Bundle Trust Board Public 4 March 2021

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates

Presented by Nick Marsden

1.2 10:10 - Staff Story (combined patient/staff story)

1.3 Welcome and Apologies

Apologies received from Michael von Bertele

1.4 Declaration of Interests/Fit and Proper/Good Character

1.5 10:25 - Minutes of the previous meeting

Minutes attached from meeting held on 14 January 2021
For approval

1.5 Draft Public Board mins 14 January 2021.docx

1.6 10:30 - Matters Arising and Action Log

1.6 Public Trust Board action log.pdf

1.7 10:35 - Chairman's Business

Presented by Nick Marsden
For information

1.8 10:40 - Chief Executive Report

Presented by Stacey Hunter
For information

1.8a CEO Board Report March.docx

1.8b nhs-providers-on-the-day-briefing-legislating-for-integrated-care-system....pdf

1.9 10:50 - Trust Board Cycle of Business

Presented by Fiona McNeight
For approval

1.9a Trust Board Annual Cycle of Business 2021 22.docx

1.9b DRAFT Public Trust Board Annual Business Cycle 2021-22.xlsx

1.9c DRAFT Private Trust Board Annual Business Cycle 2021-22.xlsx

2 ASSURANCE AND COMMITTEE REPORTS

2.1 10:55 - Clinical Governance Committee - 23 February

Presented by Eiri Jones
For approval

2.1 Escalation report - from February CGC to March Board 2021.docx

2.2 11:00 - Finance and Performance Committee - 23 February

Presented by Paul Miller
For assurance

2.2 Board - Finance and Performance Committee escalation paper 23rd February 2021.docx

2.3 11:05 - Trust Management Committee - 24 February

Presented by Stacey Hunter
For assurance

2.3 TMC Escalation report.docx

2.4 11:10 - People and Culture Committee - 25 February

Presented by Nick Marsden
For assurance

2.4 P&C Escalation report - Feb 2021.docx

2.5 11:15 - Integrated Performance Report (M10)

Presented by Peter Collins
For assurance

2.5a 040321 IPR cover Board.docx

2.5b IPR March 2021 DRAFT (2) no benchmarking.pdf

2.6 11:30 - Covid Response

Presented by Andy Hyett
For assurance

2.6a 230221 Covid update Board cover.docx

2.6b 250221 SFT Covid-19 briefing Trust board.pdf

3 FINANCIAL AND OPERATIONAL PERFORMANCE

3.1 Operational Plan Update 2021/22 - deferred to April

4 PEOPLE AND CULTURE

4.1 11:35 - Best Place to Work - Update

Presented by Lynn Lane
For assurance

4.1a Board cover sheet BPTW_March 2021_v7.docx

4.1b BP2W March 21 Trust Board Report_v4.docx

4.2 11:45 - Nursing Skill Mix Review

Presented by Judy Dyos
For assurance

4.2a Board cover sheet Safer Staffing feb 2021.docx

4.2b Skill mix review Board Jan 2021 v1 (3).docx

5 CLOSING BUSINESS

5.1 11:55 - Agreement of Principle Actions and Items for Escalation

5.2 12:00 - Any Other Business

5.3 12:05 - Public Questions

5.4 Date next meeting

8th April 2021

6 Resolution

Resolution to exclude Representatives of the Media and Members of the Public from the Remainder of the Meeting (due to the confidential nature of the business to be transacted)

Salisbury NHS Foundation Trust

Minutes of the Public Trust Board meeting held at 10:00am on Thursday 14 January 2021 via MS Teams Salisbury NHS Foundation Trust

Present:

Nick Marsden (NM)	Chairman
Tania Baker (TB)	Non-Executive Director
Paul Kemp (PK)	Non-Executive Director
Paul Miller (PM)	Non-Executive Director
Eiri Jones (EJ)	Non-Executive Director
Rakhee Aggarwal (RA)	Non-Executive Director
David Buckle (DB)	Non-Executive Director
Michael von Bertele (MvB)	Non-Executive Director
Stacey Hunter (SH)	Chief Executive Officer
Lisa Thomas (LT)	Director of Finance
Lynn Lane (LL)	Director of OD and People
Judy Dyos (JDy)	Director of Nursing

In Attendance:

Kylie Nye (KN)	Corporate Governance Manager (minutes)
Fiona McNeight (FMc)	Director of Corporate Governance
Esther Provins (EP)	Director of Transformation
Sallie Davies (SD)	Deputy Medical Director
Rex Webb (RxW)	Equality and Diversity Lead
Helen Rynne (HR)	Patient Engagement Lead
Emma Halliwell (EH)	Foundation Programme Director/ Consultant Anaesthetist
John Mangan (JM)	Lead Governor (lead observer)
Jenny Lisle (JL)	Governor (observer)
Peter Kosminsky (PKo)	Governor (observer)
Lucinda Herklots (LH)	Governor (observer)
Kevin Arnold (KA)	Governor (observer)

ACTION

TB1 14/1/01 **OPENING BUSINESS**

TB1 14/1/1.1 **Presentation of SOX (Sharing Outstanding Excellence) Certificates**

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

- Julian Panainte and Jodie Saunders, Friendly SOX
- Urology Team, December SOX of the Month

NM congratulated the members of staff who had received a SOX award and the Board noted the great effort from staff during what has been a challenging time.

TB1 14/1/1.2 **Patient Story**

HR joined the meeting to present the patient story of a gentleman who was an inpatient on Chilmark Ward. The interview with the

patient was shared with the group. The patient provided good feedback about the treatment and care he had received but made comments relating to the noise on the ward and the effects it can have on someone staying in hospital.

Discussion:

- NM thanked HR for the story and noted that the Board normally focuses on the clinical care aspects of a patient pathway. However, there should also be a focus on the infrastructure that sits behind that work. NM noted that managing noise on wards will be important when developing the hospital site and should be taken into consideration.
- PK acknowledged the requirement to take these patient comments into account but suggested that the key action should be to manage patient expectations. HR explained that negative comments from the ward are collated and noise is a common theme. As a result work is already underway to manage this, e.g. patient information leaflets. Additionally, the ward is looking to start a service improvement project which is likely to be delayed due to Covid, but this will include issues like noise pollution on hospital wards.
- PM noted that this should remind the Board that sometimes the elements of care and patient experience that require further improvement relate the simple things, e.g. food noise, and friendliness. The focus should be explaining the elements of care that matter to people to people the most in a compassionate way.
- JDy explained that one of the issues on the more modern wards is balancing the Infection, Prevention and Control requirements and how this might affect patients on a spacious but echoey ward. One of the aspects of the service improvement project is to explore what else can be done.
- RA noted that sleep is important for recovery and for clinicians and nurses it is very easy to become 'noise blind' as the gentleman in the story described. RA noted it was good to hear further improvement work is planned.

TB1 14/1/1.3 **Welcome and Apologies**

NM welcomed everyone to the meeting and noted apologies from:

- Peter Collins, Medical Director
- Andy Hyett, Chief Operating Officer

TB1 14/1/1.4 **Declarations of Conflicts of Interest**

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

TB1 14/1/1.5 **Minutes of the part 1 (public) Trust Board meeting held on 5th November 2020**

NM presented the minutes and the following points were noted:

The minutes were agreed as an accurate record of the meeting held on 5th November 2020.

TB1 14/1/1.6 **Matters Arising and Action Log**

NM presented the action log and noted that all the actions were due in March at the next Public Board.

There were no further matters arising.

TB1 14/1/1.7 **Chairman's Business**

NM explained that at the last public Board in November the Trust was in a very different position with very low numbers of Covid-19 positive patients. The Trust is now under extreme pressure with more the largest number of Covid-19 positive inpatients since the pandemic started.

NM therefore note that SH would provide a more detailed summary of the key issues in her report.

TB1 14/1/1.8 **Chief Executive's Report**

S Hunter provided a presentation and noted that she would provide a summary of the following key issues; the Trust's position in relation to the national context, an update from a BSW (Bath and North East Somerset, Swindon and Wiltshire) and regional perspective, what is happening locally and a forward look at the key priorities in the next 4-6 weeks. SH highlighted the following key points:

- Now that the UK has exited the EU this has meant significant incident management arrangements to ensure the effective transition of goods and people which AH has been leading. Whilst there are no material issues to report the Finance and Performance Committee will continue to receive assurance by exception if any issues arise.
- The 2021/22 Operating Plan was shared on 23rd December 2020. There is recognition that it will be difficult for hospitals to provide an operational plan in Quarter 4 due to the focus on managing the pressures of Covid-19.
- The Trust will also be focussing on the next steps in relation to the NHS England/ Improvement consultation on Integrated Care and what that will mean in terms of next steps.
- There has been significant and sobering work in respect of the Ockenden Review. This is interim report from 250 families who had experienced significant harm as a result of maternity care. SH noted that this would be discussed in further detail by JDy during the meeting. .
- Covid -19 is now more prevalent than during the first wave in March 2020, with the new strain being 70% more transmissible. The south-west currently has the highest growth rate of Covid-19 and the Trust has treble the number

of patients experienced at the highest peak last year. It is acknowledged that behind these numbers there are people and families who are suffering. Additionally, there is a significant emotional burden to colleagues to manage the situation and therefore the Trust is also focusing on ensuring the health and wellbeing of staff and regularly communicating with them. The Trust is focused on sustaining emergency, urgent and cancer services and clinically urgent surgery.

- There has been progress in the vaccination effort and SH thanked Ian Robinson, Steve Bleakley and Fiona Hyett on their work to organise the vaccination site. The hospital vaccination hub has been open since 29th December and has great feedback so far with approximately 300 people per day from priority groups, including NHS staff, care home staff and people over 80. SH gave thanks to colleagues who are working tirelessly and changing their normal work to support. The Trust has over 200 members of staff off either due to Covid-19 or because they are isolating. SH also gave thanks to communities who are helping with the effort by sticking to the national lockdown rules. SH noted that communication with the Trust's local population is important and that is why she had sent an open letter earlier in the week.
- In relation to BSW and the confirmation of the Integrated Care System designation, SH thanked colleagues for their hard work to achieve this. SH noted that she had attached the Acute Hospital Alliance annual briefing for information.
- Looking to the next 4-6 weeks it is anticipated that the Trust is not yet at the peak of admissions which is likely to be in the next 1-2 weeks. The Trust will continue to do all it can to manage this whilst continuing the vaccination roll out and do everything possible to support and communicate to colleagues.

Discussion:

- EJ thanked the team for their continued work and referred to those staff who have been redeployed into different areas. EJ asked how the Trust is flexing certain staff members whilst maintaining staffing levels described in national guidance. SH explained that in in critical care the Trust is maintaining levels as per national guidance. The situation is currently challenging for staff and the Trust may need to take advantage of the upper end of revised levels of staffing should the position worsen.

  SH further explained that prior to Christmas JDy had worked with nursing teams and set out what each ward's green, amber and red staffing levels are. Red level staffing areas are utilised a lot of the time but SH assured the Board that the Trust is providing safe care. There have been occasions where the Trust has not been able to meet red staffing levels and this had led to asking registered nurses in non-ward related roles to dedicate 25% of their time into core ward areas and this has proved valuable. Non-clinical

colleagues have also been asked to volunteer to undertake ward-buddying and EP's team is managing this separately. PC has further led a piece of work with clinical directors in relation to how the Trust is utilising doctors to provide the necessary support. If the next stage of escalation does occur teams will look to senior clinician involvement for support.

Therapy teams have also stepped down non-essential work and are supplementing core ward teams. JDy noted that matrons and sisters are now included in numbers working on the wards and those who are redeployed to different work areas have been asked to note the tasks they are unable to do.

- PM noted that at previous meetings there have been details on the clinical interventions that have evolved since early stages of the pandemic. PM asked if these new interventions were practised in the Trust. SD confirmed that the Trust was up to date with national and NICE guidance in relation to the care and treatment of Covid-19 patients.

- NM thanked SH for the report and noted the clear actions and areas of focus for the next 4-6 weeks. NM extended his previous offer of any support from the Non-Executive Directors to the executive team during this challenging time.

TB1 14/1/2 ASSURANCE AND REPORTS OF COMMITTEES

TB1 14/1/2.1 Clinical Governance Committee – 22 December

E Jones presented the report, providing a summary of escalation points from the meeting held on 22nd December:

- There was recognition of the ongoing hard work of staff and JDy and PC's leadership of the clinical workforce in the current situation.
- The Committee flagged the Covid-19 outbreak which has largely worsened due to the increased transmissibility of a new strain.
- Despite the challenges of Covid, there was assurance that progress is being made on the Clinical Strategy and there was further assurance of areas of improvement in Gastroenterology and Cancer.
- There was a positive and detailed discussion on how the Trust cares for patients with mental health issues within acute care. It is hoped a piece of work on this will build the foundations for improvements whilst working in partnership across the system.
- EJ noted the positive discussions in relation to areas of transformation and GIRFT (Getting it Right First Time) were linked with the Clinical Strategy.
- The Ockenden Report and maternity services were discussed in detail and further reported on later in the

meeting.

There were no further questions and the report was noted.

TB1 14/1/2.2 **Finance and Performance Committee – 22 December 2020**

P Miller provided a summary of escalation points from the Finance and Performance Committee:

- PM asked the Board to note the key points of escalation highlighted in the report. PM explained that the Committee had received positive assurance there were escalation plans in place should there be a surge in Covid-19 and thanked colleagues for this work.

Discussion:

- EJ noted that F&P and CGC do triangulate the information in these meetings and this is very helpful and ensures complete oversight of quality and performance issues.

TB1 14/1/2.3 **Trust Management Committee – 16 December 2020**

S Hunter provided a summary of escalation points from the Trust Management Committee:

- SH asked the Board to note the key points of escalation highlighted in the report. Report of the work I relation to e-outcomes.
  SH explained that the Committee had previously requested an updated implementation plan for e-outcomes given that there are patient safety risks. The paper outlined 3 options and the Committee agreed to option 3; which achieves roll-out in 6-9 months and requires circa £39k investment.

The Board noted the report.

TB1 14/1/2.4 **Audit Committee – 17 December 2020**

PK provided a summary of escalation points from the Audit Committee held on 17th December. PK asked the Board to note the report but highlighted the following as an area of concern.

- In the counter fraud report the Committee heard of an incident involving a member of staff stealing drugs from Pharmacy. The reconciliation processes within pharmacy systems were not sufficiently robust to allow the theft of controlled drugs to be proven. In parallel with this investigation, it was noted that the annual PWC internal audit of key controls had also identified some potential weaknesses in pharmacy control processes. The Committee asked LT to circulate an update in January. LT explained that internal audit have been working on this and the Head of Pharmacy has been focussed on the

vaccination rollout. Therefore, progress will be reported in due course.

The Board noted the report.

TB1 14/1/2.5 **Charitable Funds Committee – 17 December**

NM presented the report and highlighted the following key points from the 17th December meeting:

- The Committee is now working in a much more structured way with processes much improved and a monthly process for charitable funding requests.
- The Committee approved a governance structure to continue the improvements in oversight and direction of the Stars Appeal, this includes additional resource to strengthen the management team and communications.

The report was noted.

TB1 14/1/2.6 **Integrated Performance Report**

L Thomas presented the Integrated Performance Report to the Board and noted that this report provided a summary of November's performance, which due to the continued impact of Covid-19 does not reflect the hospital's most recent status. The following key points were noted

- There was a second national lockdown. This saw a slight increase in elective and day case activity, although the Trust did not meet the trajectory levels submitted to NHS England and Improvement as part of the Phase 3 recovery plan.
- LT noted that an important focus should be what the other indicators/metrics are indicating In relation to harms due to the pressures of Covid-19, e.g. pressure ulcers/ falls etc.

Discussion:

- PM noted the importance of keeping up with treatment and care in relation to cancer and the 2 week wait target and focusing on ensuring the urgent and emergency work continues.
- SH noted that the Trust is committed to continuing urgent, emergency and cancer work but explained that staffing could become an issue. To mitigate the Trust, as part of the Integrated Care System, has committed to utilising resource and capacity to ensure any staffing shortages are mitigating. SH noted that the Trust is doing all it can to sustain the current level of service but there is a risk. PM acknowledged that the next 4-6 weeks is a critical period.
- EJ referred to discharge before midday and asked if there is anything else that could be done to improve this at such a challenging time and further asked if the challenges were largely in the community or internal pressure. SH explained

that discharge before midday has always been a challenge for SFT and whilst work had started to focus on this there has been limited opportunities during Covid to progress this work. With staffing levels as they are it has been incredibly difficult to manage this. SH explained that there were ongoing discussions at system level relating to discharging patients and the possible solutions to ensure patients are discharge into an optimum setting for their needs

TB1 14/1/3 STRATEGY AND DEVELOPMENT

TB1 14/1/3.1 Communication Strategy (Deferred to March)

This item was deferred to March.

TB1 14/1/3.2 Corporate Priorities Quarterly Review

L Thomas presented the report which asked the Board to note the progress against the Trust's Corporate Objectives. The following key points were noted:

- The Board approved the revised corporate priorities in July 2020 with a focus on Covid-19 recovery.
- The presentation summarised the ongoing work in relation to:
  - Discharge before midday and super stranded patients
  - Clinical Strategy Refresh
  - Best Place to Work
  - Patient Safety and Infection, Prevention and Control
  - Outpatient Transformation Programme Measures
  - Developing the Integrated Care System.

The report was NOTED.

TB1 14/1/4 QUALITY AND RISK

TB1 14/1/4.1 Board Assurance Framework and Corporate Risk Register

F McNeight presented the report and highlighted the following key points:

- The Trust risk profile has seen a significant shift since the last report in September. There is one ongoing risk regarding the EU Exit which replaced the existing risk that had been added in the scenario of a no deal Brexit.
- A number of emerging risks will be reported to the Board committees later in January.
- One of the risks related to virtual outpatients appointments of which EP has provided a summary in the report.
- PC has reviewed all risks for which he is executive lead. These changes will be reflected in the next update to the Board Committees.
- The number of risks over 15 will have increased due to the current situation.

Discussion:

- There were no further questions relating to the BAF and PM noted this was due to the system and process working effectively.
- NM pointed out that all new and escalating risks are routinely picked up at the relevant Board Committees and the process is working well.

TB1 14/1/4.2 **Patient Experience Report Q2**

JD presented the report providing the activity for Q2 2020/21 in relation to complaints and the opportunities for learning and service change. The following key points were noted:

- The Trust did well in the 2019 cancer survey, demonstrating very positive findings with the Trust being a positive outlier for 6 questions.
- The Friends and Family Test responses are largely positive in most areas with some negative feedback in in ED which is currently under review.

Discussion:

- DB highlighted the importance of responding to all complaints within the agreed time. It is accepted that there might be some delay due to Covid-19 and JDy explained that response times are a challenge as it is the clinical teams that largely work on the complaint responses. Work to support divisional governance was underway but has been delayed because of the recent outbreak.
- PM referred to a section in the paper relating to unsatisfactory clinical treatment in gynaecology and asked if the team were on track to deliver the report of the subsequent review. SD explained that all complaints have been reviewed and will report to the relevant committees. SD noted that she was not aware of any particular themes currently and explained that the review is still underway. This will be picked up at the Clinical Governance Committee (CGC).

TB1 14/1/4.3 **Learning from Deaths Report**

SD presented the report which provided assurance that the Trust is learning from deaths and making improvements as a result. CGC reviewed the report and received positive assurance at its meeting in November. SD noted the following key points:

- The Q2 report shows that 2 deaths were unexpected, one of which was reported to the coroner and the other scrutinised by the medical examiner.
- The newly introduced role of the medical examiners is working well and providing much needed support to bereaved relatives.
- A review of 65 deaths of patients who died from was

completed highlighted the valuable lessons learnt in relation to treatment and care.

- Weekend HSMR started to decline from a peak of 133.8 in July 19 to 107 in May 20 but has subsequently risen to 109.2 and remains within the expected range.

Discussion:

- RA referred to para's 12 and 13 in the report which related to patients with learning disabilities and serious mental health issues. RA suggested that from these instances it was likely that there was learning and this should be represented in the report. RA noted that this links to a wider piece of work about a system-wide, BSW approach to enable an understanding of patients with Mental Health illness. SD thanked RA for her comments and explained that she was currently involved in a focused piece of work relating to mental health.

TB1 14/1/4.4 **DIPC (Director Of Infection Prevention and Control) Report**

JDy presented the 6 monthly DIPC report and noted that the report is to inform the Trust Board of the progress made against the 2020/21 annual action plan to reduce healthcare associated infections and sustain improvements in infection, prevention and control practices.

- For the reporting period, the Trust has experienced an exceptionally challenging time, with the major incident response to the Covid-19 pandemic. JDy provided a summary of the reported cases of infection in the last 6 months.

- JDy explained that she had not had the opportunity to add benchmarking data from the Model Hospital which indicates that the Trust is in the lowest percentile for all infections. This will be added to future reports.

- JD thanked the housekeeping team who have worked tirelessly during this period and moved to a 24 hour service.

- The Trust's aim is to complete twice-weekly anti-microbial ward rounds but due to ongoing pressures this is happening once a week.

Discussion:

- EJ noted that C.difficile will be closely reviewed at a future CGG meeting.
- PM referred to section 4 which provided a list of assurance activities and noted that there was no mention of air exchange or circulation. JDy explained that there is a ventilation oversight group and whilst new systems have been ordered there has been a delay as they are coming from overseas. JDy further noted that when reviewing the key guidance it indicates that hospitals should provide the

best ventilation possible, within the remit of an older estate like SFT. .

TB1 14/1/4.5 **Maternity Ockenden Review**

JDy presented the report providing the Trust Board with oversight of the Ockenden report into maternal and neonatal deaths and Shrewsbury and Telford NHS Trust. As part of the Ockenden review 250 cases have been looked into with a further 2000 cases to be reviewed. JDy noted the following key points:

- The Trust's metrics show that we are not a negative outlier for safety.
- The Trust has undertaken proactive commissioning of external reviewed due to soft intelligence and freedom to speak up guardians.
- Oversight of serious incidents has been brought to the Clinical Governance Committee and Private Board.

Discussion:

- NM noted that the Trust had already implemented two reviews of maternity prior to the publication of this report and improvement work had already begun. NM noted that from the Trust Board is required to receive this report but noted that this had been taken extremely seriously and it is the Board's responsibility to scrutinise these reports.
- EJ noted that she has done a walkabout and met with senior clinical team and there will be a monthly meeting with them going forward. EJ noted that the team are very welcoming and support this input into the service. EJ further noted that it had been positive to see maternity and gynaecological services wanting to work together and facilitate improvement.
- MVB referred to community led maternity services which were reorganised as part of the STP and asked what the Trust's involvement is in this service. JDy explained that the Trust have a community team but is not responsible for the maternity birthing centres in Swindon and Bath.
- TB noted that the report indicated that the Trust is not a negative outlier on safety. However, TB noted that it was not clear if the Trust was a positive outlier or sat in the middle in relation to safety. JD explained that CGC review the monthly maternity dashboard and SFT benchmark well but there are some areas that require further work. JDy explained that these figures are reviewed regularly but the Trust largely sits in the middle when benchmarked against other organisations. TB therefore suggested that maternity services should be setting specific targets.
- RA noted that outcome of the Ockenden review is sobering but noted the positive midwife led approach.
- PM referred to the Trust's response and the section that referred to the risk assessment process. PM noted that the document reads that possible solution will be scoped by 15th Jan but does not indicate when a solution will be available.

JDy explained that a response was required rapidly and there has since been an extension so this will be bought back.

- SH noted that the report was sobering and some of the themes had been seen in maternity reviews across the country. SH explained that this is a fundamental priority for Board and the response has been encouraging to date. However, SH referred back to TB's point and explained that it would be good to have a certain detail of granularity and asked for this to be reflected in the next report. **ACTION: JDy** **JDy**

TB1 14/1/4.6 **Medical Revalidation and Appraisal Annual Report**

SD presented the report which provided assurance that appropriate processes are in place for the appraisal and revalidation of doctors. SD noted the following:

- Appraisal and revalidation has been affected by the Covid-19 pandemic and appraisals being cancelled in March for four months and revalidation being delayed by one year
- There is an ambition to further improve the quality assurance of appraisal to improve the experience for non-consultant doctors over the next year. .

Discussion:

- DB acknowledged that Covid-19 had inevitably delayed the process this year but noted the importance of the process to ensure doctors are practising safely. DB noted that further work is required in relation to quality and assurance.
- MVB noted that the benefit of the system is that doctors have reflected on their practice and the Trust should be encouraging reflection on what they have learnt from this year. SD explained that reflection is a focus as part of the 'light touch' appraisal process this year. .
- EJ discussed reinforcing the lay role on regular Board Committees as this input is important. EJ further referred to the presentation the trust had received last year as a result of the Patterson recommendations. EJ asked if any concerns had been identified and if so how they are being managed. SD – used FTSU as an important resource and those are still a priority. (2:13 time).
- TB asked if performance data on doctors was still included and utilised as part of their appraisal. SD explained that basic data relating to complaints and outcomes is still involved as are Serious Incident outcomes.

TB1 14/1/4.7 **Medical Education Performance Report**

EH joined the meeting to present the report which provided an update on the developments in medical education over the past 12 months and the challenges going forward. The following key points were highlighted:

- This has been a challenging year in Medical Education due to Covid-19, which has had long term effects on education and training. The department will be looking at actions to mitigate these effects as part of service recovery going forward.
- Trainees have been exceptional in response to the pandemic. However, morale is low and the well-being of staff continues to be prioritised.
- There have been several changes in relation to the junior doctor's training, e.g. GPVTS training scheme now only have 12 months placement in hospital and junior doctors are now meant to get 2 hours of administrative time a week. These changes have added to concerns relating to gaps in the medical workforce.

Discussion:

- SH noted that due to the ongoing gaps in staffing a more multi-professional and team based approach to working is required. EH explained that the Trust is slightly behind other organisations but working towards a multi-disciplinary approach.
- RA referred to multi professional training and asked in relation to strategy if this is about diversity of input or extended roles and does the Trust have an understanding of how this is going to be developed. SH noted that the Trust is working on developing its clinical strategy, models of care and what the required workforce to support that will look like. The Trust already supports the role of advanced clinical practitioners but it is acknowledged that more needs to be done to develop the Trust's workforce.
- NM thanked EH for the comprehensive update and noted his appreciation for the support and goodwill of staff.

TB1 14/1/5 PEOPLE AND CULTURE

TB1 14/1/5.1 Equality and Diversity Annual Report

LL and RxW presented the report asking the committee to consider the report together with the Gender Pay Gap, WRES and WDES reports and highlighted the following key points:

- RxW highlighted the benefits and challenges over the last year in relation to EDI (Equality, Diversion and Inclusion).
- RxW thanked TB for chairing EDI steering group.
- The effects of Covid-19 on minority groups have been highlighted and a lot of work has been done to engage with BAME (Black, Asian, and Minority Ethnic) forum.
- The link between Freedom to Speak up (FTSU) and EDI has continued and feedback from joint training sessions and Trust induction has been positive.
- The Trust has reviewed its EDI Policy, introduced a new Equality Impact Assessment process and updated its equality pages on the Trust website.

Discussion:

- PM referred to the recommendations within the report and asked for the actions to be more specific. LL noted that the next EDI Committee will be setting the agenda and action plan based on discussions at the next meeting.
- RA noted that a lot of work had happened in the last year despite Covid-19 and thanked RxW for his leadership.
- SH thanked RxW and agreed that progress has been made but there is more to do. SH noted the Board need to think about where focus is required in relation to health inequality. Additionally, from an employee experience perspective it is important that when efforts are refocused the Trust does not miss the opportunity to change ways of working and there is a large amount of work to do in relation to this. SH noted that the Board should spend time in a seminar to give this some thought as it is a fundamental part of how we respond to Best Place to Work. **ACTION: LL/RW** **LL/RW**
- MVB noted that because of the statutory nature of the report it largely focusses on measurement but a lot of work has been done on understanding difference. There is a long way to go but the Trust has the potential to be a beacon due to the diverse workforce. There has been success in overseas recruitment and the Trust is working towards understanding and gaining from the benefits of what its diverse workforce can provide.
- TB agreed that there is a long way to go and part of this is embedding equality more broadly across the whole workforce.
- EJ noted that more focus is required to support the older workforce as there are many staff who are keen to continue working but need adaptations. There is an opportunity as part of People Plan and Clinical Strategy to bring this together.

Decision:
The report was approved.

TB1 14/1/6 GOVERNANCE

TB1 14/1/6.1 Register of Seals

FMc presented the updated register of seals report.

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

Decision:
The report was approved.

TB1 14/1/6.2 Remuneration Committee Terms of Reference

FMc presented the report which provided the revised Remuneration Committee Terms of Reference. It is recommended that the Trust Board approve the terms of reference and delegate authority to the Remuneration, Nominations and Appointments Committee to operate within the NHS guidance outlined in appendix 2 and 3.

EJ queried a point in 3.1 regarding removal of the Chief Executive and noted that governor involvement was missing. FMc noted that the Nomination Committee Terms of Reference for the Council of Governors was under review.

Decision:
The Terms of Reference were approved.

TB1 14/1/6.3 **Constitution**

FMc presented the report which provided the revised constitution and noted that the updated document had been approved at November's Council of Governors. The updates were noted.

Decision:
The Constitution was approved.

TB1 14/1/7 **CLOSING BUSINESS**

TB1 14/1/7.1 **Agreement of Principle Actions and Items for Escalation**

N Marsden noted the following highlights from the meeting:

- The key focus of the meeting and the Trust's efforts are focussed on Covid-19 but there have been other important items for discussion and assurance has been provided.
- The Ockenden Review and relevant updates of maternity services will come back to the Trust Board on a regular basis.
- The Equality and Diversity actions will report back to the Trust Board at regular intervals.

TB1 14/1/7.2 **Any Other Business**

SH thanked Non-Executive Director colleagues for their support during this time and the offers of support, help and flexibility.

NM reflected these sentiments.

TB1 14/1/7.3 **Public Questions**

There were no public questions.

TB1 14/1/7.4 **Date of Next Public Meeting**

Thursday 4th March 2021, Board Room, Salisbury NHS Foundation Trust

TB1 14/1/8 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).

Public Trust Board Action log

Deadline passed.	1
Update required /paper due at next meeting	2
Completed	3
Deadline in future.	4

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
TB1 05/11/3.1	**Patient Experience Report Q1 -** SH asked if the complaints and compliments could be triangulated with activity in the report.	**JD/KG**	~~04/02/2021~~ 08/04/2021	**Next report due April 2021**	N	4
TB1 05/11/3.2	**Learning from Deaths Report Q1 -** RA referred to how learning is evaluated and noted that the report details the learning that is required but there is no evidence of it. RA also referred to the deaths where "no learning points" have been identified. It was agreed that this would be picked up and reviewed in future reports.	**PC**	~~04/02/2021~~ 08/04/2021	**Next report due April 2021**	N	4
TB 05/11/5.1	**People Plan -** SH thanked LL for the report and asked for clear and specific trajectories that can measure what the Trust/System is trying to achieve.	**LL**	08/04/2021	~~Due March 2021~~ **People Plan Update now due April 2020**	N	4
TB1 14/1/4.5	**Maternity Ockenden Review -** TB and SH asked for future maternity reports to include more specific actions in relation to the Trust's response to the Ockenden Review.	**Jdy**	TBC	**Reporting schedule to be confirmed**	N	4
TB1 14/1/5.1	**Equality and Diversity -** The Board to have a seminar to discuss what is required in relation to health inequalities and additiionally, from an employee experience perspective how the Trust is going to focus on the opportunities that have arisen as a result of Covid-19 as this is a fundamental part of the Trust's reponse to Best Place to Work.	**LL/RW**	TBC	**Seminar to be scheduled**	N	4

Report to:	Trust Board (Public)	Agenda item:	1.8
Date of Meeting:	March 4th 2021		

Report Title:	Chief Executive's Report			
Status:	Information	Discussion	Assurance	Approval
	X	X		
Prepared by:	Gavin Thomas, Executive Services Manager			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive			
Appendices (list if applicable):	Appendix 1 NHS Providers Briefing on ICS.			

Recommendation:
The Board is asked to receive and note this paper as progress against the local, regional and national agenda.

Executive Summary:
This report provides an update for the Trust Board on some of the key issues and developments within this reporting period and covers: • **Introduction** • **BSW Regional Update** • **Workforce** • **Finance** • **Vaccination Update** • **Lateral Flow Testing Update** • **News**

1) Introduction

As the Board know the last 6 weeks the local rates of COVID-19 in our community gave rise to sustained intense pressure for our teams which have had an impact on our ability to provide all of our planned services. The detail of this has been shared with you via our daily and weekly updates.

This month brings better news with a steady and continued reduction in the number of COVID-19 patients in our hospital allowing a proportionate de-escalation of our Incident Management Response.

Our local experience reflects the national contact for the NHS and the general public which has been necessarily dominated by the on-going impact of the pandemic.
This has been a year like no other in the NHS and we are conscious we need to be careful to recognise the experience our colleagues have had as we begin to think about how we re-establish

services and address the backlog of patients waiting for routine care. This needs to be planned in a sensitive way that allows time for their recovery too, a subject we have discussed at Board.

Our leadership focus over the new few weeks will be prioritised to support these activities given the challenge ahead and I am committed to approaching this in a way that is consistent with our values.

We will share the detail of our activities via the relevant Board sub-committees and we will continue to be transparent with our partners and the public about the scale of the challenge we face and realistic about the time this will take.

I cannot thank staff enough for everything they have been doing over this extremely challenging period. 165 staff were redeployed during the height of this second wave and the Trust was also supported by 45 military personnel, who provided assistance with general duties and some clinical tasks and very quickly became a valuable part of the team.

2) BSW / Regional Updates

The Board will be aware that the response to the NHS consultation on Integrated Care Systems (ICS) has been published in this last period. The next steps to building strong and effective ICS across England includes proposed legislative changes. The direction of travel set out in the paper is welcomed particularly the emphasis on primacy of place within the system and the principles of subsidiarity. NHS providers have produced a good summary which is attached for information.

It will be important for us as a Board to spend time giving the proposals full consideration as well as aligning our Trust Clinical Strategy and priorities to place based population health priorities. We shouldn't underestimate the cultural and transformation change that is required and the support our teams will need to feel involved and influence new models of care.

The strategy update provides further details of the current material activities of the BSW ICS and the Acute Hospital Alliance (AHA)

Highlights include an ICS Outline Business Case (OBC) for a BSW Academy which has received support to be developed in more detail. This will be shared via our OD /People Board sub-committees during the Spring. The developments in our BSW system work are exciting and picking up pace. We know we have further work to do to ensure that we have alignment between the different programmes of work and our Board Governance processes.

Our local place based Wiltshire Integrated Care Alliance (ICA) will be a priority for Executives and clinical leaders over the coming year. Our Chief Operating Officer and Medical Director have dedicated significant time over the last few weeks to drive improvements in hospital discharges with our ICA partners. This will need to be consolidated and sustained. The Clinical Governance Committee had an opportunity to review the first draft of this important transformation priority at its February meeting.

3) Workforce

There was a successful HCA event held in January with 19 job offers made to individuals due to start in March. We are continuing to recruit and had 39 starters in the month. The Trust was awarded additional funding of £7,000 per nurse, to support the recruitment costs only, of overseas nurses who must arrive by April 2021 and who will join our Theatres team.

We received 1200 enquiries from individuals looking to volunteer either in the vaccination centre or as a ward buddy. Individuals who were interested in volunteering in the vaccine centre were

forwarded to 3rd party who were managing volunteers for the vaccine centre. 136 applications to date are being considered for the ward buddy roles.

In January, the Trust's overall sickness absence dramatically increased as expected to 5.31%, with 2.92% being non-COVID and 2.39% being COVID-related. Given the prevalence of COVID nationally and locally, this was to be expected.

We continue to successfully recruit high calibre consultant colleagues and have made appointments in Acute Medicine, Older Peoples Medicine and GI surgery since Christmas. Some of these specialities have significant national shortages of personnel and it is testament to our established medical and clinical teams that people continue to choose Salisbury as the place they want to work.

The recruitment to our substantive Chief Medical Officer and Chief Nurse positions are ongoing with final selection panels due to take place in March 2021.

As colleagues will be aware Lynn Lane our Director of HR/OD is leaving at the end of March taking a role closer to her home in Oxfordshire. I know the Board will want to join me in thanking Lynn for her contributions in the Trust and BSW system over the last 18 months and wish her well in her next endeavours.

We have appointed a replacement interim Director of Od in Susan Young who joins us from March 1st 2021 which will allow time for handover.

4) Finance

Throughout December through to January we have seen a much greater impact from Covid-19 than in the first wave, the effects of this have been increased staffing absence, increased demand for inpatient beds, and reduced capacity for 'business as usual' procedures. As a result we have seen increased costs for staffing backfill as well as increasing our usual bed footprint, but due to combination of the Covid-19 phase 3 funding arrangements and reduced planned work we are still confident of staffing within our financial forecast.

In order to allow Trusts to focus on their Covid response, current funding arrangements will be rolled over for April to June. This should allow us the time and space to take stock and plan the next steps for the Trust and the wider system.

We have also continued to work with our BSW system partners on the large scale vaccination programme, January seeing the opening of the centre at City Hall in Salisbury. The costs of providing this service are covered on an incremental cost incurred basis by NHS England and Improvement, with plans in place to continue into the new financial year.

5) COVID-19 Vaccination Programme

27 vaccination clinics are now up and running across the Bath & North East Somerset, Swindon & Wiltshire region. All people living in these areas who fall into one of the top four priority groups have been offered a first dose, which is fantastic progress. The vaccination programme has now begun contacting those next in the queue to receive the vaccine, who are people aged between 65 and 69 and anyone aged between 16 and 64 with an underlying health condition.
The Salisbury City Hall Large Vaccination Centre is managed by the Trust and to date has successfully provided 10,000 vaccination doses. The team, alongside volunteers, are currently vaccinating those in the latest JVCI priority cohorts.

The hospital hub vaccination centre has temporarily paused and will reopen to deliver second doses for all those who received their first dose in the centre, from March. A new system, COVIDTrack, has also been set up to more effectively manage booking second dose appointments.

I would like to pay tribute to our vaccination leadership team and all of the volunteers who have contributed to this incredible programme. We are planning on the basis that the vaccination efforts will need to be provided for a minimum of 6-12 months.

6) Lateral Flow Testing

Staff will continue to be offered and encouraged to undertake lateral flow testing for a further 12 weeks. The results of Lateral Flow Tests are monitored at a regional and national level and the proportion of positive to negative tests gives an indication of the amount of COVID-19 in hospitals as well as the current risk to staffing – this information helps guide any further extra support.

7) News

Newsnight filming in ICU

Newsnight returned to the Trust for a sixth time, and spent 12 hours shadowing the team in the ICU department. The programme really shone a light on the incredibly difficult work all our staff faced every day – I was so proud to see such calm, compassionate, skilled and humane care being provided despite the difficult circumstances.

Stacey Hunter
Chief Executive

Legislating for Integrated Care Systems: five recommendations to Government and Parliament

NHS England and NHS Improvement (NHSE/I) has today published its summary of, and response to, feedback received from the recent *Integrating Care* engagement exercise on the strategic direction of system working. You can read our response to the original proposals here.

This briefing sets out how the proposals have developed since November 2020, summarises NHSE/I's revised recommendations to Government for legislative change, and provides NHS Providers' initial views. If you have any comments, or would like to discuss the proposals further, please contact Georgia Butterworth, policy advisor (georgia.butterworth@nhsproviders.org).

Development of the proposals

In November 2020, NHSE/I published *Integrating Care*, which set out their vision of the future of Integrated Care Systems (ICSs) and asked for views in response to four consultation questions on whether to put ICSs on a statutory footing and, if so, how best to achieve this. You can read our summary here. The latest proposals, published today in *Legislating for Integrated Care Systems*, build on those put forward by NHSE/I in November 2020 and the previous iteration in September 2019.

We drew on extensive engagement with trust leaders to inform our response to the *Integrating Care* paper, which was submitted at the beginning of January 2021, and we continued to discuss key issues with NHSE/I and DHSC over the intervening weeks. We held a number of detailed bilateral meetings with key officials and senior leaders in both organisations to influence their positioning, as well as discussing with other key stakeholders – including the think tanks and other membership bodies – and participating in a broader stakeholder group where the updated proposals were discussed. We have also supported NHSE/I and DHSC to engage with different parts of the membership in recent months, including our NHS Bill Member Reference Group of chairs and CEOs, strategy directors and specific segments of the provider sector including the Community Network.

We have been in discussion with NHSE/I and DHSC over the past couple of weeks about the new, combined legislative option for ICSs to create a new NHS ICS body alongside a wider statutory partnership including local government and potentially other partners. We understand this proposal

was developed by NHSE/I in response to stakeholder feedback that their preferred option ('option 2' – a mandatory statutory ICS board) was impossible to align with the different accountability structures in the NHS and local government. This new proposal could well offer a response to concerns we, and others, raised about the multiple objectives of the ICS and the need to involve partners to deliver a meaningful focus on health inequalities. However, it also raises a host of new practical questions and we have flagged the need for full engagement and consultation particularly given this is a new development since the closure of the engagement period.

Summary of feedback received and recommendations

NHSE/I's summary of the feedback they received on *Integrating Care* concludes that there is support for putting ICSs on a stronger statutory footing than previously, citing enhanced system working during the pandemic and building on "several years of extensive co-production [...] with stakeholders".

In response to this feedback, NHSE/I has made five recommendations to Government on how to legislate for ICSs, which the Government has already accepted. Below we set out each of the five legislative recommendations NHSE/I is making to Government, and a summary the supporting evidence NHSE/I drew from the engagement period.

While some respondents, including NHS Providers, were concerned about the pace of change, NHSE/I says that an extension to the engagement timeframes would have prevented the NHS from influencing the Government's thinking in time for the Bill.

Q1: Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

- 49.2% of respondents agreed with the proposals, 43% disagreed, and 7.8% were neutral.
- Overall, NHSE/I noted a high level of support from the NHS to put ICSs on a statutory footing, but responses to this question were "nuanced and qualified", including caveats around more clarity on the role of local government, the voluntary sector and patients/service users. NHS Providers supported the overall direction of travel but did not express a preference between the options given trust leaders had a broad range of views about whether ICSs needed a statutory footing, and if so, how best to achieve this.
- NHSE/I also heard that legislative underpinnings should be "short, simple, and enabling", and designed to recognise the heterogeneity of ICSs.

- NHSE/I reassured respondents that NHS ICS bodies will be statutory public NHS bodies, not private entities, in response to concerns about 'privatisation' of the NHS in some way.
- NHSE/I does not propose legislative requirements for establishing place-based arrangements.

Legislative Recommendation 1: The Government should set out at the earliest opportunity how it intends to progress the NHS's own proposals for legislative change.

Legislative Recommendation 2: ICSs should be put on a clear statutory footing, but with minimum national legislative provision and prescription, and maximum local operational flexibility. Legislation should not dictate place-based arrangements.

Q2: Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

- 48% of responses agreed with the proposals, 39.9% disagreed, and 12.1% were neutral.
- NHSE/I identified no clear and definitive preference for one model over the other, with option 2 (repurposing CCGs as the statutory NHS ICS body) receiving support due to the benefits of clearer accountability for the NHS, and option 1 (a mandatory statutory committee) receiving support as a better model for health and care system partnership (particularly from local authorities and the voluntary sector).
- NHSE/I has therefore decided to adopt both options 1 and 2 in combination. NHSE/I now proposes that the NHS ICS body and local authorities should be required by statute to establish a statutory health and care partnership, which would be made up of a wider group of organisations than the NHS ICS body and required to develop an overarching plan to cover health, social care and public health. The NHS ICS board would have regard to that plan when developing their health plan, and local authorities would also have regard to that plan in exercising their functions.
- NHSE/I does not propose changing the accountability structures of NHS trusts and foundation trusts, and agrees that statute should not cut across existing models for partnership working. NHSE/I will develop and issue revised guidance to explain how foundation trust directors' and governors' duties can better support collaborative system working. NHSE/I also commits to working with the provider sector to navigate the complexity of working across several ICSs.
- NHSE/I states that statutory ICSs will continue to hold CCG duties and functions, including around public engagement, with patient and voluntary sector representation expected at the health and care partnership and place level. NHSE/I will work with stakeholders to develop guidance on how these arrangements can be most effectively discharged.
- Legislation should set out core requirements in terms of openness and transparency in appointments and decision-making at ICS level, including holding meetings in public.

Legislative Recommendation 3: ICSs should be underpinned by an NHS ICS statutory body *and* a wider statutory health and care partnership. Explicit provision should also be made for requirements about transparency.

Q3: Do you agree that, other than mandatory participation of NHS bodies and local authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

- 54.5% agreed with the proposals, 37.3% disagreed, and 8.2% of respondents were neutral.
- NHSE/I concluded that the NHS ICS board membership should consist of the ICS chair (formally appointed by NHSE) and chief executive, and as a minimum also draw representation from NHS trusts and foundation trusts, general practice and a local authority, with flexibility for systems to add members to suit their local circumstances.
- Formal accountability for spending and performance (and meeting statutory duties) would flow from the ICS AO (the chief executive) to NHSE AO to Parliament.
- Respondents were concerned about a primary care 'representative' being insufficient clinical input at ICS level. NHSE/I reiterated that primary care will play a key role in ICSs, including at place-level committees. NHSE/I will work with stakeholders to develop guidance on professional involvement.

Legislative Recommendation 4: There should be maximum local flexibility as to how an ICS health and care partnership is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where these work well. The composition of the board of the NHS ICS body must be sufficiently streamlined to support effective decision-making. It must be able to take account of local circumstances as well as statutory national guidance. Legislation should be broadly permissive, mandating only that the members of the NHS ICS body must include a chair and CEO and as a minimum also draw representation from (i) NHS trusts, (ii) general practice, and (iii) a senior local authority officer. As with CCGs now, NHSE/I should approve all ICS constitutions in line with national statutory guidance.

Q4: Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

- 42.5% of respondents agreed with the proposals, 43.7% disagreed, and 13.9% were neutral.
- Most responses were supportive of the principles behind the specialised commissioning proposals but raised a number of issues that will need to be addressed as part of a phased approach to implementation, including the right geographic footprints (population size) for specialised services (ICS, groups of ICSs, or national) and resources/funding to follow functions. NHSE/I recognises that this is not a simple process and will work with stakeholders to ensure legislation is flexible. NHSE/I will carefully consider how and which services are transferred/delegated, and ensure all systems are

fully prepared for any new responsibility. NHSE/I will continue to have a role in setting national standards and service specifications.

- A limited number of responses directly mentioned section 7A public health services. All were supportive or supportive in principle of the proposal, with a minority seeking further detail.
- NHSE/I confirmed its commitment to the contractual model for general practice and will undertake a comprehensive primary care commissioning transformation programme, to ensure the safe and effective transfer of these functions to ICS bodies.
- NHSE/I sees the ICS body as establishing place-based committees and delegating functions and money to them. Local authorities would also be able, voluntarily, to pool functions and money into these committees. Membership should be determined locally, but should consider being broad-based with representatives from Primary Care Networks, social care, public health, mental health services, acute care as well as voluntary sector organisations and patient groups.
- NHSE/I will produce guidance in line with future legislative proposals to ensure both system and place-based arrangements are sufficiently clear and transparent.

Legislative recommendation 5: Provisions should enable the transfer of appropriate primary medical, dental, ophthalmology and pharmaceutical services by NHS England to the NHS ICS body. Provision should also enable the transfer or delegation by NHS England of appropriate specialised and public health services we currently commission. And at the same time, NHS England should also retain the able to specify national standards or requirements for NHS ICSs in relation to any of these existing direct commissioning functions.

NHS Providers view

The publication of NHSE/I's five new recommendations for legislative change is largely grounded in its original 2019 proposals but also reflects the evolution of national policymakers' thinking over the past couple of years, and in response to learning from the pandemic. Trust leaders fully support the future vision of a health and care system based on collaboration, integration for patients, and partnership working.

We are pleased to see that a number of our comments on the *Integrating Care* proposals have been acknowledged, notably the fact that there is 'no one size fits all' for ICSs and that any legislative framework must be enabling rather than prescriptive. We therefore particularly welcome recommendation 2, which calls for minimal national legislative provision and prescription for ICSs, as maintaining local flexibility around ICS membership and place-based arrangements is key. We are also encouraged that the overall message heard by NHSE/I is "proceed, but carefully" and, we would add, "in collaboration with the health and care sector".

We welcome NHSE/I's confirmation that NHS trust and foundation trust accountability structures will not change, although there is a lot of detail still to be worked through regarding how that fits with the NHS ICS board's roles and responsibilities without overlap. NHSE/I's commitment to producing advice on how foundation trust directors' and governors' duties can support collaborative system working is welcome and responds directly to our calls.

However, we are concerned about the lack of clear majority support for the way forward evident in the detail of the feedback received across the sector. We therefore encourage NHSE/I (jointly with DHSC) to clearly set out a plan for engaging further with the health and care sector, to co-produce the detail and implementation of the proposals. Overall trust leaders are concerned about the timing of this policy development process in the midst of the pandemic response, and the level of support available for the transition and then implementation during COVID-19 recovery. A formal stakeholder engagement process is therefore essential in the next phase of guidance and Bill drafting to ensure expectations are realistic.

We are particularly concerned that NHSE/I has recommended option 1 and 2 for ICSs in combination, and that the Government has already agreed to legislate to give effect to this proposal, without full engagement or consultation on this option. While we welcome the fact that this combined option addresses our concerns about ICSs' multiple objectives (i.e. allowing for a forum to focus on health inequalities alongside a more internally focused and narrowly defined NHS commissioning and planning body), full consultation on any new proposals as significant as this is essential. This proposal raises new questions about governance and accountability and how the two boards will work effectively together.

We welcome the proposed flexibility around the membership of the NHS ICS body, which will be drawn from trusts, general practice and a local authority. However, it is unclear what this means for systems where there are many organisations, how this will align with an effective decision making board at trust level and how best to ensure strong representation of all sectors (e.g. mental health/community/ambulance/primary care) and non-NHS providers? It would help to set out how the functions, responsibilities and governance of the ICS NHS board and wider partnership will align to deliver the new collaborative future set out in the vision behind these proposals.

We look forward to working closely with NHSE/I on the next phase of policy development and guidance, with DHSC in response to today's White Paper on the drafting of the Health and Care Bill, and with Government and parliament as the Bill progresses.

Contact: Georgia Butterworth, Policy Advisor (Systems),
georgia.butterworth@nhsproviders.org

Salisbury NHS Foundation Trust

Report to	Trust Board (Public)	**Agenda item:**	1.9
Date of Meeting:	04 March 2021		

Report Title:	Trust Board Annual Cycle of Business 2021/22			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x			x
Prepared by:	Kylie Nye, Corporate Governance Manager Sasha Grandfield, Board Support Officer			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):	N/A			

Recommendation:
To note and approve the 2021/22 Trust Board cycle of business.

Executive Summary:
The Trust Board cycle of business has been split into Public and Private meetings to provide a clearer summary of which reports are expected at each meeting. Please note that the Annual Report and Accounts are currently scheduled for May 2021. However, due to the recently published guidance it is likely that an Audit Committee and Private Board will need to be held in late June instead. Dates for these meetings are currently under review.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☒
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☒
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☒
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

Public Trust Board
Annual Business Cycle 2021/22

	Sponsor	Author	April	No Public meeting May	No Public meeting June	July	August	September	October	November	December	January	No Public meeting February	March
Board Administration														
Opening Business														
Apologies for absence	Chair	Verbal	✓			✓		✓		✓		✓		✓
Declarations of interest	Chair	Verbal	✓			✓		✓		✓		✓		✓
Presentation of SOX certificates	Chair	Verbal	✓			✓		✓		✓		✓		✓
Patient story	Director of Nursing	Various	✓					✓				✓		
Staff story	Director of OD & People	Various				✓				✓				✓
Minutes from the last meeting	Chair	Director of Corporate Governance	✓			✓		✓		✓		✓		✓
Matters arising and action log	Chair	Director of Corporate Governance	✓			✓		✓		✓		✓		✓
Register of attendance	Chair	Director of Corporate Governance				✓		✓		✓				✓
Chairman's business	Chair	Verbal	✓			✓		✓		✓		✓		✓
Chief Executive report inc STP update	Chief Executive	Head of Communications	✓			✓		✓		✓		✓		✓
Assurance and reports of Committees														
Committee escalation reports	Executive Director	NED Chair of Committee	✓			✓		✓		✓		✓		✓
Integrated Performance Report (inc, operational perf, workforce, finance, quality, safer staffing and Wiltshire Health & Care)	Chief Executive	Executive Directors	✓			✓		✓		✓		✓		✓
Quality and Risk														
Board Assurance Framework and Corporate Risk Register	Director of Nursing	Director of Corporate Governance	✓							✓		✓		
Patient Experience Report	Director of Nursing	Head of Complaints	Q3			Q4/Annual Report				Q1		Q2		
Learning from Deaths Report	Medical Director	Head of Clinical Effectiveness	Q3			Q4/Annual Report				Q1		Q2		
DIPC Report	Director of Nursing	Lead Nurse Infection Control				Annual Report						✓		
Clinical Governance Annual Report	Director of Nursing	Head of Clinical Effectiveness						Annual Report						
Risk Management Strategy (3 yrly, due 2020, 2023, 2026)	Director of Nursing	Head of Risk								✓				
Quality Improvement Progress update	Director of Transformation	Director of Transformation				✓						✓		
Research Annual Report	Medical Director	Head of R&D						Annual Report						
Strategy and Development														
Annual Sustainability Strategy Report	Director of OD & People	Campus Project Programme Lead				Annual Report								
Digital Strategy Update	Director of Transformation	Interim Chief Information Officer				✓						✓		
Financial and Operational Performance														
Corporate Priorities 2021/22 and quarterly review to include Trust Strategy Progess Reports	Director of Finance	Associate Director of Strategy	✓							✓		✓		
Data Security & Protection Toolkit Self-Assessment	Director of Transformation	Chief Information Officer				✓								
Data Protection Officer Annual Report and Compliance with GDPR	Director of Transformation	Chief Information Officer				✓								
Standing Financial Instructions	Director of Finance	Director of Finance	✓											
People and Culture														
Nursing Skill Mix Review - agreed with FH January	Director of Nursing	Deputy Director of Nursing				✓						✓		
Guardian of Safe Working Annual Report	Director of OD & People	Guardian of Safe Working						Annual Report						
Equality & Diversity Annual Report	Director of OD & People	Head of Diversity and Inclusion										Annual Report		
National Staff Survey Results	Director of OD & People	Deputy Directof of OD & People	✓											
Medical Revalidation and Appraisal Annual Report	Medical Director	Medical Director								Annual Report				
Freedom to Speak Up Guardian Annual Report (quarterly to Workforce Cttee)	Director of OD & People	FTSUG Lead	✓											
Health & Safety Annual Report	Chief Operating Officer	Health and Safety Manager						Annual Report						

Education & Development Annual Report	Director of OD & People	Associate Director Education, Inclusion, Comms & Engagement									Annual Report				
Medical Education Performance Report	Medical Director	Director of Medical Education											Annual Report		
Governance															
Annual review of Board effectiveness	Director of Corporate Governance	Director of Corporate Governance						Annual Report							
Annual review of Committee effectiveness	Director of Corporate Governance	Director of Corporate Governance						Annual Report							
Annual review of Directors Interests/ Annual Review Fit and Proper Persons Test	Director of Corporate Governance	Director of Corporate Governance	✓												
Review of Board Committee Terms of Reference	Director of Corporate Governance	Director of Corporate Governance	✓												
Integrated Governance Framework	Chief Executive	Director of Corporate Governance	✓												
Accountability Framework	Chief Operating Officer	Chief Operating Officer	✓												
Emergency Preparedness Annual Report	Chief Operating Officer	EPRR Manager											Annual Report		
EPRR Compliance Statement	Chief Operating Officer	EPRR Manager	✓										✓		
Register of Seals	Director of Corporate Governance	Director of Corporate Governance	Q4			Q1				Q2			Q3		
Corporate Governance Statement Self-Assessment (Well-Led Review)	Chief Executive	Director of Corporate Governance						✓							
Annual Review of the Constitution	Chief Executive	Director of Corporate Governance											✓		
Approve Board and Committee dates for next year	Director of Corporate Governance	Director of Corporate Governance								✓					
Closing Business															
Agreement of principal actions	Chair	Verbal	✓			✓		✓		✓			✓		✓
Any Other Business	Chair	Verbal	✓			✓		✓		✓			✓		✓
Public Questions	Chair	Verbal	✓			✓		✓		✓			✓		✓
Date of Next Meeting	Chair	Verbal	✓			✓		✓		✓			✓		✓
Resolution	Chair	Verbal	✓			✓		✓		✓			✓		✓

Private Trust Board
Annual Business Cycle 2021/22

	Sponsor	Author	April	Private only May	Private only June	July	Private only August	September	private only October	November	private only December	January	private only February	March
Board Administration														
Opening Business														
Resolution	Chair	Verbal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Apologies for absence	Chair	Verbal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	Chair	Verbal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes from the last meeting	Chair	Director of Corporate Governance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matters arising and action log	Chair	Director of Corporate Governance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Register of attendance	Chair	Director of Corporate Governance				✓		✓		✓				✓
Chairman's business	Chair	Verbal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executive report inc STP update	Chief Executive	Head of Communications	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Assurance and reports of Committees														
Committee escalation reports	Executive Director	NED Chair of Committee		✓	✓		✓		✓		✓		✓	
Subsidiary Governance Escalation Report to Private Board	Executive Director	NED Chair of Committee	✓			✓			✓			✓		
Integrated Performance Report inc operational, workforce, finance, quality, safer staffing and Wiltshire Health & Care)	Chief Executive	Executive Directors		✓	✓		✓		✓		✓		✓	
Quality and Risk														
Clinical Review/SII Report	Director of Nursing	Head of Clinical Effectiveness	✓		✓		✓		✓		✓		✓	
Legal and Litigation Report	Director of Nursing	Head of Legal Services						✓						✓
Annual Quality Report and External Auditors Assurance (Quality Accounts)	Director of Nursing	Head of Clinical Effectiveness		✓										
Strategy and Development														
Campus Development	Director of Finance	Campus Project Programme Lead	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Strategy Session (90 mins)	Director of Finance	Associate Director of Strategy	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Financial and Operational Performance														
Annual Report and Accounts	Director of Finance	Deputy Director of Finance		✓										
Operating Plan 2022/23	Director of Finance	Associate Director of Strategy											✓	
Approval of the 2021/22 budget	Director of Finance	Deputy Director of Finance		✓										
System Working	Director of Finance	Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
People and Culture														
Governance														
Annual Governance Statement	Chief Executive	Director of Corporate Governance		✓										
NHSI Self-Certification (FT4, G6, CoS7)	Director of Finance	Director of Corporate Governance		✓										
Concluding Business														
Agreement of principal actions	Chair	Verbal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Any Other Business	Chair	Verbal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Date of Next Meeting	Chair	Verbal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hospital tasting menu	Chair	Eating							✓					

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	4th March 2021		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	23rd February 2021
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Miss Eiri Jones, Chair CGC			
Board Sponsor (presenting):	Miss Eiri Jones, Chair CGC			

Recommendation

Trust Board members are asked to note the items escalated from the Clinical Governance Committee (CGC) meeting held on the 23rd February 2021. The report both provides assurance and identifies areas where further assurance was sought and is required.

Key Items for Escalation

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - A follow-on update from last month was provided in relation to maternity services in the Trust and the response to the Ockenden report. The team is now awaiting feedback from the regional / national consideration of all Trust submissions. Assurance was provided that all actions arising from the cultural, quality and Ockenden reports are being coordinated into one plan and that the Board overseeing this will be Chaired by the Director of Finance. It was agreed that the team and the Maternity Board now need time to focus on this. Further updates will come back to CGC in due course and the committee agreed to move from monthly updates.
  - This month's Covid-19 update provided information in relation to the reducing numbers of patients in the hospital from the peak though outlined that critical care was still experiencing increased workload. The update also focussed on the learning from the outbreaks. Following a requested review from NHSI, a report had been received which demonstrated that the required steps had been taken by the Trust to reduce the adverse impact. A key factor is the older part of some of the estate. Assurance was provided in relation to the vaccination programme which is very successful to date. The update also provided assurance that the Trust was focussed on minimising harm whilst recognising that hospital acquired would not get to a zero level. Learning was therefore aimed at planning and adapting for the future.
  - The committee welcomed and supported the proposed approach to strengthening clinical digital leadership.
  - Discussion in relation to the quality elements of the IPR focussed on the increased levels of Pressure Ulcers and Falls and that these aligned with the

staffing challenges at the peak of the current wave. There was also an increase in serious incidents reported. It was agreed that a refocus on fundamentals of care was required as part of the resetting and restarting. It was confirmed that Duty of Candour was being considered for all relevant incidents. This was being discussed alongside incidents in the weekly executive led safety reviews.

- A report was received in relation to the transformation programme. A detailed presentation was provided on discharge and virtual outpatients. Clear plans were presented in line with the policies and direction outlined in the White Paper in relation to wider partnership and system working. The discussion covered current barriers and enablers to progress.
- An annual report (2020) was received on the Trust's position in relation to the Human Tissue Authority (HTA) licence requirements. The Trust evidenced compliance in relation to two licences – Stem Cell harvesting and Post Mortem examination. A visit from the HTA is expected though this is delayed due to Covid-19 impact.
- Detailed quarterly reports were received from the Research, Patient Experience, Children and Young People and Adult Safeguarding teams.
    - The research report outlined how the Trust had achieved over the target for participation in Covid-19 studies. The Trust continues to perform well in research activity.
    - For patient experience, there was evidence of good performance though acknowledging changing expectation from patients and their families a year on from the start of the pandemic.
    - The key focus of discussion on the children and young people's safeguarding position related to training compliance and restart.
    - For Adult Safeguarding a detailed discussion was held in relation to care for people without capacity and patients admitted with mental health needs. It was agreed that this required a further discussion with primary, community and mental health partners as part of the Place discussions and development.

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.2
Date of Meeting:	4 March 2021		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	23rd February 2021
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Paul Miller, Non Executive Director			
Board Sponsor (presenting):	Paul Miller, Non Executive Director			

Recommendation
To note key aspects of the Finance and Performance (F&P) Committee meeting of the 23rd February 2021

Items for Escalation to Board
Extension of the contract for provision of weekday locums – The recommendation to proceed with an extension of the existing contract, for the provision of 4 locums during the week, via direct award (total contract value £1.35m) for 12 months (with 2 months termination), while the gastrointestinal (GI) unit recruit to their vacant posts, was agreed by the Committee. **Replacement of Laboratory Information Management System (LIMS) and Services** – LIMS is the main IT system supporting the Salisbury Hospital pathology department, the current LIMS system is 29 years old and the Trust has been previously working with our Pathology Network (Southern Counties) to procure a replacement. The Southern Counties Pathology (SCP) network has recently been awarded £6.45m to proceed with procuring a replacement before the 31st March 2021. The intent is to procure a system against this timescale, the total costs to the Trust are expected to be £1.7m and our share of the network funding is £1.3m, leaving a worst-case shortfall of £400k. The Committee discussed the circumstances around this proposal and agreed to recommend to the Trust Board to proceed, as per the procurement recommendation report. However the Committee requested additional assurance on two aspects of the project; 1. That the project management resource detailed in the business case is made available to enable the LIMS to be successfully implemented 2. That appropriate corporate level oversight is put in place by the Executive in order to ensure that the multiplicity of major IT programmes, scheduled over the next three years, are properly integrated to ensure complexity and dependencies are properly managed. **Provision of External On-Line Sexual Health Screening Services at Great Western**

and Salisbury NHS Foundation Trusts – Following a formal joint procurement process the Committee agreed to support the recommendation to award a 4 year contract (total contract value £918k to Salisbury NHS FT), with annual break clauses to allow either Trust to respond to changing commissioner requirements.

Integrated Performance Report (including Covid-19 update) – It was clear from the report (for performance up to the 31st January 2021), that January was an exceptionally challenging month with the number of Covid-19 inpatients reaching a peak of 188. Therefore there is no surprise that operational performance in other areas of the Trust was significantly adversely affected i.e. ED 4 hour performance falling to 77.6%, the number of patients waiting more than 52 weeks grew from 505 in December 2020 to 785 in January 2021 (an increase of 280 patients in one month), the overall two week cancer wait fell to 65% in month and the two week breast cancer wait fell to 6% in month and only 30% of stroke patients reached the stroke unit within 4 hours.

The aim is now to quickly recover overall performance, as the number of Covid-19 patients in the hospital reduces, however the challenge is to do this in a hospital where (a) staff are exhausted (b) where there is still likely to be a baseline of Covid-19 patients arriving at the hospital for the foreseeable future and (c) where the hospitals estate i.e. older wards appear to present infection control challenges.

Finance report as at 31st January 2021 and 2020/21 financial outturn – In January 2021 the Trust reported an in-month breakeven financial performance, which is significantly better than both the original planned January 2021 deficit of £1.3m and the revised Covid-19 Phase 3 January 2021 forecast deficit of £700k. The result of this and other likely year end changes, means the Trust is very likely to improve on its revised Covid-19 Phase 3 forecast deficit of £3.2m.

Capital Planning 2021/22 – The Committee received a briefing paper outlining progress on the production of the Trusts 2021/22 capital plan, which will ultimately form part of the Trusts 2021/22 Operational Plan. In simple terms the Trusts annual depreciation is circa £9m, which represents its main source of internal capital funding. However the pressures against this funding significantly exceed the £9m available and the current capital planning over commitment for 2021/22 stands at £4.3m.

The Trust is not in a position to approve such an overcommitment, therefore either (a) the capital programme will have to be reduced (leaving Board Assurance Framework risks unresolved) or (b) additional external capital funding needs to be secured. Following a lengthy discussion on the issues, it was agreed that a paper would be prepared for the Trust Board meeting on the 8th April 2021 and both the Chairs of the F&P and Clinical Governance Committees would assist in the preparation of this report.

Quarterly Digital Progress Report – The Committee received this regular report and two key issues were highlighted (a) the improvement in the Trusts IT function over the last year and whilst things are not perfect they are in a better place and (b) the challenges of prioritising IT developments, within the finite technical and project management resource available. With regard to (b) the Executive team are pulling together an overarching prioritised plan, to be completed during March 2021, which will ensure approved projects can be successfully implemented.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	04 March 2021		

Report from:	Trust Management Committee (TMC)		**Committee Meeting Date:**	24 February 2021
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		X	
Prepared by:	Gavin Thomas, Executive Services Manager			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the report outlining items raised at the Trust Management Committee meeting held on 24th February 2021.

Key Items for Escalation
The Trust Management Committee Meeting was held on the 24th February. The meeting received a number of business cases namely: • Clinical Coding Business Case • Genetics – Automatic progression on registration • Genetics – Staffing/Workforce • Path LIMS Business Case **<u>Clinical Coding Business Case</u>** The committee reviewed the case and it was noted that both nationally and locally there has been a developing trend of increased bandings and payment packages for Clinical Coders together with a move to more flexible remote working as Electronic Patient Records (EPRs) are implemented and coding is not reliant on paper notes, the result of which has seen Salisbury NHS Foundation Trust (SFT) starting to lose experienced Clinical Coders to other Trusts, while also struggling to recruit replacement trained coding staff with retention risks for the remaining staff. This business case outlined two options for improving the remuneration for Clinical Coders in order to reduce the risk of losing trained staff to other Trusts. The recommended option would look to increase the bandings of clinical coding staff to bring them in line with other

organisations, thus giving the greatest chance of successful recruitment and retention alongside a number of other benefits such as improved resilience, a more structured career pathway and improved capacity of experienced coders to help provide expert advice to business planning, audit, etc.

The recommended option has a mid-point cost of £59,994.05, noting all staff would start at the bottom point of the new band so the net cost would be much lower in year 1. The existing cost for agency coders to bridge the staffing shortfall is currently a cost pressure to the organisation so this would be fully mitigated.

The committee approved this business case.

Genetics – Automatic progression on registration

The committee reviewed the case and it was noted that the aim of the business case was to address significant recruitment and retention challenges for HCPC Registered Clinical Scientists, we have instigated a “grow your own” programme using the ACS Route 2 to registration.

The business case outlined that as a Trust we currently have eight band 6 pre-registration clinical scientists (7.8 wte) for which we have agreed uplift to band 7 for 3.0 wte, which should already be captured in the 21/22 budget setting. Investment is being sought for uplift of a further 4.8 wte to ensure that all of these trainees have equity of progression to band 7 registered clinical scientist posts on completion of HCPC registration.

It was explained that in other areas of SFT, such as Pathology, automatic progression on registration is in place to help retention of valued staff.

The business case provided a proposal to provide certainty of progression but the cost pressure would be phased over 2021-22 and 2022-23 in line with predicted timeframe for individual trainees to reach registration.

The committee approved this business case.

Genetics – Staffing/Workforce

The committee reviewed the case and it was noted that the reason for submitting this business case, is to be better able to respond to the demands on the service, specifically (i) enable the service to address the clinical risks from failing to meet NHSE requirements for test turnaround times and (ii) allow the service to implement the developments and improvements that are essential to deliver the specification of the national Genomic Medicine Service.

The business case proposed transferring previously agreed temporary cover, including retired Registered Clinical Scientists, increasing establishment of HealthCare Science Practitioners to take on simpler genetic analysis tasks, thus releasing more experienced individuals to perform increasingly highly complex gene panel and whole genome sequencing interpretation and reporting.

The business case came with proposals which would lead to reduced reporting times for genomic tests which direct clinical management and therapeutic decisions thus improving patient care and outcomes.

Capability to continue to meet growth in activity which was realised in 2019-20 and drove >£840k increase in total income.

Capacity to implement urgent developments essential to the delivery of the new Genomic Medicine Service and the national Whole Genome Sequencing Service.

The committee approved this business case.

The committee also received an update on windows 10 rollout which continues to progress.

There were no other formal areas of escalation this month.

End of Report

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☒
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	26 February 2021		

Report from: (Committee Name)	People and Culture		**Committee Meeting Date:**	28th January 2021
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Michael von Bertele			
Board Sponsor (presenting):				

Recommendation

The Trust Board are asked to note the items escalated from the People and Culture Committee on 25th February.

The Committee noted good progress on the rewriting of the policy relating to consultant job planning which has been a thorny topic for some time.

There was also encouraging progress in delivering key elements of the people plan, with an important focus on Health and Wellbeing of our staff. A strategy for supporting staff whose wellbeing has been adversely affected by the pandemic is being drafted, and will be led, by the Head of Clinical Psychology Services.

An update on delivery of apprenticeship training highlighted the challenges of coordinating delivery of functions across the ICS, with potential for friction between system intent and organisational will and ability.

Several items on the agenda coalesced around a common theme – digital maturity. It was interesting to note how important this has now become with respect to managing our staff through the ESR, delivery of training and education, particularly with a focus on remote learning, new ways of working with regard to video consultation, and the focus on reducing reliance on paper medical records. All highlight the importance of investing in the training and development of our staff in parallel with the introduction of new systems. It was therefore helpful to see a renewed focus on reinforcing clinical digital leadership in the Trust.

Key Items for Escalation

As above

NHS
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Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	04 March 2021		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Louise Drayton, Performance and Capacity Manager			
Executive Sponsor (presenting):	Peter Collins, Medical Director			
Appendices (list if applicable):				

Recommendation:
The Board is requested to note the report and highlight any areas of performance where further information or assurance is required.

Executive Summary:
The impact of Covid-19 continued to intensify in the first half of January, with a peak of 188 confirmed Covid-19 positive inpatients in the hospital on 20th January. Operationally this generated a huge pressure and required escalation into many of the acute medical and surgical wards. Elective activity was impacted upon to a greater degree when the Day Surgery Unit was used for inpatient capacity, requiring surgery in the unit to be temporarily suspended. Challenges remain in increasing elective activity whilst an ITU facility is located in theatres, and significant challenges remain with theatre staffing due to vacancies, agency availability and staff shielding. Sickness across the Trust rose to 5.31% (3.43% in M9), which in addition to pressures staffing additional Covid-19 areas, led to an increase in pay expenditure of £0.2m. An increase was seen in the number of category 2 pressure ulcers, up from 26 in M9 to 36 in M10 with 16 of these in Covid-19 positive patients. High absence levels have caused difficulty with releasing staff for training on pressure ulcer prevention, education is planned to intensify in M11 as the operational pressures of the pandemic reduce. Performance fell against the Emergency Access 4 hour standard to 77.6% (85.8% in M9), the lowest performance in a number of years, and just below the national average for England. Challenges in flow with high numbers of suspected Covid-19 patients caused

significant difficulties for the Emergency Department to be able to maintain timely flow in and out of the department. There were a total of 246 Ambulance handover delays, which represented 7% of ambulance arrivals and significantly higher than delays of 1% in M9.

Pressure in ED and on flow continues to be seen in the Stroke pathway, with 32% of patients receiving a CT within 1 hour (target 50%), and only 30% of patients reaching the Stroke Unit within 4 hours. However, encouragingly, 87.5% of patients spent 90% of their time on the Stroke Unit (target 80%).

Bed occupancy levels were just under 90% for January, however this does not reflect the picture accurately – the levels of Covid-19 positive patients peaked on 20th January and bed occupancy prior to this was much higher, and more complex with the difficulty in reducing the risk of transmission to non Covid-19 patients. This complexity is evident in the number of instances of non-clinical mixed sex accommodation breaches - 58 patients were affected by this in the month. Many of the breaches occurred due to the need to cohort Covid-19 positive patients requiring CPAP treatment, or due to the need to accommodate elective patients in Covid-19 secure areas.

Referral to Treatment performance fell slightly to 71.03% (71.88% in M9), and the number of patients waiting over 52 weeks increased from 504 in M9 to 785 in M10. The issues affecting this are multifactorial with some issues specific to specialties. Ophthalmology accounts for almost a third of the over 52 week patients, with most of those waiting on a non-admitted pathway. Restrictions around social distancing, air changes and physical capacity continue to affect the ability to increase activity.

An increase in Two Week Wait referrals for the Breast service, and restricted capacity due to social distancing requirements has caused pressure on the overall cancer pathway. Performance against the Two Week Wait standard reduced to 65.5% (71.44% in M9). Of the 252 breaches 183 were related to face to face capacity, predominantly associated with breast one stop capacity. A further weekly one stop clinic began in M10, with impact beginning to be seen in reduced waiting times for clinic.

The high incidence of Covid-19 caused pressure on the diagnostic pathway, with high numbers of breaches in Cardiology (182) and Audiology (98). In addition there were 146 Radiology breaches, attributable to MRI downtime, CT head capacity and Non obstetric ultrasound capacity at SFT. Performance against the 99% standard was 86.1%, down from 90.3% in M9.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
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Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☒
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People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☒

Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

March 2021

(data for January 2021)

An outstanding experience for every patient

Summary

Salisbury NHS Foundation Trust

The impact of Covid-19 continued to intensify in the first half of January, with a peak of 188 confirmed Covid-19 positive inpatients in the hospital on 20th January. Operationally this generated a huge pressure and required escalation into many of the acute medical and surgical wards.

Elective activity was impacted upon to a greater degree when the Day Surgery Unit was used for inpatient capacity, requiring surgery in the unit to be temporarily suspended. Challenges remain in increasing elective activity whilst an ITU facility is located in theatres, and significant challenges remain with theatre staffing due to vacancies, agency availability and staff shielding. Sickness across the Trust rose to 5.31% (3.43% in M9), which in addition to pressures staffing additional Covid-19 areas, led to an increase in pay expenditure of £0.2m.

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Performance fell against the Emergency Access 4 hour standard to 77.6% (85.8% in M9), the lowest performance in a number of years, and just below the national average for England. Challenges in flow with high numbers of suspected Covid-19 patients caused significant difficulties for the Emergency Department to be able to maintain timely flow in and out of the department. There were a total of 246 Ambulance handover delays, which represented 7% of ambulance arrivals and significantly higher than delays of 1% in M9.

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Referral to Treatment performance fell slightly to 71.03% (71.88% in M9), and the number of patients waiting over 52 weeks increased from 504 in M9 to 785 in M10. The issues affecting this are multifactorial with some issues specific to specialties. Ophthalmology accounts for almost a third of the over 52 week patients, with most of those waiting on a non-admitted pathway. Restrictions around social distancing, air changes and physical capacity continue to affect the ability to increase activity.

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Structure of Report

Performance against our Strategic and Enabling Objectives

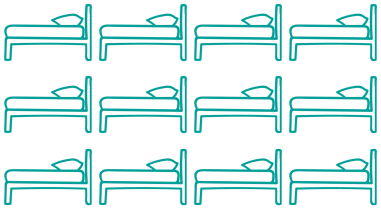
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Summary Performance
January 2021

NHS Salisbury NHS Foundation Trust

There were **2,280** Non-Elective Admissions to the Trust

We carried out **136** elective procedures & **1,309** day cases



86.1% ↓ of patients received a diagnostic test within **6 weeks**

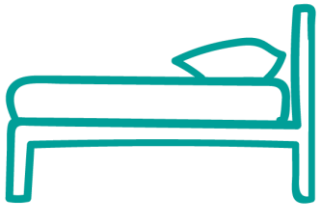
Emergency (4hr) Performance **77.6%** ↓
(Target trajectory: 95%)

We delivered **18,983** outpatient attendances, **32%** through video or telephone appointments

We provided care for a population of approximately **270,000**

Our income was **£23,689k** (£2,928k over plan)

74 patients stayed in hospital for longer than 21 days



We met **3 out of 7** Cancer treatment standards

RTT 18 Week Performance:
71% ↓
Total Waiting List: **18,184** ↓

18.5% ↓ of discharges were completed before 12:00

Our overall vacancy rate was **1.25%** ↑

Reading a Statistical Process Control (SPC) Chart

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

There should always be a minimum of 24 months worth of data

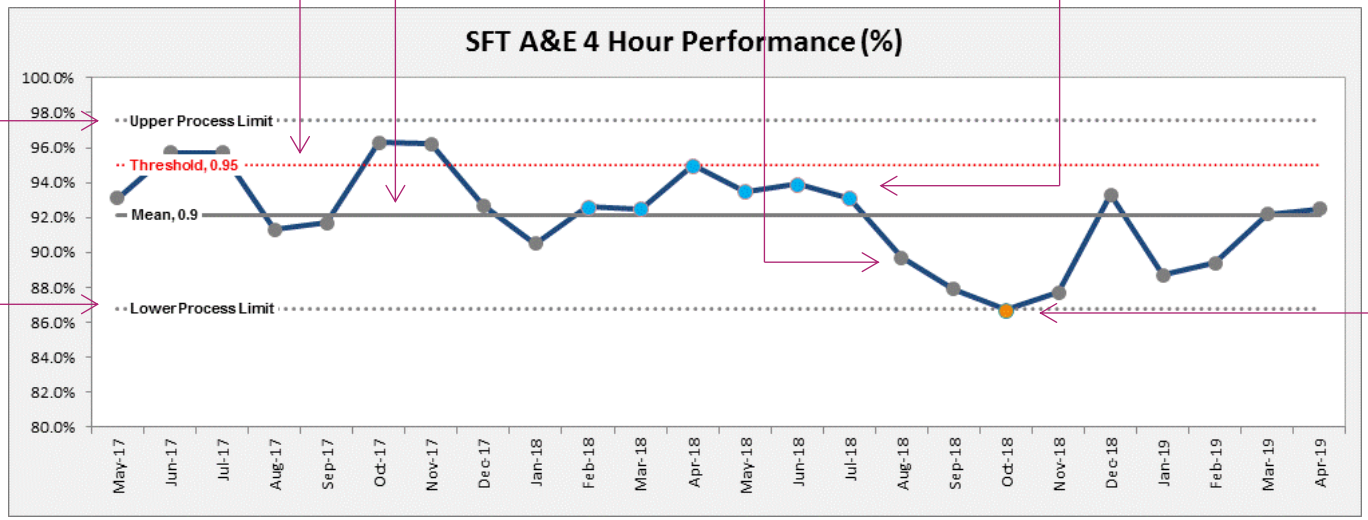
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

Blue markers indicate that there has been a marked improvement in performance, showing 6 or more points continuously improving or any point above the upper limit

Orange markers indicate that there has been a marked decline in performance, showing 6 or more points continuously deteriorating or any point below the lower limit



Statistical Process Control Chart Key:

- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points with continuous improving performance, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points with continuous deteriorating performance, or a single point outside the control limit)
- Common Cause Variation

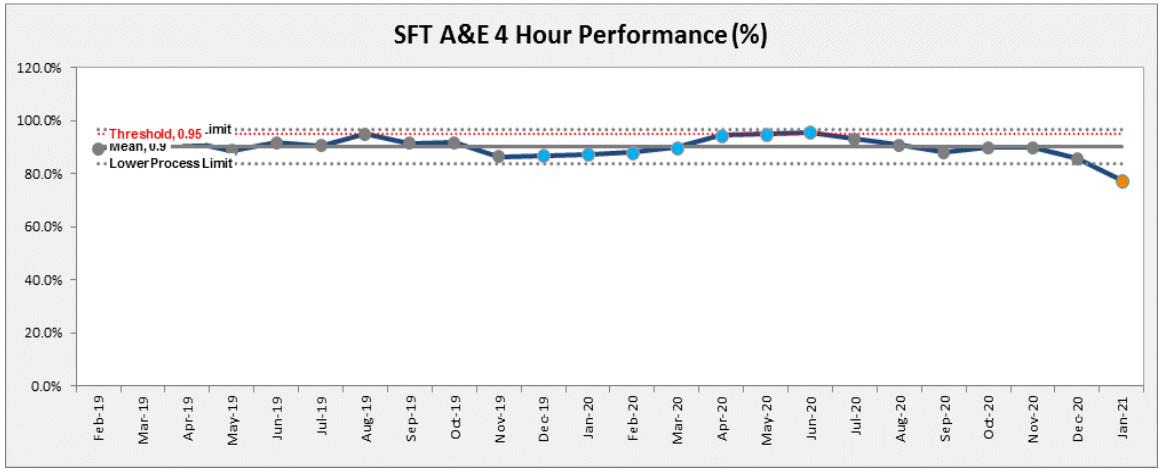
Salisbury NHS Foundation Trust

Part 1: Operational Performance

Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Emergency Access (4hr) Standard Target 95% / Trajectory 95%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	77.6%
Attendances:	3758
12 Hour Breaches:	0
ED Conversion Rate:	39.5%

Background, what the data is telling us, and underlying issues

M10 saw a deterioration in performance as compared to M9 (reducing from 85.8% to 77.6%). Attendances have also reduced in M10 (reduction of 715 as compared to M9).

Time to assessment and time to triage remained within target ranges of 15 mins (with the exception of two days) and 60 mins respectively for all patients attending via resus.

Flow out of the Department remained challenging during the month due to constrained flow to RCU for the most unwell Covid-19 patients (due to volumes).

In terms of gaps in the rota, workforce improved although availability of staff was impacted by (covid-19 related) sickness/isolation. This was particularly challenging for the nursing workforce.

Improvement actions planned, timescales, and when improvements will be seen

ED Trigger Tool (for escalation purposes) has been drafted by the ED Leadership team. This will clarify processes for escalation of ambulance delays, flow, performance etc.

Medical staffing rota coordinator appointed – this will complete the recruitment of the operational coordinating administration team.

New Service Manager in post is establishing improved relationships between AMU and ED.

Front door strategy meetings commenced.

Planned consultant recruitment remains on track.

Resolution of Mental Health room continues to be pursued to ensure appropriate environment for MH patients can be provided.

Risks to delivery and mitigations

Continued flow issues from ED to RCU throughout the month. Changes to pathway criteria throughout the month to meet the clinical requirements of covid-19 response – however, this often meant that ED was blocked, awaiting transfer.

Anticipate this improves into M11 as covid-19 demand reduces.

Ambulance handover and queuing was a significant challenge in month with 7% of arrivals waiting over 1 hour to be handed over compared to December which was under 1%, details on additional slide.

Middle grade rota continues to not be fully established (circa 4WTE in post against a 6WTE rota) – locum requirement will continue.

Statistical Process Control Chart Key:

- Target
- Mean
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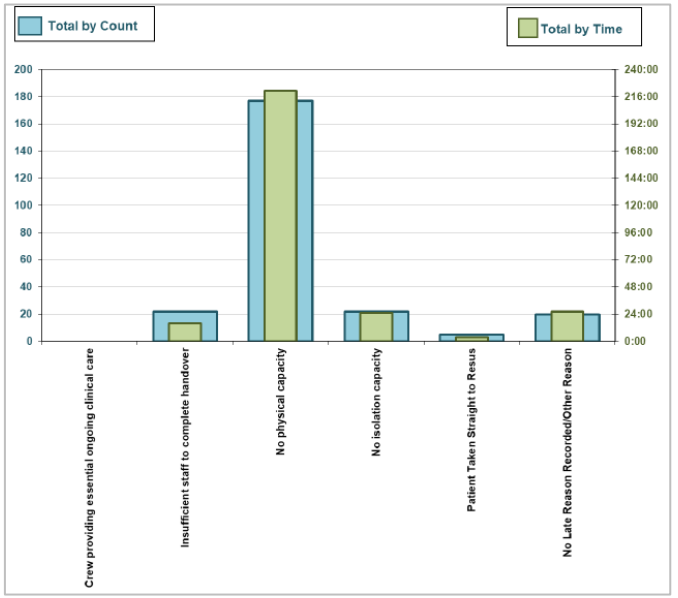
- Special Cause Variation Concern (6 or more points with continuous deteriorating performance, or a single point outside the control limit)
- Common Cause Variation

Ambulance Handover Delays

National Key Performance Indicators

Standardised Late Reason Summary	Count	Total Time Taken	% of Total Time Lost
Crew providing essential ongoing clinical care	0	0:00	0%
Insufficient staff to complete handover	22	15:49	5%
No physical capacity	177	221:36	76%
No isolation capacity	22	25:28	9%
Patient Taken Straight to Resus	5	3:39	1%
No Late Reason Recorded/Other Reason	20	26:17	9%
Totals	**246**	**292:51:23**	**100%**

Source: SWAST W020 Report 28/12/2020 – 31/01/2021



Background, what the data is telling us, and underlying issues

During the period, for all handovers over 30 minutes the most common reason recorded is 'No physical Capacity', then 'no isolation capacity'. The regional average for lack of capacity is 65% of all handovers.

Ambulance handover and queuing was a significant challenge in month with 7% of arrivals waiting over 1 hour to be handed over compared to December which was under 1%.

During this period Covid-19 presentations to SFT were at their highest, coupled with staff sickness this led to an overwhelmed Front door with poor flow through the acute Trust and system.

Improvement actions planned, timescales, and when improvements will be seen

ED Trigger Tool (for escalation purposes) has been drafted by the ED Leadership team. This will clarify processes for escalation of ambulance delays, flow, performance etc.

Medical staffing rota coordinator appointed – this will complete the recruitment of the operational coordinating administration team.

New Service Manager in post is establishing improved relationships between AMU and ED.

Clear escalation process to on call management team OOH put in place.

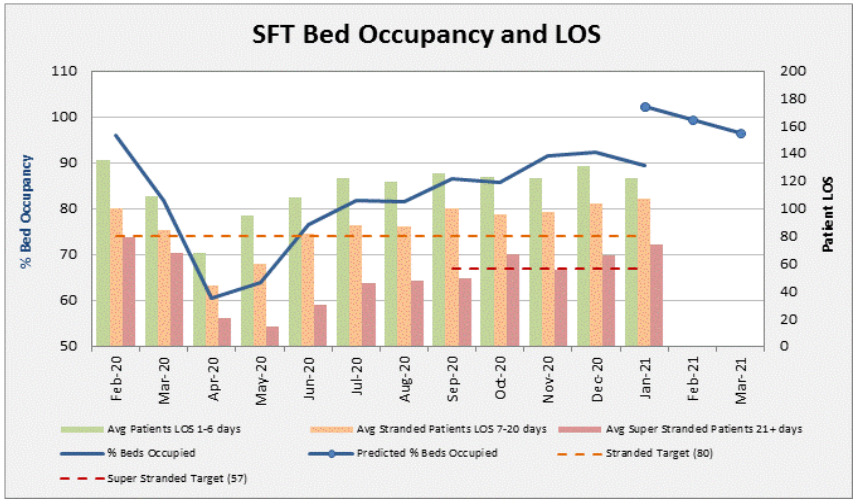
Risks to delivery and mitigations

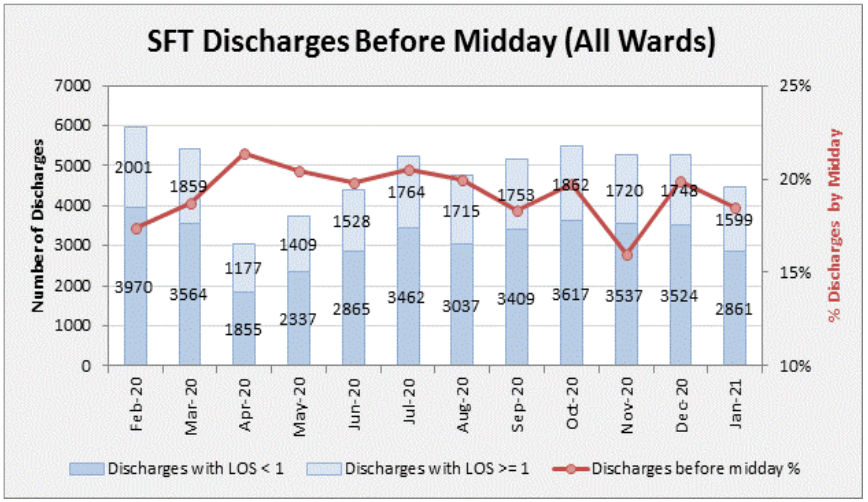
Continued flow issues from ED to RCU throughout the month. Changes to pathway criteria throughout the month to meet the clinical requirements of covid-19 response – however, this often meant that ED was blocked, awaiting transfer.

Anticipate this improves into M11 as covid-19 demand reduces and trigger tool becomes embedded.

Patient Flow and Discharge

Are We Effective?





Background, what the data is telling us, and underlying issues

January saw a particularly difficult month in relation to Covid-19 in the Trust. The graph shows a relatively steady picture regarding LOS in all groups. Staffing levels and the intensity of operational pressures meant that expert panel was suspended during January, although monitoring and reporting via the discharge team continued.

The percentage of discharges before midday also dropped although remaining higher than pre Covid-19 levels in Feb last year.

Improvement actions planned, timescales, and when improvements will be seen

There was significant activity in the health and social care system in Wiltshire to improve flow from SFT in January. Exec leads joined system flow calls and initiated responses that saw the rate of complex discharge rise and lost bed days drop. Additionally, a refreshed message regarding criteria to reside was shared with wards and clinicians to support decision making and reporting nationally to understand the clinical picture in the Trust.

Work was undertaken to enhance the ability to report patient status on whiteboards leading to overall visibility for Trust and partner organisations which then aids the focus of attention for targeted support. It is anticipated that there will be a shift in the coming months data to positively reflect the outcomes of this.

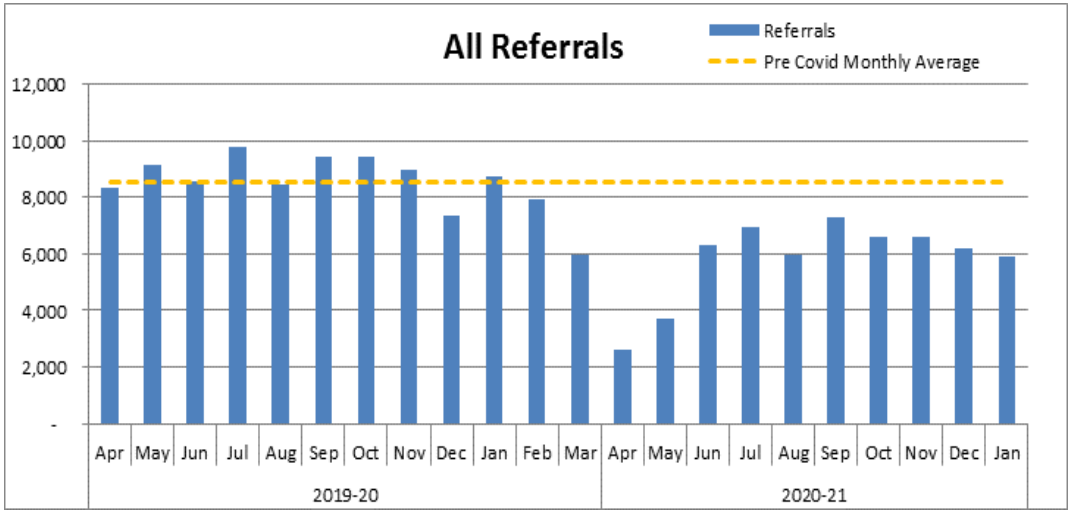
Risks to delivery and mitigations

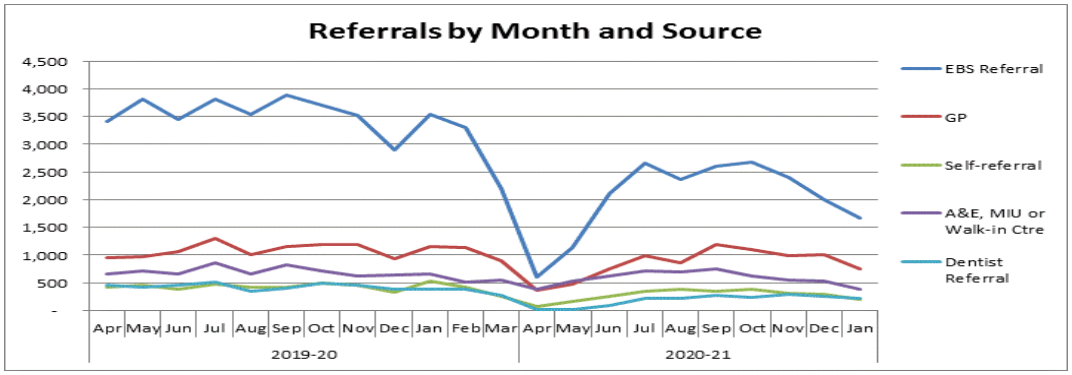
Staffing both in the acute and community and partner services continues to be an issue that could affect a downturn in flow. Military presence in the acute setting has supported Trust staff to maintain activity and capacity and this is anticipated to continue into February. The anticipated end of Covid-19 funding arrangements after the end of the financial year for discharge services in the community may see an impact as we move into April, and consideration of this is being made in the wider system.

Any unanticipated fluctuation in Covid-19 infections resulting from adjustments in current restrictions nationally could also affect Trust ability to deliver services.

Referrals

Additional Supporting Information





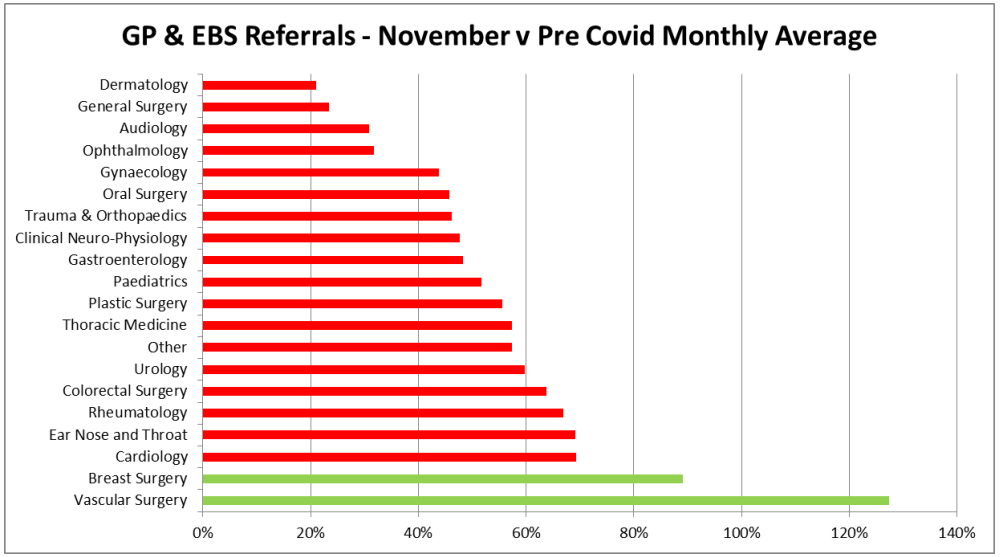
Comments

Referral levels continue to remain below pre Covid-19 levels, and with another lockdown period in place during M10 and into M11 it is expected that this will continue into months 11 and 12. Referral levels throughout January, although lower than pre Covid-19, did not fall to the levels seen in the first lockdown, reflecting the change in working practices adopted in primary care.

Referrals

Additional Supporting Information

Specialty	January '21	Pre Covid Monthly Average	% of Pre Covid Monthly Average
Vascular Surgery	73	57	127%
Breast Surgery	200	225	89%
Cardiology	175	253	69%
Ear Nose and Throat	209	303	69%
Rheumatology	113	169	67%
Colorectal Surgery	183	287	64%
Urology	144	241	60%
Other	339	591	57%
Thoracic Medicine	59	103	57%
Plastic Surgery	163	294	56%
Paediatrics	88	170	52%
Gastroenterology	79	164	48%
Clinical Neuro-Physiology	62	130	48%
Trauma & Orthopaedics	84	182	46%
Oral Surgery	24	52	46%
Gynaecology	133	304	44%
Ophthalmology	131	412	32%
Audiology	95	309	31%
General Surgery	20	86	23%
Dermatology	39	186	21%



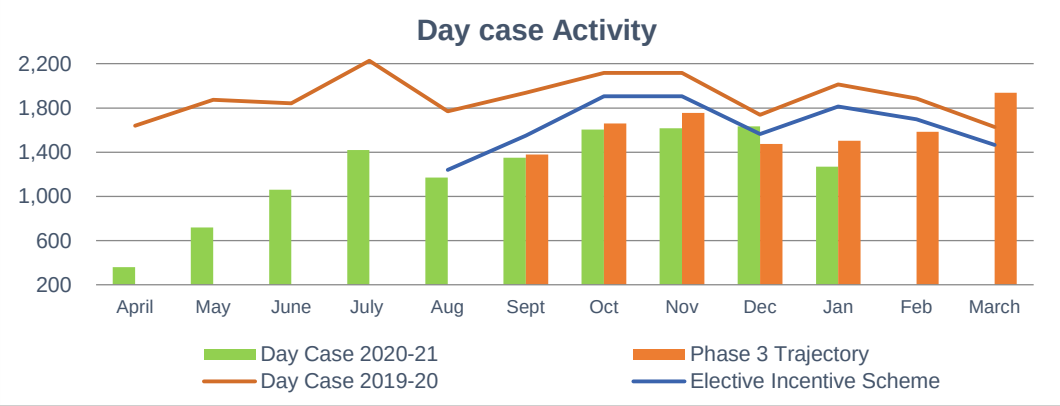
Comments

Referrals for almost all specialties remain below pre Covid-19 levels. With a further lockdown period implemented on the 5th January referral levels are expected to remain lower with people predominantly staying at home.

Breast surgery continues to see higher levels, and many of those are Two Week Wait referrals, causing pressure on the cancer pathway.

Activity recovery – Day case (target 80%)

Are We Effective?



Specialty	January	Pre Covid Monthly Average	% of Pre Covid Monthly Average
Dermatology	18	8	234%
Gastroenterology	411	379	108%
Respiratory Medicine	15	14	104%
General Surgery	185	202	91%
Plastic Surgery	192	218	88%
Urology	95	113	84%
Neurology	18	21	84%
Cardiology	76	108	70%
Colorectal Surgery	61	109	56%
Breast Surgery	7	13	54%
Rheumatology	49	109	45%
General Medicine	40	89	45%
Spinal Surgery Service	6	15	41%
Gynaecology	24	60	40%
Interventional Radiology	4	14	29%
Oral Surgery	19	89	21%
Ophthalmology	22	158	14%
Trauma & Orthopaedics	6	66	9%
ENT	4	45	9%
Vascular Surgery	0	11	0%

Daycase activity in M10 was decreased from M9 (1270 in M10 compared to 1634 in M9) and this meant the activity was 233 below the Phase 3 trajectory submitted to NHSE/I.

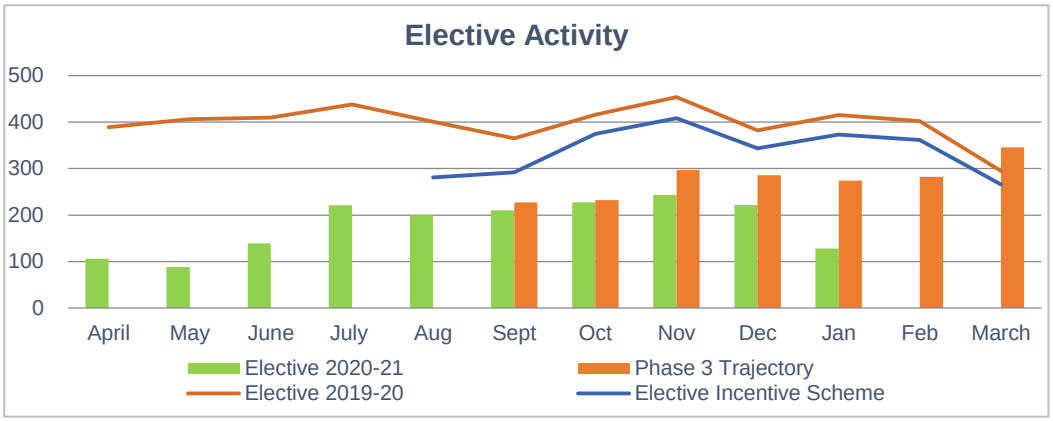
January was a particularly challenging month in relation to Covid-19 in the Trust and the response to, and effects of, this impacted both theatre capacity and activity. The workforce impact of Covid-19 related sickness/isolation and the redeployment of theatre staff leading to the cancellation of some routine priority lists. Further impact was seen following escalation into the day surgery unit to increase bed capacity for inpatients leading to the temporary closure of the unit for elective activity.

Theatre space continues to be allocated by clinical priority and need resulting in theatre access varying by specialty month to month and the impact of this can be especially seen on specialities with a high proportion of clinically routine, low priority patients such as ENT and Ophthalmology.

ENT and Oral Surgery remain challenging to increase with proportionally higher numbers of aerosol generating procedures.

Activity recovery – Electives (target 80%)

Are We Effective?



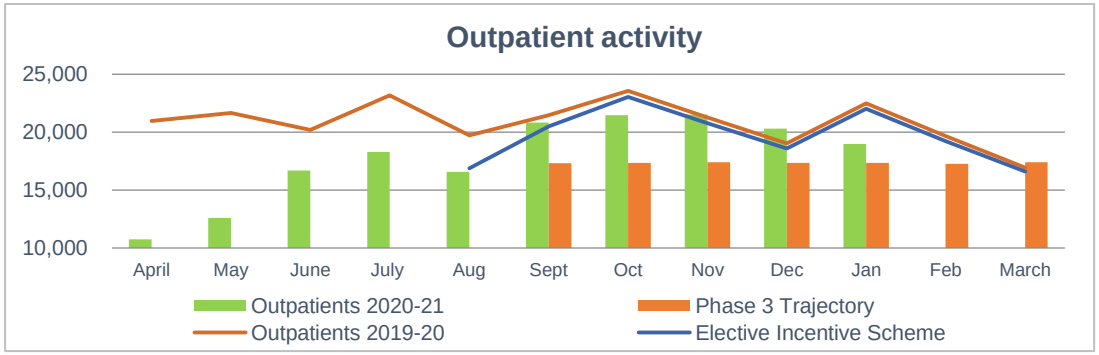
Specialty	January	Pre Covid Monthly Average	% of Pre Covid Monthly Average
General Medicine	8	6	127%
Clinical Haematology	5	4	113%
Colorectal Surgery	17	21	79%
Urology	39	60	65%
Gynaecology	9	23	40%
General Surgery	8	25	32%
Gastroenterology	1	4	24%
Plastic Surgery	19	84	23%
Cardiology	2	10	19%
Breast Surgery	2	12	17%
Oral Surgery	2	12	17%
ENT	2	28	7%
Spinal Surgery Service	1	16	6%
Trauma & Orthopaedics	2	89	2%

Elective activity was also significantly impacted by the Covid-19 challenges and fell in M10 with the gap between activity and the Phase 3 trajectory submitted to NHSE/I widening further. 128 electives were performed against a trajectory of 274 resulting in a shortfall of 146 against plan.

The specialties with the highest variance from plan were Trauma & Orthopaedics, ENT and Oral Surgery where, as with the daycases, having high proportions of clinically routine, low priority patients is impacting the access to theatre capacity as specialties with clinically urgent patients are being prioritised meaning that specialities with lower levels of urgent patients continue to recover activity levels more slowly.

Activity recovery – Outpatients (target 100%)

Are We Effective?



Specialty	January	Pre Covid Monthly Average	% of Pre Covid Monthly Average
Respiratory Medicine	1916	578	331%
Clinical Haematology	485	360	135%
Endocrinology	330	260	127%
Colorectal Surgery	548	458	120%
Medical Oncology	407	361	113%
Gastroenterology	294	281	105%
Urology	812	803	101%
ENT	675	735	92%
Rheumatology	780	868	90%
Plastic Surgery	1704	1911	89%
Gynaecology	574	657	87%
Cardiology	510	602	85%
Genito-Urinary Medicine	460	550	84%
Ophthalmology	1886	2441	77%
Breast Surgery	340	442	77%
Orthodontics	218	296	74%
Orthotics	402	555	72%
Oral Surgery	524	742	71%
Paediatrics	606	861	70%
Audiology	637	908	70%
General Surgery	220	324	68%
Trauma & Orthopaedics	1159	1762	66%
Dermatology	531	840	63%
Diabetic Medicine	140	272	51%
Spinal Surgery Service	117	238	49%
Physiotherapy	0	393	0%

Outpatient activity levels for M10, although down slightly from M9, exceeded the forecast Phase 3 trajectory submitted to NHSE/I with outpatient activity in January 2021 being 1631 ahead of plan with several specialties achieving 90% or above. Specialties with fewer Covid-19 related constraints can be seen to have fully recovered with activity for some being well over 100%.

With increased numbers of appointments being undertaken virtually, the level of outpatient procedures has reduced.

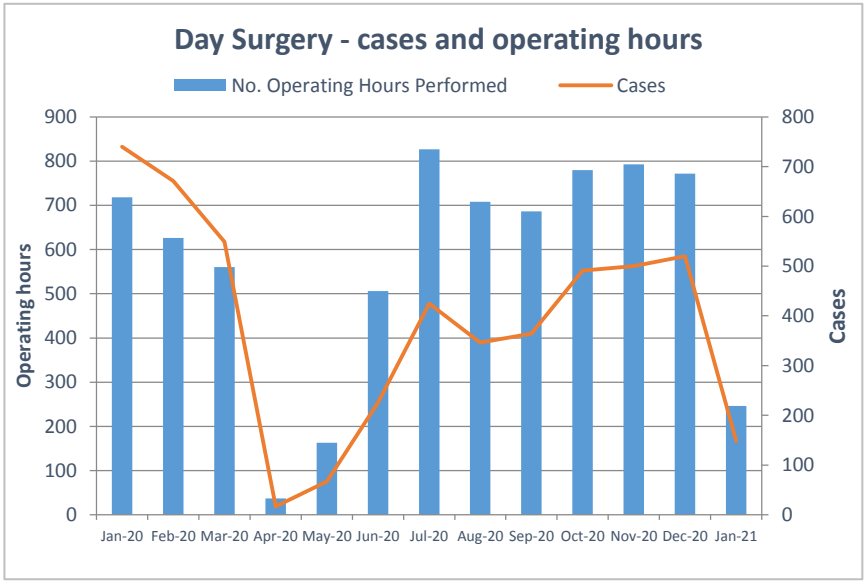
An air change solution for both the ENT & Oral Surgery outpatient departments has been identified, and work on this is due to commence in M12, with activity for these specialties expected to rise following this.

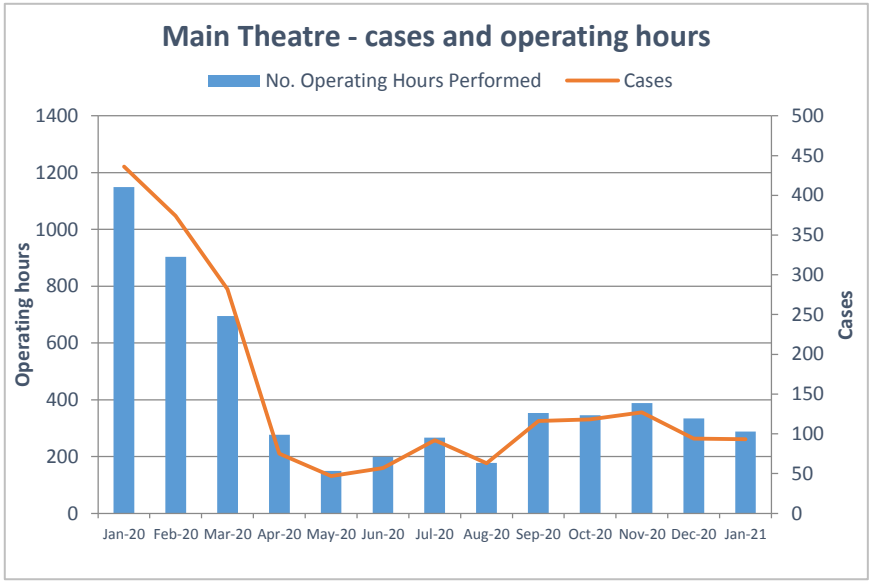
Space constraints across outpatient department continue to be a challenge, particularly in specialties with low levels of patients suitable for virtual appointments such as Trauma & Orthopaedics. The modular build, which is expected to be completed by the end of M12, will increase the number of patients that can be safely seen.

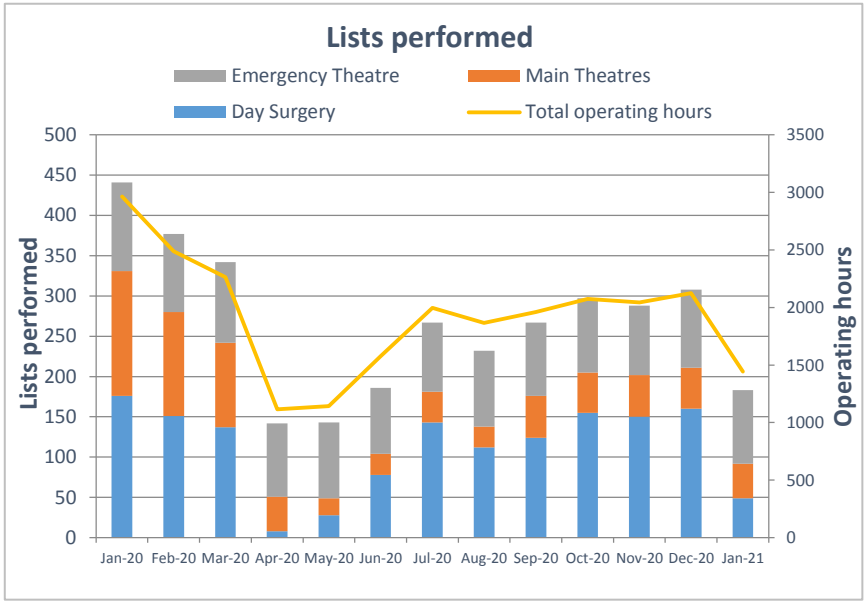
Virtual appointments are working well in some specialties with Gastroenterology seeing the majority of their outpatients virtually. Urology, Gynaecology and Colorectal Surgery are also seeing good use of virtual appointments.

Activity recovery - Theatres

Additional Supporting Information







Theatre activity decreased in M10 and was behind plan in daycase and main theatres.

Theatre activity was expected to increase in Q4 with the further re-opening of Main Theatre capacity, but this was only partially achieved and has been further impacted by the increased escalation of ITU into the Main Theatre footprint due to the second wave of Covid-19, and much larger bed requirement. The temporary closure of the Day Surgery Unit to provide additional ned capacity resulted in cancellations of theatre lists.

Significant challenges remain around staffing, sickness levels, agency fill and recruitment and Covid-19 related absence remains a difficult issue to mitigate.

Theatre staff payment incentive continues.

Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

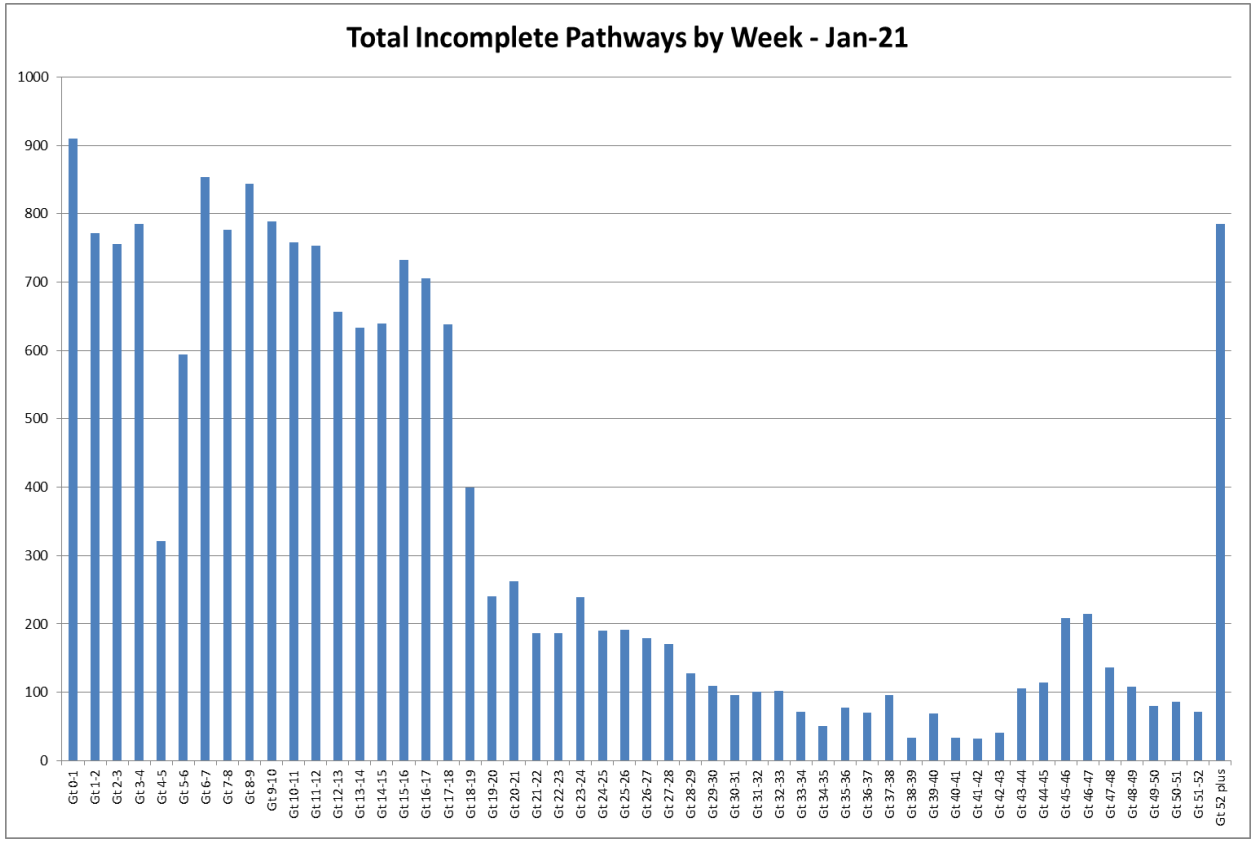
National Key Performance Indicators

Top 5 lowest 18 week performance

Specialty	WL Total	Total <18 weeks	% <18 weeks
Ophthalmology	2434	1230	50.5%
Plastic Surgery	1262	751	59.5%
Oral Surgery	1445	867	60.0%
Dermatology	550	340	61.8%
Ear, Nose & Throat (ENT)	1611	1011	62.8%

Top 5 largest 18 week breach backlog

Specialty	WL Total	Total 18 wk breaches	% <18 weeks
Ophthalmology	2434	1204	50.5%
Ear, Nose & Throat (ENT)	1611	600	62.8%
Oral Surgery	1445	578	60.0%
Other	3034	540	82.2%
Plastic Surgery	1262	511	59.5%



RTT performance declined slightly in January at 71.03% (71.88% in M9). This is due to reduced theatre activity and continued challenges in outpatient space

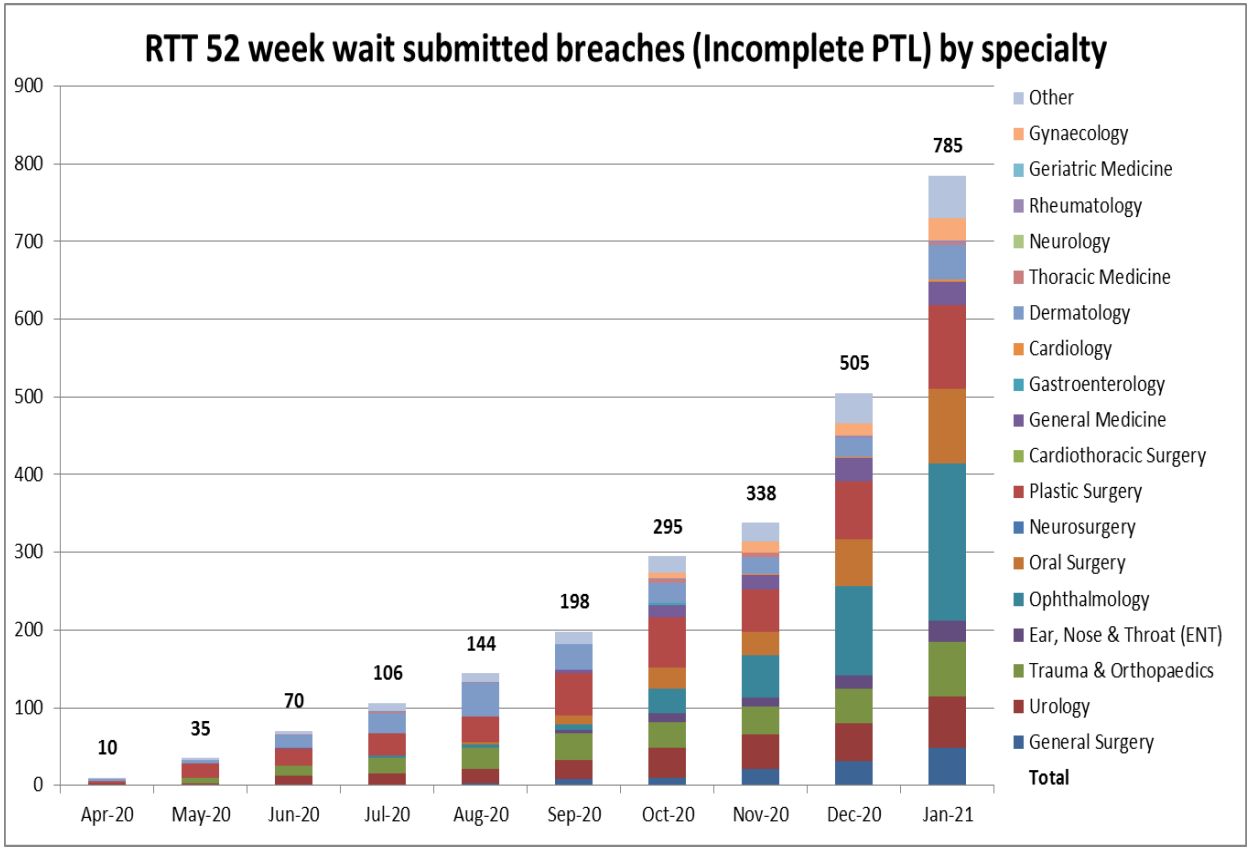
As part of the support work for areas with the poorest compliance, and largest volumes, the Surgical DMT continue to focus on Ophthalmology reviewing options to increase their outpatient capacity options with transfer of patients to two outsourcing solutions due to commence in M11. The use of a new peripheral site commenced in January.

Additionally the air change solutions now identified for ENT and Oral Surgery, which will be installed next month, will improve their capacity but improvement will be limited until these are in place.

Work on Dermatology and Plastic Surgery productivity continues and additional minor operation capacity continues to be organised including Saturday outpatient and surgical lists.

Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

National Key Performance Indicators



Top 5 with highest 52 week wait submitted breaches (Incomplete PTL)

Treatment function	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	% change from previous month
Ophthalmology	0	0	0	2	3	7	32	55	115	202	76%
Plastic Surgery	3	18	21	28	33	54	64	54	74	107	45%
Oral Surgery	0	0	0	1	3	12	27	30	61	97	59%
Trauma & Orthopaedics	1	7	14	20	27	34	34	37	44	71	61%
Urology	2	3	11	15	18	25	38	44	49	65	33%

The number of patients waiting longer than 52 weeks has grown by 280 patients to a total of 785 and there are now approaching 100 patients who have requested to pause their pathway due to Covid-19 concerns.

As part of the phase 3 activity assumptions the Trust forecast that the number of over 52 week patients would grow every month until the end of 2020-21. The forecast position for M10 was 286 patients over 52 weeks. The forecast was completed when the Trust had Zero Covid-19 inpatients and assumed that this level would continue.

Approximately 30% of patients (around 220) waiting longer than 52 weeks are waiting on an outpatient pathway and 70% waiting (around 530) on an admitted pathway.

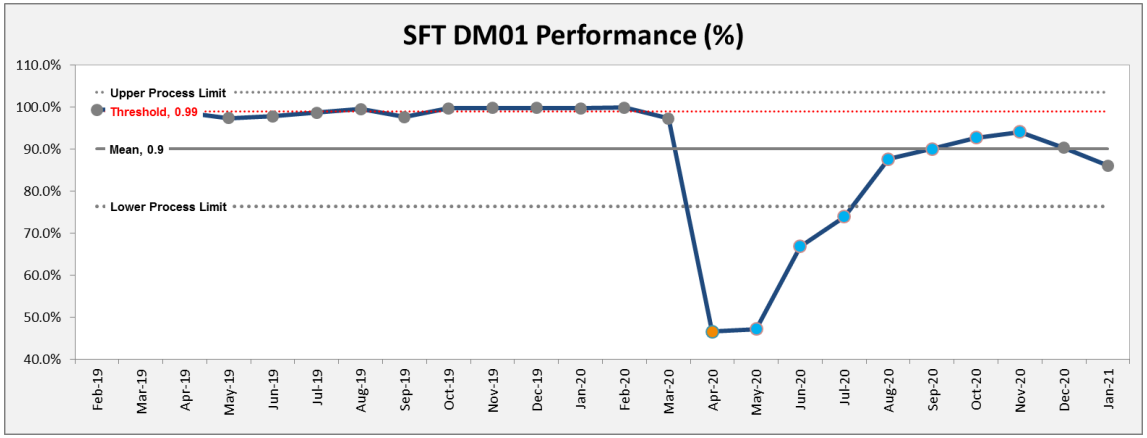
Of the 225 patients waiting on an outpatient pathway, 170 are in Ophthalmology. There are specific challenges to increasing activity in Ophthalmology in relation to the ability to socially distance, outpatient capacity and the proportion of vulnerable patients in this group. Two additional outsourcing providers are due to commence in M11.

Of the 530 patients waiting on an admitted pathway, there were 60 patients in priority level 3 (should be treated within 3 months of prioritisation), and 475 in levels 4, 5 and 6 (more than 3 months). The specialty split is more broad, with the highest being in plastics (94), Oral Surgery (86), Urology (64) and Orthopaedics (52). Theatre allocation continues on the basis of clinical priority, and specialties with a lower proportion of higher priority patients have reduced operating space for routine procedures.

Regular review of the prioritisation is undertaken to ensure that circumstances have not changed and the allocated priority is appropriate. Guidance issued from the Federation of Surgical Specialty Associations forms the basis for prioritisation.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	86.1%
Waiting List Volume:	3118
6 Week Breaches:	433
Diagnostics Performed:	5951

Background, actions being taken and risks and mitigations
Performance standard in month has not been achieved as a direct result of Covid-19. February projections confirm that the target is not achievable for M11 owing to a sustained increase in the referral rate in Cardiology and Audiology and reduced capacity in MRI. As expected, M9 Mobile MRI downtime at both SFT and New Hall, combined with reduced capacity at New Hall in M10, had a detrimental impact on 6 week waits, and this is evident in the decline in performance in this modality. Activity for M10 was overall down on that undertaken in previous months as a direct impact of Covid-19 on staff sickness levels.

Endoscopy
7 confirmed in month breaches, all attributable to Covid-19.

Radiology (Inc. DEXA)
146 confirmed in month breaches. 72 MRI attributable to M9 downtime @ SFT & New Hall and reduced capacity @ New Hall in M10. 33 CT – all attributable to elective CT Heads. Recovery plan in place for this cohort of patients for M11 & M12. 41 Non Obstetric USS owing to reduced SFT Capacity.

Radiology Reporting
2nd provider live from 08-12-2020. Sustained improvements to the number of outstanding scans week on week. Interventional Radiology remains the exception, owing to reduced functionality in the work station located at the Royal Bournemouth and Christchurch Hospital. SFT IT continue to provide support to identify resolution.

Audiology
98 confirmed in month breaches, all attributable to Covid-19. Activity within the service continues to increase incrementally, M10 greater than both M8 and M9.

Cardiology
182 confirmed in month breaches, all attributable to Covid-19. Breaches have reduced in comparison to M9 and activity increased as planned.

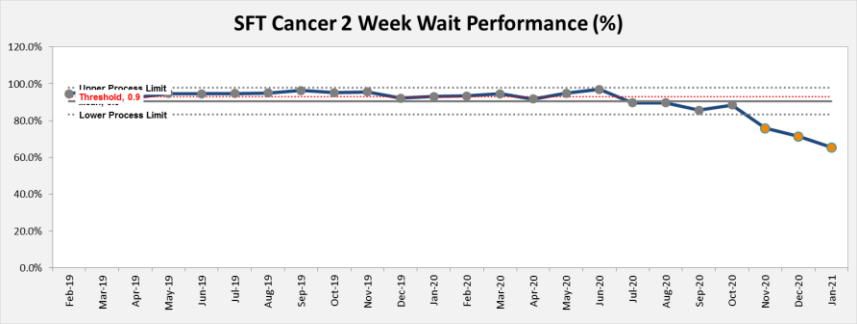
Neurophysiology
0 in month breaches. The service have recovered and sustained their waiting list position.

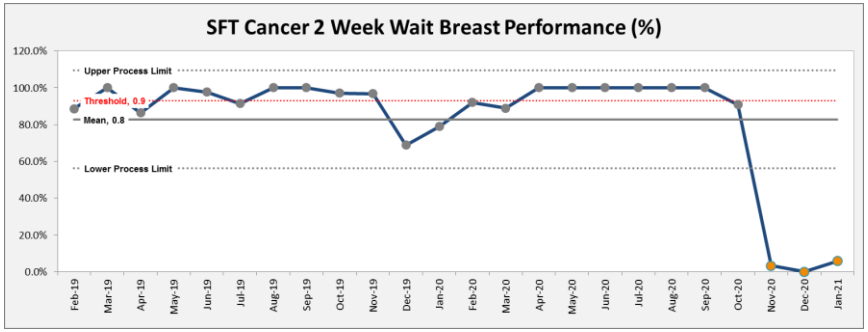
Cancer 2 Week Wait Performance Target 93%

National Key Performance Indicators

Performance Latest Month	Performance	Num/Den	Breaches
Two Week Wait Standard:	65.5%	479/731	252 (20 patient choice)
Two Week Wait Breast Symptomatic Standard:	5.9%	2/34	32

Data Quality Rating:





Background, what the data is telling us, and underlying issues

Two week wait standard not achieve for M10 (728 patients seen in total; 476 seen within target; 252 breaches). This is due to a variety of reasons including:

- Face to face outpatient capacity (183 breaches, predominantly associated with breast one stop capacity);
- Patient choice (20 breaches);
- Late receipt of qFIT result (22 breaches);
- GP delay (16 breaches);
- Clinical delay (2 breaches);
- Administrative delay (8 breaches)

Breast symptomatic two week wait performance standard not achieved for M10 (34 patients seen in total; 32 breaches). Delays again associated with patient choice and breast one stop capacity.

Improvement actions planned, timescales, and when improvements will be seen

Booking teams continue to prioritize cancer patients, though ongoing concerns related to patient choice and DNAs remain; this is likely to impact on service delivery for a significant period of time. Revised GP comms has been circulated to remind GPs of the importance of ensuring patients are willing and able to attend.

Implementation of qFIT within primary care continues to become embedded. Revised colorectal 2ww referral form agreed with MDT lead and CCG; this should be in circulation imminently and explicitly outlines the need for qFIT result prior to referral.

Significant challenges within breast service due to increase in referrals, social distancing restrictions and outpatient capacity. Fifth one stop clinic now in place which is beginning to demonstrate reduced waiting times from referral to first seen.

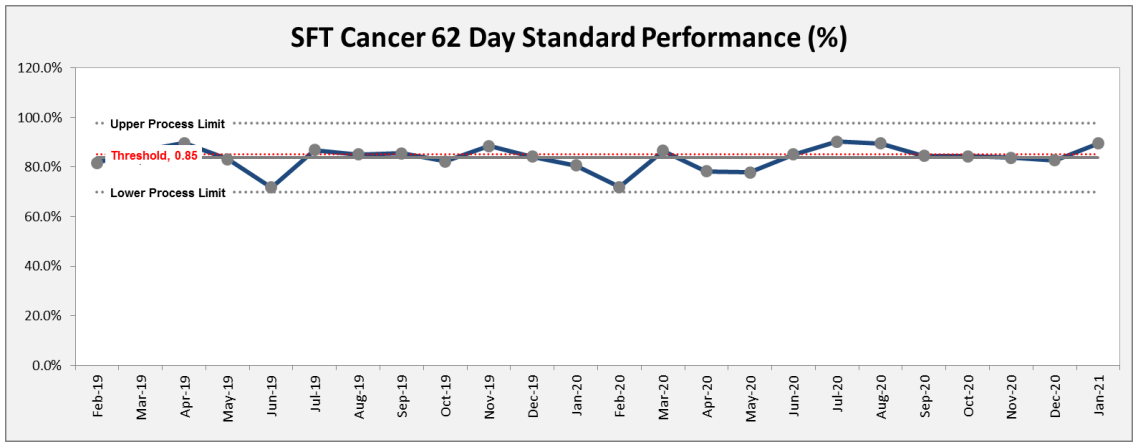
Weekly PTL, cancer ops and cancer action group in place to look to prevent avoidable breaches. His then enables cancer services to work with the relevant team to expedite where possible. Use of cancer escalation process is now business as usual to avoid unnecessary delays.

Risks to delivery and mitigations

The SWAG cancer alliance has confirmed that secondary care will be unable to book or perform diagnostic tests without the completion of qFIT; this should be completed by the patient prior to referral though there is a risk that as this is not mandated, that patient pathways will be delayed. This is affecting SDH's ability to book straight to test appointments in a timely manner within both radiology and endoscopy; a full audit is currently being undertaken within the rapid referral office to monitor the impact of this. Cancer services continue to work close with the colorectal team and CCG, who plan to target practices with low uptake.

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

January 21	Performance	Num/Den
62 Day Standard:	89.5%	98.5/110
62 Day Screening:	50%	1/2

Risks to delivery and mitigations

Month 10 62 day performance achieved, with month end performance of 89.14% (110.5 patients treated in total; 98.5 in target; 12 breaches). Breach reasons predominantly associated with complex diagnostic pathways, patient choice and capacity.

Three 104 day breaches reported in January following treatment:

- 1 x Head and Neck; complex diagnostic pathway and administrative delays;
- 1 x Gynaecology; delayed transfer from colorectal due to delay in receipt of qFIT, diagnostic capacity and patient choice delays;
- 1 x Haematology; delayed transfer from head & neck due to multiple diagnostics and subsequent delays associated with diagnostic capacity.

Month 10 62 day screening performance standard not achieved (2 patients treated in total; 1 breach). Breach associated with complex diagnostic pathway and theatre capacity.

Future performance continues to remain fragile, though cancer treatments continue to be prioritised. Cancer services and DMT continue to focus on longest waiters and overall PTL backlog (patients waiting over 62 days); this continues to show improvement. Weekly cancer action group established to maintain DMT focus on cancer care delivery.

Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

Stroke & TIA Pathways

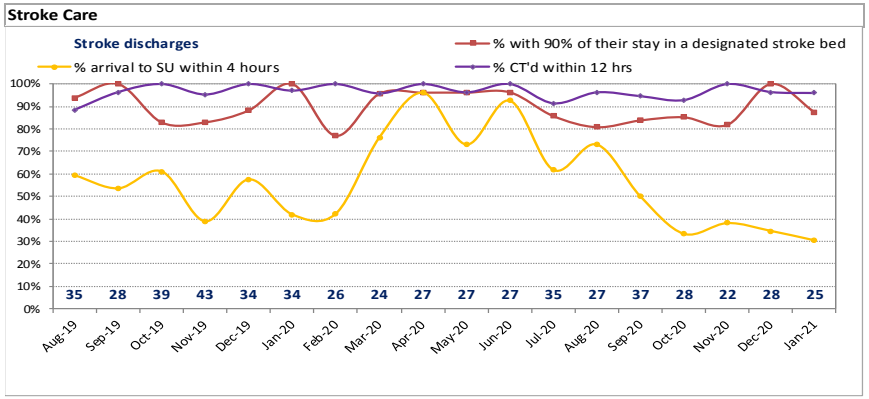
Are We Effective?

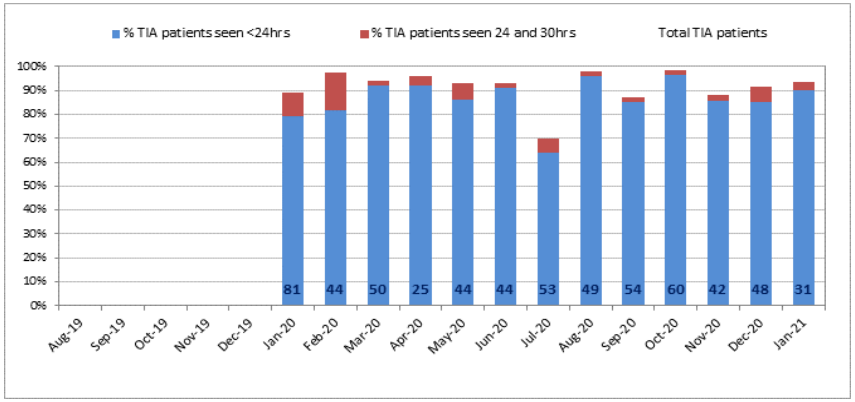
SFT SSNAP Case Ascertainment Audit Score:

Year	Q1	Q2	Q3	Q4
2019-20	B	B	B	Not Reported
2020-21	Not Reported	Not Reported	Not Reported	

Data Quality Rating:

% Arrival on SU <4 hours:	30.4%
% CT'd < 12 hours:	96.0%
% TIA Seen < 24 hours:	90.3%





Background, what the data is telling us, and underlying Issue

32% of stroke patients had a CT within 1 hour (target 50%) reflecting the number of patients arriving out of hours and the increased pressure on ED. Patients reaching the stroke unit within 4 hours remained at a low level (30%) affecting 16 patients. The median time to the Stroke Unit was 6 hours 32 mins. Delays were due to waiting for a bed (8), waiting for first doctor/specialty doctor (3), transferred to AMU (2), workload (1) and in ED at 4 hours (1). 2 (8%) stroke death within 7 days – lower than expected (10%) and 5 (20%) stroke deaths within 30 days – higher than expected (17%), however year to date is below the national target. 87.5% of stroke patients spent 90% of their time on the stroke unit exceeding the national target (80%). 44% of eligible patients accessed the Early Supported Discharge (ESD) service exceeding the national target (40%).

Good TIA performance at 90%. This despite the TIA clinic being suspended from 22 January to 1 February due to consultant sickness. Patients were diverted to Bournemouth and neighbouring hospitals and normal service resumed on 1 February.

Improvement actions planned, timescales, and when improvements will be seen

In January, due to winter/Covid-19 pressures, Laverstock ward was returned to its original configuration of 26 beds and Breamore ward to 23 beds. These additional beds supported non-stroke medical patients.

Both stroke consultants were off sick in the last week of January and the Stroke Unit was closed to new admissions. It re-opened on 1 Feb.

Following this the Stroke Unit consolidated to Laverstock ward (26 beds) and Breamore ward was reconfigured to medical escalation capacity. A replacement locum stroke consultant starts on 22 February.

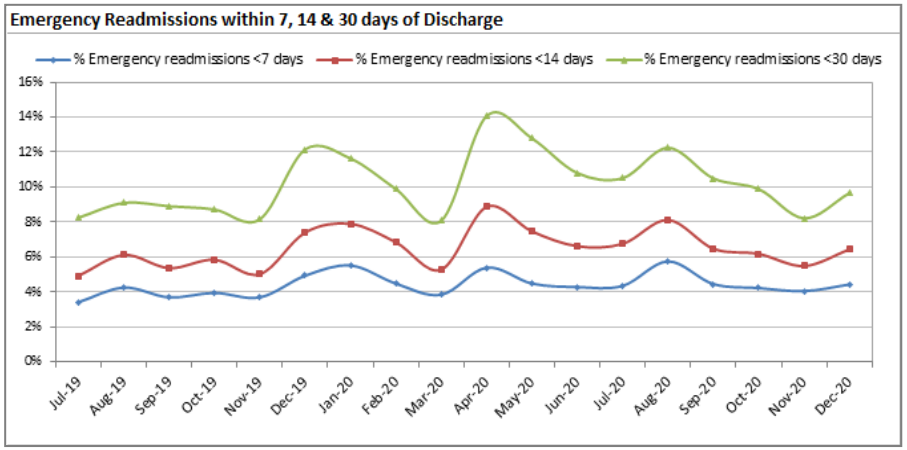
Risks to delivery and mitigations

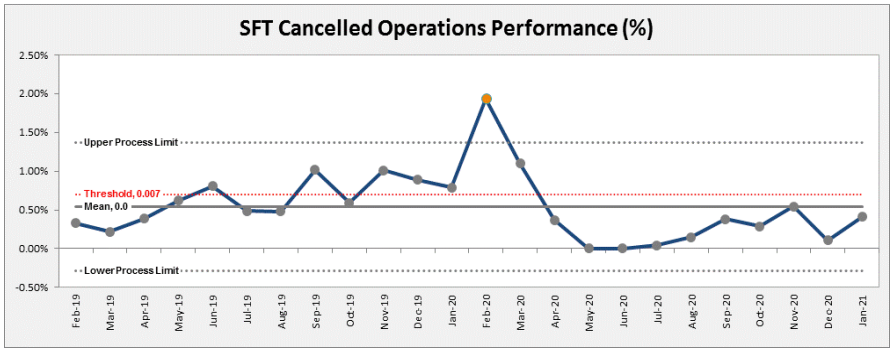
The assessment bed for GP direct admissions and transfers from ED within 4 hours is being used for bed capacity due to the increase in Covid-19 patients. Mitigated by virtual board rounds to decide on isolation and de-isolation of patients with Covid-19.

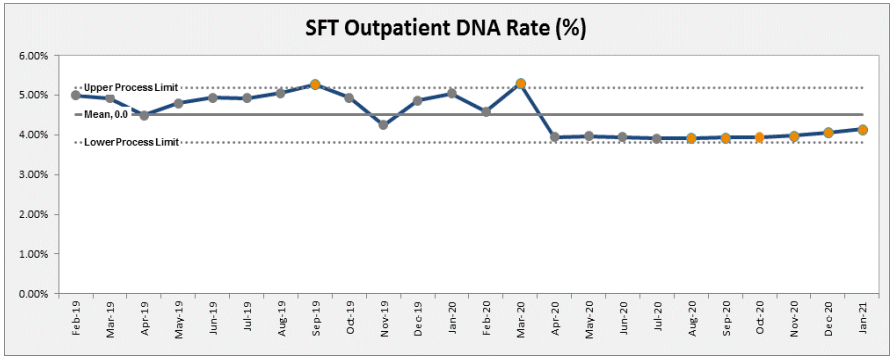
SSNAP data is not likely to be published for Q4 20/21.

Other Measures

Are We Effective?







To note, the outpatient DNA rate measurement was changed by the PMO OP Transformation Board in April 2020 to remove a filter that excluded a set of OP clinics. By removing the filter the number of attendances has gone up, and therefore the DNA rate has dropped.

Salisbury NHS Foundation Trust

Part 2: Our Care

Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	**Are We Safe?**	**Are We Caring?**
People	Are We Well Led?	Use of Resources
Resources		

Infection Control

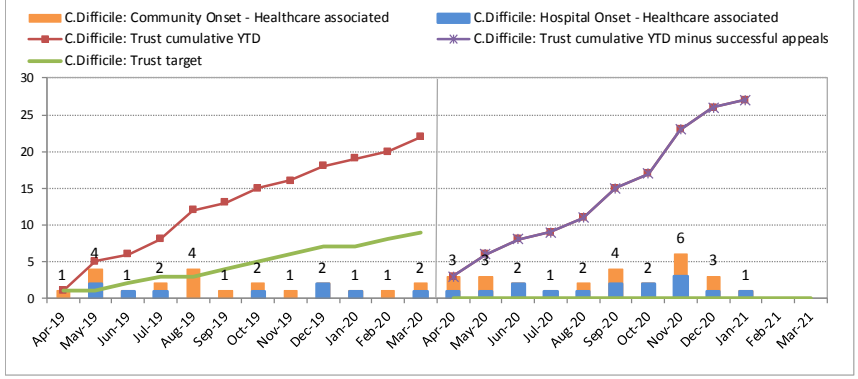
Data Quality Rating:

Are We Safe?

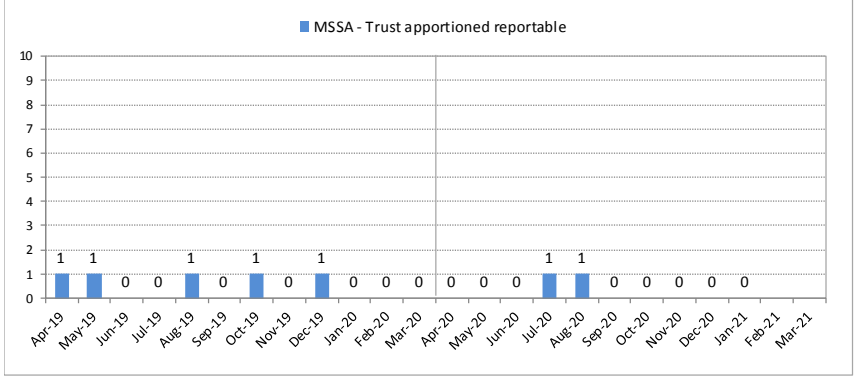
Clostridium Difficile	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21
Cases Appealed	0	0	0	0	0	0	0	0	0	0
Successful Appeals	0	0	0	0	0	0	0	0	0	0

MRSA	2019-20	2020-21
Trust Apportioned	0	2

Clostridium Difficile: Healthcare Associated Cases



MSSA - Trust apportioned



Summary and Action

- 2 hospital onset E Coli blood stream infections. Both patients were admitted to Critical Care. The source of infection was unknown in one case and in the other no underlying focus of infection was identified. Both patients were known to be Covid-19 positive.
- 1 hospital onset healthcare associated C.difficile case of a patient on Chilmark ward. Case currently under investigation.

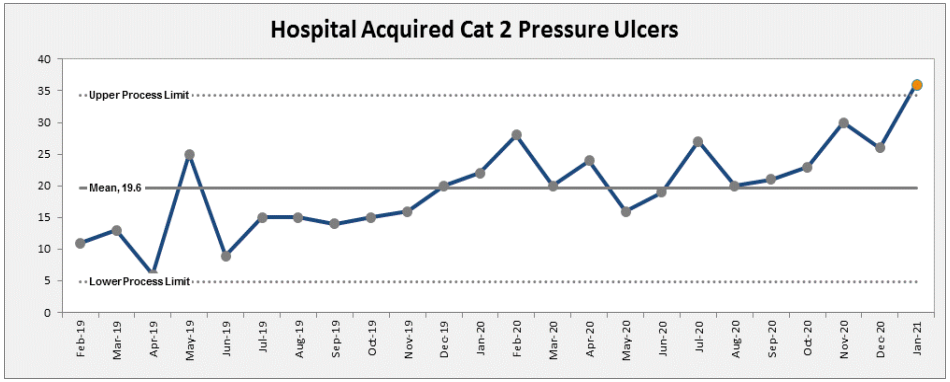
Outcome of investigations/learning from hospital onset healthcare associated cases not previously reported in November:

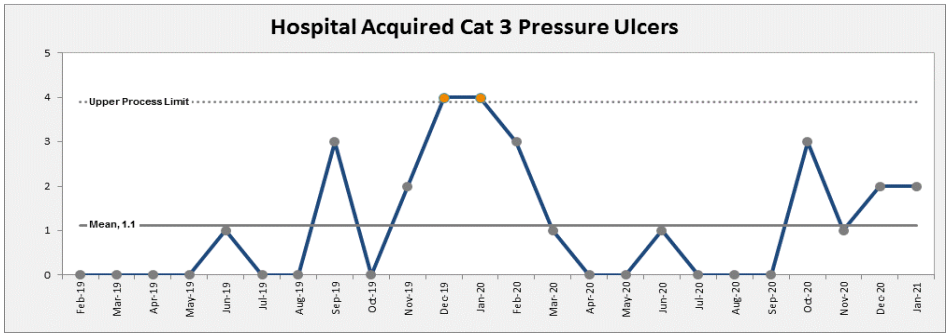
- A patient admitted due to congestive cardiac failure was being isolated on Whiteparish Ward, having been transferred from a bay on Tisbury CCU. The patient had recent antibiotics for cellulitis. Learning centred on a delay in escalating to the medical team and lack of documentation in relation to a request for a stool sample and the need to isolate the patient.
- A patient on Spire Ward who had previously been identified as C.difficile positive in July, and had been under the care of the Pembroke Team. A sample was obtained at the request of the clinicians. Learning: patients who have had a previous C.difficile diagnosis do not need to be routinely retested. The case was discussed both with the nursing and medical teams.
- A patient on the Stroke Unit, who transferred to a side room on Odstock Ward. The patient had a complex history and was admitted from a Nursing Home with underlying abdominal sepsis, constipation and had received antibiotics. Learning point: delay in requesting a medical review when the patient first developed increased frequency of symptoms.

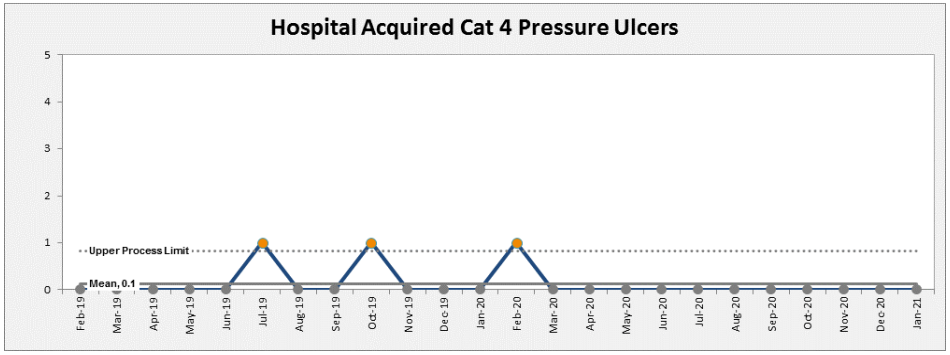
Pressure Ulcers

Are We Safe?

Data Quality Rating:







Per 1000 Bed Days	2019-20 Q3	2019-20 Q4	2020-21 Q1	2020-21 Q2	2020-21 Q3
Pressure Ulcers	1.22	1.73	2.27	1.92	2.10

Summary and Action

The number of category 2 pressure ulcers increased from 26 in December to 36 in January (16 of these in Covid-19 positive patients). The biggest increase was seen in the Surgical Division from 8 to 20 category 2 pressure ulcers mainly in Covid-19 positive patients in Critical Care. Share and learn meetings are yet to be held to understand the root cause. Themes noted are an increase in heel pressure ulcers and lack of consideration in starting nutritional supplements. In January, two category 3 pressure ulcers declared (in the same patient) but remain unstageable, but can be confirmed as a minimum of category 3 pressure ulcers.

Improvements implemented – 'aSSKINg' videos uploaded to MLE on pressure ulcer prevention. All wards have a folder with information on pressure ulcer categorisation, use of dressings, tissue viability referral and escalation process, nutritional support pathway, differentiation guide for moisture compared to pressure damage. Monthly VAC training re-established.

Challenges - sustaining the focus on pressure ulcer prevention with current workforce challenges (sickness absence) and releasing staff for training.

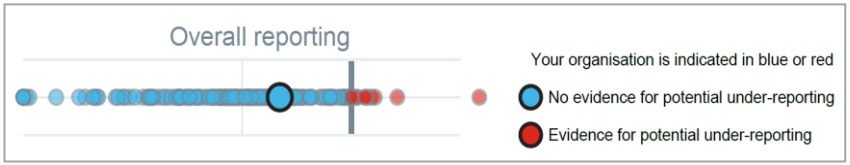
Plan is to continue the focus on pressure ulcer prevention and undertake a Plan, Do See, Act (PDSA) cycle for the new skin bundle which incorporates a body map and wound assessment. In addition, to re-establish the PDSA cycle for skin inspection in AMU and clarify with the Divisions about wound care handover and safety brief changes. Education remains a key part of the improvement plan.

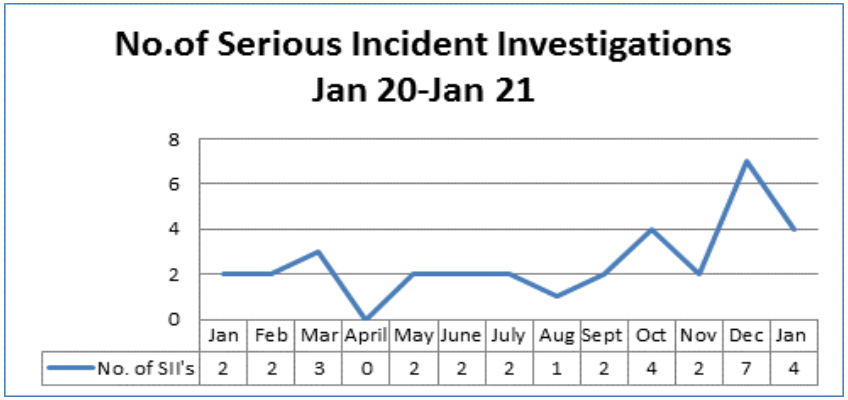
Incidents

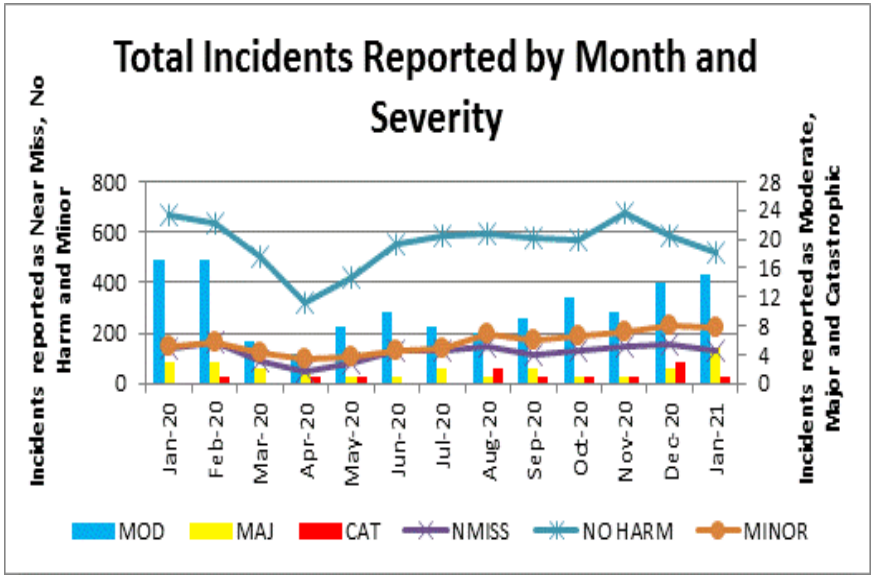
Are We Safe?

Year	2019-20	2020-21
Never Events	2	0

Information from NRLS benchmarks SFT in regard to reporting of incidents and reflects a positive reporting culture.







Summary and Action

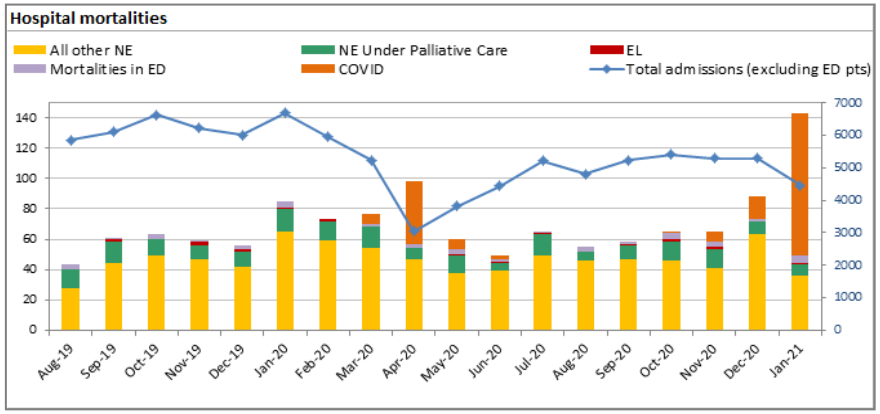
4 serious incidents investigations commissioned in January;

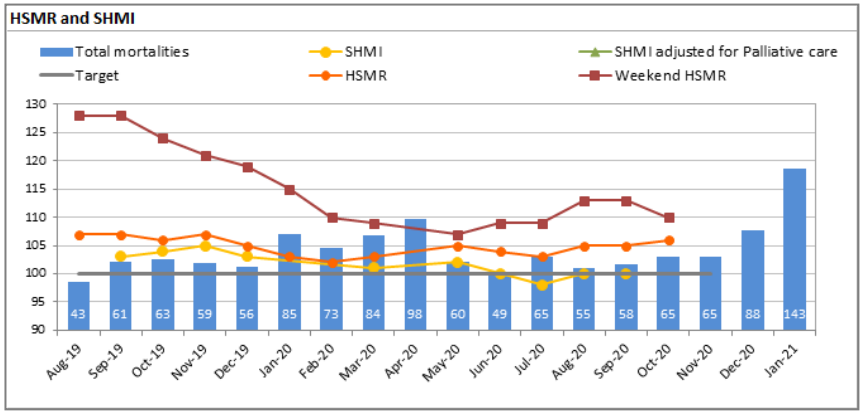
- CSFS Division - term intrauterine death at 39 weeks.
- CSFS Division – a paediatric patient with known quadriplegic cerebral palsy and seizure disorder suffered brain stem injury and died
- Trust wide - Covid-19 outbreak due to an anticipated rise in incident reporting and minor harm as a result of the pressures on staffing level seen during the second wave of the Covid-19 pandemic (in line with a regional and national trend).
- Surgical Division – a safeguarding incident currently under investigation.

Mortality Indicators

Are We Safe?

Data Quality Rating:





Summary and Action

HSMR is as expected to October 20. The weekend HSMR decreased and remains within the expected range.

Of the 143 deaths in January, 94 were associated with Covid-19 disease and of these:

- 50 cases were community onset
- 4 were hospital onset indeterminate healthcare associated cases
- 16 were hospital onset **probable** healthcare associated cases.
- 24 were hospital onset **definite** healthcare associated cases.

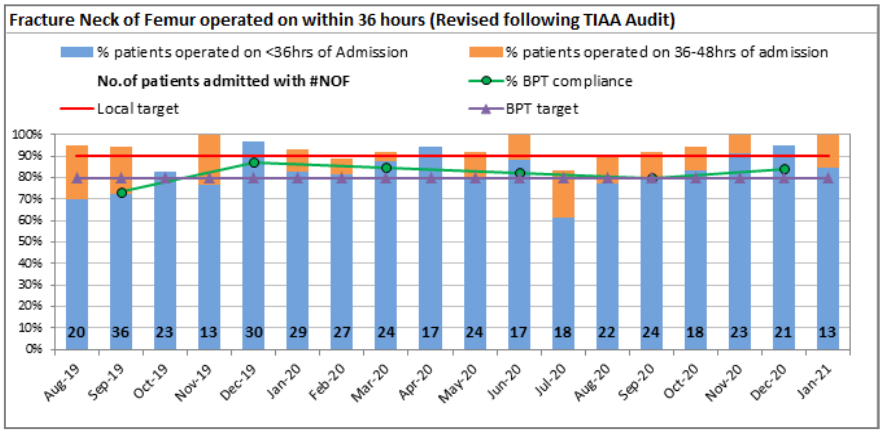
Overall, a reduction in the percentage of patients who died from Covid-19 from 35% in the first wave to 22% in the 2nd wave. The decrease can be attributed to the rapid introduction of treatments shown to be effective in clinical trials. However, an increase in the number and percentage of patients who probably or definitely acquired Covid-19 in hospital from 24% in the first wave to 42% in the second wave. The increase is almost certainly caused by the new variant of Covid-19 that emerged in the second wave which is 70% more transmissible than in the first wave.

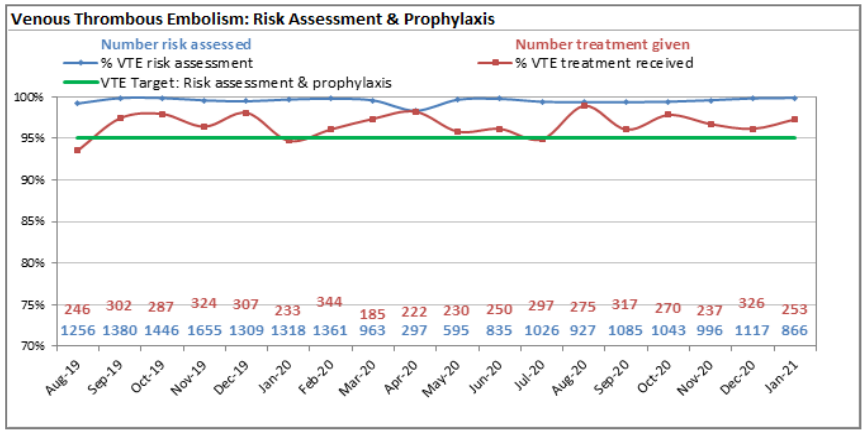
A duty of candour letter will be sent to the bereaved families of the probable and definite healthcare associated cases once contact tracing has been completed. In January, there were 5 new outbreaks of Covid-19 declared in January on 4 different wards and 1 staff area.

Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?

Data Quality Rating:





Summary and Action (Please note: due to the time it takes to complete clinical coding, the current months fracture neck of femur data will be subject to change the following month):

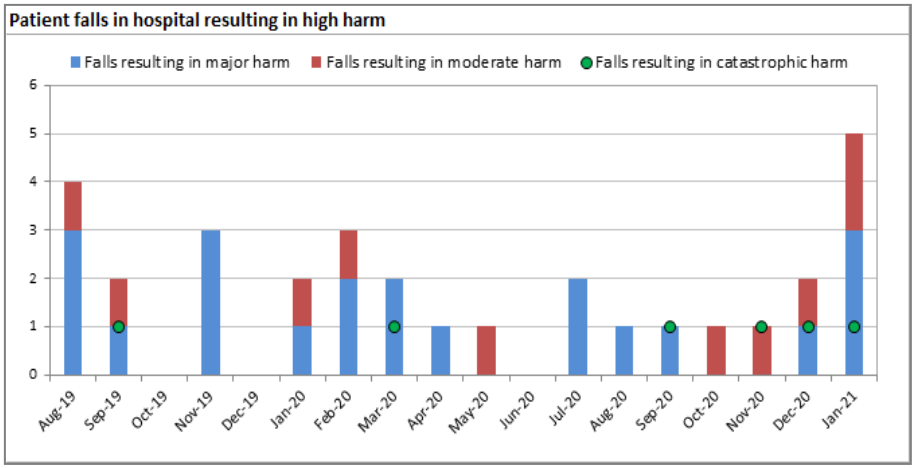
In January, 5 patients did not receive hip surgery for a hip fracture/peri-prosthetic fracture within 36 hours:

- 1 patient admitted following a fall and a fractured femur had surgery at 48 hours in order to stabilise the INR before surgery. Post-operatively the patient developed chest pain (NSTEMI) – stabilised with medical management and had a prolonged length of stay of 21 days (national average length of stay 15 days).
- 1 patient had surgery at 45 hours (initially declined surgery) was admitted with Covid-19 disease and suffered a fractured femur following an inpatient fall. Surgery was uncomplicated but he had a prolonged length of stay of 33 days.
- 1 patient had surgery at 42 hours (theatre capacity) and despite poorly controlled blood glucose post operatively was discharged at day 14.
- 1 patient who had a peri-prosthetic femur fracture had surgery at 93 hours (waiting for surgeon) – uncomplicated surgery but required a post-operative blood transfusion, developed shingles and discharged home at baseline on day 14.
- 1 patient who had a peri-prosthetic femur fracture had surgery at 92 hours (waiting for surgeon) – uncomplicated surgery but developed a post-operative urinary tract infection treated with IV antibiotics and a prolonged length of stay of 21 days.

The Trust continued to report good performance in VTE risk assessment and prophylaxis. However, in January there was a significant increase in the number of inpatients with a hospital acquired thrombosis (17 with a pulmonary embolism and 5 with a DVT). The majority occurred in Covid-19 positive patients who developed micro-thrombi in the lungs vessels due to an increase in viral load and inflammation. Root cause analysis of all hospital acquired VTEs is undertaken and showed that patients having NIV/CPAP had an intermediate dose of prophylaxis compared to the standard dose in accordance with NICE guidance. A root cause analysis report is presented to the Thrombosis Committee quarterly.

Patient Falls

Are We Safe?



Data Quality Rating:

Per 1000 Bed Days	2019-20 Q3	2019-20 Q4	2020-21 Q1	2020-21 Q2	2020-21 Q3
Patient Falls	0.07	0.17	0.08	0.14	0.16

Summary and Action

In January, 6 falls resulting in harm:

- A patient suffered catastrophic harm from a fall resulting in a head injury and intra-cranial bleed.
- A patient suffered major harm from a fractured hip requiring surgical treatment and was also Covid-19 positive on Durrington ward.
- A patient suffered major harm from a fractured hip requiring surgical treatment on Amesbury ward.
- A patient suffered major harm in the Hospice from a partial fractured femur managed conservatively as part of end of life care.
- A patient with a head laceration required a surgical washout and closure suffered moderate harm.
- A patient with an un-displaced peri-prosthetic fracture was managed conservatively and died secondary to sepsis from pneumonia suffered moderate harm.

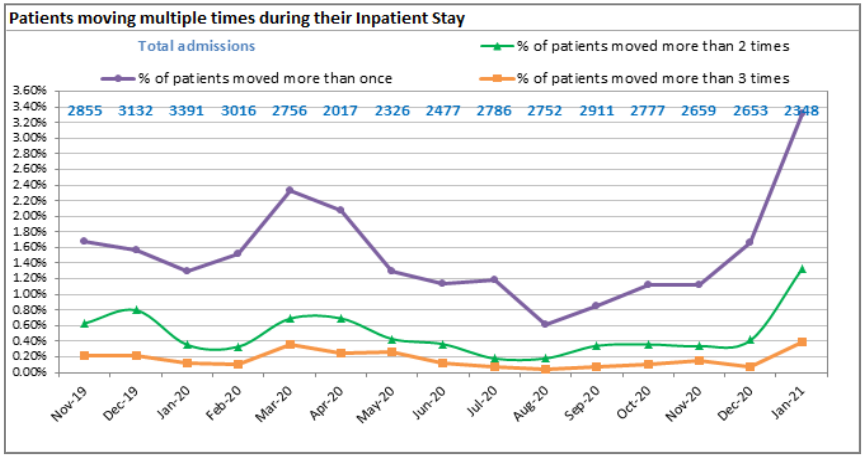
A Trust wide falls improvement plan with aggregated learning from SWARMs and serious incident inquiries is in place. There are plans to introduce a falls prevention facilitator to lead improvement work.

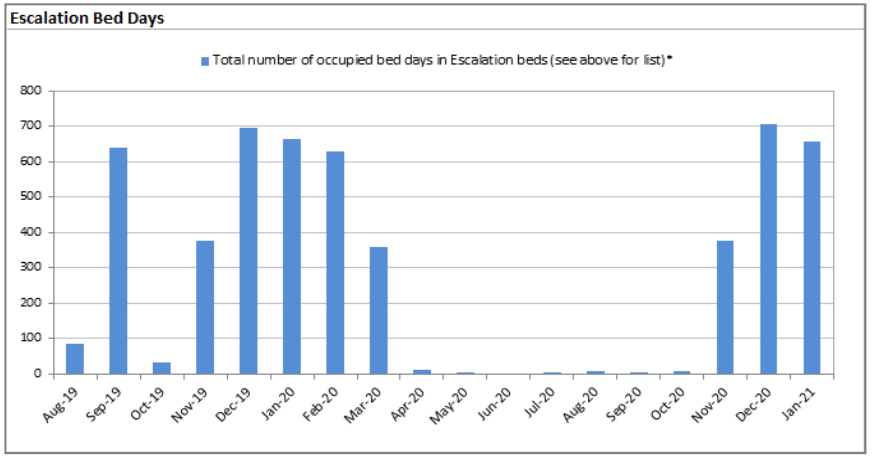
Patient Experience

Are We Safe?

Last 12 months	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21
Bed Occupancy %	96.1	81.8	60.5	64.0	76.4	81.7	81.5	86.6	85.7	91.5	92.4	89.4

Data Quality Rating:





Summary and Action

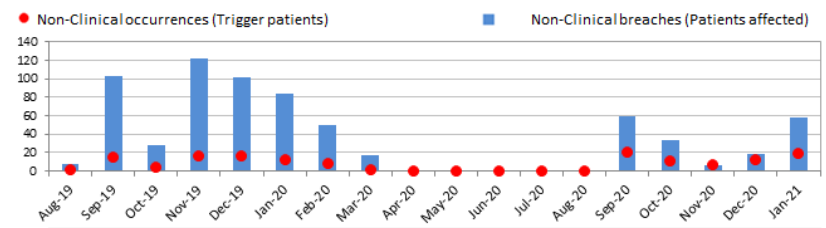
As the number of patients admitted with Covid-19 increased sharply in January, the number of ward moves significantly increased to try to separate Covid-19 positive from Covid-19 negative patients and maintain patient safety. As a consequence, escalation bed capacity remained open at a high level to enable the social distancing of beds and safe placement. The bed occupancy rate decreased to 89%.

Patient Experience

Are We Safe?

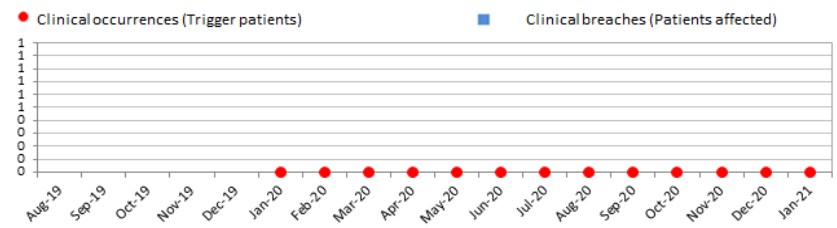
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
■	8	103	28	122	102	84	50	17	0	0	0	0	0	59	33	7	18	58
●	1	15	4	17	16	13	8	2	0	0	0	0	0	20	11	7	12	19

Delivering Same Sex Accommodation - Clinical



	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
■						0	0	0	0	0	0	0	0	0	0	0	0	0
●						0	0	0	0	0	0	0	0	0	0	0	0	0

Summary and Action

19 occurrences of non-clinical mixed sex accommodation breaches in January affecting 58 patients in the following areas:

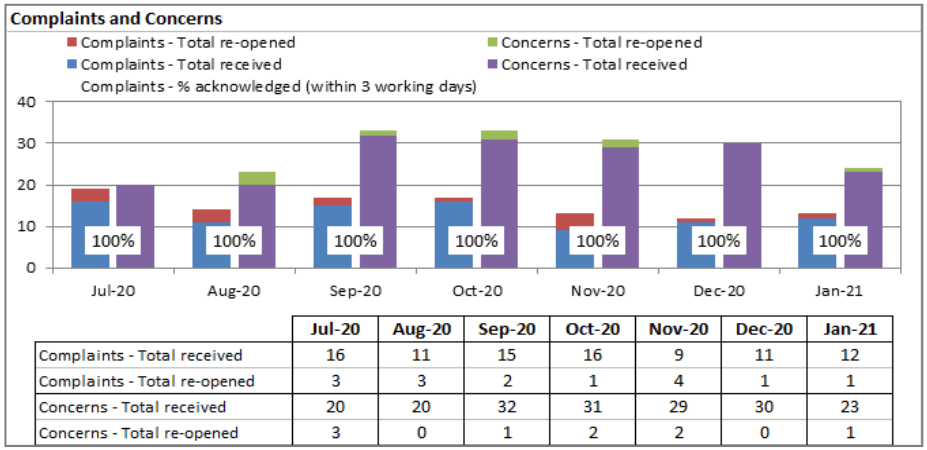
- 8 breaches affecting 8 patients in Radnor ward. Privacy and dignity was maintained in the individual bed space. These were patients unable to be transferred to a general ward within 4 hours of the decision the patient was fit to move.
- 4 breaches affecting 17 patients on Farley/RCU who were co-horted due to their acuity and ongoing CPAP which required a higher staffing ratio. Privacy and dignity was maintained with screens.
- 3 breaches in AMU affecting 20 patients in the assessment bay. Privacy and dignity was maintained with screens and separate bathroom facilities at each end of the bay.
- 3 breaches affecting 8 patients in Longford elective area to accommodate patients being admitted to a Covid-19 secure area for elective surgery.
- 1 breach in the Day Surgery Unit affected 5 patients to accommodate patients in escalation capacity.

Breaches affecting 42 patients were rectified within 24 – 48 hours. Of 16 patients affected, breaches were rectified within 2 – 4 days and 4 – 7 days - the majority were patients on RCU when they were co-horted due to their acuity and ongoing CPAP which required a higher staffing ratio.

In September 20, NHSE&I notified the Trust that a pause on mixed sex accommodation data collection and publication will continue until March 2021. The Trust remains committed to a zero tolerance of mixed sex accommodation breaches unless there is an imminent threat to safe patient care.

Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?



	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
Complaints - Total received	16	11	15	16	9	11	12
Complaints - Total re-opened	3	3	2	1	4	1	1
Concerns - Total received	20	20	32	31	29	30	23
Concerns - Total re-opened	3	0	1	2	2	0	1

Summary and Actions:

The main theme from complaints logged this month is 'unsatisfactory treatment'

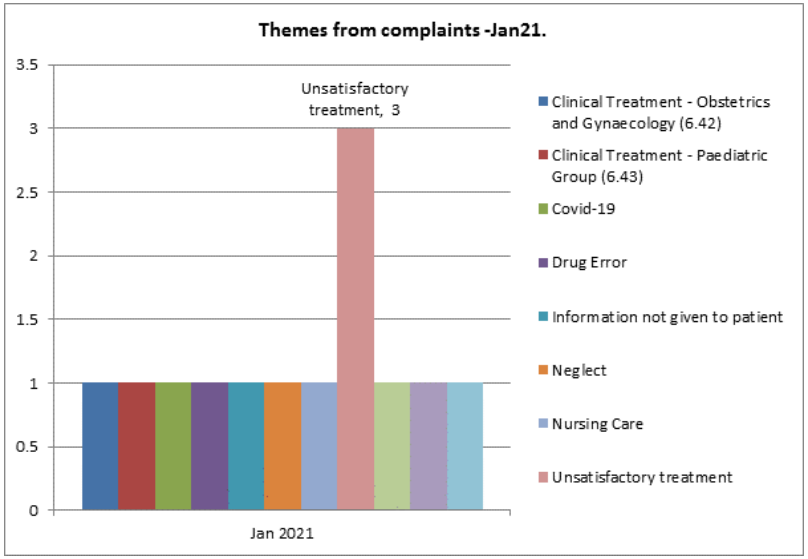
Main themes from concerns include:

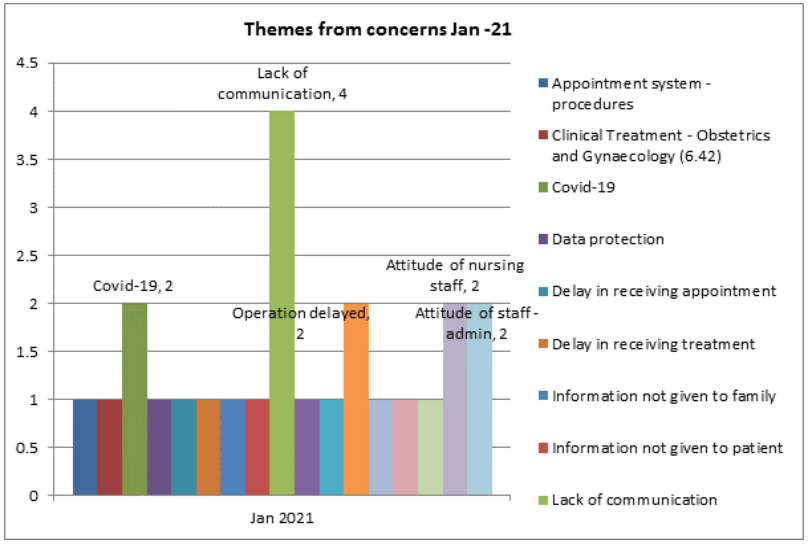
- Lack of communication
- Attitudes of nursing and admin staff
- Operational delays
- Covid-19

Examples of actions from closed complaints in Jan 21:

- Issues raised have been discussed in the MDT and the team have reflected on how the situation was managed. The patient can be referred back after surgery by private consultant and ongoing care can then be provided.
- Ward sister will reiterate to all her team regarding the importance of maintaining communications with patient's families.
- A new appointment was made for the complainant.
- Communication to be fed back to the relevant teams.

Data Quality Rating:





Part 3: Our People

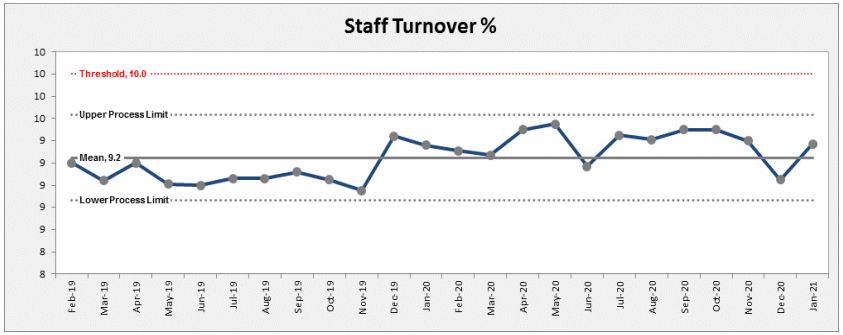
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

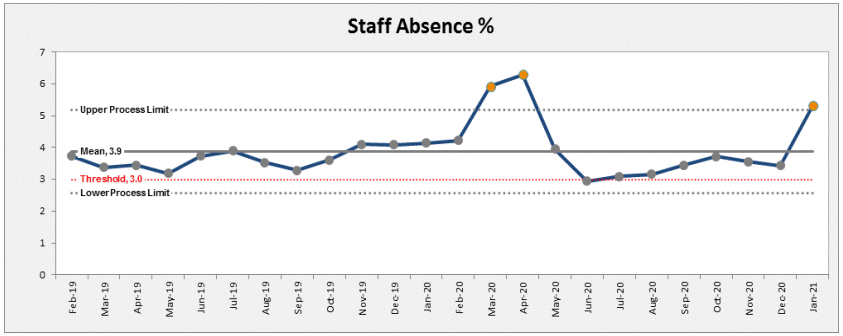
Workforce - Total

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	Jan '21		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	425.1	433.90	(8.8)
Nursing	967.1	1,058.48	(91.4)
HCAs	425.2	475.94	(50.8)
Other Clinical Staff	623.8	644.53	(20.7)
Infrastructure Staff	1,227.9	1,272.47	(44.6)
TOTAL	**3,669.1**	**3,885.3**	**(216.2)**





Summary and Action

During January, there were 39 starters and 31 leavers, and the turnover increased slightly to 9.37%, still below the target 10%. Medicine Division filled three hard to recruit Consultant posts during the month, which will have a positive impact on the Temporary spend once those individuals are in post. The Division is now commencing a workforce review.

In month 10 a total of 45 vacancies were advertised with WTE of 52.45. This is a decrease compared to the same time last year. 54 offers of employment were sent out in month 10. Four band 5 radiographers have been recruited through our contract with Yeovil.

The Trust was awarded additional funding of £7,000 per nurse, to support the recruitment costs only, of overseas nurses who must arrive by April 2021. The Trust will use this money to recruit 12 nurses for Theatres with the aim of reducing agency/bank spend.

19 job offers made to HCA's in month 10, due to commence in March, with further interviews scheduled for February.

Please note that the staffing figures in the table opposite include WTE equivalents of bank workers. According to the ledger, budget is 3,436 WTE, staff in post 3,393 with a variance of 42 and vacancy rate at 1.25%.

Sickness as predicted has shown a dramatic increase in January to 5.31%, 2.39% of which is attributable to Covid-19, with the remaining 2.92% for non Covid-19 reasons. This is the highest sickness absence rate since April 2020 when we recorded 6.29%.

All three clinical Divisions are reporting Covid-19 as the number 1 reason for sickness, with anxiety/stress/depression as the second reason. Conversely in Facilities, anxiety/stress/depression is the top reason with Covid-19 following at second.

Acknowledging that there is very little that the Trust can do to reduce the Covid-19 absences, other than promoting the correct use of PPE, hand hygiene, and social distancing to manage staff outbreaks, the Business Partners continue to focus on the non Covid-19 absences.

Currently there are 155 cases in stages 2-4 of the Attendance Management Policy and a total of 18 long term sickness cases being robustly managed.

Workforce – Staff Training and Appraisals

Use of Resources

Summary and Action

Mandatory and Statutory training overall is slightly above the 90% target, at 90.68%, with Facilities the highest compliance at over 95%. Medical Division is alone in being just under target at 89.53%.

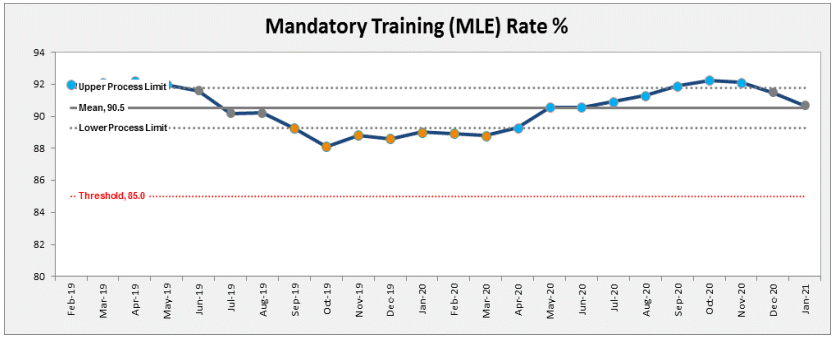
Reported subjects for lower compliance in the clinical Divisions are Hand Hygiene and Safeguarding. Light boxes are being loaned out to the wards to increase the ability for compliance on Hand Hygiene.

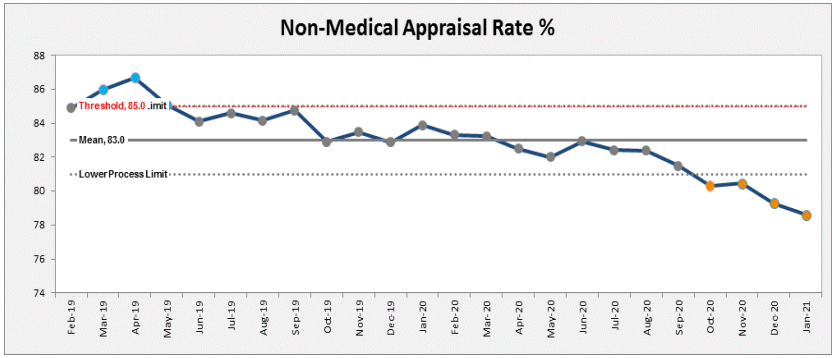
Covering for staff sickness and absence during this month have reduced the ability for staff time to complete the required training, and this is expected to improve during February and beyond.

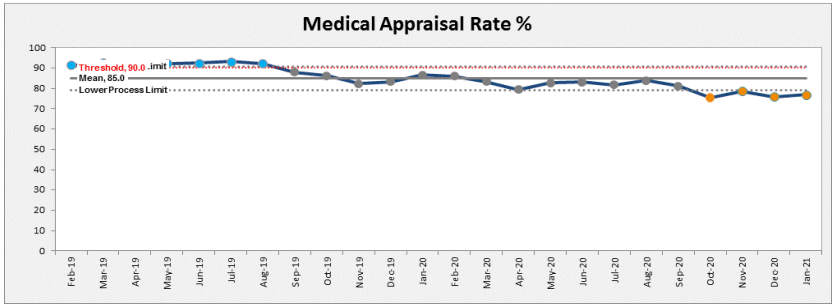
Non-medical appraisals overall are slightly down on last month at 78.62% and lowest compliance in the 2020/21 year to date, with Divisions reporting that staff not being in the Trust (absence or self-isolating) and appraisals being completed offline as the main reasons for the lower compliance against the target of 85%.

Expectations are for an increased focus on recording appraisals on SPIDA, and catching up with those out of time, as the Trust enters into a further recovery period.

Medical appraisals remain below the 90% target at 76.92%, slightly improved over last month. Medicine Division is faring the worst compliance rate and the Business Partner is working with the Clinical Director to put plans in place to correct the position. Again, this is anticipated to improve as we move out of the Covid-19 peak.







Feedback from Friends and Family test

"The team are so compassionate and caring. They are incredibly knowledgeable and have helped a huge amount. A fantastic service we are lucky to have! Thank you " *infant feeding clinic*

"Kind, caring, understanding conversation, patient, reassuring advice and offer of different support available. 1:1 meetings, group meetings, parent to parent..." *Community postnatal*

"Caring, professional, what more could you want. A wonderful stay" *Amesbury ward*

"Everything - I was looked after royally" *Pembroke ward*

"The staff were just amazing. So helpful and caring. Our main nurse was incredible and couldn't ask for a better person to care for my son. Thank you so much" *Sarum*

What was good about your experience?

January 2021

"Everyone was extremely kind, caring and accommodating of my wifes needs, especially E who cared for us throughout the day. The care they provided was completely individualised and made a difficult experience the best it could be. A massive thank you to everyone but especially E and L. You are a credit to your profession. L also cared for my wife post op and was amazing too" *DSU outpatients*

"The lady that put me onto the programme was very encouraging. Can't think of anything that could have been done better." *Smoking and alcohol liaison service*

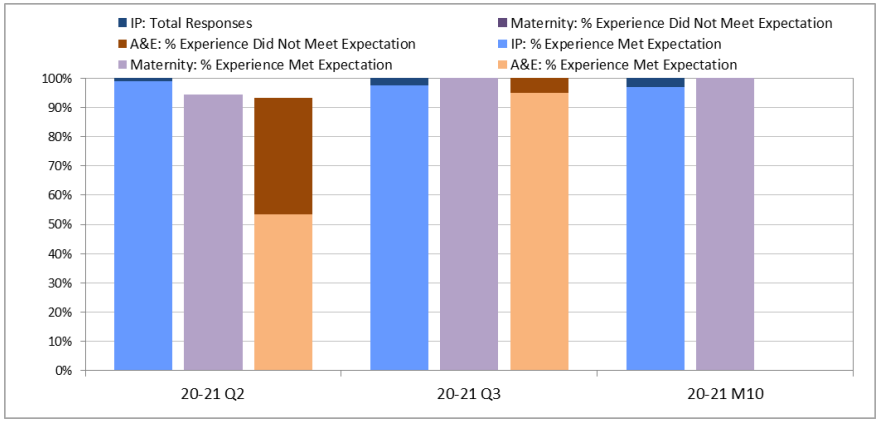
"Things happened very quickly. I was fully informed as to what they were going to do. Both staff nurses and the doctor handled it very well. I have never had a colonoscopy before and as I am a nurse it was good to see from a patients point of view. It was very uncomfortable but they talked me through it and went that extra mile." *Endoscopy*

"Friendly staff who explained the procedure in detail. I was quite nervous but the team were lovely and helped me feel at ease. Cant thank you enough. Much appreciated" *Endoscopy*

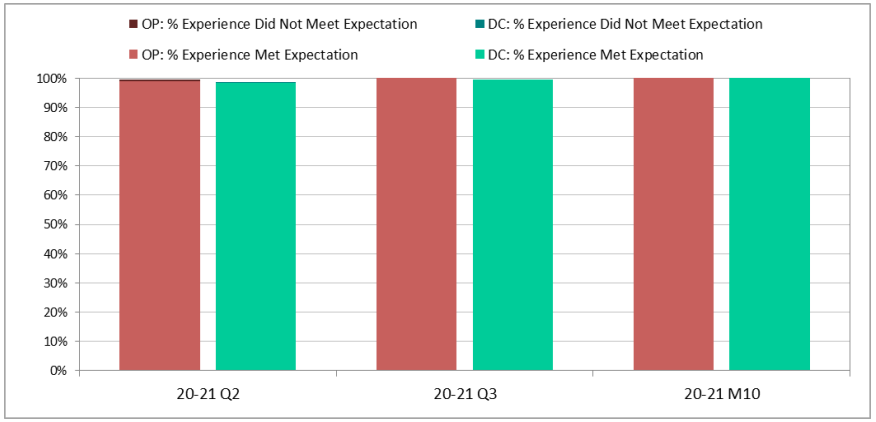
Friends and Family Test – Patients and Staff

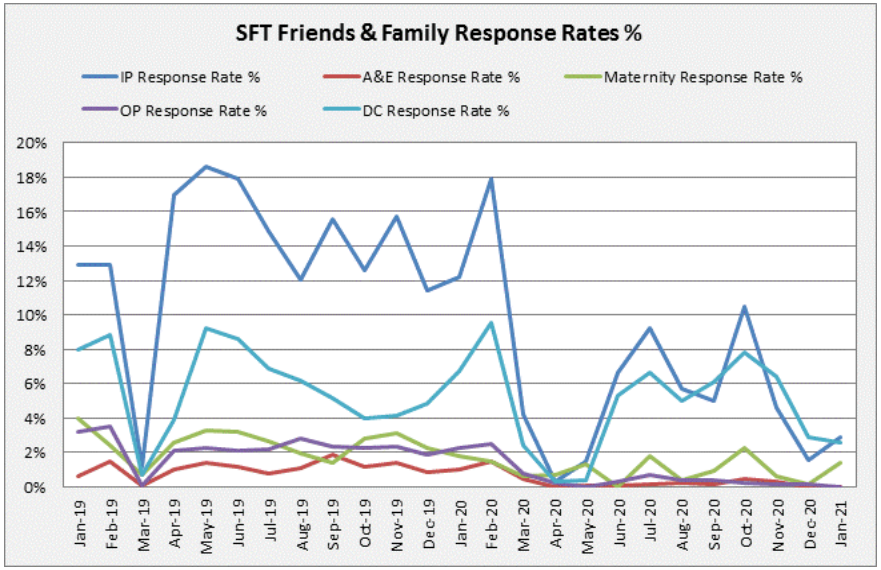
Use of Resources

Patient Responses: Inpatient, Maternity and A&E



Patient Responses: Outpatient and Daycase





The overall response rate of the Friends and Family Test remains low.
The figures in January (M10) are reported as the proportion of patients whose experience met their expectation or had not met their expectation.

The previous slide provides some quotes from patients about what was good about their experience across a range of wards and departments.

The staff Friends and Family test was suspended this year due to Covid-19.

In September, the Best Place to Work discovery phase report was published which describes the experience of our workforce. The aim was to understand the culture and the 'way we do things around here' as these shape the behaviour of everyone in the organisation and directly affects the quality of care they provide.

The discovery work acknowledged the Trust as a caring, friendly organisation with professional staff who strive to provide the best possible care for patients. Staff are proud of the hospital and proud of the care and treatment we give to our local community. The Board discussed the recommendations at its meeting in October 2020 and a Board seminar was held on 11 February to discuss the top 3 themes and work towards a commitment to inform the Trust strategy.

Part 4: Use of Resources

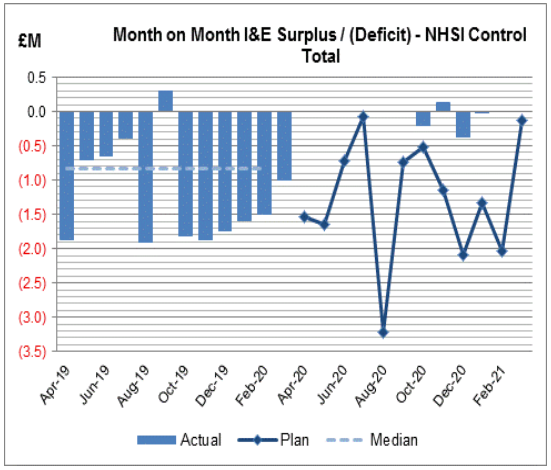
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

Position	Jan '21 In Mth			Jan '21 YTD			2020/21
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Income							
NHS Clinical Income	34,230	30,642	(3,588)	175,127	175,326	199	220,952
Other Clinical Income	(15,885)	(12,245)	3,640	8,655	17,781	9,126	0
Other Income (excl Donations)	2,416	5,292	2,876	24,160	33,191	9,031	28,992
Total income	**20,761**	**23,689**	**2,928**	**207,942**	**226,299**	**18,357**	**249,944**
Operating Expenditure							
Pay	(13,635)	(15,040)	(1,405)	(136,361)	(143,611)	(7,250)	(163,634)
Non Pay	(7,000)	(7,307)	(307)	(70,071)	(69,434)	637	(84,050)
Total Expenditure	**(20,635)**	**(22,347)**	**(1,712)**	**(206,432)**	**(213,045)**	**(6,613)**	**(247,684)**
EBITDA	**126**	**1,342**	**1,216**	**1,510**	**13,254**	**11,744**	**2,260**
Financing Costs (incl Depreciation)	(1,463)	(1,351)	112	(14,550)	(13,712)	838	(17,474)
NHSI Control Total	**(1,337)**	**(8)**	**1,329**	**(13,040)**	**(458)**	**12,582**	**(15,214)**
Add: impact of donated assets	*(48)*	*58*	*106*	*1,622*	*(492)*	*(2,114)*	*1,626*
Add: Impairments	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: Central MRET	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: FRF	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Surplus/(Deficit)	***(1,385)***	***50***	***1,435***	***(11,418)***	***(950)***	***10,468***	***(13,588)***



Variation and Action

While the Trust continues to report against the original 2020/21 plan as a baseline for continuity reasons, a focus has shifted to the delivery of the Phase 3 forecast set out in page 7.

The plan had assumed a deficit of £1.3m for the month, and a £15.2m deficit for the year, no central MRET or FRF was therefore assumed. Performance against the original plan is summarised in the table above. The Trust's improved performance against this target is due to the increase in funding made available to NHS providers in 2020/21.

Notable is the increase in Pay costs versus those planned, with the temporary cessation of cost releasing efficiency schemes (although productivity schemes remain core to the phase 3 recovery). Pay costs directly related to Covid-19 now stand at £4.8m YTD.

Loans due to DoH have been converted to PDC in 20-21 and as a consequence there is a favourable variance on loan interest payable. This is driving the under-spend on financing costs.

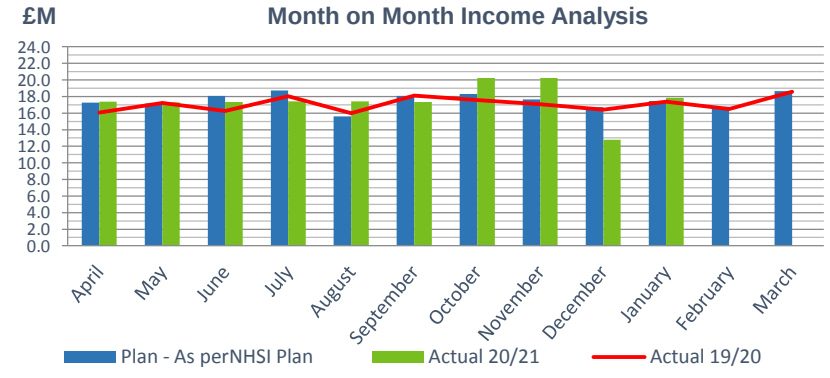
The Elective Incentive Scheme income reduction has been assessed at £1,055k but not included within the position per instruction from NHSEI.

Income & Activity Delivered by Point of Delivery

Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Jan '21 YTD Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	7,779	5,978	(1,801)
Day Case	14,305	8,124	(6,181)
Elective inpatients	15,150	4,733	(10,417)
Excluded Drugs & Devices (Inc. Lucentis)	16,014	13,037	(2,977)
Non Elective inpatients	52,378	40,921	(11,457)
Other	44,971	86,306	41,335
Outpatients	24,530	16,227	(8,303)
TOTAL	**175,127**	**175,326**	**199**



SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s	Phase 3 Forecast (YTD) £000s	Phase 3 FC Var (YTD) £000s
BSW CCG	87,740	88,333	593	88,333	-
Dorset CCG	17,918	18,633	715	18,633	-
West Hampshire CCG	12,881	12,919	38	12,919	-
Specialist Services	24,536	24,330	(206)	24,326	4
Other	14,571	13,274	(1,297)	12,693	581
TOTAL	**157,646**	**157,489**	**(157)**	**156,904**	**585**

Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
A&E	60,670	43,682	(16,988)	58,420	(14,738)
Day case	18,920	12,204	(6,716)	19,287	(7,083)
Elective	4,014	1,784	(2,230)	4,104	(2,320)
Non Elective	23,370	21,213	(2,157)	22,813	(1,600)
Outpatients	211,585	177,910	(33,675)	213,071	(35,161)

Variation and Action

Activity in January has reduced below December across all of the main points of delivery. The most significant reductions by specialty are General Surgery, Urology, Ophthalmology and Plastic Surgery Day cases, General Surgery, ENT and Plastic Surgery Elective spells, General Surgery, General Medicine and Plastic Surgery Non Elective spells and Ophthalmology, Plastic Surgery and Rheumatology Outpatients.

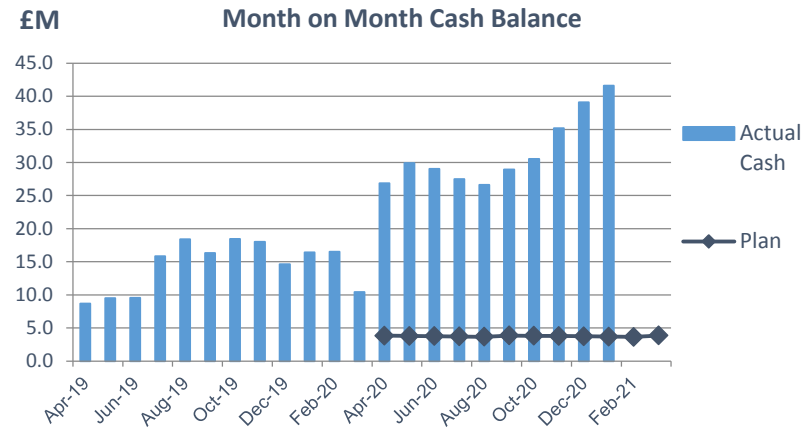
Covid-19 response contractual payment values with main commissioners were based on the Month 9 agreement of Balances (from a provider perspective), adjusted by 2.8% for inflationary pressures. From October onwards, Top up and Covid-19 funding is being received from BSW CCG c£2.5m per month but is not classified as Clinical income.

The underlying activity has been valued at less than the agreed block by £36,878k (21%) for the year to date due to the temporary cessation of non-urgent planned work and phased recovery response. The January Elective Incentive scheme has been assessed at a reduction of c£344k (c£30k in December) but not included within the position per instruction from NHSEI and is not expected to be applied due to the Covid-19 prevalence during January. The variance to the Phase 3 forecast is due to Specialist services High cost drugs and devices and Cancer drugs that sit outside of the block arrangements.

Cash Position & Capital Programme

Capital Spend: **Cash & Working:**

Use of Resources



Covid-19 response contractual arrangements are designed to ensure that there is sufficient cash in NHS providers to respond appropriately to clinical and operational challenges.

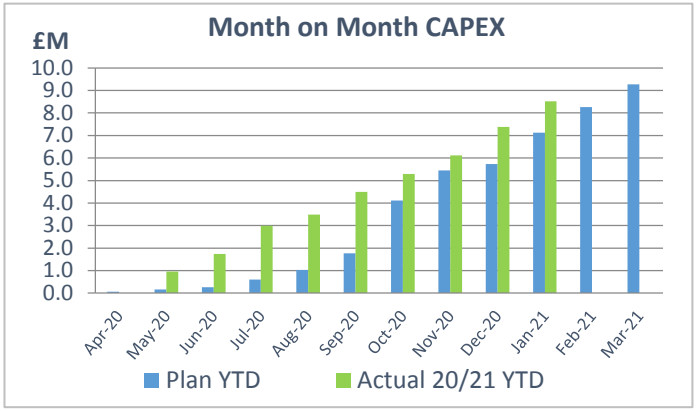
Payments on account in advance up until 28th February 2021 have been received. The clawback of these funds is expected to be in March 2021. Guidance is awaited on the cash arrangements for the first quarter of 2021-22. Core block payments for months 7-12 are at a lower level than for the first 6 months due to the Phase 3 contracting guidance but these will be supplemented by further funding from within the STP system. The cash flow position will continue to be closely monitored to ensure any potential shortfalls are identified.

The Trust is holding considerable cash balances to cover the capital spend due to take place in the last quarter of the year. The Trust received £2m additional PDC capital funding in January 2021 causing the rise in cash held at the month end.

Borrowings have previously included £21m of working capital loans. These were repaid In September and funding was returned to the Trust simultaneously as Public Dividend Capital.

Capital Expenditure Position

	Annual	Jan '21 YTD		
	Plan	Plan	Actual	Variance
Schemes	**£000s**	**£000s**	**£000s**	£000s
Building schemes	850	850	82	768
Building projects	2,600	1,900	1,484	416
IM&T	2,600	2,000	2,557	(557)
Medical Equipment	2,778	2,000	1,143	857
Other	449	374	374	0
Addition: Critical Infrastructure Fund	3,455	1,757	395	1,362
Addition: Covid 19	6,773	778	2,875	(2,097)
TOTAL	**19,505**	**9,659**	**8,910**	**1,484**



Summary and Action

Delays in capital works at the end of 2019/20, including those due to the Covid-19 response, meant slippage into 2020/21. While agreed items were brought forward to offset a proportion of this slippage, the final 2019/20 outturn was c£900k short of that initially planned for. This has inevitably affected the phasing of the plan as the delays to committed spend has mostly been incurred in the first three months of 2020-21. The most material element falls in IT, where the Microsoft environment replacement project phases out Windows 7.

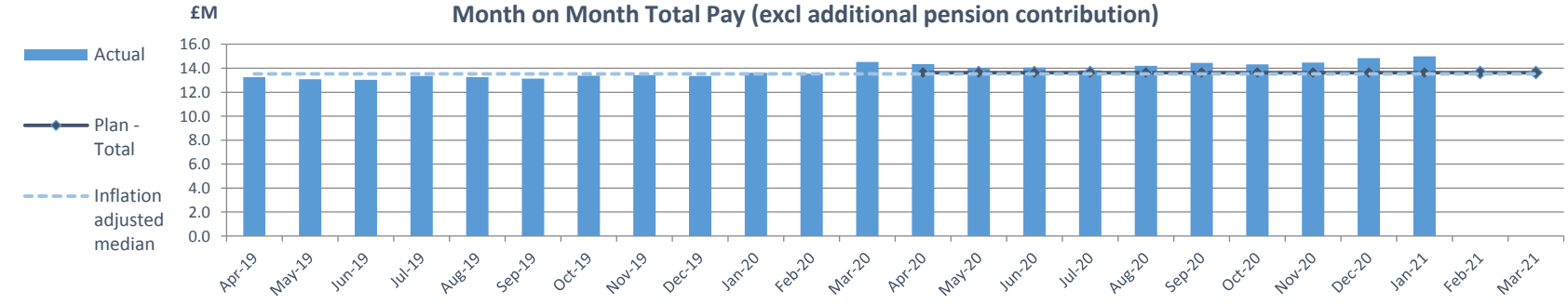
In addition to the Critical Infrastructure Fund of £3.455m, the Trust has received notification of various Covid-19 approved schemes totalling £6.773m in the year. These schemes are all funded through additional Public Dividend Capital. The Trust has still to receive cash of £1.29m relating to this additional capital. These funds are expected to be received at the end of February 2021.

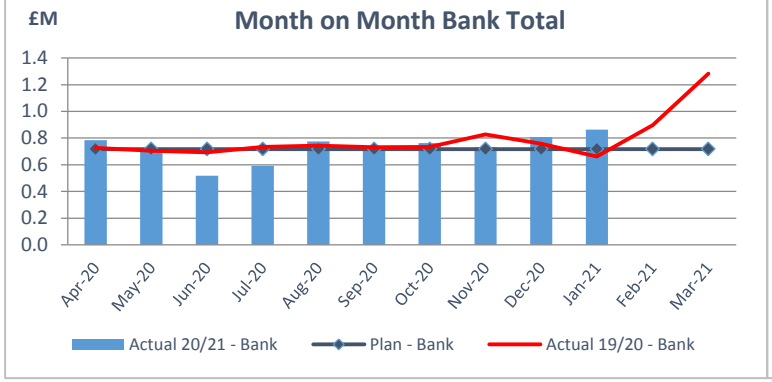
As a result of the considerable additional funding allocated to the Trust in the year, substantial funds still remain to be spent in order to achieve a balanced capital position for 2020-21. The short timescales given to the Trust to spend these funds by NHSE/I, together with the impact of the latest lockdown period means there is a significant risk the Trust will be unable to achieve a balanced position by 31 March 2021. The Trust has identified a potential shortfall of circa £2m against the total in year capital allocation. The matter is being discussed by the Regional Office with opportunities to redeploy funds being explored. A draft capital programme for 2021-22 has been compiled and is being reviewed in the context of this risk of slippage.

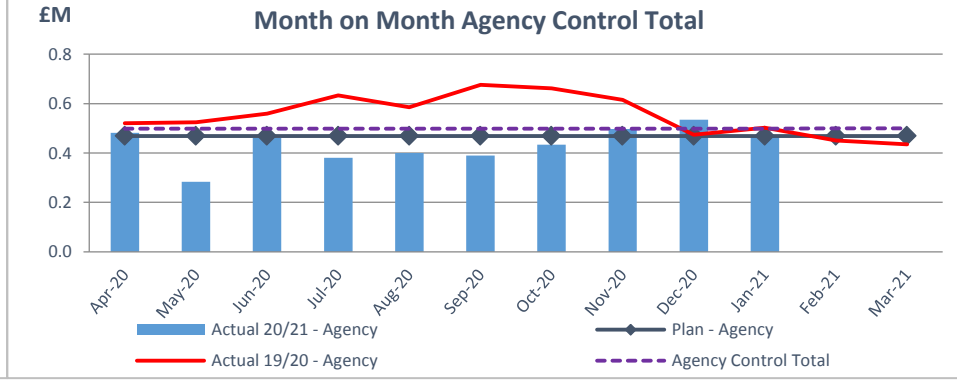
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

Pay expenditure increased by £0.2m, or 1.4%. This was due to an increase in nursing and HCA costs (£166k) as the period saw significant pressure on the Trust's bed base due to Covid-19 escalation.

A significant reduction in the number of theatres sessions due to Covid-19 has meant that staff costs in theatres have reduced, but only by £15k: bank spend here has remained at a fairly high level due to the number of staff shielding/isolating or sick (currently 38 wtes). Overall sickness absence in the Trust was 5.31%, just under half of which was accounted for by Covid-19.

The costs directly driven by the Covid-19 response have now reached £4.8m, 63% of which relates to hours worked by the Trust's existing workforce, though a combination of redeployment from BAU duties and additional hours. The high costs seen in month 9 have continued into month 10 due to the level of Covid-19 activity; bank nursing, junior doctor additional shifts and ancillary staff are the areas mainly affected.

In addition to these directly reported costs, analysis has been undertaken on the reduced availability of rostered staff (caused by a variety of reasons including sickness, self-isolation, shielding etc.), this now stands at c30%, Trust 2020/21 budgeted assumptions had been 19%. The Trust's strong recruitment position means that despite this reduction in availability, there have been sufficient temporary staffing availability to limit the increase in unfilled shifts (thought this does however lead to increased costs).

The Trust's contracted WTE decreased by 32 wtes, 19 wte of which were in Infrastructure staff, mainly agency. Of these, 15 wtes related to a reduction in agency staff in the laundry. Bank HCAs also reduced by 10 wte in month.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.6
Date of Meeting:	04 March 2021		

Report Title:	Covid-19 Response			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Louise Drayton, Performance and Capacity Manager			
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):				

Recommendation:
The attached presentation is provided to update the committee on the Covid-19 response

Executive Summary:
On the 20th January the number of Covid-19 positive inpatients peaked at 188. Since this the number has steadily declined, and has allowed a programme of de-escalation returning ward areas from Covid-19 cohorts back to their intended function. The number of cases in ITU has decreased more slowly and an ITU area is still being provided in Theatres. Bed occupancy fell over the course of M10, and by the end of the month was around 85%.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☒
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☒
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able	☒

to develop as individuals and as teams	
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

NHS
Salisbury
NHS Foundation Trust

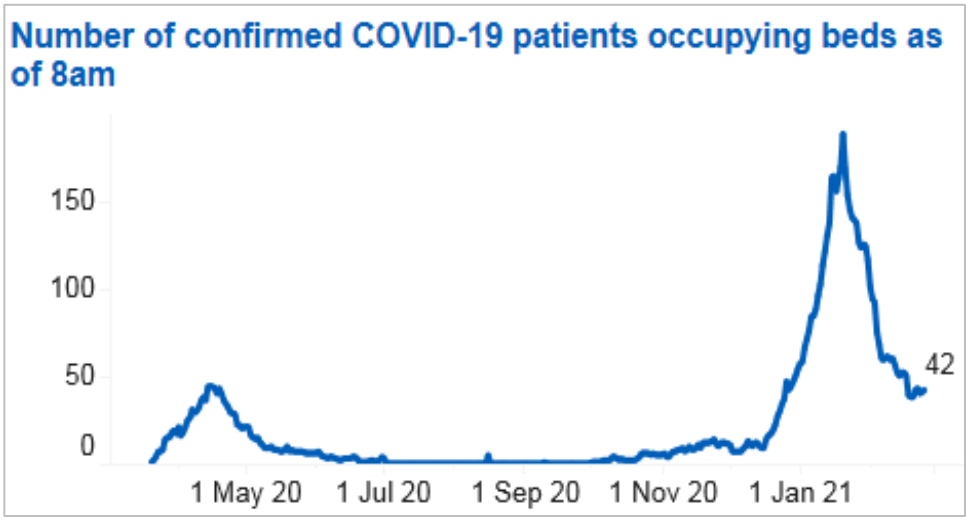
SFT COVID-19 Briefing

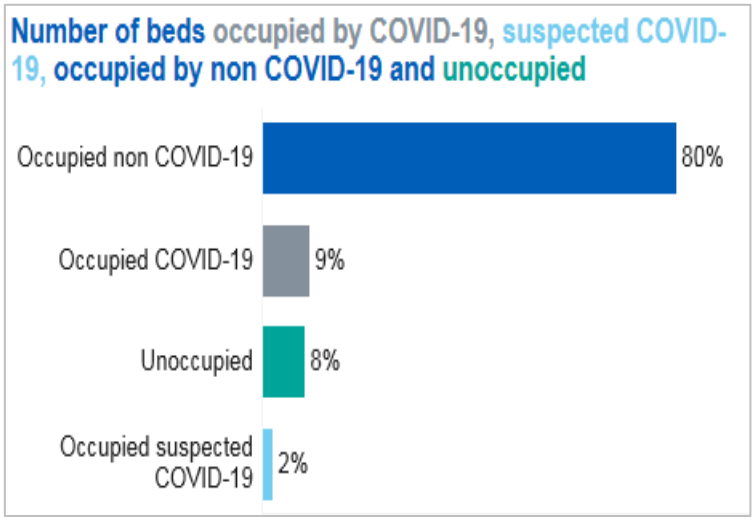
25/02/2021

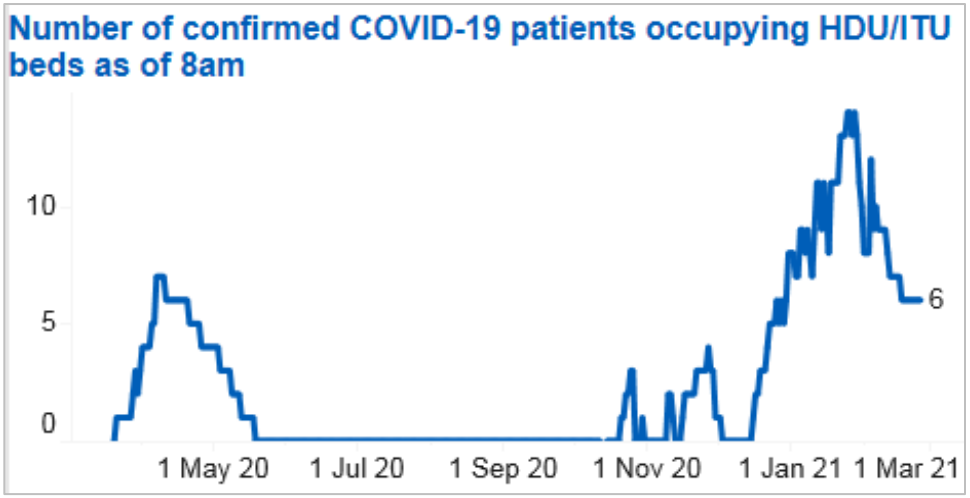
An outstanding experience for every patient

Covid-19: bed occupancy

Additional Supporting Information







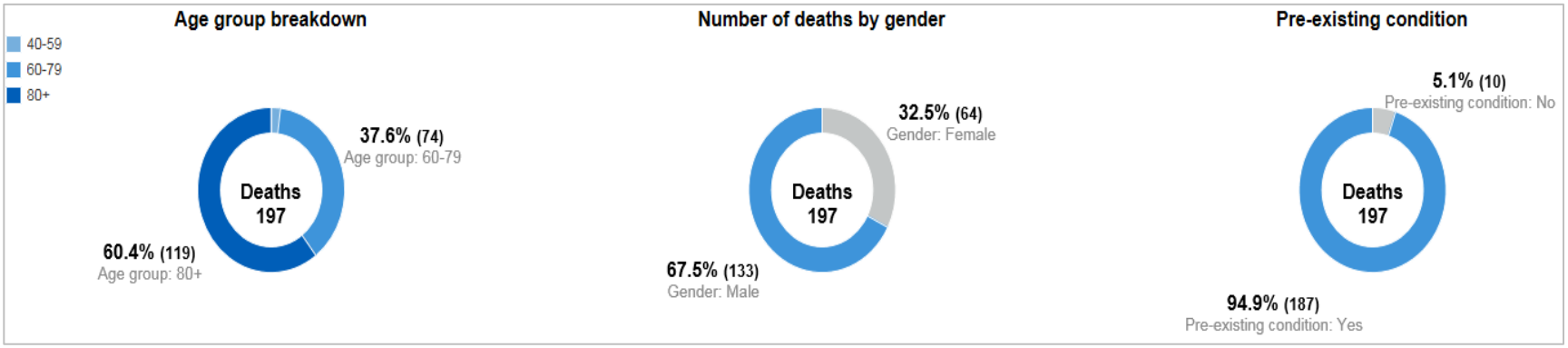
On the 20th January the number of Covid-19 positive inpatients peaked at 188. Since this the number has steadily declined, and has allowed a programme of de-escalation returning ward areas from Covid-19 cohorts back to their intended function.

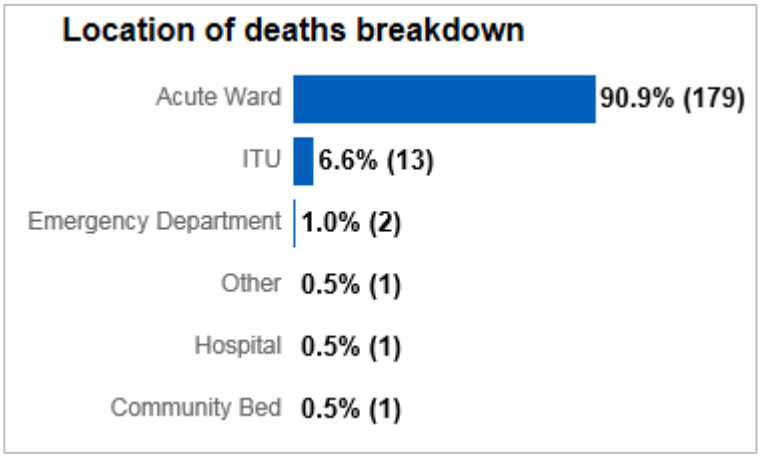
The number of cases in ITU has decreased more slowly and an ITU area is still being provided in Theatres.

Bed occupancy fell over the course of M10, and by the end of the month was around 85%.

Covid-19: mortality

Additional Supporting Information



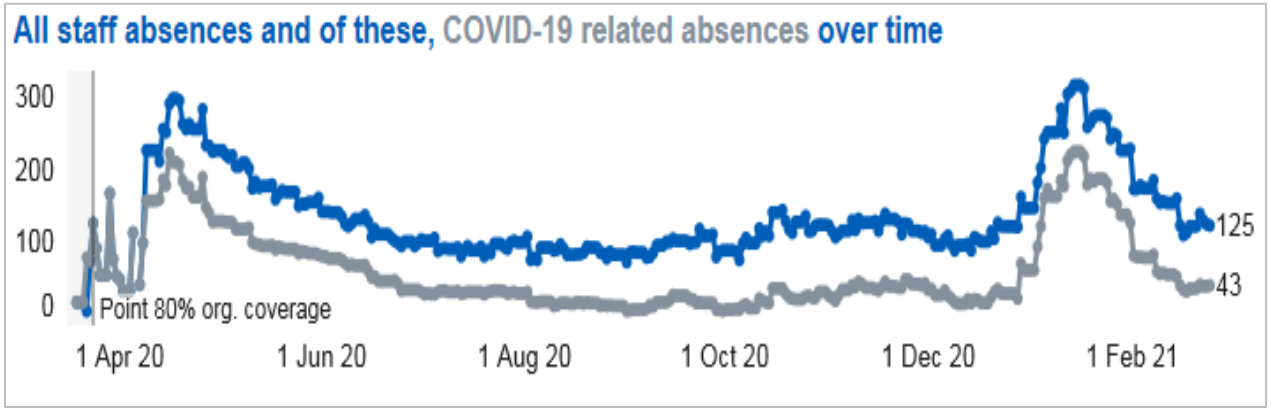


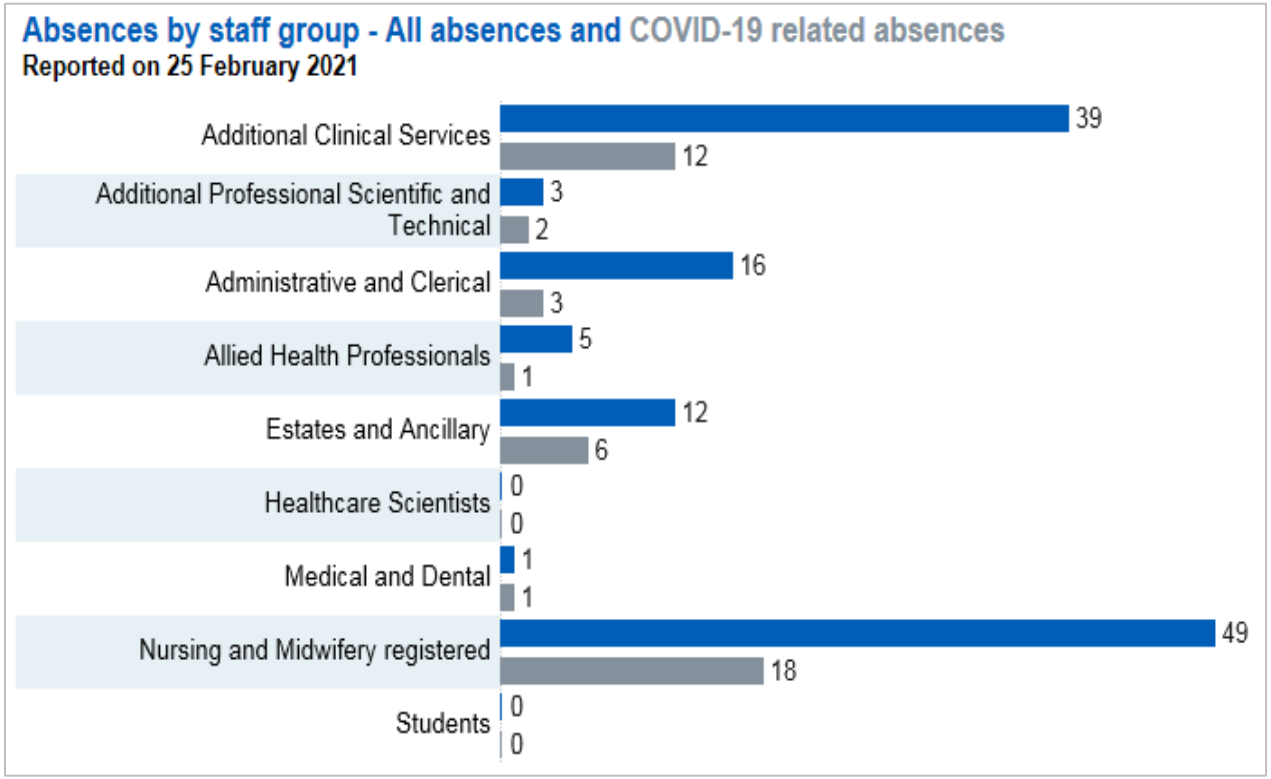
As expected, following the surge in admissions of positive patients to the Trust, the number of deaths has also increased. Following the pattern in the first wave, deaths are highest in patients over the age of 80, and patients with pre existing conditions.

Most deaths have occurred on acute wards, in particular the Respiratory Care Unit, this is both emotionally and operationally challenging for the staff working in these areas in ensuring that they support patients, their families and themselves through a very difficult period.

Covid-19: workforce

Additional Supporting Information





Staff absence related to Covid-19 peaked on 14th January, and has continued to decline.

Redeployment of staff in to roles to support the delivery of care continues, with some staff now returning to their original roles.

The rollout of the vaccination to staff has now halted at SFT, and will recommence when the second vaccination rollout begins.

Salisbury NHS Foundation Trust

Report to:	Public Trust Board	**Agenda item:**	4.1
Date of Meeting:	04 March 2021		

Report Title:	Best Place to Work Update Report and Briefing on Phase 2			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x	x	x	
Prepared by:	**Jean Scrase** Associate Director of Education, Inclusion, Comms & Engagement **Colette Martindale** Coaching and Mentoring Lead			
Executive Sponsor (presenting):	Lynn Lane, Director OD&P			
Appendices (list if applicable):	Appendix 1 Recommendations from Phase 1 report.			

Recommendations:

The board are asked to note the "Best Place to Work" Update Report and endorse the following recommendations that:

- there is wide dissemination of the diagnostic report to staff at all levels.
- there is clear decision from the Trust Board to agree the priorities and Plan.
- we continue to listen to staff and triangulate the evidence from key areas such as Occupational Health, FTSU and OD & People.
- in order to move the culture of the organisation at pace the Board acknowledges that additional resources in terms of people and expertise are required.
- Education and Training programs are designed and offered to ensure that the BP2W and NHS People Plan priorities are met.
- The SFT Leadership Strategy is described in the Corporate Strategy.

Executive Summary:

The Best Place to Work Program originally started in November 2019, and was put on hold during the first few months of the Covid-19 pandemic; continuing in May 2020. The program was supported by NHS Improvement (NHSI). A cross-section of Trust staff committed to working as part of the culture change team and were involved with Phase 1 of the program - Discovery Phase.

This evidenced based 'Culture and Leadership Program' from the NHSI is based on the fact that:

"A healthcare organisation's culture – the way we do things around here – shapes the behaviour of everyone in the organisation and directly affects the quality of care they provide. Research shows the most powerful factor influencing culture is leadership" (NHSI).

The recently published *NHS People Plan* highlights the need to focus on the development of a skilled, happy, fit and healthy workforce and ensuring that the NHS is an exemplary place to work. This report should be viewed as part of delivering the *NHS People Plan.*

The detailed findings from the Best Placed to Work diagnostic Phase 1 can be found in the paper presented to Private Board in October 2020.

In October, the paper was endorsed and four actions were agreed:

1. All board members that were not interviewed in the first round are interviewed as part of the on-going process of review and evaluation of our culture change process.
2. A facilitated board session is carried out to agree which recommendations to take forward to the Design Phase.
3. Engagement with Culture Change team to agree which recommendations to take forward to the design phase.
4. Co-create and co-produce a plan for Phase 2, the Design Phase.

This paper provides an update on work to date and our plans for Phase 2, the Design Phase, based upon NHS Improvement 'Culture and Leadership' Program.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☒
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☒
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☐

1. Executive Summary

The Trust's culture change program entitled the 'Best Place to Work' is based on the evidence based NHS Improvement (NHSI) 'Culture and Leadership' program. It is widely acknowledged that:

> "A healthcare organisation's culture – the way we do things around here – shapes the behaviour of everyone in the organisation and directly affects the quality of care they provide. Research shows the most powerful factor influencing culture is leadership" (NHSI).

Phase 1, the Discovery Stage, helped us to understand the existing culture in the Trust. A team of 25 staff from across the Trust committed to working as part of a culture change team and were involved in the Discovery Stage. At least 50% of staff engaged formally in the discovery phase of the Best Place to Work program. The final report from Phase 1 went to Trust Board in October 2020. Recommendations from that report can be found in Appendix 1.

Phase 2 of the program, the design phase, aims to help us develop our inclusive and compassionate leadership strategy based on the outputs of Phase 1. The strategy should fit with the Trust's approach to organisational and workforce development and will be aligned to the NHS People Plan and the Trust's Corporate Strategy. It will influence the future organisational design including the make-up of our workforce and the structures and processes we use.

The program closely examines five cultural elements:

1. Vision and values – everyone taking responsibility in their work for living a shared vision and embodying shared values.

2. Goals and performance – everyone ensuring that there are clear priorities and objectives at every level and intelligent data constantly informing all about performance.

3. Support and compassion – everyone making sure all interactions involve careful attention, empathy and intent to take intelligent helping action.

4. Learning and innovation – everyone taking responsibility for improving quality, learning and developing better ways of doing things.

5. Team work – everyone taking responsibility for effective team based working, interconnectedness within and across organisations, systems thinking and acting.

The recently published NHS People Plan highlights the need to focus on the development of a skilled, happy, fit and healthy workforce and ensuring that the NHS is an exemplary place to work. This update report should be viewed as part of delivering the NHS People Plan.

Following synthesis of all the feedback received in Phase 1, the culture change team concluded that there are many pockets of positive culture with strong, supportive and

compassionate leadership and excellent collaborative teamwork where patients are consistently put at the heart of the service. Staff are proud of the hospital and proud of the care and treatment we give to our local community. The impact of Covid-19 pandemic saw many benefits in our ability to transform services at pace for the benefit of patients.

There are many areas where some fairly straightforward upskilling in management and leadership skills such as having compassionate learning conversations would yield good results.

The identified themes are a baseline for improvement and will direct activity in Phase 2, to support the design of a culture for the organisation in which high quality, continuously improving, inclusive and compassionate care can be delivered both within Salisbury and the wider health care system.

2. Update since October 2020 and Phase 2, the design phase

2.1 Board Interviews

All current board members have now been interviewed to seek views on our existing culture from the perspective of the board. Emerging themes include:

- **Vision and Values:** Vision not well understood and people cannot articulate the meaning. Big piece of work needed to establish a brave vision for the future. We have strong community links and take pride in delivering care to local community. There is a high level of complacency and a lack of ambition.

- **Goals and Performance:** Cultural issues known about. Varied view on current leadership. Some examples of strong leadership. Board not working strategically at the moment due to operational priorities. Strong group of Governors. Need to establish Executive team. 2 posts are temporary (Medical and Nursing Director) and 1 post soon to be vacant (OD & People). We are not as outward looking as we could be and not everyone understands how healthcare is moving.

- **Support and Compassion:** High level of concern for staff health and well-being. People now regularly discussed at board meetings and impact of the pandemic on staff well-being is understood. Low level of complaints however some recurrent themes. We are open, honest and transparent – could do more.

- **Learning and Innovation:** Some good examples of learning and some examples of repeated incidents demonstrating a lack of learning. QI function not yet fit for purpose

- **Teamwork:** Some great team work across the Trust. Some pockets of ineffective team working. Board is coming together as a relatively new team and potential is high. There are some good examples of cross boundary working. We are strong leaders in the acute alliance.

2.2 Culture Change Team Engagement Events

The Culture Change Team have had the opportunity to engage in 3 events to agree priorities from the recommendations. Consensus view that the following areas need to be addressed:

- Care for the health & well-being of all our staff.
- Leadership development at all levels.
- Develop skills for quality, productive conversations at all levels.
- Commitment from all leaders to practice compassionate, inclusive and collaborate leadership.
- Build on lessons learned from the Covid-19 pandemic experience. No going back initiative already in place.
- Understand the conflicting view about our perceived 'permission seeking' culture.
- Build trust so leaders can act autonomously.
- Work to improve diversity, equality and inclusion.
- Work to eliminate bullying culture.

2.3 Facilitated BP2W Trust board workshop held on 11 February

Attended by all members of the Board demonstrating commitment to the BP2W program.

Rich discussion on support and compassion, goals and performance and learning and innovation. The Board accepted this is the start of the conversation and appreciated it would take more time and discussion to identify the key priorities for the design phase. Commitments agreed on the day:

- Support and compassion: To have an agreed way to interact with compassion and respect across the organisation, not in a hierarchical way and to have clarity of the expectation for everyone in our workforce.

- Goals and Performance: To co-create an ambition for the organisation. CQC rating of 'Good' was an achievement. This is about moving us from 'good' to 'outstanding'. To do this we need effective leadership, clear unified goals and for teams to be empowered to create their own goals, in alignment with Trust goals.

- Learning and Innovation: Commitment to finding a way to have targeted time for learning and innovation.

2.4 Current developments already underway to support BP2W and the NHS People Plan

- **External facilitator to support the next phase in place:** Fiona Byrne appointed for 6 months to support the design phase and to develop the leadership strategy.

- **Changing culture:** It is acknowledged the Trust is in a significantly different place culturally than when this program commenced due to the impact of the Covid pandemic and changes at board level as well as a focus on the NHS People Plan.

There is a desire from staff from board to ward to learn the valuable lessons from the Covid experience. There is an understanding we have been operating in a major incident since last March and that pace will not be sustainable when we come out of this wave of the pandemic. Conversations have started about what we should continue to do and importantly, what we should stop doing to release time for innovation and learning.

- **Ongoing listening:** The Culture Change Program is an iterative process and we are continuing to listen to understand our workforce. This is done through feedback from:
    - Culture Change Team engaging with their teams
    - Themed feedback from our Trust Coaches
    - OD&P teams generally
    - HR processes
    - Mental Health first aiders
    - Chaplaincy Team
    - Staffside colleagues
    - Freedom to Speak Up Guardian and FTSU Ambassadors
    - Occupational Health & Wellbeing
    - Clinical Psychology.

The list is not exhaustive.

- **Leadership Development:** Plans are in place for a broad leadership development offer for staff at all bands and professions. Divisional Senior Teams 6 day leadership development program will complete in April 2021. 5 days completed.

- **Health and well-being initiatives** including well-being checks with staff at handover and at the end of shifts in place. Access to clinical psychology and occupational health, staff counsellor and trust coaches in place.

- **Trust is working closely with BWS partners** in our OD practice across the ICS.

2.5 Working across the Acute Alliance

We have been involved in discussions with our Alliance partners at RUH and Great Western linked with the capacity needed to support both our cultural development programme and our QI work. Going forward it is likely that we will work together to develop our systems and processes and approaches to both cultural change and Quality Improvement. Our discussions were paused due to Covid but will recommence soon. The detail of our collaboration has still to be determined.

3.0 Next steps

1. The Trust board will continue the discussion regarding the priorities for Best Place to Work in alignment with plans to deliver the People Plan and inform the 'People' element of the Trust Strategy. The CEO and chair are considering the most productive way of moving the agenda forward from the Trust board perspective. Simultaneously the culture change leads will begin targeted work once priorities are understood.

2. Agree decisions regarding the resource implications in planning and implementing cultural interventions to address negative cultural indicators highlighted in the discovery phase. This will for example, involve the need to see significant cultural change in Estates and Facilities and Maternity Services and to a lesser extent other areas.

3. An independent consultant has been employed for 6 months to support phase 2. There is acknowledgement that this alone is insufficient resource.

4. Meetings set up with all Divisional Management Teams to discuss the report and clarify the priorities for each division.

5. Continue to listen and tie up all the links that feed into this work ensure what we are hearing and our subsequent actions are joined up and meet the requirements of the NHS People Plan.

6. Share the many evidence based NHSI culture change tools that can support the small steps to significant culture changes.

It is anticipated that the design phase will have been completed by end of June 2021 with implementation commencing July 2021. It is to be noted however that this is an iterative process and will involve constant refreshing following listening and evaluation.

4.0 Conclusions

There is much to be proud of at Salisbury Foundation Trust and a willingness from Board to Ward to address the negative cultural indicators. There are significant areas of good practice to build on and lessons to be learnt from where we do it well. Whilst there is acknowledgement that our current quality improvement program is not yet fit for purpose across the Trust some excellent ground work has been done which will enable QI methodology to support the changes.

The outcomes from the 2020 Staff Survey reflect the fact that a great deal has changed over the past year as a result of Best Place to Work, our Health & Wellbeing support, our ability to actively listen and our ability to communicate with staff Trust wide.

There is commitment from the Trust Board to develop a leadership strategy that describes the leadership culture needed to nurture the overall organisational culture and identify the leadership skills and behaviours required. The strategy also needs to identify, attract, develop and sustain our leaders of the present and future in the context of changing health care systems.

The BP2W program supports the ‘People’ element of the developing Corporate Strategy and there is wide agreement to continue to build on some of the successes gained through the pandemic. The pockets of poor culture are recognised and understood and there are action plans in place to start the focused work required for improvement. These plans will be supported by the culture change leads as required.

There is acknowledgment from the board that there is insufficient resource to manage the work required to change the culture and this is being addressed.

5. Recommendations

The board are asked to note the update report and endorse the recommendations below that:

- there is wide dissemination of the diagnostic report to staff at all levels.
- there is clear decision from the Trust board to agree the priorities and plan.
- we continue to listen to staff and triangulate the evidence from key areas such as Occupational Health, FTSU and OD and People.
- in order to move the culture of the organisation at pace the board acknowledges that we will need additional resource in terms of people and expertise.
- Education and Training programs are designed and offered to ensure we meet the BP2W and NHS People Plan priorities.
- The SFT Leadership Strategy is described in the corporate strategy.

Appendix 1 Summary recommendations from phase 1:

Vision and values:

- Consider whether the vision statement is amended to 'Outstanding Experience for Everyone'. Any decision needs to reflect the strength of feeling from those who were committed to leaving the statement as it is.
- Consider whether 'we are' is placed in front of each value. There must be a balance between changing words and changing behaviours. The statement that the Trust "is" something must reflect evidence of actual behaviour and performance.
- Encourage all leaders to move away from a command and control leadership style to that of compassionate leadership through upskilling, training and role modelling.
- Improve the quality of the appraisal conversation to make it meaningful and truly reflect the organisational values.

Goals and Performance:

- Take action to understand the pressures of staff groups and barriers to peak performance.
- Improve visibility of senior managers through meeting and interacting with staff particularly in out of the way areas, support services and admin teams.
- Encourage leaders and managers to build on the COVID-19 experience and not to revert to cumbersome decision making and act to remove the perception that many ideas and actions are lost in "black holes and red tape."
- Explore why decisions makers at times find it hard to make decisions and justify these, are willing to be held to account and benefit from learning conversations if the decision is the wrong one.
- Encourage a culture of innovation and learning.

Support and Compassion:

- Address the reported bullying culture in some areas of the Trust.
- Encourage all staff but particularly leaders to actively listen and understand before responding. Whilst this may appear relatively simple to fix we need to understand the root causes of this compassion fatigue and what motivates the bland responses staff hear.
- Support a compassionate collaborative leadership culture that encourages trust, autonomy, freedom to speak up, innovation and learning. To achieve progress how staff spend their time needs reviewing to create space for reflection, communication, training and support.
- Recognise and understand the importance of inclusion, diversity and fairness. Greater and more genuine understanding and acceptance of the experience of our

BAME community staff to work with them to truly learn how we can improve their experience.

Learning and Innovation:

- Recognise the importance of a learning culture and invest in it to create a rich learning environment.
- Develop a clear leadership and management skills pathway for all line managers. (This work has started.)
- Improve fairness and equality for learning and development opportunities to ensure compliance with standards particularly MLE and access to learning opportunities.
- Encourage the COVID-19 ‘No Going Back’ Initiative from board to ward.
- Share success with the rest of the organisation – patient feedback and non-clinical. Re-introduce the 'You said, we did', boards on the wards and ‘Feedback Friday’ (Planned to be re-launched asap).

Teams:

- Explore, understand and improve relationships between senior teams. (DMT development sessions due to commence October 2020.) Role model the improvements throughout the Trust.
- Improve connectivity between teams with a good understanding and shared view of our Trust strategy and priorities in order to drive change. This needs to cover clinical and non-clinical teams.
- Improve communications relating to strategy, priorities and partnership working.
- Embed the learning from Covid.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.2
Date of Meeting:	04 March 2021		

Report Title:	Nursing skill mix review			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	Fiona Hyett Deputy Director of Nursing Judy Dyos Director of Nursing			
Executive Sponsor (presenting):	Judy Dyos Director of Nursing			
Appendices (list if applicable):	Appendix 1 Skill mix review Appendix 2 Covid staffing model			

Recommendation:

To note the findings of the full ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels, specifically:

- SFT nursing establishments are set to achieve an average of 1:5 – 1:7 registered to patients across the majority of wards during the day.
- Wards are staffed on average 60:40 registered/unregistered ratio, with exceptions linked to the implementation of the band 4 role.
- To discuss the report at both TMC and open Trust Board as an ongoing requirement of the National Quality Board expectations on safe staffing assurance.
- To recognise that ongoing Covid activity may require an agile response to maintain safe nursing care.

Executive Summary:

The purpose of this paper is to report the outcomes of the annual review of ward staffing nursing establishments. The report historically related to the data for the previous years, so staffing reviews from July 2019-2020, however, in the current fast moving situation there is staffing information through more recent timeframes due to the Covid Pandemic. This full review forms part of the Trust's approach to the systematic review of staffing resources to ensure safe staffing levels meet patient care needs.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

1. Purpose

1.1 The purpose of this paper is to report the outcomes of the annual review of ward staffing nursing establishments. The report historically related to the data for the previous years, so staffing reviews from July 2019-2020, however, in the current fast moving situation there is information on staffing through more recent timeframes due to the Covid Pandemic. This full review forms part of the Trust's approach to the systematic review of staffing resources to ensure safe staffing levels meet patient care needs. The impact of the Covid Pandemic has affected the team in recent months leading to staffing levels that are not in line with the expected levels, however, the established number projected that remain are detailed in this paper.

1.2 The paper focuses specifically on a review of in-patient ward areas, Intensive Care, Emergency Department (ED), Spinal Unit and Children's service. Theatres and Out-patients have been subject to separate reviews.

1.3 The report fulfils expectation 1 and 2 of the NQB requirements[1,2] for trusts in relation to safe nurse staffing, and the most recent guidance Developing Workforce Safeguards[3] which requires Boards to be fully sighted on the staffing requirements.

1.4 Bringing this paper together on this occasion has been more challenging as the dynamic situation makes a significant portion of it feel out of date. As a result, a section of this report will focus on the impact of Covid in light of the ongoing global pandemic over the weeks of late December and January 2021.

2. Specific Detail

2.1 Ward staffing review methodology

2.1.1 In 2012 SFT established a systematic, evidence-based and triangulated methodological approach to reviewing ward staffing levels on a 6-monthly basis and taking proposals for changes to establishment to the Board to be approved and implemented via a budget setting process. The aim of this process is to provide safe, competent and fit for purpose staffing to ensure delivery of efficient, effective and high quality care.

2.1.2 This process has been adapted to include a full annual skill mix review presented to Board in February, followed up by an update review 6months later to ensure plans are still appropriate and to review the impact of any investment. The last full review went to Board in February 2020 and due to the impact of COVID a 6-monthly update has not been completed. It should be noted that although last year's review was agreed by the Trust Board no amendments to establishments were made as the workforce summit due to review all trust business cases did not happen.

2.1.3 The approach taken for the full skill mix review utilises the following methodologies:

- Safecare module of Allocate as a proxy for Shelford Safer Nursing Care Tool.
- Care Hours per Patient Day.
- Professional judgement.
- Peer group validation.
- Benchmarking and review of national guidance.
- Review of e-rostering data.
- Review of ward nurse sensitive indicator data.

- Review of HR indicators and finance metrics.
- INSIGHTs data (from Allocate E-Roster data).

2.2 National Guidance

2.2.1 In 2013 as part of the response to the Francis Enquiry[4] the National Quality Board (NQB) published a guide to nursing, midwifery and care staffing capacity and capability (2013) 'How to ensure the right people, with the right skills, are in the right place, at the right time'. This guidance was refreshed and broadened to include all staff groups and re-issued in July 2016 to include the need to focus on safe, sustainable and productive staffing. The expectations outlined in this guide are presented in Appendix 1.

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve -Patient outcomes, people productivity and financial sustainability – Report, investigate and act on incidents (including red flags) - Patient, carer and staff feedback		
- Implementation Care Hours per Patient Day (CHPPD) - Develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff	**Right Skills**	**Right Place and Time**
1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

2.2.2 There is now available a suite of improvement resources developed and designed to support the approved NQB guidance on safe, sustainable and productive staffing. The resources applicable to the Trust are:

- In-patient Wards for Adult Acute Hospitals - is aimed at wards that provide overnight care for adult in-patients and excludes intensive care, high dependency, acute admissions and assessment units.
- Urgent and Emergency Care.
- Maternity Services.
- Children's Services.

- Deployment of nursing associates in secondary care.

These resources have been included within the process for the skill mix reviews and assessing compliance against them.

2.2.3 In July 2014 NICE published clinical guideline 1: Safe Staffing for nursing in adult in-patient wards in acute hospitals.[5] This guideline is made up of 38 recommendations. The Trust remains compliant with these guidelines.

2.2.4 In October 2018 NHSI published 'Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing'. The document moves forward from the NQB Guidance as described above and from April 2019 NHSI will assess Trusts compliance with the triangulated approach to deciding staffing requirements described in the NQB guidance – the Trust is compliant with this through the staffing review process. The Trust is also required to include a specific workforce statement in its annual governance statement.

2.2.5 In January 2018 the NQB published an additional resource 'An improvement resource for the deployment of nursing associates in secondary care'.[6] The Trust remains compliant with the recommendations, the deployment of Nursing Associates has not resulted in a substantial change to the RN establishment (a full QIA would need to be undertaken if this approach changed). The guidance indicates that Care Hours Per Patient Day (CHPPD) needs to be reported separately for Nursing Associates, this requirement is due to be met with a planned e-rostering update early 2020, however, this upgrade is not yet implemented.

2.3 6 monthly Ward Staffing Review

2.3.1 The full review was carried out with each ward during Q3, reviewing the data from July 2019– July 2020. The reviews were attended by the Ward Sister, Head of Nursing and/or Matron and Deputy Director of Nursing. Business Partners and Finance Managers were invited to attend. The same triangulated methodology was used as in previous reviews – review of nurse sensitive indicators, HR and finance metrics, headroom data, nurse-patient ratios, Safecare data and professional judgement.

2.3.2 The detailed spreadsheets with ward by ward findings are included in Appendix 1. This provides detailed information on the current establishment levels for each ward and vacancies at time of ward reviews; registered to unregistered ratios; nurse to patient ratios by registered and total nurse staffing by shift; nurse sensitive quality and HR outcome data and detailing acuity and dependency information from the Safe Care Tool reviewed by ward.

2.3.3 <u>Nurse to patient ratios by registered and total nursing</u>

- The ward establishments allow for registered nurse to adult patient ratios during the day across SFT to range from 1:4 to 1:8 depending on specialty and overall staffing model. In some areas where there has been active implementation of the band 4 role these ratios can vary on specific shifts, although the underlying establishment ratio has not been altered. These ratios are set against establishment and can regularly increase when wards are not fully established.

- Planned staffing ratios at night require constant oversight to ensure the model is sufficient to provide the required support for patients out of hours. Ratios range from 1:5 to 1:12; all areas with higher ratios have been reviewed to ensure the registered

nurse ratio is appropriate for the acuity of the ward and is offset by higher total staff to patient ratios.

2.3.4 Registered to unregistered ratios

- The wards have been reviewed against the benchmark of 60:40 registered to unregistered ratios as the planned model of care. Of note over recent months the overall ratio is 68:32 so higher than the benchmark as an average.

- Overall the Trusts registered to unregistered workforce meets the planned 60:40 ratio and the majority of wards are at this level.

- Several wards have actively implemented the use of band 4's (elderly care and orthopaedics) and the ratios have been reviewed as registered: band 4: unregistered. This will be further supported when we are able to report CHPPD for the Nursing Associate role. The band 4 role continues to be developed as part of models of care and utilisation of the role continues to be a theme for review for each skill mix review to identify further opportunities - particularly linked to the development of apprenticeships nationally and providing a career development route for unregistered staff. The application of this is now more complex with zero RN vacancies and this report will recommend an uplift of HCAs to enable each ward to have 2/3 Band 4 posts in establishment to support workforce development.

  There are ward areas where the acuity and intensity of patients has increased and treatment and medication regimes are complex and so an overall reduction in registered to unregistered ratios would not be appropriate to maintain safe staffing levels. Focus will continue on reviewing the overall registered to unregistered ratios to ensure reductions are linked to planned model of care changes.

- A few wards are significantly above the 60:40 ratios and this tends to be where the intensity of patient needs requires a higher ratio of registered staff (intensive care, cancer care, cardiology, Acute Medical Unit).

2.3.5 Assessment against SafeCare Tool

- The Safe Care Tool (acuity/dependency model) has been used to review the staffing. This is integrated into the Healthcare roster system and provides information on the acuity/dependency levels and corresponding staffing levels on a real-time basis. When predicted levels differ from established numbers, professional judgement has been used to assure that the levels set are appropriate for the specialty and number of beds. The data is reviewed at each skill mix review as well as being used to review staffing levels on a daily basis.
- Analysis of SafeCare data is included within the reviews.
- The Deputy DON has undertaken a Safe Staffing fellowship and through this programme it has become clear there is a need to undertake a more formal assessment of staffing levels using Shelford Safer Nursing Care Tool (this is different to SafeCare within Allocate) to ensure the Trust is meeting the requirement to assess staffing levels using an evidence-based tool. The intention was to implement Shelford in this year, however, due to the impact of COVID this has been delayed and an updated version is due to be released which incorporates the impact on staffing requirements of 1:1 enhanced care. For this review SafeCare continues to be used as a proxy measure in the absence of use of an evidence-based tool.

- In line with the NHSI Developing Workforce Safeguards, licences have been obtained from Imperial Innovations to allow the use of the Shelford Safer Nursing Care Tool.[7]

2.3.6 Allowance for additional headroom requirements and supervisory ward leader

- All areas have 19% budgeted funding allocated to allow for additional headroom requirements arising from non-direct care time i.e. annual leave, study leave, sick leave (parental leave is excluded and held centrally). Review of the actual headroom for each ward continues to demonstrate that 19% is insufficient and the Trust is an outlier compared to its peers. Over the last year the impact of inadequate headroom has been exacerbated by having zero vacancies and the impact of COVID and increased absence of staff contributing to direct clinical care. Data from the e-rostering system overall would indicate on average a minimum of 23% excluding parental leave is generally required (and is comparable to peers). This is now being worked through in projected staffing plans in conjunction with the Finance Director.
- The consequence of this is the necessity to use temporary staffing over and above ward staffing establishments which challenges budget management and is less efficient and can cause wards to overspend despite good budgetary management. An increasing staffing challenge is presenting in paediatrics due to children presenting with mental health problems that require speciality placements that are not available, the use of a Registered Mental Health Nurse is required in these cases and this is a high cost speciality role.
- The Trust continues to run a supervisory model for ward sisters/charge nurses, in which they are given 0.8wte of their working week for this, with 0.2wte clinically rostered into numbers. In this review the amount of supervisory time ward leaders were able to take had improved due to the improved vacancy position with a range from 45-98%. Surgery have a Ward Secretary post which has proved successful in releasing ward sisters from administrative duties, and other areas such as MSK have rolled this out from within budget.

In summary from the evidence gained through the staffing reviews the assessment is that broadly we have staffing levels that can be seen to be safe, however, there are areas where an increase in staffing is recommended. Recruitment, alongside focused nurse retention activity has significantly reduced the vacancy gap to a position of zero for RNs with on-going work required to sustain zero HCA vacancies. This is to be commended whilst not losing focus on either of these activities within a very challenging environment locally and nationally.

Outlined below is the detail by directorate which articulates where there are opportunities on efficiency, effectiveness, patient experience and recommendations for increases in establishment.

2.4 Specific Directorate Themes

2.4.1 Medicine Directorate:

Medicine has experienced many changes with the new restructure to become the Division of Medicine now incorporating the Spinal Centre which moved across from Surgery and Therapies which relocated from the Musculoskeletal Directorate. Whilst this was launched from 01/04/2020, changes and adjustments continue in confirming alignment of services within the respective division.

The Covid–19 pandemic has brought complexities in terms of the purpose and size of wards, staffing needs and requirements, the need to support escalation areas (ITU and RCU) and the availability of existing staff due to shielding requirements and self-isolation.

Farley ward's purpose has changed as a result of the response to Covid-19. Farley ward is now referred to as the Respiratory Care Unit (RCU) with the aim to care for Covid-19 positive, or Covid-19 suspected patients, who may or may not require non-invasive ventilation (NIV) support. RCU requires a higher level of staffing with NIV care skills, resulting in NIV and medically trained nursing staff to be redeployed there to facilitate this. This poses a staffing pressure for the other medical ward areas. Staff are currently being returned to Surgical areas that were deployed to RCU from Surgery in the first wave of the pandemic, post the Surgery consultation.

The requirements for staffing the RCU vary depending on the acuity and number of patients that fall into the Covid-19 pathway categories. Adjustments will need to be considered depending on how long the RCU is anticipated to be open. Please see appendix 1 with staffing level details.

Further response to the pandemic is the requirement for Intensive Care Unit (ICU) trained nursing staff to work in ICU as the need for ICU beds increases. A number of the Medical nursing staff have completed an ICU induction which is captured as a skill on the e-roster system.

Stroke care moved from Farley ward to Laverstock ward in response to the pandemic. Stroke care saw a reduction in their bed base due to this, however, since the opening (9/11/20) of Breamore ward as part of the Winter escalation (until 31/03/21) their bed base has now increased (35 beds, plus 5 more beds from 23/12/20). Most of this has been supported by the Stroke nursing establishment, with a shortfall filled by bank nursing staff.

Emergency Department (ED) and the Respiratory Assessment Zone (RAZ)

The Emergency Department has adapted its environment three times since March 2020 due to the pandemic. Initially majors was the respiratory assessment area (RAZ). Majors have 10 cubicles which links directly into the 3 bedded resuscitation rooms. The old minors area (6 cubicles plus seated area) was changed to accommodate non respiratory majors patients. Minor injuries were subsequently moved to co-locate with the orthopaedic/fracture clinic team. In May 2020 the majors and RAZ areas were swapped as the numbers of non-respiratory majors patients increasingly outnumbered the RAZ presentations. From March 2020 the paediatric team were taking direct admissions to Sarum ward from triage for assessment, limiting the time neonatal and paediatrics cases spent in the ED. Children presenting with minor injuries remained in the minors area footprint.

In light of the number of reduced numbers, respiratory patients presenting to the department after wave 1 and the return of all paediatric patients to ED, RAZ was decommissioned from the 14th October and processes changed. This meant any patient presenting with respiratory symptoms was to be cared for in a doored cubicle. The area that was RAZ is now majors 11-15 and paeds 1-4.

To staff this extra area (majors 11-15 and paeds 1-4) safely, 2 RNs and 1 HCA are required. This requires an uplift of 1 RN 24/7 = 5.34 WTE band 5.

Minors is run by Emergency Nurse Practitioners (ENP's) with 1 RN for triage. Uplift of a HCA for minors has been required from 10.00 – 22.00 on a Sat/Sun/Mon and Tues – Fri 12.00 – 22.00. This is an uplift of 2.26 WTE band 2's.

To try to match staffing vs the footfall of patients the 12.30 – 22.00 shift has been changed to 12.30 – 00.00 7 days a week instead of 3.

The staffing uplift is the minimum number of staff required to safely staff all areas. If the areas are all full the ability to free a staff member to corridor nurse is lost.

Recruitment across the Division of Medicine is generally good, with some concerns around retention and the high turnover on the Acute Medical Unit (AMU). In terms of additional staffing needs as a result of skill mix reviews, the following are required (as seen in Appendix 1).

2.4.2 Surgical Directorate:

There has been significant divisional adjustments to the portfolio of clinical services and wards within surgery over the past 12 months. The previous directorates of MSK and Surgery were combined to form the Division of Surgery. Whilst this was launched from 01/04/2020, changes and adjustments continue in confirming alignment of services within the respective division.

For the majority of wards and services, in terms of the divisional restructure, realignment has been reached. However, the Covid–19 pandemic has added considerable complexity in to the purpose and size of wards, staffing needs and requirements, availability of existing staff given shielding requirements and the need to support escalation areas (ITU and RCU).

The surgical wards now consist of Amesbury and Chilmark (orthopaedics), Odstock (plastics and burns), Britford and Downton (general surgery) and ITU. The notable omission is Breamore ward. At the start of the Covid pandemic and the suspension of elective activity, Breamore as a short stay surgical ward closed, with its staff used to support the Trust's wider response supporting ITU and RCU. To coincide with this, the Surgical DMT reviewed the surgical bed base determining that the 21 beds in Breamore were not required and the same level of activity could be accommodated within the remaining footprint, along with an adjustment of the opening hours of DSU (extending to 22.00). The Breamore staff have undergone formal consultation, with the majority redeployed to alternative surgical specialities supporting vacancies and maternity leave.

Chilmark ward's purpose has also changed as a result of Covid. With elective orthopaedic activity currently transferred to Newhall Amesbury ward is used for trauma and orthopaedics. This switch in itself, has caused an adjustment to staffing as nursing requirements for 32 trauma patients are different to 32 elective patients, with an increase of x1 HCA 24/7.

Chilmark ward itself has become a green elective ward. Presently the ward is split to 16 elective beds and 8 trauma beds. When both areas are open, both need staffing separately due to IPC measures and maintaining the green Covid free status. As a result an increase in staffing is needed by late x1 RN X1 HCA and night x2 RN and 1 HCA).

In response to the Covid pandemic and likely ongoing need for additional resource and training in ITU, ITU itself has over recruited, and gone through a programme of training other ward based staff with ITU skills, which are now all captured and traceable via the E-roster system.

Further anticipated staffing related adjustments for 2020/21 will be the destination and placement of gastro patients to surgical wards (currently Redlynch), adjustments to SAU and Britford (adopting an AMU type approach to flow and assessment), and formal consultation with DSU staff to adopt extending opening hours.

Recruitment and retention is good, and Covid aside, teams are relatively stable with improving retention levels. In terms of additional staffing needs as a result of skill mix reviews, in order of priority;

1. Chilmark – increase of B5 and B2 late shift, x2 B5 and x1 B2 night shift (loss of B2 twilight).
2. Amesbury – increase of B2 long day and night.
3. Downton – uplift B5 to B6, uplift B2 to B4.

(Note: Changes to Amesbury not required if repurposed back to elective orthopaedics. Level of Chilmark staffing requirements could be reduced if the ward in its entirety were used for single purpose i.e. just trauma or just electives).

2.4.3 Clinical Support and Family Services – Paediatrics

Overall the staffing establishment remains appropriate for Sarum, however, the last year has seen an increased level of long-term sickness that has impacted upon the ability to work within the RCN (2013) Safer Staffing Guidance for Children and Young People, at times of high acuity and/or additional short-term sickness. This has resulted in reliance on bank and agency paediatric trained nurses to ensure that safe level of staffing are maintained on the ward and that recommended staffing ratios are maintained (i.e. 1 nurse: 2 HDU patients). Adherence to the RCN Safer Staffing model continues to help ensure an appropriate staffing level on Sarum, however, the outreach post continues to be pulled into staffing numbers at times of high acuity and/or high patient numbers to ensure patient safety and avoid the use of costly paediatric agency staff. This has resulted in challenges for ensuring appropriately skilled paediatric nurses are available for children attending the Day Surgery Unit (where outreach were intended to also support).

In February 2019, the paediatric nurse recruited to DSU left and since then the post has remained unfilled despite the post being offered to 2 successful candidates on two separate occasions, but both withdrew. The RCN (2013) guidance states that a paediatric trained nurse must be available at all times when children are admitted for Day Case Surgery. In order to mitigate this risk and ensure that paediatric operations are not cancelled on DSU, an agreement was made that the paediatric outreach nurse will support DSU with paediatric patients whenever possible. This is agreed on a weekly basis, however, due to the unforeseen nature of paediatrics, sometimes, at short notice, the outreach nurse is unable to support DSU. In these circumstances, following a review of bank options with the sisters from Sarum and NICU ward, a paediatric agency nurse may be requested to work on DSU. At the time of finalising this report the Paediatric post on DSU had been recruited to and the post holder is due to commence in March 2021. The Directorate are aware of the need to ensure that this post holder feels part of the paediatric team to avoid a single point of failure scenario in the future; the Head of Nursing CSFS is working closely on this. It is also to be noted that there has been intensive work to ensure that the DSU staff undergo their

paediatric competencies and during the Christmas break when lists were down some of the DSU staff were redeployed to Sarum to expedite this.

Paediatric staffing continues to be a challenge within the Emergency Department. A business case has been written by the ED matron and ED Lead Paediatric Consultant. This outlines various options to address the limited availability of paediatric trained nurses within ED. No decisions have been made as of yet to the outcome of this business case, which is being led by the Medicine Division with support from the CSFS Head of Nursing, in her additional role as trust lead of care of children.

The number of paediatric patients requiring support from Children and Adolescent Mental Health Services (CAMHS) has become an increasing staffing challenge, there is limited access to suitable placement for some of these patients which has resulted in extended periods of time on Sarum ward. Caring for young people in crisis has been a significant pressure on the team and required the use of Agency Paediatric Mental Health Nursing support. The Head of Nursing is working with partner organisations to increase knowledge of how best to support these patients with our own staffing group.

2.5 Trust wide risks and issues considered in the review

2.5.1 Increasing patient acuity/dependency

The development of services and changing demographic of the population continues to result in an evidenced increase in the complexity, acuity and dependency of the patients admitted into the general wards.

Information on the acuity and dependency of patients, including enhanced care needs is available to be reviewed via the SafeCare functionality in Healthroster and is used in real time as part of the daily staffing meetings. This information is also used in the 6 monthly reviews as part of the professional judgement assessment. More robust data will become available on this through the implementation of Shelford Safer Nursing Care tool.

Consideration needs to be given to nurse sensitive indicators which are part of the triangulation when reviewing nurse staffing levels. Overall, nurse sensitive indicators have been generally good, however, as we review data over the increased level of activity due to the recent Covid wave this may change.

2.5.2 Increasing enhanced care needs

The Trust continues to incur expenditure for patients requiring additional nursing care support due to their enhanced care needs. Year to date there has been £167k spend on enhanced care which is half of the expenditure for the same time period last year. Some of this is due to the impact earlier in the year of Covid but overall costs are tracking lower this year. The closure of Glenside continues to have an impact on the requirement for enhanced care. Some impact is being experienced as a result of Covid and lockdown, particularly in paediatrics, and this may have an adverse impact on costs for the remainder of the year. A SOP has been developed and the risk assessment tool updated as part of the on-going work to improve the quality of enhanced care. As the Trust continues to see an improvement in vacancies and over-recruitment in some areas then focus needs to be on rostering to areas of peak demand and channelling temporary bank staff for any required additional staffing.

2.5.3 Vacancies and temporary staffing

Nationally RN vacancies remain high, it is estimated there are about 40-50,000 vacancies across the country. Due to the success of both the retention project and international nurse recruitment programme, Salisbury continues to buck this trend and RN vacancies are currently at zero. However, the impact of COVID has seen the opening of the Respiratory Care Unit on Farley, increased staffing requirements in ED to manage RAZ , orthopaedics to manage the need for a green elective ward and on ICU where staffing requirements increased to support care of critically unwell COVID patients.

Triangulation of information on vacancies, temporary staffing usage and actions to reduce are reviewed via the Safe Staffing group. A deep dive report into nursing expenditure has been presented at the Finance and Performance Committee as nursing costs have increased this year. The summary of that report shows issues relating to headroom amplified through full recruitment and the impact of COVID. A recommendation of that report is to increase the headroom and ensure all establishments are signed off by the Director of Finance and Deputy Director of Nursing on behalf of the Director of Nursing.

The focus on nurse retention has remained and linked into wider Trust work such as Best Place to Work initiative. The release of the People Plan sees nursing as a core element and work continues. The Trust is part of a national collaborative with Allocate piloting team-rostering as part of a wider piece of work on improving flexibility for staff – a requirement within the People Plan.

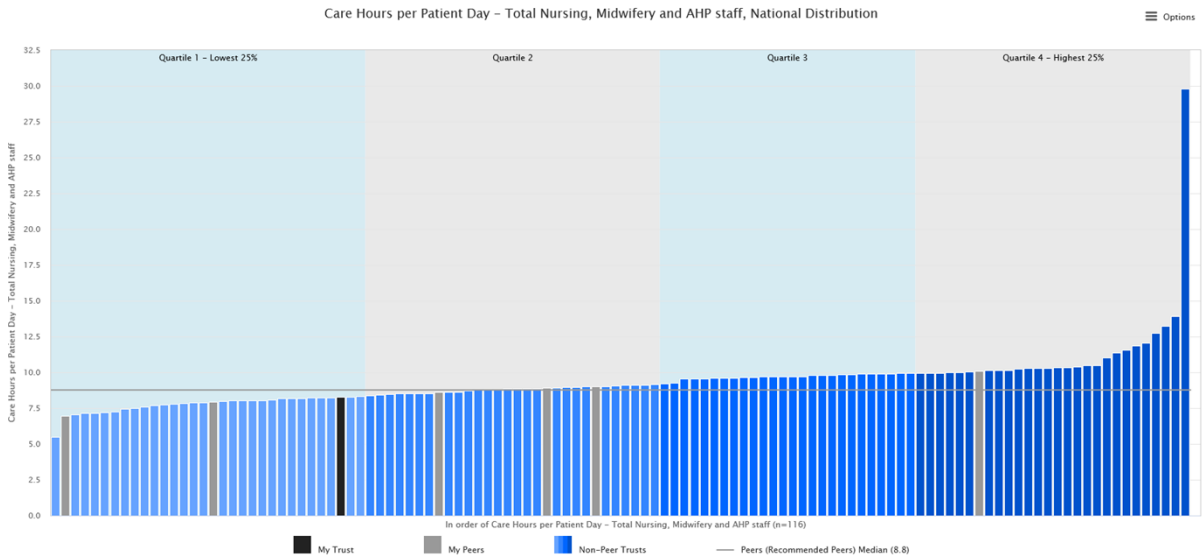
Focused recruitment campaigns continue for HealthCare Assistants to increase the numbers of substantive staff with the intention of eliminating agency expenditure in this area which is a national requirement.

2.5.4 Care Hours per Patient Day (CHPPD)

The national reporting requirements for safe staffing has changed from the planned vs actual hours' methodology to reporting on care hours per patient day. This metric provides a single comparable metric for recording and reporting nursing and care staff deployment. It's a simple calculation which divides the number of actual nursing/midwifery (registered and non-registered) hours available on the ward per day, by the number of patients on the ward at midnight. It represents the average number of hours that are nominally available to each patient that day.

Within Model Hospital comparisons can be seen at both ward and trust level, however, caution is required as the specific configuration of services in any organisation determines the level of staffing required. The data in the model hospital provides the opportunity to review staffing levels through another lens, ask questions and challenge and evaluate whether staffing levels are safe. As previously highlighted, going forward Nursing Associates (but not Assistant Practitioners) will be shown separately to RNs and HCAs.

The graph below is taken from Model Hospital. SFT whilst not the lowest appears is in the lowest quartile (Data October 2020), this does not reflect the more recent impact of the recent Covid activity.



3 Covid Staffing

During wave 1 and wave 2 of the Covid pandemic staffing has needed to adapt in differing ways. In wave 1 staffing levels were high as the hospital occupancy dropped to 46% and sickness levels were not impacted as heavily , this was visible in the care hours per patient day rising in April to May. In the recent wave starting in September but escalating in November and December the new Kent variant impacted the trust heavily and staff sickness and self-isolation increased sharply, staffing through Christmas and into mid-January was very challenging.

In anticipation of reduced staffing a planned change in ratios was developed and agreed via the Executive Gold forum (See appendix 2). The table below demonstrates the planned actions for green, amber and red staffing as we moved through increasing level of sickness during wave 2 of Covid. The focus was to facilitate an informed approach to reducing staffing during January 2021. The Trust reached the point where the teams were unable to achieve red levels, as a result of this, the Trust actioned additional resource requests in the form of implementation of the Ward Buddy programme and the use of military resources across clinical areas.

Rating	Trigger/Impact	Action	Authorisation
Green	**Staffing levels:** staffing levels match with agreed roster plan **Patient acuity & dependency**: is within usual expected range for the area **Situation**: "business as usual"	All planned care and routine tasks will be carried out	None
Amber	**Staffing levels:** A shortfall has occurred between 'We have' and 'We planned' e.g. due to staff absence and/or vacancy **Patient acuity & dependency:** is	Some non-essential activities may be postponed or cancelled until situation is resolved as	Matron – in hours Duty manager - out of hours

	increased from that usually expected e.g. requiring increased clinical observation levels or other staff intensive interventions **Situation:** A short term solution resolved by short term provision of additional resources	determined by the Nurse in Charge Matron seeks redeployment of staff from other areas or where this is unsuccessful may request additional Bank cover as required	
Red	**Staffing levels:** A shortfall has occurred between 'We have' and 'We planned' that cannot be met in the short term by redeployment of staff from other areas or by Bank staffing **Patient acuity & dependency:** risk assessment and professional judgement indicates that risks presented by a measurable increase in patient acuity/dependency necessitates a shift to be covered	All non-essential tasks are suspended – specifics agreed by Nurse in Charge Matron escalates red rated shift to HoN for consideration/approval for agency cover. Off framework agency to be approved by DoN or Deputy (Exec on-Call out of hours) Nurse in Charge reports a patient safety incident on DATIX if shift is unable to be partially/completely covered and patient safety is at risk of being compromised	Agency - Matron or Divisional Head of Nursing to Deputy Director of Nursing in hours On call manager and exec on call out of hours DoN or Deputy for non-framework requests (exec on call out of hours) Below red Ward buddies and military support was sought

4. Conclusions

A significant improvement has been made with recruitment and retention and in normal circumstances Salisbury is in a positive position which benefits to the experience of both our staff and patients. The Trust have seen the benefits of this staffing position in terms of reduced agency spend but the increased sickness and Covid activity through November to January 2021 will impact this improved position.

Nursing continues to demonstrate effectiveness in deploying workforce efficiently as seen in both INSIGHTs data which is reviewed monthly at the Safe Staffing Group and an overall underspend in nursing expenditure.

Good progress has been made against ensuring nursing continues to meet the requirements of the national publications on nurse staffing and the responsibilities in Developing Workforce Safeguards.

Work between the nursing team and the Finance team has led to an improved understanding of the required staffing position, including a review of the overhead level included in nursing calculations to bring it in line with Shelford safer staffing guidance of 22 % but work is ongoing.

Overall quality of care has been impacted by Covid and it is too early to understand what this means according to reportable nurse sensitive indicators. Despite the challenging environment of increasing acuity and dependency and some changes to the definitions of some of the measures such as pressure ulcers and clostridium difficile alongside the noted concern of the increase in grade 3 pressure ulcers.

The Director of Nursing on acceptance of the recommendations considers the nurse staffing model to be safe, effective and sustainable under normal circumstances and reflective of current levels of acuity and dependency – this will be subject to an annual review.

5. Recommendations

- To note the findings of the full ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels, specifically:
    - SFT nursing establishments are set to achieve an average of 1:5 – 1:7 registered to patients across the majority of wards during the day.
    - Wards are staffed on average 60:40 registered/unregistered ratio, with exceptions linked to the implementation of the band 4 role.
- To note the on-going progress with compliance with the guidance from the National Quality Board on safe, sustainable and productive staffing including Developing Workforce Safeguards.
- To note the requirement to implement the Safer Nursing Care tool to provide additional assurance that nurse staffing levels are safe.
- To continue momentum on actions to fill vacancies in a timely manner and improve retention and to continue the reduction on the reliance on high cost agency.
- To discuss the report at both TMC and open Trust Board as an ongoing requirement of the National Quality Board expectations on safe staffing assurance.
- To recognise that ongoing Covid activity may require an agile response to maintain safe nursing care.

Appendix 1 Requested changes to establishment

Areas Identified in Skill Mix Review	£ amount	Comments
MEDICINE		
Whiteparish 1 x B5 Day Shift Sat/Sun (0.6wte) 1 x B4 Night shift (2.55wte) Uplift 1 x B5 to B6	 £20,027 £87,369 £9,280	 All supported
Spire: 1 x B2 Day Shift (2.55wte) Uplift 1 x B5 to B6	 £74,430 £9,280	 All supported
Durrington: 1 x B4 Day Shift (2.55wte) 1 x B4 Night Shift 92.55wte)	 £75,924	 All supported
Redlynch: 1 x B5 Day shift (2.55wte) 1 x B2 Night shift (2.55wte) Uplift B5 to B6	 £85,116 £74,505 £9,280	 All supported
Stroke: 1 x B5 Night shift (2.55wte) 1 x B2 Night shift (2.55wte) 1 x B2 Late shift (1.66wte)	 £99,288 £74,505 £48,501	 Supported if return to 30 bed footprint Not supported at this review Not supported at this review *Both require further review following SNCT and if return to 30-bedded footprint*
Pembroke: Uplift B5 to B6 1 x B2 Early shift (1.33wte)	 £9,280 £31,381	 Supported Not supported at this review

Tisbury: Zero requests		
AMU: 1 x B5 Night shift (2.55wte)	£99,288	Not supported at this review –requires funding when in escalation
ED: 1 x B5 Paed Nurse (2.55wte) 1 x B7 Paed Sister (1wte) 1 x B4 Day Shift (2.55wte) 1 x B4 Night Shift (2.55wte)	 £85,116 £51,227 £75,924 £87,639	 All posts subject to separate business cases.
SURGERY		
Britford: 1 x B5 (0.6wte for SAU)	 £17,531	 Previously supported but not in budget
Downton: Uplift B5 to B6 Uplift B2 to B4 offset by other changes	 £9,280	 All supported
Orthopaedics: 1 x B2 late shift (1.66wte) 1 x B5 Night Shift (2.55wte)	 £48,501 £91,422	 All supported

Appendix 2 Covid staffing model

	Funded staffing levels
	At least 1 x RN gap, needs to be triangulated with SafeCare
	2 or more RN gaps, needs to be triangulated with SafeCare and professional judgement discussion and may require non-framework agency cover

												Total beds	SD beds
	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA		
MEDICINE													
AMU												19	0
Early	6		4		5		4		4		3		
Late	6		4		6		3		4		3		
Night	5		2		4		2		4		2		
Durrington												23	2
Early	3		4		2	1	3		2	1	2		
Late	2		2		2		2		2		2		
Night	2		2		2		2		2		1		
Farley (RCU) Note increased staffing levels when ward functioning with high number of COVID, in addition NIV 1:2 ratio												30	0
Early	5		3		5		3		4	1	3		
Late	5		3		5		3		4	1	3		
Night	5		3		4		3		4		3		
Hospice												10	0
Early	2		1		2		1		2		0		
Late	2		1		2		0		2		0		
Night	2		1		2		1		2		0		
Pembroke												10	0
Early	2		1		2		1		2		0		
Late	2		1		2		1		2		0		
Night	2		1		2		1		2		0		
Pitton												28	2

												Total beds	SD beds
	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA		
Early	5		5		4		4		3		3		
Late	5		3		4		3		3		2		
Night	4		2		3		2		2		2		
Redlynch												27	3
Early	4		4		3		4		3		2		
Late	4		3		3		3		3		2		
Night	3		2		3		2		2	1	2		
Spire												30	0
Early	4		6		4		5		3		3		
Late	4		3		3		3		2	1	3		
Night	3		2		3		2		2	1	2		
Stroke –Laverstock												26	1
Early	3		3		3		3		2	1	2		
Late	3		2		2	1	2		2	1	2		
Night	3		1		2	1	1		2		1		
Stroke – Breamore												24	4
Early	3		3		3		2		2		2		
Late	3		3 +1		2	1	2		2		1		
Night	2	1	2		2		2		2		1		
Tisbury/CCU												23	0
Early	6		2		5		2		4	1	1		
Late	6		2		5		2		4	1	1		
Night	4		1		4		1		3	1	0		
Whiteparish												23	0
Early	3		3		3		2		2		2		
Late	3		2		3		2		2		2		
Night	2		2		2		1		2		1		
Longford												39	0

												Total beds	SD beds
	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA		
Early	7		10		6		8		5	1	6		
Late	6		6		5		6		5	1	4		
Night	5		5		4		5		4		4		
SURGERY													
Britford												20	1
Early	5		2		4		2		3		2		
Late	4		2		4		2		3		2		
Night	3		2		3		2		2		2		
Downton												24	2
Early	4		3		3		2		2	1	2		
Late	3		2		3		2		2	1	2		
Night	2		2		2		2		2		2		
Odstock												17	0
Early	4		2		3		2		2	1	2		
Late	3		2		3		2		2	1	2		
Night	3		2		2		2		2		2		
Amesbury elec												6	0
Early	2		0		2		0		1		1		
Late	2		0		2		0		1		1		
Night	2		0		2		0		1		1		
Amesbury trauma												24	
Early	4		3		3	1	3		3		2		
Late	4		3		3	1	3		3		2		
Night	3		3		2		3		2		2		
Chilmark – Covid													

												Total beds	SD beds
	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA		
Early	3		2		2	1	2		2		3	16	
Late	3		2		2	1	2		2		3		
Night	3		2		2	1	2		2		2		
Chilmark - Trauma												8	0
Early	2		1		2		1		1		1		
Late	2		1		2		1		1		1		
Night	2		1		2		1		1		1		

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