Bundle Trust Board Public 5 May 2022

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates

• *April SOX of the month – Abi Shattock, SHO Emergency Dept*
• *April Patient-centered and Safe SOX – Kiereen Lock, Speech and Language Therapy*

1.2 10:10 - Staff Story

1.3 Welcome and Apologies

Apologies received from Lucinda Herklots

1.4 Declaration of Interests

1.5 10:30 - Minutes of the previous meeting

Minutes attached from meeting held on 7 April 2022
For approval

1.5 Draft Public Board mins 7 April 2022.docx

1.6 10:35 - Matters Arising and Action Log

1.6 Public Board May 2022 Action Log.pdf

1.7 10:40 - Chairman's Business

Presented by Nick Marsden
For information

1.8 10:45 - Chief Executive Report

Presented by Stacey Hunter
For information

1.8 CEO Board Report - April for May Board.docx

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:55 - Clinical Governance Committee - 26th April

Presented by Eiri Jones
For assurance

2.1 Escalation report - from April 2022 CGC to May Board 2022 finala.docx

2.2 11:00 - Finance and Performance Committee - 26th April

Presented by Paul Miller
For assurance

2.2 Finance and Performance Committee escalation paper 26th April 2022.docx

2.3 11:05 - Trust Management Committee - 27th April

Presented by Stacey Hunter
For assurance

2.3 April TMC Escalation report for Trust Board.docx

2.4 11:10 - People and Culture Committee - 28th April

Presented by Michael von Bertele
For assurance

2.4 MvB Escalation report - P&C Committee 28 Apr 22.docx

2.5 11:15 - Integrated Performance Report to include exception reports

Presented by Peter Collins
For assurance

2.5a Trust Board cover 070522.docx

2.5b IPR May 2022 DRAFT TB.pdf

3 QUALITY AND RISK

3.1 11:45 - Infection Prevention Measures - Testing Update

Verbal update by Judy Dyos
For information

3.2 11:50 - Ockenden 'One year on' Compliance Report

Presented by Judy Dyos
For assurance

3.2a New Committee cover sheet template Ockenden part one 1 year on April 22 v 3a.docx

3.2b Ockenden 1 year on final - April 22 JH v 2.pdf

3.3 12:00 - BREAK

4 FINANCIAL AND OPERATIONAL PERFORMANCE

4.1 12:10 - Board Assurance Framework and Corporate Risk Register

Presented by Fiona McNeight
For assurance

4.1a Trust Board BAF cover sheet February 2022.docx

4.1b REVISED BAF v2 April 2022.docx

4.1c Draft Corporate Risk Register April 22_v3.pdf

4.1d CRR tracker v1_April Board Committees 2022.pdf

4.2 12:20 - Corporate Priorities

Presented by Lisa Thomas
For assurance

4.2a TB corporate priorities Q4 update.docx

4.2b Corporate priorities Q4 update.pptx

5 GOVERNANCE

5.1 12:30 - NHSI Self-Certification (FT4, G6, CoS7)

Presented by Fiona McNeight

5.1a Trust Board Cover Sheet Self Certification 2021_22 - Copy.docx

5.1b 2021_22 Self-certification_template_G6.pdf

5.1c 2021_22 Self-certification_template_FT4..pdf

5.1d Appendix 1_ Provider Licence Self Certification Proposed Response_2021_22.docx

5.1e Appendix 2_ Provider Licence Conditions 2021_22.docx

6 CLOSING BUSINESS

6.1 12:40 - Agreement of Principle Actions and Items for Escalation

6.2 12:45 - Any Other Business

6.3 12:50 - Public Questions

6.4 Date next meeting

7th July 2022

7 Resolution

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

Salisbury NHS Foundation Trust

Draft

Minutes of the Public Trust Board meeting held at 10:00am on Thursday 7th April 2022, MS Teams Salisbury NHS Foundation Trust The Rugby Club, Salisbury

Board Members:

Nick Marsden (NM)	Chairman
Paul Kemp (PK)	Non-Executive Director
Paul Miller (PM)	Non-Executive Director
Eiri Jones (EJ)	Non-Executive Director
David Buckle (DB)	Non-Executive Director
Tania Baker (TB)	Non-Executive Director (Chair)
Rakhee Aggarwal (RA)	Non-Executive Director
Lisa Thomas (LT)	Chief Finance Officer
Judy Dyos (JD)	Chief Nursing Officer
Andy Hyett (AH)	Chief Operating Officer
Stacey Hunter (SH)	Chief Executive
Melanie Whitfield (MW)	Chief People Officer

In Attendance:

Esther Provins (EP)	Director of Improvement and Partnerships
Duncan Murray (DM)	Deputy Chief Medical Officer
Kylie Nye (KN)	Head of Corporate Governance (minutes)
Fiona McNeight (FMc)	Director of Integrated Governance
Lucinda Herklots (LH)	Lead Governor (observer) via teams
Angela Milne (AM)	Governor (observer) via teams
Jane Podkolinski (JP)	Governor (observer) via teams
Victoria Aldridge (VA)	Head of Patient Experience (item TB1 7/4/1.2) via teams

ACTION

TB1 7/4/1 OPENING BUSINESS

TB1 7/4/1.1 Presentation of SOX (Sharing Outstanding Excellence) Certificates

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

- **March SOX of the month – Amy Houghton, Midwife**
- **March Patient-centered and Safe SOX – The staff on Pitton Ward**.

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

SH noted that Amy Houghton had independently set up the wellbeing day and the feedback from it had been positive. Amy had joined the Trust's compassionate leadership course which had motivated her to organise the well-being day. SH acknowledged the great work Amy had put into this day and the compassion displayed for her colleagues and the service.

JD noted that it was great to hear a positive story in relation to the care on Pitton Ward, which has been impacted as a result of the current challenges.

TB1 7/4/1.2 **Patient Story**

VA joined the meeting to present the patient story which detailed the experience of a patient's relative, whose mother was treated by the hospital. VA asked for the Board's thoughts in relation to the story and also asked them to consider the structure of the patient story and if there were any suggestions in relation to how the story is delivered.

The son gave details about the difficulties he had experienced, particularly with support from SFT in relation to his mother's mental health concerns. The key themes from the story detailed the lack of support the son felt he received at times in relation to managing his mother's mental health, the repetitive nature of the conversations he had to have with multiple clinicians and how he felt that staff did not listen to him. Issues were also highlighted with documentation and IT systems.

Discussion:
AH noted the challenging position the Trust has placed on therapy services in relation to the constant focus on discharge. AH noted that the pressure to discharge patients is felt by staff and this story highlights the significant pressure services are under to improve patient flow.

PM noted that in relation to the structure of the story, he had found the graphics in the video to be a useful visual aid. PM further noted that the story highlighted the complexity of looking after patients and the different perspectives of the carer vs. staff. It is important to understand the dimensions of a problem and take in the wider picture in relation to each patient's journey.

DB noted that the story featured quality of communication several times. The NHS is struggling to maintain quality and this is a difficult message to deliver but one that is important to get right.

SH noted that the story does not make for comfortable listening. What is clear is that mental health does not have parity with physical health and whilst there are plans in place to address this, mental health provision requires significant improvement. The story also highlights the Trust's shortcomings in digital maturity and this is a part of the mid - long term plan to improve hospital systems.

The repetitive nature of the son's conversations was discussed and it was noted that communication to explain why he may have had to have these conversations several times was lacking. Developing the Trust's IT systems will go some way to improving the continuity of care when patients move around the hospital but in the interim, there needs to be some honest and difficult conversations with relatives and patients about their expectations of care in the Trust.

EP reflected on the concerns this person had about their mother's

mental health and commented that the Trust needs to get better at sign posting support services for patients and their families when the Trust does not offer or is unable to provide them. EP noted that the focus should be on how support can be provided to the 'whole person' or at least signpost help where needed. JD referred to the availability of support and noted that the Trust struggles with acute mental health provision.

RA referred to the story format and asked if the Board invited people to come in person. FMc explained that patients used to come in person pre-COVID. TB noted that where possible the Board would encourage it but noted that some might find it more appealing and comfortable if they pre-recorded their story.

TB noted that patients and families having to repeat medical history has been heard at the Board several times. If this is not going to improve the Trust needs to set patient and family expectations. TB further referred to the Occupational Therapists who the patient had praised during the story and noted how impactful patient care was when considering the whole patient experience.

It was agreed that the Board would reflect on the format of the patient and staff stories and come back with some suggestions. **ACTION: ALL** **ALL**

VA left the meeting.

TB1 7/4/1.3 **Welcome and Apologies**

TB welcomed everyone to the meeting and noted the following apologies:

- Nick Marsden, Chair (it was noted that Nick would be joining later in the meeting) TB to chair public Board.
- Michael Von Bertele, Non-Executive Director
- Peter Collins, Chief Medical Officer

SH noted that the hospital was exceptionally busy and therefore operational colleagues may have to step out of the meeting at points throughout the meeting.

TB1 7/4/.4 **Declarations of Conflicts of Interest**

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

TB1 7/4/1.5 **Minutes of the part 1 (public) Trust Board meeting held on 10th March 2022.**

TB presented the minutes from 10th March 2022, and the following amendments were suggested:

- JDy noted that the amendments picked up in January's minutes should have ready 352 compliments, not complaints.
- MW noted that a sentence on p.7 should read "formal well-being conversations will be recorded."

It was agreed that subject to these amendments the minutes were approved as a correct record of the meeting.

TB1 7/4/1.6 **Matters Arising and Action Log**

TB presented the action log and noted that both actions were to be picked up on a future agenda or closed.

TB1 13/1/5.4 Equality, Diversity and Inclusion (EDI) Annual Report/ Staff Networks – MW explained that the inclusion network, which commenced on 4th April, had reasonably good attendance and is a promising forum. Network chairs have agreed a programme of work and the Trust's draft EDI strategy will go to this forum for discussion. SH thanked MW for the update and suggested that the Board receive a formal update of Trust progress on EDI in the next few months. **MW**
ACTION: MW

TB1 10/3/2.4 IPR/ Maternity Dashboard – JD explained that the improvements on the Maternity dashboard will be coming to Clinical Governance Committee (CGC) in May. Item to remain open until then. **JD**
ACTION: JD

TB1 1 13/01/2.5 Charitable Fund Strategy - LT noted that there would be a separate meeting of the Trustees in May after private Board. Item closed.

There were no further matters arising.

TB1 7/4/1.7 **Chairman's Business**

TB reflected on the broader position of the hospital and acknowledged that whilst there are exceptional challenges, a majority of staff come to work to do good job and some do an outstanding job even in the current situation the NHS is facing. The Board should not underestimate the difficulties for staff and patients going forward, as the challenges throughout the next few years and beyond are navigated.

TB1 7/4/1.8 **Chief Executive's Report**

SH presented her report and highlighted the following key points:

- The position in the Trust and wider system is exceptionally challenging and the hospital has been reporting OPEL level 4 and a critical incident level 3 for the past few weeks. The position in relation to handover delays has also deteriorated in last 2 weeks where the Trust has been unable to achieve flow. This is an exceptionally concerning situation and due to this elective activity, apart from urgent work, over Easter has been cancelled.
- The number of inpatient patients has unfortunately trebled in the last few weeks and staff absence doubled which has placed further significant pressure on the hospital and has left many staff groups in distress.
- To manage this the system and the Trust's strategic endeavours continue. SH and LT had a very useful meeting with Wiltshire

Council and LT has been tasked with developing a business case around domiciliary care by the end of Q1.

- SH publicly apologised to those patients with excessive waits and acknowledged the difficult circumstances that colleagues are working in to provide safe and effective care.
- To further manage the stress in the organisation the private Trust Board will be considering a proposal to change the Infection, Prevention and Control (IPC) measures as it is felt that there is now more risk to other patient groups, than benefit.
- The Trust continues to deliver against the 2021/22 Elective Recovery Plan and SH gave thanks and recognition to those staff who have worked tirelessly to improve this position.
- The written report indicates that the pressure on spinal services have improved. However, as of today the Trust is having to move back into the spinal gym. Specialist commissioners have agreed to continue to monitor ad provide support as needed.
- The final report from Ockenden into Shrewsbury and Telford Hospital Trust was published on the 30th March 2022 which has set out clear recommendations for all Trusts providing maternity services. The Trust has already made progress against the interim Ockenden recommendations. What has come from the report is a recommendation around continuity of carer that indicate hospitals should not attempt to achieve this standard unless appropriately staffed.
- From 1st April the Trust have reintroduced car park charges. Some staff charges have been amended to place bands 3 and 4 in the lowest monthly charge bracket and once number plate recognition is installed in July, charges will reflect all 12 pay points.
- Going forward the Acute Hospital Alliance programme director has been asked to develop a standard board report for all three trusts. It has been agreed that the CEO Senior Responsible Officer will rotate to SFT in January 2023 and the chair of the Committee in Common (CIC) in 2024.
- On 22nd March the Trust and Salisbury Cathedral held a special service to reflect on the past 2 years. SH noted that Dave Roberts and the Communications team did an exceptional job organising the event.
- The Trust's new podcast "Cake with Joe and Jayne" has been launched internally and at the time of writing has had a high number of listens (750+) and incredible feedback on some challenging topics. Thanks were extended to Jayne and Joe for their hard work and everyone who has participated in producing the podcast.

Discussion:

JD referred to the Ockenden recommendations and noted that the reporting around Maternity is currently going to CGC and is then escalated via the chairs report from the Committee. Compliance against the first round of recommendations was 70%. However, the three standards which required further work have all been mitigated and the Trust now meets all the standards within the 7 recommendations. There are 15 standards in the new report which the team have started to work through. SH noted that the outcome of the Ockenden review will

resonate with many colleagues working in maternity services and there is work ongoing with the divisional team to ask what support they would like from the executives and the Board.

PK referred to the current and continuous status of OPEL 4 and asked how the executive is taking a broader view of risk at this level. SH explained that there is an escalation framework with a set of triggers and actions. The Trust is utilising those systematically and the conversations and decisions are consistent with these frameworks. However, due to the level of extremis the actions from this framework of escalation are not mitigating the issue. A fundamental change to the framework is required at a regional and national level.

SH noted that actions are continuously underway to keep patients safe and there is daily escalation in relation to staffing, so teams can meet patient's needs. PK asked where a separate level of oversight would come from in such exceptional circumstances. SH explained that every individual has their own accountability and work to various standards and guidance. There are the appropriate checks and balances for individual practitioners. JD explained that CGC provides oversight and assurance in terms of quality and it is acknowledged that this has been impacted as the Trust is currently working with substandard levels of staffing. The Trust is not providing the best level of care it would normally aim to deliver. JD further explained that there are touch points to discuss staffing and risks three times a day and the challenges are widely known by staff. Additionally, anyone can submit a Datix which are regularly monitored. Matrons also touch base every day on the wards and whilst this is not always documented, this does provide a senior level of oversight. It is acknowledged that it is a risky environment but there are steps in place to manage this risk.

PM reflected that in health and social care there are huge delays and no flow and it is difficult for the system to operate when wider society is managing the pandemic in a completely different way. Collectively, health and social care need to incrementally move to normalisation. PM referred to the IPC paper expected in Private Board and advised that if the Trust do change practices, the staff and public need to understand the context behind these decisions. SH explained that if approved in Private Board, staff briefings and external communications would follow.

DB thanked SH for her transparency in relation to the level of stress in the organisation. DB referred to ambulance waits and asked if everyone is being triaged within the expected time. SH confirmed that the Hospital Ambulance Liaison Officer (HALO) has direct contact with ED and is ensuring those with greatest need are triaged appropriately.

EJ noted that CGC in April would be picking up the safety implications of ambulance delays.

TB thanked SH for her report and acknowledged that many of the Trust's patients and wider population do understand the challenges the NHS currently face.

TB1 7/4/1.9 **Approve Public and Private Trust Board Cycle of Business 2022/23**

TB presented the Trust Board Cycle of Business for 2022/23.

Discussion:
JD suggested that whilst the maternity updates were generally reporting to CGC, a Maternity/ Ockenden annual report needed to be added to the public Board cycle of business. **ACTION: KN** **KN**

Decision:
The Board approved the cycle of business for 2022/23.

TB1 7/4/2 ASSURANCE AND REPORTS OF COMMITTEES

TB1 7/4/2.1 **Clinical Governance Committee (CGC) 29th March 2022**

EJ presented the report, providing a summary of escalation points from the meeting held on 29th March. EJ asked for the report to be taken as read and highlighted the key points:

- Several items were deferred in March due to the pressures on services due to the impact of COVID on workforce availability.
- EJ observed the weekly patient safety discussion and the level of exploration is robust. There are gaps in assurance in relation to controls and these will be reviewed and updated.
- A presentation from the spinal service was received. During the presentation assurance was provided to the committee that all 'must do' actions from the CQC inspection had been completed. Audit evidence was available. Further monitoring of progress will be addressed through the Divisional performance processes.

The report was noted.

TB1 7/4/2.2 **Finance and Performance Committee (F&P) 29th March 2022**

PM provided a summary of escalation points from the Finance and Performance Committee held on 29th March. PM asked for the report to be taken as read but noted the following key points.

- The draft Operational Plan is to be noted in the Private Board meeting. It was F&P's recommendation that the Board delegate authority to the Committee on 26th April, as final submission is due on 28th April.
- PM explained that the Operational Plan includes assumptions around minimal levels of COVID and the current situation led the Committee to discuss the realistic delivery of this plan.

Discussion:
SH noted that the overarching planning guidance from NHSEI states that the Operational Plan should assume low levels of COVID. PM acknowledged this but felt it was pertinent to highlight at Board as it is an assumption that does not reflect the current reality.

Decision:

The Board agreed to delegate authority to F&P Committee to sign off the 2022/23 Operational Plan prior to submission on 28th April.

TB1 7/4/2.3 **Trust Management Committee (TMC) 23rd March**

SH noted that the TMC scheduled to take place on 23rd March had been condensed and there was nothing to escalate from the short meeting that took place.

TB1 7/4/2.4 **People and Culture Committee (P&C) – 31st March 2022**

MW noted that in MvB's absence the escalation report from the Committee on 31st March should be taken as read. MW noted that it was a productive meeting and the Committee had discussed the desired aspirations for the people team. The team is currently awaiting confirmation of investment for the year ahead to enable the team to realise its ambitions.

Discussion
The Board discussed the need to invest in the OD & People team and how this aligns back to the wider plan. PM noted that the risks of not investing and the desire to strengthen the people function is clear. However, whilst there is a need to move at pace there is a requirement to hold to account for this investment, in a supportive way, to get the desired outcomes.

MW acknowledged the difficulties in terms of investment but explained that some members of the team have not been able to effectively undertake their roles which impacts the service and functional performance.

SH noted the importance of these discussions as from an executive perspective there are going to be some difficult decisions about what the Trust will be able to invest in. There should be recognition that improvement in one service will be at the expense of another.

TB1 7/4/2.6 **Audit Committee – 24th March 2022**

PK presented his escalation report from the Audit Committee on 24th March 2022 and noted the following key points:

- The Committee received the draft opinion from the Head of Internal Audit. The formal summary is that the Trust's management of its control environment has been "generally satisfactory with some improvements required". This is consistent with the opinion given for the previous two years. It is acknowledged that, largely driven by the circumstances in the last two years, there has been a decline in management of the control environment. These are being picked up but it is recognised that it is currently a reactive environment.
- All Boards are required to consider and decide whether their organisation's annual financial accounts should be prepared on what is known as a "Going Concern" basis. It is recommended that the Board approve the preparation of the 2021/22 annual accounts

on a Going Concern basis.
- There were three formal audit reports at the committee and within those there were three high risk findings which provides a high level of control concern. Need to start looking at how we manage these issues are dealt with better compliance to own procedures.

Discussion:
EP noted that the level of opinion is generally the same across the last few years and asked if there were any commons themes. PK explained that the Trust is currently working reactively, rather than managing gaps in control in a proactive way. LT agreed with PK and noted that there have been shortfalls in process. LT explained that the safety layers of governance are there to make agile decisions and ensure people do not step outside of those boundaries. There is further work to be done to improve on these processes.

SH commented that the work underway through Improving Together will ensure the organisation works together to deliver realistic targets.

PK advised that part of the issue is follow through. It is common for audit action plans to stop before the fundamental problem is fixed.

Decision:
The Board approved the preparation of the 2021/22 Annual Accounts on a Going Concern basis.

TB1 7/4/2.7 **Charitable Funds Committee – 24 March**

In NM's absence, PM noted that there has been a step change over the last 12 months in relation to charitable fund governance and there will be an update coming to the private Board meeting on 5th May to bring the Board up to speed with this area of work. PM noted that everyone involved in charitable funds has made some great improvements and this should be recognised.

TB1 7/4/2.8 **Integrated Performance Report (IPR) (M10)**

JD presented the Integrated Performance Report which provided a summary of February's performance metrics. JD noted that the operational challenges to the Trust had been discussed in detail but highlighted a few key points:

- A category 4 pressure ulcer was reported in month. This pressure injury was not noted on admission but came in with the patient.
- There is a high level of falls which is why falls have been chosen as a breakthrough objective as part of Improving Together. The number of falls reflects the level of pressure in the organisation.

Discussion:
EJ referred to stroke services and asked if everything possible is being done to manage the challenges on this service. JD explained that the proposed changes to the management of Infection, Prevention and Control will enable to Trust to bring the service back to one location which will have a positive impact on delivery of stroke services.

EJ asked for an update on theatres and the work around late starts. AH noted that these are still under review and action has been taken to address late starts. An update on this work is coming back to F&P in May.

The Board discussed those patients waiting at 104 weeks and AH reported that two were due to be operated on this week.

The Board discussed the sickness absence rate which did not appear to correlate to the previous discussion about significant levels of staff absence. SH explained that the sickness absence rate is an aggregate figure over a rolling 12-month period and the next level of detail indicates that there are some wards currently experiencing a 10% absence rate.

TB1 7/4/3 QUALITY AND RISK

TB1 7/4/3.1 Patient Experience Report Q3

JD presented the Patient Experience Report which provided a report of activity for Q3 in 2021/22. JD reported that this was the first report produced by Deborah Stott, the new PALS lead and highlighted the following key points:

- 42 complaints were received in the reporting period, which is a rate of 0.042%.
- There has been a decrease in the percentage of complaint responses sent out within the agreed timeframe. This reflects the challenges faced in the clinical teams, balancing extremely challenging circumstances on the wards and producing timely responses.
- New NHS Complaint Standards have been published by the Ombudsman and will be introduced across the NHS in 2022.

Discussion:
It was acknowledged that there were an increasing number of patients contacting the CEO with complaints. SH noted that this is a reflection of the challenges the Trust currently faces and the wider NHS. DB noted that the population's faith in the NHS has reached a low point which will impact the level of complainants.

EJ referred to the number of complaints received over time and that the trajectory is on a downward trend. EJ noted that this does indicate improvement although there is still further work to do as the Trust does not always get it right for everyone. EJ asked that the graph, indicating how many concerns and enquiries were dealt with by PALs before they led to a possible complaint, could be added back into the report. **JD**
ACTION: JD

TB1 7/4/3.2 Learning from Death Report Q3

In PC's absence DM presented the report which provided details that the Board that the Trust is learning from deaths and making improvements. DM noted that the report had been received and

discussed at CGC and highlighted the following key points:

- The findings of 170 structured judgement reviews (SJRs) of patients who died of COVID-19 during the second wave (October 2020 to August 2021) were reviewed by the Mortality Surveillance Group Key themes related to delays in the monitoring and treatment of patients. Some delays in communicating COVID status with families and difficulties with communication to wards and staff were also identified.
- A higher-than-expected relative risk of Chronic Obstructive Pulmonary Disease (COPD) and bronchiectasis was recently identified and a case note review will be undertaken for these 18 cases.
- There is an elevated Hospital Standardised Mortality Ratio (HSMR) from the previous month. The Head of Clinical Effectiveness and PC have reviewed and note that this is related to the fact that it is calculated on a 12-month rolling basis and the phasing of peaks of COVID are not perfectly aligned across the Trusts. This should return to normal levels after a period of time.

Discussion:
The Board had a detailed discussion about HSMR and mitigations to improve the data quality, for example, looking at a longer period of time, perhaps 18–24 month period to provide a consistent view. EJ notified the Board that CGC had not felt fully assured by this report and they had asked PC and the Head of Clinical Effectiveness to provide further assurance.

TB noted the excellent work that is done regarding mortality surveillance but suggested that there needs to be further understanding of the data and offered her support in developing this.

It was positively noted that SHMI is within expected levels but SH agreed with the need for further assurance and asked PC to bring this back to the Board before the next quarterly report. **ACTION: PC** **PC**

RA noted that it is not clear what learning has been identified and what the Trust is doing about it. DM explained that whenever a patient dies there is a proforma that the person notifying death needs to identify lapses in care and if anything is flagged this is passed to the Trust's Medical Examiners to undertake a Structured Judgement Review (SJR). Where there is learning, this is included in structured reviews and is fed back as part of mortality group.

DB noted that assurance of processes, procedures and practicalities are there and when there are issues picked up they are managed with learning in mind.

LT commented that thematic trends are missing from the report.
SH noted the opportunity to get better at demonstrating themes and triangulating this through Patient Safety Framework, for example, failure to recognise deterioration.

TB reflected that the Board does not spend time looking at outcome

measures and there needs to be a way of building and demonstrating these. It was agreed that SH and FMc would liaise with JD and PC to think about introducing an outcome focus at Board. **ACTION: SH/FMc/PC/JD** **SH/ FMc/ PC/ JD**

TB1 7/4/4 STRATEGY AND DEVELOPMENT

TB1 7/4/4.1 Improving Together Quarterly Update Report

EP presented the report providing the Board with a quarterly update of the Improving Together Programme. EP noted the following key points:

- The initial round of training started in February/March. Engagement has been positive and staff have welcomed the head space to consider priorities. The operational challenges discussed have had impact with some training sessions reduced and/ or cancelled. However, the team is working flexibly with colleagues to go ahead with training and flexing as much as possible to mitigate this risk. There have also been challenges completing the A3 analysis.
- There has been focused work on developing a new style IPR and new divisional and frontline scorecards are in progress.
- The report provides a proposal relating to the governance around Improving Together, clarifying how assurance will be provided to Board Committees and the Board in respect of performance against breakthrough objectives, strategic initiatives and corporate projects. The details of this were included in the paper.
- EP noted the work ongoing with the Board to ensure it has discharged its responsibility to ensure value for money and ensuring the investment is worth it. The Trust is still in the early stages of the programme and the specific benefits are being worked through.
- In relation to the timeline, based on the current delivery model the roll out of the programme is currently due to complete in summer of 2026. There is work to do to see how this might be expedited but it should also be acknowledged that it takes time to embed a coaching culture. It is recommended that the pace at which the programme is running currently is sustained with a review this time next year.

Discussion:
The Board discussed the timescale and it was noted that the coaching, organisational development and cultural elements all take time to embed and PK agreed that there should not be any changes to the delivery timescale before finishing the first wave of training.

PM noted he is content with mainstreaming actions on corporate projects through the individual working groups. In relation to benefits realisation PM suggested an annual report based on the 4 objectives, rather than these feeding through the quarterly reports. EP noted that further discussion is required around the benefits realised at an operational level and how colleagues are supported to work through this.

FMc referred to the work on the IPR and asked if the watch metrics have been mapped, in case there are any areas of escalation, to ensure

nothing is missed. It was explained that this work is ongoing and ties into the operational management system methodology and ensuring continuous improvement is embedded. Flexibility of the IPR was discussed and it was noted that the IPR will be flexible in line with the business rules which will identify parameters around this. EP noted that the IPR will not be perfect straight away but will develop over time.

EP was asked if KPMG have been flexible considering the current circumstances. EP explained that KPMG have been extremely flexible and the team were content with their responsiveness. They have delivered what was expected.

Decision:
The Board approved the governance arrangements for reporting delivery of the Improving Together Programme.

TB1 7/4/5 FINANCIAL AND OPERATIONAL PERFORMANCE

Tb1 7/4/5.1 Standing Financial Instructions (SFIs)

LT presented the SFIs asking the Board to accept the recommendation of Audit Committee on the proposed amendments, including changes to the delegated limits.

Discussion:
EJ asked if removing the £500 approval limit at junior level would have any adverse impact. LT noted it would not.

Decision:
The Board approved the revised SFIs.

TB1 7/4/6 PEOPLE AND CULTURE

TB1 7/4/6.1 Annual Medical Education Performance Report

DM presented the report which provided an overview of the recent developments and challenges in medical education.

DM noted that with COVID-19 continuing to dominate the health agenda, the main challenge this year has continued to be the impact of the pandemic on the education, training and well-being of junior doctors, the effects of which will be with us for many years to come. The educational fraternity and Trust have worked together to prioritise education and training, alongside service recovery.

Discussion:
DM was asked if there are any gaps in medical staffing that need to be raised with the Deanery. SH explained that there are gaps in medicine and paediatrics although it should be noted that there is a gap in what the Deanery supplies on a national scale.

TB gave thanks to the medical education team for delivering training in incredible circumstances and asked DM to pass on this message to the team.

NM joined the meeting.

TB1 7/4/6.2 **National Staff Survey Results**

MW presented the report which summarised the findings of the National Staff Survey which was carried out in autumn 2021. MW thanked Susan Young, who had analysed and summarised the responses. SFT's results are disappointing with a decrease seen in scores in comparison to last year and with other Trusts.

SFT is now below average on 8 out of the 9 themes of the survey and average on staff engagement. The poorest results relate to the job (motivation and resources) and the personal development questions. The health, wellbeing and safety at work theme has the most favourable results when compared with other Picker trusts. There has been a decline in the members of staff who would recommend SFT as a place to work with a greater number of staff feeling work pressure, burn out and stress.

In terms of next steps all divisions have been given their results and areas of prioritisation, impact hotspots and communication have been discussed with the senior OD & People team. The Trust is planning large scale listening events. Action plans are under development to identify quick wins. Progress will be reported to People and Culture Committee on a regular basis for assurance. Additionally, the Compassionate Leadership course which has been received so well has been extended to a 5-module course.

MW read out a few verbatim statements from the report to reflect the results and noted that the comments reflected that the hospital can be a tough and unpleasant place to work at times

Discussion:
SH noted that there was to be a Cascade Brief on Monday and there would be an honest discussion with staff about the findings in this report. There are themes including, inclusion, staffing, nepotism, training and opportunity which should be acknowledged and discussed.

PK asked if KPMG would indicate a change in approach as a result of this report. EP noted that overall, it is known the improvement in staff engagement will support the themes picked up and part of the approach is to address the problems that come forward. What the team is attempting to do is to focus the divisions to embed A3 thinking and focus on what they can influence and change within their remit, rather than focus on staff availability. EP noted that these conversations are focused on priorities and there would be an explicit link to the findings in the Staff Survey instead of there being two programmes of work.

TB suggested that on the basis of 'you said, we did,' it might be useful to push this back to divisional team and ask them what their expectations are in the next 12 months and then communicating this with staff.

Staff availability was discussed and it was noted that this referred to funded staff being absent, i.e. sickness absence relating to COVID or

other illness and isolation. MW noted that despite staff availability in the Trust, teams have done their best to accommodate study and annual leave.

LT referred to IT infrastructure and having the tools to fulfil roles which has been highlighted as a theme. The Trust recognises this and will be utilising this when negotiating investment in digital solutions as there is a direct impact on staff.

SH noted that it is difficult not to be despondent after reading the report but it provides an opportunity to be wholly transparent with staff and set some clear improvements in order to make SFT a better place to work.

TB1 7/4/7 GOVERNANCE

TB1 7/4/7.1 Annual Review of Directors Interests/Annual Review Fit and Proper Persons Test

FMc presented the report which asked the Board to note the annual Register of Interests and the outcome of the Fit and Proper Person Review as of March 2022.

- In 2021, after changing the process to include all decision-making staff, compliance was reported as 20%. The counter fraud team highlighted several areas of improvement and an action plan was produced to improve the annual process and staff's awareness of their responsibilities.
- This focused piece of work over the last 6 months has improved compliance to 60% and whilst it is acknowledged that this is still not where the Trust would like to be, this is a significant improvement on returns from the previous year.
- The executive and non-executive directors have all completed a Fit and Proper Person return and no concerns have been raised as part of this process.

Discussion:
The Board discussed the requirement for staff to complete this process when circumstances were so challenging and SH noted that she felt the process was appropriate despite the context. LT reiterated the importance of compliance with these governance processes.

MW asked if this could tie in in with appraisal and revalidation processes and FMc noted that other avenues were being investigated, particularly due to the current labour-intensive process.

TB1 7/4/7.2 Integrated Governance Framework including Review of Board Committee Terms of Reference

FMC presented the report which asked the Board to approve the amendments to the Trust's Integrated Governance Framework (IGF) and Board Committee Terms of Reference as part of the annual review. FMc noted the following:

- The Accountability Framework which is normally reported alongside this document is under review due to the ongoing

changes as part of the Improving Together work. This document will come back to the Board in the next few months once governance arrangements have been confirmed. FMc confirmed that the existing document is still fit for purpose.

- The Committee Structure, included in the IGF, is a live document and since publication of the Board papers requires further updating in relation to the health and safety structure.
- It should be noted that this document was reviewed whilst ongoing decisions relating to the Integrated Care System governance and legislation is ongoing. Once these arrangements have been confirmed the document will be updated as necessary.

Discussion:
EJ discussed the committee structure in appendix 3 and noted that the flow of assurance is not entirely clear as there are arrows missing from the operational groups to assurance groups. FMc explained that initially the diagram was produced to display the layers of assurance but due to the number of groups it would not be clear as there are several reporting layers to the Board and its committees. The operational groups ultimately report to TMC which then escalates to the Board.

PM noted that the report indicates robust organisational management but suggested that appendix 3 be renamed to Operational Delivery and Assurance Map.

Decision:
The changes to the IGF were approved and the Board Committee Terms of Reference were also approved.

TB1 7/4/7.3 **Accountability Framework**

This was discussed as part of item TB1 7/4/7.2, where it was noted this would be deferred to a future meeting.

TB1 7/4/7.4 **Register of Seals Q4**

The Board noted that there had been no update since the last report.

TB1 7/4/8 CLOSING BUSINESS

TB1 7/4/8.1 **Agreement of Principle Actions and Items for Escalation**

T Baker noted they key points from the meeting as follows:

- The Trust and wider system are currently experiencing unprecedented challenges and this environment is causing distress to staff and patients.
- There are incredible people doing a great job to ensure delivery of safe and effective care. However, the challenges are impactful and it is acknowledged that the Trust is not delivering the service it aspires to.
- TB thanked executive colleagues and staff who are working through this difficult situation.

TB1 7/4/8.2 **Any Other Business**

There was no other business.

TB1 7/4/8.3 **Public Questions**

There were no public questions.

TB1 7/4/8.4 **Date of Next Public Meeting**

Thursday 5th May 2022, Board Room, Salisbury NHS Foundation Trust

TB1 7/4/9 **RESOLUTION**

TB1 7/4/9.1 Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

Master Action Log
Open Actions

Contact Kirsty McAllister, kirsty.mcallister@nhs.net, 4439, for any issues or feedback

1	Deadline passed
2	Progress made, please detail
3	Completed
4	No progress made

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Grandfield	TB1 13/1/4.3 - DIPC report/ Ventilation	07/07/2022	Judy Dyos, JD	PM noted that the ventilation issue is an important one and whilst he is assured that it is on the executive's radar he asked that the DIPC report include a small section explaining the Trust's position.	**Jul-22**	N	4
Trust Board Public	Sasha Grandfield	1 10/3/2.4, TB1 7/4/1.6 - IPR / Maternity Dashboa	24/05/2022	Judy Dyos, JD	Further work required to maternity dashboard in the IPR as it is difficult to understand . JD to speak with TB.	**JD explained that the improvements on the Maternity dashboard will be coming to Clinical Governance Committee (CGC) in May. Item to remain open until then**	N	4
Trust Board Public	Sasha Grandfield	TB1 7/4/1.6, TB1 13/1/5.4 - Equality, Diversity and Inclusion (EDI) Annual Report/ Staff Networks	07/07/2022	Melanie Whitfield, MW	A formal update on EDI progress to come to the Board in July.	**Jul-22**	N	4
Trust Board Public	Sasha Grandfield	TB1 7/4/1.2 - Patient Story	05/05/2022	All	It was agreed that the Board would reflect on the format of the patient and staff stories and come back with some suggestions.	**May-22**	N	2
Trust Board Public	Sasha Grandfield	TB1 7/4/1.9 - Public and Private Trust Board Cycle of Business 2022/23	05/05/2022	Kylie Nye, KN	Update Board Business Cycle to include Maternity/Ockenden report	**Updated - item closed**	Y	3
Trust Board Public	Sasha Grandfield	TB1 7/4/3.1 - Patient Experience Report Q3	07/07/2022	Judy Dyos, JD	EJ asked that the graph, indicating how many concerns and enquiries were dealt with by PALs before they led to a possible complaint, could be added back into the report.	**Jul-22**	N	4
Trust Board Public	Sasha Grandfield	TB1 7/4/3.2 - Learning from Death Report Q3	09/06/2022	Peter Collins, PC	There is a requirement for further assurance re HSMR and SH asked PC to bring this back to the Board before the next quarterly report.	**Next quarterly report due in July - to bring an update back prior to this.**	N	4
Trust Board Public	Sasha Grandfield	TB1 7/4/3.2 - Learning from Death Report Q3	07/07/2022	Peter Collins, PC Fiona McNeight, FMC Stacey Hunter, SH Judy Dyos, JD	TB reflected that the Board does not spend time looking at outcome measures and there needs to be a way of building and demonstrating these. It was agreed that SH and FMc would liaise with JD and PC to think about introducing an outcome focus at Board.	**Next Learning from Deaths due to Board in Jul.**	N	4

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	1.8
Date of Meeting:	05 May 2022		

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

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

Executive Summary:
The purpose of the Chief Executive's report is to highlight developments that are of strategic relevance to the Trust and which the Board of Directors needs to be aware of. This report covers the period since the last public board meeting on the 7th April 2022. Key points to note: • The hospital continues to be under consistent and extreme pressures and on the 27th March escalated from OEPL 4 to a critical incident. The incident is ongoing at the time of writing this report. I will provide a verbal update to the Board at our meeting. • The operational and financial plan for 22/23 has been agreed. The Board have had good line of sight of the progression of this plan. The final version went to the Finance and Performance Board sub-committee on April 26th, 2022 and will be covered in that escalation report. • The system work to ensure successful transition to a statutory Integrated Care Board by July is progressing. Further details are provided in section 3 of this report.

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

1. Our Population

1.1 Operational Context

The hospital continues to be under pressure, the most material contributory factors impacting our patient flow and capacity are both the number of patients with No Criteria to Reside (NCTR), (which is tracking at circa 115 every day). As well as the availability of staff, where the ability to achieve nursing/patient ratio's on adult wards have been particularly challenging.

The challenges in ensuring available bed capacity is having a significant impact on the frequency and duration of ambulance handover delays, the length of time urgent patients who require admission to hospital are waiting for a bed and the ability for our ED and urgent care teams to provide the quality and consistency of care required. The Board will be aware that we continue to monitor a range of patient safety, quality and experience metrics and have seen deterioration in specific areas as detailed in the Integrated Performance Report.

Our OPEL level has continued to trigger at level 4 and the Trust declared a critical incident on the 27th April 2022 which I will ask the Chief Operating Officer to provide a verbal update at our Board meeting on the 5th May 2022.

The BSW system (including all the acute providers) remains exceptionally challenge. The system metrics show an escalation rather than de-escalation in ambulance handover delays and NCTR metrics. This persistent and sustained level of pressure is a significant concern which has been escalated with system partners.

The numbers of people who require hospital care for COVID have reduced to circa 30 people, which is positive, and the Chief Nurse and Medical Director have led the changes in respect of the COVID testing regime and implementation of the latest COVID Infection Prevention and Control guidance.

On behalf of the Board, I would like to thank all our staff for their continued efforts recognising that many of them have been working in a highly pressurised environment on a sustained basis over this last quarter. I would also like to apologise to anyone who has experienced a long wait in our Emergency Department. This isn't the standard we aspire to and our teams with support from system partners are working exceptionally hard to respond to this.

1.2 Elective Recovery

Despite the urgent care pressures our teams have delivered the 21/22 recovery plan and met the trajectories agreed for the reduction in the numbers of patients with the longest waits (78 weeks and 2 weeks).

We are not yet consistently meeting all the cancer standard but are making progress on most of those indicators. The detail of this is shared with colleagues via the IPR and the escalation report from our Finance and Performance Board sub-committee.

The focus over the last month has been on detailing the operational elective recovery plan for 22/23 which has been shared and agreed by the Board.

1.3 Financial sustainability

At the close of the 2021/22 financial year the Trust has achieved a small surplus position. This achievement has been in part underpinned by additional funding streams that have been made available to us as part of the response to Covid-19. This additional funding has supported us to cover the costs associated with staff unavailable to work, whether through illness or isolation requirements, and to open an escalated number of beds.

Moving into 2022/23 the impact of these pressures currently remains in place whilst the funding streams have reduced. This is driving a challenging financial position for us which is mirrored by other system acute Trusts. There will be an ongoing requirement to maximise opportunities which increase planned activity, reduce waiting lists and mitigate excess costs.

2.0 Our People

2.1 Workforce

In March staff availability remained a significant challenge. Employee turnover continued to increase to 12.98% and the vacancy rate rose slightly over the previous month (3.88%) and staff sickness related to coronavirus saw further increases.

2.2 Staff Wellbeing

The wellbeing of staff is a priority for the Trust. We recognise that staff are all different and have different ways to relax and switch off from work. To provide an opportunity for staff to kick back and laugh and go out with colleagues and partners in a relaxed atmosphere the Trust, supported by the League of Friends, hosted a stand-up comedy night at the Chapel Nightclub – over 100 people filled the space and enjoyed a side-splitting evening.

Further similar events supported by the League of Friends are planned.

The Trust organised a Food for Fuel week, delivered by the communications team and staff volunteers. The week saw food provided to staff across the Trust. It included bacon butties as staff started and finished shifts, a curry lunch, fruity Friday and pizza for night staff working the weekend. The simple gesture went down well with hard-pressed staff.

2.3 Actions taken during the period to support colleagues

- We were able to reclarify that colleagues could carry over up to 10 days leave into the 22/23 holiday year and introduced a holiday buy back scheme for the final week of March. In addition, we reissued guidance to support managers with getting next years' holidays planned as far in advance as possible.
- We have also increased support for those currently off with long-term sickness by increasing keeping in touch/welfare calls.

- Our employee survey results have been carefully scrutinised and response plans are being developed in conjunction with heads of department. The most important phase is holding listening events to engage colleagues and achieve a deeper understanding of the most important employee concerns requiring our attention.
- Towards the end of March, we commissioned an end-to-end review of recruitment practices in partnership with PwC. Their review will examine our practices at four stages of recruitment starting with "Candidate Attraction," and examining different aspects of the candidate experience and the effectiveness of selection and administration processes. The findings are updated weekly and will be fully reported toward the end of May.

2.4 Staff Inclusion Network

On the 4th April the new Staff Inclusion Network was launched. Together the new Inclusion Network and existing staff equality networks presented an opportunity to strengthen our understanding of diversity and inclusion and to build collective leadership in our response to eliminate unlawful discrimination; promote equal opportunity and foster good relations inside and outside our organisation. The existing networks will continue to play an important role in providing the opportunity for all staff with a shared interest to come together to explore issues and priorities and be part of the formal governance of the Trust.

Actions identified will be incorporated into the Trust EDI Strategy with regular communication to build confidence we are imbedding equality, diversity and inclusion into everything we do.

2.5 Admin and Clerical Governance Group

I am pleased to report that on 27th April we will be holding the second Administrative & Clerical Governance Group day where the subjects will include the Military Covenant and handling difficult conversations.

2.6 Podcast Series

Our podcasts "**Cake with Joe and Jayne**" that explore what makes us who we are has now exceeded 1000 downloads and a fourth Easter/springtime special episode has been added. The podcasts can find on Apple, Spotify or wherever you get your podcasts, or you can listen to them on our website: https://www.salisbury.nhs.uk/about-us/cake-with-joe-and-jayne-podcasts/

3.0 Our Partnerships

3.1 BSW ICS partnership

Work continues towards the launch of the BSW Partnership as a statutory Integrated Care Board on 1 July.

Six executive roles to the BSW ICB have been confirmed:

- Gill May, currently the BSW CCG Director of Nursing and Quality, has been appointed as Chief Nurse for BSW ICB.

- Richard Smale, currently the BSW CCG Director of Strategy and Transformation, has been appointed as Director of Strategy and Transformation for the BSW ICB.

- Dr Amanda Webb, currently the Swindon Locality Clinical Chair for BSW, has been appointed as the Chief Medical Officer for the BSW ICB.

- Jasvinder Sohal will join BSW as Chief People Officer. Jasvinder currently works at Solent NHS Trust where she has been Chief People Officer.

- Gary Heneage has been appointed as Chief Finance Officer. Gary joins us from NHS England and Improvement in the South West Region, where he is currently Interim Director of Operational Finance.

- Rachael Backler has been appointed as Director of Planning and Performance. Rachel joins BSW from Lewisham and Greenwich NHS Trust where she has been Executive Director of Performance.

- The advert for the three Director of Place vacancies has closed and interviews are planned for 4th and 5th May.

3.3 National ICB Guidance

A significant tranche of updated guidance has been released and is available on FutureNHS. The updates include interim draft guidance on the application of ICB Regulations, ICB Care Model Constitution Template, ICB Model Constitution Support notes, Interim Guidance on the Functions and Governance of the ICB, ICB Financial Framework FAQs, Interim guidance on ICB Functions and Governance FAQs. The impact of this on the Board's role and operation within the ICB will be covered in a future Board Development Day. All guidance is available here: https://future.nhs.uk/connect.ti/ICSGuidance/view?objectID=710820

3.4 NHS Mandate 2022-23

The government's mandate to NHS England which sets out their objectives for 2022 to 2023 has been released. The full paper is available here.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1065713/2022-to-2023-nhs-england-mandate.pdf

BSW received feedback from NHSE/I on the draft 2022/23 system plan at an assurance meeting on 11 April, attended by SFT. Feedback on the draft plan, which influences focus on the final plan, which was submitted on 28 April, included:

- The BSW draft Elective Recovery Plan shows good progress in reducing long waits but there is still more work needed to maximise efforts to achieving

104% of 2019/20 activity and progress in improving outpatient's activity against the follow up reduction target in particular

- BSW plans to achieve all three Cancer standards in 2022/23
- In Mental Health BSW is delivering in several areas but there is more work to do particularly in access to IAPT and more work was noted in the development of Learning Disability services
- In Urgent & Emergency Care and Community provision there is considerably more to do in addressing how we reduce delays in accessing the right services and demonstrating how BSW will expand virtual wards and consistently meet the 2-hour urgent community response standard

SFT has been working with system partners across these points and an updated submission, supported by the BSW Executive, was submitted on 28 April. Work will now commence on the longer term 5-year plan to cover elective recovery, recovery from COVID and addressing health inequalities over a broader, longer term.

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	5th May 2022		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	26th April 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	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 and where relevant, discuss the items escalated from the Clinical Governance Committee (CGC) meeting held on the 26th April 2022. The report both provides assurance and identifies areas where further assurance has been sought and is required.

Key Items for Escalation

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - A verbal update was provided that progress has been made with the NatSSIPS and LocSSIPS (national and local standards) and that a further update will come to the May committee to provide assurance.
  - The committee annual effectiveness report was received and considered. It was positive to note that despite the pressures of the last year, all meetings had been quorate. The committee members were satisfied that the committee had been effective. This was based on the review of the committee against the terms of reference. The quality priorities for 2022-3 are being developed in line with the Quality Account timeline and will come to May committee.
  - The CQUIN schedule (commissioning for quality improvement) has been re-introduced and the areas of focus as part of the quality contract were discussed. It was noted that whilst there are 9 CQUINs, only 5 attract a financial reward. The committee noted and supported the need to embed the CQUINs into normal clinical practice and operational arrangements.
  - Following receipt of the internal audit safer surgery report, the committee received a presentation from the Head of Nursing for Surgery. Assurance was received that the process was in place to ensure compliance with the 5 steps to safety. Full assurance in relation to culture and behaviours would come through future auditing reporting. From a cultural perspective it was positive to note that a new clinical lead and head of service had been appointed. Both individuals were being supported in their roles. The committee offered full

support to anyone who puts a “Stop” in on a process where the checklist, consent, and correct processes are not being followed.

- Detailed discussion was held in relation to the IPR noting the impact of the ongoing pressures on patient safety and harms. The number of Grade 2 pressure ulcers had increased in March and it was noted that at times care fell below the level the Trust wanted to provide causing staff to be concerned that they could not provide the quality of care they wanted to. It was noted that the equivalent of approximately 4 wards were filled with patients who met the no criteria to reside and that this, alongside staff absences impacted significantly on flow and delivery of care. This in turn was impacting on the ability to offload ambulances in a timely manner. A review of any harms due to this would be considered by a future committee.
- The discussion around the BAF and the increasing risk scores triangulated with the information provided in the IPR. The committee was therefore assured that the Executives and divisional teams were fully sighted on the challenges and were mitigating as much as possible in the current situation.
- The pressure ulcer annual report demonstrated that despite all the pressures of the last year Grade 2 pressure ulcers had reduced by 1% and Grade 3 and 4 pressure ulcers had reduced by 20%. The committee noted and praised the effort and changing practice that had gone into the reduction of harm in this area.
- The Director of Midwifery presented the Maternity Incentive Scheme and Ockenden 1-year reports to the committee. Both reports demonstrated the improvements that have been made but noted that the Trust were not yet fully compliant in either area. A particular concern was gaps in training. Due to staff sickness and the national timescales, the Ockenden position report had been submitted prior to this committee being able to sign off. Both reports would also need to go to Board. Further assurance was sought in relation to what actions were required to be fully compliant. This would come to the committee in the next quarterly report due in May 2022.
- Two CMB upward reports were received. Whilst it was positive to note the maturing of the subgroups relating to safety, experience and effectiveness in their upward reports to CMB, it was also noted that divisional attendance in these groups remained a challenge. The committee were also informed of the establishment of the health inequalities working group.

In summary, the key theme in today’s meeting was the increasing impact on quality. This was multifactorial with both staffing absence due to Covid and the number of patients with no criteria to reside having the biggest impact on flow through the organisation.

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:	5 May 2022		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	26th April 2022
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 held on the 26th April 2022

Items for Escalation to Board

(1) No Criteria to Reside (NC2R) – this is the term currently used to describe patients who have completed their treatment and care episode within Salisbury Hospital and are deemed able to be discharged. The hospital has 396 beds and over the last month NC2R patients have accounted for between 120 and 130 beds (median 126). As a consequence of this the hospital has significantly reduced" *patient flow*" and cannot properly function as clinically intended. The symptoms include;

(a) Patients arriving at the Emergency Department cannot get treated within the target of 4 hours, for example 12 hour breaches are becoming more frequent
(b) Ambulances queuing outside the hospital for long periods because they cannot discharge their patients, the result of this is longer delays in ambulances responding to 999 calls, as ambulances are waiting outside hospitals with patients in them rather than being on the road
(c) Electives capacity being used for urgent medical patients, which means our elective waiting list recovery plans risk being compromised

(d) “Unfunded” inpatient escalation capacity, which in the past used to be a winter phenomenon is now becoming a year-round reality. This increases nursing and medical agency/locum costs
(e) Finally, as the hospital is running are 100% capacity operational efficiency is compromised, indeed evidence shows peak hospital efficiency is achieved at around 85% bed occupancy.

(2) The current NHS arrangements to manage covid-19 – despite the hospital recently changing its infection control arrangements for patients, on any one day currently 200 to 300 staff are absent because of the need to follow NHS guidance on staff self-isolation. This is placing even greater pressures on the hospital, creating both safety and operational efficiency concerns.

(3) Integrated Performance report (IPR) as at 31st March 2022 – The Trust Board need to be aware of the two issues above when considering the IPR and our current operational performance.

(4) Approval of the 2022/23 Operational and Financial Plans - Once again the Board need to be aware that the discussion of these plans for 2022/23 was significantly affected by the operational realities, as at the 26th April 2022 i.e. one month into the year in question. The four key headlines are;

(a) the plans are based on a realistic, but stretching, assumption of what the Trust can actually achieve between now and the 31st March 2023
(b) despite this there are still significant risks to be managed i.e. NC2R patients reducing, covid-19 staffing absence reducing, inflation not exceeding current assumptions, elective productivity increasing as planned, additional staff being recruited and £4m of unidentified cost improvement plans being achieved
(c) the Trust cannot sign up to the NHS target of recovering elective capacity up to 104% of pre-pandemic levels, instead a “targeted” approach has been adopted, based on what is felt to be achievable given the Trusts current operational constraints
(d) Finally, the Trust is forecasting a £18m deficit, which will lead to pressure on cash management towards the end of the financial year.

Notwithstanding the above, the Committee agreed the following;

(a) the Committee approved the forwarding of the numbers (activity and financial), that make up the 2022/23 Financial and Operational Plans, to the Bath and North Somerset, Swindon and Wiltshire I(BSW) integrated Care System (ICS) to be included in their planning submission on the 28th April 2022. Note this was not a unanimous decision of the Committee.
(b) As part of this decision the Committee approved the financial plan for 2022/23, which includes the capital plan. Note this was not a unanimous decision of the Committee.
(c) The Committee requested that the Operational Plan narrative to be revised, to clearly highlight the current operating environment and how this has adversely impacted on the deliverables contained in the plan
(d) The Committee requested a comprehensively updated paper on risks and mitigations, be presented at the Trust Board meeting on the 9th June 2022.
(e) Finally, the Committee requested that the current operational challenges facing the hospital be discussed further at the Trust Board meeting on the 5th May 2022.

(5) Corporate Governance Statement, Provider License Self Certification 2022 – this was supported by the Committee and recommended to the Trust Board at the meeting on the 5th May 2022.

(6) Board Assurance Framework and Corporate Risk Register including Corporate Priorities – these documents were reviewed and discussed in-light of the conversations at today's meeting.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	5 May 2022		

Report from: (Committee Name)	Trust Management Committee		**Committee Meeting Date:**	27th April 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Gavin Thomas, Executive Services Manager			
Sponsor (presenting):	Stacey Hunter, Chief Executive Officer			

Recommendation
Trust Board are asked to note the items escalated from the Trust Management Committee meeting held on 27th April 2022.

Items for Escalation
The Trust Management Committee which was scheduled for 27th April was reduced to a 30-minute meeting to focus on urgent escalations only owing to a Critical Incident being declared at 08.00. The committee reviewed the Clinical Management Board Terms of Reference and noted the changes which were outlined, and these were approved. Furthermore, the committee reviewed and approved the updated Terms of Reference and Workplan for the Trust Management Committee following a review of the structure to now include leadership Hot Topic, which will run on alternate months commencing July 2022 which will be division led. The committee reviewed the operational plan including the financial plan for 2022/23. The committee noted that further changes were being made to the final narrative plan to reflect the operational context and challenges currently being experienced. The financial plan was discussed with the scale of the financial challenge and focus on delivering the expected changes being noted.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	5 May 2022		

Report from: (Committee Name)	People & Culture Committee		**Committee Meeting Date:**	28th April 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Michael von Bertele; Non-Executive Director			
Board Sponsor (presenting):	Michael von Bertele; Non-Executive Director			

Recommendation

A shortened committee meeting was held as a result of a critical incident in progress on the day. The meeting therefore focused on the major workforce risks and the mitigation measures in place, and how effective they are.

1. In light of the continuing and constant pressure on staff, the importance of a strategic plan was re-emphasised. In recognition of the national shortages of clinical staff, this must take into account the need yet again to evaluate how roles and tasks might be performed in a different way, and by different skills groups. Only then can we realistically start to determine how we might recruit, train, prepare and employ people to fill those roles. The challenge of motivating partners within the ICS to participate in this strategic work, at a time when they are facing the same operational challenges as us, was stressed.
2. The Trust has been selected as an exemplar site in the delivery of the NHS People Promise and with this has come resource in the shape of a dedicated programme manager for 12 months. This is an exciting opportunity and the committee will keep the board informed as the project gets underway.
3. Following publication of the Staff Survey the Divisions have each been tasked with evaluating and responding to the specific concerns raised within their own staff groups.
4. The roll-out of the Improving Together project has been adversely affected by the pressure on staff, and the difficulties of releasing people to participate. This in turn affects our ability to introduce some of the measures that are key to the way we can collectively adapt to the pressures being experienced.
5. A report on the performance of our voluntary services was encouraging. Numbers of volunteers able to operate on site were starting to return to pre-pandemic levels and there has been a renewed focus on volunteering across the NHS, in the form of cadets and Reserves. Both are in their infancy, but the contribution made by our own volunteers is highly valued. All staff are encouraged to show their appreciation if they observe them at work (identifiable by their yellow t-shirts)

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	05 May 2022		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	Sections approved by responsible committee: Operational Performance & Resources – Finance & Performance Committee Quality and Care – Clinical Governance Committee Workforce – People and Culture Committee			
Prepared by:	Louise Drayton, Performance & Capacity Manager			
Executive Sponsor (presenting):	Peter Collins, Chief Medical Officer			
Appendices (list if applicable):				

Recommendation:
The Trust Management Committee are asked to note the Trust's performance for Month 12 (March 2022).

Executive Summary:
Performance against the 4-hour standard continues to be operationally challenging, with 75.2% of patients being discharged or admitted within 4 hours (76.3% in M11). Flow out of the department remains the biggest factor with an average occupancy across the month of 96.7% There was increase in the number of times patients moved wards, an on-going reflection of the operational pressures within the Trust and the continued use of escalation beds. There was a slight decrease in same sex breach numbers. Despite the significant operational pressures over 98% of patients are reporting their experience as either good or very good via the friends and family test - 2.1% of eligible patients submitted feedback in March. The average number of patients not meeting the criteria to reside decreased, although remains high at an average of almost 60. Covid continued to impact upon bed availability with a peak of 82 inpatients testing positive and further patients identified as covid contacts requiring isolation. The proportion of patients reaching the Stroke Unit within 4 hours was 20.6% due to the flow pressures; with both Farley and Breamore being affected by covid outbreaks. There was improvement in the number of Stroke patients receiving a CT within 1 hour (47% compared to 40% in M11), the number receiving a CT within 12 hours (94.1% compared to 80% in M11), the

number of patients spending at least 90% of their admission on the Stroke Unit reduced slightly to 59% (60% in M11).

There were 34 Category 2 pressure ulcers identified in March, which is a significant increase from 23 in February. There was one category 3 pressure ulcer identified in March but no category 4 pressure ulcers. There were 5 falls with harm, of which 2 were graded 'moderate' and 1 graded 'major'.

Escalation into the Day Surgery Unit (DSU) continued, with both areas of DSU being escalated into for a period leading to some cancellations of elective surgery. Despite the bed availability challenges the average number of theatre sessions per week was 12 sessions higher than in M11. Covid continues to have an impact in terms of staff availability due to sickness and isolation, and short notice patient cancellations.

As predicted performance against the 6-week diagnostic standard deteriorated significantly at 91.3% (standard 99%) compared to 99.04% in M11. 381 patients breached the waiting time standard in M12. Of these 381 breaches, 216 were in MRI and 117 in Cardiology Echo with the remainder across Audiology and Endoscopy (25 and 24 respectively). Workforce challenges, vacancies and availability of locum staff remain the biggest factor. A forecast position for the next 6 months is being completed, is it not anticipated to recover within Q1.

There has been some improvement against the cancer standards, with Two Week Wait at 83% (77% in M11), 62 Day at 75% (72.8% in M11), and 62 Day Screening at 100% (0% in M11). The 28 Day Faster Standard was achieved at 77.7% (target 75%) and the 31 Day standard achieved at 99%. Capacity issues in relation to the Breast 2 week wait pathway remain a big factor in the performance of the 2-week wait standard, with patient choice also still having a big effect. The average wait to first appointment for the Breast pathway is 17 days.

The Trust recorded a control total surplus of £35k in month 12, bringing the YTD position to a surplus of £62k, thereby showing a small favourable variance against the full year 21-22 plan. Significant pay and non pay overspends were offset by income which included ERF, ERF+ and discretionary system allocations.

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

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

May 2022

(data for March 2022)

An outstanding experience for every patient

Summary

Salisbury NHS Foundation Trust

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Summary Performance March 2022

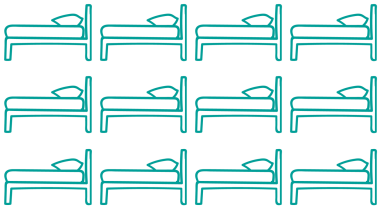
Salisbury NHS Foundation Trust

There were **2,458** Non-Elective Admissions to the Trust

We delivered **36,894** outpatient attendances, **17.5%** through video or telephone appointments

We met **4 out of 8** Cancer treatment standards

We carried out **309** elective procedures & **1,925** day cases



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

RTT 18 Week Performance: **65.9%** ↓

Total Waiting List: **18,634** ↑

91.3% ↓ of patients received a diagnostic test within **6 weeks**

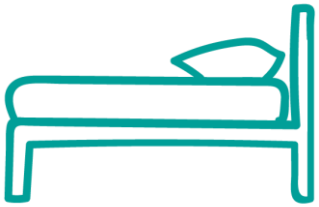
Our income was **£36,606k** (£11,506k above plan)

16.1% ↓ of discharges were completed before 12:00

Emergency (4hr) Performance **75.2%** ↓

(Target trajectory: 95%)

109 patients stayed in hospital for longer than 21 days



Our overall vacancy rate was **3.88%** ↓

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

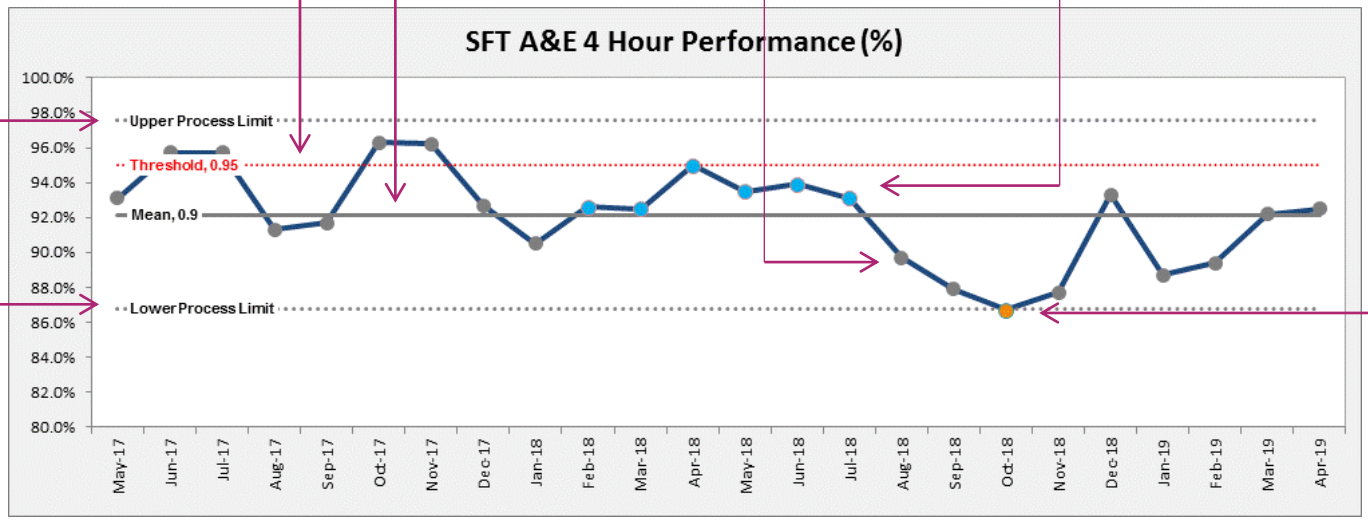
The red line shows the target for the KPI, if there is one

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

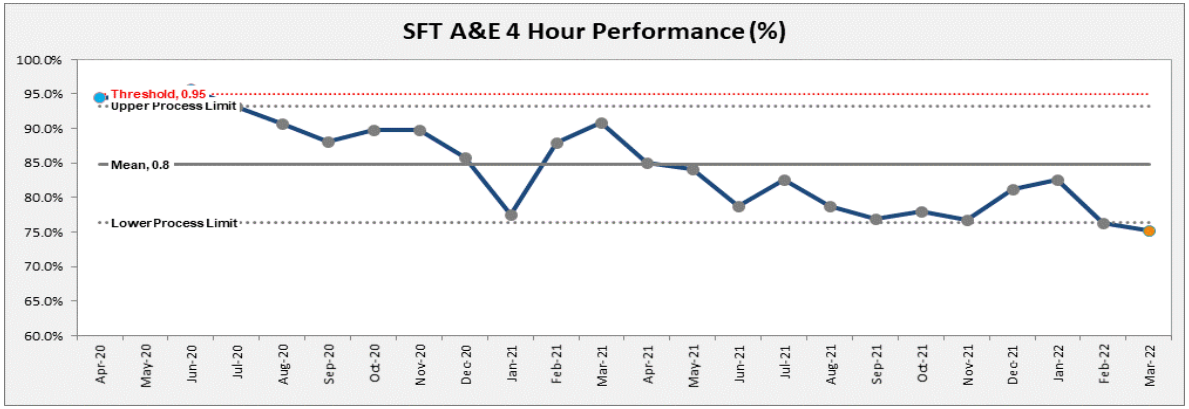
Part 1: Operational Performance

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

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

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	75.2%
Attendances:	6114
12 Hour Breaches:	0
ED Conversion Rate:	27.8%

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

M12 saw a large increase in attendances to 6114 when compared to 5276 in M11. The decrease of the 4-hour standard has unfortunately continued with the performance dropping further to from 75.2% in M12 compared to 76.3% in M11.

Despite the increased attendance the SFT ED conversion rate has decreased from 31.9% in M11 to 27.8% in M11. This is reflective of the significant amount of work being done to reduce admissions at the front door to support the ongoing capacity/flow pressures.

Capacity across the Trust and flow out of ED and AMU remains the biggest contributors to the performance against the 4-hour standard.

The ED department continues to have many unfilled nursing gaps on nearly every shift, and this continues to impact on existing staff, with minors triage in particular being impacted on a regular basis.

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

Phase 2 of the minors build is ongoing but has been delayed and is now scheduled to be finished in M2 of 22/23.

The ED Clinical Lead is continuing work with the Surgical Specialties looking at Same Day Emergency Care (SDEC) and analyzing the amount of time specialty patients await review within the ED Department and the adherence to IPS (Internal Performance standards).

Agreement has been made with SWAST to trial a HALO officer at SFT in M1 22/23. This will mirror the rest of the BSW system.

WHC pilot of a frailty rapid response team based within ED to see and treat appropriate patients and prevent admissions to take place in M1 22/23.

The ED SLT are continuing to work with Estates regarding to layout of department and how best the space can be utilized whilst trying to future proof and meet CQC recommendations. The ED SLT are also reviewing the Nunton outpatient space in order to provide space to deliver SDEC

ED continue to promote Free phone Pilot to the Walk In Centre.

Risks to delivery and mitigations

Flow out of the department continues to remain one of the biggest challenges for ED/AMU with many discharges late in the day.

AMU SDEC space continues to be escalated into overnight. This results in poor flow out of the ED department the following day and severely limits AMU's capacity to deliver SDEC the following day, often resulting in the medical take being diverted to ED.

Delays from specialty teams coming to review their referred/expected patients according to IPS (Internal Performance Standards). This results in bays being occupied for long periods waiting review with impact on capacity within the ED Department.

Staffing Gaps especially nursing and middle Grade continue to impact on existing staff and the department as a whole.

The reporting and investigation of 4-hour performance target breaches and ambulance breaches are having a significant impact on existing administration time within the department.

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)
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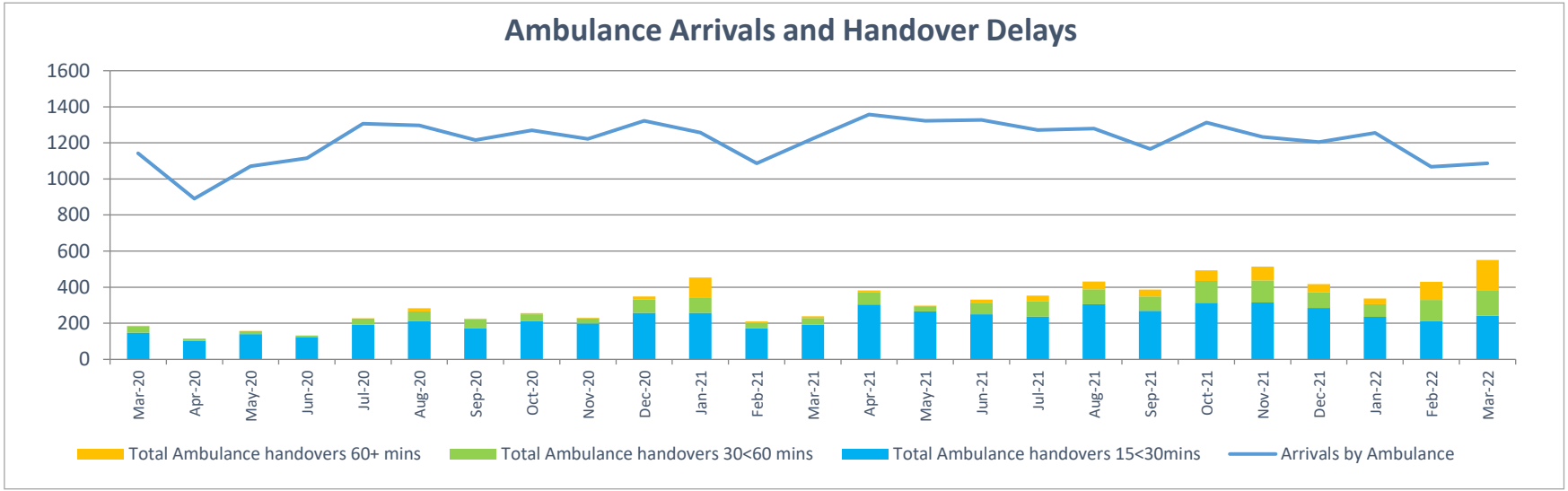
Ambulance Handover Delays

National Key Performance Indicators



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

M11 saw a slight increase in numbers of ambulances presenting to SFT of 1086 compared to 1068 in M11. The decrease in performance for ambulance conveyance continued in M12 with a performance of 72.10% compared to 79.68% in M11.

Breaches >60 minutes have seen a significant increase in M11 to 161 compared to 100 in M11. Breaches >30 minutes have also seen an increase to 142 in M11 compared to 117 in M11. There is a slight increase in breaches >15 minutes of 241 in M11 compared to 213 in M10.

When AMU ambulatory area is escalated into overnight regularly, the medical take is diverted to ED adding to pressures in off loading ambulances.

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

There will be an initial Pilot in M1 22/23 with an ACP from Wiltshire Health & Care being at the front door to provide Rapid Frailty Response. The Pilot will have ACP and HCA along with a Car in the aim to provide admission avoidance where possible.

ED are continually looking into pathways for streaming of ambulances into dedicated specialty areas. SAU and Urology with associated DMT contacted to develop surgical access for SWAST

ED staff remain aware of the need to off load ambulances as quickly and safely as possible.

SFT continue to work collaboratively with SWAST and BSW partners in accepting peripheral diverts when required in order to provide the best quality of care to our patients.

Risks to delivery and mitigations

Hospital flow constraints and the resulting impact of the department reaching capacity, remains the biggest challenge in being able to off load ambulances in a timely manner.

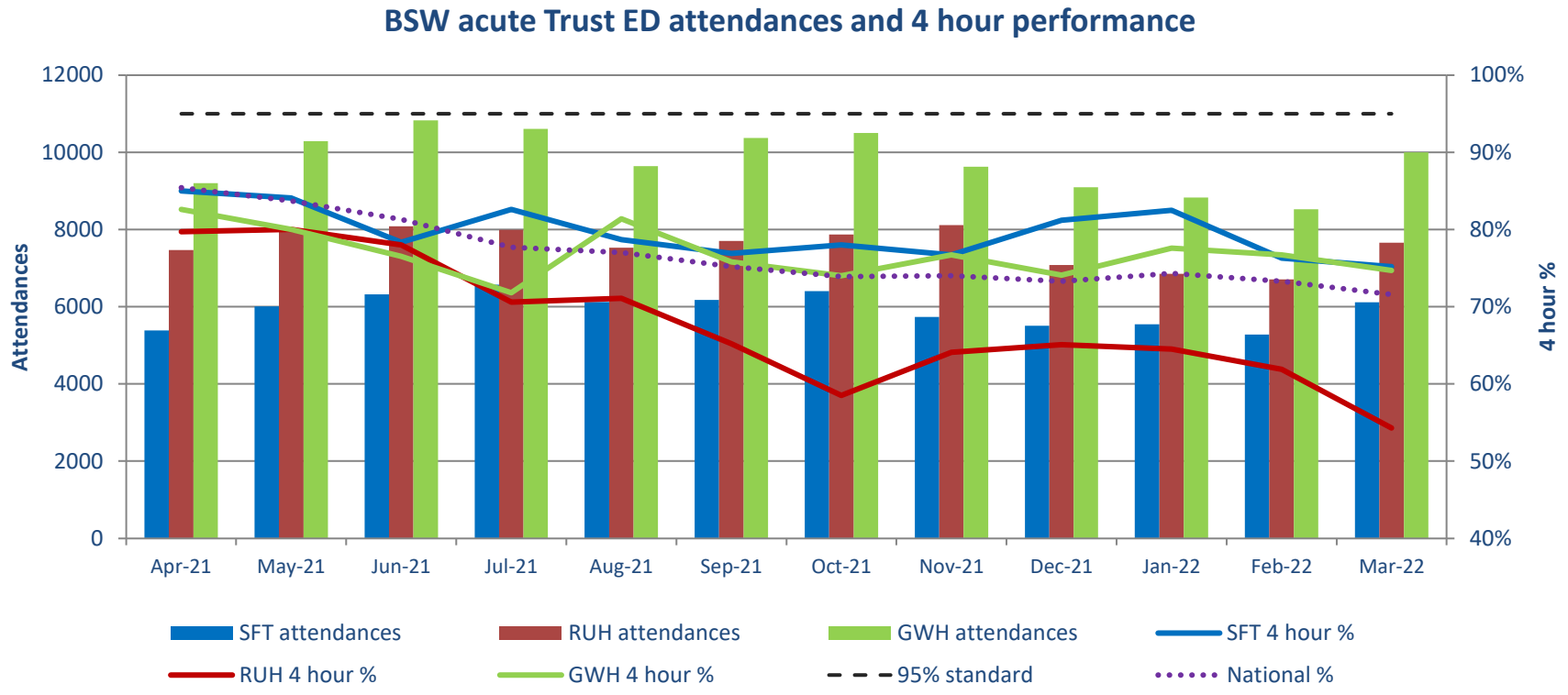
Staffing gaps, especially nursing, have a large impact on ambulance conveyance times within the department, gaps in workforce continue to remain a challenge at times.

AMU diverting the medical take will continue to impact on number of ambulances presenting to ED and our handover performance.

Impact on Paediatric space in ED from utilization as extra adult capacity impacts on statutory requirements in the management of this group of patients.

BSW Context – Emergency Access (4hr) standard

Are We Effective?



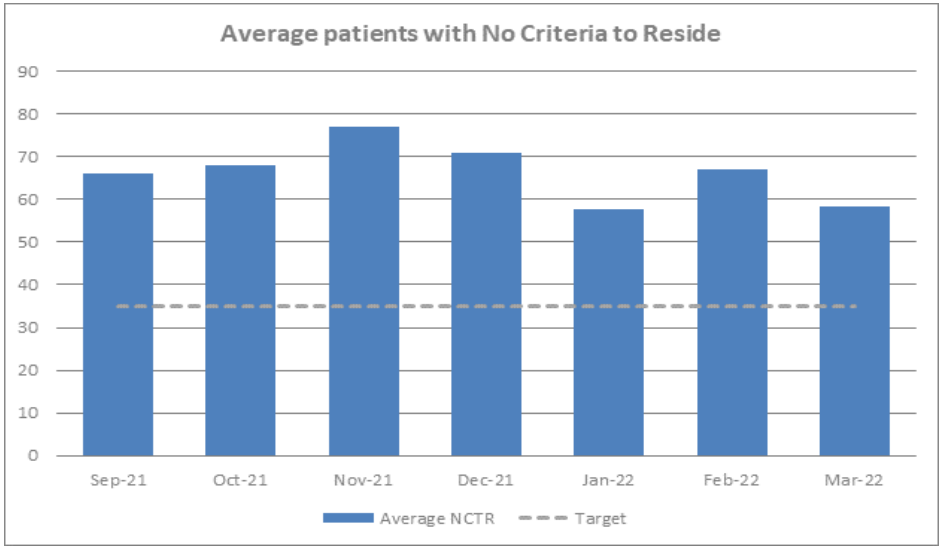
Performance against the 4-hour standard decreased in M12 compared to M11 with sustained levels of high pressures across the BSW system. Performance at RUH was particularly affected at 54.3% the lowest performance over the last three-year period, and significantly below the England average of 71.6%.

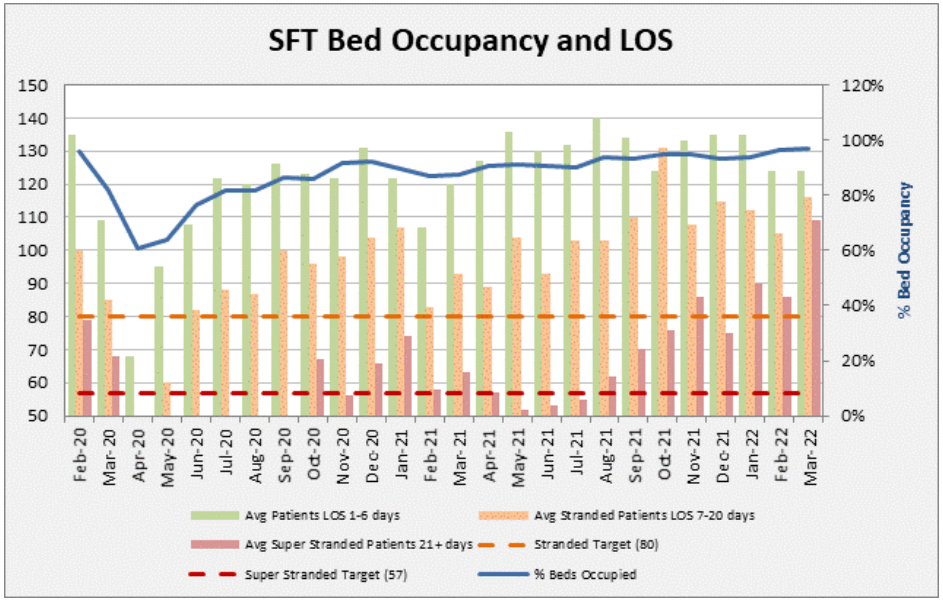
Twelve-hour trolley waits increased at RUH (39 in M12 compared to 1 in M11), and at GWH (93 in M12 compared to 77 in M11).

Attendances increased in M12 to levels in line with pre covid attendances.

Patient Flow and Discharge

Are We Effective?





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

The average number of inpatients not meeting the criteria to reside remains steady in March, alongside bed occupancy levels. However, there is a significant rise in the length of stay which can be an indicator of a result of the use of high numbers of escalation beds, challenged staffing levels and a lack of community resource to safely discharge patients requiring ongoing support.

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

Every effort continues to ensure patients receive the highest standards of care possible in significantly challenged circumstances.

Operational pressures have meant that expert panel has been suspended on several occasions resulting in reduced senior insight to issues impeding patient journeys. This is planned to improve in April, alongside a concentrated SAFER week that is designed to reduce Trust requirement for escalation beds.

New discharge protocols were issued as a national government document at the end of March which our local systems and the Trust are working to align practices to in the interests of our local populations.

Risks to delivery and mitigations

Continued staffing challenges

Delayed response to the new discharge guidance or no change/increase in community capacity to accommodate the needs of patients waiting for services

An upsurge in Covid, or other infection control issue prompting ward closures

Engagement around SAFER in April, with the Trust needing a motivated and invigorated workforce to be able to engage during a period of intense difficulty.

Theatre Performance

Theatre KPI's

	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
19/20	497	532	501	531	453	522	524	555	476	548	481	364
20/21	239	294	327	317	346	362	379	401	328	248	263	383
21/22 Actual	301	378	379	442	455	473	507	520	465	469	472	
21/22 Plan	252	411	452	456	441	463	451	463	451	435	423	482
21/22 Plan+	252	411	551	560	540	563	554	568	547	541	517	588

Measure - Theatre Performance & Efficiency	Area	Target	March22
% Utilisation	Day Surgery Theatres	90%	71.2%
	Main Theatres	85%	85.94%
Turnaround	Day Surgery Theatres	8 mins	18 mins
	Main Theatres	12 mins	30 mins
% short notice Hospital Cancellations (0-3 days)	Total	2%	1.28%
% Short notice Patient Cancellations (0-3 days)	Total	2%	9.73%

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

An average increase of 12 sessions per week were run compared to M11. However, list utilisation remained lower in DSU in month due to impact of escalation. 13th in week theatre opened on 4th March but continuing high staff sickness and elective cancellations, and the additional impact of bed pressures seeing both upstairs and downstairs in DSU utilised as an escalation ward, meant that this increase was not fully realised. Some lists at lower list numbers due to late PCR results, bed pressures and a further increase in patient cancellations

Underperformance of elective activity accounts for overall theatre activity remaining lower than plan in M12 as elective activity remained short of pre-Covid levels, at 70%, and below plan, at 78%, however this was another significant increase from 61% in M11. This continued under performance has been further exacerbated by issues around late starts, high levels of emergency and trauma and high numbers of cancellations

Daycase performance improved in M12 to 102% of pre-COVID levels and 100% of plan

Increased cancellations were also seen throughout M12, due to the continuing impact of COVID prevalence, which is reflected in the further increase in percentage of patient driven cancellations, the escalation of DSU which significantly increased capacity driven cancellations, and high levels of clinician absence due to COVID and other challenges

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

TXM workforce continued to be stable and skilled throughout March but scrubs still covering HCA shifts at full cost. However, Theatres Recruitment and Retention plan well underway with plans to phase out weekday TXM reliance and end weekend support from M2 as transition now taking place from TXM (insourced staff) to a more stable substantive workforce

Theatre Staff Incentive Payment Scheme uptake remained low in March (£6k), a further drop from January and December (£7k).

Theatre Education continues with increased numbers of Scrub Nurses, ODP's and SFA's in full time training. Theatre Service Manager and Clinical Lead for Theatres now in post

SFT IPC guidelines continue to reflect most national processes for low-risk pathways, improving the ability to book patients into cancelled slots with less notice required, in turn improving utilisation. Move to pre-surgery LFT testing rather than PCR for all patients except those undergoing, or have recently undergone, chemotherapy. This will further improve booking efficiency and flexibility in M1

Continuation of High-Volume Low Complexity (HVLC) lists running both in week and at weekends for several specialties as targeted Waiting List Initiatives focusing on Plastic Surgery as the specialty with the highest volume of elective surgery backlog

Productivity and efficiency work continues focused on the Day Surgery Unit. This is being supported by the relaunch of the weekly specialty Scheduling Meetings, returning to a F2F medium, with representation from multidisciplinary teams, including the theatre lead for the specialty, supported by the theatre management team

Risks to delivery and mitigations

Theatre workforce for local lists continues to be a risk despite slow improvement. High levels of sickness continued to impact lists in M12 although cancellations due to this were lower than in previous months due to the reduced activity that other cancellations resulted in, and other lists continued to be supported by TXM staff. The mitigation for this is the focus on delivery of the actions of the Theatre Workforce Review led by OD&P, the Theatre Service Manager and the DMT. The resilience of the local workforce is a particular focus as transition from reliance on TXM (insourced staff) to a more stable substantive workforce

An ongoing risk to elective activity remains high levels of trauma, in both Plastic Surgery and T&O, and other non-elective emergency demand. This is being mitigated by daily reviews by the Specialty, Theatre and DMT to ensure patients are clinically prioritised appropriately

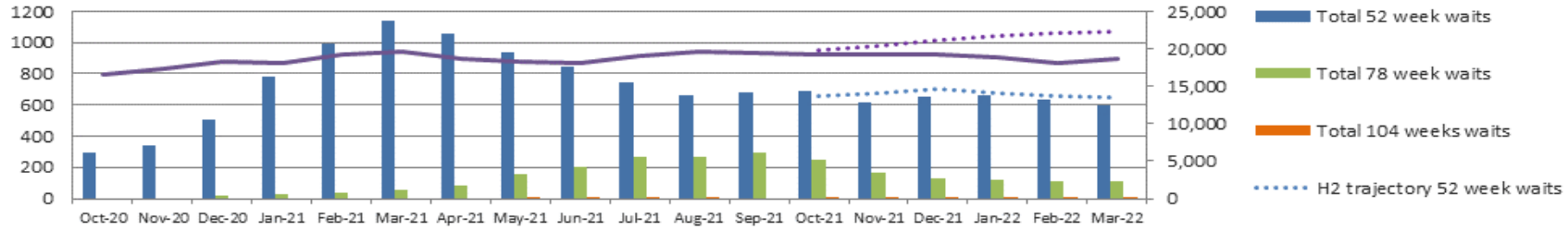
Bed pressures continue to impact the elective programme and have led to cancellations throughout M12 of elective cases and the simultaneous use of both upstairs and downstairs of DSU for inpatients has also impacted daycase performance. Daily review by the Matrons and DMT undertaken as required, avoiding cancellations whenever practical. Daily elective planning meeting set up chaired by Surgery Silver and attended by lead for theatres and lead for Chilmark elective to ensure the most efficient use of capacity to minimise cancellations

Risk of activity being impacted by cancellations due to continuing prevalence of COVID resulting in rise in sickness and isolation of clinicians. Ongoing risk due to patient cancellations which has increased to 9.73% in M12

Theatre access 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

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

National Key Performance Indicators



	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Total 52 week waits	295	338	505	785	995	1142	1059	937	847	746	660	681	688	618	652	664	634	599
Total 78 week waits	0	0	19	28	34	59	83	156	200	268	264	299	251	162	128	122	108	107
Total 104 weeks waits	0	0	0	0	0	0	0	2	5	2	2	0	5	6	5	7	4	3
Trust Performance %	70%	74%	72%	71%	68%	65%	65%	72%	73%	74%	74%	74%	72.8%	72.3%	69.4%	68.8	66.02	65.93
Total waiting list	16,574	17,392	18,352	18,184	19,207	19,583	18,665	18,196	18,118	19,015	19,540	19,367	19,265	19327	19299	18844	18039	18634

Longest Waiting patient (Weeks)	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
	110	108	112	103	106	110	110	107	111	116	116

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

Treatment function	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	% change from
Plastic Surgery	133	130	129	129	111	121	132	130	130	0%
Urology	78	52	54	59	60	63	57	60	59	-2%
Oral Surgery	76	63	63	44	38	38	38	37	34	-8%
Trauma and Orthopaedic	85	74	59	56	48	39	45	41	26	-37%
Ophthalmology	92	92	90	71	55	44	25	24	24	0%

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

The number of patients waiting longer than 52 weeks decreased by 35 to a total of 599 in M12 ending the year 82 ahead of the H2 trajectory of 681. The number of patients waiting longer than 78 weeks also continues to decrease to 107 ahead of year-end target of 289

The number of patients waiting 104 weeks in M12 reduced to 3, with the longest waiting patient waiting 116 weeks. These patients are all been dated for surgery in M2 delayed due to their complex clinical pathway and specialist kit required

Of the patients waiting on non-admitted pathways the highest volumes are within Respiratory, Plastic Surgery and ENT. Of the patients on admitted pathways awaiting surgery Plastic Surgery, Gynaecology and Urology are the most challenged specialties. Overall, the most challenged areas remain Plastics, Gynaecology and Urology at both the 78 week and 52-week interfaces

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

HVLC lists for Plastics LA lists have continued to run throughout the month of March although this was reduced due to consultant cover reducing TXM lists

Weekend outpatient clinics planned in Ophthalmology for patients that are not clinically appropriate for transfer to the IS. These have been delayed to M2 due to significant sickness levels in the clinical team

H2 trajectories were set to reflect the national guidance to eliminate 104-week breaches by 31st March 22 (unless P6 patient choice to wait), hold or reduce the number of patients waiting longer than 52 weeks, and hold total waiting list size around September 21 levels however the national target for 104-week elimination has now been revised to the end of July 22. SFT achieved two of these targets by the end of M12 but ended the year with 3 patients waiting longer than 104 weeks however on track to eliminate by mid-May ahead of the revised target

Ongoing use of IS with the transfer of clinically appropriate Orthopaedic patients to Newhall and Ophthalmic Cataract patients to Newhall continuing although transfers to IHG are on hold awaiting an updated from them on capacity

Risks to delivery and mitigations

Theatre workforce for local lists including the risk of high levels of sickness. Theatre Workforce Review being led by OD&P with support from the Theatre Service Manager, Theatre Clinical Lead and DMT

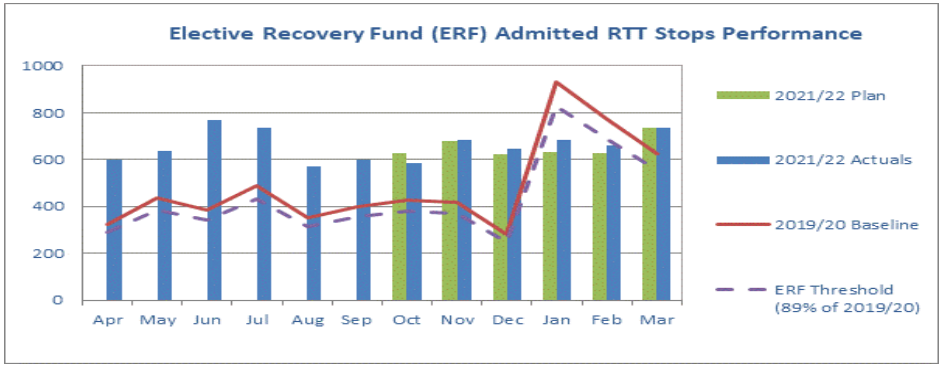
Risks associated with staffing levels as a direct result of COVID-19 with the risk of both theatre and outpatient activity being lost due sickness and isolation. Theatre lists in Ophthalmology and Oral Surgery were affected by this. High levels of non COVID absence also seen in M12 especially impacting theatre activity in Colorectal Surgery, Plastics and Gynaecology.

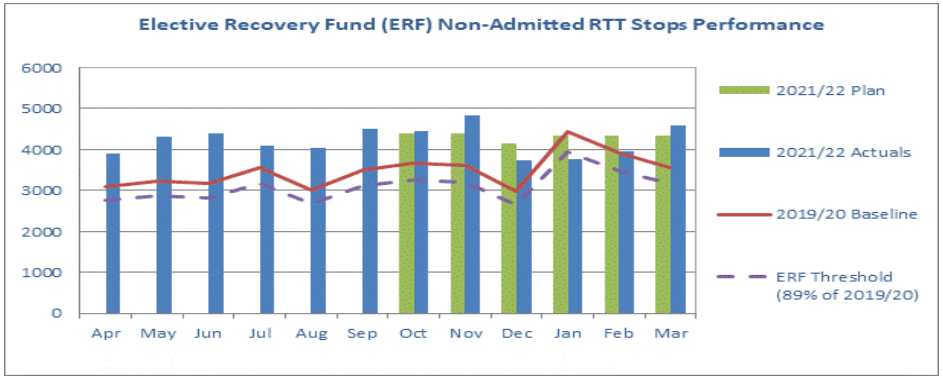
Risk of high levels of trauma, in Plastic Surgery and T&O, and other non-elective emergency demand as this may continue to result in cancellations of long waiting, clinically routine patients. Daily reviews in place to ensure patients are clinically prioritised appropriately minimising elective cancellations wherever possible

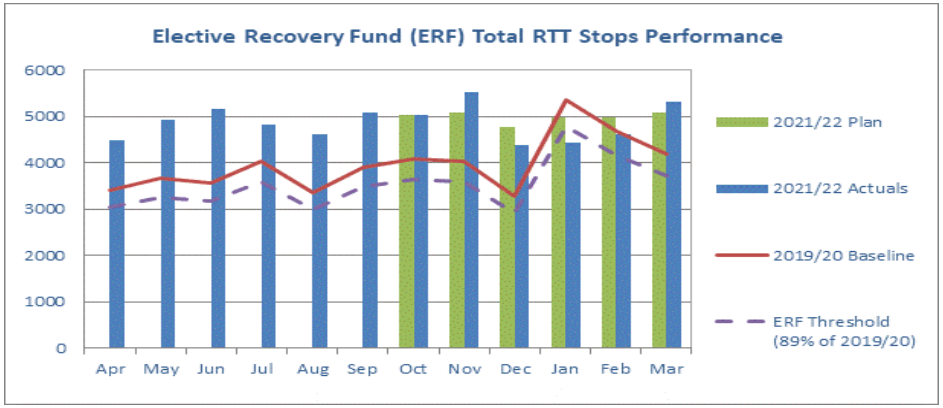
Capacity pressures continue to impact the elective programme and led to elective cancellations in M12. Daily elective planning meeting set up chaired by Surgery Silver and attended by lead for theatres and lead for Chilmark elective to ensure the most efficient use of capacity to minimalise cancellations. A further Trustwide SAFER week planned for M1 to support timely discharges. Continued high levels of patient led cancellations, especially in light of COVID prevalence, rate of nearly 10% in March.

Elective Recovery Fund - RTT Stops

National Key Performance Indicators







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

ERF total RTT stops performance hit plan in M12. Again, the admitted RTT stops performance remained above plan and the non-admitted were also above plan this month improving overall performance

Outpatient attendances in M12 exceeded current month plan, 109%, and exceeded pre COVID levels, 111%. A wide range of specialties now achieving over 100% of pre-COVID levels. High absence levels limited some specialties in M12 especially affecting Oral Surgery, General Surgery and Rheumatology

The go live of new rota and increased clinic templates in Ophthalmology in M11 continued to facilitate the optimisation of the use of the outpatient department in M12 creating increased capacity for non-admitted patients to address the current backlog and resulted in an increase to 118% of pre-COVID levels

Virtual appointments continue to work well in several specialties with Gastroenterology and Cardiology seeing high numbers of their outpatients virtually

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

Improvement actions and timescales for improvements in elective and daycase activity discussed on previous slides

Wait to First Appointment has been selected as a Breakthrough objective as part of the Trusts Improving Together program and selected by several divisions as a Divisional Driver metric. Analysis has been undertaken to identify challenges and greatest opportunities for improvement and work is ongoing as part of the Divisional Improving Together coaching sessions to confirm the Countermeasures and Watch metrics that will support this objective

Non-admitted performance impacted by continued high levels of outpatient cancellations due to COVID-19 where both patient cancellations and hospital cancellations were high due to the impact of sickness and isolation. Emergency, trauma and urgent theatre activity continued to take clinical priority over routine outpatient activity

Risks to delivery and mitigations

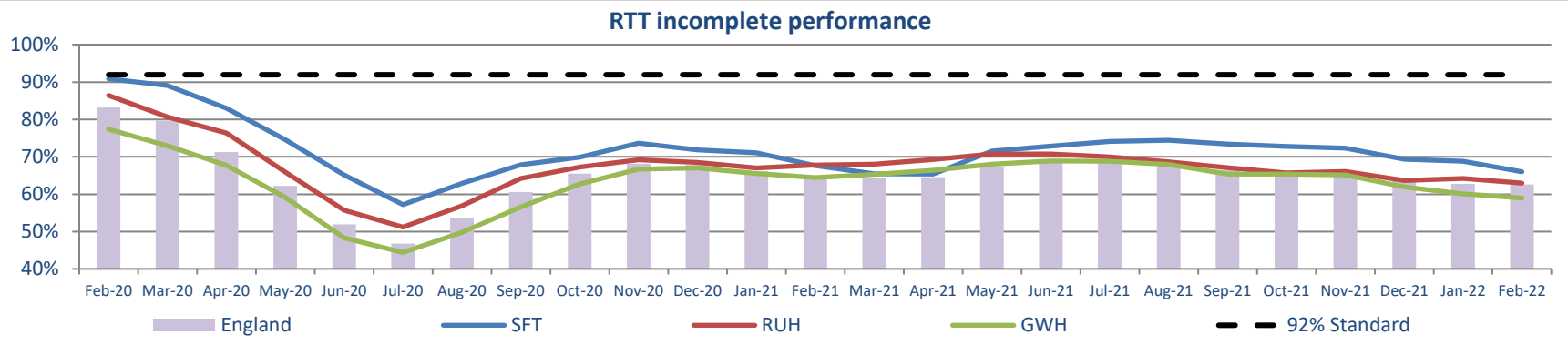
Continued risk of increased cancellations due to COVID-19

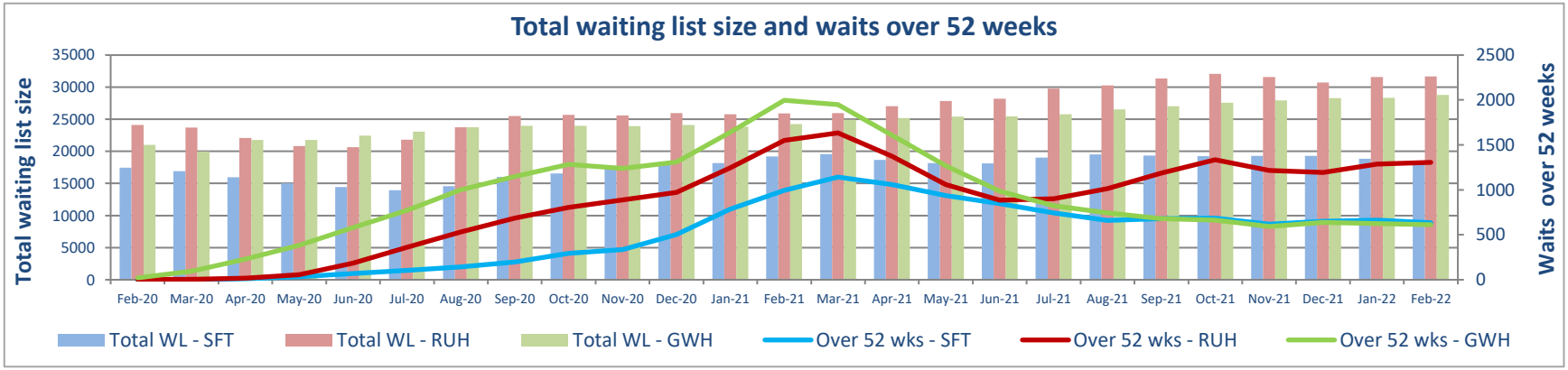
Space constraints across outpatient departments continue to be a significant risk as social distancing and IPC requirements have been reduced but not removed. Upcoming changes to social distancing guidelines to be actioned in M1 should facilitate improved capacity

Creep in some specialties back to onsite preferences. Focussed work is being undertaken with DMT's, Clinical Leads and Transformation team to continue to increase this in line with national targets and to improve medium-long virtual models in line with national and ICS targets and priorities

BSW Context – Referral To Treatment (RTT)

Are We Effective?



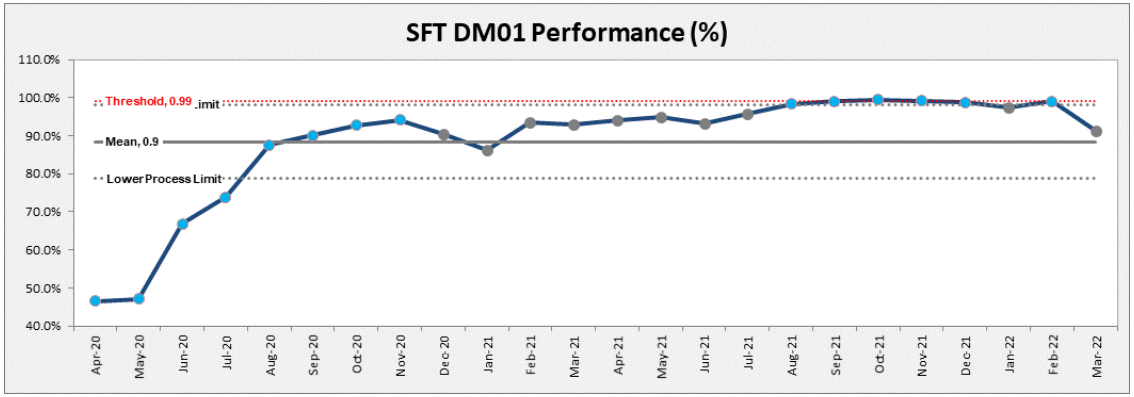


*Due to the time it takes to for NHSE to publish the data, RTT benchmark data on this slide is a month behind the reporting month.

The total waiting list size across the three acute Trusts remains static at a combined waiting list of 78,450 (78,743 in M11). The number of patients waiting over 52 weeks reduced to 2552 (633 at SFT, 1307 at RUH and 612 at GWH). The proportion of patients on the waiting list waiting over 52 weeks is 3.52% at SFT, 4.1% on RUH and 2.1% at GWH (national position is 4.8%).

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	91.3%
Waiting List Volume:	4410
6 Week Breaches:	381
Diagnostics Performed:	7188

Modality performance

MRI	76.1%	US	99.8%	Audio	83.6%	Neuro	100.0%	Flexi sig	88.4%
CT	99.8%	DEXA	100.0%	Cardio	77.8%	Colon	93.7%	Gastro	95.9%

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

M12 saw a deterioration of the DM01 standard, with performance reported at 91.36% (reduction from compliant position of 99.04% in M11). Overall waiting list size has increased from 3963 patients in M11 to 4410 in M12. Activity numbers across all modalities were higher than M11 (except for Cardiology Echo) suggesting an increasing rate of demand.

381 patients breached the waiting time standard in M12. Of these 381 breaches, 216 were in MRI and 117 in Cardiology Echo with the remainder across Audiology and Endoscopy (25 and 24 respectively). For MRI and Echo this represents a significant deterioration in performance (from 8 and 1 breach in M11 respectively) with issues in the main due to workforce resource due to vacancies and dependency on locum cover and overall unplanned workforce absence due to COVID isolation.

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

Full trajectory for performance recovery to be completed including analysis of demand (particularly in MRI, USS, Audiology and Echo). Local trajectory for MRI has already been confirmed which indicates recovery from M6 22/23.

Locum support in MRI, Cardiology Echo and Audiology continues to be scoped (options are limited).

Consideration to incentivized overtime rates for SFT Radiography and Audiology staff to be considered.

Risks to delivery and mitigations

The highest risks to future compliance are workforce related issues within MRI and Cardiology Echo and Audiology with possible future risks within USS as well due to expected vacancies that are yet to be filled. The latter will likely be a longer-term risk.

MRI mobile van reliability is also causing issues with creating additional capacity or resilience in capacity when downtime in MRI1 occurs. Replacement of van is being scoped.

There are some possible vulnerabilities within neurophysiology due to increasing referrals, but the Head of Clinical Sciences is reviewing this and trying to mitigate the risk. Divisional Director of Operations will monitor.

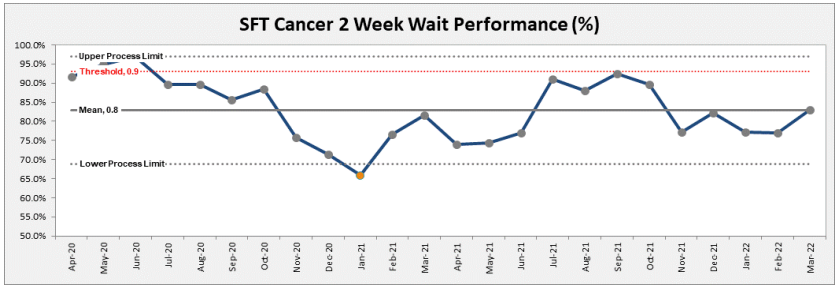
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or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

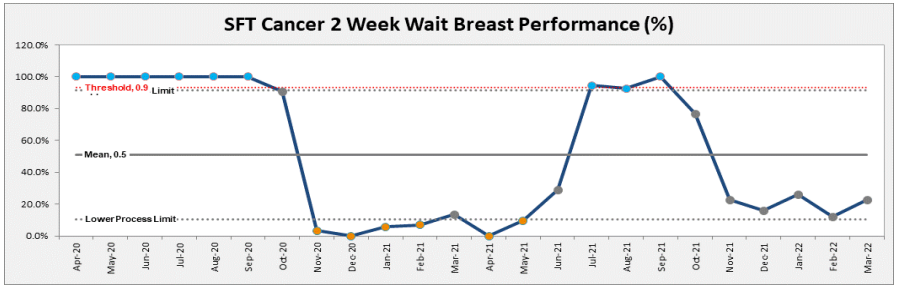
Cancer 2 Week Wait Performance Target 93%

National Key Performance Indicators

Performance Latest Month	Performance	Num/Den	Breaches
Two Week Wait Standard:	83.01%	899/1083	183 (55 patient choice)
Two Week Wait Breast Symptomatic Standard:	22.54%	16/71	55 (3 patient choice)

Data Quality Rating:





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

Two week wait standard not achieved for Month 12 with month end validated performance of 83.01% (1083 patients seen; 900 in target; 183 breaches). Breach reasons associated with:

- Clinic capacity: 102 breaches
- Patient choice: 55 breaches
- Incomplete GP referrals: 12 breaches
- Administrative delays (including triage): 8 breaches
- Clinical delays (including COVID-19): 6 breaches

Breast symptomatic two week wait standard not achieved for Month 12 (71 patients seen; 16 In target; 55 breaches). Breaches associated with patient choice and lack of breast one stop capacity due to insufficient radiology capacity to facilitate additional clinics. Current average waiting time for first appointment within breast is 17 days, though there is an overall reduction in the number of reported breaches.

28-day Faster Diagnosis Standard achieved for Month 12, with month end performance of 77.7% (1014 patients diagnosed; 788 in target; 226 breaches).

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

Breast two week wait performance: Radiology and breast service have agreed to establish ad hoc monthly clinics as required.

Patient choice: Ongoing challenges associated with patient choice delays and cancellations. There are however limited opportunities to offer a second appointment within the two-week timeframe due to capacity constraints across services.

Bowel cancer screening pathway review: Review of existing pathway and reporting underway across BSW ICS. As the BCSP hub, Salisbury reporting of 28-day FDS performance will be adversely affected. Co-ordinator now in post; currently reviewing and mapping existing pathway, with changes in the PTL management expected from May 2022.

Cancer waiting times guidance consultation: Feedback sought from NHSE/NHSI with regards to amended CWT guidelines. The proposal includes the phase out of the two week wait standard, to be replaced by the 28-day Faster Diagnosis standard. Feedback provided by SFT; final guidance awaited.

CQUIN 2022/23 re compliance with timed diagnostic pathways for cancer services: Expectation that 65% of prostate, colorectal, lung and OG cancers meet the 28-day faster diagnosis standard. Services have already completed a plan on a page against each pathway to identify gaps and opportunities. Data monitoring processes currently being established.

Risks to delivery and mitigations

Consultant radiology capacity to support additional clinics within breast service: Deterioration in two week wait performance seen from October 2021 due to increase in referrals and lack of radiology capacity to support additional one stop clinics.

Consultant vacancies in GI service.

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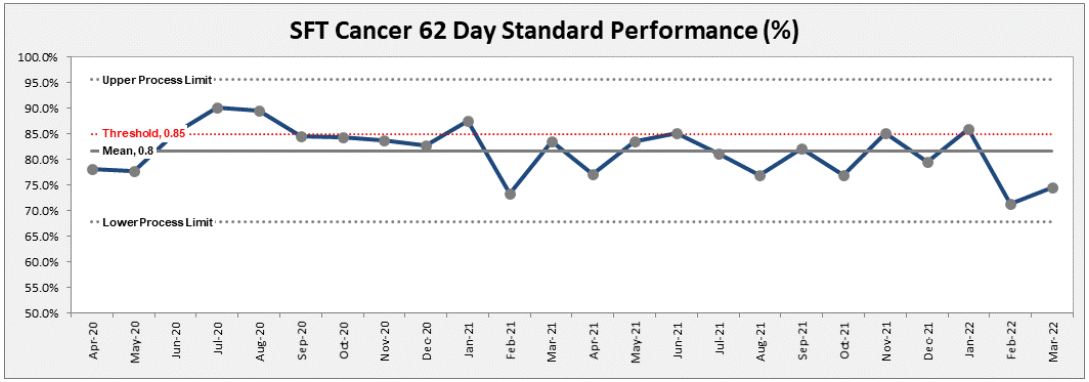
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

March 22	Performance	Num/Den
62 Day Standard:	75%*	59/77
62 Day Screening:	100%	2.5/2.5

*62 day performance is subject to change prior to final submission

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

Month 12 62-day performance standard not achieved, with validated month end performance of 75% (77 patients treated; 59 in target; 18 breaches).

- Breast: 1 breach (limited capacity for immediate reconstruction)
- Colorectal: 6.5 breaches (complex diagnostic pathways, insufficient oncology capacity)
- Haematology: 2 breaches (complex diagnostic pathways and delayed transfer from other tumour sites)
- Skin: 2 breaches (clinical delays associated with testing positive for COVID-19, and initial delays associated with incisional biopsy and outsourced pathology turnaround times)
- Upper GI: 3 breaches (complex diagnostic pathways, insufficient oncology capacity)
- Urology: 4 breaches (all prostate; insufficient diagnostic capacity)

62-day screening standard achieved for Month 12, with validated month end performance of 100% (2.5 patients treated; 2.5 in target; 0 breaches).

31-day performance standard achieved, with validated month end performance of 99.18% (122 patients treated; 121 in target; 1 breach).

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

Impact of pharmacy capacity on delivery of chemotherapy: Business case current in progress within Pharmacy to increase staffing capacity and provide resilience.

Establishment of vague symptoms/non-specific symptoms pathway: Pathway currently being scoped with BSW ICS to support patients with 'vague symptoms' who may otherwise undergo lengthy diagnostics pathways. A Navigator has been recruited who will support the implementation of the pathway. Unsuccessful recruitment of GP Lead; alternative pathway models currently being considered to ensure there is equitable pathway access across BSW.

Nursing leadership within cancer services: Matron for Cancer and Lead Cancer Nurse posts successfully recruited. Start dates confirmed for July 2022.

Prostate pathway improvement: Surgery DMT to work closely with Urology and cancer services to develop an improvement plan to reduce the length of cancer pathways for prostate patients. Initial discussions underway with service in terms of options. Intentions to recruit additional Consultant Urologist who will support increase in template biopsy capacity.

Access to PET-CT: Issue raised via Clinical Lead and Deputy COO directly with provider, as well as through SWAG/Wessex cancer alliances and BSW ICS. Working group established with regards to mobile PET-CT scanner for Salisbury patients. Timescales yet to be clarified.

Cancer waiting times guidance consultation: Feedback sought from NHSE/NHSI with regards to amended CWT guidelines. The proposal includes the amalgamation of all 31-day standards (including subsequent treatments) and all 62-day standards (including upgrades and screening). Feedback provided by SFT; final guidance awaited.

Risks to delivery and mitigations

Patient fitness: Increase in number of 62-day breaches associated with patient fitness and comorbidities. Increase in number of patients requiring anaesthetic review and pre-habilitation ahead of treatment, as well as instances whereby incidental findings have altered initial treatment plans. This is also putting significant pressure on oncology services. The complexity of these patient's pathways is likely to impact 62-day performance.

Access to PET-CT: Service provided by Alliance Medical. Capacity has the potential to adversely affect pathways across all tumour sites and could affect 62-day standard.

Histopathology reporting turnaround times: Ongoing challenges associated with Consultant Histopathologist capacity, which often results in cancer pathology being outsourced. This in turn increases the timeframes for reporting and can delay diagnosis and treatment.

Diagnostic capacity within the prostate cancer pathway: Challenges associated with diagnostic pathway for prostate cancer patients, in part due to historical pathway processes but also insufficient template biopsy capacity. This is impacting 28- and 62-day performance.

Fragility of existing workforce: Ongoing pressure on services has resulted in an increase in reported stress, staff burnout and need for annual leave. This has meant that several services have had insufficient consultant, nursing and administrative staff available to reduce waiting times.

Statistical Process Control Chart Key:
- Target
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- Common Cause Variation

Stroke & TIA Pathways

Are We Effective?

SSNAP Case Ascertainment Audit

Highest level = Grade A

Lowest level = Grade E

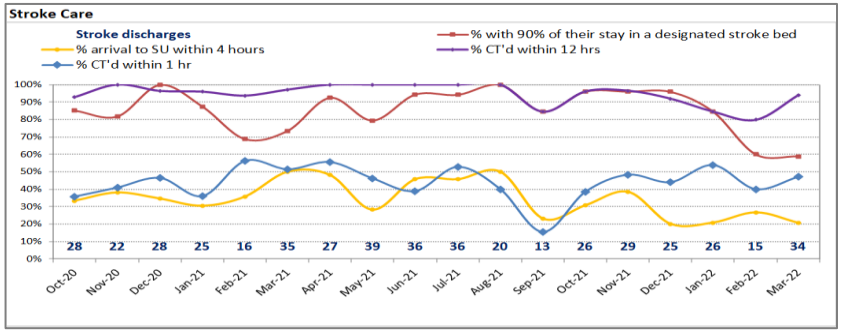
Quarterly	Q1	Q2	Q3	Q4
2019-20	B	B	B	Not Reported
2020-21	Not Reported	Not Reported	Not Reported	Not Reported
2021-22	C	C		

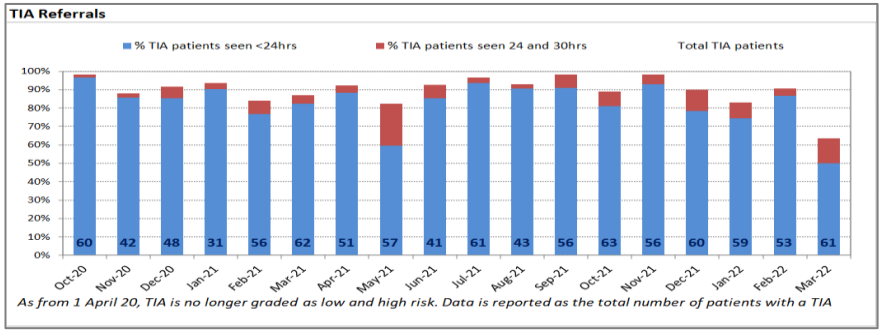
Data Quality Rating:

% Arrival on SU <4 hours: 20.6%

% CT'd < 12 hours: 94.1%

% TIA Seen < 24 hours: 50%





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

[Please note: Data is often only partially validated with informatics at the time of publishing. Coding can sometimes result in minor adjustments to the data at a later date].

- There were 34 stroke discharges this month.
- There were 2 stroke deaths within the 7-day period in March.
- 90% stay in the stroke unit was 59% this month; 1 to AMU first, 1 late referral, 7 SLOS, 2 ED >15hrs, 3 moved off ward due to Covid as mentioned above.
- The number of patients reaching the stroke unit within 4 hours is 21% due to ongoing difficulties mentioned above.
- Average Stroke Unit length of stay was 17 days, with an average total length of 19 days.
- 47% of patients had a CT within an hour which is an increase from the last month. CT within 12 hours was at 94% which is an increase from the last few months.
- 3 patients were thrombolysed, with an average door to needle time of 123 minutes.
- 25 of the eligible 15 patients were referred to ESD in March.
- 50% of the 66 TIA's had treatment complete within 24hrs; with many affected by full clinics, 2 declined earlier appointment, 3 late referral, 1 declined Bournemouth, 1 declined Poole, 1 MRI next day, 4 affected by no TIA slots due to Consultant sickness.

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

Unfortunately, both Farley and Breamore Wards have been affected by Covid positive and Covid contact bays, resulting in patients being moved off the unit and bays being closed. This will have and has had a significant impact on our performance against the stroke standards. However, recent changes to Covid IPC measures in April should contribute to an improvement in some of the standards.

As of April, there is a plan to gradually transition rehab stroke patients back to Farley Ward, enabling our Stroke services to be together once more in the Stroke Unit footprint.

Covid operational pressures and staff shortages are still impacting on our targets. There are plans in place for collaborative efforts with the Emergency Department, Clinical Radiology and bed managers to improve our future targets, this is still ongoing.

Part 2: Our Care

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Maternity

Are We Safe?

SFT Assurance Dashboard		Target	Improvement Direction	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Rolling 6m average
Perinatal Morbidity and Mortality (M&M)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)	1	Down	0	0	2	0	0	0	0
	Number of stillbirths (>+ 24 weeks excl TOP)	1	Down	0	0	2	0	0	2	1
	Number of neonatal deaths : 0-28 days	1	Down	1	0	2	0	0	0	1
	Medical termination over 24 +0 registered	NA	Down	NA	NA	NA	1	0	0	0
Maternal M&M	Number of Maternal Deaths	0	Down	0	0	0	0	0	0	0
	Number of women requiring admission to ITU	0	Down	1	1	0	0	0	0	0
Insight	Number or daytix incidents - moderate or above	1	Down	3	0	1	0	2	1	1
	Datix incidents moderate harm (not SII)	2	Down	2	5	1	0	2	1	2
	Datix incidence SII	0	Down	1	0	0	0	0	1	0
	HSIB referrals	NA	Down	0	0	0	0	0	0	0
	HSIB/NHSR/CQC or other organisation with a concern or request	0	Down	0	0	0	0	0	0	0
	Coroner Reg 28 made directly to trust	0	Down	0	0	0	0	0	0	0
Workforce	Minimum safe staffing in maternity services :Obstetric cover	40	NA	40	40	40	40	40	40	40
	Minimum to Birth ratio	1.28	NA	1.27	1.25	1.25	NA	NA	0	NA
	Midwifery vacancy rate (black= over establishment; red =under establishment	0 WTE	Down	NA	NA	NA	10 WTE	14.65	14.65	NA
	Provision of 1 to 1 care in established labour (%)	100%	Up	100	100	100	100	NA	0	NA
	Datix relating to workforce	0	Down	NA	1	0	1	0	2	1
	Compliance with supernumery status of the LW coordinator - %	100%	Up	NA	NA	NA	100	NA	0	NA
	Numbers of times maternity unit on divert	0	Down	0	0	0	0	0	0	0
Involvement	Service user feedback : Number of Compliments	NA	Up	9	9	2	19	31	31	17
	Service user feedback : Number of Complaints	1	Down	1	1	1	2	4	2	2
	Number of SOX	NA	Up	12	2	5	5	11	7	7
Assurance	Progress in achievement of 10 safety actions(CNST)	10	Up	4	4	4	4	4	4	4
	Training compliance - MDT PROMPT %	90%	Up	68	56.2	NA	74	74.2	75.9	NA

Perinatal Quality Surveillance Tool

The information provided represents the recommendation from the Ockenden report. SFT is further developing this dataset to ensure the Board is informed of safety metrics and indicators.

What does the data tell us?

Midwifery vacancy has remained the same , involved in international recruitment but yet to recruit, looking at upskilling our support workers and consideration of Registered General Nurse within maternity.
We have over recruited on support workers to mitigate the risk and flex the workforce across the community and acute settings to support women in times of high acuity .

What actions are being taken to improve?

Recruitment drives for midwives continues .
Training drive continues for both Practical Obstetric Multiprofessional Training (PROMPT) and Cardiotocograph (CTG) interpretation as identified in SII action plans.
Work ongoing to increase compliance with the Maternity Incentive Scheme (MIS) year 4 – predicted compliance presently 7/8 out of 10.

Ockenden Final Report – March 2022

Independent Review into Shrewsbury and Telford NHS Trust

15 essential and immediate actions.
Gap analysis by Women and Newborn Division – meeting with CEO 19th April to report, disseminated to all staff within division, engaged with regional and national networks to deliver on the key safety actions.

NOTE: Please see standards for reference – plan to incorporate into assurance dashboard .

Maternity Clinical Dashboard

Data Quality Rating:

Are We Safe?

South West Region							National																	
Measure	**Min**	**Median**	**Max**	**Improve direction**	**Green**	**Red**	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**Q1 Total**	**Q2 Total**	**Q3 Total**	**Q4 Total**	**Year To Date**
Babies (incl Non Reg)	149	187	222					186	163	183	191	222	217	198	187	149	161	188	167	532	630	534	516	2212
Homebirth rate	1.6%	3.4%	5.1%					2.7%	3.2%	1.6%	4.7%	4.1%	5.1%	4.6%	4.9%	2.7%	2.5%	2.1%	3.6%	2.5%	4.6%	4.2%	2.7%	3.6%
Inductions %	32.0%	38.1%	42.5%					40.1%	38.9%	32.6%	33.0%	38.3%	32.0%	37.4%	39.1%	36.9%	41.9%	42.5%	38.0%	37.1%	34.5%	37.9%	40.8%	37.4%
Total CS rate (planned & unscheduled)	24.1%	28.4%	37.6%	Down		32.0%	32% National Dash Mar21	26.9%	37.6%	24.1%	29.7%	29.3%	32.4%	26.6%	26.6%	29.5%	24.4%	29.0%	27.7%	29.1%	30.5%	27.4%	27.1%	28.6%
Elective caesarean sections %	10.2%	12.9%	16.3%	Down		15.0%	15% National Dash Mar 21	13.7%	15.9%	10.2%	12.1%	12.2%	13.7%	10.3%	16.3%	12.1%	10.6%	14.5%	16.3%	13.1%	12.7%	12.9%	13.9%	13.1%
Emergency caesarean sections %	10.3%	15.4%	21.7%	Down	17.0%	20.0%	17% National Dash Mar 21	13.2%	21.7%	13.9%	17.6%	17.1%	18.7%	16.3%	10.3%	17.4%	13.8%	14.5%	11.4%	16.0%	17.8%	14.6%	13.3%	15.5%
Instrumental deliveries %	9.2%	12.7%	17.4%	Down	12.0%	12.5%	12.5% NMPA	10.2%	13.5%	12.0%	9.9%	12.6%	9.2%	10.6%	12.8%	12.8%	17.4%	12.8%	16.8%	11.8%	10.6%	12.0%	15.5%	12.4%
Apgar less than 6 @ 5 min %				Down	1.2%	3.5%	Green <1.2%, red >3.5% NMPA	0.0%	0.6%	0.0%	0.0%	0.0%	0.9%	0.5%	1.1%	0.0%	0.0%	0.5%	1.8%	0.2%	0.3%	0.6%	0.8%	0.5%
PPH >= 1, 500 %	1.3%	4.3%	4.8%	Down	2.7%	5.6%	Green <2.7%, red >5.6% NMPA	2.2%	4.5%	4.8%	2.2%	4.5%	4.6%	4.4%	3.8%	1.3%	2.5%	4.3%		3.8%	3.9%	3.4%	2.3%	3.4%
Term babies admitted to NNU unexpectedly %	0.5%	3.1%	6.0%	Down	5.5%	5.8%	<5.8% NMPA	1.6%	3.7%	6.0%	2.6%	5.4%	0.9%	5.1%	0.5%	3.4%	3.1%	3.2%	0.6%	3.8%	3.0%	3.0%	2.3%	3.0%

Clinical outcomes good and within expected ranges.

Induction of labour rate has decreased from last month with quarterly rates within expected limits.

Caesarean Section (CS) rates now need to be presented in Robson categories – The Robson Ten Group Classification System (TGCS) is a classification system by which all perinatal events and outcomes can be compared. The system classifies all pregnant women into one of ten groups, each of which are mutually exclusive and, as a set, comprehensive. In accordance with our present Maternity Services Data Set (MSDS) we will present 3 key groups – there is on going work to incorporate into clinical dashboard. These are the 3 key groups:

Group 1 : Nulliparous women (1st pregnancy) with a single cephalic (head down) pregnancy >37 weeks in spontaneous labour

Group 2 : Nulliparous women with a single cephalic pregnancy > 37 weeks who either had labour induced or were delivered by caesarean section before labour

Group 5 : All multiparous (second or subsequent pregnancy) with at least one previous uterine scar, with a single cephalic pregnancy >37 weeks

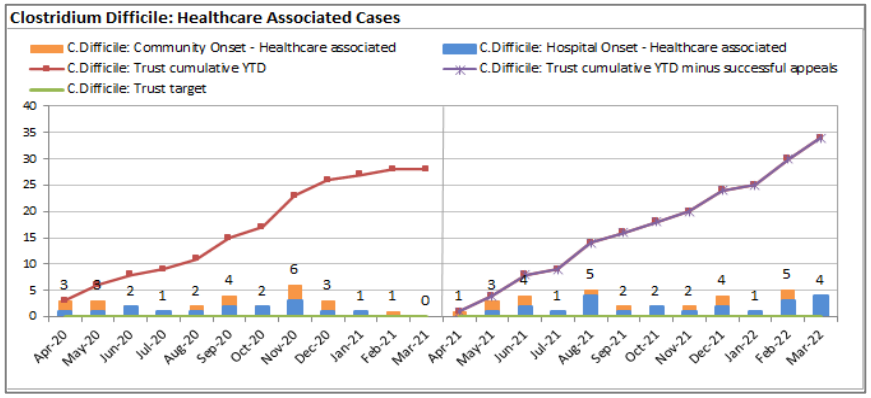
Infection Control

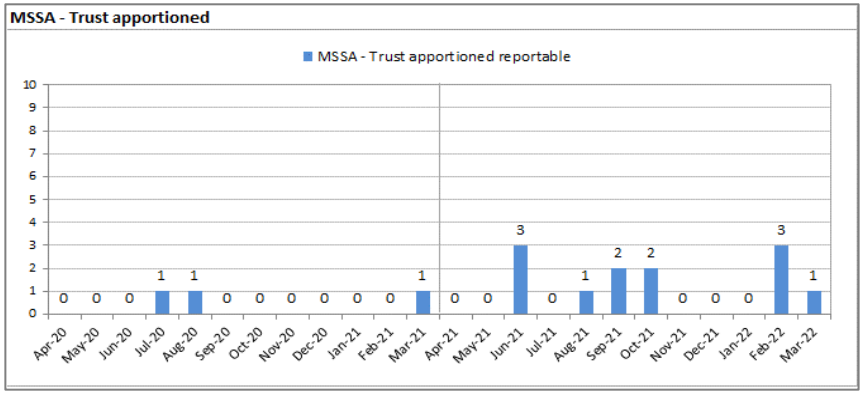
Data Quality Rating:

Are We Safe?

Clostridium Difficile	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
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	2020-21	2021-22
Trust Apportioned	3	0





Summary including learning outcomes and actions – March 2022

- No MRSA bacteraemia cases identified.
- One MSSA bacteraemia case identified for an inpatient on Pembroke Ward (unknown source). This infection episode was classed as a relapse for this patient on readmission to the Trust. Unable to identify learning as the incident investigation has not yet been returned by the ward team.
- There has been an increase in hospital onset healthcare associated *C.difficile* cases (total of 4 reportable cases). *(Of note: The Trust has experienced Norovirus activity with outbreaks declared for wards across the surgical and medical divisions. This has resulted in an increase in sampling symptomatic patients).* Learning outcomes from completed *C.difficile* case reviews by the ward teams included improvements for documentation of patient's bowel patterns; prompt review of patients by clinicians when concerns escalated by nursing staff; requirements for symptomatic patients to be isolated without delay when an infective cause is indicated and timely sampling; ensuring adherence to management of identified contacts and environmental cleaning requirements as per established Trust IPC policies.
- Two unrelated hospital onset *E.coli* bacteraemia cases identified for inpatients on Pembroke Ward (lower urinary tract source). Further case investigation to be undertaken by the ward team to identify any learning or improvement actions required.

Pressure Ulcers

Are We Safe?

Per 1000 Bed Days	2020-21 Q4	2021-22 Q1	2021-22 Q2	2021-22 Q3	2021-22 Q4
Pressure Ulcers	2.21	1.47	1.30	1.84	1.88

Data Quality Rating:

Summary and Action

There have been 34 Category 2 pressure ulcers (PU) in March, which is a significant increase from 23 in February. Medicine continues to contribute to much of this number with 22, with 12 in Surgery. 2 of these Category 2 PUs were device related and both were attributed to oxygen equipment within the Intensive Care Unit. Category 2 PUs continue to be found most on sacrum/buttocks and heels and much of this number were on patients who were already on pressure relieving devices such as air mattresses and/or utilising orthotic boots. Pressure relieving devices are, for the most part, being utilised as patients are risk assessed and found to be high risk of developing new pressure damage, but delays in pressure area care due to staffing shortages and operational pressures could also contribute to this number. All ward areas with multiple hospital acquired PUs will present their learning at Share and Learn where specific themes and actions for each ward area will be identified.

One Category 3 PU was identified in March within the Surgical Division. This was a device related PU caused by a Futura wrist splint. A 72-hour report was completed, and this case was discussed at the weekly Patient Safety Summit meeting, where it was decided that this would be for local review. After meeting with the ward lead, we identified lapses in care due to lack of guidance for short term removal of splints for regular skin checks. The Surgical ward and Tissue Viability Team have now devised a checklist for use in patients with orthopaedic/orthotic devices and it is currently being trialled on the ward. The Tissue Viability Team have also undertaken an education session with the ward and have further sessions booked for May and June.

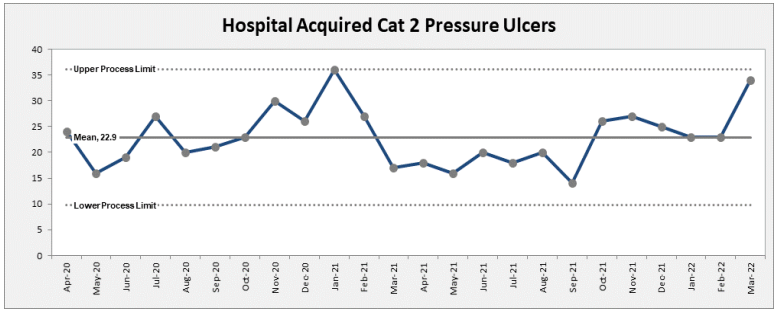
No Category 4 PUs were identified in March.

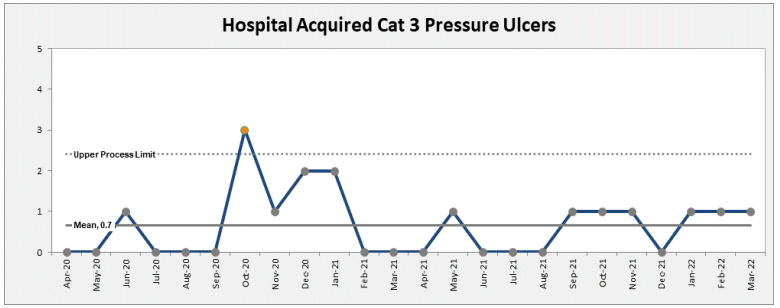
10 Deep Tissue Injuries (DTI) were identified in March, which is double the number identified in February. 4 of these DTI's were found on one patient's foot. This patient had a POP in situ for an ankle fracture and these were identified at routine POP change. The Tissue Viability Team is involved and working with the plaster room team to manage these appropriately. After discussion with an Orthopaedic surgeon, it has been identified that these PUs were not avoidable due to the severe and unstable nature of the fracture meaning a full POP was required at all times. All appropriate action was taken by ward and plaster room staff to minimise the risk of pressure damage for this patient. As in previous months, it is likely that there were missed opportunities for early identification of vulnerable areas due to staff shortages and missed education opportunities leading to DTI'S.

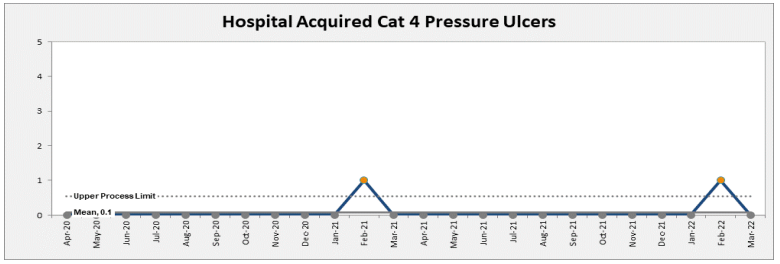
3 unstageable PUs were identified in March. These were also identified on the above patient with full POP in situ and investigation and support have been undertaken. This patient was acutely unwell and has now deceased therefore we are unable to reassess and downgrade these PUs.

Pressure ulcer prevention education continues to be available twice a month and can be booked via MLE. Tissue Viability also undertake education and training with wards informally, providing bitesize education on skin checks and pressure ulcer prevention methods during ward visits and attending ward arranged training days to deliver education in areas that have had significant PU numbers or hospital acquired cat 3/4 PUs.

The monthly Share and Learn meeting took place in March, ward specific actions were identified – the most common theme was lack of or inaccurate risk assessment which correlates with themes identified within the trust wide action plan for PU management. Within Orthopaedics, the most common theme identified was heel PUs for hip fracture patients, therefore the Orthopaedic ward now routinely fits pressure relieving boots to all patients admitted with hip fracture. April Share and Learn meeting to discuss March PU figures will take place on 19th April and will trial a new method of feedback to ensure that ward specific themes and subsequent actions are easily identified and appropriately shared with the Share and Learn group.







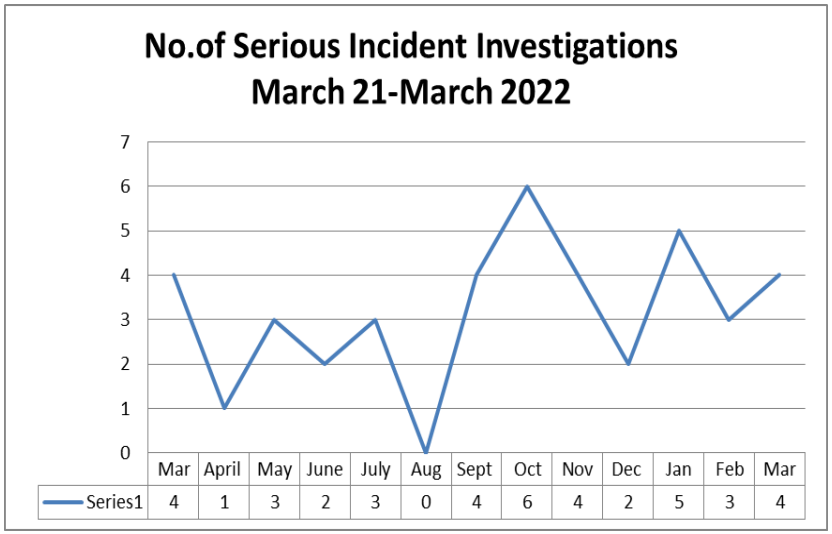
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or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

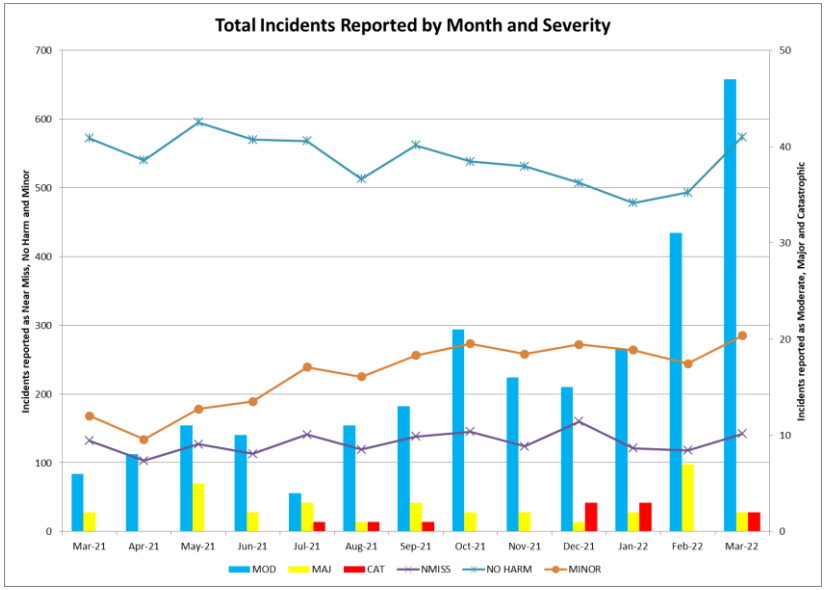
Incidents

Are We Safe?

Year	2020-21	2021-22
Never Events	0	3

Data Quality Rating:





Summary:

4 new SIIs were commissioned for March 2022:

469 Delay in starting NIV

471 Delay in diagnosis/inappropriate place of admission for adolescent

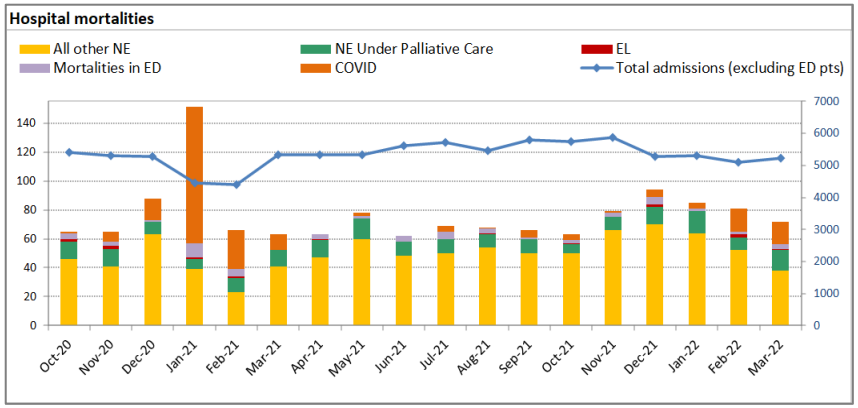
472 Intra uterine death (term)

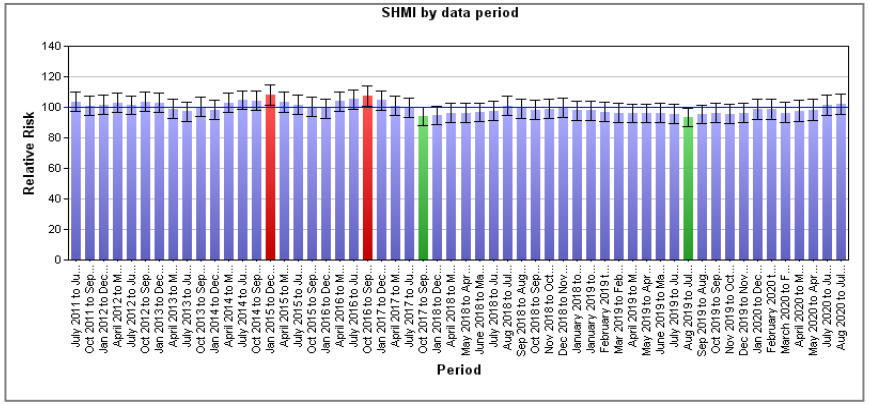
473 IT systems failure

Mortality Indicators

Data Quality Rating:

Are We Safe?



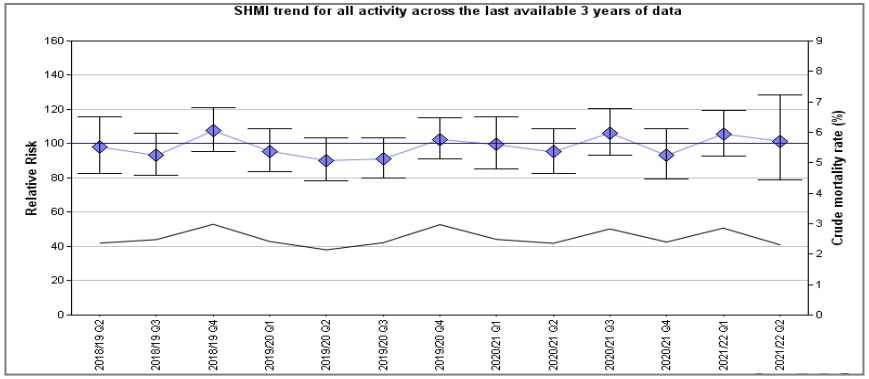


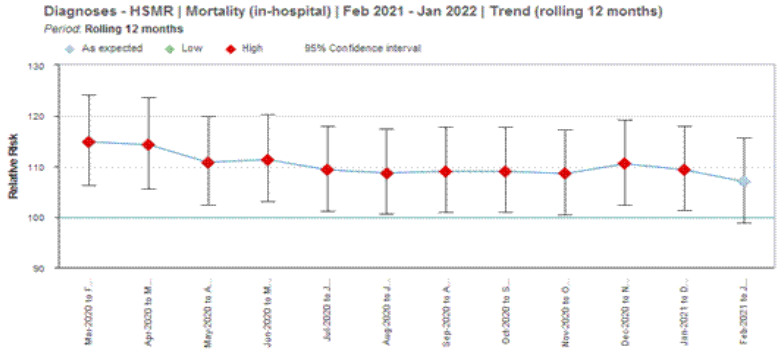
Summary and Action

1. Reported Covid deaths in March = 16 (28 day +ve test and/or COVID on death certificate)

2. The latest SHMI for Salisbury District Hospital (as reported by NHS Digital) is 1.0269 for the 12-month rolling period of November 2020 – October 2021. This is within the expected range.

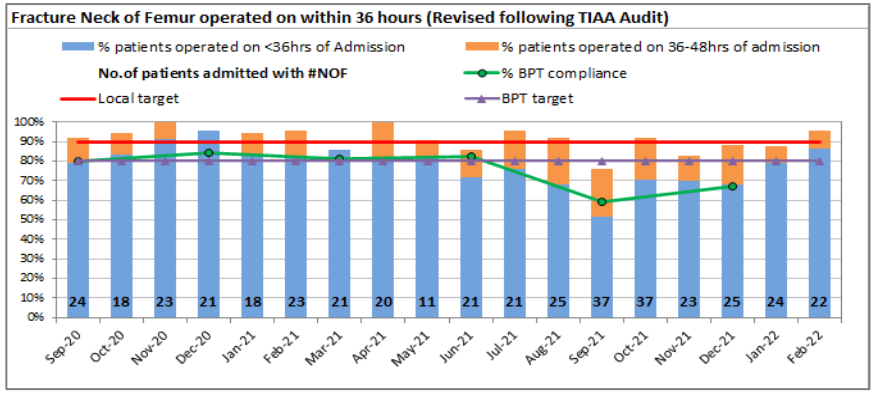
3. For the latest HSMR the relative risk is 106.9. This represents the 12-month rolling period of Feb 21- Jan 22. The HSRM now lies within the expected range.





Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?



(Please note: due to the time it takes to complete clinical coding, the fracture neck of femur data for the current month may not be displayed on the graph above)

BPT%: March 2022

Total patients discharged: 28
Not applicable for BPT: 2 (1 PP# & 1 no operation)
Number of patients who failed to meet BPT: 5

Reason for failure:

- Awaiting Theatre Space: 5 patients

BPT %: **80.8%** Average LOS = **17.57 days**

BPT Q4 21/22

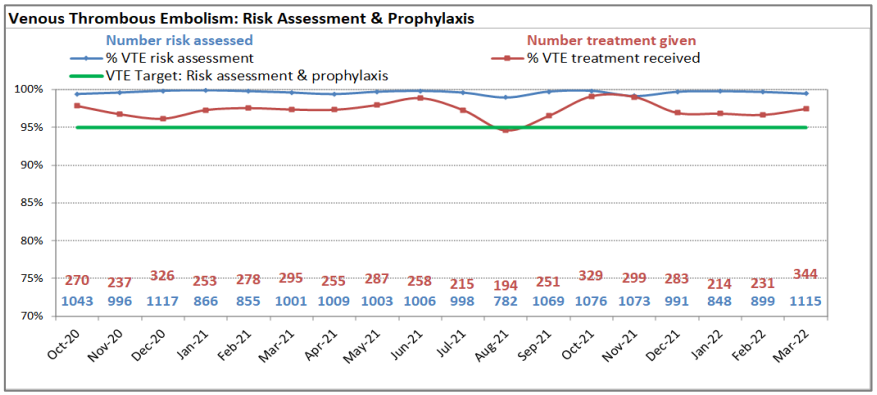
Total patients discharged: 98
Not applicable for BPT: 16 (13 PP# & 3 no operation)
Number of patients who failed to meet BPT: 17

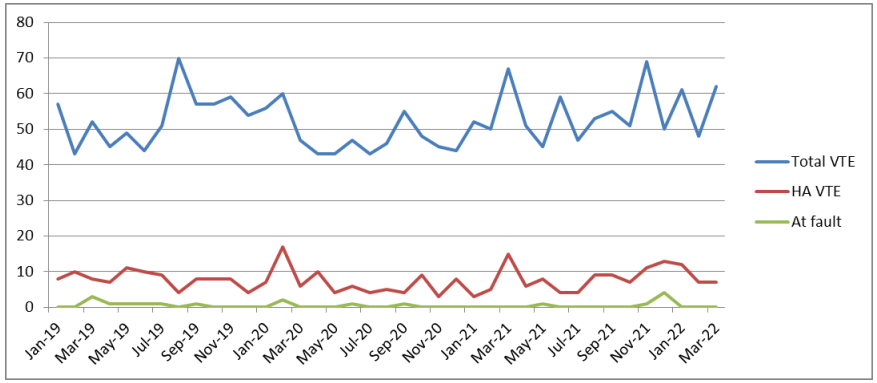
Reason for failure:

Awaiting Theatre Space: 13 patients
Awaiting medical review/investigation or stabilisation: 1 patient
Other: 1 patient
Awaiting orthopaedic diagnosis/investigation & Time to Geriatrician: 1 patient
Awaiting Specialist Surgeon & Time to Geriatrician: 1 patient

BPT %: **79.3%** Average LOS = **19.01 days**

Data Quality Rating:





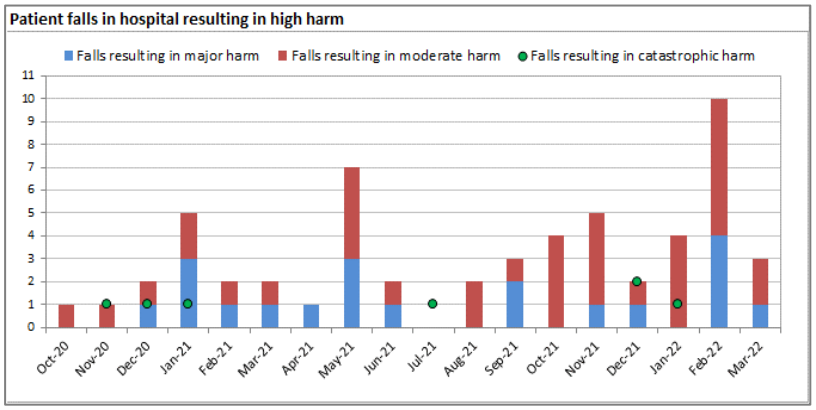
Hospital Associated VTE

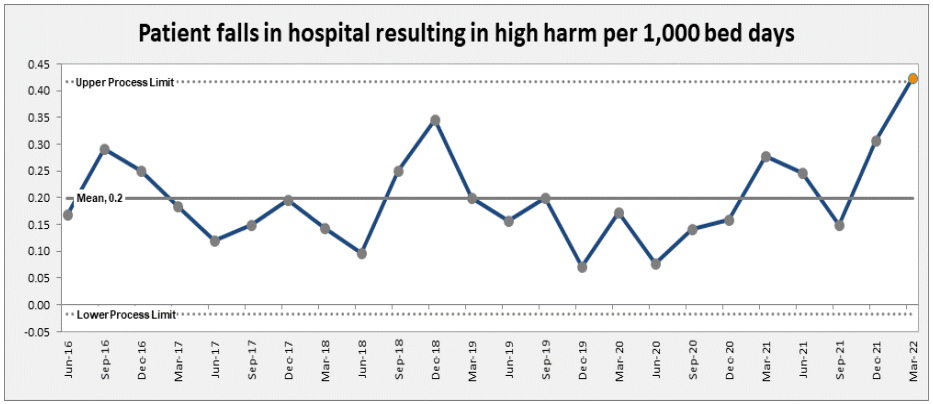
Total number of VTE in March 2022 : 62
- Hospital Acquired (HA) VTE: 7 – 11.3% of total VTE (national average 25%)
- 0.14% of total admissions (national average 0.5 – 1.6%)
- All patients diagnosed with a VTE are assessed and flagged as HA if associated with a hospital admission / surgery within 90 days of their diagnosis and a root cause analysis is completed.
- All VTE events in March developed a VTE despite being provided with appropriate VTE prophylaxis.

Patient Falls

Are We Safe?

Data Quality Rating:





Summary and Action

Reported in March, there were 5 falls with harm:

2 minor – stable # L1 and a parietal bleed

2 moderate – # ribs with pneumothorax and a fractured nasal bone

1 major – # NOF requiring hemiarthroplasty

Continuing work

All SWARMs/RCAs have been completed within the 72-hour time frame and presented to the patient safety summit. None have been commissioned for further investigation. Training continues at ward level with 61 nursing staff and 18 F2 Doctors having received training thus far.

Improvement Work

Due to sickness, the falls group meeting for March was cancelled. The quarter 4 report will be finalised by the end of April and presented to the Patient Safety Steering Group in May.

Improving Together programme has commenced with falls reduction being a breakthrough objective for Pitton Ward and the medical DMT.

Statistical Process Control Chart Key:

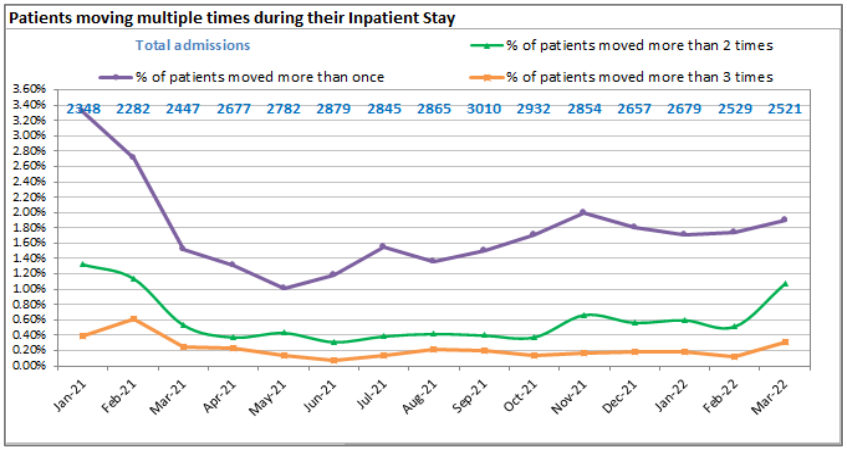
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)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

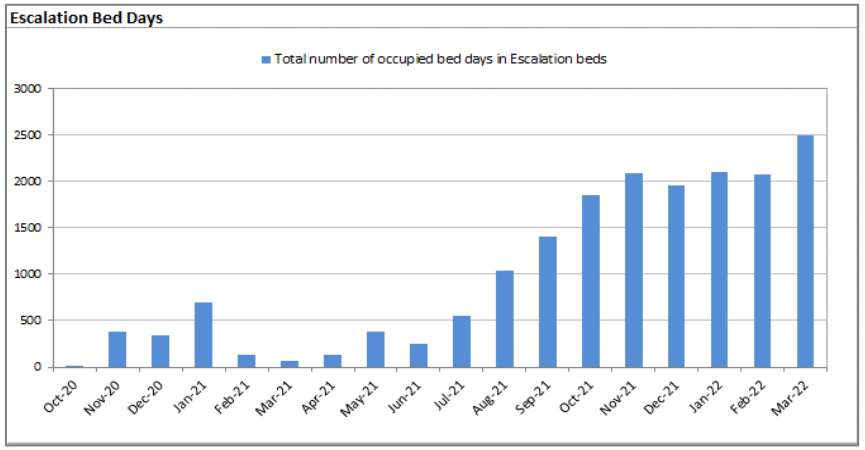
Patient Experience

Are We Safe?

Last 12 months	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Bed Occupancy %	90.8	91.2	90.8	90.0	93.9	93.0	94.6	95.0	93.2	93.8	96.3	96.7

Data Quality Rating:





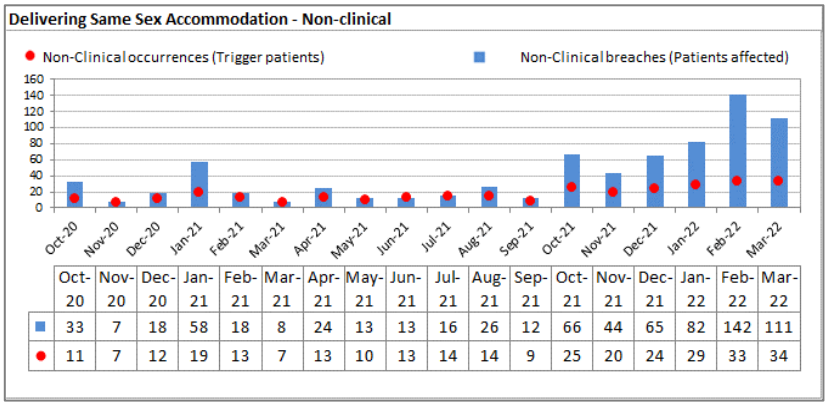
Summary and Action

In March there was increase in the number of times patients moved wards, an on-going reflection of the operational pressures within the Trust and the continued use of escalation beds. However, changes to Covid IPC measures in April should contribute to a reduction in the number of patient moves.

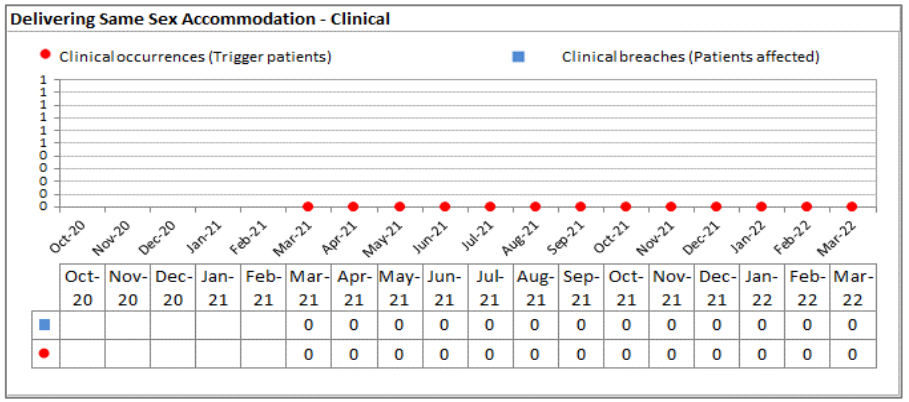
Patient Experience

Are We Safe?

Data Quality Rating:



	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
■	33	7	18	58	18	8	24	13	13	16	26	12	66	44	65	82	142	111
●	11	7	12	19	13	7	13	10	13	14	14	9	25	20	24	29	33	34



	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
■						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

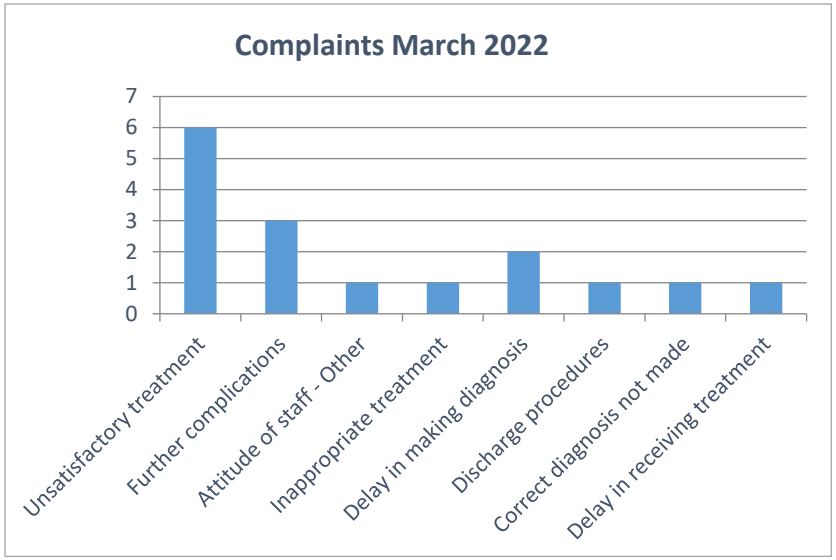
Summary and Action

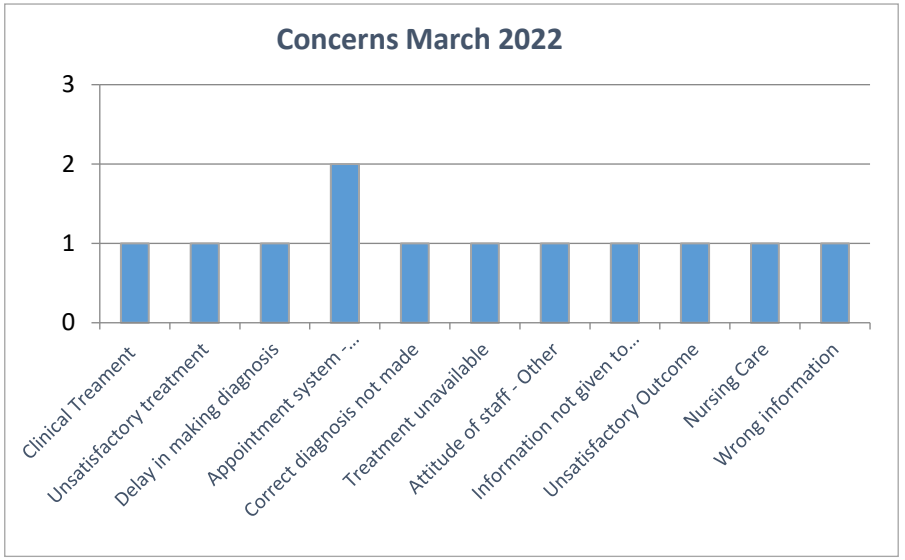
- 15 breaches affecting 15 patients which occurred on Radnor Ward were all patients who were unable to be moved off the ward within 4 hours of being declared fit to move . 7 breaches were resolved within 24 hrs. There were 8 patients who had a breach time of over 1 day while awaiting a speciality bed. Privacy and dignity was maintained at all times within the patients bed space.
- 12 breaches affecting 71 patients in AMU assessment bay. All patients had access to single sex bathrooms within the ward and screens were used to maintain privacy and dignity. 8 of the breaches were resolved within 24 hours. The remaining 4 were resolved within 48 hours.
- 1 breach on SAU affecting 3 patients. Privacy and dignity was maintained at all times within the patients bed space. The breach was resolved within 48 hours.
- 2 breaches on Pitton Ward affecting 6 patients. Privacy and dignity was maintained at all times within the patients bed space. One breach was resolved within 48 hours, the other continued for 4 days due to Covid isolation policy.
- 1 breach on Laverstock Ward affecting 5 patients. Privacy and dignity was maintained at all times within the patients bed space. The breach continued for 5 days due to Covid isolation policy.
- 3 breaches on Tisbury Ward affecting 11 patients. Privacy and dignity was maintained at all times within the patients bed space. 2 of the breaches were resolved within 24 hours , the other within 48 hours due to Covid isolation policy.

Patient & Visitor Feedback: Complaints, Concerns & Compliments

Are We Responsive?

Data Quality Rating:





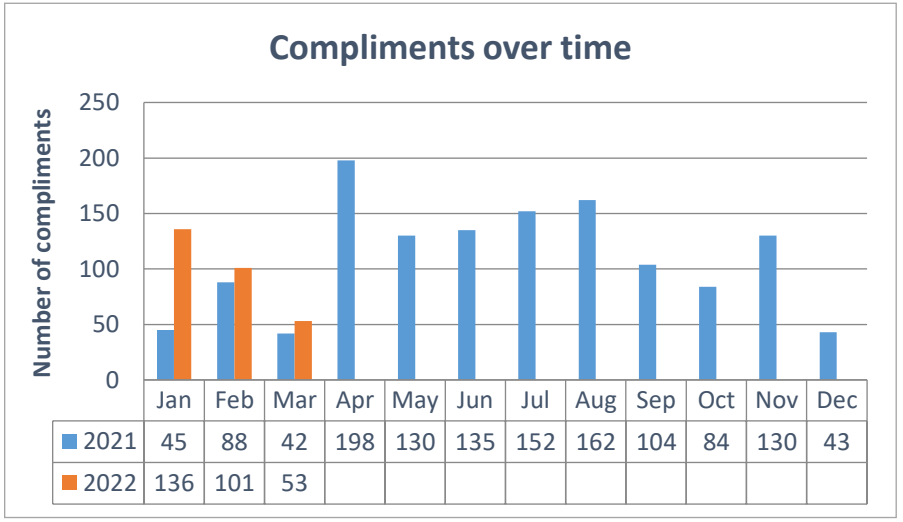
Summary and Action

The number of compliments is down on last month but higher than this time last year.

The trend for staff attitude complaints has gone down significantly with no medical or nursing staff noted.

The most common trend was unsatisfactory treatment.

The trend for concerns was appointment procedures but it was still only 2 for the month.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2021	45	88	42	198	130	135	152	162	104	84	130	43
2022	136	101	53									

Part 3: Our People

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Workforce – Turnover

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

Background – What is the data telling us, and underlying issues.

12-month turnover for month 12 is 12.98%. This was a slight increase from last month's position which was 12.64%. There were 54 leavers and 26 starters by headcount in month. The most common reason, where recorded, for leaving was "Relocation" 17% of all reasons for leaving.

BSW Benchmarking Nov 2021 - RUH Bath : 9.61%, GWH Swindon 14.32%

Corporate had the highest turnover (14.28%), the only Division whose turnover was under 12% was Women and Newborn (10.79%).

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

In the last month 24% of staff leaving (13 people) completed the exit questionnaire they received from ESR. Thematic analysis and insights to inform proactive stay interventions.

On 1st April we relaunched the Exit interview process with guidance and communications published. We have already started to receive completed interviews back; thematic analysis will be included in the quarterly report. The People Business Partners review this data monthly.

Some Clinical Divisions have incorporated turnover as a driver metric as part of the Improving Together work. All Divisions are at least monitoring turnover as watch metrics. Counter measures being agreed as part of the A3 sign off process.

People Business Partners working with Head of Resourcing focussing on recruitment strategies for Medicine and Surgery for HCA's, 2022/23 overseas nursing intake and hard to recruit.

Risks to delivery and mitigation

Managers not following the new exit interview process, People Operations to communicate this process to managers to ensure they are informed and understand principles and process.

Operational pressures, immediate need for staff availability impacts strategic initiatives.

Workforce – Vacancies

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

Mar 22	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	443.4	452.3	(8.9)
Nursing	1,030.8	1,114.5	(83.7)
HCAs	540.7	547.4	(6.6)
Other Clinical Staff	632.1	676.1	(44.0)
Infrastructure staff	1,266.4	1,354.7	(88.3)
TOTAL	**3,913.4**	**4,144.9**	**(231.5)**

Background – What is the data telling us, and underlying issues.

Vacancy rate in month 12 (March) was 3.88%, compared to 3.44% in February. The Division with the highest vacancy rate was Corporate at 5.62%.

A brief overview of the statistics tells us: of the 124 staff who have left medicine in the last year: 26 (21%) chose to relocate elsewhere, 23 (19%) left with no reason given, 22 (18%) left due to work life balance, 16 (13%) took retirement due to age and 8 (6%) left due to health reasons.

BSW benchmarking Nov 2021 – RUH Bath : 4.75%, GWH Swindon 6.55% (Dec 21)

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

International recruitment – work continues to finalize contracts with agencies for BSW RN International Recruitment Collaborative. Direct hire application process now open for prospective candidates. 1st interviews to be scheduled end of April with an aim for 1st cohort of 8 to arrive June.

International midwives – 6 offers made to date for the collaborative, out of which 1 is for Salisbury. In addition, the Trust has made 2 direct hire offers to international midwives who will join the international programme.

Recruitment for HCA's continues with a number of changes being made to the way the Trust recruits including accepting CV's without the need to apply using an application form, use of a rolling advert and paid Facebook advertising campaign. This has resulted in 28 number of offers being made (17 for Medicine, 11 for Surgery) .

Large scale recruitment event for HCA's provisionally booked for 21.05. A small working group consisting of ward representation will meet to design the programme. Current wte vacancy gap for HCA's is approximately 62.63.

The Trust's face to face welcome event is now established with phase 2 implementation being progressed. Phase 2 includes a market place style event for new joiners to attend, refining of running order and booking process as well as a welcome to the Trust sponsored by the League of Friends being implemented.

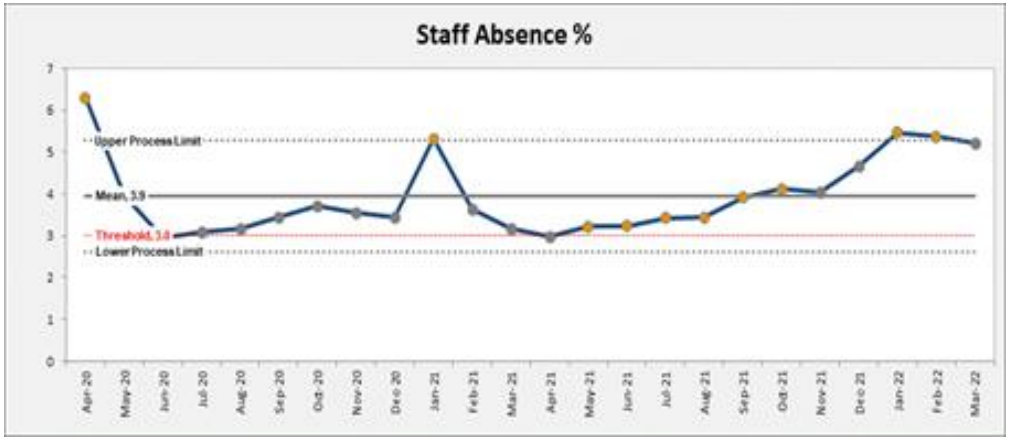
Work with contractor to overhaul recruitment and promotional practices continues. Information on current Trust process, documentation etc. has been shared, an end to end process mapping workshop scheduled to be held on 12.04 with the Recruitment Team and interviews being undertaken with Recruiting Managers on existing process. 1st workshop to deliver initial findings and quick recommendations to be held on 26.05.

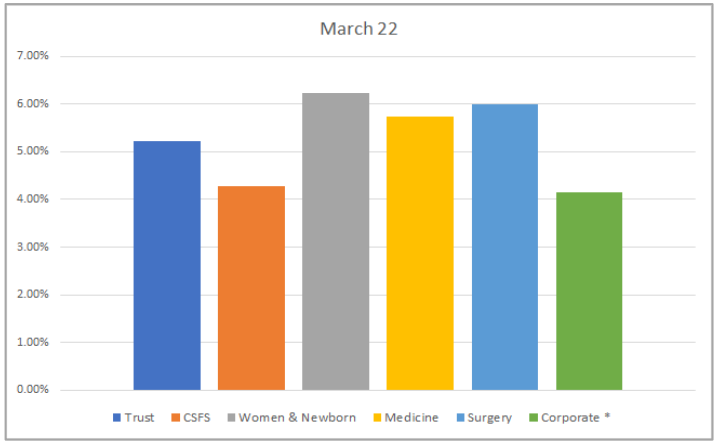
Risks to delivery and mitigation.

National professional shortages

Workforce - Sickness

Use of Resources





Background – What is the data telling us, and underlying issues.

Sickness in month 12 saw an increase to 5.22%, sickness for the rolling year was at 4.15%. All Divisions are above the Trust target of 3%. For the month of March, "Infectious Diseases" (Coronavirus) was the top cause of sickness across all Divisions.

BSW Benchmarking data for Nov 2021: RUH Bath 5.63%, GWH Swindon : 5.29%

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

The wellbeing phone calls are now part of BAU activity within the People Advisory team.

Scoping work underway for process to contact staff off sick with COVID-19 on day 5 and 6 to ensure they are undertaking LFTs in line with policy.

The purpose of both the above inventions are to encourage staff returning to work at the earliest time permitted.

Communications in month about the republished return to work interview process.

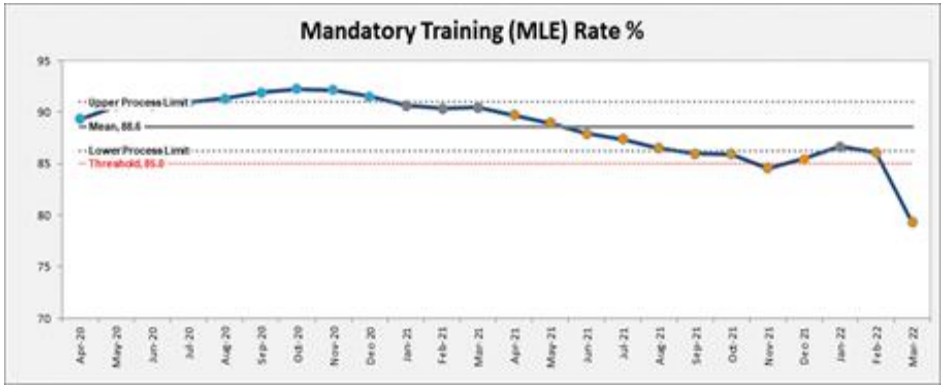
New Attendance Management policy out for consultation with increased wellbeing focus.

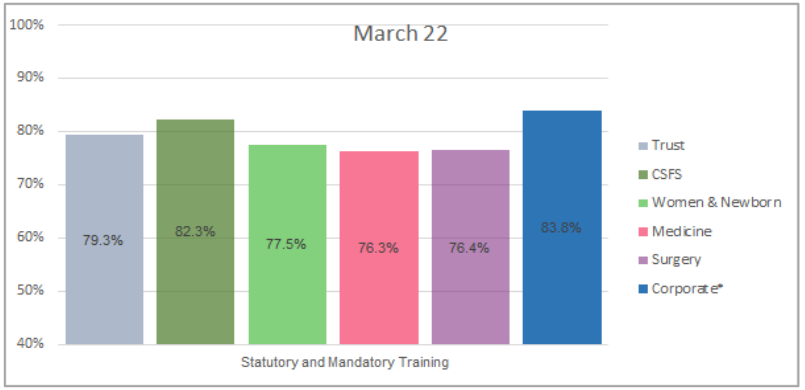
Risks to delivery and mitigation.

Operational pressures reducing managers time to undertake return to work interviews.

Workforce – Staff Training

Use of Resources





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

Trust compliance appears to have significantly dropped from 86% in February to 79% at the end of March. It has been identified by Kallidus (Managed Learning Environment (MLE) provider) that this is due to errors which have occurred due to the changes which have been made to the cost centres within ESR, which are linked to training groups on MLE. We are working closely with Kallidus to resolve this issue.

Trends across divisions remain consistent, but there is a significant in drop in certain subject areas, which reflects the issues identified. However the board are asked to consider that we do not currently have assurance of accuracy in this data

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

Kallidus are unable to restore these groups and their assignments and so we are working closely with them to review the group structures to identify where the errors are occurring. They will also work with us to review the data contained in our data feed, analysing our training matrix and where required creating new groups to support this. The majority of the required changes will need to be implemented manually, although Kallidus will attempt to map some of the training.

We have a deadline to achieve this of the end of May 2022, prior to the migration to the new platform

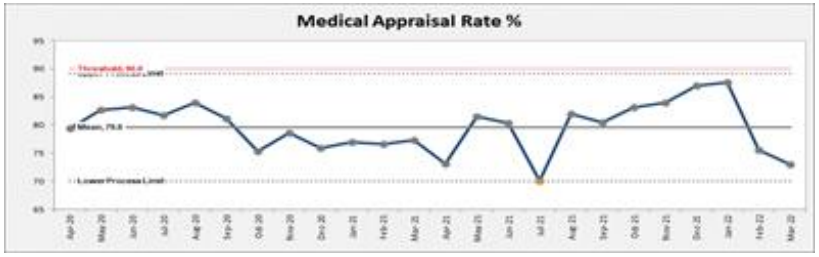
Risks to delivery and mitigation.

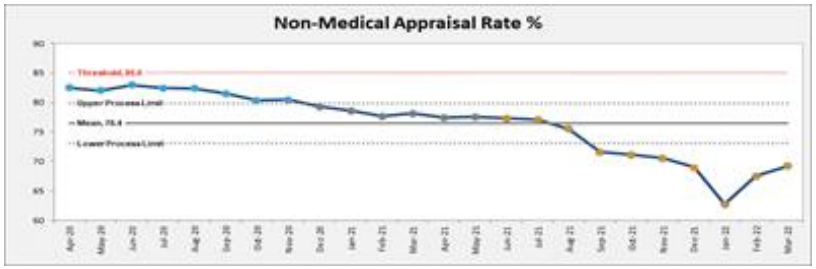
Lack of resource to carry out recovery work, unable to establish this until review has completed.

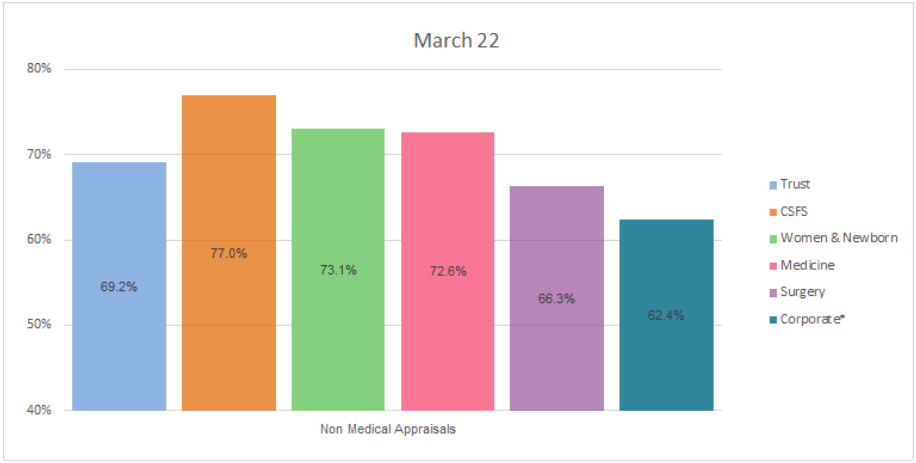
Current staff will prioritise this work, which will impact admin support available in other areas.

Workforce – Appraisals

Use of Resources







Background – What is the data telling us, and underlying issues.

Non-Medical Appraisals for month 12 remain under target at 69.2%, this is an increase on the previous month position (67.5%). Hotspot areas are Corporate (62.4%) and Surgery (66.3%)

BSW Benchmarking - RUH Bath : 61.9% (Nov 21), GWH Swindon 74.17% (Dec 21)

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

DMTs are implementing appraisal recovery plans written last month.

Workforce Information team continue to provide focused support to managers struggling with the system.

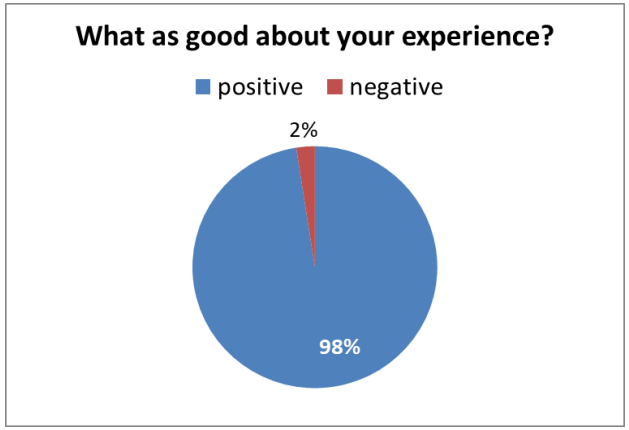
Medical Education will be sending reminders to appraisers and appraises now the Medical Education Administrator is in post.

Risks to delivery and mitigation.

Management time from operational pressures to undertake the appraisals. To mitigate the DMTs will support managers with this.

Feedback from Friends and Family test – March 2022

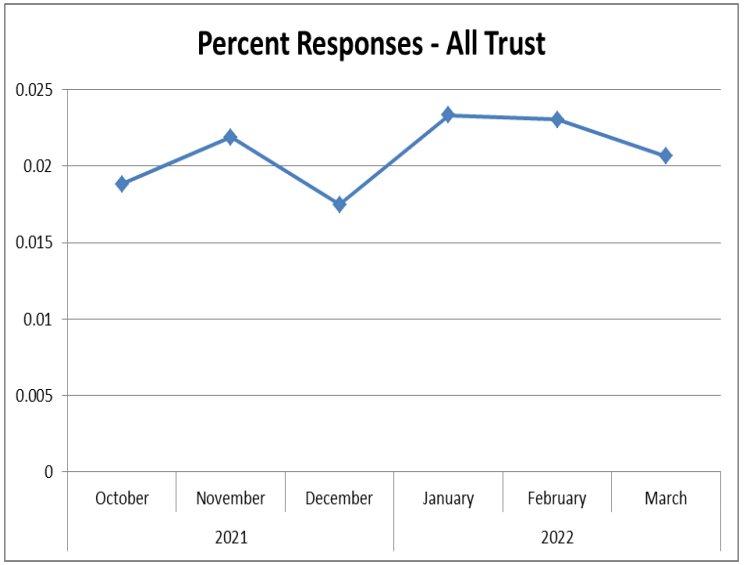
Are We Responsive?



"Very informative, helpful and friendly. Made sure my wife, who was picking me up, was kept in the picture about my condition. Whole team created a relaxing and positive atmosphere, which would put my mind at rest if I had any worries". (Surgical Admissions Lounge)

"I was anxious when I was introduced to a male ultrasonographer as my procedure was an intimate one. I needn't have worried. The Ultrasonographer was very gentle and his explanations of what would happen were exemplary. Not a pleasant test but as good as it could be in his gentle care". (Clinical Radiology)

"All of the staff were attentive and helpful and took the time to explain everything to us. They were exceptionally courteous of our needs and preferences and made us feel really safe and taken care of". (Labour Ward)



"Full explanation of MRI scan would have been easier to tolerate if I had known it would be half an hour plus and had been given countdowns at regular intervals".

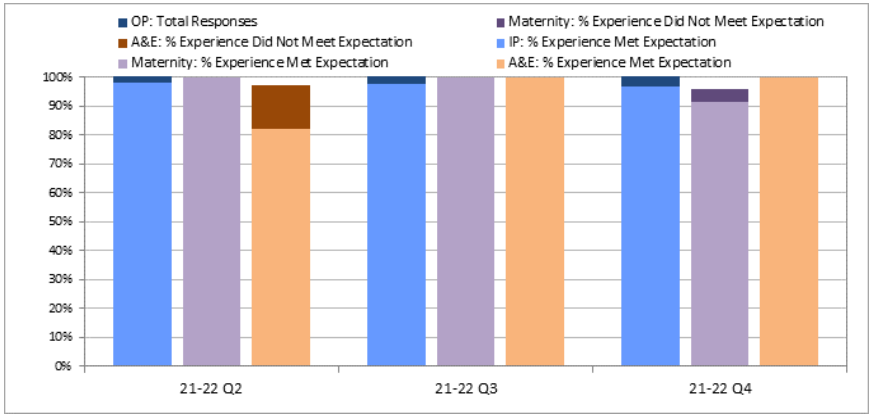
"Checking the website for clinic location it says level 3 when in fact the clinic moved last April. This is not helpful to new visitors. Wheeling an elderly patient along the path from Sarum entrance i.e. the chair caught on a drain ledge and tipped. This path should be level".

"No visual display to inform the patients of which clinics are running and of any delays. Walls very bare. Needs artwork as it's not very relaxing".

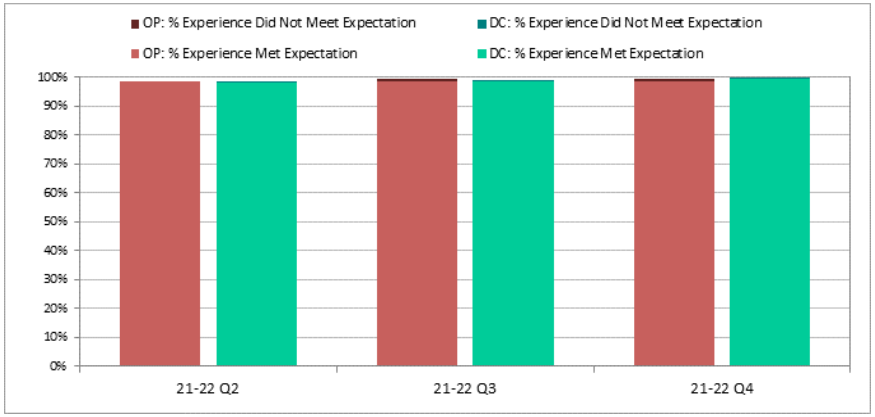
Friends and Family Test – Patients and Staff

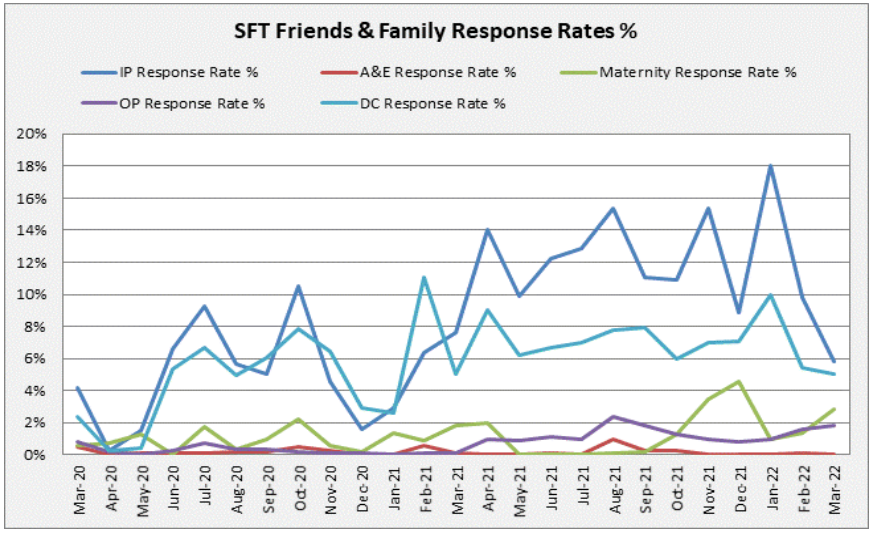
Use of Resources

Patient Responses: Inpatient, Maternity and A&E



Patient Responses: Outpatient and Daycase





Summary:

- Postnatal received feedback for over 20% of their patients this month.
- There was a big dip in responses this month with a lot less ward feedback than normal.
- Over 98% of patients reported their experience as very good or good.
- Only 2.1% of eligible patients are currently giving feedback .

Part 4: Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

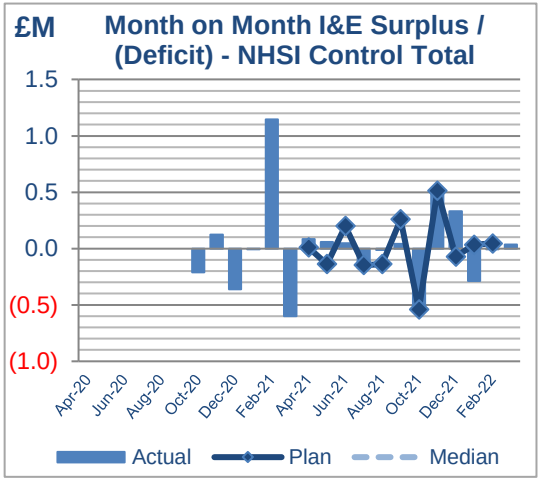
Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

	March '22 In Month			March '22 YTD			21-22 Plan
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	20,691	22,834	2,143	227,597	260,745	33,148	248,288
Other Clinical Income	1,251	1,925	674	36,523	10,274	(26,249)	15,832
Other Income (excl Donations)	3,158	11,847	8,689	35,658	44,932	9,274	35,658
Total income	**25,100**	**36,606**	**11,506**	**299,778**	**315,952**	**16,174**	**299,778**
Operating Expenditure							
Pay	(15,917)	(24,630)	(8,713)	(187,141)	(198,154)	(11,013)	(187,141)
Non Pay	(7,486)	(10,264)	(2,778)	(93,280)	(98,998)	(5,718)	(93,280)
Total Expenditure	**(23,403)**	**(34,894)**	**(11,491)**	**(280,421)**	**(297,152)**	**(16,731)**	**(280,421)**
EBITDA	**1,697**	**1,712**	**15**	**19,357**	**18,800**	**(557)**	**19,357**
Financing Costs (incl Depreciation)	(1,677)	(1,742)	(65)	(19,313)	(18,802)	511	(19,313)
Share of Gains on Joint Ventures		65	65		65	65	
NHSI Control Total	**20**	**35**	**15**	**44**	**62**	**18**	**44**
Add: impact of donated assets	(48)	179	227	(511)	(378)	*133*	(511)
Surplus/(Deficit)	(28)	214	242	(467)	(316)	151	(467)



Variation and Action

The Trust recorded a control total surplus of £35k in month 12, bringing the YTD position to a surplus of £62k, thereby showing a small favourable variance against the full year 21-22 plan. Significant pay and non pay overspends were offset by income which included ERF, ERF+ and discretionary system allocations.

The month 12 position included the notional costs and income associated with additional pension contributions which were met centrally by the DoH.

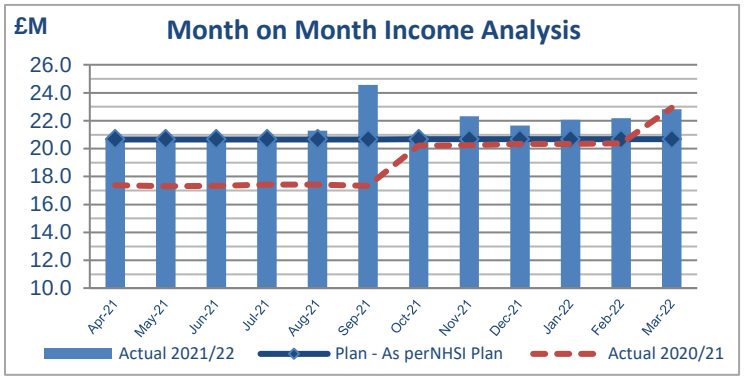
Income & Activity Delivered by Point of Delivery

Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Mar'22 YTD		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	8,982	9,582	600
Day Case	15,241	16,301	1,060
Elective inpatients	13,640	9,999	(3,641)
Excluded Drugs & Devices (inc Lucentis)	20,783	20,880	97
Non Elective inpatients	62,856	64,619	1,763
Other	101,218	108,473	7,255
Outpatients	25,568	30,890	5,322
TOTAL	**248,288**	**260,745**	**12,456**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW CCG	152,272	161,251	8,979
Dorset CCG	24,968	25,332	364
Hampshire, Southampton & IOW CCG	18,790	19,065	275
Specialist Services	33,984	36,028	2,044
Other	18,274	19,069	794
TOTAL	**248,288**	**260,745**	**12,456**



Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
A&E	68,430	67,996	(434)	51,564	16,432
Day case	20,047	20,581	534	15,030	5,551
Elective	3,751	2,830	(921)	2,111	719
Non Elective	28,073	27,829	(244)	25,228	2,601
Outpatients	234,109	268,120	34,011	216,937	51,183

Variation and Action

Activity in March in Day cases recorded 273 spells more than in February but fell short of the plan for the month by 6 cases. Day case activity remains above plan year to date and has improved this month in the specialties of Gastroenterology (157 cases) , Urology (37 cases) and Ophthalmology (36 cases) but activity levels have dipped this month in Plastic Surgery(30 cases). Activity in elective inpatients remains below plan and actual activity in March was higher than in February with improved performance in Urology (12 cases). Non-Elective spells were higher in March than in February in the specialties of Obstetrics (66 cases) and Paediatrics (28 cases) but remain below plan year to date. Outpatient activity increased this month in most specialties as there were more working days. Activity levels in A&E remain below the plan year to date.

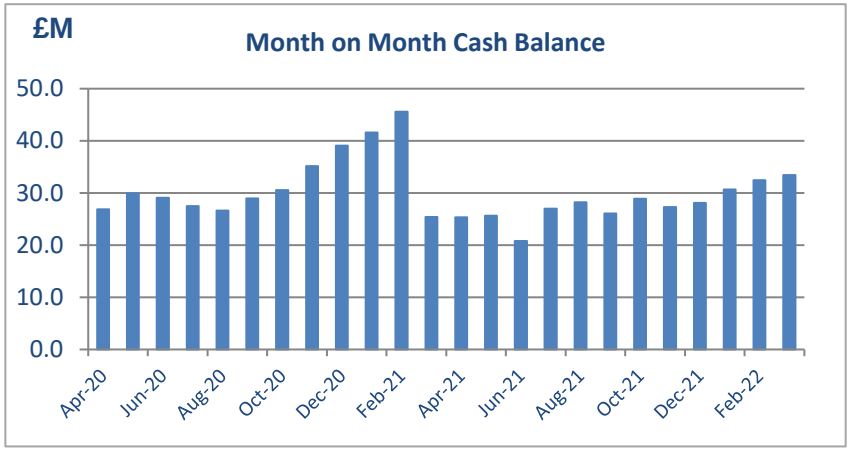
For the second 6 months of the financial year (H2) the block allocations from commissioners have been uplifted. The plans have not been adjusted and remain at H1 levels. The Elective Recovery Fund (ERF) income for the first 6 months of the financial year (H1) of £2.018m has been included in the financial position against BSW CCG. Additional H2 income from BSW CCG of £4.460m has been included in the position in March: this represents the value agreed as part of the final H2 planning process and included an additional £700k.

Cash Position & Capital Programme

Capital Spend: 

Cash & Working: 

Use of Resources



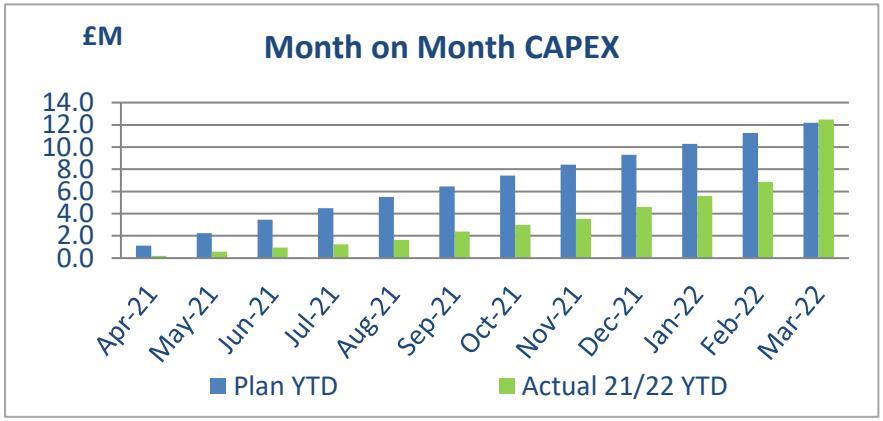
Creditors have risen since the year end partly due to the move to SBS which has resulted in taking longer to clear supplier invoices involving queries.

Purchase order related invoices have been delayed since mid-December where NHS SBS have been undertaking a 'stabilisation' process to clear invoice backlogs. These have now been cleared and invoices are moving into the internal SFT section of the approval process.

The increase in year end creditors is largely due to the high level of capital spend in March.

Capital Expenditure Position

Schemes	Annual Plan £000s	Mar'22 YTD Plan £000s	Mar'22 YTD Actual £000s	Mar'22 YTD Variance £000s
Building schemes	1,175	1,175	1,603	(428)
Building projects	4,979	4,979	3,699	1,280
IM&T	3,872	3,872	3,171	701
Medical Equipment	1,728	1,728	1,960	(232)
Other	450	450	2,055	(1,605)
Additional Funds approved in year	3,668	3,668	3,174	494
TOTAL	**15,872**	**15,872**	**15,662**	**210**



Summary and Action

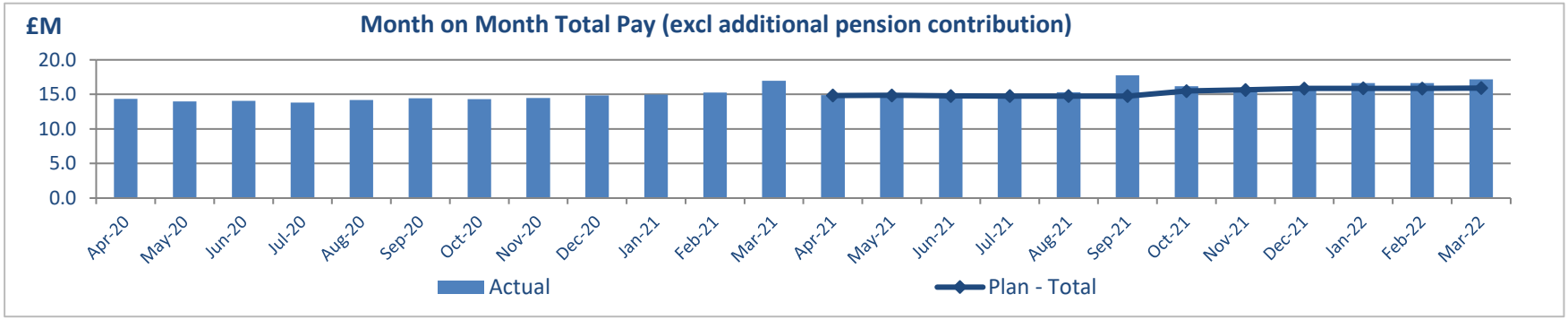
2021/22 capital allocations were made at a system level, and although the Trust's baseline allocation of £12.2m exceeds the initial 2019/20 allocation by c£3m, the Trust remains capital constrained based on an initial assessment of over £20m. The internal funding of a £12.2m capital plan was contingent on the Trust delivering a balanced revenue position in 2021/22, and a further £0.5m from the opening cash balance.

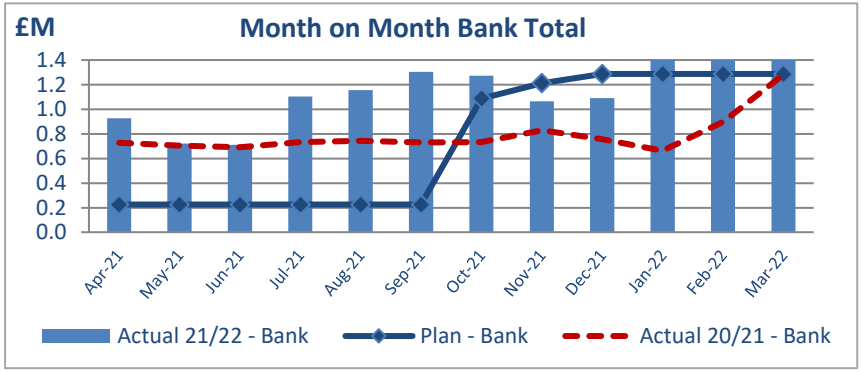
The relatively slow pace of capital expenditure during the year was reversed in month 12 and additional schemes funded by national PDC funding, including the Trust Investment Fund (TIF), were concluded. This includes the TIF Estates funds although there was a small underspend against TIF Technology funds. It was not possible to complete all schemes identified in the initial capital plan by the year end and the 22/23 capital plan allows for the slippage and completion of some of these schemes.

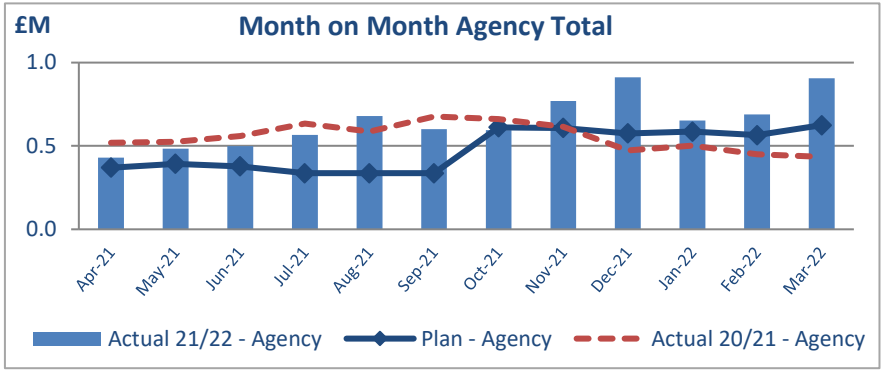
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

Pay costs were inflated by £7,460k in month to take account of the notional costs of DoH pension support. These costs were offset by notional income. Once this is accounted for, pay increased by £515k from month 11. Nursing and HCA costs fell, but these were more than offset by increases in other staff groups. Part of this relates to an increase in the year end provision for untaken annual leave £160k.

The Trust has welcomed a total of 75 overseas nurses during the course of the year.

The Trust reported 7.6 WTE infrastructure support staff (cost £46k in month) over planned levels relating to the vaccination centre at Salisbury City Hall, where the plan is for staffing to be provided by RUH, but any staffing provided by SFT is considered 'out of envelope' and directly reimbursed through NHSEI. In addition, the TUPE of 50 procurement staff from RUH to form a single BSW team has been actioned in year.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.2
Date of Meeting:	05 May 2022		

Report Title:	Ockenden 'one year on' Compliance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)				
Prepared by:	Joanne Hayward, Director Of Maternity And Neonatal Services			
Executive Sponsor (presenting):	Judy Dyos, Chief Nurse			
Appendices (list if applicable):				

Recommendation:
For the committee to provide assurance against recommendations on Ockenden part one, (December 2020)

Executive Summary:
The Ockenden report is an independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust. The initial preliminary findings were published in December 2020, where 7 immediate and essential actions were recommended. This template evidence our current compliance '1 year on 'with regards to this report. Work remains ongoing in the division to drive compliance recognizing that some of the essential actions have been superseded by the new publication. It must be noted that Ockenden part 2, has been published in March 2022.

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

Completion Guidance:

1.Overview tab – please complete in full
2.Ockenden return tab
3.Kirkup return tab – please note some recommendations have been greyed out – these do not require completion as they are superseded by information in the Ockenden recommendations. (There is a 4th tab which details the Kirkup recommendations as a helpful reminder – this doesn't require any completion)

Internal trust governance

	Confirmation of / or planned Public Trust Board update on progress against the Ockenden action plan	Date of Public Board update	Executive sign off of this return		
	Yes/No	please insert date	Date	Name	Role
Insert Trust Name					
Insert Trust Name					
Insert Trust Name					
Insert Trust Name					

LMNS sign off of the combined trust returns

LMNS Name	Executive sign off		
	Date	Name	Role
BSW			

SW Regional Ockenden /Kirkup Assurance Spring 2022

Salisbury NHS

TRUST NAME: Foundaton Trust

IEA	Question	Action	Evidence Required	
	Q1	Maternity Dashboard to LMS every 3 months	Dashboard to be shared as evidence.	
			Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	
			SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	
			Submission of minutes and organogram, that shows how this takes place.	
		Maternity Dashboard to LMS every 3 months Total		
	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Audit to demonstrate this takes place.	needs to be icluded in annual audit cycle
			Policy or SOP which is in place for involving external clinical specialists in reviews.	Trust policy and PMRT SOP in place

		External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total		**no audit**
IEA1	**Q3**	Maternity SI's to Trust Board & LMS every 3 months	Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	monitired through divisional and Trsut process
			Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	
			Submit SOP	
		Maternity SI's to Trust Board & LMS every 3 months Total		
	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	
			Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.	
		Using the National Perinatal Mortality Review Tool to review perinatal deaths Total		
	Q5	Submitting data to the Maternity Services Dataset to the required standard	Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	

	Q5	**Submitting data to the Maternity Services Dataset to the required standard Total**		**non compliant due to ?digital immatturity**
	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	
		Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total		
	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.	IPR slides
			LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	
			Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	LMNS
		Plan to implement the Perinatal Clinical Quality Surveillance Model Total		
IEA1 Total				
	Q11	Non-executive director who has oversight of maternity services	Evidence of how all voices are represented:	ivolvement at key divisonla meetings to include LMNS
			Evidence of link in to MVP; any other mechanisms	
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	CGC
			Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	walkarounds - now able since covid restrictins lifted - feedabck through maternity dsaefty champions
			Name of NED and date of appointment	Eiri Jones
			NED JD	yes

IEA2		**Non-executive director who has oversight of maternity services Total**		
	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	with MV/LMNS
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	birthing center; BAME summit;art in hospital ; individualised care planning
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	in progress
		Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total		
	Q14	Trust safety champions meeting bimonthly with Board level champions	Action log and actions taken.	
			Log of attendees and core membership.	
			Minutes of the meeting and minutes of the LMS meeting where this is discussed.	
			SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	
		Trust safety champions meeting bimonthly with Board level champions Total		

	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	feeedback from women to inlcude berevement shared and action planned alongside more general feedback - partners in attendence when covid- direct access to DOM
		Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services Total		
	Q16	Non-executive director support the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken	
			Name of ED and date of appointment	as in Q11
			Role descriptors	as in Q11
		Non-executive director support the Board maternity safety champion Total		
IEA2 Total				
		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	quarterly

	Q17		Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	in progress
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	
		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total		
	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	audit show 100% complince
			SOP created for consultant led ward rounds.	
		Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total		
	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Confirmation from Directors of Finance	
			Evidence from Budget statements.	
			Evidence of funding received and spent.	
			Evidence that additional external funding has been spent on funding including staff can attend training in work time.	
			MTP spend reports to LMS	

IEA3		**External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only Total**		
	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	trajectory in palce - not met complicne yet - predict June 22
			Attendance records - summarised	
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	
		90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total		
	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)	
		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total		

	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.	
		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place Total		
IEA3 Total				
	Q24	Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians	audit needs to be addess to annual cycle
			SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	clinical pathways in pace

IEA4		**Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total**		**no audit**
	Q25	Women with complex pregnancies must have a named consultant lead	Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	no audit
			SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	pathway in place
		Women with complex pregnancies must have a named consultant lead Total		**no audit**
	Q26	Complex pregnancies have early specialist involvement and management plans agreed	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	
			SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	pathway in place
		Complex pregnancies have early specialist involvement and management plans agreed Total		
		Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Audits for each element.	audits in place

	Q27		Guidelines with evidence for each pathway	SOP being apporved
			SOP's	
		Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total		**compliant with 3 - due to be complicnt June 22**
	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states women with complex pregnancies must have a named consultant lead.	
			Submission of an audit plan to regularly audit compliance	
		All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total		
	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Agreed pathways	
			Criteria for referrals to MMC	
			The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	
		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total		
IEA4 Total				

IEA5	**Q30**	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	How this is achieved within the organisation.	through audit , doucmentation does not support compliance , new documentation as been circulaet , plan to see marke inprovement over next 3 months - regarding risk assessent
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	PCP in place
			Review and discussed and documented intended place of birth at every visit.	as above
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	yes
			What is being risk assessed.	
		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total		
	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	yes
			Out with guidance pathway.	
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	
			SOP that includes review of intended place of birth.	yes
		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total		

	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	
			How this is achieved in the organisation	
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	
			Review and discussed and documented intended place of birth at every visit.	not at every visit
			SOP to describe risk assessment being undertaken at every contact.	
			What is being risk assessed.	
		A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total		
IEA5 Total				
		Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal	Copies of rotas / off duties to demonstrate they are given dedicated time.	

Q34	monitoring	Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	
		Incident investigations and reviews	
		Name of dedicated Lead Midwife and Lead Obstetrician	Tori Harper (RM) Hannah Rickard (O&G)
	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total		
Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Consolidating existing knowledge of monitoring fetal wellbeing	
		Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	
		Improving the practice & raising the profile of fetal wellbeing monitoring	
		Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	
		Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	
		Keeping abreast of developments in the field	
		Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	
		Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	

	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total		
Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Audits for each element	in place - no complicnt with 3 elements - expect complicne by June 22 with MIS submission
		Guidelines with evidence for each pathway	in place
		SOP's	in place
	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total		
Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	trajectory in place to be compliant by June 22
		Attendance records - summarised	
		Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	

		Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total		
IEA6 Total				
	Q39	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Information on maternal choice including choice for caesarean delivery.	
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	reviewing website
		Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total		
		Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.	
			CQC survey and associated action plans	

IEA7	**Q41**		SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.	
		Women must be enabled to participate equally in all decision-making processes Total		
	Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	
			SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	
		Women's choices following a shared and informed decision-making process must be respected Total		
	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	

		Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total		
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified	
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	with MVP
			Information on maternal choice including choice for caesarean delivery.	
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	
		Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total		
IEA7 Total				
	Q45	Demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	
			Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.	
			Most recent BR+ report and board minutes agreeing to fund.	

		Demonstrate an effective system of clinical workforce planning to the required standard Total		
	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	Most recent BR+ report and board minutes agreeing to fund.	
		Demonstrate an effective system of midwifery workforce planning to the required standard? Total		
	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	
		Director/Head of Midwifery is responsible and accountable to an executive director Total		
WF	**Q48**	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	Action plan where manifesto is not met	consideration of consultant midwife
			Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	

		Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: Total		
	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Audit to demonstrate all guidelines are in date.	
			Evidence of risk assessment where guidance is not implemented.	
			SOP in place for all guidelines with a demonstrable process for ongoing review.	
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total		
WF Total				

Kirkup report recommendations
SW Regional Update Spring 2022

Those that are greyed out are superseded by Ockenden and do not need completing on this tab.

Kirkup Action no.	Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information)	Action	Suggested documents that may support Trust assurance.
1	R1, R13, R24	Ensure that an open and honest approach is taken to any incident	Critical friend is allocated for every level 4/ 5 incident (SI's) Women and their families are kept informed of the progress of the Women and their families are invited to contribute to the investigation Offering an apology Ensure that all nurses and midwives are aware of their responsibilities in
2	R1, R13	Review the current processes for obtaining feedback from the public to increase the information received	Offering women and their families the opportunity to make suggestions Ensuring that national/ local awareness opportunities are utilised Continue to support the LSA in the feedback mechanism to staff from Share patient stories
3	R2	Review the current skills and drills programme across the directorate to ensure that a wide range of scenarios are included across all clinical settings, including bespoke skills drills for different clinical areas	Ensure a high quality training scheme is delivered
4		Foster a culture of shared learning between clinical departments that supports effective communication and practice development	Minutes of meetings showing MDT working
5	R2	Review the current preceptorship programme	Midwives/ Nurses are allocated a buddy in each clinical area and that this is supported by the clinical team. The buddy midwife is allocated time to support the preceptee Midwives are supported throughout the programme, progress is monitored and there is a clear plan developed for any midwife that is Midwives are confident and competent to go through the gateway within the agreed timeframe
6	R2	Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme	Utilise PMA feedback
7	R2, R3	Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce	Develop a robust support package for new band 6 midwives Completion of the Mentoring module Suturing competency IV therapy competency Care of women choosing epidural anaesthesia.
8		Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care	Practice educator reports and feedback
9	R2	Review the current induction programme for locum doctors	Locum policies
10		Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group.	
11	R2	Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session.	Practice educator meeting notes, discussion with DoMS/HoMs
12	R2	Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford	Practice educator reports and feedback
13	R2	Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition	Incident review and feedback, related lessons learnt, training opportunities
14	R2	Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, core huddles, NICU news	
15	R3	Review the current process for staff rotation to ensure that a competent workforce is maintained in all clinical areas.	
16	R2, R3, R4	Review and update the Education Strategy	
17	R3	Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations	
18	R3	Offer opportunities to other heads of service for staff from other trusts to broaden their experience by secondment or supernumerary status	
19	R5	Develop a list of current MDT meetings and events and share with staff across the directorate	
20	R8	Develop and implement a recruitment and retention strategy specifically for the obstetric directorate	
21		Review the current midwifery staffing establishment to ensure appropriate staffing levels in all clinical areas	
22		Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention	
23		Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns	
24	Only applicable to multi-site trusts.	Improve working relationships between the different sites located geographically apart but under the same organization.	
25	R9	Reiterate to all staff via email and team meetings the roles and responsibilities of the consultant obstetrician carrying the hot week bleep.	
26	R11, R12	Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported and the rationale for learning from incidents.	
27	R11, R12	Including a review of the processes for disseminating and learning from incidents	
28		Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively	All consultants to have completed RCA training Identified midwives to have completed RCA training Staff who have completed RCA training undertake an investigation within 1 Develop a local record of staff who have completed RCA training and the
29	R12	Ensure that the details regarding staff debriefing and support are completed on the Trust incident reporting system for all level 4 and 5 incidents	
30	R12	Ensure that all Serious Incidents (SI's)are fedback to the staff	
31	R12	Identify ways of improving attendance of midwives at SI's feedback sessions	
32	R13	Maternity Services Liaison Committee involvement in complaints	Collation of complaints reports
33	R14	Review the current obstetric clinical lead structure	
34	R15	Review past SI's and map common themes	Thematic reviews

35	**R23**	Ensure that maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths are reported, reviewed and an investigation undertaken where appropriate	Maternal deaths, stillbirths and early neonatal deaths reports
36	**R26**	Ensure that all staff are aware of how to raise concerns	Whistle blowing staff policy
37	**R31**	Provide evidence of how we deal with complaints	
38	**R31**	Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area	Identifying situations where local resolution is required
39	**R32**	Develop a plan to maintain a supervision system beyond the decommissioning of the LSAs once national recommendations have been agreed.	Implementation of the A-AQUIP model
40	**R38**	Ensure that all perinatal deaths are recorded appropriately	Sending the completed form to the Deputy Director of Nursing/ Head of Midwifery and the Divisional Clinical Effectiveness Manager
41	**R39**	Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained	MBRRACE action plan

Recommendations from the published Kirkup report

1	The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act. This should begin immediately with the response to this Report.
2	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review will be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere if applicable
3	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015.
4	Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation. This should be completed by September 2015.
5	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment. These measures should be identified by April 2015 and begun by June 2015.
6	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment. This should be completed by June 2015.
7	The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. This should be in place by September 2015.
8	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. Development of the strategy should be completed by January 2016.
9	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. This approach should be begun by September 2015.
10	The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as 'buddying' and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy. If a suitable partner is forthcoming, this arrangement should be begun by September 2015.
11	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy.
12	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016.
13	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee. This should be completed, and the improvements demonstrated at an open Board meeting, by December 2015.
14	The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015.
15	The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services. This work is already underway with the facilitation of Monitor, and we would not seek to vary or add to it, which would serve only to detract from implementation. We do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed.
16	As part of the governance systems work, we consider that the University Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. This should be completed by December 2015.
17 & 18	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017. 18. All of the previous recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care Quality Commission and Monitor. In the particular circumstances surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups.
Recommendations for the wider NHS	
19	In light of the evidence we have heard during the Investigation, we consider that the professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation. Action: the General Medical Council, the Nursing and Midwifery Council.
20	There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them. Action: NHS England, the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the National Institute for Health and Care Excellence.
21	The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments. Action: NHS England.
22	We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. Action: Health Education England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Midwives.
23	Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff. We recommend that this build on national work already begun on how such a process would work. Action: the Care Quality Commission, NHS England, the Department of Health.
24	We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. Action: the Care Quality Commission, NHS England.
25	We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts. Action: the Department of Health, the Care Quality Commission
26	We commend the introduction of a clear national policy on whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. Action: the Department of Health.
27	Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards. Action: the General Medical Council, the Nursing and Midwifery Council, the Professional Standards Authority for Health and Social Care.
28	Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts.
29	Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, all Trusts.
30	A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. Action: NHS England, the Care Quality Commission.
31	The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. Action: the Department of Health, NHS England, the Care Quality Commission, the Parliamentary and Health Service Ombudsman.
32	The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (*Midwifery regulation in the United Kingdom*) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the system. Action: the Department of Health, NHS England, the Nursing and Midwifery Council.
33	We considered carefully the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance by Monitor, given the close inter-relationship between Trust decisions in each area. However, we were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial implications. The close links, however, require a carefully coordinated approach, and we recommend that the organisations draw up a memorandum of understanding specifying roles, relationships and communication. Action: Monitor, the Care Quality Commission, the Department of Health.
34	The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave us cause for concern, in particular the breakdown in communication between the Care Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow-up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap. Action: the Care Quality Commission, the Parliamentary and Health Service Ombudsman.
35	The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear, and we are concerned that potential ambiguity persists. We recommend that NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. Action: the Care Quality Commission, NHS England, Monitor, the Department of Health.
36	The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. Whilst we do not absolve Trusts from responsibility for prioritising limited capability safely and effectively, we recommend that the Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. Action: the Department of Health.
37	Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. Action: the Department of Health.
38	Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. Action: NHS England.
39	There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. Action: the Department of Health.
40	Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. Action: the Department of Health
41	We were concerned by the ad hoc nature and variable quality of the numerous external reviews of services that were carried out at the University Hospitals of Morecambe Bay NHS Foundation Trust. We recommend that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. Action: the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives.
42	We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. Action: the Care Quality Commission, Monitor.

43	We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, *High Quality Care for All* , and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. Action: NHS England, the Department of Health.
44	This Investigation was hampered at the outset by the lack of an established framework covering such matters as access to documents, the duty of staff and former staff to cooperate, and the legal basis for handling evidence. These obstacles were overcome, but the need to do this from scratch each time an investigation of this format is set up is unnecessarily time-consuming. We believe that this is an effective investigation format that is capable of getting to the bottom of significant service and organisational problems without the need for a much more expensive, time-consuming and disruptive public inquiry. This being so, we believe that there is considerable merit in establishing a proper framework, if necessary statutory, on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	
Date of Meeting:	03 February 2022		

Report Title:	Board Assurance Framework (BAF) and Corporate Risk Register (CRR)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		x	x	
Approval Process (where has this paper been reviewed and approved)	N/A			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Integrated Governance			
Appendices (list if applicable):	Board Assurance Framework Revised v1 January 2022 (draft) Draft Corporate Risk Register January 2022 Draft Summary CRR revised tracker v2 January 2022			

Recommendation:

The Board are asked to review, discuss and make any updates to the following:

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

Specifically, the Board is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current and future risks.
- Review the principle risks and any associated gaps in control or assurance identified against the delivery of the 2021/2022 strategic priorities and review delivery of associated actions
- Review the content of the corporate risk register to ensure that it accurately reflects the corporate risks and related actions with particular attention to mitigating actions, risk score and residual risk score.

Executive Summary:

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

The BAF has been completely revised to align to the recently approved Trust Strategy and Strategic Objectives of Population, People and Partnerships. The format has been amended to

strengthen the presentation and alignment of corporate risks to the corporate priorities, making the link more explicit.

As part of the Improving Together Programme and revision of the Trust corporate priorities, the BAF will be amended to reflect any changes for 2022/23.

The Corporate Risk Tracker has been revised and risks aligned to the three Strategic Objectives.

For ease of reference, all completed actions within the CRR have been greyed out. All actions open and within date are highlighted in green. All overdue actions are highlighted in red. There are 2 overdue actions both with deadlines of 31/12/2021. These will be updated for the next report.

Summary Corporate Risk Profile

The updates to the BAF have identified a common theme within gaps in control and this relates to staff absence and the potential impact on delivery of the corporate objectives.

Following previous discussion at Clinical Governance Committee regarding the stroke service, the risks have been considered by the Chief Operating Officer and Chief Medical Officer and there is agreement that there are no current corporate risks to service delivery.

Risk 6247 relating to the estate requires an update and will be reported at the next update.

Extreme risks

- 5751 (Population) - Risk of patient harm caused by a delayed discharge from hospital (Score 15).
- 6247 (Population) - Risks associated with critical plant and building infrastructure that may result in utility or system failure (Score 16).
- 6961 (Population) - As a result of unclear governance arrangements regarding Health and safety, there is a risk that risks will not be identified and/or escalated appropriately resulting in insufficient risk mitigation which could lead to staff/patient harm (Score 16).
- 6471 (Partnerships) - Shortfall in funding available (locally and nationally) for capital programme, leading to potential risk to safety and availability of buildings and equipment to deliver services (Score 15).
- 5704 (Population) - Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce. The increase in risk score reflects the instability with the ID Medical contract delivery and likely service gaps over the Christmas and New Year period (Score 15).

Relevant new risks since November 2021

- Nil to note

Risks removed

- 6900 (Population) - As a result of a lack of capacity within the maternity leadership team there is a risk that quality improvements are not progressed with pace. This may result in failure to undertake the actions identified to improve service delivery as identified from external reviews (Score 16). This risk has been closed.
- 6942 (Population) - The Trust strategy is being replaced with a new strategy and until this is complete there is a risk that the Trust lacks coherence on its strategic priorities and direction. This risk has been closed.
- 6666 (Population) - As a result of low staffing levels within theatres there is a risk to

patient safety and provision of service which may result in cancelled/delayed surgery, staff fatique/stress, increase in staff sickness and poor skill mix. This risk has been de-escalated to the Divisional Risk Register.

- 6963 (Population) - Risk of a surge in paediatric respiratory viral infections as a result of Covid-19. This risk has been de-escalated to the Divisional Risk Register.
- 5487 (Partnerships) - The risk of a deteriorating financial position for a subsidiary company impacting on SFT cash flow and reputation. This risk has been closed.
- 6856 (Partnerships) - Due to Covid-19, the guidance for the 2021/22 planning round has not been released. There is a risk that the Trust will not deliver key objectives aligned to operational, activity and workforce plans. This risk has been closed.

Risks with an increased score

- 5704 (Population) - Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce. The increase in risk score reflects the instability with the ID Medical contract delivery and likely service gaps over the Christmas and New Year period. (Score 9 to 15).

Risks with a decreased score

- 7078 (People) - As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together Programme deadlines. (Score 12 to 9).
- 6855 (Partnerships) - The financial regime for 2021/22 is uncertain, Covid-19 has meant a delay to the planning guidance and suspension to the existing regime. This places significant uncertainty on the ability to develop a financial plan to support the Trust delivering its objectives for 2021/22. There is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency measures (Score 12 to 8).

Feedback from Board Committees

It was acknowledged that risks in relation to staffing needed to be worked through and overseen by the People and Culture Committee. Additional risks to be considered include:

- Capital Planning 2022/23
- Funding regime 2022/23
- Capital Programme Planning
- Delivery of NatSIPP and LocSIPP work

Deep Dive

The Board approved the criteria for the initiation of a deep dive of a risk on the corporate risk register in February 2020. The criteria is set out below:

- A corporate risk of 16 and above for a period of 6 months will initiate a deep dive
- A corporate risk score <16 unchanged for 12 months will initiate a deep dive
- An escalating risk score over a 3 month period will initiate a Board Committee discussion

3 risks currently meet the threshold for a deep dive:

Risk 5360 (Population): Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss has scored 10 since July 2020. This was presented to Finance and Performance Committee in September and the risk remains.

Risk 5751 (Population): Risk of patient harm caused by a delayed discharge from hospital. This risk has scored 15 since November 2020 and therefore triggers a deep dive to be presented to Finance and Performance Committee in February 2022.

Risk 6471 (Partnerships): Shortfall in funding available (locally and nationally) for capital programme, leading to potential risk to safety and availability of buildings and equipment to

deliver services. This has scored 15 since May 2020 and a deep dive was completed and a capital programme update including risks was presented to Finance and Performance Committee. The risk remains.

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

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BOARD ASSURANCE FRAMEWORK

Incorporating the revised Strategic Objectives 2021-2022

The Board Assurance Framework (BAF) has been revised and aligned to the new Trust Strategy and Strategic Objectives for 2022-2026.

Trust Vision

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

Trust Values

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

Strategic Objectives

Board Assurance Framework Glossary

Strategic priority	Executive Lead and Reporting Committee	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
What the organisation aims to deliver	Executive lead for the risk The assuring committee that has responsibility for reporting to the Board on the risk.	What management controls/ systems we have in place to assist in securing delivery of our objective	Where we gain independent evidence that our controls/ systems, on which we are placing reliance, are effective.	What evidence demonstrates we are reasonably managing our risks, and objectives are being delivered **Level 1 Internal Assurance** – Internally generated report or information which describes the effectiveness of the controls to manage the risk. For example – the Integrated Performance Report, self-assessments. **Level 2: semi-independent Assurance** For example – Non-Executive Director walk arounds, Internal Audits **Level 3 External Assurance** – Independent reports or information which describes the effectiveness of the controls to manage the risk. For example – External Audits, regulator inspection reports/reviews.	Where do we still need to put controls/ systems in place? Where do we still need to make them effective?	Where do we still need to gain evidence that our controls/ systems, on which we place reliance, are effective?

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

STRATEGIC PRIORITY: POPULATION

Improving the health and well-being of the population we serve

Strategic Risk	
Risk of insufficient capacity and capability to deliver the required cultural change to meet the needs of the local population	
Current controls	• Established performance monitoring and accountability framework • Engagement with commissioners and system (Elective and Urgent Care Boards) • Escalation processes in line with the Trust's OPEL status • Weekly Delivery Group meeting • Executive membership of Wiltshire Health and Care • Recruitment process for vacant posts • Executive engagement in all ICS workstreams • Improving Together Programme • Transformation, Innovation and Digital Board • Board Committees • BSW system capability workstream • Digital Strategy Implementation Plan • Shared Acute Alliance EPR Progamme Board
Positive Assurance	• Integrated performance report • Performance review meetings with CCG • Whole system reports (ICS) • Performance reports to weekly Delivery Group • Divisional performance reviews • Model Hospital Benchmarking • Acute Alliance reports • BSW system capability reports • BAF and CRR

CORPORATE OBJECTIVES 2021/22

Corporate Priority	Work Programme	Executive Lead
Recovery from Covid-19	Elective Recovery Programme	Chief Operating Officer
	QIA process to support decision making around increased activity and staffing models to support	Chief Nursing Officer
Improving our maternity services	Review of maternity services	Chief Nursing Officer
Improving our digital capability	ePMA, Pathology LIMS, shared EPR, SBS (ledger)	Chief Finance Officer

Gaps in control/assurance	Actions	Deadline	Lead
During the peak of the pandemic, system processes were not sufficient to support the required volume of patients to be discharged (GC)	Development of the 'No Right To Reside' Programme aligned with Improving Together Programme ***January 2022*** *– Entire system focus to reduce NRTR patients by 50%* ***April 2022*** *– No assurance on capacity being made available to meet demand. UEC Board have asked ICA Leads for mitigation plans by 08/04/2022*	~~31/12/2021~~ 30/06/2022	Chief Operating Officer
Significant numbers of 'No Right To Reside' patients (GA)			
	Delivery of the Good Discharge Framework	30/06/2022	Chief Operating Officer
	Executive contribution to BSW work programme	30/06/2022	Chief Operating Officer
Staffing and impact on escalation plan (GC)	**See action within 'People'**		
Maternity staffing to achieve Continuity of carer standard (GC)	Awaiting National guidance		

Linked Corporate Risk Register Risks to Population

Risk ID	Risk Title	Risk Score
6654	The impact on service delivery as a result of Covid and the subsequent infection control requirements impacting on the ability to recover activity to pre-Covid levels. Risk of delay to treatments, impact on quality of care and performance	20
5751	Risk of patient harm caused by a delayed discharge from hospital.	20
6570	Risk of Covid-19 outbreaks within the Trust either for staff and/or patients	20
6247	Risks associated with critical plant and building infrastructure that may result in utility or system failure	16
7206	Risk of Pharmacy Aseptic Unit closure due to a lack of adequately qualified staff impacting on provision of an aseptic service **(New risk)**	16
7283	Covid Testing and patient pathway management **(New Risk)**	12
5704	Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce	12
5970	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.	12
5972	Risk that improvement and transformation is not delivered in a timely manner	12
5360	Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss	10
6825	The scale of and demand for certain specialist or sub-specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service	10
6961	As a result of unclear governance arrangements regarding Health and safety, there is a risk that risks will not be identified and/or escalated appropriately resulting in insufficient risk mitigation which could lead to staff/patient harm. ***To be replaced with Risk 508: Risk of non-compliance with Health and Safety legislation***	9
6143	Risk to the ability of SFT to provide the same quality of service 24 hours a day, 7 days a week, with a potential impact to patient care. Difficulties in recruiting vacant posts, funding for new posts and restrictive medical contracts contribute to this risk.	9
5955	Insufficient organisation wide robust management control procedures	9
6836	There is a risk that the re-designation of the Neonatal Intensive Care Unit (NICU) will result in restricted access to neonatal intensive care for women in Wiltshire with the impact on quality and safety	5

STRATEGIC PRIORITY: PEOPLE

Supporting our people to make Salisbury NHS Foundation Trust the best place to work

Strategic Risk	
Insufficient resources (skilled staff and infrastructure) to deliver safe effective care	
Current controls	• Integrated Governance Framework • Accountability Framework • Clinical and HR policies and procedures • Workforce plan • Clinical Governance Committee • Clinical Management Board • People and Culture Committee • OD & People Management Board • Divisional Performance Meetings • Weekly patient safety summit • Contract Quality Review Meeting / contractual monitoring • Annual audit programme (national and local) • GIRFT Programme • Infection Prevention and Control Governance Framework and plan • Infection Control Board Assurance Framework • Safer Staffing Group • Health and safety Committee • Appraisal and revalidation of doctors • Improving Together Delivery Group and programme governance
Positive Assurance	• Internal reporting processes to Committees and Board • External reporting and benchmarking mechanisms • Internal audit programme • CQC inspection regime • Patient Surveys/Friends and Family Test/Real Time Feedback

	• Executive Board Safety Walks • Executive 'Back To The Floor' Programme • GIRFT reports and action plans • CQC engagement with specialist services • Ward performance reviews • Staff survey • Feedback and continuous improvement of Improving Together training

CORPORATE OBJECTIVES 2021/22

Corporate Priority	Work Programme	Executive Lead
Responding to staff health and wellbeing	Best Place to Work	Chief People Officer
	Improving Together Programme	Director of Improvement and Partnerships
	Staff health and wellbeing	Chief People Officer

Gaps in control/assurance	Actions	Deadline	Lead
Lack of strategy for EDI (GC) and Gaps in assurance from Internal Audit of EDI	Development of an EDI Strategy and associated implementation plan *January 2022 update: external support progressing deliverables. Board workshop held.* *Further session held in February 22* *April 2022 update: Still under development and consultation*	Review ~~31/12/2021~~ Review ~~31/03/2022~~ 30/06/2022	Chief People Officer
Lack of recruitment and retention plan	Development of a recruitment and retention plan *January 2022 update: process review complete. Looked at approach to recruitment and improving efficiency of the process and multiple access to sources to improve staffing*	Review ~~31/12/2021~~ 31/03/2022	Chief People Officer

	April 2022 update: Immediate recruitment plan in place and WCP. Close action. Action revised below		
Staff absence impacting on corporate objective delivery (GC)	Daily staffing meetings. Covid staff risk assessments Staff vaccination programme All actions on-going.		All
	Design a Health and Wellbeing Strategy *April 2022 update: progressing with external support*	~~31/03/2022~~ 31/07/2022	Chief People Officer (external support)
Lack of Culture and Leadership Strategy in response to the cultural diagnostic (GC)	Development of strategy *April 2022 update: In hand*	~~31/03/2022~~ 30/06/2022	Associate Director of OD & Learning
Lack of strategic workforce plan	To develop a strategic workforce plan	31/10/2022	Chief People Officer Chief Finance Officer Chief Nursing Officer

Linked Corporate Risk Register Risks to People

Risk ID	Risk Description	Risk Score
6834	As a result of Covid-19 pandemic there is a significant risk that a large proportion of the workforce could suffer from significant mental and physical wellbeing consequences. This may result in a large number of staff resignations and retirements as well as increased staff absence due to sick leave	20
7276	Risk to Occupational Health Service provision **(New Risk)**	16
7081	As a result of vacant roles which are defined as hard to recruit to posts there is a risk that there becomes a reliance on covering the vacancy with costly Agency/Locums and/or outsourcing and/or discontinue services. Risk of impact on services.	10
7078	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together Programme deadlines	9
6954	As a result of the national pay award for nurses not being accepted by the Royal College of Nursing, there is a risk of industrial action by members of the RCN. This could result in staffing shortages or staff working to rule	8

STRATEGIC PRIORITY: PARTNERSHIPS

Working through partnerships to transform and integrate our services

Strategic Risk	
Risk that the Trust will be unable to reach sustainability (income, cash, capital) and inability to shift the culture to meet priorities	
Current controls	• Finance and Performance Committee • Digital Steering Group • Accountability Framework – Directorate Performance Reviews • Contract monitoring systems • Contract performance meetings with commissioners • INNF Policy • Transformation Board • Capital control group • Budget setting process • Internal Audit Programme • Trust Investment Committee (TIG) • IT Improvement Plan • Digital Strategy Implementation Plan • Acute Alliance Programme Board • Local urgent and planned care boards
Positive Assurance	• Internal Performance reports to Trust Board • Audit Committee Reports • Internal Audit Reports • External Audit Reports • NHSI Benchmarking Report • Campus Joint Venture Agreement

CORPORATE OBJECTIVES 2021/22

Corporate Priority	Work Programme	Executive Lead
Improving patient flow	Frailty Integrated Pathway	Chief Medical Officer
	Discharge improvement programme, including therapy rehab model	Chief Operating Officer
	Integration of Urgent Care services	Chief Operating Officer

Gaps in control / Assurance	Action	Lead	Deadline
Evolving and maturing relationships with system partners could impact on the pace of developing an ICS	Active participation in Wiltshire Alliance to co-design ICS	Chief Finance Officer / Chief Medical Officer/ Chief Executive Officer	~~31/12/2021~~ 31/07/2022
National guidance evolving on ICS governance structures; therefore implications for BSW developing	~~Active participation of BSW key planning groups, including system architecture group.~~ *The above has progressed and the following action has now replaced:* Development of Acute Alliance to formal provider alliance	Chief Finance Officer	~~31/12/2021~~ 31/07/2022
Remain in a National Incident impeding strategic change (GC)	Trust responding to National Covid-19 guidance as required		
Lack of a finalised clinical and funding model for a single frailty service across all providers	To explore with the ICA the mechanism and appetite for doing this	Director of Improvement and Partnership	Review 30/06/2022

Linked Corporate Risk Register Risks to Partnerships

Risk ID	Risk Description	Risk Score
6471	Shortfall in funding available (locally and nationally) for capital programme, leading to potential risk to safety and availability of buildings and equipment to deliver services	15
7308	The financial plan for 2022/23 is a deficit plan with assumed 2.2% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Therefore, there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures. (New Risk)	15
6858	There is a risk as new guidance and models of working emerge, the immaturity of partnerships between the Trust and wider BSW organisations will impact on progress to achieve key objectives	9
6043	Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT.	8
6857	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn resulting in the Trust incurring financial losses	6

Corporate Risk Register
January 2022

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk
6836	Women and Newborn Division	Neonatal Unit	24/02/2021	Directorate risk assessment	12	There is a risk that the re-designation of the neonatal intensive care unit will result in families needing to receive intensive care (or any care when the baby is under a specific gestation) in Neonatal units across the region and not local to Salisbury or Wiltshire. This will have an impact on quality and safety for families.	Will undoubtedly recur, possibly frequently	None	5	SFT NICU Service designation strategy to be completed to ensure patient safety following re-designation.	26/02/2021	01/09/2021	Boyd, Hannah	Trust Board	01/07/2022	2	Care	Trust Board (Corporate Risk Register)	Medical Director	Kingston, Miss Abigail	24/02/2021
										Finance review of re-designation NICU. To include 3 scenarios. 27 week's, 32 week and 34 weeks gestation To include income related to births.	30/09/2021	28/09/2021	Boyd, Hannah								
										Review of impact to clinical Income to the organisation if redesignation process proceeds with the DoF.	21/01/2022	25/03/2022	Boyd, Hannah								
6857	Finance and Procurement	Trustwide	12/03/2021	Financial management	6	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn meaning the Trust incurs financial losses.	May recur occasionally	Minor	6	continue programme of fraud awareness and prevention with Counter Fraud team	31/03/2022	13/04/2022	Thomas, Lisa	Departmental Team meeting	29/04/2022	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	12/03/2021
6954	Trustwide	Trustwide	22/06/2021	Union Activity	8	As a result of the National Pay Award for nurses not being accepted by the Royal College of Nursing, there is a risk of industrial action by members of the RCN. This could result in staffing shortages or staff working to rule.	Do not expect it to happen again but it is possible	Major	8	Active monitoring of National Outcomes.	01/10/2021	13/12/2021	Dyos, Judy	Trust Board	31/07/2022	4	People (Care)	Trust Board (Corporate Risk Register)	Director of Nursing	Dyos, Judy	22/06/2021
										Active monitoring of National outcomes.	**31/07/2022**		Dyos, Judy								
6043	Finance and Procurement	Trustwide	25/10/2019	Trusts Objectives	12	The lack of a national clear model for small rural DGH services places future strategic planning uncertain at SFT. The funding regime and clinical models of care as advocated by royal college guidelines are built around average Trusts. SFT is more geographically challenged and smaller than an average DGH which in turn places its future as an independent Trust at risk which could limit and damage service provision to the local population.	Will probably recur, but is not a persistent issue	Minor	8	once the guidance is published with regards to the new Consultation on integrated care and provider collaboration, develop action plan accordingly	30/09/2021	12/10/2021	Thomas, Lisa	Trust Board	31/03/2022	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	25/10/2019
										in line with 2022/23 planning guidance ascertain financial gap and subsequent transformation plan for SFT and BSW	**31/05/2022**		Thomas, Lisa								
										Reinstate the weekend working Task and Finish Group.	31/03/2021	24/02/2021	Collins, Peter								

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6143	Quality Directorate	Trustwide	20/12/2019	Trustwide risk assessment	16	Risk that inadequate medical staffing in the organisation (due to insufficient budgeted workforce and/or failure to recruit and retain staff) will impact on the ability of the Trust to maintain safe and effective services across 7 days.	May recur occasionally	Moderate	9	The work reviewing the weekend working arrangements to be carried out as part of the Medical Division workforce review and overseen by new Medical workforce group.	31/05/2022		Henderson, Dr Stuart	Trust Board	31/05/2022	6	Care	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	02/01/2020
										Physicians Associates training programme to be commenced.	01/09/2021	31/08/2021	Murray, Dr Duncan								
										Medical e-roster business case to be refreshed by Medical Director and reconsidered by TIG and TMC.	29/10/2021	20/12/2021	Collins, Peter								
										Medical Workforce recruitment and retention strategy to be developed through Medical Workforce Group.	30/09/2022		Collins, Peter								
										Reviewing Trust wide risk training, aiming to roll out programme to all middle managers	31/03/2020	17/06/2020	Thomas, Lisa								
										Process mapping underway for business critical controls	31/12/2019	16/12/2019	Thomas, Lisa								
										Trust identifying additional procurement training for those areas of non compliance across the organisation. New process targeting individuals starts in November 2019.	29/03/2020	17/06/2020	Willoughby, Kelly								
										Trust developed draft risk training specification for additional support for directorates- view to tender and award before December 2019.	31/12/2020	07/01/2021	Thomas, Lisa								
										Introduce a monthly informatics department management committee that feeds into monthly executive performance reviews	31/10/2019	18/10/2019	Burwell, Jonathan								

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5955	Finance and Procurement	Trustwide	13/08/2019	Trustwide risk assessment	15	Insufficiently robust management control procedures across the organisation which pose a financial, reputational, legal and operational/clinical risk.	May recur occasionally	Moderate	9	Approval of IT General Controls plan at Informatics DMC and ratify at exec performance review	31/01/2020	02/03/2020	Scott, Andy	Trust Board	30/06/2022	9	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	13/08/2019
										Approach to testing of backups agreed	20/03/2020	02/03/2020	Cowling, Andrew (Inactive User)								
										All IT system contracts reviewed with IAA and IAO confirmed and delivery of duties being monitored	31/12/2020	15/12/2020	Burwell, Jonathan								
										Full review of informatics standard operating procedures including putting in place monitoring processes	30/06/2022		Scott, Andy								
										Full implementation of IT general controls framework	31/12/2021	12/03/2021	Scott, Andy								
										Complete a stocktake of all IT operational infrastructure	31/01/2020	02/03/2020	Burwell, Jonathan								
										Implement a robust asset management system	30/10/2020	01/07/2020	Burwell, Jonathan								
										Implement a centralised rolling replacement programme for computers, laptops and iPads	01/04/2020	28/04/2020	Burwell, Jonathan								
										Complete review of IT security policies	30/10/2021	09/12/2021	Burwell, Jonathan								

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										Review of existing storage locations of Informatics SOPs to centralise and improve searchability though using modern software such as CITO or Sharepoint	31/08/2021	16/08/2021	Burwell, Jonathan								
7078	Transformation & IM&T	Trust Offices	12/10/2021	Trusts Objectives	12	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together work programme deadlines	May recur occasionally	Moderate	9	Use of existing PMB groups to address issues on A3 content	22/11/2021	14/01/2022	Cox, Emma	Executive Director Meeting	31/07/2022	6		People	Trust Board (Corporate Risk Register)	Director of Transformation	Provins, Esther	13/10/2021
										SRO leads to prioritise the work and engage with specific task and finish groups	30/11/2021	14/01/2022	Cox, Emma								
6858	Finance and Procurement	Trustwide	12/03/2021	Trusts Objectives	9	There is a risk as new guidance and models of working emerge the immaturity of partnerships between SFT and wider BSW organisations will impact on progress to achieve key objectives. With the delay to the ICS formal start date and a double running with CCG's this may delay progress in system transformation.	May recur occasionally	Moderate	9	Executive team participate in Place based leadership development within the ICS to help shape collaborative arrangements. workshop 13th July	31/08/2021	12/10/2021	Thomas, Lisa	Trust Board	31/03/2022	6		Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	12/03/2021
										Trust developing committee in common with Acute Alliance - progress towards provider collaborative in line with national guidance	31/12/2021	11/01/2022	Thomas, Lisa								
										Trust to work in partnership with new emerging leadership structure to develop transformation plans to meet national operating targets.	**29/07/2022**		Thomas, Lisa								
6825	Trustwide	Trustwide	11/02/2021	Service Delivery Plan, Specialty Risk assessment, Trusts Objectives	15	The scale of and demand for certain Specialist or Sub-Specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service.	Do not expect it to happen again but it is possible	Catastrophic	10	Oncology: Develop additional joint working and new posts.	31/10/2021	20/12/2021	Barrett, Mrs Jessica	Trust Board	30/06/2022	8		Specialist Services	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	11/02/2021
										Refresh of current clinical strategy to reflect response to the NHS long term plan, formation of the BSW ICS and strengthening of specialist service operational delivery networks(ODNs).	30/09/2021	20/12/2021	Collins, Peter								
										Working within BSW AHA to develop unified clinical strategy for small services (Peter /Kieran - review June 22 as longer piece of work)	**03/06/2022**		Collins, Peter								

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										Developing provider alliances to support shared services outwith BSW (review action in 6 months)	03/06/2022		Collins, Peter								
7081	Organisational Development and People	Trustwide	15/10/2021	Trustwide risk assessment	10	The Trust identifies vacant roles which are defined as hard to recruit (the post has been vacant for more than 6 months with an attempt to recruit on more that one occasion). This list is maintained and updated with input from the Divisions, Business Partners and Head of Resourcing on a monthly basis. Impact of not being able to recruit to roles identified as hard to recruit is that there becomes a reliance on covering the vacancy with costly Agency/Locums and/or outsourcing and/or discontinue services. Risk of impact on services.	Will undoubtedly recur, possibly frequently	Minor	10	To improve the Trust approach to candidate attraction and selection	30/04/2022		Holt, Sharon	Departmental Team meeting	31/05/2022	8	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	WILKIN	
										To increase the reach of vacancy promotion, number and calibre of candidates for each role	30/04/2022		Holt, Sharon								
										02/10/18 IT Technical group on 8/10/18 to discuss what Anti virus software should be purchased	10/10/2018	14/12/2018	Noble, Bob (Inactive User)								
										Technical Group made decision to extend current product. Quotes being obtained for 1, 2 and 3 year extension.	28/02/2019	20/02/2019	Noble, Bob (Inactive User)								
										Review of practicalities of getting ransomware with financial controller.	24/07/2019	09/09/2019	Burwell, Jonathan								
										Development of Cyber Essentials plus plan to support achievement of the standard by 2021	17/01/2020	03/02/2020	Carman, Mr Stephen								
										Review of options for SIEM automated logging and impact of this on resource	31/03/2020	28/04/2020	Carman, Mr Stephen								
										Business case to TMC for agreement of option, associated resources an risk management	18/03/2020	28/04/2020	Carman, Mr Stephen								

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5360	Transformation & IM&T	Information Technology	28/02/2018	Data Protection	15	Risk of a cyber or ransomware attack, resulting in the potential loss of IT systems, compromised patient care and financial loss.	Do not expect it to happen again but it is possible	Catastrophic	10	Windows 10 migration complete	31/03/2022	13/04/2022	Arnold, Jon	Information Governance Steering Group	21/06/2022	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	11/02/2020
										Cyber essentials plus accreditation achieved	30/06/2021	09/07/2021	Carman, Mr Stephen								
										Completion of outstanding penetration test actions prior to moving into cyber essentials plus plan	28/02/2020	17/03/2020	Burwell, Jonathan								
										Implementation of SIEM solution with regional leads	30/06/2020	10/07/2020	Carman, Mr Stephen								
										ATP to be installed on Servers	31/12/2020	08/01/2021	Gibson, Richard								
										External CORS review to be undertake to support progress review	31/01/2021	24/02/2021	Burwell, Jonathan								
										Test implementation of IT Health Assurance Dashboard	31/05/2021	09/07/2021	Burwell, Jonathan								
										Review of proposed actions outlined by NHSD cyber team and CORS assessment to develop a 2021/22 updated cyber plan.	30/07/2021	12/10/2021	Gibson, Richard								
										Implementation of offline backup storage	21/12/2021	12/01/2022	Gibson, Richard								

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										Completion of KPI report for Cyber	17/09/2021	12/10/2021	Badham, Gareth								
										Completion Log4j Critical CareCERT mitigations that are currently available.	30/04/2022		Gibson, Richard								
										Implement Privileged Access Management solution	30/06/2022		Gibson, Richard								
										Development of an IT improvement plan which includes staffing, communications, infrastructure, governance and any outstanding pen test/audit actions.	22/11/2019	11/12/2019	Provins, Esther								
										Set up monthly executive performance reviews.	30/09/2019	31/10/2019	Provins, Esther								
										Completion of internal audit action plans and penetration test action plans.	31/12/2019	02/03/2020	Burwell, Jonathan								
										To complete the review and proposal for improving our capacity to do business change.	30/06/2020	18/06/2020	Provins, Esther								
										Agree long term direction of the EPR and short/medium term investment.	15/07/2020	19/08/2020	Burwell, Jonathan								
										Develop, agree and implement a new range of informatics service standards	19/05/2020	19/06/2020	Burwell, Jonathan								

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5970	Transformation & IM&T	Trustwide	23/08/2019	Trusts Objectives	16	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.	May recur occasionally	Major	12	Conclude work to agree and commence implementation of a robust and fit for purpose service delivery model	29/03/2020	28/04/2020	Burwell, Jonathan	Finance and Performance Committee	22/05/2022	9	Innovation	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	23/08/2019
										Develop and implement a communications and engagement plan aligned to digital strategy	15/01/2020	02/03/2020	Burwell, Jonathan								
										Evolve current change management approach, ensuring it is comprehensive, clinically led	31/01/2020	02/03/2020	Burwell, Jonathan								
										Implement an Informatics team development programme	30/06/2020	01/08/2020	Burwell, Jonathan								
										Strengthen clinical leadership in informatics by reaffirming priorities for CCIOs and appointing to CNIO roles	31/03/2021	09/07/2021	Provins, Esther								
										Embed information analysts into directorate management teams	31/03/2021	09/07/2021	Burwell, Jonathan								
										Informatics staff to undertake relevant customer service training	30/09/2020	23/10/2020	Burwell, Jonathan								
										Work with BSW to agree a shared EPR approach.	30/11/2021	14/01/2022	Thomas, Lisa								
										Recruitment of Lead Information Business Partner	30/11/2020	08/01/2021	Burwell, Jonathan								

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										Consider further resource requirements to strengthen strategic Informatics leadership.	31/10/2021	09/07/2021	Provins, Esther								
										Recruitment of Joint Chief Digital Officer.	30/01/2022	14/01/2022	Thomas, Lisa								
										Development of FBC for Shared EPR	**30/11/2022**		Burwell, Jonathan								
										Communication and Engagement Plan to Clinical Governance Committee for assurance.	28/02/2022	25/03/2022	Burwell, Jonathan								
										Development of a new digital plan to replace current digital strategy	**30/05/2022**		Burwell, Jonathan								
										Further development of digital champions roles	**30/06/2022**		Burwell, Jonathan								
										Review of role and purpose of Innovation Committee; develop a clear approach for innovation	13/12/2019	21/02/2020	Provins, Esther								
										Introduce a Dragon's Den event to inspire, promote and reward innovation	30/07/2020	19/08/2020	Provins, Esther								
										Develop a comms and engagement plan to promote innovation, linked to QI and continuous improvement	31/12/2019	11/12/2019	Provins, Esther								

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5972	Transformation & IM&T	Trustwide	23/08/2019	Trusts Objectives	16	As a result of deeply rooted historic ways of working, resistance to change and the absence of a mature continuous improvement culture, there is a risk that improvement and transformation is not delivered in a timely manner. This may result in poor quality services, reputational damage, financial impact, ineffectiveness, an inability to attract and retain high quality staff and non-delivery of strategic and or corporate priorities.	Will probably recur, but is not a persistent issue	Moderate	12	Review effectiveness of Quality Improvement plan.	01/06/2020	19/08/2020	Provins, Esther	Trust Board	31/07/2022	6	Innovation (Resources)	Clinical Governance Committee, Trust Board (Corporate Risk Register), Workforce Committee	Director of Transformation	Provins, Esther	23/08/2019
										Implement Quality Improvement plan (see also risk 6138).	31/03/2021	22/06/2021	Provins, Esther								
										Finalising procurement of external support to develop a QI coach network.	31/10/2019	06/11/2019	Provins, Esther								
										Develop a business case and procurement approach for an OD/Trust transformation intervention jointly with GWH.	31/03/2021	20/04/2021	Provins, Esther								
										Strengthen capability and capacity of theatres operational staff; review benefits of this and whether it has mitigated the current risk	28/08/2020	03/09/2020	Hyett, Andy								
										Escalate discussions with system partners regarding levels of DToCs. *Action covered by Corporate Risk 5751. Please see risk 5751*	31/12/2019	04/03/2020	Hyett, Andy								
										Provide increased oversight of flow programme and links to Trust KPIs, in particular length of stay, as per GIRFT data pack received 10/12/19	28/08/2020	19/08/2020	Provins, Esther								
										Review workforce transformation programme progress for 19/20 and provide support to develop the programme for 20/21	31/01/2020	21/02/2020	Provins, Esther								
										Undertake a CIP assurance exercise for 19/20	11/01/2020	21/02/2020	Provins, Esther								

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										Delivery of Best Place to Work programme.	31/03/2021	22/06/2021	Lane, Lynn (Inactive User)								
										Delivery of phase 1 of NHS Improvement Cultural Leadership Programme.	31/07/2020	18/08/2020	Lane, Lynn (Inactive User)								
										Delivery of 20/21 Transformation Priorities.	31/03/2022	11/04/2022	Provins, Esther								
										Development of the Operational Excellence Workplan.	31/12/2021	11/01/2022	Wood, Paul								
										Implement a benefits realisation tracking approach to understand the impact of Improving Together	31/07/2022		Provins, Esther								
7283	Chief Executive	Trustwide	06/04/2022	COVID-19/Coronavirus	12	The Trust is implementing local variation to the National Covid testing guidance to improve patient flow and mitigate associated risks. Patients will be tested on admission or if symptomatic only. There is a risk that Covid positive patients will go undetected which may result in unidentified outbreaks and potentially patients with significant symptoms which require ICU admission.	Will probably recur, but is not a persistent issue	Moderate	12	Set up task and finish group to oversee implementation	29/04/2022		Dyos, Judy	Executive Director Meeting	31/05/2022	6	Population	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	06/04/2022
7308		Trustwide	19/04/2022	Trusts Objectives, Trustwide risk assessment	15	The financial plan for 2022/23 is a deficit plan with assumed 2.2% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Therefore there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures.	Will undoubtedly recur, possibly frequently	Moderate	15					Finance and Performance Committee	31/05/2022	12		Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	19/04/2022
							requently			Trust compliance is assessed on an add hoc basis by Health & Safety. Yearly corporate and self assessment audits are conducted in 2 clinical and 2 non-clinical areas. Compliance results are reported to the H&S Committee, the Workforce Committee and then onto the board.	01/10/2019	08/02/2021	Knight, Paul (Inactive User)	ittee				egister)	nt and People		

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508	Organisational Development and People	Trustwide	21/11/2002	Other assurance not listed	8	The absence of a comprehensive Health and Safety Management System for the Trust runs the risk that legislative requirements will not be embedded into the Trust standards to which departments are expected to work. Without those standards, we cannot expect the Trust be be compliant, so the consequences of non-compliance with health and safety law results in Staff and all persons on site at risk of harm and the Trust at risk of prosecution and claims.	Will undoubtedly recur, possibly f	Moderate	15	Reviewed the scope of the risk assessment and have not found any significant gaps in our provision of health & safety instruction, training and baseline support.	20/05/2022		Knight, Paul (Inactive User)	Executive Workforce Comm	06/05/2022	3	People	Trust Board (Corporate Risk Re	Director of Organisational Developme	Adams, Peter	06/04/2022
										Ongoing recruitment drive.	30/09/2019	25/04/2019	Clarke, Lisa								
										Continual clinical prioritisation to ensure that high risk areas are covered.	01/04/2019	17/04/2019	Clarke, Lisa								
										Continuing insourcing of private provider to endoscopy.	30/06/2019	25/04/2019	Vandyken, Mrs Ali								
										Quantification and mitigation of the risk to bowel scope.	01/04/2019	17/04/2019	Vandyken, Mrs Ali								
										Tender for elements of the Gastroenterology service.	01/04/2019	17/04/2019	Stagg, Andrew								
										Monthly update to F&P Committee and CGC.	10/05/2019	25/04/2019	Hyett, Andy								

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5704	Surgery	Trustwide	31/01/2019	Directorate risk assessment	16	A risk that the current lack of substantive Gastroenterology medical and nursing workforce will impact on the ability of the service to deliver sustainable comprehensive safe and effective care to patients.	Will undoubtedly recur, possibly frequently	Moderate	15	Presentation of gastro strategy to Finance and Performance Committee.	31/05/2019	12/06/2019	Hyett, Andy	Intensive Support Meeting	31/05/2022	8	Local Services (Care, People)	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	31/01/2019
										Put together a workshop with CDs and Clinical Leads to discuss options for service provision.	01/10/2019	22/10/2019	Hyett, Andy								
										Continue conversations and meetings with alternative NHS providers for likely future joint partnership for delivery of service	30/09/2019	29/08/2019	Henderson, Dr Stuart								
										Medical Director to link with other STP partners around system wide solution.	31/12/2019	21/02/2020	Blanshard, Dr Christine (Inactive User)								
										Case for change to develop a GI unit to be completed	31/12/2019	04/03/2020	Hyett, Andy								
										New GI unit to be launched on 1st April	01/04/2020	07/05/2020	Hyett, Andy								
										To recruit medical and nursing staff for the GI Unit.	31/05/2022		East, Rachael								
										Confirm Southampton will be able to take over full responsibility for the GI Bleed out of hours service.	23/04/2021	23/04/2021	Branagan, Mr Graham								
										Secure support for existing junior doctors	30/07/2021	31/08/2021	Branagan, Mr Graham								

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										Ongoing regular review of workforce strategy in GI unit	01/12/2021	20/12/2021	East, Rachael								
										Recruitment to Nutrition Service Vacancy required.	31/01/2022	28/03/2022	East, Rachael								
6471	Finance and Procurement	Trustwide	24/05/2020	Financial management	15	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Will undoubtedly recur, possibly frequently	Moderate	15	Raise issue of capital funding for strategic replacement of key estate with regional director of FInance	31/07/2020	26/08/2020	Thomas, Lisa	Trust Board	31/05/2022	8	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Thomas, Lisa	26/05/2020
										In response to critical infrastructure review need to prioritise capital spending plan for next 5 years to address concerns.	30/10/2020	11/05/2021	Robinson, Ian								
										Escalate risks to estate through NHSI capital funding route, with a view to source funding for replacement day surgery as a minimum	31/12/2020	11/05/2021	Thomas, Lisa								
										confirm capital programme estate priority for next year compared to funding availability	01/02/2021	11/05/2021	Thomas, Lisa								
										completion of six facet survey to support gaps for capital investment	31/03/2022	19/04/2022	Thomas, Lisa								
										submit emergency capital bid if NHSE guidance permits	30/06/2022		Thomas, Lisa								
										Prioritise capital programme for 2022/23 within system, signal to region below levels of capital funding and risk to population of BSW and particularly SFT.	31/03/2022	19/04/2022	Thomas, Lisa								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk
6570	Quality Directorate	Trustwide	15/07/2020	COVID-19/Coronavirus	12	As a result of the fact that the highly contagious Covid variant is still circulating within the community, there is a risk that an outbreak of COVID-19 could occur within the Trust either for staff and/or patients. This may result in patient and/or staff sickness and potential mortality.	Will undoubtedly recur, possibly frequently	Moderate	15	COVID positive cohort wards to have daily COVID-19 inspections on PWA, all other wards weekly to be implemented by HoN and Matrons.	29/01/2021	22/01/2021	Major, Denise	Infection Prevention and Control Committee	29/04/2022	6	Care	Trust Board (Corporate Risk Register)	Director of Nursing	Major, Denise	15/01/2021
										The IT support for data to support swabbing dates being more easily accessed.	16/06/2021	05/05/2021	Burwell, Jonathan								
										Outbreak review to be undertaken and SII to be completed.	30/09/2021	01/09/2021	Major, Denise								
										SJR of all patient that died of Covid to be undertaken and report completed.	30/09/2021	17/01/2022	Cornforth, Dr Belinda								
										Completion and approval of action cards to facilitate reduction in contact period of exposed patients and mixing of contacts	14/01/2022	13/01/2022	Major, Denise								
										Ongoing review at daily VBR of increasing and emerging potential transmission.	14/02/2022	14/02/2022	Major, Denise								
										The Estates Transformation Steering Group has been formed with an action plan detailed to mitigate these risks.	01/09/2020	18/08/2020	Lane, Lynn (Inactive User)								
										Work through action plan to address health and safety breaches identified in the Critical Plant Survey.	31/12/2020	30/10/2020	Frith, Gerry (Inactive User)								
										Completion of actions arising from the independent Estates review (Cammies Report). The delivery of these objectives are managed via the Estates Transformation Board.	31/12/2020	31/12/2020	Frith, Gerry (Inactive User)								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk
6247	Estates	Estates	10/03/2020	Directorate risk assessment	12	As a result of a comprehensive external review of the Estates function it has been identified that the Trust has significant risks associated with critical plant and building infrastructure, that may result in utility or system failure. Including: Water ingress leading to a loss of building use. Failure to maintain critical plant leading to failure of systems e.g. nurse call, ventilation, power, gas, water, lifts and pressure systems. Failure to ensure compliance with mandatory training, leading to an inability to maintain plant. Lack of appropriately trained staff to undertake preventative maintenance. In ability to complete mandatory returns or compliance checks/reporting. Increased occurrence of sickness absence linked to workplace stress Failure to mitigate these risks may result in the loss of buildings and services/utilities, for clinical functions.	Will probably recur, but is not a persistent issue	Major	16	A plan for investment needs to be identified to address remaining concerns highlighted in the critical plant survey in July 2020.	30/11/2021	06/04/2022	O'Keeffe, John	Executive Director Meeting	31/05/2022	8	Resources	Trust Board (Corporate Risk Register)	Chief Operating Officer	O'Keeffe, John	16/03/2020
										As a result of the May 2020 review, a plan for investment to reduce the Trusts back log of maintenance is required.	30/11/2021	06/04/2022	O'Keeffe, John								
										Capital Prioritisation Group to prioritise funds for Estates.	01/04/2021	11/05/2021	Thomas, Lisa								
										BSW solution for Estates Management to be identified.	30/04/2021	11/05/2021	Thomas, Lisa								
										Plan to recruit to all vacant posts.	31/12/2021	06/04/2022	O'Keeffe, John								
										Consider options for 12 months outsourcing via contractors specifically for on-call services	29/10/2021	30/12/2021	Hyett, Andy								
										Restructure management team to ensure adequate resources are assigned to both operational and compliance issues. A review of the service has been carried out and a structure identified to allow this to take place. A business case needs to be submitted to IMT and then Trust Board.	**29/07/2022**		O'Keeffe, John								
										Training budget to be increased to allow competency training to take place and be renewed as required. This will allow competent people to be appointed into position and oversee NHS Mandatory tasks.	**31/05/2022**		O'Keeffe, John								
										Staff need to be trained and appointed into competent positions. A separate action has been raised for funding. This action is to plan and implement a training schedule over the next 12 months	**31/03/2023**		O'Keeffe, John								

Corporate Risk Register
January 2022

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk
7206	Clinical Support and Family Services	Pharmacy	02/02/2022	Departmental risk assessment	16	Due to a lack of adequately qualified staff (two key staff members are working their notice) the unit may have to close. This will result in an inability to manufacture chemotherapy and some trial medicines which our patients need.	Will probably recur, but is not a persistent issue	Major	16	Backfill from another Salisbury pharmacy staff member with a decrease in their ability to perform their actual role.	23/03/2022	14/04/2022	Raynes, Alastair	Departmental Team meeting	29/04/2022	4	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	Raynes, Alastair	06/04/2022
										Business case to put staffing on a sustainable footing	25/04/2022		Raynes, Alastair								
										Looking as sharing a post holder across the ICS	31/05/2022		Raynes, Alastair								
7276	Organisational Development and People	Occupational Health Department	30/03/2022	Specialty Risk assessment	16	As a result of resignations and retirements the Occupational Health service is operating with cc.7WTE against an establishment of 11.5WTE. This impacts on our ability to provide health monitoring and to deal with any increased demand for pre-employment or management referrals. This presents 2 threats: lack ability to understand the health impact of people working in high risk areas and; could delay recruitment and return to work following long term absence	Will probably recur, but is not a persistent issue	Major	16	Complete process maps for recruitment referrals and management referrals	29/04/2022		Holt, Sharon	Executive Workforce Committee	29/04/2022	10	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Lillis, Quentin	06/04/2022
										To recruit an interim Head of Occupational Health	31/05/2022		Lillis, Quentin								
										Recruitment to all vacant posts	30/06/2022		Lillis, Quentin								
										Review and extend formal contract with outsource provider.	30/04/2022		Lillis, Quentin								
						As a result of the Covid-19 pandemic there are Circa 750 members of the workforce who	requently			Review the implementation of the Health and Wellbeing Strategy.	31/12/2021	15/03/2022	WILKIN					gister)	nt and People		
										Review of current H&WB Strategy (commissioned external review)	31/05/2022		Whitfield, Melanie								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk
6834	Organisational Development and People	Trustwide	23/02/2021	COVID-19/Coronavirus, Human Resources	16	were originally assessed as being at greater than normal mental and physical wellbeing consequences. This is resulting in an increased percentage of staff absence and reduced staff availability. Circumstances are changing rapidly (as of April 2022) and the risk assessment criteria will need to change or be entirely removed. This poses a threat that the 139 employees in the most at risk category may face increased pressures to return to their previous work. We need to manage the necessary change in risk assessment and the communications carefully in order to avoid increased absence, potential disputes and or unfavourable PR	Will undoubtedly recur, possibly f	Major	20	H&WB group to re-start and to agree evaluation criteria of current wellbeing offers	31/05/2022		Jenkins, Kate	Trust Board	31/05/2022	9	People	Trust Board (Corporate Risk Re	Director of Organisational Developme	Lillis, Quentin	23/02/2021
										Pilot of formal H&WB conversation	30/06/2022		Lillis, Quentin							
										Recruitment of resource for OH team - approx 5wte	30/06/2022		Lillis, Quentin							
										Delivery of Phase 3 action plan.	31/01/2021	05/03/2021	Hyett, Andy							
										Short term pay incentives for Theatre staff.	01/11/2020	05/01/2021	Dyos, Judy							
										Managing Estates priorities and risk mitigation.	01/04/2021	29/04/2021	Hyett, Andy							
										Preparation of Recovery Plan for cancer breast tumour sites, diagnostics and patients waiting over a year.	30/06/2021	28/06/2021	Hyett, Andy							
										Recovery trajectories for all specialties to be completed by the end of May.	31/05/2021	28/06/2021	Hyett, Andy							
										Service recovery plans should include the non-statutory waiting times.	30/06/2021	28/06/2021	Hyett, Andy							

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk
6654	Operations Directorate	Trustwide	02/09/2020	COVID-19/Coronavirus, National guidance	15	The impact on service delivery as a result of Covid 19 and associated staffing shortages impacting on the ability of the Trust to recover activity to pre-Covid Levels. The consequence of not achieving this would be delay to treatments, impact to quality of care and impact on performance. Specific concern relates to echocardiogram waiting list, long waiting elective procedures and cancer diagnostics. (Risk merged with risk 6782).	Will undoubtedly recur, possibly frequently	Major	20	Increase outsourcing to external providers.	09/07/2021	08/10/2021	Hyett, Andy	Trust Board	30/06/2022	8	Local Services (Care, People)	Trust Board (Corporate Risk Register)	Chief Operating Officer	Hyett, Andy	02/09/2020
										Develop strategy for recruitment and retention of nursing workforce.	31/03/2022	06/04/2022	Holt, Sharon								
										Continue to increase insourcing.	30/07/2021	13/09/2021	Vandyken, Mrs Ali								
										Set up long line agency request to mitigate staffing gap.	30/07/2021	13/09/2021	Vandyken, Mrs Ali								
										Decrease IPC restrictions in line with Government guidelines and local prevalence	29/10/2021	13/12/2021	Dyos, Judy								
										Procure more theatre equipment to allow increased activity and flexibility	30/11/2021	30/12/2021	Cripps, Mandy								
										Align all data sources	30/11/2021	30/12/2021	Hyett, Andy								
										Organisation development team to work with theatres to develop improved culture within theatres	30/06/2022		Beazley, Nick								
										Development of a strategic workforce plan.	31/10/2022		Whitfield, Melanie								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk
										Winter director managing Trustwide ECIST actions.	01/05/2019	12/06/2019	Hyett, Andy								
										Winter Director coordinating trajectory for delivery of DTOC target.	01/05/2019	12/06/2019	Hyett, Andy								
										Trust actions being led by COO and Medicine CD and managed through weekly delivery meeting and monthly PMB.	01/05/2019	12/06/2019	Hyett, Andy								
										Weekly expert panel meeting to challenge discharge pathways chaired by CCG director of quality.	01/05/2019	12/06/2019	Hyett, Andy								
										Trust implementing discharge PTL	01/07/2019	04/09/2019	Hyett, Andy								
										Escalation to EDLDB non delivery of trajectory	01/07/2019	04/09/2019	Hyett, Andy								
										Mitigation actions being prepared to mitigate lack of capacity in the community.	01/08/2019	04/09/2019	Hyett, Andy								
										All providers required to present their winter plans to EDLDB in September.	30/09/2019	22/10/2019	Hyett, Andy								
										Business case to expand ESD service going to TMC in September and COO and DoF meeting Wiltshire Health and Care to align services	30/11/2019	10/12/2019	Hyett, Andy								

Corporate Risk Register
January 2022

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk
5751	Operations Directorate	Discharge Team	11/03/2019	Directorate risk assessment	16	Risk of patient harm caused by patients remaining in hospital when their clinical need does not require this (no right to reside). This risk is caused by lack of capacity within the community and delay in internal and external processes.	Will undoubtedly recur, possibly frequently	Major	20	CEO DOF and COO representing SFT at system wide winter summit on 25th October 2019.	31/10/2019	10/12/2019	Hyett, Andy	Trust Board	31/03/2022	12	Local Services (Care)	Trust Board (Corporate Risk Register)	Chief Operating Officer	Hyett, Andy	11/03/2019
										COO representing Trust at Regional Workshop w/b 9th December	14/12/2019	04/03/2020	Hyett, Andy								
										System wide actions to be monitored through the ED local delivery board.	01/04/2020	28/04/2020	Hyett, Andy								
										COO escalating the need for an ED LDB risk log reflecting the risks carried by each provider organisation.	19/12/2019	04/03/2020	Hyett, Andy								
										Risk to be captured on newly developed ED Local Delivery Board Risk Register.	31/03/2020	28/04/2020	Hyett, Andy								
										Action plan to be developed for 2021 by Urgent Care Board.	31/03/2021	04/05/2021	Hyett, Andy								
										Reinstate the challenge of stranded patients by the Medical Director by the end of October.	01/11/2020	20/10/2020	Hyett, Andy								
										Development of Transformation Programme for improved Discharge processes.	31/05/2021	28/06/2021	Hyett, Andy								

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence	Rating (current)	Actions	Action Due date	Action Done date	Action Lead	Source of Review	Review date	Rating (Target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk
										Agreement of system escalation triggers.	31/05/2021	28/06/2021	Hyett, Andy								
										Review of bed modelling in light of increased urgent and elective activity.	31/05/2021	30/06/2021	Humphrey, Kieran								
										Agreement of Improvement Trajectory with system partners.	30/07/2021	08/10/2021	Hyett, Andy								
										Delivery of the Transformation Improvement Plan.	30/11/2021	30/12/2021	Wood, Paul								
										Delivery of the BSW Urgent Care Board discharge improvement plan which the Trust is contributing to	**30/06/2022**		Hyett, Andy								

Corporate Risk Register Summary - January 2022 v2

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Mar-21	May-21	Jul-21	Sep-21	Jan-22	Apr-22	Target
Risk Detail				Score Trend							
POPULATION - Improving the health and wellbeing of the population we serve											
5704	Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce	Chief Medical Officer	31-Jan-19	16	9	15	15	9	15	12	6
5751	Risk of patient harm caused by a delayed discharge from hospital.	Chief Operating Officer	11-Mar-19	16	15	15	15	15	15	20	12
7206	Risk of Pharmacy Aseptic Unit closure due to a lack of adequately qualified staff impacting on provision of an aseptic service **(New risk)**	Chief Operating Officer	06-Apr-22	16						16	4
7283	Covid Testing and patient pathway management **(New Risk)**	Chief Medical Officer	06-Apr-22	12						12	6
6654	The impact on service delivery as a result of Covid and the subsequent infection control requirements impacting on the ability to recover activity to pre-Covid levels. Risk of delay to treatments, impact on quality of care and performance	Chief Operating Officer	02-Sep-20	15	15	12	16	12	12	20	8
6825	The scale of and demand for certain specialist or sub-specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service	Chief Medical Officer	11-Feb-21	**15**	10	10	10	10	10	10	8
5970	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.	Chief Finance Officer	23-Aug-19	16	16	16	16	12	12	12	9
6247	Risks associated with critical plant and building infrastructure that may result in utility or system failure	Chief Operating Officer	16-Mar-20	12	16	16	16	16	16	16	8

5360	Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss	Chief Finance Officer	11-Feb-20	15	10	10	10	10	10	10	6
5955	Insufficient organisation wide robust management control procedures	Chief Finance Officer	13-Aug-19	15	9	9	9	9	9	9	9
5972	Risk that improvement and transformation is not delivered in a timely manner	Director of Transformation	23-Aug-19	16	12	12	12	12	12	12	6
6143	Risk to the ability of SFT to provide the same quality of service 24 hours a day, 7 days a week, with a potential impact to patient care. Difficulties in recruiting vacant posts, funding for new posts and restrictive medical contracts contribute to this risk.	Chief Medical Officer	02-Jan-20	16	9	9	9	9	9	9	6
6570	Risk of Covid-19 outbreaks within the Trust either for staff and/or patients	Chief Nursing Officer	15-Jan-21	12	9	9	9	9	9	15	6
6961	As a result of unclear governance arrangements regarding Health and safety, there is a risk that risks will not be identified and/or escalated appropriately resulting in insufficient risk mitigation which could lead to staff/patient harm. *To be replaced with risk 508: Risk of non-compliance with Health and Safety legislation*	Chief People Officer	30-Jun-21	16			16	16	16	9	6
6836	There is a risk that the re-designation of the Neonatal Intensive Care Unit (NICU) will result in restricted access to neonatal intensive care for women in Wiltshire with the impact on quality and safety	Chief Medical Officer	24-Feb-21	12	12	12	12	4	5	5	2
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work											
7081	As a result of vacant roles which are defined as hard to recruit to posts there is a risk that there becomes a reliance on covering the vacancy with costly Agency/Locums and/or outsourcing and/or discontinue services. Risk of impact on services	Chief People Officer	15-Oct-21	10				10	10	10	8

7276	Risk to Occupational Health Service provision **(New Risk)**	Chief People Officer	06-Apr-22	16						16	10
6834	As a result of Covid-19 pandemic there is a significant risk that a large proportion of the workforce could suffer from significant mental and physical wellbeing consequences. This may result in a large number of staff resignations and retirements as well as increased staff absence due to sick leave	Chief People Officer	23-Feb-21	16	16	12	9	9	9	20	9
6954	As a result of the national pay award for nurses not being accepted by the Royal College of Nursing, there is a risk of industrial action by members of the RCN. This could result in staffing shortages or staff working to rule	Chief Nursing Officer	22-Jun-21	8			8	8	8	8	4
7078	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together Programme deadlines	Director of Transformation	13-Oct-21	12				12	9	9	6
PARTNERSHIPS - Working through partnerships to transform and integrate our services											
6857	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn resulting in the Trust incurring financial losses **Risk tolerated**	Chief Finance Officer	12-Mar-21	6	6	6	6	6	6	6	4
6858	There is a risk as new guidance and models of working emerge, the immaturity of partnerships between the Trust and wider BSW organisations will impact on progress to achieve key objectives	Chief Finance Officer	12-Mar-21	9	9	9	9	9	9	9	6
7308	The financial plan for 2022/23 is a deficit plan with assumed 2.2% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Therefore there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures. **(New Risk)**	Chief Finance Officer	12-Mar-21	15						15	12

6043	Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT.	Chief Finance Officer	25-Oct-19	12	12	8	8	8	8	8	6
6471	Shortfall in funding available (locally and nationally) for capital programme, leading to potential risk to safety and availability of buildings and equipment to deliver services	Chief Finance Officer	26-May-20	15	15	15	15	15	15	15	8

Risk Score Key

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.2
Date of Meeting:	05 May 2022		

Report Title:	Corporate priorities 21/22 Q4 update			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		x	
Approval Process (where has this paper been reviewed and approved)				
Prepared by:	Louise Drayton, Performance & Capacity Manager			
Executive Sponsor (presenting):	Lisa Thomas, Chief Finance Officer			
Appendices (list if applicable):				

Recommendation:
The Committee is asked to note the progress and Q4 updates against the 2021/22 corporate objectives agreed by Board

Executive Summary:

Corporate priorities for 21/22 were agreed as part of the annual business planning process. Five themes emerged which our priorities were framed around:

1. **Improving our patient flow**
2. **Recovery from Covid-19**
3. **Improving our maternity services**
4. **Responding to staff health & wellbeing**
5. **Improving our digital capability**

Corporate priority		**Executive lead**
Improving patient flow	Frailty Integrated pathway	Peter Collins
	Discharge improvement programme, including therapy rehab model	Andy Hyett
	Integration of Urgent care services	Andy Hyett
Recovery from Covid-19	Elective recovery programme	Andy Hyett
	QIA process to support decision making around increased activity and staffing models to support	Judy Dyos
Improving our maternity services	Review of maternity services	Judy Dyos
Responding to staff health and wellbeing	Best place to work	Melanie Whitfield
	Improving Together	Esther Provins
	Staff health and wellbeing	Melanie Whitfield

Improving our digital capability	ePMA, Pathology LIMS, shared EPR, SBS (ledger)	Lisa Thomas

The report details updates against these priorities with the exception of one – creating a QIA process around increased activity and staffing models. At the time of setting the objectives it was anticipated there may be new national guidance around staffing models to support the recovery from Covid-19. As yet this has not been received, and usual safeguarding processes are in place to manage decision making around staffing – we continue to use the ward based safe staffing RAG tool to identify areas of risk and this is reviewed daily by Matrons, Heads of Nursing at the Chief Nursing Officer team. To date there has been no new guidance received around changes to staffing models in response to the pandemic.

Progress

Progress against the priorities has varied; the prolonged pandemic and sustained periods of operational pressure have limited ability to progress some of the work identified. In particular, staffing pressures in relation to increased absence due to covid sickness and isolation, and vacancies is identified as a challenge or risk to achieving almost all of the priorities.

As we move in to 2022/23 some of the priorities remain a focus for the Trust and feature as Breakthrough objectives or vision metrics in the Improving Together programme.

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

Improving patient flow: Integrated Frailty Pathway

Exec Sponsor: Peter Collins

Frailty Improvement Key deliverables

OPAL Business Case:

OPAL business case for extended ('Twilight') hours and downstream in-reach approved by TMC in October 2019, but no current funding source.

To support pressure on flow and SDEC existing resources used to extend hours to cover twilight period (4-6pm), as a pilot until 23rd December. Data from the pilot which shows OPAL was able to successfully discharge the majority of patients home, thus avoiding admission to hospital.

OPAL is currently providing staff to cover the RCU and Durrington escalation wards and with sickness and vacancies is not in a position to cover twilight hours without further investment.

OPAL SDEC:

OPAL provides SDEC to frail patients in ED, SSEU and AMU, covering 56 hours per week which is short of the NHS long term plan recommended 70 hours per week for Frailty SDEC. Additional support to reach 70 hours identified in above business case – yet to have funding agreed.

OPAL ACP's:

OPAL has 2 trainee ACP's who are due to qualify in Spring 2023 and is developing a business case for their roles once qualified to enable them to work at an advanced level and to ensure their retention in the Trust. Business case due to reviewed at Apr 22 Trust Investment Group.

Key Highlights / Challenges

Integration with external partners:

OPAL (alongside Geriatrician colleagues) provides Frailty MDT virtual wards and GP Frailty MDT's across all our local PCN's, including recent expansion into providing MDT's to residential and nursing home patients alongside colleagues from Wiltshire Health and Care.

OPAL is developing a specific pathway for patients who present to ED with falls, which will integrate with Wiltshire Health and Care's rapid response service and other parts of the system. This and other pathways will be enhanced by the development of ACP roles within OPAL.

WAHSN will publish a Wessex Comprehensive Geriatric Assessment toolkit, which SFT frailty lead helped develop - promoting this across Wessex and more wider including nationally via the BGS, NHS Benchmarking and local ICS partners. The toolkit brings together lots of resources and best practice examples from the region and aims to help services and systems review and improve their integrated frailty pathways through CGA.

Key delivery challenges or risks

1. Lack of a finalised clinical and funding model for a single frailty service across all providers
2. Need for further transformation resource (from the Trust and or ICA) to aid development of a joint business case and further integration of current clinical teams

Ambitions for 2022/2023 - ACP led frailty SDEC supported by OPAL and Geriatricians. OPAL ED Falls attenders pathway fully functioning and showing positive results. Progress on a fully integrated frailty pathway across local systems.

OPAL twilight hours service to be fully operational 22/23.

Proposed Future Metrics

Number of patients seen by OPAL and number diverted/discharged from ED, Measurement of standards (main focus CRTP)
SDEC LOS 0 days: all very much aligned with previous slides

Improving patient flow: Discharge improvement

Exec sponsor: Andy Hyett

Patient Flow Key deliverables

- Case for change and infographic to support the engagement of staff with the Trust wide improvement programme complete
- Criteria led Discharge put on hold until Q1 due to significant staffing challenges across all ward areas.
- Slow increase in number of staff trained on the electronic whiteboard system and improve data entry across all wards. Plan in Q1 to bring use of whiteboards into staff
- The procurement, transition and use of the electronic whiteboard system underway for 22/23.
- To introduce a continuous improvement approach on an initial four identified wards, resulting in a co-designed local project plan owned by the ward MDT
- Agree and implement the Programme metrics to measure and report progress

Key milestones completed Quarter 4.

- UEC & SDEC Programme metrics agreed at PMB, dashboard agreed and live.
- Project Plan updated with new UEC deliverables complete.
- Criteria to Reside sustainability review conducted, on-going.
- Case for Change completed; to be launched alongside Improving Together activities, now for Q1.
- Dedicated radiology slots for AMU – 2 protected CT slots. Aim to treat AMU patients with the priority as ED.
- eWhiteboards specification confirmed with Procurement. Version upgrade expected to be completed Mar-May 22. Group set up to lead on review of implementation.
- Ward level Continuous Improvement Plans drafted and presented to PMB
- Pilot using community ACP to admission avoid pre- front door. Q4 into Q1.
- Further pilot of PRU car (as in Q4) into Q1 and will evaluate with SWAST.

Key delivery challenges or risks experienced during Q4.

- Clinician capacity to engage with programme of work
- Operational staffing levels due to vacancies and sickness (significant covid sickness)
- Delays to project deliverables due to multifactorial operational pressures

Success measures	How measured	Baseline	Target	March actual
1. Discharges before 5pm (as a % of total discharges) excl. 0 LOS	Patient Flow Main Scorecard	70%	80%	66.78%
2. Weekend Discharges (as a % of total discharges)	Patient Flow Main Scorecard	19.84%	23 / 25%	18.17%
3. % of patients with No Criteria2Reside	Patient Flow Main Scorecard	7.3% (3m baseline)	8%	20.2% ↑
4. Number of patients with No Criteria2Reside	Patient Flow Main Scorecard	Baseline Period TBC	35	58 ↑
5. Total Bed Days where patient has No Criteria2Reside	Patient Flow Main Scorecard	Baseline Period TBC	250	1,979 ↑

Improving Patient Flow: Integration of Urgent Care services

Exec sponsor: Andy Hyett

ED Improvements Key deliverables

- Implement a Triage booth utilising iPads and NHS Direct and full connectivity to transfer data in order to stream patients to alternative care pathways
- Explore the development and Continuous Improvement for alternative streaming pathways on the SFT site or within the local system to include:
- Explore GP sessions supporting ED
- Explore enhanced WIC capacity and capabilities off site
- UTC on site combining current Minors and a Minor Illness capability
- Restoring OOH service to SFT site to allow streaming of patients more efficiently to this service
- Hot kids clinic on site or off site to decompress Paediatric demand on ED and DAU
- Review ED triage process. Explore alternative models (e.g. Luton and Dunstable) and engage staff and national experience to implement an efficient system with reduced delays, better patient care and enhanced streaming
- Invest in the implementation and development of a RAT (Rapid Assessment and Treatment)model of care
- Continuous Improvement opportunities in 111 modelling and booked appointments
- Improved communication to public of alternatives
- Collect and analyse data to financially support and develop a staffing model to meet the new unscheduled care demand
- Explore and implement new staffing groups including Physician Assistants and Advanced Care Practitioners

Key Milestones / Delivery Challenges or Risks

Key milestones by Quarter 4

- RAT triage completed. Significant improvement in ambulance offload time, time to triage and first assessment. Data analyzed and business case in development to develop a specific RAT space and staffing model. Will incorporate ACP and senior clinicians.
- Complete Trust wide review of ACP/PA staffing model with nationally accepted banding
- Ongoing SDEC work with AMU/SAU/Surgical Specialties
- SDEC space identified. Next steps to open discussions with DMTs around identification of which services will occupy space
- Will need re-location of Oncology and other services currently utilising area
- GP sessions advertised but no applicants and represents the challenge for system around staffing Primary Care: decreasing GP workforce. Patient attendances predominately injuries and acutely unwell with minimal suitable for GP turnaround
- Concurrent advertising locally for Paediatric patients to contact WIC directly, pilot started Jan 2022. Evidence supports low numbers of Paediatric patients attending ED with minor illness when WIC open. Increase numbers seen 7/7 by WIC
- Staffing model developed for junior doctors and middle grade staffing. Awaiting ACP report to promote ACP development and training across ED and AMU. First PAs now working in Trust as students

Key delivery challenges or risks

- Triage booth/front door NHS Direct streaming – option dismissed as risked by lack of streaming options and demand on all parts of system: (RUH/GWH also placed this action on pause currently)
- Staffing resources currently failing to meet demand and future demand and new processes may prevent implementation
- Staff retention and burnout/Staff recruitment
- Physical space on site to accommodate OOH or UTC
- Inability to meet standards

UEC Metrics Update

Currently 4 hour target and aligned metrics around first assessment and ambulance offloads. Future (with current shadow reporting) new 10 metric standards. Metrics around patients diverted to alternative services, ED daily demand

Recovery from Covid-19: Elective Recovery Programme

Exec Sponsor: Andy Hyett

Programme Aims

Increasing capacity and productivity across all elective pathways to address the backlog of elective activity (admitted and non-admitted) and to meet national targets

Key Deliverables

- **In-Sourcing** – Use staff/teams model to meet required additional operating activity
- **Theatre Capacity** – Increase by addressing workforce shortfalls and maximising operating list utilisation
- **Outpatients** – Increase activity through maximising capacity and modernisation approach
- **Waiting Lists** – Reduce number of 52/78/104 week wait patients and manage overall (Note 78 not in H2 guidance)
- **Transformation** – Use GIRFT and Model Hospital gap analysis to inform pathway improvement plan

Key Highlights / Challenges

Highlights

Theatre recruitment has continued strongly, with overseas staff now firmly embedded across the theatres footprint.
Additional staffing has supported the opening of two more theatres.
Theatre business case submitted with 3yr development and staffing plan.
Head of Theatre Services Post now in post.
OPD activity levels remain strong throughout H2, but will face challenges in22/23 with regard required 25% reduction in F/up.
DM01 recovery has been strong up to March, however, multiple modalities facing significant staffing challenges.
All waiting list metrics were achieved for H2 at year end.
Total Waiting List size ahead of trajectory and target at year end, supported by an administrative review of the waiting lists.
Admitted waiting list size continues to decrease, with long waiting patients continuing steady improvement across both >52 and >78 week waits. The national target for elimination of >104ww was moved back to June 22. At year end there were 2 >104ww but will be cleared but the June 22 target date.
Improved System Wide working and relationship building at speciality level.

Challenges

Most significant challenge has and continues to be elective bed capacity and escalation into DSU, at the latter part of Qtr3 and throughout Qtr. 4. This has significantly impacted on the volume of elective activity that has been able to be undertaken, resulting from the consistently high numbers of no criteria to reside pats across the Trust's bed base..
Theatre productivity – although now starting to improve, daycase utilisation remains a challenge in light of the impact of escalation.
The Traction with GIRFT and HV/LC (see above)
Long term recruitment and development of Anaesthetic Practitioners
OPD Modernisation/Transformation –

- Virtual OPD Activity not keeping pace with increases in face to face and failing to meet 25% target
- PIFU, utilisation and adoption of PIFU was insufficient to achieve H2 target

Success Measures (Highlight)	How Measured	Target (Mar)	Actual (Mar)
1. **Elective Activity vs Pre-COVID (Plan vs Actual)** *Inpatient and Day Case*	Weekly reporting	95%	EL 55.24% DC 97.31%
2. **Outpatient Activity vs Pre-COVID (Plan vs Actual)** *New and Follow-Up*	Weekly reporting	95%	101.11%
3. **Utilisation of Sessions (DSU and MT)** *Including 10 minutes turnaround time*	Weekly reporting	90% (DSU) 85% (MT)	67% (DSU) Q4 ave 82% (MT) Q4 ave
4. **Diagnostic Activity vs Pre-COVID (Actual vs Actual)** *CT, MRI, Ultrasound, Endoscopy*	Weekly reporting	*95%*	91%
5. **Reduce Patients waiting > 52 weeks**	Monthly reporting	650	580

Improving our maternity services: Review of maternity services

Exec Sponsor: Judy Dyos

Overview

Training and development

- Mandatory study day recommenced 1St March 22
- Competency frameworks for band 3 to 8 are in development
- Growth Assessment Pathway compliance improved, obstetric compliance has reduced
- Introduction of CTG machine training – will report from March 22
- VBA compliance is steadily improving
- LMNS progress of MCA competency framework

Workforce

- Progression of the Digital Associate CNIO role
- Recruitment challenges continue within Midwifery workforce

Governance

- Updated Audit schedule to be presented to Maternity Governance December 2021
- Quality and Safety structure for the Maternity service agreed
- Plan to address backlog of guidelines awaiting upload to Microguide
- Executive Risk review deep dive completed January 2022

Quality

- Ockenden – full report expected Mar 22
- CQC engagement meeting March 2022
- Targeted focus on open Datix incidents

Key Highlights / Challenges

Highlights

- Recruitment remains a challenge however establishment from 1st April 2022 correct in line with Birthrate Plus and Ockenden funding.
- International recruitment launched – collaborative approach with Gloucester and GWH.
- Maternity services working with Theatres (following theatre review) and transformation team on QI project for WHO checklist. 7 day audit scheduled for 7.3.22
- Service developing pathway mapping as part of appraisal discussion – will be part of education dashboard in Q2 22/23
- PROMPT - significant increase in compliance for MW's and obs. Reduction for Anaesthetists. Trajectory in place to reach 90% by April
- Appointed Lead PMA retention Midwife Feb 22
- Requirements of CQC notice have been met – CQC engagement meeting March 2022
- Quality and Safety structure for maternity service agreed
- Priorities being identified through audit
- All perinatal deaths reviews undertaken

Challenges

- Continuity of carer paper submitted to region January 22, recruitment remains a challenge – unable to deliver at present
- Out to tender for the Digital external review work stream (notified no tender submissions Feb 22).
- Band 7 Quality Midwife unsuccessful recruitment
- Reduction in Junior clinical fellow recruitment (4 to 1). Long term plan for FY2's required

Proposed Future Metrics

Formal action plan in response to CQC must do and should do's

Responding to Staff Health and Wellbeing: Best place to work

Exec sponsor: Melanie Whitfield

Programme /Report aims & key deliverables

The Quarterly Report provides a thorough update on the courses that have been completed and the planned interventions scheduled for the next quarter. Key OD & Leadership Interventions (Further details & Stats in Report) have included:

- **Best Place to Work Programme – Compassionate & Inclusive Leadership Course B** 6-8: 2 Cohorts of 39 Staff Leaders completed their Course in February and we have launched a revitalised BPTW Compassionate & Inclusive Course for another x2 cohorts (36 People Leaders)
- **Coach to Lead**: A further 9 staff members attended our Coach to Lead programme to introduce coaching to their Leadership Skill set
- **Compassionate & Inclusive Culture (C&IC)**: 66 members of the trust have attended the course understanding the key requirements of building towards a C&IC. This course has now been retired to place a sustained focus on developing our wider OD offer (BPTW Modules, Leading your First Team & Imp Together Cultural Programme)
- **Leading and Managing your First Team**: 12 candidates from Facilities completed their 76 module programme in early March and evaluation is in process. Initial thoughts are that this will be revised to a shorter length programme for all new and appointed leaders in the Trust. In addition, a tool set of practical management capabilities (Appraisals, Interviewing, Performance Mgt)

Courses and Activities in plan include:

- **Clinical Leaders Programme**: In Partnership with BWS x8 Consultants from SFT are attending a 6 module course to support them in their development. Immediate feedback has been positive and we are intent on identifying the next cohort through JBF.
- **Coach House and wider OD Support for the Improving Together Programme**: a number of Action Learning Sets and bitesize modules have been delivered to support Coach House Team.
- **Improving Together Cultural Leadership Programme** is now being fully scoped to support in the first wards once they have completed the Front Line Training. Timelines are to coincide with completion of first phase of Front Line Training
- **Consultant Drs Programme (SFT)** is being scoped and developed for launch Mid/late 2022. This is to support consultants who have not received any Leadership or Mgt Training since joining the trust.

Key highlights / challenges

In the last 18 months

- Over **4097 Hours** of Personal Development has been delivered in the past 18 months
- Over **937 of these hours** have been supporting our staff to become better coaches and gain a fuller understanding of this core capability
- Over **3160 hours** have been in service of staff attending one of our Leadership development courses
- In total, over **360 of our staff** have benefited from attending this professional development

Themes Identified through ALL Programmes:

- Command & Control Leadership is the prevalent Leadership style experienced by most
- There are pockets of exceptional compassionate and inclusive leadership examples, but over the course of the last year this is reducing due to 'compassionate fatigue' and the need to 'just get stuff done'.
- Time is the biggest barrier for development and a general apathy has emerged on putting the learning into practice
- The time spent on courses is considered of huge value – the positive feedback and evaluation of BPTW – Compassionate & Inclusive Leadership Course, has been of great positive impact.

Development Principles of our Strategy

- The OD & Leadership strategy will be in service of delivering our Trust strategy and all requirements to enable the People Promise will be included.
- That in our focus on developing A3s we ensure that the metrics and countermeasure success factors align with our evaluation and measurement criteria
- As a trust we remain committed to our staff advocating that SFT is the best place to work and measurement, benefits and improvements in this theme will be at the heart of our work. This will include robust evaluation and evidence based activity for all OD interventions planned and delivered.
- We want Leadership to be associated to all staff and not just to role – *leading from every seat* – where compassionate and inclusive culture can thrive and we follow the Leadership Way.
- Central to our strategy will be the growing capability and value placed on coaching individuals and teams; unlocking the potential in our staff to thrive in their roles.
- Finally, it is vital that all OD & Leadership interactions can signpost and where appropriate enhance awareness, capability and understanding of the wider Health & Wellbeing offer, FTSU provision and EDI priorities and networks.

Responding to Staff Health and Wellbeing: Improving Together

Exec sponsor: Esther Provins

Programme aim:
To support the design, implementation, delivery and ongoing coaching of a new integrated organisational development and continuous improvement approach which underpins organisational and wider BSW strategy; including delivery of sustainable performance and high quality services alongside both incremental and transformational change.

Key progamme deliverables (year 1)
- To ensure the successful delivery of the improvement and cultural change initial development programme through to June 2022
- To deliver the targeted metrics and initial defined breakthrough objectives (associated with the time period) formulated in the development of the strategic priorities and supporting performance framework
- To establish an internal coach house team and deliver the initial tranche of coaching improvement programme on the targeted teams
- To implement the performance routines and approaches in the Trust governance structure at a Trust wide and Divisional management level

Key programme deliverables (Medium term)
- To ensure all teams in SFT receive relevant and appropriate training
- To embed Improving Together across all teams within SFT
- To embed a culture of continuous improvement across all areas of the Trust
- To ensure improvement processes and cultural change are embedded to deliver the specified medium term breakthrough objectives and supporting metrics

Key deliverables Quarter 2 (21/22)
- Complete KPMG Readiness assessment and roadmap – **Completed**
- Agree resourcing requirements, secure funding and recruit to SFT Coach House – **Completed**

Key milestones completed – Quarter 3 and 4 combined
- PMB re-purposed into a weekly Improving Together Delivery Group with workstream leads in attendance
- Improving Together comms and engagement manager in post
- Monthly workstream lead 1:1's continue to meet with KPMG
- Second three day boot camp completed, co-facilitated with KPMG and coach house colleagues
- Coach House team in post and training plan in place with KPMG and internal OD team
- Divisional management and front line training and coaching commenced
- A3 development for breakthrough objectives and strategic initiatives in progress
- Trust wide comms launched with visual identity approved and in use
- Revised IPR development in progress
- Approach for Exec review and prioritisation of corporate projects in progress, with 243 projects reviewed to date
- GWH/SFT/RUH scheduled monthly meetings continue to share and learn from our respective Trust roll-out.
- Leadership Development team in post and working closely and alongside Coach House team to develop bespoke offer for teams
- Governance and reporting structures reviewed and signed off
- Board and Exec development and coaching sessions continue with KPMG colleagues
- Divisional 'driver metrics' agreed with Execs

Points for escalation

There is a risk that current operational and severe staffing pressures are impacting on the training modules and completion as per the current timetable.

Completion of A3's for strategic initiatives have been impacted with a revised completion set for end of April 2022

Key delivery challenges/Emerging risks – Quarter 4

There is a risk that potential operational and severe staffing pressures may result in an inability to support the current planned training dates or a significant lack of attendance; resulting a delay to implementation or a lack of engagement.

Programme Metrics

1. A 20% improvement in staff engagement, experience and job satisfaction in all teams and services benefiting from the new approach.

2. Improved productivity and quality that leads to a step change in costs profile over a 4 year projection; consistently achieving higher performance and quality targets delivery in all teams and services benefiting from the new approach.

3. Increase pace and timely delivery of the Trust existing and future priorities

Responding to Staff Health and Wellbeing: Health & Wellbeing

Exec sponsor: Melanie Whitfield

Programme aims & key deliverables - To deliver high-quality patient care, our staff need to be healthy, well and at work.

- Leadership – making health and wellbeing everybody's responsibility.
- Prevention – integrating a positive culture and healthy behaviours to support staff in embedding prevention in our day-to-day business, and to promote positive health and wellbeing within the workplace.
- Interventions – delivering targeted interventions to address specific areas of need.
- Support – connecting and communicating our support for staff and managers.
- Data and metrics – using date and metrics to support health and wellbeing initiatives.

Key highlights / challenges

- Review and refresh the H&WB strategy capturing recommendations from the NHS People Plan
- To deliver immediate / ongoing interventions to promote staff health and wellbeing as part of the OD&P winter plan
- Support public health initiatives
- Support the post Covid recovery plan
- Listen to our staff feedback e.g., from national and local surveys to revise and refocus support
- Ensure our staff know what support services are available to them
- Provide ongoing covid support and guidance
- Leadership –champion staff networks in place for Race Equality, LGBTQ+, Women's, Disability and Mental Health First Aiders to support and champion positive change for staff.
- Prevention – continue to offer / refresh all staff a risk assessment in response of the pandemic. Implemented comprehensive safer working measures to protect staff from transmission of the virus.
- Training managers on psychological wellbeing

Success measures (tbc)	How measured	Baseline	Target	Actuals & Attainments
• Decreases in, and containment of sickness absence	• To develop metrics and reporting mechanisms to measure and inform decision making in relation to ill health and health improvement strategy • To introduce KPI's for access to physio and counselling services to help tackle our top causes of ill health. • Report to OD&P Management Board to monitor progress against strategy and ambitions.	KPI's agreed as : OH Intervention for employees who are 1. Off work – within 5 working days 2. At work with MH or MSK – within 10 working days 3. At work, not struggling/advice needed – within 6 weeks	Total Trust Absence level not to exceed 3% in a rolling 12 month average	**Red - Fell Short** • March 2022 – 5.22% • February 2022 – 5.37% • January 2022 – 5.46%
• Increase in participation in the staff survey particularly those scores relating to H&W	• Staff survey participation results • Each Divisional area are focussing on 3 areas to further engage with staff and to improve their working lives with the Trust.	54.2% (2020)	56% (2021)	Red - **Annual reporting** 49% participation – declined by 7 points YOY
• Reduction in the top 3 reasons for sickness absence - anxiety, stress and depression	• Reported through IPR reports. Use data to identify and if necessary target interventions/actions to improve attendance and support staff.	After Covid which has fluctuated greatly across the seasons, the main 3 causes of absences are: - 1. Mental health 2. MSK 3. Gastro	1% reduction in absence across the board by focussing on the top 3 reasons	**Red – Fell short Absence has risen over all** Days lost Reason / 20/21 / 21/22 / % / up/down Covid / 9945 / 10185 / 2% / Increased Mental Health / 11214 / 12167 / 8% / Increased MSK / 3122 / 4917 / 57% / Increased Gastro / 3838 / 3605 / -6% / Decreased Colds/Flu / 1544 / 3707 / 140% / Increased
• Data Management – EOPAS system improvement	• To track performance against workforce KPIs, H&W and Staff Survey action plans. • To identify and target areas with emerging trends in relation to work MSK and related stress	To work with Civica to achieve electronic KPI's in new OH system and to establish a new process to identify area hot spots to provide more targeted interventions	To evidence KPI measures and hotspots	We are measuring sickness through ESR data, - EOPAS is still not functional due to the need for investment.

Improving our digital capability: ePMA, Pathology LIMS, Shared EPR, SBS ledger

Exec sponsor: Naginder Dhanoa

Key deliverables

Electronic Prescribing and Medicines Administration (ePMA)
- Patient medication clerking including patient allergies and alerts through GP Connect
- Electronic prescribing of medicines:
  - Inpatient
  - Discharge, including discharge summary
- Clinical verification of prescribed medicines
- Technical validation of prescribed medicines
- Electronic medicines administration
- Ward stock control through the integration of Lorenzo EPMA dispense with Trust's Pharmacy Stock Control System (Wellsky - JAC)

Pathology Laboratory Information Management System (LIMS)
- To implement a shared enterprise wide pathology LIMS in conjunction with pathology network partners across 8 sites
- Enable connectivity to current systems including EPRs and Order Comms
- To agree the standardisation of test codes, ranges and processes

Shared EPR
- To oversee the successful approval of an outline business case including output based specification and full business case for a shared EPR across the three acute Trusts in the ICS
- To implement the agreed shared EPR, delivering benefits outlined in the Full Business Case
- To replace in house built applications with Shared EPR functionality

SBS (Ledger)
- Migrate to a modern and supported Oracle solution to include General Ledger, Accounts Payable, Accounts Receivables, Order Management, Cash Management, Oracle Purchasing and Business Intelligence
- Standardised process solution agreed and signed off

Key Milestones / Delivery Risks

Key Milestones completed – Quarter 4

ePMA
- Mar 2022 – Rephased project plan approved at programme board

Shared EPR
- Mar 2022 – Completed recruitment of Transformation and Benefits lead at SFT
- Mar 2022 – Commencement of Clinical Design Authority (CDA)

Pathology LIMS
- Mar 2022 – Agreement of high level SCP milestone plan with complete rephasing due to data migration challenges for 3/5 providers. SFT now last to go live by Sept 2023. This mitigates the risk of MSC hardware roll out delays also.

Key Milestones work in progress – Quarter 4

Shared EPR
- Scope of Shared EPR procurement reopened in Feb 2022, aiming to get this agreed in Apr 2022. Knock impact that the tender and potential detail OBS as they will need to be updated before the programme can go out to procurement.

Key milestones by Quarter 1 2022/23

ePMA
- Jun 2022 – Configuration, System Setup and user management

Shared EPR
- Apr 2022 – Agreement of 2022/23 resource plan for procurement and FBC activities
- May 2022 – Tender signed off by programme board and released to the market

Pathology LIMS
- Apr 2022 – Approval for local working practice change following LLD review (network practice alignment)

Emerging delivery risks

ePMA: Resource constraints and impact of Covid on go live timeframe. **Mitigation**: Project plan revised and reviewed at programme board with clinical ownership factoring in Lorenzo upgrade. Approach to training being reviewed including resourcing needs, digital champions/superusers to support roll out.

Pathology LIMS: Risk of resources being impacted by sickness and extension of programme. **Mitigation**: Trust internal funding in place for 2022/23 to cover costs. Network submission for national funding to support additional costs also.

Shared EPR: Staff engagement in programme given other pressures and procurement delays impacted on go live timeframes. **Mitigation:** Seeking decision on final elements required for procurement by end of April and CDA in place. Identification of staff to fill roles underway, dedicated comms support being sourced, timescales for treasury approval expecting to be much less mitigating current delay.

Success measures	How measured	Baseline	Target
1. Approval of Full Business Case (FBC)	FBC approved by Trust Boards	N/A	Oct 2022
2. Migrate ledger to Oracle	System in place	N/A	Sept 2021 - complete
3. Implement shared pathology LIMS	System in place	N/A	Sept 2023
4. Successful pilot of EPMA	System in place	N/A	Aug 2022

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	5.1
Date of Meeting:	05 May 2022		

Report Title:	Corporate Governance Statement Self-Certifications FT4, G6, CoS7 (Continuation of Services) and Training for Governors			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				✓
Approval Process (where has this paper been reviewed and approved)	Report to F&P 26th April for review and approval Report to Trust Board 5th May for approval Noted at Council of Governors 23rd May			
Prepared by:	Fiona McNeight, Director of Integrated Governance Kylie Nye, Head of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Integrated Governance			
Appendices (list if applicable):	Appendix 1 – Evidence to Support response Appendix 2 – Provider Licence Conditions			

Recommendation:

The Trust Board is asked to consider and approve the evidence aligned to each element of the provider licence conditions, which the Board is required to self-certify against, and confirm the response, noting the risks and mitigations.

Executive Summary:

NHS Foundation Trusts are required to self-certify on an annual basis, as to whether they have:

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

This paper provides the Board with assurance that the Trust fully meets the NHS Provider Licence conditions.

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

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

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Salisbury Hospital NHS Foundation Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates | 2021/22 | Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed	Please fill details in cell E22

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

1 - Confirmed- although the Trust is still subject to enforcement action where NHSI has found the Trust in breach of license conditions.

3b) The Trust's plan for 2022/23 is a planned deficit of c£18m, which includes a number of assumptions of improvements in operational efficiencies in year. There is a material risk given the current operational pressures and ongoing changes with Covid which mean there is a underlying risk to the cash position for 2022/23. The current cash position shows the Trust will not require financial support in year however this is being monitored closely. The Trust continues to identify all opportunities to reduce the projected deficit.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Nick Marsden	**Name**	Stacey Hunter
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Salisbury Hospital NHS Foundation Trust

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | **2021/22** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	**Risks:** Weaknesses in internal control identified through Internal Audit Programme for 2021/22 and regulatory enforcement. **Mitigating actions:** Systems and processes are regularly tested through internal and external audit programmes. There is a robust approach to risks management and revised governance arrangements to strengthen assurance reporting to the Board.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	**Risks:** Guidance is not identified or implemented in a timely manner. **Mitigating actions:** A central log of all communications is kept with weekly updates on correspondence received at the Executive Director's meeting.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	**Risks:** Revised governance structure is not fully embedded throughout organisation. **Mitigating actions:** Annual review of Board and Board Committee effectiveness and annual review of Board Committee Terms of Reference as part of the Integrated Governance Framework.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	**Risks:** The Trust's internal control systems are not sufficiently robust to ensure compliance with all requirements. **Mitigating actions**: The systems and processes are regularly tested through the internal and external audit programmes. There is a robust approach to risk management.	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	As per item 4.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	[including where the Board is able to respond 'Confirmed']	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name Nick Marsden **Name** Stacey Hunter

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A | Please Respond

Worksheet "Training of governors"

Financial Year to which self-certification relates 2021/22 Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Nick Marsden	**Name**	Stacey Hunter
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

‘		Proposed Response	Evidence	Risks	Mitigating Actions
	FT4 – Corporate Governance Statement				
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	• Well-led Framework CQC inspection rated Trust as ‘Good’ • Annual Governance Statement • Head of Internal Audit Opinion • Board Assurance Framework • Board Committee annual effectiveness evaluation • Annual review of corporate objectives • Annual Director declaration of interests and Fit and Proper Persons • Compliance with the Code of Governance • External audit of the annual report and accounts • Quality Account • Internal and External Audit Reports • Constitution review and updated March 2022. • Board development programme • Policy management process • Incident management structure during pandemic to ensure continued effectiveness of governance systems and processes during the National level 4 incident. • Board and Board Committee escalation reports • Governor observers on all Board and Board Committees • Contribution to ICS governance and risk management meetings	• Weaknesses in internal control identified through Internal Audit Programme for 2021/22 • Regulatory enforcement • Changing governance landscape aligned to the ICS	• The systems and processes are regularly tested through the internal and external audit programmes, and the robust approach to risk management • Revised governance arrangements to strengthen assurance reporting to Board • Contribution to ICS governance and risk management meetings
2	The Board has regard to such guidance on good corporate governance as may be issued by	Confirmed	• Central management of incoming national and local correspondence to	• Guidance is not identified or	• Central log of all communications

‘		Proposed Response	Evidence	Risks	Mitigating Actions
	NHS Improvement from time to time		ensure effective oversight of required action and deliverables.	implemented in a timely manner	• Weekly update on correspondence received at Executive meeting
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	• Integrated Governance Framework • Accountability Framework • Executive performance reviews • Divisional Governance Committees • Board and Committee annual effectiveness reviews • Scheme of Delegation and Standing Financial Instructions • Committee terms of reference annual review • Escalation reports from Board Committee Chairs to the Board • Annual review of Board and Committee work plans • Governor observers at all Board and Board Committees • Bi-weekly meetings with the Lead Governor and Chairman • Governance structure continually reviewed following a full review in March 2020. • Internal Audit reports	• Revised governance structure is not fully embedded across the organisation.	• Annual review of Board and Board Committee effectiveness • Annual review of Board and Board Committee terms of reference.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee’s duty to operate efficiently, economically and effectively;	Confirmed	• Monthly Integrated Performance Report to Board • Annual Operating Plan and budget • Standing Financial Instructions and Scheme of Delegation • Head of Internal Audit Opinion • Annual Governance Statement • Internal Audit Programme and reports	• The Trust’s internal control systems are not sufficiently robust to ensure compliance	• The systems and processes are regularly tested through the internal and external audit programmes, and the robust approach to risk management

‘		Proposed Response	Evidence	Risks	Mitigating Actions
	(b) For timely and effective scrutiny and oversight by the Board of the Licensee’s operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee’s ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and		• Continual review of the revised committee structure (following a full review in March 2020) and associated terms of reference • External audit of the annual report and accounts • Risk Management Strategy • Corporate and Divisional risk registers • Deep dive of Divisional Risk Registers with the Chief Nursing and Medical Officers • Board Assurance Framework • Risk based Board and Committee work plans • Subsidiary Governance Committee • Subsidiary Governance Framework • Annual planning process • Electronic Board administration solution • Board Committee escalation reports		

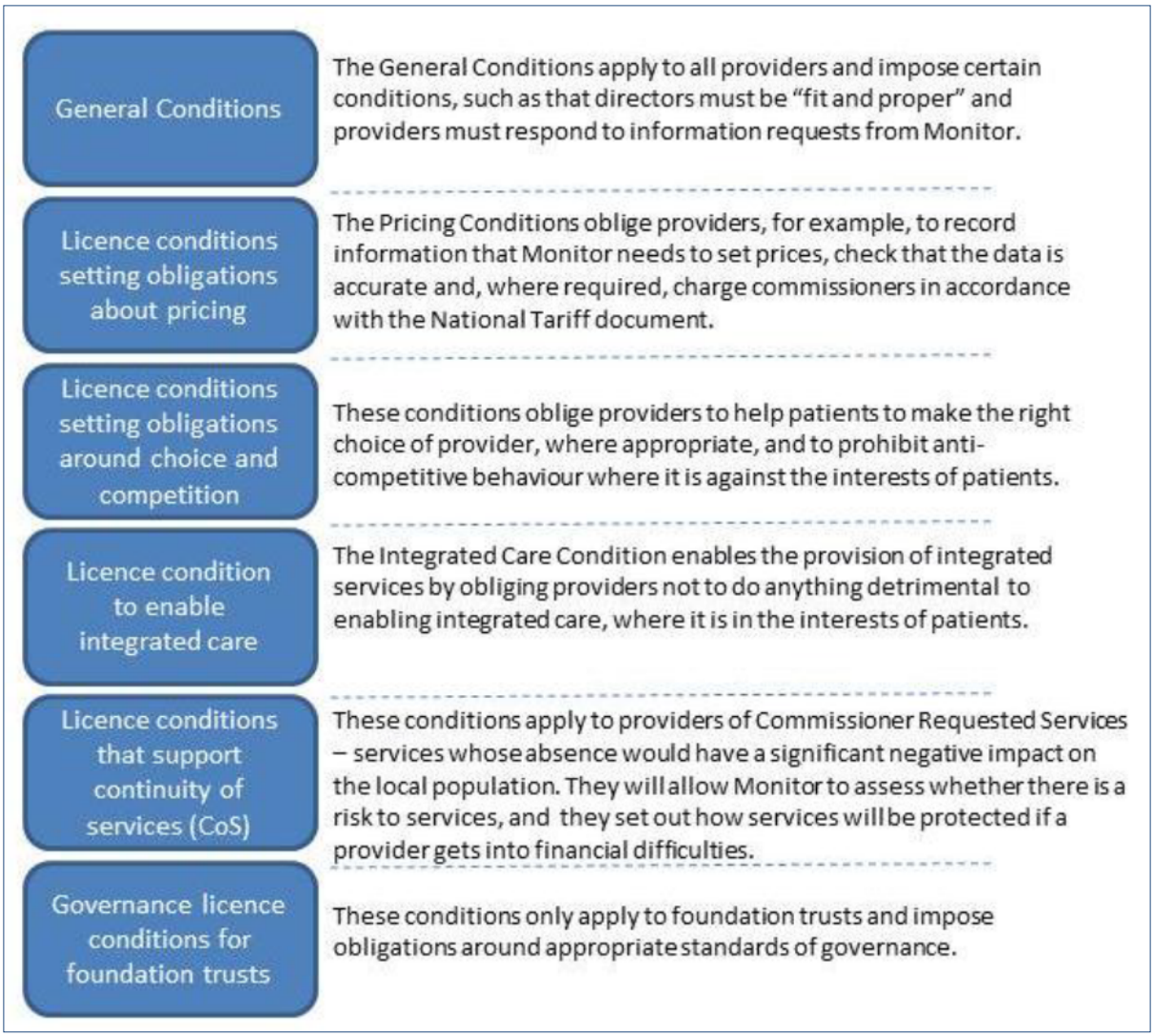
‘		Proposed Response	Evidence	Risks	Mitigating Actions
	(h) To ensure compliance with all applicable legal requirements.				
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board’s planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and	Confirmed	• Well-led Framework CQC inspection rated Trust as ‘Good’ • Board development programme • Executive Development Programme • Board effectiveness evaluation report • Monthly quality and performance reports • Executive annual appraisals • Integrated Governance Framework • Customer care reports to Board • Clinical Governance Committee (CGC) • Freedom to Speak Up Guardian and Guardian of Safe Working reports to CGC. • Board safety walks • Executive ‘Back to the Floor’ initiative • Active engagement with Commissioners, local Health Scrutiny, Health and Well-being Boards and Healthwatch • Patient and staff stories to each Public Board meeting.	• As above	• As above

‘		Proposed Response	Evidence	Risks	Mitigating Actions
	resolving quality issues including escalating them to the Board where appropriate.				
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	• Workforce report • Nurse skill mix review bi-annually • Revalidation and appraisal processes • Executive Performance Reviews • Board development programme with external facilitation • Externally facilitated Executive coaching • Annual Fit and Proper Person declaration process • Nursing workforce review/ Midwifery workforce review	• There is a risk of unforeseen workforce changes at Board and sub-Board level	• Recent substantive Executive appointments. • Governor observers for Board and Board Committees. • Recruitment process in place early to replace chief operating officer, non-executive director and chair roles in 2022/23.
General condition 6 – Systems for compliance with licence conditions					
1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed- although the Trust is still subject to enforcement action where NHSI has found the Trust in breach of license conditions.	• Internal Audit and clinical audit work programmes • Data Security and Protection Toolkit compliance • Fit and Proper Person requirements included in all Director appointments and annual declaration • Board Assurance Framework • Integrated Governance Framework • Accountability Framework • CQC Registration • Risk Management Strategy • Annual submission of reference costs • Annual reference cost assurance report • Signed contracts with Commissioners based on national tariffs	N/A	N/A

‘		Proposed Response	Evidence	Risks	Mitigating Actions
Continuity of Services condition 7 – Availability of Resources					
1	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		N/A	N/A	N/A
or	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed	The Trust’s plan for 2022/23 is a planned deficit of c£18m, which includes a number of assumptions of improvements in operational efficiencies in year. There is a material risk given the current operational pressures and ongoing changes with Covid which mean there is a underlying risk to the cash position for 2022/23. The current cash position shows the Trust will not require financial support in year however this is being monitored closely. The Trust continues to identify all opportunities to reduce the projected deficit.	N/A	N/A
Training of Governors					
	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act,	Confirmed	• Induction and mandatory training Programme • Governor development days • Governor observers on all Board and Board Committees • Informal Governor and NED meetings	N/A	N/A

‘		Proposed Response	Evidence	Risks	Mitigating Actions
	to ensure they are equipped with the skills and knowledge they need to undertake their role.		• Attendance at external training events • Governor self-assessment to review training requirements.		

Appendix 2: Provider Licence Conditions



Appendix 2: Provider Licence Conditions

General Conditions

General Conditions set out standard requirements and rules. These conditions apply to all licence holders. As well as being licence conditions, the 'fit and proper persons' test and the requirement to be registered with the CQC are also licensing criteria.

General Condition 1: Provision of information

This condition contains an obligation for all licensees to provide Monitor with any information we require for our licensing functions.

General Condition 2: Publication of information

This licence condition obliges licensees to publish such information as Monitor may require.

General Condition 3: Payment of fees to Monitor

The Act gives Monitor the ability to charge fees and this condition obliges licence holders to pay fees to Monitor if requested.

General Condition 4: Fit and proper persons

This licence condition prevents licensees from allowing unfit persons to become or continue as governors or directors (or those performing similar or equivalent functions). In exceptional circumstances and at Monitor's discretion we may issue a licence without the licensee having met this requirement.

General Condition 5: Monitor guidance

This licence condition requires licensees to have regard to any guidance that Monitor issues.

General Condition 6: Systems for compliance with licence conditions and related obligations

This licence condition requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements.

General Condition 7: Registration with the Care Quality Commission

This licence condition requires providers to be registered with the CQC (if required to do so by law) and to notify us if their registration is cancelled.

General Condition 8: Patient eligibility and selection criteria

This condition requires licence holders to set transparent eligibility and selection criteria for patients and to apply these in a transparent manner.

General Condition 9: Application of Section 5 (Continuity of Services)

This condition applies to all licence holders. It sets out the conditions under which a service will be designated as a Commissioner Requested Service. If a licensee provides any Commissioner Requested Services, all the Continuity of Services Conditions apply to the licence holder.

Pricing Conditions

In future, Monitor will be responsible, jointly with the NHS Commissioning Board, for the pricing of NHS services. Five licence conditions will help us fulfil this duty.

The Pricing Conditions will apply to all licensees providing services covered by the National Tariff document published by Monitor.

Pricing Condition 1: Recording of information

Under this licence condition, Monitor may oblige licensees to record information, particularly information about their costs, in line with guidance to be published by Monitor.

Pricing Condition 2: Provision of information

Having recorded the information in line with Pricing condition 1 above, licensees can then be required to submit this information to Monitor.

Pricing Condition 3: Assurance report on submissions to Monitor

When collecting information for price setting, it will be important that the information submitted is accurate. This condition allows Monitor to oblige licensees to submit an assurance report confirming that the information they have provided is accurate.

Pricing Condition 4: Compliance with the National Tariff

The Health and Social Care Act 2012 requires commissioners to pay providers a price which complies with, or is determined in accordance with, the National Tariff for NHS health care services. This licence condition imposes a similar obligation on licensees, i.e. the obligation to charge for NHS health care services in line with the National Tariff.

Pricing Condition 5: Constructive engagement concerning local tariff modifications

The Act allows for local modifications to prices. This licence condition requires licence holders to engage constructively with commissioners, and to try to reach agreement locally, before applying to Monitor for a modification.

Choice and Competition Conditions

Our patient choice and competition licence conditions will allow us to protect and promote patient interests by supporting patient choice of provider and, where it is in the interests of patients, take action against anti-competitive behaviour.

These conditions apply to all licence holders.

Choice and Competition Condition 1: Patient choice

This condition protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. This condition applies wherever patients have a choice of provider under the NHS Constitution, or where a choice has been conferred locally by commissioners.

Choice and Competition Condition 2: Competition oversight

This condition prevents providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. It also prohibits licensees from engaging in other conduct which has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.

Integrated Care Condition

The Integrated Care Condition applies to all licence holders.

The Integrated Care Condition is a broadly defined prohibition: the licensee shall not do anything that could reasonably be regarded as detrimental to enabling integrated care.

It also includes a patient interest test. The patient interest test means that the obligations only apply to the extent that they are in the interests of people who use health care services.

Continuity of Services Condition

The Continuity of Services Conditions allow Monitor to protect and promote patients' interests by ensuring that vital services continue to operate if a provider becomes financially distressed or insolvent. The Continuity of Services Conditions are:

General Condition 9: Application of Section 5 (Continuity of Services)

This condition applies to all licensees. It sets out how services may be designated as Commissioner Requested Services. If a licensee provides Commissioner Requested Services, the Continuity of Services Conditions apply.

Continuity of Services Condition 1: Continuing provision of Commissioner Requested Services

This condition prevents licensees from ceasing to provide Commissioner Requested Services, or from changing the way in which they provide Commissioner Requested Services, without the agreement of relevant commissioners.

Continuity of Services Condition 2: Restriction on the disposal of assets

This licence condition ensures that licensees keep an up-to-date register of *relevant* assets used in the provision of Commissioner Requested Services. It also creates a requirement for licensees to obtain Monitor's consent before disposing of these assets when Monitor is concerned about the ability of the licensee to carry on as a going concern.

Continuity of Services Condition 3: Monitor risk rating

This condition requires licensees to have due regard to adequate standards of corporate governance and financial management.

Continuity of Services Condition 4: Undertaking from the ultimate controller

This condition requires licensees to put in place a legally enforceable agreement with their 'ultimate controller' to stop ultimate controllers from taking any action that would cause licensees to breach the licence conditions. This condition specifies who is considered to be an ultimate controller.

Continuity of Services Condition 5: Risk pool levy

This licence condition obliges licensees to contribute, if required, towards the funding of the "risk pool" - this is like an insurance mechanism to pay for vital services if a provider fails.

Continuity of Services Condition 6: Cooperation in the event of financial stress

This licence condition applies when a licensee fails a test of sound finances, and obliges the licensee to cooperate with Monitor in these circumstances.

Continuity of Services Condition 7: Availability of resources

This condition requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services.