Bundle Trust Board Public 9 September 2021

1	OPENING BUSINESS
1.1	10:00 - Presentation of SOX Certificates *SOX of the month - Sarah Hall, Spinal Centre* *Living our Values, Patient-Centred and Safe - COVID-19 Testing Team*
1.2	10:05 - Patient Story
1.3	Welcome and Apologies *Apologies received from -* *Rakhee Aggarwal and Peter Collins*
1.4	Declaration of Interests, Fit and Proper/Good Character
1.5	10:15 - Minutes of the previous meeting *Minutes attached from Public meeting held on 8th July 2021* *For approval* 1.5 Draft Public Board mins 8 July 2021.docx
1.6	10:20 - Matters Arising and Action Log 1.6 Public Trust Board action log.pdf
1.7	10:25 - Chairman's Business *Presented by Nick Marsden* *For information*
1.8	10:30 - Chief Executive Report *Presented by Stacey Hunter* *For information* 1.8 CEO Board Report August for September Board.docx
2	PEOPLE AND CULTURE
2.1	10:40 - Guardian of Safe Working *Presented by Juliet Barker* *For information* 2.1 Guardian of Safe Working Annual report 20.21 with cover sheet_ PLC amended.docx
2.2	Health and Safety Annual Report - deferred to November
3	ASSURANCE AND REPORTS OF COMMITTEES
3.1	10:50 - Clinical Governance Committee - 31 August *Presented by Eiri Jones* *For assurance* 3.1 Escalation report - from August CGC to Sept Board 2021 (1).docx
3.1.1	10:55 - CQC Spinal and Maternity Update *Verbal update by Judy Dyos*
3.2	11:00 - Finance and Performance Committee - 31 August *Presented by Paul Miller* *For assurance* 3.2 Finance and Performance Committee escalation paper 31st August 2021.docx
3.3	11:05 - Trust Management Committee - 25 August *Presented by Stacey Hunter* *For assurance* 3.3 TMC Escalation report.docx
3.4	11:10 - Integrated Performance Report (M4) to include exception reports *Presented by Andy Hyett* *For assurance* 3.4a 090921 Integrated Performance Report.docx 3.4b IPR September 2021 final.pdf
4	FINANCIAL AND OPERATIONAL PERFORMANCE
4.1	11:25 - Standing Financial Instructions *Presented by Lisa Thomas* *For approval*

4.1 Standing Financial Instructions review Mar21.docx

5 QUALITY AND RISK

5.1 11:35 - Quality Improvement Progress Report (deferred from July)

Presented by Paul Wood
For assurance

5.1 Quality Improvement Progress Report (v0.2).docx

5.2 11:45 - Nursing Skill Mix Review

Presented by Judy Dyos
For assurance

5.2a Cover sheet Safer Staffing Sep 2021.docx

5.2b Skill mix review Sept 2021 HW.DOCX

5.2c Midwifery Staffing Report for CGC 190721 - appendix 1.docx

5.2d SURG combined skill mix - appendix 1.pdf

5.2e CHPPD data - appendix 1.pdf

5.2f CSFS combined skill mix - appendix 1.pdf

5.2g MED combined skill mix - appendix 1.pdf

5.3 11:55 - Clinical Governance Annual Report

Presented by Judy Dyos
For assurance

5.3 CGC Annual Clinical Governance report FINAL 21.06.21.docx

5.4 12:05 - Research Annual Report

Presented by Stef Scott
For information

5.4 Trust Board research Annual Report cover paper 202021.docx

6 GOVERNANCE

6.1 12:15 - Annual Review of Board and Committee Effectiveness

Presented by Fiona McNeight
For assurance

6.1 Board and Committee Effectiveness Report Sept 2021.docx

6.2 12:25 - Approve Board and Committee dates for 2022

Presented by Fiona McNeight
For approval

6.2a CoverTrust Board Dates.docx

6.2b DRAFT Trust Board dates 2022.docx

6.3 Corporate Governance Statement Self-Assessment (Well Led Review) deferred to November

7 CLOSING BUSINESS

7.1 12:30 - Agreement of Principle Actions and Items for Escalation

7.2 Any Other Business

7.3 12:35 - Public Questions

7.4 Date next meeting

4th November 2021

8 Resolution

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

Salisbury NHS Foundation Trust

Draft
Minutes of the Public Trust Board meeting
held at 10:00am on Thursday 8 July 2021 via MS Teams
Salisbury NHS Foundation Trust

Present:

Nick Marsden (NM)	Chairman
Paul Kemp (PK)	Non-Executive Director
Paul Miller (PM)	Non-Executive Director
Eiri Jones (EJ)	Non-Executive Director
Rakhee Aggarwal (RA)	Non-Executive Director
David Buckle (DB)	Non-Executive Director
Michael von Bertele (MvB)	Non Exec Director
Lisa Thomas (LT)	Chief Finance Officer
Susan Young (SY)	Interim Chief People Officer
Judy Dyos (JDy)	Chief Nursing Officer
Andy Hyett (AH)	Chief Operating Officer
Stacey Hunter (SH)	Chief Executive
Peter Collins (PC)	Chief Medical Officer

In Attendance:

Kieran Humphrey (KH)	Associate Director of Strategy
Kylie Nye (KN)	Corporate Governance Manager (minutes)
Fiona McNeight (FMc)	Director of Corporate Governance
Lucinda Herklots (LH)	Lead Governor (observer)
Kevin Arnold (KA)	Governor (observer)
Mark Brewin (MB)	Staff Governor (observer)
Helen Rynne (HR)	Patient Engagement Lead (for item TB1 8/7/1.2)
Elizabeth Swift (ES)	Freedom to Speak Up Guardian (for item TB1 8/7/2.1)
Michelle Brewer (MB)	Public Observer
Hannah Boyd (HB)	Interim Head of Maternity & Neonatal Services (item TB18/7/5.4)
Abigail Kingston (AK)	Consultant, Gynecology (item TB18/7/5.4)

ACTION

TB1 8/7/1 OPENING BUSINESS

TB1 8/7/1.1 Presentation of SOX (Sharing Outstanding Excellence) Certificates

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

- Zara Sanderson – Staff Nurse, Tisbury CCU who managed a difficult situation and demonstrated great compassion and care.
- The Emergency Department, the Acute Medical Unit and Cardiology. The nomination detailed that every staff member worked together to deliver great care. There was a great team approach with the patient pathway at the centre.

NM and the Board congratulated the members of staff who had received a SOX award and the Board noted the continued effort from staff who provide a great level of care to patients. HR noted that the

Friends and Family Test responses reflected the themes of the SOX awards.

TB1 8/7/1.2 Patient Story

HR presented the patient story which told the journey of a patient's experience of injuring her hand and having surgery, whilst also suffering from COVID-19. The patient told her story and noted that her experience had been a positive one from first admission to her time in Wessex Rehab as she had been treated as a person, not a patient.

Discussion:

- NM thanked the patient for sharing their story and noted that it was positive to hear about staff members who listened to and supported patients.
- EJ supported NM's comments and noted it is about what staff do every day which puts patients at the heart.
- SH noted that it was humbling to hear directly about the efforts that staff members put in. This also highlights the importance the Trust should be placing on health and wellbeing of colleagues and the emotional labour of our work.
- JDy explained that the executive team had commenced monthly 'Back to the Floor' sessions. JDy noted that each executive were visiting different areas of the Trust and the work observed has been brilliant and a privilege to watch.
- PM referred to the outcomes for the patient and the power of staff members who do go above and beyond when they believe they are adding value. PM noted that as the Trust looks to the future there needs to be a focus on empowering staff. It is not about do more but doing things differently and how this message is disseminated throughout the organisation.

TB1 8/7/1.3 Welcome and Apologies

NM welcomed everyone to the meeting and noted that the following apologies had been received:

- Paul Wood, Interim Director of Transformation
- Tania Baker, Non-Executive Director

TB1 8/7/1.4 Declarations of Conflicts of Interest

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

TB1 8/7/1.5 Minutes of the part 1 (public) Trust Board meeting held on 6th May and Electronic Trust Board Meeting held on Monday 14th June 2021

NM presented the minutes which were agreed as an accurate record of the meetings held on 6th May and 14th June 2021.

TB1 8/7/1.6 Matters Arising and Action Log

NM presented the action log and the following key points were noted:

- **TB1 14/1/4.5, TB1 4/3/1.6, TB1 4/3/2.1 – Maternity Ockenden Review –** JDy noted that slides are now included in the Integrated Performance Report (IPR) and there will be a quarterly maternity report with more detail which comes to Clinical Governance Committee (CGC). The team want to ensure the right information is being escalated without overwhelming the Committees and Board with data. The next report to Board will be September. Item closed.

- **TB1 8/4/3.2 Patient Experience/ Visiting Guidance** - the report is on agenda. JDy explained that patient visiting guidance is still one visitor for every patient and that will be reviewed and updated in line with the national roadmap. The Trust has yet to receive this guidance. JDy noted that the Head of Patient Experience has been working through visiting guidance alongside the Trust's BSW partners. There are consistent rules relating to visiting patients on end of life care and for births. PM suggested a broader conversation with governors about visiting. JDy will do this once the guidance has been published. Item closed

  SH noted that whilst the Trust is waiting on the next stage of guidance NHS hospitals will be held to a different standard due to the vulnerable nature of patients.

- **TB1 8/4/3.3 Learning from Deaths report** – The report is on July's agenda. Item closed.

- **TB1 8/4/3.3 Standing Financial Instructions –** This has been discussed at F&P. This will go to July's Audit Committee. Item closed.

- **TB1 6/5/1.9 Maternity** – It was agreed a paper would come to the Board in August in relation to staffing in Maternity which will detail expectations in relation to continuity of carer. **ACTION: JDy** **JDy**

It was agreed that all other matters arising were either on the agenda, a future agenda or closed.

TB1 8/7/1.7 Register of Attendance

The register of attendance was noted.

TB1 8/7/1.8 Chairman's Business

NM highlighted the following key points:

- There is a lot of activity underway from a national perspective, particularly with the announcement of a new Secretary of State for Health and Social Care. What is clear is that the NHS needs to get to a point where COVID is managed as part of day to day business rather than responding to it as is currently the case. There is work underway about how the Trust manages COVID in the organisation whilst also supporting and treating the local

population.

- The Trust is extremely busy delivering emergency care and focusing on elective recovery. This is also whilst focussing on staff recovery and wellbeing and managing the delta variant spread and a significant vaccination programme. This is a challenging set of issues with our patients at the centre.
- From a system perspective there is a bill going through parliament focusing largely on the detail on how a new health and care system will be structured. This includes specifications on how Integrated Care Systems are to be set up.
- Based on how busy the Trust is currently it is expected that winter is going to be a difficult period.
- The Board need to understand the priorities but also recognise there is a lot going on and do its best to ensure the Trust is addressing these challenges.

Discussion:

- PM acknowledged the long list of challenges and suggested that the Trust need to support staff to embrace change which will in turn help treat patients in more innovative ways.

TB1 8/7/1.9 Chief Executive's Report

SH presented the report and highlighted the following key points:

- SH reiterated NM's comments in relation to the significant legislation going through parliament. Partnership work is increasingly important in relation to the population's needs. Work continues with the Acute Hospital Alliance (AHA) and the Integrated Care System (ICS) and is progressing well.
- The Trust is treating small numbers of COVID patients in line with the rise in community cases. In relation to the different variations of COVID, research and current experience suggests that the vaccination does have an impact on the number of people hospitalised and the number of COVID-related deaths. The Trust continues to respond with Infection, Prevention and Control measures under constant review.
- The Trust has experienced a significant increase in non-elective pressure and has seen record numbers of attendances and emergency admissions during May and June. The Board is grateful to clinical colleagues and operational managers who have been hugely responsive and flexible during what has been a challenging time.
- The readiness assessment that KPMG are undertaking as part of the operational excellence programme has been shared with executives in June. The next stage of this work to agree the roadmap takes place on 15th July 2021.
- The recent CQC focused inspections in Maternity and Spinal services are due to be published tomorrow morning and this will be shared across the organisation. JDy and PC will lead the actions arising from the CQC report. SH extended her thanks to all colleagues in spinal and maternity for their work during and after the visit.

- SH noted that the Trust is preparing for the Staff Awards ceremony in September. Nomination timelines will be published soon.

Discussion:

- EJ referred the readiness assessment prepared by KPMG and noted that she felt disconnected from this work and did not feel like it reflected the Trust's position. SH explained that she had spoken with NM as it is important that the executive are aligned to the work required initially but also noted that she did not want other Board members to feel disengaged and therefore something needs to be done to reconcile this. However, SH did explain that the readiness assessment felt like a reasonable reflection of the Trust's position and there is a real appetite and optimism with colleagues who they have interviewed and spoken with. SH suggested the Executive speak to Non-Executive Directors outside of the meeting to discuss the work with KPMG. NM explained that KPMG have initially met with the executives and once they have a united view this will then be taken forward as a Board.
- AH reiterated that from initial feedback with senior clinicians and managers, everyone is positive about working with KPMG. The Trust is aware that it needs to start doing things differently and there is never a good time to start this piece of work.
- SH thanked the Non-Executive Directors for their feedback and noted that strategy and culture is the business of the Board and this is about how we effectively deploy these responses.

TB1 8/7/2 PEOPLE AND CULTURE

TB1 8/7/2.1 Freedom to Speak Up (FTSU) Guardian Annual Report

SY introduced ES who presented the report and highlighted the following key points:

- The Trust is making good progress in relation to the FTSU effort with the improved communications, appointing 5 new FTSU ambassadors and improved learning from those who have spoken up.
- There has been an increased focus on training and in particular line manager responsibility when it comes to staff raising concerns and how these are escalated.
- In relation to the index scores there is a concern about the question that asks 'do you feel comfortable to raise concerns about anything in the organisation?' as 31.2% of people have responded no. The Trust need to look into changing this perception and is part of working towards and open and honest culture.
- More positively, 17% of the Trust's staff are from a BAME background and 17% of FTSU concerns were raised by BAME members of staff which shows the spread of concerns are representative of the Trust's staff. The National

Guardian's Office has asked the Trust to share learning about how it links Equality, Diversity and Inclusion (EDI) and FTSU.

- The issue of detriment to speaking up has been raised as there have been some high profile cases, involving external investigations. These investigations can sometimes be slow and there is work to do on how the person who has raised the concern is supported throughout the process. SFT reported 11 cases where there was a perception of negative treatment for speaking up.

Discussion:

- AH noted that he would support training and for line managers as it is sometimes assumed that these people have the skills.
- PK noted that bulling and harassment numbers felt high and asked what the executive's focus of action would be to address this in the next year. SH explained that ultimately the Executive want the number of people who do not feel they can speak up to reduce. The data points to a differential experience of staff members which need to be addressed and a targeted focus is required. SH noted that the issue of detriment is a concern and there needs to be action at the forefront to minimise this. This is not just perceived detriment, this is real. ES explained that the complainants are not sorry they raised concerns but are saying that they would think twice about raising a concern again. SH suggested that ES and the team come back and give some specific objectives about how this can be addressed. **ACTION: ES** **ES**
- The Board had a detailed discussion about the issue of detriment and it was noted that in certain cases people had taken time off sick from work because of it. There is a need to raise awareness of the impact on staff and how these issues are managed.
- RA explained that the issue of detriment had been discussed at People and Culture Committee. RA noted that when someone makes a complaint the Trust need to ensure there is support for the complainant and thought needs to be taken to what is put in place if the compliant is not upheld.
- MvB noted that what the Trust would hope to see is when people feel they have been treated unfairly they will use the appropriate escalation route and people will feel able to challenge unacceptable behaviour, only using the FTSUG as a last resort.
- NM thanked ES for her focused and hard work.

ES left the meeting.

TB1 8/7/2.2 Nursing Skill Mix –deferred to September

This was deferred until September.

TB1 8/7/2.3 Improving our People Practices

SY presented the report which asked the Board to note, for assurance, the work being undertaken by the Trust to improve people practices following recommendations from NHSE/I in 2019. The following key points were noted:

- In May 2019 guidance was published in relation to 'learning lessons to improve people practices' which provided advice around investigations and disciplinary procedures. This included recommendations following the tragic death of Amin Abdullah.
- In December 2020, all Trusts were advised to update their disciplinary policies incorporating these recommendations.
- The Disciplinary Policy is included in Appendix 4 and was required to come to Trust Board as per NHSE/I instruction. The policy has been developed in line with the recommendations of Dido Harding's letter and has been consulted widely across the Trust prior to formal ratification process.
- There are areas of improvement detailed in the paper including Board level oversight.

Discussion:

- PM thanked SY for the report but noted that the guidance and recommendations paper did not include any dates or deadlines for improvement. PM suggested these be added. **ACTION:SY** **SY**
- EJ referred to the new patient safety approach that will be a focus for next year and explained that there will there will be different processes in relation to the disciplinary process and the patient safety framework. JDy noted that she had visited the Isle of Wight to see how they have implemented new Patient Safety Framework and part of this is improving the learning culture.

TB1 8/7/3 ASSURANCE AND REPORTS OF COMMITTEES

TB1 8/7/3.1 Charitable Funds Committee – 17 June

NM presented the report, providing a summary of escalation points from the meeting held on 17 June:

- During the COVID pandemic all of the major fundraising activities have been postponed and therefore there was a significant shortfall in the annual traditional revenue raised by the charity. However the funds that were raised managed to cover the ongoing services the charity provides funds for.
- The Committee received the management accounts for the charity and despite the reduced funding raised the charity is in a strong financial position.
- The Committee will have a strategy session in the next 2-4 months to determine the financial strategy going forward.

The report was noted.

TB1 8/7/3.2 Finance and Performance Committee – 29 June

PM provided a summary of escalation points from the Finance and Performance Committee held on 29th June:

- There was a detailed discussion re the improvements in the IPR.
- An update on Stroke will go back to CGC.
- The Committee noted that the Elective Recovery – Theatre Insourcing proposal had been approved outside of the meeting
- The Committee approved the Integrated Care System (ICS) Procurement Service Business Case.
- The Committee noted the Trust's (Data Security and Protection Toolkit) DSPT compliance submission on 30th June.
- The financial risk associated to the Elective Recovery Fund and the theatre insourcing proposal was highlighted.
- There is a golden thread of workforce related issues across the Trust which has been reflected in the recent reports to Committees. This highlights the need for detailed and strategic Trust-wide workforce planning.

The report was noted.

TB1 8/7/3.3 Clinical Governance Committee – 29 June

EJ provided a summary of escalation points from the Finance and Performance Committee held on 29th June:

- The Committee received the Maternity Clinical Negligence Scheme for Trust (CNST) and there is now a clear governance process of Maternity reports coming to CGC.
- The Committee had a detailed discussion in relation to the outpatients work as part of the Transformation Programme.
- The latest quarterly research report provided assurance of the excellent work being done by the team with 85% of pre-COVID studies up and running again
- Ares of continued focus are Stroke, GI services and mortality.
- The Chair also presented a look back over the past year's functioning of the Committee. Assurance was provided in the report that the Committee meets the requirements outlined in the Terms of Reference. The report is attached as Appendix 1.

The report was noted.

TB1 8/7/3.4 Trust Management Committee – 30 June

SH provided a summary of escalation points from the Trust Management Committee (TMC) held on 30th June.

Discussion

- EJ asked for further assurance in relation to the Maternity Ultrasound business case. LT noted that there were just a few points of clarification requested at the committee and there was no question in relation to the purpose of the post.
- AH explained that there is no expected impact on patients in making a delay in this decision and the information requested in TMC has now been received.

TB1 8/7/3.5 People and Culture Committee – 24 June

MvB provided a summary of escalation points from the People and Culture Committee held on 24th June:

- The Committee received the FTSU Annual Report and noted the good progress made. As discussed earlier concerns relating to detriment were discussed in detail.
- The Committee noted that there is further work to be done in gaining a better understanding of our culture and what is required to change it.
- The Committee reviewed the Board Assurance Framework (BAF) and concluded that it did not adequately reflect the range of challenges, in particular the recruitment of people for hard to fill posts.

Discussion:

- SH noted that the next Board Seminar in August is going to focus on inclusion and it is hoped that a programme of improvement will be proposed that the Board can sign up to.

TB1 8/7/3.6 Integrated Performance Report (M12)

SY presented the Integrated Performance Report to the Board and noted that this report provided a summary of May's performance. The following key points were noted:

- ED attendances have increased and have continued to increase in the last month.
- Patient flow has been affected with increased attendances and significant challenges in staffing gaps adding further pressure to services.
- Stroke and TIA performance continues to remain challenging, with flow issues a factor in the number of patients reaching the Stroke unit within 4 hours. A review at divisional level has been requested by PC with the expectation of a recovery action plan to return to SSNAP A and B.
- A dashboard for Maternity and detail on the Saving Babies Lives Care Bundle version 2 is included in the report for the first time. In May there were 0 stillbirths, maternal deaths or neonatal deaths within 28 days of birth.
- An increase in high harm falls has been noted in May 3 majors requiring surgery and 4 moderates. The Falls Lead post, which will sit within Medicine Division, is out to advert and there is a matron focus on falls reduction. A cluster review has been requested by the CNO to identify more detail

on themes.

Discussion:

- The Board noted that there had been a 30% increase in ED attendances across the UK. This Trust normally has on average 130 attendances a day and it has been running at 185 a day for the last few weeks.
- PK noted his disappointment at the increase in falls and asked what is being done to mitigate the issue. JDy explained that the matrons have looked at themes and are doing audit on the assessment process. There have been challenges with those patients who are recognised as a fall risk, mitigations are put in place and they still continue to fall. The team have not yet been able to appoint a falls lead.
- PC reported that he had appointed a new associate medical director for governance which will be looking these incidents in greater detail. It should be acknowledged that patient falls are everyone's responsibility and this is not just a nursing issue. It is hoped the improvement work through KPMG will also influence this.
- MvB noted that military attendance had doubled and asked if the Trust keep a detailed breakdown of data to track this. MvB further noted that military personnel helped the Trust during COVID and asked if there is capacity for these people to rotate into the Trust, particularly with the current staffing shortages. AH explained that there have been regional conversations to see how this can be taken forward on a permanent basis. AH noted that in relation to the data, it is available and there have recently been repatriations during COVID. However, some military personnel do not always tell us when they come into the hospital for treatment. NM noted that the Trust had just secured a nominated Military Governor who would be useful to link with to discuss such matters.
- EJ referred back to falls and that the cause is multifactorial with a need to understand human issues from a safety perspective, i.e. patients who do stay in bed deteriorate faster. There needs to be a balance between supporting people to mobilise and recognising that this might cause falls.
- DB referred to the two week wait breast cancer pathway and noted that the Trust have only achieved 75% against a 90% target. DB noted that whilst a majority of the women tested do not have cancer he asked if there are underlying clinical risks that could be mitigated. PC noted that the department is focusing on the restoration of the service and those patients who are missing the two week wait target are doing so by days, not weeks. In the Trust's current position it has been asked by other organisations to provide additional support to them. There are currently no known harms relating to the two week wait cancer performance. However, there has been one case of potential harm relating to a patient who was being treated in line with the family genetics pathway and was scheduled to have a mastectomy and reconstruction. The surgery was delayed due to the reconstruction being cancelled.

- SH thanked colleagues for the positive variance in relation to recovery plans.

TB1 8/7/3.7 Extraordinary Audit Committee – 18th June

PK provided a summary of escalation points from the People and Culture Committee held on 18th June:

- As requested the Audit Committee reviewed and signed off the annual report and accounts.
- It should be noted that the auditors have not yet completed their Value for Money report linked to the year-end cycle. This was committed for completion ahead of the scheduled July Audit Committee.

The Board noted this report.

TB1 8/7/4 GOVERNANCE

TB1 8/7/4.2 Register of Seals

NM presented the Register of Seals.

The register of seals was noted.

TB1 8/7/5 QUALITY AND RISK

TB1 8/7/5.1 Patient Experience Report Q4/Annual Report

JDy presented the report providing a report of activity for Q4 2020/21 in relation to complaints and opportunities for learning and service change. The following key points were noted:

- Themes that have arisen from complaints relate to communication, unsatisfactory treatment and lost property.
- There has been increased compliance in relation to response times and whilst only 50% of green complaints met the target response time, all amber cases met the target response time.
- The Friends and Family Test responses have been very positive with a majority of people noting they had a good or very good experience.

Discussion

- The Board discussed the attitude of medical staff which is a recurring theme. It does not appear to be a Trust wide issue and is related specific staff in specific areas over a period of time. JDY explained that individuals who do have complaints made about their attitude are provided with further training and support.
- SH noted that false assurance could be taken from the downward trend on complaints. JDy noted that the PALS team have discussed the reduced number of visitors may have influenced the number of complaints. However, there are still a number of drop-ins into the PALS team.
- PC explained that the reduction in complaints could signal a

national response and an allowance of situations during what has been a difficult time. PC suggested benchmarking with other organisations to see if this is the case. NM agreed but noted that complaints should always be considered as essential feedback and a route of learning and improvement.

- JDy reported that a new question had been added in Quarter 1 to the Friends and Family Test in relation to what has been good and what can be done better and there has been really positive and helpful feedback.

TB1 8/7/5.2 Learning from Deaths Report Q4/Annual Report

PC presented the report which had been completed by C Gorzanski prior to her retirement. The following key points were noted:

- In Quarter 4 (Q4) there were 281 deaths, of which 5 were unexpected. There is low mortality for Stroke and Cardiovascular which indicates that outcomes have not been affected by Stroke's performance.
- The Trust's HSMR (Hospital Standardised Mortality Ratios) increased in Q4 likely due to the effect of COVID, both in terms of direct mortality from COVID and the secondary bias effects which makes accurate benchmarking difficult.
- The Medical Examiner system is working well and has been extremely useful during COVID when people have not in some instances been able to see their loved ones.
- There has been some difficulty in interpreting HSMR data as COVID has happened in waves across the nation at different times. This has made the comparative data difficult to interpret.
- PC noted that this is the last of the old style report and when the new 0clinical effectiveness lead starts the report will be more concise, focusing on KPIs and learning.

Discussion

- PM referred to figure 4 and 5 and asked how concerned the Board should be as this indicates us as an outlier. PC noted that it is concerning but it is difficult to provide assurance until Dr Foster publish the up to date data which has been delayed. PM asked if the Board could have an update once the data has been received. **ACTION: PC** **PC**
- EJ asked if the regional team have raised queries in relation to the Trust's HSMR. PC explained that they have not as the Trust is not currently an outlier in the region. PC explained the difficulties of looking at a rolling statistic over a 12 month period as it is challenging to interpret trends as it only indicates how far away you are from the mean at a point in time.

TB1 8/7/5.3 Director of Infection Prevention Control (DIPC) Report

JD presented the report and the following key points were noted:

- This is the annual report for 2020/21 and details significant

amount of information about the amount of infection managed in the Trust over the last 12 months.

- Serious incident reviews will be undertaken on all of the reported cross contaminations. The same process will be undertaken for Duty of Candour.
- The report includes detail about hand hygiene measures and there is compliance above 85% in most areas.
- The Trust is working hard to ensure Infection; Prevention and Control measures are maintained. However, there are challenges in relation to the aging estate and the ongoing risk of COVID.
- There are currently issue in relation to management of ventilation due to the estate being older. This is being reviewed and acted upon accordingly.

Discussion

- SH referred to the way we capture and structure risks and noted that the Trust does not describe risk around estates in relation to patient safety.
- PM suggested setting up an air quality or ventilation section in the report. JDy reported that there is a ventilation group which is in its early stages but information on this can be included in future reports. **ACTION: JDy** **JDy**
- FMc highlighted that the ventilation risk is reflected in the Board Assurance Framework
- EJ referred to water safety and asked if there was impact on patients and staff. There have been no known safety concerns it is acknowledged that water systems in the Trust are complex and therefore testing and controls in place are designed to mitigate the risks to our patients and staff.

TB1 8/7/5.4 Maternity – Clinical Negligence Scheme for Trust (CNST)

JDy, AK and HB presented the report which notifies the Board that NHS Resolution (NHSR) is operating a third year of the CNST maternity incentive scheme to continue to support the delivery of safer maternity care. It was noted that this report had been discussed in detail at the Clinical Governance Committee. The following key points were noted:

- There are a number of standards the Trust has to achieve. There has been a lot more detail moved into CNST which now makes it harder to achieve.
- The Trust is not compliant with the CNST this year and a number of Trusts are now non-compliant who previously were. The Trust is compliant in four out of the ten measures and therefore there is a significant amount of work to be done.
- The Trust does require further clarity from NHSI/E in relation to action plans and compliancy.

Discussion

- SH thanked the team for the clear report and asked if the actions plans are deliverable and will the Trust be a position

where it meets compliance. AK noted that there are robust plans in place, some of which relate to posts that are yet to be recruited to. HB noted the importance of monitoring compliance as soon as different standards are introduced. SH asked if the team had the tools required to get the capacity needed to make the changes required. HB explained that the only thing is the external support in relation to compliance, i.e. with the quality division which is part of the improving culture work. AK noted that the department needs a slightly different skill set to have that bird's eye view and oversight from a wider perspective.

- PM referred to table.1 and asked what compliance would look like for Q1 2021/22 and also asked what would happen if the department is unable to recruit into posts. AK explained that compliance improved in Q1 and the table would have three more green rows. In terms of posts, maternity have pulled in external resource which will continue until crucial posts are recruited to. SH noted that maternity is a priority and there is a level of optimism in relation to ability to recruit to posts.
- EJ referred to the action plans with HB confirmed had been updated and republished in the meeting pack. HB confirmed that the action plans related to the compliant safety actions did not need to be submitted
- NM thanked AK and HB for their work.

TB1 5/7/6 FINANCIAL AND OPERATIONAL PERFORMANCE

TB1 5/7/6.1 Data Security and Protection Toolkit Self-Assessment

LT presented the report which had been presented at the Finance and Performance Committee:

The Trust has submitted a Standards Not Met data security and protection toolkit return on 28th June which is supported by an improvement plan covering the completion of three assertions. The national cyber security team approved the plan and amended the Trusts submission status to Standards Not Fully Met (Plan agreed). Work to complete the three outstanding assertions will be finished by December 2021.

It was noted at F&P that Freedom of Information compliance is not an IT issue and is a culture issue throughout the organisation that requires further work.

The report was noted.

TB1 5/7/6.2 Data Protection Officer Annual Report and Compliance with GDPR

LT presented the report which provided an update on progress made in respect of the Trust's mandatory cyber security programme and the 2020-2021 Data Security and Protection Toolkit which is overseen by NHS Digital. The report also highlights areas of improved compliance and areas of concern in relation to the

statutory and regulatory standards overseen by the Information Commissioner's Office (ICO).

The report was noted.

TB1 8/7/7 CLOSING BUSINESS

TB1 8/7/7.1 Agreement of Principle Actions and Items for Escalation

N Marsden noted they key points from the meeting as follows.

- There has been a focus on the KPMG work and NM and SH will get together after 15th July to discuss how the Board is included in this work collectively going forward.
- The issue of detriment in relation to Freedom to Speak up was discussed and specific actions to address this have been requested.
- Workforce challenges have been highlighted and the Board are well sighted on the issues. The challenge will be addressing these shortages in the short, medium and long term.
- What is clear from the SOX and patient story this month is that the Trust has to consider the innovation and encourage empowerment of staff across the organisation.

TB1 8/7/7.2 Any Other Business

NM noted that the next Board meeting would be an off-site, face to face meeting. The next Council of Governors meeting in July will be held via Teams and this will be reviewed for the following meeting once the face to face Board meetings have been trialled.

TB1 8/7/7.3 Public Questions

LH noted she found the meeting very interesting and honest and recognises the challenges facing the Trust in the coming months.

TB1 8/7/7.4 Date of Next Public Meeting

Thursday 9th September 2021, Board Room, Salisbury NHS Foundation Trust

TB1 8/7/8 RESOLUTION

TB1 8/7/8.1 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).

Public Trust Board Action log

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

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
TB1 8/7/2.1	**Freedom to Speak Up (FTSU) Guardian Annual Report -** SH suggested that ES and the team come back and give some specific objectives about how detriment can be addressed.	**ES**	28/10/2021	To go to next P&C Committee report in October (added to P&C Action Log)	N	4
TB1 8/7/2.3	**Improving our People Practices -** PM thanked SY for the report but noted that the guidance and recommendations paper did not include any dates or deadlines for improvement. PM suggested these be added.	**SY**	09/09/2021	SY has now left the Trust - this is being picked up by CW.	N	2
TB1 8/7/5.2	**Learning from Deaths Report Q4/Annual Report -** Update to come back to the Board on up to date Dr Foster HSMR data once it is published.	**PC**	04/11/2021		N	4
TB1 8/7/5.3	**Director of Infection Prevention Control (DIPC) Report -**PM suggested setting up an air quality or ventilation section in the report. JDy reported that there is a ventilation group which is in its early stages but information on this can be included in future reports.	**JDy**	Jul-22	To be included in the next Annual Report 2022		4

Report to:	Trust Board (Public)	**Agenda item:**	1.8
Date of Meeting:	09 September 2021		

Report Title:	Chief Executive's Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			
Prepared by:	Lisa Thomas, Chief Finance Officer			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive			
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 board meeting on the 8th July 2021

The Board is asked to note

- That the hospital continues to be under increased pressure with our Emergency Department being particularly busy and a rise in the number of paediatric patients with respiratory conditions. Staff have worked incredibly hard to respond with adjustments being made to facilitate better patient flow.
- We remain vigilant about Covid infection rates and subsequent impact on the services we provide across the hospital with particular concern of ensuring we can continue our elective recovery programme.
- We continue to play an active role in the development of partnership arrangements at a local place, ICS and regional level as the guidance is published and adopted.

1. Current pressures

The whole health system is still experiencing very high urgent care demand and we continue to see record levels of demand across the whole of Bath, Swindon and Wiltshire (BSW) system. Over the last month we reached our highest state of operational pressures Opel 4, reflecting the pressure upon not just our Trust, but the wider health and care system. I remain mindful of the pressure this has placed on our all colleagues across the organisation and system partners and I am grateful to all for their continued support and effort.

A significant concern raised by the Ambulance Trust has been the pressure on all of our Emergency Departments causing increased delays for ambulance crews handing over their patient to us in a timely way, which has the potential to cause harm to them and others in our communities who need to access the 999 service. We have remained focused on ensuring we facilitate timely handover of patients from ambulance crews as a key priority.

Some patients in the Emergency Department do not benefit from being seen here and would be better seen in a more suitable place. We continue to advise the public to access care in the right setting and work with system partners to signpost people appropriately, particularly highlighting the use of 111.nhs.uk.

Paediatrics has seen a particular increase in demand related to respiratory conditions. To help alleviate some of the pressure, along with our healthcare partners across BSW, we produced a video for social media with some helpful tips about getting the right treatment from the right healthcare professional when a child is unwell

The integrated performance report highlights our performance in more detail. One of the greatest challenges has been workforce gaps during August related to an increase in absence for a wide range of reasons, including Covid infection rates or Covid contact isolation rules. This has added to operational challenges during the month.

2. Maternity

The Trust shared a presentation with the Care Quality Commission (CQC) on the actions we have been progressing in relation to maternity service improvement. Whilst we are not expecting to receive any formal feedback, the presentation was received positively and the CQC indicated we could expect maternity services to be re-inspective in the next few months.

3. COVID Update

We have seen a slight increase in the number of patients in the hospital with confirmed or suspected Covid-19 over the last month, currently the levels have not hindered progress against our elective recovery programme. We will continue to monitor the situation closely and we have robust plans in place should more capacity be required for increased demand.

The vaccination team at the City Hall are now delivering vaccines via walk in clinics and for younger adults and are preparing to deliver any additional cohorts.

On 25th August the City Hall team ran their first pop up vaccination service at The Chapel Nightclubs outside bar Brown Street. The effectiveness of this will now be reviewed before other opportunities are considered

4. National policy and ICS updates

A number of national guidance documents have been published in August including guidance on the functions and governance of the integrated care board and guidance on provider collaboratives.

The Integrated Care Board (ICB) guidance outlines the action to recruit ICB leaders and governance arrangements, including the constitution and developing a functions and decision maps to support effective governance arrangements.

We will be working with all our partners following the publication regarding provider collaboratives as all trusts providing acute services are expected to be part of one or more provider collaboratives by April 2022. The Trust is already working as part of the Acute Hospital Alliance (AHA) in Bath, Swindon & Wiltshire (BSW) which provides the solid platform to working more formally collaboratively. The guidance notes that provider collaboratives offer an opportunity to lead the transformation and delivery of services within the Integrated Care Board, including elements like devolving budgets. This will shape the range of partnerships we form over the next twelve months.

BSW has been developing place based partnership governance options over the last two months, which assesses the five models for difference governance options; this is based on the national guidance published earlier this year “Thriving places”. The options ranged from lead provider model, joint committee, subcommittee of the ICB or advisory consultative forum. Discussions are ongoing as to the final form adopted.

5. Diversity and Inclusion

The Board are continuing to reflect on the last board session where we took part in equality, diversity and inclusion session. Listening to colleagues from across the Trust who shared their lived experiences has generated significant discussion and reflection. I know I can speak on behalf of the whole board in thanking those individuals for sharing with such honesty.

Reflecting on all the shared experiences means we are thinking about how and what we do differently, some immediate actions included ensuring everyone calls out of any behaviour that is prejudiced and isn't consistent with being respectful and welcoming of difference. Encouraging and listening to any ideas which may help us target opportunities for progression and development and learning for colleagues with protected characteristics would be warmly welcomed, as we seek to improve the equity and equality for everyone in the Trust.

As a Board we have further work to do to understand how we can learn from others as we seek to become a more inclusive workplace.

To also note Salisbury Pride will be taking place on 4th September in Queen Elizabeth Gardens in Salisbury, and for the first time the Trust is a core sponsor of this event.

6. Events

Dragons Den launched

The popular Trust “Dragons Den” has launched**.** This is an opportunity for staff to put forward an idea that makes improvements as well as to pitch for project funds of up to £10,000 to support.

Thank you events for Salisbury NHS Foundation Trust staff

The Trust is organising a number of thank you events for staff during September. These are the staff awards (23rd September), staff End of Summer Party (24th September) and Staff Family Fun Day (25th September). These are being kindly supported by The Stars Appeal. The Staff Awards have received over 200 nominations for 14 categories – this is the largest number of nominations for such an event.

In addition the Spoken Word project that is now supported by the League of Friends will have its live launch on 13th September at Brown Street. (At the time of writing this project is expecting to be covered in the weekend Guardian 28th August). This project has also involved staff and community workshops.

And finally congratulations to the Seven Senior Sisters within our Medicine Division who successfully completed a Tough Mudder to raise money for the Stars Appeal Staff Fund, to say thank you to staff for their efforts during the pandemic. A massive £1820 was raised, so thank you to everyone who supported them.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	09 September 2021		

Report Title:	Guardian of Safe Working Annual Report 2020/21			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x			
Approval Process (where has this paper been reviewed and approved)				
Prepared by:	Juliet Barker			
Executive Sponsor (presenting):	Peter Collins			
Appendices (list if applicable):				

Recommendation:
The Committee are asked to note the annual Guardian of Safe working report for 2021 and its recommendations

Executive Summary:
The Trust are allocated around 169 doctors in training who are subject to the conditions of the 2016 contract. Doctors report breaches of their contracted working hours to allow the trust to monitor and act on recurrent themes around work load and rightsizing of the work force. The majority of exception reports comment on inadequate staffing. This is in part due to unfilled training posts, and trainees working less than full time. The trust looks to fill unallocated rota slots with locally employed doctors (LEDs) not in training but this work force has been affected by an increased demand and reduced supply caused by the COVID-19 pandemic. In the period August 2020 to May 2021 Heath education fill rates for SFT range from 85-89% mitigated by LEDs so that the mitigated position is 88-92%. The non-fill rate is particularly high in senior training posts which can impact a smaller hospital disproportionately as this tier of doctors are considered senior decision makers and are key to high quality patient care and efficient patient flow. In order to gain a better overall picture of medical workforce pressure and pinch-points the GoSW has instigated shadow exception reporting for LED doctors which will contribute to the data considered by the trust in the new medical workforce group set up in 2021 by the Chief Medical Officer. A number of actions taken by the trust to mitigate the issues raised through exception reporting are outlined in the report with specific recommendation around the F2 tier rota in the Emergency Department

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

Purpose

The 2016 Junior doctor contract introduced the role of the guardian of Safe working and requires that the guardian reports to the board (or via a committee) every quarter and produces a consolidated annual report, which is included as a statement in the Quality Account

Background

The Trust is allocated approximately 169 trainees (including LTFT) by the Deanery to fill c161 full-time rota 'slots'. There is an overall shortfall in the number of doctors actually provided by the deanery with respect to the required number to fill the rota slots. This results in gaps in the medical workforce rotas.

Numbers of trainees across the region are controlled and limited by the General Medical Council and Health Education England. The junior doctors contract was negotiated in 2016 but not formally adopted until 2019 at which time additional restrictions on hours, consecutive long shifts and weekend working were introduced, with the aim of protecting junior doctors from overwork and protecting their training opportunities.

Since 2016 trainees are required to report any instance that they work beyond the hours in their work schedule (national and local guidance gives a leeway of up to 15 minutes), any missed training opportunities and "immediate safety concerns" when they believe patients are being put at risk by excessive hours or insufficient doctors. Excess hours can arise for a number of reasons including:

- Rota gaps resulting in fewer doctors than planned – for example due to the Deanery failing to recruit trainees, less than full time trainees, maternity leave, sick leave or poor annual leave planning.
- Unrealistic work schedules that do not meet the needs of the service
- Junior doctor factors including capability, organisational skills and clinical experience
- Supervision factors including lack of support, unrealistic expectations
- Infrastructure issues particularly IT, but also bleeps and telephones
- Lack of support from other health care professionals including nurses, pharmacists and admin staff.

We also employ locally employed doctors at junior and senior trainee level to fill rota gaps and provide additional staffing. Although their work schedules mirror those of the deanery trainees they are not required to exception report. Despite this, we have recently discussed adding them to the exception reporting process. This will be a data gathering exercise rather than as a mechanism for overtime payment, as their terms and conditions of payment are different from those on the 2016 contract. The aim is that this will give the trust a much greater view of hours worked by its medical workforce and better highlight gaps and issues. It will also give a degree of parity between deanery and LED doctors and a 'voice' to those who might otherwise feel unheard.

Rota Gaps

The rota gaps in this report occurred between August 2020 and May 2021

Number of doctors / dentists in training (total): c169
Number of doctors / dentists in training on 2016 TCS (total): c169

For context, c100 of these posts are at junior level and c68 are at senior level. Thus a for given number of WTE gap, the senior rota is disproportionately affected.

Covid-19

For the second year running, Covid-19 has caused disruption to the deployment of junior doctors. The data below does not take into account redeployment of juniors to cover other areas (eg respitatory high care) nor does it cover sickness and isolation gaps. On the other hand, the reduction in elective services due to Covid is also not recognised.

Junior Trainees (F1-CT2) WTE Gaps by Specialty and Grade

Specialty/grade	Aug 2020	Sept	Oct	Nov	Dec	Jan 2021	Feb	Mar	Apr	May
ED/GPVTS	2	2	2	2	2	2				
Anaesth CT1	0.2			0.2	0.2	0.2	0.1	0.1	0.1	0.1
Anaesthetic CT2							1	1	1	1
Urology F1	0.3	0.3	0.3	0.3						
Urology CST2							1	1	1	1
Medicine F2	0.3	0.3	0.3							
Medicine F2	+0.3									
ED F2	1	1	1	1	1	1				
Plastics F2	1	1	1	1						
PaedsST1				1	1	1				
Paeds F2					1	1	1	1		
Paeds GPVTS							1	1	1	1
T&O CST2	1	1	1	1	1	1	1	1	1	1
ACCS ST2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
ACCS ST2		1	1	1	1	1				
Resp CMT	0.2	0.2	0.2	0.2						
Obs&Gynae GPVTS	0.4			0.4	0.4	0.4	1	1	1	1
Palliative Care GPVTS		0.3	0.3	0.3	0.3	0.3	0.2	0.2	0.2	0.2
Elderly Care F1					0.3	0.3	0.3	0.3		
Elderly Care CMT									0.2	0.2
Cardiology CMT							0.2	0.2		
Community Psych F1									0.3	0.3
ITU F2				0.3						
Research F2							1	1	1	1
Total WTE Gap	5.5	6.7	6.7	7.5	7	7	8	8	7	7
Filled by LED	2	2	2	3	2	2	3	2	1	1
Unfilled WTE Gap	3.5	4.7	4.7	4.3	5	5	5	6	6	6

Senior Trainees ST3-7 WTE Gaps by Specialty and Grade.

Specialty/grade	Aug 2020	Sept	Oct	Nov	Dec	Jan 2021	Feb	Mar	Apr	May
Elderly Care	1	1	1	1	1	1				
Elderly care				1	1	1	1	1	1	1
AMU		3	2							
O&G inc MTI	3	3	1	1	1	1	1	1	1	1
Gastro	1	2	2	2	2	2	2	2	2	2
Gastro				1	1	1				
Resp				1	1	1				
Resp				1			0.2	0.2	0.2	0.2
Ophthal	1	1	1	2	2	2	3	3	2	2
Oral Surgery		1	1	1	1	1	1	1	1	1
Paeds	0.2	1	1	1	1	1	0.2	0.2	1.2	1.2
Gen surg	1	1	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.2
Plastics	2	2	2	1	1	1	1			
Plastics				1	1	1	1	2	2	2
Rehab/spinal	1	1	1	1	1	1	1	1	1	1
Radiology	1	1	1							
T&O								1	1	1
Urology	1									
ED	**0.2**	**0.2**	**0.7**	**0.7**	**0.7**	**0.7**	**0.9**	**0.9**	**0.9**	**0.9**
ED		**2**	**2**	**2**	**2**	**2**				
Total WTE gap	12.4	19.2	16	18	17	17	12.6	13.6	13.5	13.5
Filled with LED	1	4	4	6	6	6	3	4	4	5
Unfilled WTE gap	10.4	15.2	12	12	11	11	9.6	9.6	9.5	8.5

Months	August	Sept - Oct	Nov - Jan	Feb - May
WTE LED gaps	0	7.2	9	2

Yellow indicates LTFT working.
Green indicates a rota gap that is filled with a trust grade
Red indicated an unfilled gap.
Blue represents an overfilled gap eg where two >50% LTFT trainees share

Issues arising

There are more unfilled gaps at both junior and senior level across the year in comparison with last year. There are several notable reasons for this:
Directly Covid related – difficulties in international travel prevented some doctors starting posts.
Given the reduction in workload experienced by some specialties due to Covid, they did not seek to fill deanery gaps they would have otherwise filled.
Also of note is that some specialties cross cover, so a gap on one specialty rota impacts on out of hours activity in another specialty (e.g. obstetric s cover paediatrics out of hours so a shortfall in obstetric juniors impacts an already stretch paeds rota).

Of note, the ED F2/GPVTS rota is still operating at 1:2 weekends. This is contractually permitted but as an exception. This has been the case since pre Covid and ongoing efforts have not produced a solution. Two upcoming ED doctors have emailed me to point out that it is non-

compliant. I have corrected them but unhappily so. The BMA are aware and concerned. We are apparently a national outlier in this situation.

Less than full time (LTFT) working is becoming increasingly common and nationally the barriers to this working pattern are being removed. It is likely that LTFT working will increase, resulting in more rota gaps.

Actions taken to resolve issues

- Significant numbers of rota gaps have been filled with trust grade doctors, across all specialties and grades. However, some of these are not contracted to cover night or weekend working, which makes the picture less clear.
- Internal locums have been provided to help during weekend medical takes and have had a notable effect on reducing the workload. Junior doctors have strict limits on working hours, so this reserve can be in short supply.
- More recently a medical workforce review has been carried out to better describe the number of doctors needed.
- Six extra F2 posts were recruited to over this last year, which we hope will continue in the coming year, pending funding. Five extra F1 doctors have been recruited for the coming year, who will continue into F2 in 2022. They will all take part on the ED rota. It is hoped that this will make ED (F2 doctors) and night working more manageable.
- Non-medical professionals including Physicians' Assistants are being considered as part of the workforce to relieve some of the burden on junior doctors.

Summary

There are significant rota gaps across all specialties at both junior and senior grades. These gaps are often, but not always, filled with locally employed doctors. The gaps are as a result of the deanery not supplying a doctor to a post, of less than full time working and a smaller number of other reasons.
Information on the number of locally employed doctors remains difficult to obtain.
Covid has resulted in multiple redeployments, a limited number of direct rota gaps (sickness and isolation aside) and a reduction in LEDs filling posts in specialties whose services were reduced by the pandemic.
The ED rota at junior level remains a concern, with doctors working 1 in 2 weekends. This is permissible in exceptional circumstances but we are an outlier. Mitigations have been made in terms of employing more senior doctors and more F2 doctors but the rota pattern remains unchanged.

Recommendations
That the trust continues to employ LED to fill deanery rota gaps and support the service.
That particular efforts are made to look at ways to bolster the ED rota enough to make it a 1:3 weekend rota.
That we collect overtime working data from LED as well as deanery appointed juniors to better describe our workforce's activity and potentially make Salisbury a more attractive place to work.

Dr Juliet Barker
Guardian for Safe Working Hours
Consultant Anaesthetist.
July 2021

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.1
Date of Meeting:	9th September 2021		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	31st August 2021
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 31st August 2021. 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:
  - The CMO gave a verbal update in relation to safety standards (NatSSiPS and LocSSiPS). He confirmed that there were no immediate risks. These will be monitored through the CMB. An update will be brought to the CGC in the next 6 months when the new Associate Medical Director will have had time in post to develop this work further.
  - Future topics were explored in relation to relevant hot topics. Suggestions included theatre productivity from a quality perspective and new techniques and technologies. The latter was relevant to how the GIRFT programme would be embedded and used for improvement in the organisation.
  - The Transformation report for July was received. The update covered four key areas, e-outcome forms, Advice and Guidance and the changing practice re new ways of working in first appointments, Flow and ERF.
    - It was noted that there had been some slippage in the e-outcome forms being developed due to workforce challenges. It is expected that this work will be completed in October and further planning is underway to ensure that these forms are embedded and their use audited.
    - For the Advice and Guidance system, several specialities are demonstrating an interest in adopting this approach. This is being developed BSW wide and seminars are planned to share best practice.
    - Flow work is focussing on a targeted approach on criteria for discharge.
    - The ERF focus will be through the GIRFT programme and on late starts in theatres.

- The care and innovation section of the IPR was reviewed and discussed, noting some positive practice in infection prevention and control and pressure ulcer care. The reporting of incidents by category has changed and this will be explored further in the discussion around the next quarterly report. Whilst stroke performance is good in some domains, access to the ward in 4 hours remains a challenge. The Stroke lead has been invited to the October meeting to update the committee.
- A detailed discussion was held in relation to the latest update on gastroenterology services presented by the clinical lead. The Trust has actioned key improvements in relation to the Royal College review and the GIRFT report. Whilst permanent staffing remains the key issue, the current interim model is providing a safe service with 6 locum consultants in place. Tertiary care and upper GI bleed and nutrition services are provided by Southampton though there is some challenge in this arrangement as they also provide a service to the Isle of Wight. Further support has been provided by Bournemouth and the Trust has good dietetic input. It was also noted (and discussed in F&P) that the endoscopy service is high performing with no waits over 12 weeks. Future recruitment plans are in place as are plans for nurse led clinics. The clinical lead and CMO agreed that the concerns by the college had been addressed. The committee agreed that it was appropriate for the next update to be an annual one.
- The quarterly research report was noted. Following discussion, it was noted that whilst non medical research is an aspiration, it is currently early days in its development. The CNO confirmed that she had commenced discussions at regional level.
- The annual Dementia report was noted. The discussion captured the need to ensure a focus on the experience of people with dementia and their families / carers when acute care was required. It was noted that the clinical lead for dementia is changing and the new lead would be invited to a future meeting.
- Key highlights from the CMB included perinatal mortality and MMBRACE audits. These will be followed up in the September CGC as part of the maternity quarterly report. The children's surgical annual report had also been received with four workstreams planned for the coming year. The CMO then outlined how the new steering groups will upwardly report to the CMB, thus enabling the CMB to have a strong focus on quality to escalate to CGC in future.
- The Director of Integrated Governance presented an organogram outlining the changes to strengthen the Clinical Governance arrangements. These were noted.

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

Salisbury NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	3.2
Date of Meeting:	9th September 2021		

Committee Name:	Finance and Performance Committee		**Committee Meeting Date:**	31st August 2021
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Paul Miller, Non-Executive Director			
Board Sponsor (presenting):	Paul Miller, Non-Executive Director			

Recommendation
To note key aspects of the Finance and Performance (F&P) Committee meeting held on the 31st August 2021. *Please note this escalation report is written based on the performance of Salisbury NHS FT and not the wider performance of the Bath, Wiltshire and Salisbury (BSW) Integrated Care System (ICS), unless otherwise indicated.*

Items for Escalation to Board
(1) The provision of a managed pathology service – Lot 3 coagulation routine and special – procurement report outlining the outcome of a pathology tender undertaken by the Southern Counties Pathology (SCP) Network was received. The Committee support the recommendation in the tender outcome report to award a 10-year contract and the final decision will go to the Trust Board on the 9th September 2021. **(2) Improving Together Programme (additional business) –** The Trust Board has previously agreed an initial business case to award a contract to KPMG to work with the Trust to design and deliver an integrated organizational development and continuous improvement system. On the 31st August 2021 the committee received a further comprehensive business case to continue this work up to 2024/25. This business case covered additional external investments (an expanded. Contract with KPMG) and new internal investments (coaching, organisational development and culture capacity, communication and informatics). Given the size of the investment the business case will go to the Trust Board on the 9th September 2021 for a decision but the Committee had the following high level reflections;

(a) The Trust faces significant challenges and there is an urgent need to accelerate improvements and therefore there is a need
(b) The type of improvements investments outlined in the business case make sense and are supported in principle
(c) However at the Committee meeting a number of points were made about; demonstrating learning from other organisations who have followed this approach, improving the quantification of the business case benefits, tightening up arrangements to ensure contract delivery with KPMG, ensuring the actions and milestones of the delivery plan are well understood and performance managed, releasing Salisbury staff in a timely fashion to engage in the programme etc
(d) Finally given the urgency of the need (point a above) it is essential that the Trust takes a decision on this business case at its meeting on the 9th September 2021 and with this in mind the Committee recognised that there will still be a number of "unknowns" at the time of decision making i.e. how bad will the winter of 2021/22 actually be?

(3) Point of care testing (POCT) business case – In simple terms this business case proposed a six-month project costing £145,000, during the winter of 2021/22 to implement the fast track "bed side" pathology testing of 4 common respiratory viruses (covering Covid-19, influenza and respiratory syncytial virus (RSV)). This investment would reduce the pathology results turnaround from a one day to 35 minutes. The benefits will be patients would then be navigated to their appropriate care pathway in a timely fashion, without the clinical and organizational consequences of delay. The business case was approved, though the Committee noted the workforce challenges of recruiting 9 wte Band 3 staff) to cover this new role.

(4) Provision of Pharmacy Homecare Services (low and mid tech) – a single procurement exercise was undertaken across the three acute NHS Trusts in the Acute Hospital Alliance as well as Bath, Salisbury and Wiltshire Integrated Care System (ICS). The Committee received the tender outcome report (which would also go to the Trust Board on the 9th September 2021 for a formal decision) and the Committee supported the recommendation to award a two-year contract, with the ability to extended for a further 2 years.

(5) Expansion and development radiology and endoscopy business case – the Committee received a detailed paper which had been supported by sponsoring Clinical Division and the Trust Management Committee (TMC). The challenge identified in the business case is both to meet (a) increased demand (b) avoid waiting lists and (c) continuing to meet quality and safety standards.

The recommended option was 3, which is to resource a 4th endoscopy treatment room and proceed to relocate endoscopic retrograde cholangiopancreatography (ERCP) activity into endoscopy as per Joint Advisory Group (JAG) requirement. The capital cost of option 3 is £558,000 and the full year revenue costs are £495,000 (page 19 of the business case). The advice was that capital funding was available and assuming additional contract income became available (though this is unconfirmed), then the revenue costs would be funded i.e. a 40 patient list would result in contract income of over £990,000 at PBR prices. Aware of these financial risks the Committee still supported the business case, given the wider service challenges facing the Trust at the present time.

(6) Overseas Nurses recruitment campaign – the Committee received a business case

as to the best option for recruiting up to 60 overseas band 5 nurses and supported the recommended option 3. Which was a blended in-house and external recruitment approach costing a non-recurrent £693,000 (which is included within the 2021/22 budget). The Committee emphasized that the lessons learnt from previous overseas recruitment exercises should be taken into account. In particular the need for detailed management and careful control of all aspects of the "entire end to end process", from initial recruitment to fully starting to work on the ward.

(7) Integrated Performance Report as at 31st July 2021 (month 4) – There is a wealth of useful information in the month 4 report and a number of areas are showing signs of recovery, which evidences a lot of hard work across the Trust.

That said the key issue of performance concern raised at the Committee meeting was theatres (for example theatre start times and throughput). It was reported as a challenge "before covid and still is after covid". With this in mind a lot of Executive energy continues to be focused on this area and it will continue to be an area of interest for the Committee.

(8) Finance report as at 31st July 2021 (month 4) – The Trust has successfully implemented a new financial system and month 4 was the first set of financial reports produced from this system, so thanks were given to all staff involved in this implementation. The cumulative financial position as at the 31st July 2021 was an underspend of £27,000. Whilst this is a good position as at month 4, the predicted service and financial pressures forecast for winter 2021/22 are still significant and a lot depends upon the outcome of NHS financial settlement for the second half of the year, currently being negotiated with HM Treasury.

(9) Bath, Salisbury and Wiltshire ICS financial position – a lot of work is being undertaken by financial professionals within the ICS (led by Lisa Thomas) to quantify and explain the recurring underlying financial deficit faced by the ICS. This work is ongoing and initial forecasts need to be validated, but the bottom line is the ICS faces a very significant financial challenge to get back into financial balance and this task is likely to take in excess of five years and require considerable collective effort and innovation.

(10) Estates Status update report – the Board has been aware of significant risks relating to the Trust Estates function and actions to mitigate these risks. The committee received a further update on progress and whilst good work is taking place and a robust plan agreed, the pace of improvement is still being held back by the inability to recruit into key permanent roles. The committee noted the report and the verbal assurance of how risks are currently being managed on a day-to-day basis. The Committee also thanked Matt Taylor (Head of Estates at Royal United Hospitals Bath NHS FT) for taken on the additional role as interim Salisbury NHS FT Head of Estates, 2 days a week for 6 months. Finally the Committee were informed that a strategic scoping paper on the future of the Salisbury NHS FT estates function, would be produced by the September 2021 Committee meeting.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.3
Date of Meeting:	09 September 2021		

Report Title:	Trust Management Committee Escalation Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		x	
Prepared by:				
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive			
Appendices (list if applicable):	N/A			

Recommendation:
The Board is asked to note the report outlining items raised at the Trust Management Committee meeting held on 25 August 2021.

Executive Summary:
This month's Trust Management Committee Meeting had a full agenda which centred on updates against our actions for the CQC report and Warning Notice, performance challenges, policy and strategy updates and business cases from the Clinical Divisions. The Chief Nurse updated the committee in relation to the actions required following the CQC Warning notice and informed that the Maternity team had presented their updates to the CQC via a virtual meeting, it was felt the presentation had been positively received from CQC. In relation to the actions for Spinal, it was reported that whilst progress had been made, progress has been slow owing to the current holiday period. Our Director of Integrated Governance explained to the committee that she had attended the spinal SLT meeting and that it was a positive meeting, and that the whole team were all engaged in addressing the actions. The committee received the Risk Management Policy and it was noted that the last policy was ratified in October 2020, but that there had been some minor amendments and an update to section 10, Reporting and Escalating Risks, to strengthen and clarify the reporting and escalation of risk, which was a recommended action from the Internal Audit of Divisional Governance which was carried out in March 2021. The committee received a number of escalation reports from its subsidiary groups which were all noted by the committee.

The committee also received a Capital Programme Update as following changes to structures and approaches within the Estates team, the capital programme has been reviewed, and as a result some amendments have been made reflecting schemes that are challenged in terms of available funding and areas where the level of funding proposed in the initial programme is no longer supported for the current financial year.

Following discussions the committee approved funding for the fourth endoscopy room and automatic number plate recognition, (ANPR) which were both in the original capital programme, be prioritised for investment this year.

The committee received a number of business cases, in particular, the Overseas Nurses Recruitment Campaign case, which talked about the recruiting of some 60 Band 5 overseas nurses by March of next year at a cost of £693k, this was against a backdrop of having to go out to Thornbury agency with 8 requests a day, but unfortunately with no fill rate.

The committee also received a business case, following on from this year's flu guidance where it clearly stated that Trusts should commission services for the monitoring and tracking of their annual vaccination campaign. The case explained that by using the cloud based software 'FluTrack' staff can schedule their own appointment via the app or web. The booking process is quick and intuitive and takes less than 2 minutes of staff time to book.

The committee further noted that staff are given complete control of their appointment through the booking system and can reschedule it at any time. This allows the trust greater control of resources and the ability to optimise the vaccination programme.

The committee were reminded that the Trust used COVIDTrack successfully for the second doses of COVID vaccination and feedback from staff was overwhelmingly positive. The committee were also informed that currently, both FluTrack and COVIDTrack are needed as whilst co-administration is being suggested for hospital flu and COVID booster vaccination there is also a need for the ability to utilise single administration.

The committee noted that there is system support for costs in respect for year 1, but also noted that there are additional revenue costs of £5k which are not supported by the system.

As part of its meeting the committee had also noted that the hospital is under extreme pressure at the moment, and that staffing remains a key pressure point also, and it was reminded that this was the picture nationally, and especially north of BSW.

The Committee also received a verbal update on the progress with the improving together programme including the next stage of investment required to fulfil the programme objectives.

End of Report

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐

Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☐
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.4
Date of Meeting:	09 September 2021		

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 executive: Operational Performance – Finance & Performance Committee Quality – Clinical Governance Committee Workforce – People and Culture Committee Resources – Finance & Performance Committee			
Prepared by:	Louise Drayton, Performance & Capacity Manager			
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):				

Recommendation:
The Finance and Performance Committee are asked to note the Trust's operational performance for Month 4 (July 2021).

Executive Summary:
In month 4 pressure on the front door of the hospital remained high, with A&E the highest ever seen in a month at the Trust (6573, compared to 6323 in M3). This is a picture mirrored nationally, with ED performance decreasing from 81.3% to 77.7% at a national level. Despite the record attendance numbers at the Trust, performance increased from 78.8% to 82.6% in M4. Ambulance conveyances remained high, and capacity pressures in the Emergency Department resulted in a similar number of delays taking handover of patients from the Ambulance Service (1272 in M4 vs 1327 in M3). Bed occupancy levels remained above 90% for the month, and there were over 400 escalation bed days, reflecting the challenge in managing flow within the hospital with high levels of demand. Unsurprisingly non elective activity was above plan; the cost of this increased activity has been partially offset by suppressed costs associated with elective care levels being under plan. The number of patients reaching the Stroke Unit within 4 hours improved slightly to 47.1%, with delays in waiting to be seen and diagnosed/referred in ED factoring in the reasons why patients did not reach the unit within 4 hours. Encouragingly 94.1% of Stroke patients spent at least 90% of their admission in within the Stroke Unit (target 90%), and 52.9% of patients received a CT scan within an hour (target 50%).

Elective activity has improved, and reached 70% against the Elective Recovery Fund (ERF) threshold (48% in M3). Over performance in Daycases and Outpatient attendances offset some of this, although at a combined POD level the ERF threshold was not met in M4. The ERF threshold was revised by NHSe/i during M4 to 95% instead of 85%. Theatre workforce constraints remain a significant challenge to increasing elective activity further, with focused work being undertaken jointly by the Division and the OD&P team to improve this.

The increase in Elective activity enabled more patients that have been waiting longer than 52 weeks for elective treatment to be treated – the backlog decreased from 847 in M3 to 746 in M4, which was ahead of plan (plan of 820 in M4).

Recovery of the 6 week diagnostics standard further improved to 95.7% of patients receiving their diagnostic within 6 weeks, this is the highest performance achieved since March 2020. Further progress is expected in M5.

As expected performance against Two week wait standard for patients referred with suspected cancer continued to improve. 90.96% received their appointment within 2 weeks, of the 89 breaches 59 were due to patient choice. The Two Week Wait Breast Symptomatic referral standard was achieved following months of work to recover this.

Performance against the 62 Day standard for referral to first definitive treatment for patients referred with suspected cancer decreased in month 4 at 80.88% with the 85% standard not being achieved. Patient choice continues to factor into the reasons for delays, but also delays associated with diagnostics, and complex pathways. Further targeted work to identify and resolve delays continues.

Staffing challenges remained high in month, with a high level of bank and agency usage in Medicine and non-consultant medical staff in particular. Appraisals and mandatory training rates have declined in month, with sickness rates increasing, compounding the challenges of ensuring adequate staffing levels for the high levels of activity. The number of vacant nursing posts remains static at 81wte.

The Trust continues to operate within its allocated H1 2021/22 contractual envelopes up to the end of July 2021, with a YTD reported surplus of £27k. Expenditure envelopes are derived from the system's winter 2019/20 run rate, meaning expenditure growth beyond baseline inflationary (excluding that specifically funded for Covid measures) will drive a cost pressure for the Trust that needs to be mitigated.

Board Assurance Framework – Strategic Priorities	Select as applicable
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People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒
Other (please describe) -	☐

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

September 2021

(data for July 2021)

An outstanding experience for every patient

Summary

Salisbury NHS Foundation Trust

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Structure of Report

Performance against our Strategic and Enabling Objectives

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

Summary Performance
July 2021

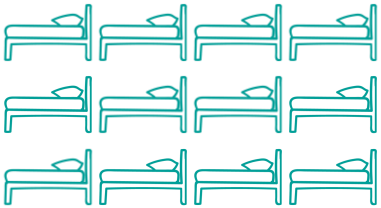
NHS Salisbury NHS Foundation Trust

There were **2,782** Non-Elective Admissions to the Trust

We delivered **36,323** outpatient attendances, **24.2%** through video or telephone appointments

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

We carried out **323** elective procedures & **1,847** day cases



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

RTT 18 Week Performance: **74.09%** ↑

Total Waiting List: **19,015** ↑

95.8% ↓ of patients received a diagnostic test within **6 weeks**

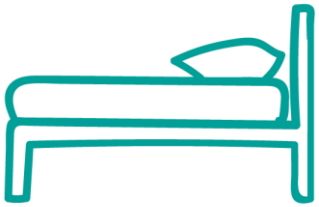
Our income was **£24,076k** (£42k above plan)

18.3% ↓ of discharges were completed before 12:00

Emergency (4hr) Performance **82.6%** ↓

(Target trajectory: 95%)

55 patients stayed in hospital for longer than 21 days



Our overall vacancy rate was **6.69%** ↑

Reading a Statistical Process Control (SPC) Chart

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

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

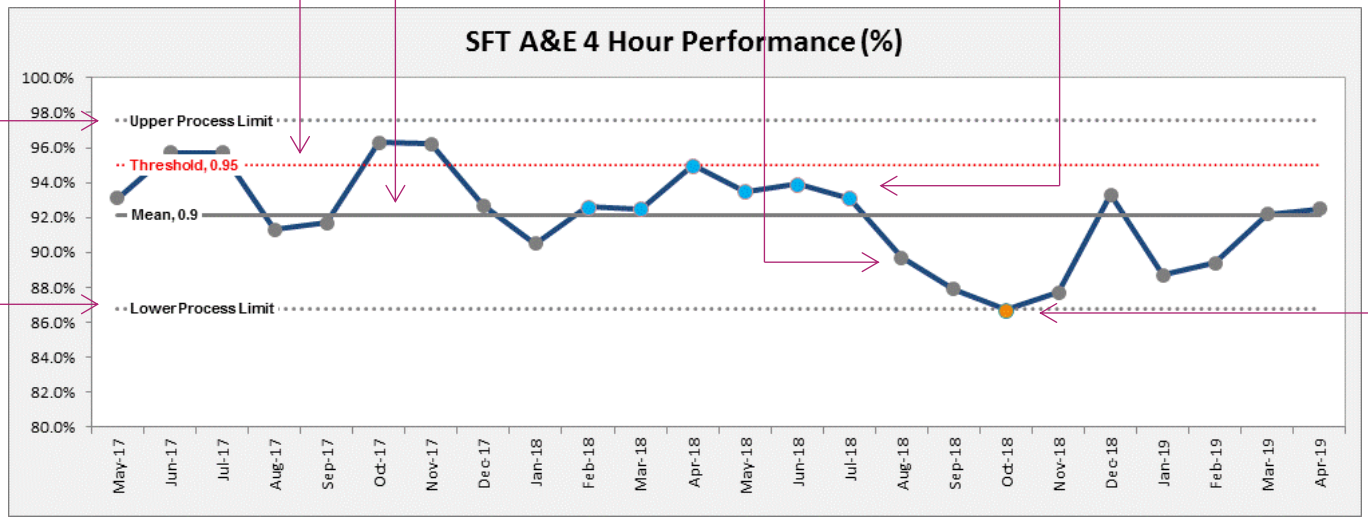
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

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

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



Statistical Process Control Chart Key:

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

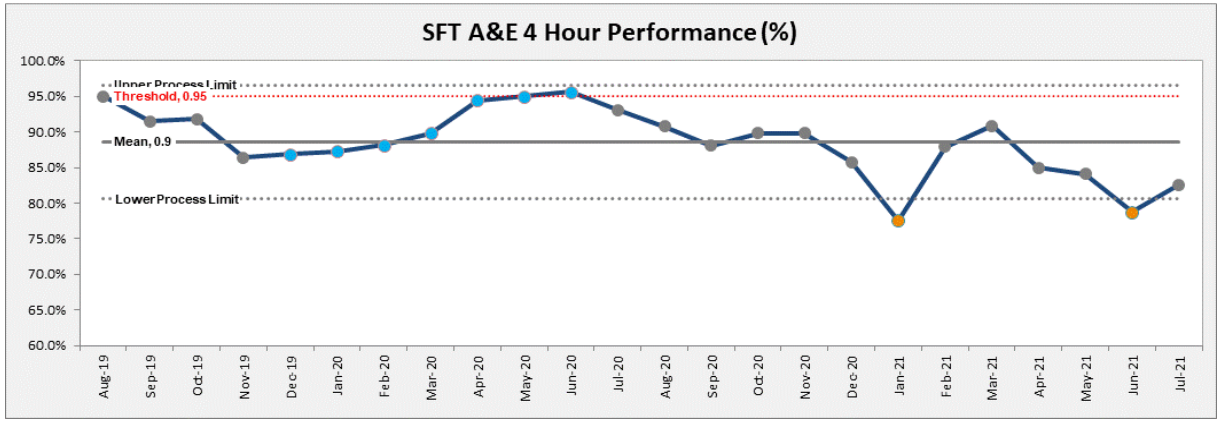
Salisbury NHS Foundation Trust

Part 1: Operational Performance

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

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

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month: 82.6%

Attendances: 6573

12 Hour Breaches: 0

ED Conversion Rate: 26.0%

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

Month 4 saw an increase in performance for the 4 hour standard as compared to M3 (increase from 78.8%). There has been an increase in numbers from 5971 in M3 compared to M4.

Conversion rate is similar to M3 (27.5%) which still shows the acuity of patients requiring admission. Again we have seen another significant increase in military attendances of 341, compared to M4 19/20 data of 201.

Staffing continues to be a challenge within the department. M4 again saw a rise in attendances, reaching >200 attendances in one day, highest number of attendances recorded within the department for a 24 hour period.

Access to primary care continues to impact on number of attendances into ED, with emphasis on our minors department. We have advertised through locums nest for a GP to support our minors service especially in twilight hours where a significant number of attendances present, but there has been no appetite for this and no shifts have been filled.

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

We have started a pilot for ED to add directly onto the AMU take to assist with flow out of the department, this will continue to be monitored through AMU SLT meetings by the UEC manager to address any issues.

Ongoing meetings with the Think 111 First programme attended by UEC manager and ED Consultant.

SDEC, ED Improvement Group and ED standard task and finish groups have been implemented to focus on SDEC care and pathways into specialties from ED to improve flow out of the department and to improve patient experience. UEC manager has started working with informatics also to ensure we have correct coding for ECDS

The Perspex screens have been implemented into both the majors and minors waiting rooms, this has had a significant impact on increasing capacity, with no capacity issues being escalated since implementation.

We have successfully recruited into vacant B7 nursing gap and are recruiting into vacant B6 position in M5.

Risks to delivery and mitigations

M5 is changeover month for junior doctors and this will impact on the 4 hour performance whilst they embed themselves into the Trust. We still have significant middle grade gaps within the department.

AMU/Medicine medical workforce gaps will also continue to have impact on flow out of the department contributing to poor performance of the 4 hour standard.

Nursing staffing remains a challenge . There is a reduction in B6's due to maternity leave and covering triage and shift coordinator roles will be challenging in M5 along with B5 vacancies.

Military exercises starting up again continues to see a significant rise in military attendances and numbers are being monitored.

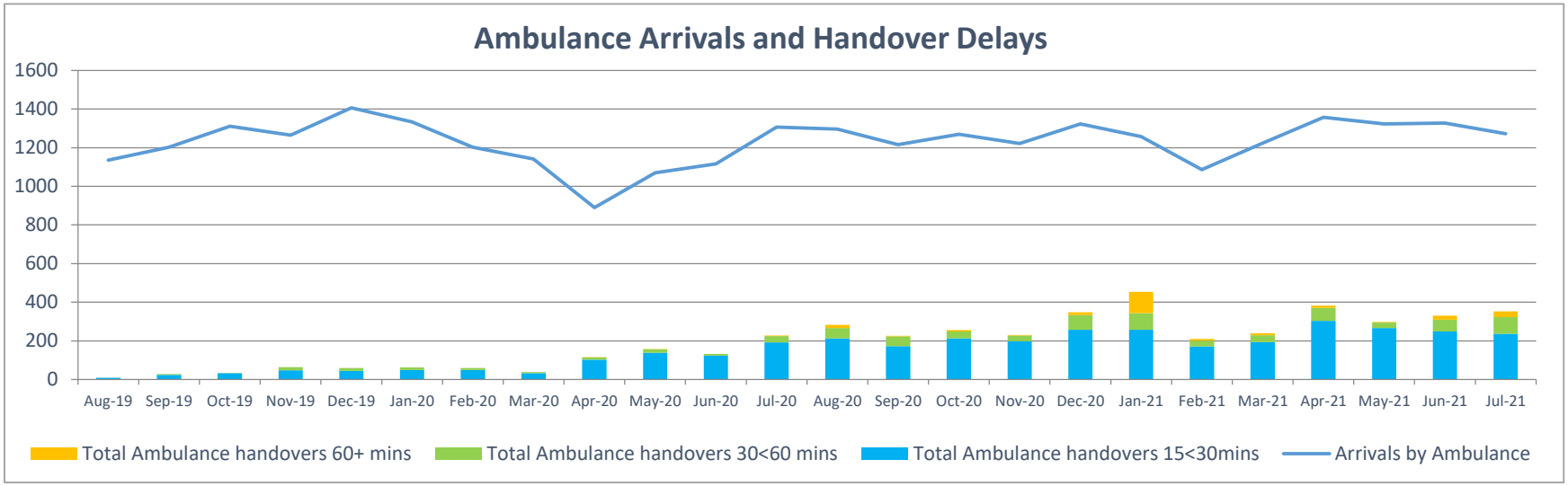
Access to primary care continues to impact on attendances into department, especially our minors service. Agreement has been made that ED1 consultant will address waiting room to keep patients informed of delays and options given to access WIC or MIU if appropriate.

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

Ambulance Handover Delays

National Key Performance Indicators



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

There has been a small decrease in number of ambulances in M4 of 1272 compared to M3 of 1327 with number of ambulances presenting remaining high.

We have seen an increase in ambulance handover delays, this is likely linked to the high overall attendance levels and capacity constraints in the department. There has been an increase from M3 of 9 >1 hour breaches to 30 >1 hour breaches in M4 and handover delays from 30-60 minutes has seen an increase of 25 in M4 from 61 in M3.

Staffing shortages in both medical and nursing workforce alongside increase in demand has been contributory to the increase in delays.

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

Bi-monthly meetings continue between SWAST and clinical leads to address concerns and contribute to collaborative working.

Currently ambulance alerts appear on 1 screen within majors but not in immediate sight of NIC. Request to SWAST to identify if the alerts can be visible on more than 1 screen with handover times rag rated if possible. Service manager to follow this up with IT once response received back from SWAST, expected in M5.

ED improvement group and SDEC groups commenced in July to incorporate the new ED standards. Ambulance handovers will be addressed within this group.

The trial of new standards for ambulances to offload directly into AMU was due to start in M4 but did not receive sign off from SWAST for this to start. This is now planned to start in M5.

Regional call in M4 with regards to off loading conveyance showed SFT to be the best performing Trust in the region. All staff are aware of focus in off loading ambulances and performance will continue to be monitored by UEC Manager

Risks to delivery and mitigations

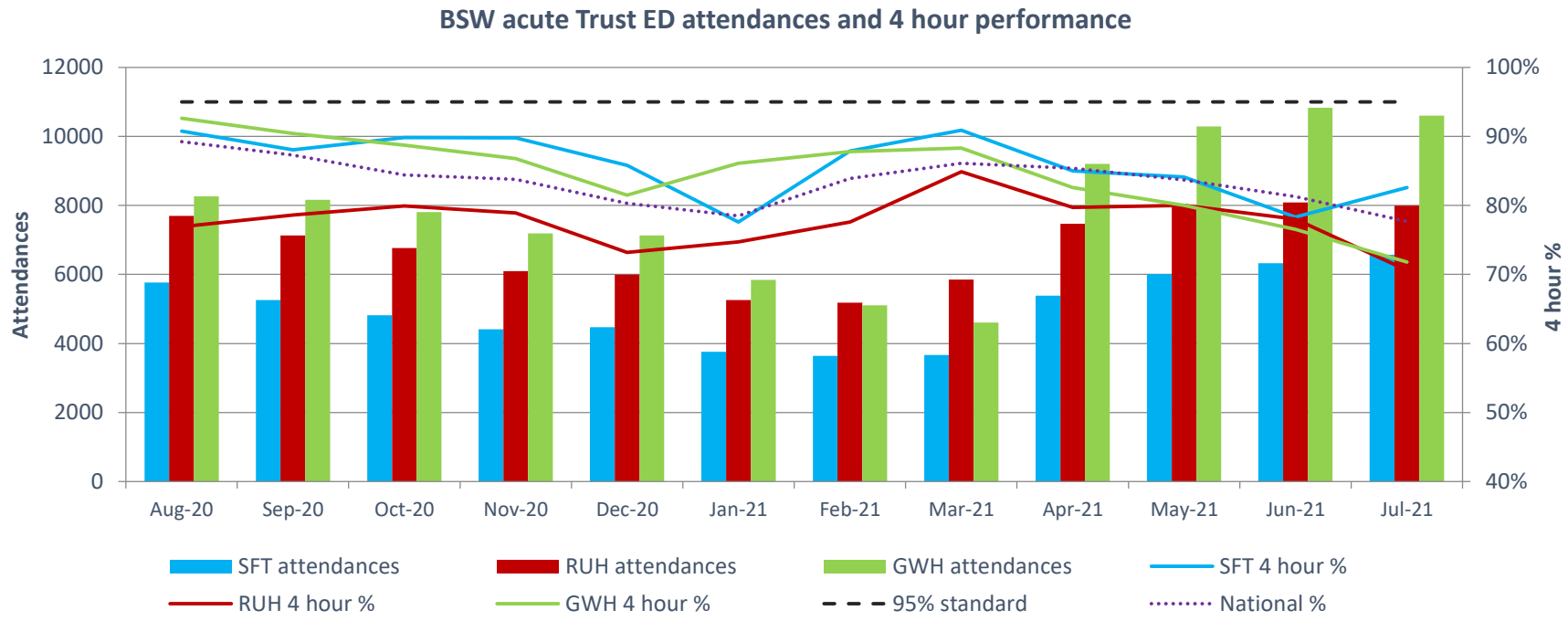
Capacity within the department continues to remain challenging especially with high volume of attendances presenting within similar timeframes (high number of presentations within one hour will impact on ability to offload ambulances)

Medical workforce gaps both in ED and AMU, alongside high number of nursing gaps in ED will continue to remain a contributing factor in being able to accept handovers within 15 minutes.

Verbal agreement with SWAST if we have capacity to off load but do not have adequate staffing to receive patients safely, they will cohort patients so that other crews can leave to attend to other calls.

BSW Context – Emergency Access (4hr) standard

Are We Effective?

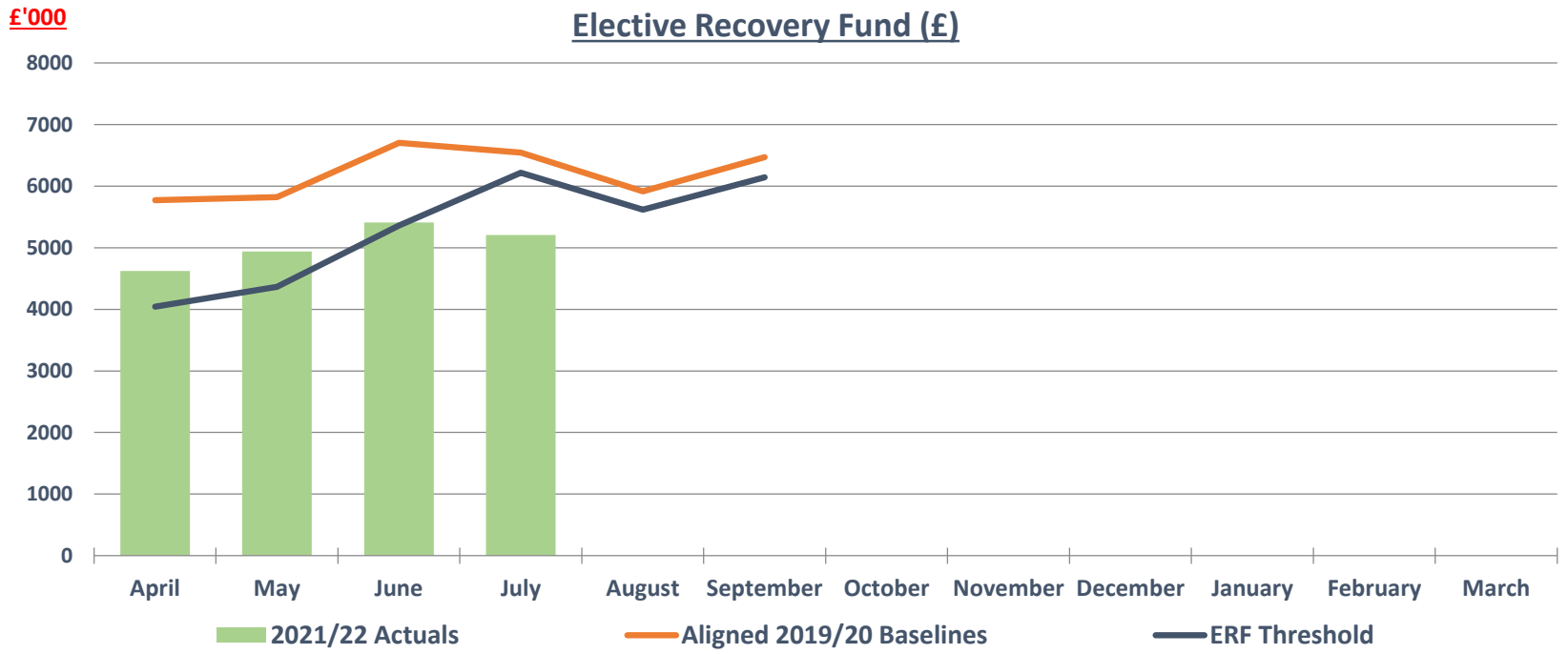


ED attendances remain high across the system, with SFT seeing the highest number of attendances ever seen in any given month at SFT (6573). RUH (7994) and GWH (10606) were broadly in line with M3, with RUH being above 2019 M4 levels, and GWH just below the 2019 M4 levels.

Performance against the standard to admit, discharge or transfer 95% patients attending the emergency department within four hours fell at a National level (81.3% in M3 to 77.7% in M4). This was reflected at GWH (71.8% in M4 vs 76.5% in M3) and RUH (70.6% in M4 vs 78% in M3). Despite the increase in attendances, performance at SFT increased to 82.6% compared to 78.3% in M3.

Activity recovery – Elective Recovery Fund

Are We Effective?

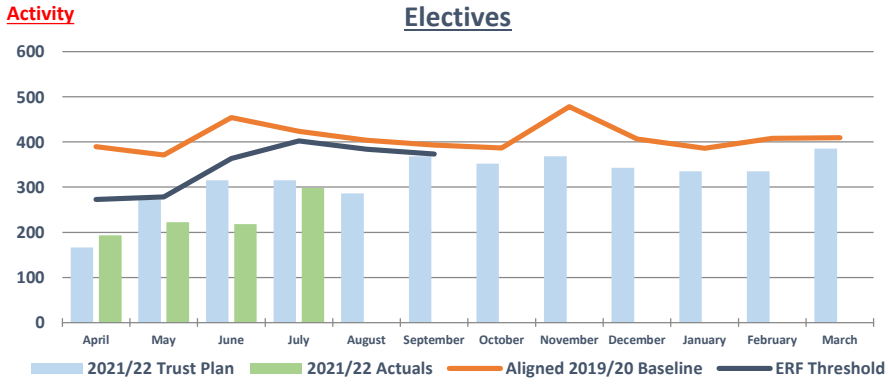


Activity in July has been strong again in day cases, with an additional 111 Day cases in month. Day case activity has improved against plan in the surgical specialties of General Surgery and Ophthalmology, but activity levels have dipped this month in Gastroenterology although activity is still above planned levels. Activity in elective inpatients showed a much improved position in total of 83 spells more than in June and T&O achieved the planned level for the month.

The delivery of day cases, electives, outpatient procedures and outpatients was at 80% against the revised threshold of 95% for July. The target is for individual months, therefore whilst no additional funding would be applicable in July, additional funding of circa £1.2m year to date would be applicable to earlier months to be deployed by BSW should other system partners deliver above the target. Therefore, the July position is concerning and significantly more work is required to trigger additional funding in quarter 2.

Activity recovery – Electives (target 95%)

Are We Effective?



Specialty	2019-20	2021-22	Delivery
Clinical Haematology	7	15	224%
Gastroenterology	2	3	157%
General Surgery	25	28	113%
Medical Oncology	1	1	105%
Ophthalmology	1	1	105%
Paediatrics	2	2	105%
Spinal Injuries	11	11	96%
Breast Surgery	10	8	84%
Cardiology	13	10	75%
ENT	26	18	70%
Colorectal Surgery	25	17	68%
Oral Surgery	13	9	67%
Plastic Surgery	69	46	67%
Urology	78	50	64%
General Medicine	9	5	58%
Trauma & Orthopaedics	82	46	56%
Interventional Radiology	2	1	52%
Paediatric Ear Nose And Throat	2	1	52%
Spinal Surgery Service	14	7	49%
Gynaecology	25	9	36%
Vascular Surgery	6	0	0%

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

The target levels for Elective activity to meet the Elective Recovery Fund (ERF) threshold in month 4 was 95%. The Trust achieved performance of 70% therefore falling short of the ERF threshold, this was also a slightly lower level of electives than expected in the plan as 298 electives were performed against a plan of 315 resulting in a shortfall of 17 against plan. This was a significant improvement from M3 thought where the Trust performance was 48%.

Main area of underperformance continued to be Trauma & Orthopaedics due to high proportions of clinically routine, low priority patients impacting their access to theatre capacity however the running of a second daily T&O elective list in the week commenced in July which will improve this. There was also a reduction in performance for both Urology and Plastic Surgery due to their access to theatres being slightly reduced compared to previous months in order to allow other more complex, routine services to restart and increase their capacity. Due to the complex nature of these services this means that the volume of patients on a list is lower than some of the other specialties due to case mix.

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

The Four Eyes productivity and efficiency work focusing on list utilisation and theatre efficiency.

Procurement of insourcing model to increase capacity continues. The majority of the capacity this has provided is for daycases however in M4 the use of the weekend insourcing teams to run elective Trauma & Orthopaedic lists commenced.

Risks to delivery and mitigations

Theatre workforce for local lists. Mitigation is work being undertaken by OD&P and the Division on recruitment and retention although this has been delayed until September. Workforce fill and skill mix to allow running of all planned insourcing activity. Work ongoing with Procurement and the Division to ensure this is robust.

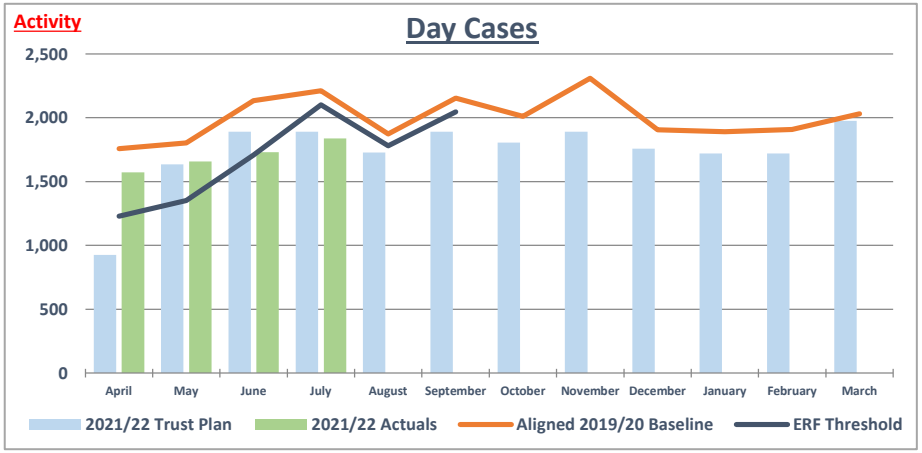
Risk that high levels of emergency and trauma will impact on elective lists.

Continued issues with late starts and slow turnarounds. Theatre Recovery Lead now in post to drive forward improvements in these areas.

Theatre access continues to be allocated by clinical priority, and volumes of patients waiting over 52 week for surgery, 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.

Activity recovery – Day case (target 95%)

Are We Effective?



Specialty	2019-20	2021-22	Delivery
General Surgery	223	247	111%
Plastic Surgery	253	277	110%
Dermatology	8	8	105%
Urology	146	148	101%
ENT	43	42	98%
Respiratory Medicine	19	18	94%
Spinal Surgery Service	15	14	91%
Ophthalmology	175	157	90%
Colorectal Surgery	161	127	79%
Breast Surgery	23	18	78%
Gastroenterology	508	392	77%
General Medicine	85	63	74%
Cardiology	120	85	71%
Neurology	23	15	65%
Rheumatology	121	77	63%
Oral Surgery	91	39	43%
Interventional Radiology	21	9	43%
Trauma & Orthopaedics	73	31	43%
Gynaecology	69	29	42%
Geriatric Medicine	8	3	39%
Vascular Surgery	27	3	11%

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

The target levels for daycase activity to meet the Elective Recovery Fund (ERF) threshold in month 4 was 95%. The Trust achieved performance of 83% but this did not exceed the revised ERF threshold which increased to 95% from 1st July. This was a slightly lower level of daycases than in the plan, 1838 were performed against a plan of 1890 with a shortfall of 52 . This was an increase from M3 where 1730 daycases were performed.

The level of activity was impacted by lower levels of weekend WLI high throughput lists being able to be run due to challenges with theatre staffing. Workforce challenges also impacted weekday activity as the target was 9.8 baseline theatres open but due to high staff sickness only 9.7 theatres open on average . Theatre Staff Incentive Payment Scheme uptake also very low in July (£9k).

Main areas of underperformance were Trauma & Orthopaedics, due to the transfer of their daycase activity to Newhall; Gynaecology and Oral Surgery, who have both been impacted by allocation of theatres based on clinical priority; and Gastroenterology. The Gastro team had significant workforce challenges in M4 due to a gap in the consultant team. This has now been rectified as a Locum has been appointed.

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

SFT IPC guidelines have now been updated to fall in line with the process recommended nationally for low risk pathways. This will enable improved utilisation of lists due to the ability to now utilise capacity that comes available due to cancellations within 14 days.

The Four Eyes productivity and efficiency work focusing on list utilisation.

Procurement of insourcing model to significantly increase capacity continues providing additional capacity focussed on Plastic Surgery, General Surgery and Urology.

Risks to delivery and mitigations

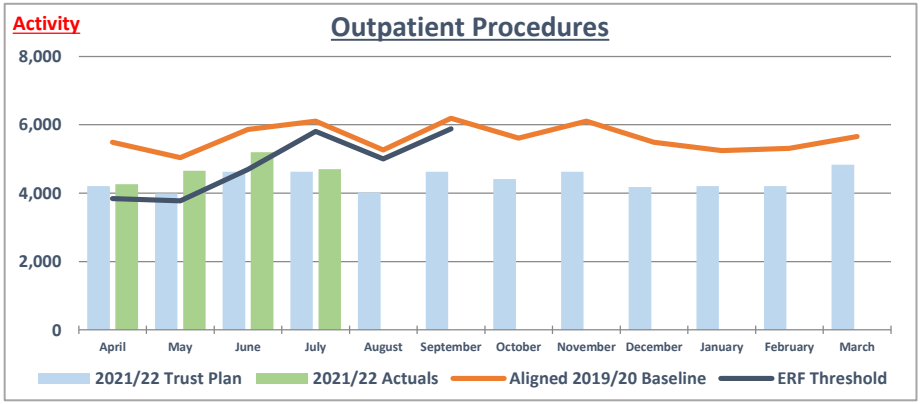
Theatre workforce for local lists. Mitigation is work being undertaken by OD&P and the Division on recruitment and retention although this has been delayed until September. Workforce fill and skill mix to allow running of all planned insourcing activity. Work ongoing with Procurement and the Division to ensure this is robust.

Continued issues with late starts and slow turnarounds. Theatre Recovery Lead appointed in post from 1st July to drive forward these improvements.

Theatre access continues to be allocated by clinical priority, and volumes of patients waiting over 52 week for surgery, 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.

Activity recovery – Outpatient Procedures (target 95%)

Are We Effective?



Specialty	2019-20	2021-22	Delivery
Gynaecology	251	660	263%
Breast Surgery	46	98	213%
Clinical Cardiac Physiology	144	255	177%
Gynaecological Oncology	22	27	123%
Orthodontics	278	278	100%
Rheumatology	18	17	94%
Oral Surgery	195	167	86%
Respiratory Physiology	93	74	80%
Audiology	629	490	78%
Clinical Neurophysiology	206	160	78%
Vascular Surgery	36	27	74%
Trauma & Orthopaedics	88	61	69%
Urology	302	206	68%
Maxillo-Facial Surgery	23	15	65%
Dermatology	418	261	62%
Interventional Radiology	23	14	61%
Ophthalmology	1,534	914	60%
Plastic Surgery	847	479	57%
Respiratory Medicine	304	157	52%
ENT	443	225	51%
Neonatal care	22	6	27%
Paediatric Ear Nose And Throat	50	5	10%
Paediatric Plastic Surgery	16	1	6%
Paediatrics	20	1	5%

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

The target levels for Outpatient Procedure activity to meet the Elective Recovery Fund (ERF) threshold in month 4 was 95% but the Trust fell short of this achieving 77%. However performance was higher than plan with 4699 procedures undertaken against a plan of 4625.

This lower than pre Covid-19 activity number has been impacted by the increased numbers of appointments being undertaken virtually, and the space constraints in many outpatient areas, which is why the level of outpatient procedures has reduced compared to 19/20 baseline but exceeding the 20/21 Trust Plan.

Specialties with fewer Covid-19 related and physical space constraints can be seen to have fully recovered more effectively with activity for some being well over 100%.

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

Specialties with fewer Covid-19 related and physical space constraints can be seen to have fully recovered more effectively with activity for some being well over 100%.

The installation of the air change solution for both the ENT & Oral Surgery outpatient departments has meant that outpatient procedure activity for these specialties, both with high levels of aerosol generating procedures (AGP), is now rising.

New peripheral site identified to provide additional capacity for Ophthalmology outpatient procedure clinics. These are due to commence in M5.

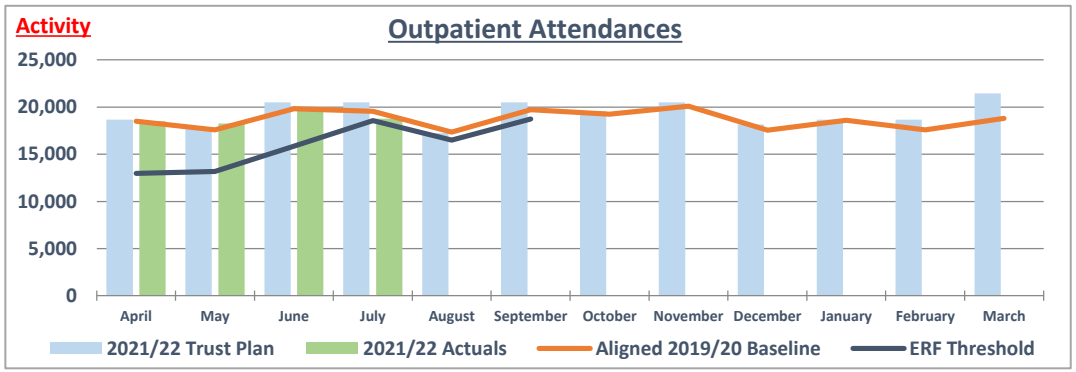
Insourcing solution for weekend capacity being procured for Respiratory Medicine.

Risks to delivery and mitigations

Space constraints across outpatient departments continue to be a significant challenge, particularly in specialties. This is particularly impacting Ophthalmology and Respiratory Medicine.

Activity recovery – Outpatient Attendances (target 95%)

Are We Effective?



Specialty	2019-20	2021-22	Delivery
Burns Care	110	214	195%
Clinical Cardiac Physiology	688	1,209	176%
ENT	308	466	151%
Geriatric Medicine	124	181	146%
Dermatology	256	371	145%
Interventional Radiology	83	120	144%
Clinical Haematology	428	595	139%
Ophthalmology	1,216	1,494	123%
Speech And Language Therapy	407	493	121%
Urology	586	691	118%
Gynaecology	359	403	112%
Occupational Therapy	85	94	110%
Rehabilitation	458	479	105%
Spinal Injuries	125	131	105%
Plastic Surgery	1,596	1,638	103%
Gastroenterology	324	332	102%
Medical Oncology	490	497	101%
Anticoagulant Service	130	132	101%
Breast Surgery	470	446	95%
Colorectal Surgery	602	564	94%
Programmed Pulmonary Rehabilitation	99	91	92%
Physiotherapy	260	237	91%
Respiratory Medicine	429	383	89%
Oral Surgery	528	451	85%
Clinical Physiology	439	373	85%
Trauma & Orthopaedics	1,869	1,574	84%
Cardiology	620	515	83%
Paediatrics	814	670	82%
Orthotics	789	600	76%
Audiology	623	473	76%
Endocrinology	278	210	75%
General Medicine	110	78	71%
General Surgery	450	311	69%
Vascular Surgery	267	182	68%
Rheumatology	928	610	66%
Clinical Psychology	169	110	65%
Cardiac Rehabilitation	356	217	61%
Orthoptics	216	110	51%
Spinal Surgery Service	206	99	48%

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

The target levels for Outpatient activity to meet the Elective Recovery Fund (ERF) threshold in month 4 was 95%. The Trust achieved performance of 96% exceeding the ERF threshold. However this was still a slightly lower level of outpatients than expected in the plan as 18, 775 were attended against a plan of 20,518.

Specialties with fewer Covid-19 related constraints can be seen to have fully recovered with activity for some being well over 100%.

The impact of the increased capacity for Oral Surgery and ENT following the completion of the air handling solution and the opening of the modular build can be seen as there has been an improvement in their performance with Oral Surgery now at 85% and ENT at 151%.

Virtual appointments are working well in a number of specialties with Gastroenterology and Cardiology seeing high numbers of their outpatients virtually.

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

Increased capacity for T&O when the move into their new footprint completed. This move is due to take place on the 31st August.

New peripheral site identified to provide additional capacity for Ophthalmology outpatient procedure clinics. These are due to commence in M5.

Insourcing solution for weekend capacity being procured for Respiratory Medicine.

Risks to delivery and mitigations

Space constraints across outpatient departments continue to be a significant challenge, particularly in specialties with low levels of patients suitable for virtual appointments such as Trauma & Orthopaedics and Spinal Surgery with recovery for these specialties being limited by a lack of access to face-to-face clinical space exacerbated by limited suitability for virtual solutions.

Creep in some specialties back to onsite preferences. Focussed work is being undertaken to improve medium-long virtual models.

Theatre Performance

Theatre KPI's

	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 21	Feb 21	Mar 21
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								
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	July 21
% Utilisation	Day Surgery Theatres	90%	75%
	Main Theatres	85%	90%
Turnaround	Day Surgery Theatres	8 mins	18m
	Main Theatres	12 mins	31m
% Late Starts (over 15 minutes beyond start of list)	Day Surgery & Main Theatres	2%	80%
% short notice Hospital Cancellations (0-3 days)	Total	2%	2.5%
% Short notice Patient Cancellations (0-3 days)	Total	2%	6.3%

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

Underperformance of elective activity accounts for the theatre activity being lower than plan in M4. This was mainly due to workforce issues in theatres which did not allow the running of as many theatres as anticipated in the plan. Ran average of 106 a week theatre sessions in June 2021, slipping slightly off trajectory to achieve baseline plan. Target of 9.8 baseline theatres open in M4 but high staff sickness led to only 9.7 theatres open on average in July.

This has been further exacerbated by issues around late starts and high levels of cancellations.

Theatre Staff Incentive Payment Scheme uptake very low in July (£9k), anecdotally pre-Elective Recovery burnout may be contributing.

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

Theatres Recruitment and Retention plan delayed to September, although advert just closed with 17 shortlistable candidates. Education in Theatres going well, 5 WTE scrubs now training full time – 3 as ODPs and 2 as SFAs (medium term plan for Theatres).

SFT IPC guidelines have now been updated to fall in line with the process recommended nationally for low risk pathways. This will enable improved utilisation of lists due to the ability to now backfill capacity that comes available due to cancellations within 14 days.

Procurement of insourcing model to significantly increase capacity continues. This focusses on Plastic Surgery, General Surgery and Urology and will provide opportunity to date increased numbers of long waiting, clinically routine, patients on additional day surgery unit lists and will also allow local teams to be utilised in main theatres to increase the number we are able to run therefore increasing elective capacity as well.

Plans to continue to run high volume, low complexity lists both in the week for a number of specialties and as WLI weekend lists for Plastic Surgery.

The Four Eyes productivity and efficiency work focusing on list utilisation will drive forward the realisation of opportunity on lists especially in the Day Surgery Unit.

Risks to delivery and mitigations

Theatre workforce for local lists. Mitigation is work being undertaken by ODP and the Division on recruitment and retention.

Workforce fill and skill mix to allow running of all planned insourcing activity. Work ongoing with Procurement and the Division to ensure this is robust.

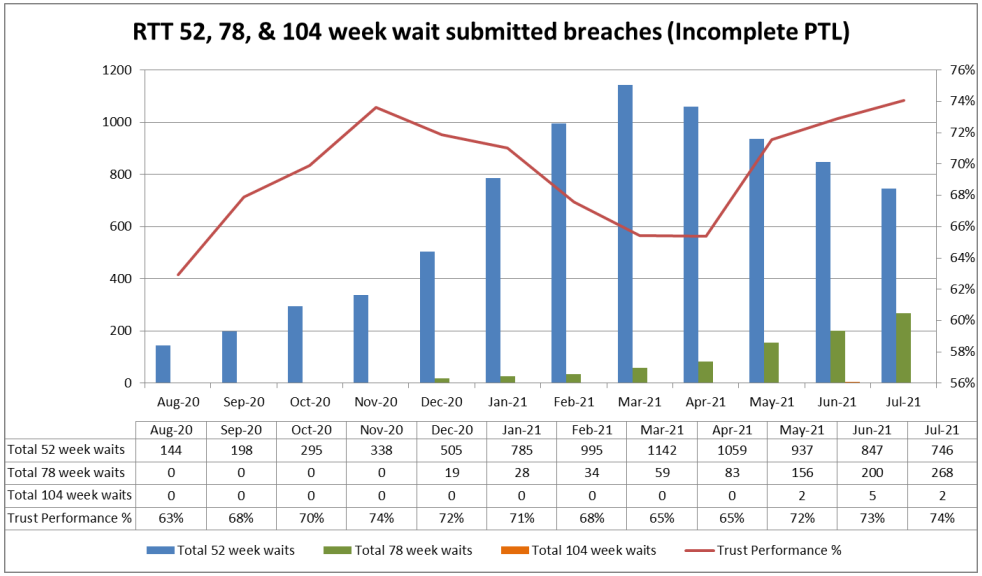
Risk that high levels of emergency and trauma will put elective lists at risk.

Continued issues with late starts and slow turnarounds. Theatre Recovery Lead appointed in post from 1st July to drive forward these improvements.

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



	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Total 52 week waits	144	198	295	338	505	785	995	1142	1059	937	847	746
Total 78 week waits	0	0	0	0	19	28	34	59	83	156	200	268
Total 104 week waits	0	0	0	0	0	0	0	0	0	2	5	2
Trust Performance %	63%	68%	70%	74%	72%	71%	68%	65%	65%	72%	73%	74%

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

Treatment function	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	% change from
Plastic Surgery	54	74	107	132	148	139	145	140	133	-5%
Ophthalmology	55	115	202	238	253	203	158	120	92	-23%
Trauma and Orthopaedic	37	44	71	104	134	130	114	99	85	-14%
Urology	44	49	65	84	96	89	94	88	78	-11%
Oral Surgery	30	61	97	117	135	146	102	87	76	-13%

Longest Waiting patient (Weeks)	Apr-21	May-21	Jun-21	Jul-21
	101	106	110	108

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

The number of patients waiting longer than 52 weeks has decreased by 88 patients to a total of 746, exceeding the trajectory position of 820. The trajectory for reducing over 52 week patients is a reduction of 80 patients per month to a total of 660 in September 2021.

Approximately 12% are patients who have requested to pause their pathway. Approximately 20% of patients waiting longer than 52 weeks are waiting at the non-admitted stage of their pathway and 80% are waiting on an admitted pathway.

Of the patients waiting on an outpatient pathway, most are in Ophthalmology. Of the patients waiting on an admitted pathway the specialty split is more broad with the highest being in Plastic Surgery, followed by Urology, Orthopaedics, Oral Surgery and Gynaecology and these specialties make up almost 70% of those waiting over 52 weeks on an admitted pathway.

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

Transfer of Plastic Surgery patients waiting for hand surgery to Sulis Bath to commence in M5.

Additional Saturday high volume lists at SFT for Plastic Surgery continue to run to further address this cohort. Further BSW WLI weekend lists planned for M6 which will provide additional capacity for paediatric ENT and Oral Surgery.

Continued transfer of Orthopaedic patients to Newhall and continued outsourcing of cataract patients for surgery and outpatient appointments to two additional providers will work to reduce these further.

Additionally the insourcing theatre model will continue to provide increases in capacity to tackle this cohort of long waiting patients as will the increase of routine elective orthopaedic lists at SFT from M4 that this facilitates.

New peripheral site identified to provide additional capacity for Ophthalmology outpatient procedure clinics. These are due to commence in M5

Risks to delivery and mitigations

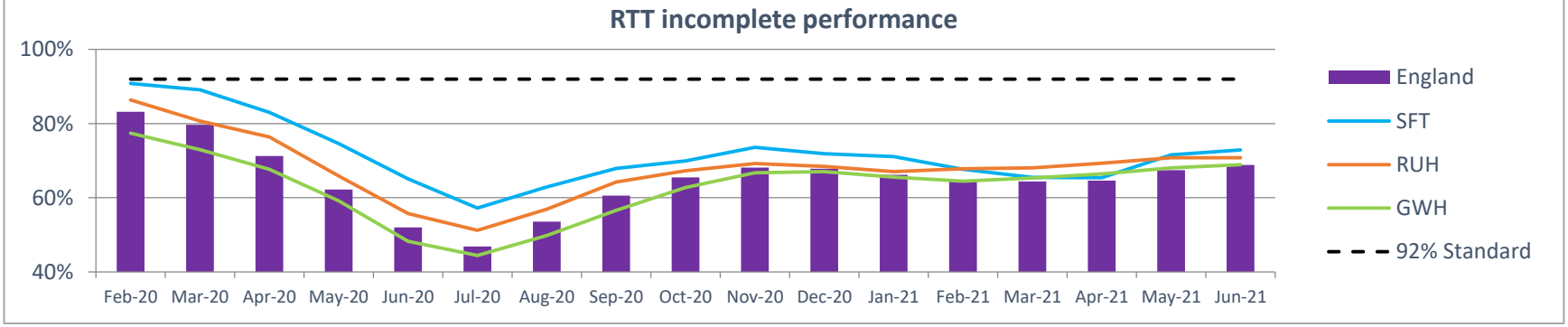
Space constraints across outpatient departments continue to be a significant challenge.

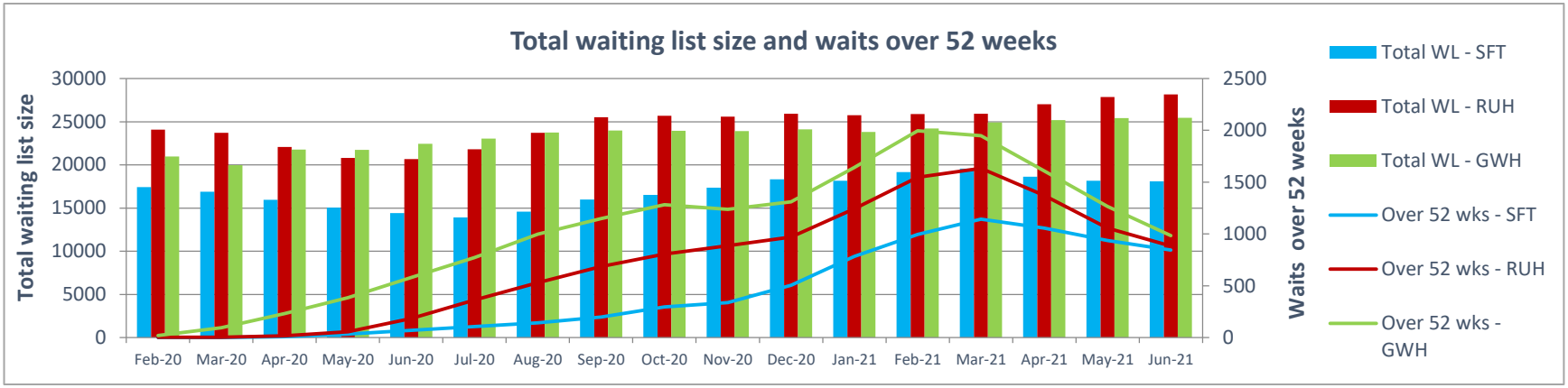
There have been specific challenges to increasing activity in Ophthalmology in relation to the ability to socially distance, outpatient capacity and the proportion of vulnerable patients in this group.

Theatre workforce challenges impacting capacity on local and insource lists.

BSW Context – Referral To Treatment (RTT)

Are We Effective?



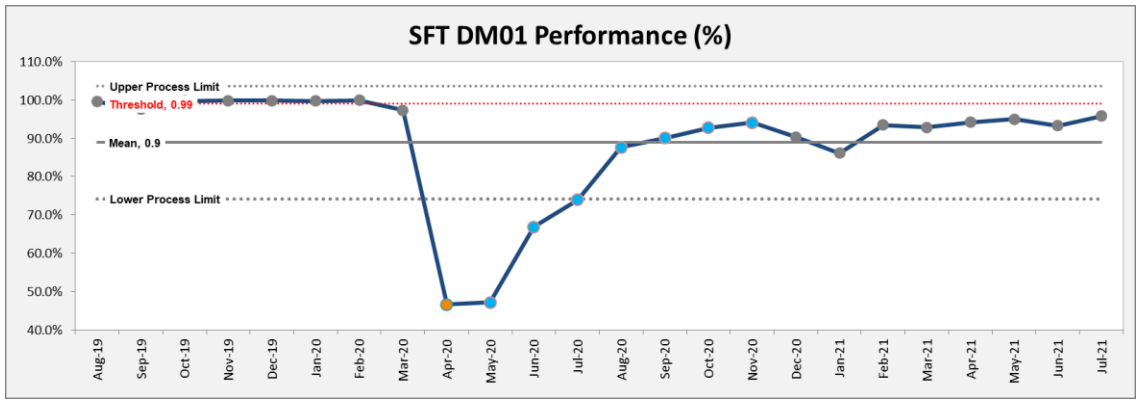


The focus continues on restoring elective services and reducing elective backlogs, and further progress was made in reducing the number of patients waiting longer than 52 weeks for treatment. In M3 this reduced collectively across the three acute Trusts to 2715 (846 at SFT, 885 at RUH and 984 at GWH) from 3260 in M2. This equates to 4.7% of the total waiting list at SFT, 3.1% at RUH and 3.9% at GWH. Nationally there was 5.6% of the total waiting list waiting longer than 52 weeks in M3. The total waiting list for England is at 5.45 million in M3, compared to 4.43 million in February 20 immediately prior to the Covid-19 pandemic.

Total waiting list size remains broadly static at all three Trusts, with marginal overall increase in performance against the 18 week Referral to Treatment standard. Nationally performance against the RTT standard improved slightly from 67.4% in M2, to 68.8% in M3. All three BSW Trusts reported performance above the national average in M3 with SFT at 72.9, RUH at 70.8% and GWH at 68.9%.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month: 95.77%

Waiting List Volume: 3549

6 Week Breaches: 150

Diagnostics Performed: 7329

Modality performance

MRI	100.0%	US	96.7%	Audio	79.6%	Neuro	100.0%	Flexi sig	100.0%
CT	100.0%	DEXA	100.0%	Cardio	81.4%	Colon	98.9%	Gastro	98.2%

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

DM01 performance improved in M4 as compared to M3, increasing from 93.3% to 95.77%. The overall performance standard has not been achieved, primarily due to under performance in USS, Cardiology Echo and Audiology.

USS breaches reduced from 118 in M3 to 49 in M4 and performance is expected to recover by end of M5.

Cardiology Echo breaches reduced from 123 in M3 to 57 in M4 and performance is expected to recover by end of M5.

Audiology breaches unexpectedly increased from 20 in M3 to 40 in M4, mostly due to workforce issues reported late in the month. Capacity issues are likely to continue for Audiology in M5 due to the workforce absences and increasing demand from ENT outpatient clinics,

There were a small number of breaches (impacting 4 patients) in Endoscopy tests due to the number of cases that required anaesthetic support.

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

USS: Additional lists will continue throughout M5 with the expectation that DM01 performance in this area will be completed by end of M5.

Echo: Additional lists continue as per M4, recovery of waiting times is possible in M5, although not definite,

Audiology: Capacity concerns remain with Audiology for M5 and performance remains vulnerable. Head of Service and Divisional Manager for Audiology to submit improvement plan/mitigating actions to Delivery Group.

Endoscopy: Anaesthetic demand and capacity being managed. It is possible that performance may deteriorate slightly in M5 within Endoscopy due to the M5 rota and workforce absences. GI Service Manager and Divisional Manager for Surgery are monitoring the capacity and increasing where possible.

Risks to delivery and mitigations

Continuing increase in referral rates and demand (particularly in USS). MRI capacity, although performing, has been more challenging in M4 due to workforce absences. This will be closely monitored into M5.

Long term sustainability of additional lists from within own workforce. This can be mitigated if suitable agency locums are sourced but it is challenging to find external workforce.

Impact of additional elective outpatient activity (e.g. in ENT) will have 'knock on' impact to diagnostic demand. Pre planning of coordinated additional activity required, to be picked up between CSFS and other Divisions.

Statistical Process Control Chart Key:

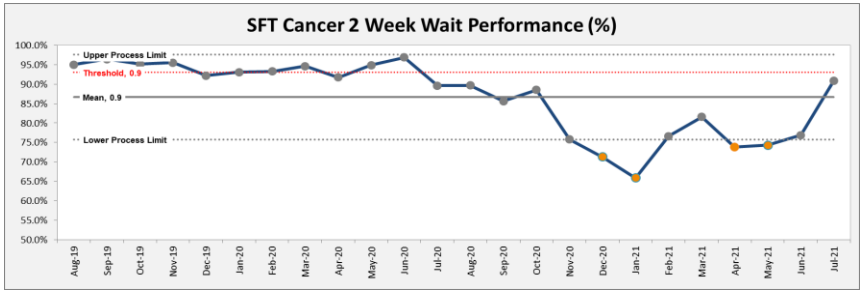
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)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

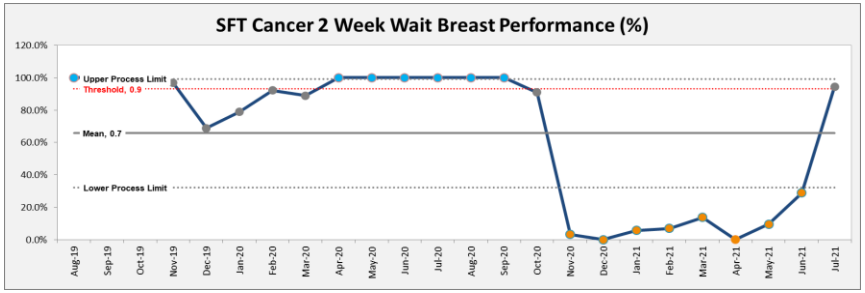
Cancer 2 Week Wait Performance Target 93%

National Key Performance Indicators

Performance Latest Month	Performance	Num/Den	Breaches
Two Week Wait Standard:	90.96%	895/984	89 (59 patient choice)
Two Week Wait Breast Symptomatic Standard:	94.44%	34/36	2 (2 patient choice)

Data Quality Rating:





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

Two week standard not achieved for Month 4, though significant improvement in number of breaches associated with capacity when compared to Quarter 1 (986 patients seen; 895 in target; 89 breaches), with month end validated performance of 90.96%. Breach reasons associated with:

- Patient choice: 59 breaches
- Incomplete GP referral: 8 breaches
- Outpatient capacity: 6 breaches
- Endoscopy capacity: 3 breaches
- Clinical delay: 4 breaches
- Administrative delay: 5 breaches
- Prison/Care Home initiated delay: 3 breaches

Breast symptomatic two week wait standard achieved for Month 4 (36 patients seen in total; 34 patients seen in target; 2 breaches), with validated month end performance of 94.44%. Both breaches were as a result of patient choice and had been offered a first appointment date within the two week timeframe.

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

Breast one stop clinic capacity: Additional clinics established over May and June 2021 to recover backlog alongside increased capacity slots in regular one stop clinics have had the desired affect; delivery remains under ongoing review to ensure improvement is sustainable. Of the breaches reported in July, 80% were as a result of patient choice as opposed to capacity.

Patient choice delays: Incremental increase in patient choice 2ww breaches on a monthly basis. Delays associated with summer holidays, child care issues and self-isolation. The service is anticipating that this may continue to increase over the summer holiday period. Revised comms has been shared with primary care to ensure patients are willing and able to attend hospital at the point of referral. Issue to be raised with BSW CCG to look at potential opportunities and solutions.

Endoscopy capacity: Reduction in capacity over July associated with staff sickness and spike in self-isolation which affected ability to provide nursing cover for lists. Two additional locum gastroenterologists in post to support capacity. Additional GA endoscopy lists in place from 21/08 to help work through backlog. GI unit continue to push for additional endoscopy room as per the national adopt and adapt priorities.

Risks to delivery and mitigations

Impact of COVID-19: Risk associated with potential increase in referrals as a result of the COVID-19 backlog (patients who chose not to present to their GP during the pandemic, who may present at a later date). Referral rates have remained consistently high across all tumour sites since March 2021.

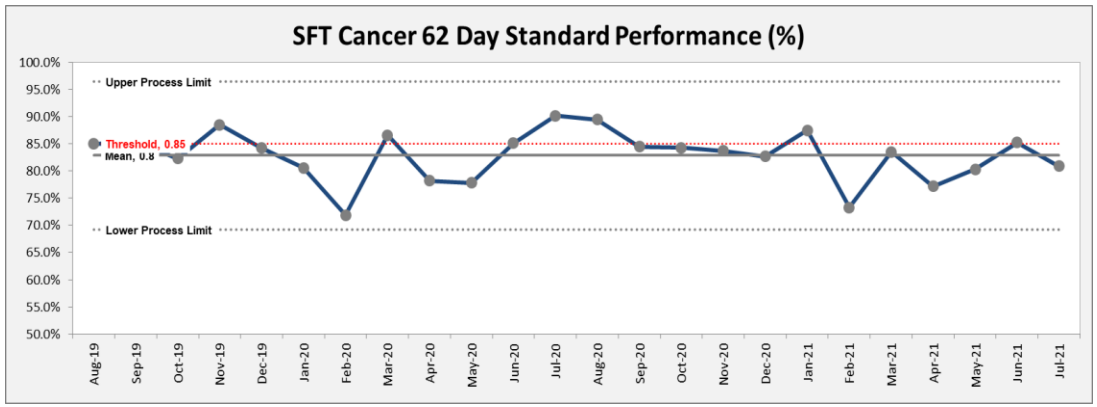
Patient choice: Incremental increase in patient choice 2ww breaches on a monthly basis. Delays associated with summer holidays, child care issues and self-isolation. The service is anticipating that this may continue to increase over the summer holiday period.

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 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

March 21	Performance	Num/Den
62 Day Standard:	80.88%	55/68
62 Day Screening:	66.67%	5/7.5

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

Month 4 62 day performance not achieved, with validated month end performance of 80.88% (68 patients treated in total; 55 in target; 8 breaches). Breach reasons summarised below:

- Colorectal: 3 breaches (1 clinical delay, 2 associated with diagnostic pathway/capacity)
- Haematology: 1 breach (delay associated with patient choice and PET CT capacity)
- Head & Neck: 0.5 breaches (shared breach with UHS as tertiary centre was unable to date TCI within target)
- Lung: 2.5 breaches (1 associated with complex medical history, 1 as a result of complex diagnostic pathway, 1 patient choice delay)
- Skin: 4 breaches (2 clinical delays, 2 delays associated with outsourced histology turnaround times from incisional biopsy)
- Urology: 2 breaches (delays associated with complex diagnostic pathways)

62 day screening standard not achieved for Month 4, with validated month end performance of 66.67% (7.5 patients treated; 5 within target; 2.5 breaches). Breaches associated with BCSP capacity and patient fitness

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

Patient choice: Services continue to see patient choice delays throughout pathways, both at point of diagnostics or treatment. Individualised input to each patient to help establish and address any concerns. Patient focus group established to receive feedback from service users to identify good practice and learning; first meeting held in July 2021 and will be rolled out across the year. Tumour site feedback mechanism currently being scoped.

Gynaecology and Head & Neck optimum time diagnostic cancer pathways: Draft optimum timed pathways shared for comment to the national team; improvement work will be established to ensure SFT pathways are aligned with best practice.

Urology cancer pathways: Cancer Pathway Navigator recruited to and due to commence in post from September. This post will predominantly provide additional support to bladder and haematuria patients and help to shorten diagnostic and treatment times.

Access to PET CT: Service is provided by Alliance Medical. Capacity issues raised via Clinical Lead directly to provider, as well as through the SWAG cancer alliance and BSW ICS for resolution. Capacity has the potential to adversely affect pathways across all tumour sites.

Risks to delivery and mitigations

Impact of COVID-19 and patient complexity: Risk associated with delayed presentation as a result of the 'COVID-19' pandemic. This may result in some patients being diagnosed with more advanced stages of cancer and multiple co-morbidities. Ongoing focus across BSW ICS to encourage patients to present to their GP with any concerns. SFT continue to circulate national campaigns/comms.

Patient choice: Services continue to see patient choice delays throughout pathways, both at point of diagnostics or treatment. Individualised input to each patient to help establish and address any concerns.

Accessibility to diagnostics and theatres as a result of routine backlog: Cancer patients have continued to be prioritised during the COVID-19 pandemic. There is a risk however that capacity is affected with recovery of the routine backlog. Any delays are escalated promptly as per the cancer escalation policy.

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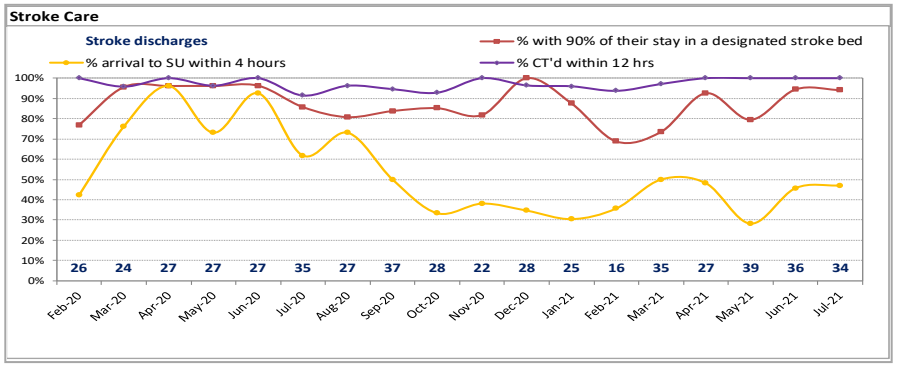
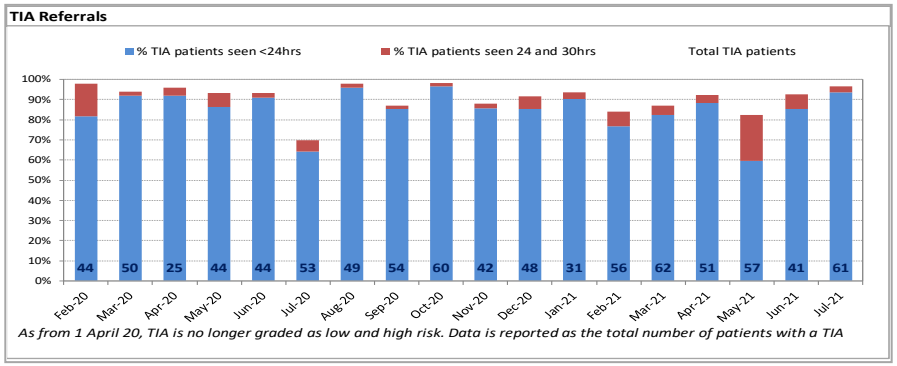
- Common Cause Variation

Stroke & TIA Pathways

Are We Effective?





As from 1 April 20, TIA is no longer graded as low and high risk. Data is reported as the total number of patients with a TIA

Data Quality Rating:	
% Arrival on SU <4 hours:	47.1%
% CT'd < 12 hours:	100.0%
% TIA Seen < 24 hours:	93.4%

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

A decline in stroke data and TIA performance has been seen during the global pandemic and has been under ongoing review at departmental and divisional level. The stroke service was moved from its base during this period, with the loss of direct admission to the unit and an emphasis on discharge over rehabilitation once deemed medically fit. The stroke service has now returned to the Farley ward base with Farley 'right' still utilised for respiratory care unit.

The business case for the stroke ANP role is currently being finalised and is due to be submitted to the TIG (October 2021). A band 7 senior sister has been appointed who will be helping to progress this further. This is in addition to the appointment of a locum consultant who started in July.

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

- There were 34 stroke discharges this month.
- There were 5 stroke deaths in July– with 7 and 30 day mortality below the national targets.
- 90% of stay in the stroke unit remains stable at 94.1% - 1 patient admitted via AMU and another late diagnosis stroke who was not treated on the stroke unit.
- The number of patient reaching the stroke unit within 4 hours improved slightly to 47.1% with 3 waiting 1st doc, 3 waiting specialist doc, 3 in ED 4hrs, 2 workload/capacity, 2 to AMU, 2 waiting bed, 1 waiting diagnostic, 1 late referral, 1 late diagnosis - never went to Stroke.
- The average stroke Unit length of stay was 13.5 and Average Total length was 13.9.
- 52.9% of patients had a CT within an hour which was above the national target of 50%.
- 5 patients were discharged this month that had been thrombolysed, with an average door to needle time of 41 minutes.
- Only 9 patients were referred to ESD in July as Wiltshire ESD had reduced capacity due to Annual Leave.
- TIA's performance was improved to 93.4%

Risks to delivery and mitigations

The stroke ward struggles with direct admission because the assessment trolley and room is on the right side of Farley ward and used for 'donning and doffing'. Temporary measures for ring-fencing beds are being discussed.

Stroke nursing remains stretched over three clinical areas. Farley left (acute stroke unit), Breamore ward (Rehabilitation stroke unit) and Farley right (Respiratory care unit). Each shift a senior stroke nurse on the stroke unit is designated the role of stroke liaison for rapid assessment of patients identified in ED for transfer to stroke. This role ensures front door stroke standards are maintained and ensures timely transfer to the stroke unit. With COVID pressures and being stretched over three clinical areas, this nurse rarely is able to function in this role as the numbers remaining on the ward would be too few. The newly appointed senior sister will therefore be looking at this factor.

There is still an unfilled vacancy for the third consultant stroke physician, currently advertised nationally. There have been long periods without a locum consultant which has impacted service delivery when one of the two stroke consultant is away. This has been partially mitigated by reducing daily TIA clinic to one session rather than two, although it is felt that the number of consultants required will still need to be expanded in order to sustain a seven-day service.

Salisbury NHS Foundation Trust

Part 2: Our Care

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

Maternity Dashboard

Data Quality Rating:

Are We Safe?

		Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar21	Apr21	May21	Jun 21	Jul 21
Denominator	Number of live births	186	167	184	207	192	182	168	159	165	186	158	182	191
Still Birth	Number	0	0	1	0	0	4	0	0	0	1	0	1	0
Babies requiring cooling	Number	0	0	1	0	1	0	0	0	0	1	0	0	0
Maternal Mortality	Number	0	0	0	0	0	0	0	0	0	0	0	0	0
Neonatal deaths within 28 days born at Trust	Number	0	0	0	0	1	0	0	0	2	0	0	1	0
Pre Term Birth Rates (24+0 – 27+0)	Number	0	0	0	0	0	2	0	0	0	0	2	0	0
Continuity of Carer	Number of women	31	28	16	24	19	21	19	17	34	5	11	7	6
	% of women with continuity	16.8%	16.9%	8.7%	11.5%	9.7%	11.7%	11.1%	10.8%	19.3%	2.7%	7.0%	3.7%	3.%

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

- In July there were no stillbirth's, maternal deaths or neonatal deaths within 28 days of birth.
- 0 term babies required transfer for cooling in July
- 0 babies were born between 24+0 and 27+0 weeks gestation
- 6 women were booked on a continuity of carer pathway. Action plan for the service around continuity of carer in progress with NHSE and regional team.
- Continuity % is against all births not just live births

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

- The service is working with NHSE and the regional team to write an action plan detailing how we will work to achieve Continuity of Carer across the service and meet the national target of 35% - with a focus on Black, Asian, Minority ethnic groups and women from area of high deprivation. Expected completion date of plan is August 2021
- Aiming for external reviewer for all cases that meet the PMRT criteria

Risks to delivery and mitigations:

- Twice weekly case review meetings for all cases where harm has been caused or that trigger a review using agreed trigger list within the service
- If SII commissioned external reviewer present on every panel (100% of cases)
- Continue to monitor and track progress through our dashboard at Maternity Risk monthly
- Risk of not achieving 35% continuity of carer within service - action plan in progress

Saving Babies' Lives Care Bundle v2

Are We Safe?

Data Quality Rating:

Saving Babies Lives Care Bundle v2			
Last regional survey: April 21	Have any responses changed since last survey?	Are you meeting all requirements of the bundle	Are you carrying out any improvement activity?
Element 1: Reducing smoking in pregnancy	Yes	Yes	Yes
Element 2: Identification and surveillance of pregnancies with fetal growth restriction	Yes	No	Yes
Element 3: Reduced fetal movement (RFM)	Yes	Yes	No
Element 4: Effective fetal monitoring during labour	Yes	Yes	No
Element 5: Reducing preterm births	Yes	No	Yes

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

- SBLCBv.2 is a care bundle that brings together 5 elements of care to reduce perinatal mortality
- Completion of quarterly surveys detailing compliance and change in practice at trust level (last completed April 2021).
- Within each element above there is criteria that determines compliance
- Compliance of SVBLCBv.2 reported through NHSR Maternity Incentive Scheme annually.

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

- Element 1 – fully compliant. SOP agreed for reintroduction for CO monitoring in pregnancy (change due to Covid-19 guidance)
- Element 2 – non compliant with 1 aspect – Uterine Artery Doppler scans for High risk women by 20-23/40. Need to increase workforce skill and capacity – compliant with current trust guidance
- Element 5 – Non compliant with recording of antenatal corticosteroids on Maternity Information system – Digital Lead (when appointed/seconded) to action by Q4 21/22. Preterm Birth guideline in draft.

Risks to delivery and mitigations:

- Non compliance to all elements of care bundle therefore unable to demonstrate full compliance with Safety Action 6 for CNST maternity incentive scheme
- Element 2 mitigation in place compliant with trust guidance, review of all cases of FGR by Fetal surveillance Lead Midwife and Lead Obstetrician reviews all unexpected FGR cases and babies born less than 3rd centile.
- Unsuccessful recruitment of digital Midwife – discussing with Transformation team and CIO re alternative solutions on a temporary basis to support the digital agenda associated with SVBLv.2

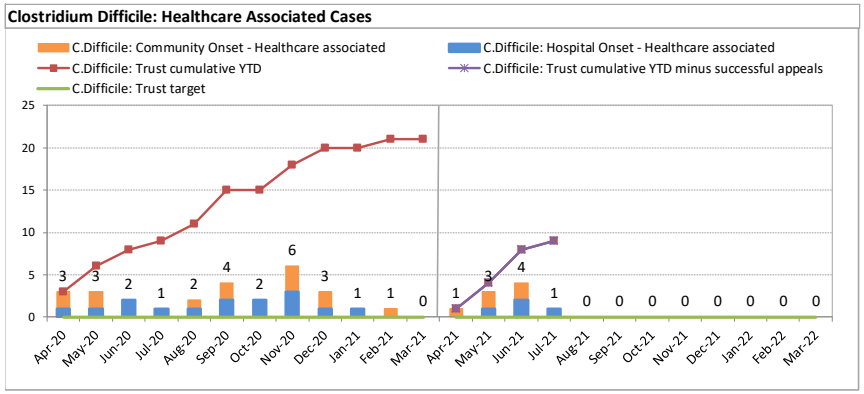
Infection Control

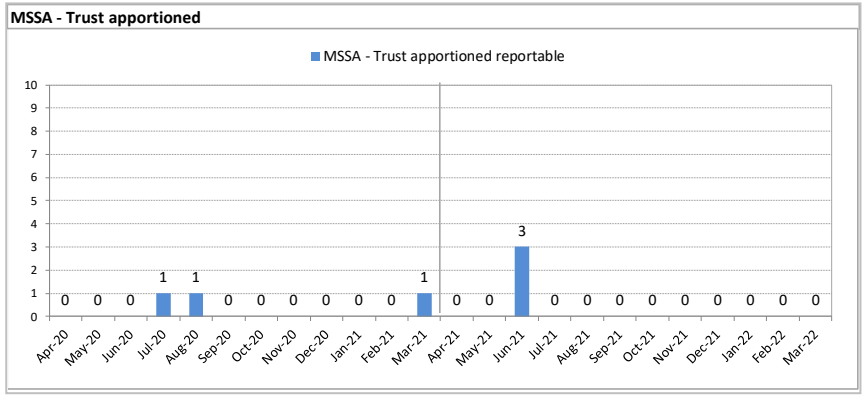
Data Quality Rating:

Are We Safe?

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

MRSA	2020-21	2021-22
Trust Apportioned	3	0





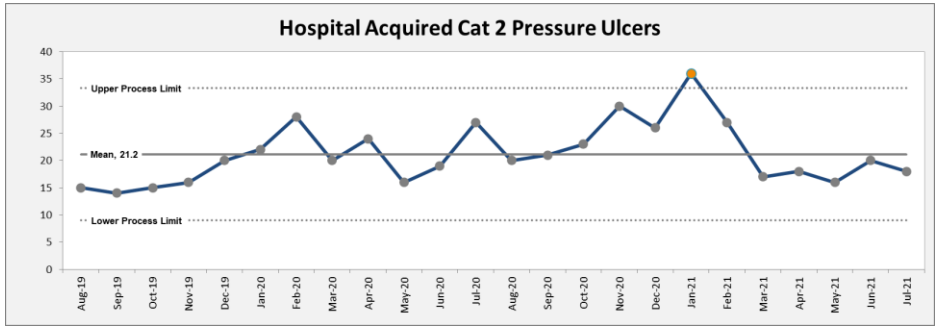
Summary and Action

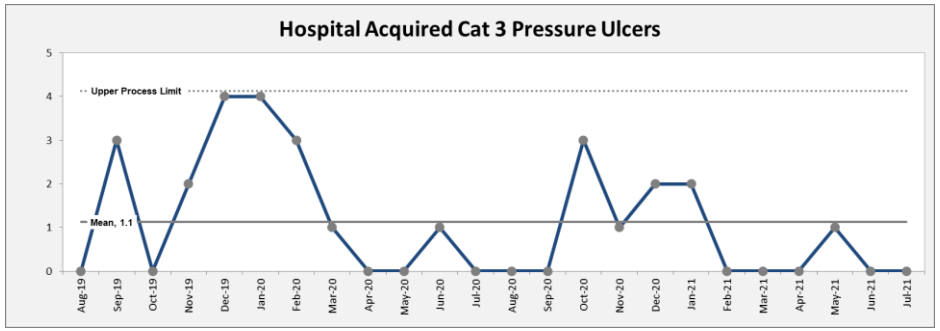
- C.difficile – *only reportable healthcare associated cases are listed*
  - 1 hospital onset healthcare associated case reportable to PHE - sample sent for a patient on Breamore Ward, who was admitted to the Trust on 03.06.21. The patient was admitted via the Emergency Department to Farley Ward on 03.06.21 and transferred to Breamore Ward on 16.06.21, being initially nursed in Bed 19 before moving to the annexe on 02.07.21. The patient developed new symptoms of diarrhoea overnight (06.07.21/07.07.21) and was reviewed by the clinicians on the morning of the 07.07.21, when a stool sample was requested. As a result the patient was moved to a side-room facility on Spire Ward and the stool sample collected 07.07.21 tested C.difficile positive. The investigation for this case remains ongoing, with the ward team and division completing the required SWARM documentation. The patient remains an inpatient now on Britford Ward.
  - No C.difficile cases have been identified for appeal.
  - No notification around a trajectory figure being set for C.difficile as yet.
- MRSA bacteraemia – No hospital onset cases have been recorded (also no community onset cases).
- MSSA bacteraemia – No hospital onset cases have been recorded and 1 community onset case.
- E.coli bacteraemia – There were no hospital onset cases for the month (and 6 community onset cases)

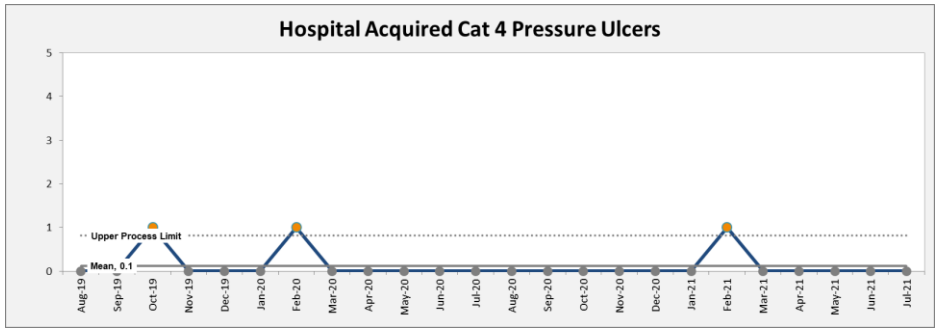
Pressure Ulcers

Are We Safe?

Data Quality Rating:







Per 1000 Bed Days	2020-21 Q2	2020-21 Q3	2020-21 Q4	2021-22 Q1	2021-22 Q2
Pressure Ulcers	1.92	2.10	2.21	1.47	1.48

Summary and Action

Category 2 Pressure Ulcers [PUs] decreased to 18 in July from 20 in June. This is not a significant decrease and there is no clear theme to identify.

Medical ward continue to have higher numbers than surgical wards.

No hospital acquired category 3 or 4 PUs have been identified for July.

An increase in Deep Tissue injury and unstageable PUs has been identified for July (7 DTIs in July compared with 4 in June and 3 Unstageable in July compared with 1 in June). These all occurred in the medical division. There were no clear themes otherwise.

Actions:

Shadow shifts have now commenced with the surgical division staff and a plan is being developed to do the same with the medical teams in the future.

Work is being undertaken with Whiteparish ward to arrange VAC training as their demand for VAC application has increased significantly over the last month. Some training for Band 2's is also being arranged.

Statistical Process Control Chart Key:
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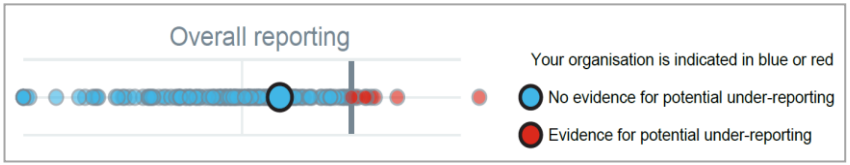
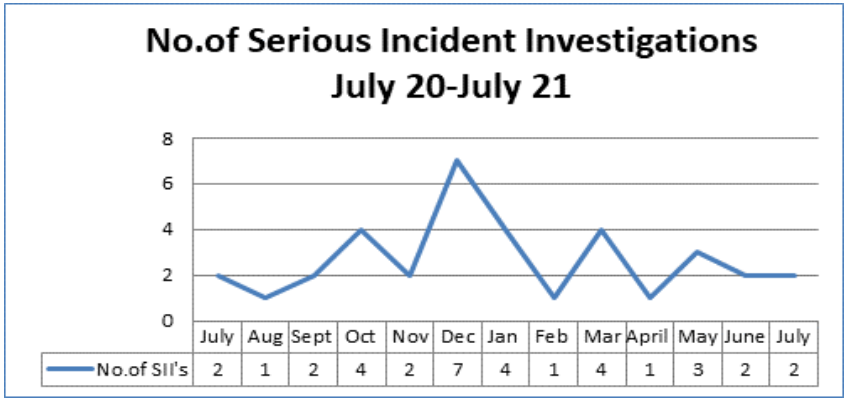
- Common Cause Variation

Incidents

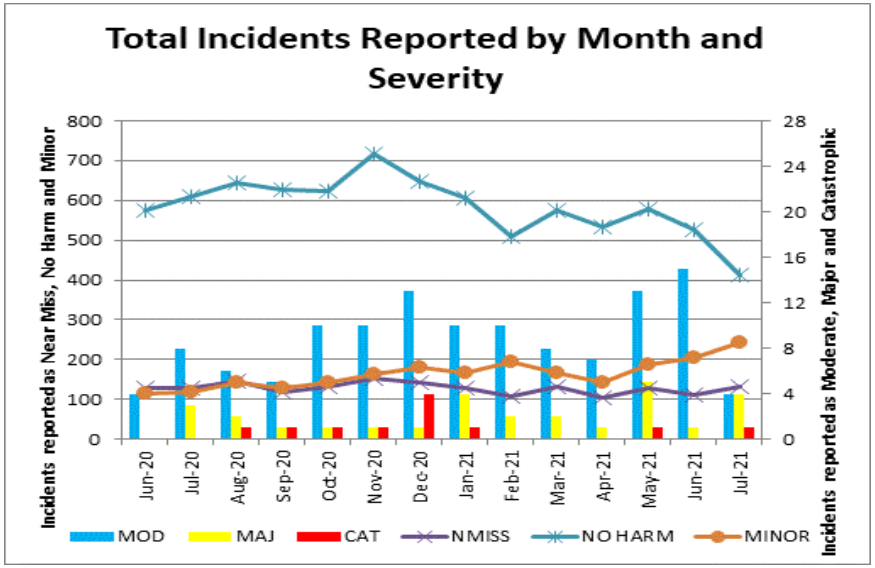
Are We Safe?

Year	2020-21	2021-22
Never Events	0	0





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



Summary and Action

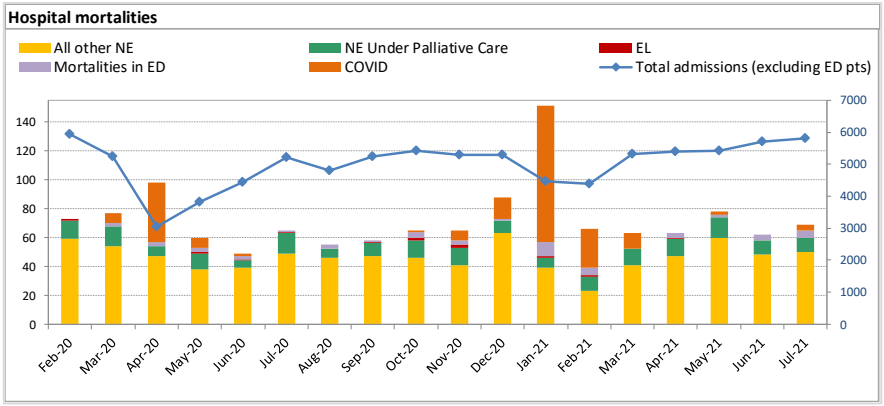
There were 2 Serious Incident investigation commissioned in July:

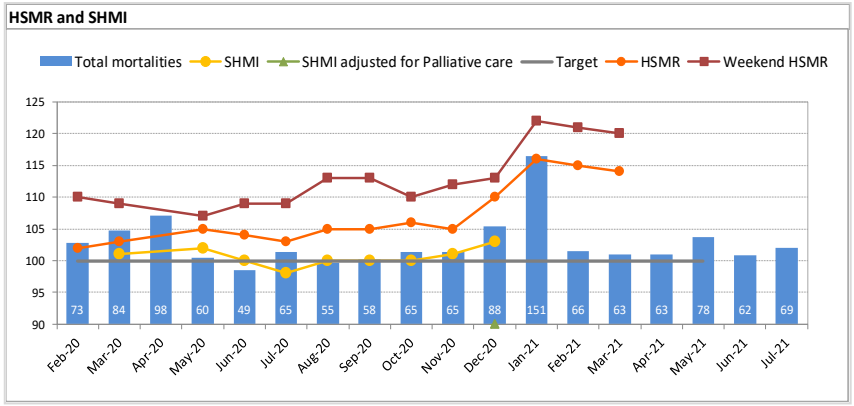
- SII 421 (Surgery) – appointment delays for an ophthalmology patient resulting in deterioration in vision
- SII 423 (Surgery) – absconded/missing patient for 24 hours

Mortality Indicators

Are We Safe?

Data Quality Rating:





Summary and Action

There were 4 deaths reported in July due to Covid-19.

HSMR for March reduced as expected, due to the reduction in the crude mortality rate. The mortality rate appears to be returning to baseline following the COVID second wave. Trust level SHMI was 1.03 (Trust level) and 0.98 (with exclusion of hospice) respectively for the period of April 2020 – March 2021.

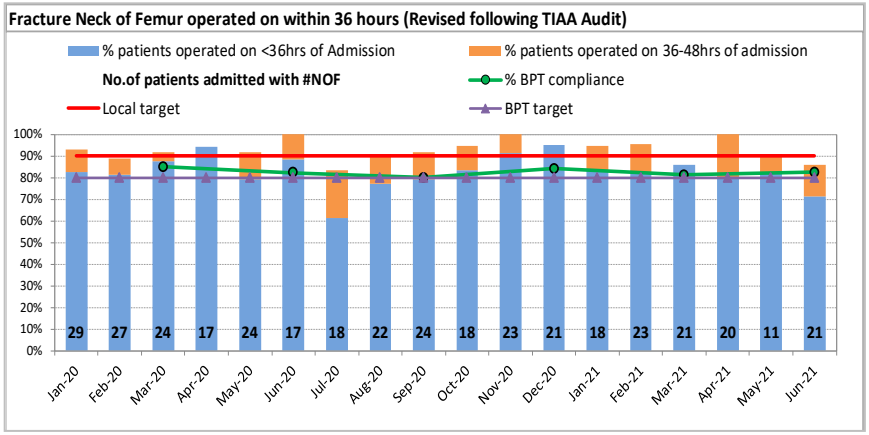
A review of all Covid-19 related deaths from the second wave remains in progress. 141 Covid-19 deaths have been reported during the second wave (from 1st January 2021 and as of 16th August 2021). A structured judgement review has been undertaken in 97 out of these cases to date.

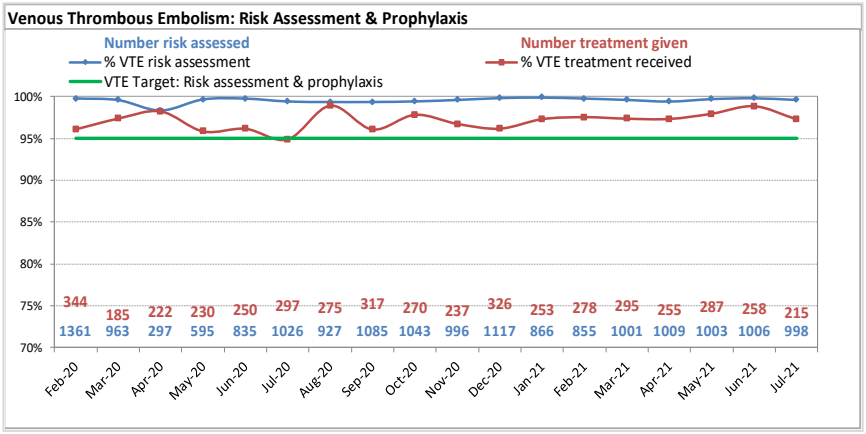
A review is currently being undertaking of processes regarding mortality data, with respect to shifting the focus to applying learning across the Trust.

Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?

Data Quality Rating:





(Please note: due to the time it takes to complete clinical coding, the fracture neck of femur data for July is not yet shown on the graph above).

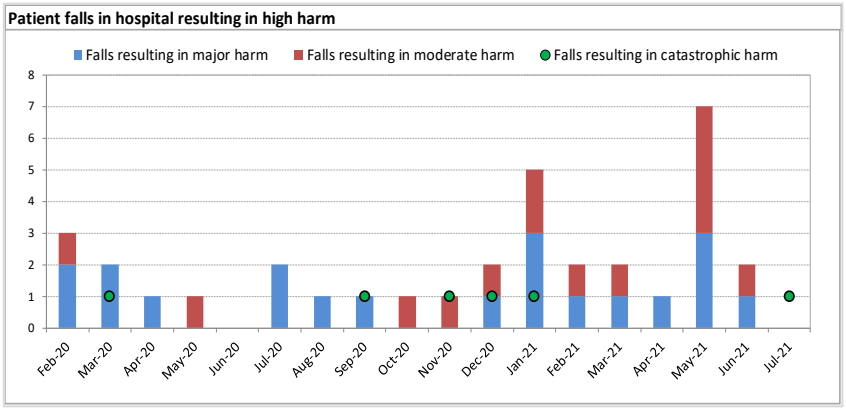
Summary and Action

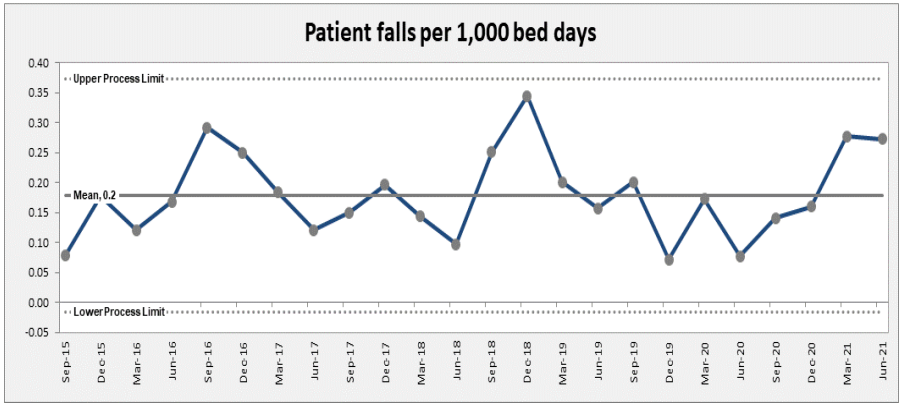
- There were 10 patients who were not operated on within 36 hours for the month of July.
- 5 Delays were reported due to administrative/logistic reasons and 1 delay was due to awaiting an orthopaedic diagnosis/investigation.
- 4 Delays were reported due to other reasons (antibodies in blood, a query missed fracture, awaiting revision surgeon and a trial of mobilisation first).
- The Trust continued to report good performance in VTE risk assessment and prophylaxis.

Patient Falls

Are We Safe?

Data Quality Rating:





Summary and Action

- There was one high harm (catastrophic) fall for the month of July:
  - A patient admitted to Spire Ward following a fall at home, had an unwitnessed fall and sustained multiple facial fractures alongside a subdural bleed. Sadly, this led to their death. This case has been commissioned as a clinical review (CR 419).
- A new falls lead is due to commence in post on 4 October 2021.
- Both medicine and surgery are actively auditing documentation weekly to ensure falls risks are completed regularly.
- Matrons are actively engaged with the ward managers in ensuring patients are risk assessed and that 'falls risks' are cascaded to the wider nursing teams, so they are all aware.
- There is no national comparison data now the safety thermometer has been ceased (which informed the Model Hospital).

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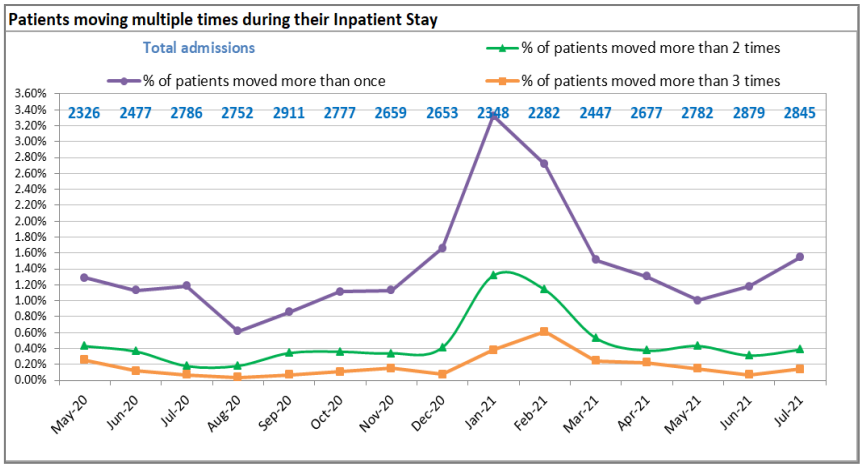
- Common Cause Variation

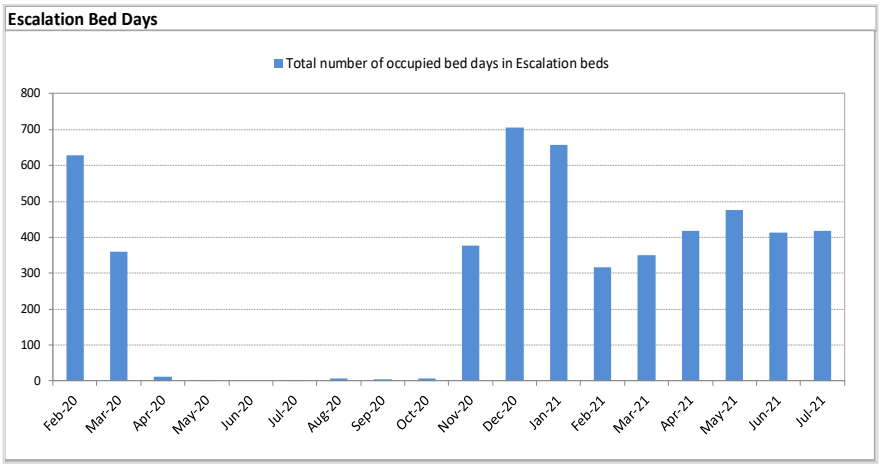
Patient Experience

Are We Safe?

Last 12 months	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Bed Occupancy %	81.5	86.6	85.8	91.6	92.4	89.4	86.8	87.6	90.8	91.2	90.8	90.0

Data Quality Rating:





Summary and Action

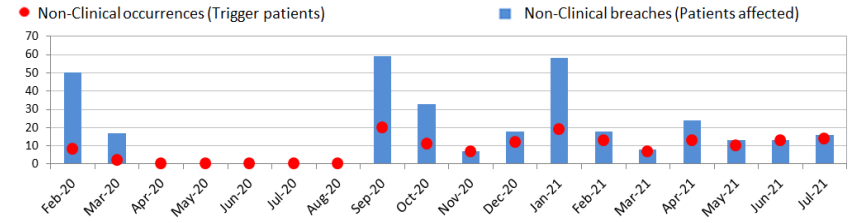
The number of patients moved more than once has increased during July and matches the volume witnessed as we went into and came out of the wave of COVID and winter pressures in the winter months. This is in line with the operational pressure the Trust has experienced in July and has been the result of several elements including accommodating infection control requirements, patients in the right place at the right time, and the use of escalation beds as a result of increased demand and reduced flow. There are continual efforts, and high awareness of the need to reduce patient movement as far as possible. Short term measures include the consideration of every patient move and its value to all patient experience, the minimal use of escalation resources, and additional Site team resource being recruited. Longer term focus is on the 'Case for Change' which will be shared across the Trust to support conversations around flow and improvements to efficiency and quality. This is being prepared to be shared in September.

Patient Experience

Are We Safe?

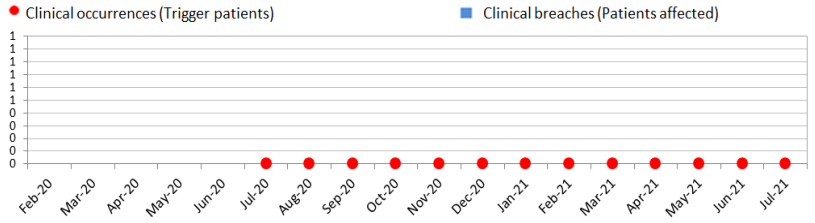
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
■	50	17	0	0	0	0	0	59	33	7	18	58	18	8	24	13	13	16
●	8	2	0	0	0	0	0	20	11	7	12	19	13	7	13	10	13	14

Delivering Same Sex Accommodation - Clinical



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

Summary and Action

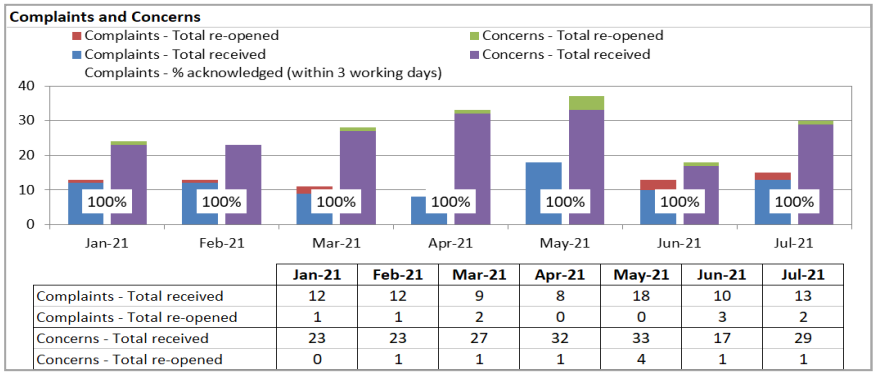
- 13 non-clinical mixed sex breaches affecting 13 patients occurred on Radnor. They were all patients who were unable to be moved off the unit within 4 hours of being declared fit to move. 9 were resolved within 24 hours. There were 4 patients who had a breach time of over 24 hours (all were awaiting a speciality bed), these were resolved within 48 hours. Privacy and dignity was maintained at all times within the patients bed space.

- 1 non-clinical mixed sex breach affecting 3 patients occurred in the AMU assessment bay. All patients had access to single sex bathrooms within the ward and screens were used to maintain privacy and dignity. The breach was resolved within 24 hours.

The Trust remains committed to a zero tolerance of mixed sex accommodation breaches unless there is imminent threat to safe patient care.

Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Complaints - Total received	12	12	9	8	18	10	13
Complaints - Total re-opened	1	1	2	0	0	3	2
Concerns - Total received	23	23	27	32	33	17	29
Concerns - Total re-opened	0	1	1	1	4	1	1

Summary and Actions:

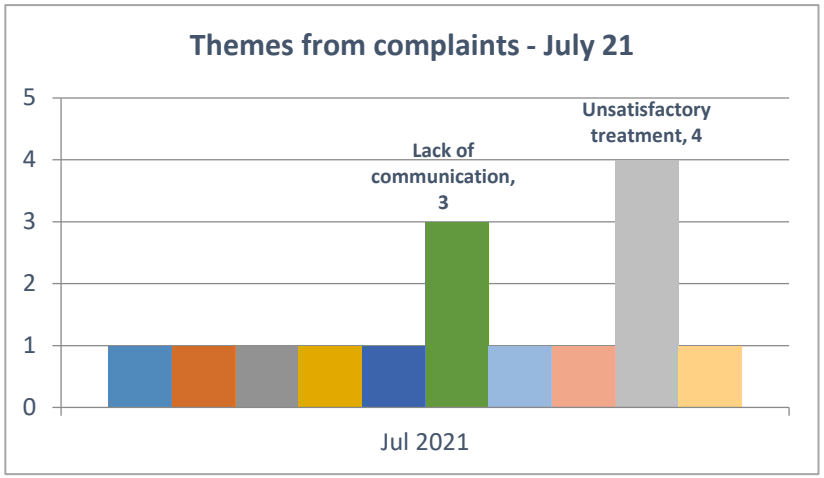
Top 2 themes from complaints are:
- Unsatisfactory treatment
- Lack of communication

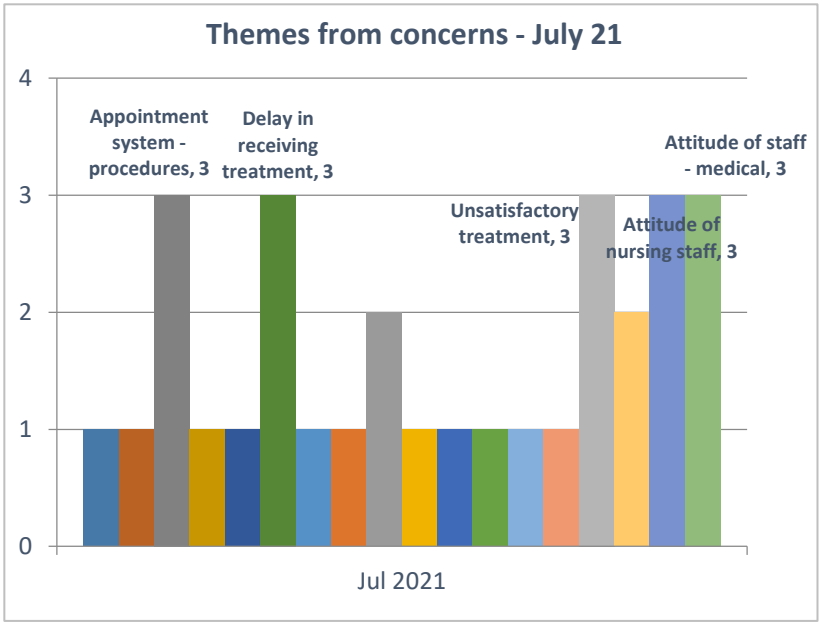
Top 5 themes from concerns are:
- Attitude of medical staff
- Attitude of nursing staff
- Unsatisfactory treatment
- Delay in receiving treatment
- Appointment system procedures

13 complaints were closed in July 21.

Examples of closed actions:
Radiology: all bank and agency staff have received 'refresher' training on the correct process to deal with referrals into the department.
ED: the patient's story will be shared at the next Clinical Governance meeting. The immediate learning points have already been disseminated to staff around starting anti-dotes in a timely fashion, re-enforcing infection control measures and also responding to and appropriately escalating patients' needs to teams within the hospital.
Antenatal clinic: annual phlebotomy competency tool is to be undertaken for all maternity care assistants (MCA) that regularly undertake phlebotomy tasks.

Data Quality Rating:



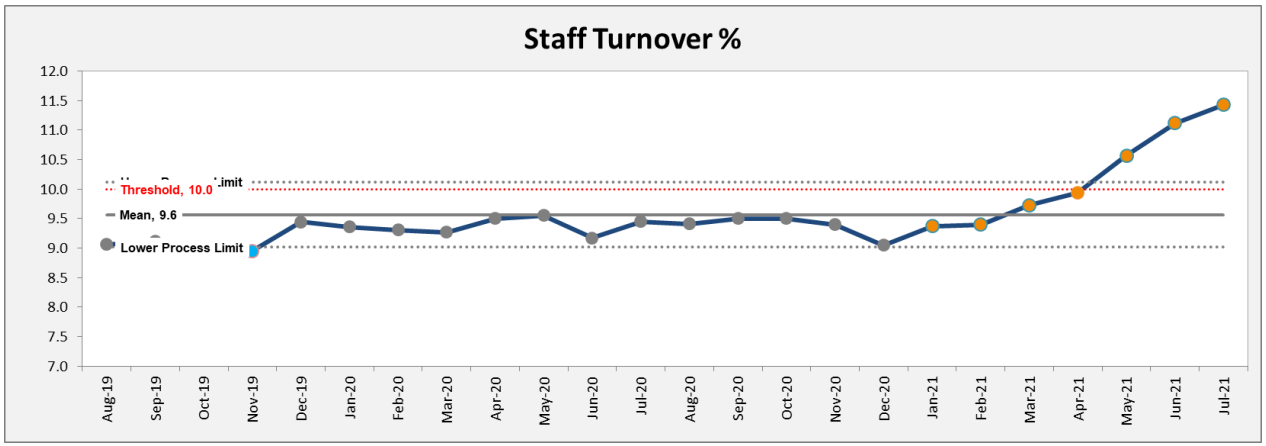


Part 3: Our People

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

Workforce – Turnover

Use of Resources



Summary and Action

Turnover for month 4 has continued to be above the Trust target (11.43%). There were 40 leavers and 37 starters by headcount. Women and Newborn had the highest turnover of the Clinical Divisions (12.87%). Of the known reasons for voluntary turnover in the last three months, the most commonly selected were “Voluntary Resignation - Work Life Balance”, and “Voluntary Resignation – Relocation” Together these formed 66% of all voluntary reasons for leaving, where a reason was given.

Women and Newborn is continuing to carry out exit interviews for staff who are leaving. Many are retaining a bank contract, as the main reason for leaving is due to lifestyle choices. The new structure in the Division has been agreed and is being worked on in terms of filling the new roles. The Deputy HOM is working with the Head of Resourcing on recruitment to band 6 roles, with an advert back open with a dedicated maternity landing page for recruitment. There have also been 14 offers made to NQ midwives.

In Surgery exit interview information is being used to formulate actions to address retention issues. For example, intelligence from Radnor on leaver dissatisfaction about redeployments has resulted in discussions with staff and led to practical efforts to standardise systems and the paperwork they use in Radnor with those on the wards, arranging for necessary badge access to ward areas to avoid Radnor staff having to ask for help, maps for Radnor staff of the wards they regularly get redeployed to help find their way around and implementing a 2 week rotation of who goes on redeployment when the ward is asked so they have a 2 week break.

Interview feedback supports work being done via the Surgery staff survey action plan this year to address wider retention issues around wellbeing – in the past month 37 staff from 10 different services attended compassionate culture workshops, listening exercises are taking place on things that effect staff wellbeing and the DMT is looking specifically at mental health initiatives with Clinical Psychology.

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

Workforce – Vacancies

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	Jul '21		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	444.71	436.71	8.0
Nursing	1,017.47	1,003.19	14.3
HCAs	472.74	477.32	(4.6)
Other Clinical Staff	662.21	715.80	(53.6)
Infrastructure staff	1,290.31	1,262.68	27.6
TOTAL	**3,887.44**	**3,895.70**	**(8.3)**

Summary and Action

Vacancy rate in month was 5.43%, compared to 5.53% in May. The Division with the highest vacancy rate was Surgery at 7.73%. The staff group with the highest number of vacancies Trust wide was Registered Nurses at 81 FTE (7.98%).

In month 91 vacancies (118 WTE) were advertised and a total of 84 offers were made. This compared to 133 vacancies and 51 offers made in month 3. Month 3 saw an increase in activity compared to normal levels

The are currently 4 vacancies which are rolling advertisements, 3 in Medical at Consultant level (Gastro, Respiratory and Stroke), RN for ED. There are currently 31 active vacancies covering both medical and general).

Recruit to hire time (authorisation to checks ok) for month 4 is 36 days against a target of 35.

A significant recruitment campaign covering all disciplines of staff in Theatres (HCA, Scrub, Recovery and Anaesthetics commenced in month 4 to support the Trust in meeting its elective recovery and longer term Theatre capacity goals.

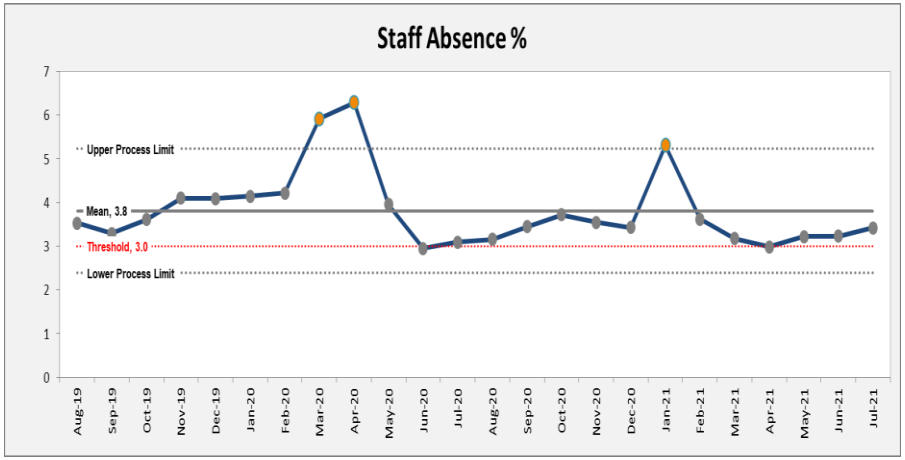
13 HCA offers made following a recruitment event.

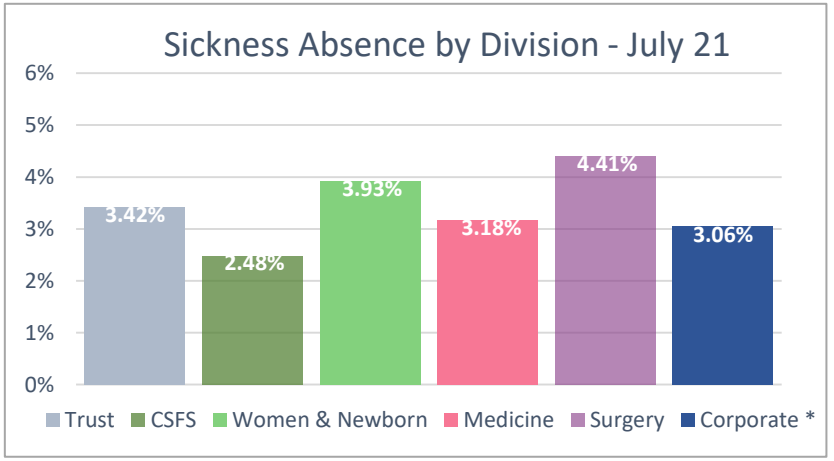
2 substantive Paediatric Consultants have been recruited.

Surgery is planning a review of Theatres to address long-standing cultural issues that influence turnover. Freedom To Speak Up Guardian data on bullying, favouritism, lack of training, poor leadership/communications and harassment is being used to develop TORs for this. This is running alongside a major recruitment campaign for elective recovery which OD&P is heavily supporting through BP, Recruitment and project management to develop a long-term workforce plan

Workforce - Sickness

Use of Resources





Summary and Action

Sickness for the month saw a slight increase to 3.42%, sickness for the rolling year was at 3.57%. Medicine, Surgery and Women and New-born and Corporate are the Divisions with sickness higher than the Trust target. Anxiety, stress and depression remains the top cause of sickness across all Divisions. Through the staff survey action plans the People BPs are working with DMTs to put strategies in place to support staff's wellbeing.

In terms of the number of staff in sickness process, there are 170 in short term processes and 28 in long term sickness processes

Sickness management continues to remain a focus in all Divisions to ensure that staff are being supported in line with the policy. Medicine are continuing with the new reporting system so that sickness is reported to the Operational Matron, and will tighten up on RTW interviews. Absence in Medicine continues to be a challenge, but the data suggests significant improvement in sickness. Work is being done to ensure absences are reported correctly. The People Advisor will join the next Senior Sisters meeting to provide clarity and support in managing sickness absence.

In both CSFS and Women and New-born there are HR surgeries taking place with teams, with sickness being discussed during these sessions. Due to stress and anxiety remaining the top reason for absence, awareness of services such as Mental Health First Aiders (MHFA), Stress Toolkit, Clinical Psych and other services on site for staff to access are being highlighted.

Surgery have 23 of 83 teams currently over the sickness target, with hotspots in Theatres/DSU, Inpatient Orthopaedics wards and Main Outpatients. Surgery has 56 staff in short term processes and 12 in LTS, though 2 LTS returned to work in July.

Primary reasons for short term absence in these hotspots are GI disorders, MSK injuries, Cold/Flu and pregnancy related sickness. Anxiety/stress is the main long term cause. BP is reviewing how manual handling support can be improved with OH and also encouraging take up of the new Staff Psychological Wellbeing mandatory training for line managers about to be launched by OD&P.

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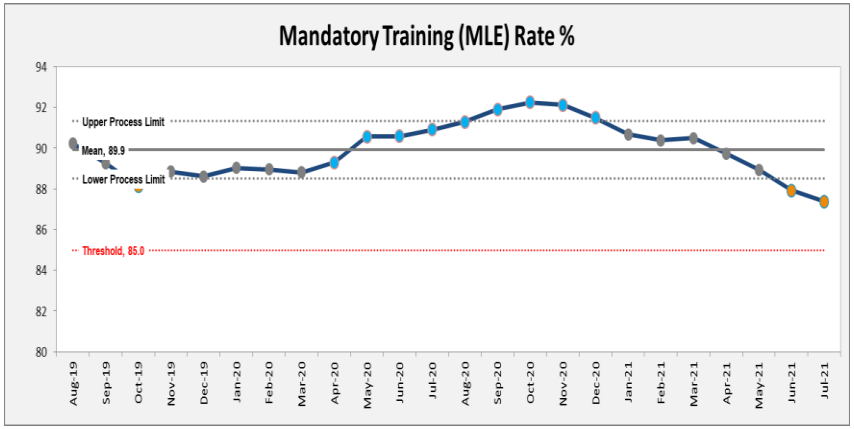
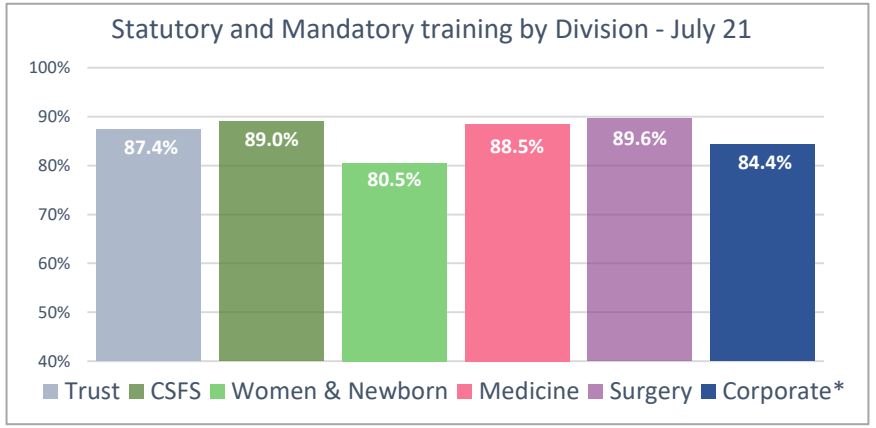
Workforce – Staff Training

Use of Resources





Summary and Action

Mandatory training was at 87.4% for month 4. All Divisions are below the target of 90%. Numbers of Mental Health First Aiders trained since January include 26 Clinical line managers and 15 non-clinical staff. There have been three appraisal workshops this year with 12 attendees.

Medicine have increased communications across the division to improve compliance, this is an ongoing effort. The management team are focused on completing their modules and have committed to doing so. We are also still working with Education to ensure that the correct staff have the correct level of BLS in their learning tree, as this is also affecting compliance at the moment. Out of 49 teams, 15 are red (less than 85%), 8 are amber (85-90%), 26 green (compliant). Compliance reports are sent to managers to address those out of compliance.

Medical Staff in Women and Newborn was split from other staff to allow more of a focus. All medical staff out of date have now been contacted individually to detail where they need to complete to be compliant. The staff who are out of date with PREVENT have also been contacted directly asking them to complete this.

In CSFS, staff continue to be contacted where they are out of date. Work continues with Education around the advanced and basic life support training – to ensure staff are in the correct one, if required. We are also working with Education around the levels of safeguarding for adults and children as different roles have different requirements and this is affecting compliance in both CSFS and Women and New-born.

The hot spots in corporate services are Finance 69,4% and Procurement 74.8% Estates (Maintenance & Improvements 68.1% and ETS Support staff 80.6%). Estates do have some staffing challenges to release staff from their operational duties to complete their training. However, they have drawn up an action plan and timetable to resolve this and are also looking into additional IT access to facilitate this. The mandatory training plan is running alongside a job role training plan where training / compliance gaps have also been identified. In relation to Finance and Procurement the BP is working with the team to devise a plan and timetable to be compliant within 3 months.

Out of 60 departments in Surgery, 29 are below the 90% compliance target overall and 8 are below 85% (red). Bowel Screening, Endoscopy, Medical Staff in 5 different services and Theatres are hotspots. Actions have been taken to facilitate mandatory training such as purchasing more computers for Theatres and bringing in a COW to make the most of opportunities during the day to do MLE. Local issues/pressures are being addressed e.g. staff in Bowel Screening are working at other sites and are being required to do multiple sets of MLE. Passporting is being agreed whereby as the lead employer staff will do our MLE, local manual handling and ALS.

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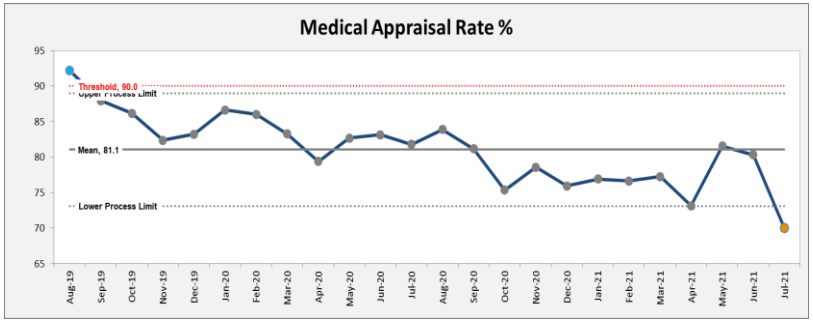
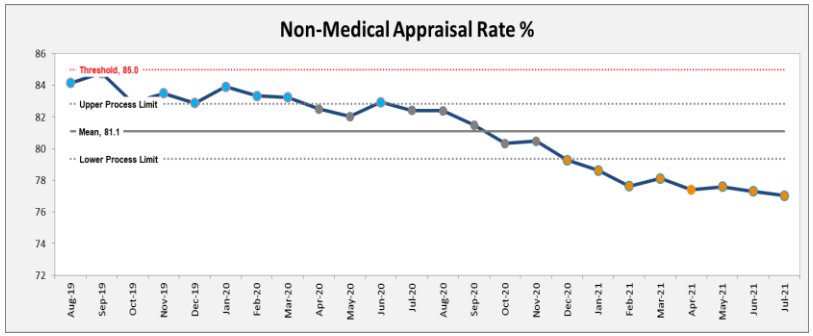
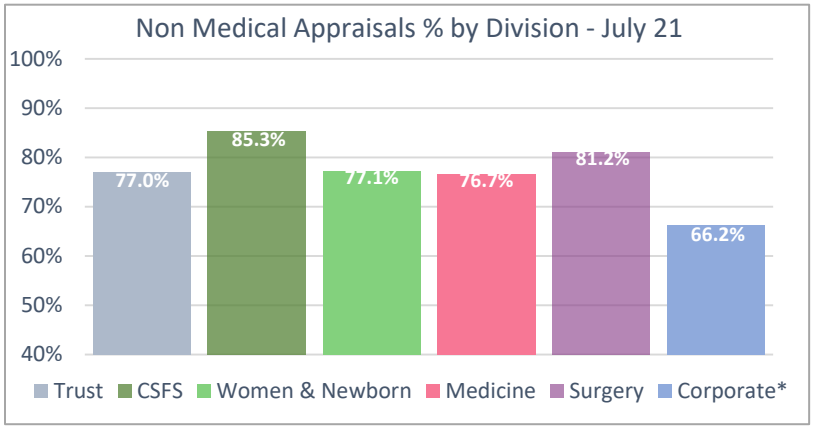
Workforce – Appraisals

Use of Resources







Summary and Action

Non medical appraisals remain under target at 77.03%, this is a deterioration on the previous month position (77.30%). Hotspot areas are Corporate (66.2%), Medicine (76.7%) and Women And Newborn (77.1)

Medicine is focussed on admin and clerical group and have seen improved compliance in this group, with only 2 outstanding. Out of 45 teams, 21 are red (below 80%), 2 amber (80-85%) the remaining 22 are green (compliant). People Advisor will follow up with all red & amber areas during monthly 121s to support. Compliance reports are sent to leads monthly.

In Women and Newborn, all staff have been contacted individually who are showing as overdue their appraisal and asked to get these completed and booked in. People Advisor is also raising appraisal compliance in 1:1 monthly meetings with Heads of Service.

Within Corporate, those areas under target are: Estates 21%, Finance and Procurement 39%, OD & People 59%, Transformation & Informatics 76% and Quality 66%.

In the Estates service until a management structure is in place it will be difficult to complete the appraisals for the team. Key roles in the process of recruiting are the Head of Estates and Operations Manager who manage over 2/3rd of the team.

Procurement is a hot spot, however there has been a two TUPE transfer in the People BP will work with the line managers to ensure all appraisals have been completed and transferred to SFT ESR. Finance is also under target, individual compliance reports are being shared with the managers to devise a plan and timetable to be compliant.

18 Surgery departments are currently below target. Hotspot areas are DSU, Rheumatology, Endoscopy, Theatres and ICU. From a medical point of view Anesthetics and Plastic Surgery are hotspots. Compliance data is routinely used in HR 1:1s with line managers by People Advisor and by BP with clinical leads. Realistic timescales set for services under the most severe operational pressures. These services have agreed to be back to green by end of December.

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- Common Cause Variation

Feedback from Friends and Family test

"Everything and everybody - receptionists, radiology, breast unit, day surgery staff and theatre team. All kind, caring, patient, thorough, friendly, supportive and efficient. We are so lucky to have such a wonderful NHS hospital in Salisbury"

"5 stars for the following - staff, food, treatment and communication. Well done to all at Odstock. A thousand times better ward than I expected ★★★★★" *Odstock*

"Everything explained, caring and professional staff. Polite, not rushed, a dedicated department of staff who respect and help you at a pivotal point in your life" *Endoscopy*

"All members of staff I came into contact with were excellent. Highly competent, listened, helpful and friendly. They provide care not just doing a job" *Amesbury*

What was good about your experience?

July 2021

"Although this was a phone appt I felt comfortable and cared for. The nurse explained in easy terms what I might expect and answered my questions. She was competent, reassuring and friendly and made me laugh!" *Cardiac rehab*

"The staff were excellent. The best care from everyone. The food was good and facilities clean and tidy" *Downton*

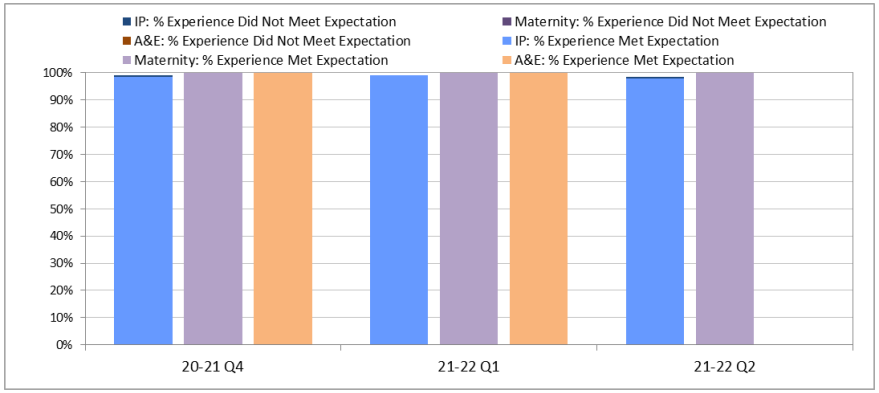
"I was treated with the utmost respect, care and humour by a dedicated and skilled workforce. " *Tisbury*

"Staff were friendly and helpful. Seen quickly and processes were explained clearly. Ward staff were kind and caring. Nothing was to much trouble. Thank you" *Britford*

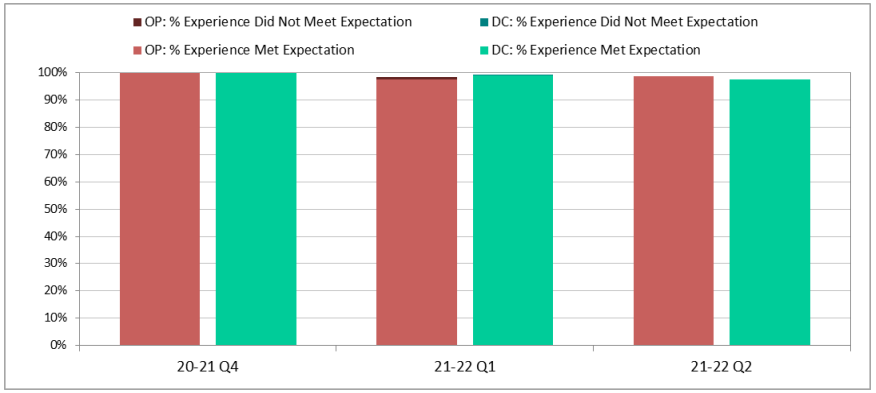
Friends and Family Test – Patients and Staff

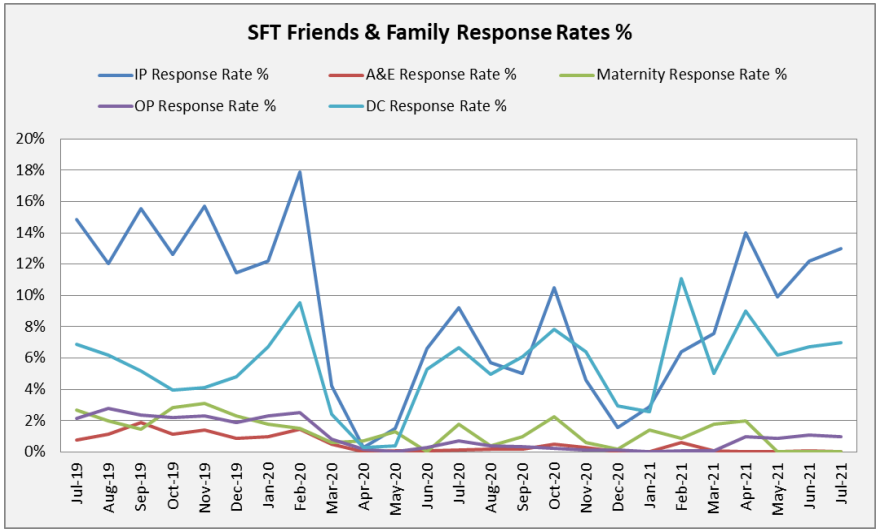
Use of Resources

Patient Responses: Inpatient, Maternity and A&E



Patient Responses: Outpatient and Daycase





More areas are now re-instating their processes for giving patients the FFT cards. All areas have target of 30%. High achievers this month are:

Amesbury Ward - 34.1%
Britford Ward - 32.8%
Chilmark Ward - 44.2%

Most outpatient areas still have a response rate of 0% with only 5 out of 18 areas receiving responses this month.
Inpatient areas are faring slightly better although only 3 out of the 20 departments reached the 30% target.

Matrons have been contacted to highlight low response rates and to ensure departments/wards are giving out cards

Part 4: Use of Resources

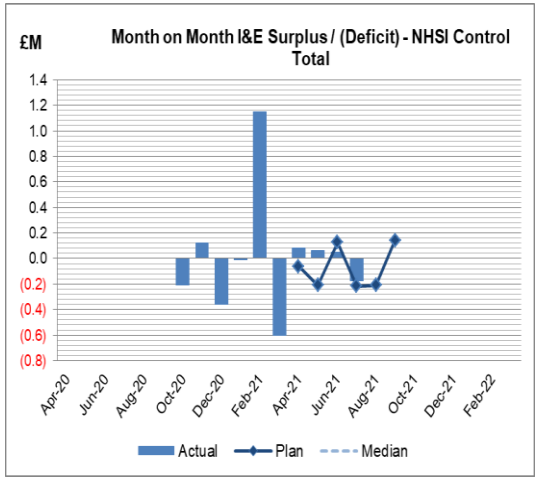
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

	Jul '21 In Mth			Jul '21 YTD			2020/21
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical Income	20,690	20,795	105	82,762	82,880	118	0
Other Clinical Income	962	1,189	227	3,084	3,211	127	129,150
Other Income (excl Donations)	2,507	2,092	(415)	10,178	9,715	(463)	15,342
Total income	**24,159**	**24,076**	**(83)**	**96,024**	**95,806**	**(218)**	**142,975**
Operating Expenditure							
Pay	(14,758)	(14,793)	(35)	(59,259)	(59,089)	170	(88,775)
Non Pay	(8,003)	(7,926)	77	(30,665)	(30,576)	89	(46,453)
Total Expenditure	**(22,761)**	**(22,719)**	**42**	**(89,924)**	**(89,666)**	**258**	**(133,714)**
EBITDA	**1,398**	**1,357**	**(41)**	**6,100**	**6,140**	**40**	**9,261**
Financing Costs (incl Depreciation)	(1,545)	(1,521)	24	(6,176)	(6,113)	63	(9,264)
NHSI Control Total	**(147)**	**(164)**	**(17)**	**(76)**	**27**	**103**	**0**
Add: impact of donated assets	*(61)*	*(81)*	*(20)*	*(246)*	*(228)*	*18*	*(368)*
Surplus/(Deficit)	***(208)***	***(245)***	***(37)***	***(322)***	***(201)***	***121***	**(368)**



Variation and Action

The Trust continues to operate within its allocated H1 2021/22 contractual envelopes up to the end of July 2021, with a YTD reported surplus of £27k (excluding the impact of donated assets). Expenditure envelopes are derived from the system's winter 2019/20 run rate, meaning expenditure growth beyond baseline inflationary (excluding that specifically funded for Covid measures) will drive a cost pressure for the Trust that needs to be mitigated.

The Trust continues to see a supressed cost associated with planned care, with activity reported for the year up to the end of July assessed as being at 80% of a 2019/20 baseline, with the July position 80%. The threshold is now 95% to receive Elective Recovery Funds.

Month 4 represents the first month reporting from SBS Oracle Version 12. Whilst accruals were required for invoices not raised and invoices from suppliers not yet processed, these were based actual information where available, however some estimates were included. There will be further review before reporting Month 5 to ensure that alignment of categorisation occurs, particularly where the national mapping used by SBS differs from the local mapping that Salisbury have previously used. Any lessons learned or issues identified will then be incorporated in Month 5 reporting.

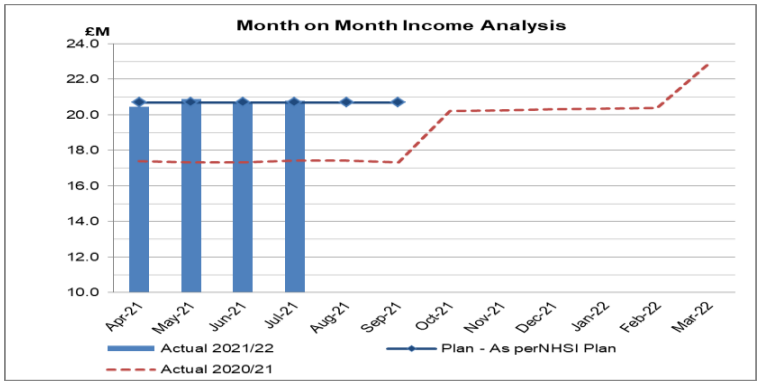
Income & Activity Delivered by Point of Delivery

Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Jul '21 YTD		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	3,071	3,315	244
Day Case	4,652	5,088	436
Elective inpatients	3,718	2,925	(793)
Excluded Drugs & Devices (inc Lucentis)	6,928	6,578	(350)
Non Elective inpatients	21,009	21,571	562
Other	34,859	33,502	(1,357)
Outpatients	8,525	9,901	1,376
TOTAL	**82,762**	**82,880**	**118**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW CCG	50,757	50,757	-
Dorset CCG	8,323	8,323	-
Hampshire,Southampton & IOW CCG	6,263	6,263	-
Specialist Services	11,328	11,300	(28)
Other	6,091	6,237	146
TOTAL	**82,762**	**82,880**	**118**



Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
A&E	23,298	23,206	(92)	16,659	6,547
Day case	6,092	6,694	602	3,572	3,122
Elective	1,043	901	(142)	559	342
Non Elective	9,383	9,606	223	8,035	1,571
Outpatients	77,925	89,298	11,373	54,441	34,857

Variation and Action

Activity in July has been strong again in day cases, with an additional 111 Day cases in month. Day case activity has improved against plan in the surgical specialties of General Surgery and Ophthalmology, but activity levels have dipped this month in Gastroenterology although activity is still above planned levels. Activity in elective inpatients showed a much improved position in total of 83 spells more than in June and T&O achieved the planned level for the month. Non-Elective spells are notably above plan year to date. Less activity was seen this month in General Medicine and Geriatric Medicine combined, as well as in Paediatrics but activity was higher in Cardiology. Outpatient performance is lower than last month with less activity this month in Rheumatology, Ophthalmology and General Medicine but improved levels in Clinical Haematology.

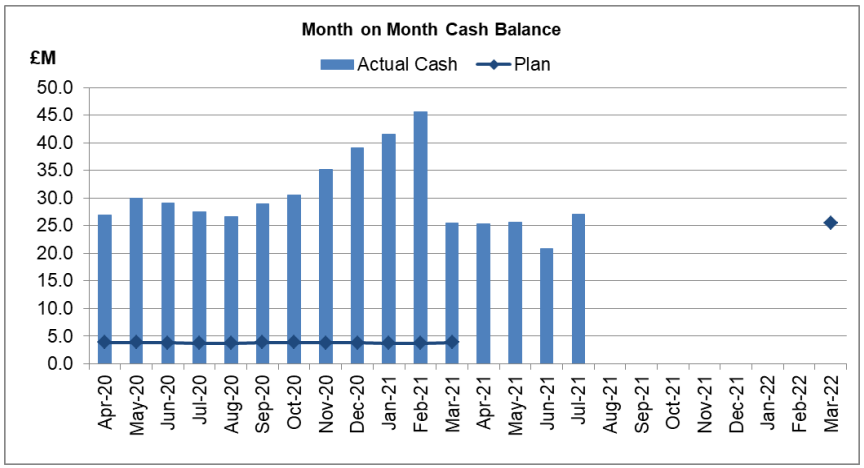
For the first six months of 2021/22 the Trust will continue to receive fixed payments from the main commissioners which have been based on Phase 3 payments (October 2020 to March 2021) uplifted by 0.5%. There is additional funding for growth and Covid. Some high cost drugs and devices are paid on a cost and volume basis by NHS E. An Elective Recovery Fund payment will be applicable in the first six months of 2021/22 to systems who achieve delivery above the set thresholds. The delivery of day cases, electives, outpatient procedures and outpatients was at 80% against the revised threshold of 95% for July. The target is for individual months, therefore whilst no additional funding would be applicable in July, additional funding of circa £1.2m year to date would be applicable to earlier months to be deployed by BSW should other system partners deliver above the target. Therefore, the July position is concerning and significantly more work is required to trigger additional funding in quarter 2.

Cash Position & Capital Programme

Capital Spend: 

Cash & Working: 

Use of Resources



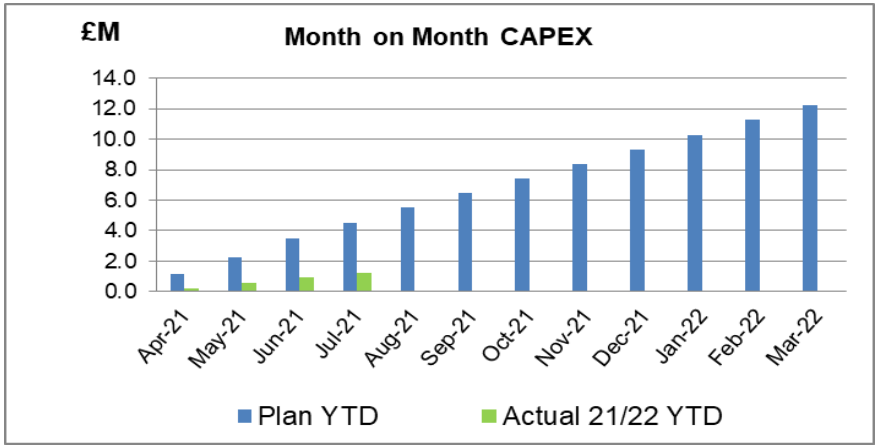
The Trust has now returned to the pre-Covid mid-month contractual payment arrangements. Block contracts and a balanced revenue plan have been agreed up to 30th September 2021, with guidance is awaiting for the second half of the year.

The base assumption from a cash forecasting perspective is that the Trust will continue to report a balanced revenue position throughout 2021/22.

The cash position increased in July 2021 primarily as a result of delays in clearing supplier invoices for payment following the move to SBS. Additional checks were required on invoices relating to purchase orders raised on the old system, delaying payment. The position is anticipated to resolve during August as goods and invoices relating to purchase orders raised after 1 July start to make their way through the system.

Capital Expenditure Position

Schemes	Annual Plan £000s	Jul '21 YTD		
		Plan £000s	Actual £000s	Variance £000s
Building schemes	900	692	131	561
Building projects	5,254	1,660	153	1,507
IM&T	3,872	1,292	610	682
Medical Equipment	1,728	691	190	501
Other	450	147	147	0
TOTAL	**12,204**	**4,482**	**1,231**	**3,251**



Summary and Action

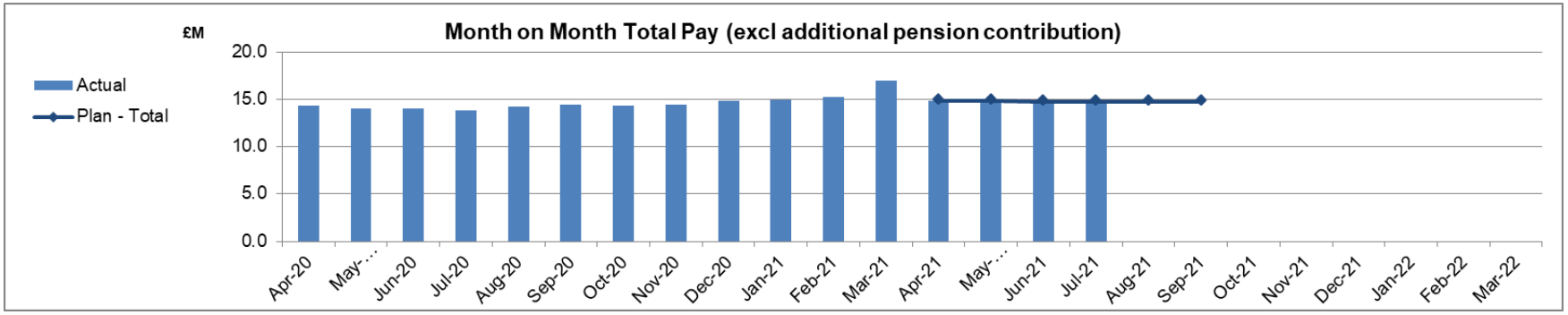
2021/22 capital allocations have been made at a system level, and although the Trust's baseline allocation of £12.2m exceeds the initial 2019/20 allocation by c£3m, the Trust remains capital constrained based on an initial assessment of over £20m. The internal funding of a £12.2m capital plan is contingent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

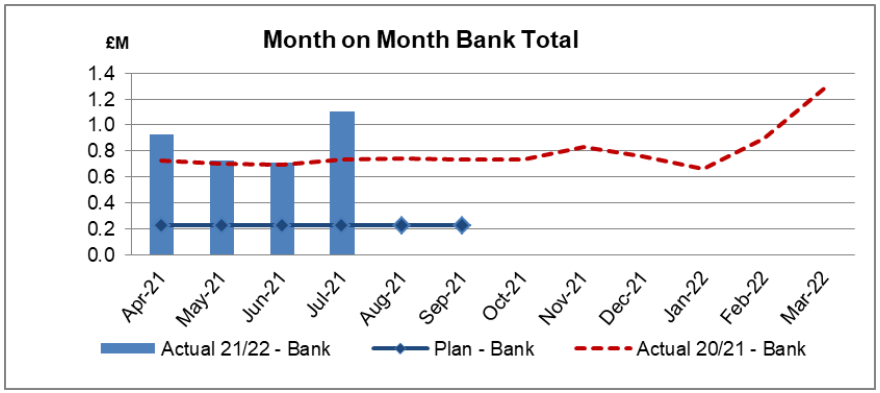
The original capital plan was based on a fairly even distribution of spend throughout the year. However, some building schemes have either been delayed or have been revised. A revised detailed profile plan of how all elements of the programme will be achieved by the end of the year was included as part of last month's Finance Report. A detailed report is being submitted to the Trust Management Committee this month to provide an update on the revised forecast, ensuring the Trust achieves its 2021/22 capital programme.

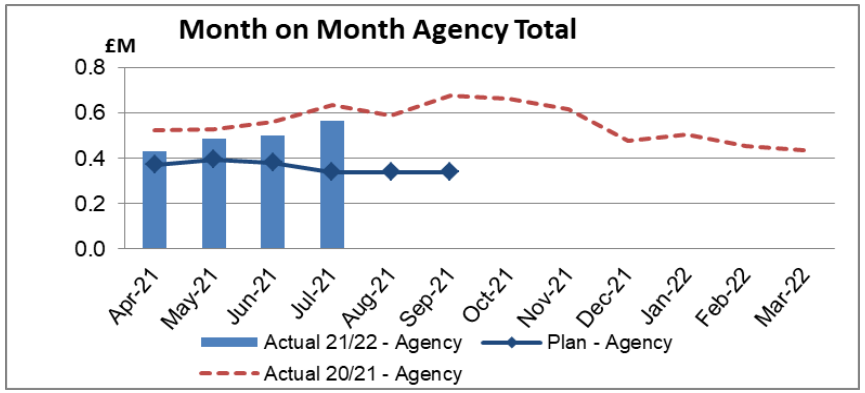
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

The Trust's pay costs have increased in July from June levels, however the Trust is still showing a modest £170k (0.3%) underspend YTD with slight reductions in the costs of medical and administration staffing costs.

Whilst some of the increase in costs relates to Elective Recovery work undertaken, there remains a high level of bank and agency within Medicine, with continued pressures around non-consultant medical staff in particular.

The Trust has reported 7 WTE infrastructure supports staff over planned levels which relates 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.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	09 September 2021		

Report Title:	Review of Standing Financial Instructions			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Lisa Thomas, Chief Financial officer			
Executive Sponsor (presenting):	Lisa Thomas, Chief Financial officer			
Appendices (list if applicable):	none			

Recommendation:
To accept the proposed amendments to the Salisbury NHS Foundation Trust's Standing Financial Instructions, including changes to the delegated limits set out in the document and to update the text to accurately reflect the current decision structure of the organisation.

Executive Summary:
Following a review of the Trust's Standing Financial Instructions one key amendment is being proposed – increasing the level of delegated authority Finance and Performance Committee has with regards to contract approvals. Increasing the limit from £1m to £2.5m. The main aim is to reduce the level of duplication of assurance and ensure board and relevant sub committees are effective and efficient in discharging their duties.

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

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

1 Purpose

1.1 The purpose of this report is to brief the Board on the review of the Trust's Standing Financial Instructions, and to recommend amendments as appropriate.

2 Background

2.1 The Trust's Standing Financial Instructions (SFIs) have been in place since 1st December 2017. The SFIs are issued for the regulation of the conduct of the Trust's members and officers in relation to all financial matters with which they are concerned.

2.2 The SFIs should be reviewed for effectiveness and appropriateness on a regular basis, the last set of changes approved were March 2021 in relation to capital spending authorisation levels.

2.3 Where the Board does elect to set delegated limits, the Chief Executive Officer remains ultimately accountable to the Board as Accountable Officer, retaining overall responsibility for the Trust's activities. All delegated powers can be re-assumed by the CEO should the need arise.

3 Changes to delegation between Finance Committee and the Board of Directors

3.1 The current authorisation levels are in place for contract authorisation, and related to the contracts lifetime value (e.g. a 5 year contract of £25,000 per year requires £125,000 authorisation). The cumulative amount spent with the supplier over a rolling 12 month period (e.g. 5 separate spends of £5k each will trigger the appropriate procurement process in line with the values above)

Contract Value	**Recommendation Report Requirement**	**Authorisation To Place or sign Contract**
<£10,000 (Inclusive of zero nominal value)	No	As per purchase order system approval hierarchy approval
£10,000 – £24,999	Recommendation report required only if contract has not be awarded to the most economically advantageous offer	As per purchase order system approval hierarchy approval
£25,000 - £99,999	Yes	Head of Procurement
£100,000 – £249,999	Yes	Director of Procurement
£250,000 - £499,999	Yes	Director of Finance
£500,000 - £999,999	Yes	Finance Committee
>£1,000,000	Yes	Trust Board/Chairman

In the last year the following summary of contracts have been to Finance and Performance Committee for approval, every contract recommendation report has also gone on to require Board of Director approval in addition due to the value being over the delegated limit of £1m.

Contract	**value**
Non urgent patient transport	£1.7m over 3 years
Pathology managed services	£9m over 10 years
Outsourced Endoscopy	£1.4m over 1 year
Pharmacy outsourcing	£2.8m over 5 years
Air handling unit replacement programme	£2m over 5 years
Knee and hip joints	£3.2m over 3 years
IT hardware	£1.7m over 1 year
Pathology managed services	£1.2m over 2 years
Software	£2.2m over 3 years

This has sparked a concern about the most efficient use of board and board subcommittee time, with regards to duplication of assurance and oversight with the recommendation reports being effectively discussed twice.

Therefore in light of the level of discussion and assurance at finance committee and in the context of a robust process led by Procurement, it is proposed that the delegated limits are increased to Finance and Performance Committee. The process for assurance and oversight is robust in that all contracts are supported by recommendation reports which give appropriate detail on the tendering process/contract details and any risks therefore it feels appropriate to change the delegated levels.

Looking back since September this would have meant only 30% would have gone to Board of Directors, reducing the duplication of assurance.

5 Recommendation

It is recommended that Audit Committee support the proposed changes for approval at Trust Board. Below is a summary of these changes:

Contract Value	**Recommendation Report Requirement**	**Authorisation To Place or sign Contract**
£500,000 - £2,500,000	Yes	Finance Committee
>£2,500,000	Yes	Trust Board/Chairman

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.1
Date of Meeting:	09 September 2021		

Report Title:	Quality Improvement Progress Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Emma Cox, Head of Quality Improvement/Coach House			
Executive Sponsor (presenting):	Paul Wood, Interim Director of Transformation			
Appendices (list if applicable):				

Recommendation:
The Board are asked to note the investment and associated programme of work relating to Improving Together that the Trust is embarking on, whilst also providing evidence of Quality improvement projects underway within the Trust.

Executive Summary:
This paper provides on progress on the delivery of the 'Strategy for Improvement' and Quality Improvement implementation plan approved at Trust Board in May 2019. In addition it provides an overview on the Improving Together Programme, which commenced in April 2021 following approval of a business case and funding via NHSEi.

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

Purpose

This paper provides a progress report on the delivery of the 'Strategy for Improvement' and Quality Improvement implementation plan so far approved at Trust Board in May 2019. This paper covers:

- Background Context to the work programme undertaken
- Key highlights of the work progressed in the last 12 months
- Key challenges and risks we are tackling at present
- Plan of action for the rest of the year

The paper also provides an overview of the 'Improving Together' Programme following successful funding case earlier in 2021, including an overview of the programme and associated timescales.

1. Background Context

1.1. Our most recent CQC inspection report noted that *"The Trust is committed to quality improvement and innovations. However, it is important that improvement principles and practices are given pace and prioritisation within the organisation."*

1.2. In response, a trust-wide approach was developed and the Board approved 'Our strategy for improvement' and Quality Improvement implementation plan in May 2019.

1.3. QI is not a quick fix but a continuous process requiring a sustained focus over time and involving a cultural shift in ways of thinking, leading and working, across the organisation.

1.4. The QI areas of focus and work streams currently underway include:

- Development of an internal talent bank*
- Use of a dragons den initiative
- Development of a ward level accreditation programme*
- Recruitment of QI coaches and associated training
- Development of QI training/workshops
- Inclusion at Trust wide induction*
- Development of a website
- Publicity/Marketing

**these items were not in the operational plan, however due to the links to QI are being supported through the programme.*

The Trust submitted an initial business case for approval to NHSE/I for funding to procure external support to **design and deliver an integrated organisational development and continuous improvement system** which underpins organisational and BSW ICS strategy; including delivery of sustainable performance and high quality services alongside both incremental and transformational change. The scope of the proposal was:

- A proposal to procure external capability and capacity directly for use in Salisbury NHS Foundation Trust, and

- A proposal to host a contract that enables similar external capability and capacity to be called off by BSW ICS partner organisations.

As you will be aware from other Board papers, this Business Case called Improving Together programme has been updated to include the requests for:

- Non recurrent investment in OD and Culture change, Communication and Informatics
- Recurrent investment in a Coach House coaching team to support the roll out of the coaching of improvement tools and approaches and supporting change projects
- additional investment requested by KPMG in supporting our upfront coaching programme across all our Divisions and initial front line teams

2. Highlights of the work programme

2.1 Improving Together Programme

Following the initial approval of a business case submission to NHSE/I, the Trust is now working closely with KPMG. This business case was jointly submitted with Great Western Hospital, and builds on the update in October 2020, of working in partnership with our system hospital partners to ensure a structured approach to continuous improvement across the system.

Working collaboratively across RUH, GWH and SFT, as part of Improving Together, is now being formally established, with key personnel from across all three Trusts meeting monthly to share learning and experiences and further discuss opportunities for increased joint working across the system and as part of the wider BSW Academy.

To date the Trust has received a readiness assessment from KPMG and this has been reported back to the Executive Directors group and Trust Board. As a result of this assessment, the programme is being structured into nine work streams (BI and analytics, Coach House, Comms and Engagement, Governance, Leadership development, Operational Management System (OMS) divisions, Operational Management system frontline, Step change projects, Strategy development) each have an Exec lead and support colleague.
The purpose and remit of these work streams and the timescales/resource/risks associated with these, as part of the whole programme, have been presented to all Executive Directors/key staff.

In addition, regular monthly meetings are now scheduled with all Execs to progress the overall programme of work. Regular workshops are also scheduled.

A Programme Management Board has been established to oversee the programme moving forward, this board will report into TID monthly, with monthly reports to this board now encompassing Improving Together and wider QI work already underway within the Trust as part of the original strategy.

The Division triumvirate will be briefed on the Improving Together programme on the 1 September with subsequent meetings scheduled mid/end of September for the division to cascade this information down to their wider DMT colleagues. Divisions will be supported by the COO, CMO, KPMG and Head of Quality Improvement.

Recruitment to identified areas (Coach House, Leadership Behaviours, Comms) are now being progressed to ensure delivery of timescales and overall programme can be achieved.

At present, all work-streams are on target in achieving the roadmap originally presented at the second workshop in July.

It is anticipated that the training for the Trust Divisional leadership teams will commence in the autumn with the front line teams starting towards the end of the calendar year. These assumptions are all critical on the development of an in house Coach House team being in post and adequately trained.

2.2. **QI Coaches development**

The Trust has now trained a total of 87 QI coaches over two cohorts. A review of the training offer and approach has been undertaken and is now being piloted and reviewed by a small core team. The training now on offer is a combination of NHS Elect webinars and a face to face session to bring together learning and experience and what this means in reality and practice at SFT. A further review of the training material and terminology, to ensure alignment to Improving Together will be undertaken as this programme continues to develop by the Coach House team under the leadership of the Head of Quality Improvement.

We continue to provide support to our QI Coaches through regular bi-monthly network meetings, with colleagues being encouraged to identify the topics they would like to cover and receive additional training on. Encouraging individuals to share new ideas, opportunities they have identified or challenges that they are facing is a key part of the session and willingness to do so is steadily growing.

Following a review of our Programme and Project Management approach, we have taken the opportunity to combine and refresh our “Improvement drop in” sessions to encompass project and quality improvement moving together. These sessions provide a space and opportunity for colleagues to attend virtually/face to face to receive mentoring/support from colleagues and members of the senior Transformation Team on issues/opportunities that they need help with progressing.

There has been a positive increase in the last 3-4 months of QI coaches being linked to QI programmes of work that are outside of their service/normal role, this has been a great opportunity for these coaches to develop their own skills and confidence in QI, to meet new people and to be involved in programmes of work that they would not necessarily have had the opportunity to experience. The areas to note are; WHO Checklist, medicine errors, tissue viability and mouth care matters. In all cases the individual’s line manager is supportive of this approach and their involvement.

2.3. **QI Publicity programme**

The Head of Quality Improvement has re-started the monthly transformation communication meetings to identify and agree communication messages relating to QI, these were paused during COVID.

The QI Twitter account continues to be managed by the Head of Quality Improvement; however, there is more that can be done to increase followers and tweets from this account. The use of twitter and other social media platforms will be further pursued

and encouraged and use increased. This will only increase in the months to come, with Improving Together officially launching.

The lightbulb framework which was developed in late 2020 (see appendix A), has had a slow uptake in its use, and this will be largely due to COVID, however, this simple format of identifying programmes of QI work that staff are identifying or working on, will be further publicised and encouraged to be submitted to continue to grow that database of QI work underway within the Trust.
The lightbulb framework was developed to align to Life QI, a system/online database that can be used to record QI work being scoped, in progress or completed within the Trust. The use of the system has increased slowly, due to inputting of work known to the Head of QI, however, there is more that can be done and as part of this, colleagues from LifeQI will be presenting the system and its functionality to QI coaches in September, as part of their regular network meetings. This cohort are recognised as a group of colleagues in the Trust that can be actively using this system to record improvements and benefits that they are involved in. The long-term use and funding for this system will be necessary and will form part of the review that the Head of Quality Improvement undertakes in the coming months and which will dovetail and be reviewed as part of the wider Improving Together programme moving forward.

As part of the Improving Together programme, there is a dedicated work-stream regarding communications, therefore, the existing relationships already established with communications will prove beneficial moving forward and will only continue to increase and develop in the months to come.

A recent Clinical Governance session was dedicated to quality improvement and three teams within the Trust presented their QI projects/ideas at various stages, virtually, to colleagues within the Trust.
The event was facilitated jointly by the Head of Quality Improvement and Head of Transformation Resourcing with encouraging feedback from those in attendance. As a result of the session and presentation by our admin team co-ordinators in Medicine, the development and establishment of Trust wide dedicated admin governance core sessions is underway, supported by the Director of Corporate Governance and with guidance from Paul Russell (Staff Governor) and Head of Quality Improvement. Further updates on the establishment of this will be provided in future reports.

Engaging with staff and finding new ways to communicate potential areas of improvement has been undertaken as part of the patient flow improvement programme. The trust has commissioned a cartoonist to design and produce a story to demonstrate the impact of patient flow, from the point the patient becomes poorly through to discharge and returning home. This cartoon has been based on real life examples here at Salisbury, releasing this story across the Trust to achieve maximum impact and engagement is now being developed.

2.4. **Dragons Den**

The first Dragons Den event was delivered in September 2020, with a total of 15 bids received. The overall winner was the Spinal Treatment Centre and support for ‘a six month pilot of part-time additional support for patients to use the facilities in the Spinal Centre gym’, unfortunately, the spinal unit gym was re-purposed during COVID and the team have not been able to initiate their original application, however, the team have been able to review the requirements that were originally requested and have been able to consider further what is needed with the funding received, to ensure best use of

funds available, once the gym is available for use, the team will be able to progress their winning proposal.

There were a further 2 bids from the first round that have made progress since September; Improved magnetic badges for Junior doctors and the issuing of blood pressure monitors for heart failure patients. Both bids have been taken forward by the individuals and are now in place in the Trust. A video message encouraging staff to submit bids was provided by a junior doctor and is being used to encourage staff to make future applications.

The second Dragons Den is scheduled for 3 November 2021, with up to £10,000 being available to the successful bidder; the event will run in exactly the same format as before, bids are being actively encouraged for submission and consideration.

2.5. **Skill Share**

Skill Share launched with a total of 14 staff submitting requests to be interviewed and offer their skills wider within the Trust. The introduction of Skill Share and subsequent ongoing delivery and development of this concept has been delayed by COVID and also due to the complex nature of HR processes and requirements to ensure an equal and fair opportunity exists for all staff who sign up. The Head of Quality Improvement is committed to resolving the issues that have arisen and further meetings to discuss and move forward are scheduled for September.

2.6. **Quality Improvement Projects- examples of work undertaken**

There has been a recognised increase in the number of QI projects that staff are involved in and progressing, and whilst it is difficult to evidence this 'change' it is definitely evident in the meetings that the Head of Quality Improvement attends and the feedback that is received or shared. Ward Performance Reviews have now been introduced, overseen by the Chief Nursing Officer, a key reporting area is Quality improvement that wards are involved in, all wards in their reporting are able to define improvements that they are making within their ward, with the Head of Quality Improvement following up with those ward leads post meeting to discuss and support further if required.

Examples of QI projects, which are being led by the teams locally, with input and support from QI coaches, Head of QI when needed and to note, are:

Heart Failure Patients – issuing of BP Machines

The issuing of BP machines to appropriate heart failure patients on discharge is now up and running. The remote monitoring of patients BP in a regular, responsive manner, will provide the opportunity to make changes to the medicine regimen of that individual in a prompt manner, thereby increasing the patients quality of life and potentially reducing hospital admission. The aims/benefits of this improvement is; to promote patient involvement in their own care, provide a more responsive service to optimise medication, reduce hospital admissions, ensure new referrals are seen promptly, reduce the number of face to face appointments, thereby reducing the number of long distance trips patients make for review.

Surgical Assessment Unit Reconfiguration A 6 month pilot is underway to improve the patient journey and flow through the unit and onwards to Britford ward. The project has swapped trollies for reclining chairs, ring fenced beds for onward admission on Downton/Britford and reviewed the staffing model. It is anticipated that the project will aim to; manage the bed flow between unit/ward, reduce waiting times from referral/admission to discharge, increase admissions/transfer from ED in a timely manner and to ultimately improve the patient experience.
Cancer Prehab pathway The development of cancer prehabilitation for patients on identified pathways. This pilot project has been further extended to run until October 2021 and is being funded by the STARS appeal, co-ordinated and overseen by a member of Odstock Health and Fitness one day a week. Evaluation of the service is being continually undertaken, long-term funding for this is currently being pursued by the division and with support from a variety of stakeholders. Further data to demonstrate the positive impact and benefits may be necessary and these have been discussed with the co-ordinator to pursue.
Maternity – bedside handover and surgical swabbing Colleagues in maternity are reviewing options and approaches to introduce bedside handover on post-natal ward. In addition, a review of the process, supplies and documentation is also in progress to ensure surgical swabbing counts are accurately recorded and processed.
Ambulatory patient pathway AMU are reviewing pathways for certain cohorts of patients who are required to return for further diagnostic tests post discharge, the aim of the review and therefore possible outcomes include; reducing the waiting times for patients on their return and utilising AMU beds more efficiently to improve flow through the unit/Trust. Further follow-up with the Head of QI to provide advice/guidance is to be arranged.

2.7. **Training**

The QI workshops were put on hold during COVID, however, these are now back up and running, with the second scheduled for early September, these sessions are delivered face to face to provide the opportunity for staff to practice tools and methodology with colleagues. These will continue to run, however, a review and refresh of the messages and alignment to the Improving Together programme will be undertaken to ensure a consistent message is provided across the Trust.

The Trust renewed their NHS Elect virtual membership throughout 2021, this membership provides staff with access to a varied offering of online training webinars, presentations, short courses, many of which support continuous improvement. The Trust is also working with NHS Elect to develop and deliver additional training sessions through this membership.

The Head of Quality Improvement and the Head of Education and Apprenticeships are working together on this. The NHS Elect virtual membership has been able to ensure

that a continual and sustained approach to delivery of QI coach training can be achieved within the Trust, a risk that was reported last time due to funding constraints.

Delivery of a workshop as part of the first Clinical Leadership Training on Creativity for Change was well received. It has been agreed that this will continue and dates have been identified and confirmed for subsequent cohorts, starting in November 2021.

2.8. **Application of CQI approach with the Trusts strategic planning**

A review of the operational planning documentation and process to include continuous improvement throughout was undertaken late last year and was implemented and introduced as part of the planning for 21/22. Workshops with each individual Division was undertaken, giving them the time and space to consider their operational planning requirements/opportunities using a continuous improvement approach. Unfortunately, COVID has impacted on the continuation of this model due to the ever changing landscape that the Trust finds themselves in with operational reporting targets. However, we are running a six monthly review workshop/planning session with one division as a tester for the new structure, with the hope that this will embed itself moving forward and in line with the Improving Together programme.

3. Key Challenges

3.1. Releasing QI coaches to attend QI coaching meetings and being able to practice their new found skills within their workplace or through support to other teams remains a challenge; however, as noted within the report, there has been a shift in releasing staff to support wider QI projects of work, with support from line managers.

3.2. The wider challenge continues to remain with staff, who are aware/engaged in continuous improvement approaches in finding ‘time’ to undertake QI programmes of work within their teams. A shift in mind-set, which Improving Together programme will provide that opportunity for change, will help change the daily culture of seeing quality improvement as part of our operational delivery.

3.3. The recovery from COVID on operational performance related targets as well as day to day operational pressures, continues to remain a priority and challenge for many front line staff. These staff are already overwhelmed and fatigued, Improving Together and the narrative/comms that is released will be critical to ensure engagement across all staff, but particularly those who are already stretched. A key challenge for the OMS Front line work-stream as part of the Improving Together programme, will be to identify the first wave of staff in attending the training are able to commit to the programme over a number of months in light of the challenges they may be experiencing operationally.

4. Plans for remainder of 21-22 FY

Identified key plans and anticipated timescales for completion. It is important to note that some of these are ongoing plans and so there is no anticipated timescale for completion, these have been identified below.

Number	Detail	Expected Timescale
4.1	The central database of improvement ideas to be logged continues to be developed and the use of LifeQI is gradually being rolled out to QI coaches and other identified colleagues within the Trust. It is hoped that the central overview of all QI work being considered, scoped and delivered will grow as the cultural shift to a continuous learning environment grows	March 2022
4.2	Continue to introduce and embed the use of the lightbulb framework to capture QI work across the Trust.	Ongoing – increased use proposed by March 2021
4.3	Deliver regular QI training sessions Trust wide, aligning programme to Improving Together	Ongoing
4.4	To continue to support the Nursing lead in developing and piloting the ward accreditation programme within the Trust. In addition, providing ward level staff with the QI skills to support the programme rollout.	March 2022 for piloting Ward accreditation Training requirements will be ongoing.
4.5	Continue to deliver training on Creativity for change, referencing Improving Together, as part of the Clinical Leadership Training offer.	Ongoing Two cohorts booked November 2021
4.6	Successfully recruit and staff the Coach House team as part of the Improving Together programme to ensure delivery of the Trust roadmap.	December 2021

5. Key risks to delivery

Risk	Mitigation
Staff do not have the time for continuous improvement	Focussed engagement and messaging to clarify messages. Direct engagement with team leaders, managers to communicate messages, and to support them and their teams. Introduction of a framework to support staff in collating information on the work that they are involved in or planning which can act as a means of sharing within their teams/Trust but also for their own personal development. Encouraging discussion with colleagues wherever possible to elicit QI work that has been undertaken and share within the Trust.
Culture shift required to support continuous improvement	An overarching programme of organisational development work, entitled 'Best Place2Work' has provided further understanding of staff beliefs and values. This feedback will help to ensure that future support and approaches taken are based on this feedback. The inclusion and alignment of Best Place To Work within the Improving Together programme is in place with the development of cultural awareness sessions/training as part of the overall offer is being developed.
QI approach may not embed across the organisation in a timely manner, or as quickly as hoped. No additional funding pipeline identified to provide ongoing training, over and above additional resources, so progress is constrained with current resources.	Internal resources and virtual resources being used as much as possible. Resources are ring-fenced. Head of Quality Improvement appointed in July 2020 The subsequent funding and development of the Improving Together programme will provide the opportunity to embed QI across the entire organisation in a structured way.

6. Conclusion/Summary

6.1. Overall, despite the inevitable impact of COVID 19, progress has been achieved in:

- Increasing the number of clinical teams who are working on quality improvement initiatives;
- Scale of engagement initiatives being undertaken as outlined that is raising the focus and awareness of quality improvement approach
- Initial development of Improving together programme

6.2. Continuous improvement has continued to develop and embed itself across the Trust with an increased number of teams and individuals undertaking quality improvement projects at a local level, but the evidencing of the number of QI initiatives and the application of PDSA cycles will be a key area of focus by the Head of Quality Improvement and as part of the Improving Together programme moving forward.

6.3. In order to accelerate the Strategy implementation, we need the Trust Board to;

a) Support the establishment and funding of an in house Coach House and provide a designated team for the Head of Quality Improvement to work with
b) Support the Improving Together programme implementation

6.4. The identification of the teams to be part of the first wave of training as part of Improving Together programme is crucial to ensure that future teams buy in to the approach and opportunities that the approach allows. Whilst the identification of teams is linked to the strategic priorities, it is also important to identify and choose teams that are able to champion the approach and the programme, moving forward.

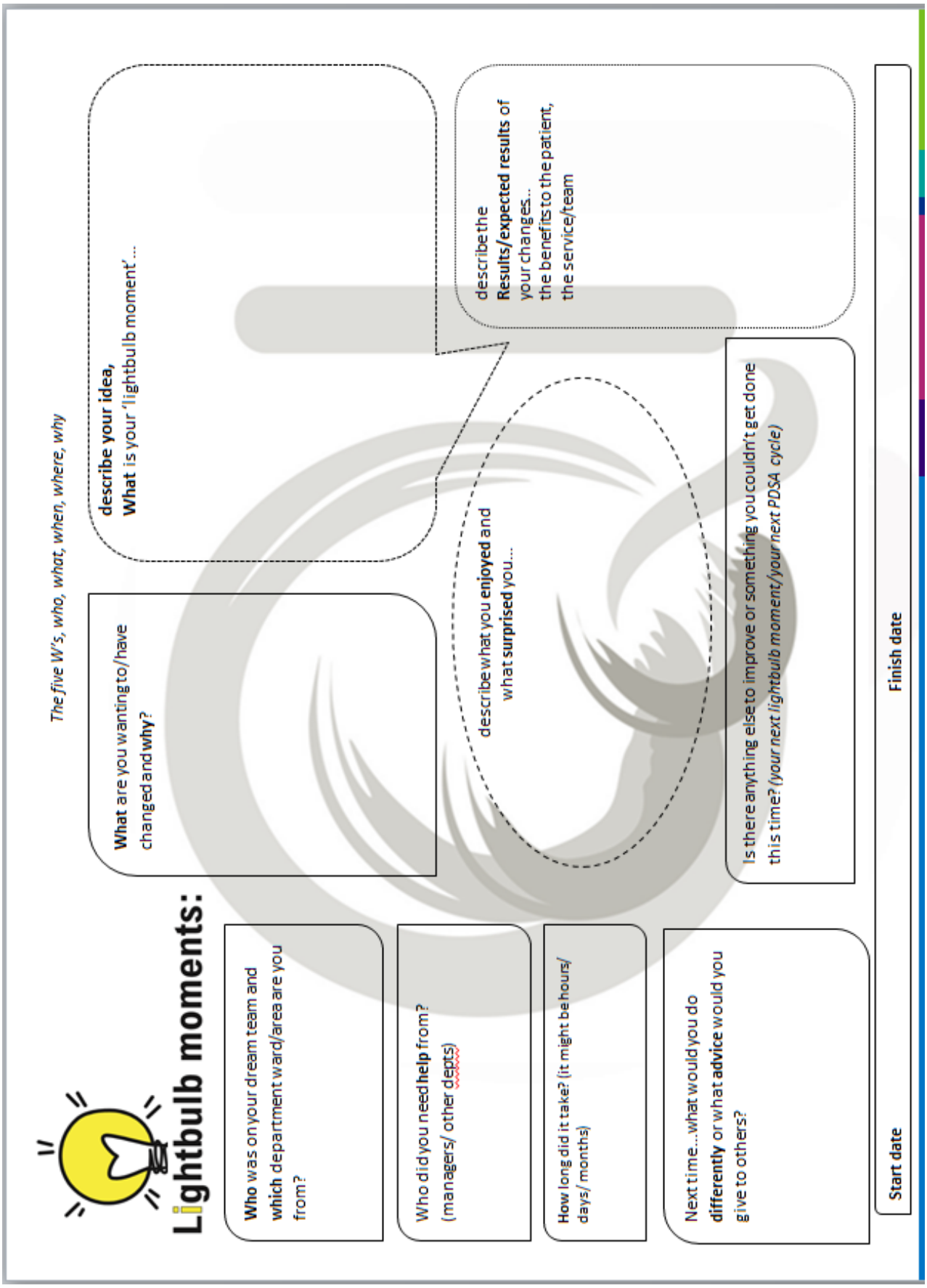
6.5. The releasing of staff across all levels of the Trust to dedicate time to engage in the Improving Together programme will continue to be challenge given our staffing shortages and the demand pressures on our services to ensure the success of the Improving Together.

6.6. We will need to rethink how the training is provided and use remote learning alongside tailoring other approaches to e.g. bite size action learning sets.

7. Recommendations

7.1. The Committee notes this progress report.

Appendix A
Light bulb Framework



Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	09 September 2021		

Report Title:	Nursing skill mix review			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	x
Prepared by:	Henry Wilding Interim Deputy Chief Nursing Officer Judy Dyos Chief Nursing Officer			
Executive Sponsor (presenting):	Judy Dyos Chief Nursing Officer			
Appendices (list if applicable):	Appendix 1 Skill mix reviews (embedded within) Appendix 2 Requested changes Appendix 3 Covid staffing model			

Recommendation:

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

- SFT nursing establishments are set to achieve an average of ration 1:6.7 (excluding ITU) in Surgery and 1:6.8 (excluding ED) in Medicine of registered nurses to patients during the day.
- Wards are staffed on average 60:40 registered/unregistered ratio, with exceptions linked to the implementation of the band 4 role.
- To note the on-going progress with compliance with the guidance from the National Quality Board on safe, sustainable and productive staffing including Developing Workforce Safeguards.
- To note the requirement to implement the Safer Nursing Care tool to provide additional assurance that nurse staffing levels are safe.
- To continue momentum on actions to fill vacancies in a timely manner and improve retention and to continue the reduction on the reliance on high cost agency.
- To discuss the report at both TMC and open Trust Board as an ongoing requirement of the National Quality Board expectations on safe staffing assurance.
- To recognise that ongoing Covid activity may require an agile response to maintain safe nursing care.

Executive Summary:

The purpose of this paper is to report the outcomes of the annual review of ward staffing nursing establishments. Over the past 12 months the approach to skill mix reviews has evolved as the previous edition was taken to Board in February 2021 and embedded with Divisional budgets predominantly in April 2021 (Surgery) and June 2021 (Medicine). This award included the headroom uplift of 19 to 24%, 2019/20 and skill mix review outcomes (previously agreed but not funded) and the 2020/21 skill mix review outcomes, allocation of B2 specials and any additional covid cost (Month 1-6 only). This adjustment to the previous rhythm of skill mix reviews was as a result of the Covid 19 pandemic, impact on services and rapidly evolving needs and adjustments to services and departments.

In order to reset the frequency and running order of skill mix reviews moving forward, and ensure clarity, understanding and implementation of previous awards, full skill mix evaluation was undertaken in Month 5 (August 2021) for presentation to September Board.

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

1. Purpose

1.1 The purpose of this paper is to report the outcomes of the annual review of ward staffing nursing establishments. Over the past 12 months the approach to skill mix reviews has evolved as the previous edition was taken to Board in February 2021 and embedded with Divisional budgets predominantly in April 2021 (Surgery) and June 2021 (Medicine). This award included the headroom uplift of 19 to 24%, 2019/20 and skill mix review outcomes (previously agreed but not funded) and the 2020/21 skill mix review outcomes, allocation of B2 specials and any additional covid cost (six months only). This adjustment to the previous rhythm of skill mix reviews was as a result of the Covid 19 pandemic, impact on services and rapidly evolving needs and adjustments to services and departments.

1.2 In order to reset the frequency and running order of skill mix reviews moving forward, and ensure clarity, understanding and implementation of previous awards, full skill mix evaluation was undertaken in Month 5 (August 2021) for presentation to September Board.

1.3 The paper focuses specifically on a review of in-patient ward areas, Intensive Care, Emergency Department (ED), Spinal Unit and Children's service.

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

2. Specific Detail

2.1 Ward staffing review methodology

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

2.1.2 This process has been adapted to include a full annual skill mix review presented to Board (this paper), followed up by an update review 6 months later to ensure plans are still appropriate and to review the impact of any investment. The last full review went to Board in February 2021 which included financial provision of the previously agreed 2019/20 skill mix, 2020/21 skill mix, uplift in headroom (19 to 24%) and provision for bank usage of Band 2 specials.

2.1.3 Whilst separate to the skill mix review process, relevant wards and services that are now required to work differently as a result of Covid went through a bidding process with the executive team to access a six month uplift to budgets, with the expectation that ongoing funding will require further review and approval for second half of year. This included ED, ITU, Amesbury, Chilmark and Farley RCU, Breamore

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

- Safecare module of Allocate as a proxy for Shelford Safer Nursing Care Tool.
- Care Hours per Patient Day.
- Professional judgement.
- Peer group validation.

- Benchmarking and review of national guidance.
- Review of e-rostering data.
- Review of ward nurse sensitive indicator data.
- Review of HR indicators and finance metrics.
- INSIGHTs data (from Allocate E-Roster data).

2.2 National Guidance

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

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

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

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

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

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

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

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

2.3 6 monthly Ward Staffing Review

2.3.1 The full review was carried out with each ward during Q2, reviewing the data from June 2020 – July 2021. The reviews were attended by the Ward Sister, Head of Nursing and/or Matron and Deputy Director of Nursing. Business Partners and Finance Managers were invited to attend, along with education. The same triangulated methodology was used as in previous reviews – review of nurse sensitive indicators, HR and finance metrics, headroom data, nurse-patient ratios, Safecare data and professional judgement.

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

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

- The ward establishments allow for registered nurse to adult patient ratios during the day across SFT to range from 1:5 to 1:10 depending on specialty and overall staffing model. In some areas where there has been active implementation of the band 4 role these ratios can vary on specific shifts, although the underlying establishment ratio has not been altered. These ratios are set against establishment and can regularly increase when wards are not fully established.

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

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

- Total number of nurses offer similar variation depending on speciality, ranging from 1:2.3 (Longford) to 1:4 (Chilmark) during the day, and 1:3.3 to 1:5.75 during the night.

2.3.4 Registered to unregistered ratios

- The wards have been reviewed against the benchmark of 60:40 registered to unregistered ratios as the planned model of care. Again this ratio varies across ward and speciality ranging from 42:58 (Amesbury) to 63:37 (Odstock) when excluding bespoke environments such as Tisbury, ED and Radnor.

- Overall the Trust average of registered to unregistered workforce is 58:42, however, the registered:unregistered ratio does not account for the presence and application of the B4 role and the extent of their role and remit offsetting the apparent lack of registered nurses.

- Several wards have actively implemented the use of band 4's (spinal, elderly care and orthopaedics) and the ratios have been reviewed as registered: band 4: unregistered. This will be further supported when we are able to report CHPPD for the Nursing Associate role. The band 4 role continues to be developed as part of models of care and utilisation of the role continues to be a theme for review for each skill mix review to identify further opportunities - particularly linked to the development of apprenticeships nationally and providing a career development route for unregistered staff.

- The previous skill mix review recommended an uplift of HCAs to enable each ward to have 2/3 Band 4 posts in establishment to support workforce development, although this was not specifically not taken forward amidst other uplift and changes to establishment.

- As a result there is some variation as to how the B4 role is represented within ward budgets with some assumptions that funding for the role is allocated from unregistered staff, and some wards funding taken from a shortfall in registered staff. However, local management and financial support ensure these roles, and the funding of, are tracked and managed in their inception, development and application.

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

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

2.3.5 Assessment against SafeCare Tool

- The Safe Care Tool (acuity/dependency model) has been used to review the staffing. This is integrated into the Healthcare roster system and provides

information on the acuity/dependency levels and corresponding staffing levels on a real-time basis. When predicted levels differ from established numbers, professional judgement has been used to assure that the levels set are appropriate for the specialty and number of beds. The data is reviewed at each skill mix review as well as being used to review staffing levels on a daily basis.

- Analysis of SafeCare data is included within the reviews.

- Previous skill mix review undertaken by the substantive Deputy DON identified the need to undertake a more formal assessment of staffing levels using Shelford Safer Nursing Care Tool (this is different to SafeCare within Allocate) to ensure the Trust is meeting the requirement to assess staffing levels using an evidence-based tool. The intention was to implement Shelford in this year (2021), however, due to the impact of COVID this has been delayed and an updated version is due to be released which incorporates the impact on staffing requirements of 1:1 enhanced care. For this review SafeCare continues to be used as a proxy measure in the absence of use of an evidence-based tool.

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

2.3.6 Allowance for additional headroom requirements and supervisory ward leader

- As a result of previous skill mix review the headroom allowance was increased from 19% to 24% across all inpatient wards and roles. This was applied to ward budgets from April 2021. Communication of this uplift to ward areas was variable across the division but the review meetings themselves provided opportunity to clarify what this uplift represents and amounts to for ward leads.

- The uplift in headroom was a welcome addition to the budget for ward leads. Whilst varied awareness and knowledge existed, concurrent recruitment challenges and high sickness rates have not yet provided wards with the opportunity to maximise and recruit into this uplift, but ward leads are liaising with OD&P, recruitment and finance to maximise the benefit of this uplift.

- An increasing staffing challenge is presenting in paediatrics due to children presenting with mental health problems that require speciality placements that are not available, the use of a Registered Mental Health Nurse is required in these cases and this is a high cost speciality role. In September 2021 the DDoN will pick up discussions with AWP (Avon and Wiltshire Mental Health Partnership) regarding the use and access to their own bank staff, which will help prevent the reliance on high cost coverage, and promote closer working and collaboration across the ICS.

- The Trust continues to run a supervisory model for ward sisters/charge nurses, in which they are given 0.8wte of their working week for this, with 0.2wte clinically rostered into numbers. In this review the average amount of supervisory time ward leaders were currently able to access had recently deteriorated with an average of 37% in Medicine and 75% in Surgery and CS&FS. Surgery have previously utilised a Ward Managers Assistant post which has proved successful in releasing ward sisters from administrative duties, and medicine are now looking to adopt a similar model, sharing between wards and utilising available B2 monies.

At the time of completing this report as a Trust we continue to report regionally a red flag regarding current nursing levels driven primarily by annual leave, sickness, maternity leave and reduced bank and agency coverage over the summer holiday period. However, this review focuses on skill mix and available establishment and broadly we have staffing levels that can be seen to be safe, however, there are areas where an increase in staffing is recommended (see appendix 2).

Outlined below is the detail by division which describes where there are opportunities to review efficiencies, effectiveness, patient experience and any recommendation for increases in establishment.

2.4 Specific Divisional Themes

2.4.1 Medicine Division:

Medicine has experienced many changes with the new restructure to become the Division of Medicine from 01/04/2020 which now incorporate the Spinal Centre and Therapies. Whilst the division was formed on 01/04/2020, the Spinal Centre did not align with medicine until September 2020.

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

Farley Stroke

Farley ward's purpose was changed as a result of our response to the Covid-19 pandemic within the year and stroke services moved to Laverstock ward for acute management and Breamore ward for stroke rehab. As Covid numbers allowed, Farley stroke returned to its original home (March 2021), but with a reduced footprint (20 beds) as the ongoing requirement remained to accommodate Farley RCU (10 beds) for Covid-19 usage. Staffing numbers described for Farley ward include the management of RCU, but any acuity change in covid care (requirement for non-invasive ventilation) will require further uplift. As has been reported and escalated separately, recent SSNAP scores have deteriorated. If Farley was to return to its original function in its entirety, the original skill mix establishment is sufficient to recover many of the highlighted issues (liaison with ED, transfer to unit). However, if RCU is to continue in its current form, additional uplift is required to address SSNAP recovery.

Breamore stroke rehab

At the outset of the pandemic and in line with Surgery Divisional plans, Breamore ward as a short stay surgical ward closed and vacated. As a result of the displacement of Farley stroke to Laverstock and the reduction in beds from 30 to 17, there was a requirement to open Breamore ward (15 beds) as a stroke rehabilitation environment. At times, an in line, with OPEL and escalation needs, Breamore ward can flex to 17 beds with nursing needs reflecting this, although any increase in occupancy is primarily driven by need to create additional acute stroke beds. Breamore ward usage is regarded as a temporary move and currently funded and offset as part of the Covid-19/RCU costs. Whilst Breamore ward staffing numbers are reported in appendix 1, all other aspects of quality and HR are included within Farley's data.

Redlynch and Whiteparish

Both Redlynch and Whiteparish wards described and evidenced increasing complexity amongst their patient groups, along with datix data referencing incident themes and timings. Whilst both requests for uplift in staffing were proportionate, the impact, appointment and application of previous skill awards had not completely been embedded as it was only applied in M3. It is therefore recommended that this is further reviewed in six months' time with additional data and assessment of previous uplift and headroom allowance.

Laverstock Respiratory

As a result of Farley stroke ward vacating Laverstock, Pitton respiratory ward moved in to Laverstock ward footprint (April 2021). This was undertaken as part of medicine's vision and anticipated future development of a respiratory high care environment which ultimately would include the ITU Laverstock annex (see Surgery themes). Moving from 23 respiratory beds to 19 beds has meant an over recruitment for Laverstock ward. Day to day this is managed within the division as available resources are utilised and shared across other wards, along with plans to redeploy staff to ensure financial and establishment balance.

Pitton Elderly Care

In the resulting vacated Pitton space, Durrington elderly care ward moved to Pitton (April 2021). This move, driven by ability to utilise a more effective, efficient and safer (IPC) space for this patient group, then in turn created a vacancy gap by moving from 21 beds to 27. The skill mix ratios described in Appendix 1 are in reference to the update ward function/speciality.

Longford

Within the year, the Spinal Centre was subject to a CQC inspection. Aspects of their assessment and evaluation focused on staffing and its allocation, composition and availability. Within the year, and driven primarily by the pandemic, bed occupancy and usage also changed. The Spinal Centre is commissioned for 39 spinal beds, and previously accommodated three further beds in anticipation of delayed discharges, and was therefore staffed for a total of 42 patients.

Whilst CQC assessment identified staffing resources fell short against NHS standard contract for specialised rehabilitation services, given the recent changes in utilisation of the spinal centre, with an establishment to care for 42 patients, it is recommended that Spinal Centre undergo a separate bespoke skill mix evaluation covering all aspects of care provision (therapy, nursing, medicine, psychology). The Medicine and Spinal Nursing Leadership team had requested a further uplift to nursing resource (B5 late and night shift 7/7 amounting to 4.34 wte) but this subsequent recommended review against available bespoke guidance and including therapy and support services will provide clarity and direction to a long debated issue.

Emergency Department

The Emergency Department continues to operate differently and settle in to its new norm, with the extension of majors cubicles (11-15) and displacement of minors. ED minors continue to share the Orthopaedic outpatient clinic environment which limits and impedes both specialities. It is anticipated that ED Minors will take over the use of the ortho outpatient area in its entirety from October 2021. To coincide with this and in response to the significant and sustained shift in type and number of attendances, the ED and Medicine Division are currently preparing a business case to support an additional ENP role along with relevant nursing support roles.

However, separate to the business case to increase ENP support, and in keeping with the remit of safe staffing review, the Emergency Department continues to

highlights aspects of their staffing that are not compliant with National Emergency Medicine Guidelines. This includes the provision of Education Facilitator and provision of second resus nurse on a night shift.

Hospice
The Hospice continues to see a change in client group and increase in intervention (blood transfusions), acuity and non-malignancy usage. This is turn results in complex discharges and a shortfall of available CHPPD. The unit is an outlier compared to other regional hospices with regards to staffing and RN availability, who also undertake additional treatments and interventions, and it is recommended that an increase is offered which has been mitigated and negotiated to total an uplift of B4 on an early shift Monday – Friday.

Covid roles and costs
In March 2021 the Divisions were requested to 'pitch' to the executive team for dedicated funding uplift to support any resource as a result of working differently due to Covid. This approval and funding only extended for the first six months, with the expectation that a similar approach would be required for the second half of the year. For ward based services approval amounted to

Department	Registered	Un-registered
ED	5.31	1.69
Breamore*	14.35	20.83
RCU*	34.02	22.34
*Partially offset by use of Escalation Laverstock (now Farley)	 -5.32 -15.96	 -5.32 -13.42

Source; Combined Skill Mix Establishment (VER3)

For the purposes of this review, assessment and recommendations have been made against core standard safe staffing numbers. Any impact or relation to covid working is identified within any recommendation.

Staff turnover
Recruitment across the Division of Medicine was generally good but over the past 12 months have struggled with increased staff turnover ranging from 8% to 46%, a sickness rate ranging from 2.8% to 9.8% and a current maternity leave at an average 2.2wte. The impact of retention is also posing a challenge within specialist services such as cardiology, emergency medicine and oncology. With OD&P and line managers undertaking exit interviews, rationale and reasoning for leaving is regarded as regular and reasonable with onward progression, geographical move or known retirements. However, the impact of covid is often cited and current demands and pressures is often referenced as causative factors of sickness, with reduced interest picking up additional bank shifts. In terms of additional staffing needs as a result of skill mix reviews, appendix 2 details the requests, assessment and recommendation of the DCNO as part of the review process, and details what is recommended and supported by the CNO.

2.4.2 Surgical Division:

Whilst the Surgical Division has remained relatively static in the past year following the formation of the Division itself, considerable change and evolution has occurred as a result of the pandemic and response and recovery to Covid-19.

ITU annex
In response to the pandemic and requirement to minimise disruption and protect the theatres and elective programme as much as possible, the bay that connects Radnor and Laverstock ward has been redesigned to accommodate ITU level 3 patients as required. The longer term ownership of this space is to be confirmed, but it is accepted that this could represent a future respiratory high care area for now established Laverstock respiratory ward. With ongoing covid prevalence and acuity, this Laverstock annex currently remains under the management and staffing responsibility of ITU.

Chilmark
With the resurrection of the elective programme Chilmark is now our established green elective ward, which from October 2020 included orthopaedic electives. Whilst there is a requirement to ringfence green elective patients in terms of covid, the patient groups themselves undergoing elective surgery, require further segregation from orthopaedics and general bowel surgery. This was anticipated in the previous skill mix review, and continues to work well in practice, flexing and distributing staff as required.

Britford SAU
As part of the Divisional plans to expand, improve and develop SAU, currently two beds within the regular Britford footprint have been repurposed as an extension of SAU as an assessment and ambulatory model. This trial is being led by Surgery and SAU/Britford team measuring flow, impact and experience for the patient, surgical teams, SAU and Britford ward itself. The trial has required the use of an additional B5 on a late shift to coordinate, which is able to be accommodated from within existing budgets. It is anticipated that the Surgical Division will undertake their own review and assessment of the trial, and establish what can be achieved from within existing budgets, and any resulting uplift be taken up as a separate business case.

Covid roles and costs
In March 2021 the Divisions were requested to 'pitch' to the executive team for dedicated funding uplift to support any resource as a result of working differently due to Covid. This approval and funding only extended for the first six months, with the expectation that a similar approach would be required for the second half of the year. For ward based services approval amounted to

Department	Registered	Un-registered
Amesbury	-	4.38
Chilmark	-	4.98

(ITU also received an uplift in staffing as a result of this process, but this was achieved by adjusting the previously applied headroom uplift)
Source; Combined Skill Mix Establishment (VER3)

2.4.3 Clinical Support and Family Services – Paediatrics

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

own staffing group, and anticipated discussions in September 2021 by the DCNO and AWP will result in shared access to RMN bank resources.

Paediatric staffing continues to be a challenge within the Emergency Department. A business case is being written by the ED matron and ED Lead Paediatric Consultant. This outlines various options to address the limited availability of paediatric trained nurses within ED. No decisions have been made as of yet to the outcome of this business case, which is being led by the Medicine Division with support from the CSFS Head of Nursing, and newly appointed Paediatric Matron (arrived in post April 2021).

Sarum staffing numbers have remained static with 3 Paediatric RNs on shift for many years now. The last previous uplift in staffing establishment was to support the POST (Paediatric Outreach Support Team) approximately 4 years ago. This has since been renamed to PASS (Paediatric Assessment Service) to more effectively describe its role and extent of interaction with services across the Trust. Over the past year, the role of PASS team/nurse has been to predominantly support Sarum acknowledging their increased acuity and change in patient type (increased CaMHS attendances). This has limited how effective the PASS team can be in fulfilling their original brief, and has to some extent masked the changing needs and acuity to Sarum ward itself. With the arrival of the newly created Paediatric Matron role, it is recommended that the PASS team is formally reviewed and evaluated, as to how well it achieves its intended purpose, and what any resulting recommendations are in relation to the PASS teams function, and Sarum ward skill mix.

The RCN (2013) guidance states that a paediatric trained nurse must be available at all times when children are admitted for Day Case Surgery (DSU). DSU currently employ 1.0 wte Paediatric RN directly, with support offered from the PASS or Sarum ward team as required. Unfortunately due to concurrent demands and acuity this is not always achievable. In these circumstances, following a review of bank options with the sisters from Sarum and NICU ward, a paediatric agency nurse may be requested to work on DSU. It is also to be noted that there has been intensive work to ensure that the DSU staff undergo their paediatric competencies with a total of 4 DSU RNs having successfully completed their competencies.

2.4.4 **Women and New Born Division**

The Women and New Born division was formed for Quarter 1 of 2021/22. This newly formed division currently includes Maternity and NICU. As a result of a cultural and safety review that was commissioned by the trust in 2020 into Maternity services, and reported at the beginning of 2021, a review into the midwifery workforce has been completed. Both these reviews recommended a significant change to the leadership structure within the service which is now in the process of being recruited into.

A subsequent staffing review of the clinical midwifery workforce to ensure safe staffing levels was undertaken for all midwifery bands (Band 5-7) and incorporated the findings of the Birthrate Plus®. To coincide with the this Birthrate Plus assessment, the National Maternity Transformation recommends a particular focus on continuity of care and personalisation for women alongside the national ambition

to reduce the stillbirth, neonatal and maternal death and neonatal brain injury by 50% by 2025.

The Maternity paper (Appendix 1) offers further detail as to recruitment, roles and developments within the service, but in terms of requested uplift in response to safe staff numbers, an uplift 1.96 B6 wte is required to be compliant with Birthrate Plus 2021. In addition to this a further 4.26 wte midwives is required to meet the recommended phased approach of 35% of women receiving Continuity of Carer.

NICU services are also experiencing significant change in terms of potential re-designation. This Network led consultation will potentially result in our NICU service being described as a Special Care Baby Unit, which limits admission to those over 34 weeks gestation. An executive paper is prepared separately to describe the risks and concerns at such an intervention with regard to clinical care, location, recruitment, funding and reputation.

However, in the meantime the NICU team and workforce remain relatively stable. Internal discussions are underway exploring the potential adoption of working long days and nights. This approach in itself will offer some flexibility within the existing budget to manage any increase in demand/acuity, and to that end no further adjustments to establishments are requested.

2.5 Trust wide risks and issues considered in the review

2.5.1 Increasing patient acuity/dependency

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

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

Consideration needs to be given to nurse sensitive indicators which are part of the triangulation when reviewing nurse staffing levels. Overall, nurse sensitive indicators have been generally good, however, falls and pressure ulcers remain high and key focus of the Trust.

The Nurse Sensitive data offered evolved and changed within the year of review. Previously the Risk Management team generated monthly ward based KQIs. With the development of Ward Performance Reviews this data is now generated and supplied by informatics with adjusted indicators. The data presented (appendix 1) correlates with the ward move, for example Pitton data represents their time in Durrington footprint from 07/20 to 03/21 combined with their data since moving to the Pitton environment from 04/21.

Nurse Sensitive data and impact on ward moves/environment

The numbers offered within appendix 1 regarding nurse sensitive data cover the whole year (June 2020 to July 2021). As described above, a number of wards moved within this period and as a result it was worth considering if these changing environments led to any adjustment in datix/incidents.

Respiratory care (formerly Pitton 07/20-03/21, now Laverstock 04/21-06/21)

Ward	PU cat 2 and above	No of falls	Complaints	No of red flags
Pitton resp 9/12 of year	34	81	4	12
Laverstock resp 3/12 of year	4 Proportionally lower since move	14 Proportionally lower since move	3 No discernible change	4 Small proportional increase since move

Elderly care (formerly Durrington 07/20-03/21, now Pitton 04/21-06/21

Ward	PU cat 2 and above	No of falls	Complaints	No of red flags
Durrington elderly care 9/12 of year	20	99	5	6
Pitton elderly care 3/12 of year	7 No discernible change	34 No discernible change	0 Proportionally lower since move	3 No discernible change

Whilst this is a very crude measure, and of limited statistical value given the period of time and variables, but it is of some reassurance at least, that as a result of the ward moves there is no discernible proportional deterioration, and certainly with the move of Respiratory care to Laverstock, data to date, suggests this is an improvement.

2.5.2 Increasing enhanced care needs

As a result of the previous skill mix review, a Band 2 bank allocation was offered to wards based on their previous usage and requirements. This amounted to 12.31 wte for medicine and 4.7 wte for surgery. It has been hard to understand the impact of this at present as these changes were applied from April 2021 for Surgery and from July 2021 for Medicine, where a varied level of awareness as to the allocation existed amongst the ward leads. As part of the ward reviews undertaken, specific reference has been made to available budget allocation along with expectations as to usage and its application. It is anticipated that subsequent staffing and financial reviews should include specific reference to this to ensure appropriate usage and ultimately financial balance and appropriate safe care and treatment for our patients.

2.5.3 Vacancies and temporary staffing

Nationally RN vacancies remain high. The latest available figures from NHS Digital[9] identify that over 36,000 RN vacancies remain across England. There is variation amongst wards as to the level of vacancies with some wards retaining their previously achieved full establishments, and others continuing to struggle. Those with the greatest gap include ED 9.2 RN wte and Radnor 4.46 RN wte vacancy.

Overseas recruitment has continued with a specific focus on Theatres, and opportunity presented to source additional overseas nurses from Yeovil's overseas recruitment which have been identified for orthopaedics. A separate paper has been prepared detailing further overseas recruitment initiatives.

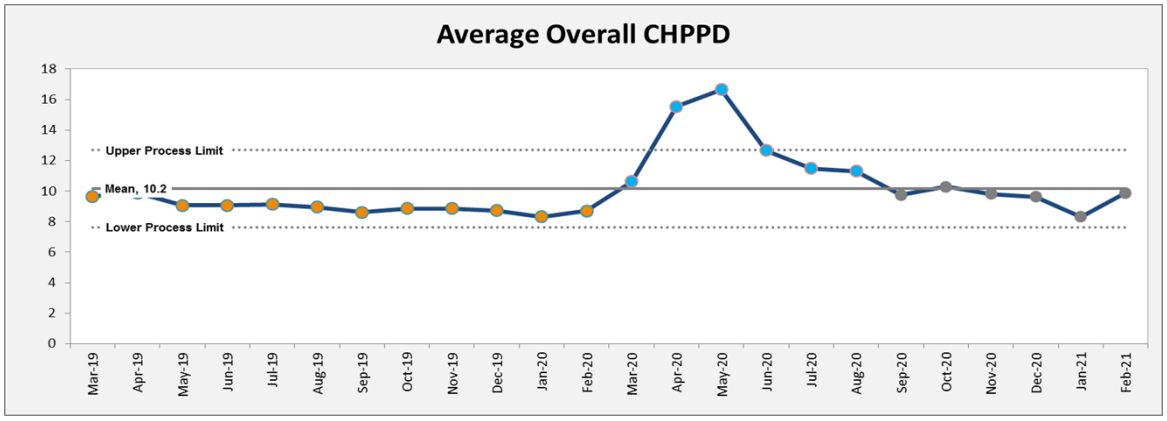
The focus on nurse retention has remained and linked into wider Trust work such as Best Place to Work initiative. The release of the People Plan sees nursing as a core element and work continues across Divisional leads and representatives with regards to flexible working pattern systems. The Trust is part of a national collaborative with Allocate piloting team-rostering (Britford and Odstock) as part of a wider piece of work on improving flexibility for staff – a requirement within the People Plan.

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

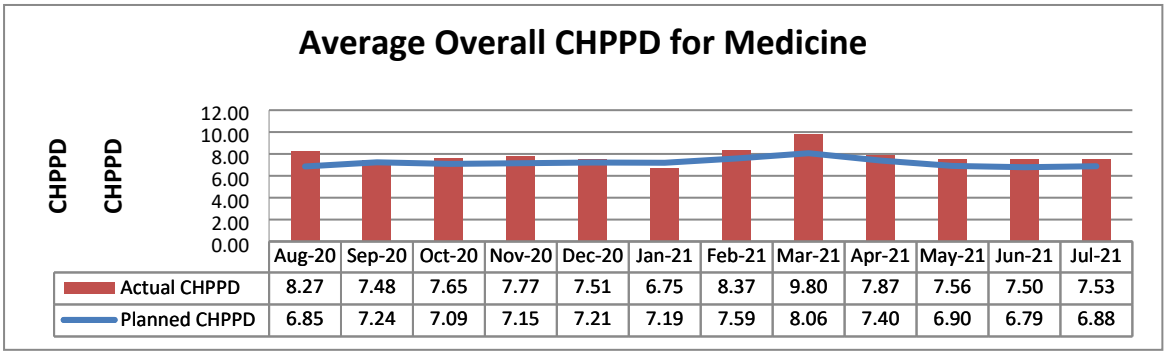
2.5.4 Care Hours per Patient Day (CHPPD)

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

Within Model Hospital comparisons can be seen at both ward and trust level, however, caution is required as the specific configuration of services in any organisation determines the level of staffing required. The data in the model hospital provides the opportunity to review staffing levels through another lens, ask questions and challenge and evaluate whether staffing levels are safe. As previously highlighted, going forward Nursing Associates (but not Assistant Practitioners) will be shown separately to RNs and HCAs, and will provide a more accurate review and assessment of CHPPD. This is anticipated to take effect from September 2021, and so subsequent six monthly review will evaluate this inclusion in more detail and provide a more accurate comparator to other organisations.

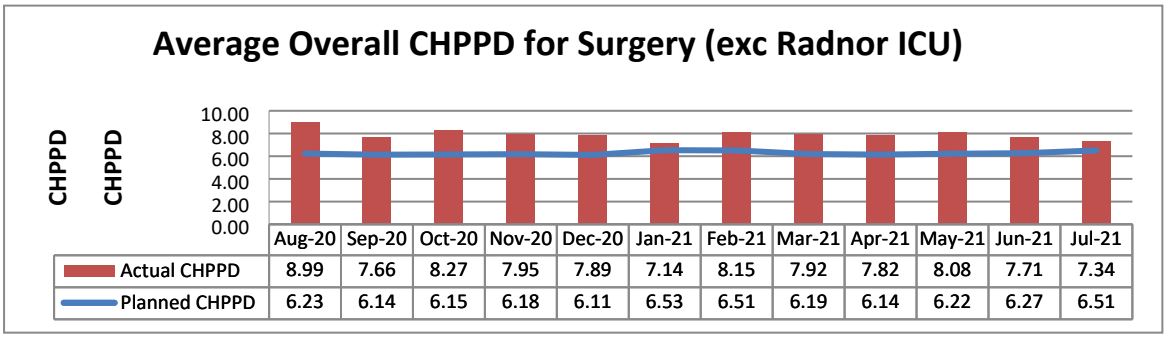


Source: Monthly Nursing Staff Fill Rate Report- July 2021



	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Actual CHPPD	8.27	7.48	7.65	7.77	7.51	6.75	8.37	9.80	7.87	7.56	7.50	7.53
Planned CHPPD	6.85	7.24	7.09	7.15	7.21	7.19	7.59	8.06	7.40	6.90	6.79	6.88

Source: Monthly Nursing Staff Fill Rate Report- July 2021



	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Actual CHPPD	8.99	7.66	8.27	7.95	7.89	7.14	8.15	7.92	7.82	8.08	7.71	7.34
Planned CHPPD	6.23	6.14	6.15	6.18	6.11	6.53	6.51	6.19	6.14	6.22	6.27	6.51

Source: Monthly Nursing Staff Fill Rate Report- July 2021

3 Covid Staffing

The period of the skill review covers July 2020 to June 2021. This period covers the tail end of wave 1 where staffing levels were high as the hospital occupancy dropped to 46% and sickness levels were not impacted as heavily as feared. In wave 2, escalating in November and December 2020 and peaking in January and February 2021 the Alpha variant impacted the trust heavily and staff sickness and self-isolation increased sharply.

As a result, and in anticipation of reduced staffing numbers, a planned change in ratios was developed and agreed via the Executive Gold forum (See appendix 3). The table

below demonstrates the planned actions for green, amber and red staffing as wards and teams are impacted as a result of leave and sickness.

The focus was to facilitate an informed approach to reducing staffing during January 2021. The Trust reached the point where the teams were unable to achieve red levels, and as a result of this, the Trust actioned additional resource requests in the form of implementation of the Ward Buddy programme and the use of military resources across clinical areas.

Whilst wave 2 resolved, the Trust continues to manage resulting waves, and whilst not as impactful in terms of patient numbers, ongoing fluctuations in acuity/demand require flex, management and resource as we move from Covid escalation one to two, and Laverstock annex/Radnor and theatre recovery, to accommodate increasing Covid numbers requiring intensive care.

Similarly, at the time of compiling this report, as referenced in 2.3.6, the Trust is currently reporting a red flag for staffing, and the use the staffing red amber green continues to be used to guide risk assessment and decision making. Staffing levels referenced in appendix 3 have been updated to reflect ward moves and staffing changes from previous skill mix outcomes.

Rating	Trigger/Impact	Action	Authorisation
Green	**Staffing levels:** staffing levels match with agreed roster plan **Patient acuity & dependency**: is within usual expected range for the area **Situation**: "business as usual"	All planned care and routine tasks will be carried out	None
Amber	**Staffing levels:** A shortfall has occurred between 'We have' and 'We planned' e.g. due to staff absence and/or vacancy **Patient acuity & dependency:** is increased from that usually expected e.g. requiring increased clinical observation levels or other staff intensive interventions **Situation:** A short term solution resolved by short term provision of additional resources	Some non-essential activities may be postponed or cancelled until situation is resolved as determined by the Nurse in Charge Matron seeks redeployment of staff from other areas or where this is unsuccessful may request additional Bank cover as required	Matron – in hours Duty manager - out of hours
Red	**Staffing levels:** A shortfall has occurred between 'We have'	All non-essential tasks are suspended – specifics agreed by	Agency - Matron or Divisional Head of Nursing to Deputy

	and 'We planned' that cannot be met in the short term by redeployment of staff from other areas or by Bank staffing **Patient acuity & dependency:** risk assessment and professional judgement indicates that risks presented by a measurable increase in patient acuity/dependency necessitates a shift to be covered	Nurse in Charge Matron escalates red rated shift to HoN for consideration/approval for agency cover. Off framework agency to be approved by DoN or Deputy (Exec on-Call out of hours) Nurse in Charge reports a patient safety incident on DATIX if shift is unable to be partially/completely covered and patient safety is at risk of being compromised	Director of Nursing in hours On call manager and exec on call out of hours DoN or Deputy for non-framework requests (exec on call out of hours) Below red Ward buddies and military support was sought

4. Conclusions

Whilst significant improvement had been made with recruitment and retention, and in 'normal' circumstances, Salisbury would have been in a positive position with benefits to the experience of both our staff and patients, the Covid-19 pandemic has impacted on the gains the Trust had made. The pandemic has impacted specifically on sickness, resilience and temporary staff fill rates along with recruitment and retention.

During specific periods of Covid activity (January/February 2021) quality of care has been impacted by Covid, with staff shortages, and increase in pressure ulcers and falls, which continues to be focused priority of the Trust.

Nursing continues to demonstrate effectiveness in deploying workforce efficiently as seen in both INSIGHTs data which is reviewed monthly at the Safe Staffing Group, and in utilisation of the Covid staffing plan.

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

The review itself and ongoing work between the nursing team and the Finance team has led to an improved understanding of the current and required staffing position, and the available establishment, but work is ongoing and further time is required to fully embed and recruit in to the previous changes and uplift, which only came in to effect from Month 3 (June 2021) for many wards.

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

5. Recommendations

- To note the findings of the full ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels, specifically:
    - SFT nursing establishments are set to achieve an average of ration 1:6.7 (excluding ITU) in Surgery and 1:6.8 (excluding ED) in Medicine of registered nurses to patients during the day.
    - Wards are staffed on average 60:40 registered/unregistered ratio, with exceptions linked to the implementation of the band 4 role.
- To note the on-going progress with compliance with the guidance from the National Quality Board on safe, sustainable and productive staffing including Developing Workforce Safeguards.
- To note the requirement to implement the Safer Nursing Care tool to provide additional assurance that nurse staffing levels are safe.
- To continue momentum on actions to fill vacancies in a timely manner and improve retention and to continue the reduction on the reliance on high cost agency.
- To discuss the report at both TMC and open Trust Board as an ongoing requirement of the National Quality Board expectations on safe staffing assurance.
- To recognise that ongoing Covid activity may require an agile response to maintain safe nursing care.

APPENDIX 1

Data and spreadsheets of skill mix discussions

See separate document

Appendix 2

Requested changes to establishment

Shaded boxes refer to requests that can be made within existing budgets, subject to separate Covid-19 funding bids, or not supported by CNO.

WARD	BANDING and WTE	ROLE/SHIFT	COST	COMMENTS OF DCNO	Supported by CNO?
MEDICINE					
ED	B7 0.6	Education Facilitator	£31,662	Role is 1.0, but 0.2 available in funded establishment and intention for Education facilitator to work clinically one a week, therefore 0.6 requested	Not supported. Ongoing review and usage of teams/leads/ matron
	B4 1.9	To accommodate existing NA roles		Confirmation sought - ? To be picked up as part of B5 funded establishment	Accommodate within B5 vacancies and turnover
	B5 2.6	Night shift 7/7 as second resus nurse in line with guidance	£118,891 maximum cost (see alternative option)	Data to follow re resus attendance at night. Option of upgrading existing TW to full night as cheaper alternative	Not supported. Await resus data and review of consistent use of TW shift
Hospice	B7 1.0	To cover current substantive role	£52,771	Previous B7 shared between community and ward, which has since been separated in to two roles	Not supported. Medicine DMT to manage cost pressure
	B4 1.24	Early 5/7	£43,904	Unit is an outlier for only 2 RNs, increasing acuity, interventions, complex discharge, non-malignancy all impacting need for additional resource	Supported by CNO
Whiteparish	B4 1.74	Late 7/7	£61,608	Increase in complex unstable diabetic patients, theatre involvement, VAC therapy, pressure ulcer management	Not supported. Review in six months when previous skill mix uplift embedded.
Durrington				Nil to add, just need appointments in to funded establishment	
Longford	B5 1.74 +2.6	Late shift + Night shift (7/7)	£198,456	Further detail requested on respiratory patients acuity/number/level of injury. Recommend separate review against bespoke spinal guidance and standards	Not supported. Commission separate staffing review of Spinal Centre.
Spire	B2	TW and night		Spire to confirm extent of	Not supported.

		shift (7/7)		previous skill mix reviews and coverage of these shifts as DMT requested to enact changes from previous award	Review in six months when previous skill mix uplift embedded.
Laverstock				No specific ask, but request confirmation re B4 1.8 establishment (or do we continue to pay from B5 establishment expecting turnover/vacancy etc?)	Accommodate within B5 vacancies and turnover
Redlynch	B2 1.74	Late shift 7/7	£52,381	Previous skill mix only just embedded so previous impact/stretch/flexibility yet TBC, but 2021 request for additional B2 on late to reflect acuity changes and incident reporting	Not supported. Review in six months when previous skill mix uplift embedded and recruited in to.
Farley	B5 5.3	LD and N (7/7)	£242,354	Only required if RCU staying in current location with Breamore continuing as is. Required to support and recover SSNAP results. If RCU to close and Breamore (rehab) stroke returned to Farley stroke, then current skill mix sufficient.	Supported. Changes as a result of Covid. Recommend funding sought as part of bidding process for second part of year.
Breamore				Funded through escalation/covid monies due to requirement to accommodate RCU. Will require covid funding for part 2 of year. No change in terms of skill mix	Currently under budget. DMT to review as part of Farley request above
Tisbury	B6 1.0	Uplift of x1 B5 to B6	£11,204	To allow provision of x1 B6 on each shift, support supervision, education, liaison with SUHT.	Supported by CNO
AMU				Nil to add	
SURGERY					
DSU				Nil to add	
Amesbury	B4	Current night shift 3+0+4 (RN+B4+B2). Request to move to 3+1+3 (7/7)		Able to be absorbed within existing budget	
Chilmark	B5	Uplift current B4 on N to a B5 (7/7)		Current night 3+1+2. Request to move to 4+0+2 due to separation of trauma/elective. Previously part of covid funding bids for first part of year. Part 2 TBC	
Odstock	B2	BDC (Burns Dressing Clinic) coverage M-F		Has been able to be absorbed from ward budget so far, but need dependent on final destination of BDC if laser activity resumes.	

	B5	Fourth RN on late (5/7)		Has been trialled for past 12/12. Support for training/ supervision/burns referrals/ theatre returns. Covered within existing budget – DMT advised to confirm approach and financial coverage and request rota template change.	
Downton	B4 2.6	Night 7/7	£92,058	To support increased acuity and ENT, trache care patients. Electives now on Chilmark, so reduced number of 'simpler' turnaround pts.	Not supported as direct uplift. To be managed internally as required and SD beds in use. Six month review
Britford				Nil to add. Ongoing trial re SAU and DMT to review +/- business case	
Radnor				Nil to add. Continue 9+1	
CS&FS					
Sarum	B5 RMN 1.0	As required		Direct link and causation with Covid. Recommended to seek funding through covid bids for second half of year	Not supported as part of skill mix uplift. Seek Covid bid +/- use of AWP bank
	B5 PASS Fri-Mon N Sat–Sun LD	2.28	£104,257	Recommend PASS assessment and evaluation, as purpose merged primarily to provide uplift to support Sarum ward	Not supported. Undertake PASS assessment and evaluation
	B6 0.5	Education Facilitator	£24,402	0.2 B6 available within current establishment. Additional 0.5 to create education role	Not supported. Review impact of newly created Paed Matron and existing B7
	B2 1.0	Play Assistant	£24,311	Current fixed term post funded by Stars. Request to confirm as substantive role within funded establishment	Supported by CNO
W&NB					
Maternity	B6	1.96 (Birthrate Plus) + 4.29 (Continuity of Carer at 35%)	£355,818	Employed as B5 for first year. Costed as B6. Funding partially offset by Ockenden funding.	Supported by CNO
NICU					
TOTAL COST			£435,237 (unshaded and CNO supported)		

Appendix 3 Covid staffing model

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

												Total beds	SD beds
	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA		
MEDICINE													
AMU												19	0
Early	6		4		5		4		4		3		
Late	6		4		6		3		4		3		
Night	4		2		4		2		3		2		
Durrington												21	2
Early	3		3		2	1	3		2	1	2		
Late	3		3		2		2		2		2		
Night	3		1		2		2		2		1		
Farley Stroke (but currently includes RCU) (Note increased staffing levels when ward functioning with high number of COVID)												30	0
Early	5		5		5		3		4	1	3		
Late	5		4		5		3		4	1	3		
Night	4		3		4		3		4		3		
Hospice												10	0
Early	2		2		2		1		2		0		
Late	2		2		2		0		2		0		
Night	2		1		2		1		2		0		
Pembroke												10	0
Early	2		1		2		1		2		0		
Late	2		1		2		1		2		0		
Night	2		1		2		1		2		0		
Pitton (Elderly Care)												28	2
Early	4		4		3		4		3		2		
Late	4		3		3		3		3		2		
Night	3		2		3		2		2		2		
Redlynch												27	3

												Total beds	SD beds
	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA		
Early	4		4		3		3		3		2		
Late	4		2		3		2		3		2		
Night	3		2		3		2		2	1	2		
Spire												30	0
Early	4		6		4		5		3		3		
Late	4		3		3		3		2	1	3		
Night	3		3		3		2		2	1	2		
Laverstock (Resp)												19	1
Early	4		3		3		3		2	1	2		
Late	4		2		3		2		2	1	2		
Night	3		2		3		1		2		1		
Breamore (Stroke rehab @13)												24	4
Early	2		2		2		2		2		1		
Late	2		1		2		1		2		1		
Night	2		1+TW		2		1		2		1		
Tisbury/CCU												23	0
Early	6		2		5		2		4		1		
Late	6		2		5		2		4		1		
Night	4		1		3		1		3		1		
Whiteparish												23	0
Early	4		3		3		2		2		2		
Late	3		3		3		2		2		2		
Night	2		2		2		1		2		1		
Longford												39	0
Early	7		10		6		8		5	1	6		
Late	6		6		5		6		5	1	4		
Night	5		5		4		5		4		4		

											Total beds	SD beds
SURGERY												
	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA			
Britford													20	1
Early	5		2		4		2		3		2			
Late	4		2		4		2		3		2			
Night	3		2		3		2		2		2			
Downton													24	2
Early	4		3		3		2		2	1	2			
Late	3		2		3		2		2	1	2			
Night	2		2		2		2		2		2			
Odstock													17	0
Early	4		2		3		2		2	1	2			
Late	3		2		3		2		2	1	2			
Night	3		2		2		2		2		2			
Amesbury – trauma													32	0
Early	4	1	5		4		4		3	1	3			
Late	4	1	5		4		4		3	1	3			
Night	3		4		3		3		3		3			
Chilmark – General Elective													12	0
Early	2		2		2		1		2		1			
Late	2		2		2		1		2		1			
Night	2		1		2		1		2		1			
Chilmark – Ortho elective													8	0
Early	2		1		2		1		2		0			
Late	2		1		2		1		2		0			
Night	2		1		2		1		2		0			

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Salisbury
NHS Foundation Trust

Maternity Services Staffing Report June 2021

Midwifery Staffing Report - SFT June 2021

Introduction and purpose

Following the cultural and safety reviews that were commissioned within the trust in 2020 into Maternity services, and reported at the beginning of 2021, a review into the midwifery workforce has been completed. Both reviews recommended a significant change to the leadership structure within the service. A revised Maternity structure has been agreed (March 2021) and new posts are in the process of being recruited into. The new structure ensures an increase in leadership roles within the service to meet demand from the regional and national work streams and to ensure clear accountability and responsibility at all levels in the service. This paper details a review of the clinical midwifery workforce to ensure safe staffing levels for all midwifery bands (Band 5-7) and to incorporate the findings of the Birthrate Plus® report from December 2019. This paper seeks to demonstrate our current position and provides an action plan for the next 6 months.

The NHSR Maternity Incentive scheme requires a 6 monthly review of midwifery staffing to demonstrate safety within the service and to ensure that gaps and concerns are raised with the trust board. A staffing review was undertaken in March 2020 and presented to the board and a further review in October 2020 was completed, but due to the Covid-19 pandemic was not progressed.

The National Maternity Transformation programme details a particular focus around an increase in continuity of care and personalisation for women alongside the national ambition to reduce the stillbirth, neonatal and maternal death and neonatal brain injury by 50% by 2025. We recognise and embrace the need to make our service as safe as possible for women and babies, and are keenly embracing and implementing the recommendations from our safety review, along with acknowledging and actioning the recommendations and points raised in the cultural survey. It was highlighted in both reports the significant impact that appropriate staffing levels have on both safety and staff wellbeing.

Alongside this work, we acknowledge the current media attention around safety as being a high priority agenda within the maternity service and especially in light of the Ockenden Review 2020. These ambitions all have the need for the recruitment, retention and training of highly skilled staff central to any possibility to improve, whilst maintaining safety.

The service will provide an entire workforce skill mix review paper in September 2021, this will include support roles and our neonatal service workforce review.

Maternity Services Staffing Report June 2021

Methodology

The current midwifery establishment at SFT was calculated using a midwife/birth ratio of 1:26 as recommended by the SFT Birthrate Plus® report in December 2019. Birthrate Plus® is the national workforce tool recommended by NICE (2014). Current funded establishment is based upon a projected total of 2200 births per annum. To monitor the safety of this approach we also use the Birthrate Plus® acuity tool, inputting precise data detailing risk and acuity of inpatients on Labour ward 4 hourly. This gives us up to date feedback on the level of safe staffing against the acuity and activity of the day. The tool also measures by exception where 1:1 care is not possible for labouring women, and when the labour ward co-ordinator is not able to maintain supernumerary status. 1:1 care in labour and the co-ordinator maintain supernumerary status is a requirement of the NHSR Year 3 Maternity Incentive Scheme.

Birthrate Plus® is the only recognised national tool for calculating midwifery staffing levels, and provides a robust and proven methodology for determining midwifery staffing establishments. Following the original Birthrate Plus® assessment in 2015 there was investment of 10 WTE registered midwives. A report following the most recent assessment by Birthrate Plus® in December 2019 recommended that midwifery staffing levels should be increased by a further 5.2 WTE; this would ensure the total **clinical** establishment was 85.90 WTE bands 3-7 (Birthrate Plus® includes Band 3 roles within the maternity service as they support midwifery tasks and should be an integral part to the workforce and skill mix). A statement of commitment from the Trust Board was received in December 2020 providing approval of these posts and we continue to ensure they are transferred in to the budget setting process.

However it has since been recognised that the figures of current clinical establishment presented to Birthrate Plus® in summer 2019, that informed the report published in December 2019, included some non-clinical roles within the variance report, and was therefore inaccurate in this calculation and subsequent recommendations.

Following liaison with Birthrate Plus® in May 2021 and a recalculation of the service requirements using 2019 clinical data, Birthrate Plus® have recalculated our staffing requirements. Table 1, below, documents the clinical establishment reported in December 2019 required for the maternity service in line with the clinical data provided. Table 2 is the updated report form Birthrate Plus® May 2021.

Birth-rate plus recommendation 2019

Table 1.

Salisbury NHS Trust Draft 19/12/2019	**RMs**	**MSWs**	**Bands 3 - 7**
Current Total Clinical	79.33	2.10	**83.03**
Contribution from Specialist MWs	1.60		
Total Current Funded	**80.93**	**2.10**	**83.03**
BR+ Clinical wte			**85.90**
Skill Mix Adjustment (95/5)	83.32	2.58	
Variance +/-	2.59	-0.48	
TOTAL CLINICAL VARIANCE			**-2.87**
	BR+	Current	**Variance**
NON CLINICAL (9%)	7.73	5.40	**-2.33**
OVERALL VARIANCE			**-5.20**

Birth-rate plus recommendation May 2021

Table 2.

Total Births	**2193**
Core Hospital Services	
Delivery Suite	33.86
Postnatal Ward	20.95
Maternity DAU	7.96
Community Inc. Homebirth provision	27.83
Total Clinical wte Band 3-7	**90.60**

In addition to the clinical workforce recommendations from Birthrate Plus® the non- clinical workforce is calculated based on a standard % of 9%. This would mean that the non-clinical wte should be 8.15wte. These roles include Named Midwife for Safeguarding Children, Antenatal and postnatal screening leads, Perinatal mental health lead midwife, birth environment lead, practice educator, fetal surveillance lead and midwifery matrons.

The recommendations for clinical staffing and the budgeted establishment versus current staffing levels are shown in Table. 3:

Table 3

Banding	Clinical Budgeted Establishment (wte) inc. BR+2019 increase (5.2wte)	Actual clinical Headcount (wte) June 2021	Maternity Leave (wte) June 2021	Variance (wte) budget vs actual	Variance (wte) budget vs Birthrate Plus® 2021 report	Variance (wte) actual vs Birthrate Plus® 2021 report
Band 3	3.11	3.91	0	+ 0.8		
Band 4	0.6	0.6	0	0		
Band 5	12.09	5.64	0	-6.45		
Band 6	65.9	58.93	5.45	-6.97 (12.42 inc. Mat leave)		
Band 7	6.94	6.22	1.72	-0.72 (2.44 wte inc. mat leave)		
Total	88.64	75.3	7.17	13.34 (20.51 wte inc. mat leave)	1.96	15.3

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Reporting

We continue to report staffing ratios monthly via safer staffing meetings to ensure transparency and awareness within the trust and to ensure that concerns and vacancies are highlighted as appropriate. This monthly scrutiny of staffing has ensured that whilst existing team members take periods of absence, including maternity leave and secondments, we are able to carefully calculate the use of temporary staffing across maternity services to ensure the correct balance of backfill into vacant positions is maintained.

As Maternity services has formed part of the new Women and Newborn Division we will be reporting our staffing dashboard to the Executive team on a monthly basis.

Recruitment

It is recognised nationally that there is a shortage of midwives in England, a recent publication by the Royal College of Midwives (RCM) states that the national shortage of midwives in England is the equivalent of 2,500 and therefore it is a recognised risk to the profession.

Recruitment to band 5 and band 6 clinical posts has been variable in the last 12 months, we recognise that there is a need to balance the junior workforce with experienced staff and the recruitment in to senior band 6 positions is a challenge for Salisbury. Although this is not just isolated to Salisbury, the military population, lack of city lifestyle and size of the maternity service are all contributory factors.

The recruitment team are currently providing focussed individual support, including weekly meetings to the Deputy Head of midwifery responsible for workforce, to ensure recruitment is advertised and promoted as widely as possible and that new starters are assisted into positions in the most efficient time frames possible. The trust lead for recruitment and retention has implemented changes around the recruitment process to ensure that we are advertising broadly on social media and in Midwifery Journals/RCM advertisement as well as via traditional routes such as NHS jobs.

In recent months there has been a need for a more flexible approach to working across the entire midwifery workforce. An example of this has been to reduce community midwifery staffing levels at a weekend in order to meet acuity demands within the hospital environment.

The concept of flexible working across the maternity pathway rather having fixed areas of working, as an alternative approach to providing maternity care, is seen as not only a more cost effective way of working but supports the vision for continuity of carer. The majority of preceptor and newly recruited midwives now rotate between all areas of maternity, offering a more integrated model of care. At the beginning of October 2020, we welcomed a cohort of 6 WTE newly qualified (Band 5) midwives who were appointed following a competitive

recruitment drive. Their preceptorship programme has been redesigned to encompass a more holistic approach to providing care to women and their families by working more flexibly across the maternity service, and includes experience in both inpatient and outpatient areas.

In October 2021 the preceptor midwives will have the opportunity to progress to a Band 6 position, following completion of all clinical competencies. We are actively recruiting Band 5 midwives and have, this week, appointed 12 Band 5 preceptors who will start in October 2021.

Other recruitment within maternity is ongoing and with a new structure in place there are several opportunities currently out to advert, or will be out in the coming weeks. It was noted in the safety review that the senior structure in Maternity did not support either the operational needs of the service, or the requirements of the strategic national maternity agenda. New senior roles will ensure that there is an appropriate management structure in place, as well as roles that are imperative to support an effective and safe maternity department to provide best care and be aligned with national units. New roles include:

- 2 Midwifery Matrons for the outpatient and quality areas
- bereavement specialist midwife
- transformation lead midwife
- digital midwife
- patient experience midwife

The Trust board has recently agreed to appoint a Director of Midwifery as the lead for the Maternity and Neonatal service, this role will replace the Head of Midwifery role and will be banded in line with national job profiles. The role will provide accountability and assurance to the trust board and will meet the requirements of the RCM: Strengthening Midwifery leadership manifesto. There is a proposal for 1wte Deputy Director of Midwifery within the new structure; this role will replace the Deputy Head of Midwifery position which is currently a job share and a hybrid role. There will be a workforce consultation in September 2021 to progress changes to the leadership structure.

Safety and overview

In order for the service to demonstrate safe staffing on a daily basis the role of the Duty Manager plays a fundamental role in responding to the constant changing clinical situations within maternity, both in the building and in the community environment. The Duty Manager is available to provide a 24/7 support to the Maternity and Neonatal Service, providing a helicopter view across all areas and maintaining safety at every level. The Maternity Duty Manager rota is covered by band 7 and band 8 midwifery leaders; with the current vacancies and maternity leave amongst the band 7s and 8s this has fallen to a small pool of staff, and whilst recognised as an imperative part of the service to maintain safety, has provided challenge due to the impact on daily workload and the ability to balance strategic work and requirements alongside daily operational pressures.

Maternity services continue to report via Datix missed breaks and when the coordinator is unable to maintain their supernumerary status (a requirement of the NHSR Maternity

Incentive scheme). At such a time the involvement of the duty manager and use of the maternity escalation policy ensures oversight and transparency when staffing and incidents occur. Additionally Red flag reporting is discussed monthly at the maternity risk meeting, with any themes being fed into the Trust Clinical Risk Group.

Staffing is discussed at maternity risk monthly, it forms part of the Executive performance review monthly meetings, and is discussed with the Board level safety champions monthly. The reporting mechanisms ensure clear escalation and visibility of staffing challenges. A staffing dashboard is being developed by the Deputy Head of Midwifery responsible for workforce.

Challenges and Mitigations

Maternity leave

Maternity leave has consistently been high in the maternity department year on year, and over the past 2-3 years is consistently around 8-10 WTE at any one time. This has impacted on the ability to staff the department on a daily basis. Rates are currently at 7.17 WTE (June 2021) which is a significant percentage out of our WTE clinical workforce, this is impacting heavily on our staffing levels on a shift to shift basis. We continue to use bank staff (however the majority of bank staff in the service as also substantive and so there is not full flexibility to utilise this group of staff on a sole bank basis).

Staffing levels

With the recalculated birth-rate plus assessment of the recommended safe staffing levels, alongside the current levels of maternity leave, recent staffing numbers have been seen to fall to substandard levels, with a significant clinical shortfall from the band 6 midwifery group.

This has been escalated to board level and is being managed accordingly, through a sharing of staffing resources across the midwifery pathways. In addition we have:

- utilised bank midwives
- community staff working flexibly in the unit as and when required
- use of agency midwives when available (November to June 2021)
- Support of Duty manager day and night as required to coordinate the escalation process ensuring coordination of staff and work as acuity dictates necessary.
- The daily staffing/safety huddle involving clinical leaders across all areas of maternity services, to ensure a team approach to day to day working also contributes to ensuring staff are assigned to clinical areas according to fluctuating activity levels.

These measures have provided assurance of safety for all ensure that care provided to women and babies in our care. It is important to recognise staff wellbeing is impacted with the shortfall of staff within the service and are feeling the pressure of this. It is recognised that although staff have undertaken bank work to close day to day gaps this is not a sustainable long term solution.

Staff absence and HR support

As a response to some emerging themes around staff sickness and primarily short-term absence, the leadership team have been supported by OD&P and the occupational health team to support employees reporting absence from work. This has enabled a stream lined, and consistent approach to staff and ensured fairness and equity is paramount when managing absence. OD&P colleagues have supported the leadership team with managing long term sickness and continue to do so.

Improving Culture

Following the recent culture survey, we also recognise that work around improving team culture is required. This will sit alongside the existing work streams which has included a particular focus on the leadership team to date. This group of midwives and Obstetricians are currently undertaking a leadership programme around leadership development, comprising opportunities to talk, listen and contribute through action learning to both person and team development. We expect with a change in culture that there will be a positive impact on recruitment and retention.

Risks

Delivery of Continuity of carer model

In February 2016 Better Births, the report of the National Maternity Review, set out the Five Year Forward View for NHS maternity services in England to become safer and more personal. At the heart of its vision is a recommendation that there should be Continuity of carer to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions. In Salisbury a pilot study for continuity of carer was established in 2019 and the 'Ivy Team' offered midwives and women the opportunity to foster the recommended pathway of care for certain cohorts of women (birth trauma and previous caesarean birth). The pilot ended in March 2021 due to concerns around entire midwifery workforce skill mix and vacancy rates at Salisbury. When moving towards the continuity model, it is recognised nationally that this will require an increased number of midwives as opposed to the traditional working model. Within the revised recommendations for staffing in the Birthrate Plus® report (May 2021) are the proposed staffing levels required to move to full continuity of carer and a phased approach to roll out this within the service.

Table 4 demonstrates the required staffing levels needed to achieve continuity of carer using SFT data and staffing establishment figures.

It is clear wihtin the report that in order to develop continuity of carer to 35% of women the service requires an additional 4.26wte midwives (this is in addition to the Birthrate Plus® report (May 2021) establishment of 90.6 wte clinical midwives.

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Table 4. Continuity of Carer modelling from Birthrate Plus® report (May 2021)

SALISBURY NHS TRUST	24% uplift	Version date: 13/05/2021			DRAFT							
TOTAL BIRTHS	**2193**	**The figures are an indication only and should be reviewed as more caseload teams are set up**. The staffing totals assume the annual births, community exports and imports remain as in the baseline and there are no other changes to services. The CoC staffing is based on a caseload ratio of 36 cases to 1wte. Factored into core staffing is that 20% of CoC women will require care from core staff on D/S and that 90% of women will require transfer to the p/n ward for maternal and/or fetal reasons. The % may reduce as CoC becomes established. It is advisable to consider minimum staffing on D/S and Maternity Ward as higher % of women are allocated to a CoC team.										
TOTAL COMMUNITY CASES	**2756**											
ELIGIBLE FOR COC	**2023**											
Minimum Staffing 24/7 x 1 m/w	**Baseline exc CoC**	*Core Staffing Nos. per Shift*	**CoC 20%**	*Core Staffing Nos. per Shift*	**CoC 35%**	*Core Staffing Nos. per Shift*	**CoC 51%**	*Core Staffing Nos. per Shift*	**CoC 75%**	*Core Staffing Nos. per Shift*	**CoC 100%**	*Core Staffing Nos. per Shift*
5.56												
Core Hospital Services												
Delivery Suite	33.86	*6.09*	30.85	*5.55*	27.86	*5.01*	24.67	*4.44*	19.88	*3.58*	14.90	*2.68*
Maternity Ward	20.95	*3.77*	20.91	*3.76*	20.27	*3.65*	19.59	*3.52*	18.58	*3.34*	17.52	*3.15*
OPD/MAU	7.96		7.96		7.96		7.96		7.96		7.96	
Core Community	25.45		21.99		18.75		15.29		10.10		4.70	
Home births	2.38											
Caseload Teams	0.00		11.24		19.67		28.66		42.15		56.19	
includes home births												
Total Clinical wte PN Band 3s to Band 7/8s	**90.60**		**92.94**		**94.51**		**96.17**		**98.67**		**101.28**	
Variance from BR+ baseline in CLINICAL WTE	0.00		2.35		3.91		5.57		8.07		10.68	
Incremental Variance in Clinical wte			2.35		1.56		1.67		2.50		2.60	
TOTAL CLINICAL, SPECIALIST, MANAGEMENT WTE	**98.75**		**101.31**		**103.01**		**104.83**		**107.55**		**110.39**	
Variance from BR+ baseline in TOTAL WTE			**2.56**		**4.26**		**3.52**		**4.54**		**5.56**	

Inability to recruit

If we continue to have difficulty recruiting we would continue to utilise agency and bank staff whilst we continued to be supported by recruitment with a recruitment drive, and looking at working creatively across all areas of maternity to utilise community midwives working in inpatient areas as and when required. Discussions have commenced regarding imitative the trust can use to attract people to midwifery roles at Salisbury.

Conclusion and next steps

The paper demonstrates the current staffing establishment in the maternity service, challenges, risks and mitigations in place. The ongoing work to recruit and retain is key to the long-term staffing within the service and in order to deliver continuity of carer across the service.

- Work with the national, regional and local team to develop an action plan modelling the rollout of continuity of carer.
- Continue with the recruitment campaign work utilising all options available to the trust for recruitment and retention incentives.
- Complete a workforce review of all staff groups in the service to ensure flexibility is explored for all clinical roles; this will include NICU, Maternity care assistants and maternity assistants working in the community.
- Utilise Bank and agency staff.
- Review working patterns and flexibility models within the current service.
- Monitor staffing monthly through staffing dashboard and escalate concerns accordingly.
- Develop an action plan to demonstrate the staffing model and SOP required to open and run the Alongside Midwifery Unit at SFT.
- Where opportunities to over recruit become an option ensure this is available to the team.
- Review the Maternity Care Assistant competency framework with the LMNS to ensure their role is included in workforce planning and skill mix – ultimately reducing midwifery staffing in the postnatal ward environment.

WARD STAFFING REVIEW
Aug-21

Current Position

Wards/department	Beds	Total Funded Establishment WTE	Funded Establishment Band 6 + 7	Funded Establishment Band 5 WTE	Funded Establishment Band 4 WTE	Funded Establishment Band 3 WTE	Funded Establishment Band 2 WTE	Current maternity leave WTE	Average % uplift during July 20 - July 21	Sisters/Charge Nurses: No Band 7	Sisters/Charge Nurses: No Band 6	Vacancies (at time of skill mix review): Band 6 Vacancy WTE	Band 5 Vacancy WTE	Band 4 vacancy WTE	Band 3 vacancy WTE	Band 2 vacancy WTE
Britford	20	41.48	3	23.1	0	5.32	7.76	1.6	5%	1	3	1.6	1.60	0.00	-1.32	2.35
(SAU)	6															
Downton	24	28.04	4	11.71	1	0	11.33	5.4	5%	1	2	1	0.00	0.00	0.00	1.35
Odstock	17	29.95	4	15.4	0.67	1.61	8.27	0.6	5%	1	3	0	0.00	0.00	0.00	2.26
Radnor	10	63.89	17.25	38.28	0	0	5.84	4.8	5%	8	11	2.84	4.46	0.00	0.00	1.84
DSU	30	62.48	6.18	33.9	4.1	4.17	7.26	1	5	1	5.18	0.00	1.00	0.00	0	1
Amesbury	32	45.97	4	15.5	2.55	1	2.92	6	5	1	3.80	0.00	1.70	0.00	1	5.6
Chilmark	24	35.21	4	12.85	5.11	1	12.25	2	5%	1	2.60	0.40	-1.96	3.11	0.2	3.45

Current Position

Wards/department	Total Number of staff per shift: E - registered	E - Band 4	E - Band 3	E - Band 2	N - Registered	N - Band 4	N - Band 3	N - B2	N - Registered	N - Band 4	N - Band 3	N - Band 2	Shift patterns (ie 2 or 3 shift pattern)	Admin support (WTE): Ward Clerk	Ward managers Assistant	Sisters/Charge Nurses: Average % supervisory	Skill mix as a proportion of nurse staff (Do not note national benchmark of this data): Registered %	B3 / B4 %	B2 %
Britford	4	1	1	2	4	0	1	2	3	1		2	2	0.5	0.3	80%	50%	12%	38%
(SAU)	1	0	0	1	1	0	0	1											
Downton	4	0	0	3	3	0	0	2	2	0	0	2	2	0.5	0.25	68%	64%	0%	36%
Odstock	4	0	0	2	3	0	0	2	2	0	0	2	2	2	0.6	80%	62%	0%	38%
Radnor	9	0	0	1	9	0	0	1	9	0	0	1	2	2	0	80%	90%	0%	10%
DSU	4	0	0	4	4	0	0	4	0	0	0	0	2	0	0%	80%	50%	0%	50%
Amesbury	4	1	0	5	4	1	0	5	3	0	0	4	2	1	0	60%	41%	7%	52%
Chilmark	4	0	0	3	4	0	0	3	4	0	0	2	2 LD/N	1	0	80%	62%	0%	39%

NB All these indicators are for period of July 2020 - July 2021

Wards/department	Trained nurse staffing relative to patients (early / day shift): RN	No Patients	Trained nurse staffing relative to patients (late shift): RN	No of patients	Trained nurse staffing relative to patients (night shift): RN	No Patients	Staffing relative to population served ie nurses per occupied bed (NPOB) on a early/day shift: Nurses	No. beds	Staffing relative to population served ie nurses per occupied bed (NPOB) on a night shift: Nurses	No beds	HR Indicators: % Staff Turnover (average)	% Sickness absence (average from e-roster data)	% Compliance Appraisals	% Compliance Stat and Mand training	Nursing Sensitive Indicators July 2019 - June 2020: No of PU Grade 2 or above	Complaints	No of Falls	No of MRSA Bacteraemia	No of MSSA Bacteraemias	No of C-diff (reportable and non-reportable)	No of Red Flag Incidents	Risk register entries reviewed	SafeCare data reviewed
Britford	1	6	1	6	1	7	1	2.5	1	3.3	12.3%	3.95%	85.00%	90.00%	35	3	28	0	0	0	5	y	y
(SAU)																							
Downton	1	8	1	8	1	12	1	3.4	1	4	15.0%	4.77%	100.00%	89.00%	20	3	23	0	1	3	1	y	y
Odstock	1	5.6	1	8.5	1	8.5	1	2.8	1	4.25	16.4%	3.73%	85.00%	94.50%	22	1	33	0	3	1	10	y	y
Radnor	1	1.25	1	1.25	1	1.25	1	1	1	1	7.5%	5.23%	76.00%	90.30%	42	0	5	0	1	0	7	y	y
DSU											6.4%	3.15%	53.19%	93.00%	2	0	8	0	0	0	0	y	y
Amesbury	1	8	1	8	1	10.6	1	3	1	4.5	7.4%	10.67%	80.00%	88.00%	55	1	148	0	0	0	7	y	y
Chilmark	1	6	1	6	1	6	1	4	1	4.6	9.9%	5.60%	91.00%	87.00%	14	1	36	0	0	2	3	y	y

Column	Descriptor	Definition
B	Beds	Number of funded beds on ward
C	Funded establishment	The establishment on the ward for all ward based posts ie nurses, nursing assistants, ward clerks etc
J	% Establishment uplift	The actual headroom on the ward to cover annual leave, sickness, maternity etc - this will be provided by the E-roster team and will be an average for the year
M-Q	Vacancies	Inlcude all current vacancies at time of skill mix
R-AC	Staff on shift	Number of registered and unregistered on the early, late and night shift. If long days please indicate the numbers of staff who are on the ward at these times
AD	Shift pattern	Identify whether 2-shift (LD) or 3-shift (E/L/N) pattern. Where use a combination please choose the option most used.
AE-AF	Admin support	Identify any additional roles on the ward which are not in the daily nursing requirements but that are funded from the ward budget
AG	Supervisory	Identify whether using supervisory shifts and how much time given to this ie 2 days per week = 0.4, 4 days = 0.8. This will be calculated from e-roster and will be percentage of the 0.8 that is funded.
AH-AJ	Skill mix	The percentage of RNs and NA's based on establishment
AL-AQ	RN staff relative to patients	If you have a 28-bed ward and you have 4 TN on the early shift then this would be 1RN to 7 patients
		As above but for late shift so may be you have 3RN on the late shift so this would be 1RN to 9 patients
AR-AU	Staffing relative to population served	Same as above but count all RNs and NA's so if you have 7 on an early shift and is 28-bed ward this would be 1 nurse to 4 patients
		As above for late shift ie if you drop to 5 on the late shift then would be 1 nurse to 5.6 patients
AV	Turnover / absence	Overall percentage for the specified time period - HR business partners can provide
AW	Sickness	Will be provided by E-roster as part of unavailablity/headroom data
AX -AY	Appraisal and MLE Compliance	Can be provided by HR business partners and MLE
AZ-BF	Nurse sensitive indicators	Provide for the specified time period - should be taken from the key quality indicators reports - you will need to add numbers from across 2 year reports.
BG	Risk register	Please bring any risk register entries related to nurse staffing
BH	SafeCare	Data will be provided by E-roster - the accuracy will be dependent on the completion of SafeCare data entry over the year

Date: **Ward:** Britford

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	divide between SAU and ward. SAU trial.
1.2	HR Indicators	x2 LT sickness- 1 handed notice in, 1 still off. Frequent sickness absences due to pregnant staff, well managed.
1.3	Finance	over spend as 4.36 staff on Chilmark one LD and one N 7 days a week.
1.4	Current establishment	over recruited on 2+5's but enough to stay within extra A&C role and chilmark staffing (4.36), extra out for staffing SAU with trial L and weekend. Maternity numbers coming up concern, 2.6 (1.6 6+5, 1 3) off currently not returning until march, sept/oct 2.31 5 and 2.2 2 on mat leave.
1.5	Supervisory	I manage most of the time to have my supervisory role. Spending time on ward with staff. Happy with my mix of on the ward and off the ward. Lots to develop (senior nurse role, SAU trial, education) struggle with these extras as so much to do with general running of the ward.
1.6	Professional judgement of staffing ratios	Ward can have high acuity however I think we are well staffed. The inclusion of the band 5 late for the SAU trial has helped immensely with staffing and our junior skill mix. Very junior on the ward due to staff leaving and having to send competent NIC staff to Chilmark.
1.7	Safe Care Data	The separate roster has caused a division between staff. Own safecare data captured on ward and SAU separate but potential issue.
1.8	Other supporting evidence to any proposed changes to skill mix	If trial successful then keeping our band 5 late to help oversee both areas.

Safecare Data

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2020:

Allocate and Eroster advise that SAU now undertakes SafeCare (as per AMU) to accurately reflect stats

Date: **Ward:** Downton

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	good key qaulity outcomes (up to Jan), good compliance with perfect ward audits generally good results, curently focosing on HH and documentation using the divisional action plans
1.2	HR Indicators	good staff turnover, high numbers of maternityy leave mainly band 5 recuirtment ongoing division aware plan being put in place maternity cover job advert pending abnd / band 4
1.3	Finance	within budget - some recent agency / RMN costs
1.4	Current establishment	over established band 5's under band 2's recuirtment days planned - band 6 attended last one and no suitable candidates 1 x band 6 post was filled but pulled out last minute
1.5	Supervisory	good mix of supervisory and clinical shifts, majority of time spent on ward
1.6	Professional judgement of staffing ratios	professional judgement tool well used - see copy
1.8	Safe Care Data	CHPPD geneally good but some spikes in acuity and dependancy howerve this data generally has 5 beds less sue to social distancing, if all beds were open I think this data would look differnet , main conerns are staffing levels overnight
1.9	Other supporting evidence to any proposed changes to skill mix	can often become very heavy with medical outliers which often increases acuity and dependancy these patitens also tend to be longer stayers and require more input from social and therapy teams aswell as increased nursing care. Due to non elective admissions general surgical acuity has increased we have devleoped 2 high care observable beds with temporary monitors - bid in place for space labs

Safecare Data

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from 2020 Skill Mix Review:

Date: **Ward:** Radnor

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	KQI data limited , end of last year not available
1.2	HR Indicators	high sickness driven by admin off lts, some planned ops covid. increasing leavers (av 1/week for last 10 weeks!) difficulties with appraisal compliance with access and staff availability & redployments
1.3	Finance	underspent
1.4	Current establishment	numbers include non clinical staff. vacancies as per dashboard. b7 new starter 27/09, awaiting HR re band 6 vacacnies (3 in secondments in numbers) and recent secondments did not fill ,3 new band 5 starters included but not starting until oct - dec, b5. b2 and admin advert out or going out. o.6 wte PE funded nationally for 1 year ?onging funding to meet GPICS standards, would like to upgrade an admin 2 to a 3 to provide cover and back up for admin facilitataor (financial impact)
1.5	Supervisory	Matrons normal. band 6 & 7 as possible
1.6	Professional judgement of staffing ratios	generally met
1.7	Safe Care Data	na
1.8	Other supporting evidence to any proposed changes to skill mix	see establishment

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from 2020 Skill Mix Review:

Date: **Ward:** DSU

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	
1.2	HR Indicators	
1.3	Finance	
1.4	Current establishment	
1.5	Supervisory	
1.6	Professional judgement of staffing ratios	
1.7	Safe Care Data	
1.8	Other supporting evidence to any proposed changes to skill mix	

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from 2020 Skill Mix Review:

Date: **Ward: Amesbury**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	
1.2	HR Indicators	
1.3	Finance	
1.4	Current establishment / Vacancies	
1.5	Supervisory	
1.6	Professional judgement of staffing ratios	
1.7	Safe Care Data	
1.8	Other supporting evidence to any proposed changes to skill mix	

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2020:

SafeCare Data

Date: **Ward: Chilmark**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	24 bedded unit We have a 2 shift pattern, long day and night 4:3 long day 4:2 night With plans for utilising band 4 each shift taking it to 3:1:2 long day
1.2	HR Indicators	HR our turnover sits at 9.93% highest turn over of band 2's Sickness average of 5.60 % high levels of stress and anxiety, related to high redeployment over the pandemic and high levels of MSK related sickness. Higher input of training opportunities for mana handling training and supply increase of slide sheets. 91% appraisal compliance and 87% MLe compliance. Band 6 groups to be re distributed with appointment of substantive and a secondment band 6.
1.3	Finance	High usage of bank due to under establishment of band 2's and sickness. High pregnancy rates of staff, multiple pregnancy related illness and maternity leave.
1.4	Current establishment / Vacancies	Established for 35.21 staff Funded band 6&7 4, 1 band 6 on mat leave, will be coming back part time as 0.60 therefore vacancy of 0.40 band 6 Band 5 funded 12.85, over established at 1.96 on current nominal role Band 4 funded at 5.11 this was established to ensure a band 4 covered 1 day and night shift, with change of usage this was stopped but can be reinstated as settled into current usage feeling safe to do so. Current vacancy of 2.11
1.5	Supervisory	Supervisory time up until now has been 100% due to my absence. All future rosters have a supervision % of 80
1.6	Professional judgement of staffing ratios	Skill mix as a proportion of total staff currently registered 62% and unregistered 39% We have same ratio of trained staff to patient (1:6) day and night with ratio of 1:4 nurse to occupied bed on the day and 1:4.6 at night. Staffing ratios adequate for ward
1.7	Safe Care Data	Safe care data is being entered in relation to acuity, unable to access compliance of professional judgement, waiting conversation with Clare in E-Roster to audit data
1.8	Other supporting evidence to any proposed changes to skill mix	

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2020:

SafeCare Data

Date: **Ward: Odstock**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	Pressure Ulcers high, but well managed and documented. Falls investigation require more care planning around this , and difficult to nurse in side rooms. Some very aggressive and violant patinets. Lots of excellent practice in wound care and patinet feedback. Low infection rates.
1.2	HR Indicators	HH and BLS can drop- some challenges with availbilty of training. Good apprasil compliance. Attendance and performance well monitored and acted upon. Some difficulties with HR support. Staff turnover due to rotation, relocation, retiement and performance issues.
1.3	Finance	No agency use. Regular requirement for 1-2-1 staff ans bank usage.
1.4	Current establishment / Vacancies	Established with Qualified staff. Current 2.26 vacancy UQ. Successful recuritement to 1.0WTE post starting Sep 2021 and interviews for internal canditate early Sep. For discussion regarding additioanl resource to staff BDC with a B2 to support the clinic nurse.
1.5	Supervisory	Reguarly 80% supervisory time alloacted.
1.6	Professional judgement of staffing ratios	Trial of 4th nurse on the late has worked well. 2:2 ratio of staff on nights can be challenging. Clinic nurses currently lone working without additional support from B2 in clinic.
1.7	Safe Care Data	
1.8	Other supporting evidence to any proposed changes to skill mix	To allow the permanent staffing of four RN's on a late. Allowing the 4th to co-ordinate, supervise take referrals and assist in admissions/discharges and returns from theatre. To ensure another Band 2 is assigned to the burns clinic if removal of the clinic from the ward is to become permanent

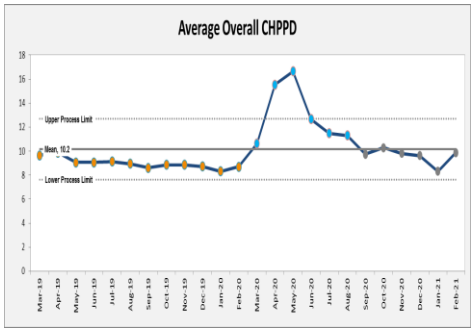
Section 2: Recommendations/Considerations

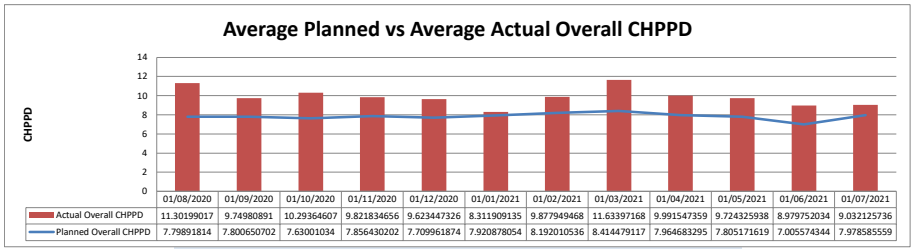
	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2020:

SafeCare Data

CHPPD Board Report Extract





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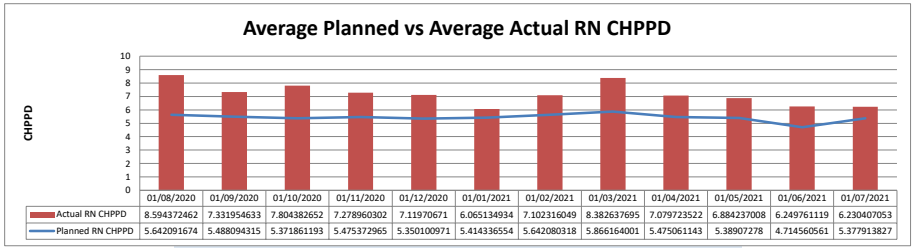
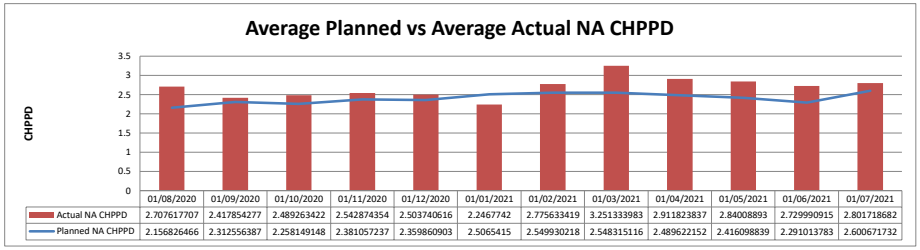
Actual Overall CHPPD	11.30199017	9.74980891	10.29364607	9.821834656	9.623447326	8.311909135	9.877949468	11.63397168	9.991547359	9.724325938	8.979752034	9.032125736
Planned Overall CHPPD	7.79891814	7.800650702	7.63001034	7.856430202	7.709961874	7.920878054	8.192010536	8.414479117	7.964683295	7.805171619	7.005574344	7.978585559



	01/08/2020	01/09/2020	01/10/2020	01/11/2020	01/12/2020	01/01/2021	01/02/2021	01/03/2021	01/04/2021	01/05/2021	01/06/2021	01/07/2021
Actual RN CHPPD	8.594372462	7.331954633	7.804382652	7.278960302	7.11970671	6.065134934	7.102316049	8.382637695	7.079723522	6.884237008	6.249761119	6.230407053
Planned RN CHPPD	5.642091674	5.488094315	5.371861193	5.475372965	5.350100971	5.414336554	5.642080318	5.866164001	5.475061143	5.38907278	4.714560561	5.377913827



	01/08/2020	01/09/2020	01/10/2020	01/11/2020	01/12/2020	01/01/2021	01/02/2021	01/03/2021	01/04/2021	01/05/2021	01/06/2021	01/07/2021
Actual NA CHPPD	2.707617707	2.417854277	2.489263422	2.542874354	2.503740616	2.2467742	2.775633419	3.251333983	2.911823837	2.84008893	2.729990915	2.801718682
Planned NA CHPPD	2.156826466	2.312556387	2.258149148	2.381057237	2.359860903	2.5065415	2.549930218	2.548315116	2.489622152	2.416098839	2.291013783	2.600671732

Average Planned vs Actual Overall CHPPD

Date 01/07/2021 <- Change to required month

Showing red when below -0.5

Row Labels	Avg Planned Overall CHPPI	Avg Actual Overall CHPPD	Difference
Medicine	**6.88**	**7.53**	**7.22**
AMU	10.76	9.83	-0.93
Durrington	5.95	6.86	0.91
Farley	7.25	7.54	0.29
Hospice	9.11	11.46	2.35
Laverstock	5.37	7.19	1.82
Pembroke	7.47	9.54	2.07
Pitton	4.18	6.01	1.83
Redlynch	5.26	5.83	0.57
Spire	5.40	7.40	2.00
Tisbury	9.47	5.82	-3.65
Whiteparish	5.42	5.40	-0.02
Surgery	**8.30**	**10.40**	**16.80**
Amesbury	6.12	6.70	0.58
Britford	8.12	8.97	0.85
Chilmark	5.23	4.77	-0.46
Downton	4.91	7.83	2.92
Breamore Stroke	5.69	6.96	1.28

Longford	7.43	7.85	0.42
Radnor	21.65	32.19	10.54
Odstock	7.25	7.92	0.67
CSFS	**11.17**	**10.89**	**-0.85**
Maternity	19.86	10.17	-9.69
NICU	7.53	11.99	4.45
Sarum	6.11	10.50	4.39

Average Planned vs Actual RN CHPPD

Date 01/07/2021 <- Change to required month

Showing red when below -0.5

Row Labels	Avg Planned RN CHPPD	Avg Actual RN CHPPD	Difference
Medicine	**4.22**	**4.56**	**3.78**
AMU	7.13	6.41	-0.72
Durrington	3.19	3.21	0.02
Farley	4.15	4.38	0.23
Hospice	4.85	6.71	1.86
Laverstock	3.42	5.11	1.69
Pembroke	5.10	6.82	1.72
Pitton	2.24	3.38	1.14
Redlynch	3.13	3.30	0.17
Spire	2.84	3.04	0.20
Tisbury	7.48	4.57	-2.91
Whiteparish	2.84	3.22	0.38
Surgery	**5.54**	**7.38**	**14.75**
Amesbury	2.89	3.48	0.59
Britford	5.74	6.36	0.62
Chilmark	2.49	2.45	-0.04
Downton	2.69	4.49	1.80
Breamore Stroke	2.62	3.47	0.86
Longford	3.66	4.02	0.36
Radnor	19.68	29.82	10.14
Odstock	4.55	4.96	0.42
CSFS	**9.21**	**9.29**	**0.22**
Maternity	15.52	7.71	-7.81
NICU	7.53	11.99	4.45
Sarum	4.58	8.16	3.58

Average Planned vs Actual HCA CHPPD

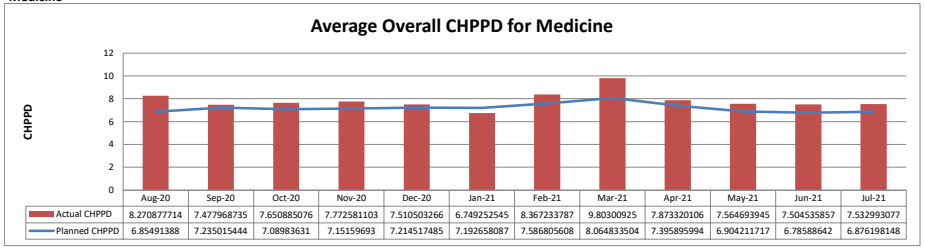
Date 01/07/2021 <- Change to required month

Showing red when below -0.5

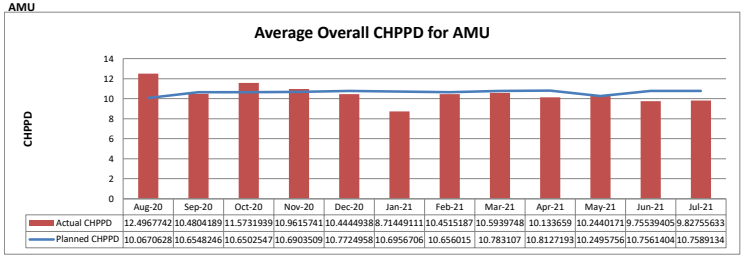
Row Labels	Avg Planned HCA CHPPD	Avg Actual HCA CHPPD	Difference
Medicine	**29.27**	**32.71**	**3.44**
AMU	3.63	3.42	-0.21
Durrington	2.75	3.64	0.89
Farley	3.10	3.17	0.06
Hospice	4.26	4.75	0.49
Laverstock	1.95	2.08	0.12
Pembroke	2.37	2.72	0.35
Pitton	1.95	2.63	0.68
Redlynch	2.13	2.53	0.40
Spire	2.55	4.36	1.80
Tisbury	1.99	1.25	-0.74
Whiteparish	2.58	2.18	-0.40
Surgery	**22.08**	**24.13**	**2.05**
Amesbury	3.23	3.22	-0.01
Britford	2.39	2.61	0.23
Chilmark	2.74	2.32	-0.42
Downton	2.22	3.34	1.12
Breamore Stroke	3.07	3.49	0.42
Longford	3.77	3.83	0.06
Radnor	1.97	2.37	0.40
Odstock	2.70	2.96	0.25
CSFS	**5.86**	**4.80**	**-1.07**
Maternity	4.34	2.46	-1.88
NICU	0.00	0.00	0.00
Sarum	1.52	2.34	0.82

Average CHPPD by Directorate/Ward

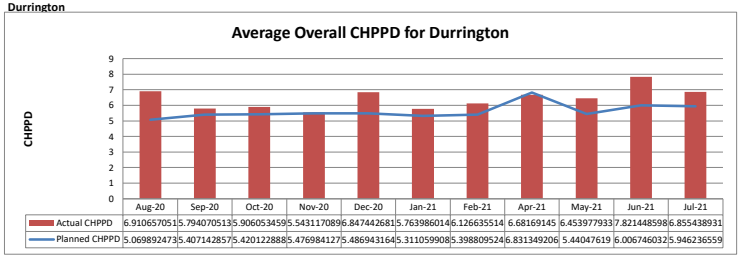
Medicine



AMU

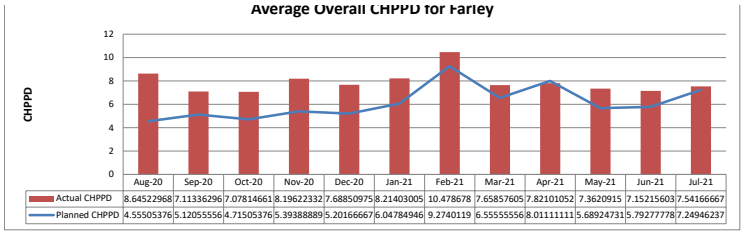


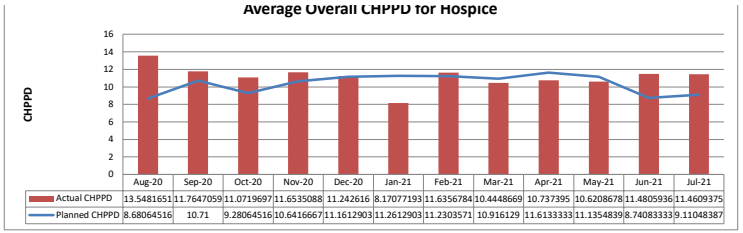
Durrington



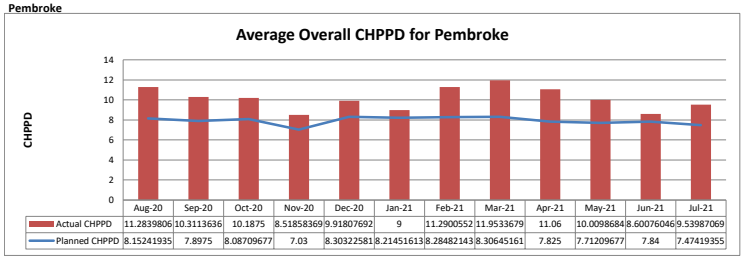
Farley

Hospice

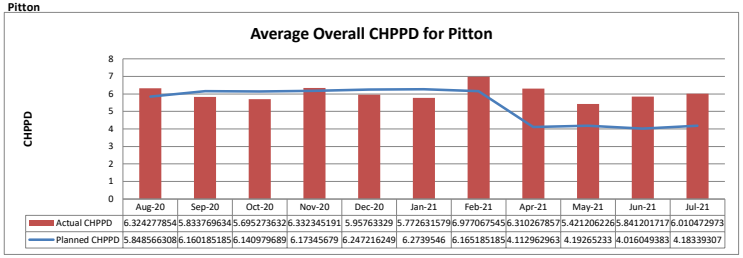




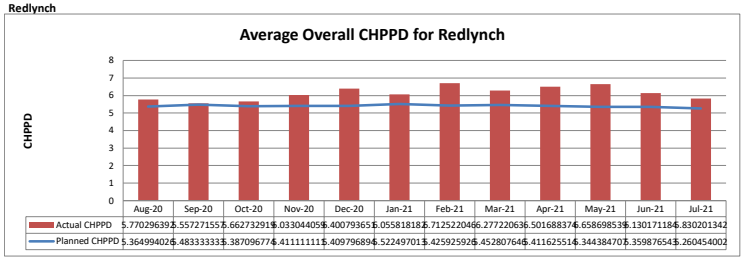
Pembroke



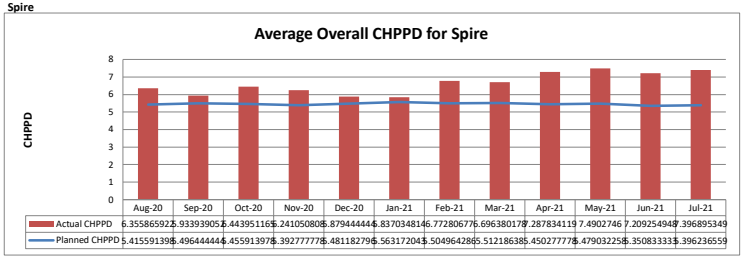
Pitton



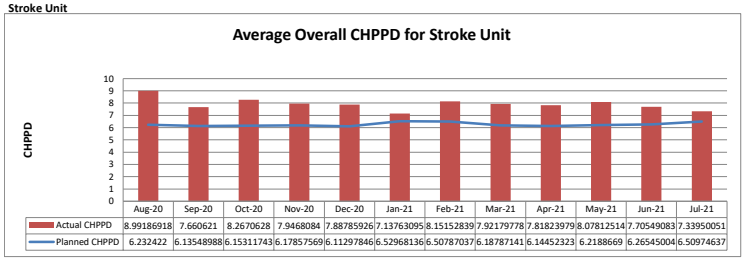
Redlynch



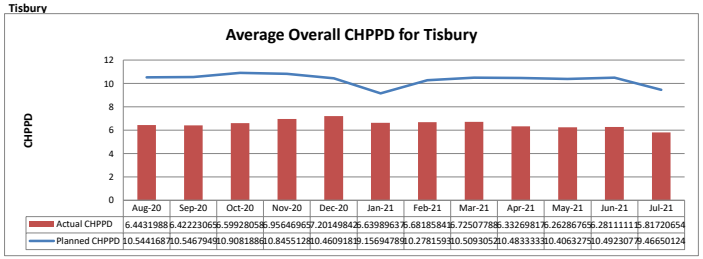
Spire



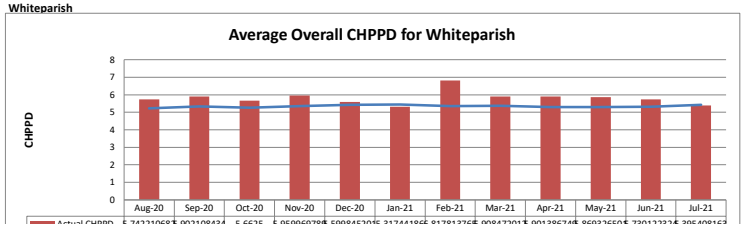
Stroke Unit



Tisbury

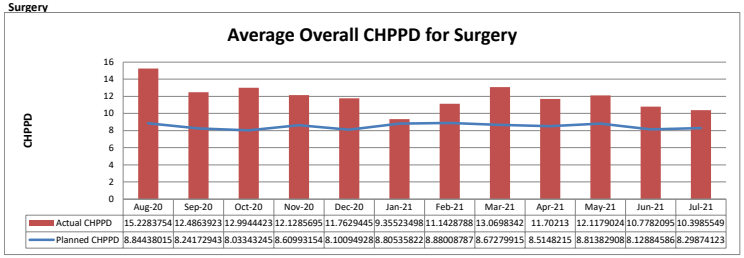


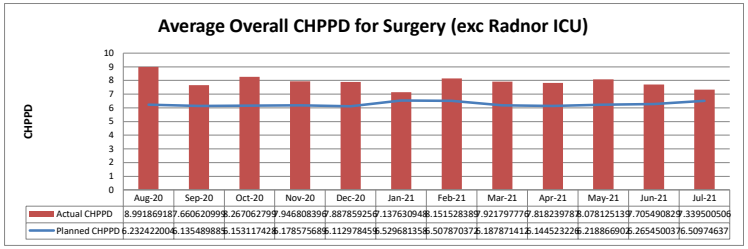
Whiteparish



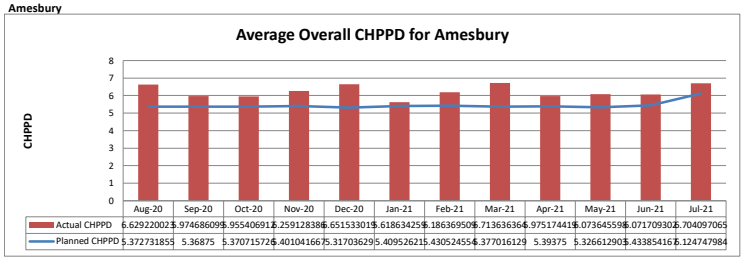
	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Actual CHPPD	5.742210683	5.902108434	5.6625	5.959969789	5.599845201	5.317441866	6.817813765	5.908472012	5.901386745	5.869326503	5.730122324	5.395408163
Planned CHPPD	5.228611501	5.344927536	5.257363254	5.349637681	5.422861157	5.446353436	5.346273292	5.373772795	5.299637681	5.305399715	5.325724638	5.420406732

Surgery



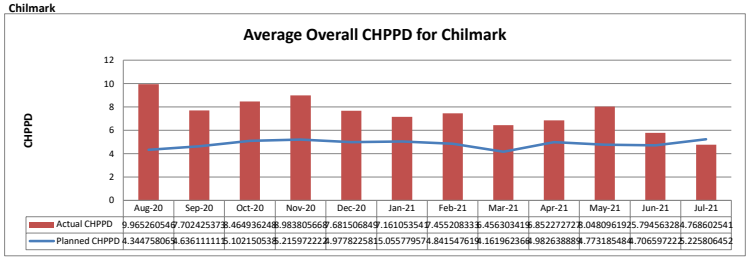


Amesbury

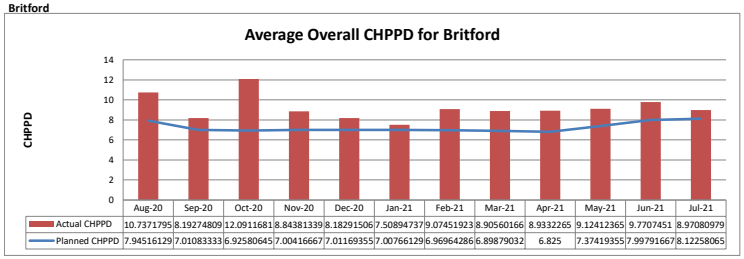


Breamore

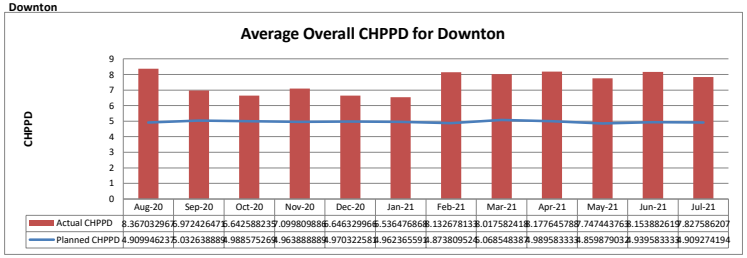
Chilmark



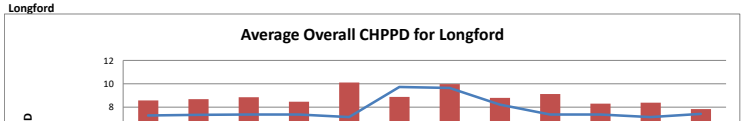
Britford



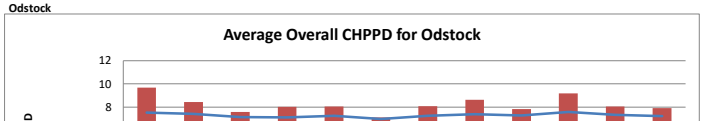
Downton

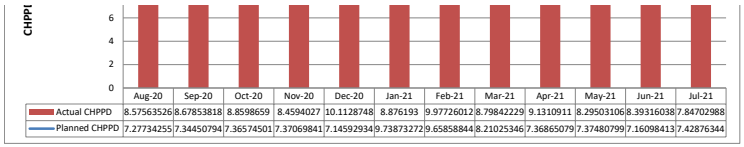


Longford

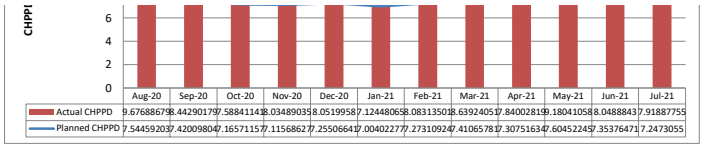


Odstock



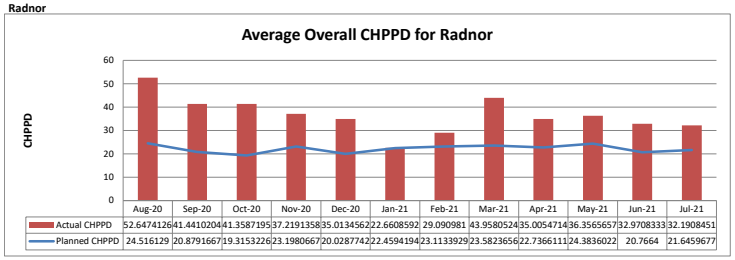


	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Actual CHPPD	8.57563526	8.67853818	8.8598659	8.4594027	10.1128748	8.876193	9.97726012	8.79842229	9.1310911	8.29503106	8.39316038	7.84702988
Planned CHPPD	7.27734255	7.34450794	7.36574501	7.37069841	7.14592934	9.73873272	9.65858844	8.21025346	7.36865079	7.37480799	7.16098413	7.42876344



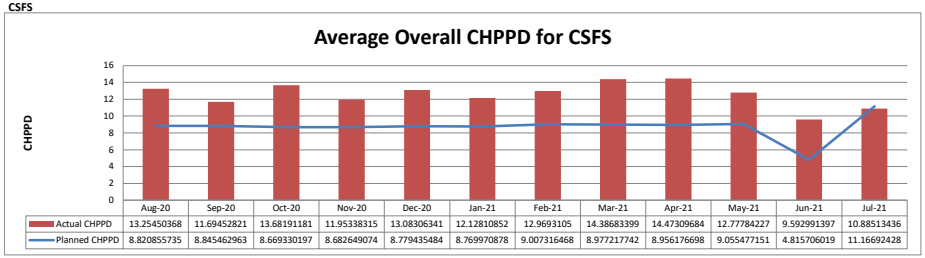
	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Actual CHPPD	9.67688679	8.44290179	7.58841143	8.03489035	8.05199587	7.12448065	8.08313501	8.63924051	7.84002819	9.18041058	8.0488843	7.91887755
Planned CHPPD	7.54459203	7.42009804	7.16571157	7.11568627	7.25506641	7.00402277	7.27310924	7.41065781	7.30751634	7.60452245	7.3537647	7.2473055

Radnor



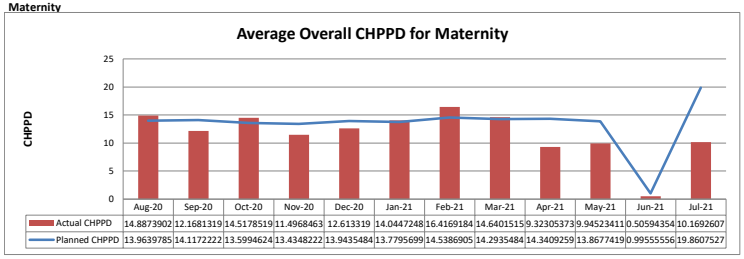
	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Actual CHPPD	52.6474126	41.4410204	41.3587195	37.2191358	35.0134562	22.6608592	29.090981	43.9580524	35.0054714	36.3565657	32.9708333	32.1908451
Planned CHPPD	24.516129	20.8791667	19.3153226	23.1980667	20.028774	22.4594194	23.1133929	23.5823656	22.7366111	24.3836022	20.7664	21.6459677

CSFS



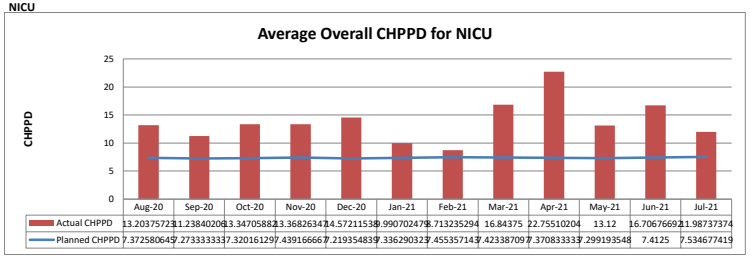
	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Actual CHPPD	13.25450368	11.69452821	13.68191181	11.95338315	13.08306341	12.12810852	12.9693105	14.38683399	14.47309684	12.77784227	9.592991397	10.88513436
Planned CHPPD	8.820855735	8.845462963	8.669330197	8.682649074	8.779435484	8.769970878	9.007316468	8.977217742	8.956176698	9.055477151	4.815706019	11.16692428

Maternity



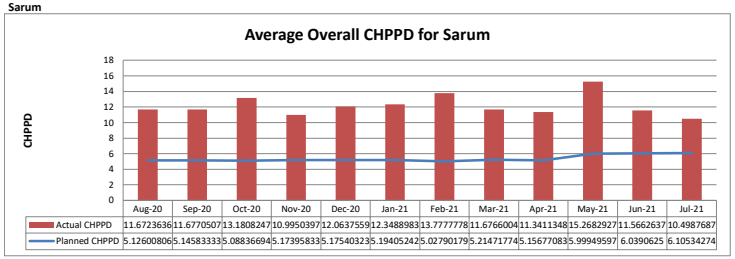
	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Actual CHPPD	14.8873902	12.1681319	14.5178519	11.4968463	12.613319	14.0447248	16.4169184	14.6401515	9.32305373	9.94523411	0.50594354	10.1692607
Planned CHPPD	13.9639785	14.1172222	13.5994624	13.4348222	13.9435484	13.7795699	14.5386905	14.2935484	14.3409259	13.8677419	0.99555556	19.8607527

NICU



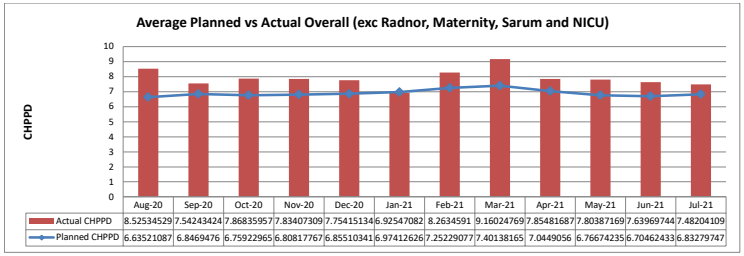
	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Actual CHPPD	13.2037572	11.2384020	13.3470588	13.3682634	14.5721153	9.99070247	8.71323529	16.84375	22.75510204	13.12	16.7067669	11.98737374
Planned CHPPD	7.37258064	7.27333333	7.32016129	7.43916667	7.21935484	7.33629032	7.45535714	7.42338709	7.37083333	7.29919354	8 7.4125	7.53467741

Sarum

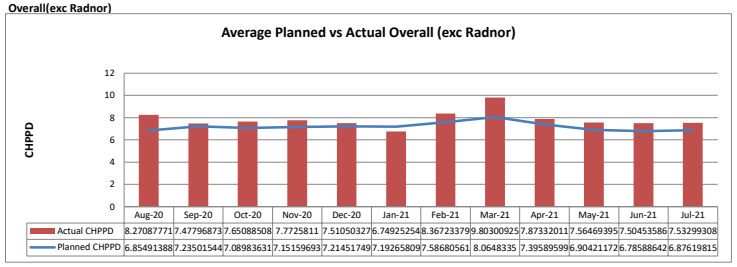


	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Actual CHPPD	11.6723636	11.6770507	13.1808247	10.9950397	12.0637559	12.3488983	13.7777778	11.6766004	11.3411348	15.2682927	11.5662637	10.4987687
Planned CHPPD	5.12600806	5.14583333	5.08836694	5.17395833	5.17540323	5.19405242	5.02790179	5.21471774	5.15677083	5.99949597	6.0390625	6.10534274

Overall (exc Radnor, Maternity, Sarum and NICU)



Overall(exc Radnor)



WARD STAFFING REVIEW
Aug-21

Current Position

Wards/department	Beds	Total Funded Establishment WTE	Funded Establishment B6 and 7 WTE	Funded Establishment Band 5 WTE	Funded Establishment Band 4 WTE	Funded Estabalishment Band 3 WTE	Funded Establishment Band 2 WTE	Current maternity leave WTE	Average % uplift during April 18 - June 19	Sisters/Charge Nurses: No Band 7	Sisters/Charge Nurses: No Band 6	Vacancies (as at time of skill mix interview): Band 6 Vacancy WTE	Band 5 Vacancy WTE	Band 4 vacancy WTE	Band 3 vacancy WTE	Band 2 vacancy WTE
Sarum	16	33.12	5.9	22.56	0	0	4.66	2.69	5%	1	4.7	0.18	3.60	0.00	0.00	1.70
PASS																
DAU																

Wards/department	Total Number of staff per shift: E- registered	E - Band 4	E - Band 3	E - Band 2	L -Registered	L -Band 4	L -Band 3	L - B2	N - Registered	N - Band 4	N - Band 3	N -Band 2	Shift patterns (ie 2 or 3 shift pattern)	Admin support (WTE): Ward Clerk	Ward managers Assistant	Sisters/Charge Nurses: Average % supervisory	Skill mix as a proportion of total staff (RCN note national benchmark of RN 65%): Registered %	Band 3 / 4 %	Band 2 %
Sarum	3	0	0	1	3	0	0	1	3	0	0	0	2	2.6	0	75%	75%	0%	25%
PASS	1	0	0	0	1	0	0	0	1 (Tu, We,	0	0	0							
DAU	2	0	0	0	2	0	0	0	0	0	0	0							

NB All these indicators are for period of July 2020 - June 2021

Wards/department	Trained nurse staffing relative to patients (early / day shift): RN	No Patients	Trained nurse staffing relative to patients (late shift): RN	No of patients	Trained nurse staffing relative to patients (night shift): RN	No Patients	Staffing relative to population served ie nurses per occupied bed (NPOB) on a eaerly/day shift: Nurses	No. beds	Staffing relative to population served ie nurses per occupied bed (NPOB) on a night shift: Nurses	No beds	HR Indicators: % Staff Turnover (average)	% Sickness absence (average)	% compliance appraisals	% compliance Stat and Mand training	Nursing Sensitive Indicators July 2020 - June 2021: No of PU Grade 2 or above	No of Falls	No of MRSA Bactaraemia	No of MSSA Bactaraemias	No of C-diff (reportable and non-reportable)	Complaints	No of Red Flag Incidents	Risk register entries reviewed	SafeCare data reviewed
Sarum	1	5.30	1	5.30	1	5.3	1	4	1	5.3	8.6%	3.7%	71.0%	84.00%								y	n
PASS																							
DAU																							

	Descriptor	Definition
	Beds	Number of funded beds on ward
	Funded establishment	The establishment on the ward for all ward based posts ie nurses, nursing assistants, ward clerks etc
	Budget	Staffing budget only
	% Establishment uplift	The headroom on the ward to cover annual leave etc - this can be taken from Allocate to sho the average in the period
	Vacancies	Inlcude all current vacancies
	Staff on shift	Number of registered and unregistered on the early, late and night shift. If long days please indicate the numbers of staff who are on the ward at these times
	Shift pattern	Identify whether 2-shift (LD) or 3-shift (E/L/N) pattern. Where use a combination please choose the option most used.
	Admin support	Identify any additional roles on the ward which are not in the daily nursing requirements but that are funded from the ward budget
	Supervisory	Identify whether using supervisory shifts and how much time given to this ie 2 days per week = 0.4
	Skill mix	The percentage of RNs and NA's based on establishment
	RN staff relative to patients	If you have a 28-bed ward and you have 4 TN on the early shift then this would be 1RN to 7 patients
		As above but for late shift so may be you have 3TN on the late shift so this would be 1RN to 9 patients
	Staffing relative to population served	Same as above but count all RNs and NA's so if you have 7 on an early shift and is 28-bed ward this would be 1 nurse to 4 patients
		As above for late shift ie if you drop to 5 on the late shift then would be 1 nurse to 5.6 patients
	Turnover / absence	Overall percentage for the specified time period
	Nurse sensitive indicators	Provide for the specified time period

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Date: **Ward: Childrens unit**

Present:

Section 1: Review of Current Position

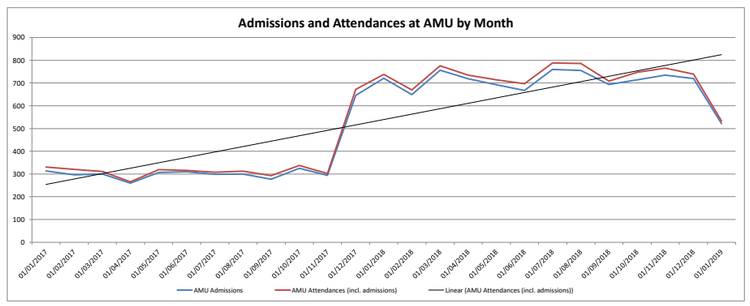
	Themes/Concerns/Good Practice from Data	Comments
1.1	**Quality/Outcome Data**	2 x SIS and action plans in place to look at staffing at night Increase in complaintsConcerns have previously been highlighted regarding unsettled team due to Band 6s leaving for Band 7 posts……new group of Sisters in position and are being positively developed and supported. There has been a shift in Skill mix due to difficulties in recruiting and so therefore employing 5 NQNs. Some long term nurses who had left. Staff ratio of 1:4 is generally met but can be challenging if more than 12 patients or if there are HDU in-patients as PASS nurse is required on the Ward and therefore difficult to then provide PASS to other areas. There has been some long term sickness. There is a need to have an extra nurse Band 5/6 during to support PASS during Winter (October to March)
1.2	**HR Indicators**	Increase in amount of CAMHs patients that are time consuming and on Risk register. Marginal increase in complaints. 2 x SIS and one complaint now local review. There have been an increasing number of datix completed in relation to staffing. Perfromance reviews sometimes difficult due to workload met approximatley 86% at present although had been 100%. However now delegated to Band 6 difficult to get time to complete IPRs. Absence average had been high but now 3.3%...this is due to long term sikness 2.4 on maternity leave. Due to varying demands of the ward staff need to keep skills and knowledge up to date so study days important for all and so attended as staffing allows; HDU, Burns , Diabetes, oncology and also safeguarding supervision very challenging to meet all of these .
1.3	**Finance**	Staff Budget 119,180 spend 134,914 over spend 15,734
1.4	**Current establishment**	Budget 33.13 Vacancy Band 5 6.6 will be 3.6 in September Continued challenges throughout the year due to sickness due to exceptional circumstances. Have been working on Home sleep studies...now have a process in place and member of DMT trying to address the Tariff as Band 5 covering Band 2 vacancy in COPD and running clinics and trying to complete sleep studies.. but this is not cowered with present staffing template. PASS team supporting when there is an increase in acuity and also trying to cover DSU, DAU, ED, increase in safeguarding and CAHMS cases...this continues to be a challenge due to increase of acuity over the years
1.5	**Supervisory**	Band 7 supervisory 80% amount of time varies depending on the acuity of the ward and unfilled shiftsBand 7 works mainly supervisory but supporting Ward with Safeguarding/medications etc
1.6	**Professional judgement of staffing ratios**	547 Additional duties….Aug 20210-August 2021 40 recoreded professional judgement…this is working progress
1.7	**Safe Care Data**	Required CPHD is more than set level therefoer acuity is shown to be regularily above demand
1.8	**Other supporting evidence to any proposed changes to skill mix**	Increase in amount of CAMHs patients that are time consuming. Marginal increase in complaints. 2 x SIS and one complaint now local review. There have been an increasing number of datix completed in relation to staffing. There is a demand on the service to increase night shifts to 4 trained Monday - Sunday and Saturday and Sunday have 4 trained on the Ward. Some of the increase for trained staff could potentially be covered by Band 4s, therefore to recruit Band 4s. Difficult to supply PASS nurse to ED when acuity on Ward is high. Nurse educator role Band 6 left and never replace but required 2/7 a week.

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1	TNA has nearly completed course...to review how many Band 4s to be in position. Difficulty recruiting Band 5s therefore to use Band 4s..To look at developing Allergy Role (see NICE guidelines) and also someone at Band 6 to manage outpatients. **1 WTE Band 6** and to **change Band 2 to Band 5 23 hours.** Some DAU work to be taking place in COPD including sweat tests, food challenges and sleep studies as well as trained nurse performing bloods or inhalor teaching etc.To review PASS support needs to increase over Winter and to work with DSU and ED. To look at increasing Burns clinic session for **Band 5 increase of 8 hours**		
2.2	To look at Developing Paediatric Education Role to support both Students and trained Staff including preceptor for newly qualified, driving education and professional development…as well as outcomes of SIIS. Also to support Claire Levi with Simm and AIM Course Debbie PILS…previous Educational funding was withdrawn. **15 hours Band 6**		
2.3	To review amount of Band 6s and Band 7s as Benchmarking indicates that this is higher elsewhere To look at introducing an extra Band5/6 for Winter Friday to Monday night		
2.4	To review Budget to accommodate funding over the winter period to incease the times of opening for DAU and to have an additional Nurse (Band4) to work in DAU at the busiest time of day...this is a long term plan. In the meantime need to increase staffing over winter for nights Friday to Monday Band 5 cost of £36,972. There is also a need to have an extra PASS shift for winter late shift to support ED...1200-2000 x 7 days.		
2.5			

All actions reviewed from 2020 Skill Mix Review:

Note data below last year ? Replicate for this year



WARD STAFFING REVIEW
Aug-21

NB All these indicators are for period of July 2020 - June 2021

Current Position

Wards/department	Beds	Total Funded Establishment WTE	Funded Establishment B6 and 7 WTE	Funded Establishment Band 5 WTE	Funded Establishment Band 4 WTE	Funded Estabalishment Band 3 WTE	Funded Establishment Band 2 WTE	Current maternity leave WTE	Average % uplift during April 20 - June 21	Sisters/Charge Nurses: No Band 7	Sisters/Charge Nurses: No Band 6	Vacancies (as at time of skill mix interview): Band 6 Vacancy WTE	Band 5 Vacancy WTE	Band 4 vacancy WTE	Band 3 vacancy WTE	Band 2 vacancy WTE
AMU	19+10 T	45.2	8.2	20.2	1.9	0	14.1	4.2	5%	1	5.8	0.2	4.20	0.00	0.00	1.80
Tisbury	23	34.1	4	22.11	0	0	8	2 (+4+1 to	5%	1	3	-0.25	0.0	0.0		-1.6
Redlynch	27	38.8	4	18.48	0	0	16.36	3	5%	1	2.6	0.4	3.3	0.0	0.0	3.9
Pitton (elderly care)	27	32.75	4	14.63	0	0	14.12	2	5%	1	2.92	mat leave	3.8	plus 2	0.0	3.4
Farley (stroke and RCU)	30	45.6	4	22.98	0	0.83	16.15	1	5%	1	4	3	2.8	0.0	0.0	4.0
Durrington (escaltion)	15							1	5%	1	2			0.0	0.0	
Spire	30	44.2	4	17.1	0	1.4	21.7	2	5%	1	3	0	-0.8	NA	NA	2.4
Hospice	10	22	1.6	11.85	0	0.8	8.58	0	5%	1	1.6	0.9	2.7			1.5
Pembroke	10	16.42	3.3	9.52	0	1	3.6	0.00	5.00%	0		0	1	0	1	1
Whiteparish	23	33.4	4.0	12.4	3	1.4	13.8	4.62	5.00%	1	3.62	0	0	0	0	0
ED		72.2	10.45	39.26	0	5.11	16.38	6.79	5%	3.8	6.85	0	9.2	0.0	0.0	5.0
Longford	39	73.04	6.4	28.03	0	27.46	11.95	1.8	5	1	5	2.6	2.07	0 (+3)	9.23	-3.78
Laverstock (respiratory)	19	31	4	14.6	0	0	12.4		5	1	3	0	-4.9	0	0	2.2

Wards/department	Total Number of staff per shift: E- registered	E - Band 4	E - Band 3	E - Band 2	L -Registered	L -Band 4	L -Band 3	L - B2	N - Registered	N - Band 4	N - Band 3	N -Band 2	Shift patterns (ie 2 or 3 shift pattern)	Admin support (WTE): Ward Clerk	Ward managers Assistant	Sisters/Charge Nurses: Average % supervisory	Skill mix as a proportion of total staff (RCN note national benchmark of RN 65%): Registered %	Band 3 / 4 %	Band 2 %
AMU	7	0	0	4	7	0	0	4	4	0	0	2	2	3	1	64%	63%	1%	36%
Tisbury	6	0	0	2	6	0	0	2	4	0	0	1	2	1		70%			
Redlynch	4	0	0	4	4	0	0	2	3	0	0	2	3	1	0	30%			
Pitton (elderly care)	4	0	0	4	4	0	0	2	3	0	0	2	3	1	1	30%	50%		41%
Farley (stroke and RCU)	5	0	0	5	5	0	0	4	4	0	0	3	2	1.72	0	39%	59%	%	41%
Durrington (escaltion)	3	0	0	3	3	0	0	3	3	0	0	1	2	1	0			0%	
Spire	4	0	0	6	4	0	0	3	3	0	0	3	3	1	0	33%	35%		65%
Hospice	2	0	0	2	2	0	0	2	2	0	0	1	3		0		50%		50%
Pembroke	2	0	0	1	2	0	0	1	2	0	0	1	3	1	MATRON	20%	66%	0.00%	33%
Whiteparish	4	0	0	3	3	0	0	3	2	0	0	2	2	0.88	0.00%	75%	53%		47%
ED	9	0	1	2	9 + 2	0	1	2 + 2	7	0	1	1		0	0		69.8	7.1	23
Longford	7 (6)	0 (1)	4	6	6(5)	0 (1)	3(2)	3(4)	5(4)	0(1)	2(3)	3(2)	3	1	0	40%	50%	35%	15%
Laverstock (respiratory)	4	0	0	3	4	0	0	2	3	0	0	2	2	1	0	70	65		25

Wards/department	Trained nurse staffing relative to patients (early / day shift): RN	No Patients	Trained nurse staffing relative to patients (late shift): RN	No of patients	Trained nurse staffing relative to patients (night shift): RN	No Patients	Staffing relative to population served ie nurses per occupied bed (NPOB) on a eaerly/day shift: Nurses	No. beds	Staffing relative to population served ie nurses per occupied bed (NPOB) on a night shift: Nurses	No beds	HR Indicators: % Staff Turnover (average)	% Sickness absence (average)	% compliance appraisals	% compliance Stat and Mand training	Nursing Sensitive Indicators July 2020 - June 2021: No of PU Grade 2 or above	No of Falls	No of MRSA Bactaraemia	No of MSSA Bactaraemias	No of C-diff (reportable and non-reportable)	Complaints	No of Red Flag Incidents	Risk register entries reviewed	SafeCare data reviewed
AMU	1	4.80	1	4.80	1	7.25	1	2.9	1	3.1	46.0%	5.0%	80.0%	80.00%	108	81	0	0	0	4	4	y	y
Tisbury	1	4.00	1	4.00	1	6	6	23	1	4.6	11.3%	2.8%	97.0%	94.00%	20	26	0	1	2	0	2	y	y
Redlynch	1	9	1	9	1	9	1	3.4	1	5.4		8.6%	52.0%	86.00%	22	102	0	0	3	3	67	y	y
Pitton (elderly care)	1	9.00	1	9.00	1	9	1	3.4	1	5.4	9.8%	6.8%	90.0%	90.00%	27	133	0	1	1	5	9	y	y
Farley (stroke and RCU)	1	7.50	1	7.50	1	7.5	1	3	1	4.2	8.0%	8.9%	81.0%	79.00%	40	58	1	0	0	5	58	y	y
Durrington (escaltion)	1	7.50	1	7.50	1	5	1	2.5	1	3.75		5.1%	71.0%	82.00%	6	22	0	0	0	1	7	y	y
Spire	1	10	1	10	1	10	1	3	1	5	16.0%	6.8%	93.0%	93.00%	22	127	0	0	7	5	15	y	y
Hospice	1	5.00	1	5.00	1	5	1	2.5	1	3.3			86.0%	87.00%	29	36	0	0	0	0	4	y	y
Pembroke	1	5.00	1	5.00	1	5	1	3.3	1	3.3	18%	3.6	75	86.00%	12	21	0	0	1	1	6	y	y
Whiteparish	1	7.70	1	11.50	1	11.5	1	3.3	1	5.75		3.73%	97%	98.00%	64	103	1	0	1	3	16	y	y
ED														91.00%	120	25	0	11	0	16	15	y	n
Longford	1	6.5	1	7.8	1	7.8	1	2.3	1	3.9		4%	75%	85%	54	36	0	0	0	6	18	y	y
Laverstock (respiratory)	1	6	1	6	1	6	1	2.7	1	3.8	12.3	8.2	82	92	38	96	0	0	0	7	16	y	y

- indicates over recruited

	Descriptor	Definition
	Beds	Number of funded beds on ward
	Funded establishment	The establishment on the ward for all ward based posts ie nurses, nursing assistants, ward clerks etc
	Budget	Staffing budget only
	% Establishment uplift	The headroom on the ward to cover annual leave etc - this can be taken from Allocate to sho the average in the period
	Vacancies	Inlcude all current vacancies
	Staff on shift	Number of registered and unregistered on the early, late and night shift. If long days please indicate the numbers of staff who are on the ward at these times
	Shift pattern	Identify whether 2-shift (LD) or 3-shift (E/L/N) pattern. Where use a combination please choose the option most used.
	Admin support	Identify any additional roles on the ward which are not in the daily nursing requirements but that are funded from the ward budget
	Supervisory	Identify whether using supervisory shifts and how much time given to this ie 2 days per week = 0.4
	Skill mix	The percentage of RNs and NA's based on establishment
	RN staff relative to patients	If you have a 28-bed ward and you have 4 TN on the early shift then this would be 1RN to 7 patients
		As above but for late shift so may be you have 3TN on the late shift so this would be 1RN to 9 patients
	Staffing relative to population served	Same as above but count all RNs and NA's so if you have 7 on an early shift and is 28-bed ward this would be 1 nurse to 4 patients
		As above for late shift ie if you drop to 5 on the late shift then would be 1 nurse to 5.6 patients
	Turnover / absence	Overall percentage for the specified time period
	Nurse sensitive indicators	Provide for the specified time period

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Date: **Ward:** AMU

Present:

Section 1: Review of Current Position

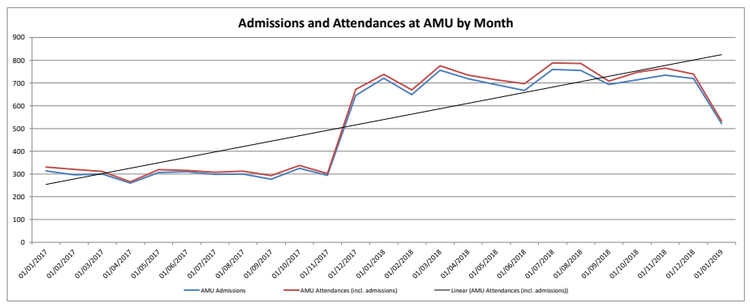
	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	
1.2	HR Indicators	
1.3	Finance	
1.4	Current establishment	
1.5	Supervisory	
1.6	Professional judgement of staffing ratios	
1.7	Safe Care Data	
1.8	Other supporting evidence to any proposed changes to skill mix	

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			
2.5			

All actions reviewed from 2020 Skill Mix Review:

Note data below last year ? Replicate for this year



Date: **Ward:**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	**Quality/Outcome Data**	KQI from July 2020 - June 2021: **CR, SII & LR:** 3; **Falls total**: 26; **Complaints:** 4 - all solved; **C-Diff:** 1; **Hand Hygiene Assessment:** 93%; **PUG2 or above:** 15; **Blood Transfusion:** above 83% on all competencies except blood collection as there is the new Blood 360 system and staff has not been trained on that yet; **Nursing red flags:** 3; **Absence:** 2.82%; **Incident Reports being investigated:** 36; Able to maintain a good balance between senior and junior staff. Difficult year to provide as much study leave as programmed due to the restrictions because of the pandemic, but when able supported junior and senior staff with study days and informal training on the ward. Invested on training for the senior nurses (B6 + B5); HAPE course and ALS by Resus council which also empowered them to escalated
1.2	**HR Indicators**	Sickness: A few stage 1's but all reviewed and under the monitoring period; In general, sickness seems to be quite low and ward manages within own staff to cover gaps. MLE compliance is 94%; Appraisals compliance: 79% with all the increments being now automatic.
1.3	**Finance**	No overspending on B6, as currently have x3 1 WTE. At the moment this is not allowing us to cover every single day with a B6, specially at times of annual leave, and rarely the nights are covered by a band 6. Most of the shifts are covered with 2 senior nurses both on LDs and Nights, but this will change as people will go on maternity leave. Most of the senior nurses (band 6 and band 5's) are all ALS providers which is in accordance with the British cardiovascular society nursing guidelines. Over most of the last year, Tisbury had all the audits done on time as well as appraisals and right trainings for staff. There was an increase in use of bank, mainly over the winter, during the peak of the pandemic due to sickness, and there are occasional shifts out to bank due to sickness, which are regularly covered by
1.4	**Current establishment**	No vacancies for B5's or B6's, however this will not reflect the capacity of covering shifts due to maternity. There are currently x2 RN's on maternity leave, and there are another x4 RN's pregnant, which will all go non-clinical after 28 weeks. Ward has been actively recruiting and trying to cover gaps in senior team as well as upskilling some of the more junior nurses. Had a difficult period at the begining of the year 2021 due to covid sickness, which most of the shifts were managed and covered by the ward staff, but at the same time staff was required to cover other areas, leaving the ward short staffed. HCA/B2 will have 1 WTE vacancy as one of the HCA is currently pregnant. On a week day we have 6 nurses + 2 HCA; on a week night shift 4 nurses + 1 HCA; Weekend day 5 + 2; and weekend night 4+1. The
1.5	**Supervisory**	Supervisory is usually respected and procteted. Each B6 is entitled 7.5h over a 4 week period which they use to manage own team, audits, datix, student nurses and teaching for the team.
1.6	**Professional judgement of staffing ratios**	The staffing ratios are appropriate for the ward. The night shifts continue to be challenging sometimes which could improve a lot if we had 4 nurses and 2 HCA. However, as it is we haven't had any incidents related to lack of staff, but 1 of the red flags we had was staff related but because a RN was redeployed to another ward. Overall, when needed to maintain the 4 nurses and the HCA on the shift, this is respected and it is always due to high acuity or patients requiring enhance care.
1.7	**Safe Care Data**	
1.8	**Other supporting evidence to any proposed changes to skill mix**	Over the last 3 months, where there was only x3 B6s, as per budget, there was an increase in time in solving incident reporting, and it was also noticeable a delay in completing the team appraisals in time. Also, some of the day shifts have not been covered by a B6 RN, as supposed to, which has, in some situations, resulted in inadequate patient transfers to the ward, which compromised patient flow.

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from 2020 Skill Mix review:

Date: **Ward:** Redlynch

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	
1.2	HR Indicators	High sickness- stress and anxiety, covid related etc, high no.of maternity leave, SPIDA-52% MLE-86%
1.3	Finance	Band 6 vacancy-0.4 Band 5 vacancy-3.28 Band 2 vacancy-3.94
1.4	Current establishment	E-4+4+SUP L-4+2 N- 3+2
1.5	Supervisory	Band 7 and band 6 lacking SUP time as constantly in number, struggling to catch up with sickness meetings, unable to complete annual appraisals, audits, DoIs applications,SWARMS/RCAs addressing complaints and concerns,student supervisions and related paperworks, perceptorship etc on time.
1.6	Professional judgement of staffing ratios	The ward is compromising patient safety and the staff are struggling to cope with the workload. Redlynch is an assessment come acute ward, with very fast Turn over.Each nurse is expected to look after x9 acutely ill patients, which reportedly is compromising care and safety.
1.7	Safe Care Data	The ward is using Shelford tool to determine acuity and dependencyy, which is not very Gastro specific to reflect the exact level of acuity. For eg: a patient requiring massive blood transfusion following acute GI bleed requires high nursing input from 2-3 nurses, which is not captured on the Shelford tool acccurately.
1.8	Other supporting evidence to any proposed changes to skill mix	The ward had 107 falls, there is an increase in no. of PU2 developed on the ward, the ward was reported to have c diff outbreaks, had 65 deaths on the ward, an average of 20-28 transferes during the week, mostly happening between 10-22:00hrs, an average of 4-8 bleeders per day requiring preparation for procedures, average 16-20 discharges per week mostly between 15:00-20:00hrs. Please refer to the emails attached

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from 2020Skill Mix review:

Date: **Ward:** Pitton

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	Difficult to report for the year due to no quality data reprorted January-June 2021 and data from Durrington to a new template on Pitton. Falls remain variable dependent on patient compleaxity, however there have been no falls with harm for the past 4 months. PU have been on a downward trajectory-believed to be due to on ward education by the TV team and the increased use of medical photography and reporting. Since moving to Pitton template there has been 1 Covid outbreak which was well managed. No C- Diff outbreaks, I MSSA bacteremia. All perfect Ward audits are now completed in a timely manner and are high scoring with no themes apart from documentation.
1.2	HR Indicators	With the move from Durrington to Pitton, it has been difficult to establish a true reflection of Pittons figures. Vacancy rates are at 3WTE each for HCA;s and RNs. 1 new RN and 1 new HCA to commence at the end of August. Recruitment are assisting with a drive unique to Pitton. Sickness levels have increased in the past year but this is mainly due to pregnancy related illnesses. 1 RN on stage 2 and 2 on stage 1. 3 HCA's on stage 1. Mandatory training and Apraisals have been increasing in success rates over the past 6 months and are both now sitting at 90%.
1.3	Finance	Again, the financial situation and budget control has not been correct for the past 4 months and so this is difficult to report on. ESR, Eroster and finance have been working to try to resolve this and should be correct for month 4's figures. Pitton still had numerous staff from both Laverstock and Durrington on the cost code and so was overspent. In reality Pitton should be underspent. Use of bank has been high to cover the new establishment, but agency has been low.
1.4	Current establishment	1 band 6 on maternity leave. 1 RN on secondment to IC. 3 RNs on maternity leave. Plus vacancies of 2 RNs and 3 HCAs. Good use of band 4's-there are 2 but these are not in establishment figures.
1.5	Supervisory	This has been reported as approx 30%. This is very variable dependent on sickness and vacancies. Ward Sister feels that she "fills the gap" when working clinically rather than supervising on the ward.
1.6	Professional judgement of staffing ratios	The team as well as the MDT feels that if the established figures were filled, then the early and night shift are satisfcatory. However , for the late shift there are only 2 HCA's on duty and this is insufficient to safely run the ward. Skin bundles are often delayed/missed as well as monitoring of patients who are at risk of falling and dehydration. The 1:1's that are requested often do not get filled for the late but do for the early and at weekends. HCA's have had to alter their working pattern from just long days to having to do a week of earlies once a month which has been quite difficult to manage.
1.7	Safe Care Data	The data inputting has definitly improved over the past year, especially in the past 4 months. Since moving to Pitton requirement against actual has been persistently high. 32 red flags have been raised since April 1st.
1.8	Other supporting evidence to any proposed changes to skill mix	Falls data shows that the majority of the falls happen overnight or on the late shift. Admissions still tend to also be afternoon into the evening and night, therefore an extra band 2 would be validated for the late shift.

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
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All actions reviewed from 2020 Skill Mix review:

Date: **Ward:** Whiteparish

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	1x complaint around dicharge of a patient. Ness worked on ward as a practice educator for 1 month, ending with a study day, also helped new band 6 put together own band 5 study day
1.2	HR Indicators	SPIDA-97 MLE-98%, sickness is currently at 3.73 % overall, down from 4.81% last year, Covid sickness was high in December and January.
1.3	Finance	breaking even. M3 underspent by 1.3
1.4	Current establishment	We are currently over recruited for band 5/4 but we have 3WTE band 5 on mat leave and 0.62 band 6. We also have 3 WTE band 5's redeployed to Durrington/RCU and 0.4 WTE on secondment with the diabetes team and 2xWTE Band 5 just handed there notice in, We have 2x B2's leaving but 2x new B2's recruited and starting with us soon and 1xB2 WTE on maternity leave, 1xB3 currently doing her TNA course.
1.5	Supervisory	I have managed to take my supervisory time the majority of the time, except when staffing was challenging across the trust with COVID and Isolation
1.6	Professional judgement of staffing ratios	I feel that the acuity of the ward is still to high for only 2 trained nurses at night and I feel an increase in RN's is required. This would also enhance the care given to patients during the night. We have a large amount of acuitley unwell patients, and many of our diabetic foot patients are on 2-3 differnt IV antibiotics each. Also we have had an increase on the amount of patients on a Variable rate insulin infusion(VRII) or a Fixed rate insulin infusion(FRII), which increases the acuity and work load of the ward. I also feel ideally we need to increase to a 4th band 5 on a late shift so that the NIC does not have there own patient load and can continue to support staff and assist with discharges and patient flo. however the 4th on the late and the 3rd on nights could also be a band 4. I would also like to increase the trained staffing at the weekend so that it is the
1.7	Safe Care Data	Safe care continues to show that we have high acuity, with still a large amount of 1B patients as well as an increasing amount of 1a patients as well.
1.8	Other supporting evidence to any proposed changes to skill mix	In july the trust had 240 hypos were recorded and 62 (15%) of these were on Whiteparish, the diabetic patients that we are seeing are becoming more complexed and requiring more nursing interventions. The ward is seeing an increasing amount of patients on Variabe rate insulin infusions (VRII) which has increased the acuity on the ward and especially at night and 2 nurses are required to make up and prepare new insuing syringes for the VRII.

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
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All actions reviewed from 2020 Skill Mix review:

Date: **Ward:** Farley

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	The falls increased from previous year by 9, one of the reasons that has been identified it was that Laverstock template and space was not suitable for stroke patients to mobilise, this increased the risk of falls and eventually the falls number. Pressure ulcers grade 2 or above have decreased to 11, 4 less than last year.0 MRSA and MSSA bactaraemias. 2 Cdiff reported cases during June-July , SWARM completed and lessons to be learnt cascaded to the team. Complaints are 4 as last year , 2 of them dealt and closed with face to face meetings and in a ward level , the other 2 had escalated to matrons level and above.
1.2	HR Indicators	Sickness abscene year to date is 8.9% which is an increase from last year due to COVID and medically suspended reasons have been identified within this year which reflects the pandemic.Several staff members on S1 and managed accordingly and with longer monitoring period,3 staff members on S2 with HR involvement. X1 staff member now on Stage 3 of the management of attendance policy and has escalated to stage4 which a management case is in progress. x3 staff members on phase return after long time sickness. x1 staff member was sheilding during the winter due to undelying health condion and x3 staff members redeployed due to risk assessments. MLE is bad at 75% (However previous RCU staff and Breamore short stay staff are showing on Strokes report with non compliance-
1.3	Finance	Unable to correctly identify financial spend due to ward move and cost codes not being coverted awaiting responses from finance.
1.4	Current establishment	Finance is still working on it , the last finance meeting we had a lot of staff that never worked within the stroke unit, discussed and escalated multiple times but still we don't have a clear picture.
1.5	Supervisory	39% which includes B6 supervisory time, with Senior Sister to be seconded since March to Matron's role and the post been filled at the end of July. TIA Clinics running well.
1.6	Professional judgement of staffing ratios	Currently Qualified staffing is the best its been, however increased my establishment in order to be able to cover Breamore ward, hence the need for bank duties to cover both areas.Staffing during the day is managed well within the nursing skill mix and adapted accordingly to match acuity and dependancy of the unit. Thrombolysis/Haemorrhagic stroke care also effectively managed during the day. All stroke patients require intensive observation and are considered level 2 patients for the first 72 hours post admission due to the increased risk of neurological deterioation. Thrombolysis patients require 1:1 trained nurse support for the fisrt 24 hours and longer if condition dictates. Intracerebral bleeds also require 1:1 due to managing high BP and administartion of medication to manage with regular BP Checks every 15 mins. With this in mind, the daily staffing is adequate and well managed. A request for a 4th B5 at night has been requested and approved during COVID ,it has been utilised since we move back to Farley ward and works well. However acuity of patients has been
1.7	Safe Care Data	Safe Care data reflects the Farley Stroke Unit and the RCU side, with high acuity and dependency. Professional judgement completed on each shift by the staff and they are getting to the routine to raise red flags when needed.
1.8	Other supporting evidence to any proposed changes to skill mix	ANP role to complete the business case until the end of October and present to DMT

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
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Actions from 2020 Skill Mix reviewed:

Date: **Ward:**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	Since April Durrington has had no MRSA/MSSA bateremias.6 pressure ulcers grade 2 and above have been reported.3 falls resulting in fractures, 2 of which required surgery. No learning from third SWARM as all recommendations from previous SWARMS had been actioned.
1.2	HR Indicators	sickness absences improving from 7% to 5% from May to June 2021. Appraisal compliance improving currently at 71%. MLE currently 82% staff unable to have study days to complete this. Staff turnover the trend seems to be that staff are leaving for further development of their career.
1.3	Finance	Since April temporary staffing has cost £144.4K. One patient on the ward for 7 weeks needing 1:1 24 hour security.
1.4	Current establishment	Currently have 1.0 WTE Band 7 end date 3/10/21, 1.92 WTE band 6, 6 WTE band 5's (1.0 WTE band 5 on maternity leave out of those numbers) 6.6 WTE band 2 and 1.0 WTE band 2 Admin. Awaiting decisions from matrons and Heads of Nursing regarding replyment of staff to Durrington. **Short 7.85 WTE Registered and 6.7 WTE non-registered**
1.5	Supervisory	0.8 WTE should be for Supervisory time per week. Due to poor staffing currently averaging at 0.2 WTE Supervisory time as needed for clinical duties and patient safety. This has a negative impact on response times to compliants, datix's, appraisals
1.6	Professional judgement of staffing ratios	Currently the ward does not have enough registered nurse to ensure more then 1 nurse on each shift. Matrons team aware of this. Red flagging shifts that are not covered. Staffing levels approved for 15 beds however mostly to 21 patients on the ward
1.7	Safe Care Data	Staff adding in red flags to shifts and professional judgements to ensure that we capture a true reflection of the ward.
1.8	Other supporting evidence to any proposed changes to skill mix	Consider 4th Registered Nurse for week day early shifts to co-ordinator the ward to ensure better patient flow.

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

Actions reviewed from 2020 Skill Mix Review:

Date: **Ward:** Spire

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	**Quality/Outcome Data**	6 c-diff over this time period which is 6 more than last year, no MRSA/MSSA bacteremias for the year (same as last year). 23 pressure sores grade 2 or above, 14 greater than the previous year however I believe the numbers have incresed trust wide this year but still remians low particularly in context of frail elderly patient group. Falls have have increased this year from 117 to 130 this year. Weve had 3 complaints this year which is 1 more than last year.
1.2	**HR Indicators**	MLE - Our compliance rate for mle currently stands at 93%, im happy with this, espacailly after the year weve had. This time last year we stood at 97%. SPIDA - many staff due in September, there are also staff that need their first aprasials completing, all are booked in with myself or one of my band 6's in the new couple of weeks so this figure will improve. It currently stands at 93%. Sickness is being managed properly through the management of attendance policy, and i believe it to be much improved than the previous years. Year to date is 6.8% which is disapointing, however we have 3 members of staff on long term sick which has contributed to this number.
1.3	**Finance**	Year To Date High spend in band 2 specials and sercurity needs. Total Pay & Non Pay Budget £581,176 Actual £629,164 Adverse Variance £47,988
1.4	**Current establishment**	I currently have 2 band 6's that are on seccondments, the substantive posts will be put out next week, both will apply, they have done so well on Spire, they have been here almost a year now and came as new 6's from different wards and have exceeded my exceptations, I feel we have a really strong senior team. Band 5's are currently over established however taking into accont our staff on maternity leave we are down currently by 0.8 wte . Band 2's we are currently under established by 2.42 this includes my 2 band 3's, one of the band 3's will be leaving soon to go back to AMU and the other I believe should be a band 4 to match the other discharge assistant in the trust. Since ive been in post we have had at least 1 special every night
1.5	**Supervisory**	Supervisory Time is 33.33% which is much lower than last year at 70%. I used what little time ive had to ensure staff have been well supported in this difficult year. When I do have sup time I make sure im visible in the mornings and worl along side the staff, I put their happiness and well being at the forfront as Im a string believer in you get out what you put in. Ive had staff approach me from other areas who have joined the team as they have heard Spire is a nice place to work. The staff here know they can approach me at any time and I will always listen and make time for this. The staff trust me and know I will always do my best for them, the patients and Spire ward in general. I really proud of how far we have come since I took over as ward lead in Jan 2019
1.6	**Professional judgement of staffing ratios**	Their have been challenges previoulsy on Spire ward however now I feel like we buildt a fantassic team who has really coped well during the hight of covid where we all had to learn different skills very quickly. Most of my RN's can be the Nic if needed, they are more than capable, this doesnt happen often as in charge is normally me or one of my senior team. I have 3 band 6's now and this has made a massive difference to many things, patient care In my view has improved massively and our spida and mle compliannce is always very good, we have a very resppsive senior team who all do everything I would expect , they also attend share and learn, expert panel, finance meetings, sickness reviews independently if im not around, they also perform saftey thromometer and all auids including perfect ward without me asking, 2 of my band 6's joint at the same time and were band 5's from other wards. I worked really hard with them and produced a good bad 6 induction and I feel this has really paid off. Our RN numbers are good however out shifts are difficult as we are a 1:10 patient ratios. We seemed to of picked up a label as a rehab ward. This is not the case at all, we take admissions straight from ED quite often, many of our patients are not medically fit and can be acutley unwell. On the early shifts it is manageable for the RN's as we have 6 NA'S on in the morning so an RN has 2 NA'S to work with. The lates are much more difficult as our NA'S drop to 3. The night shifts are always a struggle as we are 3:2 and
1.7	**Safe Care Data**	All trained staff who work as the nurse in charge ensuring accurate safe care data and recently had insights reports into safe care data, need to ensuring the timings are done as not always on time, adding in prfoessional judgement and red flag shifts needs to imporve as doesn't feel we are capturing all issues. Data shows more nursing hours needed on a very regular basis, this is mainly because of the amount of enhanced care nurses needed. Especially when we have patients with advanced dementia that can be very aggressive. Spire staff often trained taken to cover shifts on other wards. No RN shifts put to bank when roster is published, only due to sickness.
1.8	**Other supporting evidence to any proposed changes to skill mix**	Explained in staffing ratios, please consider band 2 for a night shift as not clear from last skill mix, this was argreed last skill mix but never actioned. Ratio of 1:15 at night feels very unsafe for the nature of our patients and the layout of our ward. I have had at least 1 special band 2 on a night shift since ive been in post in Jan 19. Discharge assistant to become band 4 to match other in the trust.

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from 2020 Skill Mix review.

Date: **Ward:** Pembroke

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	
1.2	HR Indicators	
1.3	Finance	
1.4	Current establishment	Current establishment is challenging to truly calculate as the chemotherapy outpatients and the ward are managed by 1 team so fluctuating levels of staff. The complexity of the ward requires at least 1 supervisory shift per day to cover ward and suite. If skill mix is poor and Band 7 is not on shift, the unit Matron is relied on to provide clinical support which then compromises all other apsects of her role. The chemotherapy day unit is undergoing demand /capacity work which will impact upon staffing. Pembroke unit manages all oncology and haematology patients and is required to keep abreast of frequent changes and challenges in service provison and development.
1.5	Supervisory	
1.6	Professional judgement of staffing ratios	Pembroke suite is not included in safe care. If staffing on Pembroke suite is 'at risk' then trained nurses from the ward and the suite will cross cover. If high number of inpatient chemotherpy patients then equally Pembroke suite will support inpatient area.
1.7	Safe Care Data	
1.8	Other supporting evidence to any proposed changes to skill mix	Changes to clinics, increase in chemotherapy, complexity of chemotherapy regimes, increase in novel agents

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from 2020 Skill Mix review.

Date: **Ward:** Hospice

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1		
1.2	HR Indicators	sickness 9.44% band 5- 1 WTE working non clinical- aw HR meeting Sept, likely redeployment. 0.8 on LTS. Multiple single days for anxiety and stress/MSK
1.3	Finance	higher use of temp staffing due to vaccancies and sickness.
1.4	Current establishment	TOTAL is 23.83 vacant 4.49. (band 7 1).0, filled. (Band 6 1.6)- 0.9 vacant (Band 5 11.85,) 2.12 vacant. (Band 2 8.58), 1.47 vacant.
1.5	Supervisory	band 7 should have 1.0 supervisory?- need to focus on staff education, retention and recruitment as well as learning role. Often used within number. Band 7 also has role in oversight of operational management of whole Palliative care services when other management team off duty(5 services plus therapy, volunteers) including strategic planning involement.The band 6 currently workin within the numbers most of the week therefore less oppotunity for own development or working alongside staff, implementing ward rounds. The unit needs supervisory time to upskill new staff members/release staff members for inhouse learning oppotunites with medical team.
1.6	Professional judgement of staffing ratios	The Hospice does not have a Nurse in charge/coordinator role on any shift therefire staffing ratios are not sufficient on every shift, the demands of the patients have increased. The level of staffing does not reflect the time needed to give high standards of Palliative Care to patients and support of loved ones. Unfortunetly symptom control/deaths/higher acuity are unpredictable. Hospice inpatient staff also plan and manage complex admissions and discharges whilst delivering direct patient care which can take a large resource of time. This and managing out of ours crisis calls require a level of competence/experience within Palliative care. Staff are often redeployed to help the main trust thus affecting these standards again
1.7	Safe Care Data	Trialled Northamptonshire acuity tool guiding that of the most part beds were full, the filled beds were at least 80% fully dependent patients which is the norm for Hospices. This highlights although we have a lower number of beds the interventions needed are timely and sometimes unpreidcatble. Safe care does not reflect this and we have to manually describe the shift- i.e level of syringe drivers (which take time + both RN's to do), IR, AD/DC/DEATHS, transfusions, drains, complex psychological support. Looking into establishment genie from a local Hospice to also guide our establishment needs.
1.8	Other supporting evidence to any proposed changes to skill mix	

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from 2020 Skill Mix Review:

Date: **Ward:** ED

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	
1.2	HR Indicators	
1.3	Finance	
1.4	Current establishment	
1.5	Supervisory	
1.6	Professional judgement of staffing ratios	
1.7	Safe Care Data	
1.8	Other supporting evidence to any proposed changes to skill mix	

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
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2.4			

Actions reviewed from 2020 Skill Mix Review:

Date: **Ward: Longford**
Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	
1.2	HR Indicators	
1.3	Finance	
1.4	Current establishment	
1.5	Supervisory	B6's are given a supervisory day every 4 weeks, however they are pulled on the ward to work. B7 mostly working on the ward to monitor due to skill mix and junior staff on ward
1.6	Professional judgement of staffing ratios	
1.7	Safe Care Data	53 red flags from July 2020 to June 2021 (13/06)
1.8	Other supporting evidence to any proposed changes to skill mix	Increase in OH referral with MKS/back problems, increase in skin damages for patients who are delayed in turning and mobilising due to shortage of staff (30), lack of fully spinal trained staff or competencies not achieved in a timely manner due to reduced number of experienced staff on shift which give an increase in incidents. "respiratory hub" has currently 2 staff member allocated each shift, however for safety there should be 3 people (incident where staff members were in a sr with a patient who was desaturating and not long after the patient in the next door sider room started desaturating and needs were not met in time). Patient education on the ward is compromised due to reduced staff and acuity

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from 2020 Skill Mix Review:

Date: 10/08/2021 **Ward: Laverstock Ward**

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	0 hospital acquired C diffs. 0 hospital acquired MRSA. 3 falls with harm. 2 complaints this year. 9 total hospital acquired pressure ulcers this year, have already seen a decrease from previous months. 22 falls this year. Working to further reduce the number of falls, appointed senior link nurse to work with risk. Have created falls education board. B6 who is non clinical, is going to work on education with the staff on falls risk assessments and look at learning from SWARMS.
1.2	HR Indicators	MLE compliance currently at 93%, at the beginnig of the year it was 89%, so this has improved, my aim is to achieve at least 95% compliancy consistently. Spida is at 87%, many staff are excempt, and/or on long term sick. Those that aren't are booked in for appraisals, so this should improve. Sickness has increased to 8.2%, this is all being managed appropriately and escalated to HR, including having regular meetings.
1.3	Finance	Over spending on bank due to high sickness and maternity. We also have LTS staff, including a ward clerk, which means paying a B2 ward clerk on bank 3 days a week.
1.4	Current establishment	Currently 6.5 over established. Soon to reduce by 1.0 B6, 1.0 B5, 0.92 B4, 1.0 B2, 0.70 B2, have asked finance for an updated establishment figure. That should put me at 1.88 over established. Advert for B6 to go out. Will await finance/DMT on further recruitment allowance. I am involved with recruitment days and interviews. I will be providing exit interviews to allow for feedback from staff, to try and improve staff retention.
1.5	Supervisory	Supervisory time is at 70%. This ensures I have the time to manage the high sickness we currently have. It has also aided me in organising staff education and training. I have been able to release staff from the ward, so that they can further develop, including spending shadow time on Radnor, respiratory clinics and spending time with practice educator.
1.6	Professional judgement of staffing ratios	As at 19 patients, staffing ratios are currently 1:6 nursing, this allows for higher acuities, such as 1:6 trachies, and even 1:1 trachies and NIV, as the coordinator can support with this. I feel that the ratio is safe and that is reflected in our acuities. If we were to increase patients, this would need review, to allow to keep the 1:6 nursing. The challenge has been skill mix, rather than numbers. Trachie and NIV training compliancy has increased (see attached graph). Nights is more of a concern, as we are 3 nurses and can sometimes only have 1 skills trained, I am looking to improve this. There have been more training days made available. We had a practice educator on the ward in July, and were able to improve our compliancy significantly.
1.7	Safe Care Data	Gaps in safe care acuity regular, have reminded nurses in charge of this daily and offered training where needed, have seen a decrease in gaps. Staffing levels at 19 patients reflect safe care data.
1.8	Other supporting evidence to any proposed changes to skill mix	Please see attached chart to reflect advantage of having practice educator. My aim would be to increase compliancy to 100% for NIV, HFN02 and tracheostomies. Trust allows for training but not always opportunities for sign off, having a practice educator enabled those sign offs to happen more efficiently, including the use of the SIM. The practice educator was able to provide NIV training on the ward, for those staff who hadn't attended the workshop. She worked 1:1 with nursing staff and provided education around ABCDE assessment and blood gas intepretation, which is beneficial for respiratory nurses. This has supported the trust for when there are CPAP/bipap and tracheostomies, in settings like RCU, where there aren't resp specialist nurses and allows for an increase in acuity on the ward and supports with staffing, which means staff aren't having to be pulled from other areas such as AMU.

Section 2: Recommendations/Considera

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

Actions reviewed from 2020 Skill Mix Review:

CLASSIFICATION
Unrestricted

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	**5.3**
Date of Meeting:	09 September 2021		

Report Title:	Annual clinical governance report 2020 - 2021			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	
Prepared by:	Claire Gorzanski, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Judy Dyos, Chief Nursing Officere			
Appendices (list if applicable):				

Recommendation:
The report is presented for assurance.

Executive Summary:
Overall, the Integrated Governance Framework and Accountability Framework ensures that the clinical governance arrangements are effective in identifying key risks to the quality of care and escalated to the Board to ensure they are sighted on the key risks and mitigation in place. Achievements, issues escalated and high priority areas for improvement in 2021/22 are highlighted in the report. **High priority areas 2021/22**: • Progress the recovery work associated with the COVID-19 pandemic to reduce risks of delays in diagnosis or treatment in clinical pathways. • Implement the 'must do' actions identified by the CQC for the Maternity Services and Spinal Treatment Centre. • Continue to progress improvements in the Gastroenterology service and plan for service sustainability and report progress to the Clinical Governance Committee • Continue to make improvements in the cancer pathways to eliminate delayed or missed cancer diagnoses and track actions through to completion. • Improve compliance with the lessons learnt from serious incident inquiries to provide assurance that they are acted upon and high harm incidents reduced. • Reduce the number of high harm falls by 30% through the refreshed Falls Prevention Improvement plan. • Reduce the number of category 2 by 20% and 3 and 4 pressure ulcers to zero acquired in hospital using a QI approach to improvement. • Improve the escalation response of adults, children and maternity cases when a patient triggers a clinical observation early warning score. • Work alongside the Divisional management teams to embed governance processes, learning and improvement.

• Re-commence an intensive quality improvement programme to increase the spread of an improvement culture to ensure sustainable change.

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

ANNUAL CLINICAL GOVERNANCE REPORT 2020 – 2021

1.0 Purpose

This report sets out the progress made in continuously improving the quality of care and provides assurance that appropriate governance processes are in place to ensure the Board is routinely sighted on key risks to the quality of care and that mitigation is in place.

2.0 Clinical governance arrangements

2.1 Integrated Governance Framework

The Board approved the updated Integrated Governance Framework in July 2020. The Integrated Governance Framework is the means by which the Trust Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the organisation's objectives. The framework is designed to ensure the strategic aim of the delivery of an 'outstanding experience for every patient', by an organisation that is well managed, cost effective and has a skilled and motivated workforce. The framework describes the system of integrated governance used within the Trust with particular reference to the provision of quality services.

Clinical governance is the responsibility of the Trust Board supported by the Clinical Governance Committee for continuously improving the quality of the services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Clinical governance is the mechanism for understanding and learning, to promote the components that facilitate the delivery of quality care: candour, learning, questioning, a just culture and excellent leadership. The Integrated Governance Framework provides evidence to the Trust Board through demonstrating its compliance with the quality and safety standards relevant to the Trust. This includes the Quality Account national framework, Data Security and Protection Toolkit, CQC standards and the Trust's performance monitoring framework. The elements of clinical governance can be mapped against the Care Quality Commission five domains of quality – safe, caring, effective, responsive and well-led.

2.2 Accountability Framework

The Integrated Governance Framework is underpinned by the Accountability Framework which specifies how the performance management systems are structured and tracked to ensure delivery of the corporate objectives at every level of the organisation focusing across the breath of quality, operations, finance and workforce. The updated Accountability Framework was approved by the Board in July 2020.

The purpose of the Accountability Framework is to ensure that the Trust has sufficient mechanisms in place to monitor and drive the delivery of the Trust's strategic and operational plans during 2020 and beyond. It provides a framework for how the Trust will monitor and manage its own performance. In order to achieve its ambitions, the Trust must ensure consistency of approach and that sufficient escalation triggers are in place and, the Board is routinely sighted on, and involved in, the mitigation of key risks.

The Accountability Framework is aligned with the NHS Improvement Oversight Framework. This framework reflects the requirements of the Care Quality Commission, financial sustainability, performance management and improvement capability. The Performance Framework sets out the metrics that each Division is held accountable for and assigns a rating of red, amber or green based on performance against the domains of quality, operational, financial and workforce performance as well as delivery of the Divisional operational plan at the monthly Executive Performance Review meeting. The overall rating for each Division acts as a trigger for additional support or escalation to the Board. Additional interventions, usually in the form of intensive support, may be enacted to support the return of performance to acceptable levels if the Divisions have failed to deliver any improvement for a sustained period of time.

3.0 Safe

3.1 Care Quality Commission (CQC)

The CQC has not routinely inspected services during the COVID-19 pandemic, although they have carried out some focused inspections. Contact with the Trust has continued through their usual engagement calls, with an agenda focused around COVID-19 arrangements and recovery plans. The Trust has continued to discuss key risks and our main quality concerns, these are, the gastroenterology services, cancer pathways and maternity services. All core services have had direct engagement with the CQC since our last inspection in December 2018, either face-to-face or via Microsoft Teams during the pandemic.

In July 2020, the Trust's engagement call specifically centred around the completion of the CQC 'Emergency Support Framework', with recommendations focusing on infection prevention and control arrangements. No concerns were raised and the CQC assessment outcome was that the Trust had managed well throughout the COVID-19 pandemic. The Trust also completed the NHSE Infection Prevention and Control Board Assurance Framework, discussed during the engagement calls and shared with the CQC. In addition, the CQC carried out a series of rapid reviews of how providers have worked collaboratively to help health and social care services learn from responding to the pandemic. Participation in the reviews was not mandatory and findings did not affect a providers rating. The Trust has participated in two reviews, provision of services within urgent and emergency care settings and provision of cancer services. No immediate concerns were raised as a result of these reviews.

On 31 March 2021, the Trust had an unannounced inspection of the Maternity Services and Spinal Treatment Centre. Progress of the work will be overseen by the Maternity Improvement Board and reported to the Clinical Governance Committee.

The Spinal Treatment Centre are required to implement 6 'must do' actions related to governance and risk and 13 'should do' actions. Progress of the work will be overseen by the Divisional Management Team and reported to the Clinical Governance Committee.

3.2 Patient safety

In 2020/21, a new Patient Experience and Patient Safety Group (PEPS) was introduced to monitor the progress of experience, safety, learning and improvement.

The focus of the patient safety improvement work in 2020/21 centred on 3 key areas. These were:

1) Reduce stillbirths and intra-uterine deaths - focused on the detection and surveillance of small for gestational age babies in pregnancy and the appointment of a fetal surveillance midwife resulting in improved compliance with CTG training. A decrease in stillbirths from 8 in 19/20 to 7 in 20/21, but an increase in neonatal deaths from 1 in 19/20 to 7 (5 died from extreme prematurity/fetal anomalies) in 20/21.

2) Reduce harm from falls - positive engagement with the Band 2 workforce as part of the seconded falls reduction facilitator post contributed to a small reduction in high harm falls from 24 in 19/20 to 23 in 20/21. In addition, the Trust participated in a national Falls Awareness week which had a positive impact on reducing falls the following month, consistent with the previous year. There are plans to appoint a full time falls prevention specialist.

3) Reduce harm from pressure ulcers - a significant increase in category 2 pressure ulcers from 1.28 per 1000 bed days (199 ulcers) in 19/20 to 2.12 per 1000 bed days (286 ulcers) in 20/21. However, a

significant reduction in category 3 and 4 pressure ulcers from 0.13 per 1000 bed days in 19/20 (18 category 3; and 3 category 4 pressure ulcers) to 0.07 per 1000 bed days in 20/21 (9 category 3; and 1 category 4 ulcers). Improvements centred on handover, a PDSA cycle for skin inspection in AMU, development of wound care education, Tissue Viability Nurses visiting wards and providing on the spot education. Pressure ulcer link nurse meetings will restart in 21/22.

The focus in 2021/22 will continue on falls and pressure ulcer prevention, sepsis and the deteriorating patient including maternity and paediatric early warning scoring and escalation arising from themes from serious incident inquiries. Appointment of a Patient Safety Specialist is key in preparation for the national patient safety strategy agenda in 2022.

3.3 Safeguarding

Trust quarterly reports provided positive assurance on sustained compliance with level 2 safeguarding children training at 89% and level 3 at 76% at the end of 20/21. Safeguarding supervision compliance for all departments remains over 50% except for the Emergency Department as arranged sessions were cancelled due to COVID-19, particularly in Q2 20/21 and this affected the overall compliance. In Q4 20/21 there was a significant increase in the number of MASH referrals (125) compared to 87 referrals in Q3 19/20. Concerns centre on the number of children and young people with complex mental health conditions requiring an MDT approach and the national availability of CAMHS beds.

Positive assurance was noted in compliance with level 1 & 2 adult safeguarding training at 98% and 87% respectively. Mental Capacity Act and Deprivation of Liberty training has improved from 71% in 19/20 to 74% in 20/21 compared to a target of 85%. Work in 21/22 will continue to focus on implementing the Adult Intercollegiate training requirements and planning the introduction of adult safeguarding supervision. The launch date for the introduction of the Liberty Protection Safeguards is planned for 1/4/2022. These safeguards are likely to shift the responsibility of assessments from the Local Authority to the acute Trust.

3.4 Staffing

In October 2018, the Developing Workforce Safeguards Framework was launched. Building on existing National Quality Board (NQB) guidance, the framework provides a set of recommendations on workforce safeguards to strengthen the delivery of safe, high quality care across all staff groups and includes new recommendations for governance processes and formal reporting from ward to board.

The Trust has a number of key mechanisms to ensure that the short, medium and long-term workforce strategies and staffing systems are in place to assure the Board that staffing processes are safe, sustainable and effective. These include:

- Resourcing programme with a strong focus on hard to recruit posts, including registered nurses, consultants and other professionals.
- Optimisation programme for the use of the Electronic Staff Record (ESR) which will have close links with the roll-out of eRoster and implementation of e-OPAS (Occupational Health) systems.
- Workforce planning and deployment of staff to ensure safe staffing levels.
- Twice daily nurse staffing meetings.
- The Board receives regular updates on key strategic staffing issues, including staff wellbeing and systems to support staffing processes. These include care hours per patient day.
- Use of evidence-based tools to support planning and rostering of permanent and temporary staff.
- Formal reports on nurse staffing to Board and Board Committees.
- Integrated performance reports showing safe staffing levels and bank/agency usage.
- Executive Performance Review meetings consider staffing issues with escalation of any concerns

3.5 Patient safety incidents

Our National Reporting Learning System rate of patient safety incidents reported, showed an increase from 39.77 incidents per 1000 bed days in 2018/19 to 43.79 incidents per 1000 bed days in 2019/20. The number of incidents that resulted in severe harm or death increased from 25 (0.38%) incidents in 2018/19 to 33 (0.52%) incidents in 2019/20. 30 serious incidents inquiries commissioned in 2020/21, 14 clinical reviews and 31 falls SWARM reviews and a departmental cluster review in response to a higher level of reported falls on AMU.

The Trust has taken the following actions to reduce the rate of patient safety incidents resulting in severe harm or death by:

- Investigating incidents and sharing the lessons learnt across the Trust and ensuring recommendations are implemented through the Executive Divisional Performance Review meetings.
- Ensuring timely identification of themes, trends and learning and escalate when progress has gone beyond the completion date. Further work is required to focus on the lessons learnt from these incidents.
- Continuing to monitor the completion of recommendations from reviews at the Clinical Risk Group, Clinical Management Board and Clinical Governance Committee.
- Set up a weekly patient safety summit with the Chief Medical Officer, Chief Nurse, Divisional Management Teams and Risk team to review the previous week's moderate, major or catastrophic incidents. Incidents, duty of candour and progress with serious incident inquiries and clinical reviews are also discussed at this forum. Overall compliance of duty of candour is reported to the Clinical Risk Group every month.
- The Transformation Board monitor progress of the cancer pathway improvement plan set up in 2019/20 following a cluster of serious incidents related to missed or delayed diagnosis of cancer.
- Set up a Maternity Improvement Board to bring together all improvement actions required from recommendations from the cultural review, clinical review, the Ockenden report 2020 and the Care Quality Commission warning notice to improve leadership, governance and risk.

Our national staff survey 2020 showed that when asked:

- My organisation treats staff who are involved in an error, near miss or incident fairly - 58.8% of staff felt they were treated fairly compared to the national average 61.4%.
- When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again – 70.1% of staff felt the Trust took action to ensure errors, near misses or incident do not happen again compared to the national average of 72.7%.
- We are given feedback about changes made in response to reported errors, near misses and incidents – 56.7% of staff felt they were given feedback about changes made compared to a national average of 61.9%.

The focus in 21/22 is to improve the key performance indicator target of 10 working days for incident investigation completion by the ward teams. These reports will be sent to the Divisions in preparation for their Executive Performance Review meetings.

4.0 Caring

The CQC rated the Trust as good for caring in 2015 and 2018.

Due to the COVID-19 pandemic, all Trusts were advised to remove any paper-based forms from display. This affected our Friends and Family Test (FFT) questionnaires but a new process for collecting the forms was approved for use and FFT was able to restart. The questions asked changed in April 2020 and the new questions (focus on meeting expectations) provide teams with new ideas for service improvement and opportunities for learning. A link to the FFT question is available on our website and the use of text messages is being explored to send to a patient after a visit to hospital.

During the time that visiting has been restricted due to COVID-19, the PALS team have supported families and patients through 'messages to a loved one', virtual visits and helping relatives stay in touch with regular updates on the progress of their relative's condition. Feedback from families has been very positive.

A quarterly patient experience report provided assurance on lessons learnt and changes in practice as a result of patient feedback. The PALS team have been relocated close to the Green Entrance and a free short-stay car parking space provided for visitors to PALS.

The Patient and Public Engagement Strategy 2019/2022 was shared with and shaped by patients and the general public. Three overarching priorities for patient engagement were identified as communication, working together and outstanding care. Progress against these priorities is presented in a bi-annual report.

5.0 Effective

The CQC rated the Trust as 'good' for effective in 2015 and 2018. A bi-annual national clinical audit report was presented to the Clinical Governance Committee which showed overall good patient outcomes with actions plans in place where standards were not met. An annual NICE guidance report also showed a high level of compliance with actions in place and escalation where needed. Our progress of our response to national enquiries and reports provided assurance that lessons are learnt and practice improved.

In 2020/21, the Trust recruited 2222 patients into 33 clinical research trials approved by the National Institute for Health Research. Of these, 1914 participants were recruited into 9 COVID-19 studies, including RECOVERY and REMAP-CAP. These interventional studies offered participants additional treatments. Findings from RECOVERY and REMAP-CAP have informed standard clinical care for COVID patients. This demonstrates our commitment to improving the quality of care we offer and to making a contribution to wider health improvement.

Microguide a web based tool, which contains all clinical and non-clinical policies and guidelines has been embedded in practice. Metrics demonstrate a high level of use. Progress of updating policies is overseen by the Corporate Records Committee.

The Trust took part in a GIRFT thrombosis survey between October 2019 and March 20, which examined the provision of thrombo-prophylaxis. The study confirmed the Trust benchmarked well against other Trusts with VTE prophylaxis. An improvement action centred on written information for patients receiving VTE prevention; written information is routinely given to patients having planned procedures but further work is required for emergency admissions. Patient information leaflets were updated and are available on Microguide.

In October 20, a GIRFT virtual deep dive visit took place in the Gastroenterology service and the recommendations were considered alongside the existing Gastroenterology Improvement Plan. Progress of the improvement plan was reported by the GI unit clinical lead to the Clinical Governance Committee in January 2021.

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A GIRFT regional deep dive of the South 6 Pathology network took place in December 20. The observation report of all Trusts in the network stated in the good practice section that Salisbury had done incredible work to get their potassium rejection rate in ED down to one of the lowest levels nationally; and monitored turnaround times from ED and primary care on a monthly basis. Proactive blood sciences and laboratory medicine that helped them hit 90%.

6.0 Responsive

As part of the NHS response to COVID-19, NHS England asked Trusts to postpone all non-urgent planned operations from 15 April 2020 for at least 3 months. Emergency surgery, cancer surgery and clinically urgent care continued unaffected. Each patient on our waiting list was assessed against the Royal College of Surgeons surgical prioritisation criteria to decide on their clinical priority for surgery or offered an alternative option if one was available. Patients with the highest priority were offered surgery first. A process of continuous re-assessment was in place to review whether any patient needed to be re-categorised. All new patients listed for surgery were assessed in the same way and allocated a clinical priority when added to the waiting list. The waiting list is monitored on a weekly basis and patients are listed for surgery according to the highest priority rather than the longest waiting time.

NHS England expected Trusts to have re-established services by the end of September 2020 to at least 80% of last year's activity for patients admitted for planned surgery, outpatients and day case procedures. Day case activity increased up to December 2020. However, January 2021 was a particularly challenging month in relation to the number of patients in hospital with COVID-19 and the response to, and effects of this, impacted on both theatre capacity and activity. Day case activity in March 2021 increased to 1674 cases compared to 1162 cases in February 2021. This meant that the activity was 265 cases below our Phase 3 trajectory. Planned surgical activity was also significantly impacted by the COVID-19 challenges. The number of cases in March 2021 increased to 174 cases compared with our Phase 3 trajectory of 346 cases, resulting in an overall shortfall of 172 cases against our plan.

Diagnostic waiting times reached the 90% target of 19/20 activity by the end of September 20 and although was impacted by the second wave of the COVID pandemic achieved 92.8% performance against a 99% target by March 2021.

Referral to treatment time performance against the 18 week standard of 92% decreased to 67.6% in February 2021 but was better than the England average of 64.5% and was similar to the other 2 acute Trusts in Wiltshire. Referral to treatment time performance against the 18 week standard of 92% in March 2021 remained just above the national average of 64.4% in March 2021.

The size of the total waiting list grew at all three acute Trusts, along with the number of patients waiting over 52 weeks for elective treatment. The proportion of patients waiting over 52 weeks at this Trust was 5.8% (1142 patients) compared to 6.3% (1634 patients) at RUH, Bath and 7.8% (1949 patients) at GWH, Swindon at the end of March 2021.A BSW ICS elective waiting list working group is in place with representatives from each of the 3 hospitals. The aim is to increase elective activity by working together to use the resources available and improve equity for patients on waiting lists across the system.

The Trust sustained performance at 90% compared to a target of 95% in patients admitted or discharged within 4 hours of arrival in the Emergency Department.

Cancer services performed close to the standard (93%) for the 2 week wait until October 2020 when the second wave of the COVID-19 pandemic occurred. The reduction in the number of patients seen between November 2020 to January 2021 was due to the need for face to face appointments predominantly associated with the breast one stop clinic mitigated by an additional one stop breast clinic expected to reduce waiting times by April 2021. The Trust achieved 83.6% in the 62 day standard compared to an 85% target in 20/21 as cancer treatments continue to be prioritised.

We increased the use of 'virtual' or digitally-enabled clinics, including telephone clinics, virtual review clinics and video call clinics using 'Attend Anywhere' during the pandemic with 34.8% of outpatient contacts by virtual appointments. 99% of patients said they would be seen by video appointment again and 78% said the consultation was the same or better than a face to face appointment.

The main objective in 2021/22 is recovery of our services to pre-COVID levels.

7.0 Well-led

During the COVID-19 pandemic, work has continued to review and progress the Trust strategy and corporate objectives. The Trust has engaged with KPMG to support it with a quality improvement approach in the development of the strategy and this remains work in progress.

As the second wave of the COVID-19 pandemic reduced significantly by March 2021, the focus is now on recovery of services to pre-COVID levels. It is the Board's plan to undertake a self-assessment in October or November 2021 against the well-led framework, re-fresh the improvement plan and then commission an external well-led review in May 2022.

8.0 Quality improvement

The Trust progressed the 'Strategy for Improvement' and Quality Improvement implementation plan approved at Trust Board in May 2019. The COVID pandemic impacted on the delivery of the strategy due to operational pressures on front line staff but despite this and where it was possible, progress was made.

Achievements:

- The Trust trained 76 staff as QI coaches, with training provided by NHS Elect. These coaches continue to be supported through regular network meetings.
- The Trust launched the first Dragons Den in September 2020; over 10 applications were received across all Divisions, with the overall winner being the Spinal Therapy service for their application to extend the Spinal Centre gym opening hours. The Dragons were so impressed with the standard of ideas, that the other 5 successful shortlisted candidates were supported with their projects.
- A Head of Quality Improvement was appointed in July 2020 to implement and develop the Quality Improvement strategy.
- A noticeable increase in the number of QI projects being scoped and worked on across Divisions by March 21.
- A QI Twitter account was launched (@QI_Salisbury), with 226 followers and itself following 48 Twitter accounts. Monthly meetings established with the Comms team to agree on messages and approaches to disseminate information to colleagues in place.
- Continued to provide training in QI to Trust colleagues in clinical and non-clinical areas.
- Continued to align QI coaches and other QI enthusiasts to opportunities across Divisions to develop and extend their QI knowledge and experience to colleagues.
- A series of #nogoingback events were undertaken throughout the year to share and celebrate quality initiatives that staff introduced to respond to COVID and which they did not want to stop.

Key areas of priorities for 21/22 are to:

1. Continue to implement the 2019 'Strategy for Improvement' plan
2. Introduce the KPMG Operational Excellence programme of work, co-designed with colleagues and ensure the existing Strategy for Improvement and Best Place To Work priorities are aligned.
3. Continue to develop and support QI coaches and QI enthusiasts in the Trust
4. Continue to share and celebrate QI stories to encourage a culture of continuous improvement in the Trust.
5. Run a second Dragons Den event in late autumn.

9.0 Quality account

The quality account provides information on the quality of services the Trust provides for patients and the public. The key message in the quality account is that quality is our number one priority.

This year, our quality priorities have been dominated by the need to reset our services in the light of the COVID-19 pandemic. Initially, this showed a positive picture of recovery up until the second wave when there was a significant increase in the number of patients admitted with COVID-19 in December 2020 and January 2021 and a high level of staff absence.

The COVID-19 pandemic has exposed health inequalities but our local response has shown our partnership working at its best to protect the most vulnerable in our population. We are proud of the good progress made in the implementation of the national learning disability and autism standards. Positive improvements have been seen in the daily consultant review at a weekend and in the redesigned Maternity Day Assessment triage and assessment pathways.

Quality priorities in 2021/22 are to:

- Sustain the recovery from COVID-19 through effective partnership working and improve the quality and experience of care for patients and staff.
- Improve the health and wellbeing of our staff in the recovery from COVID-19.
- Continue to improve patient safety and reduce avoidable harm based on our known risks.
- Provide ward to board assurance on fundamental standards of patient care at ward and department level.
- Strengthen our partnerships with other healthcare organisations to improve the health of our local population.

Progress of the priorities will be monitored via a mid-year report and an annual report to the Clinical Governance Committee

10.0 Key issues escalated from the Clinical Governance Committee to the Board in 2020/21

- COVID-19 pandemic – the Board were appraised of the significant changes made to the hospital, services and workforce in response to the pandemic, along with the associated clinical risks and mitigation. Assurance of a robust process in the review of patients on the waiting list. Recovery of services to pre-COVID levels is a key objective in 21/22. 85% of staff vaccinated.
- Gastroenterology service review – the formation of a GI unit as recommended by the Royal College of Physicians invited review was in place by May 2020 led by a Consultant Colorectal surgeon. The Committee was assured that the action plan had progressed either at service level, managed in an alternative way or at Trust level. The lead was confident that by the end of June 21 actions will be completed and will continue to be monitored.
- New clinical strategy – will be called ‘SFT shaping our future together’ and focus on aligned place based offers, bespoke but aligned tertiary relationships and BSW centres of excellence. A period of consultation with clinical teams has started on how services should adapt and their vision for the next 5 – 10 years.
- Cancer pathways – some progress in improving the electronic clinic outcome forms and a flag added to Lorenzo of cancer follow ups. Issues remain in response times to reviewing results in a timely manner, additional support was put in place to mitigate the risk. Missed/delayed cancer diagnosis – 5 cases in 20/21, 2 in 19/20 compared to 10 in 2018/19.
- Positive assurance - cancer patient survey – the Trust scored 8.7 out of 10 which put the Trust in the top quartile in the UK. Key areas for improvement – personalised care programme, workforce training. and patient and public involvement.
- Pressure ulcer performance remained under scrutiny and the Committee were assured by the quality improvement approach taken to reduce the numbers and severity of pressure ulcers, noting that category 3 and 4 ulcers reduced from 21 in 2019/20 to 10 in 2020/21.

- End of life care report - escalated workforce changes and funding of the Hospice at Home service. The National Audit of End of Life care 2020 where the Trust scored better than the national average in 2 out of 6 domains. Areas showing improvement were communication with the dying patient, individualised care plans, anticipatory prescribing, mouth care, nutrition and hydration. Actions centred on training, and engaging with loved ones before and after death
- Learning from deaths provided good assurance that learning had achieved improvement in hip fracture care. A review of patients who died from COVID in the first wave outlined the changes made to reduce the risk of nosocomial transmission. Duty of candour was applied in those cases where there was probable or definite hospital onset. Medical Examiners were introduced in August 2020 which improved support for bereaved relatives during the pandemic from the HPCT and EOLC team.
- Positive assurance - noted the good practice of the Freedom to Speak Up Guardian and the cultural improvement achieved.
- Medicines safety bi-annual report highlighted that oxygen supplies and medicines stocks were well managed and no shortages were reported during the pandemic, a 7 day pharmacy AMU service started in January 2021 along with the roll out of electronic prescribing. A new Lloyds pharmacy outpatient service opened in April 21.
- Maternity Services – limited assurance that governance arrangements were effective in relation to the length of time actions from serious incident inquiries had remained open in July 20. As an outcome, an external review was commissioned to explore the culture and performance of the service. This resulted in a period of intensive support and external support. An unannounced Care Quality Commission inspection on 31 March 21 resulted in a warning notice requiring significant improvement in the leadership and culture, governance and risk management by 4 August 2021.
- National learning disability standards - noted the good practice in identifying patients, providing continuity of care and the 'Treat me well campaign'. A work plan is in place to increase the use of Lorenzo alerts, patient engagement in service development, a learning disability strategy and an acute liaison nurse in the Trust.
- NHS 7 day services assurance framework showed all 4 priority standards for patients admitted as an emergency were met.
- Mental Health Strategy Committee – highlighted the numbers of patients seen and the major challenge for the CAMHS service in their staffing and the lack of beds available in the community which had a significant impact on the paediatric ward.
- NatSIPP/LocSIPP workstreams are behind where they should be and the Divisions were tasked to give some assurance about progress at their performance reviews.
- Trust falls prevention improvement plan – concern was raised about the lack of traction with some of the actions and the need for a falls prevention specialist role.
- Transformation programme and QI update – many of the staff were redeployed during COVID and as a result there was a slowdown in some QI projects. Priorities focused on 1) outpatient video consultations 2) criteria led discharge 3) roll out of electronic prescribing 4) joint working on QI with the BSW Acute Hospital Alliance.
- Human Tissue Authority – compliance with the stem cell licence and post mortem examination licence.
- Patient experience report evidenced good performance although acknowledgement of changing expectations from patients and their families in response to the COVID pandemic.

11.0 Areas for improvement 2021/22

High priority:

- Progress the recovery work associated with the COVID-19 pandemic to reduce risks of delays in diagnosis or treatment in clinical pathways.
- Comply with the CQC warning notice on the Maternity Service and significantly improve leadership and culture, governance and risk management by 4 August 21.

- Implement the 'must do' actions identified by the CQC for the Spinal Treatment Centre.
- Continue to progress improvements in the Gastroenterology service and plan for service sustainability and report progress to the Clinical Governance Committee
- Continue to make improvements in the cancer pathways to eliminate delayed or missed cancer diagnoses and track actions through to completion.
- Improve compliance with the lessons learnt from serious incident inquiries to provide assurance that they are acted upon and high harm incidents reduced.
- Reduce the number of high harm falls by 30% through the refreshed Falls Prevention Improvement plan.
- Reduce the number of category 2 by 20% and 3 and 4 pressure ulcers to zero acquired in hospital using a QI approach to improvement.
- Improve the escalation response of adults, children and maternity cases when a patient triggers a clinical observation early warning score.
- Work alongside the Divisional management teams to embed governance processes, learning and improvement.
- Continue with the Strategy for Improvement to increase the spread of an improvement culture and ensure sustainable change.

Priority areas:

- Review and amend the reporting structure to the Clinical Management Board to ensure triangulation of patient safety, clinical effectiveness and patient experience.
- Prepare for the new national Patient Safety Strategy and appoint a Patient Safety Specialist.
- Ensure all wards take part in a ward performance review process with the Chief Nurse and report progress via a ward accreditation dashboard.

11.0 Sharing the learning

11.1 Clinical Governance half days

There are 6 clinical governance half days a year of protected time to allow teams to meet together to discuss, review and improve quality as well as the opportunity to attend 4 core sessions which cover patient safety, effectiveness and patient experience. Core sessions are well evaluated by attendees; on average 94% of participants rate them as good or excellent.

Date	Topic
23/4/20	Clinical effectiveness – The role of the Medical Examiner. Postponed due to the peak of the 1st wave of the COVID-19 pandemic.
10/6/20	Clinical effectiveness – The role of the Medical Examiner. Rescheduled from April 20.
14/7/20	Patient Safety – 1) COVID presentation, 2) Pressure ulcer improvement plan, 3) Deteriorating patients 4) Preventing cerebral palsy in pre-term babies.
9/9/20	No core session
19/11/20	Healthcare Improvement Programme presentations (doctors in training)
10/2/21	No core session

11.2 Trust learning publications

- Mortality matters
- Serious incident inquiries anonymised summaries, learning and improvements.
- Complaints/clinical risk newsletters.
- Planned – a patient feedback learning newsletter
- Quality improvement initiatives via the Comms team

12.0 Summary

Overall, the Integrated Governance Framework and Accountability Framework have ensured that the clinical governance structure and function is effective in identifying key risks to the quality of care. These risks have been escalated to the Board to ensure they are sighted on them and involved in the mitigation to the strategic objectives of the organisation.

Claire Gorzanski
Head of Clinical Effectiveness
13 May 2021

Report to:	Trust Board (Public)	**Agenda item:**	5.4
Date of Meeting:	09 September 2021		

Report Title:	Research Performance Report 2020/21			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			
Prepared by:	Stef Scott, Head of Research			
Executive Sponsor (presenting):	Peter Collins, Medical Director			
Appendices (list if applicable):				

Recommendation:
Recommendation – the report is presented for information. **Assurance** – The national Key Performance Indicators (KPIs) for research are currently suspended. The Trust will receive flat funding for 2021/22. **Risks –** N/A

Executive Summary:
• The national research Key Performance Indicators (KPI) were suspended during 2020/21. • The Trust recruited 1914 participants into 9 national COVID-19 studies, The results from the COVID-19 studies have changed routine clinical treatment of patients hospitalised with COVID-19 around the world. • Trust staff also supported the clinical trials at the COVID-19 Vaccine Hubs. The Janssen vaccine is licenced for use in the UK and the Novavax vaccine soon to undergo regulatory review. • The majority of the Trust's research portfolio was suspended due to COVID-19. The Trust recruited 308 patients into 24 non-COVID-19 studies, giving a total of 2222 recruits. • The Trust secured funding for 3 research grants worth a total of £705k. A 4th project is under consideration from research funders. • The Trust will receive flat funding for 2021/22. • A report on the Trust's research activity and research outputs for 2020/21 is appended for the Committee's information.

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

1. Purpose

1.1. The research reports provide the Committee with assurance regarding Trust compliance with the Trust Key Performance Indicators for research.

2. Background

2.1. The NHS is encouraged to support the National Institute of Health Research (NIHR) Clinical Research Network (CRN) research. The Trust is part of the CRN: Wessex network, and receives infrastructure funding from the network to support research staff and NIHR research activity. The Trust is performance managed by both the NIHR and CRN: Wessex against a number of KPIs. Performance against the national KPIs normally informs the Trust research funding allocation. The KPIs were suspended during 2020/21.

2.2. CRN:Wessex established 2 vaccine Hubs in Southampton & Bournemouth to run vaccine clinical trials. The Hubs were staffed from Trust research depts., including Salisbury.

3. Summary

3.1. The attached report provides an update on Trust research activity and outputs during 2020/21.

4. Recommendations

4.1. The report is presented for information.

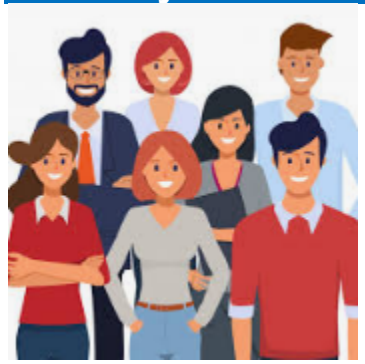
Dr Stef Scott,
Head of Research

NHS
Salisbury
NHS Foundation Trust

Research Performance Report 2020/21

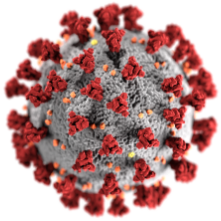
Contents

Summary



More people than ever before took part in Trust research

The Trust performed well compared to other Trusts of a similar size



Local involvement in 9 COVID-19 studies

Local COVID-19 research:
Local Involvement
↓
global impact

12% of patients with COVID-19 were recruited into interventional trials

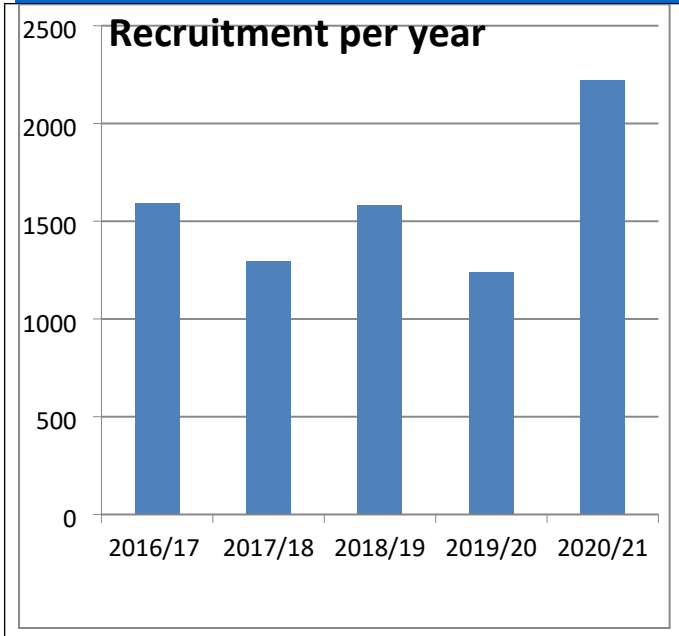
Staff helped develop 2 COVID-19 vaccines

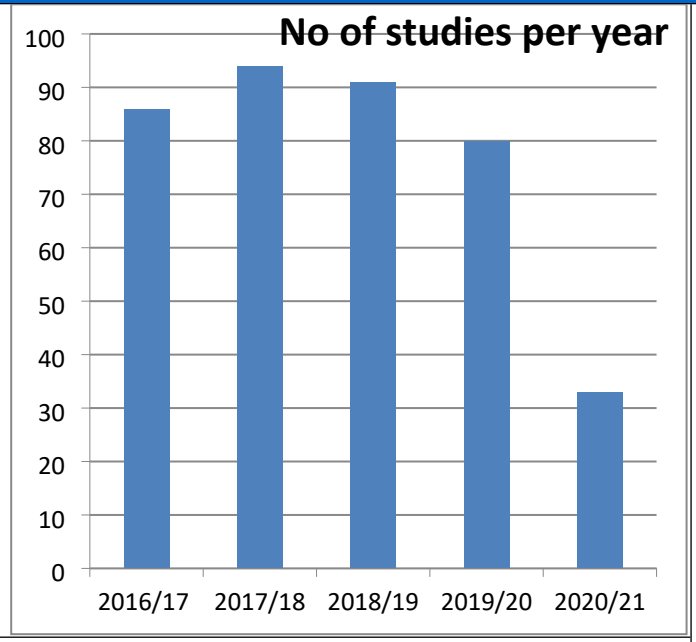
£705,32 research funding secured for 3 new research grants

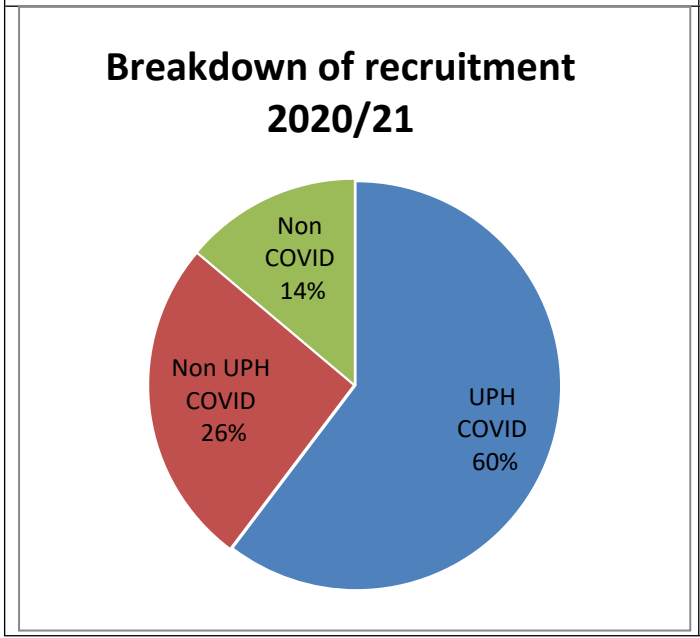
2 CRN:Wessex Research Awards for outstanding individual and team contribution to COVID-19 research awarded

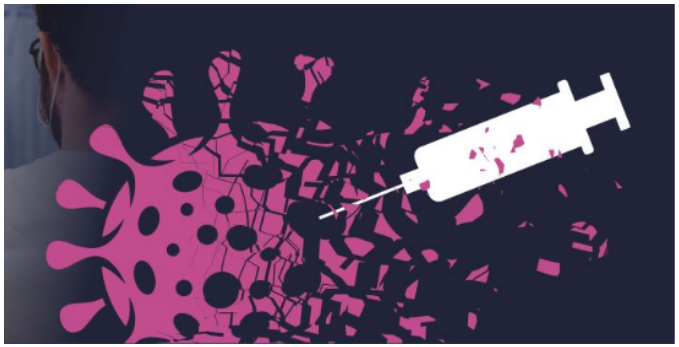
% of the pre-COVID-19 research portfolio restarted

Trust recruitment into COVID-19 & non-COVID-19 trials









Wessex Vaccine Hub

- Workforce from across Wessex NHS, including SFT
- Novavax
- Janssen

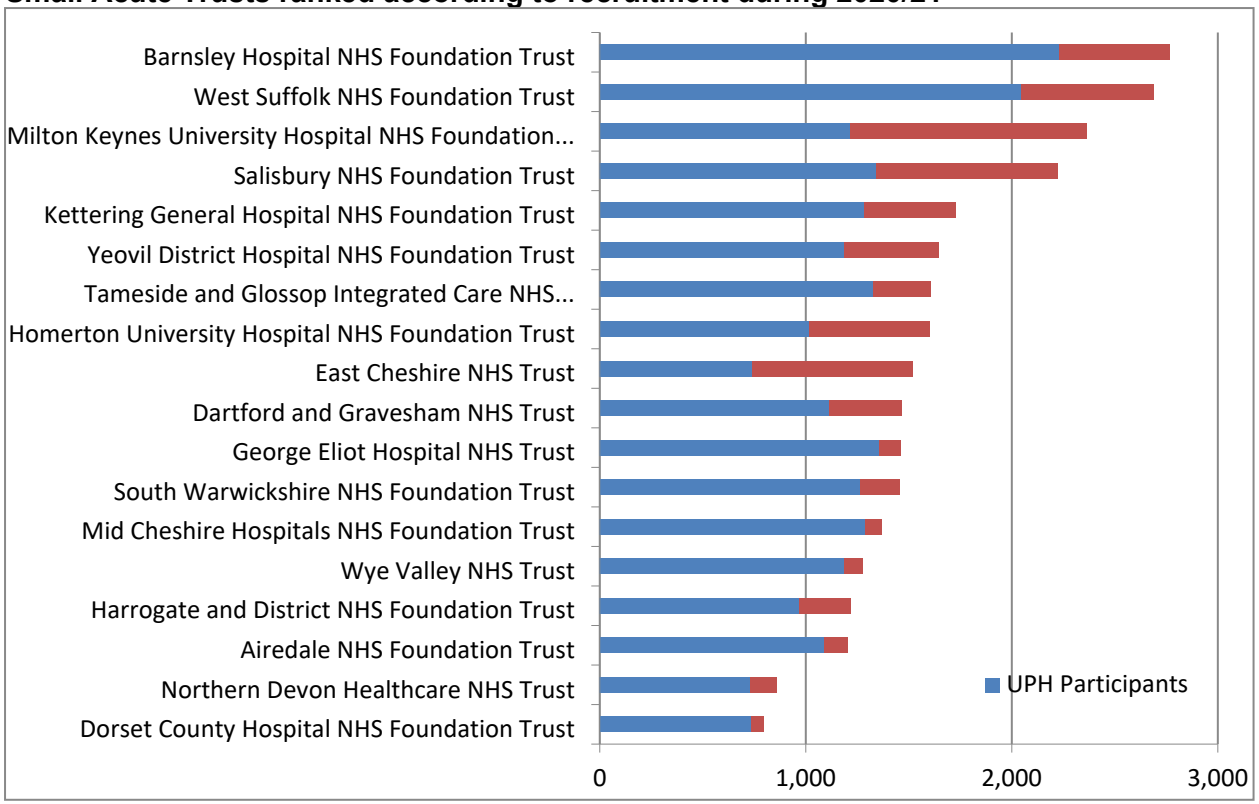
The Trust recruited 2222 study participants into NIHR portfolio research projects which more than any other year previously. 33 studies recruited study participants, which is considerably lower than previous years, and demonstrates what may be achieved when the research effort is focused on a small number of high recruiting studies.
Unsurprisingly, the majority (86%) of participants took part in Urgent Public health (UPH) COVID-19 studies. At the beginning of the pandemic, the research dept was quickly re-organised to deliver 8 national UPH studies locally. This included 2 platform treatment trials (RECOVERY & REMAP-CAP), diagnostic studies (SIREN & FALCON), national data collection studies (ISARIC, PAN COVID, CLARITY) and the genetics study GENOMICC. Overall, 12% of the COVID-19 admissions into the Trust were recruited into an interventional trial. Our local involvement in these studies has helped save lives locally, and has had global impact (as described later in this report).

CRN:Wessex mobilised the existing CRN funded NHS workforce to support vaccine trials in 2 Hubs. Trust staff worked both at the Hub and remotely to support the development of the Novavax and Janssen (J&J) vaccines. The Novavax vaccine will be submitted for UK regulatory approval later in the year. The Janssen vaccine is approved for use in the UK.

Ordinarily CRN:Wessex use a funding formulae and performance against targets to allocate funds to NHS Organisations. In the absence of targets for 2020/21, the Trust will receive flat funding from the network of £643,101.

Benchmarking – Small Acute Trusts

Small Acute Trusts ranked according to recruitment during 2020/21



High recruiting studies in SAT with greater recruitment than the Trust:
Barnsley – recruited 1635 into ISARIC
West Suffolk – recruited 600 into SIREN
Milton Keynes – recruited 452 into the Newborn cross-sectional study (NCSS)

The Trust performed well during 2020/21 when compared to other SATs, ranking 4th overall.

The Trust could have recruited more patients with COVID-19 during the second wave if the research dept had been fully staffed. Redeployment, staff sickness and staff shielding meant that the Trust lacked the capacity to be able to approach every patient with COVID-19.

Furthermore, the SATs that recruited more participants in 2020/21 that the Trust each has a unique situation with a study:

- Barnsley Hospital NHS FT recruited the highest number of participants, particularly into UPH studies. Barnsley had a much higher incidence of COVID-19 admissions that the Trust, recruiting 1635 into the ISARIC COVID-19 data collection study alone.
- West Suffolk chose the recruit 600 staff members into the SIREN study, compared to 128 in the Trust. The Trust stopped recruitment at 128 because we do not have the capacity or the room space to run daily follow up SIREN clinics for a year.
- Milton Keynes continues to recruit well into the NCSS study, which only recruits in the MK area.

The Trust was the second highest recruiting SAT into non-UPH studies, thanks to high recruitment into a Psychological impact of COVID-19 survey, and the 'molecular pathogenesis of atypical chronic myeloproliferative neoplasms and related diseases' study. Milton Keynes were the top non-UPH recruiter, thanks to the NCSS study.

Global Impact of local involvement in COVID-19 Research

How are we doing? More than 2200 participants took part in 9 C19 research studies in the Trust in 2020/21. Results from this research are saving lives globally.	**Vaccine development** Novavax & Janessen vaccines developed in collaboration with the Wessex Vaccine Hub and are undergoing UK regulatory approval. Janessen vaccine used in the USA.
UK Public Health response to C19 The results from C19 research provided critical data to inform the UK's public health response to COVID-19, and is used for early indications of trends, featuring regularly in Downing Street briefings	**Pfizer vaccine is effective** The vaccine provides high levels of protection against infection and symptomatic disease from the first dose
Dexamethasone Helps save lives of C19 patients with severe respiratory complications. Now part of NHS standard care for patients hospitalized with C19. Estimated to have saved over a million lives globally.	**Genetic link identified** 5 genes identified that make some people more susceptible to severe C19 symptoms. Drugs that targets these genes are to be included in C19 treatment trials
Tocilzumab & Sarilumab Reduces deaths of C19 patients receiving organ support. Now part of NHS standard care for our sickest patients with C19.	**C19 resistance** Most people who have had C19 are protected from catching it again for at least 5 months.
Treatments that do not work Hydroxychloroquine, Lopinavir-Ritinavir, Azithromycin, convalescent plasma do not benefit hospitalised C19 patients and are not recommended for use in the NHS	**C19 & pregnancy** There is an increased risk of preterm delivery & maternal mortality if C19 is contracted during pregnancy. Enhanced precautions are now being taken.
Clinical tools developed To help work out which adults with C19 are likely to deteriorate and who has a high risk of dying	**C19 & inflammatory bowel disease** Delayed second dose of the SARS-CoV-2 vaccine should be avoided in IBD patients treated with infliximab

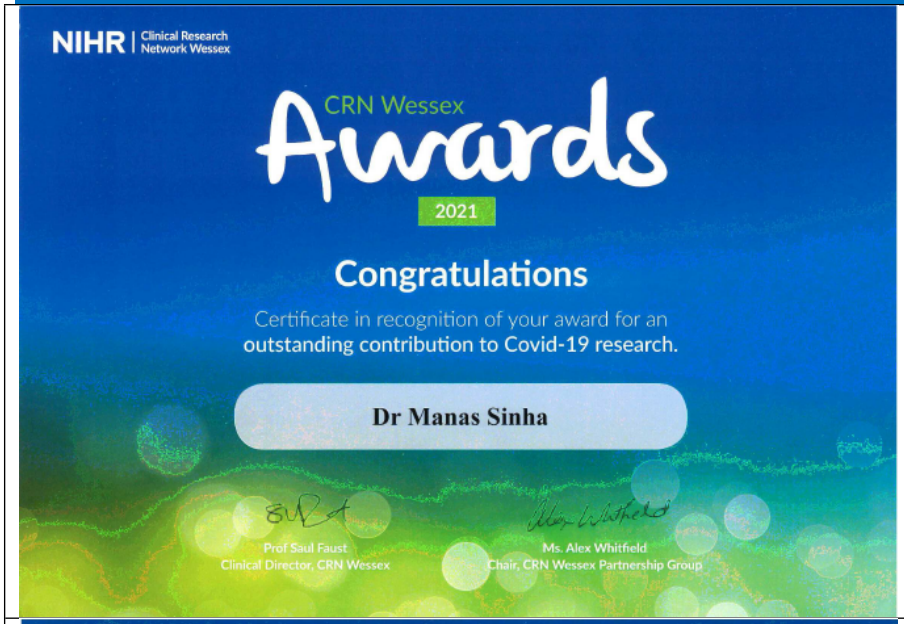
A full list of publications may be found at Appendix B

Non-COVID-19 Research Results

Antibiotics and cystic fibrosis Intravenous antibiotics should not be used to treat P aeruginosa in patients with cystic fibrosis	**Treatment for psoriasis** Secukinmab is more effective than Usekinumab when treating psoriasis
Treatment for GI Bleed Tranexamic acid should not be used in G bleeding patients.	**Genome sequencing for rare diseases** Shown to improve diagnosis and treatment for patients with rare diseases.
Wellbeing & emergency physicians Evidence-based strategies to improve well-being such as proportional out-of-hours working and improved access to annual and study leave should be carefully considered and implemented where feasible to improve Need For Recovery.	**Genetic link identified** 4 genes identified that are linked to immunodeficiency.
Configuration of Early Pregnancy Assessment Unis Early Pregnancy Assessment Units run by senior or specialist nurses and supported by sonographers and consultants may represent the optimal early pregnancy assessment unit configuration.	**Compression stockings not needed after surgery** Patients taking heparin after surgery have similar rates of blood clots to patients just taking heparin.

A full list of publications may be found at Appendix B

CRN:Wessex Research Awards



CRN:Wessex have a regular awards ceremony to celebrate outstanding research in the region. This year's CRN Wessex awards ceremony was a virtual event, via Zoom. Due to the pandemic, awards were presented to individuals and teams who had made an outstanding contribution to COVID-19 research throughout the year. Each NHS organisation was asked for nominations, and was also asked to decide who deserved to win within your organisation. The nominees from the Trust were as follows:

Outstanding individual:

- Manas Sinha
- Phil Donnison

Outstanding team:

- Radnor (ITU) team
- RCU
- RemapCAP and Recovery study research teams.

The winners were Dr Manas Sinha (individual award) and Radnor (team award). The winners were presented with their awards by Stacey Hunter. This was captured on video, and forms part of the CRN:Wessex awards ceremony, which may be viewed here:
CRN Wessex Awards 2021 - Zoom

NIHR Portfolio Restart (non COVID-19 studies).

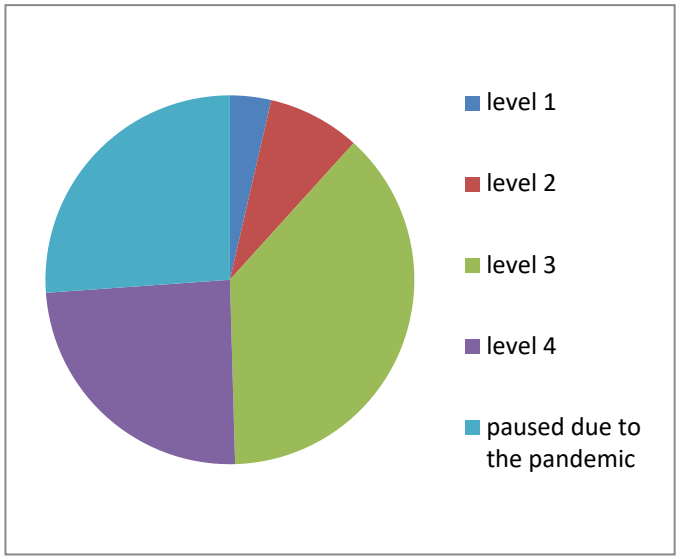
NIHR Priorities for restart:

- Level 1: COVID-19 Urgent Public Health vaccine, prophylactic studies and platform therapeutics trials
- Level 2: Other COVID-19 Urgent Public Health studies
- Level 3: Studies where the research protocol includes an urgent treatment or intervention without which patients could come to harm
- Level 4: All other studies

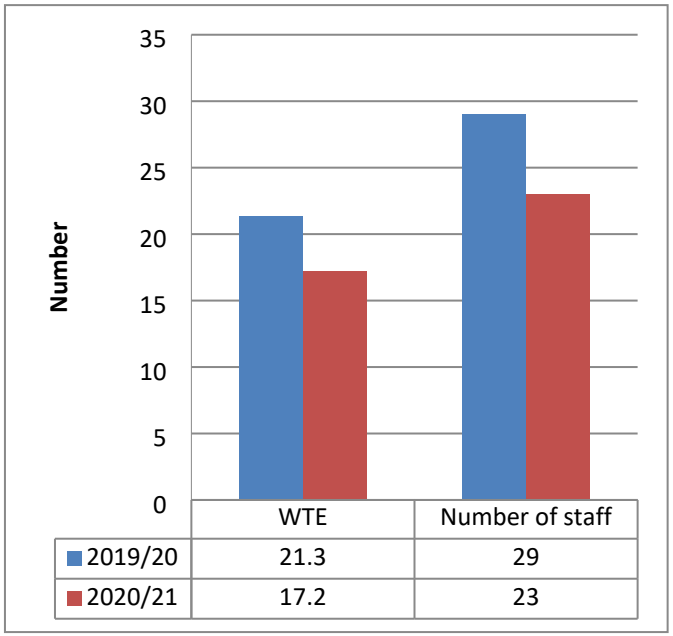
NIHR High level objectives for 2021/22

- 80% of new commercial studies recruiting to time and target (RTT)
- 80% of new commercial studies in the managed recovery process RTT
- 99% of NHS Trusts recruiting into NIHR portfolio studies
- 70% of NHS Trusts recruiting into NIHR portfolio commercial studies
- 12,000 study participants responding to the Participant Experience Survey (PES)

Trust restart as of 31 March



Research Dept Staffing levels



	WTE	Number of staff
2019/20	21.3	29
2020/21	17.2	23

The majority of the Trust research portfolio was suspended during the pandemic, alongside suspension of the clinical services and the national focus on running COVID-19 UPH therapeutic trials. Suspension of these studies meant that there was little/no income from these funding sources – a loss of approx.. £100 -150k income for 2020/21. When research staff came to the end of contracts, or left, funding was not available to replace them. The staffing levels in the research dept at the end of March 2021 was therefore 20% lower than March 2020. This has an impact on the ability to restart.

The NIHR priorities for restart and NIHR high level objectives are shown on the left. The portfolio was re-opened in accordance with the NIHR priorities, whilst also maximising Trust recruitment and performance against the other NIHR objectives (which influences future funding from CRN:Wessex). The Trust has restarted 75% of the portfolio, including the majority of the level 3 interventional studies, some of which are game changers for the patients. Most of the level 4 studies that are open are easy, high recruiting studies, or require very little/no input from the research dept. Interventional studies that are currently paused will be re-opened during 2021/22 if and when capacity becomes available.

The Trust hosts both commercial and non-commercial NIHR portfolio studies, and actively monitors and manages RTT. The Trust will offer participants the opportunity to complete a PES when available.

Research Grants Secured

Grants secured & recruitment starting in 2021/22:

ELABS

Early Laser for Burn Scars - A prospective randomised, controlled trial to study the effectiveness of the treatment of hypertrophic burn scars with Pulsed Dye Laser and standard care compared to standard care alone

PI: Dr Mark Brewin
Funding: NIHR RfPB
£348,209 over 36 months
Design: interventional

HIIT

A Feasibility Study of High Intensity Interval Training to Reduce Cardio-metabolic Disease Risks in Individuals with Acute Spinal Cord Injury

PI: Prof James Bilzon- Uni Bath
Funding: NIHR RfPB
£250,000 over 27 months
Design: interventional

BOWMAN

A Randomised, Sham-Controlled, Proof of Principle Study of Abdominal Functional Electrical Stimulation for Bowel Management in Spinal Cord Injury

PI: Dr Tamsyn Street
Funding: Inspire Foundation
£107,111 over 36 months
Design: interventional

Grants applications submitted:

STEPS II

The Efficacy of Peroneal Nerve Functional Electrical Stimulation for the Reduction of Bradykinesia in Parkinson's Disease: An Assessor Blinded Randomised Controlled Trial

PI: Prof Paul Taylor
Funding: NIHR EME
£1,188,545 over 44 months
Design: interventional

3 research projects secured £705,320 external grant funding and are in the process of being set up. The 3 grants are predicted to recruit 60 participants between them in 2021/22.
A fourth grant is currently under consideration by the NIHR EME funding scheme.

Research Capacity Funding (RCF) is awarded to research active NHS Organisations that recruit >500 participants (£20k) OR received NIHR income in the previous calendar year (0.28 of income), whichever is greater. The Trust received £20k RCF funding for both 2020/21 and 2021/22. The grant income secured should provide a RCF income of £50k for 2022/23 and £64k for 2023/24. This is estimated to rise to £117k in 2024/25 if STEPS II grant application is successful. This funding will be used to increase the research capacity in the Trust.

Strategic Plan for 2021/22

No going back

This year has delivered unprecedented challenges for us all. The NHS has led the world in COVID-19 research, with all NHS organisations contributing to the global effort. This has completely changed the way the research dept. works. Small teams supporting specific clinical teams has been replaced by the whole dept. working as 1 large team to support, at the peak of the pandemic, just 2 innovative platform trials that provided our sickest patients with the latest C19 treatments. Such an approach strengthened team working, communication, handovers, and demonstrated that it is possible to recruit 100 patients into a complex interventional study in a month with a reduced funding and workforce. We will work hard, as a team, to continue with what has worked well during the pandemic, and to build and strengthen these new ways of working.

We will also work to incorporate the NHS Health Research Authority Research Strategy 'the Future of UK Clinical Research Delivery' into the Trust wide and research specific strategies. '*The public and staff have never been so aware of clinical research, and now is the time to embed the idea that research…..is an essential and rewarding part of effective patient care*'. Research in the Trust can be seen as an optional extra, reserved predominantly for staff in the research dept. The research dept has grown the Trust research portfolio considerably over the last few years, but is now at capacity. If the Trust research portfolio is to grow further, then clinical teams need to engage with research differently. Some clinical teams already embed research into routine day to day clinical practice, working in partnership with the research team, and this is a model that we will work to roll out across the research active clinical depts. in the Trust. Such an approach will be supported by the national plans to properly embed research into CQC inspections and revalidation.

We will continue to develop our non-clinical research delivery roles, and support healthcare professionals to develop research skills relevant to their clinical roles (e.g. associate PI scheme).

Dedicated space for research clinics is also a priority.

A Trust wide strategy will be developed to expand on these ideas further.

Appendix A - Research recruitment 2020/21

Urgent Public Health (COVID-19) studies

Short Name	Managing Specialty	Design Type	Recruitment	Public Link
REMAP-CAP	Critical Care	Interventional	32	38197
GenOMICC	Critical Care	Observational	11	30540
CLARITY	Gastroenterology	Observational	51	46188
FALCON C-19	Infection	Observational	65	45932
ISARIC	Infection	Observational	899	14152
SIREN	Infection	Observational	128	45906
PAN-COVID	Reproductive Health and Childbirth	Observational	44	45571
RECOVERY	Infection	Interventional	110	45388
		TOTAL	**1340**	

COVID-19 studies not UPH

Short Name	Managing Specialty	Design Type	Recruitment	Public Link
Psychological Impact of COVID-19	Mental Health	Observational	574	45621

Non COVID-19 studies

Short Name	Managing Specialty	Design Type	Recruitment	Public Link
CASAP	Anaesthesia, Perioperative Medicine and Pain Management	Observational	7	41168
Add-Aspirin	Cancer	Interventional	1	18067
FLAIR	Cancer	Interventional	1	16675
IMPRESS	Cancer	Interventional	2	17006
LCH-IV	Cancer	Both	1	19926
OPTIMA	Cancer	Interventional	6	12255
SERENADE	Cancer	Both	3	17059
TRIGGER	Cancer	Interventional	1	20576
CLEAR SYNERGY	Cardiovascular Disease	Both	2	37105
BADBIR	Dermatology	Observational	7	8090
CLEARA	Ear, Nose and Throat	Commercial, Observational	14	-
Molecular pathogenesis of chronic myeloproliferative neoplasms	Genetics	Observational	201	9615
UK Childhood ITP Registry	Haematology	Observational	3	14145
PrEP Impact	Infection	Observational	5	35405
CLIMB survey	Mental Health	Observational	28	44205
UNITS	Mental Health	Observational	1	42099
Neuro LTC	Neurological Disorders	Observational	1	35622
PINNACLE	Ophthalmology	Observational	1	41819
FUTURE	Reproductive Health and Childbirth	Both	1	36043
Big Baby	Reproductive Health and Childbirth	Both	3	36723
The Cleft Collective Cohort Studies	Reproductive Health and Childbirth	Observational	2	14362
OPTIMAS	Stroke	Interventional	2	40836
CIPHER	Surgery	Observational	12	35821
SOLARIO	Surgery	Interventional	3	40430
		TOTAL	**308**	

Appendix B – Research publications

COVID-19 trial publications:

study	summary	link
Clarity IBD	patients with inflammatory bowel disease treated with infliximab have attenuated serological responses to a single dose of a SARS-CoV-2 vaccine. Delayed second dosing should be avoided in patients treated with infliximab	https://gut.bmj.com/content/early/2021/04/25/gutjnl-2021-324789
ISARIC	Our 4C Deterioration model thus demonstrates unprecedented clinical utility and generalisability to predict clinical deterioration among adults hospitalised with COVID-19.	https://www.medrxiv.org/content/10.1101/2020.10.09.20209957v1
PAN COVID	Pregnancy and neonatal outcomes of COVID-19 – co-reporting of common outcomes from the PAN-COVID and AAP SONPM registry	https://www.medrxiv.org/content/10.1101/2021.01.06.21249325v1
Psychological Impact of COVID-19 survey	An evaluation of the mental health impact of SARS-CoV-2 on patients, general public and healthcare professionals: A systematic review and meta-analysis	https://www.sciencedirect.com/science/article/pii/S2589537021000869
RECOVERY	Dexamethasone improves survival rate in hospitalised COVID-19 patients with severe respiratory complications.	https://bit.ly/COVID-dexamethasone
RECOVERY	COVID-19 clinical trials: learning from exceptions in the research chaos	https://www.nature.com/articles/s41591-020-1077-z
RECOVERY	In patients admitted to hospital with COVID-19, lopinavir–ritonavir did not reduce 28-day mortality, duration of hospital stay, or risk of progressing to invasive mechanical ventilation or death	https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32013-4/fulltext
RECOVERY	Completion of clinical trials in light of COVID-19	https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30460-4/fulltext
RECOVERY	The trial has found no clinical benefit from the antibiotic azithromycin for hospitalised patients with severe COVID-19.	https://www.nihr.ac.uk/news/recovery-trial-shows-no-clinical-benefit-from-azithromycin-for-hospitalised-patients/26401
RECOVERY	Between July & Dec 20, dexamethasone is estimated to have saved 12,000 lives in the UK and 650,000 globally	https://www.nature.com/articles/s41467-021-21134-2#disqus_thread
RECOVERY	tocilizumab reduces the risk of death for hospitalised patients with severe COVID-19. the drug reduces the length of hospital admission, and the risk of patients requiring mechanical ventilation.	https://www.nihr.ac.uk/news/recovery-trial-shows-tocilizumab-reduces-deaths-in-patients-hospitalised-with-covid-19/26844
REMAP-CAP	In critically ill patients with COVID-19 receiving organ support in intensive care, treatment with the IL-6 receptor antagonists, tocilizumab and sarilumab, improved outcome, including survival.	https://www.medrxiv.org/content/10.1101/2021.01.07.21249390v1
SIREN	Pfizer-BioNTech vaccine provides high levels of protection against infection and symptomatic disease from the first dose. Data shows one dose reduces the risk of catching infection by more than 70%, rising to 85% after the second dose. This suggests the vaccine may also help to interrupt virus transmission, as you cannot spread the virus if you do not have infection.	https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3790399

Non- COVID-19 trial publications

study	specialty	summary	link
TORPEDO	children	Compared with oral therapy, intravenous antibiotics did not achieve sustained eradication of P aeruginosa in a greater proportion of patients with cystic fibrosis and was more expensive. These results do not support the use of intravenous antibiotics to eradicate P aeruginosa in cystic fibrosis.	Lancet Respir Med 2020; 8: 975–86
BADBIR	Dermatology	Randomized Trial Replication Using Observational Data for Comparative Effectiveness of Secukinumab and Ustekinumab in Psoriasis. secukinumab resulted in more patients achieving a PASI of 2 or lower after 12 months of therapy compared with ustekinumab in patients with psoriasis	https://jamanetwork.com/journals/jamadermatology/fullarticle/10.1001/jamadermatol.2020.4202?guestAccessKey=d3e5aa1d-3a73-4ae4-9c6d-1cc56753ab79&utm_source=twitter&utm_medium=social_jamaderm&utm_term=4270895183&utm_campaign=article_alert&linkId=106090065
Halt-it	ED	Tranexamic acid does not improve outcomes in GI bleeding patients but instead may increase side effects	https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30848-5/fulltext
TIRED	ED	Higher NFR scores were observed among emergency physicians than reported in any other profession or population to date. While out-of-hours working is unavoidable, the linear relationship observed suggests that any reduction may result in NFR improvement.	https://bmjopen.bmj.com/content/10/11/e041485
NIHR Bioresource	Genetics	The researchers looked at 886 patients with primary immunodeficiency, which affects the ability to fight infections caused by microbes. The analysis identified four new genetic associations linked with this condition	https://www.nature.com/articles/s41586-020-2265-1
NIHR Bioresource	Genetics	The study looked at the genetics of rare diseases. The research team found that ‘sequencing whole genomes for patients with rare diseases can improve their diagnosis and care’. The researchers ‘identified 95 genes associated with rare diseases in these tissues. For at least 79 of these diseases, variants in the genes were shown to definitively cause the disease.	https://www.nature.com/articles/s41586-020-2434-2
VESPA	Reproductive Health	There was no evidence of an association between consultant presence in Early Pregnancy Assessment Units and clinical outcomes measured as the proportion of women who were admitted as emergencies.	https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr08460/#/abstract
GAPS	Surgery	Low-dose low-molecular-weight heparin was non-inferior in reducing venous thromboembolism events in surgical patients at medium or high risk compared with use of graduated compression stockings in addition to heparin.	https://www.journalslibrary.nihr.ac.uk/hta/hta24690/#/abstract

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.1
Date of Meeting:	09 September 2021		

Report Title:	Board and Committee Effectiveness			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	N/A			
Prepared by:	Kylie Nye, Head of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Integrated Governance			
Appendices (list if applicable):	Appendix 1 - CGC Committee Effectiveness Report Appendix 2 – F&P Committee Effectiveness Report Appendix 3 – Audit Committee Effectiveness Report Appendix 4 – Charitable Funds Committee Effectiveness Report			

Recommendation:
For Trust Board to note the process and outcome for the annual review of Board and Committee effectiveness.

Executive Summary:
The NHS FT Code of Governance sets out the requirements that the Board of Directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors. The Trust Board Committees, as part of their annual Committee business cycle, undertake a self-assessment of their own effectiveness. These reviews have been completed over the last few months with the exception of People and Culture Committee and concluded that the Committees were meeting the requirements as set out in their terms of reference (appendices attached). People and Culture Committee will review their effectiveness in the September meeting. All Committee terms of reference have been reviewed and agreed at Trust Board in March 2021 as part of the revised Integrated Governance Framework. In relation to Board effectiveness, during 2020 the Board undertook an in-depth evaluation process, including a facilitated 360 review, Board member questionnaire, a self-assessment against the Good Governance Maturity Matrix and a review of Board papers. The Board was due to have an external review of the CQC Well-Led Framework in 2021. However, it was agreed to defer this to 2022 in April given the ongoing executive recruitment and continued focus of the recovery plans in relation to COVID-19.

As an external assessment has been deferred until next year it was agreed that the Trust Board would undertake an internal self-assessment against the Well-Led Framework and this process will take place throughout September 2021. The Corporate Governance team has recently procured new software, Evalu8, which is designed to assess the effectiveness of the Board, to identify key issues, concerns and developmental needs and this is the key tool that will be used for this year's process. The outcome of this process will come back to Trust Board in November 2021.

In addition to this, each Executive and non-executive director completes an annual appraisal which focuses on individual performance.

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

Appendix 1

SALISBURY NHS FOUNDATION TRUST
ANNUAL SELF ASSESSMENT OF THE EFFECTIVENESS OF THE CLINICAL GOVERNANCE COMMITTEE 2019 - 2020

1.0 Introduction

The purpose of this review is to provide assurance that the Clinical Governance Committee (CGC) is complying with its duties as set out in the terms of reference in the Integrated Governance Framework 2020 and to indicate the priorities for 2021/22. The period covers the last 10 meetings from May 2020 to March 2021 and is set out in accordance with the annual review of committee guidance.

2.0 Background

The Integrated Governance Framework 2020 makes it clear that clinical governance is the responsibility of the Trust Board. This is supported by the Clinical Governance Committee which is a formal sub-committee chaired by a Non-Executive Director. The Clinical Governance Committee is responsible for continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

The terms of reference outlines that the CGC has the power to act on behalf of the Trust Board. Its purpose is to assure the Trust Board that high quality care is provided to patients throughout the Trust. The principal function is to provide assurance to the Board on:

- Patient safety
- Clinical effectiveness
- Patient experience
- Service improvement and change management

3.0 Conduct of business

The Committee has ensured that it has focussed on each of the areas of quality over the year. The Committee operates under a standard agenda which is structured in line with the Board Assurance Framework which outlines 6 strategic priorities. The CGC focuses on the following two:

- Innovation
- Care

Despite the Covid-19 pandemic the Committee met (remotely) on 10 occasions during the year. Whilst the work and priorities of the Committee shifted in 2020/21 to reflect the demands of the pandemic, the Committee's work also reflected the routine consideration of monthly or periodic reports in the following areas:

- Impact and management of Covid-19
- Quality performance of the Trust (Integrated Performance Report covering safety, effectiveness and experience)
- Deep dives and performance reviews in key areas such as Gastroenterology, Maternity and Stroke services
- Board Assurance Framework and Risk Registers
- Mortality and Learning from Deaths
- Safeguarding Adults and Children

- Patient Experience and feedback
- Clinical Effectiveness, research and audit activity
- GIRFT
- Mental Health and Learning Disability workstreams
- Freedom to Speak Up Guardian
- Transformation, quality improvement (QI) and innovation
- Upward Report from Clinical Management Board

The Committee undertook its role by:

- receiving and questioning papers and presentations;
- discussing key issues;
- seeking assurance;
- making suggestions and recommendations; and
- drawing significant issues to the attention of the Board of Directors.

The Chairman of the Committee has been involved in setting the agenda with the Chief Nurse and Chief Medical Officer and Head of Clinical Effectiveness in a monthly meeting. The minutes of the meeting are reported to the subsequent Board meeting for information, with highlights and issues for escalation presented by the Chair.

3.1 Membership and attendance (Appendix 2)

The Committee consists of:

- Three Non-Executive Directors
- Medical Director and Director of Nursing
- Chief Operating Officer

In attendance:

Regular attendees included:

- the Chief Executive Officer;
- a Registered Nurse representative; and
- key members of the Chief Nurse and Chief Medical Officer teams.
- Director of Corporate Governance

3.2 Quorum

All meetings were quorate.

3.3 Administration

In 2020/21, the PA to the Director of Nursing and Medical Director acted as the Secretary to the Committee, supporting the administration of the Committee and produced the minutes and action tracker alongside collating papers for each meeting. Where required, these activities were supported by the Director of Corporate Governance or the Corporate Governance Manager. The Head of Clinical Effectiveness agreed the agenda and attendees with the Chair, Chief Nurse and Chief Medical Officer in advance of the Committee and the Chair provided an escalation report to the Board following each meeting.

3.4 Frequency

Meetings were held ten times during the year.

3.5 Notice of meetings

The agenda was sent to each member of the Committee two weeks before and supporting papers sent out one week before the meeting. Due to the pandemic, on occasion, permission was sought and received from the Chair for late submission of some papers. Some topics were also moved to later meeting dates to ensure that the right information could be provided with the required attendees.

4.0 Duties of the Committee

4.1 Developments and review

- **Agree the annual quality plan (quality account priorities) and monitor progress**

The Clinical Governance Committee agreed the quality account priorities and reviewed progress against these. The report for 2020-21 was approved for submission to the Board.

- **Extend the Boards monitoring and scrutiny of the standards of quality, compliance and performance of Trust services.**

Each of the Board assurance committees reported performance within their scope of responsibility. The Clinical Governance Committee reviewed an integrated performance report on quality and care at each meeting and escalated risks and mitigation to the Board. In turn, the Board monitored overall performance through escalation reports and the integrated performance report which triangulates information on quality, performance, workforce and finance.

- **Make recommendations to the Board on opportunities for improvement in the quality of services.**

The following key items were escalated to the Board in 2020/21:

- Plans for the development of the Clinical Strategy
- Gastroenterology services
- Maternity services
- Mortality
- Divisional Governance
- Impact of Covid-19 including harm reviews and lessons learned
- Infection Prevention and Control
- Impact of Covid-19 on Stroke and Cancer services
- Potential impact of IT and estates issues on quality
- NatSS atSSips and LocSSips (safer systems work)
- Pressure Ulcers and Falls
- Management of Serious Incidents and harms

- **Support and encourage quality improvement where opportunities are identified**

Regular reports were presented on transformation and quality improvement, noting the support provided by the QI team to the clinical services during the pandemic. Learning from the positive changes made during the COVID-19 emergency was a key focus in 2020/21.

- **Working in conjunction with the Audit Committee, Workforce Committee and Finance and Performance Committee, cross referencing data and ensuring alignment of the Board assurances derived from the activities of each committee**

The Board Assurance Framework document is presented in totality every 2 months to facilitate assessment of risks. Escalation reports are provided from each Committee to the Board on a monthly basis. Where required, the Committee felt able to refer matters to other Committees.

- **Review the Trust's annual quality report prior to submission to the Trust Board of Directors for approval**

The quality report (quality account) for 2020-21 was presented to the May 2021 Clinical Governance Committee and upwards to the Board. It was also presented to the Council of Governors.

- **Monitor the status of the Trusts' quality objectives as set out in the annual plan.**

Detailed discussion was undertaken in relation to the quality priorities and metrics prior to sign off of the quality report (quality account).

- **Review the quality indicator report (forming part of the Integrated Performance report) prior to inclusion in the Trust Integrated Performance Report**

The quality indicator report was discussed at each Clinical Governance Committee, triangulating with the discussions held at the Finance and Performance Committee.

- **Consider relevant regional and national benchmarking statistics when assessing the performance of the Trust.**

The following reports provided national benchmark data compared with the Trust's performance:

- Infection prevention and control compared with Public Health England data
- Bi-annual national clinical audit reports compared with national average/median.
- Mortality compared to regional peer group.
- GIRFT programme compared with national average/median
- Research activity compared with regional network and national standards.
- National patient surveys benchmarked with national data.
- Freedom to Speak Up work compared with the national Guardian's office data.

- **Review quality impact assessment reviews for significant cost improvement schemes and their potential impact on quality, patient experience and patient safety.**

A discussion in relation to quality impact assessments was held with agreement that QIAs should be considered for any change which could impact on quality. The process was used in relation to the new pharmacy outsourcing provision.

- **Provide oversight of relevant internal audit recommendations as directed by the Audit Committee**

The Divisional Governance arrangements were discussed and reviewed as part of the internal audit programme.

4.2 Review of Trust activity in assigned areas

The assigned areas reviewed are outlined in section 4.1 above.

5.0 Review

5.1 The terms of reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as set out in the terms of reference and report any conclusions and recommendations for change to the Board

The Terms of Reference have been revised (minor amendments) as part of the annual update of the Integrated Governance Framework which was presented to and approved by the Board in March 2021.

5.2 As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.

Whilst this was not formally reviewed this year, the annual workplan was. Additionally, the decision was made to increase the number of meetings from 9 to 12 to acknowledge the workload for this Committee and to align with the Finance and Performance Committee. The Committee has had the full support of the Board with items of escalation. The Committee will formally review its effectiveness towards the end of this financial year.

6.0 Priorities 2021/22

The CGC will focus on:

High priority areas 2021/22:

- Progress the recovery work associated with the COVID-19 pandemic to reduce risks of delays in diagnosis or treatment in clinical pathways.
- Comply with the CQC requirements following inspection on the Maternity Service and significantly improve leadership and culture, governance and risk management by 4 August 21.
- Implement the 'must do' actions identified by the CQC for the Spinal Treatment Centre.
- Continue to progress improvements in the Gastroenterology service and plan for service sustainability and report progress to the Clinical Governance Committee
- Continue to make improvements in the cancer pathways to eliminate delayed or missed cancer diagnoses and track actions through to completion.
- Improve compliance with the lessons learnt from serious incident inquiries to provide assurance that they are acted upon and high harm incidents reduced.
- Reduce the number of high harm falls by 30% through the refreshed Falls Prevention Improvement plan.
- Reduce the number of category 2 by 20% and 3 and 4 pressure ulcers to zero acquired in hospital using a QI approach to improvement.
- Improve the escalation response of adults, children and maternity cases when a patient triggers a clinical observation early warning score.
- Work alongside the Divisional management teams to embed governance processes, learning and improvement.
- Re-commence an intensive quality improvement programme to increase the spread of an improvement culture to ensure sustainable change.

7.0 Summary

Despite the very significant challenges of Covid-19 during the last year, the Clinical Governance Committee is functioning effectively and meeting its objectives. However despite this assurance role being effectively undertaken, some key quality challenges have been identified during this year in part during the pandemic.

The report is presented for assurance that the Clinical Governance Committee is complying with its duties as set out in the terms of reference.

Eiri Jones

Chair Clinical Governance Committee
June 2021

Agreed at the Clinical Governance Committee on 29th June 2021

Appendix 2

Annual Review of Finance and Performance (F&P) Committee
April 2020 – March 2021

1. Introduction

The purpose of this report is to formally report on the work of the F&P Committee during 2020/21 and to indicate the priorities for 2021/22.

The Finance and Performance Committee is a formal sub-committee of the Board and therefore chaired by a Non-Executive Director. The Committee is an assurance committee to enable a greater insight into the Trust's performance in terms of performance and financial outcomes. In doing so, it may request additional management information on specific areas as well as providing knowledge to the Board on those areas if it is considered they may impact the delivery of the Trust's strategic objectives.

2. Work undertaken in 2020/21

The Committee has ensured that it has given due focus to each of the areas of finance and operational performance over the year. The Committee operates under a standard agenda which is structured in line with the Board Assurance Framework. Which outline 6 strategic priorities and the Finance and Performance Committee focuses on the following three:

- Local services
- Specialist services
- Resources

Despite the Covid-19 pandemic the Finance & Performance Committee has met (remotely) on 12 occasions during the year. The work and priorities of the Committee in 2020/21 naturally reflected the current pandemic, but despite this significant issue the Committee's work also reflected the routine consideration of monthly reports on the following issues:

- Oversight of (a) the how the Trust met the Covid-19 challenge and (b) how the Trust has tried to minimise and mitigate the impact that Covid-19 has had on non Covid-19 services (see below)
- Operational performance of the Trust, including reporting on key service targets e.g. 18 week RTT, 52 week Elective and Cancer Waiting Times, A&E 4 hour waits, Diagnostics, MRSA and C Difficile
- Deep dives and service reviews looking into key areas of where performance needed to improve e.g. cancer, stroke and diagnostics
- Financial performance of the Trust, including cash, balance sheet and capital programme
- Contractual and funding issues with the Trust's key commissioners (though Covid-19 resulted in emergency NHS funding arrangements during 2020/21)
- Service Transformation, in particular early in 2020/21 the previously cost improvement focused programme of projects, was refocused towards a broader range of prioritised service improvement projects
- Board Assurance Framework and risk registers
- Benchmarking and value for money information e.g. Model Hospital, service line reporting, reference costs, Use of Resources assessment
- National and regional issues and context e.g. Brexit planning
- Resilience and continuity planning e.g. Winter Plan for 2020/21 and ongoing covid-19 pandemic response planning
- Planning process for 2021/22 and beyond
- Integrated Care System (ICS) working
- Review of key business cases

- Salisbury Hospital Strategic Campus Development programme

The Committee undertook its role by receiving and questioning papers and presentations; discussion of key issues; seeking of assurance; making suggestions and recommendations where appropriate; and drawing significant issues to the attention of the Board of Directors.

The Chairman of the Committee has been involved in setting the agenda with the Director of Finance. The minutes of the meeting are reported to the subsequent Board meeting for information, with highlights and issues for escalation presented by the Chair.

Committee attendance at Finance & Performance Committee meetings April 2020 to March 2021

Member	Designation	Meetings attended
Paul Miller (Committee Chair)	Chairman	12/12
Paul Kemp	Non-Executive Director	12/12
Eiri Jones	Non-Executive Director	12/12
Cara Charles –Barks (left the Trust in August 2020)	Chief Executive	4/5
Stacey Hunter (joined the Trust in September 2020)	Chief Executive	7/7
Lisa Thomas	Director of Finance	12/12
Andy Hyett	Chief Operating Officer	10/12
Lynn Lane	Director of OD & People	9/12

3. **Work Plan for 2021/22**

The Committee's overarching objective is to continue to improve understanding of the financial and operational performance control processes of the Trust to provide assurance to the Board. In particular it will focus on the following key areas;

- The key priority for next year is to ensure the Trust recovers its performance back to pre Covid-19 levels.
- As part of this recovery process, ensure that the Trusts service transformations programme aligns with both the short term operational priorities, as well as our long term strategic ambitions
- Ensure that the Trust works effectively with its Integrated Care System (ICS) partners to support improvements in performance and financial sustainability (both in the short and long term)
- Continue to improve our approach to capital and revenue planning and forecasting
- Support the ongoing development Salisbury Hospital Strategic Campus Development programme. Ensuring that key capital business cases e.g. day surgery and maternity are progressed at speed through the ICS, Region and Nationally
- Ensure the Trust continues to implement its approved digital strategy and an effective operational digital delivery service
- Raising financial awareness throughout the Trust and empower staff to improve
- Assessment of financial risks in delivering financial plans agreed with NHS England and Improvement
- Working with our system partners to ensure the Trusts 2021/22 operational and strategic ICS plans help the Trust achieve long term sustainability

4. Terms of Reference

The Terms of Reference have been revised as part of the annual update of the Integrated Governance Framework which was presented to and approved by the Board in March 2021.

5. Conclusion

Notwithstanding the very significant challenges of Covid-19 during the last year, the Committee is functioning effectively and meeting its objectives. However despite this assurance role being effectively undertaken, the reality is because of the pandemic key parts of the Trusts non Covid-19 performance have deteriorated over the last year and the challenge for 2021/22 is to fully recover performance and start to move back towards financial sustainability.

Appendix 3

Audit Committee Annual Activity Report

1 Purpose

1.1 The purpose of this report is to summarise the activity of the Committee over the 2020/21 financial year in order to provide the Board with assurance. Details of any of the items raised in this report are available in the papers and minutes stored in the ibabs system.

2 Background

2.1 The Audit Committee has been put in place to provide the Governors, the Board and the Chief Executive with a point of focus to review and assure the effectiveness of non-clinical processes in the Trust and compliance of the Trust's personnel with those processes. In doing this the Committee will provide assurance to the Board, Governors and other key stakeholders.

3 Key Activity During 2020/21

3.1 Impact of Management of Covid Pandemic within the Hospital

Aside from the meetings of the Committee moving to an online format, which did not markedly impair the effectiveness of the Committee, there was very little direct impact on the Committee from the Covid pandemic. However, the massive adjustment of priorities within the executive team necessitated by the hospital's response did have some impact on delivery of some actions. There is no question that this change in prioritisation was entirely appropriate in the circumstances and, whilst delivery of some milestones has been delayed, there are no indicators of any substantial failures in the main control systems of the Trust.

3.2 Review of 2019/20 Annual Report

As is required, the committee reviewed the draft financial statements and governance statements for the 2019/20 annual report and recommended their adoption to the Board. The Trust and the auditors were required to make some late adjustments to the planned process of completing and reviewing the accounts, principally related to the necessity of adopting remote working. This added some time to the process and qualifications to the auditor's opinion, which were common across all NHS Trusts. There were some fairly minor difficulties in the finance team being able to evidence some of the operational controls, but these were overcome. Overall, within the constraints of the circumstances, the process and outcomes were satisfactory.

3.3 Internal Audit Reviews

Over the financial year 2020/21, PWC carried out reviews of six areas, agreeing a total of 22 actions with management, of which 3 were rated as high risk findings. The most significant of these related to process control issues in the pharmacy, where the review coincided with the discovery of a theft of drugs by a member of staff.

Of the 22 management actions agreed, 16 were due to be completed by the end of the year and 13 met this target. In addition, there were 6 management actions from an audit undertaken in 2019/20 which remained incomplete at the end of 2020/21. Both the current and previous year overdue items related to departments where there has been a recent change in executive leadership.

As a result of these reviews and other interactions with the management team, the Head of Internal Audit issued a formal opinion of "generally satisfactory with some improvements required". This was the same opinion as was given for 2019/20. The opinion also noted seven specific examples of good practice within the Trust.

3.4 Counter Fraud Activities

During the year the Local Counter Fraud Officer (LCFO) continued to work with management on both proactive and reactive work packages, linking in with guidance from the NHS Counter Fraud Authority. Proactive work included reviews of timesheet management, workforce controls within the vaccination centres and specific fraud risks related to the Covid 19 pandemic.

There was one incident during the year that resulted in investigation and action by the LCFO, regarding the theft of drugs from the pharmacy by a nurse. In addition, three incidents originating in prior years progressed, one involving theft and two relating to false representation by staff. These have all been progressed appropriately and have either resulted in criminal prosecution or referral for disciplinary action to professional bodies.

3.5 Pro-active Process Reviews

During the year, the committee continued its practice of inviting management teams to give a detailed presentation on a specific management process or area of concern.

Through the year, the Committee received presentations on capital management processes, management of outsourced service contracts, programme management processes in the Trust and management of cancer waiting lists. All of the presentations were of a good standard and led to a good discussion in the committee on the issues raised.

3.6 Other Activities

Other regularly scheduled matter dealt with during the year included,

- Two reviews of the processes used by the Trust to manage risk and the Business assurance Framework,
- A discussion on the effectiveness of the committee and a review of its terms of reference,
- Review and discussion of the internal audit and counter fraud plans for 2021/21
- Review of the effectiveness of the Standing Financial Instructions and management proposals for changes

4 Summary

Given the externally driven constraints and environment encountered by the Trust during the 2020/21 financial year, it is pleasing to see that the control environment remained effective and that the level of management control was generally maintained. There has also been evidence that management's understanding of internal control matters and use of the internal audit services available to it has become more effective, although there will always be room for improvement.

5 Recommendations

The Board is recommended to note this report.

Paul Kemp
Audit Committee Chairman

Annual Review of the Charitable Funds Committee
April 2020 – March 2021

5. Introduction

The purpose of this report is to formally report on the work of the Charitable Funds Committee during 2020/21 and to indicate the priorities for 2021/22.

The Charitable Funds Committee is a formal sub-committee of the Board and therefore chaired by a Non-Executive Director. The Committee is an assurance committee to provide the Board of Directors with assurance on the appropriate management and use of charitable funds it holds on trust.

6. Work undertaken in 2020/21

The Committee has ensured that it has given due focus to improving the governance of the Hospital Charity, the Stars Appeal. The Committee operates under a standard agenda which is structured in line with the Board Assurance Framework. The Charitable Funds Committee focuses on the following strategic priority:

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

Despite the Covid-19 pandemic the Finance & Performance Committee has met (mainly remotely) on 4 occasions during the year, including an extra workshop session in August.

The work and priorities of the Committee in 2020/21 focused in addressing the governance concerns raised in the previous financial year. In response to the findings and recommendations on the Governance Gap Analysis carried out in September 2019, the Salisbury NHS Foundation Trust (SFT) recruited an Investment Planning and Policy Manager to work in partnership with Trust and Stars Appeal staff to:

- Strengthen charity governance arrangements including policy development and review, reporting to Charitable Funds Committee and evaluating the impact of funded projects.

- Develop a clear strategic vision and operational plans for the Charity in line with Trust-wide policies, practices and priorities.

The work commenced in late May 2020 with a discovery phase lasting approximately 3 months. In June 2020 the Committee approved a work programme comprising of 8 workstreams to implement robust processes and controls for the efficient management and utilisation of charitable funds in line with the Trust's policies and strategic priorities. The outputs achieved are;

- Agreement on the Charity's corporate statements and objectives;
- Implementation of improved processes and practices reflecting the guiding principles for the Charity;

- Introduction of additional levels of assurance and controls for charitable expenditure based both on the level and nature of the spend;
- Improved scrutiny and pre-application advice on proposals in tandem with better allocation of charitable funds
- Engagement with Divisional and Departmental teams on decision making processes and future expenditure plans

- Higher level of support to wider staff with the delivery and maintenance of projects funded by the Charity, a service that has been particularly supported by staff on clinical areas;
- Development of criteria and methodology for assessing suitability and impact of projects funded by the Charity;
- Initiated proactive allocation of suitable expenditure leading to the full utilisation and closure of 19 funds to date.
- Collaboration with the Charity Commission and auditors on the fund structure for the Stars Appeal Charity. This collaboration led to the reclassification of 220 charitable funds which enables the Charity to progress with the fund rationalization work.
- Revision, development and introduction of suite of documents for the Charity including policies, guidance and templates to inform, assist and assure new processes implemented.
- Creation and implementation of the Stars Appeal Investment Committee, a forum comprised with representatives from the 3 clinical divisions and key corporate functions to consider and make recommendations for charitable expenditure in line with statutory obligations of the Charity and Trust-wide policies, procedures and priorities. The Investment Committee has delegated authority from the Charitable Funds Committee to make decisions on funding applications up to 100k. Since its formation in January 2021, the Committee has met 4 times and considered 11 funding applications of which 8 were approved, 2 declined and 1 deferred to the Charitable Funds Committee.

The Committee undertook its role by receiving and questioning papers and presentations; discussion of key issues; seeking of assurance; providing recommendations, making decisions on applications for large grant applications, as well as drawing significant decisions and issues to the attention of the Board of Directors.

Summary of the decisions made for grant applications April 2020 to March 2021*;

Grant Application	Cost	Decision	Forum
Occupational Health funded posts	£201,515 (£80,606 pa x 2 + £40,303 in 22/23)	Approved	Charitable Funds Committee
Vicon Motion	£42,000.00	Approved	Chairs' action
OML Research Fellow – retrospective approval of 3 months of salary (cover January to March 2020)	£12,164	Approved	Chairs' action
ENT Department Processor	£17,513.20	Approved	Chairs' action
Stars Appeal Play Specialist	£23,373.00	Approved	Charitable Funds Committee
Simulation Technician	£24,000.00	Approved	Charitable Funds Committee
Sim Man and artificial lung kit	£78,389.30	Approved	Charitable Funds Committee
Garden Technician	£11,000.00	Approved in principle / new application required	Charitable Funds Committee
ArtCare funding 21-22	£86,000.00	Approved	Charitable Funds Committee

Elevate funding 21-22	£45,000.00	Approved funding extension until July 2021	Charitable Funds Committee
Utilization of 200k excess raised on the MRI campaign to the delivery of the Stars Appeal MRI suite	200k	Approved	Charitable Funds Committee
Pulse Dye Laser	£56,000.00	Approved	Email approval from all members of the Committee
OML Research Fellow – 50% of 20/21 salary	**£24,141**	Approved	Charitable Funds Committee
2 additional Kangaroo care rooms & alterations to NICU family accommodation	£25,000.00	Approved	Charitable Funds Committee
Stars Appeal Bereavement Coordinator	£90,649.00	Approved	Charitable Funds Committee
Major donor support to Capital Bids: Iridex Cyclo G6 laser; Spectralis OCT-Angiography and Intra Oral scanner kit	£207,105.70	Approved	Charitable Funds Committee
Low Risk Birthing Centre	£260,300.00	Approved	Charitable Funds Committee
Application for a Third EBus	£48,175.00	Approved	Investment Committee
Fibroscanner for GI	£79,240.00	Approved	Investment Committee
Defence Medical Welfare Service (DMWS) Application Funding	£36,008.00	Declined	Investment Committee
IT Hut for clinical staff	£18,936.00	Conditionally Approved	Investment Committee
Stars Appeal Gardener	£14,000.00	Approved	Investment Committee
Stars Appeal Watercoolers-phase 2	£2,700.00 (rental)+ £6000 - 12,000.00 (installation)	Deferred to Charitable Funds Committee	Investment Committee
Stars Appeal Emergency Toiletry's Pack	£9,420.00	Approved	Investment Committee
Renewal of funding for Engage – 2 year extension	Up to £35,562.00 (£17,784,50 p/a)	Conditionally Approved	Investment Committee
Renewal of funding for Elevate – 2 year extension	up to £90,000.00 (45k per annum)	Conditionally Approved	Investment Committee
Spoken Word project - phase 2	£7,000.00	Declined	Investment Committee
Partner's Recliner Chair for Labour Ward	£16,000.00	Approved	Investment Committee

*List excludes small expenditure and grant requests below 10k which are within Fund Managers discretionary limits to approve

7. **Work Plan for 2021/22**

The Committee's overarching objective is to continue to improve the governance and processes for the effective management of charitable funds and to develop a clear strategic vision and operational plans for the Charity in line with Trust-wide policies, practices and priorities.

In particular it will focus on the following key areas;

- Raising awareness of the Hospital Charity and the role it plays in supporting enhancing the Hospital services.
- Recruitment of a Charity Manager to take the lead on the assurance, governance and strategy framework and to oversee the day to day operation, project delivery and evaluation processes to ensure the effective management of charitable funds.
- Recruitment of additional communications resource to bridge between the Trust communications team and the Stars Appeal, focus on highlighting the benefits of charitable funding and maximise the PR, communication and branding opportunities both in the community and within the Trust.
- Progressing with the restructuring of the funds rationalization work
- Continue to improve the Charity's governance and guidance to the utilization of charitable funds, empowering fund managers to make decisions in line with the charity's governing principles and statutory requirements.
- Demonstrating impact of charitable investment by implementing an objective and consistent benefit realization process to aid grant decision making.
- Working with Divisional Managers and Directors to ensure the appropriate use of charitable funds will be considered in their operational plans and priorities so that the Stars Appeal Charity will actively support the Trust in achieve its long term strategies.

8. Terms of Reference

The Terms of Reference have been revised as part of the annual update of the Integrated Governance Framework which was presented to and approved by the Board in 1st April 2021.

5. Conclusion

Notwithstanding the very significant challenges of Covid-19 during the last year, the Committee is functioning effectively and meeting its objectives. However despite strategy work being effectively delayed, the reality is because of the impact of the pandemic on the strategic planning and operational priorities for the Divisions, which is a key element to enable the development of a clear strategy for the Charity in line with the strategic priorities and corporate objectives of Salisbury NHS Foundation Trust.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.2
Date of Meeting:	09 September 2021		

Report Title:	2022 Trust Board and Committee Dates			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Approval Process (where has this paper been reviewed and approved)	Reviewed by Corporate Governance team > submitted to Trust Board for approval			
Prepared by:	Sasha Grandfield, Board Support Office Kylie Nye, Head of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Integrated Governance			
Appendices (list if applicable):	2022 Trust Board and Committee Dates			

Recommendation:
To approve the 2022 Board and Committee Dates

Executive Summary:
The Trust Board is asked to review and approve the Trust Board and Committee dates for 2022. It is important to note the following: • Due to the last minute changes to the year-end timetable during 2020 and 2021 a date has been held for a standard public/private Trust Board on 5th May. This is only a provisional date in case the private Trust Board/ Audit Committee, currently scheduled for 26th May to sign off the annual accounts, is delayed. • Organisational Development and People Management Board may move to bi-monthly meetings. This is currently under review. • Trust Management Committee will continue to be scheduled at the same time of month. It has been highlighted that the meeting should be scheduled prior to the other Board Committees to provide a better route of escalation from senior management to Board. However, due to the timing of reports this is not possible except for those months where there are 5 weeks.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒

Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☒
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☒
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☒
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒
Other (please describe) -	☐

Trust Board, Committees and Council of Governors – Meetings 2022

	Trust Board Thursday Week 1 All day	Reporting month	Operational Management Board Tuesday Week 3 11 - 12	OD & People Management Board[1] Tuesday Week 3 2 - 4	Clinical Management Board Wednesday Week 3 10.30-12.30	Transformation, Innovation and Digital Board Wednesday Week 3 1-2	Audit Committee Thursday Week 3 9.30 - 12	Subsidiary Governance Committee Thursday Week 3 1 – 2.30	Charitable Funds Committee Thursday Week 3 3 – 5	Trust Management Committee Wednesday Week 3 or 4 10 - 12	Clinical Governance Committee Tuesday Week 4 13:00-15:30	Finance and Performance Committee Tuesday Week 4 09:30 – 12:00	People and Culture Committee last Thurs 10 - 12
Chair	Nick Marsden		Andy Hyett	Melanie Whitfield	Peter Collins	Esther Provins	Paul Kemp	Paul Miller	Nick Marsden	Stacey Hunter	Eiri Jones	Paul Miller	Michael Von Bertele
January m10	**13 public/private**	**M9**	**18**	**18**	**19**	**19**	**-**	**-**	**-**	**26**	**25**	**25**	**27**
February m11	**3 private**	**M10**	**15**	**15**	**16**	**16**	**-**	**-**	**-**	**23**	**22**	**22**	**24**
March m12	**10 public/private**	**M11**	**15**	**15**	**16**	**16**	**24**	**24**	**24**	**23**	**29**	**29**	**31**
April m1	**7 public/private**	**M12**	**19**	**19**	**20**	**20**	**-**	**-**	**-**	**27**	**26**	**26**	**28**
May m2	**(hold*) 5 public/ private**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
May annual report	**26 May private**	**M1**	**17**	**17**	**18**	**18**	**26**	**-**	**-**	**25**	**24**	**24**	**-**
June m3	**9 private/rem com**	**M2**	**21**	**21**	**22**	**22**	**-**	**23**	**23**	**22**	**28**	**28**	**30**
July m4	**7 public/private**	**M3**	**19**	**19**	**20**	**20**	**21**	**-**	**-**	**27**	**26**	**26**	**28**
August m5	**4 private**	**M4**	**16**	**16**	**16**	**17**	**-**	**-**	**-**	**31**	**30**	**30**	**-**
September m6	**8 public/private**	**M5**	**20**	**20**	**21**	**21**	**22**	**22**	**22**	**22**	**27**	**27**	**29**
October m7	**6 private**	**M6**	**18**	**18**	**19**	**19**	**-**	**-**	**-**	**26**	**25**	**25**	**27**
November m8	**3 public/private**	**M7**	**15**	**15**	**16**	**16**	**-**	**-**	**-**	**30**	**29**	**29**	**24**
December m9	**8 private/rem com**	**M8**	**13**	**13**	**-**	**14**	**15**	**15**	**15**	**21**	**20**	**20**	**-**

	Council of Governors (CoG)	**Non Exec/Governor informal**
	Nick Marsden	Nick Marsden
January	-	-
February	28 Board Rm	14
March	-	-
April	-	11
May	23 Board Rm	-
June	-	13
July	25 Board Rm	-
August	-	-
September	26 AGM	-
October	-	10
November	28 Board Rm	-
December	-	-

BANK HOLIDAYS	
3 Jan	**Monday**
15 April	**Good Friday**
18 April	**Easter Monday**
2 May	**Monday**
2 June	**Thursday**
3 June	**Friday**
29 Aug	**Monday**
25 Dec	**Sunday**
26 Dec	**Monday**
27 Dec	**Tuesday**

To note:

- Trust Board – always book the room 9-5 – will include any RemCo & Seminar, Public Board starts at 10am.
- Always include a Teams' link for those joining virtually
- All meetings book 30 minutes ahead of start and end times
- NEDs/Governors – book rooms D&E
- CoG – if not virtual book Boardroom from 2.30 pm (set-up plus 3 pm pre-meeting)

*holding 5th May for Board in case the May Annual Report meeting (26th May) is too early.
[1]OD&P Management Board may move to bi-monthly meeting