

## Bundle Trust Board Public 5 November 2020

- 1 OPENING BUSINESS
- 1.1 10:00 - Presentation of SOX certificates
- 1.2 10:10 - Staff Story
- 1.3 Welcome and Apologies
- 1.4 Declaration of Interests
- 1.5 10:30 - Minutes of the previous meeting  
*Minutes attached from Public Trust Board meeting held on 3rd September  
For approval*  
Draft Public Board mins 3 September 2020.docx
- 1.6 10:35 - Matters Arising and Action Log  
Trust Board Public Action Log 5 November.docx
- 1.7 10:40 - Chairman's Business  
*Verbal update by Nick Marsden  
For information*
- 1.8 10:45 - Chief Executive Report  
*Presented by Stacey Hunter  
For information*  
1.8a CEO Board Report November.docx  
1.8b Acute Hospital Alliance Briefing Oct\_20v1.0.pdf
- 2 ASSURANCE AND REPORTS OF COMMITTEES
- 2.1 10:55 - Clinical Governance Committee - 27 October  
*Presented by Eiri Jones  
For assurance*  
2.1 Escalation report - from CGCommittee to Board October 2020.docx
- 2.2 11:00 - Finance and Performance Committee - 27 October  
*Presented by Paul Miller  
For assurance*  
2.2 Public Board - Finance and Performance Committee escalation paper 27th October 2020.docx
- 2.3 11:05 - People and Culture Committee - 29 October  
*Verbal update by Michael von Bertele  
For assurance*
- 2.4 11:10 - Trust Management Committee - 21 October  
*Presented by Stacey Hunter  
For assurance*  
2.4a TMC Escalation report November.docx  
2.4b Appendix 1 EPRR Assurance letter.pdf
- 2.5 11:15 - Integrated Performance Report - M6  
*Presented by Andy Hyett  
For assurance*  
2.5a 201105 IPR cover Board.docx  
2.5b IPR November 2020 DRAFT v2.pdf
- 3 QUALITY AND RISK
- 3.1 11:35 - Patient Experience Report Q1  
*Presented by Judy Dyos  
For assurance*  
3.1 Patient Experience Report Q1 v1\_0 Aug 2020.docx
- 3.2 11:45 - Learning from Deaths Report Q1  
*Presented by Peter Collins  
For assurance*  
3.2 TB Learning from deaths report Q1 20 21 August 20 v2.docx
- 3.3 11:55 - Quality Improvement Progress Update

*Presented by Esther Provins  
For assurance  
Emma Cox attending*

3.3a Quality improvement programme update October 2020.docx

3.3b SFT Strategy for Improvement v1\_0.pdf

4 FINANCIAL AND OPERATIONAL PERFORMANCE  
4.1 12:05 - Operating Plan 2021/22 and quarterly review  
*Verbal update by Lisa Thomas*

5 PEOPLE AND CULTURE  
5.1 12:15 - People Plan Presentation

*Presented by Lynn Lane  
For approval*

5.1a Board report People Plan 281020.docx

5.1b Appendix A to Board Report.docx.pptx

5.1c Appendix B to Board Report281020.docx

6 GOVERNANCE  
6.1 12:30 - Register of Seals

*Presented by Fiona McNeight  
For approval*

6.1 Register of Seals.docx

7 CLOSING BUSINESS  
7.1 12:35 - Agreement of Principle Actions and Items for Escalation  
7.2 12:40 - Any Other Business  
7.3 12:50 - Public Questions  
7.4 Date next meeting  
*Date of next Public Trust Board meeting 14 January 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)*

**DRAFT**

**Minutes of the Public Trust Board meeting  
held at 11:00am on Thursday 3 September 2020 via MS Teams**

**Present:**

|                        |                           |
|------------------------|---------------------------|
| Dr Nick Marsden        | Chairman                  |
| Ms Tania Baker         | Non-Executive Director    |
| Mr Paul Kemp           | Non-Executive Director    |
| Mr Paul Miller         | Non-Executive Director    |
| Ms Rakhee Aggarwal     | Non-Executive Director    |
| Dr David Buckle        | Non-Executive Director    |
| Dr Michael von Bertele | Non-Executive Director    |
| Mrs Stacey Hunter      | Chief Executive Officer   |
| Mr Andy Hyett          | Chief Operating Officer   |
| Miss Sallie Davies     | Interim Medical Director  |
| Mrs Lisa Thomas        | Director of Finance       |
| Mrs Lynn Lane          | Director of OD and People |
| Ms Judy Dyos           | Director of Nursing       |

**In Attendance:**

|                    |                                      |
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| Mr Gavin Thomas    | Executive Services Manager (minutes) |
| Mr John Mangan     | Lead Governor (observer)             |
| Mrs Fiona McNeight | Director of Corporate Governance     |
| Ms Esther Provins  | Director of Transformation           |
| Mrs Kat Glaister   | Head of Patient Experience           |

|                    |  | <b>ACTION</b> |
|--------------------|--|---------------|
| <b>TB1 3/9/01</b>  | <b>OPENING BUSINESS</b>  |               |
| <b>TB1 3/9/1.1</b> | <b>Presentation of SOX (Sharing Outstanding Excellence) Certificates</b>   |               |
|                    | <p>NM noted the following members of staff who had been awarded a SOX Certificate:</p> <ul style="list-style-type: none"> <li>• Respiratory Care Unit</li> <li>• Rowena Staples</li> </ul>   |               |
| <b>TB1 3/9/1.2</b> | <p><b>Patient Story</b></p> <p>KG presented the Staff story to the Board.</p> <p>NM opened the discussion and stated that communication was key with every patient. SH agreed with NM and explained that this is fundamental.</p> <p>AH queried if the team had been informed and if any further training has been put in place for them.</p> <p>KG confirmed that the team had been informed and that training is in place.</p> |               |

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|                    | NM thanked KG for sharing the story.   |  |
| <b>TB1 3/9/1.3</b> | <b>Welcome and Apologies</b>   |  |
|                    | NM welcomed everyone to the meeting and noted there were apologies from Eiri Jones, Non-Executive Director.  |  |
| <b>TB1 3/9/1.4</b> | <b>Declarations of Conflicts of Interest</b>   |  |
|                    | There were no declarations of conflicts of interest pertaining to the agenda.  |  |
| <b>TB1 3/9/1.5</b> | <b>Minutes of the part 1 (public) Trust Board meeting held on 2 July 2020</b>  |  |
|                    | NM presented the minutes and there were no points to note and they were approved as a true and accurate record of the meeting.   |  |
| <b>TB1 3/9/1.6</b> | <b>Matters Arising and Action Log</b>  |  |
|                    | <p>NM presented the action log and the following items were noted:</p> <ul style="list-style-type: none"> <li>• Item 207 is closed</li> <li>• Item 208 is closed</li> <li>• Item 210 is closed.</li> </ul> <p>There were no further matters arising.</p>   |  |
| <b>TB1 3/9/1.7</b> | <b>Register of Attendance</b>  |  |
|                    | Nil of note  |  |
| <b>TB1 3/9/1.8</b> | <b>Chairman's Business</b>   |  |
|                    | <p>NM provided the following update:</p> <ul style="list-style-type: none"> <li>• NM advised the Board that colleagues were working hard on the reset and recovery plans to restart as many elective services as feasible. Nationally targets have been set with monitoring against those being done at regional level.</li> <li>• NM advised that he is hearing that no further monies will be forthcoming and Trusts will be unable to apply for additional top ups.</li> <li>• NM further commented that the national approach is resulting in multiple information requests with plans changing on a daily basis.</li> <li>• NM advised the Board that it is his view that we should be putting our patients first and focusing on services for our patients.</li> </ul> <p>The Board endorsed this.</p> |  |
| <b>TB1 3/9/1.9</b> | <b>Chief Executive's Report</b>  |  |

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|                    | <p>SH presented the Chief Executive’s report and highlighted the following key points:</p> <ul style="list-style-type: none"> <li>• STP catch up took place yesterday and focused on the phase 3 reset plans</li> <li>• Local Accountable Officer catch up was taking place later today.</li> <li>• Some areas of the STP are delivering more elective activity than other areas.</li> <li>• Our ambition is that 100% of healthcare workers with direct patient contact are vaccinated with the Flu vaccination this year</li> <li>• SH provided feedback from a study undertaken with staff working with COVID where up to 40% of individuals were showing signs of PTSD.</li> </ul> <p><b>Discussion:</b></p> <ul style="list-style-type: none"> <li>• TB explained that given the current situation, it was positive that the Trust has given themselves a 100% target for flu vaccinations amongst its staff, but also noted that the Trust has struggled to achieve this in previous years, and asked what is different this year.</li> <li>• SH explained that the STP have carried out a review across a number of organisations, in terms of the different approaches they have taken to Flu immunisation of its staff, and we are looking to work with them to shape our message this year. SH further explained that nationally the message is going to be much sharper this year, in a bid to improve uptake.</li> <li>• JD explained that work has been ongoing in terms of peer vaccinators and comms messages are due to start at the beginning of October, with a view to rolling out to other colleagues via Clinical Directors.</li> <li>• LL further explained that learning has been taken from other Trusts and how they have achieved high results and this learning has been shared with the wider organisation.</li> <li>• PM stated that the mood across the STP feels upbeat, with a sense that the SW is doing well compared to other areas of the country, but noted that it is early days.</li> </ul> <p><b>The Board noted the report.</b></p> |  |
| <b>TB1 3/9/2</b>   | <b>ASSURANCE AND REPORTS OF COMMITTEES</b>   |  |
| <b>TB1 3/9/2.1</b> | <b>Trust Management Committee – 24 August 2020</b>   |  |
|                    | <p>AH presented the report, providing a summary of escalation points from the meeting held on 24 August:</p> <ul style="list-style-type: none"> <li>• There were three business cases to consider at this month’s meeting, namely Extension of LWBC service, the addition of a simulation technician and the implementation of direct award model and contract award to PlusUs</li> </ul>  |  |

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|                    | <ul style="list-style-type: none"> <li>It was noted that Extension of LWBC service, the addition of a simulation technician business cases had previously been funded by charity monies and further exploratory work is ongoing to continue to fund these going forward.</li> </ul>   |  |
| <b>TB1 3/9/2.2</b> | <b>Finance and Performance Committee – 25 August</b>  |  |
|                    | <p>P Miller provided a summary of escalation points from the Finance and Performance Committee:</p> <ul style="list-style-type: none"> <li>The majority of items to be raised from Finance and Performance Committee will be discussed in private Board, such as ED Modular build and estates</li> </ul> <p>The report was noted.</p>   |  |
| <b>TB1 3/9/2.3</b> | <b>Clinical Governance Committee – 28 July</b>  |  |
|                    | <p>This item was not discussed as the Chairman requested it be reviewed in private session when EJ was able to attend.</p> <p>The Board agreed this approach.</p>   |  |
| <b>TB1 3/9/2.4</b> | <b>Integrated Performance Report</b>  |  |
|                    | <p>LT presented the integrated performance report to the Board and the following was noted.</p> <ul style="list-style-type: none"> <li>Areas of concern are Oral Surgery, ENT and Ophthalmology, however LT explained that these areas do triangulate with our referrals which are currently at 67% of the pre Covid levels.</li> <li>In relation to our cancer targets we have not delivered the 2 week wait standard.</li> <li>LT stated that Theatre remains a hotspot also currently.</li> <li>Category two pressure ulcers have also increased which is a concern.</li> </ul> <p><b>Discussion:</b></p> <ul style="list-style-type: none"> <li>SH noted that in the previous 6 months Boards, category two pressure ulcers have always been identified as an area of concern, despite increased education and training.</li> <li>JD informed that a deep dive was completed by the former Director of Nursing, but also noted that this was an area which was increasing across our region.</li> <li>MVB queried bed occupancy and length of stay and noted that we discharged early in the community and asked if we were now back to where we were in terms of discharges to where we were pre Covid.</li> <li>AH confirmed this was a concern going into winter and numbers are being monitored. The process which has</li> </ul> |  |

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|                    | <p>worked well during COVID will be in place, but pressure on capacity out of hospital and local authority funding may impact this.</p> <ul style="list-style-type: none"> <li>• DB stated that the IPR gives the Board confidence on how we treat patients; however the Office for National Statistics (ONS) show that in Spring of 2020 excess deaths were worse across Europe and asked how this affects our own mortality rates as a Trust.</li> <li>• LT stated that the individual mortality reviews provided a further level of assurance.</li> <li>• TB advised that whilst important to note crude mortality, there is still a need to monitor HSMR and SHIMI</li> <li>• SH explained that wider planning will be key here and will be a bigger proportion, but there needs to be a conversation nationally about how to manage the data.</li> <li>• RA asked the Board in terms of BSW, what is happening in relation to the message do not attend if not necessary.</li> <li>• AH explained that we have seen an increase in patients attending, especially into A+E following advice from 111</li> <li>• AH explained that there is a piece of work taking place nationally called Think111, of which AH is the lead for our region</li> <li>• SH explained that the data was reviewed again this morning and our region of the South West remains good in relation to other areas.</li> </ul> <p>The Board noted the report.</p> |  |
| <b>TB1 3/9/3</b>   | <b>GOVERNANCE</b>   |  |
| <b>TB1 3/9/3.1</b> | <b>Approve Board and Committee dates for 2021</b>   |  |
|                    | <p>FMc shared the paper with the Board and explained that there was an addition of OD&amp;People Management Board and further explained that there was now clear escalation into the Trust Management Committee.</p> <p><b>Discussion:</b></p> <ul style="list-style-type: none"> <li>• PM noted that he Chairs the Subsidiary Governance Committee and the paper should reflect that.</li> <li>• NM thanked FMc for a very good piece of work.</li> </ul> <p><b>Decision:</b></p> <ul style="list-style-type: none"> <li>• The Board approved the Board and committee dates for 2021.</li> </ul>   |  |
| <b>TB1 3/9/3.2</b> | <b>Annual Review of Board and Committee Effectiveness</b>   |  |
|                    | <p>FMc presented the report and explained that the 360 reviews had been undertaken with Board members and outcomes of the review had previously been shared at Board. FMc further commented that</p>  |  |

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|                    | <p>the Board has gone through rigorous review, with some areas for improvement identified.</p> <p><b>Discussion:</b></p> <ul style="list-style-type: none"> <li>• PM noted that the Board had not completed the final part of the 360 feedback sessions and therefore he felt that the paper should be updated to reflect that fact</li> <li>• NM explained that he feels that the final review sessions need to be held face to face, and therefore he feels that we should hold until we get to a moment in time when they can happen.</li> <li>• PK explained he feels that the timeframe to review has now passed.</li> <li>• NM advised the Board that he would discuss with the 360 assessor and review further.</li> </ul> <p><b>ACTION: NM to discuss Board 360 final review session with the 360 assessor and inform the Board of outcome and next steps.</b></p> | NM |
| <b>TB1 3/9/3.3</b> | <b>Corporate Governance Statement Self-Assessment (Well Led Review)</b>  |    |
|                    | <p>FMc presented to the Board and explained that the external well led review is due in May 2021. FMc further explained that now that SH has commenced in the role, discussions on how to proceed with this have commenced. This is being discussed as part of the Executive Away Day.</p> <p>The Board noted the update.</p>  |    |
| <b>TB1 3/9/3.4</b> | <b>Revised Board Assurance Framework</b>   |    |
|                    | <p>FMc presented the Board Assurance Framework (BAF) to the Board and explained that the BAF has been revised during August 2020 to incorporate the revised corporate objectives for the remainder of 2020/21.</p> <p>FMc further explained that the format of the document has been simplified with the aim of ensuring that any gaps in control or assurance against each strategic aim and the corporate objectives are clear.</p> <p>FMc advised that in relation to key risks, estates had risen to 20 and in relation to Maternity, JD is reviewing this service.</p> <p><b>Discussion:</b></p> <ul style="list-style-type: none"> <li>• NM thanked FMc for a very good piece of work.</li> </ul> <p>The Board noted the report.</p>   |    |
| <b>TB1 3/9/4</b>   | <b>PEOPLE AND CULTURE</b>  |    |

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| TB 3/9/4.1 | <b>Health and Safety Annual Report</b>   |    |
|            | <p>LL presented the report and highlighted the following key points:</p> <ul style="list-style-type: none"> <li>• Statistics on accidents / incidents remain stable currently</li> <li>• Last health and safety inspection was July 2019 with all actions completed to date.</li> <li>• Work continues on SME training for Mental Health</li> <li>• In relation to violence and aggression we are awaiting the national framework which will replace the REACT framework.</li> <li>• Noted that HSE have been active in the last year with a high number of Actute Trusts issued notices.</li> <li>• AH advised that the focus has been on radiation protection.</li> </ul> <p><b>Discussion:</b></p> <ul style="list-style-type: none"> <li>• PK advised that he is struggling to understand how this addressed the independent view of HSE, despite work ongoing and staff training.</li> <li>• PKe explained that the query from Audit committee remains with high level risks identified.</li> <li>• PK explained that engagement with staff needs to continue with emphasis on a rota for staff in respect of health and safety training.</li> <li>• PK queried how robust the methodology to identify which audits to do were given the committee decided this for itself.</li> <li>• PM raised the RIDDOR section on page 7 of the Health and Safety report and commented that it would be useful to have audit committee review the methodology of the reviews and how we can move forward with them.</li> </ul> <p><b>Action: LT to ensure Audit committee review the methodology the Health and Safety Group use to prioritise which areas are audited.</b></p> <p><i>Post meeting note: this has been included in the work-plan.</i></p> <p>The Board Noted the report.</p> | LT |
| TB 3/9/4.2 | <b>Guardian of Safe Working Annual Report</b>  |    |
|            | <p>JB presented the annual report on safe working to the Board, and the following was noted.</p> <ul style="list-style-type: none"> <li>• The Gaps on rotas currently lie at 8-10%, owing to the deanery not allocating the same number of staff that they have previously.</li> <li>• COVID has had a knock on effect with filling some gaps on the rota owing to staff not rotating to other areas.</li> <li>• Workforce reviews have taken place recently.</li> <li>• Senior Nursing posts have recently helped out with other roles and we are currently reviewing to see if this is possible to extend further.</li> </ul>  |    |

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|                          | <ul style="list-style-type: none"> <li>• There have been 0 safety concern reports.</li> <li>• 1 fine has been received for working over 13 hours.</li> </ul> <p><b>Discussion:</b></p> <ul style="list-style-type: none"> <li>• MVB explained that the Board notes the work which JB has completed recently especially in relation to Hospital at Night (H@N)</li> <li>• RA asked in what capacity were senior nurses helping out in other roles</li> <li>• JB explained that senior nurses were being used to triage cases in some instances.</li> <li>• RA asked if there was a strategy going forward for this to be addressed long term.</li> <li>• JB advised that they are currently working with nursing teams both internally and externally as well as nationally to understand best practice in order to address this.</li> <li>• TB asked if we were safe from a staffing shortages perspective.</li> <li>• JB confirmed that yes we are safe.</li> <li>• NM thanked JB for his work.</li> </ul> <p>The Board noted the report.</p>   |  |
| <p><b>TB 3/9/5</b></p>   | <p><b>QUALITY AND RISK</b></p>   |  |
| <p><b>TB 3/9/5.1</b></p> | <p><b>DIPC</b></p>   |  |
|                          | <p>JD presented the report to the Board and commented that going forward there will be a more succinct report coming to the Board. The following was noted by the Board.</p> <ul style="list-style-type: none"> <li>• Low levels of hospital acquired infection.</li> <li>• Concerns raised with water safety remains with 2 cases of legionella recorded.</li> <li>• In relation to handwashing, improvements continue to be seen through perfect ward.</li> </ul> <p><b>Discussion:</b></p> <ul style="list-style-type: none"> <li>• PM queried if infection control will have a constraint on our recovery.</li> <li>• JD advised that yes it will and in particular how patients flow through the Trust.</li> <li>• JD advised that there is a national push for us to make this work and advised that action cards for each pathway have been updated in order to maximise flow of patients.</li> <li>• AH asked for it to be noted that the work which infection control have completed along with estates team to be noted by the Board.</li> <li>• NM noted and thanked both the estates and infection control team .</li> </ul> |  |

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| <b>TB 3/9/5.2</b> | <b>IPC Board Assurance Framework</b>   |           |
|                   | <p>JD presented the paper to the Board and the following was noted.</p> <ul style="list-style-type: none"> <li>• The positive is that good progress has been made.</li> <li>• The concern remains about ventilation where aerosol generated procedures take place.</li> </ul> <p>The Board noted the report.</p>   |           |
| <b>TB 3/9/5.3</b> | <b>Clinical Governance Annual Report</b>   |           |
|                   | <p>SD presented the report to the Board and the following was noted.</p> <ul style="list-style-type: none"> <li>• GI unit is going ahead and work continues.</li> <li>• Progress has been made in relation to outpatients moving to more digital ways of working.</li> <li>• Clinical Governance Meetings continue to get stronger and continue to improve.</li> </ul> <p><b>Discussion:</b></p> <ul style="list-style-type: none"> <li>• EP queried that unwarranted variation and the use of GIRFT to tackle this appears to be omitted and asked if there was a reason for this.</li> <li>• SD advised that the actions from GIRFT can be highlighted in the report going forward.</li> <li>• TB agreed with EP and commented that it needs to be embedded.</li> </ul> <p><b>Action: CG annual report to include GIRFT report highlights going forward.</b></p> | <b>SD</b> |
| <b>TB 3/9/5.4</b> | <b>Research Annual Report</b>  |           |
|                   | <p>SD presented the report to the Board and the following was noted</p> <ul style="list-style-type: none"> <li>• The trust has had a difficult year in undertaking research and the loss of income, and as a result the Trust has been unable to adequately mitigate the risk of lost income. A large number of interventional studies closed to recruitment and we were unable to identify replacement activity.</li> </ul> <p><b>Discussion</b></p> <ul style="list-style-type: none"> <li>• EP asked about linking research to the innovation agenda and opportunities to improve.</li> <li>• PM raised that the executive summary table shows that we</li> </ul>   |           |

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|                    | <p>are not reaching targets.</p> <ul style="list-style-type: none"> <li>• EP informed that the national targets do not really suit our organisation owing to the size of our Trust, but also recognised that moving forward there may be small gains which we can achieve.</li> </ul> <p>The Board noted the report.</p>   |  |
| <b>TB1 3/9/6</b>   | <b>CLOSING BUSINESS</b>  |  |
| <b>TB1 3/9/6.1</b> | <b>Agreement of Principle Actions and Items for Escalation</b>   |  |
|                    | <p>N Marsden noted the following highlights from the meeting:</p> <ul style="list-style-type: none"> <li>• The steer from the Board is that the focus is on serving our patients as best we can in the current circumstances.</li> <li>• It is beholden on the Board and the sub committees to ensure this message is heard.</li> </ul>  |  |
| <b>TB1 3/9/6.2</b> | <b>Any Other Business</b>  |  |
|                    | No other business  |  |
| <b>TB1 3/9/6.3</b> | <b>Public Questions</b>  |  |
|                    | <p>JM thanked NM for the opportunity to raise a question. JM informed the Board that concerns have been raised that patients have no central place to obtain information on what is happening in relation to hospital services and Covid. In particular in relation to appointments and what happens if patients decline appointments because they do not want to attend the hospital. JM further explained that patients believe they automatically go to the back of the queue in relation to hospital appointments. JM asked if there was something which the Trust could do in order to have a central point for information where patients could go to either look up information or a telephone number to call for all information.</p> <p><b>Discussion:</b></p> <p>AH thanked JM for his question and advised that he is able to give assurance to both JM and the Board that patients do not go to the back of the queue if they did not want to attend. AH further advised that all appointments are booked and reviewed on clinical need. AH further updated that the hospital has recently undertaken a lot of work in order to make the hospital a safe place to attend, and also undertaken a validation list exercise on the waiting list, but noted that challenges remain when it comes to specialised appointments where the clinical environment needs to be adapted. JM thanked AH for his assurance, but queried having a direct line for enquires. AH informed that he would take the action to review what would be possible to set up a central point for information and would report</p> |  |

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|                    | back to JM outside of Trust Board.<br><br><b>Action: AH to review whether it is feasible to set up a central point for information in relation to changes in the hospital and changes to appointments and will get someone to link in with JM outside of Trust Board.</b> |  |
| <b>TB1 3/9/6.4</b> | <b>Date of Next Meeting</b>   |  |
|                    | Thursday 5 <sup>th</sup> November 2020  |  |
| <b>TB1 3/9/7</b>   | <b>RESOLUTION</b>   |  |
|                    | 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).   |  |

List of action items Trust Board Public 3 September 2020

| Agenda item  |   | Assigned to      | Deadline   | Status    |
|--|---|------------------|------------|-----------|
| 3.2 Annual Review of Board and Committee Effectiveness |   |                  |            |           |
| 246.   | TB1 3/9/3.2 Annual Review of Board and Committee Effectiveness  | ● Marsden, Nick  | 05/11/2020 | ■ Pending |
|  | <i>Explanation action item</i><br>NM to discuss Board 360 final review session with the 360 assessor and inform the Board of outcome and next steps                   |                  |            |           |
| 4.1 Health and Safety Annual Report                    |   |                  |            |           |
| 247.   | TB1 3/9/4.1 Health and Safety Annual Report   | ● Thomas, Lisa   | 05/11/2020 | ■ Pending |
|  | <i>Explanation action item</i><br>LT to ensure Audit Committee review the methodology the Health and Safety Group use to prioritise which areas are audited           |                  |            |           |
| 5.3 Clinical Governance Annual Report                  |   |                  |            |           |
| 248.   | TB1 3/9/5.3 Clinical Governance Annual Report   | ● Davies, Sallie | 05/11/2020 | ■ Pending |
|  | <i>Explanation action item</i><br>CG annual report to include GIRFT report highlights going forward   |                  |            |           |
| 6.3 Public Questions                                   |   |                  |            |           |
| 249.   | TB1 3/9/6.3 Public Questions  | ● Hyett, Andy    | 05/11/2020 | ■ Pending |
|  | <i>Explanation action item</i><br>AH to review whether it is feasible to set up a central point for information in relation to changes in the hospital and changes to |                  |            |           |



**Salisbury**  
NHS Foundation Trust

29 October 2020 12:46

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| appointments and will get someone to link in with JM outside of the meeting |
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| <b>Report to:</b>       | Trust Board (Public)          | <b>Agenda item:</b> | 1.8 |
| <b>Date of Meeting:</b> | November 5 <sup>th</sup> 2020 |                     |     |

|   |  |                   |                  |                 |
|---|--|-------------------|------------------|-----------------|
| <b>Report Title:</b>                    | Chief Executive's Report                 |                   |                  |                 |
| <b>Status:</b>                          | <b>Information</b>                       | <b>Discussion</b> | <b>Assurance</b> | <b>Approval</b> |
|   | X  | X                 |                  |                 |
| <b>Prepared by:</b>                     | Gavin Thomas, Executive Services Manager |                   |                  |                 |
| <b>Executive Sponsor (presenting):</b>  | Stacey Hunter, Chief Executive           |                   |                  |                 |
| <b>Appendices (list if applicable):</b> | Appendix 1 – AHA Briefing                |                   |                  |                 |

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| <b>Recommendation:</b>   |
| The Board is asked to receive this paper as progress against the local, regional and national agenda . |

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| <b>Executive Summary:</b>  |
| <p>This report provides an update for the Trust Board on some of the key issues and developments within this reporting period and covers:</p> <ul style="list-style-type: none"> <li>• <b>Introduction</b></li> <li>• <b>National Context and Update</b></li> <li>• <b>Regional Update inc STP</b></li> <li>• <b>Salisbury NHS Foundation Trust Update</b></li> <li>• <b>News</b></li> </ul> |

## 1) Introduction

I've now completed two months at the Trust and I've really enjoyed getting to meet staff from across our hospital and from across the STP and broader South West Region. I have initiated a number of opportunities to meet with colleagues including regular 'Ask the CEO' question and answer sessions, re-started the Consultants breakfast meetings and have planned a weekly senior leadership forum which commences in November 2020.

We will also be reinstating the 'Cascade Brief', an important forum for disseminating Trust wide news and information to staff. These face-to-face briefings were paused due to COVID-19 and will resume virtually in November.

I am really impressed by the level of commitment across our services and grateful to all colleagues who have been welcoming and patient whilst I get to grips with the way things work at Salisbury FT

I am delighted that Dr Peter Collins has joined us in October as our Medical Director and I know

you will want to join me in welcoming him and also thanking Sallie Davies and Duncan Murray who provided cover for the role during August and September.

## 2) National Context and Update

2.1 As colleagues will be aware the Covid-19 pandemic is not over and over the last two weeks the government with the support of Department of Health and Social care has introduced a 3 tier system of local lockdowns as a further response to the virus.

There is significant regional and geographical variation in the levels of COVID in communities and hospitals across England, with some parts of the country experiencing significant pressure and levels of hospital admissions that are as high as at the peak of the first phase of the pandemic. Wiltshire is currently in Tier 1 (the lowest tier) as are the majority of the South West regions, a situation that we with the support of our Public Health Colleagues are keeping under constant review. From the 29<sup>th</sup> October NHS England and Improvement (NHSE/I) have announced plans to publish further details regarding the number of Covid-19 inpatients. National and regional numbers will be published daily and trust specific data will be released every Thursday.

2.2 Board colleagues will be aware that nationally there is a real focus on planning and reset as set out in the **Phase 3 letter**. As we have been discussing this isn't just a case of switching things back on; we have to ensure that patients attending can socially distance, we need plans in place for managing patients on red (COVID positive patients), amber (awaiting COVID test result) and green (COVID negative) pathways as well as who we need to test and when. I am sure the Board will appreciate the level of complexity involved in this each day and I'm impressed with the way our teams continue to respond to ensure that we continue to do the right thing for the communities we serve.

2.3 Our reset plans across BSW have been submitted to the regional and national team as per their ask and whilst we are not able to meet all of the ambitious trajectories we are making good progress. Board colleagues can see the detail of this in the revised integrated performance reports.

2.4 Winter planning has received significant focus nationally and Executive colleagues have joined webinars led by Pauline Philips and Keith Willets on the challenges of managing winter, Covid-19 and reset over the coming weeks and months.

2.5 The December deadline for Brexit is fast approach and the Chief Operating Officer is leading the preparation and mitigation work aligned with NHSE/I and the DOH on the Trust's behalf.

## 3.0 Regional Update

3.1 Responding to the COVID -19 pandemic has reinforced the importance of healthcare and other organisations working more closely together. This has given renewed impetus to the work underway to become an 'integrated care system' ( BSW) in order to deliver the NHS long term plan and the Trust is fully involved and engaged in this work.

The Board have had an opportunity to review and comment on the draft ICS submission for BSW following discussion at our October Board meeting. There is a further update to this in private Board and Richard Smale, Executive Director of Strategy and Transformation in the CCG will join the Board for this discussion. This is an important milestone for us, and one I know the Board will continue to prioritise.

3.2 The Acute Hospital Alliance are continuing to progress work looking at how we can strengthen our horizontal partnerships across BSW to respond to collective sustainability challenges e.g

workforce pressures, financial challenges and access to high quality care . The work we are prioritising as a Trust on continuing to strengthen our clinical leadership as part of our ambition to be clinically led is integral to the AHA work going forward. Attached is the October edition of the AHA newsletter which gives further information on the work. I am keen to ensure that our clinical leaders and their teams are at the forefront of this work as it progresses over the coming months

3.3 As part of the reset work the financial allocation for BSW has been detailed. The Board will receive further detail of this via the Finance and Performance committee and how we continue to respond to prioritise our efforts to close the financial gap we are facing as part of our overall response to secure sustainable services for our population

3.4 I have been invited to take part in a discussion on the 30<sup>th</sup> November with the South West Regional Director of Commissioning, re setting up a new partnership board and arrangements covering BSW and Dorset ICS for specialist commissioning going forward .This will be a priority for us given our specialist services and ensuring our population can continue to have equal access to specialist services going forward. I will verbally update the Board at our November meeting.

#### **4.0 Salisbury NHS Foundation Trust Update**

4.1 Covid-19- The hospital has maintained its state of preparedness and stepped up the incident management response as the number of people with the virus in our community and hospital admissions increase. The Chief Operating Officer will provide a verbal update to the Board given this is a dynamic situation .

4.2 Every year the NHS undertakes a huge flu vaccination programme to protect staff. This year that work is even more important to reduce any further pressure on the hospital. Our staff flu vaccination campaign launched on 05th October and already over 1200 frontline staff have been vaccinated, which is an encouraging start. Our aim is to ensure all staff receive the vaccination and this will be rolled out to all staff groups over the coming weeks.

4.3 Workforce-The Trust ran an assessment centre for HCA's on 3 October which was part of a Trust wide recruitment campaign. On the back of this campaign, 38 applied people have applied, 32 were invited to interview, 16 withdrew /could not attend due to COVID symptoms and 15 offers made on the day

For those that were unable to attend we have contacted them to invite them to interview on 6 November. There are currently 4 who have replied and will be interviewed on 6 November

There have been 54 new starters in the month, the highest since January. We are planning for increased levels of recruiting for the next few months as the number of vacancies has also increased. We have made a bid in response to an NHSE/I invitation to obtain funding to support international nursing recruitment and have already been advised of success in one bid of three. The Head of Resourcing has been involved in discussions at the BSW Recruitment and Retention work stream about international recruitment, bank and agency usage, and values based recruitment. Those discussions will continue at system level.

In September, the Trust's overall sickness absence rose to 3.45%, from August 3.16%, with 3.14% being non-COVID and 0.31% being COVID-related. .

Mandatory training has again increased slightly to 91.9%, above the 90% target, and non-medical appraisals have reduced slightly over August to 81.49%. Medical appraisal compliance is well below the target of 90%, at 81.2%, but this is due to be reset to take account of those deferred.

We are conscious of the need to continue to support all our staff and are seeking new ways of improving staff health and wellbeing through any available initiatives, and regularly communicating these through the daily bulletin.

4.4 The annual NHS Staff Survey launched on 01 October. 2020 has been a year like no other, however, it remains vital this year that we accurately measure and understand the experience of working in the NHS. The Trust is actively encouraging all staff to complete the survey to help us understand what we do well and what we need to do better – both locally here at Salisbury and nationally. Almost 20% of staff have completed the survey to date which is similar to our response at this stage last year. We are aiming to increase our response rate to circa 60-65%.

## **5.0 News**

5.1 MRI Scanner Installation- Work has now started on installing the first of two new MRI scanners. This is being installed in the Old Healthcare Library and should be completed by early 2021. The second cardiac enabled scanner will be installed later in the spring next year.

The patient suite for the Old Library scanner and the second cardiac enabled MRI scanner are being funded through the incredibly kind and generous donations made to the Stars Appeal.

This upgraded technology will help to improve patient diagnosis and care. The Library, Estates and Portering teams have worked hard to relocate our healthcare library and prepare this space.

5.2 Trust's first ever Dragons' Den took place on 30 September. The Trust recognises that staffs on the ground are best placed to know what and how things could be improved in their specific areas of work. That's why the Dragons' Den initiative was introduced to encourage innovation and improvement.

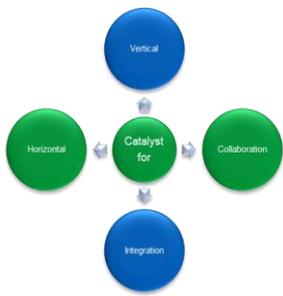
Each of the five shortlisted teams braved the den and pitched their improvement idea for the chance to win £10,000 of funding and support from the Trust.

The dragons – Nick Marsden, Chairman, Esther Provins, Director of Transformation, Chris Horwood (former Governor) and Allison Peebles, Head of Nursing Medicine, were really impressed with the high standard of ideas from all the finalists. There could however only be one overall winner and this was Catherine Whitmarsh and Rachael Coulson-Smith from the Spinal Therapy Team with their project to 'extend the spinal centre gym opening hours'. The project will now receive funding and support from the Trust to turn this idea into a reality.

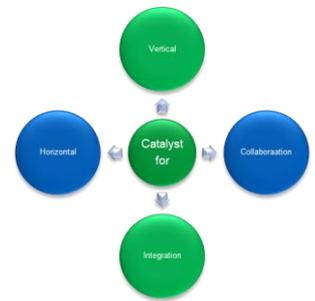
The dragons were so impressed with the other finalists that all shortlisted teams will be supported by the Trust to help them progress their ideas further.

5.3 Colleagues from our BAME network have organised a series of events to mark Black History month and celebrate our cultural diversity in the Trust. This has included opportunities to serve foods from different cultures in Springs and also take part in an education quiz with prizes which we have supported ( the Executives can take part but are exempt from claiming the prizes)

**Stacey Hunter**  
**Chief Executive**



## Acute Hospital Alliance Briefing October 2020



### Summary of Highlights

The Acute Alliance continues to meet regularly, fostering effective and collaborative working relationships between Great Western Hospital, Salisbury, and RUH Bath NHS Foundation Trusts. This short briefing is issued after each of our Programme Board meetings and is designed to provide timely updates on the Acute Hospital Alliance (AHA) Programme for Boards of Directors, Governors and Management teams.

The AHA Programme recognizes an important role for our organisations in **furthering horizontal collaboration** in clinical and back-office functions, while also underlining the vital role of AHA members in **enabling vertical integration**. The programme is organised in three complementary streams of work targeting a range of **efficiency and resilience** opportunities:

1. AHA Corporate Stream
2. AHA Recovery/ Next Phase Covid-Response
3. AHA as Effective BSW Partners.

**Our short-term focus:** Over the next 90 days our programme leads working with teams across BSW will focus on taking forward the following projects (– new schemes in italics):

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|--|---|---|
| <p><b>1. AHA Corporate</b></p> <ul style="list-style-type: none"> <li>• Financial Systems [Procurement, ledger, payroll, contracting, costing]</li> <li>• EPR Alignment OBC</li> <li>• DGH Strategy</li> </ul> | <p><b>2. Recovery/ Next Phase</b></p> <ul style="list-style-type: none"> <li>• Elective Prime Provider Model – Shared Elective Capacity; single waiting list; shared diagnostics.</li> <li>• <i>BSW AHA Peer learning</i></li> <li>• <i>BSW Critical Care Alliance</i></li> </ul> | <p><b>3. Effective BSW Partners</b></p> <ul style="list-style-type: none"> <li>• ICS Development</li> <li>• Team BSW in 1 + specialty [Dermatology, Paediatrics, Histopath]</li> <li>• Understanding structural financial gap</li> <li>• <i>AHA Improvement Approach</i></li> </ul> |
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The Programme Board met for three sessions in October. At the start of the month we held a workshop on the RUH Health Infrastructure Plan (HIP2) programme and a dedicated session designed to confirm the approach we will take to our single Electronic Patient Record business case development.

### RUH Health Infrastructure Plan (HIP2); Investing in BSW

- RUH Director of Strategy, Jocelyn Foster led a workshop session with Programme Board members designed to support development of the HIP2 Strategic Outline Case by seeking AHA partner insights into the potential clinical model and vision for the future of RUH. The session generated a wide range of ideas including the following:

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- **Scale and Locality.** Where we can deliver at scale we can realise enhanced resilience and create productivity benefits, meanwhile residents may benefit from more local area focus; a careful balance between these benefits is required. As the BSW integrated care system develops, connection between local authority, primary, community and acute care presents opportunities.
- We should think forward to the **models of the future** to forecast capacity requirements effectively – for example, if we see community diagnostics in high street hubs what might this mean for major site development?
- There are opportunities to move the provision of care off-site, using new technology where possible. There would be value in creating a **campus of complementary services** to provide **better joined-up healthcare** e.g. mental health and physical health.
- There will be major clinical and care change over the life of the new RUH facility; therefore must ensure **flexibility** in the physical space.
- The AHA could think about the art of the possible around collective back office. We could use a **framework to review all areas of back office** to identify priority areas for joined-up working.
- The HIP2 development programme should work closely with the **BSW Financial Sustainability programme**.

*Coming up soon:* In November the Programme Board looks forward to hearing about the **SFT Campus Programme**, and discussing the proposed SFT clinical model.

### Electronic Patient Record Alignment Business Case

- Our dedicated Programme Board session on development of a single EPR began with Charlotte Forsyth, Medical Director GWH, introducing the qualitative clinical benefits of adopting a common EPR on behalf of the three Medical Directors:
  - *'In light of developments we have seen over the last two years, looking forward, it is hard to see how working individually as organisations we can realise benefits of a scale anywhere near approaching those that we could achieve by working together. A single EPR would be **an essential enabler in developing integrated care system working...***
  - *Working together would enable our clinical teams, allowing establishment of **single standardised pathways**, single waiting lists, with embedded **clinical decision-making support**, decreasing unwarranted variation in care. It would allow pooling of resources – virtual BSW specialty clinical workforce – **enhancing our flexibility and resilience....'***
- Esther Provins and David McClay, then summarized **learning from other Trusts** around the UK that have pursued multi-site EPR systems, including the Royal Free, Royal Cornwall, Calderdale & Huddersfield & Bradford Teaching Hospitals. Programme Board members acknowledged the strong clinical case.
- **Funding.** Potential funding sources were discussed. Access to funding would be a critical element of the business case.
- **Next Steps:** At the end of the session it was agreed that work on the OBC should proceed promptly. The EPR Programme Board would meet fortnightly to track progress. Programme resources should be secured as quickly as possible, and work with both BSW and SW Regional teams on the **affordability element** of the business case would be vital.

**Our mid-October AHA Programme Board** welcomed Peter Collins, new interim Medical Director at SFT. The session received updates from leads on OD and Improvement approach across the Acute Alliance, our DGH Strategy Development, the BSW Structural Financial gap response, and the AHA contribution in the BSW ICS Submission.

### OD and Improvement Approach in AHA

- Jude Gray and Sally Fox from GWH, Claire Radley from RUH, Esther Provins and Lynn Lane of SFT, led a discussion on **improvement methodology and cultural change capability and capacity** – with the aim to enhance the three Trusts' ability to drive transformative change and make improvements at scale and pace.

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- The RUH had already implemented an extensive improvement programme supported by KPMG. It was agreed that the potential to spread learning from RUH’s approach would be explored.
- In discussion, the role of the **BSW System Capability group** was noted and it was recognized that plans to establish a BSW Academy might have an important supporting role.
- **Next Steps / Action:** It was agreed that a core team from the three Trusts would meet over the next six weeks to develop an OD and Improvement approach proposal, with funding implications, in readiness for consideration at the December 10<sup>th</sup> AHA Programme Board.

#### DGH Strategic Plan

- Cara Charles-Barks introduced material compiled by Joss Foster summarising conversations held recently with strategy leads across all three organisations. Those early conversations had explored where energy currently lies in terms of AHA Vision, AHA Remit and associated Governance. The Programme Board discussed a range of opportunities and potential next steps:
  - There was appetite for identifying further opportunities for joint work at scale: for example - Phase 3, sustainability, specialist services, learnings from COVID, business and service planning
  - There was recognition of the value of transparency between AHA members to support developing relationships.
  - A refresh of remit/vision/ambition and AHA TORs/MOU would be helpful.
  - Joint Board and Governor development could be explored and there is a need to develop an effective AHA communications plan across the three Trusts.
- **Next Steps / Action:** A **core team** of leads from the three Trusts would continue to **build DGH Strategic Narrative Development Plan** in readiness for a **workshop session in January 2021** that would shape the programme for the next phase.

#### Structural Financial Gap; BSW Financial Sustainability.

- Lisa Thomas, updated the Programme Board on the developing thinking of the BSW DoFs; it is clear that achieving financial sustainability must be a core component part of our maturing as a system.
- The recent **Drivers of the deficit report** noted a £70m gap between funding and current cost base in BSW. The AHA will be very actively involved in the system structural financial gap work and associated recovery planning in coming months – taking a ‘how do we respond collectively to our system problem in BSW’ approach. As provider organisations, we need to be at the centre of driving a sustainability programme which ensures services can be delivered within the available funding.
- The Programme Board recognised that achieving sustainability will require a combination of **both an achievable plan** – as well as **behaviours and values** that support change.
- Of course, as individual organisations we will align to what we have already done/have underway, but we will need to look at some things differently.

#### New Project Established: BSW AHA Peer Learning & Improvement sessions.

- Increasingly, learning from each other is becoming our start point; the AHA programme has seen us bringing our clinical and operational teams together to explore opportunities for support and development.
- In November and December BSW AHA will hold a series of workshops supported by our transformation teams to review and check with each other and align our approach to the following areas:
  - Wave 2 triggers and impact; Testing –patient and staff; Theatres including IPC measures/red/green; Beds – escalation red/green; Endoscopy; Outpatients- virtual usage.
- We plan to use the *Adapt and Adopt* framework as a template.
- These sessions will see MDs, COO’s, DoNs, and DoFs working with service managers/subject matter experts to identify areas for alignment. Invitations to sessions will be issued shortly.

#### AHA as Effective Partner in BSW

- AHA noted that the BSW ICS Designation final submission was made on 12<sup>th</sup> October. The submission included details on the following AHA schemes: *Elective Prime Provider Model; Common EPR; GIRFT: AHA Joined-Up Approach in BSW; AHA Peer Learning & Improvement Approach; BSW Procurement Collaboration.*

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## Further Updates since Last Briefing

1. The three **AHA Medical Directors** meet monthly to consider emerging areas for alignment, to support progress of AHA clinical projects and also to coordinate our input to the BSW Population Health and Care Design group – one of the BSW ICS Programme's three workstreams.
2. **Elective Prime Provider MOU and single waiting list plan.** Back in September, the Programme Board determined that we should proceed to implement and test the new networked working model, adapting it as required. Lisa Thomas, SRO and the project team are working with the three COOs and BSW CCG to establish a pilot. An update on progress will go to November Programme Board.
3. **BSW Clinical Teams – Paediatrics.** SRO Charlotte Forsyth and programme team met Paediatrics leads in early October. Next steps will see priorities for support and development being identified by clinical leads.
4. **Procurement Collaboration.** Our Procurement Transformation Board has been re-established and meets monthly. In October the Transformation Board approved a proposal to explore **options to deepen collaboration** between the three Trusts; Rob Webb has been asked to lead this options development work.
5. **The GIRFT programme** has re-started. Our three **gastroenterology** services were reviewed in recent weeks; good practice and improvement opportunities identified by these three reviews will be collated and shared between the three sites. A regionally-based **GIRFT programme to support recovery of elective activity** is being planned. Initial focus will be on **Orthopaedics** and **Ophthalmology** services – we understand that invitations to sessions in November will be issued shortly.
6. **An AHA Virtual Core team** continues to meet fortnightly to ensure timely progress. The group comprising leads in each Trust, maintains an overview of progress across the three workstreams. **Trust Core Team Leads:** Esther Provins, SFT; Stacey Saunders, GWH; Fiona Bird, RUH; Ben Irvine, AHA.

## Acute Hospital Alliance Programme Board Members

| GWH  | SFT  | RUH  |
|--|--|--|
| <ul style="list-style-type: none"><li>• Liam Coleman</li><li>• Kevin McNamara</li><li>• Charlotte Forsyth</li><li>• Tracey Cotterill</li></ul> | <ul style="list-style-type: none"><li>• Nick Marsden</li><li>• Stacey Hunter</li><li>• Lisa Thomas</li><li>• Peter Collins</li></ul> | <ul style="list-style-type: none"><li>• Alison Ryan</li><li>• Cara Charles-Barks</li><li>• Bernie Marden</li><li>• Libby Walters</li></ul> |

## And Finally...

### Acute Alliance Workshop Sessions Planned

- Mid-January 2021 [date TBC]. Our next DGH Strategy Workshop.

### Next AHA Programme Board Meetings and planned focus

- 13<sup>th</sup> November [BSW Clinical Teams (Dermatology & Paediatrics), AHA Clinical Services Strengths & Resilience mapping, SFT Campus Model, Elective Care - Single Waiting list Pilot, EPR Programme Governance]
- 10<sup>th</sup> December [OD and Improvement Approach Proposal; Specialised commissioning & bring back local; EPR Alignment; Financial systems]

## Further Information

- For further details, including who is involved in Acute Alliance project work in your organization, please **contact Programme Director, Ben Irvine** ([ben.irvine@nhs.net](mailto:ben.irvine@nhs.net)).

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| <b>Report to:</b>       | Trust Board (Public)          | <b>Agenda item:</b> | 2.1 |
| <b>Date of Meeting:</b> | 5 <sup>th</sup> November 2020 |                     |     |

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| <b>Report from:<br/>(Committee Name)</b> | Clinical Governance Committee |                   | <b>Committee Meeting Date:</b> | 27 <sup>th</sup> October 2020 |
| <b>Status:</b>                           | <b>Information</b>            | <b>Discussion</b> | <b>Assurance</b>               | <b>Approval</b>               |
|  | X                             |                   | X                              |                               |
| <b>Prepared by:</b>                      | Miss Eiri Jones, Chair CGC    |                   |                                |                               |
| <b>Board Sponsor (presenting):</b>       | Miss Eiri Jones, Chair CGC    |                   |                                |                               |

**Recommendation**

Trust Board members are asked to note the items escalated from the Clinical Governance Committee (CGC) meeting held on the 27<sup>th</sup> October 2020. The report both provides assurance and identifies areas where further assurance was sought and is required.

**Key Items for Escalation**

- The new Interim Medical Director, Divisional Director Medicine and Divisional Head of Nursing Medicine were welcomed to the committee. 2 Governors were also present and were welcomed as were those presenting reports.
- The meeting was quorate.
- Key information / issues / risks to escalate to the Board are as follows:
  - A Covid-19 update was provided. It was noted that numbers are rising with some admissions to intensive care. Assurance was provided that care has changed and improved since March due to the sharing of learning from the beginning of the pandemic. Whilst testing remains a challenge it was positive to note that there had been no nosocomial spread in the hospital.
  - The ongoing challenge in relation to theatre restart was discussed and assurance provided that a plan is being implemented to improve staffing levels and use of theatre space for elective and urgent non-Covid19 work. An increase in activity is expected from November 2020. This will be followed up in future committee meetings.
  - Further assurance was provided by the Clinical Director for Surgery that the Trust can demonstrate a robust process for reviewing patients on the waiting lists. This is currently going through another round of review. It was noted that approximately 2.5K patients were on the waiting list. The process has been approved as robust by NHSI/E. Following discussion, it was agreed that a quality impact assessment (QIA) and equality impact assessment (EQIA) would be undertaken.
  - A verbal update was received in relation to the transformation programme noting that the new e-outcome form for cancer services will roll out later this month.

Another positive improvement was the artificial intelligence (AI) work the Trust is engaging with in relation to stroke. Ongoing challenges exist in virtual consultations numbers and discharge before midday. Both of these will be further reviewed at future committee meetings.

- Two annual reports were received, risk management and maternity. Both received detailed discussion and further assurance was sought in both areas. A maternity update is on the next committee meeting agenda.
- A report was received in relation to internal audit. It was noted that there are likely to be more quality focussed audits proposed for 2021-2.
- It was positive to note that a QIA was received in relation to the front of hospital pharmacy proposal. A further QIA will be undertaken once the service has been live for 6 months.
- A very positive presentation was provided by the Cancer Matron in relation to the cancer patient survey. Positive assurance was gained with the Trust performing in the top quartile. It was also positive to note that despite this high performance the team were working on identifying further improvements. The team were thanked for their efforts and the discussion identified the need to promote the good practice in place.
- A 6 month update was presented by surgery and medicine in relation to pressure ulcers. Whilst improvements have been made and widespread training has been rolled out, all agreed that there was more work to do. The Director of Nursing outlined that the ward performance review programme would commence in November and that pressure ulcers would be included in that programme.
- The 2021-2 CGC business cycle was presented. It was agreed in the short term, recognising the need to refine the agenda setting around new strategic priorities and post Covid-19 restart.

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|-------------------------|----------------------|---------------------|-----|
| <b>Report to:</b>       | Trust Board (Public) | <b>Agenda item:</b> | 2.2 |
| <b>Date of Meeting:</b> | 5 November 2020      |                     |     |

|                                    |                                     |                   |                                |                               |
|------------------------------------|-------------------------------------|-------------------|--------------------------------|-------------------------------|
| <b>Committee Name:</b>             | Finance and Performance             |                   | <b>Committee Meeting Date:</b> | 27 <sup>th</sup> October 2020 |
| <b>Status:</b>                     | <b>Information</b>                  | <b>Discussion</b> | <b>Assurance</b>               | <b>Approval</b>               |
|                                    |                                     |                   | X                              |                               |
| <b>Prepared by:</b>                | Paul Miller, Non Executive Director |                   |                                |                               |
| <b>Board Sponsor (presenting):</b> | Paul Miller, Non Executive Director |                   |                                |                               |

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| <b>Recommendation</b>   |
| To note key aspects of the Finance and Performance (F&P) Committee meeting of the 27 <sup>th</sup> October 2020 |

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|---|
| <b>Items for Escalation to Board</b>  |
| <p><b>Replacement Finance and Accounting System</b> – The F&amp;P Committee received a business case and procurement recommendation report, which contained a recommendation on the way forward to replace the Trusts current finance and accountancy system, as it had come to the end of its useful life. The F&amp;P Committee supported the recommended way forward and this would be going to the Trust Board meeting on the 5<sup>th</sup> November 2020 for a formal decision.</p> <p><b>Recommendation Report for Non-Urgent Patient Transport</b> – The F&amp;P Committee also received a procurement recommendation report on this inpatient non-urgent transport contract, which is directly commissioned by the Trust. Noting that outpatient transport services are directly commissioned by the Clinical Commissioning Group (CCG). The F&amp;P Committee supported the recommended way forward and this would also be going to the Trust Board meeting on the 5<sup>th</sup> November 2020 for a formal decision. However the F&amp;P Committee also noted concerns about how to be assured on out-sourced contracts and service level agreements (SLA's) and the Committee would consider the best way of gaining this assurance.</p> <p><b>Integrated performance as at 30<sup>th</sup> September 2020</b> – Key themes arising from this report were (a) the hospital is slowly recovering its services after the previous covid restrictions in the Spring and early Summer (b) referrals and attendances, whilst still lower than pre-covid times, are slowly increasing and evidence of this is increasing pressure on Emergency</p> |

Department (ED) 4 hour performance, which showed reduced performance at 88% in September 2020 (c) these ED activity pressures are compounded by challenges in discharging patients, particularly into Nursing Homes with covid infections and (d) the key area of concern however is major theatre activity performance (particularly elective activity). Main theatre cases in September 2020 were around 130, where they had been over 1,200 in January 2020. The key reason is reported as the shortage of staff (particularly operating department assistants/practitioners) associated with two main theatres still being used as additional ITU capacity. The Committee was briefed on plans to increase activity going forward but this could be affected by a second wave of covid admissions during the winter. The consequence being there could be a significantly increased elective surgery waiting list by the Spring of 2021.

**Finance Report as at 30<sup>th</sup> September 2020 and Financial Outlook up to 31<sup>st</sup> March 2021-** The Trust still continues to show an actual financial break even as at the 30<sup>th</sup> September 2020, which is significantly better than the original planned 6 month cumulative deficit of £7.944m. Looking forward to the end of the financial year (31<sup>st</sup> March 2021) the Trust has received updated NHS financial guidance and we are currently forecasting a deficit of between £3.2m and £4.1m, which whilst a challenge is better than the original forecast 2020/21 deficit of £13.6m.

However going forward into 2021/22 there are major challenges that will need to be addressed by the 31<sup>st</sup> March 2021 (a) the hospital will need to agree and implement a range of fully “covid compliant” clinical pathways (b) both staff and non-staff budgets will need to be agreed for these new pathways (c) our total budgeted expenditure going forward (our cost base) will need to be within whatever our new income is for 2021/22 (noting that there is likely to be a new NHS tariff methodology for 2021/22) and (d) the Trust will need to ensure all relevant financial governance arrangements, going forward, are in place and complied with.

|                         |                      |                     |     |
|-------------------------|----------------------|---------------------|-----|
| <b>Report to:</b>       | Trust Board (Public) | <b>Agenda item:</b> | 2.4 |
| <b>Date of Meeting:</b> | 05 November 2020     |                     |     |

|   |  |                   |                  |                 |
|---|--|-------------------|------------------|-----------------|
| <b>Report Title:</b>                    | Trust Management Committee (TMC)         |                   |                  |                 |
| <b>Status:</b>                          | <b>Information</b>                       | <b>Discussion</b> | <b>Assurance</b> | <b>Approval</b> |
|   | x  | x                 | X                |                 |
| <b>Prepared by:</b>                     | Gavin Thomas, Executive Services Manager |                   |                  |                 |
| <b>Executive Sponsor (presenting):</b>  | Stacey Hunter, Chief Executive           |                   |                  |                 |
| <b>Appendices (list if applicable):</b> | Appendix 1 – EPRR Assurance Letter       |                   |                  |                 |

|   |
|---|
| <b>Recommendation:</b>  |
| The Board is asked to note the report outlining items raised at the Trust Management Committee meeting held on 21 <sup>st</sup> October 2020. |

|   |
|---|
| <b>Executive Summary:</b>   |
| <p>The Trust Management Committee met on 21<sup>st</sup> October 2020 and the following outlines the key points for the Board to note. The committee considered 2 business cases this month.</p> <ul style="list-style-type: none"> <li>• Safeguarding Business Case which asked for approval to support the enhancement of the adult and children’s safeguarding services. This business case was approved by the committee in principle with a caveat which required the department to determine how the post will be funded. This is to come back through the Executive Directors Meeting by 16<sup>th</sup> November 2020.</li> <li>• The Cardiac Catheter Lab 1 replacement business case which asked for approval of capital expenditure for the replacement of Cardiac Catheter Lab 1 within the 20/21 financial year was agreed. This is being brought forward from 2021/22 .This approval will impact on the recovery of elective activity during the replacement programme (estimated to be 4- 6 weeks). The team had suggested some mitigations including working on a weekend and will continue to work to minimise the amount of activity lost. .</li> <li>•</li> <li>• The committee also approved the revision of the Major Incident Policy following changes within the organisation of Directorates and Divisions and new staff in posts.</li> </ul> |

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**Other items for escalation:**

- The Transformation and Innovation and Board (TID) has met to discuss improvements in the cancer pathways following the Cancer Risk Summits over the last year. A cancer improvement project board is to be formed reporting into TID
- Outpatient Department works are not currently on track to achieve corporate objectives. To provide additional oversight of this colleagues are being asked to include this within Executive Performance Reviews.
- Windows 10 rollout risk – Roll out has commenced and additional bank resources have been secured to support this period of intensive work. December delivery is extremely tight with the absolute deadline of 14th January.
- PACS risk – PACS project is still aiming for achieving the key December deadlines as there is a continued risk should we run over. The supplier has agreed that we could take a 3 month extension rather than 6 month will means c. costs to be £50-60k. This can be covered in Informatics existing budgets.
- TMC received a letter from the CCG’s lead for EPRR following an assurance meeting they held with the Trust’s EPRR leads and the Chief Operating Officer on the 21<sup>st</sup> September. The assurance process this year was light touch reflecting the context of the pandemic however it is clear from the letter received that the EPRR team continue to so an excellent job and TMC congratulated and thanked them for their ongoing efforts ( see attached letter at appendix 1 )
- The Chief Executive thanked colleagues for all of the work in responding to the Phase 3 recovery in respect of COVID. It was acknowledged that this had been an intense period requiring colleagues to respond to short deadlines and work through the complexity of returning as much elective work as feasible whilst COVID remains present in the community and our hospital.

**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 | <input type="checkbox"/>            |
| Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population                       | <input type="checkbox"/>            |
| Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered      | <input type="checkbox"/>            |
| Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm                            | <input checked="" type="checkbox"/> |
| People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams                                       | <input checked="" type="checkbox"/> |
| Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources   | <input checked="" type="checkbox"/> |

**Tuesday 29 September 2020**

Letter to Andy Hyett  
Chief Operating Officer  
Salisbury NHS Foundation Trust

Dear Andy

Salisbury NHS Foundation Trust Annual EPRR Assurance Review 2019/20

Many thanks to yourself and Tracey for preparing SFT's position statement and your engagement in the EPRR assurance process on 21st September 2020. This letter summarises the outcomes of the meeting, capturing agreed actions and salient points from our discussions.

Progress through 2019/20

Last year's assurance confirmed SFT as fully compliant with all 64 core standards. Whilst the formal maintenance of EPRR and business continuity processes may have been put aside, it would be fair to say that the trust has unequivocally demonstrated its ability to adapt its services and respond efficiently to challenges and demands made on it. The amount of adaption to processes will have benefited engagement with staff across the trust and drawing in staff who may not normally be included in EPRR activity with the protracted running of an Incident Coordination Centre.

Some business as usual activity has taken place to get back EPRR governance back on track and the EPRR Steering Group was re-established in July with an EPRR Training Strategy and Terms of Reference agreed.

Covid-19 response and lessons identified

I would like to take this opportunity to thank all staff at SFT for their outstanding response to the ongoing Covid-19 incident. The support to BSW system has been very much appreciated and the EPRR team Tracey and Elise have been engaged in all activity with the number of innovative initiatives that had to be put in place quickly, ranging from establishing a POD to support suspect Covid-19 patients to supporting repatriation flights from cruise liners back to MOD Boscombe Down.

Further work on business continuity has taken place to prepare for EU Transition and consolidate learning from Phase 1 in anticipation of a 2nd wave of Covid-19 going into Winter.

In light of last year's EPRR Assurance outcome where Salisbury NHS Foundation Trust were 'fully compliant' against the EPRR Core Standards and the NHS National Level 4 response SFT have built on these solid EPRR foundations, managed a protracted command and control structure, and used this response to continue to reflect and take forward learning.

Reflections that we will take forward as a system are:

- Continue to stress the importance of the Single Point of Contact i.e. the ICC
- Continue to persuade NHSEI about the volume of situation reports required and in particular by exception where possible
- As the response to Covid-19, winter and EU Transition increases establish formal coordination structures so that timings are in diaries and the trust can focus on its own response around these timings

EPRR staffing and resilience going forward

It cannot be underestimated the amount of pressure on such a small team. SFT have always prided themselves on their fully compliant status seeking not only to maintain but improve and as an EPRR Team it will be difficult and disheartening to assess the amount of updates that will be required to get the trust back on target with EPRR activity. It was encouraging to learn about the additional EPRR resource now in place to support the EPRR Manager and also the change in line management reporting to the Deputy COO.

## Next steps and agreed actions

This year NHSEI have indicated that we do not need to submit evidence but have asked for a summary report of the system, the findings of all providers will be reported with an indication of work activity for the next 12 months. NHSEI have confirmed that EU Exit, winter and Covid-19 will be managed through the current ICC arrangements and we wait to see what the daily battle rhythm will look like. As soon as we have a clearer understanding of this and confirmed BSW CCG arrangements I will share with all Accountable Emergency Officers.

Once again, well done to the team for their response and efforts over the last twelve months

Yours sincerely



**Julie-Anne Wales**

**Director of Corporate Affairs and Data Protection Officer  
NHS Bath and North East Somerset, Swindon and Wiltshire Clinical  
Commissioning Group**

Copied to: Tracey Merrifield EPRR Manager and Prevent Lead

|                         |                      |                     |     |
|-------------------------|----------------------|---------------------|-----|
| <b>Report to:</b>       | Trust Board (Public) | <b>Agenda item:</b> | 2.5 |
| <b>Date of Meeting:</b> | 05 November 2020     |                     |     |

|   |  |                   |                  |                 |
|---|--|-------------------|------------------|-----------------|
| <b>Report Title:</b>                    | Integrated Performance Report                    |                   |                  |                 |
| <b>Status:</b>                          | <b>Information</b>                               | <b>Discussion</b> | <b>Assurance</b> | <b>Approval</b> |
|   | ✓  |                   | ✓                |                 |
| <b>Prepared by:</b>                     | Louise Drayton, Performance and Capacity Manager |                   |                  |                 |
| <b>Executive Sponsor (presenting):</b>  | Andy Hyett, Chief Operating Officer              |                   |                  |                 |
| <b>Appendices (list if applicable):</b> |  |                   |                  |                 |

|  |
|--|
| <b>Recommendation:</b>   |
| The Board is requested to note the report and highlight any areas of performance where further information or assurance is required. |

|   |
|---|
| <b>Executive Summary:</b>   |
| <p>Challenges in maintaining non-elective flow are beginning to be felt, with the number of stranded patients in the hospital increasing to pre Covid-19 levels (99 in M6), and flow out of the department in ED being a factor in the reduced performance against the 4 hour standard. Although ED attendances were lower (412 fewer than M6 2019-20), performance was reduced to 88% (91.52% for M6 in 2019-20). Whilst this is not reflected in the bed occupancy levels (86% for M6), a 12 hour breach was recorded in the month, for the first time in a number of years. Further work is being undertaken into how bed occupancy figures are reported to ensure that escalation capacity is being correctly reflected.</p> <p>This pressure is felt across the Trust – Stroke performance was affected with number of patients reaching the stroke unit within 4 hours falling to 50% (73.1% in M5). Additionally, 20 occurrences of non-clinical mixed sex accommodation breaches were seen in September affecting 59 patients. The Trust has had zero breaches of this prior to September since March.</p> <p>As part of phase 3 of the NHS response to Covid-19 elective activity levels have increased, although recovery of elective spells is the most challenging. This is reflected in the theatre activity levels, with main theatre activity still being some way off of pre covid-19 levels. An increase in the theatre recovery plan has been agreed, expected to start increasing in November, however Main theatres remain the escalation area for ITU should Covid-19 cases increase. September is the first month that the Elective Incentive scheme is in place and in line with guidance as a result of low elective levels this has been assessed at a negative impact of £113k but not included within the position per instruction from NHSEI.</p> |

**CLASSIFICATION: UNRESTRICTED**

The slow return of Elective activity is seen in the increase of patients waiting over 52 weeks for treatment. The backlog grew by 54 in M5 to a total of 198. This is above the forecast position of 166.

Encouragingly performance continues in the Diagnostic standard, reaching 90% in Month 6. The number of diagnostics performed increased in month to 6467 (6035 in M5).

Patient choice is still a big factor in cancer pathways. Performance against the Two Week wait standard dropped further to 85.47% in M6. Of the 144 breaches, 69 of them related to patient choice. Work continues with Primary care to develop materials encouraging patients to attend their appointments. 62 day performance fell just short of the 85% target at 84.57%, with legacy delays linked to Covid-19 and diagnostics earlier in the pathway having an impact.

Phase 1 contractual arrangements have been extended to 30th September 2020, and a phase 3 planning submission for October 2020 through to March 2021 has been submitted. Additional funding above the 2020/21 contractual block contracts has been allocated at a system level; initial forecasts suggest that this funding is less than the system's cost base.

| <b>Board Assurance Framework – Strategic Priorities</b>  | Select as applicable                |
|--|-------------------------------------|
| <b>Local Services</b> - 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 | <input checked="" type="checkbox"/> |
| <b>Specialist Services</b> - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population                       | <input checked="" type="checkbox"/> |
| <b>Innovation</b> - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered      | <input checked="" type="checkbox"/> |
| <b>Care</b> - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm                            | <input checked="" type="checkbox"/> |
| <b>People</b> - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams                                       | <input checked="" type="checkbox"/> |
| <b>Resources</b> - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources   | <input checked="" type="checkbox"/> |

# Integrated Performance Report

**November 2020**

(data for September 2020)

# Summary

Challenges in maintaining non-elective flow are beginning to be felt, with the number of stranded patients in the hospital increasing to pre Covid-19 levels (99 in M6), and flow out of the department in ED being a factor in the reduced performance against the 4 hour standard. Although ED attendances were lower (412 fewer than M6 2019-20), performance was reduced to 88% (91.52% for M6 in 2019-20). Whilst this is not reflected in the bed occupancy levels (86% for M6), a 12 hour breach was recorded in the month, for the first time in a number of years. Further work is being undertaken into how bed occupancy figures are reported to ensure that escalation capacity is being correctly reflected.

This pressure is felt across the Trust – Stroke performance was affected with number of patients reaching the stroke unit within 4 hours falling to 50% (73.1% in M5). Additionally, 20 occurrences of non-clinical mixed sex accommodation breaches were seen in September affecting 59 patients. The Trust has had zero breaches of this prior to September since March.

As part of phase 3 of the NHS response to Covid-19 elective activity levels have increased, although recovery of elective spells is the most challenging. This is reflected in the theatre activity levels, with main theatre activity still being some way off of pre covid-19 levels. An increase in the theatre recovery plan has been agreed, expected to start increasing in November, however Main theatres remain the escalation area for ITU should Covid-19 cases increase. September is the first month that the Elective Incentive scheme is in place and in line with guidance as a result of low elective levels this has been assessed at a negative impact of £113k but not included within the position per instruction from NHSEI.

The slow return of Elective activity is seen in the increase of patients waiting over 52 weeks for treatment. The backlog grew by 54 in M5 to a total of 198. This is above the forecast position of 166.

Encouragingly performance continues in the Diagnostic standard, reaching 90% in Month 6. The number of diagnostics performed increased in month to 6467 (6035 in M5).

Patient choice is still a big factor in cancer pathways. Performance against the Two Week wait standard dropped further to 85.47% in M6. Of the 144 breaches, 69 of them related to patient choice. Work continues with Primary care to develop materials encouraging patients to attend their appointments. 62 day performance fell just short of the 85% target at 84.57%, with legacy delays linked to Covid-19 and diagnostics earlier in the pathway having an impact.

Phase 1 contractual arrangements have been extended to 30th September 2020, and a phase 3 planning submission for October 2020 through to March 2021 has been submitted. Additional funding above the 2020/21 contractual block contracts has been allocated at a system level; initial forecasts suggest that this funding is less than the system's cost base.

# 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 September 2020

There were **2,822** Non-Elective Admissions to the Trust



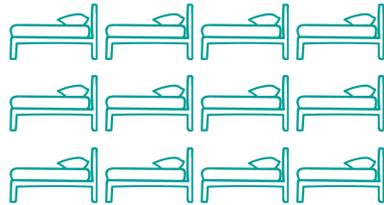
We delivered **19,217** outpatient attendances, **36%** through video or telephone appointments



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



We carried out **247** elective procedures & **1,421** day cases



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



RTT 18 Week Performance: **67.9%** ↑

Total Waiting List: **16,018** ↑



**90.0%** ↑ of patients received a diagnostic test within **6 weeks**



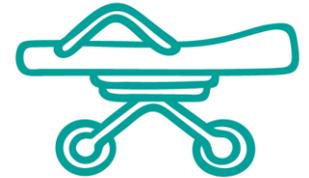
Our income was **£23,189k** (£1,829k over plan)



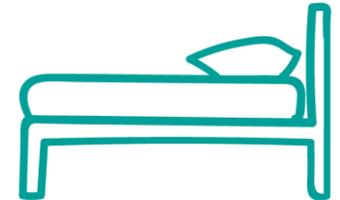
**18.0%** ↓ of discharges were completed before 12:00



Emergency (4hr) Performance **88.0%** ↓  
(Target trajectory: 95%)



**50** patients stayed in hospital for longer than 21 days



Our overall vacancy rate was **1.19%** ↑



# 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

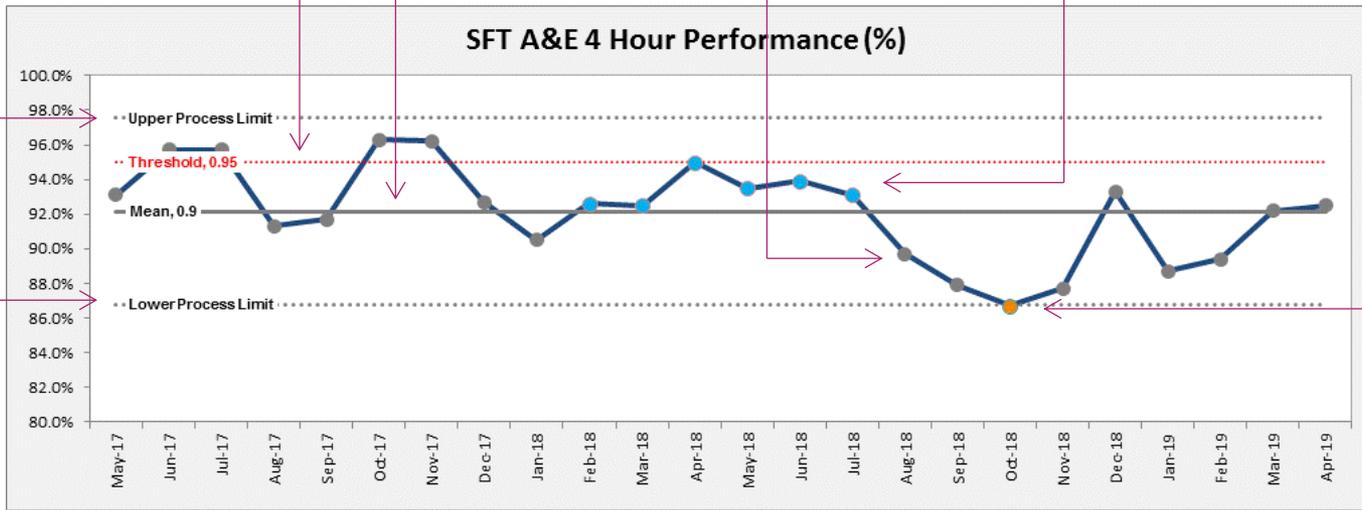
The red line shows the target for the KPI, if there is one

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



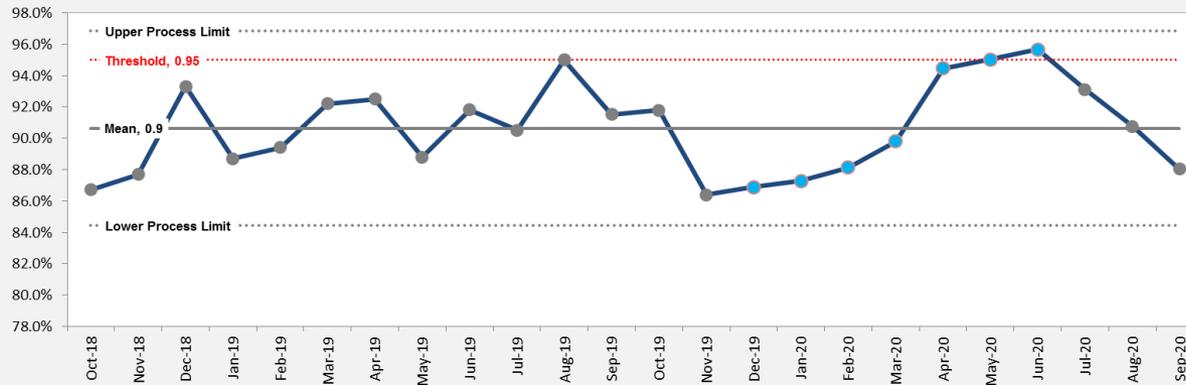
| Statistical Process Control Chart Key:               |   |
|--|---|
| --- Target   | ● Special Cause Variation Improvement (6 or more points with continuous improving performance, or a single point outside the control limit) |
| — Mean   | ● Special Cause Variation Concern (6 or more points with continuous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

# Part 1: Operational Performance



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

SFT A&E 4 Hour Performance (%)



Data Quality Rating:



Performance Latest Month:

88.0%

Attendances:

5261

12 Hour Breaches:

1

ED Conversion Rate:

29.8%

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

M6 saw a fall in ED attendances by 412 on M6 last year but a marked decrease in ED performance. Flow out of ED was a major factor in maintaining performance and an exception report for M6 was completed and submitted to board.

SII for 12 hour breach in M6 – Issues identified with appropriate escalation and lack of available bed. Identified cultural shift in managing 12 hour breaches as a result of team structure changes and Covid-19.

Children returning to school had a sharp impact on staffing in ED with staff forced to isolate, being sick themselves or needing to care for sick children.

Temporary doors were installed in ED majors which allowed the decommissioning of RAZ towards the end of the month.

Sharp spikes in attendances post 6pm for majors patients continuing to put pressure on later half of the day.

Slightly lower numbers of walk in majors and minors patients attending ED but Ambulance conveyances staying high keeping pressure on admissions from ED high.

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

Permanent doors for cubicles and cardiac monitoring in ED Majors due early November.

ENPs to revert to a midnight finish time from 2<sup>nd</sup> Nov to reduce impact on majors having to see minors patients at their busiest time

Paediatrics to return to ED from 14<sup>th</sup> October.

Improvement project underway to move minors to fracture clinic – completion date end of Jan

Work on Expedited transfer policy with specialty teams to support ED to decompress where beds are available prior to specialty review.

Senior Checkpoint daily in ED reinforcing positive narrative around escalation processes and reinforcing importance of avoiding 12 hour breaches .

**Risks to delivery and mitigations**

Turnaround time for swabbing to cover critical staffing gaps – this has been escalated but currently no capacity for rapid swabbing staff regardless of critical nature of staffing gap.

Gaps in consultant workforce – Workforce plan underway. X1 applicant for consultant post.

Nursing gaps on the rota and reduced nursing skill mix continues to create risk. Reliant on staff support from other areas and some bank shift uptake but since return to school this has been variable.

Recruitment to ED service Manager successful but there will be a gap from 21<sup>st</sup> Oct until ? Mid December – Cross cover arrangements being put in place with current ED staff and Divisional management support.

Statistical Process Control Chart Key:

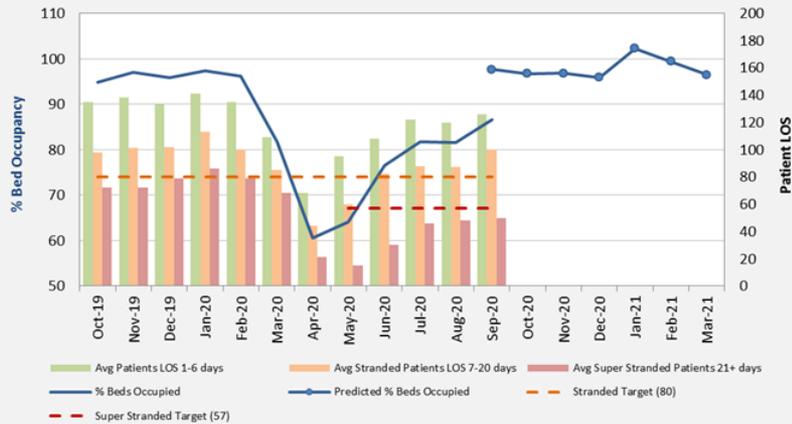
- - - Target
- Mean
- ..... Upper / Lower Process Control Limits (UPL/LPL)

- 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

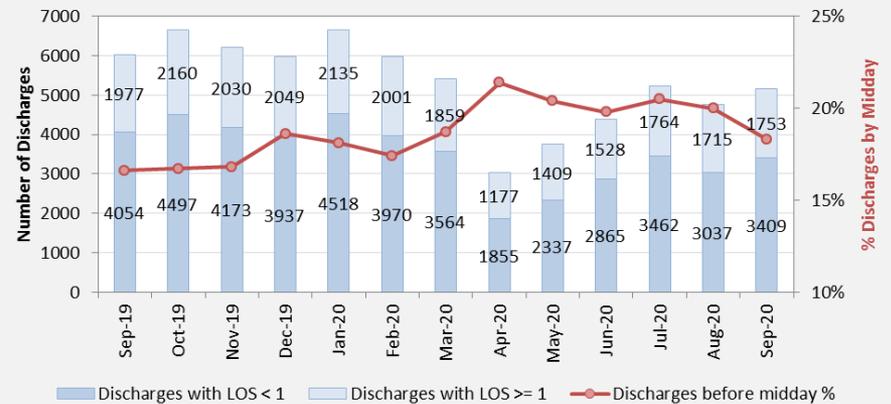
# Patient Flow and Discharge

Are We Effective?

### SFT Bed Occupancy and LOS



### SFT Discharges Before Midday (All Wards)



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

Although the graph is reflecting 21 day+ on target, the increase in 14day+ and the increased bed usage and delays in accessing services at the back door indicate that without intervention this group will develop into 21 day+.

Discharges before midday have increased in number but decreased in percentage. The volume of inpatients and therefore discharges may well have affected our ability to deliver morning discharges. However it compares positively to this month last year in terms of percentage. Further work is required to build on the improvements seen during the first Covid-19 period.

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

All health and social care partners in surrounding boundaries are implementing services and process that will be in place for the longer term and the benefit of these are anticipated in the next 2 months.

Wiltshire Health and Care have commenced a 7 day in reach service, reviewing all patients with a stay of 7 days + and providing a 'pull' for those people suitable when resource in the community allows.

Intensive rehab beds are planned to commence in October, supporting patients needing rehabilitation but not community hospital. There has been an extension of the D2A bed base to account for beds closed in the current system.

There is continued engagement from the Trust and system partners with the regional NHSi teams regarding developing practice to reflect the new discharge policy.

There is a pilot planned for criteria led discharge in both Medicine and Surgery that will inform a wider roll out, the benefits of which should be seen in the new year. This should benefit both morning and weekend discharges.

Expert panel continues, and now has established divisional escalation routes for internal issues

## Risks to delivery and mitigations

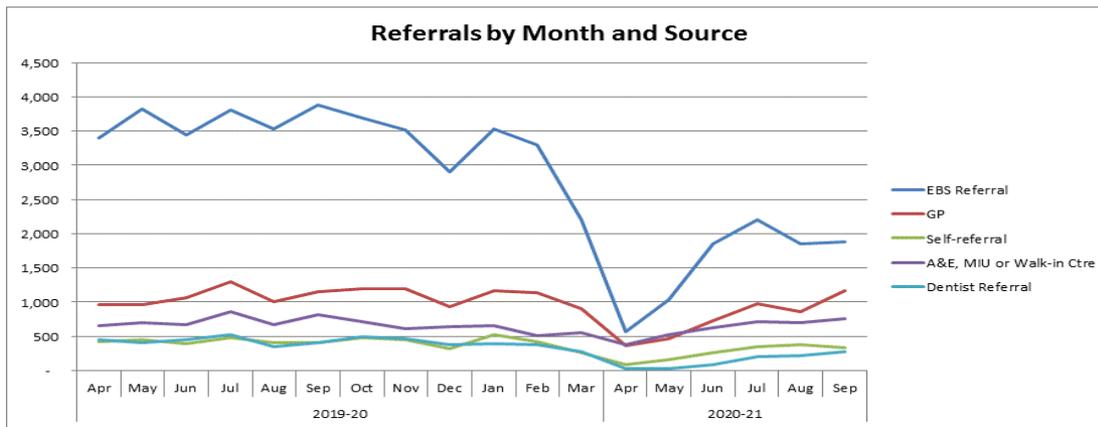
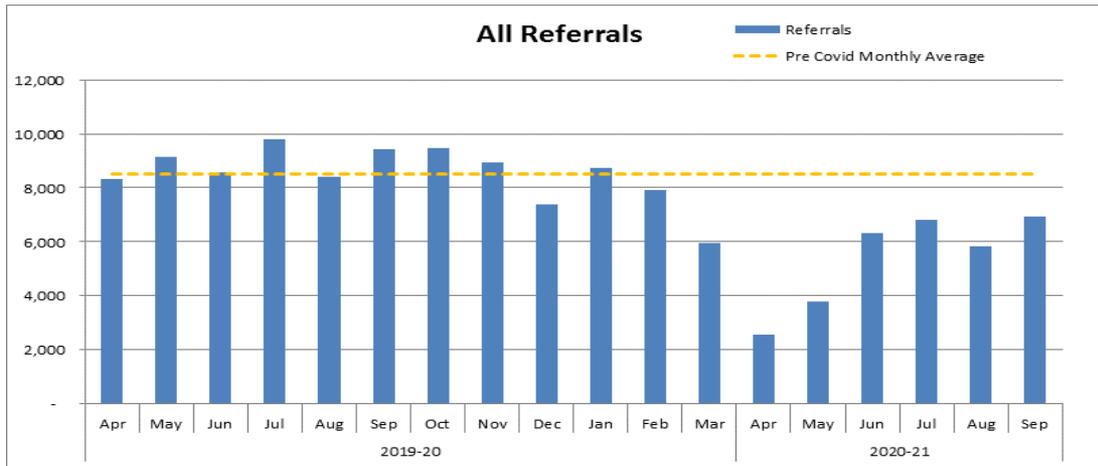
Overwhelming Covid-19 and traditional winter pressures may influence the ability to sustain planned changes in the community, for staffing and capacity reasons. They may also overwhelm the acute with patients requiring acute care, likely to affect LOS.

Uptake and scope of the criteria led discharge is as yet unknown

Flow at the back door is dependent on capacity as well as new processes and liaison services. Unless this also changes the full benefit of planned intervention will not be realised

# Referrals

Additional Supporting Information

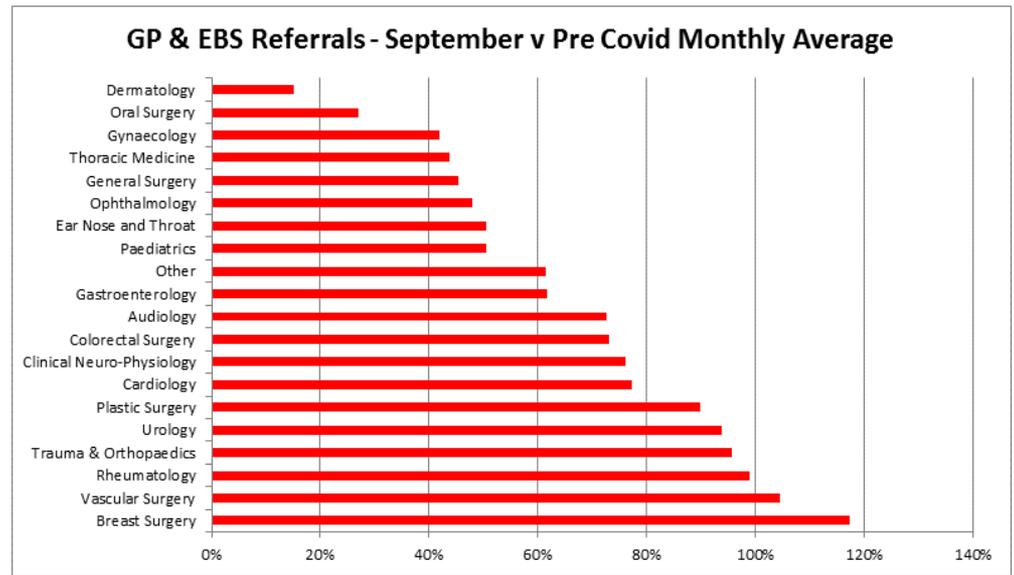


## Comments

Referral levels have been slow to recover, but are increasing month on month.

# Referrals

| Specialty                 | September | Pre Covid Monthly Average | % of Pre Covid Monthly Average |
|---------------------------|-----------|---------------------------|--------------------------------|
| Breast Surgery            | 264       | 225                       | 117%                           |
| Vascular Surgery          | 60        | 57                        | 105%                           |
| Rheumatology              | 167       | 169                       | 99%                            |
| Trauma & Orthopaedics     | 174       | 182                       | 96%                            |
| Urology                   | 226       | 241                       | 94%                            |
| Plastic Surgery           | 264       | 294                       | 90%                            |
| Cardiology                | 196       | 253                       | 77%                            |
| Clinical Neuro-Physiology | 99        | 130                       | 76%                            |
| Colorectal Surgery        | 210       | 287                       | 73%                            |
| Audiology                 | 224       | 309                       | 73%                            |
| Gastroenterology          | 101       | 164                       | 62%                            |
| Other                     | 363       | 591                       | 61%                            |
| Paediatrics               | 86        | 170                       | 51%                            |
| Ear Nose and Throat       | 153       | 303                       | 50%                            |
| Ophthalmology             | 198       | 412                       | 48%                            |
| General Surgery           | 39        | 86                        | 45%                            |
| Thoracic Medicine         | 45        | 103                       | 44%                            |
| Gynaecology               | 127       | 304                       | 42%                            |
| Oral Surgery              | 14        | 52                        | 27%                            |
| Dermatology               | 28        | 186                       | 15%                            |

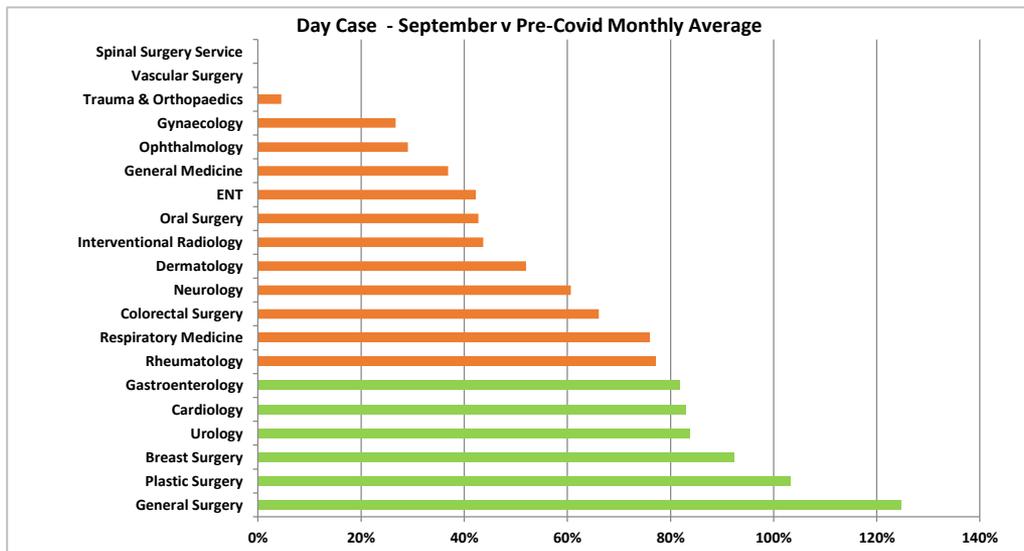
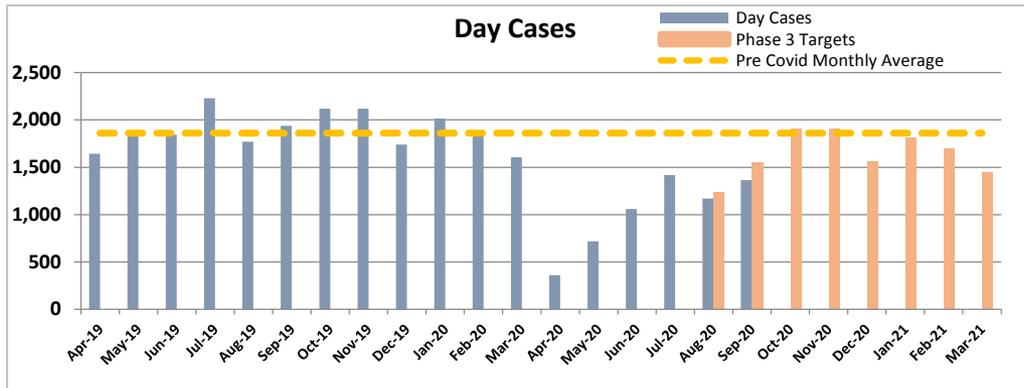


## Comments

There is considerably variation by specialty in the return to pre-covid levels of referrals. Oral Surgery is particularly affected with Dental practices struggling to reopen routine surgeries. Screening programme services are now operational again, with referrals flowing through to the relevant specialties.

# Activity recovery – Day case (target 80%)

Are We Effective?



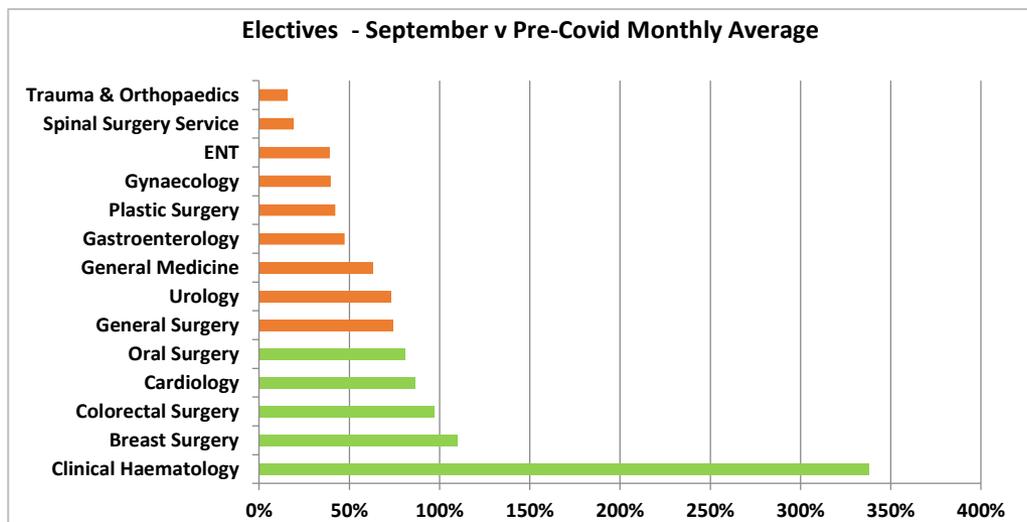
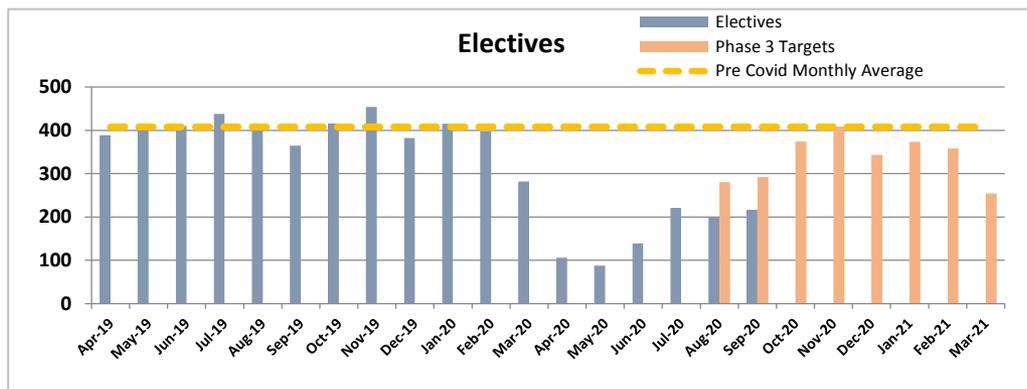
| Specialty                | September | Pre Covid Monthly Average | % of Pre Covid Monthly Average |
|--------------------------|-----------|---------------------------|--------------------------------|
| General Surgery          | 253       | 203                       | 125%                           |
| Plastic Surgery          | 226       | 219                       | 103%                           |
| Breast Surgery           | 12        | 13                        | 92%                            |
| Urology                  | 97        | 116                       | 84%                            |
| Cardiology               | 90        | 108                       | 83%                            |
| Gastroenterology         | 311       | 380                       | 82%                            |
| Rheumatology             | 84        | 109                       | 77%                            |
| Respiratory Medicine     | 11        | 14                        | 76%                            |
| Colorectal Surgery       | 72        | 109                       | 66%                            |
| Neurology                | 13        | 21                        | 61%                            |
| Dermatology              | 4         | 8                         | 52%                            |
| Interventional Radiology | 6         | 14                        | 44%                            |
| Oral Surgery             | 38        | 89                        | 43%                            |
| ENT                      | 19        | 45                        | 42%                            |
| General Medicine         | 33        | 89                        | 37%                            |
| Ophthalmology            | 46        | 158                       | 29%                            |
| Gynaecology              | 16        | 60                        | 27%                            |
| Trauma & Orthopaedics    | 3         | 67                        | 5%                             |
| Vascular Surgery         | 0         | 11                        | 0%                             |
| Spinal Surgery Service   | 0         | 15                        | 0%                             |

\*Specialties with a FY plan below 150 not included

- All New Hall activity is not included in the tables above – specialties undertaking work at New Hall include Trauma & Orthopaedic, Spinal Surgery, Ophthalmology and Plastic Surgery.
- Specialties with aerosol generating procedures remain challenging to resume previous activity levels due to – Oral Surgery, ENT, and Ophthalmology in particular are affected by this.

# Activity recovery – Electives (target 80%)

Are We Effective?



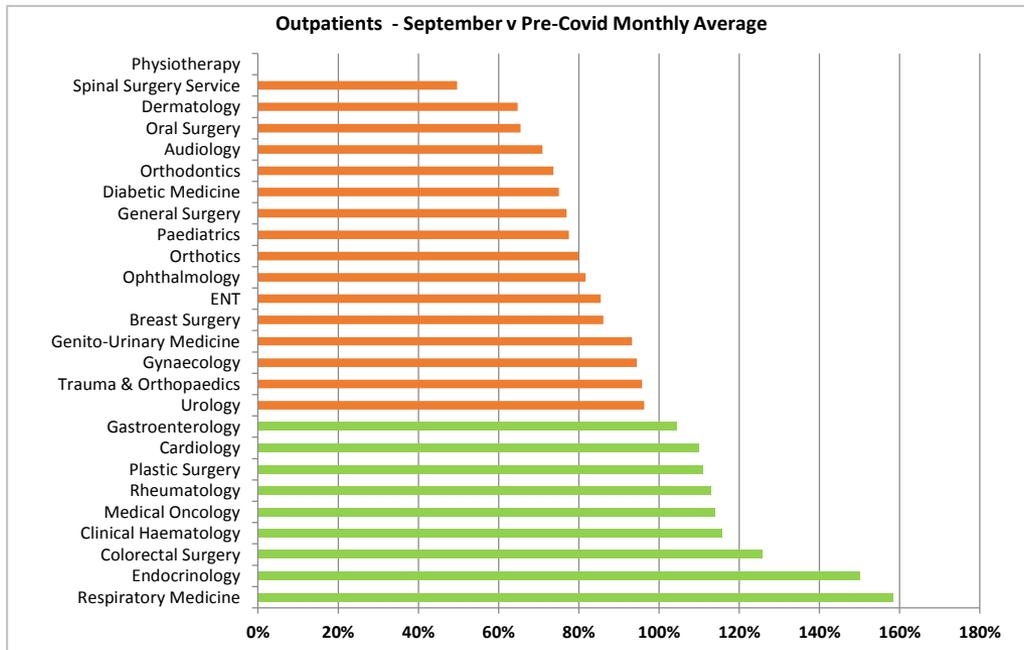
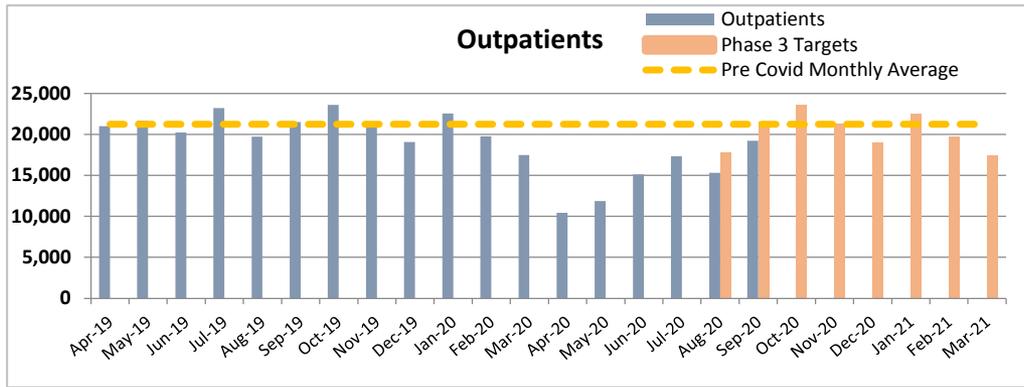
| Specialty              | September | Pre Covid Monthly Average | % of Pre Covid Monthly Average |
|------------------------|-----------|---------------------------|--------------------------------|
| Clinical Haematology   | 15        | 4                         | 338%                           |
| Breast Surgery         | 13        | 12                        | 110%                           |
| Colorectal Surgery     | 21        | 22                        | 97%                            |
| Cardiology             | 9         | 10                        | 87%                            |
| Oral Surgery           | 10        | 12                        | 81%                            |
| General Surgery        | 19        | 25                        | 75%                            |
| Urology                | 45        | 61                        | 73%                            |
| General Medicine       | 4         | 6                         | 63%                            |
| Gastroenterology       | 2         | 4                         | 47%                            |
| Plastic Surgery        | 36        | 85                        | 42%                            |
| Gynaecology            | 9         | 23                        | 40%                            |
| ENT                    | 11        | 28                        | 39%                            |
| Spinal Surgery Service | 3         | 16                        | 19%                            |
| Trauma & Orthopaedics  | 14        | 89                        | 16%                            |

\*Specialties with a FY plan below 50 not included

- All activity transferred to New Hall is not included in the above numbers – specifically Trauma & Orthopaedic, Spinal Surgery, Ophthalmology and Plastic Surgery.
- Some surgical specialties have seen a shift in the balance between daycase and elective surgery – Urology and Plastic Surgery in particular have altered the planned balance between electives and daycases.
- Clinical prioritisation of patients has been undertaken across all specialties so capacity planning and list allocation is being based on priority across the full PTL rather than just within a specialty. This has resulted in some specialties with fewer urgent patients recovering activity slower than those with higher volumes of urgent patients, as theatre space is allocated to whichever specialties have the greatest clinical priority.

# Activity recovery – Outpatients (target 100%)

Are We Effective?



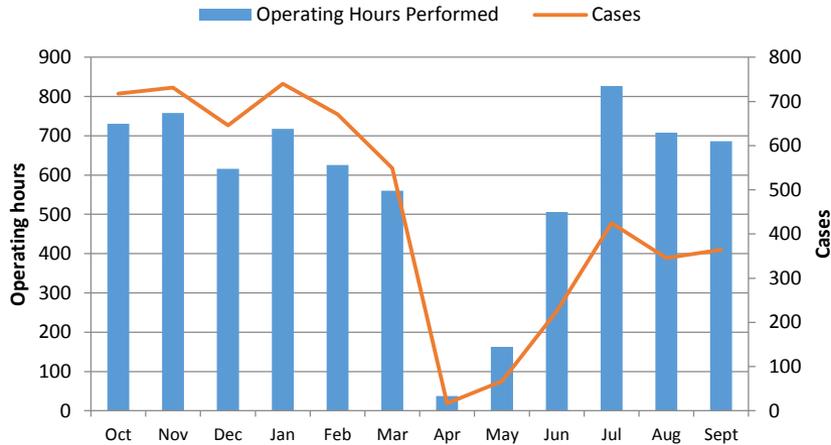
| Specialty               | September | Pre Covid Monthly Average | % of Pre Covid Monthly Average |
|-------------------------|-----------|---------------------------|--------------------------------|
| Respiratory Medicine    | 917       | 579                       | 158%                           |
| Endocrinology           | 392       | 261                       | 150%                           |
| Colorectal Surgery      | 580       | 461                       | 126%                           |
| Clinical Haematology    | 417       | 360                       | 116%                           |
| Medical Oncology        | 411       | 361                       | 114%                           |
| Rheumatology            | 985       | 871                       | 113%                           |
| Plastic Surgery         | 2146      | 1934                      | 111%                           |
| Cardiology              | 663       | 603                       | 110%                           |
| Gastroenterology        | 295       | 282                       | 105%                           |
| Urology                 | 780       | 810                       | 96%                            |
| Trauma & Orthopaedics   | 1697      | 1772                      | 96%                            |
| Gynaecology             | 623       | 660                       | 94%                            |
| Genito-Urinary Medicine | 513       | 550                       | 93%                            |
| Breast Surgery          | 382       | 444                       | 86%                            |
| ENT                     | 631       | 738                       | 85%                            |
| Ophthalmology           | 1997      | 2444                      | 82%                            |
| Orthotics               | 446       | 558                       | 80%                            |
| Paediatrics             | 670       | 864                       | 78%                            |
| General Surgery         | 250       | 325                       | 77%                            |
| Diabetic Medicine       | 205       | 273                       | 75%                            |
| Orthodontics            | 220       | 299                       | 74%                            |
| Audiology               | 645       | 910                       | 71%                            |
| Oral Surgery            | 488       | 745                       | 65%                            |
| Dermatology             | 545       | 842                       | 65%                            |
| Spinal Surgery Service  | 119       | 240                       | 50%                            |
| Physiotherapy           | 0         | 395                       | 0%                             |

\*Specialties with a FY plan below 3000 not included

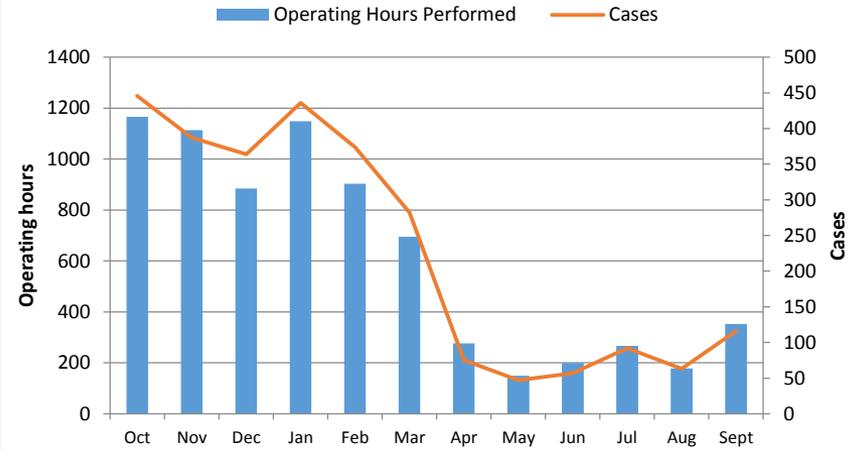
Continuing to see recovery of outpatients, but the numbers of patients requiring face to face appointments is increasing (appropriately so), and physical space in outpatients is a constraint. Modular build contractor has been appointed and expected to deliver additional OPD space in Q4.

# Activity recovery - Theatres

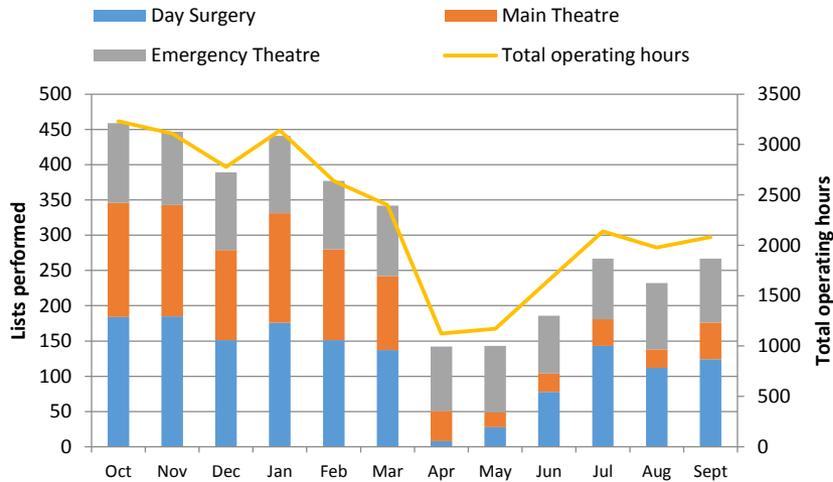
## Day Surgery - cases and operating hours



## Main Theatre - cases and operating hours



## Lists performed



- Activity in day surgery continues to be around the pre-covid levels, and main theatre activity has increased to the highest levels seen post covid-19, and in line with the agreed phase 3 recovery plan.
- An increase to the phase 3 recovery plan is expected to commence from November, with an additional 250 cases over the remainder of 2020-21 planned.
- The increase in plan needs to be supported by approval for pay enhancements and to exceed the agency caps in order to fill staffing gaps.
- An increase in Covid-19 is also a risk to the delivery of the plan – Laverstock ITU beds expected to be available in January. Theatres remain the immediate escalation area for a Covid-19 ITU if demand exceeds 2 spaces in ITU until additional beds are functional.

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

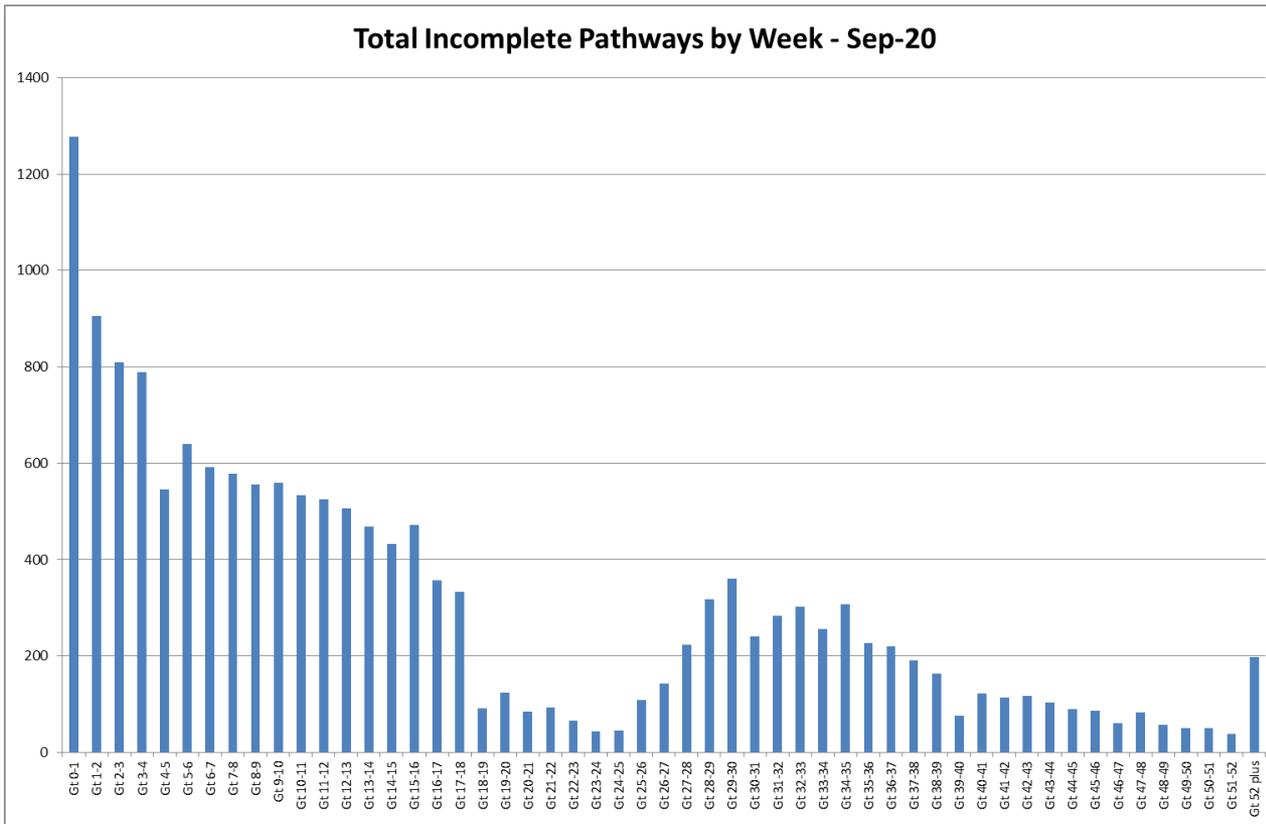
## Top 5 lowest 18 week performance

| Specialty                | WL Total | Total <18 weeks | % <18 weeks |
|--------------------------|----------|-----------------|-------------|
| Dermatology              | 361      | 133             | 36.8%       |
| Ear, Nose & Throat (ENT) | 943      | 406             | 43.1%       |
| Ophthalmology            | 1646     | 713             | 43.3%       |
| Oral Surgery             | 1446     | 654             | 45.2%       |
| Rheumatology             | 270      | 146             | 54.1%       |

## Top 5 largest 18 week breach backlog

| Specialty                | WL Total | Total 18 wk breaches | % <18 weeks |
|--------------------------|----------|----------------------|-------------|
| Ophthalmology            | 1646     | 933                  | 43.3%       |
| Oral Surgery             | 1446     | 792                  | 45.2%       |
| Other                    | 3013     | 613                  | 79.7%       |
| Ear, Nose & Throat (ENT) | 943      | 537                  | 43.1%       |
| Plastic Surgery          | 1380     | 526                  | 61.9%       |

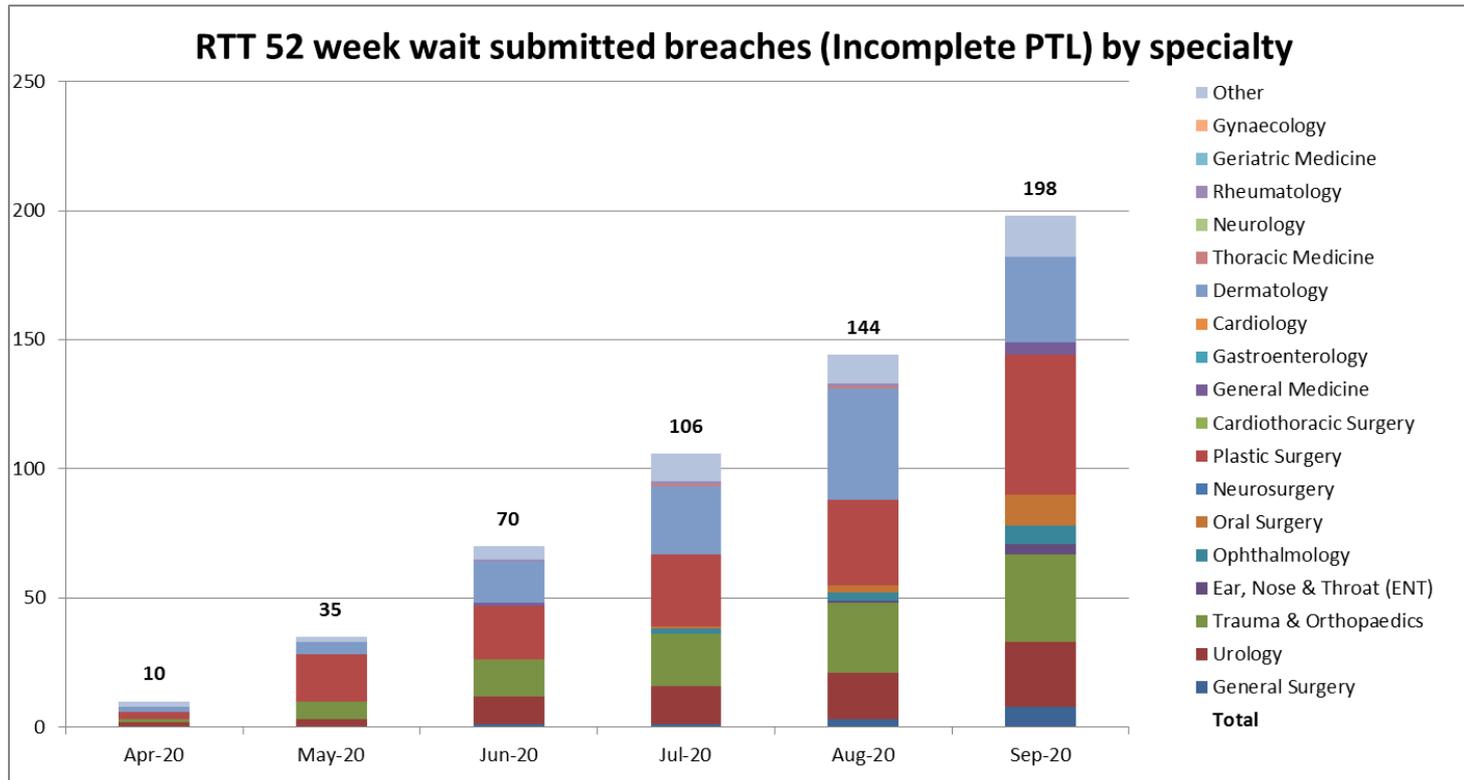
Total Incomplete Pathways by Week - Sep-20



RTT performance continued to improve in September. This is due to increased activity especially in outpatients and day cases.

As part of the support work for lowest areas the Surgical DMT are conducting a deep dive into Dermatology productivity and additional minor operation capacity has been set up for November and December.

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



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

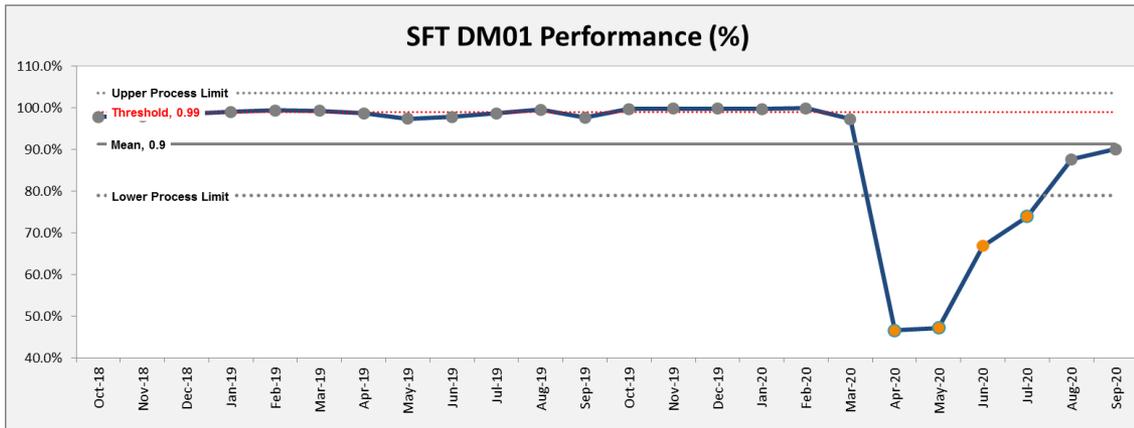
| Treatment function    | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | % change from previous month |
|-----------------------|--------|--------|--------|--------|--------|--------|------------------------------|
| Plastic Surgery       | 3      | 18     | 21     | 28     | 33     | 54     | 64%                          |
| Trauma & Orthopaedics | 1      | 7      | 14     | 20     | 27     | 34     | 26%                          |
| Dermatology           | 2      | 5      | 16     | 26     | 43     | 33     | -23%                         |
| Urology               | 2      | 3      | 11     | 15     | 18     | 25     | 39%                          |
| Other                 | 2      | 2      | 5      | 11     | 11     | 16     | 45%                          |

The number of patients waiting longer than 52 weeks has grown by 54 patients to a total of 198. As part of the phase 3 activity assumptions the Trust forecast that the number of over 52 week patients would grow every month until the end of 2020-21.

The forecast position for M6 was 166 patients over 52 weeks, the actual position was over this at 198.

Theatre capacity continues to be allocated on the basis of clinical priority and then longest waiters.

# Diagnostic Wait Times (DM01) Target 99%



|                           |                                      |
|---------------------------|--------------------------------------|
| Data Quality Rating:      | <span style="color: green;">●</span> |
| Performance Latest Month: | 90.03%                               |
| Waiting List Volume:      | 3482                                 |
| 6 Week Breaches:          | 347                                  |
| Diagnostics Performed:    | 6467                                 |

## Background, actions being taken and risks and mitigations

Performance standard in month has not been achieved as a direct impact of Covid-19. October projections confirm that the target is not achievable for M7, however further progress against waits in Endoscopy, Radiology and Neurophysiology are contributing to an improved position. In month breaches in Audiology and Cardiology have increased, recovery plans are being worked up in both areas. Concerns over the potential volume of CT breaches for M7 are noted, and discussions are ongoing with New Hall Hospital in relation to increased capacity. Improvements have been noted in relation to the number of patients who are deferring tests owing to Covid-19, this continues to be monitored on a weekly basis.

### Endoscopy

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

### Radiology (Inc. DEXA)

80 confirmed in month breaches, majority attributable to Covid-19. Owing to resource issues in the Radiology Booking Team, RDA's have been supporting. We are aware of a number of patients that were booked to breach from September without the implications on the DM01 performance being understood. Further education and support has been provided to mitigate against a reoccurrence.

### Radiology Reporting

Go live of the second provider on hold. Go/No Go decision deferred to 23<sup>rd</sup> October 2020. Reduced activity has positively impacted on the number of outstanding reports so the risk to the service is being mitigated against.

### Audiology

107 confirmed in month breaches, all attributable to Covid-19

### Cardiology

120 confirmed in month breaches, all attributable to Covid-19

### Neurophysiology

18 confirmed in month breaches, all attributable to Covid-19

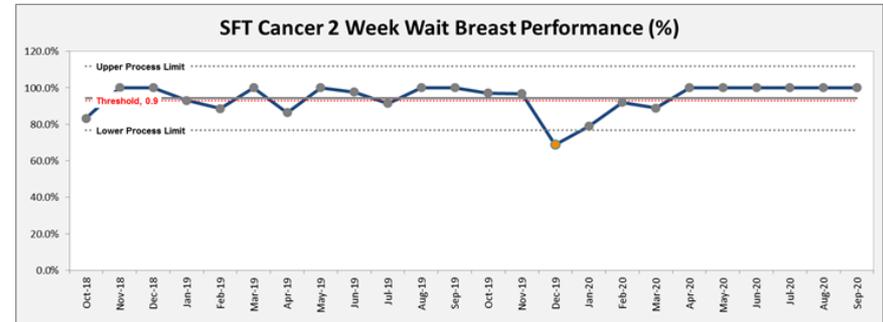
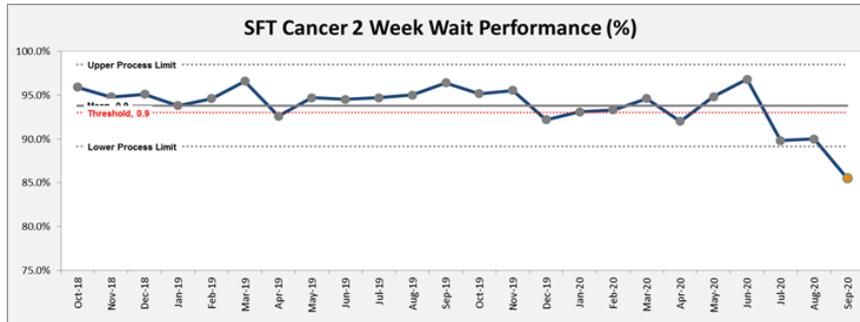
# Cancer 2 Week Wait Performance Target 93%

Data Quality Rating:



| Performance Latest Month                   | Performance | Num/Den | Breaches                |
|--|-------------|---------|-------------------------|
| Two Week Wait Standard:                    | 85.47%      | 847/991 | 144 (69 patient choice) |
| Two Week Wait Breast Symptomatic Standard: | 100%        | 11/11   | 0                       |

National Key Performance Indicators



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

Two week wait standard not achieved for M6 (991 patients seen in total; 847 seen within target; 144 breaches). This is due to a variety of reasons including:

- Patient choice (69 breaches);
- Radiology capacity (26 breaches);
- Administrative/triage delays (20 breaches);
- Endoscopy capacity (8 breaches);
- GP delays (11 breaches);
- Clinical delay (1 breach)

Breast symptomatic two week wait performance standard achieved for M6 (11 patients seen in total; 0 breaches)

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

Format of weekly ops meetings revised.

Booking teams continue to prioritise cancer pathways, though ongoing concerns related to patient choice remain; this is likely to impact on service delivery for a significant period of time. Patients are increasingly wanting to be seen face to face as opposed to telephone appointments offered within the two week wait window; this is then exacerbated by social distancing restrictions within medical & surgical outpatient departments.

Weekly PTL meetings in place, which look to mitigate against any upcoming breaches. This then enables cancer services to work with the relevant team to expedite where possible.

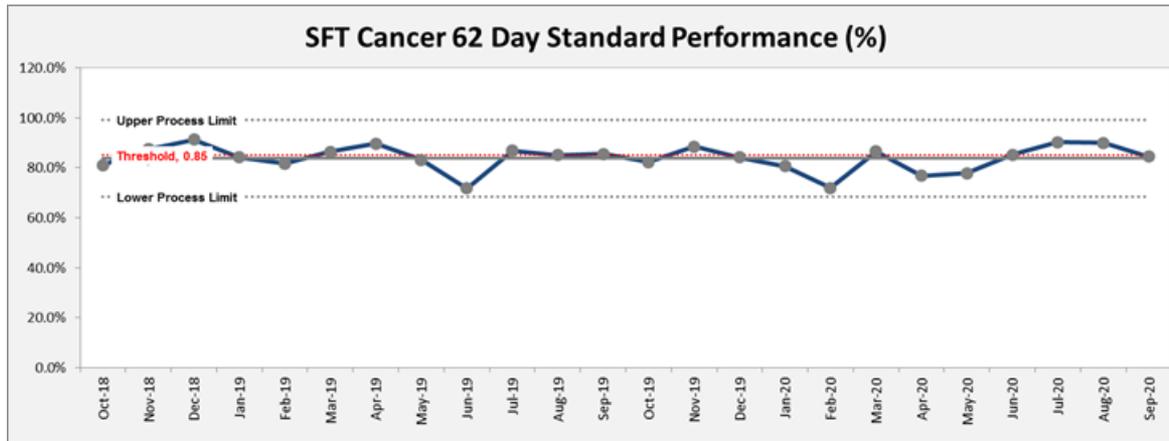
Review of existing tracking processes undertaken and improved predictor tool now in use within cancer services, which has reduced the need for manual review of upcoming breaches. Improved data extraction process in place to identify patients at risk of breaching two week wait standard.

## Risks to delivery and mitigations

Diagnostic capacity is likely to significantly affect our ability to achieve the 2ww standard going forward, particularly with services with well established straight to test pathways. The alternative is to increase the number of patients seen in outpatients, however this is hindered by space restrictions, social distancing and consultant capacity.

Patient choice continues to be an issue. Videos have been developed both within primary and secondary care to encourage patients to attend. Cancer webinars in place with primary care; intention is to reiterate importance of ensuring patients are willing and able to attend hospital within two weeks of their GP referral.

# Cancer 62 Day Standards Performance Target 85%



Data Quality Rating:



| Performance Latest Month | Performance | Num/Den |
|--------------------------|-------------|---------|
| 62 Day Standard:         | 84.57%      | 60/71   |
| 62 Day Screening:        | 0%          | 0/1     |

## Risks to delivery and mitigations

Month 6 62 day performance of 84.51% (71 patients treated in total; 60 within target; 11 breaches). Breach reasons predominantly as a result of complex diagnostic pathways (6) and previous diagnostic delays (4) as a result of the Covid-19 pandemic.

Future performance remains fragile in light of the number of long waiters, predominantly due to patient choice and previous diagnostic delays. Cancer services continue to focus on such long waiters and the overall PTL backlog (patients waiting over 62 days); this focus is showing improvement and the overall number is beginning to decline.

Month 6 62 day screening performance standard not achieved (1 patient treated in total; 1 breach). Breach as a result of diagnostic delays associated with national restrictions (endoscopy and CTC) and subsequent backlog.

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

# Stroke & TIA Pathways

SFT SSNAP Case Ascertainment Audit Score:

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

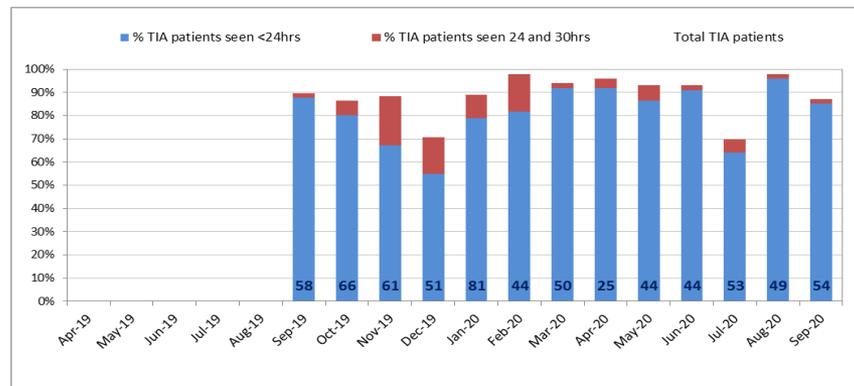
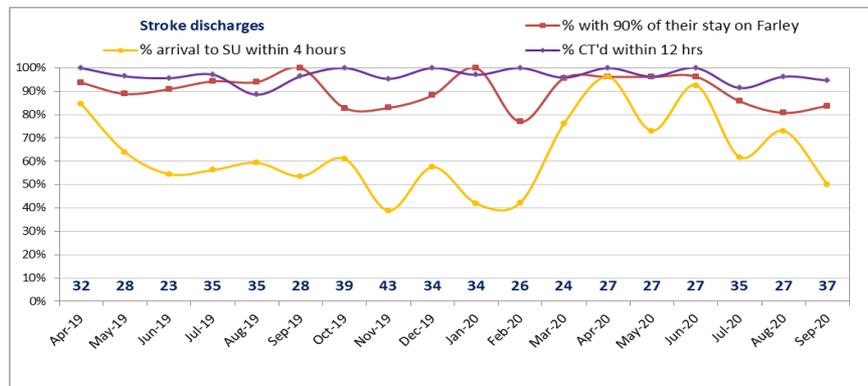
Data Quality Rating:



% Arrival on SU <4 hours: 50.0%

% CT'd < 12 hours: 94.6%

% TIA Seen < 24 hours: 85.2%



Are We Effective?

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

46% of stroke patients had a CT within 1 hour (target 50%) reflecting the number of patients arriving out of hours and increased pressures in ED. A reduction in patients reaching the stroke unit within 4 hours affected 17 patients. Delays were due to waiting for ED first doctor/speciality doctor (11) and 1 patient in ED at 3 hrs 58 mins. Other reasons were waiting for a bed (2), late diagnosis (1), admitted to AMU (1), stroke as an inpatient (1). 3 (8.1%) stroke deaths in September – lower than expected (17%). 84% of patients spent 90% of their time on the stroke unit exceeding the national target (80%).

TIA performance reduced to 85% – 3 patients were not seen within 24 hours due to full clinics, 2 patients required an MRI scan which occurred the following day and 2 patients were affected by issues with the new FAB-TIA on-line booking system. Issues with the new booking system are anticipated to be temporary.

SSNAP confirmed that Q2 20/21 scores will not be published as many hospitals did not submit data during the Covid-19 emergency. SSNAP data collection returned to normal from 15/8/20. SFT continued to submit data throughout the entire Covid-19 period.

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

Early Supported Discharge (ESD) services returned to normal levels but were impacted by annual leave in September. 36% of eligible patients achieved ESD compared to 40% target.

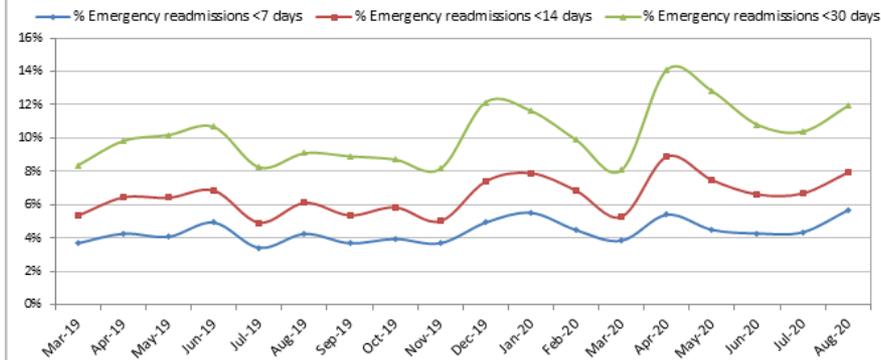
## Risks to delivery and mitigations

The stroke unit remains on Laverstock ward (25 beds) increasing the risk of stroke patients being moved off the unit. Plans to return it to its original location on level 2 (30 beds) is unlikely to happen until next year with the threat of a second wave of Covid-19 and is contingent on building works elsewhere in the hospital.

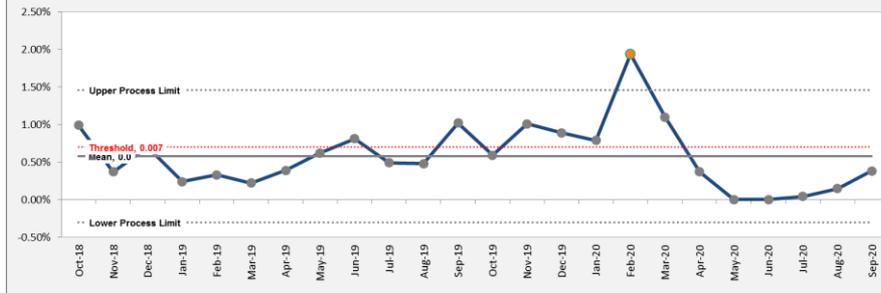
# Other Measures

Are We Effective?

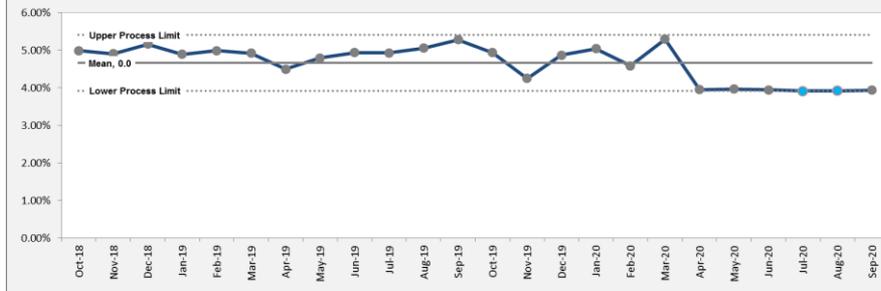
Emergency Readmissions within 7, 14 & 30 days of Discharge



SFT Cancelled Operations Performance (%)



SFT Outpatient DNA Rate (%)



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

# Part 2: Our Care



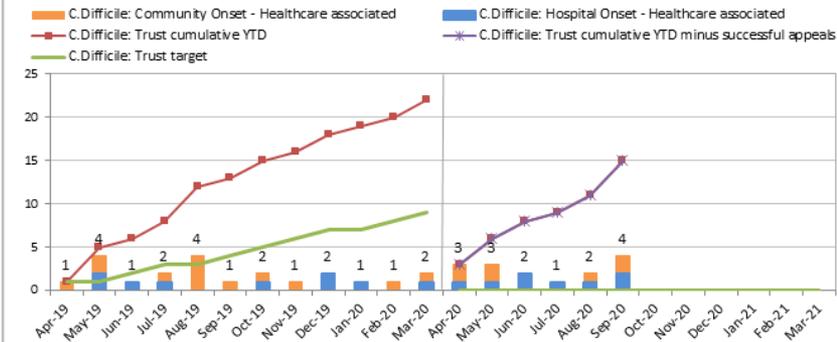
| Our Priorities      | How We Measure    |                    |
|---------------------|-------------------|--------------------|
| Local Services      | Are We Effective? | Are We Responsive? |
| Specialist Services |                   |                    |
| Innovation          |                 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



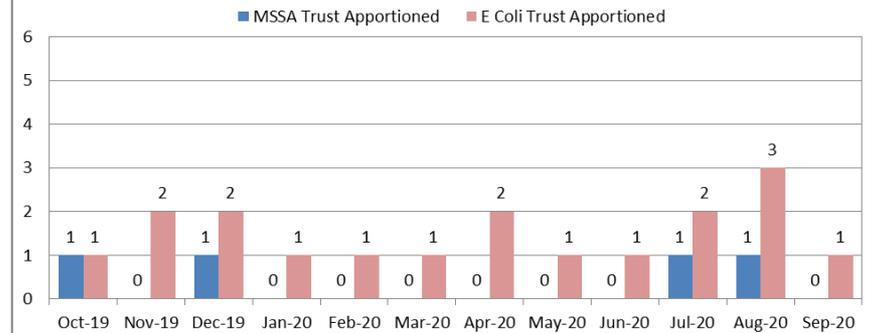
| Clostridium Difficile | Dec 19 | Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | Jun 20 | Jul 20 | Aug 20 | Sep 20 |
|-----------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Cases Appealed        | 0      | 1      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |
| Successful Appeals    | 0      | 1      | 2      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |

| MRSA              | 2019-20 | 2020-21 |
|-------------------|---------|---------|
| Trust Apportioned | 0       | 1       |

## Clostridium Difficile: Healthcare Associated Cases



## E Coli and MSSA



Are We Safe?

### Summary and Action

PHE have not set a C.Difficile upper limit for hospital onset healthcare associated and community onset healthcare associated cases.

2 hospital onset healthcare associated C.difficile cases:

- A patient on Spire Ward treated for ongoing constipation and initially the change in bowel pattern was thought to be related to bowel interventions. This case may be suitable for appeal as no lapses in care.
- A patient on Pembroke Ward with a complex history and had previously tested C.difficile detected in June. Currently under investigation.

2 community onset healthcare associated C.difficile cases:

- Sample sent via GP surgery for a patient living at a care home who had been discharged from Downton Ward a few days earlier. A number of actions identified for the Downton Ward Team. The sample has been sent for ribotyping to establish any potential links with previous cases.
- Sample sent for a patient on AMU, however the patient was not isolated when the sample was sent, and this lapse in case would preclude the case being submitted for appeal to the CCG.

1 E.Coli bacteraemia – patient admitted with biliary sepsis on a background of adrenal carcinoma and polycythaemia. The patient was later transferred to Radnor ward. This isolate was also identified to be an ESBL producer.

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

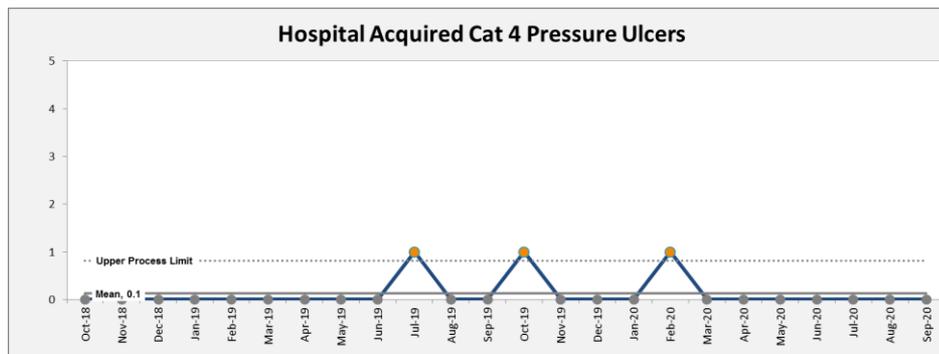
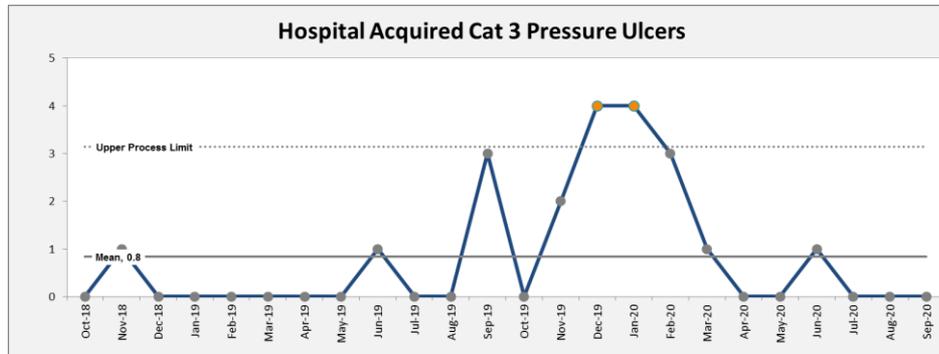
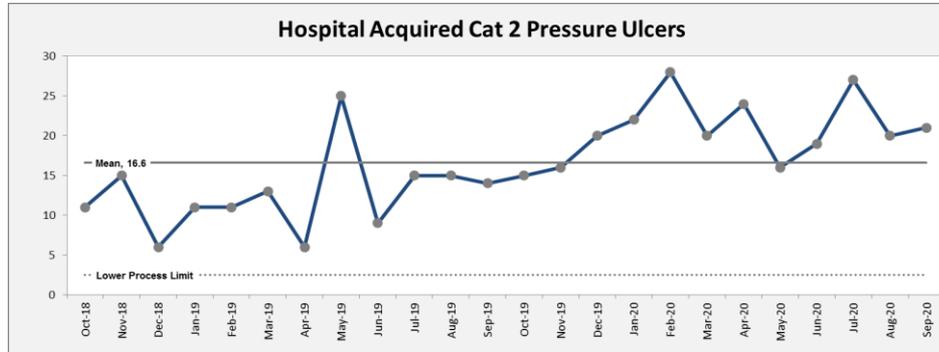
August 20 - 1 community onset healthcare associated case of C.difficile of a child admitted to Sarum Ward. The case remains under investigation. Training issue identified for the laboratory staff – the child had a previous admission when a stool sample was sent to the laboratory but not tested for C.difficile as per Trust protocol.

# Pressure Ulcers

Data Quality Rating:



Are We Safe?



| Per 1000 Bed Days | 2019-20 Q2 | 2019-20 Q3 | 2019-20 Q4 | 2020-21 Q1 | 2020-21 Q2 |
|-------------------|------------|------------|------------|------------|------------|
| Pressure Ulcers   | 1.10       | 1.22       | 1.73       | 2.27       | 1.92       |

## Summary and Action

The number of category 2 pressure ulcers remained higher than expected with hotspots in 2 wards. The Tissue Viability Team will undertake observational visits in 1 of the hotspot wards during October and work with the teams on improvements required to prevent and treat pressure ulcers.

The pressure ulcer quality improvement project has focused work in AMU. An observational audit was undertaken of patients admitted to the assessment area and showed that a task orientated approach is taken to prepare the patient for a medical assessment. A PDSA 1 day trial is still planned to offer a gown to high risk patients likely to be admitted to aid skin inspection within 1 hour as well as tests required.

Progress of the cluster review improvement plan is due to be reported to the Clinical Governance Committee in October by the Divisional Heads of Nursing. A BSW CCG improvement collaborative is likely to start in November as there has been a similar rise in pressure ulcers at RUH, GWH and nationally.

A business case to increase the size of the Tissue Viability Team by 1.0 wte was successful. The new postholder starts in November and each Division will have a named lead to work with link nurses and focus on education.

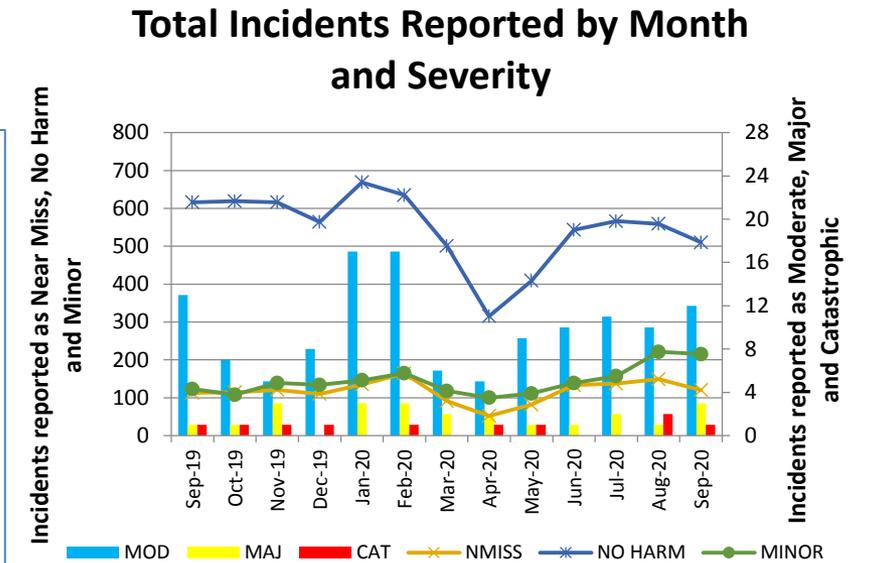
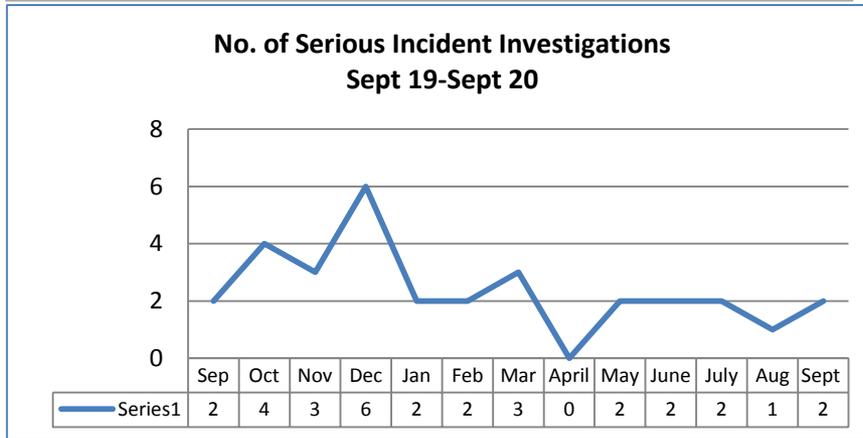
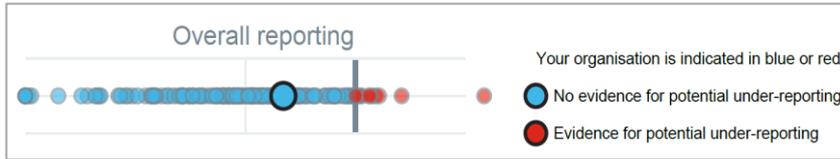
Preparation is underway for the global 'Stop the pressure' campaign on 19 November. The focus will be on education. An e-learning package is in preparation on the prevention and management of pressure ulcers.

# Incidents

Are We Safe?

| Year         | 2019-20 | 2020-21 |
|--------------|---------|---------|
| Never Events | 2       | 0       |

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



## Summary and Action

2 serious incident inquiries commissioned in September.

One patient underwent a first stage double mastectomy and when preparing for the second stage, it was identified that the expected implants in the box, were in fact, sizers. A surgical decision was made to implant the sizers instead of closing the wound because there was no device to preserve skin elasticity and cavity space for successful implantation of breast implants at a later stage.

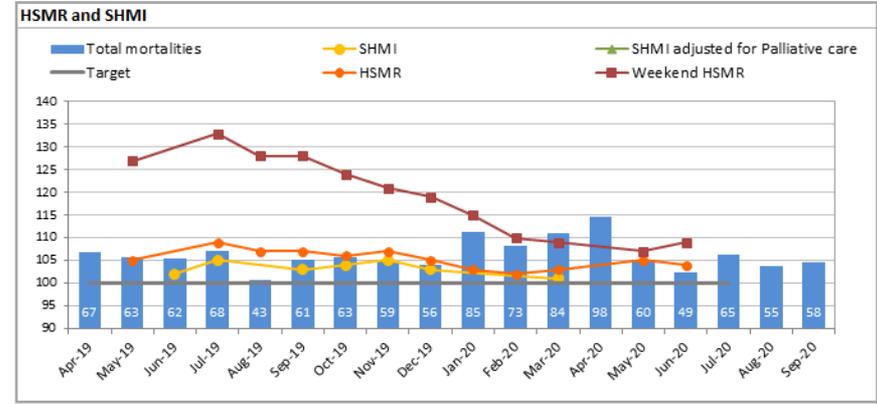
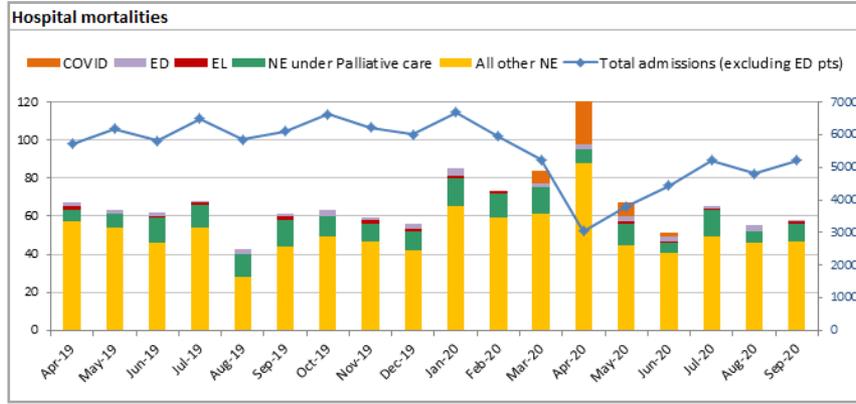
One neonatal death at 31 weeks despite continuing attempts at resuscitation following birth, care was withdrawn at 1 hour 29 minutes of age.

# Mortality Indicators

Data Quality Rating:



Are We Safe?



## Summary and Action

HSMR is as expected. The weekend HSMR increased and is within the expected range.

No deaths in September associated with Covid-19.

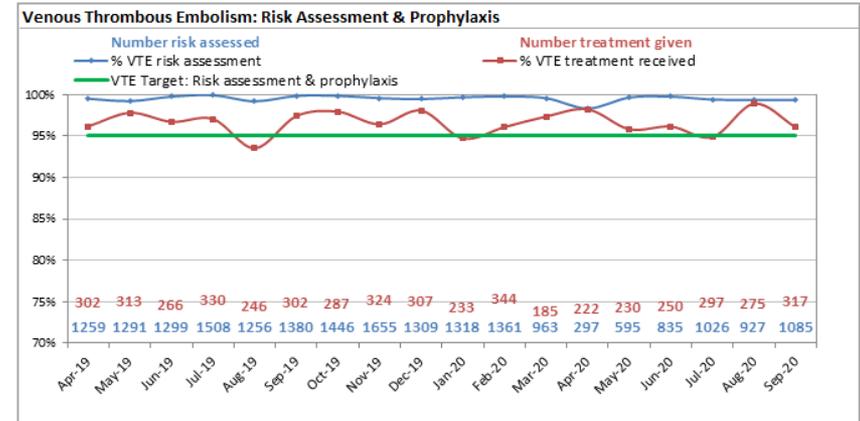
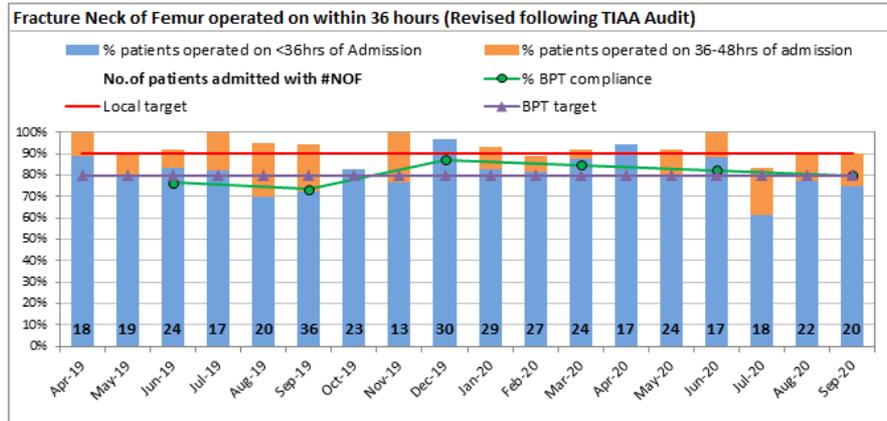
The Mortality Surveillance Group has completed a review of deaths from Covid-19 to ascertain whether patients were involved in decisions about their care, escalation was appropriate, and if patients required ventilation, received it. Further analysis is required and the review will be reported to the Mortality Surveillance Group in November 2020.

# Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Data Quality Rating:



Are We Safe?



## Summary and Action

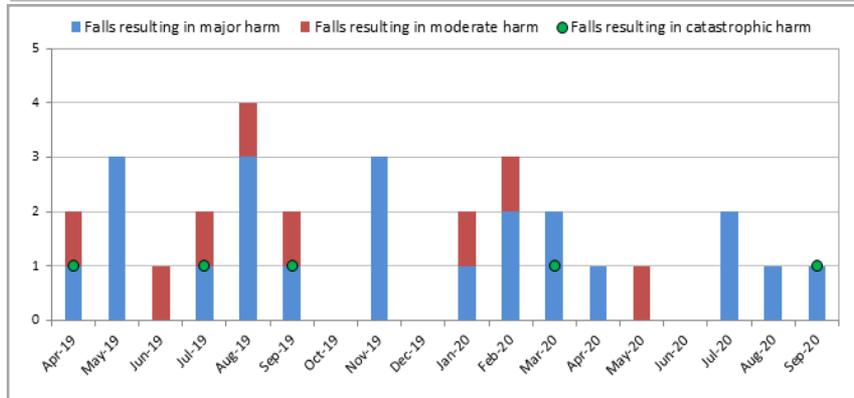
In September, 4 patients did not receive hip surgery for a fractured neck of femur within 36 hours due to waiting for theatre space. Of these, 3 had surgery between 43 – 49 hours and 1 patient had surgery at 65 hours. Root cause analysis showed no evidence of harm in the 3 patients who had surgery within 49 hours. The patient who had surgery at 65 hours required a post-operative blood transfusion and was discharged on day 10 following a good recovery. Q2 20/21 BPT compliance 80% (national target 80%).

The Trust continued to report good performance in VTE risk assessment and prophylaxis. NHSE&I notified the Trust on 29 September that due to the continued impact of Covid-19 and the ongoing need to release capacity across the NHS to support the response, a pause on VTE data collection and publication will continue until March 2021.

# Patient Falls

Are We Safe?

Patient falls in hospital resulting in high harm



Data Quality Rating:



| Per 1000 Bed Days | 2019-20 Q2 | 2019-20 Q3 | 2019-20 Q4 | 2020-21 Q1 | 2020-21 Q2 |
|-------------------|------------|------------|------------|------------|------------|
| Patient Falls     | 0.20       | 0.07       | 0.17       | 0.08       | 0.11       |

## Summary and Action

In September, 2 high harm falls.

- 1 patient fell and suffered a catastrophic subdural haemorrhage which is subject to a serious incident inquiry (commissioned in October).
- 1 patient fell and suffered a hip fracture requiring surgical treatment. The case was investigated as a SWARM and found no lapses in care.

A Trust wide falls improvement plan with aggregated learning from SWARMs and serious incident inquiries is in place. The number of high harm falls has reduced over the last 5 years.

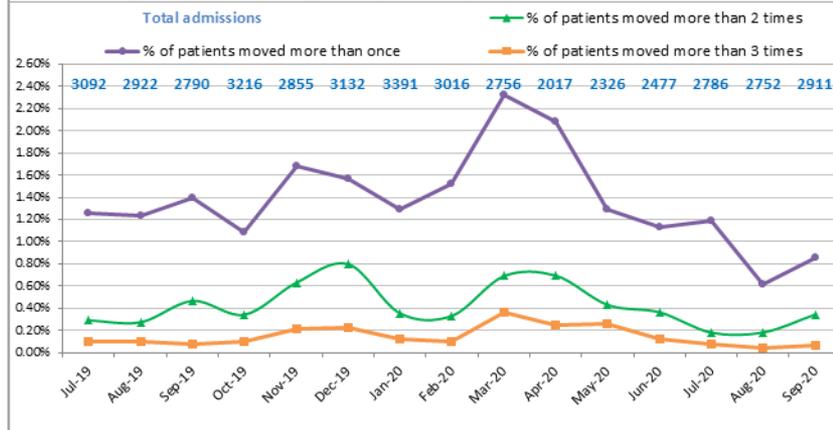
# Patient Experience

Data Quality Rating:

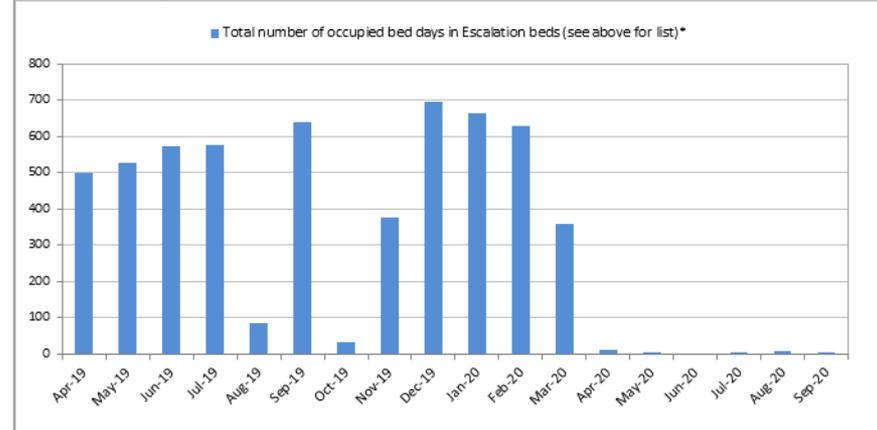


| Last 12 months  | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | Jun 20 | Jul 20 | Aug 20 | Sep 20 |
|-----------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Bed Occupancy % | 94.9   | 97.1   | 95.9   | 94.4   | 96.1   | 81.8   | 60.5   | 64.0   | 76.4   | 81.7   | 81.5   | 86.6   |

## Patients moving multiple times during their Inpatient Stay



## Escalation Bed Days



Are We Safe?

### Summary and Action

Minimal escalation bed capacity was opened in September as bed occupancy was at 86%. The percentage of multiple ward moves remained at a low level.

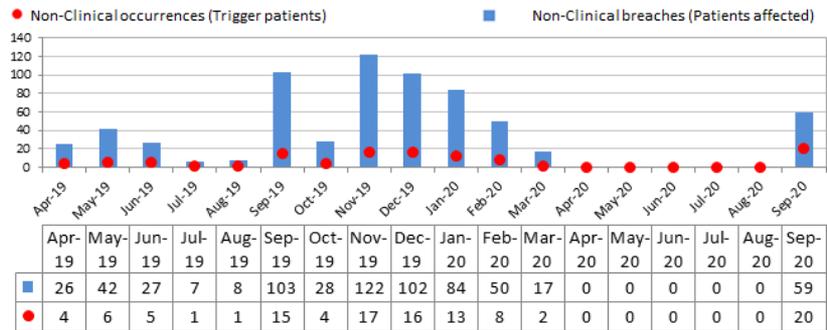
The Medical Division supported by the PMO are leading work to understand delays in discharge and improvements needed to increase the percentage of patients discharged to 33% by midday.

# Patient Experience

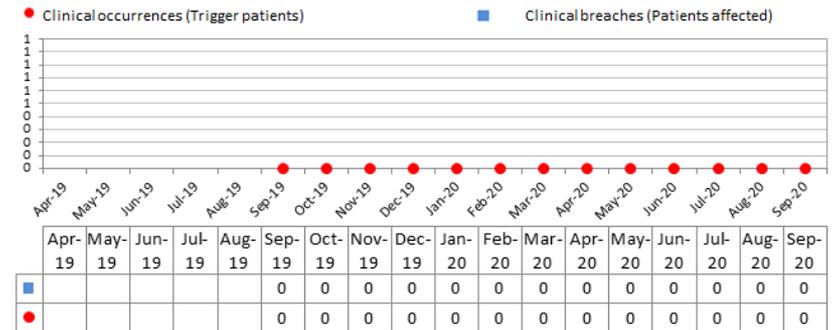
Data Quality Rating:



Delivering Same Sex Accommodation - Non-clinical



Delivering Same Sex Accommodation - Clinical



Are We Safe?

## Summary and Action

20 occurrences of non-clinical mixed sex accommodation breaches in September affecting 59 patients. 7 occurrences affected 46 patients in AMU and the majority resolved within 24 hours. Privacy and dignity is maintained during these times with the use of quick screens and identification of separation bathroom facilities. There were no breaches on any of the general wards.

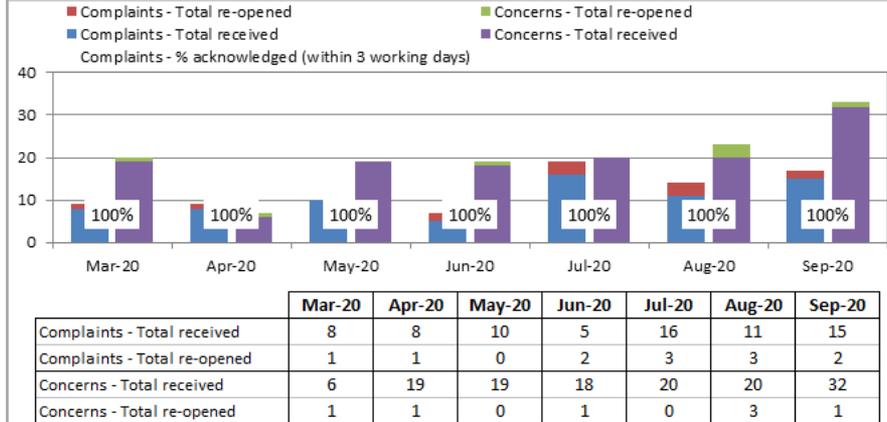
13 occurrences affected 13 patients were in Radnor ward (Critical Care) and the majority resolved within 48 hours. These were patients who were not able to be transferred out to a general ward within 4 hours of the decision that the patient was fit to be moved. Potential discharges from Radnor are raised at the twice daily bed meeting.

NHSE&I notified the Trust on 29 September that due to the continued impact of Covid-19 and the ongoing need to release capacity across the NHS to support the response, a pause on mixed sex accommodation data collection and publication will continue until March 2021.

# Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?

## Complaints and Concerns



### Summary and Actions:

#### Top 2 themes from complaints include:

- Clinical treatment – Obstetrics and Gynaecology
- Correct diagnosis not made

#### Top 3 themes from concerns include:

- Delay receiving treatment
- Unsatisfactory treatment
- Lack of communication.

16 complaints were closed in September, examples of implemented actions include:

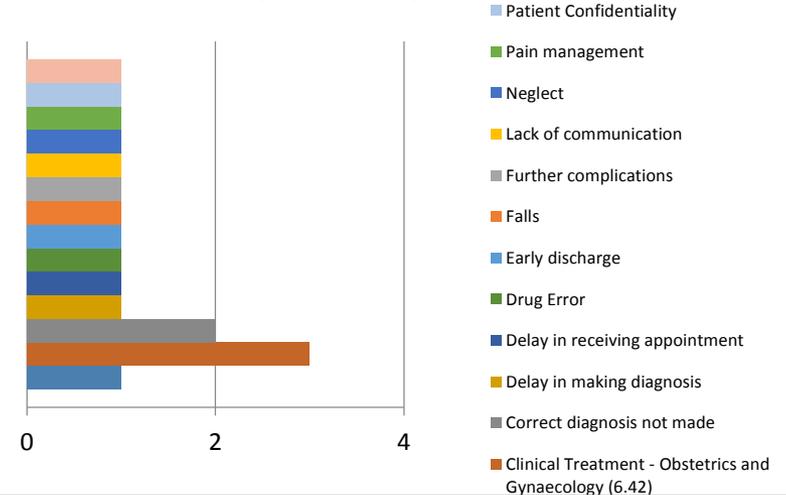
Radiology department implemented changes to their internal processes; it is now an expectation that all interventional radiology patients have a Covid-19 test arranged at the time of booking.

Maternity Services has introduced a process of scanning all women admitted for induction of labour (IOL) to ensure that babies are in the cephalic position, prior to commencing the IOL.

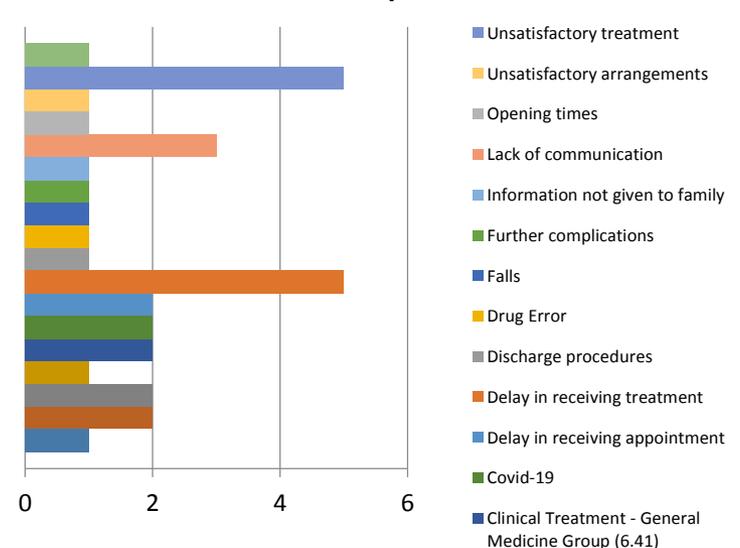
Data Quality Rating:



## Themes from complaints – Sept 20



## Themes from concerns – Sept 20



# Part 3: Our People

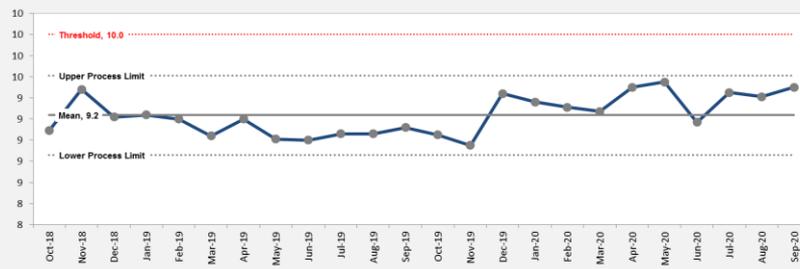


# Workforce - Total

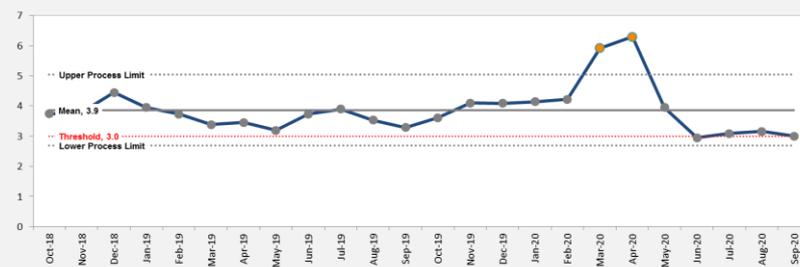
## Total Workforce vs Budgeted Plan - WTEs

|                      | Sep '20        |                |                |
|----------------------|----------------|----------------|----------------|
|                      | Plan WTEs      | Actual WTEs    | Variance WTEs  |
| Medical Staff        | 425.1          | 441.4          | (16.2)         |
| Nursing              | 950.5          | 1,010.8        | (60.3)         |
| HCA's                | 412.1          | 469.2          | (57.1)         |
| Other Clinical Staff | 619.3          | 637.9          | (18.6)         |
| Infrastructure Staff | 1,227.9        | 1,226.9        | 1.0            |
| <b>TOTAL</b>         | <b>3,634.8</b> | <b>3,786.1</b> | <b>(151.2)</b> |

### Staff Turnover %



### Staff Absence %



## Summary and Action

**Turnover:** For September, turnover stands at 9.5%, with the highest number of starters (54) since April this year and the lowest number of leavers (24) in the last three months.

There are no particular area hotspots or reasons for leaving, although Corporate, Surgery and CSFS are all above the Trust target of 10%.

Recruitment activity has increased during the month, with 75 non-medical and 10 medical vacancies being advertised, 42 more than the same time last year. During September, total time from start of recruitment to commencement in post has averaged 62 days.

Included in the appointments has been 7 Trust grade offers. We have also completed bids for funding support from NHSE/I for international nurse recruitment in three separate lots.

**Sickness:** Overall the Trust sickness absence is 3.14% non Covid-19 related and 0.31% Covid-19, with 3 instances that we know of long term Covid-19 related sickness. Generally, long term absences have slightly decreased, with a corresponding increase in short term absences.

There are no specific area hotspots, although we know that anxiety/stress/depression and infectious diseases have both increased this month. Medicine, Surgery and Facilities are all over the Trust 3% target.

There are 50 members of staff in formal attendance management processes and 20 long term sickness cases being proactively managed.

# Workforce – Nursing and Care

## % Fill of Registered Nurse/HealthCare Assistant Shifts

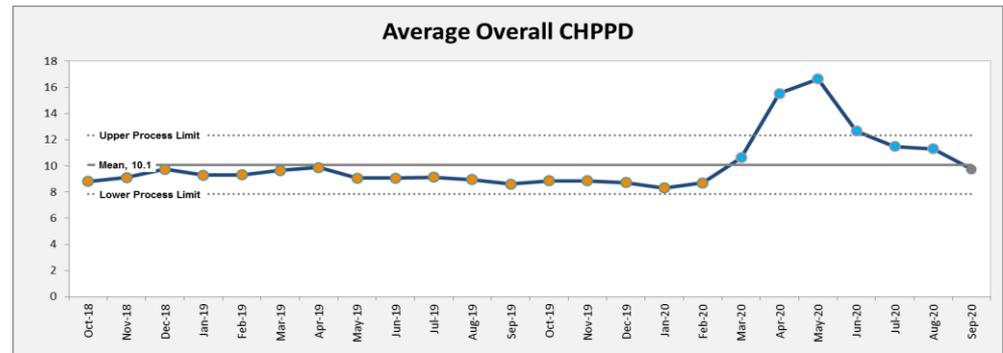
Table 1 – September Data

| Day                 | RN    | HCA   |
|---------------------|-------|-------|
| Total Planned Hours | 36718 | 20125 |
| Total Actual Hours  | 37403 | 17372 |
| Fill Rate (%)       | 102%  | 86%   |

| Night               | RN    | HCA   |
|---------------------|-------|-------|
| Total Planned Hours | 24645 | 12020 |
| Total Actual Hours  | 28226 | 12120 |
| Fill Rate (%)       | 106%  | 99%   |

## Care Hours Per Patient Day (CHPPD) - Monthly, 12 Month Trend

Table 2



## Summary and Action

Table 1 shows planned vs actual hours for RNs and HCAs across the wards for September. The graph on the right shows planned vs actual Care Hours per Patient Day at Trust level. (CHPPD is a simple calculation dividing the number of actual nursing/midwifery (both registered and unregistered) hours available on a ward per 24-hour period by the number of patients on the ward that day it therefore nominally represents the average number of nursing hours that are available to each patient on that ward.) The graph on the right shows the average overall CHPPD across all wards and the impact of bed closures for COVID can be clearly seen from April – as services start to realign to ‘normal’ then CHPPD can be seen to be returning to previous levels.

Table 1 shows the overall planned vs actual fill rate for September. Overall the RN rate is same as last month and the HCA has reduced further to 86% on days- the fill rate on days has decreased as demand has increased starting to be seen in the requirements for additional staff for enhanced care which is slowly increasing and pockets of HCA vacancies (national requirement to be at zero HCA vacancies post COVID). All wards had sufficient staff for the numbers of patients admitted, with staffing templates remain set for normal bed occupancy and a slow return to normal bed occupancy is starting to be seen. Twice daily staffing meetings continue to provide review of actual staffing requirements and ensuring staff are redeployed before temporary staffing use approved. There are virtually zero RN vacancies at RN level across the wards.

The skill mix of RN:HCA has remained consistent with last month with RN 68% /HCA 32%. The broad recommendation is 65%:35%.

2019/20 saw an overall nursing underspend. At the end of M6 (2020/21) there is a £730k overspend, which is a £22k deterioration on last month, but a significant improvement on last month. Students on paid placement have broadly completed their placements at the end of August (a small number will complete in September) resulting in them either converting to RN posts or leaving the Trust. Agency spend remains minimal at £5k which is attributable to theatres and ED. Whilst some high risk / shielding staff have returned to their clinical departments, some remain in non-clinical or extended leave ahead of maternity roles impacting on spend. In addition there is still additional pressure from areas requiring additional staffing due to COVID e.g. ED RAZ, RCU. Meeting to be held with Director of Finance, Deputy Director of Nursing and Heads of Nursing to further understand the deterioration in expenditure – meeting held with surgery but medicine still to be completed, output will be reported next month.

With regards to Nurse Sensitive Indicators no specific concerns at present, increases in NSI’s can be associated with suboptimal staffing. Trust wide programme for pressure ulcers improvement as previously reported continues.

# Workforce – Staff Training and Appraisals

## Summary and Action

**Medical Appraisals** currently stand at 81.18%, below the agreed target of 90% which is expected and acceptable currently due to the suspension of medical appraisals during the Covid-19 response. We will however, be monitoring the situation closely to be assured that this is an improving picture.

**Non Medical Appraisals** are currently below the agreed target of 85%, at 81.49% and as we know have been challenging to complete due to staff being moved around, and 1:1 meetings being difficult to arrange in Covid-19 secure rooms.

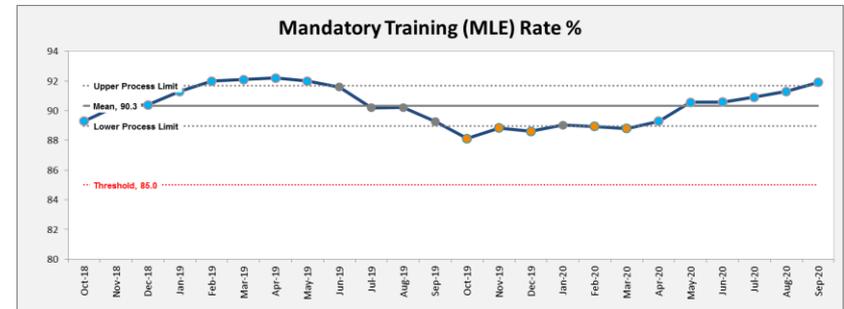
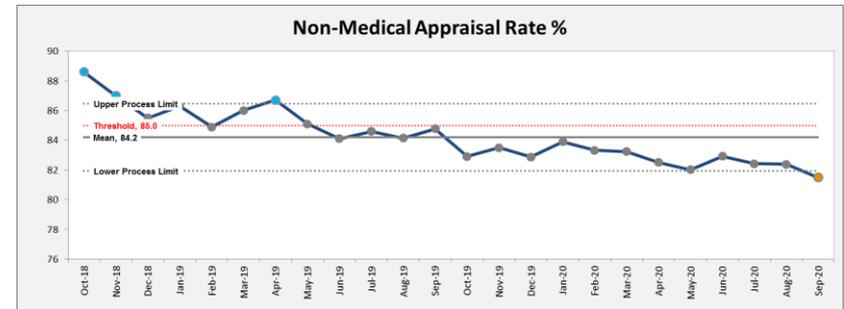
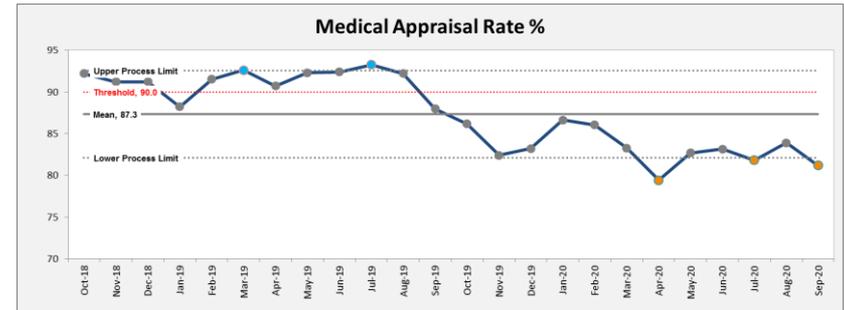
The People Business Partners are working diligently with service managers to bring compliance back to target levels. This includes suggesting alternative means of completing the appraisal discussions and providing details of non-compliance.

Appraisal training, focussing on the quality of the appraisal conversation, is being conducted for Divisions in response to results from last year's Staff Survey.

## Training

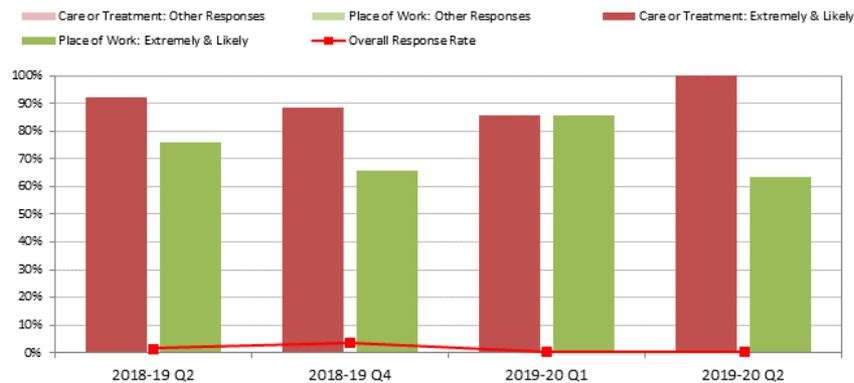
Mandatory and Statutory training compliance is currently above the 90% target at 91.9%, with all Divisions and Corporate services above 90%.

Unfortunately, Hand Hygiene and Safeguarding appear to be the common hotspot subjects for most areas. The People Business Partners are providing details to service managers on individual compliance and light boxes are being made available as much as possible for Hand Hygiene testing.



# Friends and Family Test – Patients and Staff

## Staff Responses: Place of Work and Place of Care



In April, NHSE advised Trusts to cease collecting paper-based Friends and Family Test cards due to health and safety concerns. Updated guidance was released in June and following approval of a local standard operating procedure the Trust recommenced the use of paper-based Friends and Family Test cards with the new questions. The Trust will restart reporting in December 2020.

The staff Friends and Family test was also suspended in Q1 and Q2 20/21 due to Covid-19.

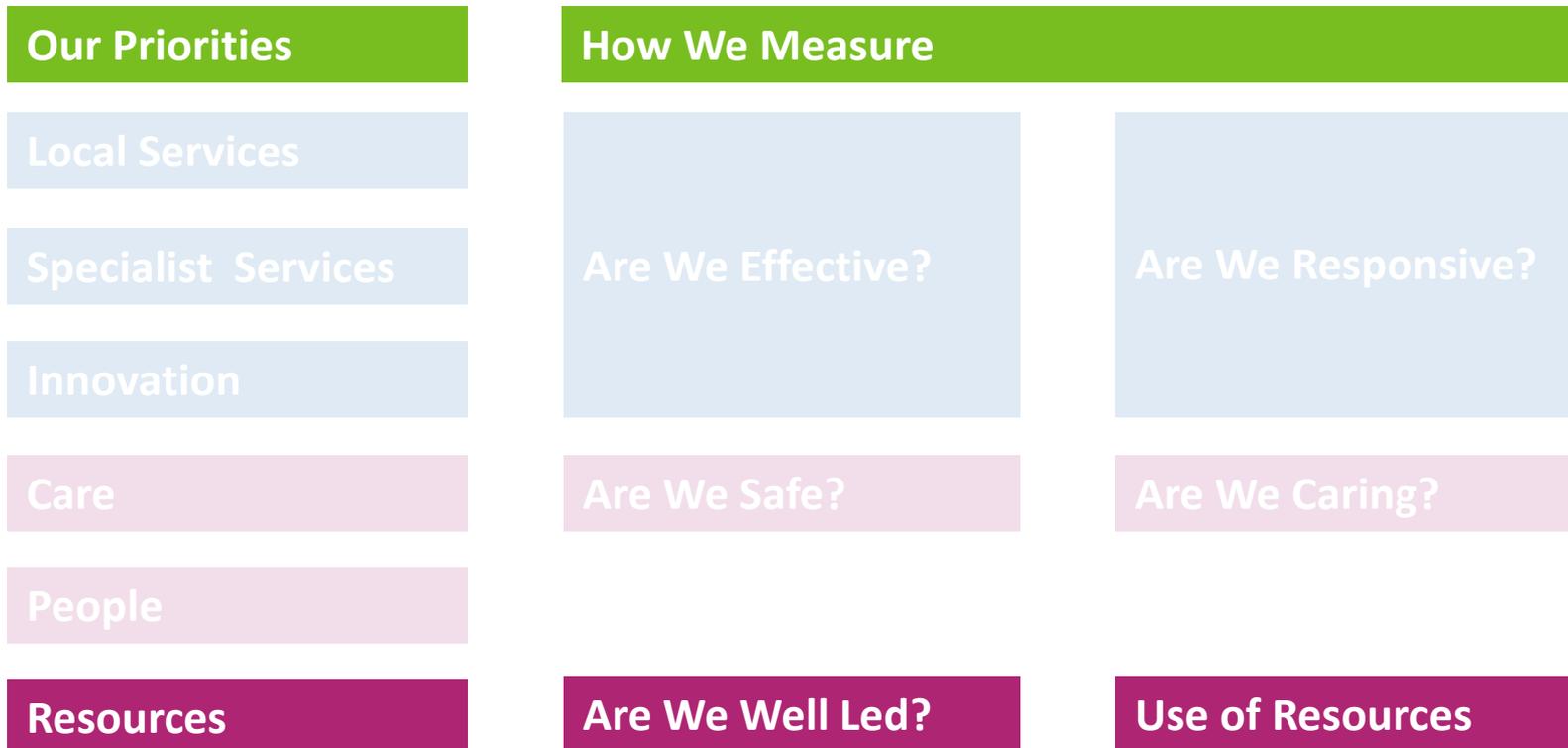
In September the Best Place to Work discovery phase report was published. This describes the experience of our workforce with at least 50% of staff engaging in the listening events and surveys. The aim was to understand the culture and the 'way we do things around here' as these shape the behaviour of everyone in the organisation and directly affects the quality of care they provide.

The discovery work acknowledged the Trust as a caring, friendly organisation with professional staff who strive to provide the best possible care for patients. Staff are proud of the hospital and proud of the care and treatment we give to our local community. The work also showed that:

- The Trust vision and values are well known and embedded. However, the strategy and Trust objectives are not well known.
- The management structure is hierarchical. Autonomy and accountability gets lost. There is a lack of direction and leadership capability is variable.
- Staff feel supported by their immediate line managers and enjoy working in their teams. However, front line teams don't feel connected to the wider Trust and listened to. They have loyalty to each other.
- Opportunities for learning and development are variable. Senior leaders do not listen well enough and sometimes fail to acknowledge and recognise the hard work of staff.
- There are concerns that blocking structures and behaviours prevent creativity and also prevent people from doing their job effectively.
- The Trust needs to be much more visible in terms of our wider links and communication with BSW, the ISC and across the South West region.

The Board discussed the recommendations at its meeting in October 2020. It was agreed a further seminar session should be held to review and prioritise the 20 recommendations. This is scheduled to take place at the beginning of December. The Board also agreed a co-creation approach whereby sessions with staff are scheduled to obtain their views on the areas that should be prioritised from the 20 recommendations.

# Part 4: Use of Resources



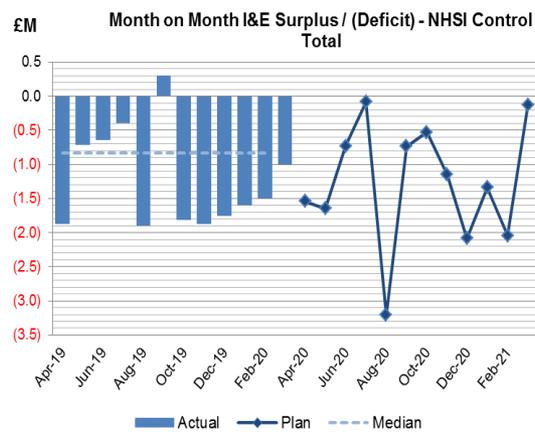
# Income and Expenditure

Income & Expenditure:



Use of Resources

|                                     | Position        |                 |                | Sep '20 YTD      |                  |              | 2020/21          |
|-------------------------------------|-----------------|-----------------|----------------|------------------|------------------|--------------|------------------|
|                                     | Sep '20 In Mth  |                 |                | Plan             | Actual           | Variance     | Plan             |
|                                     | £000s           | £000s           | £000s          | £000s            | £000s            | £000s        | £000s            |
| <b>Operating Income</b>             |                 |                 |                |                  |                  |              |                  |
| NHS Clinical Income                 | 18,066          | 17,438          | (628)          | 104,956          | 104,318          | (638)        | 220,952          |
| Other Clinical Income               | 878             | 3,674           | 2,796          | 5,191            | 15,468           | 10,277       | 0                |
| Other Income (excl Donations)       | 2,416           | 2,077           | (339)          | 14,496           | 12,773           | (1,723)      | 28,992           |
| <b>Total income</b>                 | <b>21,360</b>   | <b>23,189</b>   | <b>1,829</b>   | <b>124,643</b>   | <b>132,559</b>   | <b>7,916</b> | <b>249,944</b>   |
| <b>Operating Expenditure</b>        |                 |                 |                |                  |                  |              |                  |
| Pay                                 | (13,635)        | (14,455)        | (820)          | (81,817)         | (84,893)         | (3,076)      | (163,634)        |
| Non Pay                             | (7,010)         | (7,281)         | (271)          | (42,067)         | (39,375)         | 2,692        | (84,050)         |
| <b>Total Expenditure</b>            | <b>(20,645)</b> | <b>(21,736)</b> | <b>(1,091)</b> | <b>(123,884)</b> | <b>(124,268)</b> | <b>(384)</b> | <b>(247,684)</b> |
| <b>EBITDA</b>                       | <b>715</b>      | <b>1,454</b>    | <b>739</b>     | <b>759</b>       | <b>8,291</b>     | <b>7,532</b> | <b>2,260</b>     |
| Financing Costs (incl Depreciation) | (1,452)         | (1,454)         | (2)            | (8,703)          | (8,292)          | 411          | (17,474)         |
| <b>NHSI Control Total</b>           | <b>(737)</b>    | <b>(0)</b>      | <b>736</b>     | <b>(7,944)</b>   | <b>(0)</b>       | <b>7,943</b> | <b>(15,214)</b>  |
| Add: impact of donated assets       | 52              | (22)            | (74)           | 4                | (353)            | (357)        | 1,626            |
| Add: Impairments                    | 0               | 0               | 0              | 0                | 0                | 0            | 0                |
| Add: Central MRET                   | 0               | 0               | 0              | 0                | 0                | 0            | 0                |
| Add: FRF                            | 0               | 0               | 0              | 0                | 0                | 0            | 0                |
| <b>Surplus/(Deficit)</b>            | <b>(685)</b>    | <b>(22)</b>     | <b>663</b>     | <b>(7,940)</b>   | <b>(354)</b>     | <b>7,586</b> | <b>(13,588)</b>  |



## Variation and Action

For the purposes of financial reporting during the Phase 1 Covid-19 response the Trust is using the original 2020/21 plan as a baseline. This had assumed a deficit of £3.2m for the month, and a £15.2m deficit for the year, no central MRET or FRF was therefore assumed.

While a significant proportion of Covid-19 specific capacity has been de-escalated a minimum level at premium cost will be required for the foreseeable future. This combined with an increase in costs associated with the return of some of the Trust's 'routine' workload mean that a retrospective top up over and above the block contracts and 'top up' payments of £2.3m has been claimed year to date. This is inclusive of the recognised £0.3m per month 'shortfall' in the top up methodology caused by the instruction from NHSE&I not to invoice for provider-to-provider genetics tests.

Pay showed an increase of £0.3m (2%) in the period and non-pay increased by £0.6m (9%). The latter is explained by the Phase 3 work streams tasked with returning planned activity to near pre-Covid levels.

September is the first month that the Elective Incentive scheme is in place and in line with guidance this has been assessed at £113k but not included within the position per instruction from NHSEI.

# Income & Activity Delivered by Point of Delivery

Clinical Income:

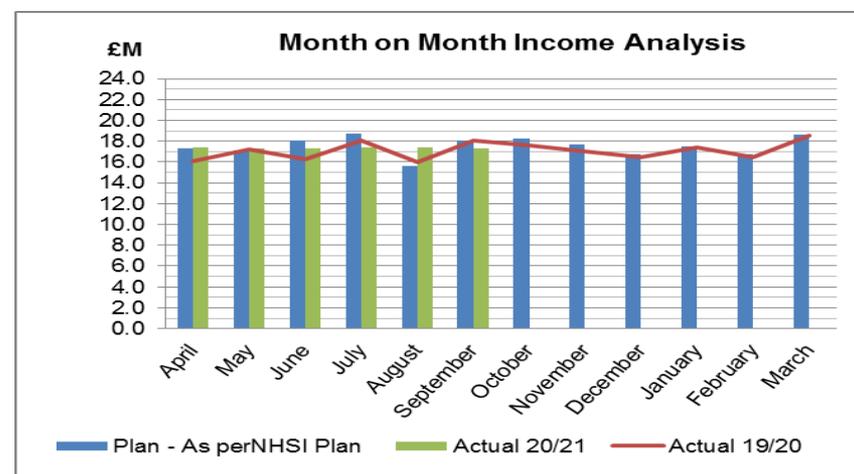


Use of Resources

| Income by Point of Delivery (PoD) for all commissioners | Sep '20 YTD    |                |                |
|---|----------------|----------------|----------------|
|   | Plan (YTD)     | Actual (YTD)   | Variance (YTD) |
|   | £000s          | £000s          | £000s          |
| A&E   | 4,754          | 4,014          | (740)          |
| Day Case  | 8,569          | 4,533          | (4,036)        |
| Elective inpatients                                     | 9,075          | 2,674          | (6,401)        |
| Excluded Drugs & Devices (inc Lucentis)                 | 9,605          | 8,499          | (1,106)        |
| Non Elective inpatients                                 | 31,320         | 26,530         | (4,790)        |
| Other   | 25,325         | 48,315         | 22,990         |
| Outpatients   | 16,308         | 9,753          | (6,555)        |
| <b>TOTAL</b>  | <b>104,956</b> | <b>104,318</b> | <b>(638)</b>   |

| SLA Income Performance of Trusts main NHS commissioners | Contract Plan (YTD) £000s | Actual (YTD) £000s | Variance (YTD) £000s |            |        |        |       |
|---|---------------------------|--------------------|----------------------|------------|--------|--------|-------|
|   |                           |                    |                      | BSW CCG    | 58,415 | 58,154 | (261) |
|   |                           |                    |                      | Dorset CCG | 11,926 | 12,422 | 496   |
| West Hampshire CCG                                      | 8,575                     | 8,613              | 38                   |            |        |        |       |
| Specialist Services                                     | 16,337                    | 16,216             | (121)                |            |        |        |       |
| Other   | 9,703                     | 8,913              | (790)                |            |        |        |       |
| <b>TOTAL</b>  | <b>104,956</b>            | <b>104,318</b>     | <b>(638)</b>         |            |        |        |       |

| Activity levels by Point of Delivery (POD) | YTD     | YTD     | YTD      | Last Year Actuals | Variance against last year |
|--|---------|---------|----------|-------------------|----------------------------|
|  | Plan    | Actuals | Variance |                   |                            |
|  | A&E     | 36,956  | 27,166   |                   |                            |
| Day case                                   | 11,333  | 6,095   | (5,238)  | 11,305            | (5,210)                    |
| Elective                                   | 2,404   | 971     | (1,433)  | 2,421             | (1,450)                    |
| Non Elective                               | 15,901  | 12,581  | (3,320)  | 13,225            | (644)                      |
| Outpatients                                | 126,741 | 89,355  | (37,386) | 126,942           | (37,587)                   |



## Variation and Action

Activity in September has increased above August levels across all of the main points of delivery with the exception of A&E. The most significant increases by specialty are Gastroenterology, Plastic Surgery and General Surgery Day cases, Clinical Haematology and Breast Surgery Elective, General Surgery and Ophthalmology, Trauma and Orthopaedics, Plastic Surgery, Respiratory, Rheumatology and Audiology Outpatients.

Contracts payment values with main commissioners have been based on Month 9 agreement of Balances (from a provider perspective), adjusted by 2.803% for inflationary pressures. Over the first six months of the year underlying activity has been valued at less than the agreed block by £27,134k (26%), owing to the temporary cessation of non-urgent planned work and phased recovery response. The September adjustment has reduced by £1,058k. September is the first month that the Elective Incentive scheme is in place and in line with guidance this has been assessed at c£113k but not included within the position per instruction from NHSEI.

# Cash Position & Capital Programme

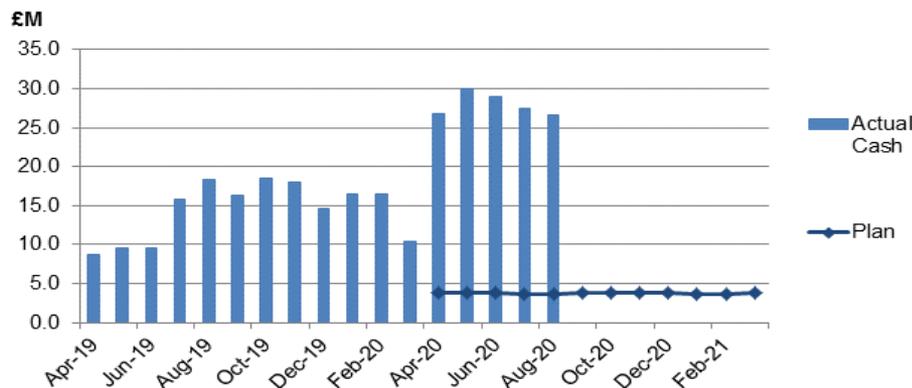
Capital Spend:



Cash & Working:



Month on Month Cash Balance



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

Payments on account in advance up until 31st October 2020 have been received. New guidance has indicated these payments will continue for the remainder of the financial year, with the clawback potentially due to take place in March 2021. Block payments for months 7-12 will be at a lower level than for the first 6 months due to the Phase 3 contracting guidance but these will be supplemented by further funding from within the STP system. The cash flow position will continue to be closely monitored to ensure any potential shortfalls are identified.

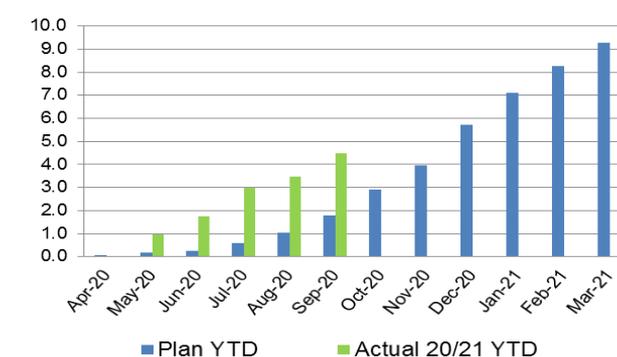
The Trust continues to press for the additional capital fund allocations in the year but had yet to receive any of these by the end of September.

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

Capital Expenditure Position

| Schemes                                | Annual        |              | Sep '20 YTD  |                |
|--|---------------|--------------|--------------|----------------|
|  | Plan          | Plan         | Actual       | Variance       |
|  | £000s         | £000s        | £000s        | £000s          |
| Building schemes                       | 850           | 200          | 16           | 184            |
| Building projects                      | 2,600         | 450          | 355          | 95             |
| IM&T                                   | 2,600         | 807          | 2,105        | (1,298)        |
| Medical Equipment                      | 2,778         | 650          | 651          | (1)            |
| Other                                  | 449           | 224          | 224          | 0              |
| Addition: Critical Infrastructure Fund | 3,455         | 145          | 106          | 39             |
| Addition: Covid 19                     | 4,417         | 421          | 1,038        | (617)          |
| <b>TOTAL</b>                           | <b>17,149</b> | <b>2,897</b> | <b>4,495</b> | <b>(1,020)</b> |

Month on Month CAPEX



Use of Resources

## Summary and Action

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

The Trust has received a number of capital allocations so far this year. These include £2,000k Emergency Department Configuration, £421k of funding for medical and IT equipment, £700k Ventilation and Endoscopy, and £1,233k Regional ICU Plan (including release of theatres as escalation space), all of which are included under the Additional Covid 19 heading above. This is additional to the £3,455k additional Critical Infrastructure Fund. Plans are underway to ensure schemes are fully developed, with the necessary resources in place, to complete these projects in 2020-21. All schemes will be funded through additional Public Dividend Capital.

A £294k bid for Covid phase 1 funding for IT equipment has been assumed unsuccessful despite regional support.

# Workforce and Agency Spend

Pay:

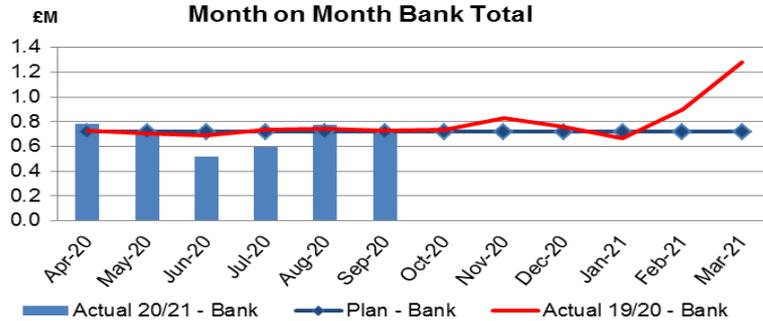


Use of Resources

Month on Month Total Pay (excl additional pension contribution)



Month on Month Bank Total



Month on Month Agency Control Total



## Summary and Action

Pay expenditure increased by £0.3m, or 1.8% month on month, some £0.4m above the previous run rate for the year. This month on month increase can be entirely accounted for by the backdated pay rise for medics (total £0.3m). The adverse variance to plan is £3m YTD. The costs directly driven by the Covid-19 response have now reached £3.4m, 73% of which relates to additional hours worked by the Trust's existing workforce. Covid-19 response costs continue to reduce as redeployed clinical staff return to their normal areas of work, however the residual cost of streamed patient pathways and protected capacity remain.

Both bank and agency costs have reduced in month, by £70k and £10k respectively.

Sickness and self isolation due to Covid-19 started to tick upwards during September. Overall sickness absence rate for the month was 3.45%, up from 3.16% in August.

|                         |                      |                     |     |
|-------------------------|----------------------|---------------------|-----|
| <b>Report to:</b>       | Trust Board (Public) | <b>Agenda item:</b> | 3.1 |
| <b>Date of Meeting:</b> | 05 November 2020     |                     |     |

|   |   |                   |                  |                 |
|---|---|-------------------|------------------|-----------------|
| <b>Report Title:</b>                    | Q1 Patient Experience Report                                      |                   |                  |                 |
| <b>Status:</b>                          | <b>Information</b>  | <b>Discussion</b> | <b>Assurance</b> | <b>Approval</b> |
|   |   |                   | X                |                 |
| <b>Prepared by:</b>                     | Katrina Glaister, Head of Patient Experience                      |                   |                  |                 |
| <b>Executive Sponsor (presenting):</b>  | Judy Dyos, Director of Nursing                                    |                   |                  |                 |
| <b>Appendices (list if applicable):</b> | 1. Themes from Covid-19 related comments, concerns and complaints |                   |                  |                 |

|   |
|---|
| <b>Recommendation:</b>                  |
| The Board is asked to note this report. |

|   |
|---|
| <b>Executive Summary:</b>   |
| <p>This report provides a report of activity for Q1 2010/21 in relation to complaints and the opportunities for learning and service change. Some key changes are highlighted below:</p> <ul style="list-style-type: none"> <li>As reported in the Patient Experience Q4/end of year report, NHS Improvement and NHS England together with the Parliamentary Health Service Ombudsman (PHSO) placed a 3 month pause on all complaint investigation from mid-March 2020. NHS England and Improvement and the PHSO have announced that they would re-start their complaints process on 1<sup>st</sup> of July. NHS Digital have not yet said when the KO41 data collection will recommence. Likewise there is no indication of when Friends and Family data submission will recommence</li> <li>We received over 80 complaints, comments and concerns in relation to COVID-19 during the first three months of the pandemic. 19% of all COVID-19 enquiries were related to donations such as PPE, clothing and food items, with an additional 8% of enquiries about how to volunteer either their transferable skills or personal time. 15% of enquires was in relation to restrictions place upon visiting. It was apparent that enquiries regarding the use of PPE and access to hand gel were also a cause for concern, which accounted for 11% of all enquiries. 9% of comments and enquiries logged were in relation to specific health related questions, as the public sought clarification on the level of risk COVID-19 posed to either themselves or a loved one.</li> <li>It is clear that during the COVID-19 pandemic (and despite the 'pause' placed on complaints) all Divisions were committed to progressing complaint investigations, where possible</li> <li>An update on initiatives implemented within PALS as a result of COVID-19 is presented.</li> </ul> |

This report provides assurance that the Trust is responding and acting appropriately to patient feedback and assurance of patient and public involvement in service co-design and improvement.

| 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 | <input checked="" type="checkbox"/> |
| Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population                       | <input type="checkbox"/>            |
| Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered      | <input checked="" type="checkbox"/> |
| Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm                            | <input checked="" type="checkbox"/> |
| People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams                                       | <input type="checkbox"/>            |
| Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources   | <input type="checkbox"/>            |

# Patient Experience Report - Quarter 1

## Purpose of paper

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

To provide assurance of patient and public involvement in service co-design and improvement.

## Background

Patient experience is defined as “the sum of all interactions, shaped by an organisation’s culture that influence patient perceptions across the continuum of care.”<sup>[1]</sup> Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and feedback is an imperative, including learning from feedback, transparency and honesty when healthcare goes wrong. This report provides some evidence of the patient experience feedback and activities in relation to self-improvement based on that feedback.

Making a complaint takes courage. Patients fear that speaking up could affect their care, but we are clear that this is not the case and welcome complaints as a means to improve our services.

The Trust takes concerns and complaints seriously. They are an important opportunity for us to learn and improve. Concerns and complaints can surface, and the quality of the investigation, response and actions allow improvements in the safety and quality of care delivery. We strive to create an open culture where complaints are welcomed and learnt from..

## Actions going forward

- The PALS team have been found a new home in offices close to The Green Entrance and hopes to move in Q2. This will make PALS more visible and accessible for visitors.

## 1. Sharing Outstanding Excellence (SOX)

There is growing awareness nationwide that since complaints are a small minority compared to other PALS feedback, learning from what goes well in a Trust is as important as learning from complaints. In this Trust, a positive report is known as a SOX.

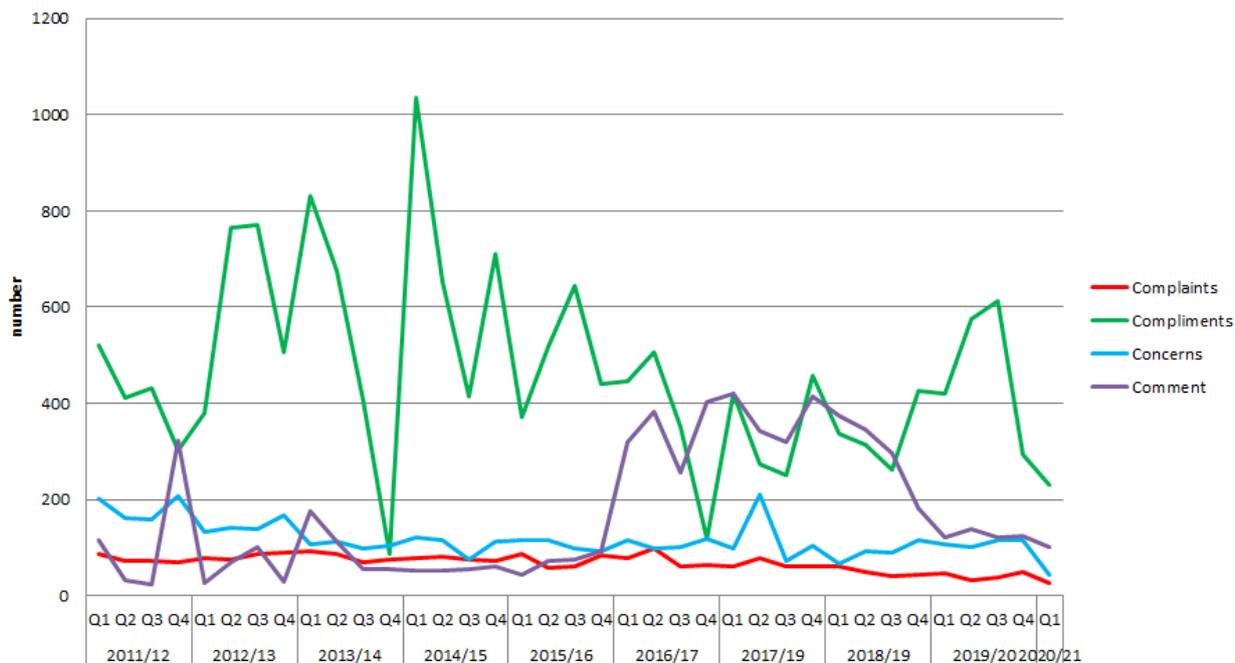
The PALS team (and patient representatives going forward) review all the SOX nominations and chose a selection to go forward to the Trust Board where recipients receive a certificate.

## 2. Complaints

The graph overleaf shows the numbers of complaints, compliments, concerns and comments over time. Below you can see that complaints continue to show a slight downward trend.



## Complaints, Compliments, Concerns and Comments



### Complaint themes Q1

|   | CSFS     | Transformation & IM&T | Medicine  | Surgery  | Total     |
|---|----------|-----------------------|-----------|----------|-----------|
| Appointment system - procedures                 | 0        | 0                     | 0         | 1        | 1         |
| Clinical Treatment - Obstetrics and Gynaecology | 1        | 0                     | 0         | 0        | 1         |
| Correct diagnosis not made                      | 0        | 0                     | 2         | 0        | 2         |
| Data protection                                 | 0        | 0                     | 0         | 1        | 1         |
| Delay in making diagnosis                       | 0        | 0                     | 0         | 1        | 1         |
| Discharge procedures                            | 0        | 0                     | 1         | 1        | 2         |
| Drug Error                                      | 0        | 0                     | 2         | 0        | 2         |
| Further complications                           | 0        | 0                     | 0         | 3        | 3         |
| Information not given to family                 | 0        | 0                     | 1         | 0        | 1         |
| Information required                            | 0        | 1                     | 0         | 0        | 1         |
| Neglect   | 0        | 0                     | 3         | 0        | 3         |
| Unsatisfactory treatment                        | 0        | 0                     | 6         | 0        | 6         |
| Wrong information                               | 0        | 0                     | 1         | 0        | 1         |
| Attitude of staff - medical                     | 0        | 0                     | 0         | 1        | 1         |
| <b>Total</b>                                    | <b>1</b> | <b>1</b>              | <b>16</b> | <b>8</b> | <b>26</b> |

In Q1 the Trust treated 11,256 people as inpatients, day cases and regular day attendees. Another 12,153 people were seen in the Emergency Department (includes the walk-in clinic) and 17,745 as outpatients (this excluded telephone calls). 26 complaints were received which is 0.063% of the number of patients treated.

232 compliments were received across the Trust in Q1. Those sent directly to the Chief Executive or PALS are acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment/national patient survey/RTF/FFT the PALS team complete a SOX which is sent to the individual and their line manager. Twelve members of staff were highlighted as providing excellent care by patients in the national inpatient survey 2019.

| Concerns, enquiries and comments - closed within 10 working days | No. | %    |
|--|-----|------|
| Not yet closed   | 11  | 4.3% |
| 0-10 working days  | 239 | 93%  |
| 11-24 working days   | 6   | 2.3% |

|                 |            |      |
|-----------------|------------|------|
| 25+working days | 1          | 0.4% |
| <b>Total</b>    | <b>257</b> |      |

Excluding complaints, the PALS team logged 257 comments, concerns and enquires in Q1. 93% of these were responded to within 0-10 working days.

### COVID 19 related complaints, comments and concerns

We received over 80 complaints, comments and concerns in relation to COVID-19 during the first three months of the pandemic.

- 19% of all COVID-19 enquiries were related to donations such as PPE, clothing and food items, with an additional 8% of enquiries about how to volunteer either their transferable skills or personal time.
- 15% of enquires was in relation to restrictions place upon visiting.
- It was apparent that enquiries regarding the use of PPE and access to hand gel were also a cause for concern, which accounted for 11% of all enquiries.
- 9% of comments and enquiries logged were in relation to specific health related questions, as the public sought clarification on the level of risk COVID-19 posed to either themselves or a loved one.

Please see Appendix 1 for a graph showing themes noted.

### Recovery Phase

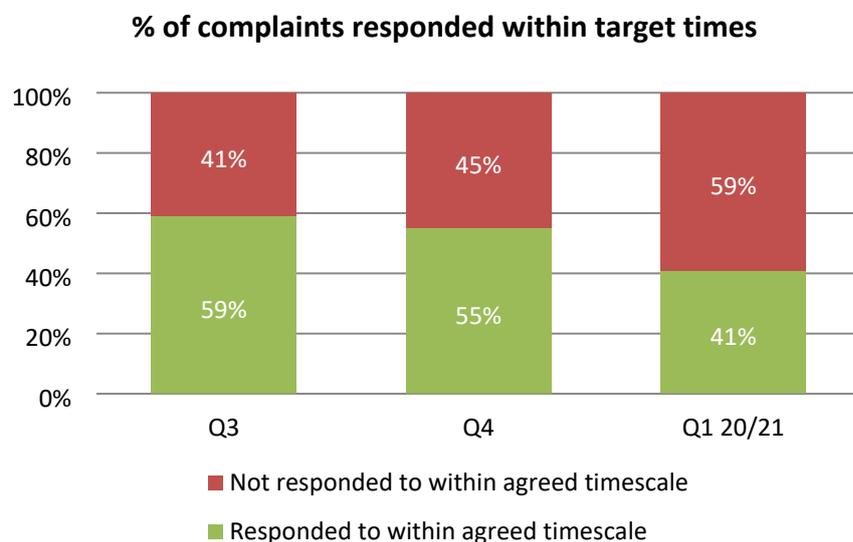
As reported in the Patient Experience Q4/end of year report, NHS Improvement and NHS England together with the Parliamentary Health Service Ombudsman (PHSO) placed a 3 month pause on all complaint investigation from mid-March 2020.

NHS England and Improvement and the PHSO have announced that they would re-start their complaints process on 1<sup>st</sup> of July.

### Timeliness of response

100% of complaints were acknowledged within 3 working days.

**Graph to show the percentage of closed complaints responded to within the agreed timescales; over the previous three quarters.**

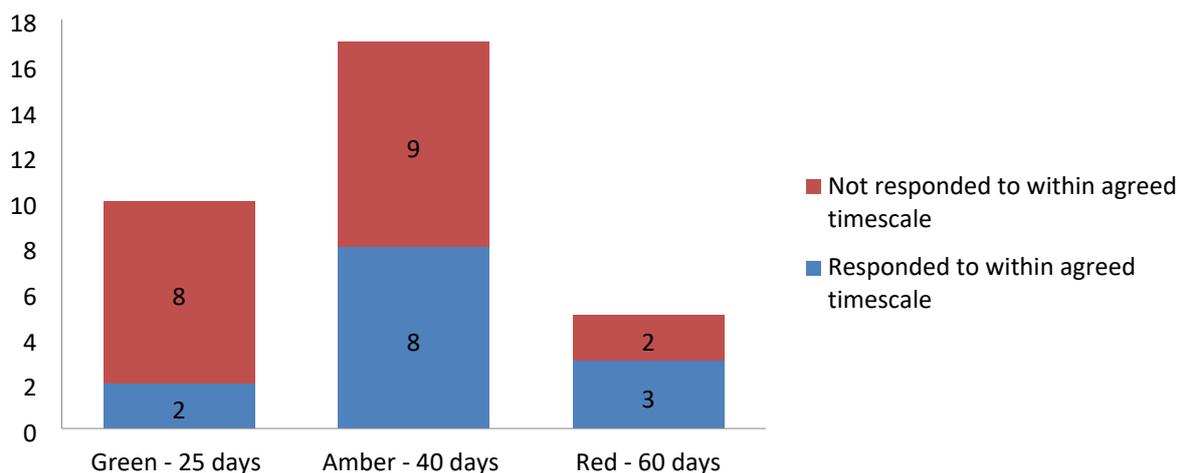


32 complaints were closed during Q1. The figures demonstrate a 14% reduction in complaints being responded to within the agreed target time. However, it is important to note that the 3 month extension was not applied to these figures; in order to maintain consistency in reporting the response times were calculated on existing timeframes only.

It is clear that during the COVID-19 pandemic (and despite the 'pause' placed on complaints) all Divisions were committed to progressing complaint investigations, where possible.

**The graph below shows the breakdown of compliance against the time frame agreed with the complainant.**

### Compliance against agreed response times



Only 20% of complaints where a 25 working day response time was agreed with the complainant were responded to within the agreed time frame.

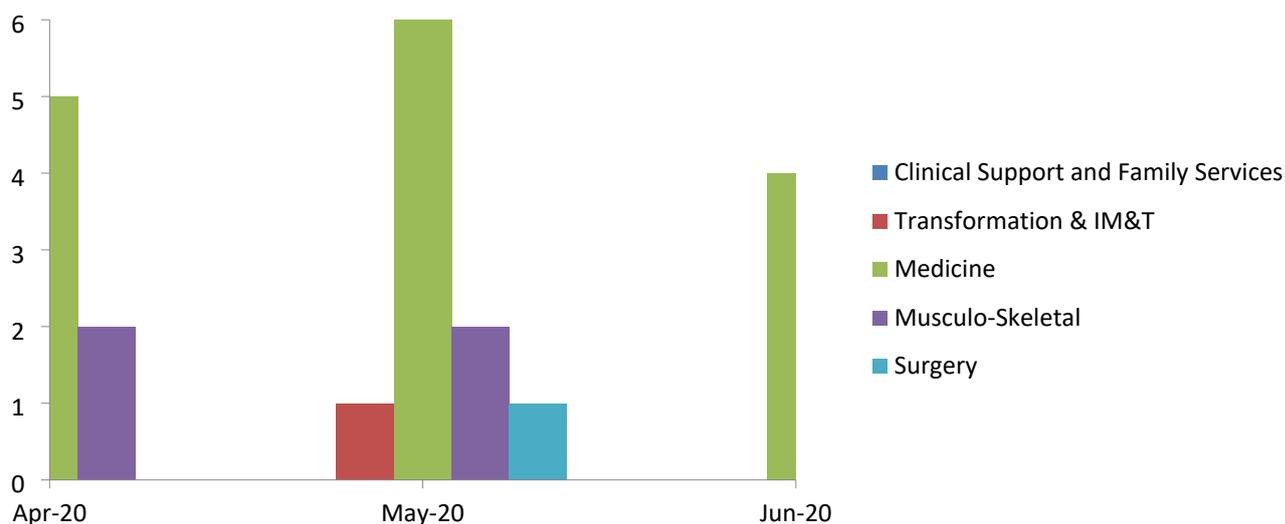
47% of Amber complaints were responded to within the specified 40 days and 60% of red complaints were responded to within agreed target times. As mentioned in the Patient Experience Q4/end of year report, a move to a 40 day response rate for all complaints bar those that fall under a Serious Incident investigation (which would follow a 60-day pathway) is being considered.

### Number of reopened concerns and complaints in Q1 20/21



The reasons cited for complaints and concerns being reopened remain the same as for previous quarters. Many complainants feel that not all the issues they raised were addressed fully within the response or they believed that the explanation or opinions offered differed from their own experiences. Two complainants had additional questions they wished to raise and there were 3 requests for a resolution meeting within this cohort.

## Number of complaints logged per Division



The Medicine Division received the most complaints in this quarter; accounting for 57% of all complaints logged during this time. These figures may be reflective of the current situation as many non-essential services across the other divisions were paused during the pandemic.

### 3. Complaints by directorate

#### Clinical Support and Family Services

|  | Q1 2019-20 | Q4 2019-20 | Q1 2020-21 |
|--|------------|------------|------------|
| Complaints   | 11         | 8          | 1          |
| Concerns   | 15         | 10         | 3          |
| Compliments  | 42         | 42         | 32         |
| Re-opened complaints                                     | 0          | 0          | 1          |
| % closed complaints responded to within agreed timescale | 63%        | 42%        | 0%         |
| Complaints closed in this quarter                        | -          | 7          | 3          |
| % concerns responded to within 25 working days           | -          | 56%        | 100%       |

- There was only one complaint raised in Q1 regarding the Gynaecology department which is overdue.
- No complaint meetings were held in this quarter.
- One complaint was re-opened regarding the Radiology department; the complainant felt the first response was unsatisfactory.
- 3 complaints were closed in Q1; however these were all closed past their due date. These delays were down to awaiting statements from clinicians, however the national pause due to the pandemic was taken into account and all complainants were sent holding letters.
- 3 concerns were raised in quarter 1 with no themes.
- The PALS department received 19 comments and enquiries for CSFS in Quarter 1 which were investigated, managed and responded to by the team.
- Total activity within the directorate was 6505 and of this number 0.01% raised a complaint.
- 3 action plans are outstanding from 1<sup>st</sup> April 2019 and the directorate have been chased for these.

#### Themes and actions from concerns and complaints closed in this quarter

All actions as a result of complaints raised in this division for 2019/20 have been evidenced as completed and have been closed.

| Q1 themes      |  |  |
|----------------|--|--|
| No theme noted |  |  |

## Compliments

32 compliments were received in quarter 1, the breakdown is as follows:

Bowel screening=14, Endoscopy=1, Maternity=3, NICU=13, Radiology=1,

## Medicine division

|  | Q1 2019-20 | Q4 2019-20 | Q1 20-21 |
|--|------------|------------|----------|
| Complaints   | 14         | 16         | 16       |
| Concerns   | 32         | 38         | 25       |
| Compliments  | 183        | 169        | 116      |
| Re-opened complaints                                     | 1          | 0          | 1        |
| % closed complaints responded to within agreed timescale | 57%        | 56%        | 54%      |
| Complaints closed in this quarter                        | -          | 16         | 11       |
| % concerns responded to within 25 working days           | -          | 90%        | 75%      |

- Even though there was a hold on the complaint process nationally due to Covid-19, the Medicine Division has done really well in responding to concerns and complaints raised during this time
- The Emergency Department and Farley RCU received the most complaints with 4 each this quarter. The main theme for the Emergency Department was unsatisfactory treatment and the main themes for Farley RCU were unsatisfactory treatment and communication issues.
- 11 complaints were closed in Q1 and of these 6 were responded to within the agreed timescale. Eight complaints raised in Q1 are still open (agreed 40/60 day timeframe with the complainants) and two are overdue; the delays for which are being investigated by the Emergency Department.
- 1 complaint was re-opened in Q1, this was a Hospice complaint and the family felt that their response letter did not answer all their questions.
- There were 25 concerns raised in Quarter 1. Spire ward received the most (n=5) but there is no specific theme seen. AMU received 4 concerns; again no specific theme is seen.
- The PALS department received 64 comments and enquiries for Medicine in Quarter 1 which were investigated, managed and responded to by the team.
- Total activity within the directorate was 21616 and of this number 0.07% raised a complaint.
- The Complaints Co-ordinator is waiting for 25 outstanding action plans from closed complaints since 1<sup>st</sup> April 2019 for the Medicine directorate. These have been chased.

### Themes and actions from concerns and complaints closed in this quarter

All actions as a result of complaints raised in this division for 2019/20 have been evidenced as completed and have been closed.

| Q1 20-21 themes      |  |   |
|----------------------|--|---|
| Department/Ward      | Topic                                      | Action  |
| Emergency Department | Unsatisfactory treatment                   | Prompt telephone contact with complainants.<br>Work within the department with setting professional behaviours and encouraging civility, compassion etc.<br>Focus on education and training of staff - increased SIM activity which includes communication of difficult news to patients and relatives. Development of a new junior doctor rota pattern to include dedicated time for learning and development. |
| Farley RCU           | Unsatisfactory treatment and communication | Many of these concerns are around the problems highlighted because of Covid-19 and the lack of visiting by relatives. A white board has been set up in the office on RCU to record all conversations with families and should be completed at least once during the day.<br>There has been a general theme around communication throughout medicine as a whole.   |

Farley/RCU, Spire and Laverstock wards are setting up communication sessions for staff especially around end of life issues. One such session has taken place and more will be arranged.

## Compliments

116 compliments were received in Quarter 1, the breakdown is as follows:

AMU=13, Durrington =7, Emergency Department =7, Farley=1, Hospice=31, Pembroke=4, Redlynch=7, Tisbury=18, Spire=21, Vascular=1, Whiteparish =6.

## Surgical Division

|  | Q1 2019-2020 |     | Q4 2019-20 |     | Q1 2020-21            |
|--|--------------|-----|------------|-----|-----------------------|
|  | Surgery      | MSK | Surgery    | MSK | Divisions amalgamated |
| Complaints   | 12           | 10  | 12         | 11  | 8                     |
| Concerns   | 33           | 22  | 27         | 22  | 10                    |
| Compliments  | 158          | 37  | 74         | 13  | 64                    |
| Re-opened Complaints & Concerns                          | 1            | 5   | 1          | 2   | 3                     |
| % closed complaints responded to within agreed timescale | 50%          | 50% | 83%        | 64% | 28%                   |
| Complaints closed in this quarter                        | -            | -   | 6          | 8   | 18                    |
| % closed concerns responded to within 25 working days    | -            | -   | 83%        | 52% | 37%                   |

- There were 8 complaints received this quarter with Orthopaedics having the most (n=3). The most evident theme was "Further Complications" (n = 2).
- There were no complaint meetings held in this quarter; 1 has been booked for Q2.
- There were ten concerns raised in Quarter 1. Longford Ward received the most (n = 3), two of which were due to "Treatment and Care on the Ward".
- There was one complaint and two concerns re-opened in Quarter 1. All three are now closed with the issues having been resolved.
- The main themes for the 18 complaints closed in Q1 were; further complications (n = 4); and correct diagnosis not made (n = 2).
- The main themes for the 19 concerns closed in Q1 were; lack of communication (n=4); appointment system – procedures (n = 3); wrong information (n = 2) and unsatisfactory treatment ( n=2).
- There were three concerns which were related to the impact of COVID-19 on services.
- The PALS department received 52 comments and enquiries for Surgery in Quarter 1 which were investigated, managed and responded to by the team.
- Total activity within the Division was 13,033 and of this number 0.06% raised a complaint.
- There are no outstanding action plans from closed complaints since 1<sup>st</sup> April 2020 for the Surgery Division.

Themes and actions from concerns and complaints closed in this quarter:

| Q1 2020-2021 themes |  |  |
|---------------------|--|--|
| Department/Ward     | Topic  | Actions  |
| Orthopaedics        | <p>Further complications/correct diagnosis not made</p> <p>Information Governance</p>  | <p>Further investigation of the orthopaedic complaints revealed no shared issues or root cause. No actions</p> <p>Investigation showed that our procedures had been followed. No action</p>  |
| Longford Ward       | Treatment and care on the Ward   | <p>Four concerns have had meetings to resolve issues on the ward. No additional actions required.</p> <p>The Consultant has reflected on actions and the care of the patient has been transferred to another consultant</p>  |
| Division Wide       | <p>The Impact of COVID-19 (three concerns)</p> <p>Delays to routine appointments and operations increased in this quarter due to the continued impact of elective cancellations and restrictions during the height of COVID-19 and the continuing limitations on COVID-19 Recovery.</p> <p>Urgent and cancer surgical activity has continued, mainly in the main theatres not being used for ITU escalation. Elective recovery theatre lists are now running for most specialties in all theatres in the day surgery unit, although capacity is still significantly under pre- COVID-19 levels</p> <p>Cases also continue to be transferred to Newhall, if clinically suitable. Activity mapping is also being undertaken for all surgery lists to ensure maximum efficiency of the lists bearing in mind the limitations on capacity due to turnaround and PPE.</p> | <p>The Recovery approach is to continue with as much elective outpatient activity as possible using virtual solutions (video and telephone) and enhanced advice and guidance, referral triage and treatment pathways. Capacity in outpatient areas is being mapped in detail to ensure the ability to increase face-to-face activity which started in late May, where clinically necessary.</p> <p>Activity mapping is also being undertaken to identify those specialties not yet back to pre-COVID-19 levels so that the limiting factors for this can be identified and work undertaken to resolve these.</p> <p>Validation of the outpatient PTL (Patient Tracking List) and follow up waiting lists have been undertaken during the pandemic period to both confirm accuracy and to ensure recovery plans are based on the clinical priority of patients. A clinical triage of the full surgery PTL was undertaken by the clinical teams in order to grade the patients based on the national best practice guidance. This triage forms the basis of the Theatre Recovery Plan to restart further elective activity in the near future and to ensure the minimalizing of delays for clinically urgent patients.</p> |

Feedback on actions that remain open from previous quarters:

| Q4 2019/20 themes and updates                  |  |   |
|--|--|---|
| <b>Laser Clinic and Orthopaedic Department</b> | Lack of capacity; resulting in delayed and cancelled appointments. | <b>Laser Clinic</b> has experienced some service delivery issues; which the team are working to resolve. There is a programme of training ongoing, and it is anticipated that in the near future they will have two fully trained members of the nursing staff, in the Dermatology/Plastics team. It is hope this will increase the |

|  |  |   |
|--|--|---|
|  |  | <p>capacity of the laser clinic; thus reducing the need for the service to reschedule patient's appointments.</p> <p><b>Update Q1 2020:</b> The training plan is in progress. Activity in the laser clinic was put on hold as part of the Trust's response to the pandemic, and has not yet restarted.</p> <p><b>Orthopaedic Department:</b> Patients are allocated follow up appointments as appropriate based on clinical priority; unfortunately over Q4, patients were waiting longer than initially indicated due to capacity issues. Details of this case has been shared with the relevant teams and lessons learnt</p>  |
| <b>Orthopaedic and Orthopaedic Outpatients</b> | Lack of information or miscommunication  | <p>Miscommunication regarding treatment plan. Plan of care has been agreed with patient.</p> <p>Misinformation received regarding preoperative testing; which was unfortunately due to human error. This has been addressed with both the booking and administration teams in Central Booking. A crib card to remind staff of the timings regarding the validity of pre-ops and bloods and swabs for various specialties has been produced and circulated to the teams. Plans are in place to amend the letter template for orthopaedic operations to include further information about the timeframes for pre-op bloods and swabs.</p> <p><b>Update Q1 2020:</b> Changes to template letters currently on hold due to COVID-19 as we are not currently able to undertake any routine orthopaedic procedures and several main theatres have been repurposed for the COVID-19 escalation</p> |
| <b>Amesbury Ward and Plastic Department.</b>   | Medication errors  | <p>Amesbury: Issues raised within the complaint have been shared with the team informally through team meetings and via the safety briefings.</p> <p>Amesbury: Apologies given regarding the omission of insulin. More education regarding the management of patient with diabetes is required. Training sessions will be undertaken.</p> <p><b>Update Q1 2020:</b> Confirmation of training course dates to be confirmed within the next report.</p>   |
| <b>Q3 2019/20 themes and updates</b>           |  |   |
| <b>Central Booking</b>                         | Appointment Dates: Central Booking unable to book appointments in time due to capacity pressures in clinical areas meaning there aren't appointments available. These are escalated to the department heads of the areas involved and discussed regularly to clinically triage those waiting and add extra clinics and appointments wherever possible. | <p>This is ongoing.</p> <p>Please see Division Wide Impact of COVID-19 comments in Q1 Themes above.</p>   |

### Compliments

78 compliments were received in Quarter 1, the breakdown is as follows:

Radnor Ward = 30, Longford Ward =14, Downton Ward = 13, Britford Ward = 11, Amesbury Ward = 5, Plastics O/P = 1, Wessex Rehab = 1, Breast Team = 1, OMFS = 1, Urology = 1.

## 4. Patient Experience and COVID-19

As soon as visiting was restricted across the hospital site a number of additional measures were put in place to help family/loved ones keep in touch:

### A message to a loved one

Since the start of the pandemic over 400 messages from families to loved ones being cared for in the hospital have been received into the dedicated inbox: [sft.message.to.love.done@nhs.net](mailto:sft.message.to.love.done@nhs.net)

Messages and photos have been received from all over the world. Each message and photo is printed out and placed in an ArtCare greeting card before they are delivered. Monday to Friday the pharmacy volunteers deliver the cards and at the weekend a member of the PALS team does this.



Feedback from families has been overwhelmingly positive. For example:

- *A big thank you to you and all the volunteers for this invaluable service. It really means a lot and makes such a positive difference!*
- *So kind of you. What a lovely initiative this is so that everyone can keep in touch.*
- *I just wanted to thank you on behalf of my mother's children and grandchildren for printing out our messages and photos. I think this service is invaluable and so thoughtful especially during the restrictions of Covid. It has been so hard for all of us not to see her but I know the enjoyment the messages have given my mother along with seeing the photos as they showed her how much we all cared for her.*

### Virtual visiting

The wards have been able to set up virtual visiting times via Attend Anywhere for relatives and patients using ward iPads. This too has been very welcomed and local, national and international virtual visits have taken place with multiple family members attending the same visit. PALS have helped promote the service to families who have contacted us via the 'message to a loved one' email address.

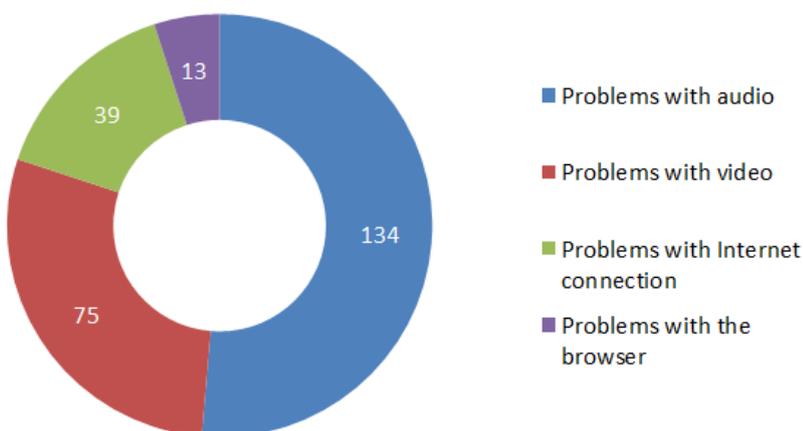
### Drop off point for essential items

Friends and families can leave essential items for their loved one without entering the ward areas. Items can be left in PALS from Monday - Friday between 9-10am and 2-3pm. A free short stay car parking space is available outside PALS which has been very welcomed.

### Attend Anywhere remote consultations

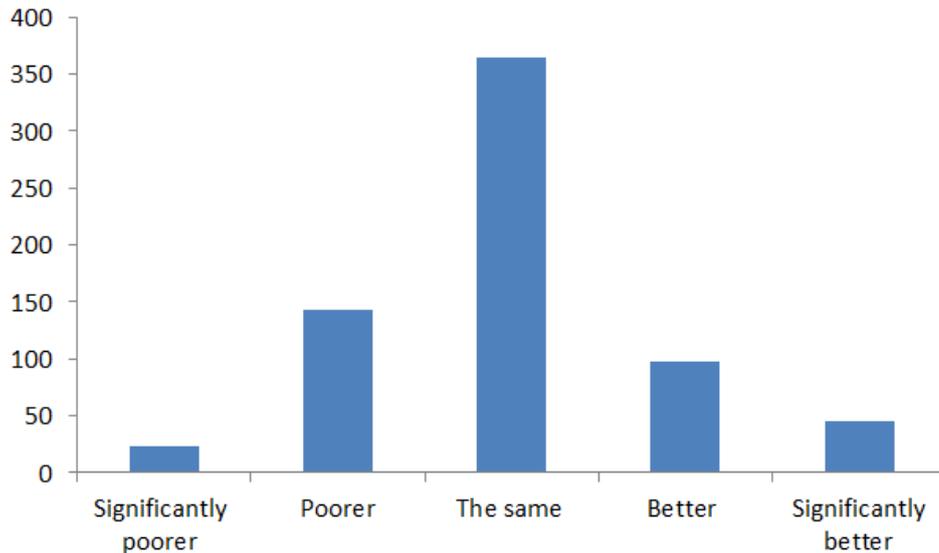
A feedback form is made available to all patients attending a remote (video) consultation and to date 805 patients have given us feedback:

- 95% of our patients who had an Attend Anywhere consultation said that they would be happy to do so again. Only 1% would not be happy to have a remote consultation in the future.
- 83% of respondents rated their experience as 8, 9 or 10/10 (56% rated it as 10/10)
- 59% of all patients connected to Attend Anywhere without any problems and had no problem with audio or video:



Examples of comments made:

- Needed to adjust sound level
  - Had to open in Chrome to get the video to work
  - Very slight lag in audio
  - Quality good but not perfect
  - Mismatch between the audio and video is quite difficult at times.
- 
- 75% of patients felt that the consultation was the same, or better than a face-to-face consultation



Examples of comments made by patients who did not find their remote consultation as good as face-to-face ones they had had in the past:

- *It is just not the same as talking to somebody face to face, even though the doctor was very pleasant*
- *Delayed video transmission required phone call. Really needed to be able to physically examine.*
- *Because the doctor couldn't touch my ankles to feel the problem*
- *A lot of technical difficulties. Last appointment was significantly better than the first though.*
- *Only because the auto noise cancelling makes the conversation difficult.*
- *I do not think that video consults could replace face-to-face appointments but are useful to keep in touch and reassure*

Examples of comments made by patients who felt their remote consultation was as good as (or better) than face-to-face ones

- *Didn't need to leave the house and go to the hospital. Could easily combine with working from home.*
- *Less time needed off from work*
- *There was not much difference between face-to-face and video conference (VC). The VC rather saved travel time and expenses. So VC is the better option.*
- *Excellent quality of personal consultation but no waiting time or journey time or parking cost at the hospital.*
- *I felt more comfortable asking questions, more informal.*
- *Due to my mobility issues not having to attend the clinic was better and we were able to get the same outcome. Thank you for this new service.*

## 5. Parliamentary and Health Service Ombudsman (PHSO)

We have received notification that from 1st July 2020 the PHSO is again accepting new NHS complaints and progressing existing health casework.

The PHSO have extended the timeframe in which they will accept new complaints due to the pause placed on complaint investigations. If the 12-month time limit had fallen between 26 March and 30 June 2020; (when the PHSO were not accepting new complaints) then the complainant will have until 1st September 2020 to register their concerns.

Since the end of their Pause, we have received four ‘information requests’ from the PHSO and one confirmation of their ‘intention to investigate’.

For the first time the PHSO has published data about their recommendations [for upheld and partially upheld cases](#). They have also published a [data table](#) of complaints received, assessed and investigated about NHS Organisations. This data will be published every quarter alongside their existing [health complaints statistics report](#).

## 6. Trust wide feedback

### Patients surveyed

At the request of NHS England and NHS Digital data collection and publication for the Friends and Family Test was paused during the response to COVID-19 and we have not been informed when data submission should recommence although it is likely that the Friends and Family Test will formally resume in September with data submission in October 2020.

A total of 296 patients provided feedback during the quarter through the Friends and Family Test (FFT). This is much less than the previous quarter (Q4 – 2,135)

### Friends and Family test

The new FFT questions went live in April 2020 albeit with less fanfare.

There is a new standard question for all settings: **“Thinking about...”** (Britford Ward for example) **“Overall, how was your experience of our service?”**

The new question has a new response scale:

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Don't know

In addition to the new question there are two new free text boxes for patients to give specific feedback:

- What was good about your experience?
- Please tell us about anything we could have done better?

Nationwide the response rates which have previously been published for individual trusts showing response rates for inpatients, ED and maternity have been removed, as there is now no limit on how often a patient can give feedback. We will still have to submit the same data but instead of a response rate being published an indicator will be which puts the number of responses collected in the context of the size of the service provided. It is felt that this will give commissioners and regulators a sense of how effectively the FFT is being implemented.

Responses for the quarter are set out in the table below.

|            | Total responses received | Very good |      | Good |     | Neither good nor poor |  | Poor |  | Very poor |  | Don't know |  |
|------------|--------------------------|-----------|------|------|-----|-----------------------|--|------|--|-----------|--|------------|--|
| Day Case   | 84                       | 75        | 89%  | 9    | 11% | 0                     |  | 0    |  | 0         |  | 0          |  |
| ED         | 8                        | 8         | 100% | 0    |     | 0                     |  | 0    |  | 0         |  | 0          |  |
| Inpatients | 115                      | 103       | 90%  | 12   | 10% | 0                     |  | 0    |  | 0         |  | 0          |  |
| Maternity  | 13                       | 13        | 100% | 0    |     | 0                     |  | 0    |  | 0         |  | 0          |  |

|             |    |    |     |   |     |   |  |   |  |   |    |   |    |
|-------------|----|----|-----|---|-----|---|--|---|--|---|----|---|----|
| Outpatients | 44 | 35 | 80% | 6 | 14% | 0 |  | 0 |  | 2 | 4% | 1 | 2% |
|-------------|----|----|-----|---|-----|---|--|---|--|---|----|---|----|

There was only one negative comment received during the reporting period and that related to the length of time a patient had to wait in the Outpatient Department.

### Some feedback received during the quarter

- *“All staff were practical, tender hearted, patient with even the most difficult of patients, and a real credit to profession and NHS. Thank you”*
- *“In these difficult times, every member of staff still acted professionally and always had a smile on their face. They put their own health on the line every day and for that I am truly grateful”*
- *“The attitude, efficiency and friendliness of the staff. I didn't meet anyone who was grumpy or couldn't explain when I had a question. Your greatest aptitude is your staff”*

### Patient and Public Involvement – National surveys

No national survey results were published within the reporting period.

#### Inpatient Survey 2019

The results were published on 2 July 2019 and will be included in the next quarter's report.

#### Maternity Survey 20202

This survey was cancelled by the Care Quality Commission as a result of Covid-19.

### Action taken on areas of concern

Wards, the Emergency Department and Maternity, have action plans in place to address the main areas of concern in their location. Progress is monitored via the Trust's Matrons Monitoring Group and is overseen by the Clinical Management Board.

## 7. Health Watch Wiltshire feedback

Regular meetings are held between PALS and Health Watch Wiltshire and any feedback they receive about this hospital is shared with us.

### Complaint Focus Group

A focus group for patients who had made a complaint and had been unhappy with their response had been planned for Q4 but was cancelled due to social distancing measures for COVID-19. Healthwatch agreed to telephone those people who had planned to attend and 4 people gave their feedback. Healthwatch felt it was important to recognise that the people involved were self-selecting and may have chosen to be involved as they had a negative experience and wanted to share their story so that the process could improve going forwards.

#### Findings:

The language used within the letters was brought up by three people. The letters received contained technical medical terms, were repetitive and did not address the points raised in the complaint. This led to confusion and them therefore not understanding the letter received.

Three people said that there was no clear plan of action or follow up. They wanted to know that their complaint had been dealt with and that the issues raised had been discussed with individuals involved where necessary. Generally, they wanted reassurance that what happened to them wouldn't happen again to others.

- *“I don't feel that I have been listened to by the doctors. I want to be constructive and to know that this wouldn't happen to anybody else. Some things would have been so simple to prevent but they just didn't listen to me.”*

Two people were invited to meetings to talk about their complaint and this led to one person having a better experience than the other. The other meeting seemed to go less well, with the staff present not able to give any insight or explanation into the complaint.

### Top tips for future letters

- Ensure the letter is personal

- Acknowledge the complaint and the person's feelings
- Address issues raised
- Use language that is simple and clear
- Give assurance that the complaint is being investigated
- Set out a clear plan of action of what they can expect to happen next and a timeframe if possible.

*“What I needed in a letter was acknowledgement of my distress, to know that the situation had been investigated and that it would not be repeated.”*

Action: The Complaint Lead is arranging new education sessions for staff involved in drafting complaint responses. These will be more interactive than the sessions that have traditionally been held with those attending working on 'real' complaints for their area and sharing drafts with their peers.

## Health watch Reports

The COVID-19 outbreak has resulted in changes to way that Health Watch work, with much of their planned public engagement and visits to services paused and a greater focus on providing advice to the public and supporting the local response to the pandemic. They have published a fortnightly report that highlights what they are hearing from local people and identifies any gaps. In the first report they published the account of one patient's experience with Salisbury NHS Foundation Trust:

*Care given at Salisbury District Hospital at the beginning of the outbreak was fantastic. Arrangements were made and supplies of all necessary drugs and equipment was rapid to say the least, as I was more at risk of catching something in hospital. Both the Respiratory department and Rheumatology department are only ever a phone call away. I have been assured that I am to contact them if I become unwell or have any concerns.*

In their final report on their survey feedback from a family member who had used the Message to a Loved on service is highlighted:

*I sent a message to my friend who was in Salisbury Hospital using the service set up by the hospital to send a message to your loved ones. I had a lovely message from PALS to say the message had been received. I replied and said what a lovely gesture it was and they said I was welcome, they enjoyed doing it. Unfortunately my friend passed away yesterday. It was comforting know that she knew how much we loved and missed her as none of us will be able to go to her funeral due to self-isolation.*

A 'need for information' is a key theme in their recommendations with 'changes to the health care services usually accessed by the patient' being the item of information that the general public had most difficulty finding during the pandemic.

## 8. Translation and Interpretation

With the need for social distancing and restricted visiting due to COVID-19 there was no face-to-face interpretation for Q1.

Where the telephone translation service could not be used, interpreters joined patients via the Attend Anywhere platform.

Access to a BSL app-based solution was provided free to all hospitals for the duration of the pandemic.

The Procurement team are working with PALS on a new tender for Translation Services and an update on progress will be presented here in due course.

## 9. Patient Stories

Patient stories are taken to every public Board meeting. The Trust's website is due for complete re-design (due for completion in October 2020) and will include a private section where patient stories can be posted for staff to access for individual/team learning.

## 10. NHS Digital

As the health and care system continues to respond to the Covid-19 pandemic, NHS Digital is adjusting key data services activity. This is partly to create additional capacity to support national planning and delivery through the provision of new collections and analysis to support the Covid-19 response, and partly to ease the pressure on NHS staff completing these returns. NHS Digital has therefore suspended both the KO41a secondary care and KO41b primary care collections for Q4 2019-20 and Q1 2020-21.

Q3 data (2019-20) is available here <https://digital.nhs.uk/data-and-information/publications/statistical/data-on-written-complaints-in-the-nhs/2019-20-quarter-3-ns>

## 11. Patient and public involvement (PPI)

### New website

The hospital's website is being developed and the new version will be launched in Q3 2020/21. Patient representatives are key members of the website steering group and their views/ideas have shaped the design of the website from the very start of the project. Patients and the general public were asked to give their feedback on the new design in Q1 2020/21 (although this had to be done virtually due to the need for social distancing and restrictions on visitors to the site). Feedback thus far has been very positive and patients and the next testing stage (functionality) will begin in Q2 as soon as content has been added to the site.

### Low Risk Birthing Unit

Building on the results of focus groups that were held with mums and mums-to-be in Q4 19/20 and working with ArtCare, PALS will take what we have heard forward to the design phase. A number of women/family members have contacted PALS to say that they would like to continue to be involved in the project and they will be invited to help us with the design and fitting out of the Unit which will take place in Q2/3 2020/21. Social media platforms have been used with some success with regards to reaching out to people who want to engage further with us as well as publicising surveys and on-line Teams Meetings.

### Cancer services video

As a result of reports that patients were too frightened to attend the hospital PALS worked with the Communication Team and Pembroke Unit to film a video designed to encourage patients to attend. The video is available here: [https://youtu.be/\\_0z3fl4Ltpo](https://youtu.be/_0z3fl4Ltpo).

PALS are working with communication teams across the STP to create additional resources for patients.

### COVID-19 – information and letters

A group of patient volunteers have reviewed and commented on a large number of COVID-19-related information sheets (including a carer who had been unhappy with the information given when her cared-for person tested positive after a visit to ED). The leaflets have all been published on MicroGuide.

During the restart period, a large number of letters for patients were drafted. These too were shared with volunteers whose feedback ensured that the letters are accessible and provide unambiguous guidance.

*PPI Projects are shared on the following web page on the Intranet:*

<http://intranet/website/staff/quality/customer-care/patient-and-public-involvement/ppi-projects/index.asp>

The PPI toolkit is available here: <https://viewer.microguide.global/guide/1000000334#content,1df17a5a-25ee-4524-ab5e-96031930d247>

## 12. Social media

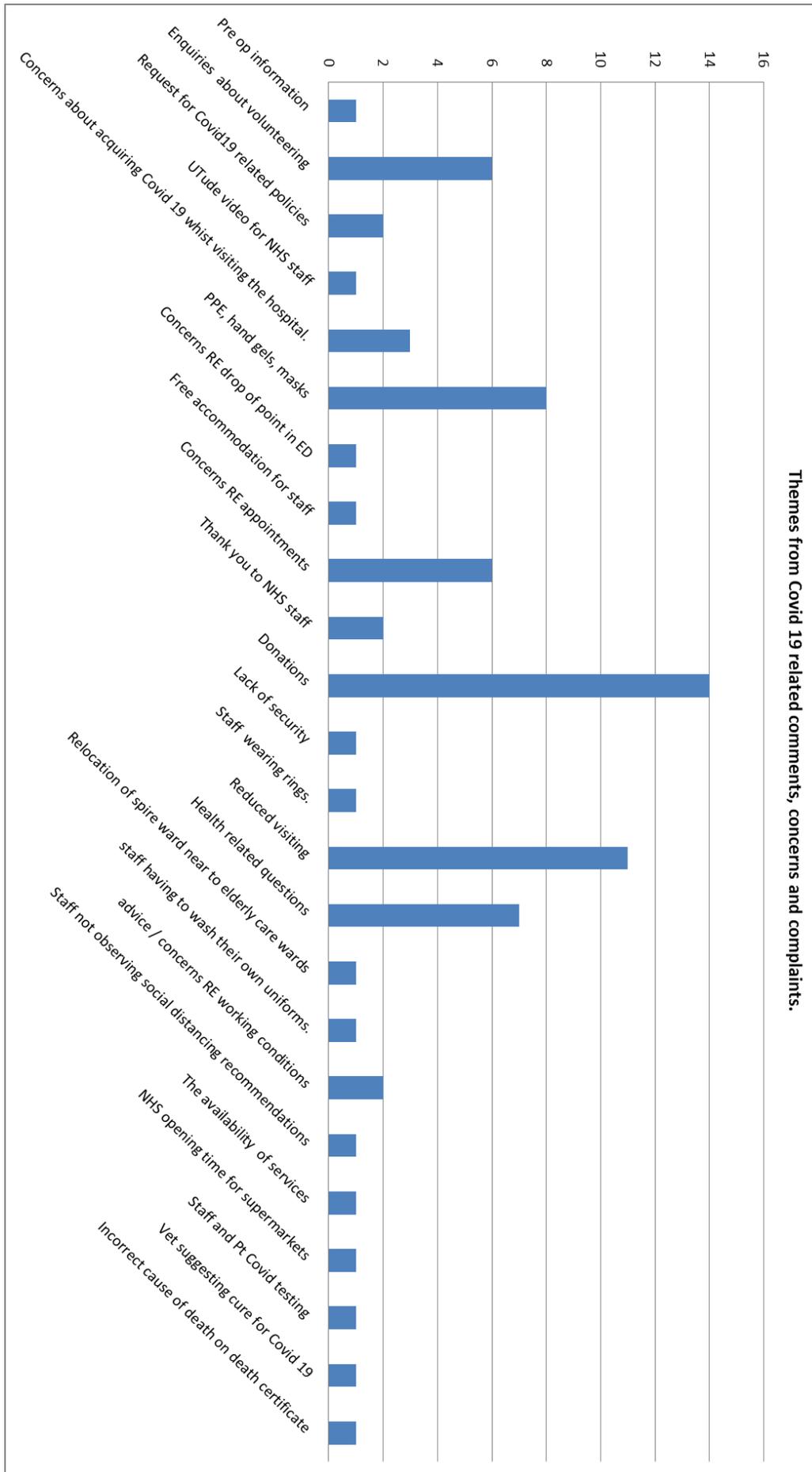
### NHS Website feedback

There was one feedback posted NHS Website in Q1. This was positive and rated the experience within the Emergency Department as five stars.

*No waiting in the A and E and as usual brilliant treatment in these hard times from all nurses, doctor and receptionist. Cannot thank them enough for their totally painless treatments (I am an arch wimp!) and great efficiency, but most of all their kindness and reassurance. I have always praised my treatment at this hospital, but even more right now. I count myself extremely lucky to be able to attend this fantastic hospital!*

# Appendix 1

## Themes from Covid-19 related comments, concerns and complaints



|                         |                      |                     |     |
|-------------------------|----------------------|---------------------|-----|
| <b>Report to:</b>       | Trust Board (Public) | <b>Agenda item:</b> | 3.2 |
| <b>Date of Meeting:</b> | 5 November 2020      |                     |     |

|   |  |                   |                  |                 |
|---|--|-------------------|------------------|-----------------|
| <b>Report Title:</b>                    | Q1 Learning from Deaths 2020 - 2021  |                   |                  |                 |
| <b>Status:</b>                          | <b>Information</b>   | <b>Discussion</b> | <b>Assurance</b> | <b>Approval</b> |
|   |  |                   | ✓                |                 |
| <b>Prepared by:</b>                     | Dr Belinda Cornforth, Consultant Anaesthetist<br>Claire Gorzanski, Head of Clinical Effectiveness  |                   |                  |                 |
| <b>Executive Sponsor (presenting):</b>  | Dr Peter Collins, Medical Director   |                   |                  |                 |
| <b>Appendices (list if applicable):</b> | Appendix 1 – Mortality dashboard Q1 2020/21<br>Appendix 2 - Learning from death themes and improvement actions.<br>Appendix 3 – Mortality dashboard explanation of terms |                   |                  |                 |

|  |
|--|
| <b>Recommendation:</b>   |
| <b>Recommendation</b> – assurance that the Trust is learning from deaths and making improvements.<br><br>The report was presented at the Clinical Governance Committee on 22 September 20. |

|   |
|---|
| <b>Executive Summary:</b>   |
| <p>The report highlights the progress made in the Medical Examiner system and the outcome in bereavement support of relatives of all patients who died during the COVID-19 emergency. The Q1 mortality dashboard shows the number of deaths and outcome of reviews. The majority of deaths were unavoidable and expected. 2 deaths were unexpected of which one is subject to a serious incident inquiry and the other scrutinised by two Medical Examiners and at the Critical Care mortality and morbidity meeting.</p> <p>Weekend HSMR has declined from a peak of 133 in July 19 to 107 in May 20 and is within the expected range. In Q4, a working group to improve the safety and effectiveness of services at the weekend was set up but put on hold due to COVID. This group is to be re-established to consider the re-introduction of a Critical Care Outreach Team co-ordination role, particularly on a Sunday. This will be measured at the next NHS 7 day services survey in September 20.</p> <p>A review of 33 patients who died following a fractured neck of femur action plan has seen an increase in the use of local analgesia blocks to national levels reducing the need for opioids and more consistent performance in time to theatre. Hip fracture HSMR has started to show a downward trend.</p> <p>The Clinical Governance Committee was updated on the good progress made in actions arising from the gastrointestinal haemorrhage death review in June 20. GI haemorrhage HSMR is now as expected.</p> |

A review of 57 deaths of patients who tested positive for COVID and 8 patients who tested negative for COVID but had a high suspicion of it or was recorded on the medical certificate of the cause of death have been reviewed, but further analysis is required before the report is finalised. The review will be reported to the Clinical Governance Committee in November 20 and Q1 learning will be generated from the review of this group of patients.

| <b>Board Assurance Framework – Strategic Priorities</b>  |                                     |
|--|-------------------------------------|
| <b>Local Services</b> - 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 | <input type="checkbox"/>            |
| <b>Specialist Services</b> - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population                       | <input type="checkbox"/>            |
| <b>Innovation</b> - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered      | <input type="checkbox"/>            |
| <b>Care</b> - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm                            | <input checked="" type="checkbox"/> |
| <b>People</b> - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams                                       | <input type="checkbox"/>            |
| <b>Resources</b> - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources   | <input type="checkbox"/>            |

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## Q1 2020/2021 Learning from Deaths report

### 1. Purpose

To comply with the national requirements of the learning from deaths framework, Trust Boards must publish information on deaths, reviews and investigations via a quarterly report to a public board meeting.

### 2. Background

The Learning from Deaths initiative aims to promote learning and improve how Trusts support and engage bereaved families and carers of those who die in our care.

A system of Medical Examiners was introduced in April 2020 to strengthen the support of bereaved families and drive improvements in the investigation and reporting of deaths.

### 3. Medical Examiners (ME)

The new ME system was introduced in April 20 to ensure excellence in care for the bereaved. The system was fully established in August 2020 and the following is now in place:

- 7 MEs are fully trained and a further two are in training. A 5 day (ME) roster covering adult and paediatric deaths within the Trust.
- The Qualified Attending Physicians (junior doctors) are given an appointment for a face to face discussion of each case with an ME and then completes the medical certificate of cause of death (MCCD). The ME then has a discussion with the bereaved relatives.
- Two part time Medical Examiners' Officers (MEO) started at the end of June 2020. They support the MEs, and if delegated, have a discussion with bereaved relatives about the MCCD and any concerns about care.
- A system is in place to ensure any deaths highlighted as requiring further review by the ME are sent to the Trust's Mortality Surveillance Group to ensure learning is shared across the organisation.
- A summary of our data is submitted to the regional ME. It is anticipated that we will be required to submit data to the national ME IT system when it is available in October 2020.
- A local network of MEs to share learning and provide an independent review facility if needed.
- Dr Stephen Jukes is now the Lead Medical Examiner whilst Dr Belinda Cornforth remains the chair of the Mortality Surveillance Group to ensure independence between the two functions.
- The Clinical Governance core session in July 20 was on the Medical Examiner role.

### 4. Working with bereaved families

At the beginning of April 20, our bereavement survey 'Your views matter' was suspended due to visiting restrictions as a result of COVID-19. Instead, a phone bereavement service for the next of kin of all patients that died between 16 March 2020 and 21 June 20 was introduced. It was recognised that there were issues arising from the COVID pandemic that would impact on the bereaved due to:

- Anxiety and distress over COVID and in some cases multiple bereavements.
- Restricted visiting resulting in many relatives not seeing loved ones prior to or at the time of death
- No face to face support at the bereavement suite after a death or Registrar of Births and Deaths office as all paperwork was completed online
- Limited funeral options

During this period, 207 patients died in the acute Trust and the Hospice. The team contacted 162 next of kin to provide bereavement support. In 57 cases, relatives were not contacted as they were either already involved with another bereavement team, contact numbers were not available or the call not answered after 3 attempts. Of the 162 relatives contacted, 152 required only 1 initial phone call, 8 required 2 calls and 2 required 3 calls. Some bereaved relatives were referred on to Salisbury Specialist Palliative Care Service Family Support Team, but the vast majority required no further follow up or were sign posted to external agencies such as Cruise. The call also allowed the bereaved to raise any concerns and the caller was able to sign post them to the appropriate service including PALS if this was required.

The calls were purely supportive and made by staff with experience in undertaking bereavement calls. Staff did not ask any specific questions about the care of their loved one but frequently documented themes included:

- 51 specifically mentioned that they appreciated the bereavement call.
- 46 commented on the excellent care and support they received from staff at SFT
- 30 commented on funeral arrangements, most mentioning sadness at not holding a usual funeral. There were a few positives over the funeral being more intimate.
- 27 commented on visiting in the acute Trust, where family were able to visit, this was felt to be really positive.
- 18 commented on excellent family support as a result of “lockdown” and family being able to support more.
- 8 commented on negative aspects of care, usually around poor communication.

This bereavement service stopped at the end of August and will be replaced with the ‘Your views matter’ survey and bereavement support if needed.

### 5. Mortality dashboard, learning, themes and actions

In Q1 20/21, 207 deaths occurred in the Trust. The total includes patients who died in the Emergency Department and the Hospice. Of these, 198 (96%) deaths were screened to ascertain whether the death needed a full case review. 80 (39%) deaths were subject to a full case review, 65 of which related to patients who tested COVID positive and negative where there was a high suspicion of COVID disease or was recorded on the MCCD. In Q1 20/21, 2 were probably avoidable, 4 were possibly avoidable, and 7 had slight evidence of avoidability.

### 6. Learning from Q1 20/21 deaths

On 11 March 20, the WHO declared a global pandemic caused by coronavirus (COVID-19). A national lockdown of ‘stay at home, protect the NHS and save lives’ started on 23 March, social distancing and hand hygiene. This approach worked in slowing down the rate of infection and protecting the NHS from being overwhelmed. Hospital bed and ICU capacity remained available during this period.

A review commissioned by the Medical Director was undertaken to ascertain whether patients received standards of care in accordance with NICE COVID-19 rapid guideline: critical care in adults and whether patients were involved in decisions about their care, were escalated appropriately and if ventilation was required, whether it was provided. 57 deaths of patients who tested positive for COVID and 8 patients who tested negative for COVID but had a high suspicion of COVID or was recorded on the medical certificate of the cause of death were reviewed, but further analysis is needed before the report is finalised.

The review will be reported to the Clinical Governance Committee in November 20 and the learning will be generated from the review of this group of patients.

### 7. CUSUM alerts

One new CUSUM alert raised in Q1 20/21:

- Deficiency and other anaemia - 9 cases observed compared to 3.6 expected, relative risk 251. The Mortality Surveillance Group felt that further statistical analysis of this group would be unlikely to provide any meaningful insight. No further action was planned for this alert.

## 8. Death following a planned admission to hospital

In Q1 20/21, 2 deaths of patients following a planned admission:

- An 84 year old man admitted from clinic with a new diagnosis of acute myeloid leukaemia with fatigue and night fevers. He elected not to have chemotherapy and was treated symptomatically and continued to deteriorate. He died peacefully in the Hospice with his family present. Death was definitely not avoidable. No learning points.
- An 85 year old frail woman developed an upper GI bleed which did not resolve with endoscopic intervention. She was transferred to RBH for interventional radiology to embolise the artery and re-admitted to SFT. She was treated for recurrent pneumonia and diagnosed with a haematological malignancy but despite treatment sadly succumbed. Death was definitely not avoidable. No learning points.

## 9. Unexpected deaths

In Q1, there were 2 unexpected deaths:

1. A 79 year old patient with a confirmed neurological deterioration and a delay in an MRI scan which later revealed an epidural mass resulting in paralysis. (SII363).
2. A 32 year old patient treated for ulcerative colitis and cytomegalovirus and discharged. Re-admitted 8 days later with pulmonary embolus and possible COVID. 48 hours later showed signs of cardiovascular collapse, thrombolysed and transferred to Critical Care. Good management of cardiac arrest from which she succumbed. Learning: Persistent tachycardia during first admission was not addressed but could have been due to other factors and was not unreasonable and unlikely to have made a difference to the outcome. Consider diagnosis of pulmonary embolus in a patient with persistent tachycardia. Slight evidence of avoidability (Lead Medical Examiner scrutiny - case discussion completed with trainees involved, second Medical Examiner scrutiny and Critical Care mortality and morbidity meeting). Bereavement call made to the patients mother – has all the family support she need and did not feel she wanted any further contact. GP notified.

## 10. Stillbirths, neonatal deaths and child death

In Q1 20/21:

- In April, one neonatal death at 15 weeks and 4 days died from extreme prematurity and one intra-uterine death at term resulting in a stillborn baby.
- In May, one intra-uterine death at 29 weeks as a result of domestic violence.
- No child deaths.

## 11. Patients with a learning disability

In Q1, 1 patient with a learning disability died in April. The case has not been reviewed yet and will be reported in the Q2 20/21 report. The case will also be reported to the LeDeR programme.

In Q4 19/20, 2 patients with a learning disability died in March 20:

- A 40 year old patient with learning disabilities lived in residential care with increasing deterioration in function over the months prior to admission. Admitted with seizures with persistent unresponsive pupils thought due to an acute intracerebral event. Not investigated at the request of her parents (in her best interests) and care was provided on the personalised care framework. She died 3 days later. Overall assessment of care - very good care. Definitely not avoidable. No learning points.
- A 66 year old patient with cerebral palsy, asthma, COPD and bladder cancer with possible lung metastases. Admitted hypoxic with a chest infection and treated with IV antibiotics with ward based care as the level of escalation and a DNACPR in place. Overnight, the patient deteriorated and

declined further treatment, became unresponsive and died. Overall, there was early recognition that the patient may not survive and end of life care would be in the patient's best interests if the patient deteriorated further. Learning: Poor record keeping when the patient was unresponsive and end of life care could have been managed better with more support.

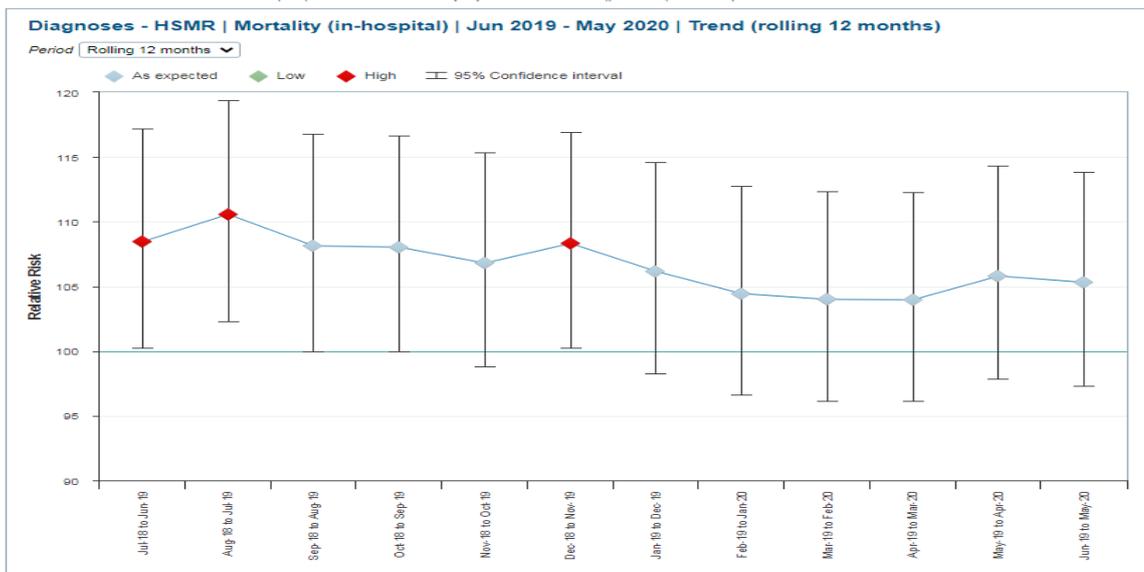
These cases were reported to the LeDeR programme.

12. Patients with a serious mental illness

In Q1, no patients with a serious mental illness died in the Trust.

13. HSMR rolling 12 month trend to May 2020

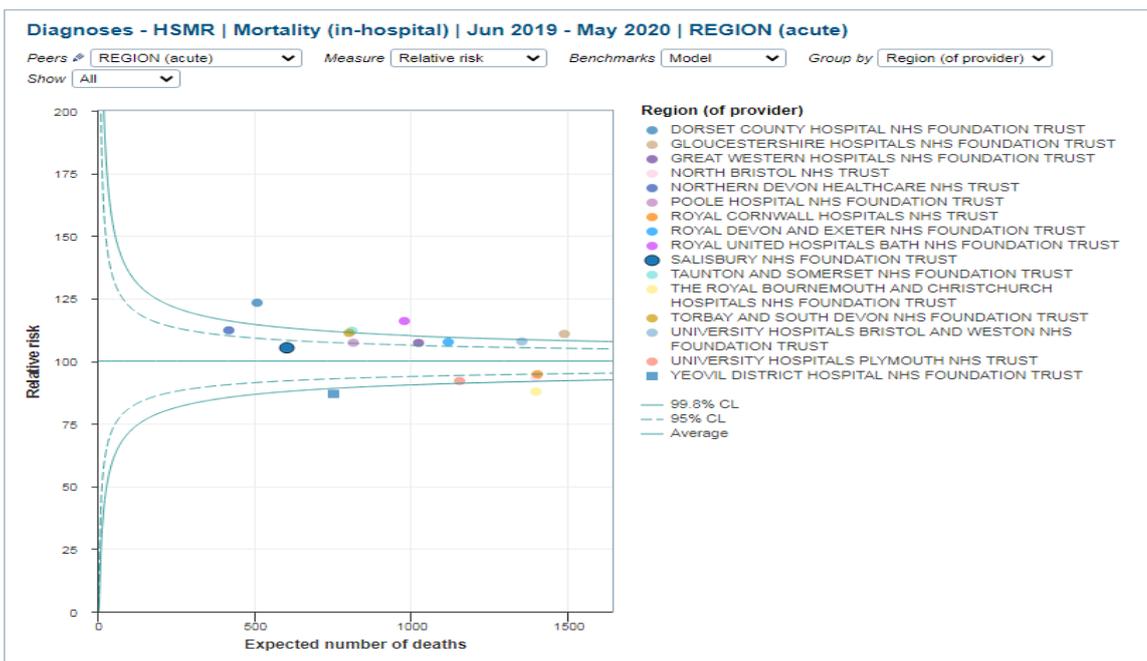
Figure 1: HSMR relative risk of all diagnoses June 19 – May 20



HSMR is 105.3 and is as expected over the last 12 month rolling period to May 20.

14. Mortality (in-hospital) regional peer comparison June 19 – May 20

Figure 2: Mortality (in-hospital) regional peer comparison June 19 – May 20

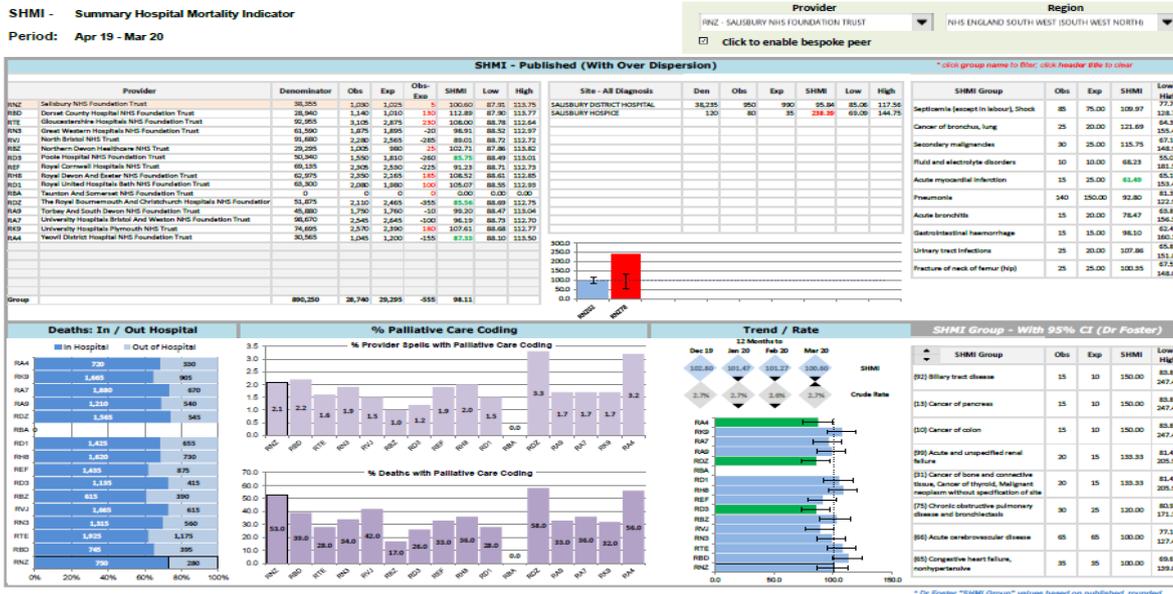


HSMR regional peer comparison shows 10 other acute Trusts have a higher HSMR than this Trust.

15. SHMI April 2019 – March 2020

SHMI is 101 within the expected range to March 2020 and when adjusted for palliative care is 89.88 to February 2020. When comparing SHMI by site Salisbury District Hospital is 95.84 and Salisbury Hospice is 238.39. When compared with regional peers the Trust has a SHMI within the expected range.

Figure 3: SHMI regional peer comparison April 2019 – March 2020



16. Comorbidity and palliative care profile 20/21

Trends in comorbidity coding shows a significant decline in the Trust's Charlson comorbidity upper quartile rate for the HSMR basket to 20.7% and 83 as an index of national. This means the proportion of a Trust's HSMR spells are where the Charlson comorbidity score for the primary diagnosis episode is in the national upper quartile for that diagnosis and admission type (the observed value). The expected value is the equivalent proportion nationally (100). The reason may be because other Trusts have improved their comorbidity capture and coding so comparatively SFT looks worse. It could be our comorbidity capture rate has got worse or a combination of both. Of note, is that SFT has a lower than average number of secondary diagnosis codes overall.

In response, the Clinical Coding Department undertook a review of 28 patients who died where no Charlson co-morbidities had been coded. Of these, 4 episodes had comorbidities missing and another 4 had comorbidities coded outside the range counted by Dr Foster. In addition, 55 records of patients who had abdominal hernias repaired (not deaths) found 6 (11%) patients with missing Charlson comorbidities. Improvement actions include feedback of errors to individual coders for correction and team education on positioning of codes and excess use of symptom codes.

Figure 4: Trend in comorbidity profile

Comorbidity Profile

Organisation: SALISBURY NHS FOUNDATION TRUST

Report Date: 26 August 2020

|   | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---------|---------|---------|---------|
| Upper-quartile comorbidity as index of national (100) | 24.5%   | 24.2%   | 23.2%   | 20.7%   |
|   | 98      | 97      | 93      | 83      |

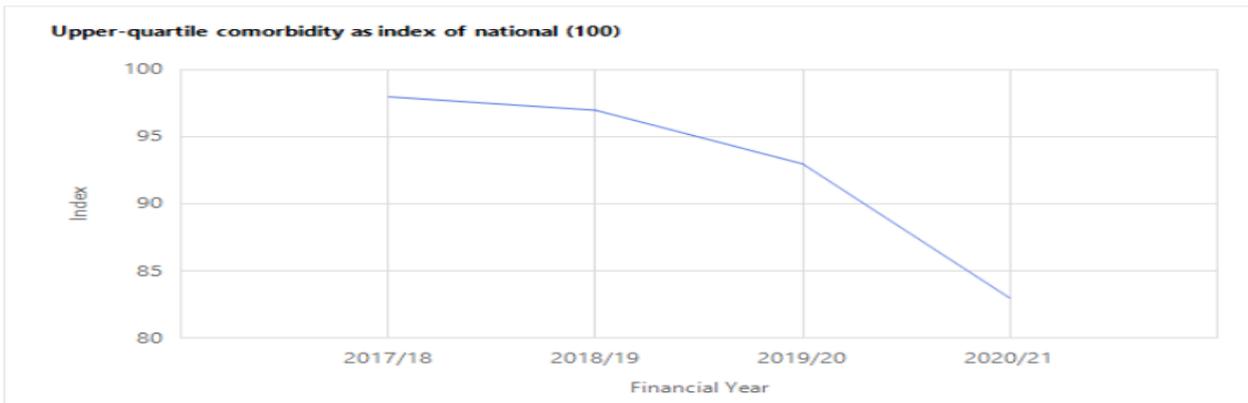
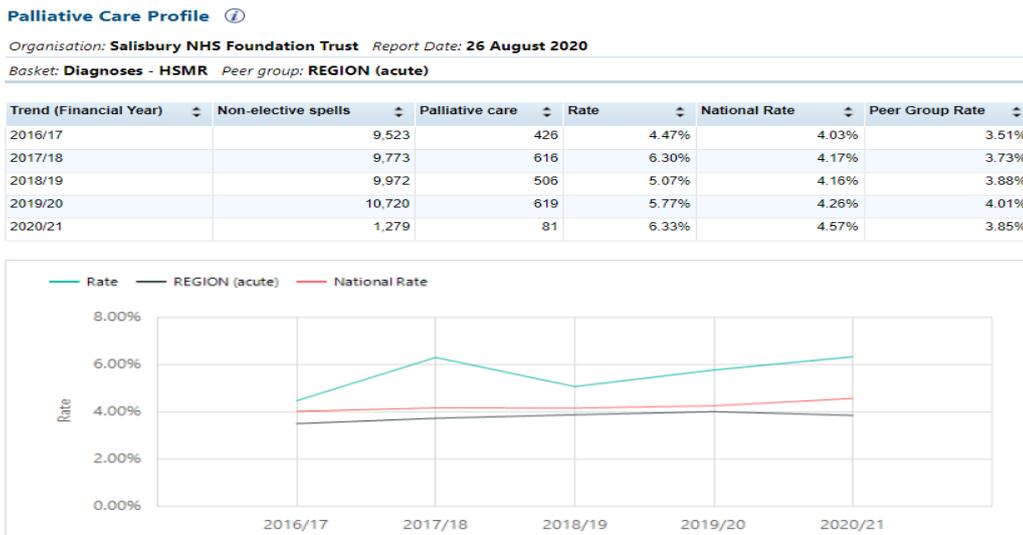


Figure 5: Trend in palliative care profile



An upward trend in the Trust's palliative care coding rate for 20/21 (6.33%), higher than the national rate of 4.57% and peer group rate of 3.85%.

17. Weekday/weekend HSMR

Figure 6 shows the non-elective weekday HSMR is within the expected range at 104.8 and weekend HSMR is as expected at 107.1 to May 20 having reduced from a peak of 133.8 in July 2019.

Figure 6: HSMR weekday/weekend admission June 2019 – May 20

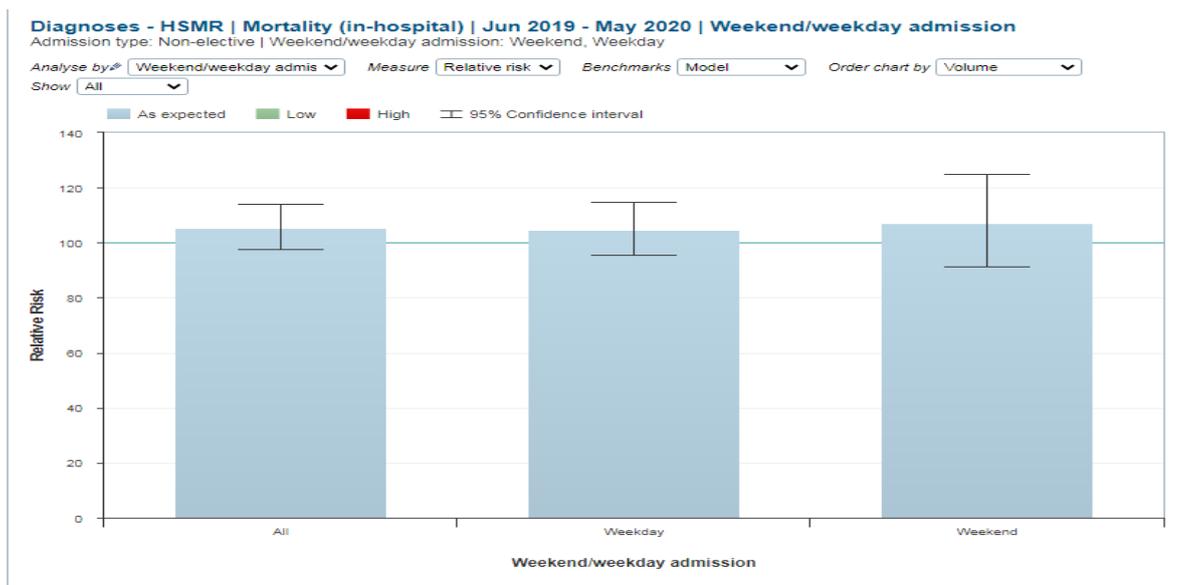
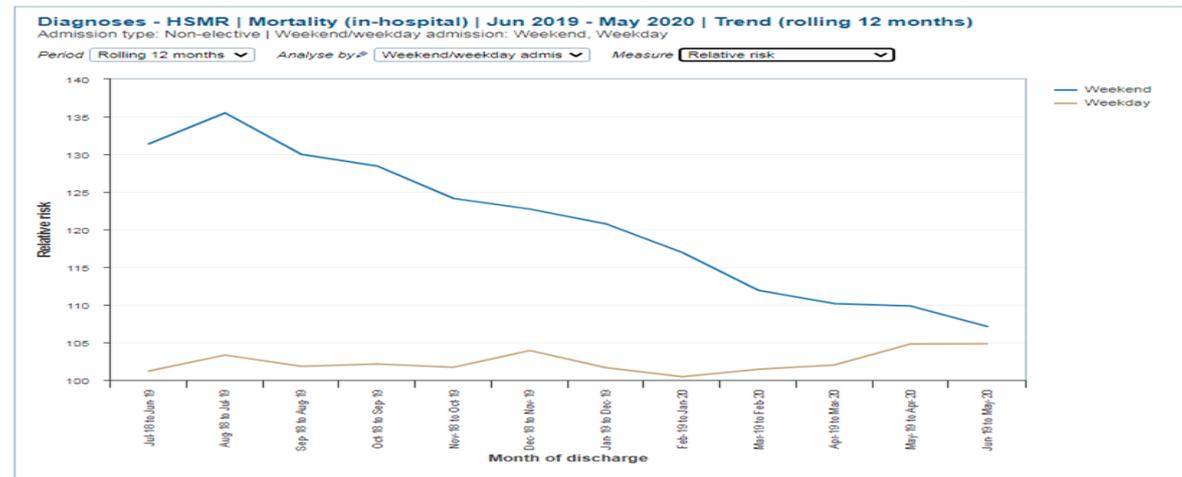


Figure 7: Rolling 12 month trend in emergency weekend and weekday June 19 – May 20



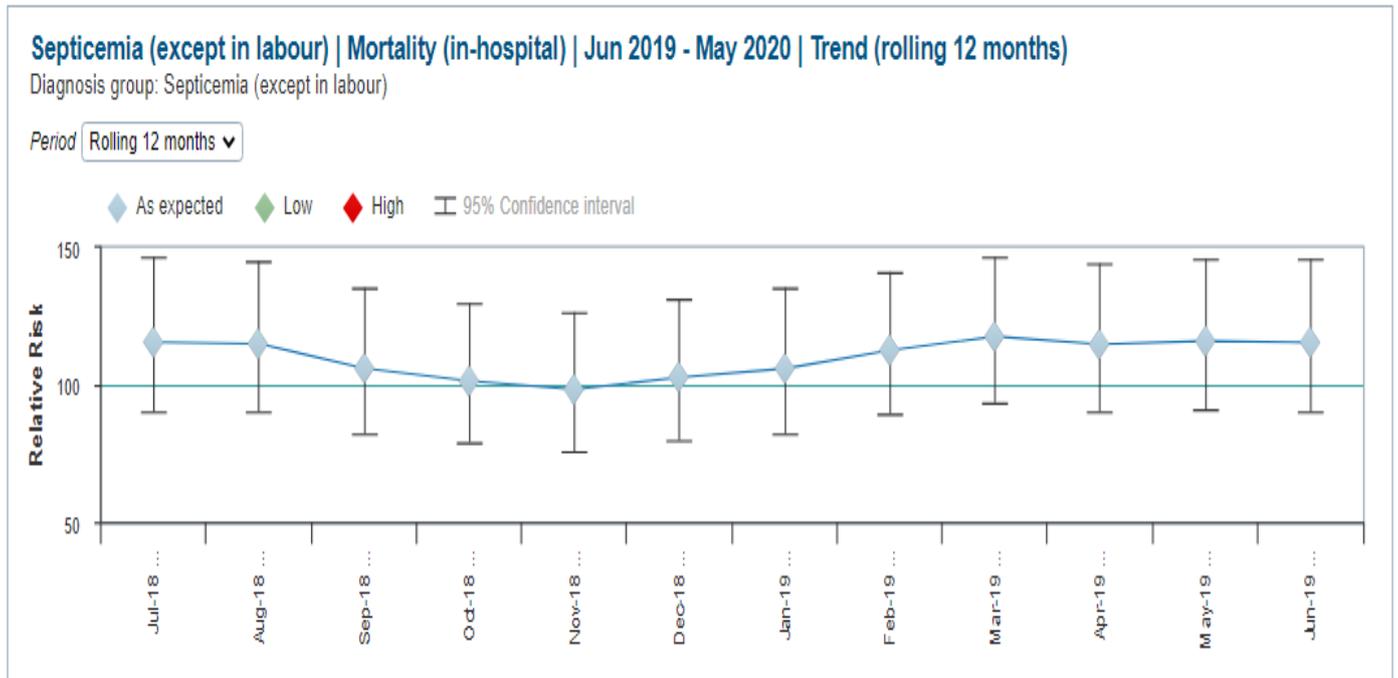
The emergency weekend HSMR started to decline from a peak of 133.8 in July 19 to 107 by May 20 and is as expected. The continuing downward trend in relative risk is due to a decrease in the crude rate and an increase in the expected rate. The narrowing of the gap between the crude rate and expected rate has caused the decline in relative risk.

A weekend quality improvement group was set up in January 20 which included the Chief Registrar and 3 doctors in training with the aim of improving the management of the workload at weekends. The group was put on hold due to the COVID-19 emergency and this will be re-established in Q3 2020/21. Improvements progressed so far have been the weekend handover and a pilot of a Critical Care Outreach Team co-ordinator on a Sunday from 2 – 10 pm to triage and allocate the workload. Feedback from doctors in training has been positive.

**18. Deaths in high risk diagnosis groups (June 19 – May 20)**

The Mortality Surveillance Group monitors a 12 month rolling trend in the relative risk for 8 high risk diagnosis groups

**Figure 8: Trend in relative risk for septicaemia (except in labour)**



**Figure 9: Trend in relative risk for pneumonia**

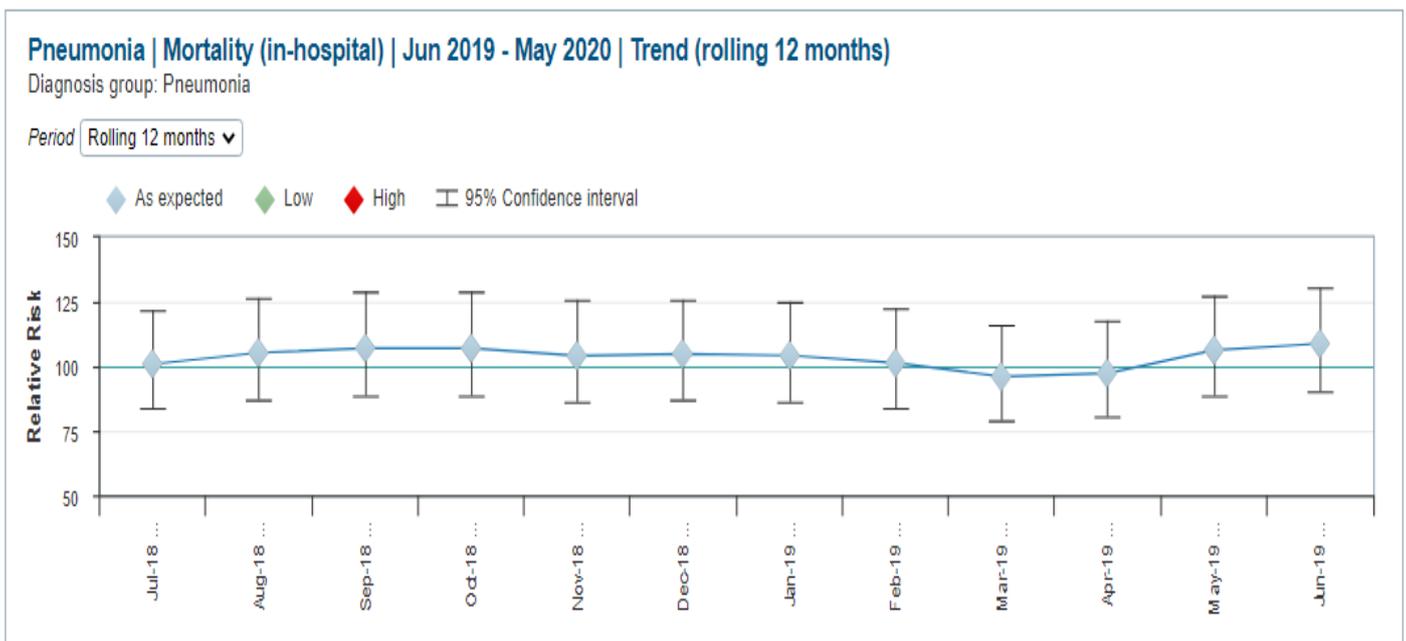


Figure 10: Trend in relative risk for acute cerebrovascular disease

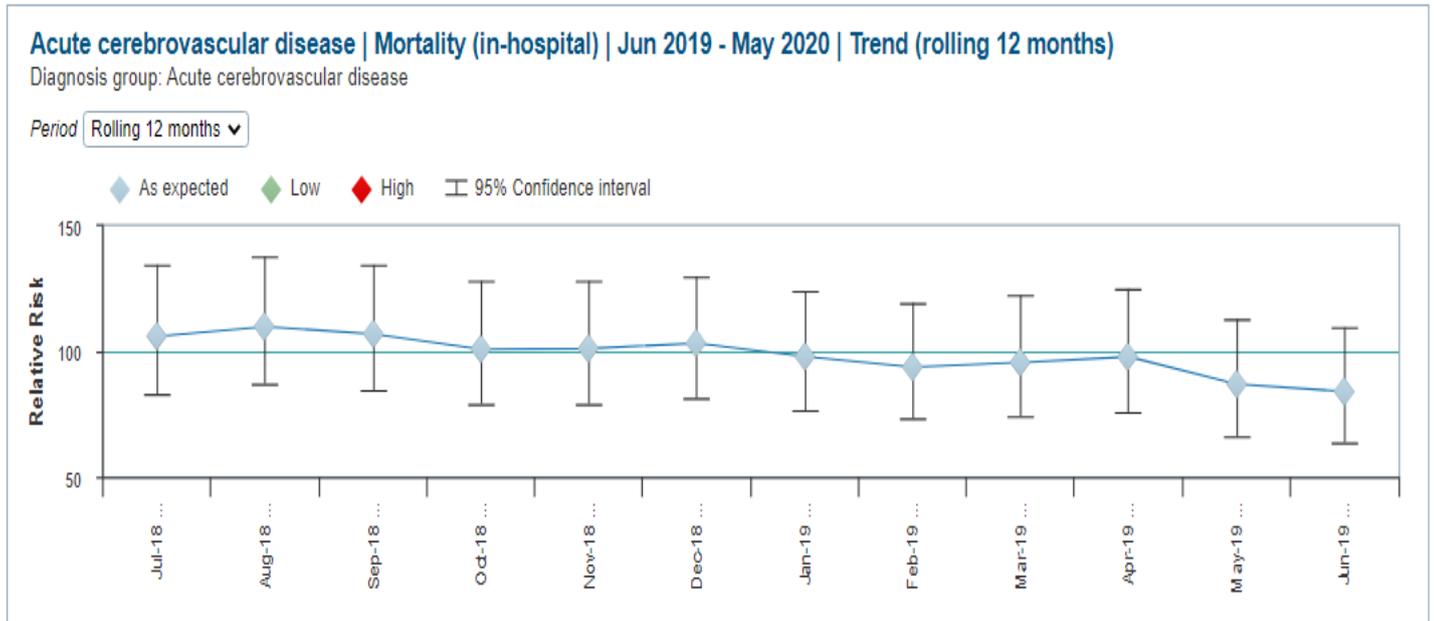


Figure 11: Trend in relative risk for acute myocardial infarction

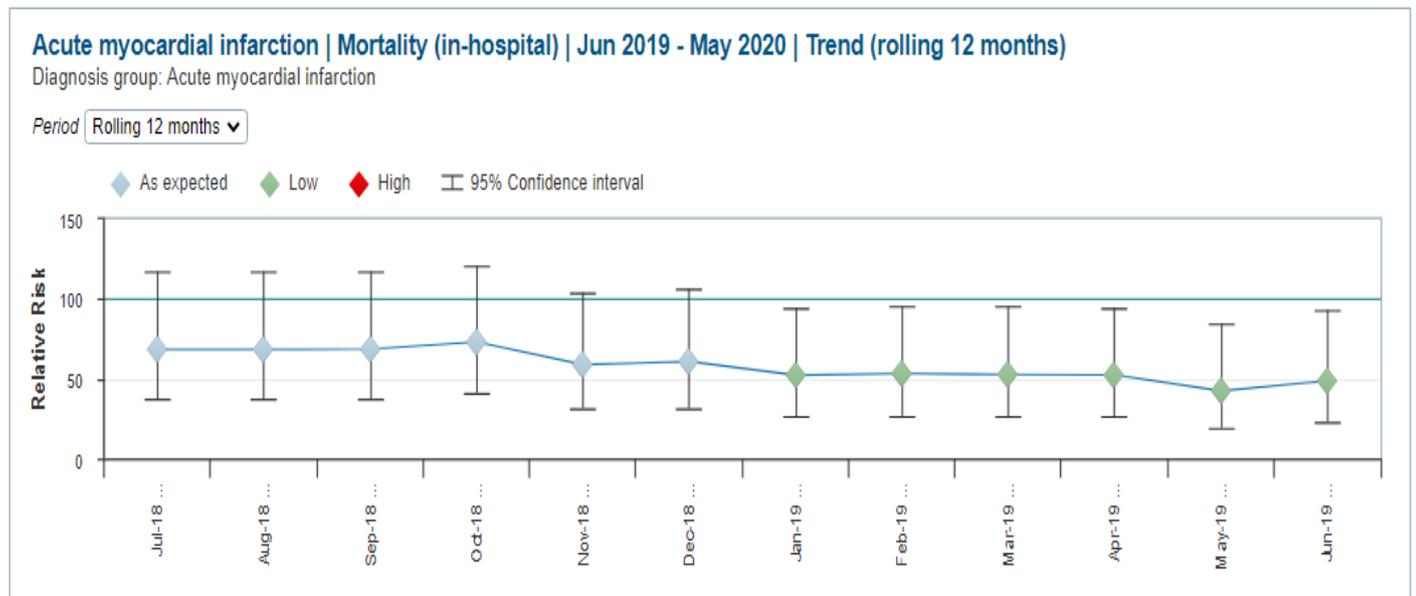


Figure 12: Trend in relative risk for congestive heart failure

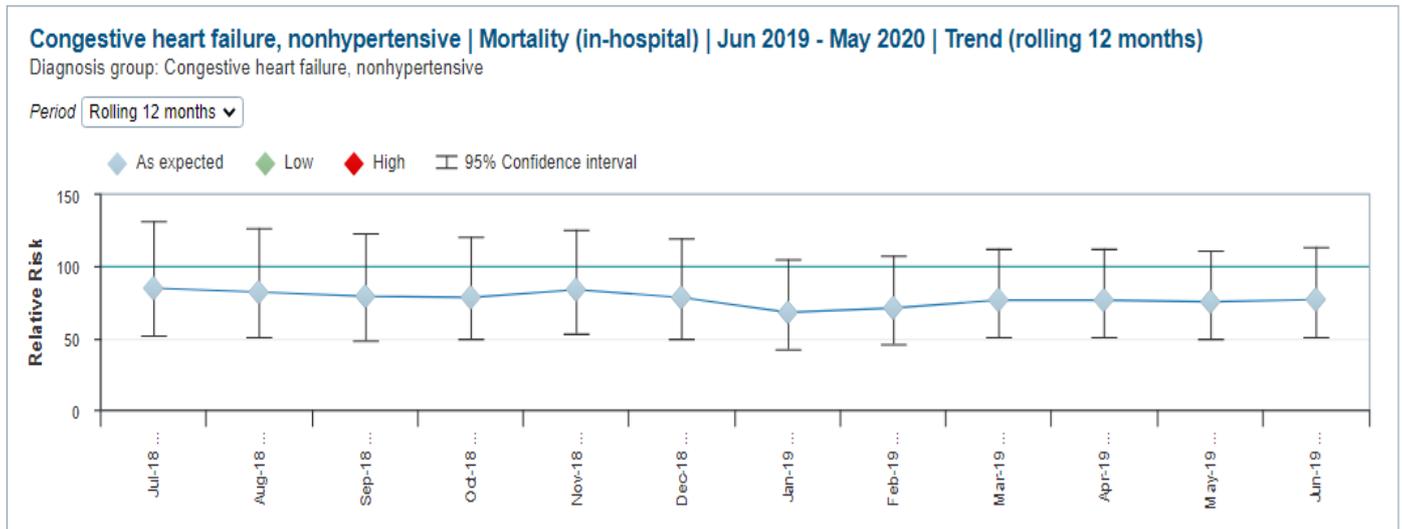
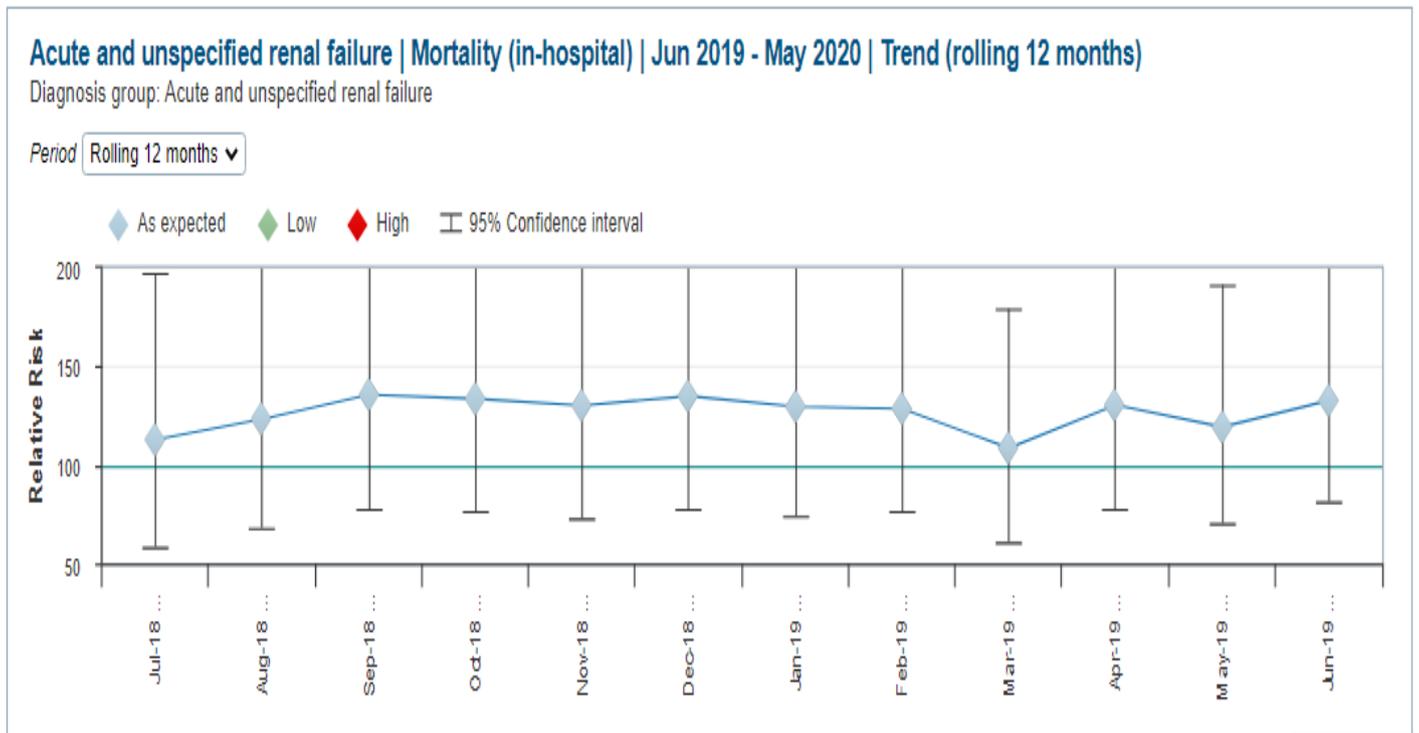


Figure 13: Trend in relative risk for acute and unspecified renal failure



The relative risk of death from acute renal failure has been rising since July 2018 but remains within the expected range. The Mortality Surveillance Group received a report on a case notes review of 15 deaths of patients admitted to hospital between November 2018 and October 2019.

The report concluded that 86% (12/14) patients had AKI on admission to hospital and despite initial treatment only 1 patient's renal function improved. Although the cause of the AKI was felt to be pre-renal in nature, no urinalysis was carried out to confirm this hypothesis or determine the urgency of the medical treatment plan. There were significant gaps in the monitoring and accuracy of fluid balance therefore treatment evaluation and early detection was delayed. Sepsis screening was missed in 2 cases and specimen results were not reviewed which may represent a missed opportunity to review antibiotic therapy. It is recognised however that changing antibiotic therapy may not have changed the overall outcome. Despite these omissions, all patients had significant co-morbidities which would account for the increased mortality rate in this group.

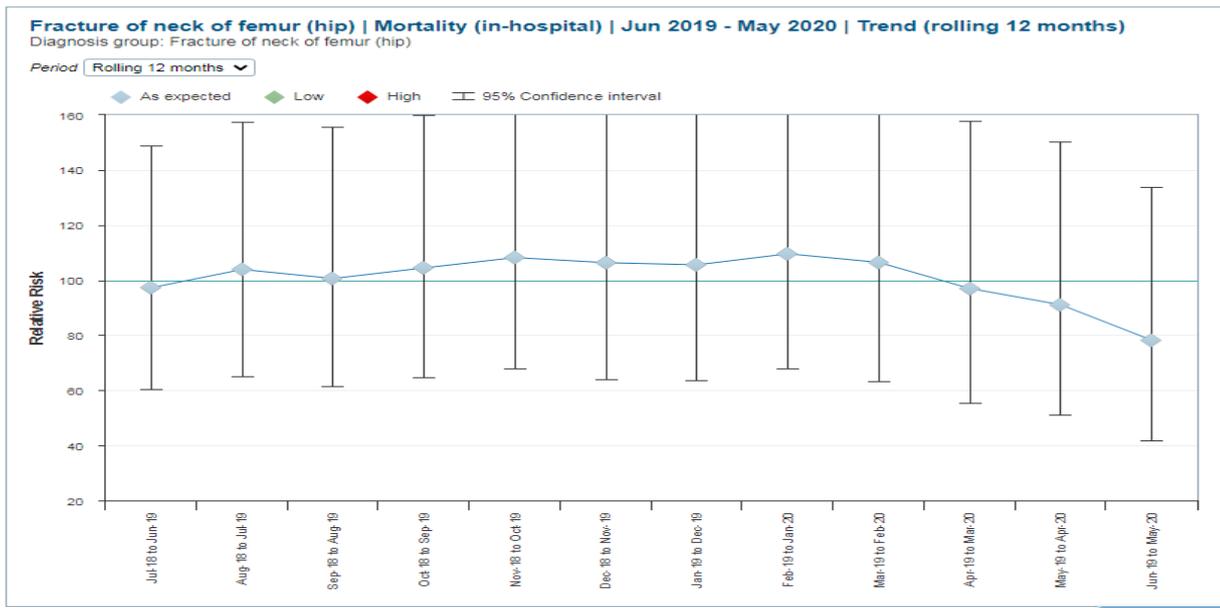
Two patients, developed iatrogenic AKI following contrast administration which may have contributed to a destabilisation of their pre-existing comorbidities and thus to their death. One patient had a missed diagnosis of AKI and was discharged but readmitted the same day.

#### Action plan:

1. Review the Trust guidelines for the management of metabolic acidosis
2. Obtain an update on the implementation of NHSI (2019) alert 'resources to support safe and timely management of hyperkalaemia'
3. Improve the compliance with accurate fluid balance monitoring
4. Ensure all patients admitted to hospital with AKI or those that develop the disease have a urinalysis undertaken as part of the screening process.
5. Evaluation of the use of the AKI care bundle.
6. Evaluate the follow up monitoring of patients who have received IV contrast as an inpatient

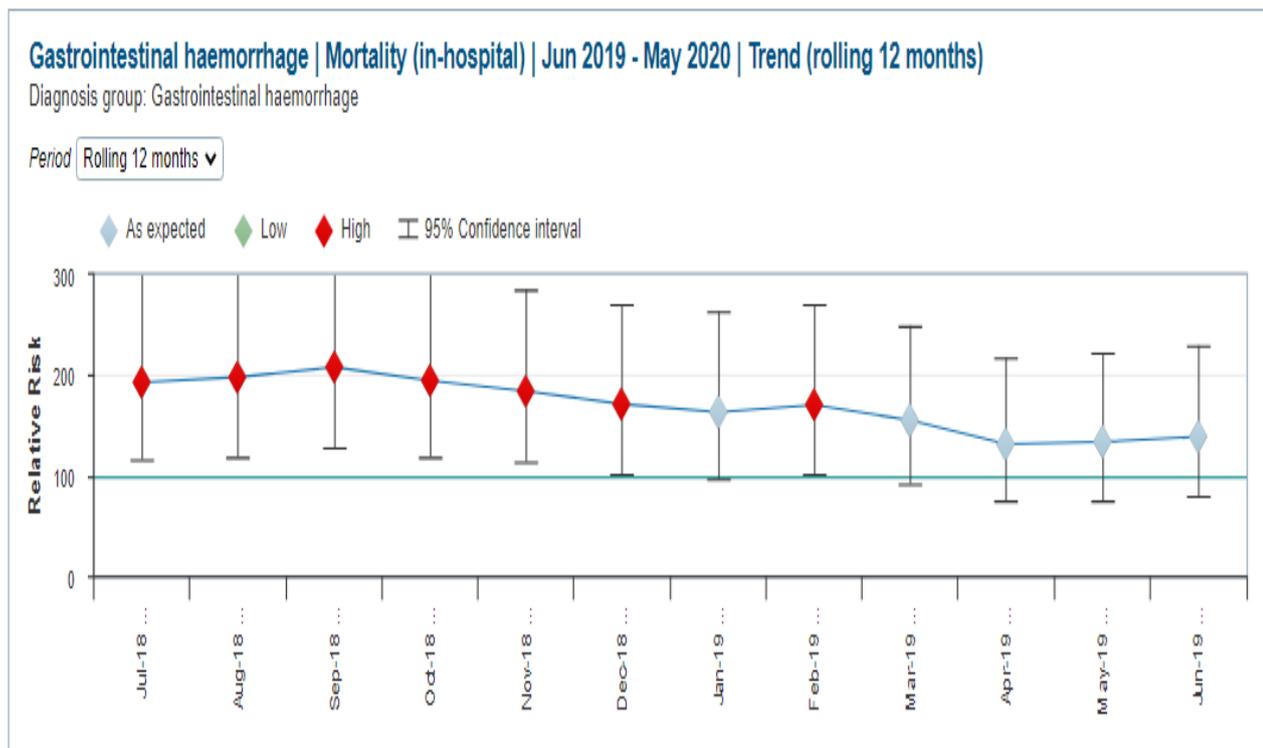
An update on progress of the AKI action plan will be presented to the Mortality Surveillance Group in November 20.

Figure 14: Trend in relative risk for fracture of neck of femur



A review of 33 patients who died with a fractured neck of femur was undertaken in October 2019. The review was discussed at a joint Trauma and Orthopaedic and Anaesthetic meeting in February 20. Since then, there has been an increase in the use of local analgesia blocks (FICBs) to national levels to March 20 reducing the need for opioids and a more consistent performance in time to theatre within 36 hours.

Figure 15: Trend in relative risk for gastrointestinal haemorrhage



A multidisciplinary review of 18 patients who died following a gastrointestinal haemorrhage was completed by December 19. An overall update on the progress of the action plan was reported to the Clinical Governance Committee in June 2020 in the context of the Royal College of Physicians invited review which took place in January 20. In respect of the actions from the review of deaths, good progress has been made in improving the care of patients with an acute upper GI bleed. An electronic requesting system was introduced with real time monitoring of performance including mandatory fields for risk assessments in March 20. Formation of a GI Unit took place in May 20, led by a Consultant Colorectal surgeon. However, consultant gastroenterologists still need to be released from the general internal medicine inpatient work to fully establish the new arrangement and the timeline for completion is contingent upon recruitment. An acute GI bleed care bundle was introduced and education provided to the AMU core staff but further

education is required to embed the use of the care bundle in practice. Audits and mortality reviews are presented at the Endoscopy User Group chaired by the GI lead to ensure learning and improvements continue to take place.

## **19. Summary**

The report highlights the progress made in the Medical Examiner system and the outcome in bereavement support of relatives of all patients who died during the COVID-19 emergency. The Q1 mortality dashboard shows the number of deaths and outcome of reviews. The majority of deaths were unavoidable and expected. 2 deaths were unexpected of which one is subject to a serious incident inquiry and the other scrutinised by the Lead Medical Examiner and at the Critical Care mortality and morbidity meeting.

Weekend HSMR has declined from a peak of 133 in July 19 to 107 in May 20 and is within the expected range. In Q4, a working group to improve the safety and effectiveness of services at the weekend was set up but put on hold due to COVID. This group is to be re-established to consider the re-introduction of a CCOT co-ordination role, particularly on a Sunday. This will be measured at the next NHS 7 day services survey in the September 20.

A review of 33 patients who died following a fractured neck of femur action plan has seen an increase in the use of local analgesia blocks to national levels, reducing the need for opioids and more consistent performance in time to theatre. Hip fracture HSMR has started to show a downward trend.

The Clinical Governance Committee was updated on the good progress made in actions arising from the gastrointestinal haemorrhage death review in June 20. GI haemorrhage HSMR is now as expected.

A review of 57 deaths of patients who tested positive for COVID and 8 patients who tested negative for COVID but had a high suspicion of it or was recorded on the medical certificate of the cause of death have been reviewed, but further analysis is needed before the report is finalised. The review will be reported to the Clinical Governance Committee in November 20 and Q1 learning will be generated from the review of this group of patients.

## **20. Recommendation**

The report is provided for assurance that the Trust is learning from deaths and making improvements.

**Dr Belinda Cornforth, Consultant Anaesthetist  
Chair of the Mortality Surveillance Group**

**Claire Gorzanski,  
Head of Clinical Effectiveness,**

**3 September 2020**

## Appendix 1

## SALISBURY NHS FOUNDATION TRUST - MORTALITY DASHBOARD 2020/2021

|                                       | Apr 20 | May 20 | Jun 20 | Q1  | Jul 20 | Aug20 | Sep 20 | Q2 | Oct 20 | Nov 20 | Dec 20 | Q3 | Jan 21 | Feb 21 | Mar 21 | Q4 | Total |
|---------------------------------------|--------|--------|--------|-----|--------|-------|--------|----|--------|--------|--------|----|--------|--------|--------|----|-------|
| Deaths                                | 98     | 60     | 49     | 207 |        |       |        |    |        |        |        |    |        |        |        |    | 207   |
| 1 <sup>st</sup> screen                | 94     | 56     | 48     | 198 |        |       |        |    |        |        |        |    |        |        |        |    | 198   |
| % 1 <sup>st</sup> screen              | 96%    | 93%    | 98%    | 96% |        |       |        |    |        |        |        |    |        |        |        |    | 96%   |
| Case reviews (SJR)                    | 54     | 16     | 10     | 80  |        |       |        |    |        |        |        |    |        |        |        |    | 80    |
| % case reviews                        | 55%    | 27%    | 20%    | 39% |        |       |        |    |        |        |        |    |        |        |        |    | 39%   |
| COVID deaths                          | 41     | 7      | 3      | 51  |        |       |        |    |        |        |        |    |        |        |        |    | 51    |
| Deaths with Hogan score 1             | 89     | 58     | 47     | 194 |        |       |        |    |        |        |        |    |        |        |        |    | 194   |
| Deaths with Hogan score 2 - 3         | 7      | 2      | 2      | 11  |        |       |        |    |        |        |        |    |        |        |        |    | 11    |
| Deaths with Hogan score 4 - 6         | 2      | 0      | 0      | 2   |        |       |        |    |        |        |        |    |        |        |        |    | 2     |
| Learning points                       | TBC    | TBC    | TBC    | TBC |        |       |        |    |        |        |        |    |        |        |        |    | TBC   |
| Family/carer concerns                 | 1      | 6      | 5      | 12  |        |       |        |    |        |        |        |    |        |        |        |    | 12    |
| CUSUM alerts                          | 1      | 0      | 0      | 1   |        |       |        |    |        |        |        |    |        |        |        |    | 1     |
| CUSUM investigated                    | 0      | 0      | 0      | 0   |        |       |        |    |        |        |        |    |        |        |        |    | 0     |
| Deaths investigated as an SII         | 1      | 1      | 0      | 2   |        |       |        |    |        |        |        |    |        |        |        |    | 2     |
| SIIs graded as catastrophic           | 0      | 0      | 0      | 0   |        |       |        |    |        |        |        |    |        |        |        |    | 0     |
| Death following an elective admission | 0      | 1      | 1      | 2   |        |       |        |    |        |        |        |    |        |        |        |    | 2     |
| Unexpected death                      | 1      | 1      | 0      | 2   |        |       |        |    |        |        |        |    |        |        |        |    | 2     |
| Stillbirth                            | 1      | 1      | 0      | 2   |        |       |        |    |        |        |        |    |        |        |        |    | 2     |
| Neonatal death                        | 1      | 0      | 0      | 1   |        |       |        |    |        |        |        |    |        |        |        |    | 1     |
| Child death                           | 0      | 0      | 0      | 0   |        |       |        |    |        |        |        |    |        |        |        |    | 0     |

**Salisbury NHS Foundation Trust**

|                             |   |   |   |   |  |  |  |  |  |  |  |  |  |  |  |   |
|-----------------------------|---|---|---|---|--|--|--|--|--|--|--|--|--|--|--|---|
| Learning disability deaths  | 1 | 0 | 0 | 1 |  |  |  |  |  |  |  |  |  |  |  | 1 |
| Reported to LeDeR programme | 0 | 0 | 0 | 0 |  |  |  |  |  |  |  |  |  |  |  | 0 |
| Serious mental illness      | 0 | 0 | 0 | 0 |  |  |  |  |  |  |  |  |  |  |  | 0 |
| Maternal deaths             | 0 | 0 | 0 | 0 |  |  |  |  |  |  |  |  |  |  |  | 0 |

Note explanatory notes in appendix 3 \* 2 cases will be reported to the LeDeR programme when reviews completed.

| No | Learning points   | Action point  | By whom                 | By when  | Update 3/9/2020   | Status |
|----|---|---|-------------------------|----------|---|--------|
| 1  | Plan the introduction of the ReSPECT form (Treatment Escalation Plan & DNAR form) | Work programme to be developed with planned implementation by 31/3/2021   | Resuscitation Committee | 31/03/21 | The national version 3 was published in August 20. BSW CCG will be leading the introduction of ReSPECT with support from SFT's Resuscitation Officer and Resuscitation Committee. |        |
| 2. | Learning arising from the COVID death review in Q1 20/21                          | Implement actions arising from the review of patients who died from COVID | To be confirmed         | 30/11/20 | The review of 65 patients has been completed but requires further analysis  |        |

**SALISBURY NHS FOUNDATION TRUST  
MORTALITY DASHBOARD – EXPLANATION OF TERMS**

1. Deaths – the number of adult, child and young people deaths in the hospital including the Emergency Department and the Hospice.
2. 1<sup>st</sup> screen - the number of deaths screened by medical staff to decide whether they need a full case review.
3. Case review - the number of deaths subject to a full case review using the structured judgement review method. Case record reviews involve finely balanced judgements. Different reviewers may have different opinions about whether problems in care caused a death. This is why the data is not comparable.
4. Deaths with a Hogan score\* of 1 – 3. The scores are defined as: 1) Definitely not avoidable 2) Slight evidence of avoidability 3) Possibly avoidable but not very likely less than 50/50.
5. Deaths with a Hogan score\* of 4 – 6. The scores are defined as 4) Probably avoidable more than 50/50. 5) Strong evidence of avoidability 6) Definitely avoidable. NHSI guidance 'Any publication that seeks to compare organisations on the basis of the number of deaths thought likely to be due to problems in care is actively and recklessly misleading the reader'.
6. Learning points – the number of issues identified from reviews and investigation (including examples of good practice). The main purpose of this initiative is to promote learning and improve how Trusts support and engage with families and carers of those who die in our care.
7. Family/carer concerns – the number of concerns raised by families and carers that have been considered when determining whether or not to review or investigate a death. All families are offered support from our bereavement service and involved in investigations where relevant.
8. CUSUM (or cumulative sum) alerts - are statistical quality control measures which alert the Trust to when the number of deaths observed exceeds the number expected in a diagnostic or procedure group. Each death in a CUSUM alert is usually subject to a full case review to promote learning and improvement.
9. Deaths investigated as a SII (serious incident inquiry). Whether the serious incident inquiry was graded as catastrophic.
10. Deaths following a planned admission – are patients who died following a planned admission to hospital. Our reviews indicate that the majority of these patients had progressive disease and were admitted to hospital for symptom control or a procedure to relieve their symptoms.
11. Unexpected deaths – of patients who were not expected to die during their admission to hospital are subject to a full case review.
12. Stillbirth – is a baby that is born dead after 24 completed weeks of pregnancy.
13. Neonatal death – is the death of a live born baby during the first 28 days after birth.

14. Child death – the death of a child up to the age of 18. All unexpected child deaths are reviewed by the Wiltshire and Swindon Child Death Overview Panel.
15. Learning disability deaths – all patients with learning disabilities aged 4 to 74 years. The Trust reports all these deaths to the LeDeR programme.
16. LeDeR programme – Learning Disabilities Mortality review programme hosted by the University of Bristol aims to guide improvements in the quality of health and social care services for people with learning disabilities across England. The programme reviews the deaths of people with learning disabilities.
17. Serious mental illness – all patients who die with a serious mental illness.
18. Maternal deaths – is the death of a woman while pregnant or within 42 days of the end of pregnancy from any cause related to or aggravated by the pregnancy or its management. Maternal deaths are rare events.

## References

\*Hogan H et al, 2015 Avoidability of hospital deaths and association with hospital wide mortality ratios: retrospective case record review and regression analysis. BMJ 2015;351 <https://www.bmj.com/content/351/bmj.h3239>

NHS Improvement, July 2017. Implementing the learning from deaths framework: key requirements for Trust Boards. NHS Improvement, London.



|                   |                      |                      |     |
|-------------------|----------------------|----------------------|-----|
| <b>Report to:</b> | Trust Board (Public) | <b>Agenda items:</b> | 3.3 |
|-------------------|----------------------|----------------------|-----|

|   |  |                   |                  |                 |
|---|--|-------------------|------------------|-----------------|
| <b>Report Title:</b>                    | Quality Improvement progress report        |                   |                  |                 |
| <b>Status:</b>                          | <b>Information</b>                         | <b>Discussion</b> | <b>Assurance</b> | <b>Approval</b> |
|   | x  |                   | x                |                 |
| <b>Prepared by:</b>                     | Emma Cox, Head of Quality Improvement      |                   |                  |                 |
| <b>Executive Sponsor (presenting):</b>  | Esther Provins, Director of Transformation |                   |                  |                 |
| <b>Appendices (list if applicable):</b> | Appendix A: Strategy for Improvement       |                   |                  |                 |

**Recommendations:**

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

- Progress made to date, despite COVID and funding constraints
- Work to spread a structured improvement approach is now being embedded into corporate processes
- A business case for additional investment is being developed, in line with a consistent BSW / acute alliance approach, and will be processed in line with Trust SFIs.

**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.

The 19/20 implementation plan was successfully delivered and the following highlights can be noted:

- 38 QI coaches have been trained with a further 40 staff starting their training in November, resulting in an increased amount of improvement work being undertaken within the Trust and a forum to share learning and best practice.
- A #nogoingback campaign and related virtual network events were launched to support the sustainability of improvements made as part of our COVID response, these have been well received and have significantly improved the transparency of improvement activity and shared learning.
- The Trust’s first Dragon’s den event was a success, with 15 bids to secure up to £10,000 seed funding received. The winner was the Spinal Treatment Centre with their proposal to improve support for spinal injury patients to use the gym, however support for all 5 bids that made it to ‘The Den’ is being provided. The impact of

## CLASSIFICATION: UNRESTRICTED

|  |
|--|
| <p>these projects will be evaluated over the next 6 months.</p> <ul style="list-style-type: none"><li>- Additional training and support for colleagues in QI has been developed and is now being rolled out.</li><li>- Corporate processes are starting to be re-designed with an improvement approach, with operational business planning and strategic service reviews being the first.</li></ul> <p>The COVID pandemic caused a level of disruption in some planned training and activity, however COVID also brought about significant improvements that would likely not otherwise have been realised. The lack of resources to coach and support colleagues to embed a continuous improvement approach has been a limiting factor.</p> <p>Plans for 21/22 are in place and a key milestone is to complete work with colleagues from the Acute Alliance to agree a consistent approach, and development a business case for additional funding.</p> |
|--|

| Board Assurance Framework – Strategic Priorities   | Select                              |
|--|-------------------------------------|
| <b>Local Services</b> - 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 | <input checked="" type="checkbox"/> |
| <b>Specialist Services</b> - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population                       | <input checked="" type="checkbox"/> |
| <b>Innovation</b> - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered      | <input checked="" type="checkbox"/> |
| <b>Care</b> - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm                            | <input checked="" type="checkbox"/> |
| <b>People</b> - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams                                       | <input checked="" type="checkbox"/> |
| <b>Resources</b> - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources   | <input checked="" type="checkbox"/> |

### 1. Introduction and Purpose

- 1.1 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.
- 1.2 The Board were due to receive an update on this in April 2020, however this was deferred due to COVID.
- 1.3 The paper provides an overview of the work streams in progress, their overall position and risks/mitigations to ensure continued delivery and sustainability of the programme.
- 1.4 The paper provides an overview of the 'new' work streams that have been identified and are progressing

### 2. Background

- 2.1. 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."
- 2.2. In response, a trust-wide approach was developed and the Board approved 'Our strategy for improvement' and Quality Improvement implementation plan in May 2019.
- 2.3. For reference, the Strategy for Improvement is included as Appendix A

2.4. 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.

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

- Development of an internal talent bank\*
- Development 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 now being supported through the programme.*

2.6. The absence of a mature continuous improvement culture is a corporate risk included on the Trust's Board Assurance Framework (score of 9; high, against a target of 6). "As a result of deeply rooted historic ways of working, resistance to change and the absence of a mature continuous improvement culture, there is a risk that improvement and transformation is not delivered in a timely manner. This may result in poor quality services, reputational damage, financial impact, ineffectiveness, an inability to attract and retain high quality staff and non-delivery of strategic and or corporate priorities."

### **3. Highlights**

#### **3.1. QI Coaches**

The Trust trained a total of 37 QI coaches as part of the first cohort in November, the delayed second cohort, due to COVID-19, is due to commence on the 5 November, with a further 40 staff attending. The training is provided by NHS Elect, and will be combination of virtual/face to face learning. Following negotiation with the provider, this second section will be recorded, thereby enabling the Trust to provide ongoing independent training in the future and a third cohort scheduled for March 2021. Continued support is available to our QI coaches, via quarterly network meetings and wider Trust staff, through the monthly Improvement Drop Sessions, this support is provided by the Head of Quality Improvement and the Project Support Officer. As the number of QI coaches continues to increase these quarterly meetings will increase to monthly and will continue to be shaped by the coaches themselves.

3.2. There is a general sense of increased QI work being identified and undertaken within the Trust, and as such QI coaches continue to be approached to support that work inside of their own department, where capacity allows, this provides them with the opportunity to develop skills learned in the training, examples include, process mapping of the new MEO role within the Bereavement suite, Trust wide pressure ulcer improvements and process mapping Trust wide induction processes as part of the review

#### **3.3. #Nogoingback Campaign and Publicity**

The introduction of the #nogoingback campaign within the Trust to support the identification of improvements made to respond to COVID-19 was launched in June and three virtual network events with internal and external staff were arranged so that learning and experiences could be shared with colleagues. These were well received and a decision has been made to continue to hold these until March 2021. In addition, The Head of Quality Improvement was invited to speak during the ECIST Lunchtime takeaway slot during FabChange Day 2020 to present the concept introduced in the Trust and this was well received.

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3.4. A QI twitter account is now live and is managed by the Head of Quality Improvement; activity and followers through this account is increasing. A lightbulb framework has been developed to make it easier for staff to submit their improvement ideas easily to a central team, and which can then be uploaded and managed centrally via the LifeQI platform; a platform designed to log improvement activity and support colleagues in recording and measuring the impact. The Life QI Programme also enables shared learning between teams and organisations.

### **3.5. Dragons Den**

The first Dragons Den event was delivered in September, 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'. Whilst only one bid could be the overall winner, it was agreed that all bids received will have an Exec sponsor, along with support and guidance on how to progress their idea, the QI steering group will oversee progress. It is intended that this event will run annually moving forward.

### **3.6. SkillShare**

Skill Share launched with a total of 14 staff submitting requests to be interviewed and offer their skills wider within the Trust. The opportunities and the process to align individuals to other areas is now being worked through with the Head of Quality Improvement, Programme Support Officer, OD&P colleagues, Transformation and Informatics Business Partners.

### **3.7. Training**

A full training offer for staff has been developed and is available for staff to attend, using the concept of bronze, silver and gold levels. QI Masterclasses have been made available to QI coaches to help them further develop their skills and experience, this offer has been possible following the successful procurement of a virtual online package through NHS Elect with funding being made available through the Education department and the HEE Wessex Funding bid.

### **3.8. BSW and System Partnerships**

Prior to the COVID pandemic, preparation work to procure a partner to support the implementation of a structured approach to expand the Trust's capability, capacity and culture, in partnership with Great Western Hospital, Swindon had commenced. The Trusts have individually reviewed their requirements and a market engagement event is being planned for November to further develop this partnership and opportunity. The Director of Transformation chairs two separate BSW work-streams as part of the BSW Academy; improvement and innovation and through these links the various opportunities across the system are able to 'join up' rather than being developed in isolation.

### **3.9. Expanding our improvement approach: Operational Business Planning and Strategic Service Reviews**

The focus of the 'Strategy for Improvement' and the majority of QI activity during 19/20 through into this year has been focussed on spreading a QI approach on the front line, within teams and services.

3.10. The Trust's approach to improvement is now being expanded to examine some corporate processes, with the first of these being our operational business planning process. A review of the process has been undertaken, and an improvement approach applied, which will be implemented as part of the planning for 21-22. The same process will be adopted for formal strategic service reviews. The Head of Quality Improvement and colleagues will support the divisions and directorates to adopt this new way of working.

## **4. Impact and benefits identified so far**

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4.1. It is evident that through the successful launch and delivery of existing key work-streams within the original plan and new ideas that have been developed and publicised, there is a steady increase in areas adopting a QI approach to make improvements at a local level. It is difficult to evidence the true extent of this spread, a number of opportunities to engage with staff to discuss QI opportunities and programmes of work are being identified. Colleagues that have been actively involved in QI work are recognising the benefit of adopting a continuous improvement approach and have a genuine interest and desire to want to make a difference and make a lasting change within their area of work to ensure an outstanding experience is achieved for every patient.

### **5. Challenges**

5.1. 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 has been a challenge.

5.2. The COVID pandemic has prevented some planned activities taking place; however it is recognised that much improvement activity has been done, at pace and during a time of significant challenge. The #nogoingback campaign has helped publicise these initiatives, however, the speed at which staff have been able to progress ideas and improvements has been significantly quicker than before the pandemic. Staff have fed back there has been a removal of “red tape and bureaucratic processes” to enable this to occur.

5.3. Being able to extend the QI offering and approach within the Trust with no additional funding has been a significant challenge. The QI 19/20 implementation plan was a realistic and pragmatic plan, developed to deliver within current resources and at no additional cost. It should be noted that without additional funding, truly embedding a culture of continuous improvement is very unlikely to occur within the next 5 years. This is a high risk logged on the Trust’s current Board Assurance Framework.

5.4. Where possible, the Trust continues to actively identify opportunities to bid for small pockets of money to support the development and spread of QI within the Trust. A bid has been submitted to the Q Exchange to help support a #nogoingback submission and outcome of that bid will be made in January 2021.

### **6. Plans for remainder of 20-21 FY.**

6.1. 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.

6.2. Continue to embed Continuous improvement approaches and methodology within existing Trust wide meeting (i.e. Clinical risk group, Patient experience, patient safety group).

6.3. Continue to expand the #nogoingback event and use of the lightbulb framework to capture QI work across the Trust.

6.4. Embed new Operational Planning and strategic service review processes which incorporate continuous improvement approaches.

6.5. Deliver regular QI training sessions Trust wide working with the Head of Learning and Development to incorporate QI into Trust induction, mandatory training; clinical and non-clinical.

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- 6.6. 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.
- 6.7. Continue to work in partnership with Great Western Hospital and the Acute Alliance to establish a consistent approach to structure improvement, which will likely result in a business case for additional investment.
- 6.8. Submit a bid to the Health Foundation in collaboration with partners across BSW to establish a BSW Innovation Hub.

### **7. Key risks**

- 7.1. The key risk to the Trust fully embedding a continuous improvement culture is the current absence of an identified funding stream to enable a more comprehensive and intensive programme of work.
- 7.2. Work to mitigate this risk is underway, with the alignment of approaches between the acute alliance and an associated business case under development.

### **8. Conclusion**

- 8.1. The programme is now in its second year of implementation and whilst good progress has been made in all areas, it is difficult to evidence the impact to date. However, there is evidence of 'pockets of improvement' with a noticeable shift and a sense of increased engagement across teams in adopting a continuous improvement approach.
- 8.2. The appointment to Head of Quality Improvement has increased the visibility of continuous improvement and has provided much needed ring-fenced capacity to drive the programme forward.
- 8.3. It is anticipated that during 2021 there are a number of system wide changes and opportunities to further extend the continuous improvement offering within the Trust.
- 8.4. COVID19 has provided a catalyst for departments to think differently and introduce new ways of working rapidly and at pace. It is these stories that we hope will encourage others to look at opportunities local to their own department/service

### **9. Recommendations**

- 9.1. The Board is asked to note this report, and in particular:
  - Progress made to date, despite COVID and funding constraints.
  - Work to spread a structured improvement approach is now being embedded into corporate processes
  - A business case for additional investment is being developed, in line with a consistent BSW / acute alliance approach, and will be processed in line with Trust SFIs.

## **An outstanding experience for every patient: *our strategy for improvement 2019-2021***

### **Introduction and background**

Salisbury NHS Foundation Trust is operating under challenging circumstances. Workforce shortages across health and care in our local area are common, and this, along with financial challenges and a rising demand for our services means we are operating under significant pressure.

Notwithstanding the above the Trust has a clear vision: **to achieve an outstanding experience for every patient**. Our strategic priorities remain clear and focused with a clear foundation in improvement: “to meet the needs of the local population by developing new and improved ways of working...” “to provide innovative, high quality specialist care...” and “to promote new and better ways of working...”

There is a clear commitment to improvement and getting the best for our patients in all we do.

The purpose of this strategy is to set out:

- What we mean by improvement
- how we will make sustainable improvements
- roles and responsibilities, and
- actions we plan to take.

### **Improvement, change and transformation**

Often these terms are used interchangeably however there are some subtle but important differences.

Improvement refers to making something better, something that already exists in the first place whereas change means to make something different. Transformation refers to a complete overhaul or the emergence of an entirely new state, involving both improvement and change. In healthcare it is often incremental in nature rather than truly transformational *per se*<sup>1</sup> however it nonetheless requires a fundamental rethink along with a new approach to enable new and better solutions to be found.

### **Where are we now?**

It is clear that our staff are dedicated to delivering high quality care and are passionate about improving the quality of services we provide. However, there is more we can do to support continuous improvement throughout the Trust.

Our latest CQC report confirmed this when stating “*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*”. This recognition of commitment is positive and recognises our progress to date, whilst also recognising the need to prioritise improvement.

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<sup>1</sup> (Durka Dougall, 2018)

Our scores for 'quality of care' in our latest staff survey results have deteriorated by a slight margin of 0.1 point. Of particular note are scores for how satisfied our staff are with the quality of care they provide (79% compared to the best result of 89.4%); whether our staff feel their role makes a difference (89.6% against the best of 92.9%) and whether are staff feel they are able to deliver the care they aspire to (63.7% compared to the best result of 80.9%).

These recent measures highlight that we still have many opportunities to improve patient care, improve job satisfaction and morale. It is for this reason we need a different approach to improvement and transformation.

## **Aims and Objectives**

Adopting a continuous quality improvement approach has been shown to deliver better patient outcomes alongside improvement in operational, organisational and financial performance. Organisations that have adopted this new approach 'feel different' – there is a palpable focus on quality and patient centred care<sup>2</sup>. Thus, the aim of this strategy is ultimately to improve patient care.

The following objectives will help us to achieve this.

1. Every member of staff is supported to do their job and to improve their job
2. Everyone takes every opportunity to improve patient care on a daily basis
3. Every member of staff feels satisfied about what they have achieved each day and want to return the next, and
4. Every member of staff uses the lived experience of friends, family, patients, partners and community to improve.

Quite simply, we want to reach our full potential. As an organisation, as services, teams, wards, and as individuals.

## **How we will achieve our objectives**

To meet our full potential, we need to make 'making change' an intrinsic part of everyone's job, every day, in every part of the organisation.

Our success relies on a step change in three distinct areas; our *culture*, our *capability* and our *capacity*.

**Culture** describes our way of life, our behaviour and what is normal to us. Our organisational culture in Salisbury NHS FT has grown over time and we are more than likely comfortable with the way things have always been. In order to improve and sustain improvement our culture needs to shift, to a culture where:

- Continuous improvement is built into everything we do. This means each and every member of staff is encouraged to initiate, support and lead improvement initiatives. Just because this is the 'way we have always done things around here' does not make it the most effective or appropriate way of doing things now.

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<sup>2</sup> (Care Quality Commission, 2018)

- Each and every member of staff is encouraged to keep an open mind, and to adopt a questioning approach of 'appreciate enquiry'. This means listening to, and being open to consider opposing opinions, and being open to trying something new.
- We shift from an 'organisation as a machine to an organisation as an organism'<sup>3</sup>. This means a shift away from a top-down hierarchy to an environment where leaders set direction and empower staff on the ground to take action. A culture of 'no more heroes'<sup>4</sup> where the role of a leader is about 'creating bridges, holding the space in the middle and facilitating change'<sup>5</sup>.
- We co-produce change and improvement with our patients and carers and partners, harnessing the power of our community and using the collective wisdom of our lived experience.
- We continue to learn, where staff are encouraged to try new things in safe environments and not worry if something doesn't work out as expected. A culture where we evaluate the changes we make and we build on lessons learned to improve further.
- Teams celebrate success together and support and challenge each other.
- We involve all stakeholders and their representatives in transformation, rather than imposing top down change.

**Capability** describes our ability or power to do something. In the context of improvement, capability refers to our 'understanding, readiness and commitment to improvement and its skilled resources to achieve transformation'<sup>6</sup>. It not only describes the knowledge of how to do something, but the ability to do it well. Building our capability for improvement means:

- We have the right people, in the right number, with the right skills in the right place at the right time. This particularly relates to both clinical and non-clinical staff leading and supporting change programmes.
- All members of staff know where to go to access easy to use tools and resources to support them with improvement projects.
- Training in quality improvement, planning, project management and evaluation is available to all staff.
- We focus on building capacity in others by adopting a coaching approach.
- We build our competencies by doing, practicing and experiencing, whilst safely managing any associated risk.
- We provide supportive leadership that promotes taking time for improvement.

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<sup>3</sup> (Wouter Aghina, 2018)

<sup>4</sup> (The Kings Fund, 2011)

<sup>5</sup> (Timmins, 2015)

<sup>6</sup> (Hamer, 2012)

- We encourage everyone to be empowered and take ownership for things within their control, reducing reliance on power from 'above'.

**Capacity**, in this context, refers to an individuals, team or organisations ability to absorb change effectively<sup>7</sup>. Both individuals and organisations can only assimilate a certain amount of change before negative symptoms occur, affecting both individuals and the success of change. Building our capacity for improvement means:

- The pace and scope of change is managed, to ensure we are able to absorb and sustain such change.
- Everyone understands the emotional impact of change, and people are given time and space to think through the purpose of change.
- Staff are given opportunities to undertake new challenges in line with opportunity and ability.
- Improvement and transformation programmes are led, support and facilitated by multi-disciplinary staff across different staff groups.
- Resources are freed up or introduced where needed.
- Different and new ways of working to increase our capacity to support and lead improvement are encouraged.

### **Actions we will take**

1. We will **embed a culture of quality improvement** throughout the organisation, to include adoption of a standard quality improvement methodology across the Trust and provision of tools, techniques and training. This will commence in 2019/20.
2. We will work with our partners across our STP to **a consistent system-wide approach** to improvement, starting in 2019/20.
3. We will **develop a network of improvement agents**, by developing our current network of Save 7 agents and supporting them to champion improvement. This will commence in 2019/20.
4. We will **embed a new approach to clinical and non-clinical leadership** involving a shift away from problem solving to 'being enablers of change'. This will start in 2019/20, as part of our People Strategy.
5. We will **encourage innovation and reward good practice**, commencing with a Dragons Den Innovation Forum in 2019/20.
6. We will **introduce a programme of team development**, firstly targeting teams that are involved in leading change but rolling out to all teams over time. This will commence in 19/20, as part of our People Strategy.

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<sup>7</sup> (Kealey, 2015)

7. We will build on our **talent management strategy**, increasing our improvement capability and capacity by matching available skills and ability to opportunities. This will commence in 19/20, as part of our People Strategy.
8. We will ensure that **all major transformation schemes are co-produced and have patient representation** included in project board membership. This will be reviewed during 2019/20.
9. We will continue to **improve our programme management approach**, resulting in improved governance and oversight of our transformation and improvement programmes. We will do this in 2019/20.
10. We will **review the business support** available to clinical services to support major transformation, along with our systems and processes. We will do this in 2019/20.

### **How we will measure our success**

In addition to the deliverables listed above, we will monitor the success of our improvement strategy by the following measures.

#### Process measures: (short / medium term achievement 2019/20)

- All major change programmes are co-produced with patients / carers and appropriate partners
- We will provide a transparent view of all improvement initiatives being undertaken
- All improvement programmes demonstrate the impact on patient care and experience
- Our staff feel able and empowered to make improvements themselves
- The majority of improvements are initiated 'bottom up'; rather than 'top down'.

#### Outcome measures (medium / long term achievement) 2021/22 and beyond

- A positive impact on patient care and experience (Family & Friends Test, outcomes)
- Staff job satisfaction has improved (staff survey)
- Staff retention has improved (workforce metrics)
- Improved efficiency and productivity (performance metrics)
- Financial performance (performance metrics)
- Our stakeholders view of Salisbury NHS FT (feedback)

### **Governance arrangements**

Delivery of this strategy will be overseen jointly by the Clinical Governance and Workforce committees, and will be reported to the Board on a 6 monthly basis.

Esther Provins  
Director of Transformation  
18<sup>th</sup> March 2019

|                         |                      |                     |     |
|-------------------------|----------------------|---------------------|-----|
| <b>Report to:</b>       | Trust Board (Public) | <b>Agenda item:</b> | 5.1 |
| <b>Date of Meeting:</b> | 05 November 2020     |                     |     |

|   |   |                   |                  |                 |
|---|---|-------------------|------------------|-----------------|
| <b>Report Title:</b>                    | Trust Actions identified from the NHS People Plan   |                   |                  |                 |
| <b>Status:</b>                          | <b>Information</b>  | <b>Discussion</b> | <b>Assurance</b> | <b>Approval</b> |
|   | X   | X                 |                  | X               |
| <b>Prepared by:</b>                     | Glennis Toms, Deputy Director of OD & People<br>Jean Scrase, Associate Director of Education, Inclusion, Comms & Engagement |                   |                  |                 |
| <b>Executive Sponsor (presenting):</b>  | Lynn Lane, Director of OD & People  |                   |                  |                 |
| <b>Appendices (list if applicable):</b> | Appendix A – The BSW 2020/21 People Plan<br>Appendix B – Actions designated to others or already completed                  |                   |                  |                 |

|  |
|--|
| <b>Recommendation:</b>   |
| The Trust Board is requested to endorse the proposed actions identified in Section 3 of this report. |

|   |
|---|
| <b>Executive Summary:</b>   |
| <p>The NHS People Plan was published on 30 July 2020, having been delayed by the onset of the COVID-19 pandemic earlier in the year.</p> <p>The current People Plan identifies short term actions required in the remainder of this business year to March 2021, with further actions to be identified and mobilised in 2021/22 and beyond.</p> <p>Salisbury FT has been involved in discussions throughout August/September at HRD level with BSW partners in identifying actions in which this Trust will take the lead to contribute to the System response to the Plan.</p> <p>Progress of this local Plan will be monitored through the OD &amp; People Management Board on a monthly basis, which in turn reports to TMC. The Board will receive up-dates in January and March 2021.</p> <p>From Section 3, and Appendix B, it can be seen that the Trust already has some significant actions in place, although with a considerable amount of work still to do.</p> |

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The short term actions identified here will form the content of the OD & People workplan for the remainder of this 2020/21 year.

| Board Assurance Framework – Strategic Priorities   | Select as applicable                |
|--|-------------------------------------|
| <b>Local Services</b> - 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 | <input checked="" type="checkbox"/> |
| <b>Specialist Services</b> - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population                       | <input checked="" type="checkbox"/> |
| <b>Innovation</b> - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered      | <input checked="" type="checkbox"/> |
| <b>Care</b> - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm                            | <input checked="" type="checkbox"/> |
| <b>People</b> - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams                                       | <input checked="" type="checkbox"/> |
| <b>Resources</b> - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources   | <input checked="" type="checkbox"/> |

### 1 Purpose

- 1.1 The purpose of this report is primarily to inform the Board of the detail of the National NHS People Plan, and propose the associated actions that the Trust needs to take in order to be compliant with its requirements.
- 1.2 The secondary purpose is to inform the Board of the Trust's contribution to the wider BSW People Plan and the Regional SW People Plan and People Board.

### 2 Background

- 2.1 The NHS People Plan was published on 30 July 2020, having been delayed by the onset of the COVID-19 pandemic earlier in the year.
- 2.2 The current People Plan identifies short term actions required in the remainder of this business year to March 2021, with further actions to be identified and mobilised in 2021/22 and beyond.
- 2.3 In the introduction to the Plan, it said:
  - *“This plan sets out actions to support transformation across the whole NHS. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care. It focuses on activity through 2020/21, but the principles underpinning this action must endure beyond that time.*
  - *The NHS is made up of people in many different roles, in different settings, employed in different ways, by a wide range of organisations. Many people providing NHS services work for NHS trusts. But others are employed by community interest and other companies or partnerships – for example, in primary care across GP practices, dental surgeries, pharmacies and optometrists.*
  - *The NHS also works closely with partners in social care and local government, as well as with the voluntary and independent sectors. We benefit from the contribution of those in unpaid roles too – particularly, carers and volunteers.*

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- *How different elements of the plan are implemented will vary across these different settings, but the principles it sets out apply across all organisations, and to all of our people involved in providing or commissioning NHS care. NHS England and NHS Improvement and Health Education England (HEE) will work with non-NHS employers and their representatives too, to agree how they support delivery of these principles in their organisations. Local systems and clinical commissioning groups (CCGs) need to do the same for services they commission.*
- *Systems have an important role in leading and overseeing progress on this agenda, strengthening collaboration among all health and care partners – particularly with social care – to meet the complex and evolving staffing needs of our services.”*

2.4 The NHS was immediately mobilised at System level to respond to the call to action identified in the nine themes of the Plan:

- 2.4.1 Health and Wellbeing
- 2.4.2 Flexible Working
- 2.4.3 Equality and Diversity
- 2.4.4 Culture and Leadership
- 2.4.5 New Ways of Delivering Care
- 2.4.6 Growing the Workforce
- 2.4.7 Recruitment
- 2.4.8 Retaining Staff
- 2.4.9 Recruitment and Deployment Across Systems

2.5 Salisbury FT has been involved in discussions throughout August/September at HRD level with BSW partners in identifying actions in which this Trust will take the lead to contribute to the System response to the Plan.

2.6 The current BSW LWAB will be converted to the BSW People Board, as shown on Slide 32 Governance arrangements, of the attached Appendix A.

**3 The Salisbury FT People Plan 2020/21**

3.1 The Director and Deputy Director of OD & People, with the Associate Director of Education, Inclusion, Communications and Engagement, have identified the actions we need to take within this Trust to ensure that we are fully engaged with the system actions and, more importantly, that our staff benefit from the positive intentions of the Plan.

3.2 This section outlines each theme, actions required, who is responsible for the action, and the target date.

3.2.1 Health and Wellbeing – there are a total of 23 actions related to this theme, 18 of which are designated to NHS Trusts, with the remainder allocated to NHS England/Improvement. The table below shows Trust actions which require our attention, those not included are designated to NHS England/Improvement or are completed, as shown in Appendix B.

|   | Action  | Progress to Date   | Timeline      | Lead  |
|---|---|--|---------------|-------|
| 5 | Ensure people working from home can do safely and have support to do so, including having | Risk assessments and DSE are completed to ensure that working from home is managed appropriately | December 2020 | GT/DR |

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|    |  |  |               |            |
|----|--|--|---------------|------------|
|    | the equipment they need.   |  |               |            |
| 6  | Ensure people have sufficient rests and breaks from work and encourage them to take their annual leave allowance in a managed way.                   | Staff are encouraged to take their full annual entitlement to leave. However, there is more work to be done on shift breaks and WTD.   | March 2021    | GT/DR      |
| 8  | Prevent and control violence in the workplace – in line with existing legislation.   | Mandatory conflict resolution training for all staff. Additional training available for specific groups  | March 2021    | PK         |
| 12 | Support staff to use other modes of transport and identify a cycle-to-work lead.   | This will be achieved through the HAWB Steering Group and will also address shelters and security.   | December 2020 | LMcL       |
| 13 | Ensure staff have safe rest spaces to manage and process the physical and psychological demands of the work.   | This will be achieved through the HAWB Steering Group and will require additional funding and potential psychology input.  | March 2021    | GT/LMcL/LL |
| 14 | Ensure that all staff have access to psychological support.  | Currently provided through the national helpline, there is specification for a local EAP which can be mobilised as necessary   | January 2021  | GT         |
| 17 | Ensure that workplaces offer opportunities to be physically active and that staff are able to access physical activity throughout their working day. | Appropriate facilities available in Odstock Fitness Centre; there are additionally outside walking routes and exercises on the green<br>Need to ensure that these are accessible for all staff | December 2020 | LMcL/RW    |
| 18 | Make sure line managers and teams actively encourage wellbeing to decrease work-related stress and burnout.  | Links to 6. Executives and managers to role model (for example) breaks at lunchtime and leaving work on time.  | November 2020 | LL         |

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3.2.2 Flexible Working – there are a total of 11 actions under this heading. Only 5 of these are designated to NHS Trusts, with 5 allocated to NHS England/Improvement and one to Health Education England. The table below shows Trust actions which require our attention, those not included are designated to NHS England/Improvement or are completed, as shown in Appendix B.

|   | Action   | Progress to Date  | Timeline                   | Lead  |
|---|--|---|----------------------------|-------|
| 1 | Be open to all clinical and non-clinical permanent roles being flexible.   | This is accepted as a principle and we work towards practical application incorporating those things that we have learnt through the COVID experience.  | March 2021                 | GT/LL |
| 4 | Cover flexible working in standard induction conversations for new starters and in annual appraisals.  | Conversations about flexible working opportunities will take place during induction and through the updated appraisal process.  | December 2020              | JS    |
| 5 | Requesting flexibility – whether in hours or location, should (as far as possible) be offered regardless of role, team, organisation or grade. | The ability to request flexibility is already open to all. However, more work is required on the positive consideration of requests in some areas, bearing in mind lessons learned through COVID. | March/April 2021 & ongoing | DP    |
| 6 | Board members must give flexible working their focus and support.  | This occurs through the debate around policy  | March 2021                 | LL    |

3.2.3 Equality and Diversity– there are a total of 6 actions under this heading. Only 4 of these are designated to NHS Trusts, with 2 allocated to NHS England/Improvement. The table below shows Trust actions which require our attention, those not included are designated to NHS England/Improvement or are completed, as shown in Appendix B.

|   | Action   | Progress to Date   | Timeline   | Lead  |
|---|--|--|------------|-------|
| 1 | Overhaul recruitment and promotion practices to make sure that staffing reflects the | We are using the WRES, WDES and GPG reports and data to discuss with OD & People leadership team the | March 2021 | RW/SH |

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|   |  |   |               |    |
|---|--|---|---------------|----|
|   | diversity of the community, and regional and national labour markets.  | recruitment and promotion processes. From a BAME perspective we have gone further than reflecting the local community which is about 6 to 7% BAME as we have 17% of BAME staff mainly due to overseas recruitment and therefore mainly within our nursing workforce. We plan to carry out more work with the local authority, police, local groups, college and schools to support BAME staff integrating into the local community.   |               |    |
| 2 | Discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the health and wellbeing table. | From September 2020 The OD & People Leadership team will use the Equality Impact Assessment when looking at Health and Wellbeing issues to assist this process. ED&I is a regular component of induction and introduction of H&WB into induction and appraisal conversations will support this process. By introducing the EIA process across all the areas of the People Plan action plan we will influence EDI being included and the creation of a more inclusive culture. | December 2020 | RW |

3.2.4 Culture and Leadership– there are a total of 15 actions under this heading. Only 1 of these is designated to NHS Organisations, with the remainder allocated to NHS England/Improvement, HEE or the CCG. The single action allocated to NHS employers has been completed and can be seen in Appendix B.

3.2.5 New Ways of Delivering Care– there are a total of 6 actions under this heading. Only 3 of these are designated to NHS Trusts, with the remaining 3 to Health Education England. The table below shows Trust actions which require our attention, those not included are either Health Education England or are completed, as shown in Appendix B.

**CLASSIFICATION: UNRESTRICTED**

|   | Action   | Progress to Date  | Timeline      | Lead  |
|---|--|---|---------------|-------|
| 2 | Continued focus on developing skills and expanding capabilities to create more flexibility, boost morale and support career progression. | We have an emerging leadership programme available from September together with a new comprehensive training programme for all staff. Our OD Best Place to Work Programme has engaged with staff and the responses are due to be considered by the Trust board in the autumn when appropriate design and delivery of OD responses to the engagement will take place.<br>As part of our no going back initiative we are thinking about how we can work differently post Covid. | December 2020 | JS/LL |

3.2.6 Growing the Workforce– there are a total of 16 actions under this heading. 13 are designated to Health Education England, one of these in conjunction with universities. The remaining 3 are assigned to employers. Our completed actions can be seen in Appendix B.

3.2.7 Recruitment – there are 9 actions under this heading; only three of which are designated to NHS Trusts. The remainder are actions for systems, NHS England/Improvement and/or Health Education England. The table below shows Trust actions which require our attention, those not included are either Health Education England or are completed, as shown in Appendix B.

|   | Action   | Progress to Date   | Timeline             | Lead |
|---|--|--|----------------------|------|
| 1 | Increase recruitment to roles such as clinical support workers, highlighting the importance of these roles for patients and other healthcare workers as well as potential career pathways to other registered roles. | There is a requirement to redesign the workforce which will demand better workforce planning coupled with the development of career pathways and talent management<br>Through 2020/21/22 | March 2021 & ongoing | SC   |
| 2 | Offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial  | We currently have a range of apprentices at different levels within the organisation (level 2-7). We plan to encourage more apprenticeships to support our                               | March 2021 & ongoing | NS   |

**CLASSIFICATION: UNRESTRICTED**

|   |  |   |            |    |
|---|--|---|------------|----|
|   | roles.   | talent pipeline and workforce plans.<br>The next area of focus is apprentices to support our estates and facilities team.   |            |    |
| 8 | Encourage our former people to return to practice as a key part of recruitment drives during 2020/21, building on the interest of clinical staff who returned to the NHS to support the COVID-19 response. | All return to practice as a result of COVID have been registered to the bank rather than going into fixed term or substantive posts. A lot of the individuals who joined the temporary register aren't necessarily fit for practice in the jobs they were previously doing so by having pre-requisites identified this may help manage expectations prior to running campaigns. Explore different types of contracts for return to practise to provide flexibility around when and how they work. | March 2021 | SH |

3.2.8 Retaining Staff– there are a total of 10 actions under this heading. Only 4 of these are designated to Employers, with 3 allocated to Health Education England and 3 to the System. The table below shows Trust actions which require our attention, those not included are designated to HEE or the System or are completed and can be seen in Appendix B.

|   | Action   | Progress to Date  | Timeline     | Lead  |
|---|--|---|--------------|-------|
| 1 | Design roles which make the greatest use of each person's skills and experiences and fit with their needs and preferences. | We plan to ensure that all recruiting managers have attended appropriate interview training.<br>We are piloting a Skills Share Scheme where staff have the opportunity to get involved with projects which utilise the skills that might not currently be used in their regular role. | March 2021   | SC    |
| 2 | Ensure that staff who are mid-career have a career conversation with their line manager, HR and occupational health.       | This is a conversation that will form part of the revised appraisal process.  | January 2021 | CF    |
| 3 | Ensure staff are aware of the increase in the annual allowance pensions tax threshold.                                     | The finance team will be asked to run workshops as part of the revised CPD offer.   | January 2021 | SH/CF |

## CLASSIFICATION: UNRESTRICTED

|   |   |   |               |    |
|---|---|---|---------------|----|
| 4 | Make sure future potential returners, or those who plan to retire and return this financial year, are aware of the ongoing pension flexibilities. | This will form part of the “benefits” package in future recruitment campaigns | December 2020 | SH |
|---|---|---|---------------|----|

3.2.9 Recruitment and Deployment Across Systems – these are actions required of the whole System and, whilst Salisbury will make a significant contribution with BSW partners to these actions, there is no specific local action for us to take.

3.3 Progress of this local Plan will be monitored through the OD & People Management Board on a monthly basis, reporting into TMC, with reports to the Trust Board in January and March 2021.

3.4 In addition to the People Plan the Trust has recently completed the Diagnostic phase of its cultural change programme ‘*Best Place to Work.*’ The recommendations from this report are being considered by the board and staff groups in order to prioritise the associated actions into short, medium and long-term.

The recommendations fall into the following themes:  
General, Vision and Values, Goals and Performance, Support and Compassion, Learning and Innovation and Teams.

The resulting actions from our prioritisation work will be embedded into our local People Plan and together the requirements of the People Plan both at local and System level will influence the design and implementation phases of our Best Place to Work Cultural Change programme.

## 4 Summary

4.1 From the foregoing section, and Appendix B, it can be seen that the Trust already has some significant actions in place, although with a considerable amount of work still to do.

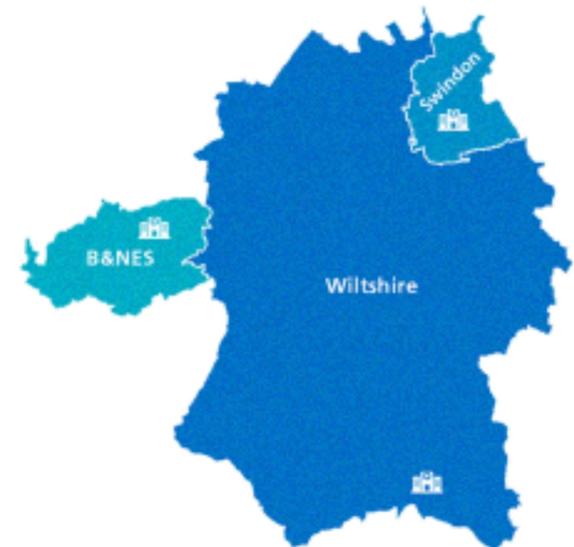
4.2 The short term actions identified here will form the content of the OD & People workplan for the remainder of this 2020/21 year.

## 5 Recommendations

5.1 The Trust Board is requested to endorse the proposed actions identified in Section 3 of this report.

# BSW People Plan 2020-21

20 September 2020



This document is a People Plan for BaNES, Swindon and Wiltshire (BSW). It sets out how BSW will take early steps to develop and deliver the local NHS workforce.

Responding to the NHSE/I 'Phase 3' letter of 31 July 2020, this document addresses the key themes of:

- *Looking after our people*
- *Belonging in the NHS*
- *New ways of working and delivering care*
- *Growing for the future.*

This BSW People plan does not replicate the work of the NHS Trusts and other employers within the BSW system. Individual organisations will develop their own detailed plans for workforce development and transformation; and through the proposed BSW People Board, progress will be reviewed and best practice shared.

This document sets out plans, for the remaining part of 2020-21, for actions that will be undertaken at system level. System level actions are defined as:

- Those that the NHS People Plan makes explicit as requiring to be managed at system level
- Actions that BSW workforce leaders have agreed can be better planned and/or delivered collectively rather than at employer level.

The timeframe for this plan is short term - to March 2021. A longer-term People Plan will be developed in early 2021.

|   |    |
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As partners in providing health and social care we recognise that the needs of our patients and clients are best met by well trained, motivated and joined-up workforce. The BSW vision is to *work together to empower people to lead their best life*. Our People Plan is a key enabler to realising that vision.

This BSW People Plan 2020-21 sets out some strategic priorities for workforce. It has been co-created by partner organisations within BSW. The principles of collaboration have been applied where we think it is more effective to plan and deliver change together, rather than as individual organisations, as we work towards becoming an Integrated Care System.

To this end we will work to create a cohesive and complementary way of working with and managing the staff in our organisations. Some examples of our success in doing this are shown in this document.

This plan sets out the challenges as identified by the system, and what we will do and are doing to meet those challenges. A vital component of delivering these actions is our ability to work together to maximise efficiency and share our successes, which will also be borne out through the system adopt and adapt activity in relation to workforce such as:

- Workforce support including working from home flexibilities; upskilling and reskilling, health and wellbeing inclusive of flu vaccination, EAP and OHS support and access to psychological interventions, and reinstatement of the volunteer workforce

**Workforce development takes place within the context of service development and improvement. For BSW, this means redesigning the workforce to meet changing needs of patients, their carers and our communities, as set out in the BSW Long Term Plan.**

This plan sets out a number of actions that we will take at system level. The actions are drawn from the national document *We are the NHS: People Plan for 2020/21 – action for us all*. System-level actions have been selected as those we think the system, as opposed to individual employing organisations, can deliver more effectively. In some cases, system-level action is mandated.

These actions have been identified through an agreed set of principles;

- Recognising that employer organisations may lack skills in specific areas, and that working collaboratively will share skills and resources
- Economy of scale – where working together will offer partners better value for money
- Identify and utilise strength among partners (subject matter experts) to benefit the system as a whole.
- Agree that the plan is an interim plan for the next 6 months and lays the foundation for a 5 year system plan from April 2021

The system actions outlined in this plan fall into four broad theme areas;

- Equality, Diversity and Inclusion
- Workforce Planning and New Ways of Working
- Recruitment, Retention and Attraction
- Leadership & Development of Staff

This plan does not include all of the employer actions as outlined in the NHS People Plan as these will be delivered by each organisation recognising that each partner may be at a different starting point.

Partners are committed to sharing their work with one another and this will be done through the proposed BSW People Board and other forums that are in place.

Our plan of action is predicated on being able to continue to resource it. If there is a significant rise or 'second wave' of Covid-19, this may compromise our efforts. We have set out to reflect a balance of ambition for workforce development with a pragmatic approach to what can be achieved in the remainder of 2020-21.

All deadlines for the actions are March 2021 unless stated otherwise. In many cases, the work through to March is concerned with putting in place the foundations for longer-term work, from 2021 onwards.

The actions set out in this document were agreed by workforce leads drawn from organisations across the BSW system and recognises the need for the system to restore service delivery in all acute, primary care and community services.

Our strategic priorities are set out in the BSW Long Term Plan; with a focus on Ageing Well, All Age Mental Health and Learning Disabilities and Autism. Delivery plans are in place and are continuing to be developed and refined.

The development of **Primary Care Networks** and their capabilities and improving the workforce in primary care is a key facet in developing the BSW system.

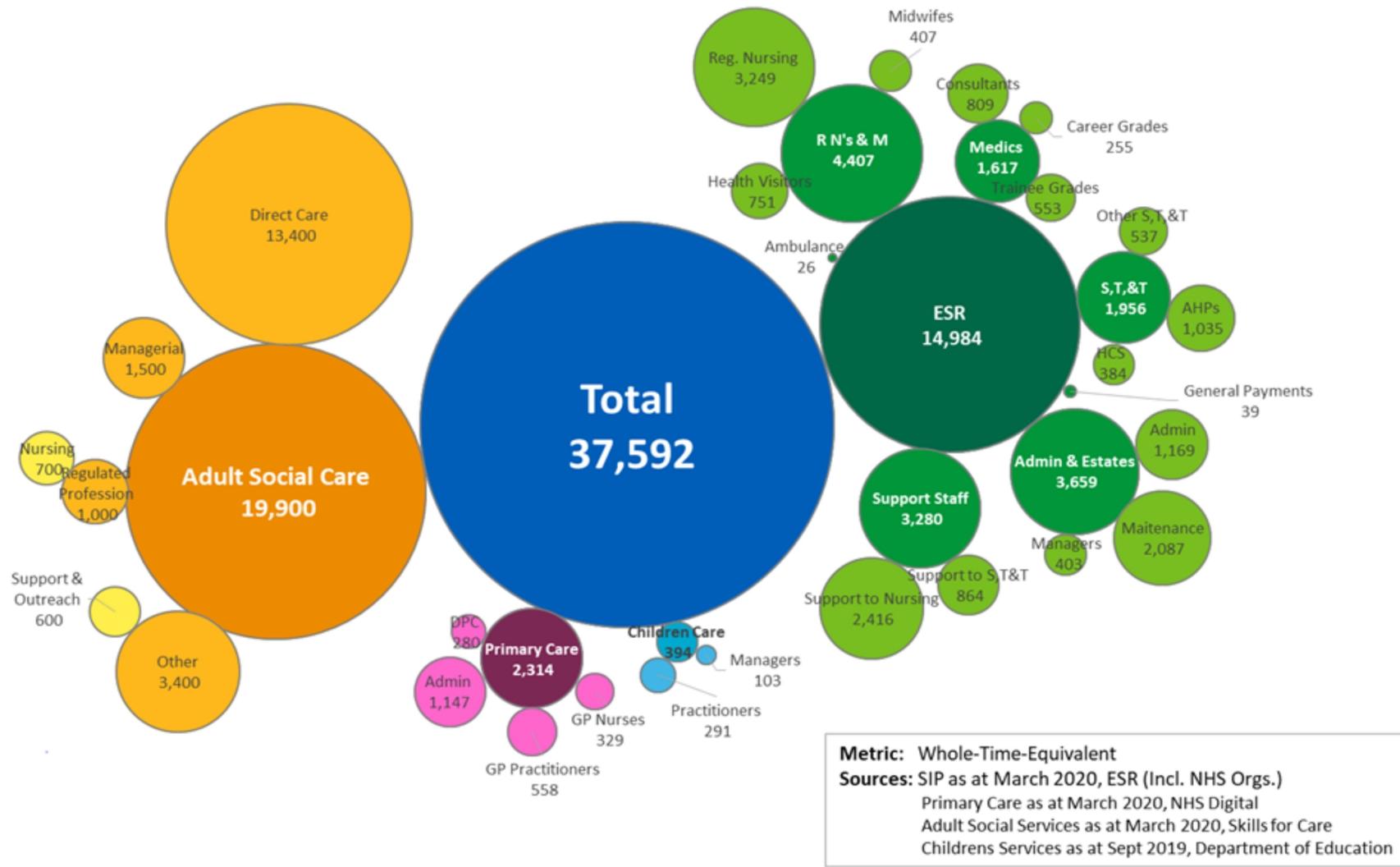
**Ageing Well** addresses the unsustainable demands on the health and care system driven by an aging population; and we are developing a shared decision model, medications optimisation, enhanced health in care homes and developing a two hour community response service and a 48 hour re-ablement service.

Within **mental health**, crisis services are a priority for 2020-21, aiming to support people before a crisis and then ensure appropriate support when required reducing the need to people to attend A&E or require an admission into bed based services. We have co-designed a pilot for a new single point of access for MH crisis and we will open *places of calm*.

**Learning disabilities and autism** will initially focus on understanding future service requirements to support people to remain close to home and to reduce out of area placements. We will work with PCNs to ensure that people with a learning disability or autism are accessing health checks and screening programmes.

As with all NHS care, these initiatives require a valued and motivated workforce, in sufficient numbers, and with the right skills. This means supporting and developing our workforce, in line with the national NHS People Plan. The BSW People plan therefore sets out key actions for each of the People Plan areas of focus: *looking after our people; belonging in the NHS; new ways of working and delivering care; and growing for the future.*

# Our workforce in 2020



Looking after our people means the actions we must all take to keep our people safe, healthy and well – both physically and psychologically

## *A BSW success story: Retaining staff as a key driver of service stability*

*As the main specialist mental health provider across two systems, stretching from Weston Super-Mare and Bristol, to Swindon and Salisbury, AWP has some unique workforce challenges to contend with.*

*Registered mental health nurses are nationally in very short supply, and the vast majority of them chose to retire relatively early compared to other professions. This is in part due to the very challenging and sometimes dangerous nature of their work. At its peak, turnover of staff was close to **20% five years ago**. Retaining staff leaves managers more able to support and engage with their teams, utilise experienced staff as coaches, reduce agency spend and improve the quality of services....rather than taking time to recruit and train replacement staff.*

*A dedicated project and senior operational manager were established in 2018 to provide focus, creativity and energy in this arena, across the entire geography of AWP's footprint. A considerable range of initiatives were set up including using creative turnover posters, "stay-interviews", performance targeting, a collaborative group of local champions, a whole new approach to on-boarding, and much more besides. **Within two years the turnover rate has fallen to 12%** and the number of people leaving in their first 12 months has also fallen.*

As a system, BSW will undertake the following *looking after our people* actions in 2020-21

## ***Prevent and tackle bullying, harassment and abuse against staff, and a create a culture of civility and respect***

NHS organisations and partners will collectively review the following data sources, where available: NHS Staff Survey results; WRES; WDES; Model Hospital; reasons for turnover; and absence reasons and levels by group. This will provide a baseline for the STP to analyse staff experience, from which annual improvements will be made.

Collaborative actions undertaken to make such improvements may include:

- Implementation of Just and Learning Culture principles
- Extended Freedom to Speak Up roles
- Partnership working
- Prevention and management of violence and aggression training
- Enhanced Equality, Diversity and Inclusion (EDI) training
- Adoption of the NHSE&I toolkit on civility
- Adoption of the NHSI NHS Violence Reduction Standard
- Provision of counselling.

Learning from best practice will be shared via BSW governance arrangements (LWAB and proposed BSW People Board).

***Support the GP workforce through full use of the GP retention initiatives outlined in the GP contract, which will be launched in summer 2020***

BSW CCG have designed and are delivering (September 2020) a programme to deliver the national newly qualified fellowship scheme as part of a retention initiative. This scheme provides support through educational delivery, mentorship and release time, under the co-ordination of a GP fellowship lead. There are currently 20 newly qualified GPs signed up for this two year programme, with provision for more if required.

We will build on previous work in this area of retention and will explore more system offers in this regard, such as expanding portfolios across multiple providers. Other workforce initiatives are expected to contribute to GP retention by addressing workforce supply, such as return to practice nurses (a full cohort of 20 is with UWE in September 2020); additional roles reimbursement scheme, as discussed on page 28 (currently collating requests); and other nursing fellowship roles (numbers to be confirmed when the scheme is launched).

We will also draw on best practice from our colleagues within the South West region and maximise the use of our Training Hub in providing support to Primary Care Networks (PCN) adopting the retention offers.

***Strengthen the approach to workforce planning to use the skills of our people and teams more effectively and efficiently***

BSW will continue to strengthen its approach to workforce planning. The appointment of a system wide strategic workforce planning lead in 2020-21 will enable more effective collaborative system-level workforce planning.

**Actions:**

- We will use HEE resources to appoint a system workforce planning team, to raise the level and amount of workforce analytical capacity and capability across the system
- We will create place-based workforce planning networks in direct support of the various transformative work programmes set out in our Long Term Plan, ensuring that workforce planning is 'at the table' in service redesign
- NHS organisations and partners will collectively review their workforce planning approaches, share best practice, collaborate with workforce data and analysis and align local and system level workforce planning priorities.

*Work with HEE and NHSEI regional teams to further develop competency-based workforce modelling and planning for the remainder of 2020/21, including assessing any existing skill gap and agreeing system-wide actions to address it*

The BSW strategic workforce planning lead will provide a main point of contact to work with HEE and NHSEI.

The drive towards collaborative system level workforce planning will support better workforce modelling to support and enable developing new models of care, aligned to service transformation. Competency gaps and opportunities for the existing and future workforce will be addressed (new roles, new clinical skills, etc.), and system based solutions and mitigations put in place. Workforce planning will therefore address strategic supply issues as well as demand.

With HEE and NHSEI we will identify and agree best practice and share learning gained from local initiatives and those from elsewhere in the NHS. In accordance with national requirements, actions will be agreed by **March 2021**.

***Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets***

To support the work of employers and to monitor ongoing improvement we will scope current practice and collate current data for system wide monitoring. This will provide a staff diversity 'benchmark'.

We will facilitate the sharing of best practice and innovation around recruitment practices, addressing the need for more diverse applicants. We will collate data and monitor improvement across the system to evidence success, provide oversight and ensure improvement is sustained. In accordance with national requirements, this will be done by **October 2020**.

***Publish progress against the Model Employer goals to ensure that the workforce leadership is representative of the overall BAME workforce***

We will work together to address the KPIs aligned to Model Employer goals and targets and collate data on a regular basis so we can show improvement and areas of good practice. As a system we will continually monitor and publish improvements through our LWAB. We will identify areas of best practice and improvements and share approaches across the system to support improvements across out whole geography. We will promote the Level 7 Senior Leaders Apprenticeship across our BAME community to underpins the skills and knowledge to increase leadership competence and confidence that is representative of our communities.

***51 percent of organisations to have eliminated the ethnicity gap when entering into a formal disciplinary processes***

While this action is addressed to employers rather than systems, as a system we can help to support local initiatives. We will agree a set of KPIs and associated data sets, utilising our WRES data, that can be used to demonstrate progress towards eliminating the ethnicity gap. We will collate data on a regular basis to measure improvement. As a system we will share areas of good practice and monitor improvements.

We will identify areas of best practice and share approaches taken across the system to support improvements overall optimum improvement. In accordance with national requirements, this approach will be in place by **December 2020**.



*Belonging in the NHS means highlighting the support and action needed to create an organisational culture where everyone feels they belong*

## ***A BSW success story: A system wide approach to CPD***

*An agreement has been made to share CPD and training resource across the system so that we put the needs of staff at the centre of our education delivery.*

*As a result all CPD events planned will include places for system partners. In order to achieve this we have agreed to procure a digital platform on which all of our in-house education offerings can be advertised and booked with 'spare' places open to anyone across the system who requires that training.*

*These approaches will deliver viable and well-attended programmes, introduce multi-organisational cohorts where relationships, conversations and understanding across our system will be built. They will also potentially release efficiencies across our system as well as a greater overall education offering to our staff.*

As a system, BSW will undertake the following *belonging in the NHS* actions in 2020-21

***Promote and encourage employers to complete the free online just and learning culture training and accredited learning packages, and take demonstrable action to model these leadership behaviours***

A Task and Finish Group is being established for the South West to drive the implementation of the Just and Learning Culture. The over-arching principles will be agreed at regional level and individual organisations will develop their own plans in recognition of the different starting points across organisations. Where there are benefits to doing so, organisations across BSW will work collaboratively to source and deliver training and to ensure learning is shared.

***Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes***

All organisations in the BSW system will continue to build and expand their staff networks to provide safe and encouraging environments where staff can come together, share their experiences and facilitate individual and organisational learning and development. BSW will engage with staff across the system to explore system-wide networks, crossing organisational boundaries, and the BSW LWAB will facilitate and support this where there is staff interest in doing so.

BSW LWAB, as well as individual organisations, will review existing governance arrangements to ensure that staff networks have a clearly defined role in assisting in shaping and delivering strategy, policy and decision-making. The impact of the input from staff networks will be measured through staff experience such as WRES; WDES; Staff Surveys and retention data. In accordance with national requirements, actions will be complete by **December 2021**.

New ways of working and delivering care means emphasising that we need to make effective use of the full range of our people's skills and experience to deliver the best possible patient care

## ***A BSW success story: First Contact Physiotherapy***

*Primary and secondary care organisations, led by Wiltshire Health and Care, have remodelled the physiotherapy workforce, to improve access and care, and to better manage clinical workload in primary care. First contact physiotherapists provide quick access to expert assessment, diagnosis, advice and signposting for patients presenting to their GP with a musculoskeletal condition. Services are up and running in seven PCNs, with 17 first contact physiotherapists now in post.*

*Data suggests that the majority of patients are managed independently, with limited involvement from the GP. The FCPs maintain close links with secondary care services such as the MSK Physiotherapy Department and the Orthopaedic Interface Service.*

*A competency framework has been developed to ensure staff working at a level to ensure they meet the requirements of the NHS primary care Directed Enhanced Service.*

As a system, BSW will undertake these *new ways of working and delivering care* actions in 2020-21

## ***Continued focus on developing skills and expanding capabilities to create more flexibility, boost morale and support career progression***

We will ensure that all staff delivering NHS services have access to development and skills training by co-designing and procuring an online/ digital platform/ website to support the sharing of education and development programmes. We will issue a BSW prospectus of virtual offerings to all BSW organisations – health and care – and facilitate staff booking, which will help to address historical training fund inequalities. This platform will be developed in consideration of the expertise of *eLearning for Health* and will promote the extensive e-learning for health resources.

Not all employer providers receive the HEE CPD funding support and this has resulted in key risks to service delivery and development in some areas particularly in community services. We will resolve some of the inequalities in funding and access to CPD across the system by designing a process to support system wide CPD, mitigating against the morale impact of inequitable CPD funding. (See *'Belonging in the NHS'* success story above).

Where appropriate and possible, we will plan and commission BSW wide or locality based training events, offering places system-wide to support partnership learning and relationship building as well as harnessing, sharing and valuing specialist expertise across the system.

## *Actively work alongside schools, colleges, universities and local communities to attract a more diverse range of people into health and care careers*

We will agree a BSW wide approach to support the workforce pipeline via system careers support to schools and colleges. We will support the introduction and of the new T-Levels and target increased numbers of people completing Level 3 courses at college to go on to health and care careers or training. Alongside positive work experience and placements for students, we will develop supported pathways into our careers for the students including application and interview advice and guaranteed interviews.

We will also use the scoping supply/ pipeline data and workforce planning data for BSW to plan increases in BSW located pre-registration training for adult nursing. This will lead to increased numbers of newly qualified nurses trained and employed across BSW. Our work will include exploring apprenticeship options.

Building on the BSW MoU to share unspent Apprenticeship Levy funds (see page 23), we will increase the numbers of apprenticeships to address predicted skills and numbers shortfalls and support the delivery of the long-term plan around primary care transformation. This will create new pathways for existing and new staff to pursue healthcare career, while facing fewer academic and financial barriers.

To date, 18 BSW people have benefited from apprenticeship levy transfers meaning that £285,000 will not be returned. We aim to reduce the amount of predicted sunseting levy by 30%.

*Make better use of routes into NHS careers (including volunteering, apprenticeships and direct-entry clinical roles) as well as supporting recruitment into non-clinical roles*

We will design and recruit to healthcare career pathways from volunteer roles – ‘bespoking’ volunteer roles to align to key careers and entry points (clinical and non-clinical), in full consideration of existing skills that can add value to our services.

We will make full use of our MoU to transfer Apprenticeship Levy funds and increase the number of apprenticeship roles, especially in areas yet to embrace the opportunity. In order to proactively engage with these organisations we will recruit an apprenticeship lead.

We will promote the enhancement of careers ‘direct entry’ registrants by using higher level apprenticeships (level 6 and 7) showing a clear career pathway from entry point to senior roles.

In accordance with national requirements, we will do this by **March 2021**.

***Develop workforce sharing agreements locally, to enable rapid deployment of our people across localities.***

We have a current embedded secondment / redeployment agreement in place that we have used effectively across partners to redeploy staff during the Covid-19 pandemic. We will continue to utilise this way of working to ensure that we are able to flex our workforce as required to meet the needs of our service users.

***When recruiting temporary staff, prioritise the use of bank staff before more expensive agency and locum options and reducing the use of 'off framework' agency shifts during 2020/21***

We have previously reviewed the opportunity of creating a shared system bank, however due to the geography of BSW we will focus on effective local collaborations rather than a single BSW approach. We will review the BNSSG model, which RUH participates in, and we will consider if this model can be applied more widely in BSW, collaborating with other systems that meet geographical requirements.

In accordance with national requirements, we will do this by **March 2021**.

*Note: Work on bank and agency staffing is predicated on current levels of the prevalence of COVID. If there is a second wave or parts of BSW are subject to local 'lockdowns', reliance on bank and agency may increase.*

*Growing for the future means building on the renewed interest in NHS careers to expand and develop our workforce, as well as retaining colleagues for longer*

## ***A BSW success story: Apprenticeship levy transfer and sharing***

*If funds raised through the employers' Apprenticeship Levy are unspent after a period of time, they become 'sun-setted' and are lost. This usually happens because it can take quite a long time to establish and fill a new apprenticeship programme. In BSW, we devised a formal requirement to transfer and share unspent apprenticeship levy funds, as they become at risk of sun-setting.*

*A Memorandum of Understanding ensures that we minimise unused apprenticeship levy funds across the system and instead support the development of the workforce through a range of apprenticeship schemes. These help to close the current and future gaps in our current and future workforce, and reduce workforce risks. So far 19 training roles have benefited. Primary and social care organisations that couldn't previously access levy funds now are able to and are developing apprenticeship roles in therapies and nursing.*

As a system, BSW will undertake the following *growing for the future* actions in 2020-21

***Ensure people have access to continuing professional development, supportive supervision and protected time for training***

We will resolve some of the inequalities in funding and access to CPD across the system, notably the inconsistent application of CPD to all partners. We will design a strategy and process to support system wide CPD and to mitigate against skills shortages in key services across the system, (particularly in community settings), which could lead to bottle necks and overuse of secondary care.

We will plan BSW wide or locality based training events to deliver some efficiencies and allow partnership learning and relationship building. These will be marketed and booked via a procured BSW Learning and development digital platform.

We will co-design principles, to be shared across our system, that underpin the deliver of excellent supervision and support for protected training time.

In accordance with national requirements, we will do this by **March 2021**, and on the basis of a scoping exercise agree what can be implemented in 2021-22.

*Start delivering a pre-registration blended learning nursing degree programme. The programme aims to increase the appeal of a nursing career by widening access and providing a more flexible approach to learning, using current and emerging innovative and immersive technologies*

At a system level we will work with HEE and universities to identify learning opportunities for blended learning nurse degree programmes for pre-registered nurses. At system level we will analyse and clarify our trajectory of workforce supply to inform workforce plans. In accordance with national requirements, we will work with HEE and universities to do this by from **January 2021**.

Organisations will share information regarding university intake information, access points and work collaboratively to maximise this opportunity.



***Increase recruitment to roles such as clinical support workers, highlighting the importance of these roles for patients and other healthcare workers as well as potential career pathways to other registered roles***

Leads from each organisation will work collaboratively to review the work already been undertaken in this area. They will share learning, best practice and success stories. The leads will then scope demand in each organisation, the main blocks to recruitment and the potential solutions, including working in new ways. Each organisation will determine and confirm the needs and timescales involved.

Working with key partners, we will increase the numbers of trainee nursing associates in primary care and social care by at least 100%, to reduce the numbers of vacancies across nursing in these areas against the predicted shortfall due to an ageing workforce. This will include agreeing and aligning core job descriptions and writing core competency profiles for the TNA role in all settings. We will establish a BSW job evaluation system and appropriate training for staff and trade union members.

We will expand the number of Physician Associates and Advanced Care Practitioners to build on the numbers of PA's already deployed in acute settings and ACPs plans for further recruitment are already in place.

By targeting this area, using workforce planning information (which will be improved - see pages 12 and 13) on vacancies and the age profile of staff, we will mitigate skills gaps in the community and primary care and support the long term plan for GP services.

***Develop lead-recruiter and system-level models of international recruitment, which will improve support to new starters as well as being more efficient and better value for money***

We will jointly review each organisation in BSW and determine which have developed and implemented a successful overseas recruitment campaign. We will:

- Share best practice, learning, success stories and understand where the specialist knowledge and experience is within the system, potentially through a 'buddying' system
- Confirm which organisation is to lead the programme and identify a project lead, who will work with HR and workforce planning
- Contact and learn from other STP areas, regionally and nationally, who have shown particular success in overseas recruitment.

Working together, Directors of Nursing and other key stakeholders will determine short, medium and long term workforce requirements for qualified nursing staff in each organisation. We will then develop a system wide recruitment strategy and associated recruitment plan to deliver the system needs. We would expect to respond to the recent announcement of additional funds being made available to support lead recruiter hubs.

Recruitment strategy and plans will include an employee value proposition tailored to meet the needs of overseas staff, a candidate attraction strategy (direct or via a partner agency), procurement of agency service if indirect sourcing, campaign management (if direct), candidate engagement, recruitment and selection process, on boarding and welcome process for overseas staff, induction specifically tailored for overseas staff, housing arrangements, resource and budget requirements, and development of a 'buddy' system.

***Primary care networks to recruit additional roles, funded by the additional roles reimbursement scheme, which will fund 26,000 additional staff until 2023/24***

BSW supports this initiative in line with national guidance and associated funding streams. Templates have been submitted by primary care practices and PCNs to the CCG in relation to ARRS. The CCG is able to support this activity and provide guidance on the workforce planning element; and will ensure PCNs benefit from the enhanced local workforce planning capability discussed on pages 12 and 13. Funding will be available within the system to meet the identified needs with a timeline of October 2020 for submission. Early indications are that demand will be highest for clinical pharmacists and technicians, followed by social prescribers and health coaches. The BSW training hub is working in partnership with the CCG to provide development support packages required for each of the professional groups.

There will be a focus on multi-disciplinary supervision and mentorship and the intention is to work alongside neighbouring STP localities if peer group sizes do not provide an adequate peer experience.

In accordance with national requirements, this is an **immediate** action.

***Encourage our former people to return to practice as a key part of recruitment drives during 2020/21, building on the interest of clinical staff who returned to the NHS to support the COVID-19 response***

We will continue to build on being the highest user of the return to practice (RTP) places offered by the University of the West of England. We will agree a system wide approach to marketing RTP placements, taking on board our learning from Covid returners and provide support to those who return. We will collaborate with partners to ensure RTP learners secure roles that fit with their geographical and flexibility requirements.

In accordance with national requirements, we will do this by **March 2021**.

In parallel with the work to prepare this People Plan, a BSW **workforce forecast** has been made, with an accompanying narrative. It is partly summarised here.

Overall growth in the substantive acute workforce will be 2.3% between September 2020 and March 2021. There is a forecast increase of registered nurses of 4.5%, non-medical clinical staff of 2.5%, consultant medical staff of 2.3% and in the overall medical workforce of 1.5%. Further work is needed to measure workforce growth against forecast activity growth. Further detail is provided overleaf.

This growth is offset against planned reduction in the use of bank and agency staffing of 9.2% and 0.5%\* respectively, resulting in an overall growth in the workforce of 1.6%. We will continue to recruit to replace agency staff, with bank staff being the first temporary workforce solution we will utilise when filling gaps.

Covid-19 saw many staff returning to NHS practice. We will be offering additional support, mentoring and flexible contracts as required to enable returners to stay.

Covid-19 meant suspension of all oversea and international recruitment, but it has now recommenced. We have targeted campaigns for “hard to recruit” posts such as radiographers, biomedical scientists, pharmacists, and some medical specialties. We will work as a system to identify a lead-recruiter and system-level ethical models of international recruitment in line with the People Plan.

We will continue to develop flexible working and to review skill mix to determine the safest and cost effective balance of staff.

BSW successfully redeployed staff across the system in response to the pandemic and an all system secondment/redeployment agreement was made in March 2020. This is still in force and continues to allow partners to deploy staff across the system. Appropriate assessment are made to protect staff groups who may be more vulnerable to Covid-19.

\* All acutes are reducing agency usage in their core services but the SFT consolidated subsidiary's use of Agency is expected to increase and will impact overall agency reduction at system level.

## ***A BSW success story: Alignment and pass porting of mandatory training***

*All organisations must ensure that their staff undertake various types of training, including mandatory training, such as basic life support or information governance. It has long been recognised that when staff move between organisations, they must undertake a full range of mandatory training, even if recently trained by their previous employer. This is frustrating for staff and it can be expensive.*

*Six BSW organisations have agreed to align their mandatory training to the Skills for Health UK Core Skills Framework. Organisations agreed to ensure that recruitment teams transfer training records for mandatory training when staff move across BSW, and accept the training provided by others as, preventing the repetition of training. This makes better use of training days and training resource. It results in greater employee satisfaction as staff are not asked to repeat training they already feel competent in.*

*Note: Care and support colleagues are currently working on aligning and passporting of mandatory training which will expand the number of BSW system partners with aligned mandatory training to the Skills for Health UK Core Skills Framework training*

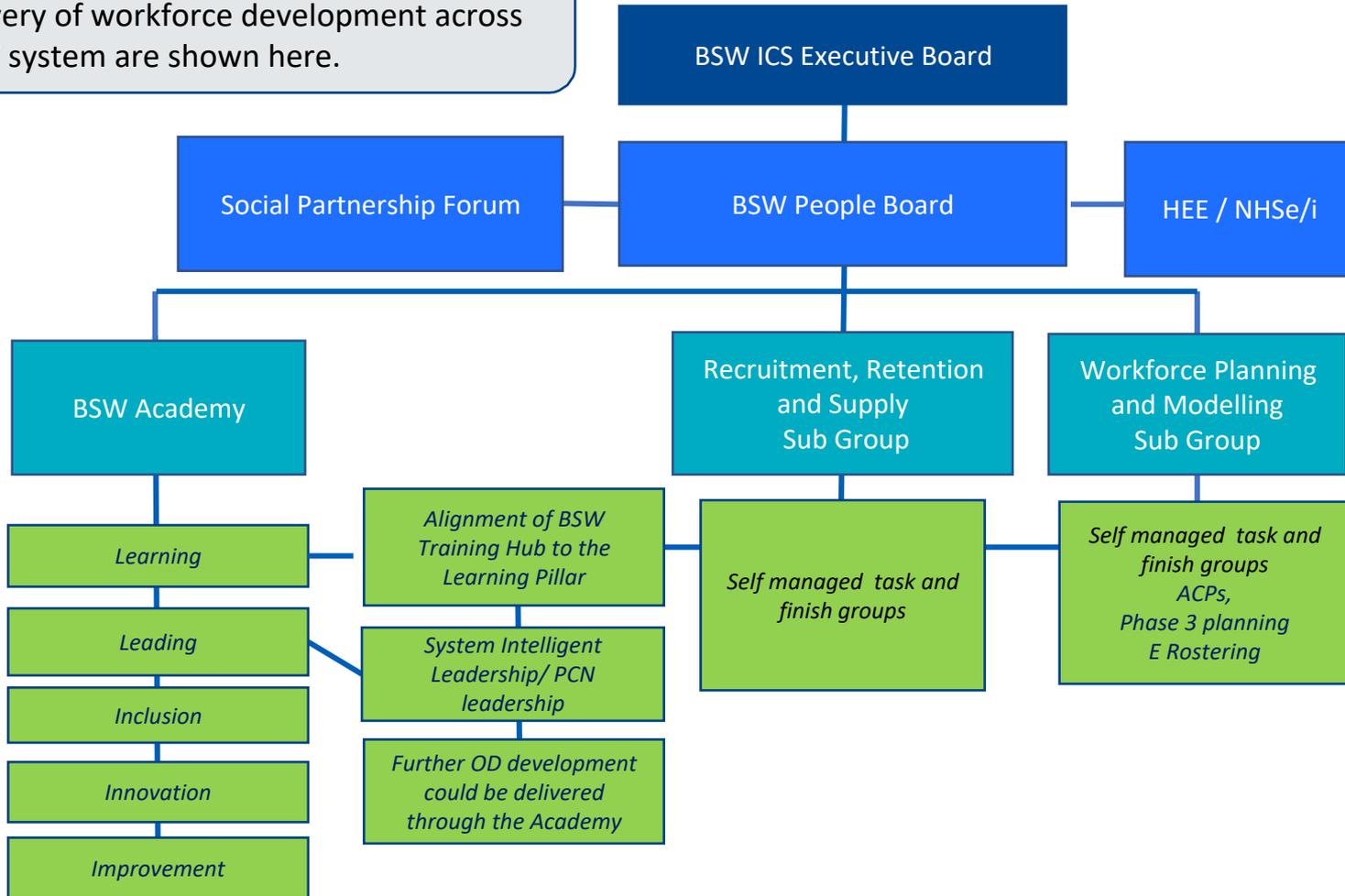
In the BSW workforce plan of November 2019, we discussed initiatives to address service quality and sustainability, which will drive aspects of workforce development. The transformation of health and care services will, in turn, mean workforce transformation. Specifically, we will align workforce design with transformational changes within BSW, in line with agreed priorities, to:

- Facilitate cross-system collaboration in workforce
- Positively address the challenges of the BSW geography, fostering shared learning and development
- Link workforce planning to transformational work, so that a picture of future staffing requirements is based on new and emerging care models within BSW (demand-side)
- Take a 'workforce first' approach, so that the supply of workforce, skills and competences is taken into account when service changes are being considered, rather than being considered late in the process.

By doing this we will develop more robust and realistic workforce plans, and will ensure that supply-side challenges are mitigated. By basing workforce models on service design rather than past practice, we will identify opportunities for new ways of working, including 'working at the top of the grade'. This operating model will be delivered through strengthened governance, discussed on the next page.

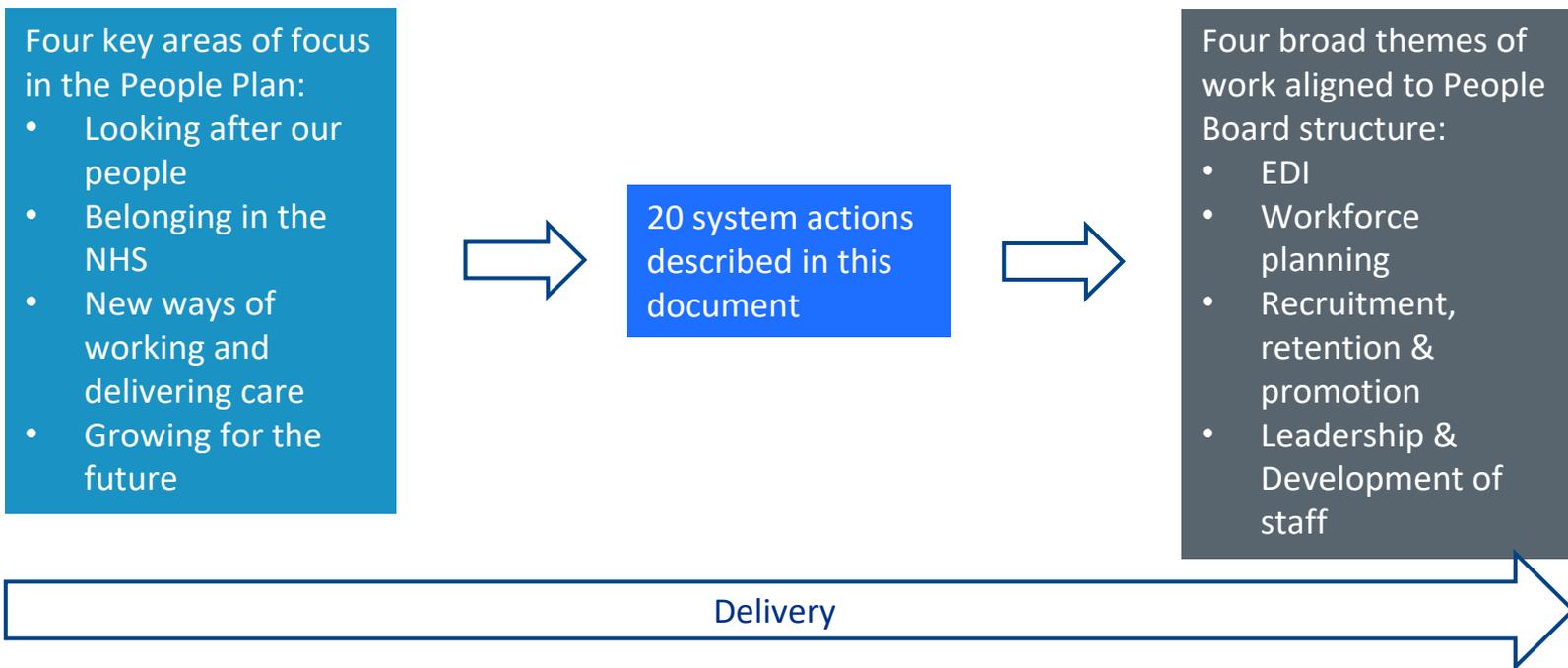
# Governance and delivery

Proposed governance arrangements to support the delivery of workforce development across the BSW system are shown here.



The proposed BSW People Board\* model has been developed with system partners as part of the ICS system capability workstream (\*subject to comment and possible re-design).

It is planned that the Board will commence in October/November and will monitor the arrangements in place for workforce development within the People Plan and the LWAB workstreams. Progress against the actions set out in this document and delivery of improvements will be monitored and assured by the People Board, in accordance with its themes of work. This is illustrated below.



Actions that have delivery dates are listed here for ease of reference.

| Action  | Date          |
|---|---------------|
| Work with HEE and NHSEI regional teams to further develop competency-based workforce modelling and planning for the remainder of 2020/21, including assessing any existing skill gap and agreeing system-wide actions to address it | March 2021    |
| Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets   | October 2021  |
| 51 percent of organisations to have eliminated the ethnicity gap when entering into a formal disciplinary processes   | December 2020 |
| Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes   | December 2020 |
| Make better use of routes into NHS careers (including volunteering, apprenticeships and direct-entry clinical roles) as well as supporting recruitment into non-clinical roles  | March 2021    |
| When recruiting temporary staff, prioritise the use of bank staff before more expensive agency and locum options and reducing the use of 'off framework' agency shifts during 2020/21   | March 2021    |

*Continues over*

# Timeline



*Continued*

| Action   | Date              |
|--|-------------------|
| Ensure people have access to continuing professional development, supportive supervision and protected time for training   | March 2021        |
| Start delivering a pre-registration blended learning nursing degree programme. The programme aims to increase the appeal of a nursing career by widening access and providing a more flexible approach to learning, using current and emerging innovative and immersive technologies | From January 2021 |
| Primary care networks to recruit additional roles, funded by the additional roles reimbursement scheme, which will fund 26,000 additional staff until 2023/24  | Immediate         |
| Encourage our former people to return to practice as a key part of recruitment drives during 2020/21, building on the interest of clinical staff who returned to the NHS to support the COVID-19 response  | March 2021        |
| All other actions: foundations to be put in place for a five-year BSW People Plan to be prepared in early 2021   | March 2021        |

In March 2020 we updated the 2019 BSW workforce plan with more detail for the year 2020-21. While the Covid-19 pandemic has impacted on delivery, much of what we committed to is reflected in this document. As we measure progress, we will also review progress against the earlier plans to ensure consistency and completeness.

# Developing a longer term People Plan



It is reiterated that this People Plan only addresses the remaining part of the business year 2020-21. It is expected that a Five-year People Plan will be prepared in early 2021. This document is intended to put in place the foundations for longer-term work.



# Next steps

To meet with system partners in October 2020 to;

- Identify SRO's for actions and workstreams
- Mobilise workstreams to deliver actions
- Agree timescales and outcomes to be delivered
- Agree governance arrangements
- Develop performance dashboard



The following table depicts the actions from the NHS People Plan which have either been designated to other bodies – Systems, NHS England/Improvement, Health Education England – or have been completed. Actions completed have been highlighted green.

## HEALTH AND WELLBEING

|   | Action   | Who                             | Timeline (where provided)  |
|---|--|---------------------------------|--|
| 1 | Put in place effective infection prevention and control procedures.  | Employers                       | There is already in place the structures, process & people to ensure effective IPC   |
| 2 | Ensure all staff have access to appropriate personal protective equipment (PPE) and are trained to use it.                                       | Employers                       | PPE fit testing & training is carried out by trained experienced people and a central database is being developed to record all results  |
| 3 | All frontline healthcare workers should have a vaccine provided by their employer.   | Employers                       | The Trust offers all employees an annual flu vaccine and particularly encourages frontline staff to take up the offer  |
| 4 | Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed. | Employers                       | Completed with 99% coverage of BAME staff  |
| 7 | Prevent and tackle bullying, harassment and abuse against staff, and a create a culture of civility and respect.                                 | Employers                       | Conflict resolution training for all staff, both e-learning and face to face. Involves de-escalation training (level 1&2). Level 3 for security staff involves restraint but we advocate prevention. Coach to lead training including managing difficult conversations. Freedom to Speak Up training at every induction. In addition, Bespoke FTSU and ED&I training for areas with specific concerns. |
| 9 | NHS violence reduction standard to be launched.  | NHS England and NHS Improvement | December 2020  |

|    |  |                                 |   |
|----|--|---------------------------------|---|
| 10 | Appoint a wellbeing guardian.  | Employers                       | Director of OD & People   |
| 11 | Continue to give staff free car parking at their place of work.                                | Employers                       | At least the duration of the pandemic   |
| 15 | Continue to provide and evaluate the national health and wellbeing programme.                  | NHS England and NHS Improvement |   |
| 16 | Identify and proactively support staff when they go off sick and support their return to work. | Employers                       | Already have in place comprehensive arrangements of line management, OHA and HR professionals working together to maintain staff in work.                           |
| 19 | Every member of NHS staff should have a health and wellbeing conversation.                     | Employers                       | From August 2020<br>The appraisal process is being reviewed and will incorporate a health & wellbeing conversation. This will also be a regular component of 1:1's. |
| 20 | All new starters should have a health and wellbeing induction.                                 | Employers                       | From October 2020<br>A review of Corporate induction is currently taking place. A key element of our new induction programme will be health & wellbeing.            |
| 21 | Provide a toolkit on civility and respect for all employees.                                   | NHS England and NHS Improvement | March 2021  |
| 22 | Pilot an approach to improving staff mental health by establishing resilience hubs.            | NHS England and NHS Improvement |   |
| 23 | Pilot improved occupational health support in line with the SEQOHS standard.                   | NHS England and NHS Improvement |   |

## FLEXIBLE WORKING

|    | Action   | Who                             | Timeline (where provided)   |
|----|--|---------------------------------|---|
| 2  | All job roles across NHS England and NHS Improvement and HEE will be advertised as being available for flexible working patterns.                          | NHS England and NHS Improvement | January 2020  |
| 3  | Develop guidance to support employers.   | NHS England and NHS Improvement | September 2020  |
| 7  | Add a key performance indicator on the percentage of roles advertised as flexible at the point of advertising to the oversight and performance frameworks. | NHS England and NHS Improvement |   |
| 8  | Support organisations to continue the implementation and effective use of e-rostering systems.   | NHS England and NHS Improvement |   |
| 9  | Roll out the new working carers passport to support people with caring responsibilities.   | Employers                       | A Carer Passport is already embedded into the organisation. Carer Passports ensure our patients and their carers have a seamless journey, from admission to discharge. It creates an identity for carers which allows carers to be part of care. The carers passport entitles carers to discount in our restaurants, open visiting hours, concessionary parking and an opportunity to network and access support at our weekly Carers Café. |
| 10 | Work with professional bodies to apply the same principles for flexible working in primary care.   | NHS England and NHS Improvement |   |

|    |  |                          |  |
|----|--|--------------------------|--|
| 11 | Continue to increase the flexibility of training for junior doctors. | Health Education England |  |
|----|--|--------------------------|--|

## EQUALITY AND DIVERSITY

|   | Action   | Who       | Timeline (where provided)   |
|---|--|-----------|---|
| 1 | Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets. | Employers | By October 2020<br>We will use the WRES, WDES and GPG reports and data to start a discussion with OD & People leadership team regarding recruitment and promotion. From a BAME perspective we have gone further than reflecting the local community which is about 6 to 7% BAME as we have 17% of BAME staff mainly due to overseas recruitment and therefore mainly within our nursing workforce. We plan to carry out more work with the local authority, police, local groups, college and schools to support BAME staff integrating into the local community. |
| 2 | Discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the health and wellbeing table.                   | Employers | From September 2020<br>The OD & People Leadership team will use the Equality Impact Assessment when looking at Health and Wellbeing issues to assist this process. ED&I is a regular component of induction and introduction of H&WB into induction and appraisal conversations will support this process. By introducing the EIA process across  |

|   |   |                                 |  |
|---|---|---------------------------------|--|
|   |   |                                 | all the areas of the People Plan action plan we will influence EDI being included and the creation of a more inclusive culture.  |
| 3 | Publish progress against the Model Employer goals to ensure that the workforce leadership is representative of the overall BAME workforce.  | Employers                       | A review of our progress against the Model Employer goals is included in the WRES report 2020.   |
| 4 | 51 per cent of organisations to have eliminated the ethnicity gap when entering into a formal disciplinary processes.   | Employers                       | By the end of 2020 Our Data in this area does not show that we have a gap. According to our WRES data we have no members of BAME staff who have entered the formal disciplinary process in the past two years. |
| 5 | Support organisations to achieve the above goal, including establishing robust decision-tree checklists for managers, post-action audits on disciplinary decisions, and pre-formal action checks. | NHS England and NHS Improvement | From September 2020  |
| 6 | Refresh the evidence base for action, to ensure senior leadership represents the diversity of the NHS, spanning all protected characteristics.  | NHS England and NHS Improvement | From September 2020  |

## CULTURE AND LEADERSHIP

|   | Action   | Who  | Timeline (where provided) |
|---|--|--|---------------------------|
| 1 | Work with the National Guardians office to support leaders and managers to foster a listening, speaking up culture.    | NHS England and NHS Improvement            | With immediate effect     |
| 2 | Promote and encourage employers to complete the free online just and learning culture training and accredited learning | NHS England and NHS Improvement and Health | With immediate effect     |

|    |   |   |  |
|----|---|---|--|
|    | packages, and take demonstrable action to model these leadership behaviours.  | Education England   |  |
| 3  | Provide refreshed support for leaders in response to the current operating environment.   | NHS England and NHS Improvement                           | From September 2020  |
| 4  | Work with the Faculty of Medical Leadership and Management to expand the number of placements available for talented clinical leaders each year.  | NHS England and NHS Improvement                           | By March 2021  |
| 5  | Update the talent management process to make sure there is greater prioritisation and consistency of diversity in talent being considered for director, executive senior manager, chair and board roles.              | NHS England and NHS Improvement                           | By December 2020   |
| 6  | Launch an updated and expanded free online training material for all NHS line managers, and a management apprenticeship pathway for those who want to progress.   | NHS England and NHS Improvement                           | By January 2021  |
| 7  | All central NHS leadership programmes to be available in digital format and accessible to all.  | NHS England and NHS Improvement, Health Education England | By April 2021  |
| 8  | Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.  | All NHS organisations                                     | By December 2021<br>All staff networks feed into the ED&I committee which in turn report to the OD&P management board. |
| 9  | Publish resources, guides and tools to help leaders and individuals have productive conversations about race, and to support each other to make tangible progress on equality, diversity and inclusion for all staff. | NHS England and NHS Improvement                           | From October 2020  |
| 10 | Publish competency frameworks for every board-level position in NHS provider and commissioning organisations.   | NHS England and NHS Improvement                           | By March 2021  |
| 11 | Place increasing emphasis on whether organisations have made real and measurable progress on equality, diversity and inclusion, as part of the well-led assessment.   | Care Quality Commission                                   | Throughout 2020/21   |

|    |   |                                 |                       |
|----|---|---------------------------------|-----------------------|
| 12 | Launch a joint training programme for Freedom to Speak Up Guardians and WRES Experts, and recruit more BAME staff to Freedom to Speak Up Guardian roles.                                  | NHS England and NHS Improvement | By March 2021         |
| 13 | Publish a consultation on a set of competency frameworks for board positions in NHS provider and commissioning organisations.   | NHS England and NHS Improvement | During October 2020   |
| 14 | Finalise a response to the Kark review.   | NHS England and NHS Improvement | No timeframe provided |
| 15 | Launch a new NHS leadership observatory highlighting areas of best practice globally, commissioning research, and translating learning into practical advice and support for NHS leaders. | NHS England and NHS Improvement | By March 2021         |

## NEW WAYS OF DELIVERING CARE

|   | Action  | Who                         | Timeline (where provided)   |
|---|---|-----------------------------|---|
| 1 | Use guidance on safely redeploying existing staff and deploying returning staff, developed in response to COVID-19 by NHSEI and key partners, alongside the existing tool to support a structured approach to ongoing workforce transformation. | Employers                   | Check with Alison and Sheriden what this means.   |
| 3 | Use HEE's e-Learning for Healthcare programme and a new online Learning Hub, which was launched to support learning during COVID-19.  | Employers and organisations | This is available for all staff to use and has been publicised regularly during the Covid Comm's. |
| 4 | Work with the medical Royal Colleges and regulators to ensure that competencies gained by medical trainees while working in other roles during COVID-19 can count towards training.   | Health Education England    |   |
| 5 | Develop the educational offer for generalist training and work with local systems to develop the leadership and infrastructure required to deliver it.  | Health Education England    | During 2020/21  |
| 6 | Support the expansion of multidisciplinary teams in primary care.   | Health Education England    | End of 2020/21  |

## GROWING THE WORKFORCE

|   | Action  | Who                      | Timeline (where provided) |
|---|---|--------------------------|---------------------------|
| 1 | Enabling up to 300 peer-support workers to join the mental health workforce and expanding education and training posts for the future workforce.  | Health Education England | 2020/21                   |
| 2 | Increasing the number of training places for clinical psychology and child and adolescent psychotherapy by 25 per cent (with 734 starting training in 2020/21).   | Health Education England |                           |
| 3 | Investing in measures to expand psychiatry, starting with an additional 17 core psychiatry training programmes in 2020/21 in areas where it is hard to recruit, and the development of bespoke return to practice and preceptorship programmes for mental health nursing. | Health Education England |                           |
| 4 | Prioritise the training of 400 clinical endoscopists and 450 reporting radiographers.   | Health Education England | 2021                      |
| 5 | Training grants are being offered for 350 nurses to become cancer nurse specialists and chemotherapy nurses.  | Health Education England | 2021                      |
| 6 | Training 58 biomedical scientists, developing an advanced clinical practice qualification in oncology, and extending cancer support-worker training.  | Health Education England | 2021                      |
| 7 | HEE is funding a further 400 entrants to advanced clinical practice training.   | Health Education England | 2020/21                   |
| 8 | Investing in an extra 250 foundation year 2 posts, to enable the doctors filling them to grow the pipeline into psychiatry, general practice and other priority areas, notably cancer, including clinical radiology, oncology and histopathology.                         | Health Education England | 2020/21                   |
| 9 | Increase of over 5,000 undergraduate places from September 2020 in nursing, midwifery, allied health professions, and dental  | Health Education England | 2020/21                   |

|    |   |                          |   |
|----|---|--------------------------|---|
|    | therapy and hygienist courses.  |                          |   |
| 10 | Employers should fully integrate education and training into their plans to rebuild and restart clinical services, releasing the time of educators and supervisors; supporting expansion of clinical placement capacity during the remainder of 2020/21; and providing an increased focus on support for students and trainees, particularly those deployed during the pandemic response. | Employers                | 2020/21<br>We are considering capacity to support students across the BSW system. During Covid we continued to support students on placements and some of the revised training condensed education programmes developed during Covid, we plan to continue to utilise rather than reverting back to pre-Covid training. Our practice education team work to support the Health & Wellbeing of our students at all times. |
| 11 | For medical trainees, employers should ensure that training in procedure-based competencies is restored as services resume and are redesigned to sustain the pipeline of new consultants in hospital specialties.   | Employers                | 2020/21<br>We deliver this in a number of ways including Simulation, both point of care and within the education centre.  |
| 12 | Ensure people have access to continuing professional development, supportive supervision and protected time for training.   | Employers                | 2020/21<br>Doctors, Apprentices have protected time for training. Our ambition for the Trust is that in addition to continuing professional development being available for everyone that there is support for release to attend training. Supervision is available to some but not all staff at the moment.  |
| 13 | Establish a £10m fund for nurses, midwives and allied health professionals to drive increased placement capacity and the development of technology-enhanced clinical placements.  | Health Education England |   |
| 14 | HEE to further develop its e-learning materials, including simulation, building on the offer provided in response to COVID-19.  | Health Education England | 2020/21   |

|    |   |  |               |
|----|---|--|---------------|
| 15 | Start delivering a pre-registration blended learning nursing degree programme. The programme aims to increase the appeal of a nursing career by widening access and providing a more flexible approach to learning, using current and emerging innovative and immersive technologies. | Health Education England /Universities | From Jan 2021 |
| 16 | HEE to pursue this blended learning model for entry to other professions.   | Health Education England               | From Jan 2021 |

## RECRUITMENT

|   | Action  | Who  | Timeline (where provided) |
|---|---|--|---------------------------|
| 3 | Develop lead-recruiter and system-level models of international recruitment, which will improve support to new starters as well as being more efficient and better value for money.         | Systems  |                           |
| 4 | Primary care networks to recruit additional roles, funded by the additional roles reimbursement scheme, which will fund 26,000 additional staff until 2023/24.                              | Systems  | Immediate                 |
| 5 | Increase ethical international recruitment and build partnerships with new countries, making sure this brings benefit for the person and their country, as well as the NHS.                 | NHS England and NHS Improvement and Health Education England |                           |
| 6 | HEE will pilot English language programmes – including computer-based tests, across different regions as well as offering English language training.  | Health Education England                                     | 2020/21                   |
| 7 | Establish a new international marketing campaign to promote the NHS as an employer of choice for international health workers.  | NHS England and NHS Improvement                              | 2020/21                   |
| 9 | Continue to work with professional regulators to support returners who wish to continue working in the NHS to move off the temporary professional register and onto the permanent register. | NHS England and NHS Improvement and Health Education England | 2020/21                   |

## RETAINING STAFF

|   | Action   | Who                      | Timeline (where provided)   |
|---|--|--------------------------|---|
| 1 | Design roles which make the greatest use of each person's skills and experiences and fit with their needs and preferences.   | Employers                | We plan to ensure that all recruiting managers have attended appropriate interview training.<br>We are piloting a Skills Share Scheme where staff have the opportunity to get involved with projects which utilise the skills that might not currently be used in their regular role. |
| 2 | Ensure that staff who are mid-career have a career conversation with their line manager, HR and occupational health.   | Employers                | This is a conversation that will form part of the revised appraisal process.  |
| 3 | Ensure staff are aware of the increase in the annual allowance pensions tax threshold.   | Employers                | The finance team will be asked to run workshops as part of the revised CPD offer.   |
| 4 | Make sure future potential returners, or those who plan to retire and return this financial year, are aware of the ongoing pension flexibilities.  | Employers                | This will form part of the "benefits" package in future recruitment campaigns   |
| 5 | Explore the development of a return to practice scheme for other doctors in the remainder of 2020/21, creating a route from temporary professional registration back to full registration. | Health Education England | 2020/21   |
| 6 | Develop an online package to train systems in using the HEE star model for workforce transformation.   | Health Education England | 2020/21   |
| 7 | Improve workforce data collection at employer, system and national level.  | Health Education England | 2020/21   |
| 8 | Support the GP workforce through full use of the GP retention initiatives outlined in the GP contract, which will be launched in summer 2020.  | Systems                  |   |

|    |  |         |         |
|----|--|---------|---------|
| 9  | Strengthen the approach to workforce planning to use the skills of our people and teams more effectively and efficiently.  | Systems |         |
| 10 | Work with HEE and NHSEI regional teams to further develop competency-based workforce modelling and planning for the remainder of 2020/21, including assessing any existing skill gap and agreeing system-wide actions to address it. | Systems | 2020/21 |

## RECRUITMENT AND DEPLOYMENT ACROSS SYSTEMS

|   | Action   | Who   | Timeline (where provided) |
|---|--|---|---------------------------|
| 1 | Actively work alongside schools, colleges, universities and local communities to attract a more diverse range of people into health and care careers.                                  | Systems                                     |                           |
| 2 | Make better use of routes into NHS careers (including volunteering, apprenticeships and direct-entry clinical roles) as well as supporting recruitment into non-clinical roles.        | Systems                                     | By March 2021             |
| 3 | Develop workforce sharing agreements locally, to enable rapid deployment of our people across localities.  | Systems                                     |                           |
| 4 | When recruiting temporary staff, prioritise the use of bank staff before more expensive agency and locum options and reducing the use of 'off framework' agency shifts during 2020/21. | Systems, employer and primary care networks | 2020/21                   |
| 5 | Work with employers and systems to improve existing staff banks' performance on fill rates and staff experience.   | NHS England and NHS Improvement             |                           |

|                         |                      |                     |     |
|-------------------------|----------------------|---------------------|-----|
| <b>Report to:</b>       | Trust Board (Public) | <b>Agenda item:</b> | 6.1 |
| <b>Date of Meeting:</b> | 05 November 2020     |                     |     |

|   |  |                   |                  |                 |
|---|--|-------------------|------------------|-----------------|
| <b>Report Title:</b>                    | Register of Seals                                |                   |                  |                 |
| <b>Status:</b>                          | <b>Information</b>                               | <b>Discussion</b> | <b>Assurance</b> | <b>Approval</b> |
|   |  |                   |                  | x               |
| <b>Prepared by:</b>                     | Sasha Grandfield, PA and Board Support Officer   |                   |                  |                 |
| <b>Executive Sponsor (presenting):</b>  | Fiona McNeight, Director of Corporate Governance |                   |                  |                 |
| <b>Appendices (list if applicable):</b> |  |                   |                  |                 |

|  |
|--|
| <b>Recommendation:</b>   |
| The Board is asked to note the entries to the Trust's Register of Seals which, while not formally authorised by resolution of the Trust Board, have been authorised through powers delegated by the Trust Board. |

|  |
|--|
| <b>Executive Summary:</b>  |
| To report entries in the Trust's Register of Seals since the last report to Board in December 2019.  |
| None of the signatories who witnessed the fixing of the seal of Salisbury NHS Foundation Trust had an interest in the transactions they witnessed. |

### Register of Seals entries

| No. | Date signed in Register | Approval Details   | Held on file with: | Signature one:     | Signature Two: |
|-----|-------------------------|--|--------------------|--------------------|----------------|
| 353 | 20/3/20                 | Lease between SFT (landlord) and Inspire (tenant) for part of Block 90 for a term of 1 year                        | Laurence Arnold    | Cara Charles-Barks | Nick Marsden   |
| 354 | 20/3/20                 | Licence to occupy between SFT (landlord) and Wiltshire Health and Care (tenant) for Block 15 for a term of 3 years | Laurence Arnold    | Cara Charles-Barks | Nick Marsden   |

|     |          |  |                 |                    |              |
|-----|----------|--|-----------------|--------------------|--------------|
| 355 | 20/3/20  | Licence to occupy between SFT (landlord) and Wiltshire Health and Care (tenant) for part of Block 59 for a term of 3 years   | Laurence Arnold | Cara Charles-Barks | Nick Marsden |
| 356 | 20/3/20  | Licence to occupy between SFT (landlord) and Wiltshire Health and Care (tenant) for part of Block G1 Level 3 for a term of 3 years   | Laurence Arnold | Cara Charles-Barks | Nick Marsden |
| 357 | 16/6/20  | Licence to sub-underlet and Deed of Variation of Lease and Underlease relating to former kitchens (Block 08) at SDH between SFT and Renal Services Operations Ltd and Renal Services Trading Ltd and Diaverum Facilities Management Ltd and Renal Services Plc | Laurence Arnold | Lisa Thomas        | Nick Marsden |
| 358 | 2/10/20  | Lease between SFT (landlord) and Private Secretarial Services Ltd (tenant) for rooms in Block 26 for a term of 3 years   | Laurence Arnold | Stacey Hunter      | Nick Marsden |
| 359 | 21/10/20 | Licence for alterations or retail shop and cafe at main entrance of SDH between SFT and WHSmith Hospitals Ltd  | Laurence Arnold | Stacey Hunter      | Paul Kemp    |
| 360 | 21/10/20 | Lease of retail shop and café at main entrance of SDH between SFT and WHSmith Hospitals Ltd for a term of 10 years   | Laurence Arnold | Stacey Hunter      | Paul Kemp    |