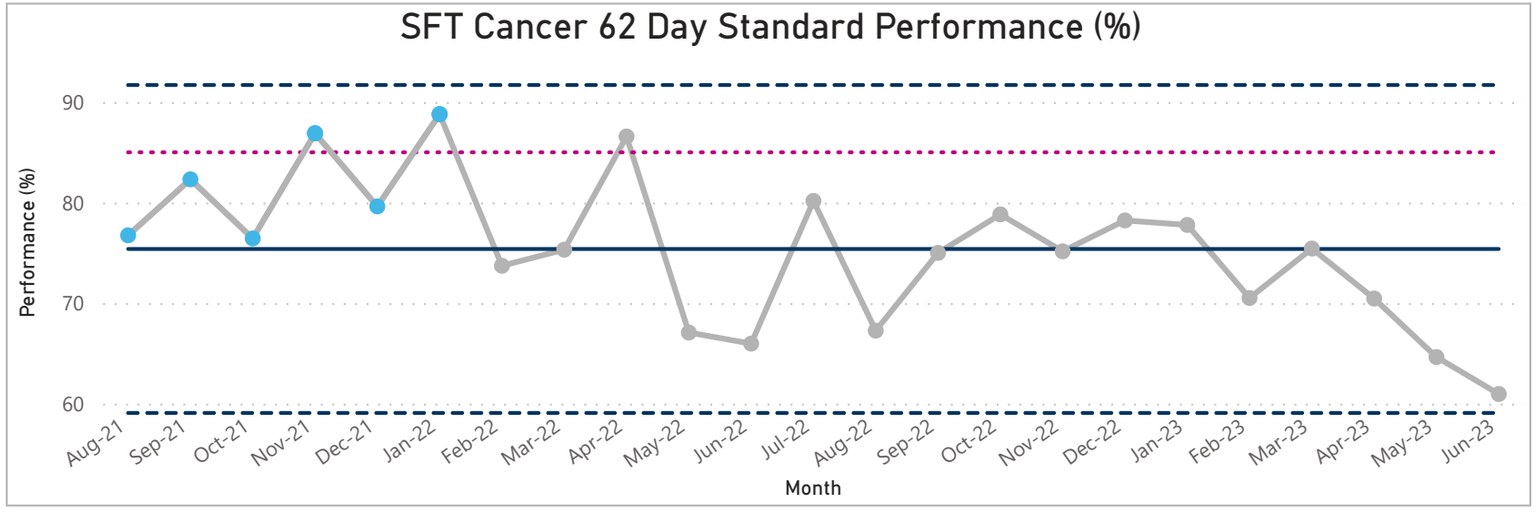
Risks and Mitigations

Skin FDS Performance is a risk to the trusts overall FDS compliance. Skin usually achieve 95% compliance against the faster diagnosis standard, this is due to patients being listed for surgery as a clock stop for faster diagnosis. Due to the capacity challenges within Plastics and the 2WW - the average wait to first seen is exceeding 28 days and slipping week-on-week. We are anticipating their performance to be around 5% in July - this will have a massive impact on the trusts compliance. This has been escalated in delivery group, cancer board and to the skin DMT. Cancer Services have asked Skin to try and pull the first seen date to before day 28 to help support the trusts performance. We are awaiting updates on the plan for recovery but this includes appointment of a trust grade to help support 2WW provision and insourcing to support routine work to free capacity for 2WW.

Cancer 62 Day Standard Performance

Target 85%

National Key Performance Indicators



	Performance	Num	Den
62 Day Standard:	61.0%	57	94
62 Day Screening:	50.0%	2	3

Understanding the performance

The trusts performance against the 62d standard was reported at 61% the break down of breaches are shown below:

Urology - 14.5 Breaches
Colorectal - 7.0 Breaches
Skin - 5.0 Breaches
Breast - 3.0 Breaches
Gynaecology - 2.5 Breaches
Lung - 2.0 Breaches
Upper GI - 2.0 Breaches
Haematology - 1.5 Breaches

The main themes for breach reasons were:
Complex diagnostic pathway - 9.0 breaches
Healthcare delay to diagnostic - 7.5 Breaches
Elective capacity inadequate - 5.0 Breaches
Patient initiated delays - 6.0 Breaches

Actions (SMART)

The large proportion of Urology breaches have resulted in the work that has been undertaken on working on the over 62d PTL Backlog position. In previous months Urology have remained at around 50 patients sat within the backlog which was approximately 50% of our trust position. Since the implementation of the Clinical PTL we have been able to remove patients off which has resulted in an increased number of Urology breaches. As a forward look we are predicting an improved performance for Urology across July / August.

Colorectal's number of breaches has grown due to challenges within consultant availability due to annual leave / unavailability, as well as this challenges with industrial action have increased the number of breaches. The planned recruitment of the endoscopy business manager and early diagnosis nurse should help support the front end of the pathway which will support the back-end pathway allowing for additional time for clinical follow-up.

We have been sharing the breach reasons with operational teams through the Cancer Improvement group after the monthly validation. Trying to draw themes from the breaches, this is ongoing and we will continue to monitor this at Cancer Improvement Group.

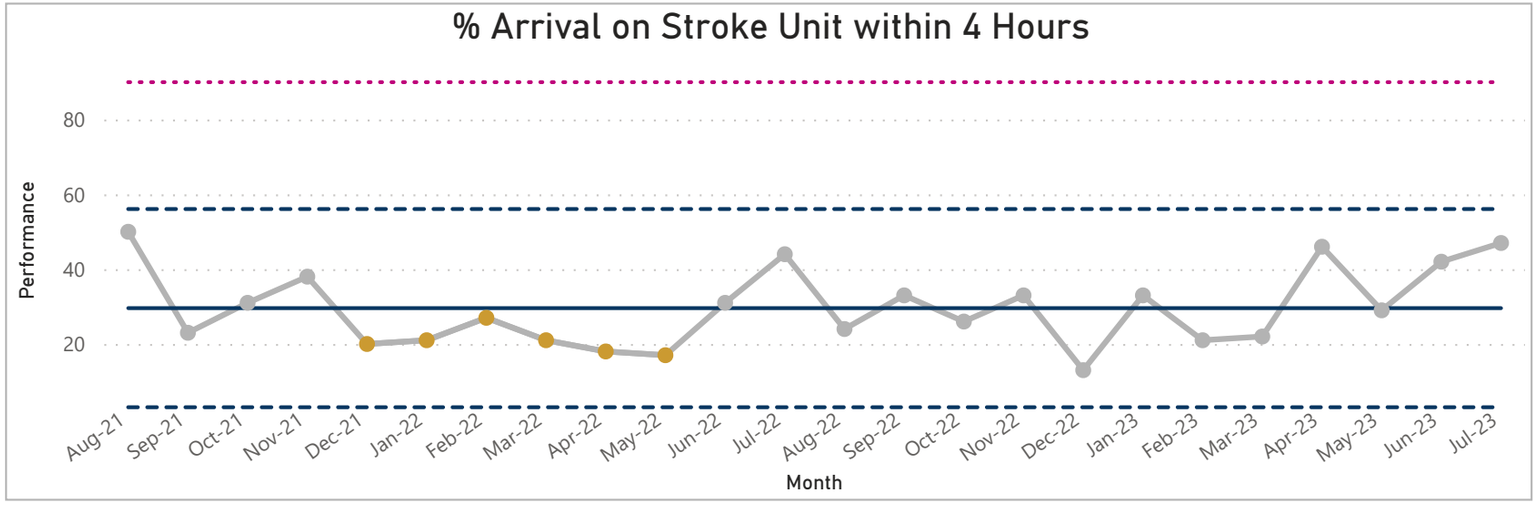
Risks and Mitigations

There is a risk to the trusts 62d Performance as per above with the challenges within Skin. Patients are waiting longer for their first OPA which will subsequently delay their ability to provide a treatment within 62 days and put additional burden on MDT and Histopathology. We are likely to see this in August / September and as above the insourcing and additional recruitment are planned to help support and mitigate this challenge.

Radiology outsourcing is a risk due to the waiting times for outsourced imaging and the ongoing impact on MDT discussion and Post-MDT follow-up. We have been discussing with Radiology on how we can try and provide support by giving as much oversight on patients with a high risk of a cancer diagnosis and escalating appropriate to their turn around times for the external reporting companies.

Stroke Care

National Key Performance Indicators



SSNAP Case Ascertainment Grade

Highest Level = Grade A
Lowest Level = Grade E

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

Understanding the performance

The national target for patients admitted to the stroke unit within 4 hours is 90%

July's month end performance was 47%. This is the second month in a row that performance has improved.
In July 32 patients were admitted to the stroke unit and the target was achieved for 15 patients.
The reasons that the standars was not achieved for the remaining patients was as follows:
- 2 delayed transfers from ED
- 9 waiting for bed
- 1 late referral to stroke unit
- 4 awaiting speciality doctor
- 1 awaiting first doctor

Further analysis via a 'Go See' has been undertaken to understand the differences in the stroke pathway from ED to the stroke unit.

Actions (SMART)

The first stroke study day for ward nurses was completed in July with 7 registered nurses attending. There is a further study day booked for the 4th October for registered nurses in ED.
A simulation training day for ward and ED nurses is planned but awaiting availability of a suitable date.
A3 was completed to understand the pathway of patients attending ED. The patients fall into 2 categories:
- Patients presenting to ED by ambulance
- Patients presenting to ED as walk ins

Countermeasures and actions have been identified.
Posters are being printed to display in ED to improve understanding and recognition of stroke symptoms. The aim of this is to improve the late referrals to the stroke team of patients with non 'FAST' symptoms.

The ward continues to identify non-stroke patients that can be transferred off the ward to make capacity for stroke patients. This information is available for all ward staff and the clinical site managers. The ward are admitting clinically stable patients to the assessment room to support 4 hour performance. The nurse in charge of the ward and the stroke data officer will support in ED and on the ward when a patient is identified in ED to ensure the timely transfer of the patient.
The stroke data officer is auditing the stroke bundle which is completed for all stroke patients admitted to the ward. This will help identify challenges in achieving the 4 hour performance.

Risks and Mitigations

It is known that hyperacute stroke patients are at risk of worsening outcomes if their specialist care is delayed which increases their length of stay. The average length of stay increased slightly in July from 16.9 to 18.7 days. We will continue to have meetings with stroke, ED and patient flow teams to improve this, and we are currently setting up a stroke operational working group.

The 4 experienced stroke nurses that had been redeployed have now returned to the ward and the registered nurse vacancy has fallen to 3.75% for July. The improved staffing numbers and skill mix is reflected in an improvement of the daily clinical hours per patient from 7.2 in June to 7.6 in July.

Maternity

Are We Safe?

01/07/2023 <- Reporting Month (Input the first of the REPORTING month)

	SFT Assurance Dashboard	Guidance	Standard	RAG rating: Red	RAG rating: Green	Improvement Direction	Rolling 6 months: Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Rolling 6m average
Perinatal Morbidity and Mortality (M&M)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)			>= 2	= 0	Down	0	0	0	0	0	0	0
	Number of stillbirths (> 24 weeks excl TOP)			NA	NA	Down	0	1	0	0	1	0	0
	Number of neonatal deaths : 0-28 days			NA	NA	Down	0.0	0.0	0.0	0.0	1.0	0.0	0.2
	Number of neonatal deaths : 0-28 days per 1,000 Live (Reg) Births	ONS	2.7 per 1000 live births	>= 2.8	<= 2.6	Down	0.0	0.0	0.0	0.0	6.3	0.0	1.0
	Medical termination over 24 +0 registered			NA	NA	Down	0	0	0	0	0	0	0
Maternal M&M	Number of Maternal Deaths			NA	NA	Down	0	0	0	0	0	0	0
	Number of Maternal Deaths per 100,000 Maternal Deaths	ONS	9.1 per 100,000 women who	>= 9.2	<= 9	Down	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Number of women requiring admission to ITU	6 month SFT rolling		>= 2	= 0	Down	0	0	0	0	1	0	0.166667
Insight	Datix incidence SII	6 month SFT rolling		>= 1	= 0	Down	1	1	0	0	2	0	0.666667
	HSIB referrals	6 month SFT rolling		>= 1	= 0	Down	0	1	0	0	0	0	0.2
	HSIB/MNHSR/CQC or other organisation with a concern or request	6 month SFT rolling		>= 1	= 0	Down	0	0	0	0	0	0	0
	Coroner Reg 28 made directly to trust	6 month SFT rolling		>= 1	= 0	Down	0	0	0	0	0	0	0
Workforce	Obstetric cover - labour ward	RCOG guidence		<= 39	>= 40	Up	40	40	40	40	40	40	40
	Midwife to Birth ratio	RCM/NHSR/BR+	1:26	>= 1:28	<= 1:26	Down	1:27	1:31	1:25	1:31	1:29	1:30	NA
	Midwifery vacancy rate (black= over establishment; red =under establishment)			>= 1	NA	Down	20.9	21.9	21.9	23.2	23.0	23.9	NA
	Provision of 1 to 1 care in established labour (%)	NICE, RCM, MIS	100%	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Datix relating to workforce	6 month SFT rolling		>= 2	= 0	Down	2*	2	3	1	1	2	1.8
	Compliance with supernumery status of the L\/ coordinator - %	NICE;RCM;NHSR	100% rostered	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Numbers of times maternity unit on divert	6 month SFT rolling		>= 2	= 0	Down	0	0	0	0	0	0	0
Involvement	Service user feedback : Number of Compliments	6 month SFT rolling		NA	>= 26	Up	10	25	31	22	3	0	15
	Service user feedback : Number of Complaints	6 month SFT rolling		NA	NA	Down	3	1	0	2	0	1	1.2
	Number of SOX	6 month SFT rolling		NA	>= 10	Up	6	17	2	12	7	0	7

Understanding the performance

2 datix relating to workforce (1 shortage of ODP (Surgery Division), 1 shortage of HCSW).
Rolling 6-month averages for mortality remain below national average.
Neonatal death in June relating to a congenital abnormality – note artificially inflated rate per 1,000 births due to one baby whose condition was incompatible with life.

Actions (SMART)

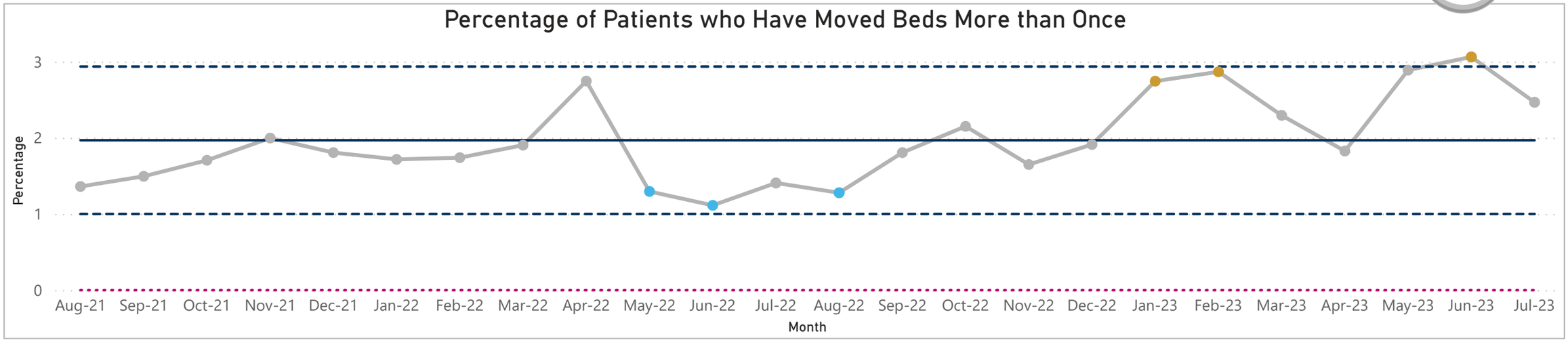
Targeted recruitment drive in place with welcome incentive. 11 WTE band 5 midwives to start in October. Three further band 5 midwives to be interviewed.
2.6 WTE band 6 midwives offered roles to start as soon as notice periods completed.
One further band 6 bank midwife recruited.

Risks and Mitigations

Midwifery staffing remains a risk, mitigated by long line agency usage until qualification and employment of band 5 midwives.
Escalation policy followed to ensure one to one and safe care maintained.
Maternity care assistants supporting with non midwifery care.
Registered nurses employed within maternity services, supporting with non midwifery specific roles, e.g., working alongside midwives in postnatal care.
Discussion with Surgery Division relating to ODP shortage and policy regarding theatre utilization when only one ODP available followed correctly.

Patients Who Have Moved Beds More Than Once

Are We Safe?



Understanding the performance

The percentage of pts who have moved more than once has fallen in July 2023. This is a result in the significant reduction of the escalation beds in use over this period. There has also been a drive to decrease the number of medical outliers within the trust, which has improved the ability to ensure patients are in the right clinical area from admission. The use of Same Day Emergency Care (SDEC) has had a postive impact on patient flow throughout the trust, with patients that are likely to have an extended stay being triaged and transferred appropriately. As planned the beds at South Newton hospital closed in M3 which has reduced the number of moves for patients.

Actions (SMART)

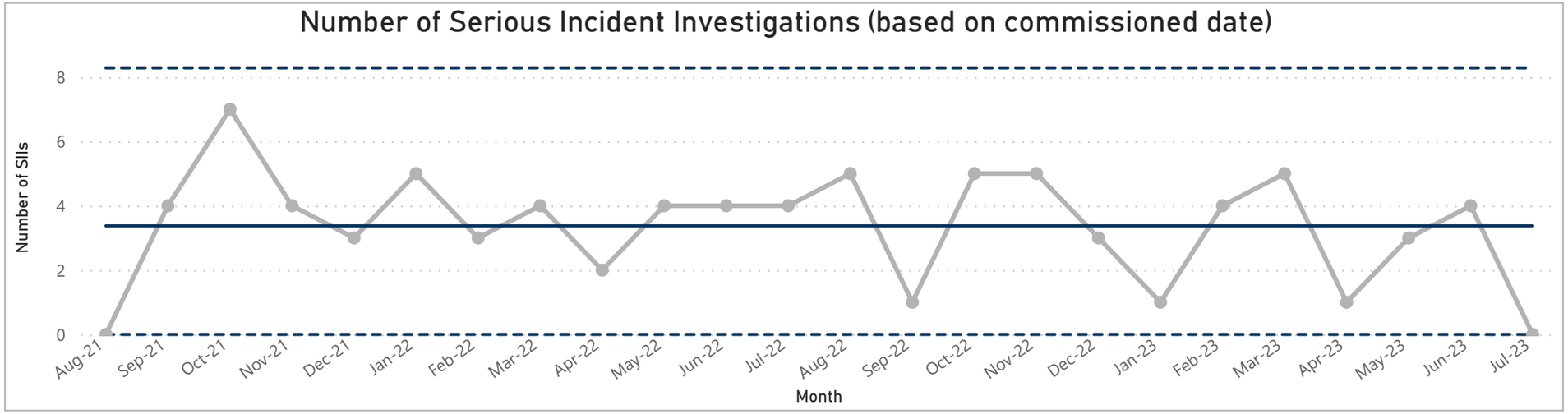
The commencing of the new Acute Fraility Unit SOP in July will aim to see engagement with teams to help reduce the length of stay for our elderly patients. Ongoing work with the site team and Farley team to ensure that stroke patients are admitted to the unit within the four hour targets. The implementation of the new discharge hub has seen improved flow from the hospital to system partners, which has prevented the use of escalation beds.

Risks and Mitigations

Ongoing work with E-whiteboards with the site team to identify patient moves in their hospital journey.
Linking in with Stroke team to ensure we are continuining to improve the targets. Ongoing work with the AFU team to improve the engagement and working processes. Continue to monitor the number of outlying patients and work through with teams to reduce this number.

Incidents

Are We Safe?



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

Understanding the performance

0 commissioned this month.

Actions (SMART)

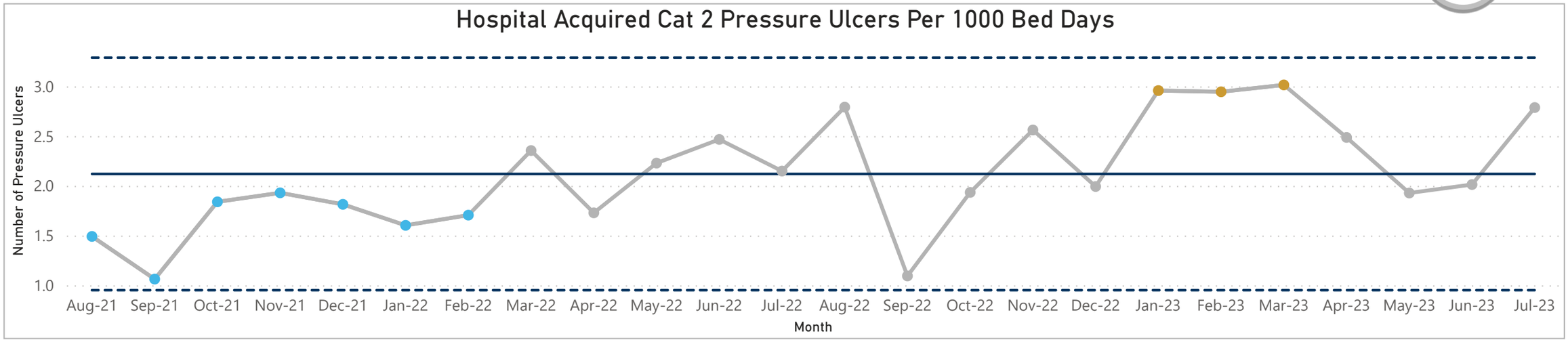
Following the commissioning of an SII, the incident will be investigted as per Trust Policy.

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 staff via area leads.

Pressure Ulcers

Are We Safe?



Understanding the performance

The process for collecting the pressure ulcer and MASD (moisture associated skin damage) data was completed differently for the month of July. Each individual datix was reviewed and compared to the TV Pressure ulcer spread sheet and where possible medical photographs. The data shows an increase of pressure ulcers for July compared with June. This will need to be reviewed alongside Trust activity to provide further analysis and understanding of these numbers.

The HA category 2 pressure ulcers have increased and there has been a rise in the severity of harm as the data identifies four category 3 pressure ulcers, this is compared with zero in June, and three unstageable compared with two. The new process for collecting pressure ulcer data led to 2 cases being recategorized to category 3 which is partly responsible for the increase in reported category 3 ulcers.

One of the category 2 pressure ulcers (present on admission) had deteriorated, this has been counted in the Trusts numbers and re-categorised as a 3.

There has been a decrease in Hospital moisture associated skin damage. The number of patients admitted with pressure ulcers has increased. However, the number of existing pressure ulcers patients were admitted with has decreased.

Actions (SMART)

The team have been reviewing the current pressure ulcer prevention documentation.

An application has been sent to the STARS appeal for consideration of additional pressure ulcer prevention equipment.

Work has commenced on reviewing products/consumables available within the Trust that supports with MASD prevention.

Share and Learn group continues and are currently agreeing the escalation of ward themes and learning across the Trust for Hospital Acquired Pressure Ulcers.

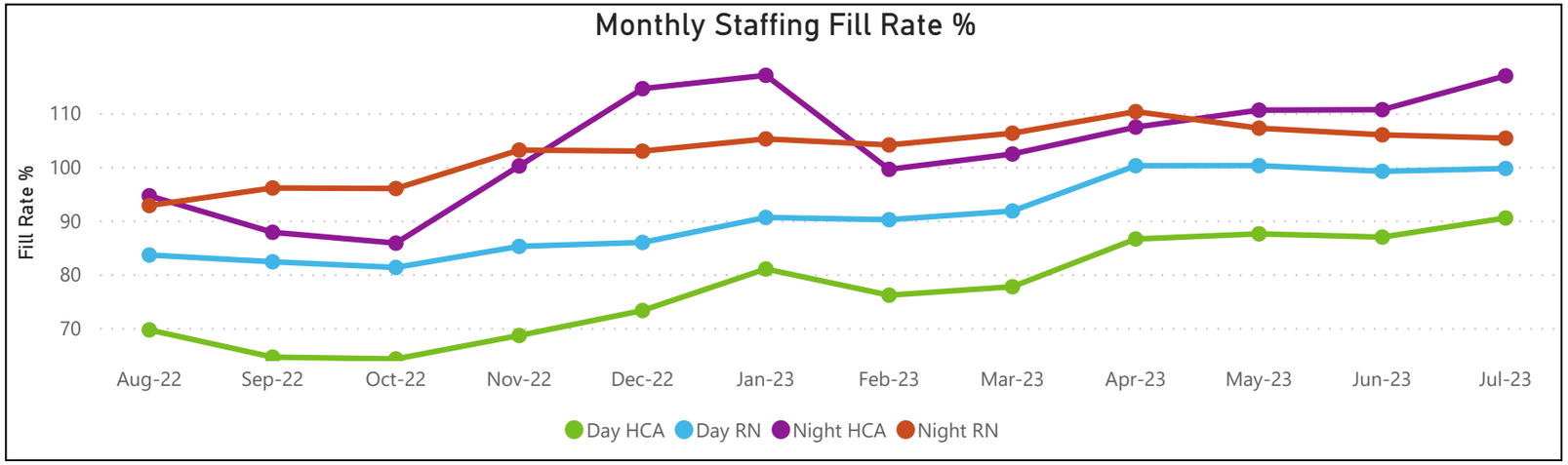
The new Pressure ulcer prevention and management policy is currently in Draft.

Risks and Mitigations

Tissue Viability team have had to reduce the amount of pressure ulcer prevention and management teaching to staff in response to leave in the team. However, continue to review patients requiring specialist input. The team is currently reviewing the service. Work towards heel offloading devices is still undergoing. The prevention and management of MASD is being reviewed.

Nurse Staff Fill Rate

Are We Safe?



Ward	Day RN	Night RN	Day HCA	Night HCA
Amesbury	115%	118%	90%	112%
AMU	99%	108%	73%	103%
Britford	97%	101%	96%	108%
Chilmark	98%	101%	98%	125%
Downton	107%	148%	110%	107%
Durrington	100%	99%	77%	103%
Farley	90%	104%	79%	126%
Hospice	96%	100%	99%	104%
Laverstock	96%	109%	72%	111%
Longford	106%	107%	86%	100%
Maternity	91%	97%		
NICU	108%	101%	75%	
Odstock	104%	100%	100%	102%
Pembroke	110%	104%	99%	110%
Pitton	100%	104%	95%	140%
Radnor	84%	93%	71%	79%
Redlynch	110%	119%	76%	100%
Sarum	98%	124%	103%	
South Newton	98%	99%	85%	102%
Spire	104%	131%	109%	146%
Tisbury	96%	105%	55%	93%
Whiteparish	104%	103%	76%	100%

Understanding the performance

All 4 markers remain broadly static, normal variation. HCA rate still under 100% - is driven in part by areas such as critical care who only have 1HCA which they do not replace if unfilled but also due to unfilled additional duties added for specials at ward level. If unfilled on roster they remain to demonstrate need was required but shift not filled.
Allocate-on-arrival – shift numbers reduced in response to improvement in vacancy rate.

CHPPD 8.4 in month (up 0.5 on last month) and 7.9 (0.5 up) when excluding critical care and maternity excluded – this shift in CHPPD is then seen in the increased staff costs as less shifts go unfilled. NICU much higher in month due to very low occupied bed days in month (98 vs 200+in previous months).

Actions (SMART)

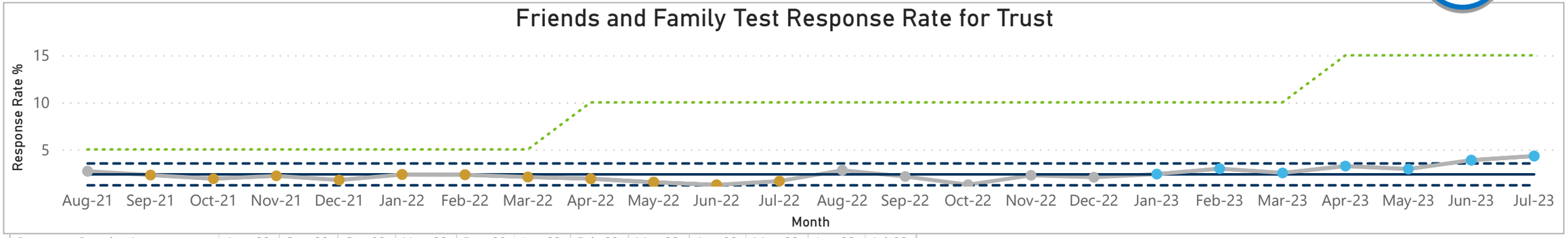
Band 3 bank lift implemented – pay costs will be seen over August and September.
Ward assistant project – KPIs from matrons awaited (data being collated)
IEN Recruitment – visit to Sri Lanka now planned for September which is scoping and interviewing combined.
Business cases for RNDA, Nurse associate to RN and Return to Practice all due at TMC in August.
Trailers obtained to use as training hub to bring OSCE training back in house (saving £800 per candidate) – expected launch in October.
Work on A3 for enhanced care and RMNs – meeting dates planned for September.
On-going work with partners on opportunity for mental health support worker to replace some RMNs – led by AWP.
Process flow being developed to ensure IENs being utilised in staffing numbers in consistent approach – going to August NMAHP forum.

Risks and Mitigations

On-going turnover for HCAs and RNs exceeds starters (risk)
Increase demand for patients requiring RMN support (risk)
Additional beds utilised which are reliant on temporary workforce and not in establishment (risk)
Domestic and international recruitment campaigns (mitigation)
OD+P led work on retention, turnover and inclusion (mitigation and risk)

Friends and Family Test Response Rate

Our Care



Response Rate by Area	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
FFT Response Rate - A&E	0.3%	0.4%	0.3%	1.1%	0.3%	0.8%	1.6%	1.0%	0.6%	0.6%	0.8%	1.1%
FFT Response Rate - Day Case	8.9%	6.8%	3.1%	2.5%	1.4%	0.3%	2.0%	2.5%	3.4%	4.2%	6.4%	6.6%
FFT Response Rate - Inpatient	10.9%	11.4%	5.1%	10.5%	5.8%	11.5%	13.0%	3.2%	14.5%	12.9%	17.1%	28.4%
FFT Response Rate - Maternity	7.8%	1.1%	1.2%	0.0%	2.6%	2.2%	3.7%	1.4%	0.0%	0.5%	0.0%	0.0%
FFT Response Rate - Outpatient	1.5%	0.9%	0.9%	1.6%	2.0%	2.0%	2.2%	2.1%	2.5%	2.3%	2.6%	2.2%

Understanding the performance

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving NHS care or treatment Areas are encouraged to offer feedback forms to patients at discharge or during their stay. Weekly emails are sent to leads showing feedback received in the previous week, allowing them to pick up any immediate causes for concern and mitigate these where possible.

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

FFT response figures have started to increase now. Staff are still being encouraged and reminded to offer FFT through the PALS outreach services although we appreciate that this sole method of obtaining response will inevitably mean fluctuations in activity consequent to pressures.

New cards have gone to all areas and offer free postage. Gender options have also now been extended in line with national guidance

Actions (SMART)

Delay in the rollout of digital provider (see below risk/mitigations) will now require interim actions to be developed, such as:

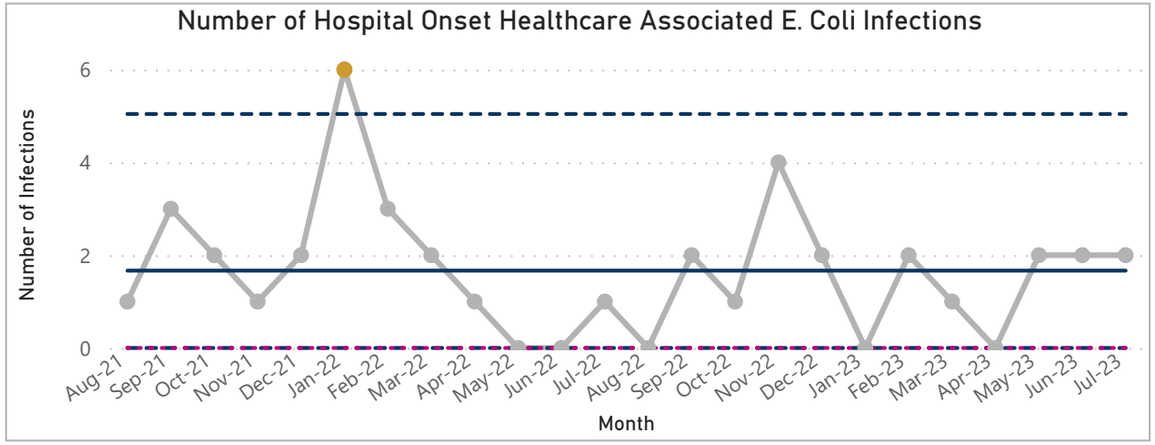
1. Use of QR codes on posters, outpatient letters and within discharge packs – this has been held back as we may be adopting the online form earlier which will change any QR codes we put on posters.
2. Text messaging via Dr Doctor – this has also been held as the process is more complex than anticipated and this would effectively be an interim solution.
3. More volunteers to input cards – this was considered as a mitigation for the potential impact of the above two plans. Responses are increasing steadily (owed to increased profiling of the FFT through mitigations 4 and 5), but remains manageable with current resources.
4. Promotion in inpatient areas through PALS Outreach services – ongoing and now part of BAU.
5. Regular presentation of feedback and response rates at Divisional Governance meetings – ongoing and now part of BAU

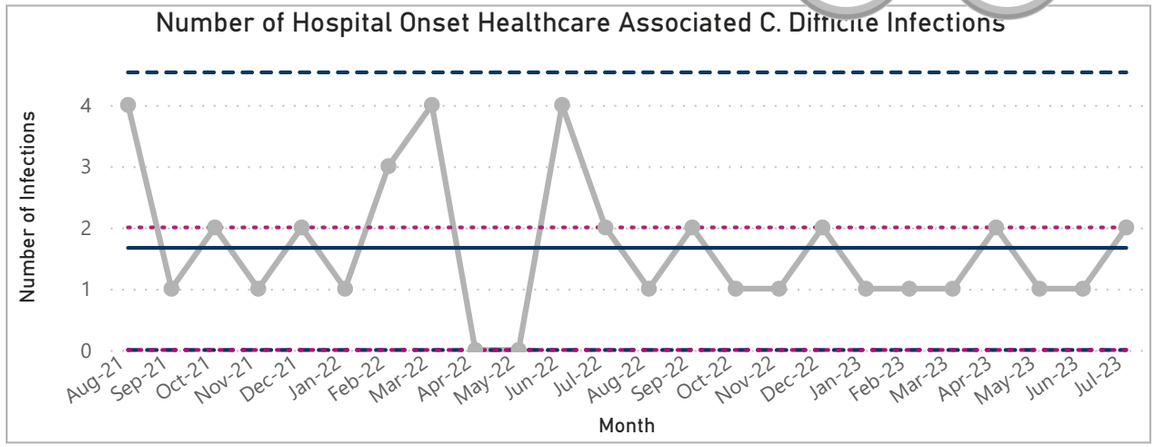
Risks and Mitigations

In June 2023 we saw the highest response rate across Inpatient, Day case and Outpatient areas in the past 12months, demonstrating that mitigations 4 + 5 may be 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. We anticipate that the dashboard will further increase this as we will be in a position to draw themes and insights from the comments. We are currently working with the new digital provider on the data analysis dashboard and we hope to be in a position to analyse and theme the comments we collected during Q1 and Q2 of this year and plan to showcase this through the Divisional Governance structures and PALS Outreach Services in the meantime. These mitigations may not have any dramatic impact on responses rates but will significantly improve our data quality and therefore the insights we draw from this feedback. We hope to have the dashboard populated and begin extractions from this, this Autumn, and plan to introduce this reporting within the Patient Experience Report from Q3.

Infection Control

Are We Safe?





Understanding the performance

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

Year	2021-2022	2022-2023	2023-2024
MSSA Bacteraemia Infections: Hospital Onset	12	10	3
MRSA Bacteraemia Infections: Hospital Onset	0	0	0

Actions (SMART)

Progress with an alternative approach for staff in ward areas to complete hand hygiene education and assessments remains ongoing within the surgical unit, with positive feedback from the division.
Completion of required case investigations by clinical areas to identify good practice and any new learning continues. SFT IP&C team facilitate this process so that areas can take ownership and progress any actions or identified learning (including sharing good practice).
Of the reviews completed, lapses in care have been identified but no action plans developed. This continues to be followed up by the divisions as the 'Share & Learn' meeting process is on hold.
Involvement with BSW collaborative workstreams related to IPC and Gram-Negative Bloodstream Infections: Any feedback communicated from the sessions to identified individuals in the organisation is to be shared at the SFT Infection Prevention & Control Working Group as part of a standing agenda item. There have been no HCAI collaborative meetings held this month.

Risks and Mitigations

Ongoing clinical and non-clinical workload for existing IPC nursing team continues to have an impact on ability to progress other HCAI prevention work e.g. policy reviews/development, and innovation activities.
Band 6 nurse interviews held end of the month, with successful candidate identified.
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	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Crude Mortality	69	65	64	79	94	86	84	84	88	84	77	88	82	73	75	77	102	106	88	95	81	89	51
HSMR District Hospital (excludes deaths recorded by Salisbury Hospice)	102.46	102.85	103.49	106.41	105.02	99.28	102.37	104.12	106.35	107.17	108.78	110.60	112.21	112.68	114.27	114.26	113.38	113.68					
HSMR Trust	111.61	112.07	114.35	116.13	118.21	106.53	108.89	110.50	112.01	112.30	114.43	116.05	117.96	118.43	120.38	120.47	120.24	121.16					
SHMI District Hospital (excludes deaths recorded by Salisbury Hospice)	101.88	102.61	102.69	102.81	102.70	104.38	105.48	107.66	106.81	106.05	106.48	106.90	106.98	107.03	106.65	107.29	106.83	107.71	108.68				
SHMI Trust	106.22	107.07	106.90	106.67	106.77	108.47	109.13	111.34	110.43	109.56	110.01	110.87	111.16	111.41	111.08	111.79	111.52	112.92	113.77				

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

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

Understanding the performance

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

The SHMI for the 12-month rolling period ending in Feb-23 for Salisbury District Hospital is 108.68.

The HSMR for the 12-month rolling period ending in Jan-23 for Salisbury District Hospital is 113.68.

Actions (SMART)

N/A

Risks and Mitigations

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

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

Watch Metrics: Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Complaints Acknowledged within agreed timescale %	38.0%	40.0%	45.0%	90.0%		H	Special Cause Improving - Above Upper Control Limit	✗	28
Pressure Ulcers Hospital Acquired Cat 3	0	0	4			H	Special Cause Concerning - Above Upper Control Limit		
Ambulance Handovers 60+ mins	107	61	24		0		Common Cause Variation	✗	28
ED 12 Hour Breaches (Arrival to Departure)	60	28	16		0		Common Cause Variation	✗	28
Mixed Sex Accommodation Breaches	16	16	12	0	0	L	Special Cause Improving - Run Below Mean	✗	11
Number of High Harm Falls in Hospital	7	2	1	0	0		Common Cause Variation	✗	12
RTT Incomplete Pathways: Total 52 week waits	1093	1273	1367	940	0	H	Special Cause Concerning - Above Upper Control Limit	✗	7
RTT Incomplete Pathways: Total 65 week waits	181	235	236	250	0	H	Special Cause Concerning - Increasing Run	✓	0
Cancer 62 Day Screening Performance	55.6%	80.0%	50.0%		90%		Common Cause Variation	✗	10
Trust Performance RTT %	61.7%	61.8%	62.5%		92%	L	Special Cause Concerning - Run Below Mean	✗	28
Inpatients Undergoing VTE Risk Assessment %	%	%	%		95%		Common Cause Variation	✗	6

Please note: due to a process change in February the data to % of Inpatients undergoing VTE risk assessment is currently absent and expected to remain so until Autumn 2023 to allow thorough analysis on the new dataset.

Watch Metrics: Alerting Narrative

Quality of Care, Access and Outcomes

Understanding the performance

The proportion of complaints responded to within agreed timescale remains someway below target but encouragingly improved for the second consecutive month. Mixed sex breaches are also alerting due to special cause improvement, with only 12 occasions of mixed sex accommodation in July.
Metrics in relation to Referral to Treatment (RTT) continue to alert, with the number of pathways over 52 and 65 weeks both above plans. Industrial action at junior doctor level, and now consultant level too, continues to disrupt services and as a result the number of long waiting patients that have received treatment has reduced.
There has been an increase in the number of category 3 pressure ulcers. The process for collecting the pressure ulcer data was completed differently for the month of July. Each individual datix was reviewed and compared to the TV pressure ulcer spread sheet and where possible medical photographs which may have resulted in a higher number of category 3 ulcers being reported.
Metrics in relation to ambulance handovers over 60 minutes, the number of patients spending more than 12 hours in the Emergency Department and the number of high harm falls all improved for the second consecutive month within common cause variation.

Actions (SMART)

As part of an overall review of performance management introduce a stand-alone PTL meeting out with of Delivery Group to ensure sufficient oversight and escalation is available for both Trust and Divisions. 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.

Pressure ulcer documentation is under review and an application has been sent to the STARS appeal for consideration of additional pressure ulcer prevention equipment. Work has commenced on reviewing products/consumables available within the Trust that supports with MASD prevention.

Risks and Mitigations

Staffing pressures exist across a number of specialities not least Dermatology and Plastics which present a potential individual speciality pressure into next financial year. The Division of Surgery has an approved business case currently under mobilisation to provide insourcing support. Plastics have recruited in the interim to a Micro Plastics Fellow and Locum Consultant post.

Ongoing Jnr Doctor Industrial Action, present significant risk to maintaining levels of capacity, with mitigations options limited.

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	124	111	86	122		L	Special Cause Improving - Below Lower Control Limit	✓	0
Cancer 2 Week Wait Breast Performance	100.0%	97.1%	97.6%		90%	H	Special Cause Improving - Two Out of Three High	✓	0
Cancer 31 Day Performance Overall	91.8%	97.7%	97.4%		96%		Common Cause Variation	✓	0
Cancer Patients with a decision to treat waiting > 62 days	109	89	78	112				✓	0
Diagnostics Activity	8656	8176	7673	6740			Common Cause Variation	✓	0
ED Attendances	6561	6589	6527				Common Cause Variation		
Neonatal Deaths Per 1000 Live Births	0	6	0		0		Common Cause Variation	✓	0
Pressure Ulcers Hospital Acquired Cat 2	29	28	38				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 4	0	0	0			L	Special Cause Improving - Run Below Mean		
Proportion of patients spending more than 12 hours in an emergency department	1.3%	0.6%	0.4%				Common Cause Variation		
RTT Incomplete Pathways: Total 78 week waits	0	0	0	0	0	L	Special Cause Improving - Below Lower Control Limit	✓	0
Serious Incident Investigations	3	4	0				Common Cause Variation		
Stillbirths Per 1000 Total Births	0	6	0				Common Cause Variation		
Stroke patients receiving a CT scan within one hour of arrival	48.0%	58.0%	63.0%		50%		Common Cause Variation	✓	0
Total Incidents (All Grading) per 1000 Bed Days	60	63	58				Common Cause Variation		
Total Incidents Resulting in High Harm (Mod/Maj/Cat) %	2.8%	4.7%	3.6%				Common Cause Variation		
Total Number of Complaints Received	11	12	12				Common Cause Variation		
Total Number of Compliments Received	34	34	51				Common Cause Variation		

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

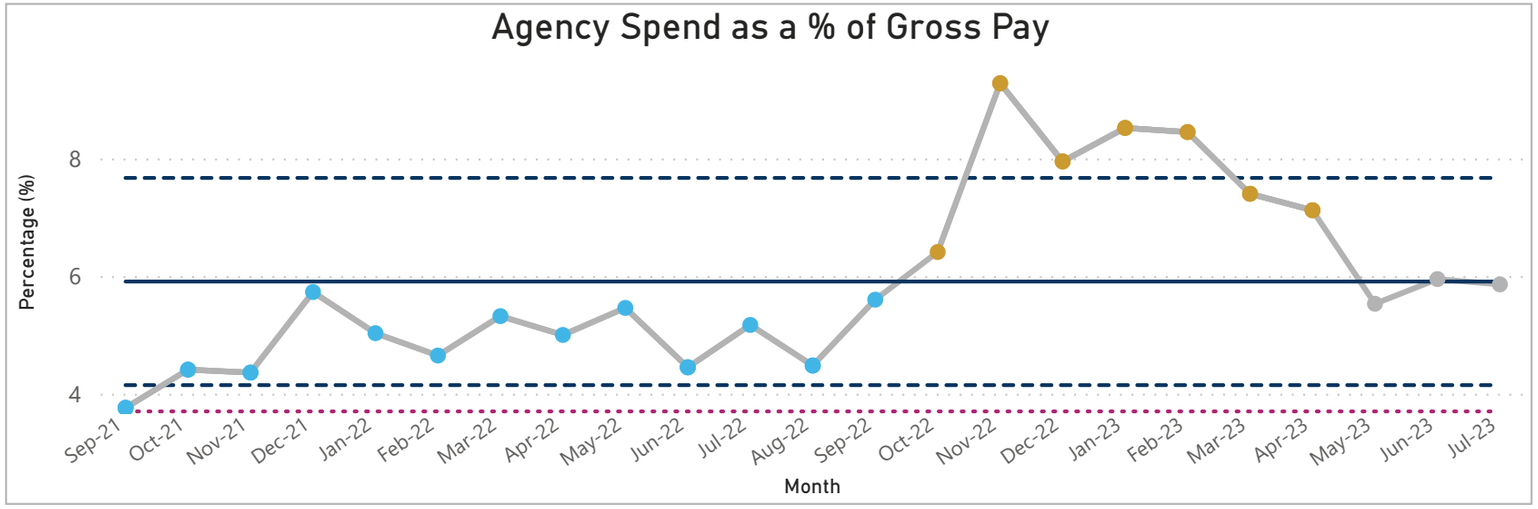
Partnerships

People

Staffing Availability

Target 3.7%

Breakthrough Objective



We are driving this measure because...

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

Understanding the performance

Agency spend totals 5.86% of the total pay bill in Jul. The 3 month trend (grey dots) average a 5.77% spend. This is a marked reduction compared to the previous seven month's spend average of 7.87% (Orange Dots) but still above the previous average of 5.06% (Blue Dots), and above target. Nursing (62%) and Medical staffing (23%) remain the two largest contributors to Agency spend accounting for £967K of the £1.2M spend this month.

Medicine continue to dominate Agency spend through high returns in ED, Elderly Medicine and Acute Medicine. Theatres is the next highest spend.

It is clear that to target these areas in medicine and surgery, further detail is now required to understand the breakdown of spend against unscheduled care, unestablished care (eg RMN requirements), absences, and process issues.

Actions (SMART)

Temp Staffing Deep Dive into Medicine and Surgery. Work has commenced to identify the break down of Agency and Bank spend in Medicine and Surgery, seeking to better understand the process levers that can reduce spend, where unestablished positions generate spend, and how operational factors impact spend. This study will report in late September.

Establishment Control: NHS BSA team has started work on the implementation of ESR Establishment Control modules. The project aims to complete a reconciliation of finance ledger with organisational design on ESR by end Sep 23. Oversight of the establishment will aid strategic WF planning

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

Risks and Mitigations

Corporate Risk – Sustainable Workforce
Mitigations:

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

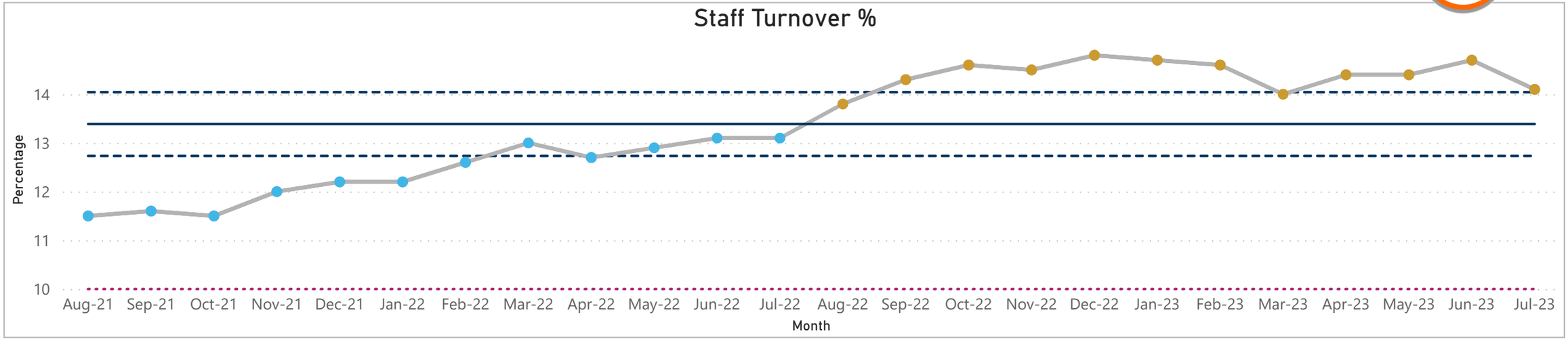
Vacancies not sufficiently understood – Support to DMT to establish organisational design and prioritise vacancies to enable effective targeting of attraction campaigns.

Estb Control project timelines are tight and require detailed engagement from DMT, Fin BP and HR BP. The new timetable has just been released.

Workforce - Turnover

Target 10%

People



Understanding the performance

Overall turnover rates have dropped to 14.1% this month and following the negative WF growth in Jun 23, there has been a return to the recent modest increase of numbers month on month. In Jul 23, 33.80(FTE) left the Trust, with 36.86 (FTE) new staff starting work, a gross gain of 3 FTE. Turnover metrics remain stubbornly difficult to move closer to target.

All Divisions remain red against the Trust 10% target. The highest level of turnover is with Women & New Born (17.5%) for the third successive month. Whilst this continues to reflect the impact of individual moves in the smallest division, understanding the reasons for leaving is a priority for W&NB.

A total of 39 staff left the trust in Jul, of which 21 were in their first 2 years of service and nearly a third under 30. A refresh of the Turnover A3 will seek to better understand these numbers, and identify mitigations.

Actions (SMART)

AD HR Ops will refresh the turnover A3, seeking to better understand the root causes of staff leaving, with particular focus on those in their first 2 years of service.

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

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

Risks and Mitigations

Corporate Risk – Sustainable Workforce.

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

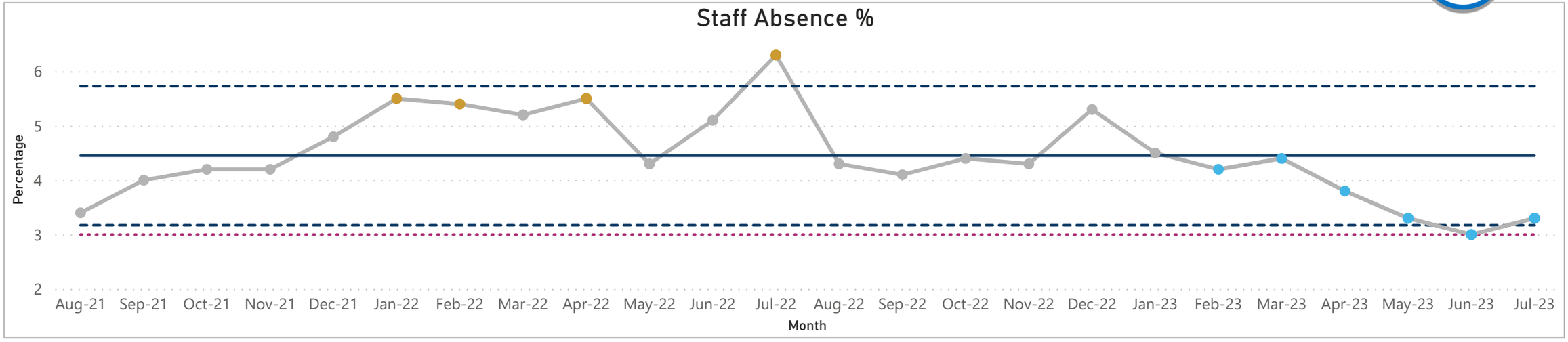
Divisional Staff Survey Action Plans

Line Manager Training interventions

Workforce - Sickness

Target 3%

People



Understanding the performance

Sickness absence for Jul was recorded as 3.3%, a slight increase on the previous month but close to Target dropped close to target at 3.3% for the first time since Aug 21. CSFS remain the best scoring clinical division at 2.49%. Medicine remain the division with highest absence rates at 4.34%, with elderly care the highest contributor at 5.76% absence. This correlates with one of the areas of high agency soend.

Staff from Additional Clinical Services remain the staff group with the highest absence rate at 5.29%. This group includes HCAs, Therapy assistants and Radiography helpers, and there is high absence in elderly care at 8.34%.

Sickness accounted for 3808 FTE days lost to the Trust, of which 2291 were for short term absence. Anxiety and stress continues to be the major reason for absence accounting for c25% of all absence in the month.

Actions (SMART)

Absence Management: The direct support pilot for 3 wards in Medicine (Pitton, Redlynch and Laverstock) has completed and results are being analysed. The support was welcomed by line managers and several areas where improvements could be made to policy, processes and management of absence cases have been identified as part of the pilot.

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

Risks and Mitigations

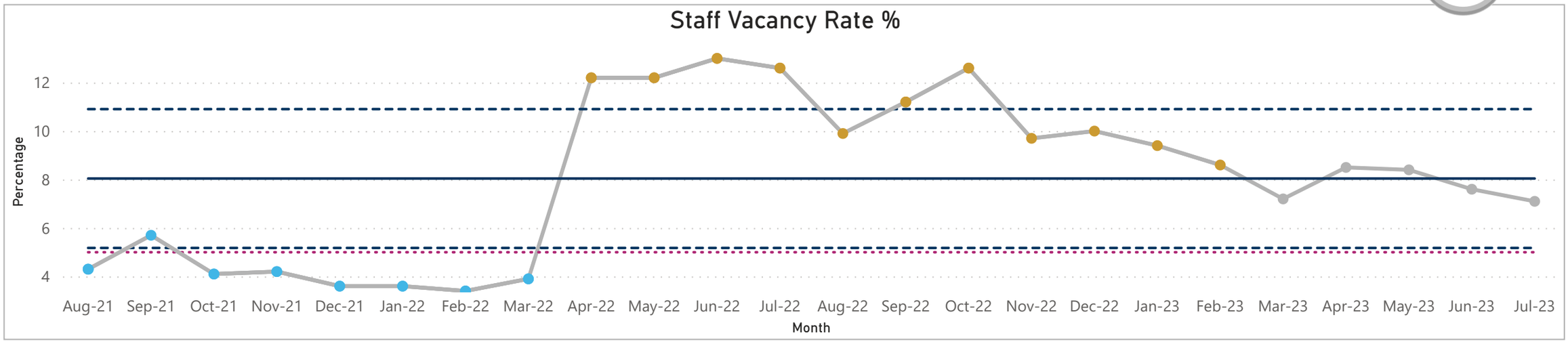
Corporate Risk – Delivery of OH service
Increased counselling and physio hours have been agreed and staff recruited for the counselling post. Delivery of an initial health intelligence capability is planned for Summer 23.

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

Workforce - Vacancies

Target 5%

People



Understanding the performance

Vacancy rates have continued to fall in Jul, reaching 7.11% against the target of 5%. Although a relatively minor fall, it represents a downward trend since Apr when established FTE rose – the trust has now absorbed the additional funded posts and is still closing the vacancies gap. Total vacancies stand at 283.

Nursing staff remain the staff group with the highest number of vacancies. This gap is being targeted through the international recruitment campaign this year and further work on apprenticeships and nursing associates going forward.

Elderly Medicine and Emergency medicine are the highest vacancy rates in Medicine with 47 staff gaps, and theatres have 80 staff gaps. These areas all correlate with high agency spend.

Actions (SMART)

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

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

Workforce trajectory forecasting work is ongoing, seeking to support Divisions and Line Managers with targeted attraction and recruitment campaigns.

Risks and Mitigations

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

Watch Metrics: Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Mandatory Training Rate %	88.6%	89.7%	89.5%	90.0%	85%		Special Cause Improving - Run Above Mean	X	6
Non-Medical Appraisal Rate %	60.9%	60.1%	60.2%	86.0%			Special Cause Concerning - Below Lower Control Limit	X	28

Watch Metrics: Alerting Narrative

People

Understanding the performance

Mandatory training activity remains close to the improvement target of 90%, sitting at 89.5% in Jul. A refresh of the MLE, linked with ESR is underway to ensure that data is accurately captured, this activity takes time and is aligned with reconciling ESR to the finance ledger as part of the establishment control project.
Medical appraisals have returned to non-alerting as numbers have risen to 95.4%, above the 90% improvement target. This is positive news.
Non-Medical appraisals remain just above 60% completion against an improvement target of 86%. Ineffective management of appraisals remains a key area of concern in Staff Survey and Pulse survey data, leading to low morale amongst staff. Time to complete and complexity of the process are the most common challenges put forward to explain the challenges to correct this reducing completion rate.

Actions (SMART)

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

Appraisals: A simplified process for appraisals was rolled out as of 31st May. At this stage there has been no discernible improvement on non-medical appraisal numbers across the Trust. Data shows that there are 55 line managers who have 6 or greater outstanding appraisals – this represents 538 appraisals. Understanding why some line managers have such a high volume of appraisals is key to supporting staff and improving completion rates.

Risks and Mitigations

Corporate Risk - Sustainable Workforce.

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

Watch Metrics: Non-Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Medical Appraisal Rate %	93.3%	94.7%	95.4%	90.0%			Special Cause Improving - Above Upper Control Limit	✓	0

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

Partnerships

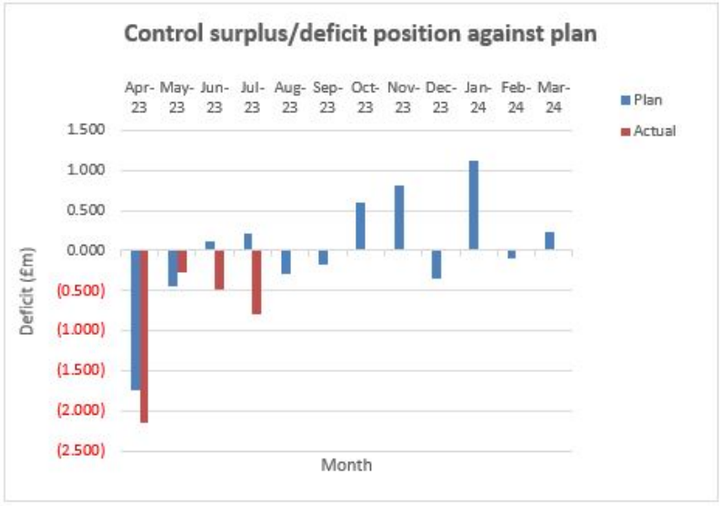
People

Income and Expenditure

Income & Expenditure:

Finance and Use of Resources

	July '23 In Month			July '23 YTD			23-24 Plan
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	24,965	25,122	157	97,640	97,831	191	273,576
Other Clinical Income	1,349	1,639	290	3,199	6,323	3,123	9,478
Other Income (excl Donations)	2,185	3,486	1,301	10,871	13,485	2,614	70,426
Total income	**28,499**	**30,247**	**1,747**	**111,710**	**117,639**	**5,928**	**353,480**
Operating Expenditure							
Pay	(17,374)	(19,779)	(2,404)	(69,921)	(76,554)	(6,633)	(210,895)
Non Pay	(9,326)	(9,677)	(351)	(37,297)	(38,023)	(726)	(123,527)
Total Expenditure	**(26,700)**	**(29,456)**	**(2,755)**	**(107,218)**	**(114,577)**	**(7,359)**	**(334,422)**
EBITDA	**1,799**	**791**	**(1,008)**	**4,492**	**3,061**	**(1,431)**	**19,058**
Financing Costs (incl Depreciation)	(1,588)	(1,589)	(1)	(6,350)	(6,760)	(410)	(19,058)
NHSI Control Total	**211**	**(798)**	**(1,009)**	**(1,858)**	**(3,698)**	**(1,840)**	**0**
Add: impact of donated assets	232	2,339	2,107	228	1,977	1,749	9,989
Surplus/(Deficit)	**443**	**1,542**	**1,099**	**(1,630)**	**(1,722)**	**(92)**	**9,989**



Understanding the performance

The financial plan submitted to NHS England on 4 May shows a breakeven control total position for the year. The 2023/24 financial arrangements have moved to the 2023/25 NHS payment scheme with fixed and variable elements of an Aligned Payment Incentive (API) arrangement following the transitional arrangements from COVID block payments in 2022/23. Although the majority of the Trust's NHS contractual income base is fixed, the guidance allows for additional income to be earned through the variable element of the API and the Elective Recovery Fund (ERF) from commissioners. SFT has not assumed any ERF income within the 2023/24 plan, or the year to date position in line with national guidance, as the Trust's planned activity levels do not meet the thresholds for payment. In Month 4 the Trust recorded a control total deficit of £3.698m against a target of £1.858m - an adverse variance of £1.840m. The position is due to additional income partially offsetting the premium costs of staffing, mainly to cover vacancies, and Industrial action costs which now exceed c£1.2m.

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 25% non recurrent delivery and signals a risk if further recurrent efficiencies cannot be identified. Actions are ongoing to identify additional schemes. Impacts of Industrial action which drives the increased costs of cover and constrains the elective programme, introducing risk to income, with additional Junior doctors and Consultant action planned in August.

Income & Activity Delivered by Point of Delivery

Clinical Income:

Finance and Use of Resources

Income by Point of Delivery (PoD) for all commissioners	July 23 Year to Date (YTD) Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	3,499	3,725	226
Day Case	6,980	6,905	(75)
Elective inpatients	4,505	4,745	240
Excluded Drugs & Devices (inc Lucentis)	8,019	8,147	128
Non Elective inpatients	25,792	25,236	(556)
Other	37,139	36,599	(540)
Outpatients	11,706	12,474	768
TOTAL	97,640	97,831	191

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	53,091	53,470	379
Dorset ICB	9,588	9,158	(430)
Hampshire, Southampton & IOW ICB	8,197	8,055	(142)
Specialist Services	13,303	13,456	153
Other	13,461	13,692	231
TOTAL	97,640	97,831	191

	Activity YTD Plan	Actuals	Variance	Activity Last Year Actuals	Variance last year
A&E	24,633	24,761	128	25,011	(250)
Day case	7,596	7,985	389	7,388	597
Elective	1,063	1,078	15	1,141	(63)
Non Elective	9,189	9,212	23	8,925	287
Outpatients	83,074	87,158	4,084	80,810	6,348

Understanding the performance

The Trust is broadly in line with the Clinical income plan year to date due to BSW ICB overperformance on Diagnostic activity and Other commissioners, mainly University Hospital Southampton NHS Foundation Trust, offset by underperformance on Dorset and Hampshire ICBs.

The level of uncoded day cases and inpatient spells is 29% in June and 93% in July at the time the activity was taken for reporting purposes. May's activity was fully coded at the SUS submission.

Activity was lower in July than in June across the majority of points of delivery with increases in Non Elective of 98 spells.

Actions (SMART)

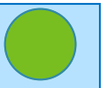
The contracts with ICBs and NHS England remain under negotiation at this stage. Several contract schedules have been agreed with ICB commissioners and discussions are progressing around the finance schedules with BSW and Dorset ICBs. Further guidance is anticipated around Dental commissioning arrangements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

Risks and Mitigations

The impact of industrial action constrains the elective programme, introducing risk to income. Additional guidance has been received which reduces the ERF target by 2% across all commissioners. The impact of this on the Trust is being confirmed with BSW ICB and the regional team as the Trust was not planning to achieve the ERF target. All commissioner contracts outside BSW are required at 101% of 2019/20 Elective activity levels. The Trust is seeking to mitigate the impact by maximising activity recording opportunities and via the contract negotiations.

Cash Position & Capital Programme

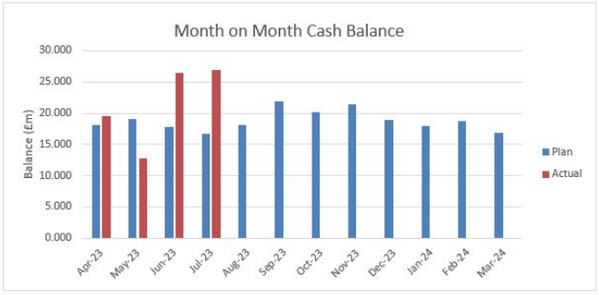
Capital Spend: 

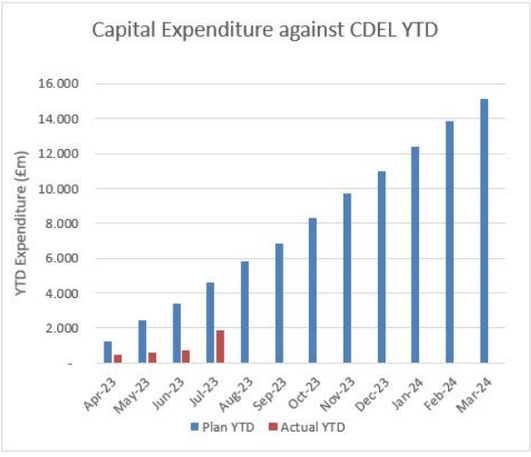
Cash & Working: 

Finance and Use of Resources

	Closing Balance March 2023 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,954	8,523	569
Debtors	24,999	22,889	(2,110)
Cash	28,891	26,910	(1,981)
TOTAL CURRENT ASSETS	**61,844**	**58,322**	**(3,522)**
Creditors	(58,026)	(58,013)	13
Borrowings	(641)	(635)	6
Provisions	(474)	(470)	4
TOTAL CURRENT LIABILITIES	**(59,141)**	**(59,118)**	**23**
TOTAL WORKING CAPITAL	**2,703**	**(796)**	**(3,499)**

Payables age profile	Total Payables £'000	0-30 days £'000	31-60 days £'000	61-90 days £'000	90+ days £'000
Jul-23	**9,501**	8,470	238	174	619
Jun-23	**8,446**	7,306	231	379	530
May-23	**7,462**	5,942	802	125	593
Movement vs prev mth	*1,055*	*1,164*	*7*	*(205)*	*89*





Schemes	Annual Plan £000s	July '23 YTD Plan £000s	July '23 YTD Actual £000s	July '23 YTD Variance £000s
CDEL Schemes				
Building schemes CIR	2,800	933	312	621
Building projects	6,235	2,078	1,972	106
IM&T	3,451	966	1,108	(142)
Medical Equipment	2,713	904	256	648
Total CDEL schemes	**15,199**	**4,882**	**3,648**	**1,234**
National Funding				
New Elective Ward TIF	*11,952*	*566*	*566*	0
Salix Decarbonisation	*10,005*	*2,452*	*2,452*	0
Shared EPR - national element	*3,760*	*0*	*0*	0
Digital Pathology	*1,053*	*310*	*310*	0
Pathology LIMS	*310*	*39*	*39*	0
SW Imaging (ATVS)	*174*	*2*	*2*	0
Total National Funding	**27,254**	**3,369**	**3,369**	**0**
GRAND TOTAL	**42,453**	**8,251**	**7,017**	**1,234**

Understanding the performance

Month 4 was the highest monthly expenditure at c£2.9m in month due to expenditure on the Salix scheme £652k, Whiteparish refurbishment £678k and Network kit £460k. Forecast expenditure by capital sub group will be reviewed each month at the Trust Capital Control Group to ensure full allocations will be spent by the year end. Specific projects, including Salix, do have expenditure profiles weighted towards the end of the year and actions will to taken to maximise the funding in year and manage any slippage. Cash reserves are now c£10m above plan following the reduction in debtors, the year to date deficit of c£3.7m which is c£1.8m adverse to plan and the payment received from BSW ICB of £11m in relation to the pay awards and risk share agreements on account.

Actions (SMART)

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

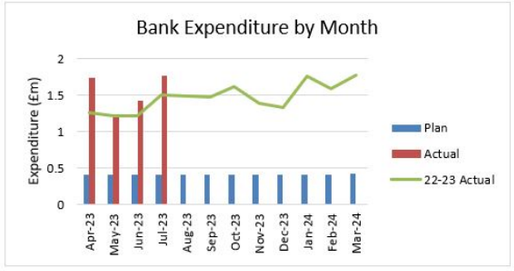
Risks and Mitigations

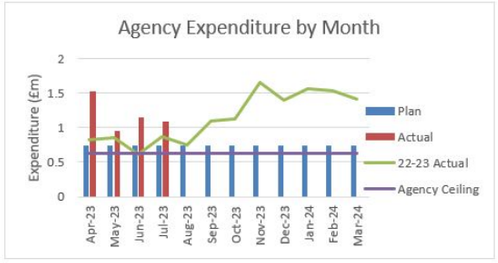
Additional capital pressures are emerging in year and such risks will have to be managed within the overall capital envelope if additional funding cannot be secured. Following the resubmission of financial plans on 4th May 2023 the Trust is awaiting confirmation from NHS England of the Capital leases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

Workforce and Agency Spend

Pay:

Finance and Use of Resources





	Plan £000s	July '23 YTD Actual £000s	Variance £000s
Pay - In Post	65,214	65,409	194
Pay - Bank	1,678	6,173	4,495
Pay - Agency	3,029	4,727	1,698
Other (eg apprenticeship levy)		246	246
TOTAL	**69,921**	**76,554**	**6,633**
Medical Staff	18,492	18,983	491
Nursing	18,421	21,045	2,624
Support to Nursing	5,039	7,165	2,126
Other Clinical Staff	9,962	10,094	132
Infrastructure staff	18,007	19,021	1,014
Other (eg apprenticeship levy)		246	246
TOTAL	**69,921**	**76,554**	**6,633**

	Plan WTEs	July '23 YTD Actual WTEs	Variance WTEs
Medical Staff	473.0	486.6	13.6
Nursing	1,124.8	1,218.1	93.2
Support to Nursing	497.2	616.0	118.8
Other Clinical Staff	638.4	624.8	(13.6)
Infrastructure staff	1,452.5	1,421.5	(31.0)
TOTAL	**4,185.9**	**4,366.8**	**180.9**

Understanding the performance

Pay costs totalled c£19.8m in Month 4: an adverse variance to plan in month of c£2.4m and year to date £6.3m. This is an increase of £0.9m on the Month 3 run rate with £0.6m due to Subsidiaries and is offset within the income position. The position also includes the cumulative pay savings target at month 4 of £2.9m of which £1.7m is delivered to date. The increases in bank spend in month are linked to cover for Junior doctors Industrial action, enhanced care, vacancy cover and sickness in month within Orthopaedics Inpatients, ICU and Theatres and supernumerary cover for overseas and newly recruited staff.

Vacancies across the Trust have increased from 4% to 5% overall in Month 4 with the highest proportion of vacancies within the Consultant, NHS Infrastructure and Nursing groups. The unfilled rate has reduced from 3% to 2% mainly across AHPs 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, temporary staffing and sickness.

Risks and Mitigations

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

Data Sources: Narrative and Breakthrough Objectives

Understand the Data

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

Data Sources: Watch Metrics (1)

Understand the Data

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

Data Sources: Watch Metrics (2)

Understand the Data

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

Data Sources: Other Metrics (1)

Understand the Data

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

Data Sources: Other Metrics (2)

Understand the Data

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

Data Sources: Other Metrics (3)

Understand the Data

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

Data Sources: Other Metrics (4)

Understand the Data

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

Data Sources: Other Metrics (5)

Understand the Data

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

Data Sources: Other Metrics (6)

Understand the Data

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.1
Date of Meeting:	07 September 2023		

Report Title:	SIRO Annual Data Security and Protection Assurance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	Discussed at Audit Committee 20th July 2023			
Prepared by:	Mark Arnold, Data Protection Officer (DPO) Jon Burwell, Chief Information Officer (CIO)			
Executive Sponsor	Naginder Dhanoa, Chief Digital Officer			
Appendices (list if applicable):	None			

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

Executive Summary:
This report is the quarterly SIRO report, providing an update on progress made by the organisation since the last report. It highlights areas of improved compliance, and areas of concern within the Trust's compliance with statutory and regulatory standards overseen by the Information Commissioner's Office (ICO). This report confirms that the Senior Information Risk Owner, Chief Information Officer, Data Protection Officer, and members of the IGSG, regularly, scrutinises the Trust Risk Register, in compliance with the DSPT, and legislative standards. Where appropriate, action is taken to improve performance and compliance with the Trust's risk management and governance framework. The Trust's Freedom of Information compliance consistently exceeds the 90% set by the ICO. There was an FOI complaint upheld against the Trust during the year for failure to follow the correct procedure. The Trust self-declared two incidents to the Privacy Regulator the Information Commissioners Office (ICO). The ICO assessed each and found no actions would be taken against the Trust. The report confirms that the Trust has successfully submitted the 2022/23 DSPT assessment. The work programme associated with Data Protection Impact Assessments (DPIAs), asset management and subject access requests continue to be closely monitored. The Trust's Data Protection Officer continues to fulfil their statutory duties by being accessible to patients, staff and the Trust, providing advice and guidance on privacy related matters and acting as the contact for the ICO. Any areas of concern are discussed documented and escalated to senior management.

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. Introduction and Purpose

1.1. This report confirms and combines the final Data Security and Protection Toolkit (DSPT) submission report and the Data Protection Officer yearly report.

1.2. This report serves to inform and advise the Board of the Trust's statutory compliance, whilst recognising areas of good practice, to ensure personal and corporate information is handled legally, securely, efficiently and effectively to deliver the highest standard of care by staff and the organisation. Information Governance plays a vital role as the foundation of all governance by supporting integrated governance within the Trust.

1.3. It provides an update on progress made by the organisation since the last submission. It highlights areas of improved compliance and areas of concern within the Trust's compliance, with statutory and regulatory standards overseen by the Information Commissioner's Office (ICO).

1.4. In addition, the report provides an update on progress made in respect of our mandatory cyber security programme and the 2022-2023 Data Security and Protection Toolkit assessment.

2. Data Security and Protection Toolkit 22-23

2.1. For 2022-23, the DSPT assessment contained 113 mandatory evidence items compared to 100 in 2021-22. On 30th June 2023 the Trust submitted a 'Standards Met' assessment. The information contained within this report was used as part of the DSPT assessment.

2.2. In February 2023, the DSPT assessment was subject to the annual internal audit. The findings showed there was substantial assurance and the confidence level in the evidence submitted was high.

1	2	3				4		5
		Assertion level Risk Assessments				NDG standard level Risk Ratings		Overall DSP Toolkit level Ratings
National Data Guardian (NDG) Standard	Number of DSP Toolkit Assertions Assessed by Independent Assessor	Number of Assertions rated **Critical**	Number of Assertions rated **High**	Number of Assertions rated **Medium**	Number of Assertions rated **Low**	Risk Rating Scores [total points/ no. assertions assessed- see table 4.]	Overall Risk Rating at the National Data Guardian Standard level [see table 5.]	**Overall risk assessment across all 10 NDG Standards**
1. Personal Confidential Data	1				1	1	Substantial	Substantial
2. Staff Responsibilities	1				1	1	Substantial	
3. Training	1				1	1	Substantial	
4. Managing Data Access	3				3	1	Substantial	
5. Process Reviews	1				1	1	Substantial	
6. Responding to Incidents	1				1	1	Substantial	
7. Continuity Planning	2				2	1	Substantial	
8. Unsupported Systems	1				1	1	Substantial	
9. IT Protection	1				1	1	Substantial	
10. Accountable Suppliers	1				1	1	Substantial	
TOTAL	13				13			

PwC Internal audit re

3. Information Asset Management

3.1. There is a requirement in the Data Security and Protection Toolkit (DSPT) to ensure that an asset register is maintained. There is also a requirement to ensure that systems (assets) are assessed regularly to determine their level of risk and if required, that the risk is acted upon.

3.2. The Asset Register is a list of all known systems within the trust. It details the purpose of the system, who the Information Asset Owners (IAO's) and Information Asset Administrators (IAA's) are and the risk associated with each system. There are a total of 285 known assets as of 30th June 2023. The

systems have been assigned a business continuity management (BCM) level based on the impact to the Trust if the system was unavailable.

3.3. Information is added to the register throughout the year and entries are added when new assets are used. There are various workstreams to assess each asset and its security tools. This can include a DPIA, a DTAC assessment, system audit reports and security logs. The DSPT makes recommendations on complex passwords, multi-factor authentication and user accounts. Summary information about the Trust's key systems are listed at appendix A.

3.4. In addition to DPIAs and DTACs, basic due diligence checks are completed for suppliers. This is done for new suppliers and also updated annually for existing suppliers. Due diligence checks showed the following companies had breaches reported in the last 12 months:

Company	Year	Details	GWH Impact
Apetito	2022	Frozen food manufacturer used by the NHS was the victim of ransomware gang Hive.	None known
Advanced	2022	Advanced systems, which included Adastra that was used by NHS 111 and others was hit with a cyber-attack. Attack had an impact on the Child Protection Information System (CP-IS) used by national safeguarding teams	Patients impacted predominantly. Communications interrupted. SCR had to be used as an alternative
Apogee	2023	Exploitation of a Critical RCE Vulnerability in PaperCut, the managed printer services.	Servers offline during investigation.

3.5. The Trust is also required to maintain a Register of Processing Activities under the GDPR. Previously, the Trust has done this on separate spreadsheets known locally as data flow mapping. The IG team update the log at least annually with new data flows that have been identified through DPIAs, contracts and sharing agreements. From 2022/23, the DSPT required that the data flows are recorded on the same document as the information assets.

3.6. In late 2022/23, the IT and IG teams began a collaborative programme of work between Salisbury NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust to review our separate asset registers. They will be brought into a consistent format that will support key work across the Trusts and comply with the recommendations within the DSPT to record assets and data flows together.

4. Current Risk Level

4.1. The number of risks being overseen by the IGSG Members has decreased by 1 since June 2023. **Table 1** below provides a breakdown of the risks by Division. The split is as follows:

Division/Department	No. of Risks May 2022
Transformation and Informatics	40
Clinical Support and Family Services	11
Surgery	8
Organisational Development and People	4
Facilities	2
Finance and Procurement	1
Operations	1
Medicine	2
Total	**69**

5. Top Three Risks 1.3.6

5.1. There are two risks owned by Informatics, one scoring 6 and the other scoring 12. Risk 5546 relates to the Microsoft licence being used by the Trust's subsidiaries. It was approved at Informatics DMC on the 16th December 2022 to Accept this risk. Whilst risk, 7180, is associated with the Log4j, cyber security vulnerability which is being overseen by the National Cyber Security Centre.

5.2. The Trust continues to proactively engage with both suppliers, the NHS National Cyber Security Centre (NCSC) and NHS Digital to apply updates for Log4j as they are released. Whilst older versions of Log4j are not directly relevant to the critical CareCERT, there is still challenge being put to suppliers to update to the latest version. Since the last report, there has been a 62% reduction in the number of servers vulnerable to Log4j and the figure now stands at 30.

5.3. The NCSC have confirmed to all NHS Trusts that the existence of the Log4j vulnerability will not adversely affect the Trust's 2022-23 DSPT submission.

6. CareCert Compliance

6.1. The Trust is signed up to receive notification from the Data Security Centre, part of NHS England (formerly NHS Digital). Threat intelligence bulletins are issued by NHS Digital weekly via email when assessed as medium or low severity. High severity threats are immediately sent to organisations, rather than waiting for the weekly bulletin.

6.2. If a high severity 'CareCERT Alert' is received then these must be acknowledged within 48 hours with a status provided to NHS England which details whether the organisation is impacted. Actions, such as applying patches must then be completed within 14 days unless stated otherwise.

6.3. Appendix B has a list of the CareCERT alerts since 2021/22.

7. Unsupported Systems and Devices

7.1. SFT have the majority of our devices running the Windows 10 platform. All devices benefit from:

- Trend Apex One IDS/IPS/Anti Malware being installed and operational.
- This provides a layer of Virtual Shielding Protection using IDS/IPS rulesets.
- Being registered on MDE platform.

7.2. The following servers are no longer in support. The Trust's Trend product is deployed to the following operating systems to provide virtual security.

- Windows 7 – total computers 5
- Server 2000 – total computers 2
- Server 2003 – total computers 13
- Server 2008 – total computers 1

7.3. There is a migration plan in place and this approach has been shared with NHS Digital with migration dates supplied. The Trust has reduced the number of Windows 7 devices to 7 and continue to engage with NHS Digital to update on the actions to remove these devices. All the remaining devices are protected (virtually patched) by Trend Deep security.

7.4. The programme to migrate or decommission unsupported operating systems (servers) has suffered delays. We currently have 99 live Server operating systems remaining, this is a significant improvement in the past 7 months, the improvement in throughput is directly linked to how delays

have been addressed, as part of the routine review withing program board meetings and prioritise as required. Trend Deep security (Virtual Patching) is used on remaining servers.

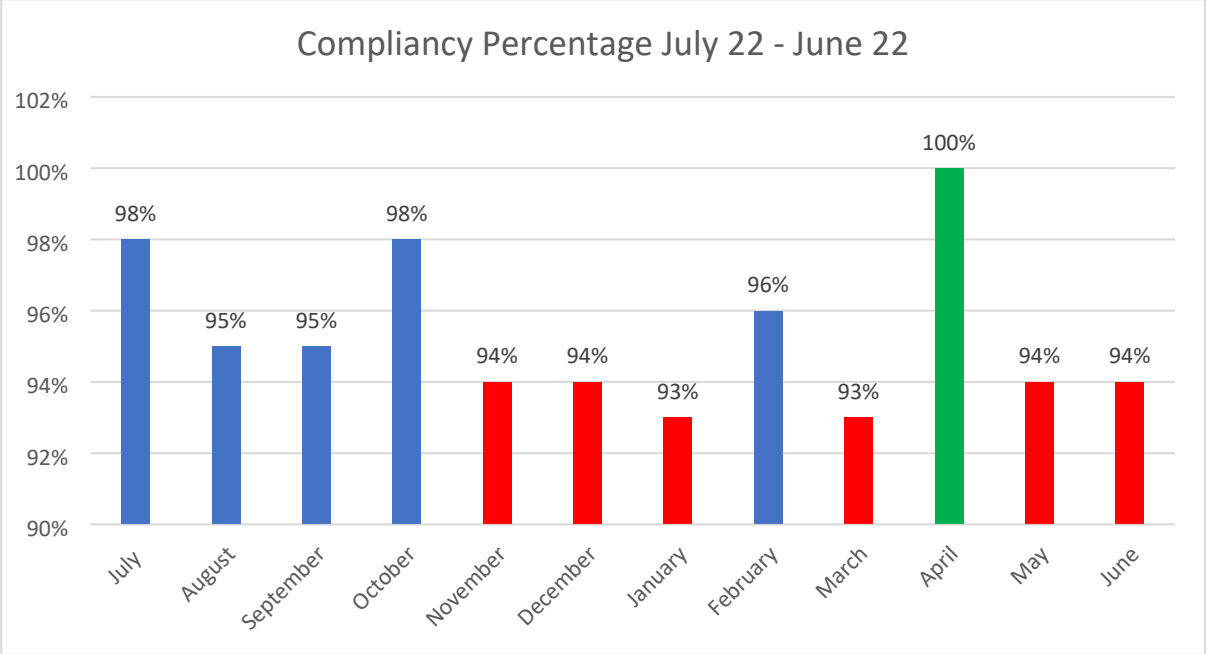
8. Freedom of Information (FOI) Compliance

8.1. Between 1st July 2022 and 30th June 2023, the Trust received 607 requests for information. 16 were processed as line of business requests and the remaining 591 as FOI's.

8.2. The Trust applied 33 exemptions. The breakdown of the exceptions is as follows. Two related to Section 38, Health and Safety. 9 sighted Section 36, the release of information would prejudice effective conduct of public affairs. 5 sighted Section 43 and therefore would have resulted in legal action being taken against the Trust by breaching the commercial interests of a third-party. 13 sighted Section 12 and were refused on the grounds of cost for exceeding the appropriate 18hr time limit. 6 Section 40 exemptions were applied prohibiting the release of personal data. One Section 23 and one Section 24 were applied around the protection of national security.

8.3. 25 FOIs responses breached the 20 day response timeframe in between July 2022 and June 2023.

8.4. The ICO has mandated that authorities must respond to 90% of requests within 20 working days. **Chart 2**, below, confirms the Trust is now consistently exceeding the 90% target, average being 95%.



8.5. **Internal Reviews**

8.5.1. The Trust received correspondence from four requestors challenging the Trust's decision to apply an exemption under Section 17(7) of the FOI Act 2000. It is the responsibility of the Data Protection Officer/FOI Lead and Director of Integrated Governance to conduct the internal review process.

- In response to FOI 6677 - internal review, the FOI asked the Trust around EPRR Planning - the response confirmed the original decision to exempt release of information.
- In response to FOI 6824 - internal review, the FOI asked the Trust to supply details of data centre information. On balance, and with reference to the FOI Act and NIS Regulation, it is believed the release of this information requested would compromise the security of the Trust's IT network. The section 36 exemption notice was upheld.

- In response to FOI 6901 – internal review, the FOI asked the Trust to supply information around agency staff and costings, requesting the names of the most expensive agency and how much they charge. Section 43 was applied. Internal review finding the Trust supplied the most expensive cost but not naming the agency.

- In response to FOI 6908 – internal review, the FOI asked the Trust to supply information around staffing, disciplinary's, appeals over 5 years. A section 12 was applied around this collation of information going over 18 hours. – The response to the internal review – The decision was upheld but an estimated break down of costing was also supplied should the requestor wish to proceed.

8.6. In November 2022, FOI 6677 was escalated to the ICO by the requester. The ICO upheld the complaint and stated that SFT did not follow the correct procedure. The Trust had incorrectly stated that it could not confirm or deny holding the information and subsequently had not applied an exemption. The information was provided to the requester following the outcome.

9. Mandatory UK GDPR, Information Governance and Cyber Security Training

9.1. This report confirms that as of the 30th June 2023 the Trust exceeded the minimum target, which requires at least 95% to have successfully completed annual Data Security and Awareness training between 1st July 2022 and 30th June 2023. Details of the requirement are set out in DSPT Standard 3.1.

9.2. **Table 3** below provides a breakdown of the percentage compliance by Division.

9.3. Clinical Support and Family Services and Women and New-born achieved a 97%, whilst Surgery had a slight decline year on year to 90%. The Medicine Division had the biggest increase year on year to 93% which previously was at 86%.

9.4. Facilities (99%) and Quality (100%) were the strongest performers. Surgery as highlighted above, and the Corporate Division requires the most improvement (latter also at 90%).

IG TRAINING COMPLIANCE BY DIVISION/DIRECTORATE

	Number complete	Number incomplete	Number in target group	Compliance
Clinical Support & Family Services (Direct)	867	30	897	97%
Corporate Directorate (Direct)	1114	130	1244	90%
Facilities Directorate (Direct)	261	2	263	99%
Medicine Directorate (Direct)	766	58	824	93%
Quality Directorate (Direct)	73	0	73	100%
Surgery (Direct)	1004	113	1117	90%
Women and Newborn (Direct)	225	13	238	95%
Trust Totals	**4310**	**346**	**4656**	**93%**
Adjustments (based on average errors in MLE data and any adjustments for any known necessary corrections)		120		
Revised Totals	**4310**	**226**	**4536**	**95.02%**
Report database last refreshed on 17/01/2022 at 09:02:58	KEY:	0-79%	80-94%	95-100%
** Data extracted from the 'Corporate' numbers*				

9.5. The Data Security and Protection Toolkit requires the Trust to report the number of Trust Board members who are compliant with their relevant data and security protection training. An extract from the Managed Learning Environment (MLE), confirms 100% of the substantive Executive Directors have completed their annual IG training.

10. Subject Access Requests

10.1. The Trust's organisational oversight of the number of SARs being processed continues to improve and there is greater engagement across the organisation. The number of complaints about subject access requests being delayed beyond the statutory 1-month timeframe remains at 2 since October 2021.

10.2. All departments releasing and handling SARs maintain statistical compliance information which is incorporated into an overarching disclosure compliance report to IGSG measuring the trends, number of complaints received, in addition to lessons learnt and action taken.

10.3. In total, the Trust has responded to the following:

- 1335 medical records requests
- 13 Court Orders
- 96 Police requests
- 25 Inquests
- 7 employer/public liability
- 4 CCTV requests
- 251 Radiology/MRI images
- 7 OD&P/Occupational Health requests
- 59 requests from solicitors.
- The Occupational Health department processed 3 requests.

10.4. The Trust claimed two-time limited extensions on the grounds of complexity in relation to two employee requests which together took in-excess of 75 hours to complete.

11. External Data Security Incident Reporting

11.1. During the 2022/23 DSPT year, the Trust has submitted two notifiable incidents to NHS England, NHS Digital and the ICO.

11.2. DSPT Incident reference 28567, reported on the 5th of July 2022, related to a subject access request delay beyond the statutory timeframe of 30 days. The Privacy Regulator, the ICO decided not to take formal action against the Trust preferring to request the DPO to review its internal subject access procedures. A task which has now been completed.

11.3. On Friday 16th September 2022, Salisbury along with 18 other NHS Trust, experienced a national electronic patient record system outage (DSPT Incident: 29592). The system supplier Dedalus informed the ICO of the incident within the 72hr statutory timeframe. Dedalus are still awaiting to receive a decision by the ICO as to whether regulatory action may or may not be taken.

Ref	Date	Description	ICO Reportable?
32704	13/06/2023 15:18	The Teams link to the antenatal class with the participants' email addresses was sent via a calendar invite by mistake, where email addresses cannot be made blind to other attendees.	Not required to report
29592	27/09/2022 10:35	The Trust was notified by staff that the Trust's Electronic Patient Record (EPR), Lorenzo was off line.	DHSC/NHS England and ICO
28567	05/07/2022 08:09	A subject access request submitted to the Trust has breached the agreed extension time frame.	DHSC/NHS England and ICO

12. Recommendations

The Committee is asked to note this report, and in particular:

12.4.1 Data protection and information security risks are proactively managed by members of the IGSG on behalf of the Chief Digital Officer

12.4.2 The Trust submitted a Standards Met DSPT submission on 30th June 2022, with the internal audit confirming there was substantial assurance.

12.4.3 FOI compliance exceeds the 90% compliance figure set by the ICO for all Trusts. A complaint against the Trust was upheld against the Trust stating that we had not followed the correct procedure.

12.4.4 The Trust self-declared two incidents to the Information Commissioners Office (ICO). Both have been assessed as requiring no action and the remainder is still being considered by the ICO and NHS Digital.

12.4.5 The work programme associated with Data Protection Impact Assessments (DPIAs) and Asset Management continue to be closely monitored by the Data Protection Officer and IGSG Member.

12.4.6 The Trust's Data Protection Officer continues to fulfil their statutory duties by being accessible to patients, staff and the Trust. Providing advice and guidance on privacy related matters and acting as the contact for the ICO. Any areas of concern are discussed documented and escalated to senior management.

Appendix A: System Logon Specifications

System	Unique Usernames and Passwords?	Accessed by non-Trust personnel?	Any temporary or generic accounts?	Date and time of logons recorded?	Part of the Single Sign-On (SSO)?	Require complex passwords?
Acculink	Yes	No	No	Yes	No	Yes
Aria	Yes	No	No	Yes	Yes	Yes
AuditBase	Yes	No	Yes	Yes	No	No
BADGER net	Yes	No	No	Yes	Yes	Yes
Biotronik	Yes	Yes	No	Yes	No	Yes
Bloodhound	Yes	No	No	Yes	No	No
Bravo	Yes	No	No	Yes	No	Yes
Choose & Book	Yes	No	No	Yes	N/A	Yes
Coloplast	Yes	Yes	No	Yes	No	Yes
CRIS	Yes	Yes	No	Yes	Yes	No
CVIS	Yes	Yes	Yes	N/A	Yes	No
CYRES	Yes	No	No	No	No	No
DexCom	Yes	Yes	No	Yes	No	Yes
Dict8	Yes	No	No	No	No	Yes
DrDoctor	Yes	Yes	No	Yes	No	Yes
Epic	Yes	No	No	Yes	Yes	Yes
EPMA	Yes	Yes	Yes	No	Yes	Yes
ESR	Yes	No	No	Yes	No	Yes
GI Reporting	Yes	Yes	No	Yes	No	No
HESSDA	Yes	Yes	No	No	No	No
ICE Mobile	Yes	Yes	Yes	N/A	Yes	N/A
Infoflex	Yes	No	No	Yes	No	No
JAC	Yes	Yes	No	Yes	No	Yes
Lorenzo	Yes	Yes	Yes	Yes	Yes	Yes
MobiMed	No	No	Yes	N/A	No	Yes
NHS Mail	Yes	Yes	Yes	Yes	Yes	Yes
PACS	Yes	Yes	Yes	Yes	Yes	No
RAID	Yes	No	No	Yes	No	No
SBS Ledger	Yes	Yes	Yes	Yes	No	Yes
SystmOne	Yes	Yes	Yes	Yes	No	Yes
Tdoc	Yes	Yes	No	Yes	N/A	No
Winpath	Yes	No	No	Yes	Yes	No

Appendix B: CareCERT Remedial Action

CareCERT High Severity Alerts since 2021/22:

Reference	Description	Actions
CC-3894	“PrintNightmare” RCE Vulnerability	Microsoft Patches.
CC-3948	VMware Server Vulnerabilities	Not applicable
CC-3989	Log4j 2 vulnerability	Various actions as directed by partners, suppliers and software providers
CC-4072	VMware Workspace Vulnerability	Not applicable
CC-4074	Vulnerability in Windows Remote Procedure Call Runtime	Some protection in place from Firewall Intrusion Protection System. Microsoft patch was tested prior to full release.
CC-4282	Critical Privilege Escalation Vulnerability in Microsoft Outlook for Windows	Patch tested and deployed to auto-update on devices.

NHS Salisbury NHS Foundation Trust

Report to:	Board of Directors	Agenda item:	3.2
Date of meeting:	7th September 2023		

Report tile:	Protecting and expanding elective capacity			
Status:	Information	Discussion	Assurance	Approval
	Yes			
Approval Process: (where has this paper been reviewed and approved):	N /A			
Prepared by:	Lisa Thomas, Chief Operating Officer			
Executive Sponsor: (presenting)	Lisa Thomas, Chief Operating Officer			

Recommendation:

The Board to note the draft completion, and delegate final sign off for submission to Septembers Finance and Performance Committee.

Executive Summary:

The Trust received a national letter on the 4th August focusing on protecting and expanding elective capacity during winter. Boards have been asked to consider several questions regarding outpatient activity namely:

- Identifying more opportunities for outpatient transformation
- Set an ambition that no patient in the 65-week cohort will be waiting for a first outpatient appointment after 31st October 2023.
- Maintain an accurate and valid waiting list, by ensuring that at least 90% of patient waiting over 12 weeks are contacted and validated by 31st October 2023.
-

The Board need to sign off the **self-certification process by the 30th September** 2023.

The assurance template is in draft with some further work to review (challenging to complete due to the timing of letter received, annual leave and Board date).

The assurance template highlights that the Trust has an access policy in place, has processes for validation which are well embedded in the Trust. Planned Care board had already begun the process of ensuring focus shifted from inpatient/theatres to outpatient activity, as the focus area for ensuring outpatient transformation is embedded to achieve the key performance targets.

There are number of gaps which require further focus including, increased focus on PIFU, DNA and advice and guidance. The improvement plans are being worked through and more information will be shared with Finance and performance Committee.

The Trust has a number of patients on a non RTT pathway (in line with national guidance) further work is being undertaken to align demand and capacity to ensure waiting times across all areas reduce in line with the national objective. Further work is required in this area before the end of September sign off.

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

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS England regional directors

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

4 August 2023

Dear Colleagues,

Protecting and expanding elective capacity

In May, we wrote to you outlining the priorities for elective and cancer recovery for the year ahead. Last week, as part of the winter letter, we also asked you to maintain as far as possible ring-fenced elective and cancer capacity through winter.

We would like to thank you for your continued hard work in these areas, in the face of significant wider operational challenges, including ongoing industrial action. Thanks to the efforts put in by staff across the NHS, we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021 (and now representing c0.1% of the total list), and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today.

However, one area where we know there remains more to do is outpatients. We have listened to your feedback on the support you need for this transformation and have set out the next steps below.

National support for outpatient transformation

To support outpatient transformation, we have met with royal colleges, specialist societies and patient representatives to agree a way forward, working in partnership, to champion and enable outpatient recovery and transformation. At the ‘call to arms’, colleges agreed to:

- review their guidance on outpatient follow-ups
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically-informed access policies.

Together with this clinical leadership, we need to build on the expectation of freeing up capacity and increasing productivity. This can be achieved through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

We are continuing to provide support to trusts in this area, through the following:

- Regional support
- NHS England's GIRFT outpatient guidance
- Action on Outpatients series
- The Model Health System
- Support to specific trusts via NHS England's GIRFT Further Faster programme, NHSE Tiering programme and Elective Care Improvement Support Team (IST) – learning from the Further Faster programme will be shared in the Autumn
- Access to additional capacity through the NHS Emeritus Consultant programme
- Luna weekly data quality report, which can be accessed by contacting lunadq@mbihealthcaretechnologies.com and Foundry data dashboards
- RTT rules suite
- Elective Care IST Recovery Hub - FutureNHS Collaboration Platform
- Guidance on shared decision making.

Next steps on outpatient transformation

With the majority (c80%) of patient waits ending with an outpatient appointments, we need to increase the pace in transforming outpatient services to release capacity for patients awaiting their first contact and diagnosis. This will be particularly important ahead of and during winter, when pressure on inpatient beds can be at its highest. Nationally, achieving a 25% reduction in follow up attendances without procedures would provide the equivalent to approximately 1m outpatient appointments per month.

This letter therefore sets out further detail on three key actions that we are asking you to take:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.

- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

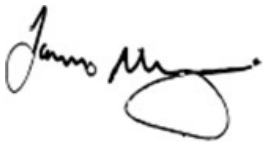
We are now asking trusts to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of the above priorities, we are asking each provider to ensure that this work is discussed and challenged appropriately at board, undertake a board self-certification process and have it signed off by trust chairs and chief executives by **30 September 2023**.

The details of this self-certification can be found at Appendix A. Please share this letter with your board, key clinical and operational teams, and relevant committees.

If you are unable to complete the self-certification process then please discuss next steps with your regional team.

Thank you again for colleagues' efforts in this area, which are making a real difference to the timeliness of care we deliver to patients. We look forward to receiving your returns and, as always, if you need to discuss this in more detail, or support in conducting this exercise, please contact england.electiverecoverypmo@nhs.net.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
Chair, Getting It Right First Time (GIRFT) Programme
NHS England

Appendix A: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

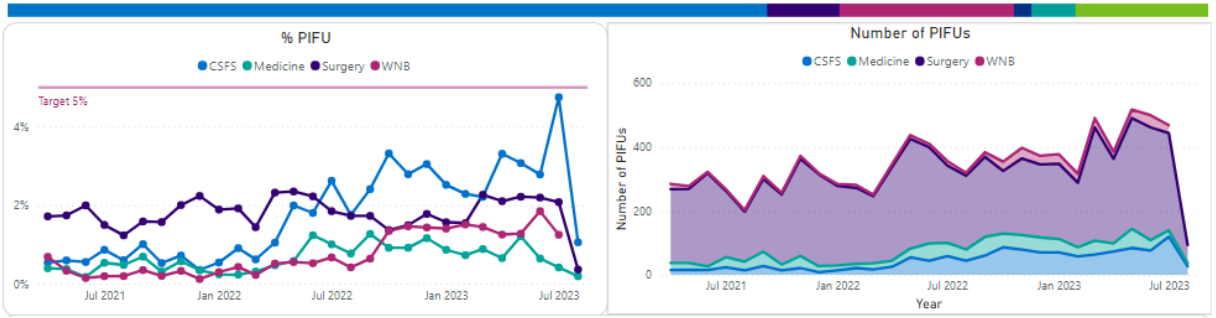
Trust return: [insert trust name here]

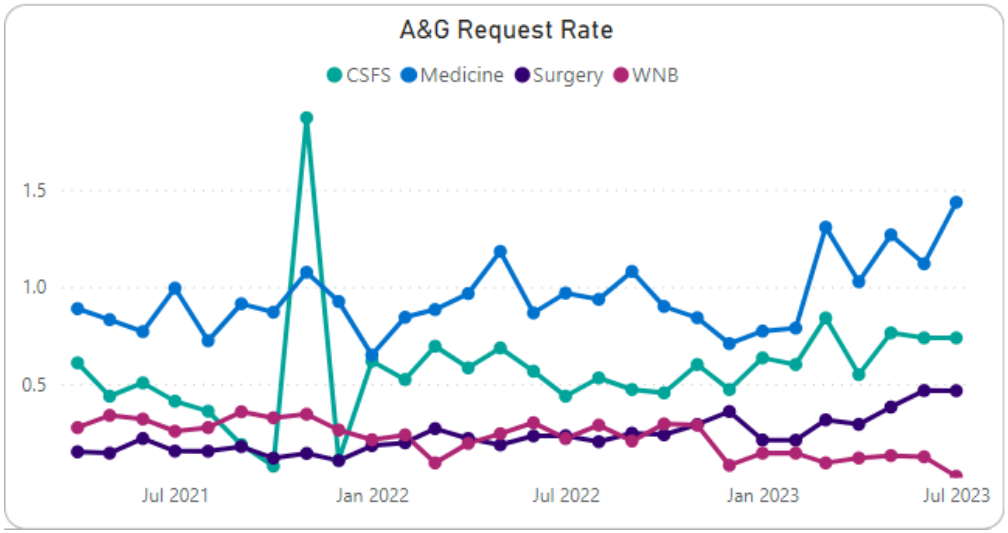
The chair and CEO are asked to confirm that the board:

Assurance area	Assurance/Comments
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.	The Trust did not record validation rates pre-covid and as such there is no documented comparator available. However, the Trust engaged Source Group to undertake an administrative validation exercise on the Trusts RTT waiting list which was completed in April 2022. Informatics have routine access to LUNA, however the tool is unable to utilize patient identifiable data and as such is unable to provide specific validation data, merely indications of where the Trust may find areas of DQ interest. The report is therefore utilised as a signpost for underlying data quality issues. The Trust has its own mechanisms for validation of DQ issues that have been developed over the year by the Access Manager and Validation and DQ Teams. In addition the Trust is currently embarking on the mobilization of the Outpatient Module of the CCS Tool, and is at the vanguard of the development of the CCS RTT Validation Module itself, which in themselves will provide DQ reports but unlike LUNA will be at a patient identifiable level allowing for directed and targeted action at specific individual pathways and as such ensure validation resources are used most effectively and efficiently. Information will be included to F&P Committee monthly on the numbers of patients validated per month as part of the RTT reported position (currently approx. 4,000 per week validated, of which 1700 are long waiters).
b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation.	There are currently 16,964 patients waiting over 12weeks. The Trust's validation team is currently insufficient to meet and maintain the requirements by the 31st October. As the Trust is currently embarking on the mobilization of the Outpatient Module of the CCS Tool (see comment above) this is seen as the sustainable and efficient way of validating. The tool is being rolled out between now and December 2023 which assuming success mitigates the need for additional workforce investment in expanding the validation team. An assessment has been made of the increase in staffing required to meet this target and has been communicated to System colleagues for review. In addition there are discussions with NHSE colleagues as to the potential engagement of NHS validation capacity for this work, subject to availability and funding.

C. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	The Trust's Access Policy has recently been revised and rewritten to reflect up to date NHSE guidance and formally adopted from August 2023. It has been reviewed as part of the Trust's Internal Audit of the Trust's waiting list management processes, by PWC in the last 9 months The internal audit found that the policy was being appropriately applied. Digital communication with patients is being developed via DrDoctor to enhance ease of communication and patient experience

d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	There are a number of patients on non RTT cohort which are currently being reviewed. As more theatre sessions are planned this gives the Trust more opportunity to increase capacity to address all pathways. More work is being undertaken to ensure clinical risk is managed appriopriately.
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.	Despite the monthly industrial action (IA) the Trust remains slightly ahead of trajectory for the actual numbers of 65ww as set out in SFTs signed off annual plan. However, the Junior Dr IA in particular has resulted in a significant, monthly loss of outpatient capacity which has impacted on progress. As of 21st August the Trust had 5798 patients in the 'at risk' 65ww cohort. 4868 of these are on a non-admitted (outpatient pathway). The Trust currently has circa 4213 awaiting a 1st Appointment. 590 have existing appointments booked, with a remainder of 3623 currently without a 1st Appointment date (3511 across 12 specialties). The clearance rate for this cohort of patients over the last 2 months has been circa 2789, requiring a 30% increase in aggregate clearance rate, but a 43% increase in clearance rate across the 12 specialties with the greatest number of patients awaiting a 1st Appt. Given that the consultant body has recently joined in industrial action. The ability to secure additional clinics in the context of increased industrial action means capacity remains challenged.
b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	BSW Independent Sector is predominantly commissioned, monitored and managed at a System Level. Progress against national targets is monitored through the respective divisional Executive Performance Review Meetings (EPR), supported by a number of other performance monitoring meetings including Delivery Group. Approval for outsourcing and Insourcing arrangements are reviewed and approved in line with the Trust's Governance structures. SFT engages with a number of both insourcing and outsourcing companies to support operational delivery, across Diagnostics, Surgery and Medicine. The Trust is registered with DMAS. To date the Trust has not needed to use this System beyond one Breast Reconstruction patient IPT's to Portsmouth.

3. Outpatient follow-ups The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan.	The Trust has a breakthrough objective of time to first outpatient appointment, which by default means a reduction in the number of Outpatient follow ups forms a significant component part of the improvement target. Reporting on this metric this is included in the Integrated Performance Report monthly. The Divisions monitor this monthly as part of the executive performance review. The Trust has not made the progress expected so far during 2023, and action plans are being escalated. Outpatient improvement programmes are taken through Planned care Board, the meetings scheduled for September to December are focused on outpatient improvement at specialty level. To date the Divisions have been focused on three key specialities to embed learning through improvement huddles. These have been Cardiology, Plastics, Gynaecology and ENT. The Divisions are working through the outpatient checklist over the last two months with a view that they will be reviewed at planned Care Board for prioritisation to produce one action plan for outpatient improvement. This will then be subject to targeted improvement for the next few months.
b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty.	PIFU remains part of the Trust improvement plans, there has been marginal improvement over the year, with pockets of improvement in some areas. 

c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments.	The Trust through the implementation of the DrDoctor platform is increasing the digital options for communication between the SFT and patients. Targeted work has been completed in Paediatrics to improve DNA rates (or Did not Bring for Paeds) which has showed marked improvement. The access policy has been updated and implemented which reflects national guidance.
d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking data (via the Model Health System and data packs) to identify further areas for opportunity.	The specialities are completing outpatient GIRFT checklists currently (due to Sept Planned care Board) to identify gaps and opportunities for improvements which also covers Advice and Guidance. Overall rates have increased, however capacity gaps in a number of specialities will hamper expansion. The work being undertaken at system level on the clinical strategy should also highlight opportunities for share Advice and Guidance to mitigate workforce gaps. 

e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	The Trust has a number of models in place for outpatient delivery including one stop clinics, nurse led clinics and group therapy appointments. The completion of the GIFT checklists by September will identify further actions to be considered at Planned Care Board and subsequently feed into outpatient deep dive at Finance and Performance committee.
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	

Sign off

Trust lead (name, job title and email address):	Lisa Thomas, Chief Operating Officer Lisathomas2@nhs.net
Signed off by chair and chief executive (names, job titles and date signed off):	Stacey Hunter, Chief Executive Ian Green, Chair

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	07 September 2023		

Report Title:	Risk Management Strategy			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	x	X
Approval Process (where has this paper been reviewed and approved)	Clinical Management Board 19th July Trust Management Board 23rd August			
Prepared by:	Louise Jones			
Executive Sponsor (presenting):	Judy Dyos			
Appendices (list if applicable):				

Recommendation:
To note the report and identify any areas requiring further clarity or focus. Trust Board are asked to consider and approve the Risk Management Strategy

Executive Summary:
The Risk Management Strategy sets out the strategic direction for Risk Management. It provides a framework for the Trust, specifying the direction of travel with objectives, responsibilities, and monitoring mechanisms.

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) -	☐

Risk Management Strategy

2023-26

Risk Management Strategy 2023 - 2026

Document Ratification:	
Directorate Responsible for Strategy:	Quality Directorate
Name of responsible board/committee:	Trust Board
Post Holder Responsible for Strategy:	Head of Risk Management
Contact Details:	Risk Management 01722 336262 x2496
Date Written:	April 2023
Approved and Ratified by:	Trust Board
Date ratified:	
Date Strategy Becomes Live:	
Next Due for Review:	

VERSION INFORMATION

Version No	Updated By	Updated On	Description of Changes
1.0	Head of Risk		Aligned to Improving Together. Updated Risk appetite

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1. Introduction

1.1 Risk Management is an integral part of Salisbury NHS Foundation Trust's (SFT) management activity and is a fundamental pillar in embedding high quality, sustainable services for the people of Salisbury and the surrounding area. As a complex organisation delivering a range of services in a challenging financial environment, we accept that risks are an inherent part of the everyday life of the trust. Effective risk management processes are central to providing Salisbury NHS Foundation Trust (SFT) Board with assurance on the framework for clinical quality and corporate governance. They also ensure the organisation focuses its efforts on the key risks and issues for our strategic goals.

1.2 The stated vision for Salisbury NHS Foundation Trust is to provide an outstanding experience for our patients, their families and the people who work for and with us. To ensure the care provided at SFT is safe, effective, caring, and responsive for patients, the board must be supported by a robust governance structure.

1.3 SFT is committed to developing and implementing a risk management strategy that will identify, analyse, evaluate, and control the risks that threaten the delivery of its critical success factors. The Board Assurance Framework (BAF) will be used by the Assuring Committees and Board to identify, monitor and evaluate risks to the achievement of the Trust's strategy.

1.3.1 The Improving Together approach used at SFT and across the Acute Hospital Alliance (AHA) in the Bath, Swindon, and Wiltshire (BSW) system is the way in which we will deliver our strategy. This approach ensures a small number of strategic goals, develops a culture of continuous improvement, and focuses teams on priorities and collective efforts to make improvements in the strategic goals. Improving Together introduces an operational management system which delivers ward-to-board escalation of the key issues and risks affecting delivery of our strategy. This will be achieved by the cascade of ward and speciality Performance Review Meetings (PRM) into the divisional Executive Performance Reviews (EPR), which in turn populates the Integrated Performance Report (IPR).

1.4 The management of risk underpins the achievement of the Trust's strategy. SFT believes effective risk management is imperative to not only provide a safe environment and improved quality of care for service users and staff, but also significant in the financial and business planning process where a successful and competitive edge and public accountability in delivering health services is required. This illustrates risk management is the responsibility of all staff. This is further overseen by the quality impact assessment process for any service changes.

1.5 The risk management process involves the identification, evaluation, and treatment of risk as part of a continuous process aimed at helping the Trust and individuals reduce the incidence and impacts of risks that they face. Risk management is therefore a fundamental part of both the operational and strategic thinking of every part of the service delivery within the organisation. This includes clinical, non-clinical, corporate, business, and financial risks. Improving Together supports staff across the organisation to have the tools, knowledge, and skills to manage risks as close to the operational delivery of services as possible.

1.6 The Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities. The risk management strategy represents a developing and improving approach to risk management which will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, effective performance management and accountability for organisational learning in order to continuously improve the quality of services.

1.7 The Trust Board recognises that complete risk control and/or avoidance is impossible, but the risks can be minimised by making sound judgments from a range of fully identified options and having a common understanding on risk appetite.

1.8 As part of the Annual Governance Statement, SFT will make a public declaration of compliance against meeting risk management standards. The Trust currently has good systems and process for risk management in place as evidenced by internal and external audit opinion.

1.9 The strategy is subject to review and approval by the Trust Board.

2. Purpose and Scope of the Risk Management Strategy

2.1 The purpose and scope of the Trusts Risk Management Strategy is to detail the Trust's framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health and Safety legislation, NHS Improvement (NHSI) compliance requirements, key regulatory requirements such as Care Quality Commission, and its strategic objectives. The Risk Management Strategy underpins the Trust's reputation and performance and is fully endorsed by the Board. The framework will enable the Trust to comply with health and safety legislation, its provider licence, and principles of good governance.

3. Responsibility for Risk Management

The success of the risk management programme is dependent on the defined and demonstrated support and leadership offered by the Trust Board as a whole.

However, the day-to-day management of risk is the responsibility of everyone in our organisation at every level, and the identification and management of risks requires the active engagement and involvement of staff at all levels. Our staff are best placed to understand the risks relevant to their areas of work and must be enabled to manage these risks, within a structured risk management framework. We will achieve this through teaching and utilising Improving Together's tools, behaviours, and management system.

The Trust has adopted an integrated governance approach to the management of risk. Integrated governance is defined as; "the systems, processes and behaviours by which we lead, direct and control our functions in order to achieve our organisational objectives and the safety, quality and value for money of services as they relate to patients and carers, the wider community and partner organisations".

Corporate Governance is the system by which an organisation is directed and controlled at its most senior level to achieve the Trust's objectives and meet the standards of accountability and probity.

The Trust is required to demonstrate that it is doing ''it's reasonable best to manage risk''. In practice, this means having systems and processes in place to identify, assess, evaluate and assign responsibilities to manage risks within the Trust. This is achieved by ensuring that risk management and corporate governance is an integrated process through which the organisation will identify, assess, analyse and manage risks and incidents at every level of the organisation and aggregate the results at a corporate level. The Trust, therefore:

- Integrates risk management into all decision-making processes
- Integrates risk management functions with service developments and clinical governance activity to unify frameworks and improve patient safety
- Implements a consistent approach to investigation of risks and incidents

4. Promoting a Fair and Just Culture

4.1 All members of staff have an important role to play in identifying, assessing, and managing risk. The Trust is committed to ensuring a 'Just and restorative Culture' of fairness, openness and learning in the organisation by supporting staff to feel confident to speak up when things go wrong, rather than fearing blame. In turn, this will encourage a culture and willingness to be open and honest to report any situation where things have or could go wrong. Executive and Non-Executive go & see visits support this approach by supporting teams to identify their key risks and review incidents in a learning environment. Exceptional cases may arise where this is clear evidence of wilful or gross neglect contravening the Trust's policies and procedures and/or gross breaches of professional codes of conduct which will be managed and referred accordingly.

When identifying a risk, consideration should be given to what could pose a potential threat (or opportunity) to the achievement of objectives within the context of the organisation. For example, whether the risk is strategic, programme or operational.

Risks and Incidents are often confused and a useful way of differentiating them is;

- Risks are things that may happen and prevent services and the Trust achieving objectives, or otherwise impact on the success of the organisation.
- Incidents are things that have happened, were not planned and require management action.

Once identified, the risk needs to be described clearly to ensure that there is a common understanding by stakeholders of the risk.

The recommended form for risk descriptions is to identify the cause, the event, and the effect. Appendix A includes guidance on how to record a risk.

5. Strategic Goals

5.1 To ensure that the Trust remains within its licensing authorisation as defined by NHSE and to deliver a risk management framework which highlights to the Executive Team and Trust Board any risks which may prevent the Trust from complying with its provider licence.

5.2 Continued development of the Board Assurance Framework (BAF) to ensure that organisation wide strategic risks are identified. The BAF enables the Board to demonstrate how it has identified and met its assurance needs and is also the vehicle for informing the Annual Governance Statement. The BAF aligns with the Trust's strategic goals.

5.3 To ensure that Risk Management policies are implemented ensuring that:

- All risks, including business risks, service development risks, and project risks, are being identified through a comprehensive and informed Risk Register and risk assessment process.
- The open reporting of adverse events/incidents is encouraged, and learning is shared throughout the organisation

5.4 To monitor the effectiveness of Risk Management Policies and procedures via the monitoring of agreed Key Performance Indicators.

5.5 To further develop the organisational safety culture and its effectiveness through implementation of local, regional, and national Patient Safety interventions.

5.6 To ensure that the Trust can demonstrate compliance with the statutory Duty of Candour ensuring that it maintains a consistent open and honest culture, involving patients and families in investigations where appropriate.

5.7 To ensure that all individuals within the organisation are aware of their role, responsibilities, and accountability with regard to Risk Management.

5.8 To ensure that the structure and process for managing risk across the organisation is reviewed and monitored annually via the operational management system the Trust is putting in place through its Improving Together approach.

5.9 To ensure compliance with NHSE, Care Quality Commission registration requirements, and Health and Safety Standards.

6. Compliance and Assurance

6.1 NHS England utilise a 'Single Oversight Framework' to ensure there is a clear compliance framework which ensures that all Trusts are able to demonstrate that they are remaining within their agreed provider licence. It is therefore imperative that the Trust is aware of any risks (e.g., associated with new business or service changes) which may impact on its ability to adhere to this framework.

6.2 The Board Assurance Framework provides the Trust Board with a vehicle for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being met to satisfy internal and external requirements. In turn it will inform the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance. This allows the organisation to respond rapidly.

6.3 All NHS bodies are required to sign a full Annual Governance Statement (AGS) and must have the evidence to support this Statement. The Assurance Framework brings together this evidence.

6.4 In order to identify the risks against delivery of principal objectives and gaps in control/assurance the Trust Board must have a comprehensive Performance Management Reporting framework. The Trust Board must agree its own indicators for Performance Reports which will act as assurance on service delivery and quality. Any significant gaps in assurance or control within the Performance reports must be identified, translated onto the Board Assurance Framework and remedial action agreed. Such gaps are identified from the sharing of information and discussion at the performance review and executive performance review meetings as part of the operational management system. These feed into the assurance committees.

6.5 The Board Assurance Framework is reviewed bi-monthly, in its entirety, by the Trust Board. The Framework identifies the principal risks facing delivery of the Trust's strategic objectives and informs the Trust Board how each of these risks is being managed and monitored effectively. Every risk on the BAF is assigned to an Executive Director who is responsible for reporting on progress to the Board of Directors. An Assurance Committee is also identified for each principal risk to assure the Trust Board that it is being monitored, gaps in control and assurance are identified, and processes put into to place to minimise the risk to the organisation.

6.6 The designated Assurance Committees of the Trust Board are the Clinical Governance Committee (Clinical Risk), the Finance and Performance Committee (Financial and Performance Risk), and the People and Culture Committee (Workforce and Health and Safety Risk). The Audit Committee monitors the Assurance Framework process overall biannually.

6.7 It is the responsibility of the Assurance Committees to report to the Trust Board, any new risks identified and gaps in assurance/control, as well as positive assurance on an exception basis. If a significant risk to the Trust's service delivery or gap in control/assurance is identified then this should be reported immediately via the Executive Directors, including the current controls, gaps in controls, current assurances, gaps in assurances, risk rating and mitigation and the rationale for escalation (see Appendix C).

6.8 The Director of Integrated Governance shall work closely with the Executive Lead for Risk (Chief Nurse), Chief Medical Officer, Chief Operating Officer, Chief Finance Officer, Chief People Officer, to ensure that the BAF remains dynamic and is integral to the Business Planning cycle.

6.9 If at any time performance reporting and risk management processes indicate that the Trust will not meet a current or future regulatory requirement/target then the Board must notify NHSI via an Exception Report.

7. The Trust Risk Register

7.1 Each Department will continue to carry out risk assessments which are held on Datix. A single framework for the assessment, rating, and management of risk is to be used throughout the Trust; this process is described in detail within the Risk Management Policy and Procedure (intranet), alongside how department risk registers are escalated, where appropriate to the divisional risk register.

7.2 Each Division will continue to maintain a comprehensive risk register, which will be formally reviewed in full at quarterly intervals, with key headlines and top risks presented monthly, through the Executive Performance Meetings. At these meetings the divisions will be expected to report on their divisional risk register (risks scoring 10 or above that require executive knowledge and support), highlight any new or emerging risks that threaten their service delivery or Divisional objectives and present action plans for minimising and managing these risks. The performance meeting should identify those departmental risks which also pose a corporate threat and so require escalation to the Trust's Corporate Risk Register. The risk register should be seen as a dynamic process as ranking/prioritisation of risks that will change as risk reduction practices take place. The Divisional Management Committee (DMC) has responsibility for ensuring that all risks within the Division are appropriately graded and have sufficient actions in place to mitigate/reduce the risk.

7.3 The departmental and divisional risks identified at the performance meetings, which impact on the corporate objectives, are combined with the corporate risks on the Trust's Corporate Risk Register, thus allowing for a bottom-up top-down approach to identifying the Trust's principal risks and informing the Board Assurance Framework. Risks can move up and down between risk registers depending on control measures being implemented and their success. This proactive approach to risk management should be holistic and identify all risks to the organisation, including clinical, organisational, health and safety, business, marketing and financial.

7.4 There is a requirement to detail, for every risk on the risk register, the plan for the ongoing management of the risk i.e., accept, tolerate or mitigate the risk. Where a decision is made to accept or tolerate the risk it needs to be documented where the decision was made and agreed. Risks that require mitigation must have an action plan.

8. Risk Management Policy

8.1 Risk assessments carried out across the Trust must utilise the format as set out in the Risk Management Policy and Procedure (available on the intranet). This process for submission and review must be adhered to.

8.2 This strategy should also be read in conjunction with the following Risk Management Policies which are all available on the intranet:

- Risk Management Policy and Procedure
- Adverse Events Reporting Policy
- Serious Incidents Requiring Investigation Policy
- Duty of Candour and Being Open Policy

9 Risk Appetite

The Board has agreed the following levels of risk appetite against the trust's strategic objectives.

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

Strategic Objective	Risk Appetite	Statement
Capability & Skills (Ensure our workforce have the capability and skills to deliver high quality, safe and effective Services)	Open	The Trust will continue to provide and review creative opportunities to develop our workforce to build the operational capability and skills needed to deliver our strategic priorities
Capacity (Ensure the Trust has the capacity to deliver high quality safe services and respond to the changing needs in our communities)	Open	Salisbury NHS Foundation Trust's appetite for risks relating to capacity has been set as open. The Trust is eager to change, innovate and provide an environment that stimulates new approaches to service delivery and improves clinical outcomes
Supporting our community's recovery from COVID-19 (Ensure the Trust can design and implement effective Covid19 Service response & recovery plans)	Open	Salisbury NHS Foundation Trust will have an open risk appetite to risks relating to ongoing management and recovery from Covid19. This openness will be reflected in decisions that increase the likelihood of positive outcomes for patients but also encompass wider improvements to service delivery models.
Compliance & Professionalism (Ensure the Trust acts as a role model for our teams and our communities by being	Cautious	Compliance is of the upmost importance. To reflect this Salisbury NHS Foundation Trust has a cautious risk appetite when making decisions

open, honest, and compliant with all regulatory and quality standards)		about any matter or risk that may influence compliance particularly in regard to safety, quality of care, legal implications and/or wellbeing of any person
Continuous improvement & Innovation (Ensure we constantly seek to improve and transform the way we work, to guarantee that our services can respond to the changing needs of our communities)	Open	Salisbury NHS Foundation Trust will have an open risk appetite when looking at continuous improvement and innovation. This openness will be reflected in decisions that increase the likelihood of positive outcomes for patients but also encompass wider improvements to service delivery models.
Infrastructure (Ensure the Trust implement appropriate, cost effective and innovative approaches to infrastructure that can deliver high quality, safe and person focussed care today, and in the future (Digital & Estates)	Open	Salisbury NHS Foundation Trust will have an open risk appetite to risk relating to our infrastructure. The Trust is willing to consider all potential options recognising that there is a need to continually improve and a failure to do so will impact on our ability to provide an outstanding experience for our patients, their families and the people who work for and with us.
Finance (Ensure we manage our finances effectively to deliver value to guarantee the long-term sustainability, quality, and safety of services)	Open	Salisbury NHS Foundation Trust's risk appetite for effective financial management is open. To constantly seek to improve and transform the way we work will require sound financial management whilst also maximising opportunities. However, the Trust will remain vigilant of any quality, resource, reputational and safety implications that may outweigh any perceived financial benefits.
Governance (Ensure the Trust has appropriate governance structures to deliver high quality, safe and person focussed care while improving and transforming the way we work, so our services can respond to the changing needs of our communities)	Cautious	Salisbury NHS Foundation Trust's natural position is to not tolerate risks that breakdown or impact our governance arrangements. However, we understand that to be averse may stifle improvement and transformation, therefore the appetite is agreed at cautious.
Wellbeing (Ensure the Trust can effectively support and promote a positive approach to staff wellbeing)	Open	We recognise that staff health and wellbeing is a key enabler to outstanding services. To achieve this, we shall have an open risk appetite so productivity, performance and the experience of our patients can improve because our staff are happy and well.
Integration & Partnership (Ensure we can work together to empower people to lead their best life)	Open	We will be cautious in our risk appetite when working with healthcare partners and other agencies to improve the health of the population. We acknowledge that risk exposure may exist in these decisions to work with others, so shall be open in our approach to those risks that could have quality, reputational and safety implications for patients and/or Salisbury NHS Foundation Trust.
Capacity (Ensure the Trust has the capacity to deliver high quality safe services and respond to the changing needs in our communities)	Open	Salisbury NHS Foundation Trust's appetite for risks relating to capacity has been set as open. The Trust is eager to change, innovate and provide an environment that stimulates new

		approaches to service delivery and improves clinical outcomes

10. Risk Strategic Objectives 2023-2026

10.1 To monitor the effectiveness of the Risk Management processes and policies the following strategic objectives have been set and will be monitored via the Patient Safety Steering Group, Clinical Management Board, Clinical Governance Committee, Divisional Executive Performance Meetings and Assurance Committees.

Embedding the Patient Safety Incident Response Framework (PSIRF)
PSIRF is aligned to the Trust's Total incidents with moderate or high harm vision metric. It is a major step towards improving safety management across the Trust and will greatly support the key principles of a patient safety culture. It will support the Trust to understand how incidents happen, rather than apportioning blame on individuals, allowing for more effective learning and improvement, and ultimately making care safer for patients.
PSIRF removes the requirement that all/only incidents meeting the criteria of a 'serious incident' are investigated, allowing for other incidents to be investigated and for learning response resource to focus on areas with the greatest potential for patient safety improvement. The patient safety incident response plan (PSIRP) will outline how the Trust will respond to patient safety incidents reported by staff and families to continually improve the quality and safety of the care the Trust provides. The plan will set out how the Trust plans to respond to patient safety incidents to learn and improve through patient safety incident investigations (PSII's).

Monitoring of incidents to highlight trends and areas requiring further investigation/action

- Weekly review of all moderate, major, and catastrophic patient safety incidents through the weekly Patient Safety Summit.
- Provision of monthly incident report card at the Patient Safety Steering Group to support theming of all incidents and monitoring of high harm incidents.
- Support to Divisions to enable them to monitor themes and trends in reporting within their divisions, departments and specialties' and take remedial action, evidence learning and provide support enable wider sharing.
- Triangulation with PALS, Freedom to Speak Up and the legal Team to look at broader themes and learning.

Embedding risk management at all levels of the organisation – embedding a just culture

- Ownership of risks at a local level
- Enhance the use of risk registers at Departmental and Divisional level.
- Evidence that dynamic risk registers are held within all departments covering key risks
- Ensuring a transparent system for aggregation and escalation between departmental and Divisional risk registers, with the Corporate Risk Register and Assurance Framework.

Promoting reporting

- Ensure all staff are aware of their responsibility for reporting incidents.
- Participation in divisional meetings, departmental and Clinical Governance Sessions.
- Facilitation of "go see" safety walkabouts to coach staff to recognise and manage risks in their area using a Quality Improvement methodology.

Ensuring there is appropriate provision of training in line with:

Datix Incident Module training

- Datix Incident Investigation training
- Datix Risk Module training
- Delivery of Department/Divisional specific training to enhance the user experience of Datix and showcase functionality in relation to reports.

Ensuring compliance with 'Duty of Candour' requirements

- Ensure all staff are aware of their responsibilities through cascade of the Duty of Candour and Being Open Policy.
- Appropriate and responsive training as required by the Head of Legal Services.
- Monitoring of incidents through the weekly patient safety summit to ensure appropriate grading.
- Where Duty of Candour triggered liaise with clinicians to ensure they are aware of the correct notification and follow up procedures, feeding back to DMC's and teams where gaps identified.
- Monitoring of Duty of Candour compliance at Divisional Executive Performance Meetings.

The following KPI's are also in place:

- Achieve compliance with regulations and requirements as determined by NHSE.
- Maintain full registration with the Care Quality Commission, aiming for good.
- To demonstrate an increase in the number of reported incidents but a decrease in the level of actual harm.
- Support a culture where staff feel risk management processes are fair and responsive, evidenced through the annual Staff Survey.
- Compliance with current contractual requirements associated with the reporting and management of Serious Incidents - implementation of new Patient Safety Incident Response Framework.
- Evidence of shared learning from incidents via departmental governance meetings, Executive Performance Meetings, nursing, midwifery, AHP forum, share and learn, etc.
- Clear identification and mitigation of risks via the Risk Register and Board Assurance Framework.

11. Accountability and Responsibility Arrangements

The management of risk is an integral part of management and clinical practice. Every individual within the Trust is therefore responsible for identifying and managing risk.

The Chief Executive has overall responsibility for risk management within Salisbury NHS Foundation Trust.

The Chief Nurse has been designated as the responsible Executive Director and is supported in this role by the Head of Risk Management.

The sub committees of the Trust Board – the Clinical Governance Committee, the Finance and Performance Committee and the OD, People and Culture Committee- have been designated as the Assurance Committees.

The Audit Committee has a responsibility for monitoring the Assurance Framework processes.

The Assurance Committees are responsible for:

- Providing assurance to the Trust Board that high and extreme risks that threaten the corporate objectives have been escalated as requiring Executive support and are being managed via the Assurance Framework process.
- Reporting new extreme risks to the Trust Board and those where actions to mitigate the risk are out of the organisation's control or resource.
- Prioritising actions in accordance with the risk assessment process in conjunction with Trust Board priorities.
- Contributing to the risk reduction measures where appropriate.

Trust Board

As a unitary board the Trust Board is collectively accountable for risk management and has a responsibility to ensure that the Board provide review and challenge to support the management of risk. The Board is made up of both Executive and Non-Executive Directors.

The Trust Board shall review the Trust Corporate Risk Register, together with the Board Assurance Framework, a minimum of three times a year. Where the full Corporate Risk Register is not discussed, any new risks since the last meeting are highlighted to the Board. The Trust Board is responsible for reviewing the effectiveness of internal controls and sources of assurance, ensuring they are comprehensive and/or sufficiently independent. The Trust Board is also responsible for assessing the level of acceptable risk within the Trust Risk Register.

The Executive Directors have specific responsibilities for managing the Trust's principal risks, which relate to their portfolio. For example, the Director of Finance is the local risk manager for managing the Trust's principal risks relating to ensuring financial balance, and the Director of Nursing for managing the principal risks relating to infection control.
The Executive and Non-Executive Directors are responsible for ensuring that they are adequately equipped with the knowledge and skills to fulfil this role. Risk Management training sessions can be accessed via the Risk Department

Divisional Management Teams

The Divisional Management Teams have a key role where new risks are identified, at both a strategic and operational level, through which specific management action is taken in order to contain, manage, and mitigate identified risks.

The Divisional Governance Committee Risk Register should include all risks identified against the Divisional service plan objectives. Departmental risks scoring 10 or above should be considered for escalation onto the Directorate Governance Committee Risk Register. Where there are multiple departmental risks scoring 10 or above for the same issue i.e., staffing the Division may choose to include one Divisional risk for the issue and link the related risks as evidence.

The Divisional Governance Committee Risk Register should also include risks related to strategic and corporate objectives e.g., those relating to key performance targets.

Clinical Divisions Risk Registers shall be reviewed via the monthly performance meetings where the higher scoring risks will be discussed. The quarterly divisional deep dives provides further scrutiny and review for the lower scoring divisional risks.

For all non-clinical areas (i.e., Finance, Facilities, IT, OD &P), where a risk requires escalation, this is through the Trust committee governance structure up to the Trust management Committee and further to Trust Board if required.

It will then be agreed which risks require escalation to the assuring committees and/or inclusion on the Trust's Corporate Risk Register. Risks may be appropriately escalated to the Trust's Corporate Risk Register if:

- All action has been taken to minimise the risk, but the risk score remains 12 or above
- Trust wide consequences associated with corporate objectives have been identified
- Activity presents a risk at corporate level

The Risk Management Administrator and Head of Risk Management must be informed where it has been agreed to escalate a risk to the assuring committees and/or for inclusion on the Trust's Corporate Risk Register.

All Divisions have access rights to the Datix risk register module in order to manage their risk registers.

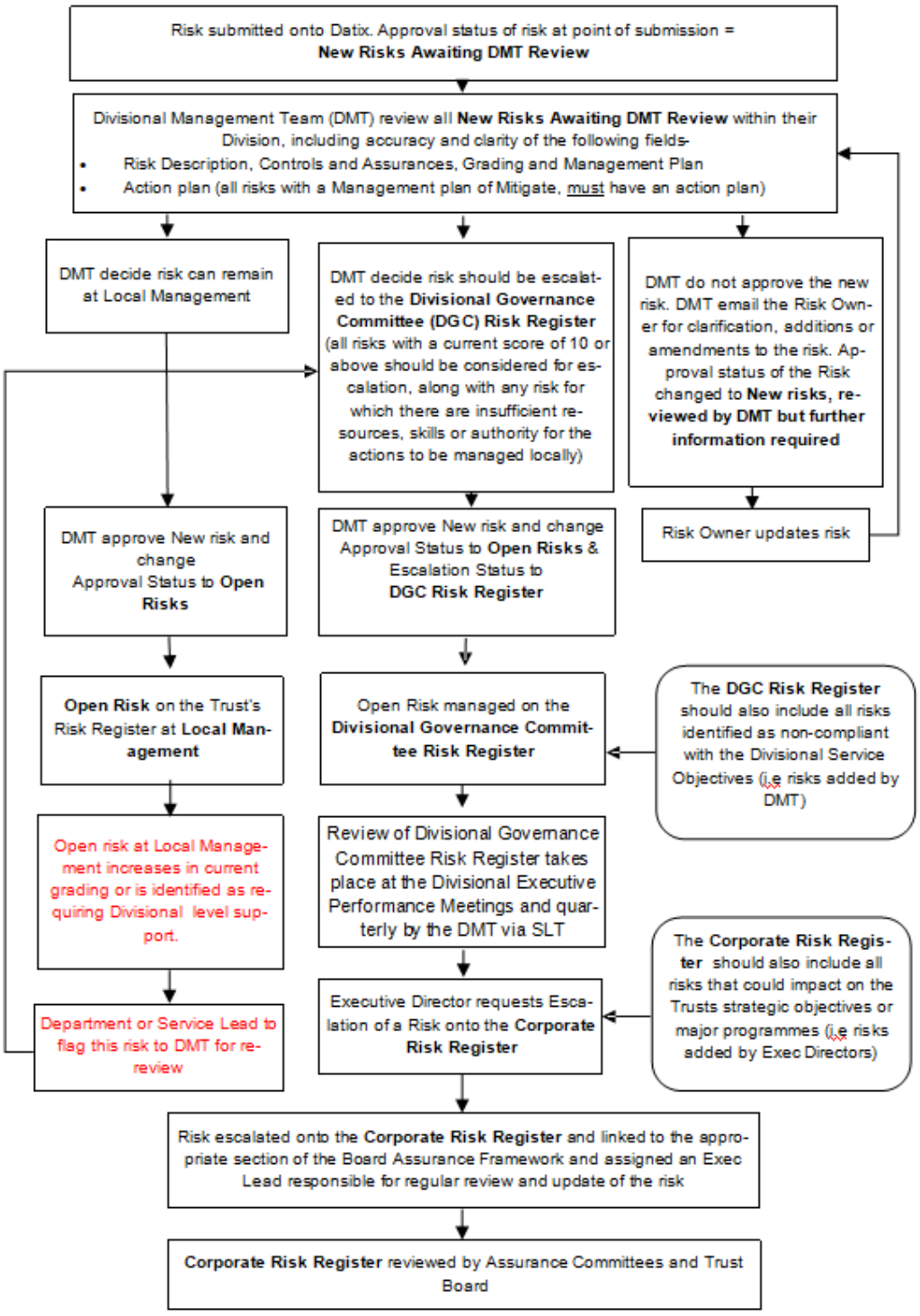
It is the Divisional Manager's responsibility to bring any new high/extreme risks to the attention of the Head of Risk Management and Risk Management Administrator.

12. Monitoring and Review

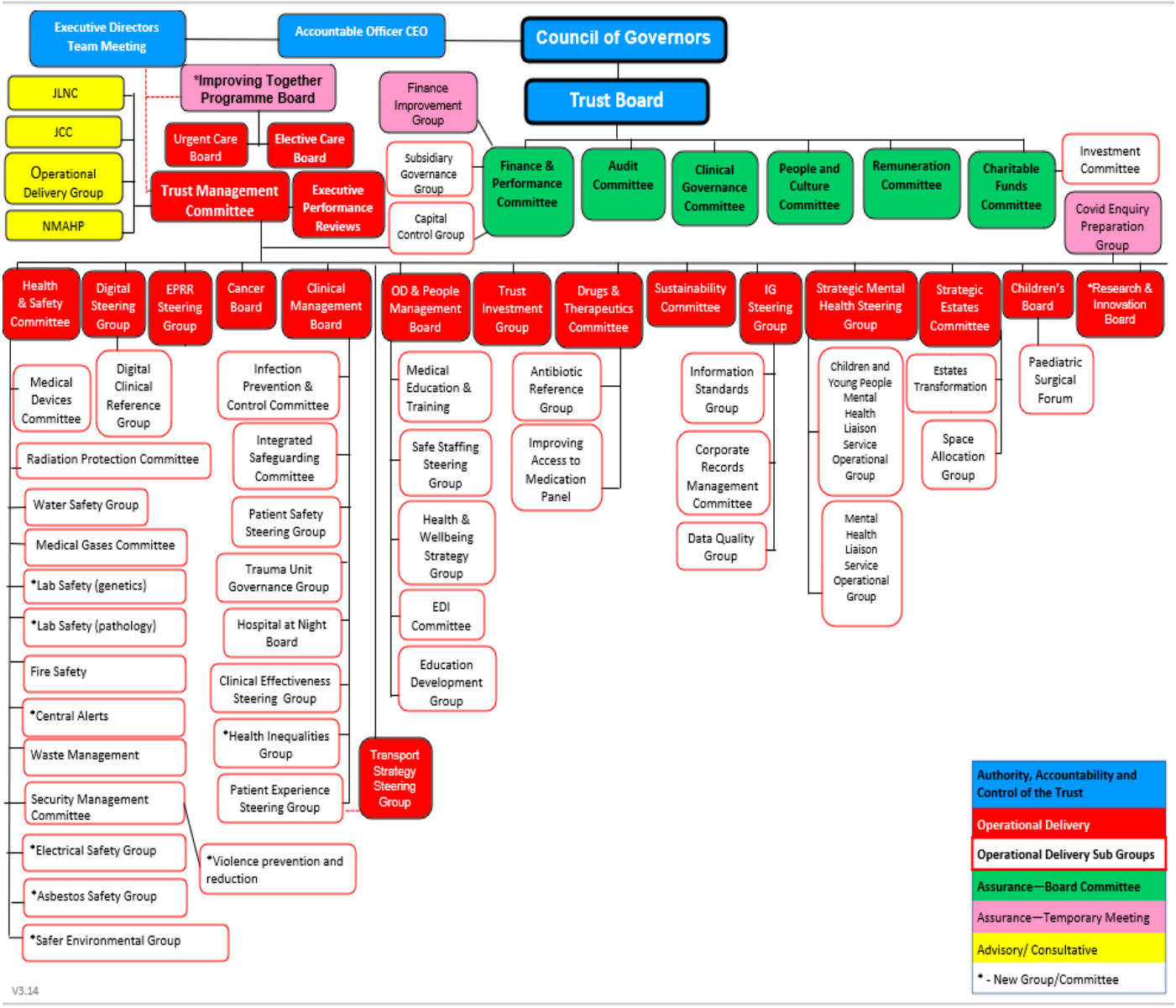
This Strategy shall be reviewed three yearly by the Trust Board.
The Head of Risk shall monitor that the process for managing risk locally is being complied with as per this Strategy and the Risk Management Policy and Procedure.

The overall implementation of this strategy shall be monitored through the annual internal audit review.

Appendix 1 Flowchart for the Escalation



Appendix 2 Trusts Governance Structure



NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.3
Date of meeting:	7th September 2023		

Report tile:	Maternity and Neonatal Quality and Safety Report for Quarter 1 2023/24			
Status:	Information	Discussion	Assurance	Approval
	X	x	X	
Approval Process: (where has this paper been reviewed and approved):	• Approved virtually via DMT • Noted at Divisional Governance – 25th July 2023 • CGC on 25th July 2023			
Prepared by:	Vicki Marston- Interim Director of Maternity and Neonatal Services.			
Executive Sponsor: (presenting)	Judy Dyos – Chief Nursing Officer			

Recommendation:

The Committee are asked to note the report.

CNST requirements state board minutes to note the following:

1. PMRT findings to be noted in board minutes
2. Compliance with labour ward coordinator being supernumerary and women receiving 1:1 care =100% in Q1

Executive Summary:

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

It will evidence current compliance with national reporting to include Care Quality Commission (CQC), Maternity Incentive Scheme (MIS) and Ockenden 2020 recommendations. It will also demonstrate patient experience and feedback and learning.

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

This report reflects data from quarter 1 23/24.

Positive points to note:

- Patient experience

- Safety Champions staff engagement
- Stillbirth and Neonatal death rate

Points needing to focus on

- Progress with Screening quality assurance action plan
- Ockenden compliance
- Progress on the Maternity safety support programme

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

Maternity and Neonatal Services Quality and Safety Report Q1 2023

Women and Newborn Division

Maternity Quality and Safety Report to Board Quarter 1 2023/24

Trust: Salisbury Foundation Trust

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

Maternity Safety Support Programme	Select Y / N	Yes

	2023/24											
	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1.Findings of review of all perinatal deaths using the real time data monitoring tool	✓	✓	✓									
2. Findings of review of all cases eligible for referral to HSIB	✓	✓	✓									
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	✓	✓	✓									
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	✓	✓	✓									
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									
7.Progress in achievement of CNST 10	✓	✓	✓									

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

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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.

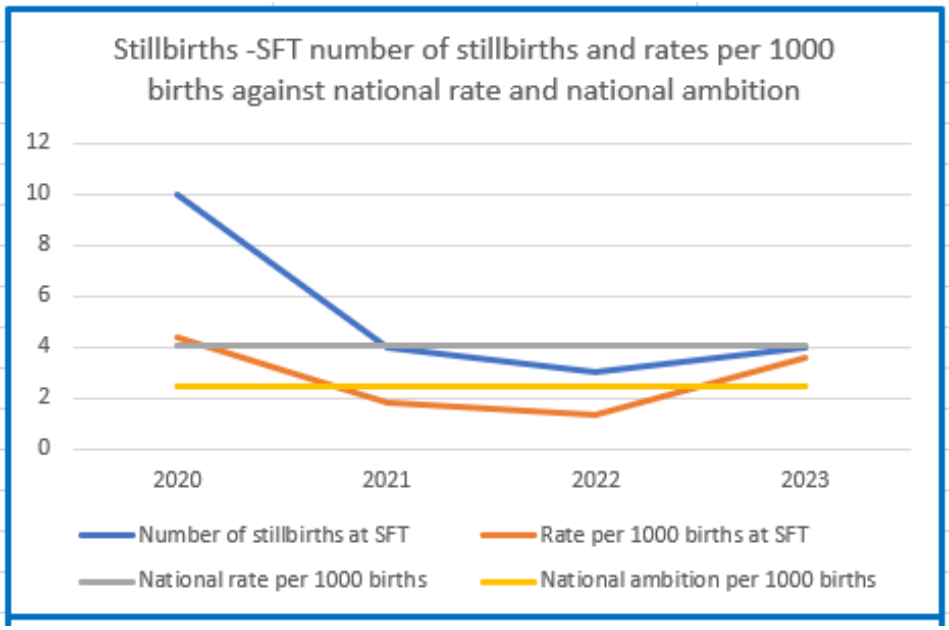
2.Good news stories

We ran a successful recruitment campaign throughout quarter 1 and have offered substantive posts to 12 midwives who qualify in September 2023, and 2.6 WTE band 6 midwives. Out of the 7 international midwives we have employed at SFT 4 have now passed their OSCE and are awaiting NMC pin prior to starting as band 5 midwives.

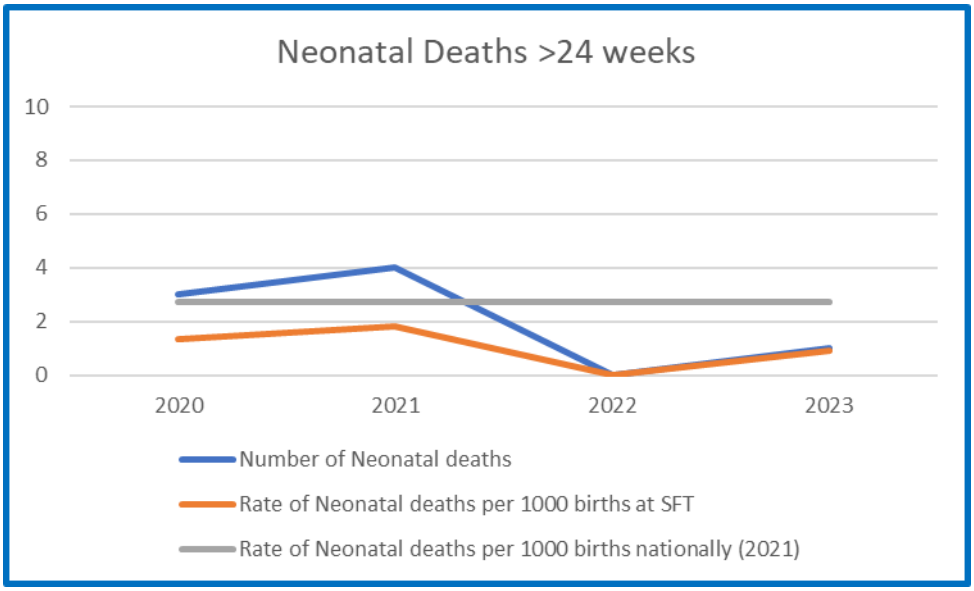
3.Perinatal Mortality Rate

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 Q1 we have had 1 stillbirth as detailed in the chart below, this makes a total of 4 in 2023 so far, which equates to 1.8 per 1000. The national rate per 1000 births is 4.1 per 1000 with a national ambition to reduce to 2.5 per 1000 births



In Q1 we had 1 reportable neonatal death



Perinatal Mortality Review Tool (PMRT) Summary Quarter 1 2023/24 (Maternity Safety Action 1)

Safety Action One requires evidence that Trusts are using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard.

Safety Action One sets required standards, as below:

a) All eligible perinatal deaths from 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) 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 they have sought from 30 May 2023 onwards.

c) 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) d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.

PMRT was designed and will be further developed with user and parent involvement to support high quality standardised perinatal mortality reviews on the principle of 'review once, review well'. Introduced in 2018 PMRT is a collaboration led by MBRRACE-UK, who were appointed by the Healthcare Quality Improvement Partnership (HQIP) to develop and establish a national standardised tool building on the work of the DH/Sands Perinatal Mortality Review 'Task and Finish Group'.

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 Q1 23/24 there were 9 pregnancy losses in Salisbury Maternity Unit, 3 met the criteria for MBRRACE notification, 2 met the criteria for MBRRACE surveillance and 2 met the criteria for PMRT review.

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

During Q1 2023/24 there was one outstanding case to be reviewed by the PMRT group from previous quarters.

Datix Number/PMRT ID	Incident Category	Outcome/learning/Actions
87885	Neonatal Death	Neonatal Death following Termination of Pregnancy for fetal abnormalities. Referral to Coroner as per national guidance. *
156236/88241	Neonatal Death	Neonatal Death following palliative care. Parental engagement is being sought to meet standard 1b. A review was conducted by the Quality and Safety Team to ascertain if antenatal screening was performed to the required national standard. The review found that antenatal screening was appropriate and that this case did not require further investigation aside from PMRT process.
154163/86616	Intrapartum Stillbirth	Intrapartum Stillbirth. MBRRACE notification and surveillance completed (Standard a). Factual information entered into PMRT tool within safety action 1 timescales, meeting standard c. Case referred to HSIB and will be reviewed through PMRT following the final HSIB report (first draft received for review of factual accuracy 10/7/23). HSIB seek parental engagement.

*To note:

MIS guidance suggests downloading a report generated through the PMRT tool to send to board.

As there were no cases reviewed in Q1 23/24 therefore is no report to download.

This report will achieve compliance with the required standard d and will be submitted to the board on a quarterly basis.

4. Healthcare Safety Investigation Branch (HSIB) and Maternity Serious Incidents (SI's)

Background

The National Maternity Safety Ambition launched in November 2015 aims 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.

HSIB undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

Maternal Deaths: 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 HSIB. There were no cases that qualified for notification to HSIB during Quarter 1 2023/2024.

5.Investigation progress update

Ref	HSIB Reference	Confirmed level of investigation	Date confirmed Investigation	External Notifications and Other Investigations
SII 555	MI-024309	HSIB Investigation	21/03/2023	Reported via STEIS. Draft report received from HSIB 10/7/23 for factual accuracy review.
Datix 156236/ PMRT 88241	MI-027643	Local Investigation	n/a	Referred to HSIB for opinion, but review of care demonstrated neonatal death due to congenital abnormalities and therefore out of scope for HSIB.

Coroner Reg 28 made directly to Trust

Nil in this reporting period.

Maternity Serious Incidents

During quarter 1 2023/24 there were 3 maternity Serious Incident investigations commissioned as follows:

SI number	Incident	Panel	Immediate Learning
SII570	Retained Swab	External Panel Chair identified, awaiting panel date	Reminder of Accountable Items, Swab, Instrument and Sharps Counts Policy sent to all staff working in maternity services / main theatres.
SII571	Placenta Acreta	Panel Chair identified, awaiting panel date	Shared learning for fundal height measurement when woman presents prior to commencement of planned serial scans.
SII574	Stillbirth	Panel Chair identified, awaiting panel date	An urgent review of all currently pregnant women with a history of uterine surgery with a low lying placenta at anomaly scan.

Investigations Action Compliance Tracker:

W&NB SII / CR Open Compliance Matrix

SII/CR No.	Link to Sheet	Directorate	Incident Date	Recommendation RAG Rating (Green = Completion Date, Amber/Red: Target Date)										
				1	2	3	4	5	6	7	8	9	10	11
SII 432	Click	W&NB	September 2021	Q3 21-22	June 22	Q2 22-23	Q2 22-23	Q2 22-23	Q2 22-23	Q2 22-23				
CR 454	Click	W&NB	December 2021	Q2 23-24	Oct 22	Oct 22	Q4 22-23							
SII 472	Click	W&NB	February 2022	Q1 22-23	Oct 22	Oct 22	Q3 22-23	Q3 22-23						
SII 477	Click	W&NB	April 2022	Q1 22-23	Q2 23-24	Jan 23	Q4 22-23	Q4 22-23	Q4 22-23	Q3 22-23	Q4 22-23	Q1 23-24		
SII 484	Click	W&NB	May 2022	Q4 22-23	Q1 23-24	Q1 23-24	Q1 23-24	Q1 23-24	Q2 23-24					
SII 489	Click	W&NB	May 2022	Q1 22-23	Dec 22	Q4 22-23	Q4 22-23	Q3 22-23	Q3 22-23					
SII 497	Click	Surgery	July 2022	Surg	Q1 23-24	Q2 23-24	Med	Apr 23						
SII 506	Click	W&NB	March 2021	CSFS	Jun 23	Q1 23-24	CSFS							
SII 510	Click	W&NB	August 2022	Q1 23-24	Q1 23-24	Feb 23	Feb 23	Feb 23	Jan 23	Jan 23	Q1 23-24	Jan 23		
CR 514	Click	W&NB	September 2022	Q3 22-23	Jan 23	Q1 23-24	Dec 22	Feb 23	Mar 23	Q1 23-24				
CR 527	Click	W&NB	October 2022	Q1 23-24	Q1 23-24	Jun 23	Apr 23							
CR 540	Click	W&NB	November 2022	Jul 23	Jun 23	Sep 23	Jul 23	Jun 24						

Colour Code		
No Evidence	Evidence of Progress	Evidence of Completion

In June 2023 there were 12 investigations open, containing a total of 62 actions. 22 of these actions remain unresolved. In May there were 31 unresolved actions, which demonstrates the work being undertaken within the Quality and Safety team to ensure learning from investigations is completed.

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 updates

Ockenden, 2020, set out 7 essential and immediate actions (IEAs). A regional assessment agreed with our internal assessment that we were 76% compliant.

Standard operating procedures and guidelines need to be identified and approved to achieve full compliance. It was also recognised that these 7 IEAs may be superseded by the full Ockenden report (2022) which was published on March 30th, 2022.

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.

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. Current progress is as follows:

Ockenden Actions

Ockenden 2020: Seven actions, separated into 22 local actions. Compliance has been assured for 13/22.

Ockenden Final Actions 2022: 15 essential actions, separated into 84 actions. Compliance has been assured for 16/84.

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 that are particularly relevant to both obstetricians and midwives:

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

- 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 individual compliance with above training modules. We have included this data to continue monitoring compliance during MIS year 5.

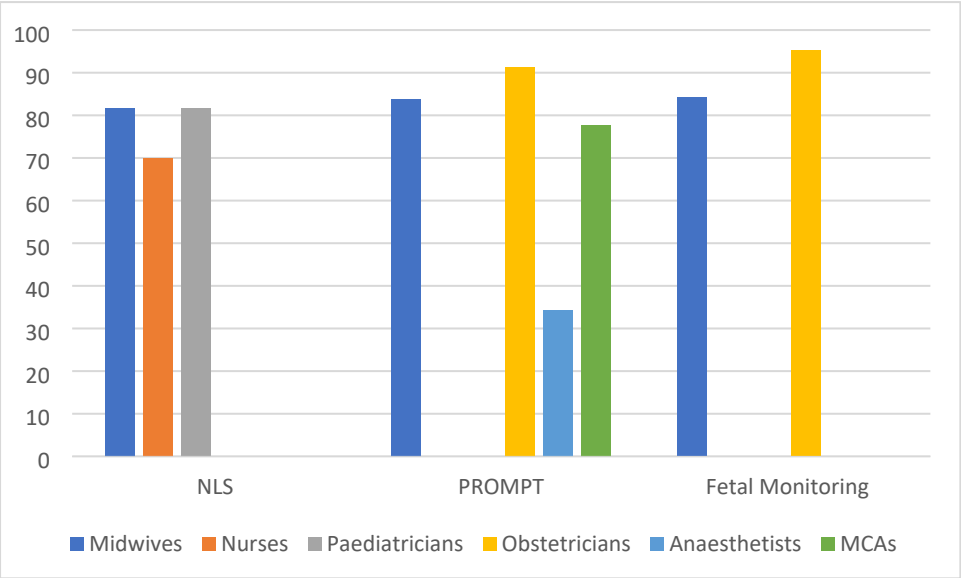


Figure 4 Key training by staff group (01.06.2023)

This chart shows full compliance for the obstetric staff group. PROMPT is non-compliant for anaesthetists however with a trajectory in place we expect to be fully compliant for anaesthetic training by submission date. Midwives and MCAs compliance is predicted to become over 90% compliant in Q2 based on staff bookings. NLS compliance is not above 90% for any staff group. Midwives are now completing NLS during PROMPT, a new method for 2023, so compliance will meet by December. Nurses and paediatricians have new GIC instructors – the low compliance in these staff groups has been escalated and a plan is in place to ensure compliance has been formulated by neonatal and paediatric leads.

9.Maternity and Neonatal Safety Champions meetings

In Quarter 1 bimonthly meetings for the Safety Champions continued in accordance with Safety action 9 of the Maternity Incentive Scheme.

Minutes can be accessed:

Safety Champion minutes May 2023.d

10.Saving Babies Lives V3

Update

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 and will be reported to Board next month.

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.

11. NHS Resolution Maternity Incentive Scheme Year 5 progress as of end Q1.

SFT self-declared that they were compliant with 5 out of the 10-safety action as defined in the Maternity Incentive Scheme year 4. Following publication of year 5 on 31st May 2023 we are benchmarking current position and have an improvement plan in place to move towards compliance of the standards. Regular meetings and review are supporting our expectation of improved compliance for 2024 submission.

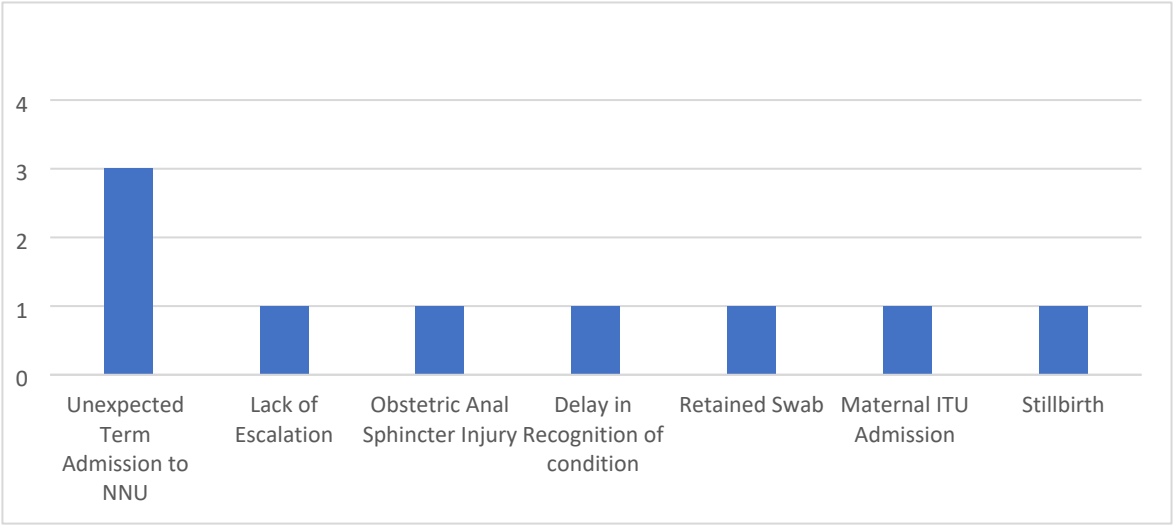
Are we well led?

NHSR Maternity Incentive Scheme – Year 5 – submission by 1st February 2024				
	Description	Yr 4 Submission	Comment	Current Assessment
1.	**Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Compliant	No issues identified or anticipated	
2.	**Maternity Services Dataset** Submission to required standard	Compliant	No issues identified or anticipated	
3.	**Transitional care Services** minimise separation of mothers and babies	Non-Compliant	Plan in place to achieve compliance.	
4.	**Clinical Workforce Planning** effective system	Non-Compliant	Work in progress. Compliance is achievable	
5.	**Midwifery Workforce Planning**	Compliant	No issues identified or anticipated	
6.	**Saving Babies Lives Care Bundle v3** compliance with all elements	Non-Compliant	New bundle published 31/5/23. Extra element for women with pre-pregnancy diabetes. Work in progress. Several barriers to achieving compliance. Compliance is achievable	
7.	**Service user involvement and co-production**	Compliant	No issues identified or anticipated	
8.	**Multidisciplinary Training**	Non-Compliant	Work in progress. Compliance is achievable	
9.	**Board Assurance** Board to Ward to Board	Non-Compliant	Awaiting ratification of new Maternity Governance Framework. Proposed changes to Trust Policy "Accountability and Integrated Governance Framework". Compliance is achievable	
10.	**HSIB and EN Reporting**	Non-Compliant	Awaiting ratification of new Maternity Governance Framework. Compliance is achievable	

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

12.The number of incidents logged graded as moderate or above

Figure 5: Summary of Moderate or above incidents in quarter 1 2023/24



Description of Moderate or above incidents in Quarter 1 2023/24

Datix number	Incident Category	Outcome/learning/Actions
156388	OASI	Local review as part of rolling audit
155592	Term Admission to NNU	Infant found to have congenital abnormality – local review
155624	Lack of Escalation	Learning shared with staff working in community settings regarding use of messages when verbal conversation required. Also working with LMNS to share encourage parents to contact maternity service 24/7 and not wait until next scheduled appointment
155929	Term Admission to NNU	No concerns on initial review of case, will be included in ATAIN review and rolling audit.
156305	Delay in recognition of condition	Clinical Review 559 commissioned.
156497	Retained Swab	Never Event. Serious Incident Investigation SII570 commissioned.
156623	Maternal ITU admission	72 hour review found no modifiable factors in care. Presented at Trust Patient Safety Summit. Local review agreed. Learning identified: There will be a review of local guidance for discharging women prior to receiving laboratory test results for pre-eclampsia.
156876	Stillbirth	Serious Incident Investigation SII574 commissioned

13.Safe Maternity Staffing

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to
provide safe care at all times to women and babies in all settings. Midwifery staffing is

reported separately to the Clinical Governance Committee and Trust Board biannually.

Midwifery Staffing

A bi-annual staffing review paper was submitted to clinical governance committee as per Maternity Incentive Scheme Safety Action 5 in Quarter 4 2022/23, a further report will be submitted in September 2023 as per requirement. Midwifery vacancies are monitored monthly through IPR and highlighted at Executive performance review monthly.

To ensure continued focus on them staff vacancies across the division remain 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.

Measure	Aim	March 23	April 23	May 23	Jun 23
Midwife to Birth Ratio	1:28	1:31	1:25	1:31	1:29
Supernumerary labour ward coordinator status	100%	100%	100%	100%	100%
1:1 care in labour	100%	100%	100%	100%	100%

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.

Whilst midwifery vacancies remain an ongoing challenge, several initiatives have been employed to maintain a safe service as detailed below:

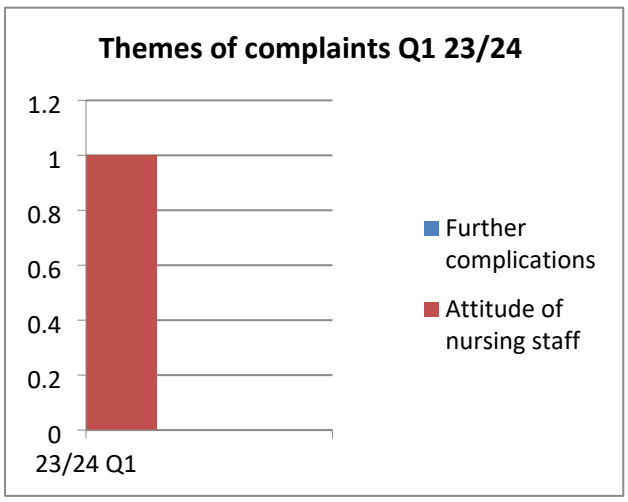
- A robust maternity escalation plan
- Registered General Nurse employed in clinical areas
- Over recruitment of maternity care assistants
- Engaged in collaboration to recruit International Midwives- we have 7 within the service, 2 have passed OSCEs, 2 with 1 to 2 elements to complete and further 3 awaiting exam.

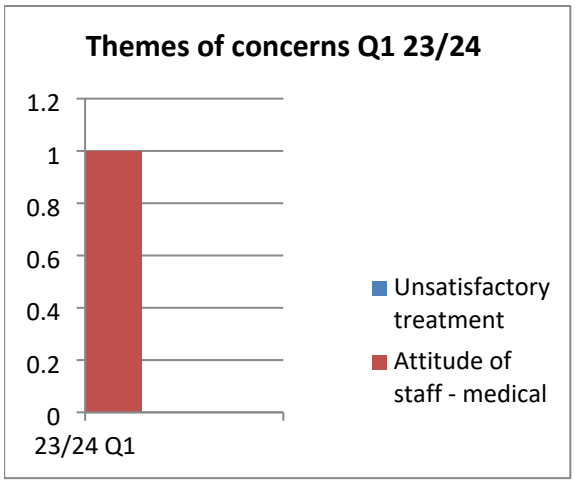
- Use of agency midwives
- Recruitment campaign to include executive agreed incentivised payment once in post
- Relocation package promoted
- Flexible working party to review working patterns

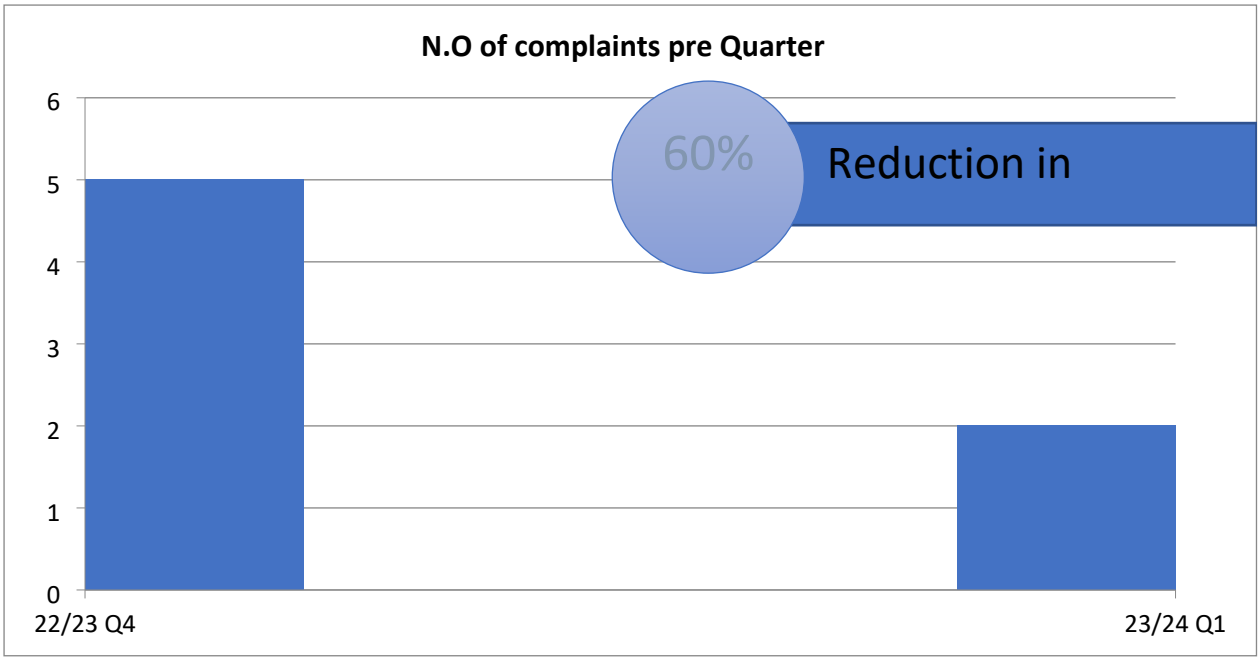
We have an ongoing recruitment campaign and have 14.6 WTE midwives who have accepted posts to commence work at SFT in the coming months, with further interviews in the coming weeks.
We continue to closely monitor staffing daily to ensure a safe service is maintained at all times.

14.Insights from service users and Maternity Voices Partnership Co-production

Themes of complaints and concerns:







Closures with target times:

There were 3 complaints and 2 concerns closed in Q1, with a 20% compliance rate to agreed target times.

Actions:

- Complaint training to be offered to all staff involved in responding to or leading on complaint investigations.

Agreed actions form Closed complaints and concerns in Q1.

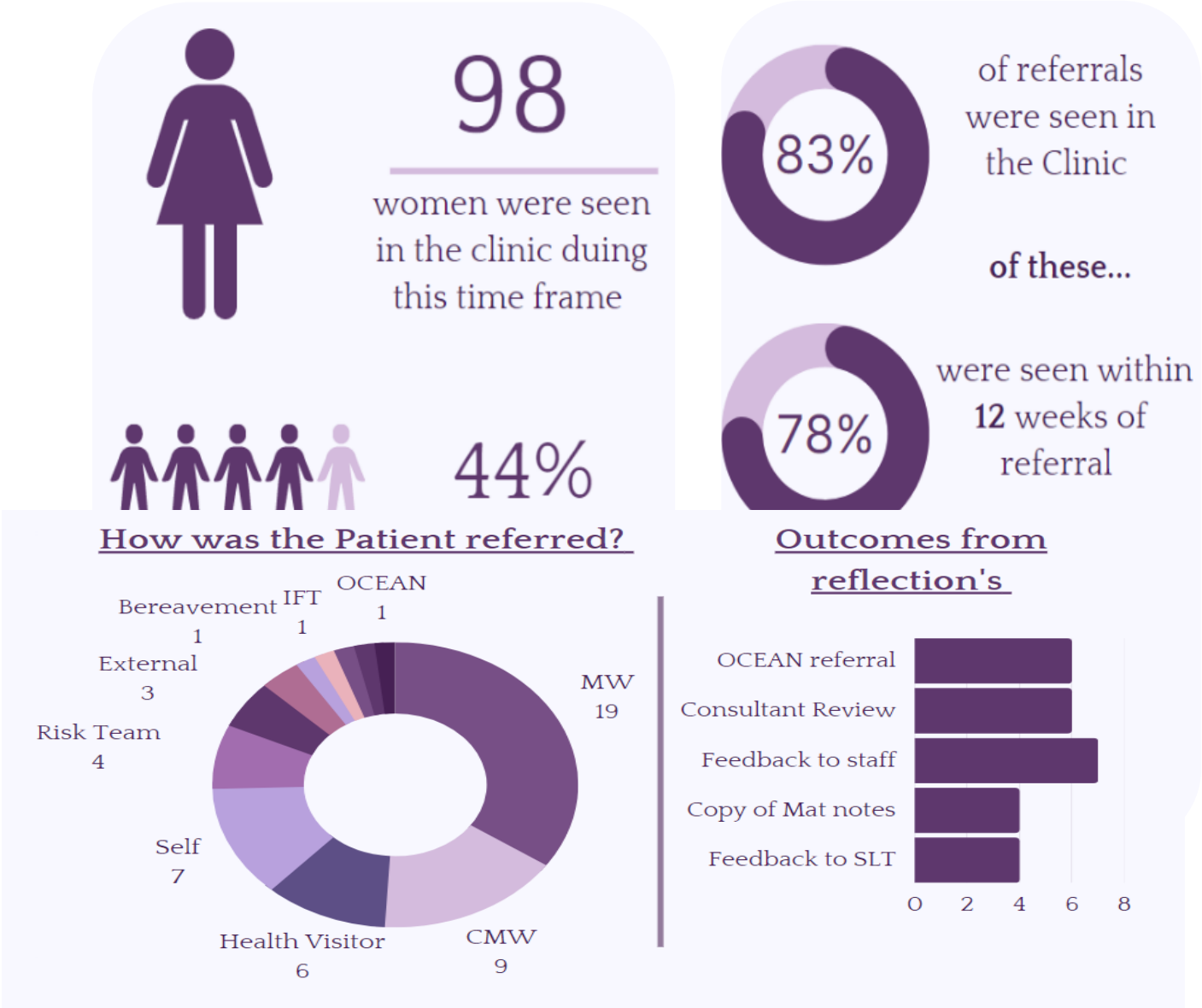
Actions:

- ANC lead is to discuss the possibility of the Clinical Psychology team offering staff who undertake phlebotomy tasks (in ANC) training on supporting women who have a needle phobia. **Action ongoing**
- The staff member cited in the complaint to undertake personal reflection. Letter of apology sent to the family. **Action completed**
- As an opportunity for learning, the Family Experience Midwife will discuss with the midwife the current management of prolonged rupture of membranes (PROM) and

the use of antibiotics, and the reason why we ask women to refrain from eating whilst on Oxytocin. **Action completed**

- The Neonatal Manager is to discuss with staff the process of the bedside handover, and that the expectation is that this is undertaken in partnership with the parents. **Action completed**
- Several actions implemented in support of women who access the bereavement suite following a fetal loss, these include additional bereavement training for identify staff groups, the installation of a bell at the entrance of the Bereavement suite, and new larger receivers to be place on all the toilets in the Benson Suite. **Action implemented, awaiting bereavement training, however funding secured.**

Maternity Birth Reflection Clinic Review- Financial year 22/23 figures



Research shows that about 4-5% (30,000 women in the UK) of women who give birth develop post-traumatic stress disorder (PTSD), with symptoms such as flashbacks, nightmares and extreme anxiety that makes daily life immensely challenging. Many more have some trauma symptoms, but not enough for a PTSD diagnosis. The term "birth trauma" covers everyone who feels that their traumatic birth is continuing to affect them.

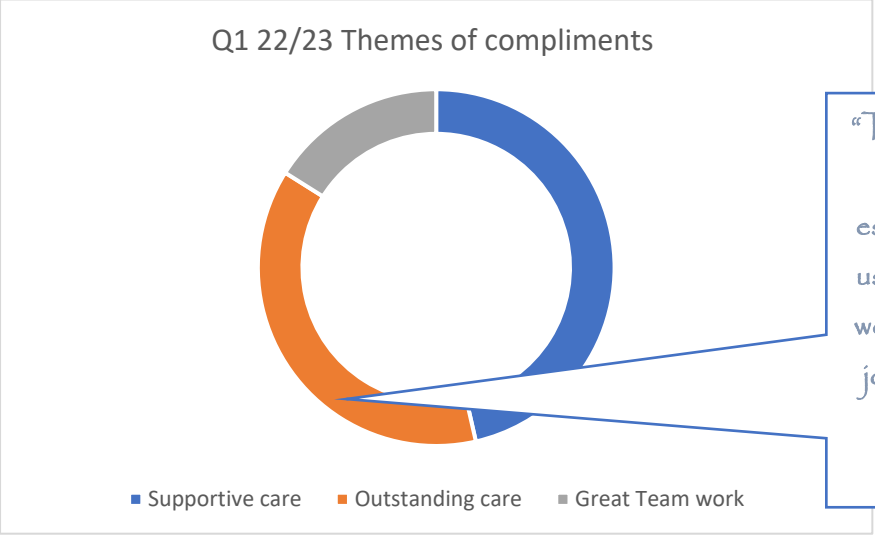
The figures above demonstrate the number of women who access the service and the timeframes in which women are seen in clinic and the outcomes. There has been an ask form the LMNS and our Local Maternity and Neonatal Partnership (MNVP) to increase accessibility of the service, opening it up to **all** women who require support after the birth. Currently this service is not commissioned and therefore capacity is limited.

SOX and compliments

Learning: Showing commitment to supporting learning within your teams, showing enthusiasm and going above and beyond to support each other!

We received 20 SOX in Q1

"The doctor volunteered to support our PROMPT obstetric emergency training. He did so in his own time between shifts, showing commitment to improving teaching resources. He did so with a positive and enthusiastic attitude to learning, bringing smiles and fun to the morning" .



"Thank you for your kindness top tips and support with our new arrival, especially with feeding. You really set us up to succeed on coming home and we can tell that you really do love your job and the help and care given to us by you and all the team was so appreciated and exceeded what I

Patient feedback and Family Test (FFT)

Ward / Department	Score	What was good about your experience?	What could we have done better?
Antenatal	Very Good	Staff have always been friendly, professional, and non-judgmental. We saw Diane and Ada (student) who were extremely kind and put our minds at ease.	
Community Postnatal	Very Good	A lot of checks after birth which is good. Great information given and help with tongue tie.	
Hospital Postnatal Ward	Very Good	The staff are great and abundance of breast-feeding support.	I think it's great, only positive thing to say.

15.Implementation of the A-EQUIP model

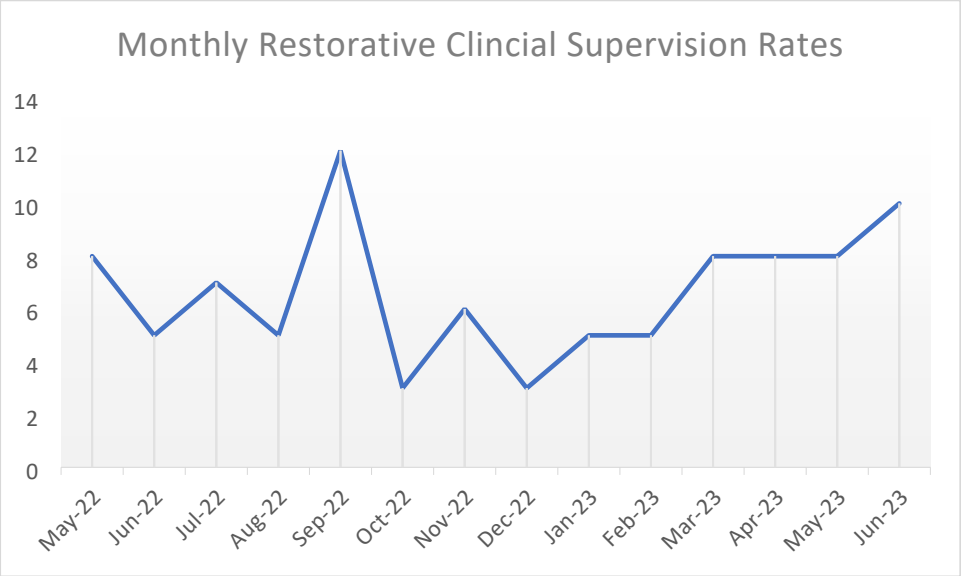
The Professional Midwifery Advocate (PMA) team are responsible for implementing and deploying the A-EQUIP model (Advocating for Education and Quality Improvement) which supports a continuous improvement process that aims to build personal and professional resilience, enhance quality of care and support preparedness for appraisal and professional revalidation.

Restorative Clinical Supervision:

RCS supports the Restorative element of the A-equip model. Through Q1, all Midwives returning from long term sick or Maternity leave, and all new starters have received a RCS session. Intensive RCS support for all NQMW and international midwives has continued through Q1.

Secure data is kept on the number of RCS sessions taking place, and themes are collected (whilst ensuring confidentiality is maintained). If any themes emerge from RCS, they are escalated to the Director of Maternity.

The PMA's held a three day 'Civility awareness event' in May, which was made up of a roadshow around the division talking about 'Civility saves lives' and launching the new divisional Behaviour Charter.



26 RCS sessions were carried out in Q1, an increase from 18 in Q4 22/23. 2 of these were Midwives returning to work after long term sickness,1 was returning to work from maternity leave, 2 were new members of staff and the other 21 were Midwives who had a work-related issue they needed support with.

- PMA Training
  No further new PMA's qualified, 1 PMA training ongoing.
- PNA/PMA collaborative working –
  The Lead PMA has written a 'PMA/PNA plan to deliver the a-equip model at Salisbury NHS Trust'. This is currently sitting with deputy Director of Nursing for ratification. This joint plan will form the basis of collaborative working between the PMA's and the wider trust so that each service can benefit from the experiences of the other.

There is a plan to deliver joint monthly meetings and training sessions with the PNA's and going forward regular supervision from the psychology department has been agreed for both PNA's and PMAs to ensure their wellbeing.

16.Avoidable Admission into the Neonatal Unit (ATAIN)

The National Ambition

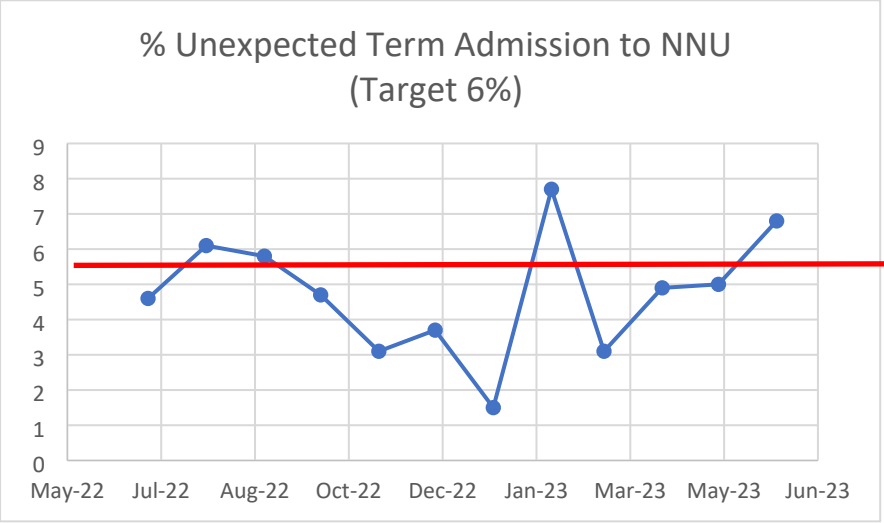
In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, 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 babies admitted to NICU to be <6%, however our local Operational Delivery Network aims for a rate of <5%. The Q1 rate in Salisbury 5.56% with an overall rate below the 5% for the past financial year 2022-23. There was a higher-than-average number of admissions in June 2023 – all of these cases have been subject to a MDT review. Two babies were admitted and subsequently found to have cardiac issues and a theme noted of babies admitted with respiratory distress following Caesarean section at 37/38 weeks. The MDT are looking at steroid use and balancing consideration of timing of caesarean section in order to support the best outcomes.

17.Maternity Safety Support Programme (NHSE)

Formal support from the NHSE programme continues and work remains ongoing with SFTs allocated Maternity Improvement Advisor. The Maternity Improvement plan is being refined within the division to ensure that fits with the improving together framework and aligns with the Trust and divisional strategies and is being amalgamated into a single action plan to address all recommendations, both local and national.

Maternity Improvement Plan (MIP)

The maternity improvement plan was finalised at the end of March with input from the MDT, DMT and our NHS Maternity Improvement Advisor from NHS England. Monthly meetings to monitor progress against the identified actions and feed into the divisional governance process are ensuring progress and improvements are ongoing.

18.Care Quality Commission

Following inspection in 2021 we are continuing to monitor ourselves against the standards set and ‘must’ and ‘should’ dos. The most recent audits for pool cleaning and emergency checking are non-compliant. The target compliance is 100% yet we have been just below this. Further training has been given and a daily check is now in place to be completed by the maternity duty manager to improve compliance and awareness.

Learning from governance activities including investigations is ongoing, but due to absence in the Quality and Safety team cannot be progressed further as the team concentrate on clearing the backlog of investigations and statutory Duty of Candour.

We are non-compliant with our fluid balance chart audit. This is included in our Improving Together work as a driver and 'go and see' have been frequently undertaken with the team, this highlighted challenges around the audit indicators and has resulted in a change to the guidance. Compliance has improved towards the end of Q1. Monthly audit will continue to ensure improvements are consistent and learning is embedded.

19.Risk register highlights

Risk ID	Title	Rating
6773	Infusion training competencies do not meet the minimum requirements of the blood policy of 85%	15
7672	Antenatal CO monitoring	10
7221	There is a risk of cases with harm not being escalated due to the large backlog of datix	10
5713	Shortage of midwives which may pose a risk to deliver safe care throughout the maternity care pathway	10

20.Safeguarding

Safeguarding training Level 3 compliance is 98% for midwives. Obstetric Team compliance is 41%. An email was sent to all obstetric staff who are non-compliant advising them to book onto the L3 training.

5 of the 6 of the required 1:1's by the Named Midwife is compliant for this quarter.1 midwife is on long term sick.

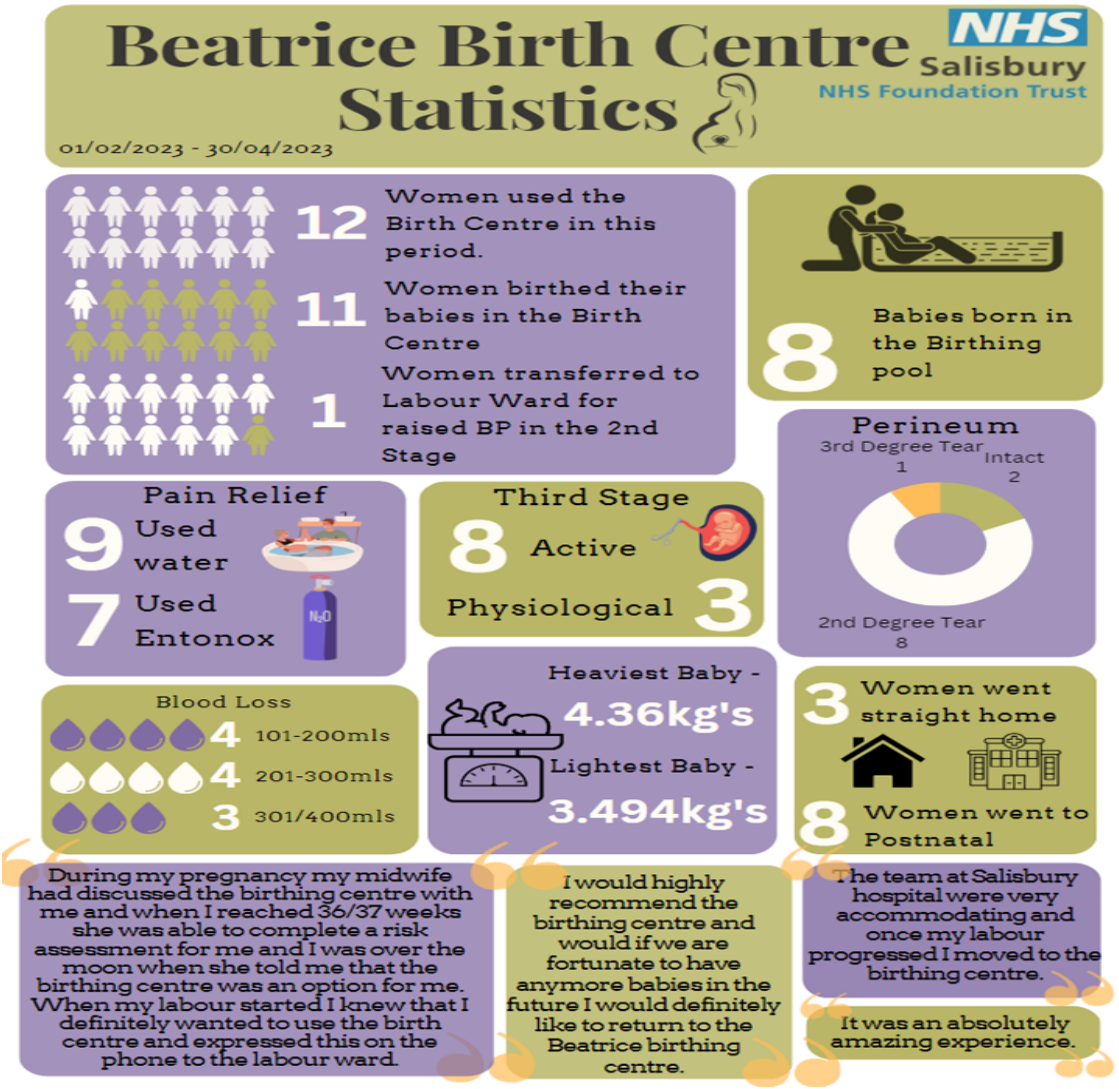
- Safeguarding supervision for CMW's is 100%.
- Safeguarding supervision sessions for unit midwives are 3 x per month and remain on Teams, although mandatory study days and ad hoc sessions are completed face to face.
- 36% of unit midwives have attended 0 sessions. They have all been emailed.
- 40% of unit midwives have attended 1 session. They have all been emailed.

- 20% of unit midwives have attended 2 sessions.
- 2% of unit midwives have attended 3 sessions.
- CP plans = 6
- CIN plans = 8
- Level 2B = 3.
- Single assessments currently in progress = 5
- 18 MASH requests for information were sent These are sent by the CMW's if a woman has disclosed a history of police or social care involvement and the CMW needs to check that this is correct information. This is a good example of communication with our colleagues in MASH.
- DPM. 4 babies went home with their mother. 1 mum and baby went to a foster placement and 1 baby went to MGM under an ICO.
- One incident of a baby under a protection plan being removed from NNU, the unharmed baby was retrieved by the Police.

21.Beatrice Birthing Unit

Between 1/2/23 and 30/4/23, 12 women have used the Beatrice Birth Centre. Only one of those needed to be transferred to consultant led care on labour ward, this was during the 2nd stage for raised blood pressure. The numbers of women currently eligible and using the Birth Centre are low but the low transfer rate illustrates that risk assessments are correct and of high quality. Eight of the women who used the Birth Centre had their baby in the birthing pool. One Birth centre user did sustain a third-degree tear, this is likely to have occurred regardless of the place of delivery.

Feedback from women who have birthed their baby in the Beatrice Birth Centre is extremely positive. There have been no negative comments, other than women voicing that they would like to birth in the Centre and do not fit the current criteria. With the reassuring robust risk assessment and encouraging staff and patient feedback, it is planned that the criteria will be reviewed and broadened to support more women to birth in the Beatrice Birth centre.



22. Screening Services

Six Screening programmes are offered at SDH

- Sickle cell and thalassaemia Screening
- Infectious Diseases in pregnant screening
- Fetal Anomaly Screening
- New-born Hearing Screening
- Newborn and Infant physical examination
- Newborn blood spot screening

There was a second QA visit to the antenatal and newborn screening services at SDH following an initial visit on September 13th, 2022.

44 recommendations were identified following the first visit, with a deadline of May 2023 for a specified proportion of the actions and November 2023 for the remaining actions. All of the 18 actions which were due for closure in May are now closed with several more awaiting confirmation of closure from the QA team. The remaining actions have a deadline of November 2023 for completion.

Good progress and feedback has been received from QA team who have provided face to face monthly support since January 2023.

There is now a band 7 Screening coordinator in post following intense induction at UHS, who is continuing to drive forwards and embed the improvements in this service.

All screening guidelines have now been updated and are all available on microguide.

23.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
- Quality and Safety Matron role recruited to and substantive postholder commences in August 2023
- To continue with work to co-design an LMNS Perinatal Quality Surveillance dashboard across BSW

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.4
Date of meeting:	7th September 23		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services (August 23 -July Data)			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance on 17.8.23			
Prepared by:	Vicki Marston – Interim 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 July 2023.

Summary:

Staffing:

- Staffing noted and remained a driver for improving together.
- Midwifery vacancies and maternity leave mitigated by bank and agency usage
- Midwife to birth ratio 1:30
- 1:1 care in labour achieved at all times
- Supernumerary status of labour ward maintained 100% time
- Datix relating to workforce 2

PMRT

- No outstanding actions

Incidences reported as moderate

- 6 – Review planned for term admissions to Neonatal Unit via Atain process. No themes identified with other incidents.

Training

- Compliance shows slight decrease in PROMPT and NLS training, Plan in place to address this and improve compliance.

Service user and staff feedback

- As detailed and actions taken forward to address any concerns or areas for improvement

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

NHS
Salisbury
NHS Foundation Trust

Virtual Meeting Etiquette:

- Mute microphones when not speaking (to minimise background noise)
- Turn cameras off – unless speaking (to maximise call quality)
- Please use the *Raise Your Hand* to ask a question
- Please note, this event will be recorded

Perinatal Quality Surveillance

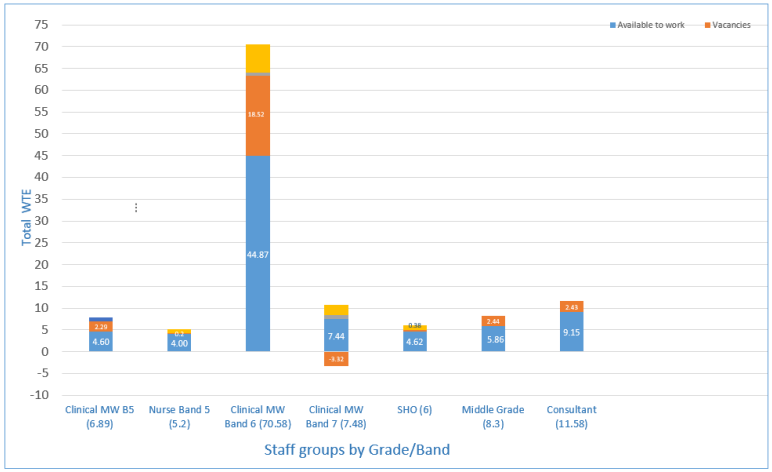
Salisbury NHSFT Maternity & Neonatal services

August 2023 (July data)

Safe - workforce

Salisbury NHS Foundation Trust

Stratified Data
Active Available Workforce M 4



Is the standard of care being delivered?

- 1:1 care in labour was achieved 100% of the time
- Supernumerary status of Labour Ward coordinator maintained 100% of time in July
- Midwife to birth ratio is stable
- -22 WTE clinical midwifery rate

What are the top contributors for over/under achievement?

- Vacancy rate
- Maternity leave
- Challenges in recruiting midwives
- Accuracy in data capture for fill rates

Active Available Workforce

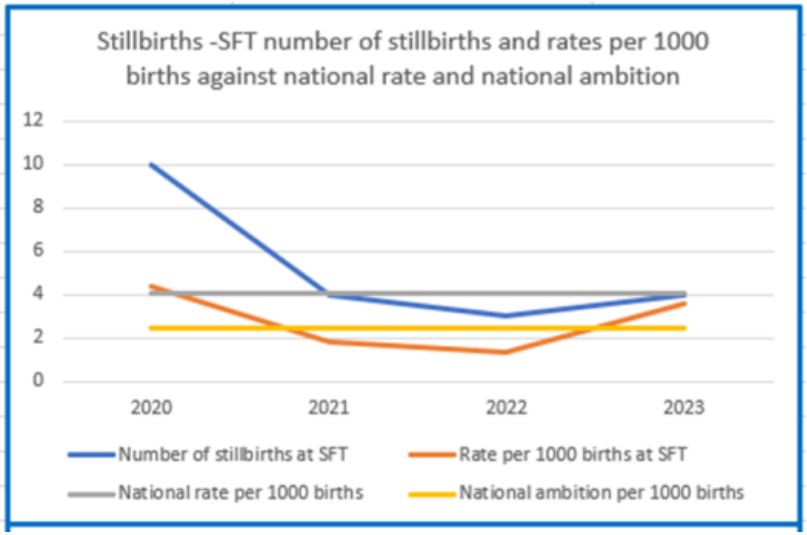
Concern	Cause	Countermeasure	Owner	Due Date
Recruitment of MWs	Attraction Materials	Utilise R and R policy requirements to implement a financial incentive to join the trust as a clinical band 5 or 6 midwife to attract new staff members. **Incentive agreed and completed – launched with advert in April.**	Vicki M, Sharon Holt, C.Richardson	Complete
		Practice Education Midwife visiting Southampton and Bournemouth University in April to showcase our preceptorship programme and incentive package. Band 5 midwives interviewed and accepted posts – 12 Band 5 midwives booked for interview - 4 Band 6 midwives interviewed and accepted posts – 2.6	S.Leahy	Complete 30/06/23
	International recruitment	Update: • 7 International Midwives commenced in service • 4 completed and passed OSCE (1 has NMC PIN and commenced work – 3 awaiting pin) • 2 taking OSCE in July • 1 recruited and commenced in June.	Vicki M/International Recruitment lead	Ongoing
	Development opportunities	2 x places secured on Nurse to Midwife conversion course. Commencing Jan '24, training funded by HEE, completion Jan'26. 2 x places secured for Midwifery apprenticeship which will be open to current MSW with appropriate education (education fees funded by apprenticeship levy). 3 year apprenticeship starting Jan '24	VM SL	Ongoing
	Workforce Total	Birthrate plus team meet in June 23. Data collection to start September, report expected November to December 2023. This will inform workforce numbers based on current activity and acuity and align with MIS requirement for workforce review.	VM	June 23
Retention of MW and MCAs	Education and Training	Medled human factors training bespoke to MCA's planned for June 23 – funded by NHSE monies – to extend to whole MDT to facilitate group training	VM	ongoing
Data Format		RGN'S included against clinical midwives in stratified data to ensure they are represented. – Data shows vacancies minus nurses in addition.	VM	complete
Flexible Working		Task and finish group complete, final meeting and action plan agreed with group members, cascaded to all staff members Link to divisional work with staff survey.	VM/CR	Complete
Middle Grade Doctors		Awaiting Deanery confirmation of posts 1 Registrar starting September SAS Doctor to be confirmed – review of Job plan	Shelley King Greg Pearson/Abi Kingston	Ongoing

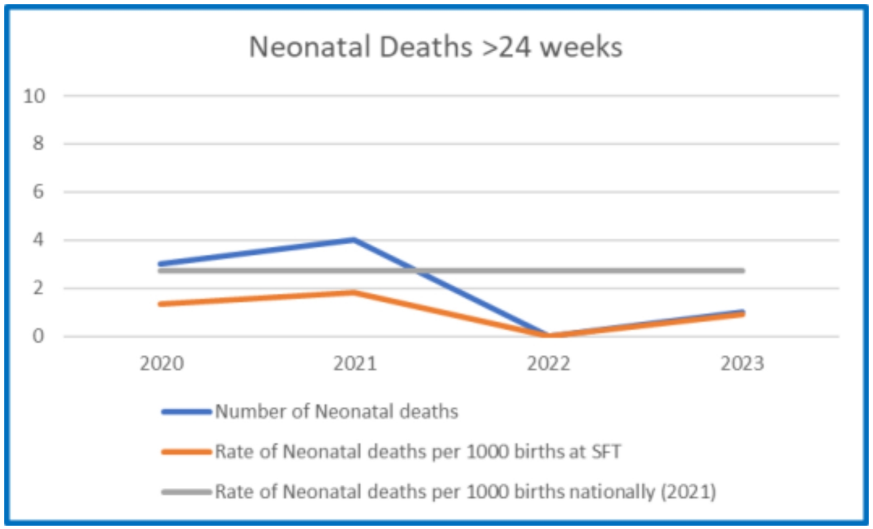
Safe – workforce M4

Salisbury NHS Foundation Trust

SFT Assurance Dashboard		Guidance	Standard	Red	Green	Improvement Direction	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Rolling 6m average
Workforce	Obstetric cover - labour ward	RCOG guidence		<= 39	>= 40	Up	40	40	40	40	40	40	40
	Midwife to Birth ratio	RCM;NHSR;BR +	1.26	>= 1.28	<= 1.26	Down	1.27	1.31	1.25	1.31	1.29	1.30	NA
	Midwifery vacancy rate (black= over establishment; red =under establishment)			>= 1	NA	Down	20.9	21.9	21.9	23.2	23.0	23.9	NA
	Provision of 1 to 1 care in established labour (%)	NICE, RCM, MIS	100%	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Datix relating to workforce	6 month SFT rolling		>= 2	= 0	Down	2*	2	3	1	1	2	1.8
	Compliance with supernumery status of the LW coordinator - %	NICE;RCM;NHSR	100% rostered	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Numbers of times maternity unit on divert	6 month SFT rolling		>= 2	= 0	Down	0	0	0	0	0	0	0

Safe – perinatal mortality review





July 23		
Stillbirths	0	
Neonatal Deaths	0	

PMRT action plans update				
Case ID	Action plan	Responsible person	Target date	completion
No outstanding actions				

Incidents and review update

Salisbury NHS Foundation Trust

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
SII 548	Maternity/W&NB	Term admission to NICU	23/02/2023	28/02/2023		26/05/2023
SII 555	Maternity/W&NB	Intrapartum stillbirth - HSIB	16/03/2023	21/03/2023		08/06/2023
CR 565	Maternity/W&NB	Uexpected admission to neonatal unit	18/05/2023	30/05/2023		22/08/2023
CR 569	Maternity	Uncrossmatchable Blood	02/06/2023	13/06/2023		08/09/2023
SII 570	Maternity	Retained Swab	09/06/2023	13/06/2023		08/09/2023
SII 571	Maternity	Placenta Acreta	25/05/2023	20/06/2023		14/09/2023
SII 574	Maternity	Stillbirth		27/06/2023		21/09/2023
CR 579	WNB	Term admission to NICU	20/04/2023	18/07/2023		
CR 580	WNB	Term admission to NICU	16/07/2023	01/08/2023		23/10/2023
Reports for EXIT						
ID	Directorate / Ward / Dept	Summary of incident	Date commissioned	CRG	Date Due to CCG	
SII 492	Maternity/W&NB	baby fitted in first 24 hrs - not HSIB - fitting was due to metabolic disorder	13/07/2022	19/07/2022		
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	
CR 509	Maternity/W&NB	Inappropriate Hep B vaccine	30/08/2022	06/07/2023		

Incident moderate or above

Date	Grading	Detail
03/07/2023	Moderate	3b Obstetric Anal Sphincter Injury
05/07/2023	Moderate	Unexpected Term Admission to Neonatal Unit
10/07/2023	Moderate	3? Obstetric Anal Sphincter Injury
16/07/2023	Moderate	Unexpected Term Admission to Neonatal Unit
24/07/2023	Moderate	Major Obstetric Haemorrhage and Hysterectomy
31/07/2023	Moderate	Pulmonary Embolism (missed opportunity to provide prophylactic anticoagulation therapy)

Incidents – actions

Salisbury NHS Foundation Trust

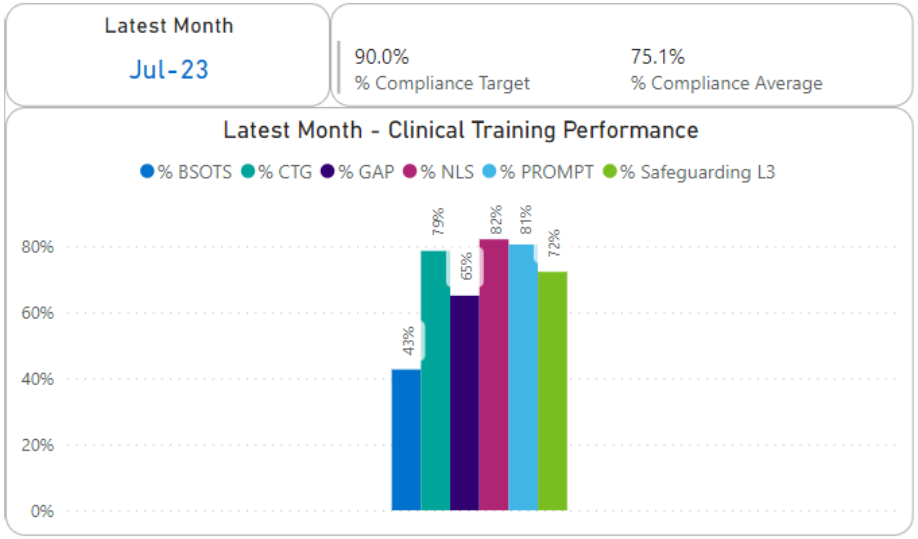
W&NB SII / CR Open Compliance Matrix

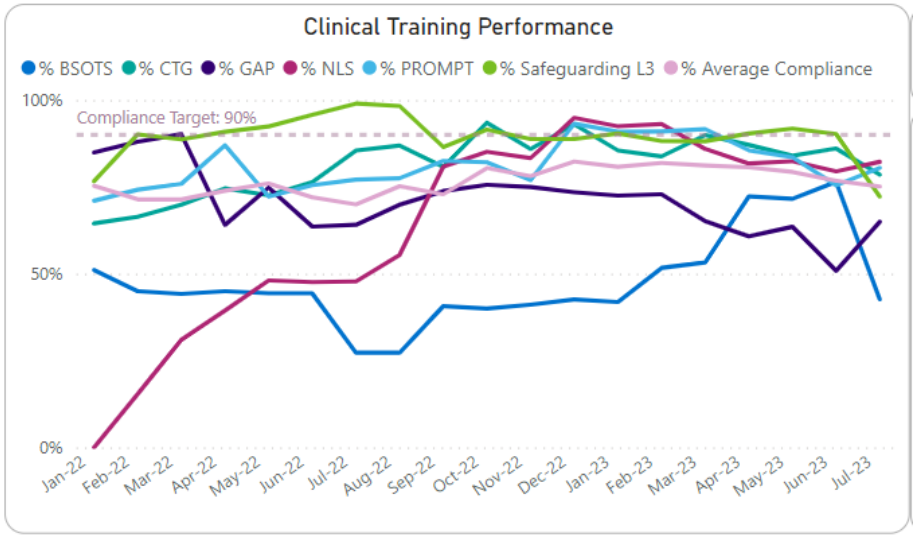
SII/CR No.	Link to Sheet	Directorate	Incident Date	Recommendation RAG Rating (Green = Completion Date, Amber/Red: Target Date)										
				1	2	3	4	5	6	7	8	9	10	11
SII 432	Click	W&NB	September 2021	Q3 21-22	June 22	Q2 22-23	Q2 22-23	Q2 22-23	Q2 22-23	Q2 22-23				
CR 454	Click	W&NB	December 2021	Q2 23-24	Q2 23-24	Oct 22	Q4 22-23							
SII 472	Click	W&NB	February 2022	Q1 22-23	Oct 22	Oct 22	Q3 22-23	Q3 22-23						
SII 477	Click	W&NB	April 2022	Q1 22-23	Q2 23-24	Jan 23	Q4 22-23	Q4 22-23	Q4 22-23	Q3 22-23	Q4 22-23	Q1 23-24		
SII 484	Click	W&NB	May 2022	Q4 22-23	Q1 23-24	Q1 23-24	Q1 23-24	Q1 23-24	Q2 23-24					
SII 489	Click	W&NB	May 2022	Q1 22-23	Dec 22	Q4 22-23	Q4 22-23	Q3 22-23	Q3 22-23					
SII 497	Click	Surgery	July 2022	Surg	Q1 23-24	Q2 23-24	Med	Apr 23						
SII 506	Click	W&NB	March 2021	CSFS	Jun 23	Q1 23-24	CSFS							
CR 509	Click	W&NB	July 2022	Q2 22-23	Oct 23	Aug 23	Oct 23	Aug 23						
SII 510	Click	W&NB	August 2022	Q1 23-24	Q1 23-24	Feb 23	Feb 23	Feb 23	Jan 23	Jan 23	Q1 23-24	Jan 23		
CR 512	Click	W&NB	September 2022	Sept 23	Jul 23									
CR 514	Click	W&NB	September 2022	Q3 22-23	Jan 23	Q1 23-24	Dec 22	Feb 23	Q2 23-24	Q1 23-24				
CR 527	Click	W&NB	October 2022	Q1 23-24	Q1 23-24	Jun 23	Q2 23-24							
SII 537	Click	W&NB	December 22	Jul 23	Jul 23	Jul 23								
CR 540	Click	W&NB	November 2022	Jul 23	Jun 23	Sep 23	Jul 23	Jun 24						

Colour Code		
No Evidence	Evidence of Progress	Evidence of Completion

Training Compliance July 2023

Salisbury NHS Foundation Trust





Training-

New training database in place to support allocation of all required maternity training, with oversight by divisional workforce lead to ensure staff are appropriately allocated study leave to improve training compliance.

Slight decrease in PROMPT and NLS this month – plan agreed with surgery for training to be prioritised for anaesthetists.

Trajectory for BSOT's training completed, all midwifery staff to have completed training by end June 23

Trajectory for Registrars to be completed and training plan implemented.

Fetal monitoring team and PDM to create a sustainability plan for keeping compliance at or around 90%

Service user and Staff Feedback

NHS Salisbury

Feedback from families	Feedback from staff
Positive from the MVP: The staff were nothing but kind, caring and soothing when we were concerned. Later that morning we were then sent to labour ward to begin the long process of having my son. The staff were nothing but kind, caring and soothing when we were concerned. Later that morning we were then sent to labour ward to begin the long process of having my son. **Areas for improvement :** Postnatal ward – Concerns about communication and care.	**Feedback** • Concerns over staffing levels • Concerns over community on call model **Actions**: • Findings from flexible working focus group and changes formalised • Incentive and recruitment drive in place – 15 midwifery roles offered and accepted to start Sept/Oct • Options appraisal around new model of community on-calls being worked through

Compliments	Concerns	Complaints
2	0	1

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.3
Date of meeting:	7th September 2023		

Report tile:	Freedom to Speak Up Guardian Annual Report 2022-23			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	This paper has been reviewed and approved through People and Culture Committee			
Prepared by:	Elizabeth Swift – Freedom to Speak Up Guardian (presenting)			
Executive Sponsor: (presenting)	Melanie Whitfield – Chief People Officer			

Recommendation:

Discuss and note the Freedom to Speak Up Annual Report
Support on-going work to ensure an open and transparent culture of speaking up in the organisation
Support the work underway to ensure Black and ethnically diverse colleagues can safely report concerns
Note the improvements in the numbers of colleagues speaking up (47% increase from 2021/22)

Executive Summary:

For information:

- FTSU Annual Report 2022-23

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

1 Purpose

1.1 To present an overview of the work of the Freedom to Speak Up (FTSU) Guardian over the year including high level details of the number of cases raised, a thematic analysis and any learning from these cases.

2 Background

2.1 The standard NHS contract requires that all trusts and foundation trusts employ a Freedom to Speak up (FTSU) Guardian. FTSU Guardians are now employed across the health and care sector, including in primary care, health charities, independent providers and arms' length bodies including health regulators. The FTSU Guardian's role is to ensure patient safety and staff wellbeing by providing a mechanism for staff to speak up when they see or hear something that is not right. The FTSU Guardian also provides support to staff raise concerns and supports the Board to develop a 'positive, compassionate, and inclusive' workplace culture in line with the vision set out in the NHS People Plan.

2.2 In addition, while the mission of the National Guardian's Office is to make speaking up business as usual in the NHS, the broader strategy is to effect cultural change.

2.3 Salisbury NHS Foundation Trust is committed to implementing the recommendations of the Francis Report 2015 and embedding a strong speaking up culture throughout the Trust.

2.4 Speaking up: what it is, why it matters and what good looks like. Concerns can be raised about anything that gets in the way of providing good care. When things go wrong, it is important to ensure that lessons are learnt, and improvements made. Where there is the potential for something to go wrong, it is important that staff feel able to speak up so that potential harm is avoided. Even when things are going well, but could be even better, staff should feel confident to make suggestions and that these would be taken on board. Speaking up is about all of these things.

People want to work for high performing organisations. Fostering a Speak Up, Listen Up, Follow Up culture promotes excellence and increases staff engagement, boosting morale and performance.

3 National Guardian's Office

The 2021-22 Annual Report of the National Guardian for the NHS was laid before Parliament in January 2023, highlighting the work of Freedom to Speak Up Guardians and the National Guardian's Office in making speaking up business as usual.
The laying of the report, a commitment called for by the Secretary of State in his response to the events at Gosport War Memorial Hospital, had been delayed due to parliamentary changes and the death of the Queen.
The report shares intelligence and learning collated by the National Guardian's Office, including **speaking up data** shared by Freedom to Speak Up guardians of the cases they receive. Over 20,000 cases have been brought to them last year, remaining at the record level set in 2020/21 (20,362, compared with 20,388 in 2020/21). Freedom to Speak Up guardians have handled over 75,000 cases since the National Guardian's Office first started collecting data in 2017.

With NHS England we have been working together to develop a revised version of the National Integrated Freedom to Speak Up Policy. The new universal policy applies throughout the NHS and to all organisations delivering NHS services. We have also helped to develop guidance to support this new policy, together with a self-reflection tool to help leaders identify opportunities for improvements in their speak up culture. We have been working with the Care Quality Commission on the inclusion of Freedom to Speak Up as a quality indicator in their new regulatory framework.

Other highlights over the 2022/23 period include:

Progress continues to be made to improve the speak up culture across a range of organisations. There are now more than 820 Freedom to Speak Up Guardians in over 500 organisations who have handled nearly 75,000 speak up cases to date, allowing workers to speak up who might otherwise not be heard.
Support and development have improved for FTSU Guardians including revised training for new Guardians, refresher training for existing Guardians, and a refreshed Network Chair role in 2022.
A new role Mentor role has been introduced to support success of FTSU services. The FTSU Guardian from SFT has been selected to be one of these mentors and is actively supporting other Guardians from different organisations.
There is a new National Speaking up Policy. The SFT policy is currently under review to ensure alignment with national guidance.

4 Freedom to Speak Up Annual Survey 2022

The annual survey was carried out identifying key areas for future focus, in particular Senior Leaders' essential role in Freedom to Speak Up. Recommendations include:

Recommendation	SFT's current Position	Meeting expectations Y/N?
Senior leaders should deepen their support for speaking up by taking action to demonstrate learning from speaking up, tackling detriment, and supporting further cooperation within organisations on all matters related to speaking up.	Current SFT processes in place. Board Assessment tool will test and add further assurance. With each case managers are educated on FTSU culture and safe speaking up for all staff. Training is available and essential for all staff. Currently staff share inconsistencies and report fear of speaking up due to fear of detriment from their mangers/ culture of the organisation.	Partly *Recommendations to organisation for success:* Instigate Follow up training for leaders Current data is themed and triangulated to identify and support areas where staff report fear of speaking up Ensure Restorative Just Culture is embedded with consistency so all staff can benefit, and the organisation can learn from concerns. Current leadership programmes incorporate psychological safety and FTSU including Listen Up training as part of the module
There should be visible action on detriment for speaking up wherever this is reported.	Current process- staff can report detriment at any time. All detriment cases are reported and shared with Exec Lead for FTSU to be investigated.	No clear process for detriment cases – approached on an individual basis. Ensure NED Lead is aware of all detriment cases
The frequency and status of training on speaking up matters should be reviewed so that guardians and leaders can satisfy themselves that workers and those who support them have the knowledge and skills they need to speak up, listen up, and follow up, well.	Current training regime in place that seeks to address any staff barriers. Current training targets are over and above expectation. FTSUG has done face to face training with approximately 1,200 members of staff.	Yes

Senior leaders should take the necessary steps to tackle the perception that speaking up is futile, including ensuring appropriate action is taken when individuals speak up and that they are offered timely and meaningful feedback.	Open communication from Senior leaders encourage staff to speak up. Execs and senior managers refer staff and encourage staff to access FTSU.	Yes

The full report can be found with the link below:
https://nationalguardian.org.uk/wp-content/uploads/2023/01/NGO_AR_2022_Accessible.pdf

5 Freedom to Speak Up Guardian Activity

5.1 **National Work –** The FTSUG has continued to actively engage with the National Guardian's Office, including responding to surveys, timely submission of quarterly data returns and putting forwards ideas for future development of the Guardian role.

To support Freedom to Speak Up Guardian development, the National Guardian's Office held three Community of Practice sessions to complement the support which local Freedom to Speak Up network meetings give guardians. As well as the opportunity to meet new colleagues and develop and spread good practice, these also developed group facilitation skills for Freedom to Speak Up guardians to support both their peer networks and internal meetings. The Guardian from SFT facilitated one of these sessions.

The Trust's Chief People Officer, Melanie Whitfield, accompanied the FTSUG to the National Guardian's Conference held in London in March 2023. The focus this year was on futility, as this has been reflected nationally in the Annual Staff Survey. On reading the results for the speaking up questions in the staff survey, Dr Jayne Chidgey-Clark said:
"It is disappointing that the staff survey results reflect a decrease in workers' confidence to speak up, and especially concerning that this includes about clinical matters.
"No one should feel they cannot speak up to protect their patients or their colleagues. These survey results must be a wake up call to leaders at all levels that Freedom to Speak Up is not just a 'nice to have' – it is essential for safe services."

In response to the Speak Up Review of Ambulance Trusts - The National Guardian Jayne Chidgey-Clark says 'within the last 12 months, there have been several other reviews, reports and recommendations examining aspects of culture within ambulance trusts. Recognising the work of our partners, I am calling for Ministerial oversight of an independent cultural review. This will bring together all these pieces of work in a collaborative way to facilitate shared learning. This cultural review should act as a catalyst to accelerate the pace of meaningful change, to support the ambulance sector in making the improvements it wants and needs to make'. SFT meets in full the recommendations set out in this review.

The National Guardian Jayne Chidgey-Clark has been invited to deliver a session at the Trust's Tent Talk event in July 2023. This will give leaders at the organisation the opportunity to engage with Speaking Up at the highest level, to gain insight for improvement at both a personal and organisational level.

5.2 **Regional Work -** The FTSUG attends Regional Network meetings and actively participates in driving the FTSU agenda forward. As the health landscape continues to evolve with the development of integrated care systems (ICS), Regional Integration Plans have been produced to describe actions going forwards and how to measure progress and uptake. The National Guardian's Office is working with primary care organisations to show how this can work at system level consultancy.

FTSUG along with several colleagues from OD&P has completed the Restorative Just and Learning Culture Training which was provided by Merseycare NHS Foundation Trust in conjunction with Northumbria University. These places were funded by the BSW as it is recognised that there is a need for all providers in the system to be aligned in this way of working. FTSUG attends the BSW regional meeting to represent the Trust on RJLC.

The FTSUG is in regular contact with the Guardians at Royal United Hospitals Bath. This relationship is key for peer support, benchmarking and working together to push the Speaking Up agenda forwards as part of the BSW partnership. The FTSUG at SFT invited the Associate Director for Education and OD and FTSUG from RUH Bath to share their experience of implementing a Restorative Just and Learning Culture across their organisation at an OD&P Lunch and Learn session. This was an excellent opportunity for us to ask questions and consider how this important culture change can be initiated at SFT.

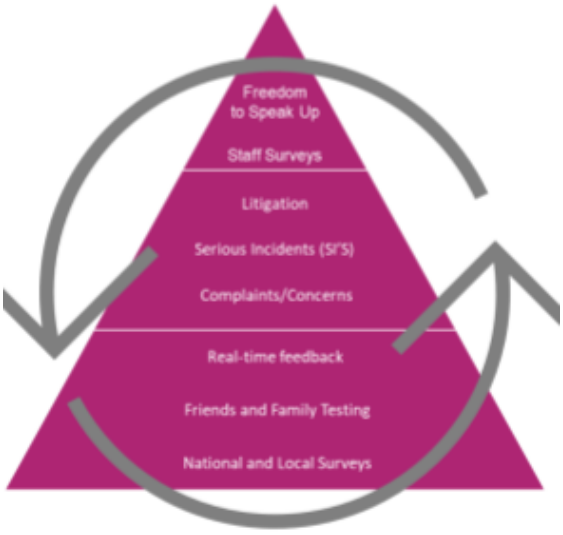
Comparisons in current cases:

RUH Bath	Salisbury NHSFT	Great Western Hospitals
150	134	No data available

`FTSUG provides ongoing mentorship to new and existing Guardians in the South West region.

5.3 Local work –

- **Triangulating Feedback – Leads Meeting** - Throughout 2022/23 leads from Patient Experience, Risk, Freedom to Speak Up and Legal have been exploring ways to compare data sets in an attempt to triangulate these to better understand if there were opportunities to improve both patient and staff experiences.



So far this year, we have held 3 meetings (on a quarterly basis) and through these have considered different ways to compare our data. We have most recently trialled collating the numbers of risk incidents (SI's and Clinical Reviews), along with Freedom to Speak Up records and numbers of Complaints, allocating a figure for relative comparison based on a per 1,000 patient activity (at Division level). The idea behind this was to help understand if there were any commonalities across these areas, as well as be able to compare (relatively) the scale of these across divisions. In summary, the data showed areas of commonality, in particular Women and Newborn across Risk, Complaints and FTSU. Going forwards, we will be looking to develop this triangulation further by incorporating Friends and Family Test feedback (once theming capabilities are in place, planned for Q3/Q4 of 2023/24). We will also be looking a more robust method of considering litigation alerts vs number of enquiries to litigation (both successful and unsuccessful claims).

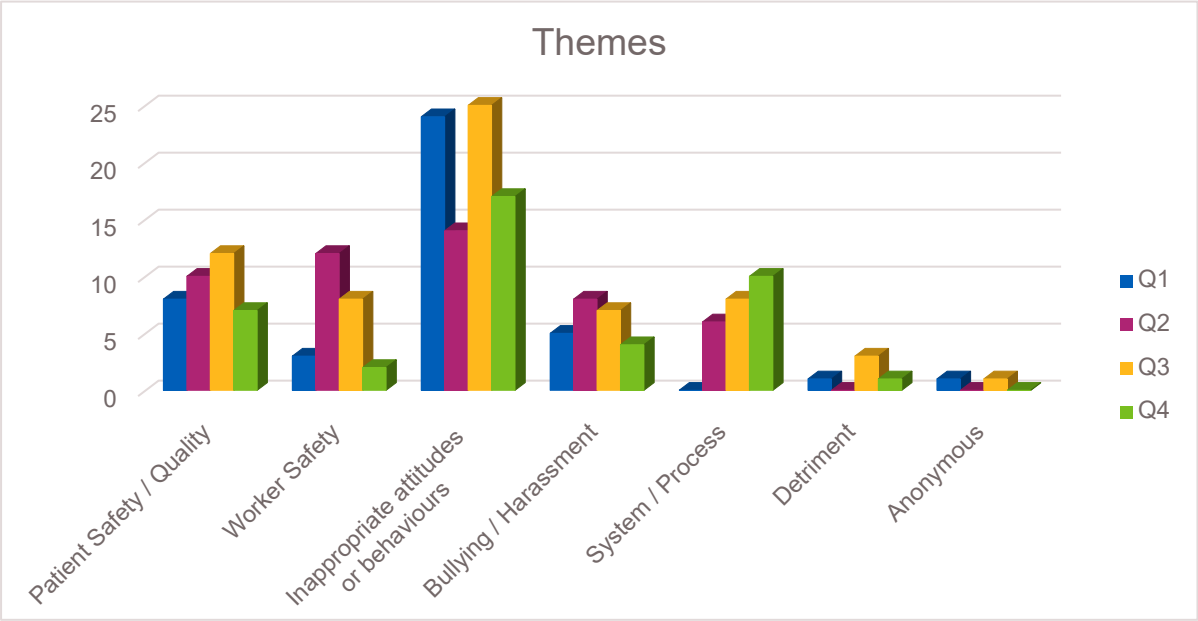
Meetings will continue each quarter and we aim to produce an annual summary of our findings. When necessary, any notable themes that may require escalation will need to have a clear and defined route of escalation.

- **Care Quality Commission (CQC) –**Although the last formal inspection was in 2018 the FTSUG continues to engage with the local CQC team providing information and assurance when needed. This forms part of the new CQC assessment framework under the Well- Led category.
- **Training** - The National Guardian's Office has launched, with Health Education England, training for all workers, and plan training for managers and leaders – with the view that everyone needs to take personal responsibility for their actions. In response to this, the Trust has agreed that this basic training 'Speak Up' became mandatory from 1st April 2021. From 1st April 2022 to 31st March 2023 2705 staff have completed this module (52%) of the 5051 workforce which is up from 37% in the previous year. 'Listen Up' is the next training package which is being delivered as part of the Leadership and Management offer which targets staff with line management responsibilities. In response to our own Maternity Services Review and the Ockenden Report, the Trust's Guardian presents at Midwives Study Days, Preceptee Study Days and meets regularly with the Director of Women and Newborn and divisional team. Raising Concerns is also part of the Foundation Doctors training programme and the FTSUG delivers this training. Including Trust Induction, over 1,300 staff have had face to face training with the FTSUG.
- **Induction** - This event has been reviewed and re-styled with more emphasis on staff support and well-being. The FTSUG presents weekly at this event, supporting the Trust's aim to enable a compassionate and open culture.
- **Promoting FTSU** – Contact details for Freedom to Speak Up support is in the daily trust wide bulletins, and new posters have been produced and are placed in prominent places across the entire estate. The CEO and CPO do approximately 6 focussed FTSU bulletins throughout the year.
- **100 day and 1 year Anniversary Listening events** - The FTSUG attends these listening events with the Chief People Officer to gain valuable insight into the experiences of our new starters. The feedback we have received has shown that there are inconsistencies across the organisation regarding induction in different departments and process issues in all parts of the recruitment process. These insights have given us the opportunity to rectify issues and improve the experiences of our new colleagues, with the whole induction process currently under review to incorporate the lessons learned.
- **Key relationships** – the FTSUG continues to collaborate with many teams to support speaking up despite the challenges of staff shortages and turnover. Regular meetings are held with People Business Partners, Divisional Management Teams, People Advisors, Risk, PALS, Litigation, Clinical Psychology, Staff Side, Chaplaincy, Guardian of Safe Working, Chief Resident, Executives and Non-Executives and protected groups such as the Race Equality Network and the Disability Network. FTSUG has also contributed to the Improving Together Programme, The People Promise Exemplar Site project and supports line managers and leaders to develop a heathy speaking up culture. The FTSUG has access to the CEO, Chairman and CPO as Executive Lead as and when required, as well as having monthly 1:1's
- **PSIRF (Patient Safety Incident Response Framework)** The FTSUG attends the implementation group to contribute to the aspects regarding what is being done to support the development of a just culture.
- **FTSU Ambassadors** – The FTSU Guardian and the Chief People Officer recruited an additional 10 FTSU Ambassadors to support the Guardian. The Ambassadors come from a variety of clinical and non-clinical backgrounds and provide a gateway to hard-to-reach groups. In addition, they raise the profile of the speak up culture in the Trust and uphold the Trust values. SFT is fully compliant with the NGO's guidance on developing and maintaining ambassador networks, including ring fenced time for Ambassadors to support speaking up.
- **Cases** – 134 concerns were raised to the FTSUG during 2022-23, an increase of 47% from the previous year. Where issues are complex external investigations commissioned by the Executive Team have taken place. Approximately 11% of staff who raised concerns have left the organisation, which is a decrease from 15% the previous year.

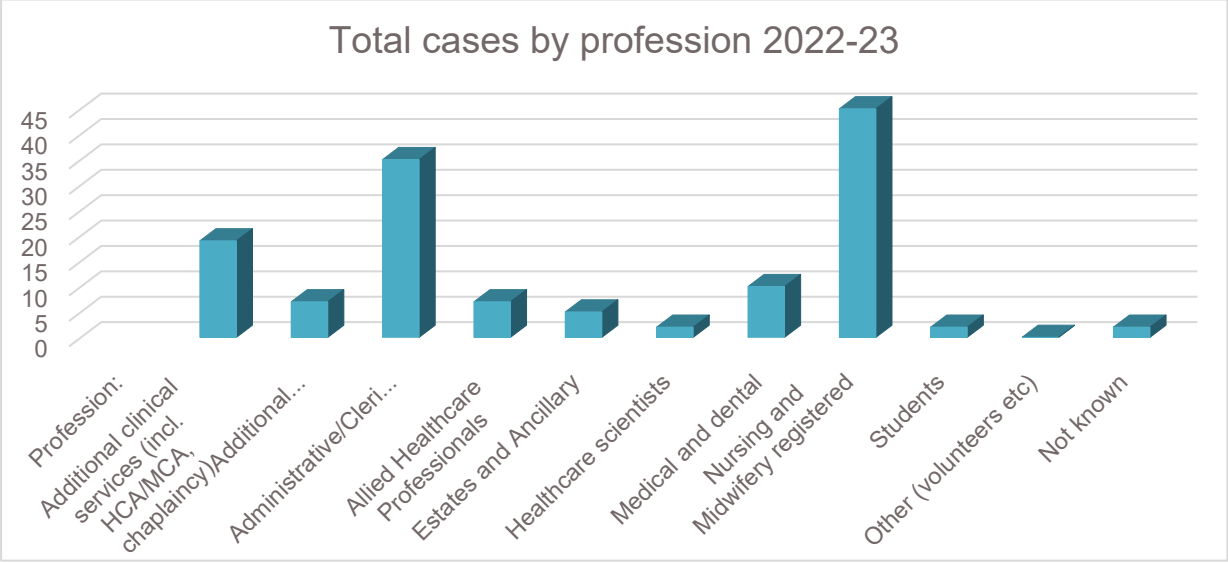
6. Summary of Concerns 2022-23

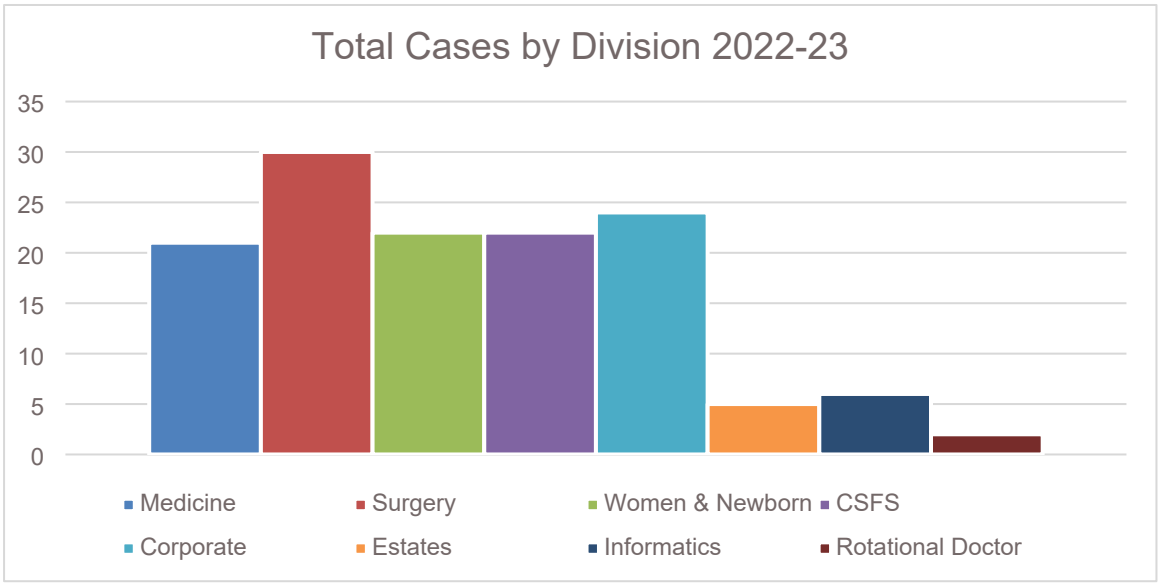
6.1 Annual data - summary of issues raised 1st April 2022 – 31st March 202

During this period 89 cases were raised with the FTSUG and the charts below show the breakdown by professional group and National Guardian Office identified themes and trends.



*Themes required to be reported to the National Guardians Office. The other themes are for local use. Some cases will contain more than one theme.





As we can see from the data, there are similar amounts of concerns being raised in the clinical divisions, with the Surgical Division being the highest.

Cases that have an element of patient safety or quality have been reported to the Clinical Governance Committee and assurance provided that appropriate steps have been taken.

WRES data – during this period at SFT approximately 20% of the 5051 staff were from a Black, Asian or Minority Ethnic background. Of the 134 concerns raised, 29% were raised by staff from a Black, Asian or Minority Ethnic background which is above proportional representation of the BAME workforce. The FTSUG works closely with the Race Equality Network to ensure that speaking up is promoted and barriers that this particular staff group may face are discussed and addressed.

Of note, disability issues were connected to 9% of staff who raised concerns, with several staff mentioning caring responsibilities that were having an impact on their role. The reinvigorated staff networks and wellbeing offers that have been introduced will give more support and guidance in the future.

7. Benchmarking

7.1 The national data is summarised below for 2017/18, 2018/19, 2019/20,2020/2021 and 2021/2022. There has been a delay due to staff shortages for the reconciliation and publication of the data for 2022/23 from the National Guardian's Office. Patient safety and worker safety have now been separated into two categories.

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Total cases	7,087	12,244	16,199	20,388	20,362	25,382
Element of Patient Safety/Quality	2,267	3,523	3,732	3,668	3,838	4,898
Worker Safety	No data	No data	No data	No data	2,757	6,953
Element of Bullying & Harassment	3,189	4,969	5,831	6,131	6,471	5,506
Inappropriate attitudes/behaviours	No data	No data	No data	No data	No data	7,621
Suffered Detriment	361	564	544	632	856	1,000
Anonymous	1,254	1,491	2,037	2,379	2,120	2,373

SFT data for the same period:

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Total cases	28	21	85	105	89	134
Element of Patient Safety/Quality	16	11	44	43	36	37
Worker Safety	No data	No data	No data	No data	14	25
Inappropriate attitudes or behaviours						80
Element of Bullying & Harassment	9	12	60	49	37	24
Suffered Detriment	No data	No data	16	11	8	5
Anonymous	1	0	1	1	1	2

The following should be noted from a comparison of the Trust data with the national data:

- The trends described, particularly the increase in the number concerns, reflects the picture seen nationally
- Nurses and midwives continue to be the staff group who raise the most concerns both nationally and locally.
- The Guardian has only received two anonymous concerns
- Inappropriate attitudes or behaviours is similar as is patient safety
- SFT reported 5 cases where there was a perception of negative treatment for speaking up

Comparisons in current cases:

RUH Bath	Salisbury NHSFT	Great Western Hospitals
150	134	No data available

7.2 **Feedback -** A feedback form is sent to all staff who raise a concern, which asks if they would speak up again, how they found the experience and if they have suffered detriment due to speaking up. Approximately 20% of staff returned the form and the FTSUG also seeks verbal feedback when appropriate. There have been positive and negative experiences from staff who have raised concerns, below are a few examples:-

"I feel stronger and now enjoy coming to work despite it being so busy. I feel listened to and cared for after speaking up. I bear no grudges towards the person who made my life so difficult."

"Overall, we have been reassured that the concerns are taken seriously, nobody is asked to put up with any such behaviours in their working environment, however the individual involved is given another opportunity to improve and move on"

"You have been so lovely, kind and supportive. I really do appreciate your time."

"Things are so much better in the department – would definitely speak up again."

"Really positive outcome after our conversation. I spoke with my line manager and everything is so much better".

"Despite all the hard times and changes in maternity services, I just wanted you to know it has been worth it as there is definitely a change in the culture. Thank you for being persistent."

"I feel I have no option but to resign".

"I am being treated differently to the rest of the team after raising concerns"

For those who feel they have suffered detriment after raising a concern, the FTSUG flags this to the Chief People Officer and those who have been involved in managing the concern. Development of clear guidance and protocol when detriment is identified needs to be a priority to create the psychological safety for colleagues to raise concerns.

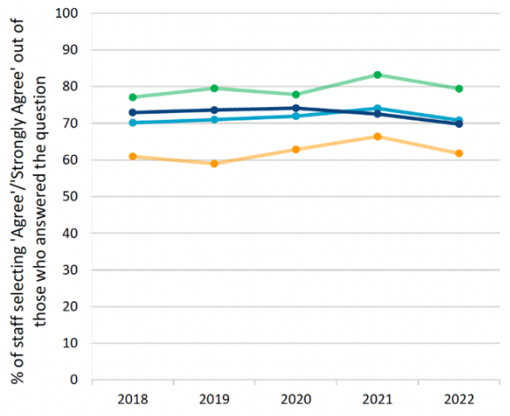
7.3 NHS Staff Survey – SFT Results

The staff survey results reflect the national picture in that staff feeling safe to raise concerns has deteriorated. There is also a decline in staff feeling that concerns when raised are being addressed.

People Promise elements and theme results – We each have a voice that counts: Raising concerns

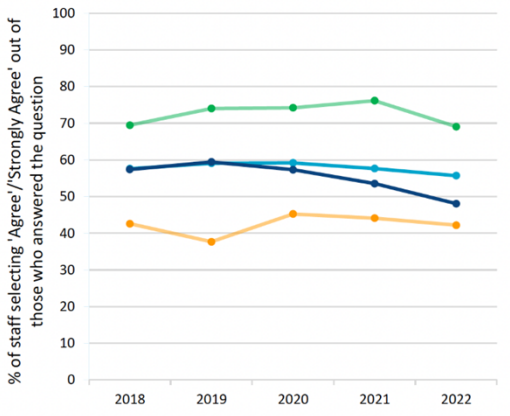
Survey Coordination Centre

Q19a I would feel secure raising concerns about unsafe clinical practice.



	2018	2019	2020	2021	2022
Your org	72.9%	73.6%	74.1%	72.5%	69.8%
Best	77.1%	79.5%	77.9%	83.2%	79.4%
Average	70.1%	71.0%	71.9%	74.1%	70.8%
Worst	60.9%	59.0%	62.8%	66.4%	61.8%
Responses	1292	1916	1997	1809	1851

Q19b I am confident that my organisation would address my concern.

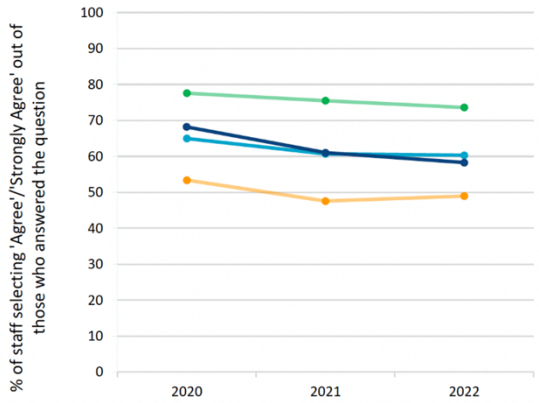


	2018	2019	2020	2021	2022
Your org	57.4%	59.4%	57.3%	53.6%	48.1%
Best	69.5%	74.0%	74.2%	76.2%	69.1%
Average	57.6%	59.1%	59.2%	57.7%	55.7%
Worst	42.6%	37.7%	45.3%	44.1%	42.2%
Responses	1289	1917	1998	1803	1849

People Promise elements and theme results – We each have a voice that counts: Raising concerns

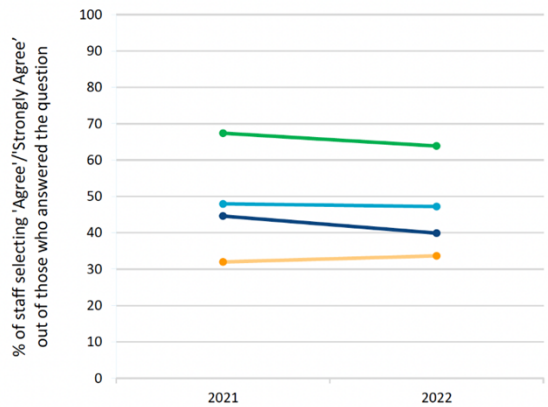
Survey Coordination Centre

Q23e I feel safe to speak up about anything that concerns me in this organisation.



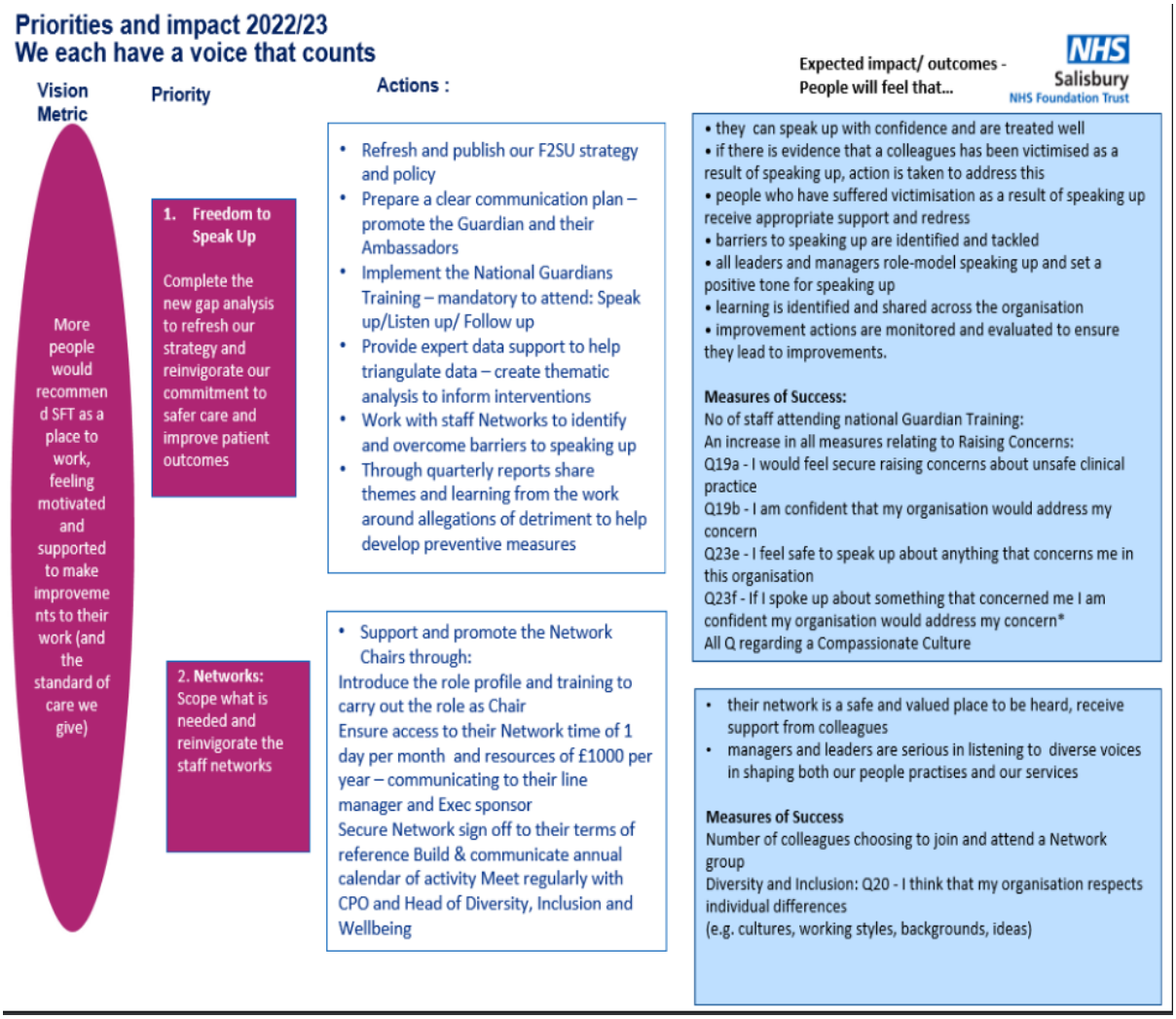
	2020	2021	2022
Your org	68.2%	61.0%	58.3%
Best	77.6%	75.5%	73.6%
Average	65.0%	60.7%	60.3%
Worst	53.4%	47.6%	49.0%
Responses	1999	1799	1849

Q23f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022
Your org	44.6%	39.9%
Best	67.4%	63.9%
Average	48.0%	47.2%
Worst	32.0%	33.7%
Responses	1801	1850

7.4 NHS People Promise – We each have a voice that counts. In response to the staff survey results the FTSUG continues to work with the wider OD&P team to deliver this particular aspect of the People Promise. Actions include :-



FTSUG is also leading on Civility and Respect as the starting place for the future delivery of a Restorative Just and Learning Culture. There is a pilot scheme running in Theatres with FTSUG supporting the management team to deliver. This pilot will form the basis of Civility and Respect being rolled out to wider teams across the organisation.

8.0 Summary of Learning from Speaking Up

The majority of the concerns raised have resulted in learning for the Trust. A summary of this learning is described below:

- Focus groups arranged for staff to have a safe place to talk openly with feedback themed and anonymised for line managers to reflect on and action plans put in place.
- Identified support for colleagues whose domestic arrangements have changed and the need for flexible working to retained skilled workforce
- Clarity and clear role expectations put in place for Maternity Care Assistants.

- Additional support and training given to new Maternity Nurses with safe care being delivered to patients
- Challenged poor behaviours to include openness and visibility of managers, disciplinary action taken where appropriate.
- Independent cultural review to take place to assess employee experience and wellbeing within a department where recurrent concerns have been raised.
- Discriminatory behaviour has been addressed by appropriate training given to the individuals concerned with support put in place for those who spoke up.
- Managers should hold regular meetings with their teams to ensure that staff are aware of local changes and issues, as well as wider Trust changes that may affect them.
- FTSUG works with the Divisions looking at themes and trends of concerns raised. Action plans are developed in response.

All these improvements will help our staff deliver an outstanding experience every time for our patients.

Speaking up is about anything that gets in the way of delivering high quality care.

9.0 Summary

All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the Freedom to Speak Up (FTSU) report and recent guidance from NHSI/E and the CQC: This paper provides the Committee with assurance that best employment practice for FTSUG has been adopted at Salisbury NHS Foundation Trust.

10 Recommendations

10.1 The Board is asked to note the Freedom to Speak Up Annual Report 2022/23 and consider appropriate actions for improvement going forwards.

It is recognised that improved leadership and management across the Trust will drive improvements in staff experience and wellbeing – this has been clear in our most recent Staff Survey and in ongoing conversations identified within this report.

The Trust Board to complete 'Follow Up' FTSU training. This is available on MLE.

It is the Trust Board's responsibility to support the Chief People Officer and FTSU Guardian to complete the refreshed Board Self Reflection Toolkit which needs to be completed by September 2023.

Detriment to be identified and appropriately managed. This includes input from the Executive and Non-Executive Leads, expectations for those managing a concern, whether a concern is raised through FTSU or not, and don't just move the problem. My recommendation would be that FTSU to work with Employee Relation Team and HR Business Partners to come up with a clear protocol which can be embedded into our Leadership Development Programme and relevant people policies.

FTSU has good reach across organisation as colleagues from all areas speak up, we need to continue to develop communication plans to reach all.

Therefore, the author wishes to thank the Board for the continued support, scrutiny and awareness of our plans and their critical support in addressing the cultural changes and that appropriate resource is in place to enable.

Elizabeth Swift
Freedom to Speak Up Guardian

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board Meeting - Public	Agenda item:	5.4
Date of meeting:	7 September 2023		

Report tile:	Health and Safety Report – Q1			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):	TMC			
Prepared by:	Troy Ready – Health and Safety Manager			
Executive Sponsor: (presenting)	Melanie Whitfield – Chief People Officer			

Recommendation:

The Board is asked to note the improved H&S performance during Q1, and take assurance from the:

- plan to improve the management of violence and aggression across the Trust, as agreed by the Violence Prevention and Reduction Working Group, and
- Ongoing actions to improve the implementation of a formal H&S management system.

Whilst improvements in H&S performance are evident, the Board is asked to note actions still required to embed a robust H&S management system. Actions the H&S team will look to implement in Q2 that include, but are not limited to, improving injury investigations, the completion of local risk assessments, reintroducing local department safety inspections and training on managing violence and aggression.

Executive Summary:

H&S performance in Q1 shows reduced injury rates, by comparison with 22/23. Specifically:

- LTIFR is down from 15 to 5.
- Lost time injuries are down from 35 to 13.
- LTFR is down from 10 to 2.3.

Violence and aggression towards staff remains a focus area. In Q1 the Trust has developed, and agreed on, a trust wide strategy to reduce the increase in violence and aggression, has completed Divisional risk assessments in areas of greatest risk, completed individual patient risk assessments on specific wards and has commenced dementia, confusion and delirium training on targeted wards.

Audit and task analysis activity by the H&S team suggests risks such as manual handling and sharps are well managed but there remain a number of actions for Q2. For example, improving injury investigations, recommencing department inspections, increasing the number of risk assessments available and ensuring a competency based training in some non clinical areas.

Finally, the H&S Team is in receipt of nitrous oxide testing equipment to measure time weighted exposure (TWE) to nitrous oxide as highlighted by NHSE in March 2023. Testing will commence in September with results to follow in the Q2 H&S report.

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

HEALTH AND SAFETY PERFORMANCE REPORT

23/24FY QUARTER ONE

Salisbury NHS Foundation Trust

1. Report Summary

There has been continued progress in the management of H&S across the Trust in Q1. Highlights of which include:

- Ongoing development of the H&S management system.
- Lower injury rates (quarter comparison) from 22/23.
  - LTIFR down from 15 to 5.
  - Lost time injuries down from 35 to 13.
  - LTFR down from 10 to 2.3.
- Management of risks such as manual handling are well established.
- Development of a formal strategy to manage violence and aggression.
- Implementation of risk activity such as auditing and task analysis by the H&S team.

Despite these positives, violence and aggression remains the most obvious risk and considerable work has been undertaken to develop a Trust wide strategy to manage this risk.

And whilst the H&S management system is evolving, there are a number of actions required to ensure a robust and effective H&S management system has been developed. For example, improving injury investigations, the completion of risk assessments, reintroducing local department safety inspections and training on H&S responsibilities. This report identifies a number of clear actions to be taken during Q2 as a result of audits, investigations or the ongoing plans of works undertaken by the H&S team.

2. Health and Safety Report Q1

The following report provides performance against objectives, describes the nature of injuries reported in the first 3 months of the financial year and actions to be taken during Q2.

2.1 Injury Statistics by Division

Number of Injuries by Type	55
Violence and aggression	26
Struck by a moving object	8
Slip and trips	6
Exposure to sharps	3
Manual handling	3
Chemical	3
Radiation	2
Struck an object	2
Laceration	1
Other	1

2.2 Injury Performance Measures

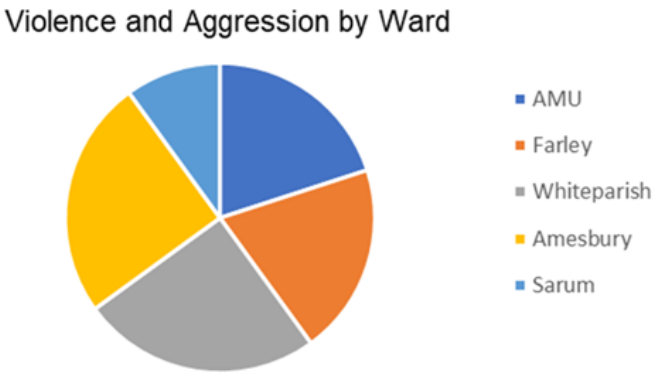
Injury and Frequency Rates by Division												
	Days Lost	YTD	LTI	YTD	LTIFR	YTD	LTFR	YTD	Near Miss	YTD	RIDDOR	YTD
Estates	2		1		28		4					
Facilities	36		2		13		18		2		1	
Surgery	8		5		7		1					
Medicine	30		4		8		4				1	
W&N	-		-		-		-		-		-	
CSFS	3		1		2		0.5					
Corporate	-		-		-		-		-		-	
Total	79		13		5.1		2.3		2		2	

Definitions:
Days lost are the accumulated total of days lost because staff are unfit to work due to work related injury reported in that quarter.
Lost Time Injury Frequency Rate (LTIFR) measures work related hours lost per 1,000,000 hours.
Lost Time Frequency Rate (LTFR) measures work related hours lost per 10,000 hours.
RIDDOR is an incident that must be reported to the Health and Safety Executive
Near Miss is an incident that did not result in harm to staff.

2.3 Breakdown of Violence and Aggression

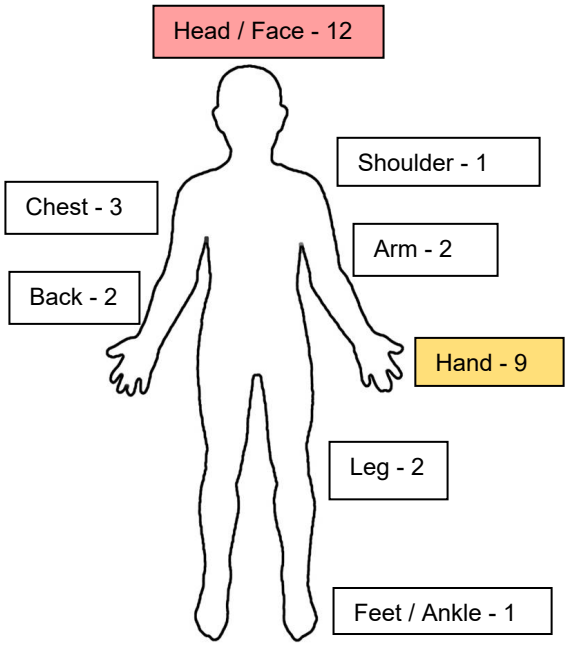
By Type

Physical act	**15**
Confusion	14
Antisocial	0
Mental health	1
Verbal abuse	**11**
Confusion	3
Antisocial	4
Mental Health	4



Performance results do not show the impact a small number of patients, who have caused considerable damage to various departments across the Trust, has had. Damage to Sarum Ward as a result of aggressive and violent behaviour has seen windows broken, walls broken, roof spaces broken and staff being abused and struck. Nor do these results explain the impact on staff who continue to work under tense and uncertain conditions.

2.4 Injuries by Body Location



Head and Face

Of the 12 head and face injuries reported, 9 were the result of being struck by patients. 1 injury resulted in a reportable injury (RIDDOR) to the Health and Safety Executive.

Hand injuries

All injuries were due to staff hitting hands on fixed objects or being struck by moving equipment as walking past.

2.5 Injury Analysis

The number of days lost, and the frequency of injuries, in Q1 shows a significant reduction on annualised results from 22/23, and although manual handling and sharps injuries continue to occur, they are reported in relatively low numbers with little impact on time lost. 8 staff reported hand injuries as a result of being struck by closing doors, trolleys being pushed by staff or in desk draws. Violence and aggression remains an obvious trend, with 26 datix reports recorded and continues to dictate the attention of the H&S team and some clinical areas.

There is a lack of information available to better understand the root cause of injuries and incidents. Many of the Datix investigations offer limited insight into causation, if investigated at all. Evidence suggests there are opportunities lost across the Trust, as a result of inadequate investigations, to learn from and to prevent injuries reoccurring. This is further supported by staff interviewed during the audit program who state they rarely receive formal feedback from Datix reports completed.

Action
Whilst the H&S team are investigating Datix reports that have resulted in lost time, there is still a need to ensure these are formally documented and involve greater, and more formal input from divisional managers. The H&S Team is developing a formal injury investigation tool to improve the documentation of investigations, root cause and formal actions that can be communicated to the relevant department and division and provide lessons learned to the H&S Committee and Trust.

3. Key Risks Defined by the Health and Safety Executive

3.1 Manual Handling

Whilst there are a significant number of injuries associated with hitting objects or being exposed to violent behaviour, there is a lack of injuries to backs and shoulders that are known to be associated with manual handling injuries.

The lack of injuries can infer the management of manual handling is well established across the Trust. Risk assessments are completed and many actions that reduce the risk of injury, such as competency based induction, lifting equipment and patients falls assessments are widely available and have been implemented for some time.

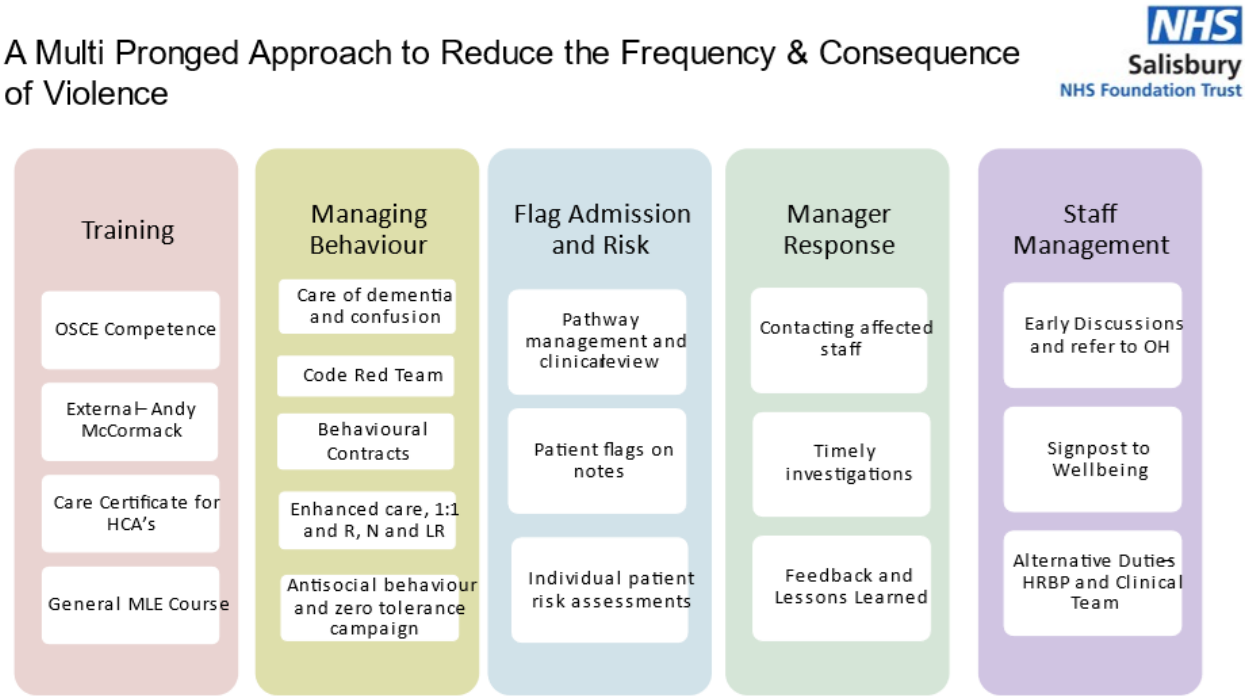
The Annual H&S Report identified manual handling injuries on the spinal unit as an outlier to the overall Trust manual handling performance. Discussions with the Spinal Matron and Senior Sister identified a gap in the management of manual handling risks that can be attributed to the dead weight of limbs when helping patients. Staff on the spinal unit complete the manual handling competency course delivered by the Education Team, but training is not specific to the nuances of spinal care. Spinal manual handling training was previously provided by the department for all new starters but ceased. There is scope to reintroduce spinal specific training for new staff, in consultation with the Manual Handling Lead.

Action
The H&S Manager will consult with the Manual Handling Lead to investigate the reintroduction of local spinal manual handling training.

3.2 Violence and Aggression (V&A)

As identified above, and as previously documented in the annual H&S report, V&A towards staff is the most reported cause of work related injury and time lost. The Violence Prevention and Reduction Working Group (VP&RWG) in Q1 agreed the below strategy to improve the management of V&A across the Trust. The agreed strategy looks to distinguish the management of V&A into 3 groups:

- Dementia, confusion and delerium;
- Antisocial behaviour; and
- Mental health



Whilst there is evidence to support the need for significant training on dementia, confusion, delirium and the risk of violence, there is also a cohort of young patients who have caused signicant damage to areas of the Trust, as seen in ED and Sarum Ward recently. Despite attempts to make the room safe, remove ligature points, objects that can be used to self harm or injure others and provide immediate arms length supervision, the patient continues to damage equipment, verbally abuse and hit staff that creates an ongoing challenge for staff, patients and next of kin.

3.2.1 V&A specific actions completed in Q1 include:

- Develop and agree to trust wide strategy on managing vioance and aggression
- Divisional risk assessments have been completed for Medicine and CSFS.
- Individual patient risk assessments have been completed on demand with clinical teams for patients on Sarum Ward and ED.
- Local ward training on managing care of dementia has commenced on Amesbury Ward.

3.2.2 Key Initiatives for Q2 include:

- Local ward training on managing care of dementia (Pitton Ward).
- Develop an external training schedule with approved provider of V&A training.
- Develop a Zero Tolerance to Violence and Aggression Campaign.
- Reintroduce use of the Dementia Care Bundle.

4. H&S Activity – Auditing and Task Analysis

As a result of the Annual H&S Report, the decision was made to expand the auditing within Medicine to include Pitton Ward. This is a change to the published calendar that was looking to commence audits in CSFS. The change in audit location was the result of the annual H&S report identifying higher injury rates on Pitton Ward and therefore shifting priorities based on a known risk profile.

Internal audits have been completed in Estates and in Medicine and Task Analysis have been completed in the kitchen, cleaning, fitness centre and portering. Despite the significant differences in risk profiles between clinical and non clinical divisions, there are a number of common themes identified. These are:

4.1 Risk Assessments

The management of H&S in ETS is vicariously achieved through the implementation of Health Technical Memoranda (HTM's) but where no HTM is available risks are often managed in a reactive manner and risk assessments are not generally available. Within clinical areas, risk assessments are completed in response to a risk that has caused harm, or for inclusion on the divisional risk register.

There is no evidence of risk assessments to demonstrate how risks are identified, assessed and controlled locally. There is an opportunity to utilise trust risk assessments for risk such as manual handling, slips and trips, violence and aggression, sharps and tailor this to reflect nuanced clinical situations within departments.

Action
The H&S Team, as part of the task analysis and auditing program, is identifying where risk assessments are available or not. Where not available, the prudent approach is to focus on higher risk tasks responsible for injuries, or simply higher risk activity that is more likely to cause injury, and ensuring risk assessments are available. The H&S Manager will consult with Divisions to develop local, and retrospective, risk assessments for risks to H&S that are being managed.

4.2 Competency Assessments, Induction and Development

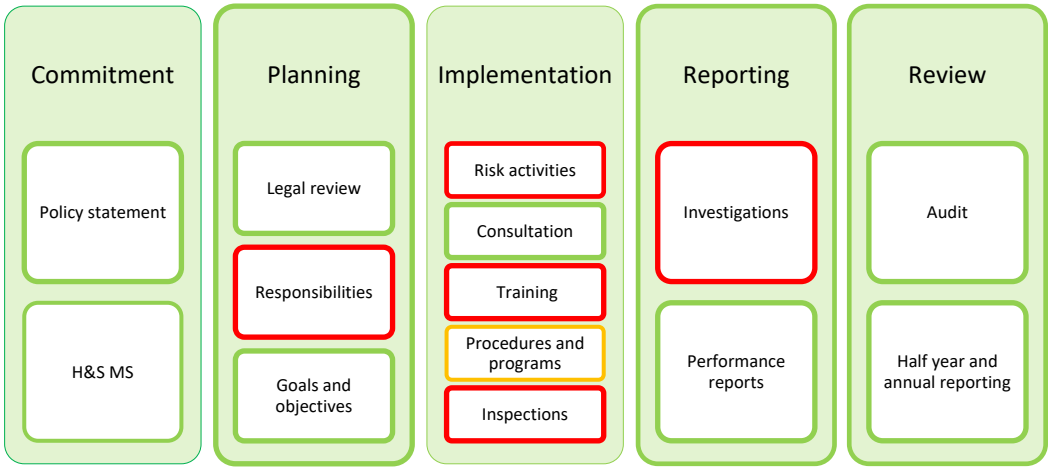
There are many competency assessments clinical staff are required to complete before, or soon after, commencing on the ward and there is evidence to demonstrate a robust induction program where staff are buddied, supernumerary and supervised for a 2 week period of time. This is also evidence of a formal training program in ETS, through consultation with the Trust Authorising Engineers, to become an Authorised Person to manage risks such as fire, pressure and electricity. Whilst Tug operators are required to undertake formal competency testing, induction and training prior to use.

But there is no formal competency based induction program for ETS staff performing technical work and little trust wide development training specific to H&S - unless external training is completed. Examples of H&S expected to be available include investigating injuries to understand root cause, undertaking return to work conversations and how to complete a risk assessment. Violence and aggression training is a further example and a calendar of internal and external training is being developed with the VP&RWG.

Action
Gaps in management training are being addressed with the development of line manager training, in which H&S has been included as a training session with content being developed by the H&S Manager.

5. H&S Management System Update

Progress continues with the development and implementation of the Trust H&S management system as shown below. The areas highlighted in red remain a work in progress as identified in the audit and task analysis activity or as previously report.



In addition to the actions identified above there are a number of actions to be implemented in Q2. These are:

5.1 Documented H&S Responsibilities – There are no specific H&S responsibilities for a number of clinical roles such as Matrons or Divisional Heads and staff interviewed during audit discussions are generally not aware of specific H&S responsibilities, unless couched in general terms.

Action
The easiest way to document H&S responsibilities is to develop a H&S Responsibility Policy. The H&S Manager will develop a DRAFT policy for the H&S Committee to consider and approve.

5.2 Inspections – Prior to Covid, wards and clinical areas would conduct inspections of the work areas. These ceased during Covid and have yet to recommence. There is no reason why inspections cannot recommence.

Action
The checklist previously used has been modified, H&S key workers have been identified in most areas, and the H&S team will support wards with completing inspections over the coming quarter against a schedule of inspections.

6. Further H&S Priorities in Q2

6.1 Nitrous Oxide Exposure Testing

In response to the NHSE publication on the risk to long term exposure to low levels of nitrous oxide (N_2O), the H&S Team in consultation with Medical Gases Group and Chief Pharmacist have identified a cohort of staff using N_2O and agreed on a testing regime that includes but is not limited to Maternity, Theatres, Endoscopy Suite and ED Minors.

Testing equipment has been purchased, testing locations are being identified and a cohort of staff will be identified with a calendar of staff testing by department to be available. Anonymised results will be reported to the MGG and H&S Committee, whilst individual staff and the Occupational Health Team will receive confidential reports.

Action
The H&S Manager will develop a schedule of testing by department and staff in consultation with each Division.

6.2 Noise Testing

Noise volumes in corridors as a result of trolleys / cages being manoeuvred by tugs could be above both the peak limits and time weighted averages (TWA). There is a need to assess the noise levels, especially within corridors between Maternity and Hedgerows.

Action
The H&S Team will undertake noise testing of both peak exposure and TWA to determine the extent of the risk of hearing damage. The H&S Team has noise monitoring equipment to measure peak limits but not time weighted averages.

Report written by

Troy Ready

Health and Safety Manager

August 2023

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.1
Date of meeting:	7 September 2023		

Report tile:	Remuneration Committee Terms of Reference Review			
Status:	Information	Discussion	Assurance	Approval
				x
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor: (presenting)	Ian Green, Chair			

Recommendation:
The Trust Board to review and approve the terms of reference.

Executive Summary:
All Board and Board Committees terms of reference are reviewed annually. The Remuneration Committee terms of reference have been reviewed jointly by the Director of Integrated Governance and one of the Non-Executive Directors. These were approved by the Remuneration Committee on 6th July 2023. The Terms of Reference have had a major review and all changes were approved. Section 5 has been further updated to clarify that the termination payments relate to those of Executive Directors at the request of the Committee.

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

Salisbury NHS Foundation Trust

Remuneration, Nominations and Appointments Committee

Terms of Reference

Document Change Control				
Date of version	**Version number**	**Type of Revision Major/minor**	**Description of Revisions**	**Author**
September 2019	1	New ToR		Director of Corporate Governance
November 2020	1.1	Minor	Updates to membership and attendance sections and minor formatting	Director of Corporate Governance
March 2022	1.2	Minor		Head of Corporate Governance
May 2023	1.3	Major	Complete review	Director of Integrated Governance/ Non- Executive Director

Date Adopted	~~7th April~~
Review Frequency	Annual
Terms of Reference Drafting	Director of Integrated Governance
Review and Approval	Remcom Approved 6th July 2023
Adoption and ratification	Trust Board

1. Purpose

1.1. To be responsible for review of the composition of the Board, identifying and appointing candidates to fill all the Executive Director positions on the Board and for determining their remuneration and other conditions of service.

2. Authority

2.1. The Remuneration, Nominations and Appointments Committee (the Committee) is constituted as a standing committee of the Trust's Board of Directors (the Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

2.2. The committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the committee.

2.3. The committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

2.4. The committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. Membership and Attendance

Membership

3.1 Members of the Committee are appointed by the Board and will be made of at least three Non-Executive Directors, one of which will be the SFT Chair.

3.2 When appointing or removing the Chief Executive, the Committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 (the Act). When appointing or removing the other Executive Directors the committee shall be the committee described in Schedule 7, 17(4) of the Act (that is, the Chairman, Chief Executive and the Non-Executive Directors).

3.3 The Committee will be chaired by one of the Non-Executive Directors. In the absence of the nominated Chair, another Non-Executive Director will chair the meeting.

Attendance

3.4 Members of the Committee are expected to attend meetings.

3.5 At the invitation of the Committee, the Chief People Officer will attend to advise the Committee but will not attend for discussions about their own remuneration and terms of service.

3.6 Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations, at the discretion of the Chair. At the invitation of the Committee, meetings shall normally be attended by the Director of OD and People.

3.7 Any non-member, including the secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

Quorum

3.8 The quorum for meetings and necessary for the transaction of business is three non-executives including the Committee Chair.

3.9 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Secretary

3.10 The Director of Integrated Governance or their nominee will act as secretary to the Committee.

4. Duties

4.1. Appointments

The Committee will:

4.1.1 Regularly review the structure, size, and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the Board, and Nomination Committee of the Council of Governors, as applicable, with regard to any changes. The Constitution sets out the requirements of the Board composition.

4.1.2 Consider and make plans for succession planning for the Chief Executive and other Executive Directors considering the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future.

4.1.3 Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy.

4.1.4 Be responsible for identifying and appointing Executive Director candidates to fill posts within its remit as and when they arise.

4.1.5 Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

4.1.6 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

4.1.7 Consider any matter relating to the continuation in office of any Board Executive Director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract.

4.1.8 When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the appointment. In identifying suitable candidates, the Committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.

4.2 Remuneration

The Committee will:

4.2.1 Determine and agree with the Board the framework and policy for the remuneration of SFT Chief Executive Officer and Executive Directors. In determining such policy, consider all factors which it deems necessary including relevant legal and regulatory requirements, and other best practice as appropriate. The objective of such policy shall be to ensure that SFT'S Chief Executive Officer and Executive Directors, are provided with appropriate incentives to encourage enhanced performance and are, in a fair and responsible manner, rewarded for their individual contributions to the success of the organisation.

4.2.2. Consult the Chief Executive about proposals relating to the remuneration of the other Executive Directors.

4.2.3. In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's Executive Directors, including:

- Salary, including any performance-related pay or bonus;
- Provisions for other benefits, including pensions and cars.
- Allowances.
- Payable expenses.
- Compensation payments.

4.2.4. In adhering to all relevant laws, regulations and trust policies establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust.

4.2.5. Use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors, while ensuring that increases are not made where trust or individual performance do not justify them.

4.2.6. Be sensitive to pay and employment conditions elsewhere in the Trust.

4.2.7. Monitor and assess the output of the evaluation of the performance of individual Executive Directors and consider this output when reviewing changes to remuneration levels.

4.2.8. Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.

5. Executive termination payments

Approve any policies relating to early termination payments. Approve termination payments (including contractual payments such as redundancy or early retirement provisions as well as other payments) for Executive Directors. In doing so the Committee will ensure that any payments are fair, failure is not rewarded and the duty to mitigate loss is fully considered. Payments exceeding £100,000 will require subsequent Board approval.

6. Conduct of Business

Administration

6.1 The Director of Integrated Governance or their nominee will act as secretary to the Committee. The secretary will minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance.

6.2 Any member of the Committee can ask for an extraordinary meeting to be convened to meet business needs.

Frequency

6.3 The Committee will be held quarterly and at such other times as the Chair of the Committee shall require.

Notice of meetings

6.4 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be available to each member of the Committee and where appropriate, other persons required to attend, no later than five working days before the date of the meeting,

Reporting

6.5 The Committee's Chair will report formally to the Board, in the private session, on its proceedings after each meeting.

6.6 The Committee will make whatever recommendations to the Board it deems appropriate in any area within its remit where action or improvement is required.

6.7 Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

7. Review

7.1 These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.2
Date of meeting:	7 September 2023		

Report title:	Final 2022/23 Annual Report and Accounts			
Status:	Information	Discussion	Assurance	Approval
	x			
Approval Process: (where has this paper been reviewed and approved):	Audit Committee – Approved on 22nd June			
Prepared by:	Kylie Nye, Head of Corporate Governance			
Executive Sponsor: (presenting)	Kylie Nye, Head of Corporate Governance			

Recommendation:
The Board is asked to note the Trust's final 2022/23 Annual Report and Accounts.

Executive Summary:
The Trust's Annual Report and Accounts was approved at the Audit Committee on 22nd June 2023. The report was laid before parliament in early July and can therefore be published in the Trust's public Board papers and on the website. The communications team will be producing an 'Annual Review' which summarises the key highlights from the Annual Report and this will be shared with staff, governors and members prior to the Annual General Meeting in October.

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

Salisbury NHS Foundation Trust

Salisbury NHS Foundation Trust Annual Report and Accounts
1 April 2022 to 31 March 2023

Salisbury NHS Foundation Trust

Annual Report and Accounts 2022 to 2023

Presented to Parliament pursuant to
Schedule 7, paragraph 25(4)(a) of the National Health Service Act 2006.

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If you would like further copies of this report, need a copy in larger print, another language or audio format please contact the Chief Executive's Department.

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PERFORMANCE REPORT

STATEMENT FROM THE CHAIR AND CHIEF EXECUTIVE

Context and Overview of Performance

As we write this annual report it has now been more than 3 years since the first case of COVID-19-19 was recorded in the UK. We have become used to working through a pandemic and the last year has seen surges of COIVD-19 variants which place pressure on our services. We cannot escape the national context with industrial action, financial pressures and workforce challenges and we are very proud of the way our teams have continued to respond.

Our colleagues have been amazing. Resilient and resourceful in the face of pressure they continue to find new and innovative ways to work around the challenges and offer expert and compassionate care to embody the spirit of *Improving Together*, the vision and values that underpin everything we do at the Trust.

We have asked a lot of our communities too. Like elsewhere in the UK our need to respond to COVID-19-19 has left a backlog of patients waiting for elective treatment. Our teams have worked tirelessly over the last year with colleagues, the independent sector and partners in Bath and Northeast Somerset, Swindon, and Wiltshire to use all available measures to reduce waiting times in line with national requirements. Whilst there is more for us to do it is positive that we have delivered on the national 22/23 targets in respect of recovering waiting times.

We have continued to develop our approach to continuous quality improvement with over 351 people having accessed training and development as we build a culture and ways of working that allows everyone to flourish. Whilst there is more for us to do our colleagues are putting this into practice and delivering significant improvements for patients.

Our Stroke team have been using daily huddles and data to reduce the number of patients who fall whilst they are in hospital and our Respiratory team have reduced the waiting times for first outpatient appointments by over 30 percent.

Our values – that we are *patient centred and safe, professional, responsive, progressive, and friendly* are at the heart of who we are and what we do at the Trust. Devised in collaboration with our staff we strive to be an inclusive, kind and welcoming organisation. More than 4,500 people work in our teams. We are a community where everyone plays a vital role in our organisation. We are passionate in ensuring that everyone is treated with dignity and respect and diversity and inclusion is celebrated.

We have fantastic colleagues, and their health and wellbeing are a major focus in our recovery and reset, learning from measures and resources we have put in place to support them and empower them to deliver outstanding care for patients and their families. Listening and learning from them is crucial and whilst we have seen some improvements in our staff survey, we are determined to continue to make meaningful changes that improve their working lives.

We have always been proud to deliver excellent care and experiences for our patients and in addition to recovering our waiting times for planned care, we have made good progress with recovering our cancer standards and in access to diagnostic services.

Collaboration and Integrated Care

The past year has seen the formation of Integrated Care Systems (ICS), boards (ICB), and partnerships (ICP). Salisbury NHS Foundation Trust (SFT) is one of three acutes in the ‘Bath and Northeast Somerset, Swindon, and Wiltshire’ system (BSW). Supporting system wide aims is a key element of SFT activity and

good progress was made around defining the integrated care system's vision and defining governance structures throughout 2022/23.

As a trust we have a long and positive history of working in partnership to improve health and social care for our communities. We know that collaboration produces fantastic results as the COVID-19-19 vaccination programme shows. Bringing together the Trust as lead agency with partners from the local authority and third sector at City Hall in Salisbury saw more people in Wiltshire receiving their vaccinations than anywhere else in the South West.

Strategically we are a key partner in the Bath and Northeast Somerset, Swindon, and Wiltshire (BSW) partnership and contribute to its newly established Integrated Care Board. This aims to improve people's health and wellbeing by tackling inequalities in health and social care across BSW, improving the quality of services and ensuring resources are used effectively.

We are also part of the Acute Hospital Alliance (AHA) a provider collaborative with our acute trust partners. We are working closely together to ensure our patients have access to high quality sustainable services. The AHA has joined up our services in procurement to deliver efficiencies and savings and we are working collectively to secure a single Electronic Paper Record system which will enable our clinical teams to work more effectively with each other.

A major focus of our collaboration with our partners in Wiltshire – both internally and externally has been on improving the systems for discharging patients from hospital and moving them to a setting more suitable for their continued recovery and care. We have taken part in the national Discharge Taskforce and worked hard to reduce delays including measures to open a dedicated lounge and implement several improvements to patient flow with our colleagues in adult social care, community health teams and our local care homes.

This year has given us much to reflect on. There is no doubt it has tested us, but it has also brought opportunities for improvements to transform our services as we continue to deliver our strategy.

We are very grateful to our colleagues, our partners and would like to thank our partner charities Stars Appeal, Salisbury Hospice Charity, and the League of Friends for their ongoing support.

To our colleagues and our patients – Thank you. Without you we wouldn't have a hospital I know the Board and our local community are very proud of.

Ian Green OBE

Chair
22 June 2023 (on behalf of the Trust Board)

Stacey Hunter

Chief Executive (Accounting Officer)
22 June 2023 (on behalf of the Trust Board

Purpose and Activities of the Trust

Introduction to Salisbury NHS Foundation Trust

Salisbury NHS Foundation Trust was formally established on 1 June 2006. The Trust deliver a broad range of clinical care to approximately 270,000 people in Wiltshire, Dorset and Hampshire which includes:

- Emergency and elective inpatient services
- Day Case services
- Outpatient services
- Diagnostic and therapeutic services

The Trust also provides Specialist services, such as burns, plastic surgery, cleft lip and palate and specialist rehabilitation which extends to a much wider population of more than three million people. The hospital includes the Duke of Cornwall Spinal Treatment Centre. This is a purpose built, 40 bedded unit which specialises in caring for people who have spinal cord injury and serves a population of 11 million covering an area across most of southern England.

The Trust has more than 4000 staff who deliver over 50 different clinical services at Salisbury, providing care to the local population and beyond, making SFT one of the biggest employers in South Wiltshire.

Integrated Care system

Salisbury is part of Bath Swindon and Wiltshire (BSW) Integrated Care system (BSW ICS), the Trust works in partnership with local NHS organisations and the Local Authority to take collective responsibility for planning services, improving health, and reducing inequalities across the area.

The Trust works closely with partners at a local level to deliver more integrated care, effectively working with the health and care organisations in the immediate geography, Wiltshire Health and Care for Adult community services, Wiltshire Council for care services and many voluntary and third sector organisations for the benefit of the local population.

As part of the new Integrated Care System (ICS) arrangements nationally, provider organisations are being asked to step forward in formal collaboratives to better enable them to work together to continuously improve quality, efficiency, and outcomes for the populations they serve together. SFT is working with Great Western NHS Foundation Trust in Swindon and The Royal United Hospitals in Bath as part of an Acute Hospital Alliance (AHA) in the BSW ICS.

To continually improve the services that we run for our patients and carers, the ability to work with partner health and care agencies remains crucial. The Trust has many partners, many beyond the BSW ICS boundary, all of which remain pertinent to delivering outstanding care.

Our Strategy 2022-26

The strategy is a key document for the hospital as the Trust sets out the future plans and priorities. It articulates the important commitments the Trust is making to the local communities over the next five years, and is underpinned by the vision:

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

The strategy confirms three priorities:

- Improving the health & wellbeing 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

These three priorities guide how the Trust works as part of an Integrated Care System. The August 2022 publication of the strategy was the first step in using these priorities to continuously improve the way the Trust works and focus on the things that are most important to the local community and staff.

As the 'Improving Together' way of working is rolled out across the Trust, work will be prioritised through the identification of key short- and long-term improvement projects and programmes:

Strategic initiatives. These are 'must do, cannot fail' programmes of work that apply Trust-wide and are planned to deliver over 3-5 years. Because they are so important to the successful delivery of the strategy, they have dedicated delivery teams working to ensure they are delivered consistently with every SFT colleague. There are four strategic initiatives:

1. Delivering digital care
2. Delivering our people promise
3. Improving health and reducing health inequalities
4. Having a culture of continuous improvement (Improving Together)

Breakthrough objectives. These are operational in nature and where improvement efforts are focused for 12-18 months. They are reviewed each year and can evolve when the targets have been achieved for 6+ months.

In 2022-23 as part of Improving Together, the breakthrough objectives below were aligned to the Trust's quality priorities and further detail on progress against the Trust's quality improvement plans can be found in the Quality Account, published annually on the Trust's website. These priorities represent the three indicators of quality (patient safety, clinical effectiveness, and patient experience).

The continuous improvement approach applies to every aspect of our strategy and everyone in the Trust has a role to play in delivering and operationalising it.

Breakthrough Objectives 2022-2023

In 2022-23 the Trust chose the following four breakthrough objectives:

1. Reduction in falls
2. Reduction in time to first appointment
3. Same Day Emergency Care (SDEC) pathways
4. Reduction in No Criteria to Reside length of stay

As 2022/23 progressed the understanding of the Improving Together methodology matured. Ahead of a winter of anticipated intense operational pressure the Trust refreshed the breakthrough objectives.

The four breakthrough objectives became:

1. Reducing falls to ≤7 falls per 1,000 bed days
2. Reducing time to first outpatient appointment to an average of 87 days
3. Staff availability – reducing staff agency costs as a percentage of gross pay to 3.7%
4. Reducing bed occupancy to 96%

These changes recognised the need to focus on staffing levels alongside falls and time to first outpatient appointment. The use of bed occupancy as a breakthrough objective provided a greater focus on the areas of a patient's pathways the Trust has a significant influence over. For example, improving pathways for patients who can go home without packages of care.

Progress against the 2022-2023 breakthrough objectives

The evolution of the breakthrough objectives did not mean stopping work on SDEC and discharge pathways for those waiting for onwards care. The medical SDEC service launched in March 2023 and early analysis shows a two-fold increase in same day discharges, which is supporting the focus on reducing bed occupancy and improving patient experience. Work to streamline pathways for out of hospital care

continues with partners, with increased capacity of virtual wards and care co-ordination will continue to grow in 2023/24.

The recovery from the impact of COVID-19, especially on elective care is a continued priority. The primary objective of improving patient care through reduced waiting times is a key focus. The Trust achieved the target of ensuring no patients waited more than 78 weeks for their treatment in February 2023, a month ahead of the national March 2023 target. The Trust is now focusing on the delivery of having no patient waiting 65 weeks for their treatment by March 2024.

Improving Patient Flow & Reducing Bed Occupancy

A key challenge throughout 2022/23 has been ensuring flow through the hospital, ensuring people are not in hospital longer than they need to be and patients have a positive experience. This requires all parts of the health and care system to work in an integrated way. Our partners continue to work with the Trust in looking at all parts of the patient pathway for improvements with a clear aim to improve patient experience

We have deployed our same day emergency care (SDEC) service to alleviate admission demand, and this has begun to reduce inpatient capacity pressure as we exit 2022/23.

Over 2022/23 we had a record number of escalation beds open, including a ward at South Newton. These high levels of bed occupancy made patient flow through our Emergency Department challenging and unfortunately our patients have regularly experienced long waits for treatment in the department, with increased handover delays between our ambulance services and the department.

In managing winter, the Trust focused on a number of interventions including opening a discharge lounge, which facilitates discharges earlier in the day, ensuring that less patients are waiting within the ED department for an inpatient bed. In addition, the Trust focused on ensuring staffing levels improved with a range of interventions including recruitment and addressing pay differentials.

The Trust worked closely with system partners, and continues to do so, in an effort to reduce the time patients stay awaiting onwards care. This will improve flow, reduce costs, and most critically of all, ensure that patients experience the right care in the right place at the right time.

Recovery from COVID-19-19 – Elective Recovery

Good progress has been made in reducing the time patients are waiting for planned care. The greatest challenges have been access to inpatient beds and theatre capacity related to staffing levels.

Theatre recruitment has continued strongly again this year, with overseas staff now firmly embedded across the theatre's footprint. The increase in staffing levels and management and leadership time in theatres have supported the attainment of the nationally recommended utilisation levels within main theatres which has been maintained throughout the year.

Theatre utilisation is one of the component parts of a wider three-year development plan for theatres. The ongoing improvements have meant we were able to meet our waiting times management objectives in eliminating all RTT 78week waits by the end of February 2023.

Outpatient services are a significant focus nationally and locally in transforming service to be able to see and treat more patients and improve patient experience by reducing the number of routine follow up appointments.

Our improvement programmes are a response to both national guidance but also the BSW local ICB strategy, ensuring alignment as the Trust works in partnership to deliver transformation programmes. Supporting elective recovery, diagnostics performed well in the first half of the year however, remained challenged throughout the winter period particularly related to gaps in key staffing groups. A recovery plan is in place and the Trust's performance is now improving.

The most significant challenge has and continues to be elective bed capacity and escalation into our Day Surgery Unit, across most of the year, increasingly across the winter months. This significantly impacted on the volume of elective activity that has been able to be undertaken, resulting from the consistently high numbers of patients waiting for onward care, across the Trust's bed base.

Improving our Maternity Services

The Maternity Service has continued to work with the Care Quality Commission (CQC), Ockenden report and East Kent recommendations to improve maternity and neonatal services for women and families. They have actively engaged in the Maternity Services Support Programme, supported by NHSE, to improve and transform local services and in response to national work streams.

In October 2022 the Beatrice Birth Centre opened, which was funded by the Local Maternity and Neonatal System (LMNS), Salisbury NHS Foundation Trust and the Stars Appeal. The new place of birth offers another choice for women and birthing people and to date has had good clinical outcomes and positive user feedback. The Women and Newborn Division has also seen the successful launch of the PERIPrem (Perinatal Excellence to Reduce Injury in Premature Birth) care bundle within Neonatal services. This includes eleven interventions that demonstrate a significant impact on brain injury and mortality rates amongst premature babies. This year has also continued to see effective collaboration with the Maternity Voices Partnership, to support an improvement in experiences for all.

There has been further work in year to embed the governance structure within maternity services, allowing floor to Board transparency. This has meant continued work on strengthening leadership within the divisions, using external human factors training, internal transformational leadership, matron development, coaching, clinical director leadership development and an ongoing commitment to regular senior leadership away days. Additionally, there has been co-production of the maternity vision by the staff and a behaviour charter to express the unit employee's demand for professional standards in behaviour. Significant progress has also been made on staff communications to ensure everyone is informed of any developments or challenges. This has meant a continued progression of the improvement in culture, leadership and transformation within the service.

Recruitment of midwives continues to pose a challenge. However, five international midwives are currently working to achieve their OSCE qualification. Recruitment into Middle Grade and Consultant positions has been variable through the last year, and this is a national challenge. There has been an expansion in obstetric leadership to meet national requirements and successful consultant recruitment to maintain clinical care. The team is transitioning into 'Hub' working in the community, with work underway to identify locations and model staff and service delivery.

Responding to Staff Health and Wellbeing

2022-23 has continued to be very challenging for our staff across all professions. The Trust has managed a slight decrease in sickness absence levels from 31,218 working days lost in 2021-22, to 29,738 days lost in 2022-23. The continuing impact of COVID-19-19 and an increase in year of winter Flu and other respiratory infections have continued to contribute to a high level of short-term absences which impacts a challenging operational environment. However, the Trust performed well in the Health Care Worker vaccination programme, achieving the highest COVID-19 vaccination rate for staff (74.4%) and second highest for Flu vaccinations (66.4%) in the southwest, which was the highest performing region.

Under the 'we are safe and healthy' element of the People Promise, the Trust has been developing an improved health surveillance function, which has identified that Mental Health related issues and Musculo-Skeletal injury are the biggest contributors to absence after infectious diseases. This data has enabled improved interventions particularly in the wellbeing area, where a new website has been launched to signpost staff and managers to a number of additional resources to help with mental, financial and physical wellbeing. Clinical Psychology services have also continued offering wellbeing interventions to staff as a supportive mechanism of preventing sickness absence. The Trust's Occupational Health service has been

a focus for recruitment and now provides a full suite of OH support including staff counselling and physiotherapy.

The Trust appointed a Head of Wellbeing, Equality and Inclusion this year to provide greater focus on wellbeing and promote better health in conjunction with our Occupational Health service and Health and Safety team. Under this collaboration the Trust has monthly health and wellbeing topics/events, trained mental health first aiders, and health improvement coaches for weight management, alcohol, smoking cessation support, healthy eating, increasing physical activity and building confidence and motivation. Staff also retain access to the onsite health and fitness centre, green spaces, and walking routes.

National Staff Survey Results 2022

The NHS staff survey is conducted annually, with 2022 being the second year when the questions were aligned with the NHS people promise to track progress against our ambition to make Salisbury Foundation Trust (SFT) workplace the 'best place to work'. The national Staff Survey reports against the seven elements of the people promise, and two of the original themes of the staff survey: morale and staff engagement.

The 2022-23 response rate was slightly lower than the previous year with 1861 members of staff responding compared to 1881 in 2021. Details of the scores for each indicator, together with the average, best and worst scores in the benchmarking group across the NHS can be found in the Staff Report or on the NHS Staff Survey website:
https://cms.nhsstaffsurveys.com/app/reports/2022/RNZ-benchmark-2022.pdf

SFT demonstrated a comprehensive programme of improvement against each of the seven elements of the People Promise and has continued to be one of 23 Trusts exemplar sites continuing this work for a second year. Following these results there are a number of future priorities identified and both people services and divisional teams are developing action plans to address the key themes arising from the survey which was published in March 2023. Staff survey action plans will continue to be monitored by the Organisational Development and People Management Board and People and Culture Committee on behalf of the Trust Board.

Improving our digital capability

The Trust has launched a new Digital Plan in 2022/23, building on the work undertaken across the digital agenda over the life of the previous Digital Strategy. During 2022/23 we have made progress in our plans to implement electronic prescribing and medicines administration (ePMA), electronic patient records systems (EPR) and pathology laboratory management systems (LIMS). We have successfully upgraded a range of systems, commenced a programme of replacing paper-based nursing documentation with digital versions and implemented an integrated shared care record in conjunction with our partners in BSW. Improving Digital Healthcare remains a Strategic Initiative for the Trust over the next 5 years, with an initial focus on these projects and improved Business Intelligence and analytics tools.

We continue to improve digital access to our services for both patients and clinicians. Our outpatients' transformation programmes have included the expansion in the use of virtual appointment technologies for patient appointments and remote Advice and Guidance for our clinical partners. We are progressing a programme to implement a patient portal aligned with BSW peers, enabling patients to reschedule their own appointments and see key correspondence electronically.

Trust risks and mitigation

The Trust's Board Assurance Framework (BAF) details the principal strategic risks of the Trust's corporate objectives. This is received by the Board on a quarterly basis, alongside the Corporate Risk Register (CRR). The Board Committees have oversight of the BAF and CRR where the risk profile is reviewed and

discussed in detail. The BAF records that the Trust has been managing 12 significant risks during the 2022-23, with 6 risks outside of the Board agreed risk appetite (outlined below). For each BAF risk there is a detailed series of mitigations which will continue to be implemented throughout 2023/24.

The delivery of these mitigations and their impact on the risks is monitored through the appropriate Committee of the Board. As we enter 2023/2024, the Trust remains focussed on enacting recovery plans whilst dealing with significant operational challenges and staffing availability, compounded by on-going strike action.

Risk	Mitigation strategies
Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.	• Implemented an improvement programme for theatres and outpatients to support improvements in waiting times for planned care.
Financial sustainability.	• Increased focus on financial controls, emphasising best value decisions.
Staffing availability impacting on service delivery and health and wellbeing of staff.	• Implemented a range of initiatives to support staff attraction and retention including incentivised pay rates, wellbeing offers and significant recruitment campaigns.
Capacity versus demand and impact of delayed discharge from hospital	• Full engagement within the Wiltshire Alliance to improve discharge processes. • New urgent care transformation programme including SDEC, ED and Elderly Care.
Information technology, clinical systems and technical infrastructure.	• Implementation of the digital strategy and continued focus on development of the infrastructure and controls.
Critical plant and building infrastructure within limited capital funding.	• Robust capital prioritisation processes to ensure resources are deployed effectively.

Going Concern

Our Board considered an assessment of the Trust as a going concern at its meeting on 6 April 2023. A number of risks to this position were identified including a planned deficit position for 2023-24 and the uncertainty on industrial action giving material financial risk.

After making enquiries the directors have a reasonable expectation that the services provided by the NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Overview of financial performance in 2022/23

In 2022/23 the NHS had a continued focus on the recovery of elective pathways and addressing waiting times alongside managing emergency pathways. The pressure on the emergency pathway manifested through increased costs associated with the Trust's bed base, the loss of elective capacity to accommodate medically sick patients and the premium costs of bank and agency to cover vacancies and unavailability. Higher levels of beds occupied by patients no longer in need of acute clinical care than had been planned for has been reflected across the local BSW system and wider NHS.

The Trust incurred material cost pressures in year with significant volatility around Utilities costs, increasing drugs costs linked to activity levels and increases in bank and agency associated with pressures on the emergency care pathway and patient acuity and complexity. A number of pay initiatives were introduced to improve and enhance staff recruitment and retention in year with notable changes within the Band 2 and Band 3 staff groups during December to March.

The Group closed the year with a deficit of £1.3 million. Following required adjustments for national reporting, SFT reported a position of £39,000 surplus.

Group Statement of Comprehensive Income	2022/23 £'000	2021/22 £'000
Income		
From clinical activities	**316,728**	**278,480**
Other operating income	**44,826**	**39,252**
Total Operating Income	**361,554**	**317,732**
Operating Expenses	**-356,713**	**-311,781**
Operating Surplus/(Deficit)	**4,841**	**5,951**
Finance income	**1082**	**309**
Public Dividend Capital payable	**-4,447**	**-4,073**
Other finance costs	**-2,218**	**-2,002**
Net Finance Costs	**-5,583**	**-5,766**
Revaluation gains (+) / losses (-) on assets	**-305**	**189**
Fair value gains (+) / losses (-) on investments	**54**	**65**
Transfers by absorption gains (+) / losses (-)	**-329**	
Total Retained Surplus / (Deficit)	**-1,322**	**439**
Retained Surplus / (Deficit) for the year for SFT only	**39**	**49**

The Trust delivered £9.705m savings in year, which was in line with the plan, with the non-recurrent element of £5.005m achieved. Key workstreams underpinning the delivery included:

- Workforce redesign including skill mix reviews and vacancies (£3.5m);
- Procurement efficiency programmes (£2.9m);
- Other operating income sources realised (£2.2m); and

Capital investment

The Trust invested £20.4m in infrastructure and equipment during 2022/23 (£15.7m in 2021/22). This was funded internally through cash and I&E surpluses, donations and additional PDC from the Department of Health primarily for the Elective ward and Digital Pathology funding. The capital programme continues to achieve a balance between maintaining and replenishing the asset infrastructure, reducing risk and improving patient experience.

Significant in-year programmes included expenditure of:

- £5.5m on building and critical infrastructure schemes including the replacement of standby generators, the MRI Air handling unit, preliminary ward refurbishment costs, chiller upgrades and fire compliance works.
- £4.0m on the works and decant costs for the new Elective ward build and renovation of the Douglas Arter Centre.
- £4m on replacement and additional medical equipment, including Xray equipment, Theatre power tools, Portable Echocardiograph, Optical Coherence Tomography (OCT) scanners.
- £3.8m on the digital programme, including £2.0m investment in Network kit and £0.7m on the implementation of Electronic Prescribing and Medicines Administration.

- £1.2m on schemes related to Digital Pathology and replacement of the Pathology Laboratory Information Management System

Looking forward to 2023/24

2023/24 will be a year in which we continue to deliver our 2022-26 strategy, including training more of our teams in the Improving Together approach for strategy deployment. Our annual plan and strategic planning framework are aligned to deliver reduced bed occupancy, reduced agency staff spending, and to drive down wait times.

While delivery of our operational plan is partially reliant on interdependencies across our health and care system, we have credible and strong partnerships in place to de-risk that delivery.

We continue to develop our workforce across the domains of both recruitment and retention and we are delivering improvements across all seven elements of the NHS people promise to our staff. The biggest risk to delivery of our people plan and workforce ambitions is a general shortage of qualified staff exacerbated by the pandemic, the continuation of escalation of our clinicals spaces and the macroeconomic context.

Ultimately, our plan for 2023-24 is based on both meeting NHS England operating targets and continued deployment of the Trust strategy, particularly against our priorities of People, Population and Partnerships. We continue to strive for incremental improvements through our Improving Together programme, while remaining open to step change innovation that can drive benefit for our patients and colleagues. Elective activity has not fully recovered since the pandemic and the complex interdependencies of bed occupancy, escalation beds open, workforce availability, elective and diagnostic activity, and our cost improvement plans make delivery challenging. We have a robust plan in place to deliver over the coming year and remain confident we are on track to deliver an outstanding experience for our patients, their families, and our colleagues.

PERFORMANCE ANALYSIS

The Trust publishes a monthly Integrated Performance Report (IPR) which provides both the Board and the public with an overview of our performance. The report is structured around the strategic and enabling priorities identified by the Trust, Key Performance Indicators, and a range of watch metrics. The report evolves to reflect new areas of monitoring or national focus.

Our monthly integrated performance reports are available on our website as part of monthly Board papers and can be downloaded via:

https://www.salisbury.nhs.uk/about-us/the-trust-board/board-papers/

The IPR is presented at Board Committees, and then presented as one integrated document for scrutiny at Trust Board. The statistical process charts allow our Board and Committees to see trend analysis for the previous 24 months which provides more depth and understanding around our performance and emerging trends.

Performance overview

2022-23 was a challenging year for the Trust with the requirement to transition to an environment increasingly focused on post pandemic service recovery, whilst also continuing to improve the responsiveness of urgent and emergency care (UEC).

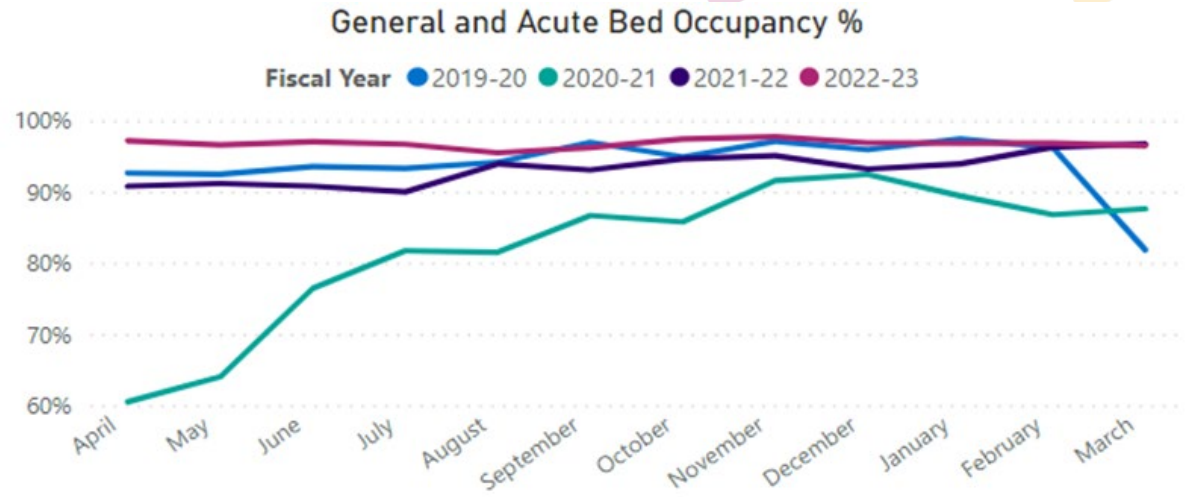
- Increase elective activity to above pre pandemic levels
- Reduce longest waiting times and improve performance against cancer waiting times standards
- Reduce the number of patients spending over 12 hours in the emergency department
- Improve ambulance handover delays

Ultimately, our operational plan was based on a series of balances – a commitment to move forward with the Trust strategy and make progress against our priorities of People, Population and Partnerships, renewed drive for operational improvements through Improving Together, a clear and ambitious national expectation for elective recovery and the need for a system response to non-elective demand.

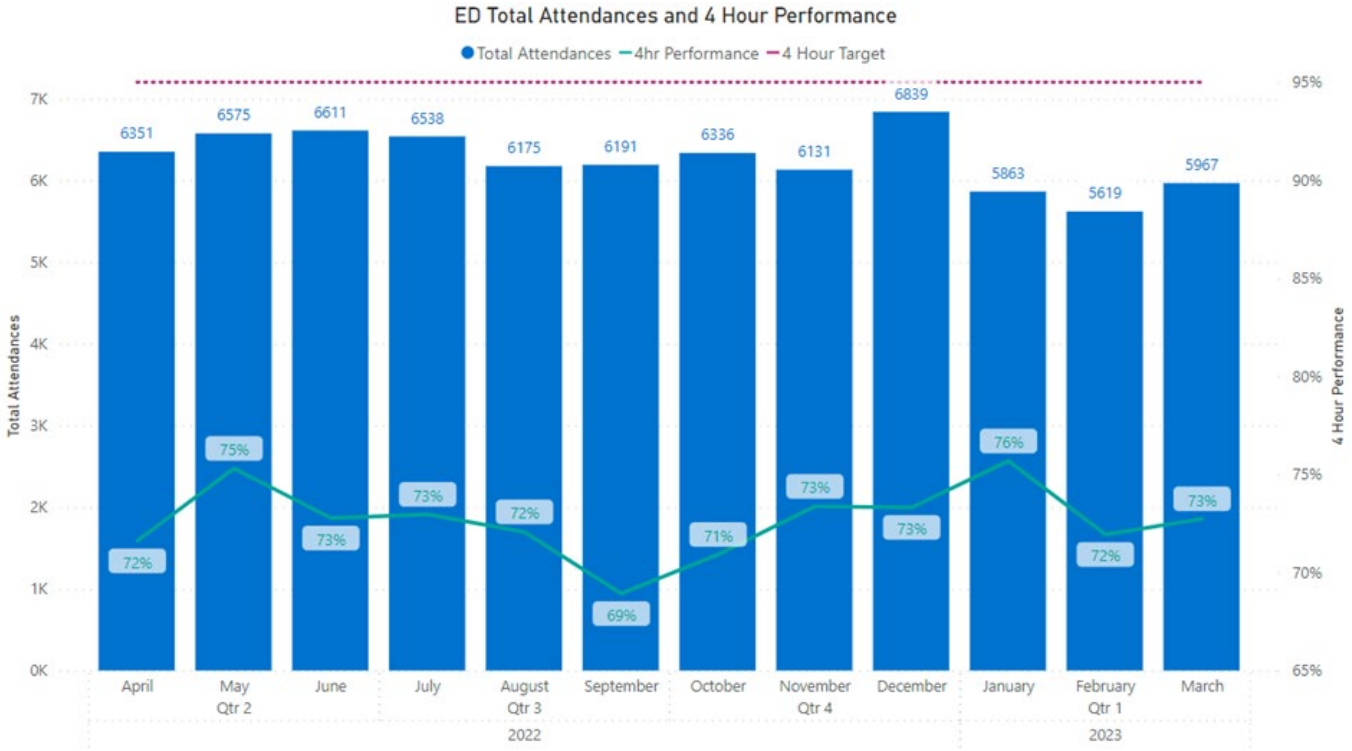
Urgent and Emergency Care

High levels of bed occupancy in the Trust over much of the year have placed considerable pressure on flow and inevitably the impact of this has been felt in our front door services. The high levels have been driven, at least partly, by an increasing number of patients staying in the hospital waiting for services elsewhere. During the Winter months this peaked at around 140, which represents around 30% of our total bed capacity.

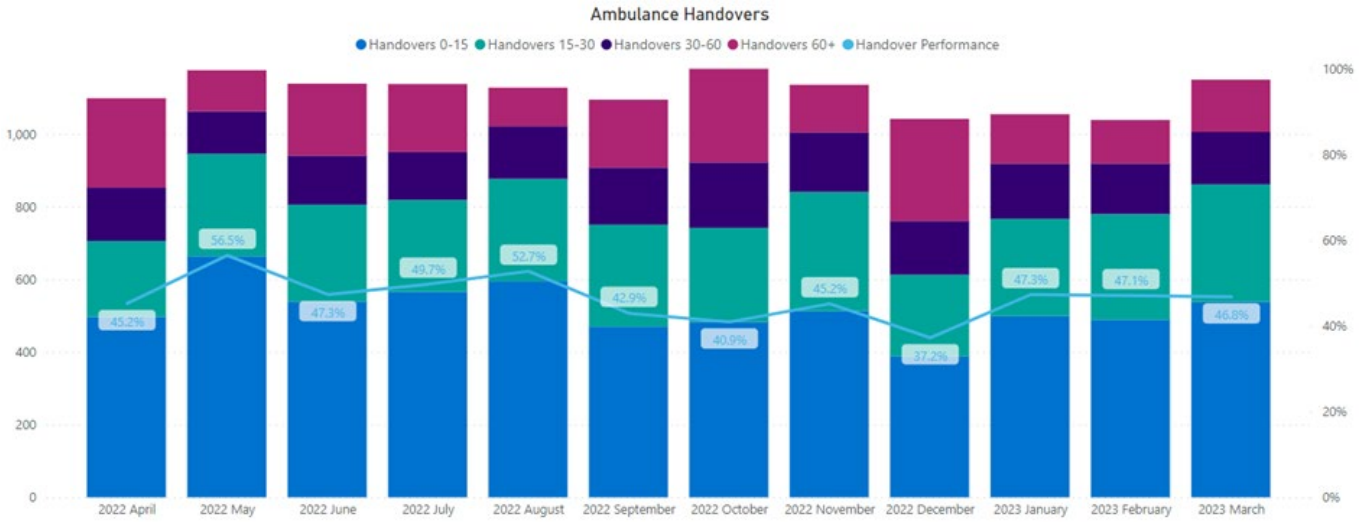
The development of same day emergency care services at the tail end of the year has started to make some improvement in our flow, and encouragingly, the number of patients spending longer than 12 hours in the Emergency Department made steady improvement over the last quarter of the year.



ED attendances have increased by 6% overall when compared to 21/22, however attendances at the main Emergency Department are slightly lower than last year, and static in comparison to the pre COVID-19 period. Attendances at the Walk in Centre in Salisbury were slow to recover during COVID-19, however over the last year have increased significantly and were 43% higher than 21/22, and 28% higher than the pre COVID-19 year (19/20). There has been collaboration with our partners on the promotion of the Walk in Centre services, particularly in relation to children, and this has been effective in diverting patients with more minor illnesses and injuries to the Walk in Centre.



The Trust did not achieve the 95% national target for admitting or discharging patients within 4 hours in the emergency department, however, the performance compared favourably with the average for acute trusts in England. Additionally, there were a higher number of delays in taking handover of patients arriving by ambulance to the emergency department. Almost half of patients were handed over within the expected 15 minutes of arrival. We know that when bed occupancy is high the impact of this is felt right back to the front door, and the focus on reducing our occupancy in the coming year will be critical to being able to release ambulances back out to the community more quickly.



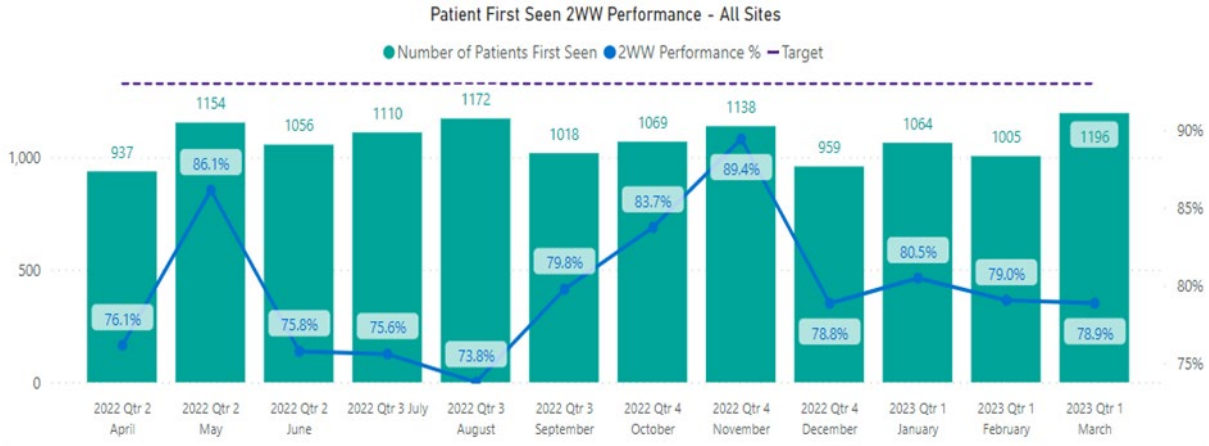
Elective Care

Cancer pathways

Suspected Cancer two week wait referrals

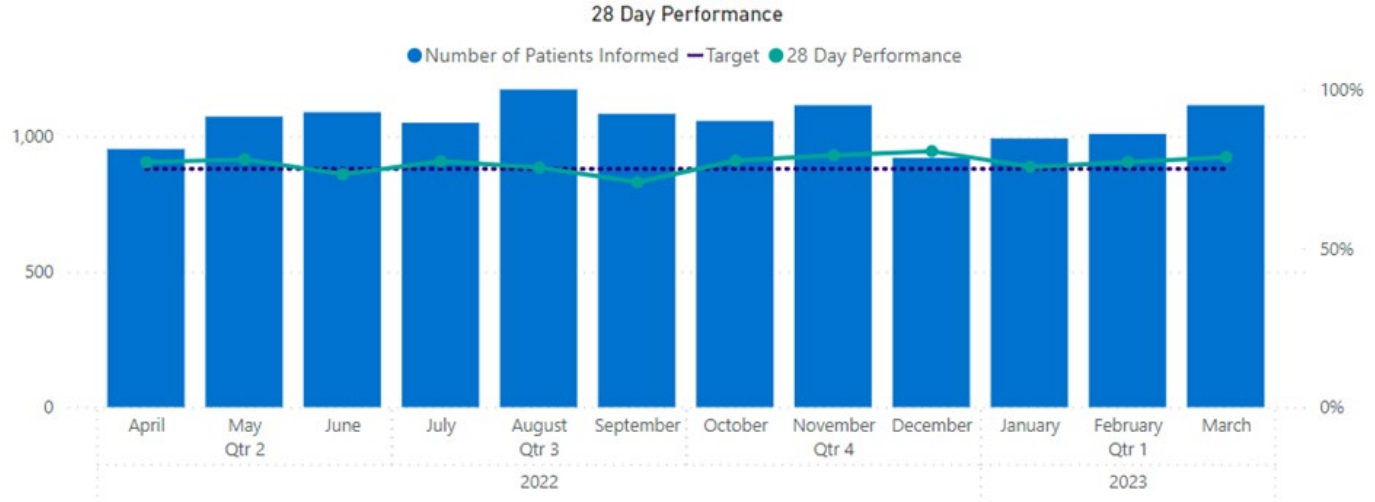
There was around a 3% growth in referrals for suspected cancer which was below cancer network projections. Performance against the 14-day target has been variable, with peak performance on 89.4% in September, but a reduction to 78% by the end of year. The skin and lower gastrointestinal (GI) pathways experienced particular challenges, with approximately 70% of the breaches occurring in these two high volume pathways.

Improvements have been made in the lower GI pathway with successful recruitment to the gastroenterology service, and performance improved from 49.3% in August, to 77.2% by March.
The skin pathway remains challenged with workforce constraints, the average waiting time in March was 14.1 days. Although there are challenges with the first appointment, the skin service performs well in patients receiving their first treatment with an average of 95% of patients receiving treatment within 62 days (85% target).



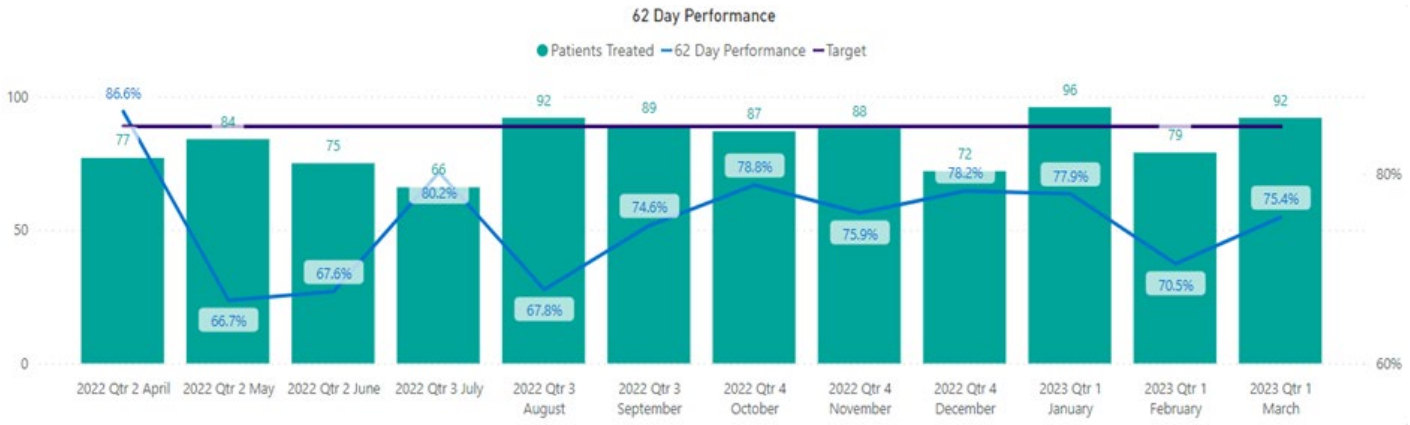
28-Day Faster Diagnosis Standard

Despite the challenges in the Two Week Wait pathway, we continue to perform well against the 28-day Faster Standard which aims to ensure patients who are referred for suspected cancer receive a timely diagnosis, with the standard met in all bar two months.



62 Day Standard

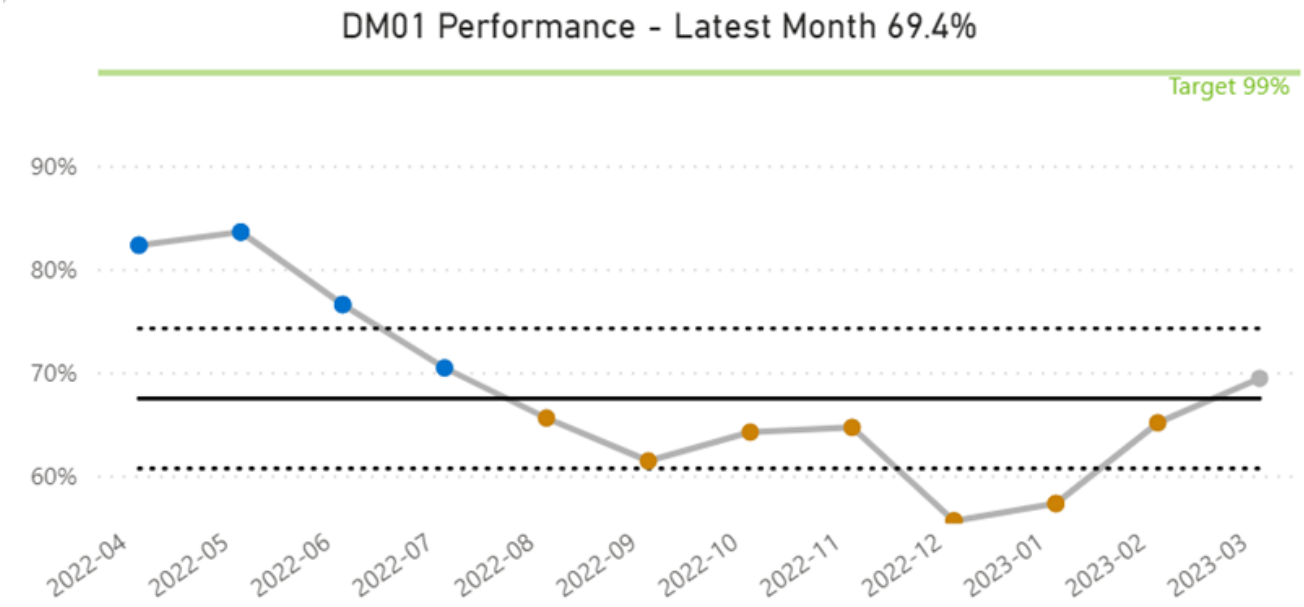
The 62 Day standard aims to ensure that at least 85% patients who are diagnosed with cancer wait no longer than two months from urgent suspected cancer referral to starting treatment. The standard is rightly challenging, and we achieved meeting the standard for an average of 75% of patients. We need to do better against this important standard despite being above the England average of 60%. Our Urology pathways in particular are areas that we will improve next year.



Diagnostics

After initially making good progress in recovering the 6-week diagnostic standard in 21-22, we hit some challenges this year which saw our performance deteriorate from 83% in May to a low of 55% in December. MRI, Ultrasound and Cardiac Echo all experienced issues with managing vacancies and recruiting. In January we started to see some signs of improvement and by March had increased to almost 70% of tests within 6 weeks. Notably, Cardiology Echo improved from 47% in August to 100% in January and maintained this through the rest of the year.

Improvements are also building in MRI and Ultrasound, with a clear plan to go further in 23/24.



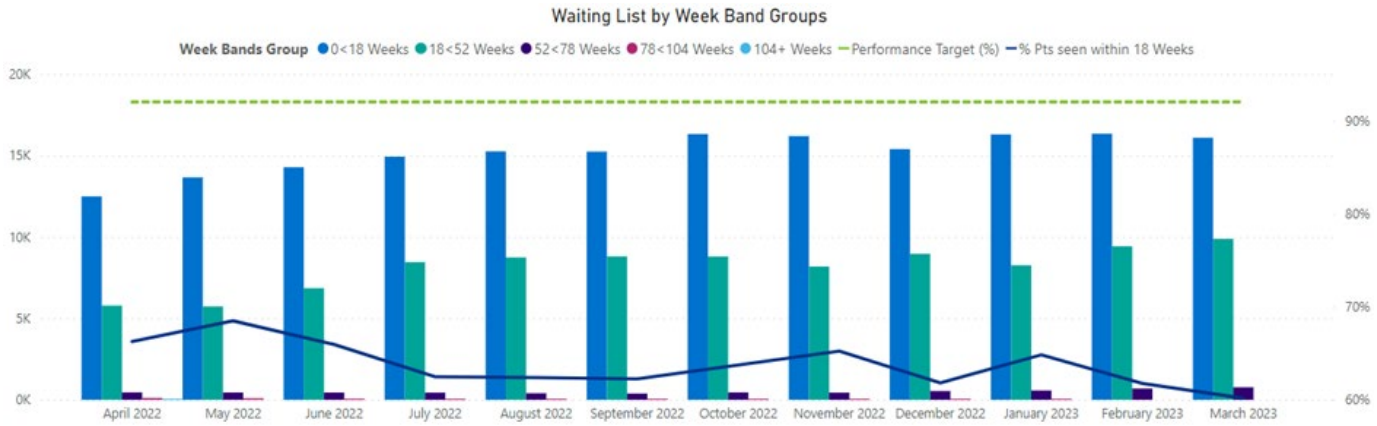
Referral to Treatment (18 weeks)

We have made progress this year in reducing the number of long waits, and by the end of February had eliminated any waits of over 78 weeks, one month ahead of our plan. The longest wait reduced from 120 weeks in April, to 75 by March 23. Our total waiting list has grown in the same period from 18,853 to 26,736. Increasing our elective activity levels in 23/24 will be critical for reducing the waiting list size and waiting times for elective care.

Restoring our activity levels to above that of the pre pandemic years remains a critical focus for us; the growth in waiting list size is being driven by fewer patients completing their pathways each month rather than increased referrals. Referral levels throughout the year remained fairly static and not quite yet to recover beyond the levels prior to COVID-19.

Of the patients on our waiting list, approximately 75% are waiting on a non-admitted pathway most likely requiring an appointment in an outpatient setting. Industrial action in the last quarter of the year impacted upon the outpatient capacity and our time to first outpatient wait, and our average wait to first appointment has risen from 107 days at the start of the year to 126 in March.

We continue to focus on seeing patients in line with clinical need and by longest wait in line with NHS England requirements.



Tackling Health Inequalities

Reducing health inequalities in both access to healthcare and clinical outcomes is a central theme in national guidance, and a key element of our strategic planning framework that drives everything we do in the Trust. Reducing health inequalities is one of our 4 strategic initiatives garnering significant attention and multi-year support from our executive team to those working on the frontline of our services. This strategic initiative flows from our vision to provide outstanding care and it is acknowledged that a measurable outcome, would be an increase in healthy life years. This is an outcome affected significantly by the wider determinants of health, and we are determined to use the influence of our acute hospital as an anchor institution, working with local place-based partners to reduce health inequity and increase the years of life lived in good health.

We have a Health Inequalities Group, in partnership with Wiltshire Council and third sector colleagues, chaired by the Chief Medical Officer. This group has been established to oversee work in this area. Our initial focus has been:

- Improved understanding of data relating to inequalities in our population – focused on economic and social deprivation and inequalities for people with protected characteristics – informed by the Wiltshire joint strategic needs assessment (JSNA).
- Addressing how our services cater for people with learning disabilities.
- Continued partnerships to support access to healthcare for our military and veteran populations and their families – including achieving Employee Recognition Scheme Gold status and Veterans Covenant Healthcare Alliance reaccreditation.
- We have continued participation and learning from BSW's participation in Wave 3 of the national Population Health Management programme.

We will report on our plans and progress in addressing Health Inequalities to the Trust Board, and into the ICS health inequalities board. We are adopting the national CORE20PLUS5 approach to reducing inequalities. This is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level.

ACCOUNTABILITY REPORT

DIRECTORS' REPORT

Board of Directors

The Board of Directors is accountable, through the Chair, to NHS England and NHS Improvement and is collectively responsible for the strategic direction and performance of the Trust. It has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation.

Directors of Salisbury NHS Foundation Trust during 2022-23

Ian Green	Chair (from February 2023)
Stacey Hunter	Chief Executive
Dr Peter Collins	Chief Medical Officer
Judy Dyos	Chief Nursing Officer
Mark Ellis	Interim Chief Finance Officer (from August 2022)
Lisa Thomas	Chief Finance Officer (until August 2022) Interim Chief Operating Officer (from August 2022)
Melanie Whitfield	Chief People Officer
Michael von Bertele CB, OBE	Non-Executive Director
Tania Baker	Non-Executive Director (Senior Independent Director)
Margaret (Eiri) Jones	Non-Executive Director
Rakhee Aggarwal	Non-Executive Director
Dr David Buckle	Non-Executive Director
Debbie Beaven	Non-Executive Director (from January 2023)
Richard Holmes	Non-Executive Director (from January 2023)
Dr Nick Marsden	Chair (left December 2022)
Andy Hyett	Chief Operating Officer (left August 2022)
Paul Kemp	Non-Executive Director (left January 2023)
Paul Miller	Non-Executive Director (left June 2022)

Register of Directors' Interests

NHS employees are required to be impartial and honest in the conduct of their business. It is also the responsibility of all staff to ensure they are not placed in a position which risks, or appears to risk, conflict between their private interests and NHS duties.

Members of the Board of Directors are required to disclose details of company directorships or other material interests in companies held which may conflict with their role and management responsibilities at the Trust. There is an annual review of the Register of Interests and compliance with the Fit and Proper Persons Requirements. As a standing agenda item, the Directors declare any interests before each Board and Board Committee meeting which may conflict with the business of the Trust and excuse themselves from any discussion where such conflict may arise. The Trust Board considers that all its Non-Executive Directors are independent in character and judgement.

The Register of Declared Interests is made available to the public by contacting the Head of Corporate Governance, Trust Offices, Salisbury NHS Foundation Trust, Salisbury District Hospital, Salisbury, SP2 8BJ. This can also be found on the Trust website following the link below:
https://www.salisbury.nhs.uk/about-us/corporate-governance/

NHS Improvement's Well Led Framework

The Trust has considered NHS Improvement's well-led framework in arriving at its overall evaluation of the organisation's performance and in developing its approach to internal control, board assurance framework and the governance of quality.

The Care Quality Commission (CQC) undertook a well-led inspection in December 2019 and rated the Trust as 'Good'. The CQC stated that 'There was effective, experienced, and skilled leadership, a strong vision for the organisation and embedded values. The leadership had the capacity and capability to deliver high-quality sustainable care. Leaders understood the challenges to quality and sustainability and they were visible and approachable. There was a clear vision for the Trust and strong values.'

During 2022-23, the Trust has welcomed new members to the Board, including a new Chair Ian Green OBE. An external well-led review has been commissioned to start in April 2023 for a period of 3 months. This is a developmental review with the key aim to understand our strengths and also areas that require improvement from a well-led perspective.

The Annual Governance Statement describes in further detail the Trust's approach to ensuring services are well-led and quality governance. The Quality Account describes quality improvements in more detail.

Other disclosures

Modern Slavery Act 2022-23 annual statement

At the Trust we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. We are fully aware of the responsibilities we hold towards our service users, employees, and local communities. We are guided by a strict set of ethical values in all our business dealings and expect our suppliers (i.e., all companies that we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking.

Cost allocation and charging guidance issued by HM Treasury

Salisbury NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance.

Political Donations

The Trust has made no political donations of its own.

Better Payment Practice Code

The Trust conforms to the principles of the Better Payment Practice Code and aims to pay its bills promptly. Performance against the code can be viewed below. No interest was paid under the late Payment of Commercial Debts (Interest) Act 1998.

Better payment practice code	By Number	By Value £'000
Non-NHS	92.6%	92.1%
NHS	81.4%	77.2%
Total	92.4%	91.4%

Information on fees and charges

Please see table below which provides an aggregate of all schemes that, individually, have cost exceeding £1million.

		2022-23	2021-22	2020-21
	Expected sign			
Income	+	17,753	14,028	13,065
Full cost	-	15,561	12,787	12,103
Surplus/Deficit	+/-	**2,192**	**1,241**	**962**

Income Disclosure

The Trust can confirm that income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

Other Income and Impact on Provision of Services

The Trust provides a variety of services to patients, visitors, staff and external bodies that generate income which cover the cost of the service and makes a contribution towards funding patient care. Services that generate income include payroll services, accommodation, catering, car parking, private patient treatment, pharmacy products and sterile supplies. The total income from all these areas amounted to around £7.7 million. The other areas contributed surpluses, which have been applied to meeting patient care expenditure. In addition, the Trust received £12.0 million through Salisbury Trading Ltd (excluding laundry undertaken for the Trust) and £2.6 million through Odstock Medical Ltd.

The Accountability Report has been approved by the Trust Board.

Stacey Hunter
Chief Executive (Accounting Officer)
22 June 2023 (on behalf of the Trust Board)

REMUNERATION REPORT

Chair of the Remuneration Committee's Annual Statement on Remuneration

In accordance with the requirements of NHS England and NHS Improvement, this remuneration report consists of the following parts:

- An Annual Statement on remuneration
- The Senior Manager Remuneration Policy
- The Annual Report on remuneration

As the Chair of the Remuneration Committee, I am pleased to present our remuneration report for 2022-23

Senior managers have the authority or responsibility for directing and controlling the major activities of the Trust and for Salisbury NHS Foundation Trust this covers the Chair, the Executive and Non-Executive Directors. It is important to note that the Remuneration Committee of the Board has responsibility for setting the terms and conditions for the Executive Directors, while responsibility for setting the terms and conditions for the Chair and Non-Executive Directors lies with the Council of Governors, which is advised by the Performance Committee.

The Remuneration Committee reviewed the salaries and the individual reward packages of the Executive Directors for 2022-23. Salaries are set in comparison with those given to holders of equivalent posts within the NHS. Advancement within the individual salary scales of Executive Directors is based on successful appraisal outcomes and this is the only performance-related element of the Executive Director's remuneration. The Remuneration Committee works closely with the Chief Executive in reviewing each Executive Director's performance and the Chair advises the committee on the performance of the Chief Executive.

2022-23 major decisions on remuneration

During 2022-23, the Remuneration and Nominations Committee recognised the annual pay increase for Very Senior Managers as laid out in guidance shared from NHS England by 3.5% with effect from 1 April 2022. Two Executive Directors have also received an uplift in pay in 2022-23 in consideration of national benchmarking and guidance.

The changes to the Trust's Executive team during 2022-23 were:

- Andy Hyett left his post as Chief Operating Officer in August 2022
- Lisa Thomas commenced a secondment as interim Chief Operating Officer in August 2022
- Mark Ellis was appointed as interim Chief Finance Officer in August 2022

Ian Green OBE
Remuneration Committee Chair
22 June 2023

Senior Managers' Remuneration Policy

The following report details how the remuneration of senior managers is determined. A 'senior manager' is defined as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust'. The Trust deems this to be the Executive and Non-Executive members of the Board of Directors.

The remuneration of the Chief Executive and Executive Directors (with the exception of the Chief Medical Officer*) is determined by the Board of Directors' Remuneration Committee considering market levels, key skills, performance, and responsibilities. In reviewing remuneration, including making decisions about whether to pay the Chief Executive and any of the individual Executive Directors more than £150,000 per annum, as outlined in the guidance issued by the Cabinet Office, the Committee has regard to the Trust's overall performance, delivery of agreed objectives, remuneration benchmarking data in relation to similar NHS Foundation Trusts and the wider NHS and the individual Director's level of experience and development of the role.

*The pay, terms and conditions for the Chief Medical Officer are determined by the national Consultant Contract and the associated Medical Terms and Conditions. An additional payment is made which reflects the additional responsibilities for the role of Chief Medical Officer. The Chief Medical Officer is eligible to apply for discretionary performance-related pay under Medical Terms and Conditions.

The Trust's overarching approach to remuneration is designed to ensure that senior managers' remuneration supports its strategy and business objectives. The approach has been developed to support the provision of high-quality services for patients through its strategic aim of delivering an outstanding experience for every patient, financial stability, and improved service performance. The Trust is mindful of a broad range of factors in setting this approach including the equality, diversity, and inclusion agenda.

The Trust's remuneration principles are that rewards to senior managers should enable the Trust to:

- Attract, motivate, and retain senior managers with the necessary abilities to manage and develop the Trust's activities fully for the benefit of patients
- Align remuneration with objectives that match the long-term interests of the Trust
- Drive appropriate behaviours in line with the Trust's values
- Focus senior managers on the business aims and appraise them against challenging objectives
- Comply with the Public Sector Equality Duty under the Equality Act 2010, our compliance with equality and diversity requirements of the NHS Constitution and Care Quality Commission and meet the standards set within the Trust Equality, Diversity and Inclusion Policy.

Future Policy Table

Element of pay (Component)	How component supports short- and long-term strategic objective/goal of the Trust	Operation of the component	Performance metric used and time period
Basic salary	Provides a stable basis for recruitment and retention, taking into account the Trust's position in the labour market and a need for a consistent approach to leadership.	Individual pay point is set within a predesigned pay band which has a minimum and maximum limit. (See salary scales at the end of the Future Policies table which sets out the rates	Pay is reviewed annually in relation to individual performance based on agreed objectives set out prior to the start of that financial year which runs

	Stability, experience, reputation and widespread knowledge of local needs and requirements supports the Trust's short term strategic objectives and its long-term strategic priorities of: • Improving the health and wellbeing 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	payable). Please note that this does not include additional payments over and above the role such as clinical duties, Clinical Excellence Awards. Total remuneration can be found in the Remuneration tables in the Annual Report on Remuneration. Initial positioning on this pay band is based on experience and benchmarked against the NHSI Guidance for pay for very senior managers.	between 1 April and 31 March.
Benefits	Benefits in kind relate to either the provision of a car, training or additional pension contributions. Salary for Executive Directors includes any amount received (See Basic salary on how this component supports short- and long-term strategic objective/goal of the Trust)	(See above)	(see above)
Pension	Provides a solid basis for recruitment and retention of top leaders in sector. Supports the Trust's short term strategic objectives outlined in its annual priorities and its long-term strategic goals stated in the basic salary component.	Contributions within the relevant NHS Pension Scheme	Contribution rates are set by the NHS Pension Scheme
Bonus	N/A	N/A	N/A
Fees	N/A	N/A	N/A

The components above apply generally to all Executives and there are no particular arrangements that are specific to an individual Executive Director. The Remuneration Committee adopts the principles of the Agenda for Change framework when considering Executive Director's pay. However, unlike Agenda for

Change, there is no automatic salary progression within the salary scale, even if individual directors meet their annual objectives.

The performance measures were chosen to reflect the Trust's adopted values and its strategic goals form the basis for Directors' objectives. Objectives for each Executive are set at the start of the financial year in order to deliver the strategic intentions (longer term) and the operational plans (short to medium term). These SMART objectives are the performance measures for the individual Executives. The objectives / performance measures are reviewed during the year and progress recorded.

There is no specific minimum level of performance that affects the payment and no further levels of performance which would result in additional amounts being paid. There is no specific provision for the recovery of sums paid to directors or for withholding the payment of sums to senior managers that relate to their basic salary. However, the Remuneration Committee in respect of the Executive Directors and the Council of Governors for the Non-Executive Directors does have the authority to decide on whether any pay or remuneration increase should be awarded each year based on performance.

No Executive Directors have been released to undertake other paid work elsewhere.

Where an individual Director is paid more than the Prime Minister, the Trust has taken steps to assure itself that remuneration is set at a competitive rate in relation to other similar NHS Foundation Trusts and that this rate enables the Trust to attract, motivate and retain senior managers with the necessary abilities to manage and develop the Trust's activities fully for the benefit of patients. This has been benchmarked against the NHSI guidance for pay for very senior managers.

Remuneration of Non-Executive Directors

Element of pay (Component)	How component supports short- and long-term strategic objective of the Trust	Operation of the component	Performance metric used and time period
Basic salary	The pay level reflects the part time nature of the role. It is set at a level that gives recognition for the post holder's commitment and responsibility of the role. Supports the Trust's short term strategic objectives outlined in its annual priorities and its long-term strategic priorities of: • Improving the health and wellbeing 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.	It is one single pay point based on research of NHS remuneration for Non-Executive Directors in other NHS Foundation Trusts	The pay level is reviewed annually by the Council of Governors, advised by the Performance Committee
Benefits	N/A	N/A	N/A
Pension	N/A	N/A	N/A

Bonus	N/A	N/A	N/A
*Fees	N/A	N/A	N/A

*Non-Executive Directors Fees: Responsibility for setting the terms and conditions for the Chair and Non-Executive Directors lies with the Council of Governors. The policy on remuneration is that the Non-Executive Directors are paid a basic salary (see Salary Scales). No additional duties which require a fee are carried out by the Non-Executive Directors.

Statement of consideration of employment conditions elsewhere in the Trust

While the Trust did not consult with employees on the remuneration policy regarding senior managers, it did take into account the national pay and conditions of NHS employees.

Responsibility for setting the terms and conditions of appointment for Non-Executive Directors rests with the Council of Governors, which is advised by the Performance Committee and takes into account remuneration in other NHS organisations by reviewing available national comparisons in NHS Employers information. This was determined when the Trust was authorised, on the basis of independent advice. Please note that no additional fees are paid to the Chair and the Non-Executives Directors, other than travel and subsistence costs incurred.

Annual Report on Remuneration

Service contracts obligations

None of the current substantive Executive Directors are subject to an employment contract that stipulates a length of appointment. The appointment of the Chief Executive is made by the Non- Executive Directors and approved by the Council of Governors. The Chief Executive and Executive Directors have a permanent employment contract and the contract can be terminated by either party with six months' notice. The contract is subject to normal employment legislation. Executive Directors are appointed by a committee consisting of the Chair, Chief Executive and Non-Executive Directors.

There are no specific obligations on Salisbury NHS Foundation Trust that impact on remuneration payments or payments for loss of office that are not disclosed elsewhere within the Remuneration Report.

The Service Contract for Non-Executive Directors is not an employment contract. Non-Executive Directors are appointed for an initial term of up to three years and are eligible for a further term of three years and a third term of two years. Where a director has served eight years, their appointment may be renewed for a further year provided that exceptional circumstances exist in relation to the renewal. The Council of Governors is responsible for appointing, suspending, and dismissing the Chair and Non-Executive Directors as set out in the Trust's Constitution.

Name	Role	Current term of office	Notice Period (months)
Ian Green	Chair	Commenced February 2023	3
Rakhee Aggarwal	Non-Executive Director	Commenced January 2023	3
Tania Baker	Non-Executive Director	Commenced May 2022	3
Michael von Bertele	Non-Executive Director	Commenced October 2022	3
David Buckle	Non-Executive Director	Commenced January 2023	3
Margaret (Eiri) Jones	Non-Executive Director	Commenced November 2022	3
Richard Holmes	Non-Executive Director	Commenced January 2023	3

Debbie Beavan	Non-Executive Director	Commenced January 2023	3
Peter Collins	Chief Medical Officer	Commenced October 2020	6
Judy Dyos	Chief Nursing Officer	Commenced June 2020	6
Mark Ellis	Interim Chief Finance Officer	Commenced August 2022	6
Stacey Hunter	Chief Executive	Commenced September 2020	6
Lisa Thomas	Chief Finance Officer Interim Chief Operating Officer	Commenced September 2017 Commenced August 2022	6
Melanie Whitfield	Chief People Officer	Commenced September 2021	6
Nick Marsden	Chair	Left December 2022	3
Paul Kemp	Non-Executive Director	Left January 2023	3
Paul Miller	Non-Executive Director	Left June 2022	3
Andy Hyett	Chief Operating Officer	Left August 2022	6

The remuneration and expenses for the Trust Chair and non-executive directors are determined by the Council of Governors, taking account of any National guidance.

Remuneration Committee

The Remuneration Committee decides the pay, allowances and other terms and conditions of the Executive Directors. The Trust's Chair is chair of the Remuneration Committee and all Non-Executive Directors are members of the committee.

The Remuneration Committee reviews the salaries and where relevant, the individual reward packages of the Executive Directors. Most other staff within the NHS have contracts based on Agenda for Change national terms and conditions, which is the single pay system in operation in the NHS. Doctors, dentists, very senior managers and directors have separate terms and conditions. Pay circulars inform of changes to pay and terms and conditions for medical and dental staff, doctors in public health medicine and the community health service, along with staff covered by Agenda for Change. The Trust follows these nationally set pay polices in negotiating with Trade Unions on areas of local discretion.

Name	Role	Attendance
Nick Marsden	Chair	3/3
Rakhee Aggarwal	Non-Executive Director	3/3
Tania Baker	Non-Executive Director	3/3
Michael von Bertele	Non-Executive Director	3/3
David Buckle	Non-Executive Director	3/3
Margaret (Eiri) Jones	Non-Executive Director	3/3
Paul Kemp	Non-Executive Director	2/3
Paul Miller	Non-Executive Director	1/1
Debbie Beaven	Non-Executive Director	0/0
Richard Holmes	Non-Executive Director	0/0
Ian Green	Chair	0/0

External advice is not routinely provided to the Remuneration Committee. However, the Chief Executive, Chief People Officer and the Director of Integrated Governance attend and provide internal advice to the committee.

Disclosures in accordance with the Health and Social Care Act

Expenses for Senior Managers and Governors

Year	Number of Directors in Office	Number of Directors Reimbursed	Amount Reimbursed to Directors	Number of Elected Governors in Office	Number of Elected Governors Reimbursed	Amount Reimbursed to Elected Governors
2021/2022	15	5	£13,040	22	1	£133
2022/2023	14	2	£958	21	1	£27
Expenses incurred during the course of their duties relate to travel, accommodation and subsistence. Directors include those who were in post in an interim capacity during the year						

Salary and Pension Entitlement

Name and Title	Remuneration Year to 1 April 2022 - 31 March 2023					
	Salary	Benefits in Kind	Annual Performance Related Bonus	Long-Term Performance Related Bonus	Pension Related Benefits	Total
	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Nick Marsden - Chairman	35-40	0	0	0	0	35-40
Ian Green - Chairman	5-10	0	0	0	0	5-10
Paul Kemp - Non-Executive	10-15	0	0	0	0	10-15
Tania Baker - Non-Executive	15-20	0	0	0	0	15-20
Paul Miller - Non-Executive	0-5	0	0	0	0	0-5
Michael von Bertele – Non-Executive	10-15	0	0	0	0	10-15
Rakhee Aggarwal - Non-Executive	10-15	0	0	0	0	10-15
Margaret (Eiri) Jones - Non-Executive	10-15	0	0	0	0	10-15
David Buckle - Non-Executive	10-15	0	0	0	0	10-15
Richard Holmes - Non-Executive	0-5	0	0	0	0	0-5
Debbie Beavan - Non-Executive	0-5	0	0	0	0	0-5

Stacey Hunter - Chief Executive	185-190	0	0	0	102.5-105	290-295
Lisa Thomas - Interim Chief Operating Officer	140-145	0	0	0	7.5-10	150-155
Peter Collins - Chief Medical Officer	190-195	0	0	0	112.5-115	305-310
Judy Dyos - Chief Nursing Officer	120-125	0	0	0	50-52.5	170-175
Mark Ellis - Interim Chief Finance Officer	80-85	0	0	0	27.5-30	110-115
Melanie Whitfield - Chief People Officer	125-130	0	0	0	30-32.5	155-160
Andy Hyett - Chief Operating Officer	50-55	0	0	0	0	50-55

This table is subject to audit

- *Ian Green joined the Trust on 1 February 2023*
- *Richard Holmes and Debbie Beavan joined on 1 January 2023*
- *Mark Ellis was appointed as Interim Chief Finance Officer on 8 August 2022*
- *Lisa Thomas was appointed as Interim Chief Operating Officer on 22 August 2022, prior to this Lisa was the Chief Finance Officer*
- *Paul Miller left the Trust on 30 June 2022*
- *Andy Hyett left the Trust on 31 August 2022*
- *Nick Marsden left the Trust on 31 December 2022*
- *Paul Kemp left the Trust on 31 January 2023*
- *Lisa Thomas opted out of the NHS Pension Scheme on 1 December 2022.*

There were no taxable benefits paid to Directors in the year. Salary for Executive Directors includes any amount received for car allowance.

There is no additional benefit that will become receivable by a director in the event that that senior manager retires early.

No member above received remuneration for additional duties. No remuneration was received from another body and no severance payments were made within the year.

There were no taxable benefits paid to Directors in the year. Salary for Executive Directors includes any amount received for car allowance.

Name and Title	Remuneration Year to 1 April 2021 - 31 March 2022					
	Salary	Benefits in Kind	Annual Performance Related Bonus	Long-Term Performance Related Bonus	Pension Related Benefits	Total
	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Nick Marsden Chair	45-50	0	0	0	0	45-50
Paul Kemp Non-Executive	10-15	0	0	0	0	10-15
Tania Baker Non-Executive	15-20	0	0	0	0	15-20
Paul Miller - Non-Executive	10-15	0	0	0	0	10-15
Michael von Bertele OBE Non-Executive	10-15	0	0	0	0	10-15
Rakhee Aggarwal Non-Executive	10-15	0	0	0	0	10-15
Margaret (Eiri) Jones Non-Executive	10-15	0	0	0	0	10-15
David Buckle Non-Executive	10-15	0	0	0	0	10-15
Stacey Hunter Chief Executive	170-175	0	0	0	122.5-125	295-300
Lisa Thomas Chief Finance Officer	135-140	0	0	0	67.5-70	205-210
Peter Collins Chief Medical Officer	175-180	0	0	0	225-227.5	405-410
Judy Dyos Chief Nursing Officer	110-115	0	0	0	65-67.5	175-180
Andy Hyett Chief Operating Officer	125-130	0	0	0	70-72.5	195-200
Susan Young Interim Chief People Officer	45-50	0	0	0	0	45-50
Lynn Lane Interim Director of OD and People	50-55	0	0	0	0	50-55
Melanie Whitfield Chief People Officer	65-70	0	0	0	15-17.5	85-90

This table is subject to audit

- *Lynn Lane left her position as interim Chief People Officer on 6 April 2021. Her remuneration figure includes a contractual payment in lieu of notice of £44k.*
- *Susan Young left her post as interim Chief People Officer on 31 August 2021 and Melanie Whitfield started as Chief People Officer on 6 September 2021.*

The amount shown above for Peter Collins Chief Medical Officer represents his total salary and any remuneration received from his clinical roles. No other member above received remuneration for additional duties. No remuneration was received from another body and no severance payments were made within the year.

There were no taxable benefits paid to Directors in the year. Salary for Executive Directors includes any amount received for car allowance.

There is no additional benefit that will become receivable by a director in the event that that senior manager retires early.

No member above received remuneration for additional duties. No remuneration was received from another body and no severance payments were made within the year.

There were no taxable benefits paid to Directors in the year. Salary for Executive Directors includes any amount received for car allowance.

Pension Benefits

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2023	Lump sum at pension age related to accrued pension at 31 March 2023	Cash Equivalent Transfer Value at 31 March 2023	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 1 April 2022	Employers Contribution to Stakeholder Pension
	(Bands of £2,500) £000	(Bands of £2,500) £000	(Bands of £5,000) £000	(Bands of £5,000) £000	£000	£000	£000	To nearest £100
Stacey Hunter Chief Executive	5-7.5	5-7.5	60-65	115-120	1,157	99	1,000	0
Peter Collins Chief Medical Officer	5-7.5	7.5-10	65-70	130-135	1,230	107	1,064	0
Judy Dyos Chief Nursing Officer	2.5-5	2.5-5	35-40	70-75	613	41	539	0
Lisa Thomas	0-2.5	0	45-50	80-85	681	8	629	0

Interim Chief Operating Officer								
Andy Hyett Chief Operating Officer	0-2.5	0	50-55	105-110	931	2	880	0
Melanie Whitfield Chief People Officer	0-2.5	0	10-15	0	183	21	141	0
Mark Ellis Interim Chief Finance Officer	0-2.5	0-2.5	25-30	40-45	363	19	314	0

This table is subject to audit

Notes to Remuneration and Pension Tables

As Non-Executive directors do not receive pensionable remuneration, there are no entries in respect of any pensions.

Lisa Thomas opted out of the NHS Pension Scheme on 1 December 2022

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation and contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

NHS Pensions is still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

Pay ratio information
This section is subject to audit

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2022-23 was £193,000 (2021-22 £180,000). This is a change between years of +8%, which was caused by the payment of a Clinical Excellence Award in 2022-23 and the sale of annual leave entitlement for the year back to the Trust in addition to a 3.5% pay award.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2022-23 was from £14,000 to £264,000 (2021-22 £14,000 to £233,000). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 5.1%. Nine employees received remuneration more than the highest-paid director in 2022-23.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest-paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2022/2023	25th percentile	Median	75th percentile
Salary component of pay	£ 24,600	£ 34,200	£ 46,100
Total pay and benefits excluding pension benefits	£ 24,600	£34,200	£ 46,100
Pay and benefits excluding pension: pay ratio for highest paid director	7.85	5.65	4.19

The banded remuneration of the highest paid director was 5.33 times the median remuneration of the workforce in 2021-22. The Trust's median remuneration increased in 2022-2023 compared with the previous year. This resulted from the highest paid director being in receipt of a Clinical Excellence Award in 2022-23 and the sale of annual leave entitlement for the year back to the Trust in addition to a 3.5% pay award.

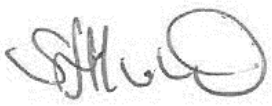
Payments for loss of office

There were no payments made to senior managers for loss of office in 2022-3.

Payments to past senior managers

None to report in 2022-23.

The Remuneration Report has been approved by the Trust Board.



Chief Executive (Accounting Officer)
22 June 2023 (on behalf of the Trust Board)

STAFF REPORT

Analysis of average staff costs

	Total 2022/23 £000	Permanently employed Total £000	Other Total £000
Salaries and wages	169,646	169,229	417
Social security costs	17,013	17,013	0
Pension cost- defined contribution plans employer's contributions to NHS pensions	18,622	18,622	0
Paid by NHSE on provider's behalf (6.3%)	8,062	8,062	0
Pension cost – other	42	42	0
Temporary staff/agency contract staff	13,666	0	13,666
Apprenticeship levy	789	789	0
TOTAL STAFF COSTS	227,840	213,757	14,083
Less: Costs capitalised as part of assets	(904)	(904)	0
TOTAL STAFF COSTS IN OPERATING EXPENDITURE	**226,936**	**212,853**	**14,083**

Analysis of average staff numbers (subject to audit)

	Total 2022/ 2023	Permanently employed 2022/ 2023	Other 2022/ 2023	Total 2021/22 number	Permanently employed 2021/ 2022 number	Other 2021/ 2022 number
Medical and Dental	473	463	10	459	450	9
Administration and Estates	1407	1329	78	1,327	1,252	75
Healthcare assistants and other support staff	685	677	8	673	673	0
Nursing, midwifery & health visiting staff	1095	1017	78	1,049	1,006	43
Scientific, therapeutic and technical staff	485	469	16	527	512	15
Total	4145	3955	190	4,035	3,893	142

The figure shown under the other column relates to other staff engaged on the objectives of the organisation such as, short term contract staff, agency/temporary staff, locally engaged staff overseas and inward secondments where the organisation is paying the whole or most of their costs.

The comparative numbers have been restated to bring them in line with the occupation codes within the electronic staff record, the NHS human resource and payroll database system.

The number of male and female directors, senior managers and employees 31 March 2023

Head Count	Female	Male	Total
Directors	8	6	14
***Senior managers**	16	6	22
All other staff	3,866	1,270	5,136

**Senior managers are defined as members of the Trust Management Committee which provides a forum for the Chief Executive, supported by the Executive Directors and Clinical Directors, to advise on the strategic direction of the Trust and the Trust's involvement in the wider health economy. Senior managers in this context include members of the Trust Management Committee who are not included in the two remaining groups.*

Staff Turnover

Staff turnover information can be found on the NHS Digital website:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Sickness Absence

Year April March	Overall absence days lost	% of total available days	% Short term <28 days	% Long term >28 days	Absence Recorded with No reason given
21/22	*31,218*	*4.15%*	*2.11%*	*2.04%*	*3.25%*
22/23	*29,738*	*3.95%*	*1.95%*	*2.00%*	*3.00%*
23/24 Forecast	*26,715*	*3.50%*	*2.00%*	*1.50%*	*1.00%*

Between April 2022 and March 2023, the Trust has managed a slight decrease in sickness absence levels from 31,218 working days lost in 2021-22, to 29,738 days lost in 2022-23. This represents a 0.2 percentage point fall on the previous year to 3.95% but remains above the Trust's target of 3%. Time lost to absence has remained relatively equally balanced between long term sick and short-term absence. The continuing impact of COVID-19-19 and an increase in year of winter Flu and other respiratory infections have continued to contribute to a high level of short-term absences. The 23/24 Forecast assumes a 1% growth in workforce and an average 3.5% absence rate, with improved action to reduce long term sickness absences.

Under the 'we are safe and healthy' element of the People Promise, the Trust has been developing an improved health surveillance function, which has identified that Mental Health related issues and Musculo-Skeletal injury are the biggest contributors to absence after infectious diseases. This data has enabled improved interventions particularly in the wellbeing area, where a new website has been launched to signpost staff and managers to an increased range of resources to help with Staff mental, financial and physical wellbeing. Clinical Psychology services have also continued offering wellbeing interventions to staff as a supportive mechanism of preventing sickness absence. The Trust's Occupational Health service has been a focus for recruitment and now provides a full suite of OH support including staff counselling and physiotherapy. Work is underway to identify proactive interventions to reduce the instance of Musculo-skeletal injuries, with focus in the Spinal department initially.

We appointed a Head of Wellbeing, Equality, and Inclusion this year to provide greater focus on wellbeing and promote better health in conjunction with our Occupational Health service and Health and Safety team. Under this collaboration the Trust has monthly health and wellbeing topics/events, trained mental health first aiders, and health improvement coaches for weight management, alcohol, smoking cessation support, healthy eating, increasing physical activity and building confidence and motivation. Staff also retain access to the onsite health and fitness centre, green spaces and walking routes.

A health and wellbeing presentation has been implemented for all new starters as part of their induction and we have updated Flexible working and Remote working policies that will support greater agile working introducing practical ergonomic support. Our aim is to routinely update information to include financial, legal and other matters that may be underlying causes of stress.

Managers can view team absence data via ESR Manager Self Service and for teams on Health Roster, this system identifies and highlights staff that have triggered one of the Trust absence management policy thresholds, enabling managers to identify where additional interventions and support are required.

People Policies

People policies have been a focus this year, with significant work completed to ensure our policies are up to date, fair and consistent.

Our policies and associated procedures are designed to make clear what is expected of our employees when they come to work, setting clear guidance on how performance and behaviour is managed. They also sign-post our managers and staff to a wealth of information on a range of work-related subjects and entitlements. This is an important step in realising our ambition in making Salisbury Foundation Trust the best place to work for us all. Work to update policies has been conducted in consultation with our staff side colleagues and with our staff networks.

Key policies which have been introduced or refreshed include:

- **New Parental Leave and pay** – Maternity/Adoption leave (including fostering and surrogacy), Shared Parental Leave, New Parent Support Leave (formally paternity leave).
- **Transgender Policy** – advice and guidance for members of staff in relation to transgender matters and includes guidance for managers in supporting transgender colleagues.
- **Menopause Policy** – whilst aimed at women supporting the 70+% of our female workforce it also provides advice and guidance available to **all staff** who may have family members with menopausal symptoms.
- **Flexible Working Policy** supported by a revised **Home Working Policy.**
- **Mandatory and Statutory Training Policy**
- **Retirement** - including the **retire and return** option for staff who are eligible

Work has been undertaken this year to develop a management system which will forecast and assure Board that policies are reviewed by the appropriate consultation and stakeholder group and then approved in a timely and effective manner. Whilst typically reviewed every two - three years, when legislation changes, we review the new legislation or circumstance outside this formal program to continue to ensure the effectiveness of our policies. Work is planned to further streamline some of our key performance policies (for example Disciplinary, Grievance, Dignity at Work and Attendance Management) to not only make them easier to use and more easily understood, but to support our aspiration to introduce a restorative just and learning culture in support of both an improved staff employment experience and health outcomes for our patients.

Health and Safety (H&S)

Responsibility for H&S lies with the Chief Executive Officer (CEO), who is supported by the Chief People Officer (CPO). The Deputy Chief People Officer has direct oversight of the Trust's H&S Manager who has responsibility for the design and implementation of H&S Management policy and practices across the Trust.

The H&S function is supported by a Health and Safety Committee (the Committee), which includes representatives from across the Trust's management functions and staff side representatives. The Committee meets quarterly to provide direction and guidance to management representatives and to

receive assurance, information, and act as a point of escalation for several sub-committees that include, but are not limited to, fire, waste, radiation, water, electricity, and radiation protection. The Health and Safety Committee reports through the Trust Management Committee to the Trust Board.

In the past 12 months the H&S team has developed and implemented a formal H&S management system with specific and tangible performance measures designed to enable clear understanding of H&S performance across the Trust. This approach also identifies areas of improvement, based on frequency and consequence of hazard reports and injuries by location and job role. Improved reporting against formal performance measures commenced in April 2023. Metrics include:

- Lost time due to work related injuries as a frequency of hours worked.
- Number of injuries reported that resulted in lost time as a frequency of hours worked.

Incorporated into this formal H&S management system is an internal audit program implemented by the H&S Team. Internal audits are scheduled across the trust according to a rolling audit calendar and are conducted by the H&S team who are trained and experienced H&S auditors. Improving the strategic approach, and providing an audit program ensures that first-hand knowledge of risks by the H&S team and information provided from audits, performance measurement and risk-based task analysis allow TMC and the Board to make better informed decisions about H&S.

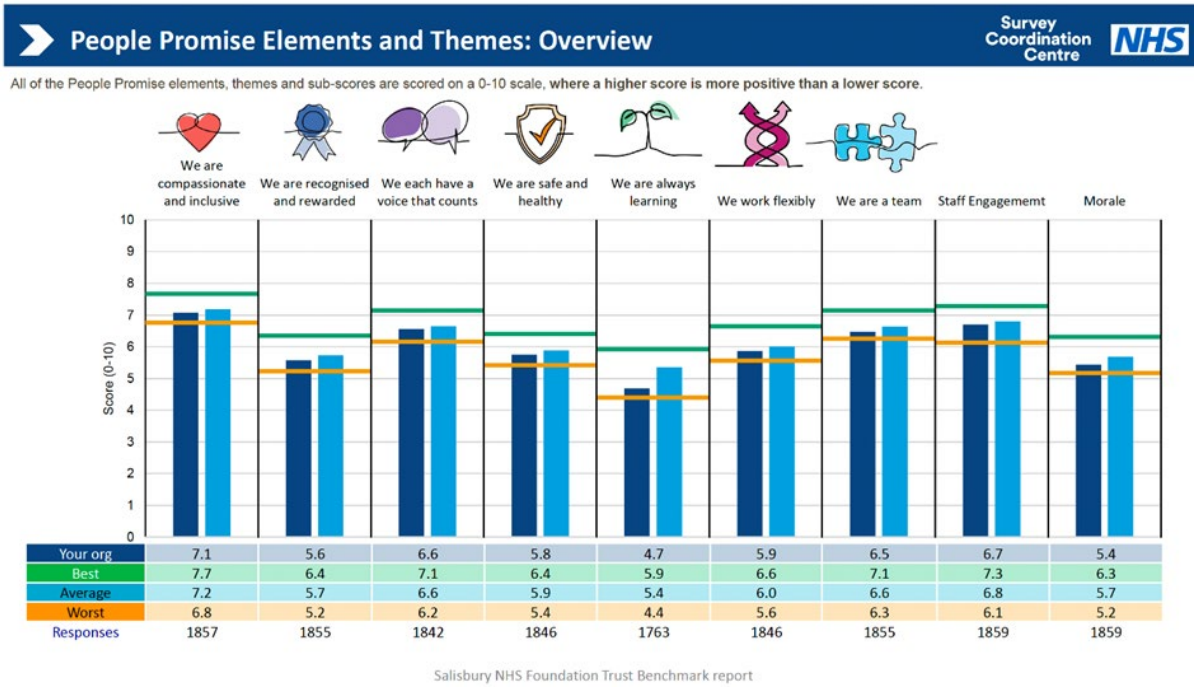
In addition to improving the systematic approach to H&S, routine activity such as investigations of injuries and incidents, trend analysis, completion of risk assessments and management of contractors performing specialty works across the Trust continued throughout the year.

Staff Survey

The NHS staff survey is conducted annually, with 2022 being the second year when the questions were aligned with the NHS people promise to track progress against our ambition to make Salisbury Foundation Trust (SFT) workplace the ‘best place to work’. The national Staff Survey reports against the seven elements of the people promise, and two of the original themes of the staff survey: morale and staff engagement.

The SFT response rate for the 2022-23 survey was 48% (1861 responses) compared with 48.5% for the 2021 survey (1881) responses. By comparison the median response rate in 2021 for our benchmarking group (acute and acute and community trusts) was 44%.

Scores for each indicator together with the average, best and worst scores in the benchmarking group across the NHS are presented below for 2022:



Comparisons between 2022/23 and 2021/22 are shown in the following table:

Indicators ('People Promise' elements and themes)	2022/23		2021/22	
People Promise elements:	**Trust score**	**Benchmarking group score**	**Trust score**	**Benchmarking group score**
We are compassionate and inclusive	7.1	7.2	7.1	7.2
We are recognised and rewarded	5.6	5.7	5.6	5.8
We each have a voice that counts	6.6	6.6	6.6	6.7
We are safe and healthy	5.8	5.9	5.8	5.9
We are always learning	4.7	5.4	5.0	5.2
We work flexibly	5.9	6.0	5.7	5.9
We are a team	6.5	6.6	6.4	6.6
Theme: Staff engagement score	6.7	6.8	6.8	6.8
Theme: Morale	5.4	5.7	5.5	5.7

Future priorities and targets

SFT is 1 of 23 People Promise exemplar sites in the country. The Trust benefits from the addition of a People Promise project manager who has supported people services to build a comprehensive improvement programme against all 7 elements of the Promise. In addition, Divisional and departmental action plans are being developed to address the key themes arising from the survey which was published on 8 March 2023. These are aligned with the Trust's People Promise improvement plans alongside the

'Improving Together' programme, with the focus on our vision and 'watch' metrics for 'people' including staff engagement, morale, and inclusion.

We aim to have more people recommending SFT as a place to work, feeling motivated and supported to make improvements to their work and the standard of care we give. We aspire to achieve the upper quartile in engagement for acute providers. We also want our people to recognise and experience SFT as an inclusive employer, and we will measure this by the trends in the staff survey questions which form part of the national NHS Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES).

Following the latest results, we will build on previous activities supporting staff survey outcomes, such as listening events to give our staff a greater voice, lunch and learn sessions to increase training and development opportunities and improved communications through the refreshed Intranet (SALi) and digital screens to increase understanding. Across all of our divisions we will encourage staff to get involved and generate ideas for improvement. Staff engagement and inclusion are our highest priorities.

Staff survey action plans will continue to be monitored by the Organisational Development and People Management Board and People and Culture Committee on behalf of the Trust Board.

Staff engagement

Identified as a breakthrough objective within the Improving Together methodology, Staff Engagement is a priority with the Trust aiming to achieve top quartile status amongst peer organisations in the Staff Survey. The Trust therefore remains committed to engaging with staff at all levels through the 'We all have a voice' element of the People Promise. More widely we seek to ensure that we remain an anchor organisation, meaning our long-term sustainability is aligned to the wellbeing of the population we serve. Establishing a new Communications, Engagement and Community Relations team, under the direction of the Chief People Officer in the OD&P team has reinforced the focus on our engagement ambition.

The Trust is committed to engaging with staff at all levels and through many different media. We continue to hold regular briefings and dialogue through MS Teams and now face to face. Our monthly Cascade briefings give the Trust the opportunity to share information and to take views from staff on a wide range of topics. These are well attended and give all staff an opportunity to engage with colleagues at all levels. For new staff there are 100 day and 1 year feedback sessions hosted by the Chief People Officer. In addition, the Trust has a regular Daily Bulletin, a weekly Chief Executive message and a Friday Line Manager's round up. The annual national NHS staff survey had a 47% response rate, which was slightly above the national average, we also ran the regular Pulse Survey to take up to date feedback from staff.

Our Staff Thank You Week included the staff awards, family fun day and staff party and was a key part of our engagement activity - we presented awards to our remarkable staff covering a mix of categories from the Chair's award, the CEO Award to Best Team and Unsung Contribution. In addition, at the volunteer's night we presented the Volunteer of the Year Award and long service certificates. We continue to have regular peer to peer SOX Awards and SOX of the month that enable staff to recognise the contributions made by their colleagues.

In 2022 the Trust launched its own podcast series *The Cake with Joe & Jayne*. The series looked at personal experiences and personal characteristics that make us who we are. There were 16 episodes in series one and subjects included Faith, Race, Sexuality, Ability, Mental Health, Grief, Parenthood, the Menopause, Military Service and Love. To date episodes have been downloaded nearly 4000 times. 2022 also saw the conclusion of the *My Name is Mercy* project and COVID-19-19 *Reflections*. *My Name is Mercy* is an award-winning poetry project written by Martin Figura and funded by our charity The Stars Appeal and the hospital League of Friends. The work was built from direct engagement with staff that explored how it felt to work in the hospital during the COVID-19-19 pandemic. In addition, the Trust worked with partners in social care to produce the impactful *Reflections* service at Salisbury Cathedral.

Board safety walks give our Board members the opportunity to engage directly with staff. These occur monthly with an Executive Director, Non-Executive Director and divisional management team visiting patient and non-patient facing areas, speaking to staff and listening to their concerns. 'Back to the floor' sessions have also taken place with Executive colleagues shadowing colleagues for half a day on a regular basis to learn from and engage with staff.

Equality, Diversity & Inclusion (EDI)

During this year much work has been completed to meet the recommendations identified in the EDI Audit covered in last year's report. The Trust's EDI Strategy was launched as part of the SFT People Plan 2022-26. One of the Trusts vision metrics is that our staff recognise, and experience SFT as an inclusive employer which will be measured using a number of qualitative measures and the quantitative measures of WRES and WDES data. More recently, we have adopted the South West Regional leadership community strategy on 'leading for inclusion', which will enable us to refresh our own strategy to include an Equality Delivery System and a six-point plan to increase equality within recruitment and promotion processes.

We have begun developing further our staff networks. Six are active (Ability Confident, Armed Forces, Carers, LGBTQ+, Race Equality and Women's). A faith network will be launching in 2023. Networks have been given a small annual budget for 23/24 to enable them to fund Network activities and events in accordance with their 12-month plans. In addition, protected time of one day per month remains in place for our staff network leads to facilitate their development. Terms of reference are being refreshed to ensure that we have a robust system of governance and reporting in line with the aims of the EDI strategy and the needs of each Network's members. All staff networks have been asked to develop three priority areas for their members for the next 12 months and have their own staff network pages on the Trust's intranet. The aim being that our networks become the cultural barometer of the Trust.

This year the Trust's long standing EDI adviser retired and has been replaced with a new combined lead for EDI and Wellbeing.

On the 31 March 2023, The Trust had a total of 5145 staff in the workforce. This consisted of 3881 who described themselves as White and 1129 who described themselves as Black and Minority Ethnic and 135 had unknown ethnicity. Of the 5145, 151 declared themselves as disabled with a further 288 with disability unknown.

Our 2022/23 Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap reports and action plans have been published on the Trust internet. Over the next year as part of the OD and P 5-year ambition, the Trust is aiming to increase our staff's experience of being an equitable and inclusive employer of choice. We are focusing on the seven WDES and four WRES indicators in the NHS staff survey.

Further Board development days on EDI have been agreed, and the Trust continues to play an active part on developing and embedding EDI across the Bath, Swindon and Wiltshire (BSW) ICS.

The Freedom to Speak Up Service is provided by the Trust to empower staff to raise a concern outside of an individual's management chain should they require it. The service is led by a Freedom to Speak Up Guardian. During the past year the Trust has increased the number of Freedom to Speak Up Ambassadors from right across the organisation to increase the accessibility for staff who need support to speak up. The remit of the service is to support the development of a culture that is open and transparent so that raising concerns becomes business as usual for all staff. The Trust's Freedom to Speak Up Guardian has direct access to all senior leaders including the Chief Executive and all Board members.

Level 2 Freedom to Speak Up enhanced online training, 'Listen Up' package will apply to all staff with line management responsibilities, which forms part of the Aspiring Leaders and Transformational Leaders offer which is currently being delivered by the Organisational Development Team. This approach will enable consistency and quality when concerns are raised.

Information on how to access the Freedom to Speak Up service is readily available via daily communication on the Staff Bulletin email, posters are displayed in prominent areas, and business cards are handed to every new member of staff at Trust Induction.

Themes and trends are reported quarterly to Board for assurance and to highlight lessons learned from concerns that have been raised. In the year 2022-23 124 concerns were raised to the Freedom to Speak Up Guardian, which is an increase of 50% compared to the previous year. Of these 37 had an element of patient safety and quality, these concerns are escalated immediately to senior leaders for appropriate action.

	Themes	Cases Q1 2022-23	Cases Q2 2022-23	Cases Q3 2022-23	Cases Q4 2022-23
1	Patient Safety/Quality	8	10	12	7
2	Worker Safety	3	12	8	2
3	Element of inappropriate attitude or behaviours	24	14	25	17
4	Bullying/Harassment	5	8	7	4
5	Disadvantageous and/or demeaning treatment (Detriment)	10	0	3	1

**Please note that some cases record more than one theme*

Apprenticeships

The Trust supports the aim of creating a highly skilled workforce, including via our apprenticeship offer. An apprenticeship combines practical training in an occupation with study. It can be accessed by people in entry-level jobs right through to those in senior clinical, scientific, or managerial roles. Depending on the apprenticeship, upon successful completion, apprentices may be eligible to apply for professional registration.

	2020/2021	2021/2022	2022/23
Total Number of apprentices	128	153	143
Current Funds	£1,318,012.00	£1,481,729.00	£1,575,253
Total Spent to Date	£832,402.11	£1,265,125.39	£1,972,717.77
Total Spend in Year	£445,354.91 Of which £12,557 (2.8%) was transferred to other organisations	£432,724.28 Of which £6,918.43 (1.6%) was transferred to other organisations	£579,197.20 Of which £71,377.58 (12.32%) was transferred to other organisations
Annual Expired Levy	£87,493.45	£112,685.57	£136,370.30

SFT currently offer apprenticeships to 142 people in 29 different occupations including: Nursing Associate, Registered Nurse, Physiotherapist, Pharmacy Technician, Diagnostic Radiographer, Senior Healthcare Support Worker, Associate Project Manager, Business Administration, Clinical Coder and more. We are proud to say that 37 of our apprentices successfully completed their apprenticeships in 2022.

The Apprenticeship Levy is used to pay the training providers who deliver training which makes up a minimum of 20% of the apprentices' time. SFT currently pays 0.5% (c. £60k) of its total pay bill into the Apprenticeship Levy per month, with a current total of £1.6 million available for us to access. Levy utilisation has continued to improve in the last 12 months. In 2022/3 the trust spent £579,197, which is a 12.78% increase of spend compared to last year. Our planned spending estimate for the next 12 months is currently £588,221 which equates to approximately one third of the available levy funds. Any Levy not utilised within 2 years of being paid into the fund will expire and we recognise the opportunity to encourage further take up.

Leadership and Development

The Trust has finalised its Education, OD and Leadership Strategy which will support our people to develop themselves in 'Leading Self' (self-awareness), 'Leading Others' and 'Leading the Organisation' to build capability and the desire to shape the culture we seek.

A new Leadership Behaviours Framework, based on the feedback from Improving Together methodologies, development of our work as an exemplar site within the NHS People Promise programme, staff/pulse survey results and previous gap analysis has been designed. Our identified Leadership Behaviours align with those we want our leaders to model to achieve the Trust vision and achieve People Plan outcomes.

Alongside strategy development we have continued to provide a significant and impactful offer of Leadership and wider Organisational Development (OD) training interventions. This Leadership and OD activity aligns with the Strategy, which highlighted the need for greater emphasis on, and a move towards a more collaborative and compassionate style of Leadership. The success of this initial programme has allowed us to build a broader offering supporting our junior team leaders through to our senior managers with further leadership development programmes.

We are pleased that over 130 leaders attended our internal Best Place to Work (BPTW) leadership programme and a further 85 started our newly designed Leadership programmes. Coaching skills programmes have seen 240 leaders participate, with a further 116 leaders receiving one-to-one coaching support from our network of 18 coaches to support our 'We are always learning' people promise element.

Looking forward, a 360° self-assessment tool for managers will be tailored to provide feedback against the new behavioural framework to be introduced in the year ahead. Our Talent Management aspirations defined by a welcome Talent and Succession Management strategy is a key contributor to our ambition of "Always Learning" alongside a meaningful annual appraisal and we recognise the value of ensuring their timely completion.

We are looking to create a clear 'pathway' for aspiring leaders and our current leaders that will support all talent development through improving core leadership and management skills/capabilities and aligning opportunities for personal growth and performance.

Consultancy Expenditure - Off Payroll Payments

Table 1: Highly paid off-payroll worker engagements as at 31 March 2021 earning £245 per day or greater For all off-payroll engagements as of 31 March 2023	**22/23**	**21/22**	**20/21**
Number of existing engagements as of 31 March 2023	**25**	124	11
Of which:			
Number that have existed for less than one year at the time of reporting	**6**	114	2

Number that have existed for between one and two years at the time of reporting	**13**	2	5
Number that have existed for between 2 and 3 years at the time of reporting	**3**	3	1
Number that have existed for between 3 and 4 years at the time of reporting	**2**	3	2
Number that have existed for 4 or more years at the time of reporting	**1**	3	1
	25	125	11

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2021 earning £245 per day or greater.	**22/23**	**21/22**	**20/21**
Number of off-payroll workers engaged during the year ended 31 March 2023	**692**	466	12
Of which:			
Not subject to off-payroll legislation	**682**	16	0
No. assessed as caught by IR35	**0**	0	6
No. assessed as not caught by IR35	**4**	450	6
No. of engagements reassessed for consistency / assurance purposes during the year	**0**	16	6
No. of engagements that saw a change to IR35 status following the consistency review	**0**	0	0

Table 3: Off-payroll board member/senior official engagements for any off-payroll engagements of board members and/or senior officials with significant financial responsibility, between 1 April 2022 and 31 March 2023	**22/23**	**21/22**	**20/21**
Number of off-payroll engagements of board members and/or senior officers with significant financial responsibility, during the financial year (1)	**0**	0	0
Total number of individuals on payroll and off-payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year. This figure must include both on payroll and off-payroll engagements. (2)	**18**	18	18

Staff Exit Packages

Staff exit packages include those made under nationally agreed arrangements or local arrangements for which Treasury approval is required. This does not include retirements due to ill health. Figures for 2022-23 included in this table. The 2021-22 figure is in brackets.

Exit package cost band	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
Under £10,000	0(0)	6(0)	29(0)
£10,000 - £25,000	0(0)	1(1)	14(1)
£25,001 – £50,000	0(0)	0(1)	0(1)

£50,001 - £100,000	0(0)	0(0)	0(0)
£100,001 - £150,000	0(0)	0(0)	0(0)
£150,001 - £200,000	0(0)	0(0)	0(0)
Total number of exit packages by type	0(0)	7(2)	43(2)
Total resource cost	£0(£0)	£43,000(£59,000)	£43,000(£59,000)

This table is subject to audit.

The other departures shown above relate to contractual payments in lieu of notice.

Trade Union Facility Time Disclosures

Since April 2017, public sector organisations are required to report on trade union facility time.

Table 1 - Relevant Union Officials

Number of employees who were union reps	23
FTE union reps	21.37

Table 2 Percentage of time spent on facility time

Percentage of time	**%**
0%	12
0-50%	11
51-99%	0
100%	0

Table 3 Percentage of pay bill spent on facility time

Percentage of pay bill on facility time	
Total cost of facility time	£25,699.03
Total pay bill	£218,532,000.00
Percentage facility time	0.01%

Paid Union Activities	
Time spent	0

NHS FOUNDATION TRUST CODE OF GOVERNANCE

Disclosure Statement

Salisbury NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board considers that for the 2022-23 year the Trust has been fully compliant with the provisions of the Code, with the exception of provision B.6.2 that states “evaluation of the boards of NHS foundation trusts should be externally facilitated at least every three years”. An external review was delayed given the ongoing executive recruitment during 2012-22 and the continued focus on COVID-19-19 recovery. The Trust Board has previously undertaken a self-assessment which has highlighted specific areas of focus for improvement, prior to the external review which will run from April-June 2023.

The Board is committed to the highest standards of good corporate governance and follows an approach that complies with this code through the arrangements that it puts in place for our governance structures, policies and processes and how it will keep them under review. These arrangements are set out in documents that include:

- The Constitution of the Trust
- Standing orders
- Standing financial instructions
- Integrated Governance Framework
- Accountability Framework
- Terms of reference for the Board of Directors, the Council of Governors and their committees
- Annual declarations of interest
- Annual Governance Statement

Council of Governors Public Constituency

The Trust’s Governors are the representatives of members, staff, our stakeholders, and public interests, and are an integral part of advising us on how best to meet the needs of patients and the wider community. Our Governors have a number of statutory duties but their key role is to hold the Non-Executive Directors to account individually and collectively for the performance of the Board of Directors. Other statutory duties of the Council of Governors’ role include:

- Appointing the Chair and Non-Executive Directors
- Approving the appointment of the Chief Executive
- Deciding on the remuneration of the Chair and Non-Executive Directors
- Receiving the Trust’s Annual Accounts, Auditors Report and Annual Report
- Reviewing the Membership and Public Engagement Strategy

The Council has been placed into groups to consider various topics over which they can have an influence. In 2022-23 these covered:

- Membership and Communications Committee
- Performance Committee (Chair and Non-Executive Directors)
- The Trust’s Annual Plan prior to submission to the regulator
- Nominations Committee
- Staff Governors Committee
- Self-assessment Committee
- Patient Experience Group
- The strategic direction of the Trust
- Volunteers

The Governors review their work programme and the make-up of their working groups annually. They appreciate that, statutory roles apart, their principal duties are to monitor, advise and inform. Governors are also party to discussions about elements of the Trust's strategy when items are taken at meetings of the Trust Board and Council of Governors.

The public and staff members of the Council are elected from and by the Foundation Trust membership to serve for three years. They may stand for re-election but they may not serve for more than nine years in total.

In addition, some of the organisations we work most closely with nominate stakeholder Governors. An appointed Governor may hold office for three years and can be re-appointed in line with elected Governors.

The representatives of public constituencies must make up at least 51% of the total number of Governors on the Council of Governors.

The Council of Governors hold four meetings a year, in addition to the Annual General Meeting (AGM). The Governors canvass opinions of the members and public through their constituency meetings and at the AGM. The Trust held its first constituency meeting in four years on 27th March 2023 in Kennet. Constituency meetings had not been scheduled largely due to the restrictions in place during the COVID-19-19 pandemic. However, membership engagement has been highlighted as a priority in the Membership Strategy and more meetings are scheduled to take place in 2023-24.

Elected Governors - Public Constituency

Name	Constituency	Elected or Re-elected	Term of Office	Attendance from 6 meetings
Kevin Arnold	Salisbury City	June 2020	Three years	3 / 4
Lucinda Herklots (Lead)	Salisbury City	May 2018	Three years	4 / 4
Joanna Bennett	Salisbury City	June 2020	Three years	4 / 4
Dr James Robertson	South Wiltshire Rural	June 2020	Three years	3 / 6
Anthony Pryor-Jones	South Wiltshire Rural	June 2020	Three years	4 / 6
Angela Milne	South Wiltshire Rural	June 2021	Three years	5 / 6
Andrew Rhind-Tutt	South Wiltshire Rural	June 2021	Three years	6 / 6
Peter Russell	South Wiltshire Rural	June 2021	Three years	5 / 6
John Parker	North Dorset	June 2021	Three years	6 / 6
Christine Wynne[1]	North Dorset	June 2021	Three years	0 / 1
John Mangan (Lead)	New Forest	June 2021	Three years	5 / 6
Peter Kosminsky	Kennet	June 2020	Three years	4 / 6
Mary Clunie	Rest of England	June 2021	Three years	5 / 6

[1] Christine Wynne resigned from her post in May 2022

Elected Governors - Staff Constituency

Name	Constituency	Elected or Re-elected	Term of Office	Attendance from 6 meetings
Paul Russell	Clerical, Administrative and Managerial	June 2020	Three years	6 / 6
Jane Podkolinski	Volunteers	June 2021	Three years	6 / 6
Anisa Nazeer	Medical & Dental	June 2021	Three years	4 / 6

Mark Brewin	Scientific, Technical & Therapeutic	June 2021	Three years	4 / 6
Jayne Sheppard	Nurses & Midwives	June 2021	Three years	5 / 6

Nominated Governors

Name	Constituency	Appointed or Re-appointed	Term of Office	Attendance from 6 meetings
Cllr Richard Rogers	Wiltshire Council	9 March 2022	Three Years	N/A
Vacant	Wessex Community Action	N/A	N/A	N/A
Vacant	Dorset Integrated Care Board (ICB)	N/A	N/A	N/A
Vacant	Bath and Northeast Somerset, Swindon, and Wiltshire ICB	N/A	N/A	N/A
James House	Hampshire and Isle of Wight ICB	July 2021	Three years	4 / 6
Sarah Walker	Military	July 2021	Three years	2 / 6

During the year the Directors have used a variety of methods to ensure that they take account of, and understand, the views expressed by Governors and members. The Council of Governors is chaired by the Chair of the Trust and these meetings are attended by the Chief Executive, who is there to provide clarifications on the Integrated Performance Report (IPR). There is an opportunity for Governors to express their views and raise any other issues, so that members of the Board, including Non-Executive Directors can respond.

There have been no formal requests for Director attendance at the Council of Governors meetings, but it has been standard practice for the Chief Executive to attend. Other executives attend as and when required dependent on the topics raised as part of the agenda.

An informal meeting is normally held between the Governors and the Non-Executive Directors a week after a public board meeting approximately four times a year.

The Trust Board is aware of the work carried out by the Governor committees and information is fed back to the directors.

In 2022-23, the Trust Board met regularly in public and, as part of its commitment to openness, Governors and members are invited by the Chair to comment or ask questions on any issues that they may wish to raise at the end of the public session. A response is provided by the appropriate member of the Trust Board.

Public Trust Board papers are made available on the website and Governors alerted so that these can be viewed prior to the meetings.

The Trust Board has invited Governor observers to attend the meetings of the Board's Finance and Performance Committee, its Clinical Governance Committee and its People and Culture Committee.

Register of Governor Interests

A register of interests is held in the Trust Offices. Information regarding the Governors' interests and whether they have undertaken any material transactions with Salisbury NHS Foundation Trust can be obtained by contacting:

Head of Corporate Governance,
Trust Offices,
Salisbury NHS Foundation Trust,
Salisbury
SP2 8BJ

Dispute Resolution

There are several mechanisms in place that allow an issue or concern to be discussed and escalated. Informally, there are meetings between the Lead Governor and the Chair. There are also regular meetings between the Governors and the Non-Executive Directors. A formal procedure is in place (see point 51, Dispute Resolution in the Trust's Constitution) should there be a dispute between the Council of Governors and Trust Board. There have been no disputes during 2022-23.

The Board of Directors

The Board comprises the Chair, Chief Executive, five other Executive Directors and seven other Non-Executive Directors. There is a clear separation between the roles of the Chair and the Chief Executive, which has been set out in writing and agreed by the Board. As Chair, Ian Green, has responsibility for the running of the Board, setting the agenda for the Trust and for ensuring that all Directors are fully informed of matters relevant to their roles. The Chief Executive has responsibility for implementing the strategies agreed by the Board and for managing the day-to-day business of the Trust.

All of the Non-Executive Directors are considered to be independent in accordance with the NHS Foundation Trust Code of Governance. The Board considers that the Non-Executive Directors bring a wide range of business, commercial and financial knowledge required for the successful direction of the Trust. All directors are equally accountable for the proper management of the Trust's affairs.

All directors are subject to an annual review of their performance and contribution to the management and leadership of the Trust.

The Board Committees including the Clinical Governance Committee, Audit Committee, Finance and Performance Committee and People and Culture Committee have completed a self-assessment of committee effectiveness. These reviews concluded that these Committees were meeting the requirements as set out in their terms of reference.

In Quarter 4 2022-23, the Trust, alongside Royal United Hospitals Bath NHS Foundation Trust (RUH Bath) and Great Western Hospitals NHS Foundation Trust (GWH) secured an external company to undertake a well-led developmental review. The Trust review commenced in April 2023.

The Trust has Board approved Standing Financial Instructions and a Scheme of Delegation and Reservation of Powers, which outline the decisions that must be taken by the Board and the decisions that are delegated to the management of the hospital. These documents include, but are not limited to, instructions on budgetary control, contracts and tendering procedures, capital investment and security of the Trust's property, delegated approval limits, fraud and corruption and payroll.

The Board is satisfied as to its balance, completeness and appropriateness but will keep these matters under review.

Trust Board Members

Non-Executive Directors

Ian Green OBE– Chair (Independent)

Ian Green joined the Trust as Chair in February 2023 for his first three-year term. Ian has held Non-Executive Director posts within the NHS over the past 15 years, including Non-Executive Director of South-Central Ambulance Trust Board. This broad experience has provided Ian with an excellent grasp of the challenges of healthcare delivery and of those specific to Salisbury. He is committed to ensuring services are delivered in accordance with best possible practice and emphasises the importance of working with partners to ensure population health needs are met, in a safe and effective environment. Most recently Ian has been Chief Executive of the Terrence Higgins Trust.

Rakhee Aggarwal – Non-Executive Director (Independent)

Rakhee Aggarwal joined the Trust in January 2020. Rakhee has been a mental health nurse since 1999; She has a BSc in Behavioural Studies (Psychology); and a Master's in teaching and Learning for Health Professionals. She has worked for the University of the West of England for the past 15 years as a Senior Lecturer; Associate Head of Nursing and Midwifery - Mental Health and Learning Disability Nursing; Associate Head of Nursing and Midwifery - Adult Nursing; and as Associate Head of Nursing and Midwifery - Continuing Professional Development. Rakhee is leading and developing the CPD Education provision for the NHS and private and voluntary sectors. In addition to her work at the University she has been a Non-Executive Director with the South Western Ambulance Trust since 2017. Rakhee was appointed for her second term of office of three years in December 2022.

Tania Baker - Non-Executive Director (Independent)

Tania Baker joined the Trust in June 2016 for a three-year period. Her term of office was extended for a further two years in February 2019. She was Chief Executive Officer at health analytics company, Dr Foster where she was involved in developing the business nationally and internationally. Before this Tania held senior appointments in private healthcare and was Commercial Director at Aviva Health insurance. Tania is the Senior Independent Director (SID) and was appointed for her third term of office, for two years in May 2022.

Michael von Bertele CB, OBE - Non-Executive Director (Independent)

Michael joined the Trust in November 2016 for a three-year period. His term of office was extended for a further three years in October 2019. As an army junior doctor, he trained in occupational and environmental medicine, and became a consultant in 1992. Michael has served in the UN Protection Force in Croatia, was chief medical planner in the Ministry of Defence and was Director General of the Army Medical Services. He retired in 2012 and worked for Save the Children International until 2015. Michael was appointed for his third term of office, for two years in October 2022.

Dr David Buckle – Non-Executive Director (Independent)

Dr David Buckle joined the Trust in January 2020. He is MB BS, DRCOG and MRCGP qualified and is a Fellow of the Royal College of General Practitioners. He was a practising GP until 2017 whilst latterly working part-time (until May 2018) as the Medical Director for Herts Valley Clinical Commissioning Group, where he was the Director of General Practice development. He has previously held other roles comprising various positions within Berkshire East and Berkshire West Primary Care Trusts and with NHS Berkshire West Primary Care Trust. David currently has a portfolio of non-Executive appointments, as the President of the Society for Assistance of Medical Families, Non-Executive Director with Berkshire Healthcare NHS Foundation Trust, Non-Executive Director with East and North Hertfordshire NHS Hospitals Trust; and Vice Chair (clinical) of the Stroke Association. David became a voting member of the Board in May 2020. David was appointed for his second term of three years in January 2023.

Debbie Beaven– Non-Executive Director (Independent)

Debbie Beaven joined the Trust in January 2023 for her first three-year term as Non-Executive Director. Debbie is a qualified accountant and experienced executive and board director. She has a career spanning 25 years in financial leadership, from which she brings sound financial expertise around good governance, financial improvement plans and long-term financial modelling. Debbie also works as a Non-Executive Director at Isle of Wight NHS Trust, chairing their finance committee and working with the board to help evolve their health and care plans and trust strategy.

Richard Holmes– Non-Executive Director (Independent)

Richard Holmes joined the Trust in January 2023 for his first three-year term as Non-Executive Director. Richard has had a wide range of senior appointments with responsibility for business services, including IT, HR, estates, and infrastructure. However, Richard's fundamental background is in finance and assurance as finance director and chief operating officer, and corporate governance as Company Secretary. Richard currently chairs an audit committee for a multi-academy school trust and is also appointed to the audit committee for two other charities that support people and communities in the wider Bristol area. He has been instrumental in improving organisational systems of control and assurance in organisations across many sectors ranging from both large corporate organisations to small charities, from public to private, and from education to manufacturing and construction.

Margaret (Eiri) Jones – Non-Executive Director (Independent)

Eiri Jones joined the Trust in November 2019. Eiri is a registered adult and children's Nurse, has an MA in Professional Development and is a QSIR Practitioner. She has clinical, managerial, and executive leadership knowledge and skills gained during a career spanning over 40 years.

Eiri has held senior and board positions in a range of Trusts in England and Wales and has also held regional (Trust Development Authority), national (Welsh Government and State of Qatar) and regulatory (Nursing and Midwifery Council) appointments. Her last UK Executive role was as the Director of Nursing for the United Lincolnshire Hospitals NHS Trust (2012 – 2014). Since then, she has held roles as an interim Quality Manager at NHS Crawley CCG; interim Director of Quality Governance at Barts Health NHS Trust; Implementation Director of GIRFT in the Southwest of England and most recently as a Quality Programme Director for Cwm Taf Morgannwg Health Board. Eiri is also Non-Executive Director at Dorset County Hospital and sits on Allocate's Advisory Board.

Executive Directors

Stacey Hunter – Chief Executive

Stacey is an experienced NHS Board Director with over 35 years' experience working in the NHS and a decade operating in Chief Operating Officer, Divisional Director, and Executive System Transformation roles. She has spent time working in large scale teaching hospitals, an integrated acute and community trust and is passionate about reducing the inequalities patients experience in respect of their access to, experience of and outcomes from care.

A nurse by background Stacey spent several years working in clinical leadership roles before expanding her experience in general management. She has invested in her leadership development having undertaken the NHS Leadership Academy Aspiring CEO programme and is keen to continue to support the Trust to develop an inclusive culture that develops clinical and operational leaders to seek to continuously improve their services. Stacey has experience of being a trustee in a number of different charities over the last 20 years most of them related to health and care. Stacey joined the Trust in September 2020.

Dr Peter Collins – Chief Medical Officer

Peter trained as a liver specialist and was the clinical lecturer at the Sheila Sherlock Liver Centre at the Royal Free Hospital prior to taking up a consultant post at University Hospitals Bristol Foundation Trust in 2005. He has a research interest in primary liver cancer and alcohol related liver failure and led the regional Primary Liver Cancer Service for the West of England. He has had a number of senior leadership positions in research, education and hospital care.

In 2017, Peter was appointed to the role of Medical Director at Weston Area Health Trust where he played a key role in developing models of integrated care, reconfiguring services across Bristol and North Somerset and readying the organisation for a successful merger with University Hospitals Bristol. Since the merger Peter worked as a Deputy Medical Director for the large organisation focusing on the delivery of safe and effective COVID-19-19 care and the restoration of non-COVID-19 services for the Trust and the local Healthcare system. Peter joined the Trust as Interim Medical Director in October 2020 and was successfully appointed to the substantive position in March 2021.

Judy Dyos – Chief Nursing Officer

Judy joined the Trust from Isle of Wight NHS Trust where she was formerly Deputy Director of Nursing and was instrumental in the Isle of Wight Trust obtaining a CQC rating of Good in many areas. Prior to this she was the Lead for Clinical Assurance and Quality Governance at University Hospital Southampton. Judy joined the Trust as Interim Director of Nursing in June 2020 and was successfully appointed to the substantive position in March 2021.

Mark Ellis – Interim Chief Finance Officer

Mark has worked in the Trust as Deputy Chief Finance Officer was appointed as Interim Chief Finance Officer in August 2022, responsible for the Trust's Finance, Payroll, and Procurement departments. Mark has over 18 years' NHS finance experience, working in senior finance positions at a number of NHS Trusts across Hampshire and Berkshire until joining the Trust in late 2017. Mark has an undergraduate master's degree in engineering science from the University of Oxford and obtained Chartered Management Accountant status as part of the NHS Graduate Training Scheme.

Lisa Thomas – Interim Chief Operating Officer / Chief Finance Officer

Lisa has over 18 years' finance experience in a number of NHS organisations having started her career in 1999 on the Graduate Financial Management Training scheme. She was previously Deputy Director of Finance at Royal United Hospitals Bath NHS Foundation Trust, and prior to that she spent time working in Basingstoke, Winchester, and Gloucestershire NHS organisations in senior roles. Lisa joined Salisbury in 2017 as Chief Finance Officer. In August 2022, she took on the role as Interim Chief Operating Officer on a one-year secondment.

Melanie Whitfield – Chief People Officer

Melanie is an accomplished HR leader and coach with many years' experience leading on significant programmes of change and people strategy in both the private and public sector. With years of organisational HR experience, including Board level experience within private equity and public charity sectors, Melanie joined the national team at NHS England and Improvement as one of the founding authors of the People Plan.

Melanie began her career in retail working for some of the best-known brands on the high street including The John Lewis Partnership, Sainsbury's, and Boots. She has continued both her formal academic studies and professional development and has a particular interest in the value and impact of team coaching. On joining the Trust Melanie expressed her wish to support all staff to be the best they could be, by helping create the kind of environment where everyone can thrive and in doing so, provide the best possible care to

the community we serve. Within the Trust's executive team, she is the responsible leader for our Operational HR Services, Resourcing, Organisation design and Development, Education and Communication strategies alongside our Health and Safety and Occupational Health services.

Directors that left the Trust during 2022-23

Dr Nick Marsden
Nick joined the Trust in January 2014 as chair of the Trust. He was appointed as Chair for a total of 9 years, which included an additional year extension, considering the extenuating circumstances around the COVID-19-19 pandemic and recent recruitment into the executive team. Nick left the Trust on 31st December 2022.

Paul Kemp
Paul joined the Trust in February 2015 as Non-Executive Director and was appointed for a total of 8 years. Paul chaired the Trust's Audit Committee until he left on 31st January 2023.

Paul Miller
Paul joined the Trust in March 2018 as Non-Executive Director and was appointed until June 2022 when he left the Trust to take up a non-Executive position with the Bath and North-East Somerset, Swindon, and Wiltshire Integrated Care Board (BSW ICB).

Andy Hyett
Andy joined the Trust in 2015 and worked as Chief Operating Officer (COO) until he left the Trust in August 2022.

Board of Directors' Attendance (Members' attendance only) 2022-23

	Appointment Date		Trust Board (13 meetings)	Audit Committee (6 meetings)	Remuneration Committee (3 meetings)	Finance & Performance (13 meetings)	Clinical Governance Committee (12 meetings)	People and Culture Committee (9 meetings)	Subsidiary Governance Committee[2] (3 meetings)
	From	To							
Rakhee Aggarwal Non-Executive	01/01/20	-	11		3			7	
Tania Baker Non-Executive	01/06/16	-	12	6	3				
Debbie Beaven Non-Executive	01/01/23		2		0	4	3		
Michael Von Bertele Non-Executive	01/11/16	-	11	6	3			7	
Dr David Buckle Non-Executive	27/01/20	-	13		3		11		
Peter Collins Medical Director	05/10/20	-	10				12	8	
Judy Dyos Director of Nursing	15/06/20	-	13				8	7	
Mark Ellis Interim Chief Finance Officer	08/08/22	-	7	3		9		1	1
Richard Holmes Non-Executive	01/01/23	-	3	1	0	3			
Andy Hyett Chief Operating Officer	13/04/15	31/08/22	5			2	3		
Stacey Hunter Chief Executive	01/09/20	-	13	1		12	9		
Ian Green Chair	01/02/23	-	2		0				
Margaret (Eiri) Jones Non-Executive	11/11/19	-	12		3	12	12		
Paul Kemp Non-Executive	01/02/15	31/01/23	10	5	2	9			2
Nick Marsden Chairman	01/01/14	31/12/22	10		3				2
Paul Miller Non-Executive	16/04/18	30/06/22	3	1	1	2	2		0
Lisa Thomas[1] Chief Finance Officer/ Interim Chief Operating Officer	03/07/17	-	13	3		13	7		2
Melanie Whitfield Chief People Officer	06/09/21	-	12			11		8	2

[1] Lisa began her role as Interim Chief Operating Officer in August 2023.

[2] Subsidiary Governance Committee was disbanded in 2022/23 and oversight and assurance of governance and performance is now received through Finance and Performance Committee.

Register of Director's Attendance – Public Council of Governors 2022-23

	23 May 2022	25 July 2022	28 Nov 2022	2 Nov* 2022	10 Nov* 2022	27 Feb 2023	Attendance rate
Nick Marsden	✓	✓	✓	✓	✓		5/5
Ian Green						✓	1/1
Tania Baker	✓	✓	✓		✓	✓	5/5
Michael von Bertele	✓	x	x			✓	2/4
Paul Kemp	x	x	x				0/3
Rakhee Aggarwal		x	x			✓	1/4
Paul Miller	✓						1/1
Stacey Hunter	✓	✓	✓			✓	4/4
Peter Collins	✓	✓	x			x	2/4
Lisa Thomas	x	✓	✓			x	2/4
Andy Hyett	x	x					0/2
Judy Dyos	x	x	x			x	0/4
Melanie Whitfield	x	x	✓			x	1/4
Margaret (Eiri) Jones	✓	x	x			✓	2/4
David Buckle	x	✓	✓			x	2/4
Mark Ellis			✓			✓	2/2

*Directors are not invited to extraordinary meetings.
Tania Baker chaired the meeting on 2nd November to support the CoG in approving the new Trust Chair.

The Audit Committee

Name	Committee Role	Attendance
Paul Kemp	Chair	5/5
Richard Holmes	Chair (from 1st Jan 2023)	1/1
Michael von Bertele	Non- Executive Director	6/6
Tania Baker	Non- Executive Director	6/6
Paul Miller	Non- Executive Director	1/2

The Work of the Audit Committee in Discharging its Responsibilities

The Audit Committee is in place to provide the Board with assurance as to the effectiveness of the processes overseen by the Board itself and by the Finance & Performance, People and Culture, and Clinical Governance Committees.

The committee is supported by the Appointed Auditor, Grant Thornton LLP who took office from November 2018. In October 2019 the Council of Governors approved the appointment of Grant Thornton as the Trust's External Auditor for the next four years.

During 2022-23, the internal audit service was provided by PwC UK.

The Committee has an annual work programme as well as dealing with other items that arise during the year. It also agrees annual work programmes with the auditors and the Executive.

The Audit Committee is chaired by Richard Holmes, Non-Executive Director. He took on this role on 1st January 2023. Paul Kemp, Non-Executive Director, chaired the Audit Committee from April 2022 - December 2022. The Audit Committee is responsible for:

- Monitoring the integrity of the financial statements of the Trust, any formal announcements relating to the Trust's financial performance and reviewing significant financial reporting judgements contained in them.

- Assisting the Board of Directors with its oversight responsibilities and independently and objectively monitoring, reviewing, and reporting to the Board on the adequacy of the processes for governance, assurance, and risk management; where appropriate, facilitates and supports through its independence, the attainment of effective processes.

- Reviews the effectiveness of the Trust's internal audit and external audit function.

- In discharging its role and function, the Committee shall provide assurance to the Board of Directors that an appropriate system of internal control is in place to ensure that business is conducted in accordance with the law and proper standards.

In addition to its standing items of business, which includes payroll analysis, internal audit recommendation tracker, Internal Audit Reports, External Audit Reports and Counter-Fraud progress reports, the Audit Committee has reviewed risk management systems and processes.

The committee reviewed the draft financial statements and governance statements for the 2021-22 annual report and recommended their adoption to the Board. The Audit Committee signed off the Annual Accounts on 16th June 2022, acting on the delegated authority of the Board.

During the financial year 2022-23, PWC conducted eight internal audits, resulting in the identification of 4 high, 14 medium and 11 low risk findings to improve weaknesses in the design of controls and/or operating effectiveness. The 2022-23 Head of Internal Audit Opinion remains unchanged from the opinion given in 2021-22. The opinion on the adequacy and effectiveness of governance, risk management and control is that there is "Reasonable/moderate assurance" which states "Governance, risk management and control in relation to business-critical areas is generally satisfactory." There is a focused effort on action plans to address the identified risks, with the Trust utilising an electronic system to track all audit recommendations and actions to enhance monitoring and oversight.

During the year, the committee continued its practice of inviting management teams to give a detailed 'deep dive' presentation on a specific management process or area of concern. The Audit committee has received presentations on the progress made against the internal audit recommendations in relation to Sterile Services Limited (SSL), fraud risks and mitigations, security provision and contract management and an update on progress of the finance and accounting environment, since implementation of NHS Shared Business Services (SBS) in July 2021. All the presentations were of a good standard and led to a good discussion in the committee on the issues raised.

The Local Counter Fraud Officer (LCFO) continued to work with management on both proactive and reactive work packages, linking in with guidance from the NHS Counter Fraud Authority. Good progress was achieved through the year on the actions required to improve the Trust's rating in the NHS Counter

Fraud Functional Standard Return, with all components achieving green rating, except for component 12, Declaration of Interests, which achieved an amber rating.

The Audit Committee is also responsible for monitoring the external auditor's independence and objectivity, including the effectiveness of the audit process. The committee reviews the effectiveness of the audit process including verifying compliance with statutory requirements and deadlines, communication with key senior management personnel, satisfactory planning processes, and confirmation that the provision of staff to carry out work for the Trust are those named and qualified.

Grant Thornton has not provided any non-audit services for the Trust in 2022-23.

Membership of the Audit Committee

The Audit Committee is comprised of three of the eight eligible Non-Executive Directors. The other main assurance committees of the Board are the Finance & Performance, People and Culture and Clinical Governance committees.

Financial Audit

The external auditors for the Trust are Grant Thornton. During the 2022-23 period, the Trust has incurred the following costs on external audit:

- Audit services: £125,000 (plus VAT)
- Other services: Nil

As mentioned above, no other remuneration was paid to the auditor and the auditor was not involved in any other work for the Trust that may have compromised their independence.

The Trust has an internal audit function which was delivered under contract by PwC in 2022-23. The work programme is reviewed and approved by the Audit Committee. Senior representatives of PwC report to the audit committee and a working protocol is in place with Grant Thornton, the Trust's appointed auditor. The delivery of the contract with PwC is overseen by the Chief Finance Officer and the internal audit fee for 2022-23 was £100,000.

Revaluation of Property and Land

The Trust's accounting policies requires a land and buildings revaluation to be undertaken at least every five years, dependent upon the changes in the fair value of the property. The five-yearly revaluations are carried out by a professional qualified valuer in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and valuation manual. The valuations are carried out on the basis of a Modern Equivalent Asset, as required by HM Treasury. The annual reviews are carried out using the most appropriate information available at the date of the review. The last full revaluation was carried out during 2019-20. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – modern equivalent depreciated replacement cost

Annual desktop valuations and annual impairment reviews are carried out in all other years where a full revaluation has not taken place.

Recognition of Income

Of the Trust's income, 89% is received from other NHS organisations, with the majority being receivable from NHS Bath and North-East Somerset, Swindon, and Wiltshire ICB. The Trust participates in the Department of Health and Social Care's agreement of balances exercise. This exercise seeks to identify all income and expenditure transactions and payable and receivable balances that arise from Whole

Government Accounting (WGA) bodies. The Audit Committee is satisfied that by participating with this exercise it helps to provide further assurance that the vast majority of income and expenditure with WGA have been properly recognised and WGA payable and receivable balances are appropriately recorded. The Trust's external auditors will review the outcome of the exercise and report their findings to the Audit Committee.

Directors' Responsibilities for Preparing the Annual Report and Accounts

The Directors are aware of their responsibilities for preparing the annual report and accounts and are satisfied that they meet the requirements as reflected in the statement of Chief Executive's Responsibilities as the Accounting Officer at Salisbury NHS Foundation Trust. This can be found in the Annual Accounts for Salisbury NHS Foundation Trust. In Summary, the Annual Report and Accounts taken as a whole are fair, balanced, and understandable and provide the information necessary for patients, regulators, and other stakeholders to assess the Trust's performance, business model and strategy.

NOMINATIONS COMMITTEE

The purpose of the Directors' Nominations Committee is to conduct the formal appointment to, and removal from office, of Executive Directors of the Trust, other than the Chief Executive (who is appointed or removed by the Non-Executive Directors subject to approval by the Council of Governors).

The Committee membership includes the Trust Chair, as Chair and all Non-Executive Directors.

FOUNDATION TRUST MEMBERSHIP

The membership of the Trust is made up of local people, patients and staff who have an interest in healthcare and their local hospital. Public members have to be aged 16 and over.

The staff membership has five classes to reflect the following occupational areas:

- Medical and Dental
- Nurses and Midwives
- Scientific, Therapeutic and Technical
- Administrative, Facilities and Managerial
- Voluntary

Public members (including volunteers) can only be a member of one constituency. Staff members can only be a member of the staff constituency. Eligibility requirements for joining different membership constituencies, including the boundaries for public membership, are shown in the Trust's Constitution, which is available on the Trust's website.

During the year the Trust sought to broadly maintain membership numbers. At 31 March 2023 the membership for Salisbury NHS Foundation Trust is as follows:

Public Constituency	Number
Salisbury City	2,445
South Wiltshire Rural	4,382
Kennet	1,161
North Dorset	1,307
East Dorset	558
New Forest	987
Rest of England	1,095
Staff Constituency	1,866
Total	**13,801**

Ownership of the Trust's Membership Strategy sits with the Governors with support from the Trust. A key objective of the strategy is to maintain an engaged membership of Salisbury NHS Foundation Trust which broadly represents the population it serves, taking account of age, ethnicity, and diversity in the population of the catchment area.

The Trust's Membership Strategy was revised by the governor-led Membership and Communications Committee and approved by the Council of Governors in February 2023. The Trust should continually seek to communicate with its members, through a variety of effective means, i.e., governor newsletters, Medicine for Members meetings, constituency meetings, public Council of Governor meetings, the Annual General Meeting and through local and social media.

With an updated Membership Strategy, the Membership and Communications Committee is focusing on different methods of recruitment, including using the Trust's social media platforms. Furthermore, it is hoped that an updated membership page on the Trust's website and the re-introduction of constituency meetings and other events, for example, 'Medicine for Members' will attract a more representative membership and is a focus for 2023-24.

This year, a digital summary of the Annual Review was published to enable a wider reach to the local population. This document was published on the Trust website, promoted to our members. This document provides a succinct and informative summary of the year's events, including our ambitions for the year ahead.

During 2022-23 Governors continued to join their committee's and groups in person and virtually to enable flexibility for those who are not always able to travel to the Trust. They have been focusing on their statutory duties and have also been involved in the development of the Trust's Annual Plan and Quality Account. Governors have been able to participate on Trust-led working groups, such as Food and Nutrition and the Transport Strategy. With restrictions easing in terms of COVID-19-19 during the year, Governors have been given other opportunities to be involved in or sample the 'patient experience' e.g., Real Time Feedback.

A dedicated section on the Trust's website and intranet provides details of each Governor, their interests, and a means for members to communicate with them. There are also members' newsletters for staff and people in the public constituencies.

Table 1 below sets out the Code of Governance Provisions to be included in the Annual Report and their location.

Table 1: Code of Governance Provisions included in the Annual Report and their location

Relating to	*Code of Governance* reference	Summary of requirement	Annual Report Location
Board and Council of Governors	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of Governors. This statement should also describe how any disagreements between the council of Governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of Governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Code of Governance 'Board of Directors'/ 'Council of Governors' pg.50-53
Board, Nomination Committee(s), Audit Committee, Remuneration Committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Part of this requirement is also contained within paragraph 2.24 as part of the directors' report.	Code of Governance 'Board of Directors'/ Accountability Report 'Directors Report' Pg. 54-55 & 58
Council of Governors	A.5.3	The annual report should identify the members of the council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead Governor.	Code of Governance 'Council of Governors' pg.51-52
Council of Governors	n/a	The annual report should include a statement about the number of meetings of the council of Governors and individual attendance by Governors and directors.	Code of Governance 'Council of Governors'/ 'Board of

Board	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	Code of Governance 'Board of Directors' pg. 53
Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Code of Governance 'Board of Directors' pg.53-56
Board	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	Code of governance 'Board of Directors'/ Remuneration Report pg.30
Nominations Committee(s)	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Code of Governance 'Nominations Committee' pg. 62
Nominations Committee(s)	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	N/A – external consultancy agency used
Chair/Council of Governors	B.3.1	A chairperson's other significant commitments should be disclosed to the council of Governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of Governors as they arise and included in the next annual report.	Code of Governance 'Board of Directors' None to disclose
Council of Governors	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed Governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Code of Governance 'Council of Governors' pg. 50-52

Council of Governors	n/a	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a Governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trusts or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Code of Governance 'Council of Governors'. No issues identified in the reporting year.
Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Code of Governance 'Board of Directors' pg.50 & 53
Board	B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	Code of Governance 'Board of Directors' No commissioned external reviews in 2022/23.
Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 2.97.	See Annual Accounts and Annual Report. 'Directors Responsibilities for preparing the Accounts, the Independent Auditor's Report to the Governors and the Annual Governance Statement'

Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Annual Governance Statement pg.72
Audit Committee/control environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Code of Governance 'Financial Audit' pg.61
Audit Committee/ Council of Governors	C.3.5	If the council of Governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of Governors has taken a different position.	No issues identified in the reporting year.
Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed. • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Code of Governance 'Audit Committee' pg.59

Board/ Remuneration Committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Nil to report for the reporting year
Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of Governors and members about the NHS foundation trust, for example through attendance at meetings of the council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	Code of Governance 'Foundation Trust Membership' and 'Council of Governors' pg.52
Board/ Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Code of Governance 'Foundation Trust Membership' pg.62
Membership	E.1.4	Contact procedures for members who wish to communicate with Governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Code of Governance 'Foundation Trust Membership' pg. 63
Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership. • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Code of Governance 'Foundation Trust Membership' pg.62

Board/Council of Governors	n/a	The annual report should disclose details of company directorships or other material interests in companies held by Governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of Governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 2.24 as directors' report requirement.	Accountability Report 'Board of Directors' pg.53

NHS OVERSIGHT FRAMEWORK

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

The Trust is currently segmented at 2. This rating has been maintained, meaning that plans to address areas of challenge are being managed within the system, but targeted support may be required to address specific issues. The specific areas under review are the Trust's financial performance, having met in year targets largely through the means of non-recurrent funds. The Trust's ability to achieve financial sustainability is highlighted as major risk going into 2023-24. Further detail on mitigations and controls in relation to this can be found in the Annual Governance Statement (AGS)

The second area of focus is the Trust's engagement in the maternity safety support programme, which will remain until the Trust exits the support programme. The Board is kept appraised of this through regular report by the Chief Nursing Officer.

This segmentation information is the Trust's position as of 31 March 2023. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/.

Salisbury NHS Foundation Trust remains subject to enforcement undertakings due to the suspected breach of licence since January 2018 for the deteriorating financial position.

Statement of the Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities, as the accounting officer of Salisbury NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given Accounts Directions which require Salisbury NHS foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Salisbury NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

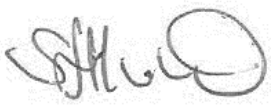
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities, and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.



Stacey Hunter
Chief Executive (Accounting Officer)
22 June 2023 (on behalf of the Trust Board)

ANNUAL GOVERNANCE STATEMENT

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Salisbury NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. The system of internal control has been in place in Salisbury NHS Foundation Trust for the year ended 31 March 2023 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

Trust Board

The Trust has a Risk Management Strategy and Policy, endorsed by the Board of Directors. The Board recognise that risk management is an integral part of good management practice and to be most effective should be embedded within the Trust's culture. This is embodied within the Strategy and Policy as this documents the Board's risk appetite and the processes applied across the Trust which see the oversight of the Trust's corporate and strategic risks assigned to a Board Committee and each risk has a named Executive Lead. The Board is committed to ensuring that risk management is embedded across all functions and is not seen or practiced as a separate programme and that responsibility for implementation is accepted at all levels of the organisation.

The Board maintained its governance arrangements throughout the COVID-19-19 pandemic and continued scheduled Board and Board Committee meetings with the use of technology. This facilitated robust information flows to Board recognising the continued challenges facing the Trust. This was supplemented by the bronze, silver and gold command structure established to oversee the development of the Trust COVID-19 19 incident response plan. The Trust has subsequently moved back to face-to-face Board and Board Committee meetings but continues to support these with technology in a hybrid model where necessary.

The Board brings together the corporate, financial, workforce, clinical and operational risk agendas. The Board Assurance Framework (BAF) ensures that there is clarity about the risks that may impact on the Trust's ability to deliver its strategic objectives together with any gaps in control or assurance.

Board Committees

The Audit Committee has overall responsibility for ensuring there is effective risk management process employed across the Trust. The Audit Committee receive information annually from the Trust's internal auditors through their work which supports the Board Assurance Framework and through this work the Committee supports the Board to be assured over the robustness of the Trust's application of sound internal control processes.

The other key Board Committees of Clinical Governance, Finance and Performance and People and Culture receive and consider the strength of assurance of actions being taken to manage key corporate

and strategic risks outside of the Board's stated risk appetite and request further assurance in the form of deep dives or specific reports where necessary.

Non-Executive Directors
All Committees are chaired by a nominated Non-Executive Director. The Audit Committee which plays a pivotal role in providing assurance on the risk management processes of the Trust has a membership of only Non-Executive Directors. Through the Non-Executive Directors, together with the Non-Executive Audit Committee chair, they all have a responsibility to challenge robustly the effective management of risk and to seek reasonable assurance of adequate control.

The Audit Committee provides a key forum through which the Trust's Non-Executive Directors bring independent judgement to bear on issues of risk management and performance. The constructive interface between the Audit Committee and Board supports the effectiveness of the Trust's systems of internal control.

Executive Directors
The Chief Executive has overall responsibility for risk management within the Trust.

The day-to-day oversight has been delegated to the Chief Nursing Officer who is responsible for the strategic development and implementation of organisational risk management systems and processes and for ensuring there is a robust system in place for monitoring compliance with standards and the Care Quality Commission (CQC) registration and legal requirements. The Chief Nursing Officer is also responsible for patient safety, patient experience and medical legal matters.

The Chief Finance Officer oversees the adoption and operation of the Trust's Standing Financial Instructions including the rules relating to budgetary control, procurement, banking, losses and controls over income and expenditure transactions, and is the lead for counter fraud. The Chief Finance Officer attends the Trust's Audit Committee and liaises with internal audit, external audit and counter fraud services, who undertake programmes of audit with a risk-based approach.

The Trust's Senior Leadership Team Committee, chaired by the Chief Executive Officer, has the remit to ensure oversight of the adequacy of the management of key risks facing the organisation.

The day-to-day management of risks is undertaken by Divisions and corporate managers, who are charged with ensuring that risk assessments are undertaken proactively throughout their area of responsibility and remedial action is carried out where issues are identified. There is a process of escalation to Executive Directors through Executive Performance Reviews, relevant committees and governance groups as required where there are challenges in implementing mitigations.

Divisional Governance committees introduced to further strengthen the governance arrangements are now embedded in the risk management structure and have responsibility for the oversight of divisional governance and risk processes.

The Trust's capacity to handle risk was evidenced through the Care Quality Commission (CQC) Inspection report 1 March 2019 that "The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected". The CQC rated the Trust Good for the Well-led domain which recognised the strong culture of good governance.

The Head of Risk Management supports the Executive Lead and is responsible for ensuring that staff are trained and equipped to manage risk in a way appropriate to their authority and duties. This is achieved through risk training programmes and through supporting and facilitating departments and teams directly.

The Risk and Control Framework

The Trust understands that healthcare provision and the activities associated with caring for patients, employing staff, providing premises, and managing finances will always involve an inherent degree of risk.

Good risk management practice requires that identified risk is analysed, evaluated, treated and actions followed up for the purposes of monitoring and review to further improve.

The overall objective of the Risk Management Strategy is to ensure that robust risk management processes are in place which provide assurance to the Board that the Trust is discharging its responsibilities as an NHS Foundation Trust in ensuring business and financial acumen, improving services and the quality-of-care provision, whilst operating as a model employer and service provider in achieving the Trust's operational and strategic objectives. The strategy is updated every three years to ensure that it continues to reflect best practice in risk management methodologies and sets out the key responsibilities and accountabilities and includes a review of the Trust's risk appetite. The Risk Management Strategy sets out the strategic goals towards which the Trust is working with regard to risk management and provides a framework that sets out the key responsibilities for managing risk within the organisation, including ways in which risk is identified, evaluated and controlled.

Risk management requires participation, commitment and collaboration from all staff. The process starts with the systematic identification of risks via structured risk assessments. These risks are documented on risk registers throughout the organisation.

These risks are then analysed in order to determine their relative importance using a risk scoring matrix. Low scoring risks are managed by the area in which they are found, whilst higher scoring risks are managed at progressively higher levels within the organisation.

Risk control measures are identified and implemented to reduce the potential for harm. The potential consequence and likelihood of the risk occurring are scored along with the effectiveness of existing control measures. It is the sum of these scores which determines the level in the organisation at which the risk is reported and monitored to ensure effective mitigation.

Each Division maintains risk registers containing clinical and non-clinical risks. All unresolved risks affecting multiple departments, or the division as a whole, are recorded within the Divisional risk register whilst individual departments/specialties maintain departmental risk registers containing risk to the achievement of individual department's objectives. The escalation process between these risk registers is monitored via the divisional management team with oversight through the Divisional Governance Committees. Escalation of Divisional risks to the Corporate Risk Register is via the Executive Performance Reviews.

Risks are identified through third-party inspections, recommendations, comments and guidelines from external stakeholders and internally through incident forms, complaints, risk assessments, audits (including clinical and internal), information from the Patient Advice and Liaison Service (PALS), benchmarking and claims and national survey results. External stakeholders include the Care Quality Commission, NHS England, the Health and Safety Executive, NHS Resolution, the Medicines and Healthcare Products Regulatory Agency and the Information Commissioner's Office.

The Audit Committee oversees and monitors the performance of the risk management system, with internal and external auditors working closely with this committee. The internal auditors use a risk-based model to undertake reviews and provide assurances on the systems of internal control operating within the Trust. The results of internal audit reviews are reported to the Audit Committee which oversees that weaknesses in the system are addressed. Procedures are in place to monitor the implementation of control improvements and to undertake follow-up reviews if systems are deemed less than adequate. Internal Audit recommendations are tracked via reports to the Audit Committee. The Counter Fraud programme is also monitored by the Audit Committee.

The Clinical Effectiveness Steering Group, reporting to the Clinical Management Board consider evidence that the Trust's comprehensive programme of clinical audit effectively supports improving clinical quality in alignment with the Trust's quality objectives. The Clinical effectiveness agenda is overseen by the Chief Medical Officer.

The Trust's Board Assurance Framework (BAF) details the principal strategic risks to the achievement of the Trust's corporate objectives. This is received by the Board on a quarterly basis together with the Corporate Risk Register. The Finance and Performance Committee, People and Culture Committee and Clinical Governance Committee have oversight of the BAF and Corporate Risk Register on a quarterly basis where the risk profile is reviewed and discussed in detail. The work plan of the Board Committees is linked so that the Board is assured that there is an aligned independent and executive focus on strategic risk and assurance. Referral of issues between committees ensures a respective understanding of risk and assurance concerns.

The BAF records that the Trust has been managing 12 significant risks during the year, with 6 risks outside of the Board-agreed risk appetite, focussed around:

- Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.
- Financial sustainability.
- Staffing availability impacting on service delivery and health and wellbeing of staff.
- Capacity versus demand and impact of delayed discharge from hospital
- Information technology, clinical systems, and technical infrastructure.
- Critical plant and building infrastructure within limited capital funding.

For each of the BAF risks, there is a detailed series of mitigations which will continue to be implemented throughout 2023/24. The delivery of these mitigations and their impact on the risks is monitored through the appropriate Committee of the Board.

The Trust established controls or implemented actions to manage these risks as summarised below:

- Implemented an improvement programme for theatres and outpatients to support improvements in waiting times for planned care.
- New urgent care transformation programme including SDEC, ED and Elderly Care.
- Implemented a range of initiatives to support staff attraction and retention including incentivised pay rates, wellbeing offers and significant recruitment campaigns.
- Increased focus on financial controls, emphasising best value decisions.
- Implementation of the digital strategy and continued focus on development of the infrastructure and controls.
- Robust capital prioritisation processes to ensure resources are deployed effectively.
- Full engagement within the Wiltshire Alliance to improve discharge processes.

Major risks 2023/24

As we enter 2023/2024, the Trust remains focussed on enacting recovery plans whilst dealing with significant operational challenges and staffing availability, compounded by on-going strike action. The focus will be on the delivery of NHS England Operational Planning Priorities 2023/24:

- Supporting the health and wellbeing of staff.
- Accelerate the restoration of elective and cancer care and reduce waiting times.
- Working with partners to transform community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay.
- Working collaboratively across systems to deliver on these priorities.
- Ability to achieve financial sustainability.

Key risks include:

- Scale of the transformation required to achieve both urgent and planned care requirements.
- No control over external factors such as on-going industrial action and/or infection control outbreaks.
- Financial constraints.
- A sustainable workforce to deliver the Trust priorities.

- Reliance on whole system change to enact plans.

Within this context, we acknowledge the great opportunity in our closer integration with local partners and will continue to prioritise this and the benefits it provides in the delivery of our wider strategic objectives. We will review these to ensure the Trust is best placed to deliver the NHS and Bath, Swindon, and Wiltshire Integrated Care System (BSW ICS) Long Term Plans and we will embrace the priorities of the NHS People Plan with the vision to make the Trust 'the Best Place to Work.'

Our underlying financial position remains a significant challenge. The financial regime for 2023-24 signals a return to the national tariff (i.e., payment by volume) for a significant proportion of planned activity and with it comes an income risk compounding the expenditure risk associated with emergency pathway and workforce availability pressures. As a healthcare system, financial sustainability is also a priority; BSW ICS is developing plans to address the system deficit where Salisbury will play a significant role. The pathway redesign that began in response to COVID-19-19 presents both a challenge and opportunity to deliver, with particular focus on urgent and emergency care and outpatient pathways.

The future sustainability of the Trust will also be dependent on our ability to progress the delivery of our Estates masterplan. The operational resilience of areas such as Day Surgery and the Maternity Unit remain regular concerns, alongside managing the risk of high capital expenditure on reactive maintenance in the ageing parts of our estate.

Quality Governance

The Trust is committed to and expects to provide excellent healthcare services that meet the needs of our patients and their families and provides the highest quality standards. The Board and Senior Management Team have a critical role in leading a culture which promotes the delivery of high-quality services. All efforts are focussed on creating an environment for change and continuous improvement.

The Trust has a robust Quality Governance reporting structure in place through an established Clinical Governance Committee. The Quality Governance arrangements are described in the recently merged Integrated Governance Framework and Accountability Framework to form one integrated accountability and governance framework. The framework was presented for approval at the Trust Board in May 2023. This framework is a means by which the Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the strategic objectives. The Integrated Accountability and Governance Framework makes it clear that quality governance is the responsibility of the Board supported by the Clinical Governance Committee for continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. The Quality Account published alongside this Annual Report and Accounts describes quality improvements and quality governance in more detail.

The Chief Executive is the Accountable Officer for quality governance. Each Director is a lead for a number of Board objectives. The responsible officers for quality are the Chief Medical Officer who leads on clinical effectiveness and the Chief Nursing Officer who leads on patient safety and patient experience.
Improving Together is our Board approved approach to embedding operational excellence through continuous improvement. It is the 'how' to achieve the Trust's strategy and is founded on the development of a coaching culture, which enables every member of staff to improve the services they work in.
Evidence shows that Trusts that have a continuous improvement approach provide better patient care, and colleagues working in these Trusts have greater job satisfaction.
Ultimately Improving Together is about improving the quality-of-care provision. By focusing our efforts where they'll have the most positive impact on our services, we'll improve the way we work. It covers the following main areas:

- Alignment of priorities – using the strategic planning framework from board to ward we focus on linked priorities, helping us achieve our goals more effectively.
- Empowerment – Colleagues will know they are empowered to make changes in their team. Every member of SFT will be supported to develop and improve their skills to be able to identify and adopt improved ways of working.

- Developing our culture – by empowering each and every member of staff to have a voice and supporting our leaders to adopt compassionate and enabling leadership approaches.
- Improving quality – by adopting an evidenced based continuous improvement approach to better understand and continually improve the services we offer.
- Stopping doing things that do not add value to our people, population and partners.

With the simple goal of delivering an outstanding experience for patients, their families and the people who work with us - and being in a position where everyone can proudly say that Salisbury NHS Foundation Trust is the best place to work

The Trust has a robust approach to the assessment of the potential impact of cost reduction programmes on the quality of services. The quality impact assessment process involves a structured risk assessment using a standard template which requires Divisional Management Team sign off. The Chief Medical Officer and Chief Nursing Officer are responsible for assuring themselves and the Board that Cost Improvement Programmes will not have an adverse impact on quality. This process is under review and will be refreshed for 2023-24.

Delivery of the Trust's strategic objectives is underpinned by the publication of the annual quality account which sets out the progress made against our quality priorities in 2022-23 and the quality priorities selected for 2023-24. Progress of the priorities is monitored via the Clinical management Board and Clinical Governance Committee; reviewing a suite of quality metrics that track performance against key quality indicators. There is no requirement currently for Foundation Trusts to produce a separate quality report.

The Integrated Performance Report (IPR) is aligned to our key areas of focus within the strategic planning framework. It comprises of detailed reports on quality, operational performance, finance and workforce, has been received by the Board monthly and is considered in detail. Our divisions follow the same approach via the Executive Performance Reviews, which feed into the IPR.

Dedicated data quality teams pro-actively manage elements of data quality within key Trust systems and provide appropriate training and guidance to service colleagues across the Trust. Independent assurance regarding data quality is provided using SUS dashboards, ad hoc internal audits which review internal processes and the annual Data Security and Protection Toolkit self-assessment audit review.

Risks to data quality and data security are continually assessed and added to the Trust's risk register and scored appropriately. These are all managed through internal governance processes, overseen at the Information Standards Group and assured through the Digital Steering Group. Escalation of issues goes to the Trust Management Committee and the Trust's Finance and Performance Committee where appropriate.

The Trust has a Freedom to Speak Up Guardian (FTSUG) to act in an independent and impartial capacity to support staff who raise concerns and whom has access to the Chief Executive and the Trust's nominated Non-Executive Director for 'Freedom to Speak Up'.

Risk management is embedded in the activity of the organisation in a variety of ways. A suite of risk management policies underpins the Risk Management Strategy and are available to staff on the intranet. Training and awareness sessions are available to staff across the Trust and via mandatory training. Divisions and Corporate Functions proactively identify risks which are recorded on risk registers. The specialties and divisions also retrospectively identify risk through adverse incident reporting, receipt and response to complaints and claims, patient and staff surveys and feedback, and concerns raised by the coroner.

Due to the devolved nature of risk management and compliance of incident reporting and investigation at a local level, quality and quantity of incident reporting continues to improve and develop. The Trust actively promotes an open and fair culture that encourages the honest and timely reporting of adverse events and near misses to ensure learning takes place and improvement actions are taken. The Trust submits patient safety incident data to the National Reporting Learning System. The Trust works in partnership with our commissioners to share learning and improvement actions. The ICS quality leads are an integral part of the Trust quality governance arrangements and attend key quality committees. The Trust reviews all incidents

graded moderate or severe together with compliance with Duty of Candour on a weekly basis through the Patient Safety Summit. The Trust has commenced a programme of work to transition to the new National Patient Safety Incident Response Framework (PSIRF) and has established a PSIRF Implementation Group.

Salisbury NHS Foundation Trust has taken the following actions to improve the quality of its services and reduce the rate of patient safety incidents that have resulted in severe harm or death by:

- Refreshed Board Assurance Framework and application of the Board approved risk appetite and risk tolerances which has enabled a focus on risks outside of tolerance.
- Monitoring ward to board reporting on key patient safety and experience indicators and reporting these monthly to Board via the Integrated Performance Report.
- Service level deep dive reviews through the Clinical Governance Committee receiving assurance on the quality-of-service provision and areas for improvement.
- Reviewing a significant proportion of deaths in hospital through the Trust's Medical Examiners, Learning from Deaths Process and Mortality Review Group.
- Preparations for the community Medical Examiner roll-out have been ongoing, with several GPs having been newly appointed to the role of Medical Examiner during 2022/23.
- The Trust's Mortality Surveillance Group (MSG) continue to meet every two months, providing assurances that the Trust has a robust process for overseeing mortality. Structured training has been provided to staff to improve our understanding of local and national mortality data
- Weekly review of all reported incidents graded moderate and above to agree the appropriate level of investigation and identify any immediate actions to mitigate identified risk.
- Ensuring that learning from incidents is maximised and disseminated via the Patient Safety Steering Group, Clinical Risk Group, Clinical Management Board and Divisional Governance Committees.
- Weekly oversight of compliance for any notifiable safety incident where unintended or unexpected moderate or above harm occurred to service users.
- Our Risk Management System (RMS) provides a range of quantitative data to support analysis across services and wards to provide assurance that we have effective systems for the monitoring of incidents.
- To improve patient safety, the Trust is preparing for the introduction of the new NHS Patient Safety Incident Response Framework (PSIRF). The PSIRF places emphasis on reviewing incidents thematically to increase the amount of potential learning.

The Trust's patient and public involvement and consultation process ensures compliance with relevant legislation and is described in the Patient and Public Involvement Strategy. All departments, both clinical and non-clinical, are responsible for planning and public involvement initiatives, where appropriate. The Trust completes an annual patient and public engagement report, which is reported to Trust Board.

The Trust is fully committed to ensuring that voices of our service users have forums and means by which to share their experiences and use these to help us shape future services.

Our first fully patient-led committee for service improvement was launched in 2023 under our Spinal Specialty. The group meets every 4-6 weeks currently and has an agreed terms of reference and has appointed a chair. The purpose of this forum is to use shared, lived experiences of previous service users to drive improvement and change that would positively impact patient experience in the future. Their current focus is on improvements to facilities and equipment, better utilising existing resources and how we can promote self-rehabilitation to speed up recovery, boost morale and improve patient flow.

This group is pioneering the patient-led model of engagement and through their learning we hope to be able to introduce this model to other specialities in the future.

The Trust is continuing to invest in the digitisation and extraction of data insights from our Friends and Family Test (FFT) surveys, to help shape service improvements. Response rates and overall experience

ratings are nationally reported currently, but it is recognised the additional value this data could provide if we were able to robustly theme and analyse feedback received through this mechanism.

In the Autumn of 2023, we anticipate a phased roll-out of a new digital provider that will aid our achievement of the following objectives:

- Increase overall response rates to FFT to achieve the targets set under our Improving Together Metrics (>10% of eligible patients in 2022-23 and >15% of eligible patients in 2023-24)
- Diversify methods for completion (including, online, SMS, over the phone)
- Increase accessibility and options for inclusivity (sight impairments, languages and additional demographic options)
- Robust analysis of data for insight and meaningful comparison/benchmarking via a real-time dashboard.

The Trust works with Healthwatch Wiltshire through regular liaison and communication to identify opportunities for the involvement of Healthwatch in Trust activities. During the summer of 2022 the Trust engaged in a co-produced complaints process review project with Healthwatch Wiltshire (HWW). Healthwatch Wiltshire are an independent statutory body, which has the power to make sure NHS leaders and other decision makers are made aware of and listen to local feedback in order to improve standards of care.

The survey was co-developed and based around the principles of the PHSO Complaints Framework; early resolution; meaningful apology; full and thorough investigation; promotion of learning and improvement cultures; and training and support for staff. 90 participants were invited to give their feedback and the only criteria for inclusion was a closed complaint with the Trust between 1st January 2022 and 30th June 2022. Multiple methods for completion of the survey were offered, by post, over the phone or online. A mixture of quantitative and qualitative analysis were used and demographic information was also collected. The survey achieved a 25% response rate. A full action plan has since been developed in response to the findings of this report, many of which are already in progress and on track for completion. The full report publication and the Trust's response to the findings can be found (here).

The Trust's Council of Governors engage with the quality agenda through its relevant working groups and a nominated Governor attends the Clinical Governance Committee. There is nominated Governor representation on all Board and Board Committees.

The Trust has assessed compliance with the NHS provider Condition 4. The Trust believes that effective systems and processes are in place to maintain and monitor the following conditions:

- The effectiveness of governance structures
- The responsibilities of Directors and subcommittees
- Reporting lines and accountabilities between the Board, its subcommittees, and the executive team
- The submission of timely and accurate information to assess risks to compliance with the trust's licence *and*
- The degree and rigour of oversight the Board has over the Trust's performance.

These conditions are detailed within the Corporate Governance Statement, the validity of which is assured via the Finance and Performance Committee and subsequently Trust Board. Finance and Performance Committee reviewed the assessment in detail at its meeting on 25 April 2023 and confirmed that no material risks had been identified. Trust Board approved the submission at their meeting on 4 May 2023.

The Trust implements key approaches and mechanisms to ensure that the short, medium, and long-term workforce strategies and staffing systems are in place to assure the Board that staffing processes are safe, sustainable and effective. These include the following:

- Workforce plans are developed at Divisional Level, informed by clinical strategy work within the NHS, the system and the Trust. These plans are then aligned to operational and financial priorities at Trust level to ensure staffing is safe, sustainable and efficient. The plan is resourced through an

agreed programme with a strong focus on hard to recruit posts (including registered nurses, consultants and AHPs) and through bulk recruitment campaigns for non-specialist posts.
- Proposed changes to staffing profiles undergo Quality Impact Assessment in accordance with national guidance by the Chief Medical and Nursing Officers.
- Collaborative working between Divisional Management Teams and the Strategic Workforce Planning team, using Organisational Development and People (OD&P) business partners, optimises workforce planning to define effective establishments which meet safe staffing policy.
- An assessment of the nursing establishment and skill mix is reported to the Board twice a year, in accordance with National Quality Board guidance.
- Workforce risks are identified and monitored in the Board Assurance Framework and divisional risk registers.
- The Guardian for Safe Working liaises with educational and clinical supervisors to ensure that the health, wellbeing, and safety of junior doctors is maintained. Monthly forums are in place to address issues and concerns raised by junior doctors. The Guardian reports through the People and Culture Committee to assure the Trust Board. Wider health and wellbeing issues for staff are raised through the Wellbeing committee, which monitors the effectiveness of a number of wellbeing initiatives through wellbeing ambassadors, staff side representation and management input.
- E-Roster is used to capture and collate staffing numbers and skill mix for nursing staff. A project is in place to roll out this system to the remainder of the Trust. The Trust is implementing the results of an end-to-end review of resourcing practices and is also implementing a project to improve temporary staffing processes, reducing Agency Spend and increasing Staffing agility through development of increased numbers of Bank staff.

Assurance on the above is provided by:

- Regular board updates on key strategic staffing issues, including staff wellbeing and systems to support staffing processes. These include care hours per patient day.
- Formal reports on nurse staffing to Board and Board Committees.
- Integrated performance reports showing safe staffing levels and bank/agency usage.
- Executive Performance Review meetings consider staffing issues with escalation of any concerns
- The Trust's BAF reflects increased risk to sustainable staffing level in 2022/23 to reflect increased risks around staffing.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

The Trust was last subject to a full CQC inspection, including Use of Resources and Well-Led, in November and December 2018, receiving an improved rating of 'Good'. Two core services, Maternity and Spinal, were subject to an unannounced inspection in March 2021. The Maternity Service had a further announced inspection in October 2021, which focused on the parts of the service that did not meet legal requirements in the March inspection. The rating for Maternity Service changed from 'good' to 'requires improvement' and the Spinal Service remained 'requires improvement.' The Maternity Services team has continued with engagement in the NHSE/I Maternity Safety Support Programme during 2022/23. There have been no further inspections.

Our engagement with the CQC has continued through scheduled meetings via Teams. These include bi-monthly meetings with designated Executives and the Head of Compliance and bi-monthly meetings with the Head of Risk Management and Head of Compliance to monitor our Clinical Reviews and Serious Incident Investigations. The Trust's internal peer review programme was reviewed, and it was found that there was an overlap between this and the Matrons Quality Assurance Round, a quarterly audit of wards using the CQC's key lines of enquiry, so the peer review programme was not reintroduced.

Registration of an additional location with the Care Quality Commission

Due to the need to provide alternative accommodation to enable the completion of some environmental work on one of the wards at the hospital and, later, to provide additional capacity as part of winter planning

processes, alternative accommodation was secured at South Newton Hospital, an independent hospital approximately six miles from the main hospital site.

In September 2022, the Trust applied to the CQC to add a location to its existing registration. Following review of submitted evidence and pre-registration inspection by CQC of the potential new location, the Trust was granted registration to provide the regulated activity of treatment of disease, disorder or injury. Three additional conditions were applied to this location:

- The registered provider is only permitted to use SFT inpatients - South Newton Hospital, Nadder Ward and Pembroke Lodge as a condition of registration until 30 June 2023.
- The registered provider must not accommodate patients anywhere within the location other than Nadder Ward and Pembroke Lodge.
- In order to ensure patient safety, the registered provider must ensure there is an effective traffic management procedure in place within the location that supports the following: pedestrian only access to areas marked as "Time Limited Vehicle Access" on the registered providers South Newton Hospital Site Plan between 8am and 7.30pm except for vehicles with a staff escort.

The patients transferred to this location have been deemed medically fit for discharge with no criteria to reside and each patient is individually assessed against approved criteria to ensure the most appropriate patients are transferred. Management and oversight of the new location is part of the established Medicine Divisional governance arrangements, with the Medicine Division Management Team having day to day oversight.

External Well-led Developmental Review

In Quarter 4, 2022/23 a successful system wide procurement process was undertaken across the 3 BSW Acute Trusts to secure an external company to undertake a well-led developmental review. The Trust last had a review in 2018 and due to COVID-19, the Board approved a delay to a further review until 2023. The Trust review is due to commence in April 2023 for a period of 3 months.
There are no material inconsistencies between the Annual Governance Statement, the annual and board statements required by NHS England and the corporate governance statement.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the *Managing Conflicts of Interest in the NHS* guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of Economy, Efficiency and Effectiveness of the use of Resources

The Trust regularly reviews the economy, efficiency, and effectiveness of the use of resources through benchmarking, reference costs, regular meetings between Divisions and the Executive Directors, and assessing performance against plans. Investments are determined against detailed business plans and outcomes are reviewed against those plans.

The Audit Committee gives specific consideration to matters of probity, the propriety, regularity of public finances and value for money, which arise from the work of the external auditors and the Trust's local counter fraud specialist and internal audit service.

The Trust continues to actively pursue the opportunities as identified through the model hospital, GIRFT and the right care data, increasingly the Trust is working with system partners to identify how working collaboratively can reduce the cost base. This is reviewed at the Acute Alliance and BSW Directors of Finance meetings.

Arrangements to operate efficiently, economically, and effectively are formally reviewed by external audit. Departmental cost improvement programmes and their delivery is tracked through the Directorate Performance Reviews and facilitated by the deployment of the 'Improving Together' operating management system. This will continue to be taken forward as a key part of financial governance and controls.

The Trust's finances are reviewed by the Finance and Performance Committee at its monthly meetings. Monthly performance, workforce and quality information is scrutinised each month by the Board through the Integrated Performance Report.

Information Governance

The Trust acknowledges the importance patients and staff place on the security, confidentiality, integrity and availability of corporate and personal information. The Trust is committed to proactively managing all its resources through clear leadership and accountability, which is underpinned by the Trusts values and behaviours through awareness and education.

The Chief Medical Officer, Caldicott Guardian and Chief Digital Officer, Senior Information Risk Owner (SIRO), oversee compliance and adherence to the Trusts Confidentiality, Information Risk and Security policies and procedures which define how the Trust proactively manages the security and confidentiality of personal information and systems.

Information Governance arrangements within the organisation are constantly reviewed by the Trust. The Data Security and Protection Toolkit (DSPT) provides the conduit to demonstrate that the organisation can be trusted to maintain the confidentiality and security of personal information, in an open and transparent manner thereby increasing public confidence. The DSPT reporting year runs from the 1st July to the 30th of June, with the Trust ensuring that a comprehensive evidence-based assurance programme exists to underpin the DSPT assertions.

Since July 2022, the Trust reported two security incidents to the Information Commissioners Office and NHS Digital. The incidents related to a subject access request submitted to the Trust which had breached the agreed extension time frame, and the Trust was notified by staff that the Trust's Electronic Patient Record (EPR), Lorenzo was offline. The Information Commissioners Office considered the information provided by the Trust and decided in all instances that no further action was necessary.

Work continued to ensure that a comprehensive and robust evidence-based assurance programme exists to reinforce the work of the DSPT to demonstrate that the organisation can be trusted to maintain the confidentiality and security of personal information, in an open and transparent manner thereby increasing public confidence.

In line with the NHS Digital guidance, the Trust confirms it will submit the 2022/2023 Data Security and Protection Toolkit assessment on or before 30th June 2023.

Data Quality and Governance

There is corporate leadership for data quality with the Chief Digital Officer (SIRO) holding responsibility for the quality of performance data which is reported monthly at the Trust Board and assurance committees.

The Trust has an up-to-date Data Quality Policy that was last refreshed during 2021-22. The policy outlines a comprehensive approach to data quality, focussing on the following key areas:

- Raising awareness of the importance of high-quality data.
- Assisting all staff in understanding their role and responsibility in maintaining high quality data.
- Assisting staff in getting data quality 'Right First Time' through supporting staff to implement and maintain working practices and processes that enable high data quality at the first time of input.
- Minimising risks arising from poor data quality.
- Monitoring the quality of data used by the Trust and where needed, to highlight where data is inaccurate and needs to be checked and improved.
- Establishing a framework within which data quality issues can be raised and actioned.

The Trust's Information Standards Group, chaired by the Head of Information, oversees implementation of the Data Quality Policy. This includes the routine assessment of data quality maturity for all metrics used in core external returns and internal monitoring by Trust committees. Where potential improvements have been highlighted a full analysis of the impact on reporting is completed and undergoes a robust change control process.

The Trust is an active participant in a system wide Business Intelligence Group which seeks to standardise the approach to reporting, ensuring best practice methodologies are followed and building a shared pool of expert resource across the system in the use of tools such as Power BI and demand and capacity. The system wide Business Intelligence strategy developed in 2021-22 sets a clear direction towards convergence on cloud-based technology for our underpinning business intelligence infrastructure in the coming years. This will enable improved collaborative working, reduced duplication of reporting and increased ability to support detailed interpretation and predictive analysis on areas such as population health management.

All data used for quality reporting is derived from operational clinical systems which are well known and reviewed by the staff using them. The weekly division-led Delivery Performance Group regularly reviews performance data, including patient level information, especially on elective waiting times.

Waiting list data is updated daily and this feeds into a suite of reports that allow various operational teams to monitor the size and performance of the waiting list. There is a dedicated team that review and validate the waiting list daily, ensuring that records are accurate and up to date as far as possible. There is close review of the longest waiting patients by the divisional teams, providing the Trust with the greatest possible opportunity to meet waiting list targets and be assured of data accuracy. All external performance reporting returns are reviewed and signed off at Executive level before being submitted. Waiting list size data is included as part of the integrated performance report which is reviewed monthly at Trust Board. This is supported by the use of Statistical Process Control (SPC) charts to allow close monitoring of specialty level performance over time, highlighting any deteriorating or improving trends or outliers.

One of the Data Quality Policy's activities is to improve the education of staff in the role they play in meeting the Trust's high standards of data quality aspirations.

Data Quality features within staff job descriptions who have roles and responsibilities for inputting data into systems, and those who review and assess data accuracy.

A Data Quality Improvement Group reviews key data quality issues and oversees data quality improvement across the following areas:

- Training – design and delivery of targeted training to support high quality data.
- Awareness – using existing forums (e.g., ward clerk meetings) to communicate data quality issues.
- Process change – use of structured Standard Operating Procedures to meet operational and reporting requirements.
- Information systems – regular checks to ensure data being used is compliant and accurate.

- Data quality monitoring – reviewing nationally and locally developed data quality reports, use of spot checks (e.g., monthly review of waiting list data) and software such as coding software to check data quality.
- Data Quality Standards - agree and approve different DQ standards within the Trust e.g., Identifying an Admitting Consultant. This is created as a document (which is reviewed annually) and published to the Intranet.

The Improvement Group also feeds up any persistent DQ issues to the Trust's Digital Improvement Network which meets regularly. This is an opportunity to reflect current performance to operational staff.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Clinical Governance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors and its committees have met regularly and kept arrangements for internal control under review through discussion and approval of policies and practice and monitoring of outcomes agreed as indicators of effective controls. The Board and its committees review the Integrated Performance Report monthly which covers the key national priority and regulatory indicators, and locally derived key performance indicators. The report provides more detailed briefings on any areas of adverse performance. This report is supported by a number of more granular reports reviewed by Board committees and regular Executive performance review meetings with the Divisions.

The selection of appropriate metrics is subject to regular review, with changes in definitions or strategic priorities reflected in the selection and these are underpinned by the Improving Together methodology.

The Audit Committee has provided the Board of Directors with an independent and objective review of financial and corporate governance, and internal financial control within the Trust. The Audit Committee has received reports from external and internal audit, including reports relating to the Trust's counter fraud arrangements. There is a full programme of clinical audit in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit opinion for 2022-23 remains unchanged from the opinion given for the year 2021-22. The opinion on the adequacy and effectiveness of governance, risk management and control is that there is "Reasonable/moderate assurance" which states "Governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required in those areas to enhance the adequacy and/or effectiveness of the framework of governance, risk management and control". The opinion was based on the following:

- Medium risk rated weaknesses identified in individual assignments that are not significant in aggregate to the system of internal control.
- High risk rated weaknesses identified in individual assignments that are isolated to specific systems or processes; and
- None of the individual assignment reports have an overall classification of critical risk.

During 2022-23, Internal Audit conducted eight internal audits. The finalised reports have resulted in the identification of 4 high, 14 medium and 11 low risk findings to improve weaknesses in the design of controls and/or operating effectiveness.

A summary of the four high risk findings were considered in forming the opinion as to the adequacy and effectiveness of the Trust's framework of governance, risk management and control is set out below:

- A lack of Conflicts of Interest (CoI) disclosures during procurements – these were not being consistently disclosed, recorded, and monitored throughout the procurement process. Procurement policy and procedure documents made limited reference to the requirement to consider CoI. Action deadline: 31 July 2023.
- No password monitoring for the POET IT Application – this stores patient information and is used by clinicians. The Trust uses a Security Information and Event Management (SIEM) tool to monitor password settings for Active Directory however, the tool does not cover this specific application. There is a risk of unauthorised access not being detected. Action deadline: 30 April 2023. Action completed.
- There is a lack of transparency over the actions taken by line managers - Neither the ESR nor the Healthroster system is being used/has the capability to capture the evidence to demonstrate how line managers are complying with the Absence Management Policy. Unless the individual has been referred to the People Advisors, who will have then created their own personnel file for the individual, there is no mechanism for them to easily identify what steps are being taken by management. This makes it impossible to provide accurate data on the status of employees across the stages of the Absence Management process within the Trust. It also impacts on the ability of the Trust to hold Line Managers to account for their compliance with the policy. Action deadline: 30th June 2023.
- Multiple exceptions identified when testing compliance with the Absence management Policy – this includes informal/formal meetings not being held despite breaches of the absence triggers, incomplete records, lack of Occupational health referral and escalation between stages not in line with policy. Action deadline: 31st May 2023 with training on-going.

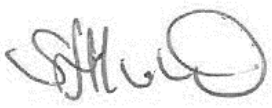
A report is produced at the conclusion of each audit assignment and, where scope for improvement is found, recommendations are made and appropriate action plans agreed with management. Reports are issued to and followed up with the responsible Executive Directors, with the results of audit work reported to the Audit Committee. In addition to the planned programme of work, internal audit provides advice and assistance to senior management on control issues and other matters of concern. Where Internal Audit issued a report rated high risk, the relevant audit executive lead attended the Audit Committee to discuss the report and actions taken. A process was implemented that any extension to action deadlines requires collective executive approval and is presented by the executive Sponsor for the audit.

The Trust is focused on action plans to address the identified risks reported in 2022-23 which have been approved by the Trust Audit Committee. The Trust utilises an electronic solution to track all audit recommendations and actions to enhance monitoring and oversight. The success of this has been sustained and is demonstrated by quarterly reports to Audit Committee.

Conclusion

The Trust Board is committed to the continuous improvement of its governance arrangements to ensure that systems are in place to identify and manage risks correctly. Any serious incidents or incidents of non-compliance with standards and regulatory requirements are escalated and are subject to prompt and effective remedial action. This is to ensure that patients, service users, staff and stakeholders can be confident in the quality of the services delivered, and the effective, economic, and efficient use of resources.

Overall, there is in place a dynamic process for the management of internal control which is reviewed and updated regularly by the Executive Team and various Board Committees that are in place in the Trust to help me meet my responsibilities as Accounting Officer. The risks the Trust has faced, together with the actions taken to address each of these areas are detailed within this annual governance statement. My review confirms that Salisbury NHS Foundation Trust has sound systems of internal control up to the date of approval of the annual report and accounts and no significant internal control issues have been identified.



Stacey Hunter
Chief Executive (Accounting Officer)
22 June 2023 (on behalf of the Trust Board)

SALISBURY NHS FOUNDATION TRUST

CONSOLIDATED FINANCIAL STATEMENTS

FOR THE YEAR TO 31 MARCH 2023

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FOREWORD TO THE ACCOUNTS

These consolidated accounts for the year ended 31 March 2023 have been prepared by Salisbury NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Signed: 

Stacey Hunter - Chief Executive

Date: 22 June 2023

Independent auditor's report to the Council of Governors of Salisbury NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of Salisbury NHS Foundation Trust (the 'Trust') and its subsidiaries (the 'group') for the year ended 31 March 2023, which comprise the Statements of Comprehensive Income, the Statements of Financial Position, the Consolidated Statements of Changes in Taxpayers Equity, the Consolidated Statements of Cash Flows and Notes to the Accounts, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2023 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group's and the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the group or the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the group and Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the group and Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the group and Trust and the group and Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2022/23 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with NHS foundation trust annual reporting manual 2022/23; and

- based on the work undertaken in the course of the audit of the financial the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or

- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2022/23, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of the services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the group and Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).

- We enquired of management and the Audit Committee, concerning the group and Trust's policies and procedures relating to:

  - the identification, evaluation and compliance with laws and regulations;

  - the detection and response to the risks of fraud; and

  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

- We enquired of management, internal audit and the Audit Committe, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

- We assessed the susceptibility of the group and Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:

  - high risk and unusual journals;

  - management estimates including land, buildings and dwellings valuations for indicators of management bias;

  - fraudulent revenue recognition – we rebutted income recognition under block contract arrangements, where income could be verified to agreements with third parties. For other income streams the Trust's ability to manipulate revenue recognition in any meaningful way, or to adopt aggressive revenue recognition policies, is determined to be low.

- Our audit procedures involved:

  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;

  - journal entry testing, with a focus on high risk and unusual journals, including those journals processed by senior officers, journals posted by unauthorised users, journals with blank decriptions, journals that appeared to be unauthorised, journals with related party entities and journals that contained other criteria that we determined presented a higher risk;

  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations;

  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

- The team communicated with management and the Audit Committee in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue, and the significant accounting estimates related to land and building valuations.

- Our assessment of the appropriateness of the collective competence and capabilities of the group and Trust's engagement team included consideration of the engagement team's;
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the group and Trust operates
  - understanding of the legal and regulatory requirements specific to the group and Trust including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The group and Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation processes, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The group and Trust's control environment, including the policies and procedures implemented by the group and Trust to ensure compliance with the requirements of the financial reporting framework.
- For components at which audit procedures were performed, we requested component auditors to report to us instances of non-compliance with laws and regulations that gave rise to a risk of material misstatement of the group financial statements. [No such matters were identified by the component auditors.]

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at:

www.frc.org.uk/auditorsresponsibilities

This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2023.

We have nothing to report in respect of the above matter.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of Salisbury NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Signature:

Barrie Morris

Barrie Morris, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol
Date: 28 June 2023

STATEMENTS OF COMPREHENSIVE INCOME
For The Year Ended 31 March 2023

		Group		Trust	
		2022/23	2021/22	**2022/23**	2021/22
	Note	**£000**	£000	**£000**	£000
Revenue from patient care activities	3	**316,728**	278,480	**316,728**	278,480
Other operating revenue	4	**44,826**	39,252	**31,206**	26,887
Operating expenses	6	**(355,455)**	(311,781)	**(340,321)**	(299,976)
OPERATING SURPLUS		**6,099**	5,951	**7,613**	5,391
FINANCE COSTS					
Finance income	11	**1,082**	309	**1,012**	233
Finance expense	12	**(2,218)**	(2,002)	**(2,159)**	(2,002)
PDC Dividends payable		**(4,447)**	(4,073)	**(4,447)**	(4,073)
NET FINANCE COSTS		**(5,583)**	(5,766)	**(5,594)**	(5,842)
Losses on disposal of assets	15	**(5)**	(249)	**(5)**	(249)
Share of profit of associates/ joint ventures	32	**54**	65	**54**	65
Movement in fair value of other investments	17	**(300)**	438	**-**	-
(Losses) from transfers by absorption	38	**(329)**	-	**(329)**	-
RETAINED SURPLUS/ (DEFICIT) FOR THE YEAR		**(64)**	439	**1,739**	(635)
OTHER COMPREHENSIVE INCOME:					
Items that will not be reclassified to income and expenditure					
Revaluations		**8,869**	10,261	**8,949**	10,042
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**8,805**	10,700	**10,688**	9,407
NOTE: ALLOCATION OF PROFIT/(LOSSES) FOR THE YEAR					
(a) Surplus/(Deficit) for the period attributable to:					
(i) Minority interest, and		**10**	27	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**(74)**	412	**1,739**	(635)
TOTAL		**(64)**	439	**1,739**	(635)
(b) Total comprehensive income/ (expense) for the year attributable to:					
(i) Minority interest, and		**10**	27	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**8,795**	10,673	**10,688**	9,407
TOTAL		**8,805**	10,700	**10,688**	9,407

The notes on pages 5 to 56 form an integral part of these financial statements.
All revenue and expenditure is derived from continuing operations.

STATEMENTS OF FINANCIAL POSITION
31 MARCH 2023

		Group		Trust	
		31 March 2023	31 March 2022	**31 March 2023**	31 March 2022
	Note	**£000**	£000	**£000**	£000
NON-CURRENT ASSETS					
Intangible assets	14	**6,967**	9,896	**6,967**	9,896
Property, plant and equipment	15	**181,572**	162,419	**179,333**	158,532
Right of use assets	16	**4,805**	-	**2,587**	-
Investments in joint ventures	32	**300**	246	**300**	246
Investments	17	**8,245**	8,225	**500**	-
Other financial assets	18	**2,658**	2,497	**3,900**	4,006
Receivables	20	**402**	656	**402**	656
Total non-current assets		**204,949**	183,939	**193,989**	173,336
CURRENT ASSETS					
Inventories	19	**7,955**	7,939	**6,098**	6,311
Receivables	20	**23,607**	14,211	**21,445**	13,103
Investments	17	**123**	337	**-**	-
Other financial assets	18	**-**	-	**654**	1,940
Cash and cash equivalents	21	**33,179**	39,306	**27,455**	30,819
Total current assets		**64,864**	61,793	**55,652**	52,173
Total assets		**269,813**	245,732	**249,641**	225,509
CURRENT LIABILITIES					
Trade and other payables	22	**(56,668)**	(46,071)	**(54,258)**	(44,755)
Borrowings	23	**(2,000)**	(1,714)	**(1,488)**	(1,546)
Provisions	24	**(475)**	(1,234)	**(475)**	(1,234)
Total current liabilities		**(59,143)**	(49,019)	**(56,221)**	(47,535)
Total assets less current liabilities		**210,670**	196,713	**193,420**	177,974
NON-CURRENT LIABILITIES					
Borrowings	23	**(17,668)**	(18,145)	**(16,275)**	(17,146)
Provisions	24	**(594)**	(895)	**(594)**	(895)
Total non-current liabilities		**(18,262)**	(19,040)	**(16,869)**	(18,041)
TOTAL ASSETS EMPLOYED		**192,408**	177,673	**176,551**	159,933
FINANCED BY:					
TAXPAYERS' EQUITY					
Public dividend capital	33	**99,600**	94,826	**99,600**	94,826
Revaluation reserve		**84,729**	75,780	**84,729**	75,780
Income and expenditure reserve		**(6,173)**	(9,239)	**(7,778)**	(10,673)
OTHERS' EQUITY					
Minority Interest		**90**	80	**-**	-
Charitable fund reserves	34	**14,162**	16,226	**-**	-
TOTAL TAXPAYERS' AND OTHERS' EQUITY		**192,408**	177,673	**176,551**	159,933

The notes on pages 5 to 56 form an integral part of these financial statements.
The financial statements on pages 1 to 56 were approved by the Board on 22 June 2023 and signed on its behalf by:

Signed: 

Stacey Hunter - Chief Executive

CONSOLIDATED STATEMENTS OF CHANGES IN TAXPAYERS EQUITY

	Trust				Subsidiary		Charitable Fund	Group
	Public dividend capital (PDC)	Income and expenditure reserve	Revaluation reserve	Trust Reserves	Profit & Loss Reserves	Minority interest	Charitable Funds reserve	Total taxpayers' equity
	£000	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and Others' Equity at 1 April 2021	90,997	(10,038)	65,738	146,697	1,142	53	15,252	163,144
Changes in taxpayers' equity for 2021/22								
Retained surplus/(deficit) for the year	-	(635)	-	(635)	292	27	755	439
Other recognised gains and losses	-	-	-	-	-	-	-	-
Impairment of property plant and equipment	-	-	-	-	-	-	-	-
Net gain/(loss) on revaluation of property plant and equipment	-	-	10,042	10,042	-	-	-	10,042
Transfers between reserves	-	-	-	-	-	-	-	-
Revaluations and impairments - charitable fund assets	-	-	-	-	-	-	219	219
Fair Value gains/(losses) on Available-for-sale financial investments	-	-	-	-	-	-	-	-
Other reserve movements	-			-	-	-	-	-
Public dividend capital received in year	4,112	-	-	4,112	-	-	-	4,112
Public dividend capital repaid in year	(283)	-	-	(283)	-	-	-	(283)
Balance at 31 March 2022	**94,826**	**(10,673)**	**75,780**	**159,933**	**1,434**	**80**	**16,226**	**177,673**
Changes in taxpayers' equity for 2022/23								
Implementation of IFRS 16 on 1 April 2022	-	1,156	-	**1,156**	-	-	-	**1,156**
Retained surplus/(deficit) for the year	-	1,739	-	**1,739**	171	10	(1,984)	**(64)**
Other recognised gains and losses	-	-	-	**-**	-	-	-	**-**
Impairment of property plant and equipment	-	-	-	**-**	-	-	-	**-**
Net gain/(loss) on revaluation of property plant and equipment	-	-	8,949	**8,949**	-	-	-	**8,949**
Transfers between reserves	-	-	-	**-**	-	-	-	**-**
Revaluations and impairments - charitable fund assets	-	-	-	**-**	-	-	(80)	**(80)**
Fair Value gains/(losses) on Available-for-sale financial investments	-	-	-	**-**	-	-	**-**	**-**
Other reserve movements	-			**-**	-	-	**-**	**-**
Public dividend capital received in year	4,774	-	-	**4,774**	-	-	**-**	**4,774**
Public dividend capital repaid in year	-	-	-	**-**	-	-	**-**	**-**
Balance at 31 March 2023	**99,600**	**(7,778)**	**84,729**	**176,551**	**1,605**	**90**	**14,162**	**192,408**

The notes on pages 5 to 56 form an integral part of these financial statements.

CONSOLIDATED STATEMENTS OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2023

	Note	Group 2023 £000	Group 2022 £000	Trust 2023 £000	Trust 2022 £000
CASH FLOWS FROM OPERATING ACTIVITIES					
Total operating surplus		**6,099**	5,951	**7,613**	5,391
NON-CASH INCOME AND EXPENSE					
Depreciation and amortisation charge	6	**14,553**	13,682	**13,759**	13,481
Impairments	6	**-**	474	**-**	474
Income recognised in respect of capital donations - NHS Charity		**(2,308)**	(685)	**(2,308)**	(685)
Income recognised in respect of capital donations - Other		**(1,116)**	-	**(1,116)**	-
(Increase)/ decrease in trade and other receivables	20	**(9,324)**	(2,036)	**(8,057)**	(1,229)
(Increase)/ decrease in inventories	19	**(16)**	(305)	**213**	(261)
Increase/ (decrease) in trade and other payables	22	**14,430**	4,608	**13,333**	4,665
Increase/ (decrease) in provisions	24	**(1,058)**	(96)	**(1,058)**	(96)
Movements in charitable fund working capital		**209**	(17)	**-**	-
Net cash inflow from operating activities		**21,469**	21,576	**22,379**	21,740
CASH FLOWS FROM INVESTING ACTIVITIES					
Interest received		**752**	32	**802**	115
Purchase of financial assets		**-**	-	**-**	-
Payments to acquire property, plant and equipment	15	**(24,210)**	(7,839)	**(24,109)**	(7,390)
Receipts from sale of property, plant and equipment		**-**	50	**-**	50
Payments to acquire intangible assets	14	**-**	(1,922)	**-**	(1,922)
NHS charitable funds - net cash flows from investing activities		**58**	57	**-**	-
Net cash (outflow) from investing activities		**(23,400)**	(9,622)	**(23,307)**	(9,147)
CASH FLOWS FROM FINANCING ACTIVITIES					
New public dividend capital received	33	**4,774**	4,112	**4,774**	4,112
Public dividend capital repaid	33	**-**	(283)	**-**	(283)
Loans received		**-**	-	**-**	40
Loan to subsidiary		**-**	-	**-**	(306)
Loan repayment received		**-**	-	**1,053**	-
Movement in loans from the Department of Health and Social Care		**(631)**	(631)	**(631)**	(631)
Capital element of lease liability repayments		**(1,030)**	(435)	**(382)**	(435)
Capital element of Private Finance Initiative obligations	28	**(612)**	(525)	**(612)**	(525)
Interest paid		**(34)**	(44)	**(34)**	(44)
Interest element of lease liability repayments		**(64)**	(20)	**(5)**	(20)
Interest element of Private Finance Initiative obligations	28	**(2,126)**	(1,944)	**(2,126)**	(1,944)
PDC dividend paid		**(4,473)**	(4,047)	**(4,473)**	(4,047)
Net cash inflow/ (outflow) from financing		**(4,196)**	(3,817)	**(2,436)**	(4,083)
Increase/ (decrease) in cash and cash equivalents		**(6,127)**	8,137	**(3,364)**	8,510
Cash and cash equivalents at the beginning of the financial year		**39,306**	31,169	**30,819**	22,309
Cash and cash equivalents at the end of the financial year	21	**33,179**	39,306	**27,455**	30,819

The notes on pages 5 to 56 form an integral part of these financial statements.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2022/23 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern.

After making enquiries, the directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

1.3 Critical accounting estimates and judgements

International accounting standard IAS1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The purpose of evaluation is to consider whether there may be a significant risk of causing material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts.

Critical accounting judgements employed in the year are outlined in note 35.

Critical accounting estimates made in the year are outlined in note 36.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.4 Basis of Consolidation

1.4.1 NHS Charitable Fund

The Trust is the Corporate Trustee to Salisbury District Hospital Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The consolidation is for reporting purposes only and does not affect the charity's legal and regulatory independence and day to day operations.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

1.4.2 Subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the previous year together with draft figures for the current year.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Unless otherwise stated the notes to the accounts refer to the Group and not the Trust. Where the Trust's balances are materially different, these are stated separately.

1.4.3 Associates

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, e.g., share dividends are received by the Trust from the associate.

1.4.4 Joint ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement.

Joint ventures are accounted for using the equity method.

1.4.5 Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement.

The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Income Recognition

1.5.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised.

Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity.

In 2022/23 fixed payments are set at a level assuming the achievement of elective activity targets.

These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differs from the agreed level set in the fixed payments, the variable element either increases or reduces the income earned by the Trust at a rate of 75% of the tariff price

Elective recovery funding provides additional funding for the delivery of elective services. In 2022/23 elective recovery funding was included within the aligned payment and incentive contracts.

In 2021/22 income earned by the system for elective recovery was distributed between individual entities by local agreement. Income earned from the fund in 2021/22 was accounted for as variable consideration.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner. In 2022/23 payment under these schemes is included in fixed payments from commissioners based on assumed achievement of criteria.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Income Recognition (continued)

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Education and training
Income for training and education is received from Health Education England. The Trust recognises the income when the conditions of the contract have been met.

1.5.2 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Income received by the Charity
Charitable incoming resources are recognised once the charity has entitlement to the resources, it is certain that the resources will be received and the monetary value of the incoming resources can be measured with sufficient reliability.

Legacy income is accounted for within the charity as incoming resources, either upon receipt, or where the receipt of the legacy is probable; this will be once confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made, or property transferred, and once all conditions attached to the legacy have been fulfilled.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Expenditure on employee benefits

1.6.1 Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.6.2 Pension costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

National Employment Savings Trust (NEST)
Employees that are not entitled to enrol on the NHS Pension Scheme are auto-enrolled into the Government NEST defined contribution workplace pension scheme.

Under the terms of the NEST scheme employees retain the right to opt-out after having been auto-enrolled.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Subsidiary pension scheme
The subsidiary companies operate defined contribution schemes for employees who have contracts of employment directly with the companies. Employer's pension costs are charged to operating expenses as and when they become due.

These schemes comply with legislative requirements.

1.7 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.8 Intangible assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost (DRC) and the value in use where the asset is income generating. The Trust uses historic cost less depreciation as an approximation of DRC. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

Software 1 - 7 Years

1.9 Property, plant and equipment

1.9.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.9.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land – market value for existing use.
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Valuation guidance issued by the Royal Institution of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust’s Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Useful lives of property, plant and equipment
Items of property, plant and equipment are depreciated over their remaining useful lives, as follows:

Buildings (excluding dwellings)	5 - 72 years
Dwellings	5 - 58 years
Plant and Machinery	1 - 15 years
Transport equipment	3 - 10 years
Information Technology	1 - 10 years
Furniture and Fittings	5 - 15 years

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

1.9.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds, less costs associated with the sale, and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.9.4 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

1.9.5 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Services received

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator
Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.10 Investments

Investments in subsidiary undertakings, associates and joint ventures are treated as fixed asset investments and stated at cost.

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cash flow statement.

Investments in quoted stocks, shares, gilts and alternative investments are included in the Statement of Financial Position at mid-market price, ex-dividend.

All gains and losses are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening market value (or value at purchase date if later).

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.11 Borrowing costs

Borrowing costs are recognised as expenses as they are incurred.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured on the First In, First Out (FIFO) method. Work-in-progress comprises goods in intermediate stages of production. The Laundry stock value is based on the original cost less an adjustment to reflect usage, over a three year life (except for Towels and Scrub Suits which have a two year life), in determining an approximation of net realisable value.

The Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.14 Financial assets and financial liabilities

1.14.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

1.14.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure.

Financial liabilities classified as subsequently measured at amortised cost.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.14.3 Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets and financial liabilities at fair value through income and expenditure
Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.14.4 Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The Trust does not normally recognise expected credit losses in relation to other NHS bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.14.5 De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.15 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

1.15.1 The Trust as lessee

Initial recognition and measurement
At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement
As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.15 Leases (continued)

1.15.2 The Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases
Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.15.3 Initial application of IFRS 16

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee
For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

The Trust as lessor
Leases of owned assets where the Trust is lessor were unaffected by initial application of IFRS 16. For existing arrangements where the Trust is an intermediate lessor, classification of all continuing sublease arrangements has been reassessed with reference to the right of use asset.

2021/22 comparatives
Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line or other systematic basis.

1. ACCOUNTING POLICIES (CONTINUED)

1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2023:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.27%	0.47%
Medium-term	After 5 years up to 10 years	3.20%	0.70%
Long-term	After 10 years up to 40 years	3.51%	0.95%
Very long-term	Exceeding 40 years	3.00%	0.66%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2023:

	Inflation rate	Prior year rate
Year 1	7.40%	4.00%
Year 2	0.60%	2.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 1.70% in real terms (prior year: minus 1.30%).

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust.

The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 24 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

A Contingent liability is disclosed unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

1. ACCOUNTING POLICIES (CONTINUED)

1.18 Public dividend capital (continued)

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at

https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.19 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 Corporation Tax

The Trust does not have a corporation tax liability for the year 2022/23 (2021/22 £nil). Tax may be payable by the Trust on activities described below:

- The activity is not related to the provision of core healthcare as defined under Section 14(1) of the HSCA. Private Healthcare falls under this legislation and is not therefore taxable.
- The activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax.
- Annual profits from the activity must exceed £50,000

The Trust's subsidiary companies have made a modest profit leading to a corporation tax liability of £34k (2021/22: £37k).

1.21 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.22 Foreign exchange

The functional and presentational currency of the Trust is sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note (note 30) to the accounts in accordance with the requirements of HM Treasury’s FReM.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.24 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.26 Transfers of functions to other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised within income / expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

1.27 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2022/23

1.28 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases - application of liability measurement principles to PFI and other service concession arrangements

From 1 April 2023, the measurement principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to Retail Prices Index (RPI). The PFI liability will be remeasured when a change in the index causes a change in future repayments and that change has taken effect in the cash flow. Such remeasurements will be recognised as a financing cost. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred.

Initial application of these principles will be on 1 April 2023 using a modified retrospective approach with the cumulative impact taken to reserves. This is expected to result in an increased PFI liability on the statement of financial position. The effect of this has not yet been quantified.

NOTES TO THE ACCOUNTS

2. Segmental Analysis

Group and Trust

The business activities of the Group can be summarised as that of 'healthcare'. The Trust's activities comprise six key operating areas where costs are closely monitored during the year. The chief operating decision maker for Salisbury NHS Foundation Trust is the Trust Board. Key decisions are agreed at monthly Board meetings and sub-committee meetings of the Board, following scrutiny of performance and resource allocation. The Trust Board review and make decisions on activity and performance of the Trust as a whole entity, not for its separate business activities. The activities of the subsidiary companies, Odstock Medical Limited and Salisbury Trading Limited, and of the charity, Salisbury District Hospital Charitable Fund, are not considered sufficiently material to require separate disclosure.

NOTES TO THE ACCOUNTS

3 Revenue From Patient Care Activities

3.1 Revenue by Nature

	Group and Trust	
	2023	2022
	£000	£000
Aligned payment and incentive (API) contract income/ system block income*	**257,252**	233,471
High cost drugs income from commissioners	**23,908**	20,952
Other NHS clinical income	**5,007**	2,882
Total revenue at full tariff	**286,167**	257,305
Private patient revenue	**2,583**	2,416
Elective recovery fund	**7,919**	3,440
Agenda for change pay award central funding**	**6,740**	-
Additional pension contribution central funding***	**8,062**	7,460
Other clinical income	**5,257**	7,859
Total income from patient care activities	**316,728**	278,480

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2022/23 National tariff payments system documentation.
https://www.england.nhs.uk/publication/past-national-tariffs-documents-and-policies/

Other types of activity revenue above includes amounts due for specialist services (e.g. spinal, burns, genetics, cleft lip and palate), direct access, intensive care, community and hospice services.

**In March 2023 the government announced an additional pay offer for 2022/23, in addition to the pay award earlier in the year. Additional funding was made available by NHS England for implementing this pay offer for 2022/23 and the income and expenditure has been included in these accounts as guided by the Department of Health and Social Care and NHS England. In May 2023 the government confirmed this offer will be implemented as a further pay award in respect of 2022/23 based on individuals in employment at 31 March 2023.

***The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

3.2 Revenue by Source

	Group and Trust	
	2023	2022
	£000	£000
NHS England	**68,745**	59,779
Clinical commissioning groups	**51,231**	206,667
Integrated Care Boards	**182,987**	-
Department of Health and Social Care	**39**	7
Other NHS providers	**5,007**	3,853
NHS other	**592**	553
Local authorities	**1,724**	1,553
Non NHS:		
- Private patients	**2,451**	2,416
- Overseas patients (chargeable to patient)	**132**	93
- NHS Injury cost recovery scheme	**906**	640
- Other	**2,914**	2,919
	316,728	278,480

NHS Injury Scheme revenue is subject to a provision for doubtful debts of 24.86% (2022: 23.76%) to reflect expected rates of collection. The doubtful debt provision is included in the allowance for impaired contract receivables included in note 20.3

NOTES TO THE ACCOUNTS

3 Revenue From Patient Care Activities (continued)

3.3 Commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Group and Trust	
	2023	2022
	£000	£000
Income from services designated as commissioner requested services	**293,874**	259,382
Income from services not designated as commissioner requested services	**22,854**	19,098
	316,728	278,480

3.4 Overseas visitors (relating to patients charged directly by the provider)

	Group and Trust	
	2023	2022
	£000	£000
Income recognised this year	**132**	93
Cash payments received in-year	**75**	90
Amounts added to provision for impairment of receivables	**-**	-
Amounts written off in-year	**3**	2

NOTES TO THE ACCOUNTS

4. Other operating revenue

	Group		Trust	
	2023	2022	**2023**	2022
	£000	£000	**£000**	£000
Reimbursement and top up funding	**1,229**	3,050	**1,229**	3,050
Research and development	**862**	916	**862**	916
Education and training	**10,400**	10,142	**10,400**	10,142
Non-patient care services to other bodies	**4,855**	3,980	**4,855**	3,980
Received from DHSC group bodies for COVID response- donated assets	**184**	-	**184**	-
Received from NHS charities - donated assets	**-**	-	**2,308**	685
Contributions to expenditure - equipment donated from DHSC group bodies for COVID response below capitalisation threshold	**-**	-	**-**	-
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	**619**	883	**619**	883
Peppercorn leased assets recognised	**932**	-	**932**	-
Salisbury Trading Limited	**11,954**	9,593	**-**	-
NHS Charitable Funds: Incoming Resources excluding investment income	**1,803**	1,820	**-**	-
Odstock Medical Limited	**2,632**	2,151	**-**	-
Accommodation	**1,383**	1,259	**1,383**	1,259
Administrative services provided to Sterile Supplies Limited	**198**	229	**198**	229
Car Parking	**792**	198	**792**	198
Catering	**693**	500	**693**	500
Payroll services provided to other organisations	**2,180**	1,961	**2,180**	1,961
Other	**4,110**	2,570	**4,571**	3,084
	44,826	39,252	**31,206**	26,887

Included within 'Other' revenue above are: Covid mass vaccination centre income £1,750k (2022: £1,188k), Royalty Income £475k (2022: £890k), procurement framework income re: apprenticeships £475k (2022: £433k), Leisure Centre income £148k (2022: £121k), income from the rent and hire of rooms £118k (2022: £166k), cancer transformation £606k (2022: £432k) and overseas recruitment £468k (2022: £23k).

5. Operating lease income

5.1 As lessor

The Trust has entered into short term commercial leases on buildings, which primarily relate to the rental of an area within the hospital main entrance to a high street retailer and properties rented to subsidiary companies.

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis. This includes a different maturity analysis of future minimum lease receipts under IAS 17 compared to IFRS 16.

5.2 Receipts recognised as income

	Group		Trust	
	2023	2022	**2023**	2022
	£000	£000	**£000**	£000
Rental revenue from operating leases - minimum lease receipts	**113**	166	**277**	413

5.3 Total future lease income

	Group		Trust	
	2023	2022	**2023**	2022
Future minimum lease receipts due at 31 March 2023:	**£000**	£000	**£000**	£000
- not later than one year	**105**	93	**213**	257
- later than one year and not later than two years	**120**	91	**170**	198
- later than two years and not later than three years	**137**	90	**187**	140
- later than three years and not later than four years	**145**	90	**145**	140
- later than four years and not later than five years	**145**	90	**145**	90
- later than five years	**367**	323	**367**	323
Total	**1,019**	777	**1,227**	1,148

NOTES TO THE ACCOUNTS

6. Operating Expenses

Operating expenses comprise:

	Group		Trust	
	2023	2022	**2023**	2022
	£000	£000	**£000**	£000
Purchase of healthcare from NHS and DHSC bodies	**4,225**	3,871	**4,225**	3,871
Purchase of healthcare from non-NHS and non-DHSC bodies	**3,569**	3,097	**3,569**	3,097
Staff and executive directors costs	**226,936**	198,535	**218,532**	191,336
Non-executive directors	**156**	166	**156**	166
Supplies and services – clinical (excluding drugs costs)	**29,508**	25,943	**28,244**	25,127
Supplies and services - general	**4,512**	4,861	**3,124**	3,684
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	**29,305**	25,213	**29,305**	25,213
Inventories written down	**-**	99	**-**	99
Consultancy costs	**280**	680	**280**	680
Establishment	**5,490**	3,065	**5,490**	3,065
Premises	**21,364**	16,838	**19,725**	15,649
Transport	**1,872**	1,660	**1,356**	1,056
Depreciation on property, plant and equipment and right of use assets	**11,629**	10,714	**10,835**	10,513
Amortisation on intangible assets	**2,924**	2,968	**2,924**	2,968
Impairments net of (reversals)	**-**	474	**-**	474
Movement in credit loss allowance: contract receivables / contract assets	**342**	15	**342**	15
Provisions arising /(released) in year	**84**	(43)	**84**	(43)
Change in provisions discount rate(s)	**(27)**	4	**(27)**	4
Lease expenditure - short term leases (<= 12 months)	**-**	-		-
Lease expenditure - low value assets (<£5k, excluding short term leases)	**-**	-		-
Lease expenditure - variable lease payments not included in the liability	**-**	-		-
Operating lease expenditure (net)	**-**	94	**-**	136
Audit fees payable to the external auditor				
audit services- statutory audit	**150**	117	**150**	117
Internal audit costs	**126**	111	**126**	111
Clinical negligence	**6,756**	8,190	**6,756**	8,190
Legal fees	**25**	67	**25**	67
Insurance	**213**	292	**213**	292
Research and development	**76**	46	**76**	46
Education and training	**2,665**	1,465	**2,665**	1,465
Charges to operating expenditure for on-SoFP PFI scheme	**1,166**	1,114	**1,166**	1,114
Other NHS charitable fund resources expended	**1,052**	591	**-**	-
Other	**1,057**	1,534	**980**	1,464
	355,455	311,781	**340,321**	299,976

The total employer's pension contributions are disclosed in note 8.1

Redundancy payments totalling £nil (2022: £nil).

There is a limitation on the Auditor's liability of £2.0m (2022: £2.0m). The fees payable to auditors for the statutory audit and additional services above are quoted gross of VAT at 20%, reflecting the Trust's inability to reclaim VAT on this type of expenditure.

Other expenses include professional fees associated with the hospital site development £0.1m (2022: £0.3m) and home testing kits £0.2m (2022: £0.2m).

NOTES TO THE ACCOUNTS

7. Impairment of assets

	Group		Trust	
	2023	2022	**2023**	2022
	£000	£000	**£000**	£000
Net impairments charged to operating surplus / deficit resulting from:				
Loss or damage from normal operations	**-**	18	**-**	18
Over specification of assets	**-**	456	**-**	456
Total net impairments charged to operating surplus / deficit	**-**	474	**-**	474
Impairments charged to the revaluation reserve	**-**	-	**-**	
Total net impairments	**-**	474	**-**	474

8. Employee benefits

8.1 Staff costs

	Group		Trust	
	2023	2022	**2023**	2022
	£000	£000	**£000**	£000
Salaries and wages	**169,646**	151,408	**163,028**	145,387
Social security costs	**17,013**	14,788	**17,013**	14,788
Apprenticeship levy	**789**	737	**789**	737
Employer's contributions to NHS pensions	**26,684**	24,583	**26,564**	24,489
Pension cost - other	**42**	42	**42**	42
Temporary staff (including agency)	**13,666**	7,735	**12,000**	6,651
Total gross staff costs	**227,840**	199,293	**219,436**	192,094
Of which				
Costs capitalised as part of assets	**904**	758	**904**	758

NOTES TO THE ACCOUNTS

8. Employee benefits (continued)

8.2 Directors' remuneration

	Group and Trust	
	2023	2022
	£000	£000
Salaries and wages	**1,038**	1,040
Social Security Costs	**134**	127
Employer contributions to Pension Schemes	**168**	161
	1,340	1,328

The total number of Directors accruing benefits under pension schemes is 6 (2022: 6). The Directors Remuneration only relates to the Group.

9. Pension costs

The total cost charged to income in respect of the Group's obligations to the NHS Pension Agency and the defined contribution schemes for Odstock Medical Limited and Salisbury Trading Limited was £18.6m (2022: £17.1m). With the exception of employer contributions to NHSPA paid by NHSE on provider's behalf (6.3%), as at 31 March 2023 (and 2022), contributions of £2.90m (2022: £2.53m) due in respect of the current reporting period (representing the contributions for the final month of the year) had not been paid over to the schemes by the balance sheet date.

9.1 NHS Pension Schemes

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as at 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

NOTES TO THE ACCOUNTS

9. Pension costs (continued)

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

10. Retirements due to ill-health

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

During the year to 31 March 2023 there was 6 (2022: 5) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £477k (2022: £474k). The cost of the 2023 ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

NOTES TO THE ACCOUNTS

11. Finance income

	Group		Trust	
	2023	2022	**2023**	2022
	£000	£000	**£000**	£000
Interest on bank accounts	**756**	32	**756**	102
Interest income on finance leases	**-**	-	**-**	
Interest on other investments / financial assets	**162**	102	**256**	131
NHS charitable fund investment income	**164**	175	**-**	-
Other finance income	**-**	-	**-**	-
	1,082	309	**1,012**	233

12. Finance expenditure

	Group		Trust	
	2023	2022	**2023**	2022
	£000	£000	**£000**	£000
Interest on loans from the Department of Health and Social Care	**30**	40	**30**	40
Interest on other loans	**-**	-	**-**	-
Interest on overdrafts	**-**	-	**-**	-
Interest on lease obligations	**64**	20	**5**	20
Interest on late payment of commercial debt	**-**	-	**-**	-
Main finance costs on PFI obligations	**1,061**	1,098	**1,061**	1,098
Contingent finance costs on PFI obligations	**1,065**	846	**1,065**	846
Total finance expense - financial liabilities	**2,220**	2,004	**2,161**	2,004
Unwinding of discounts on provisions	**(2)**	(2)	**(2)**	(2)
Total	**2,218**	2,002	**2,159**	2,002

13. Losses and special payments

	Group and Trust			
	2023		2022	
	Number	**Value**	Number	Value
		£000		£000
Losses				
Cash losses	**1**	**1**	-	-
Fruitless payments and constructive losses	**-**	**-**	1	-
Bad debts and claims abandoned	**140**	**26**	445	308
Stores losses	**4**	**1**	5	100
	145	**28**	451	408
Special payments				
Compensation payments	**-**	**-**	-	-
Extra-contractual payments	**-**	**-**	-	-
Ex-gratia payments	**40**	**45**	23	247
Special severance payments	**-**	**-**	-	-
Extra-statutory and extra-regulatory payments	**-**	**-**	-	-
	40	**45**	23	247
Total losses and special payments	**185**	**73**	474	655

There were no case payments that exceeded £0.1m.

NOTES TO THE ACCOUNTS

14. Intangible Assets

14.1 Intangible assets at the balance sheet date comprise the following elements:

Group and Trust

	Assets under Construction £000	Software Licences £000	Total £000
Cost or valuation			
At 1 April 2022	3,306	17,869	21,175
Additions - purchased	-	-	-
Additions - donated	-	-	-
Impairments charged to operating expenses	-	-	-
Reclassifications	(1,052)	1,052	-
Disposals	-	(217)	(217)
At 31 March 2023	**2,254**	**18,704**	**20,958**
Amortisation			
At 1 April 2022	-	11,279	11,279
Provided during the period	-	2,924	2,924
Impairments charged to operating expenses	-	-	-
Disposals	-	(212)	(212)
Amortisation at 31 March 2023	**-**	**13,991**	**13,991**
Net book value at 31 March 2023			
- Purchased at 31 March 2023	2,254	4,713	6,967
- Donated at 31 March 2023	-	-	-
Total at 31 March 2023	**2,254**	**4,713**	**6,967**

Cost or valuation			
At 1 April 2021	2,143	19,077	21,220
Additions - purchased	1,922	-	1,922
Additions - donated	-	-	-
Impairments charged to operating expenses	-	-	-
Reclassifications	(759)	759	-
Disposals	-	(1,967)	(1,967)
At 31 March 2022	**3,306**	**17,869**	**21,175**
Amortisation			
At 1 April 2021	-	10,268	10,268
Provided during the period	-	2,968	2,968
Impairments charged to operating expenses	-	-	-
Disposals	-	(1,957)	(1,957)
Amortisation at 31 March 2022	**-**	**11,279**	**11,279**
Net book value at 31 March 2022			
- Purchased at 31 March 2022	3,306	6,579	9,885
- Donated at 31 March 2022	-	11	11
Total at 31 March 2022	**3,306**	**6,590**	**9,896**

NOTES TO THE ACCOUNTS

15. Property, plant and equipment

Group

15.1 Property, Plant and equipment at the balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2022	2,401	116,709	7,938	6,007	48,530	110	13,351	3,369	198,415
Reclassification of existing finance leased assets to right of use assets at 1 April 2022	-	-	-	-	(1,782)	-	(1,943)	-	(3,725)
Transfers by absorption	-	-	-	-	(952)	-	(206)	-	(1,158)
Additions - purchased	-	-	-	20,376	-	-	-	-	20,376
Additions - donated	-	-	-	-	2,492	-	-	-	2,492
Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	3,284	8	(9,723)	2,857	-	3,490	84	-
Revaluation	19	4,252	(82)	-	-	-	-	-	4,189
Transfer to assets held for sale	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(2,083)	-	-	-	(2,083)
At 31 March 2023	**2,420**	**124,245**	**7,864**	**16,660**	**49,062**	**110**	**14,692**	**3,453**	**218,506**
Accumulated depreciation									
At 1 April 2022	-	220	-	-	25,098	39	8,292	2,347	35,996
Reclassification of existing finance leased assets to right of use assets at 1 April 2022	-	-	-	-	(108)	-	(1,263)	-	(1,371)
Transfers by absorption	-	-	-	-	(637)	-	(197)	-	(834)
Provided during the period	-	4,224	236	-	3,768	11	1,427	240	9,906
Revaluation	-	(4,444)	(236)	-	-	-	-	-	(4,680)
Impairments	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(2,083)	-	-	-	(2,083)
Accumulated depreciation at 31 March 2023	**-**	**-**	**-**	**-**	**26,038**	**50**	**8,259**	**2,587**	**36,934**
Net book value at 31 March 2022									
Owned	2,401	94,593	7,938	6,007	21,592	71	4,379	1,022	138,003
Finance leased	-	-	-	-	1,286	-	680	-	1,966
On balance sheet PFI	-	21,896	-	-	-	-	-	-	21,896
Donated	-	-	-	-	554	-	-	-	554
Total at 31 March 2022	**2,401**	**116,489**	**7,938**	**6,007**	**23,432**	**71**	**5,059**	**1,022**	**162,419**
Net book value at 31 March 2023									
Owned	2,420	101,080	7,864	16,660	22,347	60	6,433	866	157,730
Finance leased	-	-	-	-	-	-	-	-	-
On-SoFP PFI	-	23,165	-	-	-	-	-	-	23,165
Donated	-	-	-	-	677	-	-	-	677
Total at 31 March 2023	**2,420**	**124,245**	**7,864**	**16,660**	**23,024**	**60**	**6,433**	**866**	**181,572**

On 31 March 2023 Gerald Eve LLP revalued the Trust's land, buildings and dwellings on a Modern Equivalent Asset basis in accordance with the guidance included in the Royal Institution of Chartered Surveyors Valuation Standards. As a result, these assets were revalued to bring them to their current value at that date.

NOTES TO THE ACCOUNTS

15. Property, plant and equipment (continued)

Group

15.2 Property, plant and equipment at the previous balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2021	1,813	106,610	7,587	6,082	50,207	251	14,432	3,708	190,690
Additions - purchased	-	-	-	12,574	1,166	-	-	-	13,740
Additions - donated	-	351	-	-	289	-	7	38	685
Impairments	-	(456)	-	-	(18)	-	-	-	(474)
Reclassifications	-	5,373	-	(12,649)	5,209	33	1,877	157	-
Revaluation	588	4,831	351	-	-	-	-	-	5,770
Disposals	-	-	-	-	(8,323)	(174)	(2,965)	(534)	(11,996)
At 31 March 2022	**2,401**	**116,709**	**7,938**	**6,007**	**48,530**	**110**	**13,351**	**3,369**	**198,415**
Accumulated depreciation									
At 1 April 2021	-	-	-	-	29,190	202	9,495	2,593	41,480
Provided during the period	-	4,362	219	-	4,077	11	1,762	282	10,713
Revaluation	-	(4,271)	(219)	-	-	-	-	-	(4,490)
Impairments	-	129	-	-	(129)	-	-	-	-
Disposals	-	-	-	-	(8,040)	(174)	(2,965)	(528)	(11,707)
Accumulated depreciation at 31 March 2022	**-**	**220**	**-**	**-**	**25,098**	**39**	**8,292**	**2,347**	**35,996**
Net book value at 31 March 2021									
Owned	1,813	85,874	7,587	6,082	20,005	49	3,869	1,115	126,394
Finance leased	-	-	-	-	143	-	1,068	-	1,211
On-SoFP PFI	-	20,736	-	-	-	-	-	-	20,736
Donated	-	-	-	-	869	-	-	-	869
Total at 31 March 2021	**1,813**	**106,610**	**7,587**	**6,082**	**21,017**	**49**	**4,937**	**1,115**	**149,210**
Net book value at 31 March 2022									
Owned	2,401	94,593	7,938	6,007	21,592	71	4,379	1,022	138,003
Finance leased	-	-	-	-	1,286	-	680	-	1,966
On-SoFP PFI	-	21,896	-	-	-	-	-	-	21,896
Donated	-	-	-	-	554	-	-	-	554
Total at 31 March 2022	**2,401**	**116,489**	**7,938**	**6,007**	**23,432**	**71**	**5,059**	**1,022**	**162,419**

On 31 March 2022 Gerald Eve LLP reviewed the Trust's land, buildings and dwellings on a Modern Equivalent Asset basis in accordance with the guidance included in the Royal Institution of Chartered Surveyors Valuation Standards. As a result, these assets were revalued to bring them to their current value at that date.

NOTES TO THE ACCOUNTS

15. Property, plant and equipment (continued)

Trust

15.3 Property, Plant and equipment at the balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2022	1,460	116,709	6,941	6,007	44,677	110	13,351	3,369	192,624
Reclassification of existing finance leased assets to right of use assets at 1 April 2022	-	-	-	-	(228)	-	(1,943)	-	(2,171)
Transfers by absorption	-	-	-	-	(952)	-	(206)	-	(1,158)
Additions - purchased	-	-	-	20,267	-	-	-	-	20,267
Additions - donated	-	-	-	-	2,492	-	-	-	2,492
Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	3,284	8	(9,713)	2,847	-	3,490	84	-
Revaluation	-	4,252	42	-	-	-	-	-	4,294
Transfer to assets held for sale	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(2,073)	-	-	-	(2,073)
At 31 March 2023	**1,460**	**124,245**	**6,991**	**16,561**	**46,763**	**110**	**14,692**	**3,453**	**214,275**
Accumulated depreciation									
At 1 April 2022	-	220	-	-	23,204	39	8,292	2,347	34,102
Reclassification of existing finance leased assets to right of use assets at 1 April 2022	-	-	-	-	(108)	-	(1,263)	-	(1,371)
Transfers by absorption	-	-	-	-	(637)	-	(197)	-	(834)
Provided during the period	-	4,224	211	-	3,670	11	1,427	240	9,783
Revaluation	-	(4,444)	(211)	-	-	-	-	-	(4,655)
Impairments	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(2,083)	-	-	-	(2,083)
Accumulated depreciation at 31 March 2023	**-**	**-**	**-**	**-**	**24,046**	**50**	**8,259**	**2,587**	**34,942**
Net book value at 31 March 2022									
Owned	1,460	89,049	6,941	6,007	18,792	71	4,358	804	127,482
Finance leased	-	-	-	-	120	-	680	-	800
On balance sheet PFI	-	21,896	-	-	-	-	-	-	21,896
Donated	-	5,544	-	-	2,571	-	21	218	8,354
Total at 31 March 2022	**1,460**	**116,489**	**6,941**	**6,007**	**21,483**	**71**	**5,059**	**1,022**	**158,532**
Net book value at 31 March 2023									
Owned	1,460	95,360	6,991	16,561	22,717	60	6,433	866	150,448
Finance leased	-	-	-	-	-	-	-	-	-
On-SoFP PFI	-	23,165	-	-	-	-	-	-	23,165
Donated	-	5,720	-	-	-	-	-	-	5,720
Total at 31 March 2023	**1,460**	**124,245**	**6,991**	**16,561**	**22,717**	**60**	**6,433**	**866**	**179,333**

On 31 March 2023 Gerald Eve LLP revalued the Trust's land, buildings and dwellings on a Modern Equivalent Asset basis in accordance with the guidance included in the Royal Institution of Chartered Surveyors Valuation Standards. As a result, these assets were revalued to bring them to their current value at that date.

NOTES TO THE ACCOUNTS

15. Property, plant and equipment (continued)

Trust

15.4 Property, plant and equipment at the previous balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2021	1,010	106,610	6,647	6,082	46,732	251	14,432	3,708	185,472
Additions - purchased	-	-	-	12,125	-	-	-	-	12,125
Additions - donated	-	351	-	-	289	-	7	38	685
Impairments	-	(456)	-	-	(18)	-	-	-	(474)
Reclassifications	-	5,373	-	(12,200)	4,760	33	1,877	157	-
Revaluation	450	4,831	294	-	-	-	-	-	5,575
Disposals	-	-	-	-	(7,076)	(174)	(2,965)	(534)	(10,749)
At 31 March 2022	**1,460**	**116,709**	**6,941**	**6,007**	**44,687**	**110**	**13,351**	**3,369**	**192,634**
Accumulated depreciation									
At 1 April 2021	-	-	-	-	26,236	202	9,495	2,593	38,526
Provided during the period	-	4,362	196	-	3,900	11	1,762	282	10,513
Revaluation	-	(4,271)	(196)	-	-	-	-	-	(4,467)
Impairments	-	129	-	-	(129)	-	-	-	-
Disposals	-	-	-	-	(6,803)	(174)	(2,965)	(528)	(10,470)
Accumulated depreciation at 31 March 2022	**-**	**220**	**-**	**-**	**23,204**	**39**	**8,292**	**2,347**	**34,102**
Net book value at 31 March 2021									
Owned	1,010	80,588	6,647	6,082	17,245	49	3,851	868	116,340
Finance leased	-	-	-	-	143	-	1,068	-	1,211
On-SoFP PFI	-	20,736	-	-	-	-	-	-	20,736
Donated	-	5,286	-	-	3,118	-	18	247	8,669
Total at 31 March 2021	**1,010**	**106,610**	**6,647**	**6,082**	**20,506**	**49**	**4,937**	**1,115**	**146,956**
Net book value at 31 March 2022									
Owned	1,460	89,049	6,941	6,007	18,792	71	4,358	804	127,482
Finance leased	-	-	-	-	120	-	680	-	800
On-SoFP PFI	-	21,896	-	-	-	-	-	-	21,896
Donated	-	5,544	-	-	2,571	-	21	218	8,354
Total at 31 March 2022	**1,460**	**116,489**	**6,941**	**6,007**	**21,483**	**71**	**5,059**	**1,022**	**158,532**

On 31 March 2022 Gerald Eve LLP reviewed the Trust's land, buildings and dwellings on a Modern Equivalent Asset basis in accordance with the guidance included in the Royal Institution of Chartered Surveyors Valuation Standards. As a result, these assets were revalued to bring them to their current value at that date.

NOTES TO THE ACCOUNTS

16. Leases - Salisbury NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust leases rooms in medical centres/ practices to provide outreach clinics closer to the population it serves, vehicles for staff visiting these sites as well as patients in their own homes, commercial vehicles for site management, a computer server environment and medical equipment provided as part of managed service agreements. The subsidiary company, Salisbury Trading Limited, is purchasing through a leasing arrangement new laundry equipment as well as the hire of commercial premises for production and storage of laundered items and vehicles for delivery.

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis.

16.1 Right of use assets - 2022/23

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total	Of which:leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation							
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	-	1,782	-	1,943	-	3,725	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	947	1,166	390	-	-	2,503	-
Transfers by absorption	-	-	-	-	-	-	-
Additions - leases	120	17	602	-	-	739	-
Additions - peppercorn leases	-	932	-	-	-	932	-
Remeasurements of the lease liability	-	-	-	-	-	-	-
Movements in provisions for restoration / removal costs	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-
At 31 March 2023	**1,067**	**3,897**	**992**	**1,943**	**-**	**7,899**	**-**
Accumulated depreciation							
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	-	108	-	1,263	-	1,371	-
IFRS 16 implementation - adjustments for existing subleases	-	-	-	-	-	-	-
Transfers by absorption	-	-	-	-	-	-	-
Provided during the year	301	745	288	389	-	1,723	-
Impairments	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2023	**301**	**853**	**288**	**1,652**	**-**	**3,094**	**-**
Net book value at 31 March 2023	**766**	**3,044**	**704**	**291**	**-**	**4,805**	**-**

NOTES TO THE ACCOUNTS

16. Leases - Salisbury NHS Foundation Trust as a lessee (continued)

16.2 Right of use assets - 2022/23

Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total	Of which:leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation							
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	-	228	-	1,943	-	2,171	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	475	1,158	129	-	-	1,762	-
Transfers by absorption	-	-	-	-	-	-	-
Additions - leases	120	17	9	-	-	146	-
Additions - peppercorn leases	-	932	-	-	-	932	-
Remeasurements of the lease liability	-	-	-	-	-	-	-
Movements in provisions for restoration / removal costs	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-
At 31 March 2023	**595**	**2,335**	**138**	**1,943**	**-**	**5,011**	**-**
Accumulated depreciation							
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	-	108	-	1,263	-	1,371	-
IFRS 16 implementation - adjustments for existing subleases	-	-	-	-	-	-	-
Transfers by absorption	-	-	-	-	-	-	-
Provided during the year	88	522	54	389	-	1,053	-
Impairments	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2023	**88**	**630**	**54**	**1,652**	**-**	**2,424**	**-**
Net book value at 31 March 2023	**507**	**1,705**	**84**	**291**	**-**	**2,587**	**-**

NOTES TO THE ACCOUNTS

16. Leases - Salisbury NHS Foundation Trust as a lessee (continued)

16.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 23.

	Group 2022/23 £'000	Trust 2022/23 £'000
Carrying value at 31 March 2022	**1,457**	**291**
IFRS 16 implementation - adjustments for existing operating leases	1,347	613
Transfers by absorption	-	-
Lease additions	739	145
Lease liability remeasurements	-	-
Interest charge arising in year	64	5
Early terminations	-	-
Lease payments (cash outflows)	(1,094)	(446)
Other changes	-	-
Carrying value at 31 March 2023	**2,513**	**608**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

16.4 Maturity analysis of future lease payments at 31 March 2023

	Group 31 March 2023 £000	Trust 31 March 2023 £000
Undiscounted future lease payments payable in:		
- not later than one year;	728	138
- later than one year and not later than five years;	1,538	221
- later than five years.	508	297
Total gross future lease payments	**2,774**	**656**
Finance charges allocated to future periods	(261)	(48)
Net lease liabilities at 31 March 2023	**2,513**	**608**
Of which:		
- Leased from other NHS providers	-	-
- Leased from other DHSC group bodies	-	-

16.5 Maturity analysis of finance lease liabilities at 31 March 2022 (IAS 17 basis)

The following table details the maturity of obligations under leases the trust previously determined to be finance leases under IAS 17 at 31 March 2022.

	Group 31 March 2022 £000	Trust 31 March 2022 £000
Undiscounted future lease payments payable in:		
- not later than one year;	502	306
- later than one year and not later than five years;	1,172	-
- later than five years.	-	-
Total gross future lease payments	**1,674**	**306**
Finance charges allocated to future periods	(217)	(15)
Net finance lease liabilities at 31 March 2022	1,457	291
of which payable:		
- not later than one year;	458	291
- later than one year and not later than five years;	999	-
- later than five years.	-	-

NOTES TO THE ACCOUNTS

16. Leases - Salisbury NHS Foundation Trust as a lessee (continued)

16.6 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the trust previously determined to be operating leases under IAS 17.

	Group 2021/22 £000	Trust 2021/22 £000
Operating lease expense		
Minimum lease payments	94	108
Contingent rents	-	-
Less sublease payments received	-	-
Total	94	108

	Group 31 March 2022 £000	Trust 31 March 2022 £000
Future minimum lease payments due:		
- not later than one year;	28	52
- later than one year and not later than five years;	27	26
- later than five years.	-	-
Total	55	78
Future minimum sublease payments to be received	-	

16.7 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 1.15

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

	Group 1 April 2022 £000	Trust 1 April 2022 £000
Operating lease commitments under IAS 17 at 31 March 2022	**55**	**78**
Impact of discounting at the incremental borrowing rate	-	-
IAS 17 operating lease commitment discounted at incremental borrowing rate	**55**	**78**
adjustments:		
Adjustments for contracts reassessed for being or containing a lease on transition to IFRS 16.	1,292	535
Finance lease liabilities under IAS 17 as at 31 March 2022	1,457	291
Total lease liabilities under IFRS 16 as at 1 April 2022	**2,804**	**904**

17. Investments

Non-current	Group		Trust	
	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
Carrying value at 1 April	**8,225**	7,893	-	-
Additions	**3,160**	7,415	500	-
Fair value (losses)/ gains taken to I & E	**(300)**	438	-	-
Fair value movements taken to OCI	**-**	-	-	-
Disposals	**(2,840)**	(7,521)	-	-
Carrying value at 31 March	**8,245**	8,225	**500**	-
Current				
Financial assets designated at amortised cost	**123**	337	**-**	-

NOTES TO THE ACCOUNTS

17. Investments (continued)

Non-current investments represents an investment portfolio managed by HSBC Private Bank (UK) Limited on behalf of the charitable fund.

Current asset investments are the cash balances held by HSBC Private Bank (UK) Limited on behalf of the charitable fund and represents dividend income, interest income and the proceeds of fixed asset investment disposals which have not yet been reinvested.

During 2022-23 a loan of £500k previously provided to Salisbury Trading Limited by the Trust was converted into Salisbury Trading Limited ordinary shares, see also note 18.

Fair value measurement of investments
Financial assets and financial liabilities measured at fair value in the Statement of Financial Position are grouped into three levels of a fair value hierarchy. The three levels are defined based on the observability of significant inputs to the measurement, as follows:

Level 1: quoted prices (unadjusted) in active markets for identical assets or liabilities
Level 2: inputs other than quoted prices included in level 1 that are observable for the asset or liability, either directly or indirectly
Level 3: unobservable inputs for the asset or liability

The investments in the group financial statements are all level 1 investments and are measured at quoted prices at the date of the Statement of Financial Position.

18. Other financial assets

Non-current	**Group**		**Trust**	
	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
Carrying value at 1 April	**2,497**	2,395	**4,006**	4,551
Loans provided in year	**-**	-		306
Transfer (to)/ from current assets	**-**	-	**1,286**	(913)
Amortisation at the effective interest rate	**161**	102	**161**	102
Loan converted to share capital			**(500)**	-
Repayments in year	**-**	-	**(1,053)**	(40)
Carrying value at 31 March	**2,658**	2,497	**3,900**	4,006
Current				
Carrying value at 1 April	**-**	-	**1,940**	1,027
Transfer from/ (to) non-current assets	**-**	-	**(1,286)**	913
Loans	**-**	-	**-**	-
Carrying value at 31 March	**-**	-	**654**	1,940

NOTES TO THE ACCOUNTS

18. Other financial assets (continued)

Current other financial assets represent loans made to:
a) Salisbury Trading Limited to purchase laundry equipment and laundry stocks from Salisbury NHS Foundation Trust on the commencement of the subsidiary business due in less than one year; and
b) Salisbury Trading Limited to purchase laundry stocks following the successful tender to acquire new business.
c) Odstock Medical Limited to assist with working capital requirements

Non-current other financial assets represent loans made to:
a) Salisbury Trading Limited to purchase laundry equipment and laundry stocks from Salisbury NHS Foundation Trust on the commencement of the subsidiary business due after more than one year: and
b) Sterile Supplies Limited to re-develop a new production facility with a third party.
c) Odstock Medical Limited to assist with working capital requirements

Details of the loans to Salisbury Trading Limited are as follows:
1. £1.3m to purchase the laundry stock.
2. £2.0m to purchase the laundry equipment.
3. £0.5m to purchase laundry stocks.
4. £0.7m to purchase laundry stock.
5. £0.5m to purchase laundry stock to assist with the Covid 19 pandemic.

The first four of the loans with an outstanding balance of £2.682m at 31 March 2022 were amalgamated into one loan during the year. This loan will be repaid over the next five years culminating in the final repayment on 1 April 2026.

The remaining fifth loan of £0.5m at 31 March 2022 was converted into ordinary shares in Salisbury Trading Limited during 2022-23.

Details of the loan to Sterile Supplies Limited is as follows:
In March 2016 the Trust made a loan to its then wholly owned subsidiary company, Sterile Supplies Limited. The intention was for this sum to be used to help finance a joint venture arrangement with a third party, which will deliver cost savings into the future. Until the joint venture agreement was finalised and formal agreement signed, the loan remained repayable on demand.

During 2016-17 Sterile Supplies Limited became the joint venture vehicle between the Trust and a third party, Steris Plc (Registered in Ireland (formerly Synergy Health Plc)). As part of the joint venture agreement the Trust ceded control of Sterile Supplies Limited and the loan agreement was formalised as long term.

The long term loan of £2.0m is to assist the development of a new production facility. Loan repayments will commence when the building becomes operational. Interest is payable at 4% above the Bank of England base rate and is capitalised and added to the principal sum.

Details of the loan to Odstock Medical Limited is as follows:
During 2021-22 the Trust made a loan to its wholly owned subsidiary company, Odstock Medical Limited, to assist with its working capital requirements. The loan repayments commenced in November 2021. Interest is payable at 3.5% above the Bank of England base rate and is capitalised and added to the principal sum.

NOTES TO THE ACCOUNTS

19. Inventories

	Group		Trust	
	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
Drugs	**1,933**	1,395	**1,933**	1,395
Consumables	**3,784**	4,554	**3,784**	4,554
Laundry	**1,857**	1,628	**-**	-
Other	**381**	362	**381**	362
	7,955	7,939	**6,098**	6,311
Inventories recognised as an expense in the period	**60,007**	54,095	**58,814**	52,697

In response to the Covid pandemic, The Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During the year the Trust received £619k (2021/22: £883k) items free of charge.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

20. Receivables

20.1 Amounts falling due after more than one year:

	Group		Trust	
	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
Clinician pension tax provision reimbursement funding from NHSE	**402**	656	**402**	656
	402	656	**402**	656
Of which receivables from NHS and DHSC group	**402**	656	**402**	656

20.2 Amounts falling due within one year:

	Group		Trust	
	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
Contract receivables	**20,619**	11,079	**18,409**	9,900
Allowance for impaired contract receivables / assets	**(1,270)**	(954)	**(1,270)**	(954)
Prepayments (non-PFI)	**2,880**	2,930	**2,928**	2,930
PDC dividend receivable	**57**	31	**57**	31
VAT receivable	**1,136**	950	**1,136**	950
Clinician pension tax provision reimbursement funding from NHSE	**16**	9	**16**	9
Other receivables	**169**	166	**169**	237
	23,607	14,211	**21,445**	13,103
Of which receivables from NHS and DHSC group	**11,315**	3,464	**11,315**	3,464

NOTES TO THE ACCOUNTS

20. Receivables (continued)

The majority of transactions are with Integrated Care Boards (ICBs) or NHS England's Specialist Commissioners, as commissioners for NHS patient care services. As ICBs and Specialist Commissioners are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

The average credit period taken on sale of goods is 24 days (2022: 17 days). No interest is charged on trade receivables.

20.3 Allowance for credit losses

Group and Trust

	31 March 2023 receivables and contract assets £000	**All other receivables £000**	31 March 2022 receivables and contract assets £000	All other receivables £000
Allowance for credit losses at 1 April - brought forward	**954**	**-**	1,351	-
New allowances arising	**342**	**-**	15	-
Utilisation of allowances (write offs)	**(26)**	**-**	(412)	-
Balance at 31 March	**1,270**	**-**	954	-

An allowance for impairment is made where there is an identifiable event which, based on previous experience, is evidence that the monies will not be recovered in full.

21. Cash and cash equivalents

	Group		**Trust**	
	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
Balance at beginning of year	**39,306**	31,169	**30,819**	22,309
Net change in year	**(6,127)**	8,137	**(3,364)**	8,510
Balance at end of year	**33,179**	39,306	**27,455**	30,819
Made up of:				
Cash with Government Banking Service	**27,240**	30,791	**27,240**	30,791
Cash at commercial banks and in hand	**5,939**	8,515	**215**	28
Cash and cash equivalents as in balance sheet	**33,179**	39,306	**27,455**	30,819
Bank overdrafts	**-**	-	**-**	-
Cash and cash equivalents as in cash flow statement	**33,179**	39,306	**27,455**	30,819

NOTES TO THE ACCOUNTS

22. Trade and other payables

	Group		Trust	
	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
Amounts falling due within one year:				
Trade payables	**28,342**	18,942	**25,902**	17,614
Capital payable	**5,455**	9,289	**5,455**	9,289
Accruals and deferred income	**2,357**	2,514	**2,357**	2,514
Receipts in advance	**1,456**	2,140	**1,456**	2,140
Social security and other taxes payable	**4,559**	4,115	**4,559**	4,115
PDC dividend payable	**-**	-	**-**	-
Pay creditor re: agenda for change pay offer	**7,101**	-	**7,101**	-
Pay and pensions related	**5,280**	5,449	**5,280**	5,449
Other	**2,118**	3,622	**2,148**	3,634
	56,668	46,071	**54,258**	44,755
Of which payables from NHS and DHSC group bodies:	**3,731**	2,845	**3,731**	2,845

Included in 'Other' payables is £1.1m (2022: £1.2m) potential exposure following change in Vat guidance, £Nil (2022: £0.9m) funds due as an agent on an education training contract, £Nil (2022: £0.3m) Public Dividend capital repayable.

All Trade and other payables are current liabilities.

23. Borrowings

Group	Current		Non-current	
	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
Lease liabilities *	**660**	458	**1,853**	999
Amounts due under PFI (note 29.7)	**699**	612	**14,865**	15,564
Loans from Department of Health and Social Care (DHSC)	**641**	644	**950**	1,582
	2,000	1,714	**17,668**	18,145

Trust	Current		Non-current	
	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
Lease liabilities *	**148**	290	**460**	-
Amounts due under PFI (note 29.7)	**699**	612	**14,865**	15,564
Loans from Department of Health and Social Care (DHSC)	**641**	644	**950**	1,582
	1,488	1,546	**16,275**	17,146

* The Trust has applied IFRS 16 to lease arrangements within these accounts from 1 April 2022 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in note 16.

The capital loan from the Department of Health and Social Care is unsecured and for a 10 year period, repayable in equal instalments commencing on 18 May 2016. Interest is payable on the loan at a rate of 1.64% pa.

NOTES TO THE ACCOUNTS

23. Borrowings (continued)

23.1 Reconciliation of liabilities arising from financing activities (Group)

Group - 2022/23	Loans from DHSC £000	Other loans £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2022	**2,226**	**-**	**1,457**	**16,176**	**19,859**
Cash movements:					
Financing cash flows - payments and receipts of principal	(631)	-	(1,030)	(612)	**(2,273)**
Financing cash flows - payments of interest	(34)	-	(64)	(1,061)	**(1,159)**
Non-cash movements:					
IFRS 16 implementation - adjustments for existing operating leases / subleases	-	-	1,347	-	**1,347**
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	739	-	**739**
Lease liability remeasurements	-	-	-	-	**-**
Application of effective interest rate	30	-	64	1,061	**1,155**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Early terminations	-	-	-	-	**-**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2023	**1,591**	**-**	**2,513**	**15,564**	**19,668**

Group - 2021/22	Loans from DHSC £000	Other loans £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2021	**2,861**	**-**	**726**	**16,701**	**20,288**
Cash movements:					
Financing cash flows - payments and receipts of principal	(631)	-	(435)	(525)	**(1,591)**
Financing cash flows - payments of interest	(44)	-	(20)	(1,098)	**(1,162)**
Non-cash movements:					
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	1,166	-	**1,166**
Application of effective interest rate	40	-	20	1,098	**1,158**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Early terminations	-	-	-	-	**-**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2022	**2,226**	**-**	**1,457**	**16,176**	**19,859**

NOTES TO THE ACCOUNTS

23. Borrowings (continued)

23.2 Reconciliation of liabilities arising from financing activities (Trust)

Trust - 2022/23	Loans from DHSC £000	Other loans £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2022	**2,226**	**-**	**291**	**16,176**	**18,693**
Cash movements:					
Financing cash flows - payments and receipts of principal	(631)	-	(441)	(612)	**(1,684)**
Financing cash flows - payments of interest	(34)	-	(5)	(1,061)	**(1,100)**
Non-cash movements:					
IFRS 16 implementation - adjustments for existing operating leases / subleases	-	-	613	-	**613**
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	145	-	**145**
Lease liability remeasurements	-	-	-	-	**-**
Application of effective interest rate	30	-	5	1,061	**1,096**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Early terminations	-	-	-	-	**-**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2023	**1,591**	**-**	**608**	**15,564**	**17,763**

Trust - 2021/22	Loans from DHSC £000	Other loans £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2021	**2,861**	**-**	**726**	**16,701**	**20,288**
Cash movements:					
Financing cash flows - payments and receipts of principal	(631)	-	(435)	(525)	**(1,591)**
Financing cash flows - payments of interest	(44)	-	(20)	(1,098)	**(1,162)**
Non-cash movements:					
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	-	-	**-**
Application of effective interest rate	40	-	20	1,098	**1,158**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Early terminations	-	-	-	-	**-**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2022	**2,226**	**-**	**291**	**16,176**	**18,693**

NOTES TO THE ACCOUNTS

24. Provisions for liabilities and charges

Group and Trust	Current		Non-current	
	31 March 2023	31 March 2022	**31 March 2023**	31 March 2022
	£000	£000	**£000**	£000
Pensions - early departure costs	**14**	13	**26**	25
Pensions - injury benefits	**25**	24	**166**	214
Legal claims	**375**	973	**-**	-
Clinician pension tax reimbursement	**16**	9	**402**	656
Other	**45**	215	**-**	-
	475	1,234	**594**	895

	Pensions - Early departure costs	Pensions - Injury benefits	Legal claims	Clinician pension tax	Other	**Total**
	£000	£000	£000	£000	£000	**£000**
At 1 April 2022	38	238	973	665	215	**2,129**
Change in the discount rate	-	(27)	-	(368)	-	**(395)**
Arising during the year	16	6	182	133	-	**337**
Utilised during the year	(14)	(24)	(35)	(20)	-	**(93)**
Reversed unused	-	-	(745)	-	(170)	**(915)**
Unwinding of discount	-	(2)	-	8	-	**6**
At 31 March 2023	**40**	**191**	**375**	**418**	**45**	**1,069**
Expected timing of cash flows:						
Within 1 year	14	25	375	16	45	**475**
1 - 5 years	26	88	-	19	-	**133**
5+ years	-	78	-	383	-	**461**
	40	**191**	**375**	**418**	**45**	**1,069**

	Pensions - Early departure costs	Pensions - Injury benefits	Legal claims	Clinician pension tax	Other	**Total**
	£000	£000	£000	£000	£000	**£000**
At 1 April 2021	32	259	453	762	721	**2,227**
Change in the discount rate	-	4	-	-	-	**4**
Arising during the year	20	1	528	-	-	**549**
Utilised during the year	(14)	(24)	(8)	-	-	**(46)**
Reversed unused	-	-	-	(97)	(506)	**(603)**
Unwinding of discount	-	(2)	-	-	-	**(2)**
At 31 March 2022	**38**	**238**	**973**	**665**	**215**	**2,129**
Expected timing of cash flows:						
Within 1 year	13	24	973	9	215	**1,234**
1 - 5 years	5	96	-	6	-	**107**
5+ years	20	118	-	650	-	**788**
	38	**238**	**973**	**665**	**215**	**2,129**

Pension provisions arise from early retirements which do not result from ill health. These liabilities are not funded by the NHS Pension Scheme.

Legal claims relate to the Trust's provision for personal injury and employee claims. These are based on valuation reports provided by the Trust's legal advisers.

NOTES TO THE ACCOUNTS

24. Provisions for liabilities and charges (continued)

Clinician pension tax reimbursement provision arises in respect of clinicians who are members of the NHS Pension Scheme, and who as a result of work undertaken, face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold. Government policy is that the Trust will reimburse the NHS Pension Scheme on the retirement of the clinician in exchange for the Scheme paying the additional tax due.

Other provisions relate to an additional tax liability following revised guidance by HMRC.

£88.1 m is included in the provisions of NHS Resolution at 31 March 2023 in respect of clinical negligence liabilities of the Trust (2022: £122.9 m).

25. Capital and other commitments

Capital commitments - Group and Trust

Commitments under capital expenditure contracts at the balance sheet date were £4.3 m (2022:£1.7 m).

26. Contingent liabilities

The Trust has agreed in principle to underwrite any loans to its subsidiary company, Odstock Medical Limited, up to a value of £0.5m.

27. Related Party Transactions

Salisbury NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The Department of Health and Social Care is regarded as a related party. During the year ended 31 March 2023 the Foundation Trust has had a significant number of material transactions with other entities for which the Department is regarded as the parent. These entities include Clinical Commissioning Groups, NHS England, Health Education England, NHS Resolution and other Trusts and Foundation Trusts.

Salisbury NHS Foundation Trust also has transactions with its subsidiary companies, joint ventures and charitable funds (for which it is the Corporate Trustee) These are listed below:

	Income £000	Expenditure £000	Receivables £000	Payables £000
Year ending 31 March 2023				
Salisbury Trading Limited	**206**	**997**	**1,081**	**128**
Odstock Medical Limited	**214**	**-**	**63**	**1**
Salisbury District Hospital Charitable Fund	**1,089**	**39**	**470**	**-**
Sterile Supplies Limited	**263**	**2,123**	**1**	**222**
Wiltshire Health and Care LLP	**591**	**224**	**140**	**24**
Locums Nest Limited	**-**	**64**	**-**	**-**
Year ending 31 March 2022				
Salisbury Trading Limited	261	817	239	59
Odstock Medical Limited	214	-	78	1
Salisbury District Hospital Charitable Fund	724	42	543	-
Sterile Supplies Limited	1,178	1,988	243	199
Wiltshire Health and Care LLP	616	269	64	21

During the period none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Salisbury NHS Foundation Trust.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies.

NOTES TO THE ACCOUNTS

28. Private Finance Initiative Schemes (PFI)

28.1 PFI schemes deemed to be on-Statement of Financial Position

Contract start date: 3 March 2004
Contract end date: 31 January 2036
The PFI scheme provides modern clinical buildings for patient services
At the end of the contract term the hospital buildings revert back to the Trust for
There were no changes to the terms and conditions of the PFI agreement

Terms of the Arrangement - the unitary payment is comprised of two elements, an Availability fee which is fixed for the duration of the contract and a service fee which is subject to indexation based upon 'the Retail Prices Index (RPI) All items'. At the end of the project term the Agreement will terminate with no compensation payable. In the event of re-financing of the PFI the Trust is entitled to receive half of the re-financing cash flow benefits.

28.2 PFI scheme - Charge to operating expense in Statement of Comprehensive Income

	Group and Trust	
	2023	2022
	£000	£000
Amounts included within operating expenses in respect of the 'service' element of PFI schemes deemed to be on-Statement of Financial Position	**1,166**	1,114
Depreciation of PFI asset	**638**	594
Net charge to operating expenses	**1,804**	1,708

28.3 PFI scheme - Analysis of amounts payable to service concession operator

	Group and Trust	
	2023	2022
	£000	£000
Interest	**1,061**	1,098
Repayment of finance lease liability	**612**	526
Service element	**1,166**	1,114
Capital lifecycle maintenance	**425**	440
Contingent rent	**1,065**	846
Unitary payment payable to service concession operator	**4,329**	4,024

28.4 Annual commitments under Private Finance Transactions - On Statement of Financial Position

The Trust is committed to make the following service payments on the PFI:	**2023**	2022
	£000	£000
Due within one year	**1,290**	1,166
Due within 2 to 5 years	**5,406**	4,794
Due after 5 years	**10,994**	11,190
	17,690	17,150

The annual charge will be indexed each year. Indexation will be increased in line with the Retail Price Index.

Imputed finance lease obligations comprise:	**Minimum lease payments**		**Present value of minimum lease payments**	
	2023	2022	**2023**	2022
	£000	£000	**£000**	£000
Rentals due within one year	**1,718**	1,673	**699**	612
Rentals due within 2 to 5 years	**6,976**	6,936	**3,413**	3,159
Rentals due thereafter	**15,002**	16,761	**11,452**	12,405
	23,696	25,370	**15,564**	16,176
Less: interest element	**(8,132)**	(9,194)		
Total	**15,564**	16,176		

NOTES TO THE ACCOUNTS

28. Private Finance Initiative Schemes (PFI) (continued)

28.5 Total future payments committed in respect of PFI

	2023	2022
	£000	£000
Total	**73,244**	70,510
of which due:		
Within one year	**4,910**	4,329
Within 2 to 5 years	**20,900**	18,424
Due thereafter	**47,434**	47,757
Total	**73,244**	70,510

29. Financial instruments

IFRS 7 and IFRS 9 require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The main source of income for the Group is under contracts from commissioners in respect of healthcare services. Due to the way that the Commissioners are financed, the Group is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Group in undertaking its activities.

29.1 Currency risk

The Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Group has no overseas operations although the charity holds a small number of investments denominated in United States dollars and Euros, these are immaterial and, as a result, the Group has low exposure to currency fluctuations.

29.2 Liquidity risk

The NHS Foundation Trust's net operating costs are incurred under contracts with commissioners, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government. Salisbury NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

29.3 Interest-rate risk

The Group's financial liabilities carry either nil or fixed rates of interest. The Group is not exposed to significant interest-rate risk.

29.4 Liquidity and interest risk tables

The interest rate profile of the non-derivative financial liabilities of the Group, their contractual maturity profile and their weighted average effective interest rates are as follows:

As at 31 March 2023

	Weighted average effective interest rate	Less than one month	1-3 months	3 months to 1 year	1-2 years	2-5 years	over 5 years	Discount	**Total**
	%	£000	£000	£000	£000	£000	£000	£000	**£000**
Fixed rate									
Finance lease obligations	**3.4 - 5.1**	**61**	**121**	**546**	**385**	**1,153**	**508**	**(261)**	**2,513**
PFI obligations	**6.5**	**139**	**278**	**1,301**	**1,718**	**5,258**	**15,002**	**(8,132)**	**15,564**
DHSC capital loan	**1.64**	**-**	**328**	**326**	**644**	**322**	**-**	**(29)**	**1,591**
Floating rate									
Trade and other payables	**-**	**36,154**	**-**	**-**	**-**	**-**	**-**	**-**	**36,154**

As at 31 March 2022

	Weighted average effective interest rate	Less than one month	1-3 months	3 months to 1 year	1-2 years	2-5 years	over 5 years	Discount	**Total**
	%	£000	£000	£000	£000	£000	£000	£000	**£000**
Fixed rate									
Finance lease obligations	3.4 - 5.1	16	33	453	195	586	391	(217)	1,457
PFI obligations	6.5	139	278	1,256	1,718	5,218	16,761	(9,194)	16,176
DHSC capital loan	1.64	-	334	331	655	966	-	(73)	2,213
Floating rate									
Trade and other payables	-	30,745	-	-	-	-	-	-	30,745

NOTES TO THE ACCOUNTS

29. Financial instruments (continued)

29.5 Credit risk

As the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk, the maximum exposures at 31 March 2023 are in receivables from customers, as disclosed in note 20.

29.6 Carrying values of financial assets

Group	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2023				
Trade and other receivables excluding non financial assets	**19,745**	**-**	-	**19,745**
Other investments / financial assets	**2,658**	**-**	-	**2,658**
Cash and cash equivalents	**28,891**	**-**	-	**28,891**
Consolidated NHS Charitable fund financial assets	**4,602**	**8,245**	**-**	**12,847**
Total at 31 March 2023	**55,896**	**8,245**	**-**	**64,141**

Group	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2022				
Trade and other receivables excluding non financial assets	10,557	-	-	10,557
Other investments / financial assets	2,497	-	-	2,497
Cash and cash equivalents	33,448	-	-	33,448
Consolidated NHS Charitable fund financial assets	6,197	8,225	-	14,422
Total at 31 March 2022	52,699	8,225	-	60,924

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2023				
Trade and other receivables excluding non financial assets	**17,324**	-	-	**17,324**
Other investments / financial assets	**5,354**	-	-	**5,354**
Cash and cash equivalents	**27,455**	-	-	**27,455**
Total at 31 March 2023	**50,133**	**-**	**-**	**50,133**

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2022				
Trade and other receivables excluding non financial assets	9,848	-	-	9,848
Other investments / financial assets	6,192	-	-	6,192
Cash and cash equivalents	30,819	-	-	30,819
Total at 31 March 2022	46,859	-	-	46,859

NOTES TO THE ACCOUNTS

29. Financial Instruments (continued)

29.7 Carrying values of financial liabilities

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2023			
Loans from the Department of Health and Social Care	**1,591**	**-**	**1,591**
Obligations under leases	**2,513**	**-**	**2,513**
Obligations under PFI, LIFT and other service concession contracts	**15,564**	**-**	**15,564**
Trade and other payables excluding non financial liabilities	**50,605**	**-**	**50,605**
Provisions under contract	**903**	**-**	**903**
Total at 31 March 2023	**71,176**	**-**	**71,176**

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2022			
Loans from the Department of Health and Social Care	2,226	-	2,226
Obligations under finance leases	1,457	-	1,457
Obligations under PFI, LIFT and other service concession contracts	16,176	-	16,176
Trade and other payables excluding non financial liabilities	39,486	-	39,486
Provisions under contract	1,820	-	1,820
Total at 31 March 2022	61,165	-	61,165

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2023			
Loans from the Department of Health and Social Care	**1,591**	**-**	**1,591**
Obligations under finance leases	**608**	**-**	**608**
Obligations under PFI, LIFT and other service concession contracts	**15,564**	**-**	**15,564**
Trade and other payables excluding non financial liabilities	**48,243**	**-**	**48,243**
Provisions under contract	**903**	**-**	**903**
Total at 31 March 2023	**66,909**	**-**	**66,909**

Unless otherwise stated above, carrying value is considered to be a reasonable approximation of fair value.

NOTES TO THE ACCOUNTS

29. Financial Instruments (continued)

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2022			
Loans from the Department of Health and Social Care	2,226	-	2,226
Obligations under finance leases	291	-	291
Obligations under PFI, LIFT and other service concession contracts	16,176	-	16,176
Trade and other payables excluding non financial liabilities	38,217	-	38,217
Provisions under contract	1,820	-	1,820
Total at 31 March 2022	58,730	-	58,730

Maturity of financial liabilities - undiscounted future cash flows

	Group		Trust	
	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
In one year or less	**54,784**	43,251	**52,421**	42,262
In more than one year but not more than five years	**9,613**	9,836	**9,613**	9,836
In more than five years	**15,971**	17,549	**15,971**	17,549
Total	**80,368**	70,636	**78,005**	69,647

30. Third Party Assets

The Trust held £nil cash at bank and in hand at 31 March 2023 (2022: £0.5k) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

31. Investment in subsidiary

31.1 Odstock Medical Limited

Salisbury NHS Foundation Trust established, following Department of Health approval, a subsidiary company, Odstock Medical Limited (registered in England), to market and develop a technology created at Salisbury District Hospital. The technology assists patients to obtain increased mobility following illnesses which reduce their muscular co-ordination. The company was established in August 2005 and commenced trading on 1 April 2006. Salisbury NHS Foundation Trust owns 70% of Odstock Medical Limited.

Shares at cost	**Trust 2023 £'000**	Trust 2022 £'000
At 31 March	**-**	**-**

The Trust established the company and received an interest in the company equal to the fair value of assets on its formation.

In 2021/22 the Trust charged the goodwill on the purchase of shares from former employees of the subsidiary to expenditure.

The Trust's charity, Salisbury District Hospital Charitable Fund, owns a further 18% of Odstock Medical Limited.

NOTES TO THE ACCOUNTS

31. Investment in subsidiary (continued)

31.2 Salisbury Trading Limited

Salisbury NHS Foundation Trust established a subsidiary company, Salisbury Trading Limited (registered in England), to market and deliver laundry and linen services. The company commenced trading on 1 October 2013. Salisbury NHS Foundation Trust owns 100% of Salisbury Trading Limited. The company has experienced steady growth since commencing to trade by winning new linen contracts. It has increased operational capacity through arrangements involving the management of another NHS laundry facility, which will provide an additional base for future expansion.

	2023	2022
Shares at cost	**£000**	£000
At 31 March 2023 and 31 March 2022	**500**	**-**

No goodwill arose in respect of the subsidiary as the reporting Trust established the company and received an interest in the company equal to the fair value of assets on its formation.

During 2022-23 a loan of £500k previously provided to Salisbury Trading Limited by the Trust was converted into Salisbury Trading Limited ordinary shares, see also notes 17. and 18.

32. Investment in Joint Ventures

32.1 Sterile Supplies Limited

Salisbury NHS Foundation Trust owns 50% of the issued share capital of Sterile Supplies Limited, the remaining 50% is owned by Steris Plc (Registered in Ireland (formerly Synergy Health Plc)). The Board structure and voting rights are such that the Trust is not able to exert overall control of Sterile Supplies Limited, the Trust therefore recognises the company as a joint venture. The joint venture is re-developing a new production facility, from which it will market and deliver sterilisation services. The Joint Venture currently trades from the Trust's existing sterilisation and Disinfection Unit.

Group and Trust	**2023**	2022
	£000	£000
Carrying value of investment at 1 April	**86**	68
Share of profit/ (loss) in the period	**51**	18
Carrying value of investment at 31 March	**137**	**86**

32.2 Wiltshire Health and Care

The Trust is a one third partner in Wiltshire Health and Care LLP. The other equal partners being Royal United Hospitals Bath NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust. Wiltshire Health and Care is focused solely on delivering improved community services in Wiltshire and enabling people to live independent and fulfilling lives for as long as possible.

Salisbury NHS Foundation Trust has not invested any capital sum in this partnership.

Group and Trust	**2023**	2022
	£000	£000
Carrying value of investment at 1 April	**160**	113
Share of surplus in the period	**3**	47
Carrying value of investment at 31 March	**163**	**160**

NOTES TO THE ACCOUNTS

33. Movements on Public Dividend Capital

Group and Trust	2023	2022
	£000	£000
Public Dividend Capital at 1 April	**94,826**	90,997
New public dividend capital received	**4,774**	4,112
Public dividend capital repaid	**-**	(283)
Public Dividend Capital at 31 March	**99,600**	94,826

The new public dividend capital received in the year relates to additional funding to purchase capital items of £4,774k (2022: £3,829k).

34. Charitable fund balances

Group only	2023	2022
	£000	£000
Restricted funds	**4,162**	6,217
Unrestricted funds	**10,000**	10,000
Endowment funds	**-**	9
	14,162	16,226

Restricted funds are funds that are to be used in accordance with specific restrictions imposed by the donor, or where the donor has restricted the use of their donation to a specified ward, patients', nurses' or project fund. Where the restriction requires the gift to be invested to produce income but the trustees have the power to spend the capital, it is classed as expendable endowment.

Unrestricted income funds comprise those funds that the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include general funds, where the donor has not specified or restricted the use the Charity may make of their donation. General funds additionally generate income from Gift Aid, investment income, interest and donations given specifically to cover running costs.

During 2022-23 the Charity Trustees performed a review of funds resulting in endowment funds being converted into distributable funds..

35. Critical accounting judgements

The Trust has made no critical judgements in the application of the accounting policies set out on pages 5 to 21.

36. Critical accounting estimates

In the application of the Trust's accounting policies, the Trust has made estimates and assumptions in a number of areas, as the actual value is not known with certainty at the Statement of Financial Position date. By definition, these estimations are subject to some degree of uncertainty; however in each case the Foundation Trust has taken all reasonable steps to assure itself that these items do not create a significant risk of material uncertainty. Key areas of estimation include:

- The valuation of the Trust's estate of land and buildings was carried out on 31 March 2023 by Gerald Eve, Chartered Surveyors. Gerald Eve valued the land and buildings (including dwellings) at £134.6m, of which £125.8m relates to specialised assets valued on a depreciated replacement cost basis.

  It is the rebuilding cost values determined by the valuer using industry standard rates that gives rise to the uncertainty in the valuation.

  A 10% change in the valuation would have £13.5m impact on the statement of financial position with a £451k impact on the PDC dividend due to be paid next year and accrued in these financial statements.

NOTES TO THE ACCOUNTS

37. Reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time the establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend..

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Group and the Trust.

Minority interest
Minority interest relates to the ownership stake in the subsidiary companies which is under 50% of the total shares in terms of voting rights and hence doesn't exercise control of the company.

38. Transfers by absorption

During 2022-23 the Genetics service provided by the Trust was transferred to University Hospital Southampton Foundation Trust. This included the transfer of equipment with a net book value of £329k. This was transferred by absorption in accordance with DHSC GAM, with no payment received, resulting in a loss on disposal.

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.3
Date of meeting:	7 September 2023		

Report title:	Board and Committee Effectiveness Annual Report			
Status:	Information	Discussion	Assurance	Approval
			x	
Approval Process: (where has this paper been reviewed and approved):	Committee effectiveness is reviewed at each Board Committee			
Prepared by:	Kylie Nye, Head of Corporate Governance			
Executive Sponsor: (presenting)	Kylie Nye, Head of Corporate Governance			
Appendices:	• F&P Committee Effectiveness Report 2022/23 • CGC Committee Effectiveness Report 2022/23 • People and Culture Committee Effectiveness 2022/23			

Recommendation:

For the Trust Board to note and support the process and outcome for the annual review of Board and Committee Effectiveness.

Executive Summary:

The Trust Board Committees, as part of their annual Committee business cycle, undertake a self-assessment of their own effectiveness. These reviews have been completed over the last few months. Due to a change in chair in early 2023, the Audit Committee and Charitable Funds Committee have not yet completed a committee effectiveness report during 2023. However, these committees have been observed as part of the well-led review and the annual effectiveness reviews are scheduled in to align with the other committees for 2023/24. The reports appended to this paper conclude that the committees are meeting the requirements as set out in their terms of reference.

All Committee Terms of Reference have been reviewed and agreed at Trust Board in 2023 as part of the revised Integrated Governance Framework.

The Board has utliised several methods to review and improve effectiveness in the last year. This includes:

- Participating in Board Seminar sessions including, Equality, Diversity and inclusion, Health Inequalities, and strategy.
- Participating in sessions in relation to the Trust's "Improving Together" programme to learn and understand how to support the organisation in developing and sustaining a culture of continuous improvement.
- The executive team have participated in focused development sessions with an external provider to develop individual and group executive leadership skills.

- In addition to this, each executive and non-executive director completes an annual appraisal which focuses on individual performance. The executive appraisals are reviewed at the Remuneration Committee and the non-executive appraisals reviewed and discussed at the governor Performance Committee.
- The Trust commissioned an external well-led developmental review, led by Aqua, which was procured jointly alongside Royal United Hospitals Bath NHS Foundation Trust (RUH) and Great Western Hospital NHS Foundation Trust (GWH). The review was undertaken between April-June 2023 with the outcome report received in August. The outcome report has been shared with Board colleagues and an additional session will be scheduled to work through the recommendations.

In summary, no significant concerns have arisen from the review of Board and Board Committee effectiveness, although areas of improvement taken from the well-led review will be discussed and focused work on agreed improvements will be taken forward.

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

Appendix A

Annual Review of Finance and Performance (F&P) Committee
April 2022 – March 2023

1. Introduction

The purpose of this report is to formally report on the work of the F&P Committee during 2022/23 and to indicate the key priorities for 2023/24 and beyond.

The Finance and Performance Committee is a formal sub-committee of the Board and therefore chaired by a Non-Executive Director. The role of Chair changed twice during the financial year due to the substantive committee Chair moving to a new role and the lead in time for recruitment of a new committee Chair. The new substantive Chair commenced in January 2023.

The Committee is an assurance committee to enable a greater insight into the Trust's performance in terms of performance and financial outcomes. In doing so, it may request additional management information on specific areas as well as providing knowledge to the Board on those areas if it is considered they may impact the delivery of the Trust's strategic objectives.

2. Work undertaken in 2022/23

The Committee has ensured that it has given significant focus to each of the areas of finance and operational performance over the year. The Committee operates under a standard agenda which is structured in line with the Board Assurance Framework (BAF). The BAF was revised in July 2022 in line with the approval of the Trusts new Strategy, which outline 3 strategic priorities and the Finance and Performance Committee focuses on the financial aspects of each:

- Population
- People
- Partnerships

Despite the ongoing Covid-19 pandemic the Finance & Performance Committee on 12 occasions during the year and returned to meeting mostly face to face. Whilst the work and priorities of the Committee in 2022/23 continued to reflect the challenges of the ongoing pandemic and the need to recover services, there was also a strong focus on getting back to gaining assurance on core business.

Monthly / quarterly reports covered the following issues:

- Oversight of (a) the how the Trust met the Covid-19 challenge and (b) how the Trust has tried to minimise and mitigate the impact that Covid-19 has had on non-Covid-19 services (see below)
- Operational performance of the Trust, including reporting on key service targets and issues e.g., 18-week RTT, 52 week Elective and Cancer Waiting Times, A&E 4 hour waits, NCTR (including South Newton mitigation), Diagnostics, aseptic services, spinal services noting the successful removal of 104 week waits and introduction of the new 28 day standard
- Improvements in the estates function with an emphasis on risk and safety management

- Deep dives and service reviews looking into key areas of where performance needed to improve e.g. cancer, theatres, coding, stroke and diagnostics
- Financial performance of the Trust, including cash, balance sheet and capital programme
- Re-establishment of the Contractual and funding issues with the Trust's key commissioners from April 2022
- Further development of system working since the establishment of the ICB in July 2022 and the implications in relation to finance and performance from a system perspective.
- Service Transformation, which in 2021/22 was re-focused through the Trust Improving Together programme, now in the 12-18 months phase of the programme.
- Board Assurance Framework and risk registers
- Digital risks and progress including SIRO.
- Resilience and continuity planning e.g., Winter Plan for 2022/23 and ongoing Covid-19 / winter respiratory pandemic and industrial action response planning.
- Planning process for 2023/24 and beyond
- Review of key business cases
- Salisbury Hospital Strategic Campus Development programme, including TIF funded new ward development.

The Committee undertook its role by receiving and questioning papers and presentations; discussion of key issues; seeking of assurance; making suggestions and recommendations where appropriate; and drawing significant issues to the attention of the Board of Directors.

The 3 Chairs of the Committee has been involved in setting the agenda with the Chief Finance and Chief Operating Officers. The minutes of the meeting are reported to the subsequent Board meeting for information, with highlights and issues for escalation presented by the Chair.

Committee membership attendance at Finance & Performance Committee meetings April 2021 to March 2022.

It was positive to note that all meetings were quorate. There was 13 meetings April 2022 – March 2023, including an extraordinary meeting to discuss the operational and financial plan.

Member	Designation	Meetings attended (based on membership tenure)
Eiri Jones (Interim Chair July to December)	Non-Executive Director	13/13*
Stacey Hunter	Chief Executive	12/13*
Lisa Thomas	Chief Finance Officer (to August 2022) Chief Operating Officer (August 2022)	13/13*
Mark Ellis	Chief Finance Officer (from August 2022)	9/9*
Melanie Whitfield	Chief People Officer	12/13*

Debbie Beaven (Commenced 1 Jan 2023)	Chair	3/3*
Richard Holmes (Commenced 1 Jan 2023)	Non-Executive Director	2/3*
Andy Hyett (left August 2022)	Chief Operating Officer	2/4
Paul Kemp (Left 31st Jan 2023)	Non-Executive Director	9/10
Paul Miller (Left June 22)	Chair	2 /4

* Subject to attendance on 28th March 2023.

3. Work Plan for 2023/24

The Committee's overarching objective is to continue to improve understanding of the financial and operational performance control processes of the Trust to provide assurance to the Board. In particular it will focus on the following key areas and enablers;

- A key priority for next year is to ensure the Trust delivers its operational and financial plan for 2023/24, with a focus on recovering financial and operational performance back to pre-Covid-19 levels and beyond. Key to achieving this is a determination and focus on operational and cost efficiencies as well as reducing bed numbers by reduction of NCTR and length of stay. The Committee will want clarity and regular updates on target reductions, CIPs and progress being made.
- Another key priority is to work both internally and externally with ICS partners to develop an agreed financial recovery plan to achieve future financial sustainability. Given the size of our 2023/24 financial challenge (planned £25.3m deficit, of which some is structural) it is expected that financial recovery will take a number of years to achieve and will require the "system" to tackle social care provision and other interventions. The Committee will be supported by regular updates in these respects from those interacting and negotiating with the system.
- Delivery of the transformation programme (supported culturally by Improving Together) is an essential driver in the recovery process. The transformation programme must align with both the short-term operational priorities, as well as our long-term strategic ambitions with the Committee having oversight of the programme timescales, investments, deliverables, and benefits throughout all phases of the programmes.
- Continual improvements to our approach and methodology of capital and revenue planning and forecasting, working with the ICS to agree a long-term system capital programme that provide operational and financial Value for Money.
- Assessment of risks outside of tolerance, considering the mitigations and timescales back to tolerance.
- Support the ongoing development Salisbury Hospital Strategic Campus Development programme.
- Ensure the Trust continues to implement its approved digital strategy and an effective operational digital delivery service.
- Raising financial awareness throughout the Trust and empower staff to reduce waste and improve financial and performance outcomes as a result of improved processes and education.
- Assessment of financial risks in delivering financial plans agreed with the ICB and the mitigations.
- Working with our system partners to ensure the Trusts 2023/24 operational and strategic ICS plans help the Trust achieve long term sustainability.

4. Terms of Reference

The Terms of Reference have been revised as part of the annual update of the Integrated Governance Framework which was presented to and approved by the Board in April 2022. The Terms of Reference will need to be revised to reflect the changing meeting cycle planned for 2023-4.

5. Conclusion

Notwithstanding the very significant ongoing challenges of Covid-19 during the second year of the pandemic, the Committee is functioning effectively and meeting its objectives.

However, despite this assurance role being effectively undertaken, there is a reality that continuing pressures which include the ongoing impact of the pandemic, other winter viruses, no criteria to reside (NCTR) patients, industrial action and workforce pressures, add to the challenge of returning the Trusts performance; operational, clinical and financial to pre-covid levels and beyond, which has delayed the timescales to achieve financial sustainability, although not dampened the determination.

Salisbury NHS Foundation Trust

Appendix B

SALISBURY NHS FOUNDATION TRUST
ANNUAL SELF ASSESSMENT OF THE EFFECTIVENESS OF THE CLINICAL GOVERNANCE COMMITTEE 2022 - 2023

1.0 Introduction

The purpose of this review is to provide assurance to the Trust Board and the Council of Governors that the Clinical Governance Committee (CGC) is complying with its duties as set out in the terms of reference in the Integrated Governance Framework 2022 and to indicate the priorities for 2023/24. The period covers the last 12 meetings from April 2022 to March 2023 and is set out in accordance with the annual review of committee guidance.

2.0 Background

The Integrated Governance Framework 2022 makes it clear that clinical governance is the responsibility of the Trust Board. This is supported by the Clinical Governance Committee which is a formal sub-committee chaired by a Non-Executive Director. The Clinical Governance Committee is responsible for gaining assurance that there is a focus on continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

The terms of reference outlines that the CGC has the power to act on behalf of the Trust Board. Its purpose is to assure the Trust Board that high quality care is provided to patients throughout the Trust. The principal function is to provide assurance to the Board on:

- Patient safety
- Clinical effectiveness
- Patient experience
- Service improvement and transformation

3.0 Conduct of business

The Committee has ensured that it has focussed on each of the areas of quality over the year. The Committee operates under a standard agenda which is structured in line with safe, effective and experience domains. It is aligned with the Board Assurance Framework revised in June 2022.

Despite the ongoing operational pressures (Covid-19 pandemic, winter viruses, workforce challenges and industrial action) the Committee met (mostly face to face) on 12 occasions during the year. Whilst the work and priorities of the Committee continued as outlined in the workplan for 2022/23, to reflect the ongoing and changing demands of operational pressures, the Committee's work also reflected the routine consideration of monthly or periodic reports in the following areas:

- Clinical Strategy (with a system view)
- Impact and management of Covid-19 and other pressures
- Quality performance of the Trust (Integrated Performance Report covering safety, effectiveness and experience)
- Presentations and deep dives and performance reviews in key areas such as Emergency Department, Safety workstreams, Maternity, Stroke, Spinal services, Vaccinations, Oral health, Monkey Pox, Consent, Electronic Discharge Summaries, impact of diagnostics performance on quality, PSIRF, respiratory illnesses and areas of harm such as serious incidents and falls / pressure ulcers
- Board Assurance Framework and Risk Registers

- Mortality and Learning from Deaths
- Safeguarding Adults and Children
- Patient Experience and feedback
- Clinical Effectiveness, research, and audit activity
- Meeting national standards and expectations e.g., Cancer standards, GIRFT, Model Hospital, NICE guidance, End of Life care
- Mental Health and Learning Disability workstreams.
- Transformation, quality improvement (QI) and innovation (Improving Together)
- Commencement of Divisional quality reports
- Upward Report from Clinical Management Board

The Committee undertook its role by:

- receiving and questioning papers and presentations.
- discussing key issues;
- seeking assurance;
- making suggestions and recommendations; and
- drawing significant issues to the attention of the Board of Directors.

The Chair of the Committee has been involved in setting the agenda with the Chief Nurse and Chief Medical Officer and on occasion with the Director of Integrated Governance in a monthly meeting. The minutes of the meeting are reported to the subsequent Board meeting for information, with highlights and issues for escalation presented by the Chair.

3.1 Membership and attendance

The Committee consists of:

- Three Non-Executive Directors
- Medical Director and Director of Nursing
- Chief Operating Officer

In attendance:

Regular / occasional attendees included:

- the Chief Executive Officer;
- a Registered Nurse representative; and
- key members of the Chief Nurse and Chief Medical Officer teams.
- Director of Integrated Governance

In addition, there has been regular attendance by Governors as observers of the committee.

3.2 Quorum

All meetings were quorate between April 2022 and February 2023

Member	**Designation**	**Meetings attended** (based on membership tenure)
Eiri Jones	Chairman	11/11

David Buckle	Non-Executive Director	10/11
Paul Miller	Non-Executive Director	2/3
Debbie Beaven	Non-Executive Director	2/2
Stacey Hunter	Chief Executive	9/11
Judy Dyos	Chief Nursing Officer	7/11
Peter Collins	Chief Medical Officer	11/11
Andy Hyett	Chief Operating Officer	3/4
Lisa Thomas	Chief Operating Officer	6/7

3.3 Administration

In 2022/23, the PA to the Director of Nursing and Medical Director acted as the Secretary to the Committee, supporting the administration of the Committee and produced the minutes and action tracker alongside collating papers for each meeting. During change in staff in this role, other members of the corporate team have provided support.

3.4 Frequency

Meetings were held twelve times during the year.

3.5 Notice of meetings

The agenda and call for papers were sent to each member of the Committee two weeks before and supporting papers sent out one week before the meeting. Due to operational pressures, on occasion, permission was sought and received from the Chair for late submission of some papers. Some topics were also moved to later meeting dates to ensure that the right information could be provided with the required attendees.

4.0 Duties of the Committee

4.1 Developments and review

- **Agree the annual quality plan (quality account priorities) and monitor progress**

The Clinical Governance Committee agreed the quality account priorities and reviewed progress against these. The report for 2022-23 was approved for submission to the Board.

- **Extend the Boards monitoring and scrutiny of the standards of quality, compliance and performance of Trust services.**

Each of the Board assurance committees are required to report performance within their scope of responsibility. The Clinical Governance Committee reviewed an integrated performance report on quality and care at each meeting and escalated risks and mitigation to the Board. In turn, the Board monitored overall performance through escalation reports and the integrated performance report which triangulates information on quality, performance, workforce and finance.

- **Make recommendations to the Board on opportunities for improvement in the quality of services.**

The following key items were escalated to the Board in 2022/23:

- Safer Surgery (also reviewed by Audit Committee)
- Safer staffing and the impact of workforce shortages on care
- Ongoing impact of Covid 19, winter viruses, workforce challenges and industrial action on quality of care
- Maternity services, including Ockenden and Maternity Incentive Scheme
- Spinal services
- Stroke services
- Mortality and Learning from Deaths
- Infection Prevention and Control and housekeeping services
- GIRFT
- Medicines safety and management and aseptic services
- End of Life care
- Human Tissue Authority assurance
- Quality Account
- Clinical Audits, NICE guidance
- NatSS atSSips and LocSSips (safer systems work)
- Pressure Ulcers and Falls
- Management of Serious Incidents and harms
- Patient experience including national surveys
- Safeguarding children and adults
- Mental Health partnership working, Dementia care and Learning Disability developments
- Child and Adolescent Mental Health challenges
- Any other gaps in assurance

- **Support and encourage quality improvement where opportunities are identified**

Information in relation to the establishment and embedding of the Improving Together programme was reported to the committee. A focus on Falls as a breakthrough objective was given.

Ongoing work linked to improvement programmes in both maternity and spinal services were presented to the committee.

- **Working in conjunction with the Audit Committee, Workforce Committee and Finance and Performance Committee, cross referencing data and ensuring alignment of the Board assurances derived from the activities of each committee.**

The Board Assurance Framework document is presented in totality every quarter to facilitate assessment of risks. Escalation reports are provided from each Committee to the Board on a monthly basis. Where required, the Committee felt able to refer matters to other Committees. A focus on requests from the audit committee continued in this year.

- **Review the Trust's annual quality report prior to submission to the Trust Board of Directors for approval.**

At the time of this report, the quality report (quality account) for 2022-23 is development and is scheduled into the 2023-24 workplan as per national requirements.

- **Monitor the status of the Trusts' quality objectives as set out in the annual plan.**

Quality objectives were reported to the committee in regular reports as part of the annual workplan.

- **Review the quality indicator report (forming part of the Integrated Performance report) prior to inclusion in the Trust Integrated Performance Report**

The quality indicator report was discussed at each Clinical Governance Committee as part of the IPR, triangulating with the discussions held at the Finance and Performance Committee.

- **Consider relevant regional and national benchmarking statistics when assessing the performance of the Trust.**

The following reports provided national benchmark data compared with the Trust's performance:

- Infection prevention and control compared with Public Health England data.
- Bi-annual national clinical audit reports compared with national average/median.
- Mortality compared to regional peer group.
- GIRFT programme compared with national average/median.
- Research activity compared with regional network and national standards.
- National patient surveys benchmarked with national data.

- **Review quality impact assessment reviews for significant cost improvement schemes and their potential impact on quality, patient experience and patient safety.**

The Clinical Executives lead the process for QIAs. The committee agreed that these should be considered for any change which could impact on quality.

- **Provide oversight of relevant internal audit recommendations as directed by the Audit Committee**

The Divisional Governance arrangements were discussed and reviewed as part of the internal audit programme. A focus on requests from the audit committee continued in this year.

4.2 Review of Trust activity in assigned areas

The assigned areas reviewed are outlined in section 4.1 above.

5.0 Review

5.1 The terms of reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as set out in the terms of reference and report any conclusions and recommendations for change to the Board.

The Terms of Reference were revised (minor amendments) as part of the annual update of the Integrated Governance Framework. The CGC reviewed the ToRs in March 2022 and this was upwardly reported to Board in April 2022. They will be reviewed further for the start of 2023-24.

5.2 As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.

The annual workplan was reviewed in year and each agenda planned to align with the current Trust priorities. Each meeting has had a full agenda using up the time allocated. The Committee has had the full support of the Board with items of escalation. The Committee will continually formally review its effectiveness towards the end of each financial year.

6.0 Priorities 2023/24

High priority areas 2022/24:

The CGC will focus on:

- Safety
- Patient Safety Incident Response Framework (PSIRF)
- Learning Disability and Mental Health provision in acute care
- Reduction of harms e.g., Falls as part of Improving Together programme.
- Maternity improvement programme
- Areas outlined in the quality account.
- Enhanced system working to support high quality care.

7.0 Summary

Despite the very significant ongoing challenges of Covid-19 pandemic, winter viruses, workforce challenges and industrial action during the financial year 2022-23, the Clinical Governance Committee is functioning effectively and meeting its objectives. However, despite this assurance role being effectively undertaken, some key quality challenges have continued during this year.

The report is presented for assurance that the Clinical Governance Committee is complying with its duties as set out in the terms of reference.

Eiri Jones
Chair Clinical Governance Committee
March 2023

Agreed at the Clinical Governance Committee on 28th March 2023

Appendix C

Annual Review of People and Culture Committee
April 2022 – March 2023

5. Introduction.

5.1. Purpose

The purpose of this committee is to ensure that the Trust has a workforce strategy in place that recognises the importance of all of the people who work within the Trust and that will enable it to recruit and retain sufficient numbers of people with the necessary skills, training and motivation to deliver the Trust's clinical objectives. This is an assurance committee but inevitably, because of the strength of interest and opinion in this subject, conversations often stray into the operational and tactical domains. While strictly the preserve of executive committees and the OD&P committee, these conversations often provide a useful sense check on the views and concerns of our executive colleagues. The terms of reference were recently reviewed and it was agreed that more prominence should be given to the factors that impact on the overall culture of the Trust, in particular understanding and improving the experience and wellbeing of staff from a wide range of backgrounds and recognising and dealing with behaviours that undermine it.

6. Work undertaken in 2022/23.

6.1. This has been a year of considerable challenge and transformation. The relatively new Chief People Officer was faced with the task of restructuring her team while re-writing the Trust's People Plan to align with the central direction of the NHS People Plan and the People Promise. The assessment at the start of the year had been that the old HR directorate was no longer adequately resourced or configured for the delivery of business support across the whole life cycle of our staff. Restructuring and recruitment took up the whole of 2022 and was successfully completed by Christmas, in tandem with publication of a refreshed People Plan for the Trust. The translation of this into a series of taut and measurable objectives continues, but the work of the directorate has focussed appropriately on the recruitment and retention of staff and their overall wellbeing, with the aim of delivering on the promise of making Salisbury NHS FT the place where they will want to work and develop their careers. This has been condensed into a series of measures that monitor staff availability, taking into account agency spend, recruitment and retention.

6.2. The agenda of the committee is set by the need to review and approve a large number of statutory and advisory annual and quarterly reports, to confirm that things that must be done are completed in a timely and satisfactory way. In addition, risks and issues highlighted in the Board Assurance Framework are reviewed and actions to mitigate and manage are scrutinised. New risks are identified and escalated, and overall staff shortages have been a significant risk throughout the period. In the course of the year particular concern has centred on rising turnover and staff sickness, not all of which can be explained by the hangover of the pandemic. The requirement to open a large number of escalation beds, many to accommodate patients who would ordinarily have been discharged, has resulted in a growing bill for agency staff and has impacted on the morale of staff who may be moved at short notice to cover gaps in the workforce. Some of this dissatisfaction was reflected in the Annual Staff Survey, but it has been agreed that more focused and timely interventions are required to monitor the experience and motivation of our staff, and to understand why so many choose to leave the Trust. A focus for the committee over the next year will be to assist in developing and monitoring sources of feedback that will deliver a more granular view of workforce behaviours across the whole of the lifecycle, from attraction, recruitment, development, retention and through to departure. Incremental improvements in delivery of the ESR and manager self-service will assist in achieving this, but the pressure online managers is acute and the committee recognises that these pressures must ease if improvement is to be sustained. On the plus side, recruitment has been excellent in the face of strong headwinds.

6.3. Good progress has been made against the recommendations of three internal audit reports: on EDI (an action plan has been agreed and is being implemented); on Workforce Planning (including work to invigorate strategic planning, reconciling establishment and staff numbers through the implementation of ESR, greater visibility of staff availability, and roll out of e-rostering); on Absence Management (introduction of simplified procedures and training of line managers to understand and manage absence and RtW in line with policies). This has all contributed to the transformation of the HR function into a directorate with a stronger and more effective focus on OD&P.

7. Committee attendance at People and Culture Committee April 2020 to March 2021

Committee Members	Attendance
Michael von Bertele (Chair)	7//8
Melanie Whitfield (Chief People Officer)	8/8
Judy Dyos (Chief Nurse Officer)	6/8
Rakhee Aggarwal (Non-Executive Director)	7/8
Peter Collins (Chief Medical Officer)	7/8
Mark Ellis (Chief Finance Officer) (Joined Committee Feb 2023)	1/1
Esther Provins (left Aug 2022)	2/3

8. Terms of Reference

The Terms of Reference have been revised as part of the annual update of the Integrated Governance Framework that will be presented and approved by the Board in April/May 2023. The Terms of Reference are on March's People and Culture Committee agenda for approval prior to ratification at Board.

9. Conclusion

This has been a year of considerable challenge and change within the Trust but the restructuring of the OD&P directorate under a new CPO and the publishing of a new People Plan has put in place the conditions for sustained improvement over the course of the next year.