Bundle Trust Board Public 4 July 2024

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates
May SOX of the month – Sharon Bury, Radnor ICU and Kim Blencowe, Radiology
May Patient Centred SOX – Anne Macrae, Gastroenterology
June SOX of the month – Teodor Strugariu, Housekeeping
June Patient Centred SOX – Andrea Taylor, Clinical Science and Engineering

1.2 10:10 - Patient Story

1.3 Welcome and Apologies
Apologies received from : Jon Burwell

1.4 Declaration of Interests, Fit & Proper / Good Character

1.5 10:25 - Minutes of the previous meeting
Minutes attached from meeting held on 2nd May
For approval
1.5 Draft Public Board mins 2 May 2024

1.6 10:30 - Matters Arising and Action Log
1.6 Public Trust Board Action Log

1.7 10:35 - Chair's Business
Presented by Ian Green
For information

1.8 10:40 - Chief Executive Report
Presented by Lisa Thomas
For information
1.8 CEO report July 2024

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:50 - Integrated Performance Report to include exception reports
Presented by Judy Dyos
For assurance
2.1a IPR Cover Sheet - Trust Board 2024-07 v2
2.1b New IPR July 2024 V3

2.2 11:20 - Charitable Funds Committee 20th June
Verbal update by Ian Green

2.3 11:25 - Trust Management Committee 22nd May and 26th June
Presented by Lisa Thomas
For assurance
2.3 TMC esclation report

2.4 11:30 - People and Culture Committee 27th June
Presented by Eiri Jones
For assurance
2.4 PCC Escalation Report to Trust Board from PCC June 2024 to Board July 2024

2.5 11:35 - Finance and Performance Committee 25th June
Presented by Debbie Beaven
For assurance
2.5 Finance and Performance Escalation Report June 2024

2.6 11:40 - Clinical Governance Committee 25th June
Presented by David Buckle
For assurance
2.6 CGC Escalation Report 25 June 2024

3 QUALITY AND RISK

3.1 11:45 - Quarterly Maternity and Neonatal Quality and Safety Report Q4
Presented by Judy Dyos / Vicki Marston
For assurance

3.1a Front sheet Q and S report Q4 23 24
3.1b Q4 Maternity and Neonatal Quality and Safety Report 2023-24

3.2 11:55 - Perinatal Quality Surveillance Report May (April data)
Presented by Judy Dyos / Vicki Marston
For assurance
3.2a Front sheet Perinatal quality surveillance May (April data)
3.2b Perinatal Quality Surveillance May 2024 Slides (April Data) (Final)

3.3 12:00 - Perinatal Quality Surveillance Report June (May data)
Presented by Judy Dyos / Vicki Marston
For assurance
3.3a Front sheet Perinatal quality surveillance June (May data) (003)
3.3b Perinatal Quality Surveillance JUNE 2024 Slides (May data)

3.4 12:05 - Board Assurance Framework and Corporate Risk Register
Presented by Fiona McNeight
For discussion
3.4a Trust Board BAF report July 2024
3.4b Board Assurance Framework June 2024 V1
3.4c Corporate Risk Register June 2024
3.4d CRR Tracker June 2024

3.4.1 12:15 - BREAK

3.5 12:45 - Risk Appetite Statements - Workforce, Operational and Clinical Risks
Presented by Fiona McNeight
For approval
3.5a Trust Board Risk Appetite Definitions July 2024
3.5b Risk Appetite Definitions June 2024

3.6 12:55 - Q4 Patient Experience Report
Presented by Judy Dyos
For assurance
3.6a Patient Experience - Patient Feedback Report Q4 23-24 v2.0 CGC
3.6b Appendix 1 - Cancer Patient Public Voice Partners update Feb 24
3.6c Appendix 1a - Patient Public Voice for Cancer Services - Patient Story Mar 24
3.6d Appendix 2 - MNVP Feedback June - Aug 23
3.6e Appendix 3 - F2 Core Teaching Presentation January 2024
3.6f Appendix 4 - KPMG Management Action Plan v1.4
3.6g Appendix 6 - Friends and Family Feedback Comments Slides Q4 2024
3.6h Appendix 7 - YVM - Bereavement Survey Annual Report 2023-24 v2

3.7 13:05 - Q4 Learning from Deaths Report
Presented by Peter Collins
For assurance
3.7a Q4 2023-24 Learning from Deaths Report Cover Sheet
3.7b Q4 LFD Report 2023-24v1.1
3.7c Appendix A- Changes to SHMI Methodology

3.8 13:15 - Director of Infection Prevention Control Report
Presented by Judy Dyos
For assurance
3.8a Front sheet DIPC 6 monthly
3.8b Annual DIPC Report 2023-24 (Final draft v.1) (004)

3.9 13:25 - Q4 Incident Reporting and Risk Report
Presented by Judy Dyos
For assurance
3.9a Q4 Incident and risk report front sheet
3.9b Risk Report Q4 Final

3.10 Research Annual Report - deferred to September

Presented by Peter Collins
For assurance

4 STRATEGY AND DEVELOPMENT

4.1 13:35 - Care Quality Commission Update June 2024
Presented by Fiona McNeight
For assurance

- 4.1a Well Led CQC cover Sheet and CQC Update. Jun 24
- 4.1b Well Led Progress Report June 2024
- 4.1c Appendix 1 CQC Single Assessment Framework and new monitoring and regulatory approach. Updated Jan 24
- 4.1d Appendix 1 Well-Led Developmental Review Areas for Improvement June 2024
- 4.1e Appendix 2 6.4 TMC presentation 24.01.2024 CQC self assessment Surgery Core Service

4.2 Improving Together Quarterly Update Report - deferred to September

5 FINANCIAL AND OPERATIONAL PERFORMANCE

5.1 13:40 - Estates Technical Service Update
Presented by Mark Ellis
For assurance

- 5.1 Estates Report July 2024

6 PEOPLE AND CULTURE

6.1 13:50 - Medical Revalidation and Appraisal Annual Report - including Statement of Compliance
Presented by Peter Collins
For assurance

- 6.1a Cover Sheet annual baord report and statement of complience Responsible officer and revalidation 23.24
- 6.1b B1844-framework-of-quality-assurance-for-responsible-officers-and-revalidation-23-24

6.2 14:00 - Health and Safety Quarterly Report - Annual Performance Review
Presented by Melanie Whitfield
For assurance

- 6.2a Public Board H&S report cover sheet
- 6.2b HS Report Q4 - Annual HS Report 2024FY

7 GOVERNANCE

7.1 14:10 - Register of Seals
Presented by Fiona McNeight
For information

- 7.1 Register of Seals

7.2 14:15 - Non Executive Director Responsibilities
Presented by Ian Green
For information

- 7.2 NED Responsibilities

8 CLOSING BUSINESS

8.1 14:20 - Any Other Business

8.2 14:25 - Agreement of Principal Actions and Items for Escalation

8.3 14:30 - Public Questions

8.4 14:40 - Meeting Reflection

8.5 Date next meeting
5th September 2024

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

Salisbury NHS Foundation Trust

Draft
Minutes of the Public Trust Board meeting held at 10:00am on Thursday 2nd May 2024, Boardroom/MS Teams
Salisbury NHS Foundation Trust
Boardroom

Board Members:

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

In Attendance:

Kylie Nye (KN)	Head of Corporate Governance (minutes)
Jayne Sheppard (JS)	Lead Governor (observer)
Jane Podkolinski (JP)	Governor (observer)
Frances Owen (FO)	Governor (observer via Teams)
Lizzie Swift (LS)	Freedom to Speak Up Guardian (for item TB1 2/5/1.2)
Alex Talbott (AT)	Associate Director of Improvement (for item TB1 2/5/7.1)
Vicki Marston (VM)	Director of Midwifery (for maternity items)
Helen Benfield (HB)	Divisional Head of Nursing Medicine (for item TB1 2/5/1.2)
Nimi Haneef (NH)	Sister (for item TB1 2/5/1.2)
Mark Wareham (MW)	Staff Side Representative (observer via Teams)

ACTION

TB1 02/5/1 **OPENING BUSINESS**

TB1 2/5/1.1 **Presentation of SOX (Sharing Outstanding Excellence) Certificates**

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

March SOX of the month – Alex Hurley, Theatre Operational Manager

March Patient Centred SOX – Sara Wilds, Principal Clinical Physiologist, Neurophysiology

April SOX of the month – Jo Chown, Clinical Trials Assistant, Research Department and The ICU Team

April Patient Centred SOX – Louise Morris, Staff Nurse, Laverstock Ward

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

TB1 2/5/1.2 **Staff Story**

MW introduced LS, Freedom to Speak Up Guardian, who had suggested this as a staff story. LS welcomed NH and HB to the meeting, noting that NH had joined the Trust from India, as part of the overseas recruitment campaign and had joined Board to tell her story of her induction and experience into the Trust. HB had also joined as she had supported NH through this process.

NH explained that she had a challenging start to her appointment. It had not been easy to start a new life in this country, with a different language and culture to settle in to. NH found the Trust induction very helpful and started her appointment in 2020 in Elderly Medicine. NH was pleased to work on this ward and found it to be multicultural which she hoped would help her settle into her new job. The initial few days of working there was very pressured and she could feel the stress building and gradually, she began to notice that there were some concerns amongst some staff on the ward.

The staff spoke to each other, and it became apparent that a number of the challenges centred around the team lead who was coordinating their orientation. Unfortunately, there was evidence of discrimination, biased behaviour, and public discrimination. This culminated to a level which required escalation, although many of the team were apprehensive. NH met with LS about support in finding accommodation and ended up discussing her concerns. The group of staff developed a ward sub-group to maintain confidentiality. After the first conversation the team felt relieved and it helped to clarify the issue. From the initial meeting onwards, actions and interventions were taken, with a change to teams and approach to line management changed. There was also an issue regarding pay progression for the overseas nurses which was addressed and back-pay was received according to their contracts.

Confidentiality standards were maintained at a high level and effort was made to communicate action plans and include the right people in the escalation process. NH noted that she was thankful to HB and the team who were engaged in making this change and taking the time to ensure the values of the Trust are kept intact. NH applauded the work of the Freedom to Speak Up team as a significant intervention. NH noted there are a large number of overseas nurses who have benefitted from the improved induction processes. NH closed by thanking the Board for their time and that she is committed to ensuring the Trust is the Best Place to Work.

Discussion:
There was a discussion on NH's experience with HB offering her perspective as she had been responsible for the initial recruitment. HB had met with the team when LS had provided the background to their concerns and it was clear how anxious the team were. HB discussed the action taken to address the behaviours that had led to these concerns. HB reflected how far the teams have come and the improvements that have been made. However, the Board noted that the Staff Survey still identifies pockets of unhappiness at work from Black, Asian and Minority Ethnic (BAME) staff groups.

IG thanked NH for sharing her story and for speaking up and offered his apologies that she had experienced such a difficult start to her employment in the Trust.

JDy also thanked NH, noting that coffee sessions with overseas nurses had been scheduled for the last Thursday of every month. From initial conversations some have had good experiences and others have experienced micro-aggressions. The issue around securing accommodation has been raised as a bigger issue.

MvB reflected on NH's perseverance and noted that when considering the conscious or unconscious behaviours of line managers, is the Trust preparing our managers for these different experiences and ensuring that individuals and teams are observing and championing diversity.

RA further thanked NH for showing so much courage in speaking out to LS and HB, noting the difficulties in speaking out and the risk that staff can face sometimes in doing so.

DBe reflected on NH's bravery and self-awareness and the reaction of her colleague. DBe noted that the Trust should be encouraging staff to raise their concerns to their peers without being confrontational. HB agreed but explained that the reality is often overseas nurses are not used to speaking out as their culture centres on politeness and being respectful.

LT thanked NH, noting that whilst this story positively indicated improvements since NH's induction period, she was still hearing stories like this one. There has been a reflective conversation as an executive team in how we showcase stories in a way people feel comfortable. Using the FTSU service it is right thing to do but what we're not doing is sharing what that means and the potential impact and evidencing how we are taking the learning from stories. It was suggested that perhaps using the podcast or cascade brief to share stories would be appropriate.

The Board thanked LS, HB and NH and they left the meeting.

TB1 2/5/1.3 **Welcome and Apologies**

IG welcomed everyone to the meeting and noted apologies had been received from

- Jon Burwell, Interim Chief Digital Officer
- Fiona McNeight, Director of Integrated Governance

IG noted the purpose of the meeting, asking members and attendees to be present in the room and reminding them to highlight if they needed to step out during the meeting.

TB1 2/5/1.4 **Declarations of Conflicts of Interest**

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

TB1 2/5/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 7th March 2024**

IG presented the public minutes from 7th March 2024 and they were agreed as a correct record of the meeting.

TB1 2/5/1.6 **Matters Arising and Action Log**

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

- **TB1 07/12/3.2 Digital Plan Update -** It was noted that an updated project and planned work update had been included in the update to F&P and included dates. **Item closed.**

- **TB1 11/1/3.1 Quarterly Strategy Update –** LT noted that the strategy update was on the agenda and would cover progress against the actions to deliver the Trust Strategy. **Item closed.**

It was noted that all other matters arising were either closed or to be considered on a future agenda.

TB1 2/5/1.7 **Chair's Business**

IG noted the following key points:

- Three new NEDS were recruited during April. They are currently going through the Fit and Proper Person Test process and they will be announced as soon as that is confirmed. Two of the three NEDs will be 'associates' to account for the composition of the Board, ensuring we're in line with the constitution. IG. KN and FMc have been reviewing the composition of committees.

- This is TB's last meeting. IG noted that there will be further chances to say goodbye but everyone recognises Tania's dedication, compassion, and commitment and on behalf of board he thanked her for her time as NED.

- IG reported that external consultants, Carnell Farrar, were supporting the system in considering the case for collaboration. A number of Board members have been engaged with the process and joined a workshop on Tuesday regarding the potential approach for collaboration. The outcome reports will be published in the next few weeks with emerging potential recommendations and a meeting planned in early June.

The update was noted.

TB1 2/5/1.8 **Chief Executive's Report**

LT presented her CEO report, asking the Board to take it as read but highlighted the following key points:

- A lot of work has been undertaken in the 2024/25 planning process and teams have been working for some weeks to help balance organisational and operational problems and challenges against the national imperative around money.

- The 2024/25 plan is an ambitious one, acknowledging how much we have achieved in terms of the Improving Together methodology approach and the consistency this provides**.**

Discussion:
MvB referenced the statistics included in the report, noting the 277,525 people seen in outpatients and highlighting the staggering number of people the hospital treats on an annual basis. The Board noted that there is a lot to be proud of and it is important not to lose focus on the positives.

EJ congratulated the Trust on the new Helipad, which had been donated from the HELP appeal. The Board noted that the Helipad development had not incurred any cost to the Trust.

It was noted that in the Acute Hospital Alliance (AHA) report, the EPR business case has been signed off.

The report was noted.

TB1 2/5/2 GOVERNANCE

TB1 2/5/2.1 Annual Review of Constitution

KN presented the report noting that the Trust's constitution is reviewed on an annual basis and has to be approved by both the Trust Board and Council of Governors. KN noted the following key points:

- All the proposed amendments are listed on the cover sheet.
- Key areas to note include the various sections that have been updated to reflect the establishment of Joint Committees and Committees in Common. This wording is reflected in GWH and RUH's constitution to ensure consistency.

In reference to appointed governors, the Trust has not been able to recruit 6 Appointed Governors in a number of years. Whilst we consistently have a representative from Wiltshire Council and from the military on the Council, other positions have not been filled for some time. Therefore, the proposal is to remove the three Integrated Care Boards (ICBs) from the list and have three partnership organisations to include the military. The other two partnership organisations are to be decided but will have to be approved by the Board and Council of Governors (to align with the NHS Act 2006 - schedule 7).

Discussion:
The Board discussed the changes and proposed amendments. PC asked if, considering the case for collaboration work, the Constitution required updating and approving now. He queried whether this could wait as further changes may arise in the coming months. IG noted that it would be useful to approve as it is currently, to ensure the wording regarding joint committees and committees in common are included and so this can be ratified at the Council of Governors on 20 May.

NP noted a few references to 'NHS Improvement' and Monitor. (Post meeting note: this has now been updated to NHS England).

Decision
The Board approved the proposed changes, noting that the document would be going to the Council of Governors on 20th May for final approval.

TB1 2/5/2.2 **Annual Review of Declarations of Interest (including Directors)**

KN presented the annual review of the register of interests, which provides the Board with a list of all director and decision-making declarations. The following key points were highlighted:

- There has been a positive increase in the return rate, particularly from consultant staff, which now sits slightly above the 71.5% return rate reported on the cover sheet.
- Whilst this is not yet deemed compliant by counter fraud standards (they propose an 80% return), it does mark an 18.5% increase on the return rate from last year.
- No concerns have been raised as part of this process and ongoing work is underway to deliver on the actions set by our Counter Fraud Team.

Discussion:
ME noted that from this week he would take over as director of Sterile Services from LT. It was noted this would be updated on the register.

The returns were discussed with RH querying the assurance around secondary employment in the consultant body. PC assured the Board that consultants discuss secondary employment and private work as part of revalidation and job planning and suggested that it might be useful to align this to the declaration process.

KN noted that the directive and actions arising from the counter fraud review were focused on how the Trust use this information in a useful way to safeguard the Trust from fraud.

EJ noted that as Senior Independent Director (SID) she had reviewed the returns and it was a positive position in terms of the increased return. Additionally, it was good to note the line manager sign-off when there could be a potential conflict.

KN noted that the report has historically included the Fit and Proper Persons return. Due to the new requirements around FPPT, this will be completed later in the year, with a report submitted to Board to align with the requirement for the chair's submission to NHSE.

Decision:
The register was approved, noting it would be published on the Trust's website.

TB1 2/5/2.3 **Integrated Governance and Accountability Framework (including Board Committee Terms of Reference)**

KN presented the Integrated Governance and Accountability framework (IGAF), noting that Board approval was required. The following key points were noted:

- There have only been minor amendments to the document, following a total re-write last year. The document has been taken through TMC, who were content to support.
- The Board Terms of Reference are appended and also require approval as part of this process.
- Once approved, this document will be published on the Trust's website.

Decision:
The Board approved the IGAF and the Board Committee Terms of Reference.

TB1 2/5/2.4 **Fit and Proper Persons Policy**

KN presented the updated Fit and Proper Person Policy and noted the following key points:

- The policy is coming to the Board for approval and has been supported at TMC.
- The policy has been completely revised to align with the updated guidance published by NHSE last year.
- All of the additional requirements in relation to the Fit and Proper Person test have been previously summarised by the Director of Integrated Governance and are summarised on the cover sheet of the Policy.
- The next step is to work with OD&P to confirm responsibilities when new directors are appointed.

Discussion:
PC queried the process in relation to social media checks and asked for further understanding of how they are conducted in relation to personal information. KN noted that she would confirm outside of the meeting.
ACTION: KN **KN**

(*Post meeting note: KN circulated a procedure for social media checks to the Board on 09/05 – the procedure outlines that the check identifies a candidate's/ current Board member's online presence to help review any negative behaviours).*

Decision:
The Board approved the Fit and Proper Person Policy.

TB1 2/5/3 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 2/5/3.1 **Integrated Performance Report (IPR) (M11)**

ME presented the Integrated Performance Report which provided a summary of March 2024 performance metrics and is used to monitor progress towards the Trust's overall vision. ME noted the purpose of the report and highlighted the following key points:

- In relation to the Breakthrough Objectives, wait to first Outpatient (OP) appointment remained static and at the lowest point since March 2023. Bed occupancy reduction from 101.5% to 98% is supported by

the decrease in patients with No Criteria to Reside (NCTR) to 73 patients as a daily average.

- The Trust continues to reduce patient harm via falls – there has been a slightly increase to 6.6 per 1000 bed days but this is below the improvement target line. Additionally, staff availability has reduced from 4.55 to 3.8% which is slightly above the Trust target. The focus will shift onto staff retention as the new breakthrough objectives are finalised for 2024/25
- In terms of deteriorating performance, cancer remains under national monitoring for or current 62-day backlog position. However, performance against this metric improved for the second consecutive month during March.
- Stroke is a concern as it remains significantly below the target at 30% in relation to the 4-hour standard.

Discussion:
The Board discussed with MvB reflecting on a recent visit to outpatients. MvB noted that two senior staff in OP had barely heard of Improving Together but had raised issues which indicated opportunities for continuous improvement processes to be implemented. MvB pointed out that there was no divisional representation at the safety walk which had been disappointing The Board discussed that a lot of the OP improvement work is required within the specific elements of the service at specialty level. NP explained that teams are re-focusing their efforts in relation to first outpatient appointment, e.g., reviewing how patients are booked, reviewing clinical rooms and what is being used and taking an approach which focuses on specialities. There needs to be organisational ownership of OP.

DBe acknowledge good progress across the metrics, noting that whilst all the evidence had not been provided it was clear a lot of this improvement is via the Improving Together methodology. DBe referenced a discussion at F&P Committee regarding the discharge process. Shed noted that the IPR is focused on performance against target metrics. However, the discussion about discharge highlighted that the focus on the root cause is the most important intervention as this will improve trajectories.

EJ noted that the work in OP requires the correct focus, noting that it would be useful to observe and gain assurance from the corporate ownership of the outpatient's function and leadership approach, which is a support function for all specialties. It was agreed that an update would come to the F&P Committee on the plan and how the culture of OP will be addressed from an A3 thinking approach. **ACTION: NP** **NP**

EJ noted the introduction of A3s in the F&P papers which is really positive and provided a detailed understanding of the issue and countermeasures.

DBe noted that going forward it is clear that productivity is a focus and there needs to be some further thought in how this is demonstrated through the IPR.

JDy referenced in the alerting metrics, the number of complaints closed within the agreed timescale. JDy has followed up with VA and this has largely been due to leave and it has been agreed in Medicine and Women and Newborn that junior doctors will be released to draft their responses. JDy also

noted that the maternity slide in the IPR will be removed as it is included in the BSW slides.

IG referenced cancer, asking what more the Trust needs to do to ensure an improved trajectory continues. NP reported that whilst the Trust sits slightly below target position it has been helpful to understand and work on the threshold to be out of the current tiering position and the Trust is close to this. This position has also meant we're in tiering for diagnostics as well as cancer. LT explained this is in relation to the system position. NP assured the Board that with best practice time pathways and utilising new specialty managers, the Trust will reach delivery of this target.

The Board discussed bed occupancy, NCTR and tracking this to ensure patients are placed in the most appropriate bed. It was noted that F&P Committee have asked for further assurance around early discharge improvements and NP explained that the Urgent Care and Flow Board is focusing on this too.

TB thanked the team for changing the mortality table to SPC in the IPR as whilst statistically not 100% correct, it does make sense and provides a clearer picture.

EJ noted her concerns in removing the maternity grid as it is duplicated. It was suggested that a standard statement in IPR was needed to highlight that the data was included in a separate paper which is required nationally. **NP/ JDy**

ACTION: NP/ JDy

NP noted that the IPR was being refreshed to enable the Trust to have a forward look and discuss actions taken to drive future performance.

The report was noted.

TB1 2/5/3.2 **Charitable Funds Committee – 12th March**

IG presented the report which provided a summary of escalation points from the meeting held on 12th March 2024: IG took the report as read.

The report was noted.

TB1 2/5/3.3 **Audit Committee – 21st March**

RH presented the report which provided a summary of escalation points from the meeting held on 21st March. RH asked the Board to take the report as read, highlighted the following key points:

- There is reference to partial assurance in relation to cancer data quality. Assurance was provided that the new cancer services manager would ensure improvement in the current position.
- The Committee received a deep dive of international nurse recruitment and they were pleased to note the significant improvements. It was noted that the staff story at the start of Board is a testament to the improvements that have been made.

The report was noted.

TB1 2/5/3.4 **Trust Management Committee - 24th April 2024**

LT presented the report which provided a summary of escalation points from the meetings held on 27th March and 24th April. LT asked the Board to take the report as read and noted the following points:

- There is an ongoing challenge re policies. There are still a number outstanding with all departments given actions to update their position.
- In terms of business cases there is now a triple lock situation, meaning investment decisions have to be signed off at ICB level. The committee signed off an invest to save case on Reporting radiographers, which would reduce the level of outsource reporting and offer new opportunities to upskill staff. This would now be taken to the system wide investment group for approval.
- The ICB investment group meets on fortnightly basis and should meet next Friday.

Discussion:
The Board discussed the issue in relation to national standards for healthcare cleanliness. The Trust has fallen below the standard for some time and relates to non-clinical areas. It is recognised that this needs to be better but the issue centres around workforce availability and recruitment challenges. It was noted that it had been some time since the Board received the update from Ian Robinson, Head of Facilities. JDy had requested external review of IPC in theatres and that raised some concerns. It was agreed an update should report to CGC to provide an update on compliance with national cleanliness standards. **ACTION: NP** **NP**

MvB asked about reporting in relation to the Community Diagnostics Centre (CDC). PC explained that the reporting of CDC activity goes through the BSW Elective Care Board. However, there are live conversations around what is needed locally and the ability to flex. The CDC has a management board that oversees this work. NP noted that work is underway to move away from high-cost temporary facilities and reporting to a sustained CDC offering.

The report was noted.

TB1 2/5/3.5 **Clinical Governance Committee – 26th March and 30th April 2024**

DBu presented the report which provided a summary of escalation points from the meetings held on 26th March and 30th April. The following points were noted:

- The Committee discussed and noted the maternity reports which are included in the Board Papers.
- The IPR was reviewed and discussed with a particular focus on complaints. The issue was response to agreed timelines had dropped to 28% and it was agreed the Trust should aspire to a much higher figure.
- The Committee received an in-depth review from gastroenterology. The conclusion is that this is a safe and good service for patients but remains fragile in relation to staffing so 6 monthly reviews will continue.

- The Committee had also received an Audiology report. As part of a review of paediatric audiology in a Trust in Scotland it had been reported that 5 children had missed the opportunity of receiving life-changing implants. Further to this, a table-top review of all Trusts identified SFT as needing a review. The Trust has received a visit and the Audiology Lead presented the outcome at CGC. The team were not expecting any adverse outcomes and the Committee received assurance on the service. The key area of discussion was around the Trust gaining the specific accreditation in audiology.

Discussion:
PC referenced the discussion regarding Audiology accreditation, noting that to move this forward the process of accreditation required Board approval. PC asked if the Board would like any further information or would they be content to support the Trust to seek accreditation based on the escalation from CGC. The anticipated timeframe to become compliant is within a 12-month period. The Board noted that the accreditation is not just in audiology it also relates to physiology, which adds a level of complexity. The Board agreed this is a position that should be pursued. It was agreed that PC would circulate some separate words before sending to CGC for sign-off. **ACTION: PC.** **PC**

IG referenced the Never Event. The Board noted this will report back through CGC.

The report was noted.

TB1 2/5/3.6 **Finance and Performance Committee – 26th March and 30th April**

DBe presented the report which provided a summary of escalation points from the meetings held on 26th March and 30th April. The following key points were noted:

- The Committee discussed cancer performance which has been discussed several times as part of this Board meeting. There is a moderate level of confidence that the Trust will be out of tier two soon.
- In terms of the financial outturn, the position remains complex. However, the Trust is within expectations of the H2 forecast, with a deficit of £4.4m at year-end.
- There have been challenging conversations regarding the level of risk which culminated in an extraordinary Board meeting to discuss and approve an additional £5m stretch on this year's plan.
- The Committee noted the positive CIP savings achieved during 2023/24, reaching £15.3m. Whilst this achievement should be recognised and applauded, there is also recognition that this year's plan will be even more challenging.

The report was noted.

TB1 2/5/3.7 **People and Culture Committee – 28th March and 25th April**

EJ presented the report which provided a summary of escalation points from the meetings held on 28th March and 25th April. The following key points were noted:

- The Committee continues to receive assurance in relation to the Trust's Strategic Workforce Plan and the People Promise.
- The Improving together methodology is being used to support improvement in workforce metrics.
- The Committee heard that the 2024/25 Strategic Workforce Plan addressed the required reduction in whole time equivalents linked to the reduction in beds and reduction in use of temporary staffing. The committee felt the Board should be made aware of the risks involved noting that both clinical Executives were sighted on this. High level detail of the reductions will be shared with the Board by the Chief People Officer.
- The workforce planning submission is to be completed in June and is on track, although the 5-year forward plan remains challenge.
- There has been an improvement on the audit report actions with only one now open and due to be completed by the end of July.

The report was noted.

TB1 2/5/4 FINANCIAL AND OPERATIONAL PERFORMANCE

TB1 2/5/4.1 Estates Technical Service Report

ME presented, noting that John O'Keefe, Head of Estates, had taken on statutory compliance elements for the estates function now that Brian Johnson had left the Trust. ME noted the following key points:

- There are two key factors to highlight, the first is the strong progress made in risk and compliance and the other is around funding for estates.
- In terms of risk and compliance, the Trust started off with 383 risks and the team is now down to 130, with one extreme risk which relates to the information management system CAFM. In terms of the scale of work completed by this team, they have also led on £30m worth of capital programmes, which represents around 50% of capital funded programme. This also demonstrates allocating the correct capital to the most appropriate risks.
- In terms of workforce, for an estates team they are lean. However, there has been a focus to transition away from high-cost contractors.

Discussion:
RH referenced the delays to Imber Ward opening and asked what the operational impact is and how the Trust manages the associated with legal issues. ME explained the challenges in relation to the high voltage supply. Some of the cables are now embedded in concrete and teams are looking into the best way of resolving this issue looking at best way of tackling that. The two options are generated power or a longer process of design works to see how we would do this without generators. That appraisal will be around 6 weeks long, noting that the generator option will affect spinal too. Due diligence is currently underway as this might impact the Trust in securing a long-term contractor.

MW queried the extreme risk in relation to CFAM querying what the implications are. LT explained that whilst an extreme risk in relation to the

estates work, in the current context this was not the highest priority to resolve. A full business case to replace the system is currently under development.

IG suggested that a clear plan is required for Imber Ward to ensure as little impact to patients as possible. The Board discussed estates updates noting that issues like this should be proactively raised outside of the normal report structure. IG noted that further monitoring of capital projects might be useful to understand the learning from situations like this one. ME confirmed that the Trust will be receiving a refund for some of the work carried out.

NP noted that in terms of clinical and operational impact, the deep dive to F&P Committee on rebalancing the hospital using Imber Ward outlined the expected improvements and impact on better use of assessment units and SDEC. The delays in opening will somewhat the expected improvements. The Board discussed assurance of project management and capital expenditure and balancing risk and patient safety.

The report was noted.

TB1 2/5/5 QUALITY AND RISK

TB1 2/5/5.1 Perinatal Quality Surveillance Report March (February data)

VM joined the meeting to present the report which asks the Board to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 5 – Safety Action 9. VM referenced the cover sheet which summarised the key points and highlighted the following:

- Reduction in Midwifery vacancies, although still significant gap in clinical Midwives.
- 1:27 midwife to birth ratio, although this was largely due to an unexpected reduction in births.
- In relation to incidences reported as moderate a twin sadly died. The baby had a known congenital anomaly and palliative care was received. There was a stillbirth at 36 weeks.
- Achieving the mandatory training standards remains a challenge with work ongoing to improve compliance.

Discussion:
IG referred to the CNST compliance with the Board noting that it is achievable, although there are challenges in the department's ability to undertake certain workstreams, including the 'saving babies lives' care bundle due to resource constraints and the delayed implementation of BadgerNet.

VM noted that CNST monies have been confirmed and the Trust is out to advert for an Assurance Midwife, it is hoped interviews will take place in the next 10 days so it could be another few months until they start.

The Board discussed BadgerNet implementation which is looking likely for January 2025. The teams have been pushed for a sooner date and this has been discussed at F&P Committee with the Chief Digital Officer but this is currently looking like the earlies possible date.

The report was noted.

TB1 2/5/5.2 **Perinatal Quality Surveillance Report April (March data)**

VM joined the meeting to present the report which asks the Board to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 5 – Safety Action 9. VM referenced the cover sheet which summarised the key points and highlighted the following:

- There were 5 incidences reported as moderate, including a massive obstetric haemorrhage, 2 3b perineal tears and 2 admissions to the Neonatal unit.

Discussion:
The Board discussed any learning from the review of these incidents. VM noted that thematic reviews of haemorrhages have taken place and whilst rates increased this is associated with increased induction of labour. DBe asked why midwifery teams are inducing more labours. VM explained the complexities, noting that it is related to the national ambition to reduce neonatal deaths. Maternity departments now undertake more scans to look at the size of babies with the hope of improving outcomes.

RA noted that she was pleased to see the actions and themes and what has been learnt and how this has been shared.

The report was noted.

TB1 2/5/5.3 **Midwifery and Neonatal Staffing Report March 2024**

VM presented the report which the Board was asked to note for information and assurance purposes.

VM reported that whilst the Trust was compliant when the report was written, this is now not compliant with the latest Birthrate Plus report which was confirmed after the report was written. Therefore, we are no longer compliant with Safety Action 5 CNST due to these changes and the recommended increase in funded midwifery establishment.

The Board discussed and noted the following standards:

a) systematic, evidence-based process to calculate midwifery staffing establishment is completed.
b) Midwifery staffing budget reflects establishment as calculated in a) above. The Trust is non-compliant due to Birthrate plus 2024 individualised SFT report being published post this report being written.
c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.
d) All women in active labour receive one-to-one midwifery care.

Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.

TB1 2/5/5.4 **NHS Annual Maternity Survey 2023 – deferred from March**

VM presented the report which outlines the outcomes from the survey which reviews the experiences of 25,515 women and pregnant people, across 121 NHS trusts, who gave birth in February 2023 (and January 2023 for smaller trusts).

VM summarised the findings, with the key themes in terms of the more positive responses and areas of improvement noted. A comprehensive action plan has been developed, worked to and monitored to enable continued improvements.

Discussion:
JDy noted that the worst scores were in the post labour ward. VM noted this is reflected nationally. EJ reflected that when walking around the wards it is sad to see all the curtains closed, as whilst people want privacy, they are sometimes missing out on that peer support and it can feel isolating.

The report was noted.

TB1 2/5/5.5 **Birth Rate Plus Reassessment**

VM presented the report which asked the Board to agree the recommendation for an uplift in Midwifery staffing establishment from 104 WE to 107.27 WTE Midwives. This will allow SFT to provide the recommended Midwife to birth ratio of 1:23, which is not achievable currently. In order to maintain compliance with the Maternity Incentive scheme, Trust Boards are required to demonstrate a funded establishment in line with Birthrate plus recommendations, without uplift of establishment SFT will be non-complaint with Safety action 5 and thus overall non-compliant.

Discussion:
The Board discussed with VM noting that the report was the outcome of a 3-month review period of every single patient across a spectrum of acuity. There was a discussion at Workforce Control Panel (WCP) and a level of challenge due to the current financial environment. However, not doing this will ensure the Trust is non-compliant against CNST standards and essentially, this is the number that has been proposed to provide safe and effective care.

ME noted that it is hoped the Trust will receive further funding in relation to Ockenden but at this time it's an unknown. The approval of this request will be subject to the triple lock, with ICB approval required. LT noted that importantly, the increase in WTE in midwives will mean reduction elsewhere.

NP queried the context of the review in relation to birth numbers and complexity. VM noted that the outcomes of the review are drawn from the complexity of cases, with the review focused on 3 months chosen by them. The complexity of cases has increased, particularly with increased induction and hospital stay. This is an independent process benchmarked nationally.

RH queried how their suggestions compared with expectations. VM noted that it was less than expected and she felt this was a sensible suggestion as the department are close to the required number if all posts were filled. She noted it had been challenging to meet community needs too.

VM was asked if the new suggested WTE will be achievable. VM assured the Board that she felt confident as they have interviewed 23 newly qualified midwives and there was a new preceptorship programme.

Decision:
The Board approved the recommended increase in WTE midwives, noting that this will also need to be approved by the ICB.

TB1 2/5/5.6 **Quarterly Risk Report (deferred from March)**

JDy presented the report, which aims to inform the Board of the process and data related to incident reporting and the management of risk registers during Q3. The following key points were noted:

- This refreshed report has already been through CGC, with a stable incident reporting number noted.
- There are several workstreams (e.g., Deteriorating patient and pressure ulcer working group) in the Trust which look at the current top categories of reported incidents.
- The numbers reported are higher than what is actually experienced as a number are duplicates reports. 3% are reporting high harm.
- In terms of Duty of Candour (DoC), the team is striving to make progress. This is reliant on all clinicians understanding their responsibilities and the Patient Safety Incident (PSI) report written quickly. The team have got a back-log of risks but they have undertaken a review and agreed new ways of working which will allow focused work on incident reporting and the risk registers, especially at service level.

Discussion:
EJ referenced slide 5, noting the increase of moderate and severe incidents and asked if this is accurate reporting or an increasing trend. JDy explained that upon receiving reports they are quality checked to see if they are correctly reported and categorised appropriately.

RH asked that in relation to DoC, were the cases that were not resolved now completed. JDy explained the time taken to complete investigations, noting that some of those 20 people will have been written to but some will still be waiting. IG noted that there is clearly some further work needed to improve the current situation.

EJ noted that she was pleased to see an enhanced focus on deteriorating patients.

The report was noted.

TB1 2/5/6 **PEOPLE AND CULTURE**

TB1 2/5/6.1 **Safe Staffing Six Monthly Update**

JDy presented the report which provided the Board with a 6-monthly safe staffing review, with an update on progress of implementation and the recommendations from the full safe staffing review in Sept 2023. JDy noted the following key points:

- The picture has improved in terms of the number of staff which is also reflected in the care hours per patient, per day.
- There are ongoing mitigations in relation to MSK support through the Stars Appeal and a professional efficacy programme to provide emotional support.
- In relation to the formal safer nursing care tool, the Trust has trained 65 staff in how to do the data collection and feedback has been received that this is a positive thing to do.
- There is an ongoing challenged regarding registered Mental Health nurses although the Trust do have some recruited via the bank.

Discussion:
EJ noted that the report had been discussed in detail at CGC. EJ queried the essential requirements outlined last August in terms of safer staffing and if this had been implemented. JDy noted that this had been implemented in terms of temporary workforce and run rate. However, not all posts had been substantively recruited to. This does go through the business planning process and there is a hope to shift to a more substantive position.

The Board discussed peer comparison between the number of Health Care Assistants (HCAs) and Registered Nurses (RNs). JDy explained that our ratio of RNs to HCAs is 60:40 and we do not have an evidence base to suggest a different ratio. GWH and RUH Bath have slightly different ratios. However, this may be due to the larger number of assistant practitioners.

The report was noted.

TB1 2/5/6.2 **Health and Safety Report – deferred from March**

MW presented the report, noting there were no alerting items. MW took the report as read and noted the following key points:

- Work continues to finalise the Trust strategy on reducing and preventing violence. The Design Council toolkit to reduce violence and aggression through improved communication and signposting in ED is close to being agreed and campaign materials are being developed to roll out the No Excuse for Abuse Campaign (after a delay in staff members stepping forward to have their images included in posters being developed).

Discussion:
DBe referenced the incidents of violence and aggression and asked about follow-up and support for those who add to Datix, querying the timescale so trauma doesn't have a lasting impact. MW explained that the Deputy Chief Nursing Officer and the head of Health and Safety co-chair the violence and aggression group and they recommend the appropriate timeframe for each case.

The Board discussed staff member's reluctance to have their picture taken for the campaign. LT noted that from conversations with various members of staff the reluctance comes from fear of what happens outside the Trust if known offenders recognise them from the campaign posters.

PC confirmed the Trust already use bodycams in the Emergency dept (ED).

RH noted the importance of reporting near misses, noting numbers had increased to 30. However, this is not reflected equally across the divisions and medicine have a number and what efforts are there to encourage learning from these near misses. The Board agreed that more could be done to learn from these near misses.

DBe referenced the exposure testing update in the report around Nitrous Oxide N_2O and asked if there is an alternative. PC confirmed there is not an alternative.

The report was noted.

TB1 2/5/7 STRATEGY AND DEVELOPMENT

TB1 2/5/7.1 Improving Together Quarterly Update Report Q4

AT joined the meeting to present the report which is provided to assure the Board of progress against the programme roadmap and the benefits realised from deploying Improving Together across the Trust. It was noted that the report had been through F&P with a discussion around understanding the actual benefits of the previously agreed funding. AT noted he had added to the paper since this discussion.

- The Trust is transitioning from a method of pushing Improving Together into organisation to position where colleagues are now taking a proactive stance in terms of deployment, with teams now approaching transformation and coach house team asking to be involved.
- Challenge is to meet demand and this should be possible within the agreed investment. The next quarter will be focussed on how we coordinate Organisational Development (OD) and leadership teams to support the continued integrated of this work into business as usual. AT and PC are also providing coaching via the Catalysis Academy which supports development of leaders across the organisation.
- Work continues to introduce and support improvement huddles and Performance Meeting Reviews (PMR) both of which are critical to success and sustainability of this programme.
- The Project Delivery System has aligned with the breakthrough objectives and the delivery work of SDEC and Outpatients.
- The key challenge into next year is how the teams maintain strategic alignment. A key area of work is utilising the Corporate Projects Prioritisation Group (CPPG) to build out and resource the programme for improvement in 2024/25.
- AT noted that next steps were summarised in the paper.

Discussion:

DBe noted that the report was really encouraging and it was particularly helpful to now see the benefits included, as requested at F&P Committee. It was noted that capturing the expected benefits in the next 2-5 years ensures the Board can see and measure the value of investment and therefore observe the cumulative benefit.

EJ noted that it is clear from Board Committees and walkarounds Improving Together has embedded in a lot of areas far quicker than expected, particularly when considering the challenging circumstances.

LT recognised PC and AT's efforts in championing this work and thanked them for their work in progressing Improving Together and for their visible leadership. There is a noticeable impact around the Board which culminates in an increased curiosity of Board members and approach to seeking assurance.

TB queried how the Trust will ensure its remaining true to the fundamental processes and values. PC noted that ultimately the Board has to hold itself to account for delivery but there is going to be more alignment of this programme of work within the AHA. Additionally, there will be continued participation in the CEO forum and contact with the European and American forums for those running these programmes. In October, that forum is coming to SFT to understand work that has progressed here. Within the Trust it is about challenging complacency and ensuring the sustainability of huddles. It is important for us not to just recognise the successes and move on it should be about circling back and testing the more and different we need to do to deliver.

MvB noted that he recognised the benefits and the efforts in trying to embed good management and leadership into the organisation. Whilst this is challenging the two should not be separated and that is why there is a close partnership OD&P colleagues and the coach house. The pillars of this approach including improvement coaching, leadership development and the transformation function need to work like a single team to support a collaborative and sustained approach.

In terms of prioritising resource via CPPG, the focus is not about recruiting more people. The group will be considering workplans and mapping against strategic filter through the Strategic Initiatives or Breakthrough Objectives and considering if there are enough people to deliver.

The report was NOTED.

TB1 2/5/7.2 **Review of Trust Strategy Progress Report**

LT presented the report which provides the Board with an update on the actions progressed to deliver the Trust strategy under the three pillars, Population, People and Partnerships. The Strategic Planning Framework (SPF) is used to oversee delivery of the vision metrics.

Overall, the Trust is making positive progress, with a number of the vision metrics and a number of the less developed metrics have action plans to ensure the metrics are meaningful and embedded. Oversight of progress is by the executive team through the engine room with regular updates still planned to come back to Board.

LT noted that the Community Services tender is a key part of the Trust's strategic focus recognising integrated services as the only way to improve healthcare for the population and mitigate further demand.

LT summarised the next steps outlined in the report.

Discussion:
DBe queried if the executive team felt the operating plan articulates where the Trust expects to be at the end of this year in terms of strategic objectives. LT explained that the breakthrough objectives move this forward with an aim to supporting the Trust's strategic objectives. LT suggested that a roadmap is required relating to where we are heading as an organisation and the specific milestones.

DBe further raised a point on p.7 which noted that the ICB s mid-way through a consultation to reduce staffing levels by 30%. LT explained that all ICBs and NHS England had a national directive to reduce staff. The ICB consultations have been ongoing for the last 12 months. LT noted that this has meant some moving functions from NHSE to ICB level. The Board discussed the strategic implications and the coordination role around local authority and community.

EJ queried the patient engagement score which peaked in 2023 and has now lowered. JDy noted the great work that the Patient Advice and Liaison (PALs) team are doing noting that they have launched an app and we are hoping to encourage use of this to obtain that useful feedback from our users.

PC noted that this tied into when Improving Together commenced and when developing the vision metrics, the Trust was not sophisticated enough to understand what should be measured. Patient engagement is one of those vision metrics that we could re-explore to find a suitable score.

The report was noted.

TB1 2/5/8 CLOSING BUSINESS

TB1 2/5/8.1 Any Other Business

JDy reported that GoJo, the supplier of hand gel and soaps have ceased to trade so procurement are working to resolve this situation. The team is working through the process with the Emergency Planning team. IG queried alternative solutions. LT noted this will be a national problem and the NHS supply chain will coordinate.

JDy further noted that there has been some unusual infection activity. Whooping cough is nationally on rise although it can be treated quickly once identified.

TB1 2/5/3/8.2 Agreement of Principle Actions and Meeting Reflection

IG summarised the board's discussion, noting the pertinent topics that had been raised.

TB1 2/5/8.3 Public Questions

JP acknowledged the current challenges and noted her admiration on how the Board is managing these challenges and risk.

TB1 2/5/8.4 **Meeting Reflection**

The Board reflected on the meeting and the following was discussed:

- There had been useful conversations, with helpful suggestions re papers and the issues have been correctly escalated from the Board Committees. Board reports are improving.
- Reference was made to the Maternity reports at Board and CGC and the duplication and repeated conversations. Possible reflection suggested on how this could be better.
- MvB noted the positive assurance he gained from NP and commended his clear understanding of the detail.
- Whilst assurance has been given that similar themes are discussed across Committee and at Board, there was a discussion at F&P Committee around further triangulation of information.
- There was a suggestion around increased exposure to divisional management teams. DBu noted that divisions do report to CGC every month. PC suggested that due to time constraints there was a need to perhaps repurpose walkabouts, focusing on interaction at that level rather than divisional management attending Board meetings.

TB1 2/5/7.4 **Date of Next Public Meeting**

The next Public Trust Board meeting will be held on 4th July 2024, in the Board Room, Salisbury NHS Foundation Trust

TB1 2/53/9 **RESOLUTION**

TB1 2/53/9.1 Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

Master Action Log

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

1	Deadline passed, Update required
2	Progress made, update required at next meeting
3	Completed
4	Deadline in future

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Grandfield	TB1 11/1/5.1 Health and Safety Quarterly Report	04/07/2024	Melanie Whitfield, MW	EJ noted that some areas of the H&S report links to the issues highlighted in the Estates report. It was agreed that MW would review how the information in each report could be triangulated and picked up via People and Culture Committee.	Update from MW - noted and actioned, will be seen in the Health and Safety update report July People Committee and September Board	Y	3
Trust Board Public	Sasha Grandfield	TB1 2/5/2.4 Fit and Proper Persons Policy	04/07/2024	Kylie Nye, KN	PC queried the process in relation to social media checks and asked for further understanding of how they are conducted in relation to personal information. KN noted that she would confirm outside of the meeting.	KN circulated a procedure for social media checks to the Board on 09/05 – the procedure outlines that the check identifies a candidate's/ current Board member's online presence to help review any negative behaviours	Y	3
Trust Board Public	Sasha Grandfield	TB1 2/5/3.1 Integrated Performance Report (IPR) (M11)/ Outpatients	TBC	Niall Prosser, NP	It was agreed that an update would come to the F&P Committee on the plan and how the culture of OP will be addressed from an A3 thinking approach.	update from NP - undertake an Outpatient deep dive later in the year and will present A3 to the committee at that stage.	N	2
Trust Board Public	Sasha Grandfield	TB1 2/5/3.1 Integrated Performance Report (IPR) (M11) / Maternity	04/07/2024	Niall Prosser, NP Just Dyos, JDY	Concerns noted in removing the maternity grid from IPR as it is duplicated elsewhere. It was suggested that a standard statement in IPR was needed to highlight that the data was included in a separate paper which is required nationally.	Update from NP - IPR has been through F&P and CGC and the new format has been approved noting the comment from the previous action.	Y	3
Trust Board Public	Sasha Grandfield	TB1 2/5/3.4 Trust Management Committee - 24th April 2024/ National Cleanliness standards	TBC	Niall Prosser, NP	It was agreed a paper should come to CGC to provide an update on compliance with national cleanliness standards.	On 25th June CGC agenda	Y	3
Trust Board Public	Sasha Grandfield	TB1 2/5/3.5 Clinical Governance Committee – 26th March and 30th April 2024/ Audiology Accreditation	TBC	Peter Collins, PC	The Board agreed seeking audiolgy accreditation should be pursued. It was agreed that PC would circulate some separate words before sending to CGC for sign-off.	Update from PC - The Trust does not currently hold IQUIPS accreditation. Following the visit from NHS England the Audiology department have conducted an initial gap analysis against the standards and will work towards accreditation as well as implementing any other formal recommendations following the visit. The expected timeline for accreditation is 12-18 months. Progress will be monitored via updates to Clinical Governance Committee. CMO will report Trust Board postion to CQC and ensure an appropriate risk is recorded (as per all Trust CQC request dated 8th April 2024).	Y	3

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	1.8
Date of meeting:	4th July 2024		

Report title:	Chief Executive Report			
Status:	Information	Discussion	Assurance	Approval
	x			
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Lisa Thomas interim Chief Executive			
Executive Sponsor: (presenting)	Lisa Thomas interim Chief Executive			
Appendices	N/A			

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

Executive Summary:
The purpose of the Chief Executive's report is to highlight developments that are of strategic and significant relevance to the Trust and which the Board of Directors needs to be aware of.

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

1. Population

The Trust has been busy, overall, we have seen a significant increase in non-elective admissions which is putting pressure on bed capacity in the Trust. We continue to work with our system partners to improve patient flow in and out of the hospital and ultimately improve patient experience. More information is covered in the Integrated Performance Report.

Performance across the key standards is improving slowly, there are noticeable improvements in cancer care (although we still remain under national monitoring within the BSW system), diagnostic standards and some of our planned care targets in waiting time to first outpatient appointment. Referral to treatment waiting list reduced this month which aligns with our ambition to reduce waiting times for our patients.

The Trust held its second open day in June which was a fantastic success. I want to thank formally all the teams who opened up their departments, engaged with hundreds of visitors through competitions and games to showcase the hospital so positively. This also gave the public the chance to look around the new Imber ward which opened to patients on the 18th June, which is a fantastic new ward offering a modern new environment for patients.

We have begun the programme for a replacement Electronic Patient Record (EPR), The Shared EPR will create a single care record for patients replacing several of our current clinical systems. Implementing a new EPR is a major change programme and will enable us all to look into doing things differently. As part of this, we'll be removing the reliance on paper, moving towards a full electronic patient record. This will enable our clinical and frontline staff to have instant information at their fingertips, supporting clinical decisions safely and efficiently at the point of care.

2. Our People

It has been an incredibly busy few months celebrating people, we have had pride month, armed forces week, international nurses' day, volunteer's week and more. People are at the heart of the Trust and the different events and celebrations are a way to recognise individuals' contribution to the success of the Trust.

This year we held our second year of tent talks, two days of learning, wellbeing and fun, the event being an important part of our commitment to being an organisation that is always learning. I'd also like to congratulate the team behind the first ever Bhangra Night – an evening full of colour joy and energy – and some outstanding cooking. It was the most culturally diverse event we have had on The Green yet.

Our annual staff awards are now open for nomination, staff and patients are invited to submit nominations across 15 categories. 2024 is a year when we not only get to celebrate our staff but also celebrate the fact that as an NHS organisation, we want to improve equality, diversity, and inclusion here at SFT, to enhance the sense of belonging for our staff to improve their experience. The awards ceremony is on the 5th of September and its held alongside a number of other thank you events. We get the opportunity to thank and celebrate our

long service awards for staff, volunteers thank you lunch and family and friends' fun day. It is one of the highlights of the year and a real chance to celebrate our staff.

Dr Peter Collins our Chief Medical Officer will be leaving the organisation in October. Peter has been a pivotal leader since he joined in October 2020. His enthusiasm, commitment and passion will leave a significant legacy for SFT particularly as leader for our improving together programme. Peter is moving to a new role with the Devon Integrated Care Board (ICB), where he will focus on his passion for population health. This new position will enable him to further his work in reducing health inequalities and improving population health outcomes in Devon. Duncan Murray has kindly agreed to be Interim Chief Medical Officer and the recruitment process will start shortly for a new chief Medical Director.

3 Our Partnerships

The financial challenges in the BSW integrated Care system are significant and we play a significant role in helping to develop and deliver sustainable improvement plans. SFT continues to work with partners closely on developing better services which deliver sustainable value. The development of a medium-term financial plan will be imperative to sustainability of services in BSW and at SFT.

The Trust is working with military colleagues on a project to improve the interface between military primary care services and the Trust. This aims to address the unique way serving military personnel access healthcare and how this can be improved to ensure timely treatment in line with the armed forces covenant.

The Spinal unit was 40 in June, the Duke of Cornwall spinal Treatment Centre was officially opened in 1984. There were many celebrations across the unit looking back how patient care has evolved. The spinal team also hosted the 41st Guttmann Conference for Spinal Cord Injury. The conference bought many professionals together who work in spinal cord injury to share and learn best practice in spinal care and rehabilitation. This was a chance to host a national event with our partners from across the country and really facilitate shared learning.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.1
Date of meeting:	4th July 2024		

Report title:	Integrated Performance Report			
Status:	Information	Discussion	Assurance	Approval
			Yes	
Approval Process: (where has this paper been reviewed and approved):	Niall Prosser, Chief Operating Officer			
Prepared by:	Adam Parsons, Operational Performance Lead			
Executive Sponsor: (presenting)	Judy Dyos, Chief Nurse			
Appendices				

Recommendation:
The Trust Board are asked to note the Trust's operational performance for Month 2 (May 2024).

Executive Summary:

Breakthrough Objectives

- *Wait Time to 1st Appointment* reduced slightly down to 137 days from 140, which is an improved position from the same time last year.
- *Managing Patient Deterioration* continued improvement and steady upward trend to 31.5% from 29.1% against the target of 50%.
- *Staff Turnover* of Additional Clinical Services continued to improve, reducing to 19.1% from 20.4% against the target of 15%.
- *Productivity* remained static at -16% against the 2019/20 equivalent period, sustaining an improving trend against the target of -8%.

Deteriorating Performance

- Cancer performance remains under national monitoring with the Trust in Tier 2 Cancer oversight for the *28-day Faster Diagnosis Standard (FDS)* and *62-day Referral to Treatment Standards*. Cancer performance generally improved although is behind trajectory as detailed:
  - *28-day Faster Diagnosis Standard (FDS)* from 65% to 69.5% (just below trajectory)
  - *62-day Standard* from 72% to 69.7% (above trajectory)
  - The number of patients waiting *longer than 62 days* for cancer treatment reduced from 91 to 76.

  The criteria to exit national tiering is to achieve >70% performance against the *28-Day FDS Standard* and >60% performance against the *62-day Standard* for all of Q1 2024/25 and is now a collective BSW target. *Note: Cancer data is one month behind, reporting April in this IPR.*

Alerting Metrics

- The Emergency Department (ED) is positively alerting for improved position despite growing attendances up to 7,366 in month from 6,722 in April and close to the March record high of 7,411:
  - *Ambulance Handovers >60 minutes* down to 57 from 79
  - *12-hour breaches (arrival to departure)* down to 26 from 33
- *Bed Occupancy* decreased to 96% from 101% supporting improved flow and contributing to ED performance.
- *Pressure Ulcers* that were Hospital acquired *Category 3* increased sharply in month from 3 to 7 as did the *Category 2* from 1.39 to 2.59.
- The total number of *Complaints Received* increased significantly from 15 to 30 although *Complaints Closed* increased from 47% to 50%.
- *RTT Incomplete Pathways* for 52ww and 65ww patients both reduced in month to 1,069 from 1,139 and 129 from 130 respectively.

Please note that to remove duplication in reporting, performance data relating to maternity services has been removed from this report and is contained within the dedicated Maternity reports that are a standing agenda item at Trust Board

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

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

July 2024

(May 2024 data)

Our Strategy 2022-26
IMPROVING together

Summary

Salisbury NHS Foundation Trust

Trust performance in May demonstrates progress from recent months. The number of patients with *No Criteria to Reside (NCTR)* and overall *Bed Occupancy* both reduced to 67 and 96% daily average respectively, supporting improved flow. The Emergency Department (ED) continue to see growth in the number of attendances, rising to 7,366 in month from 6,722 in April and only just below the record high in of 7,411 in March. Year to date attendances are 5% up on trajectory, and 11% up on the same period last year. Additionally, non-elective activity is high, at 9% above trajectory.

Despite attendance numbers, ED performance improved, with the *4-hour Standard* rising to 75% and remain above trajectory for the year to date. *Ambulance Handover* time also improved reducing back into the mean time of 21 minutes, as did the number of Handovers waiting *more than 60 minutes* as this reduced to 57. Also, the number of patients waiting in ED *more than 12 hours* decreased to lowest level in three months at 26, demonstrating the ease in flow challenges.

Cancer performance remains under national monitoring with BSW system, including the Trust in Tier 2 Cancer oversight for the *28-day Faster Diagnosis Standard (FDS)* and *62-day Referral to Treatment Standards*. Cancer performance generally improved, as the *28-day FDS* increased significantly from 65% to 69.5% and is only just below local plan of 71%. The *62-day Standard* despite a marginal decrease from 72% to 69.7% is above the trajectory of 62%. The number of patients waiting over 62 days for cancer treatment improved again for the fourth consecutive month, reducing from 91 to 76 patients. *Note: Cancer data is one month behind, reporting April in this IPR.*

Diagnostics *6-week Standard (DM01)* saw an expected improvement in performance, increasing to 84.9% and is almost on track with trajectory of 86%. This sustains a much-improved position for an entire year and is almost identical to the May 2023 performance at 85%. Also improved was the Stroke care measure of *Arrival on Stroke Unit within 4 hours* as this increased again for the second month to 63% and is now the highest position on record.

Waiting list related metrics both improved, with the breakthrough objective of *Wait Time to 1st Appointment* decreasing slightly to 137 days and the overall *Referral to Treatment (RTT) waiting list* reducing to 27,423 patients and far below the local plan of 30,503. These align with progress being made against national targets to reduce overall long waits in both the 65 weeks and 52 weeks categories.

Quality related breakthrough objective of *Managing Patient Deterioration* continued its steady upward trend by rising again to 31.5% of observations completed on time. Wider metrics were contrasting, with the number of *Pressure Ulcers* increasing sharply to 2.6 per 1,000 bed days whereas the number of *Complaints Closed within agreed Timescale* improved to 50%. *Incidents* remained static at 2.9% however the *Patients Who Moved Bed more than once* increased despite ease in flow to 2.8%.

Workforce breakthrough objective relating to retention measured by *Staff Turnover* continued its progress as this decreased again to 19.1%. Further metrics of *Staff Absence* and *Vacancies* both held static improved positions at 3.4% and 3.3% respectively and are both commendably close to and below their targets.

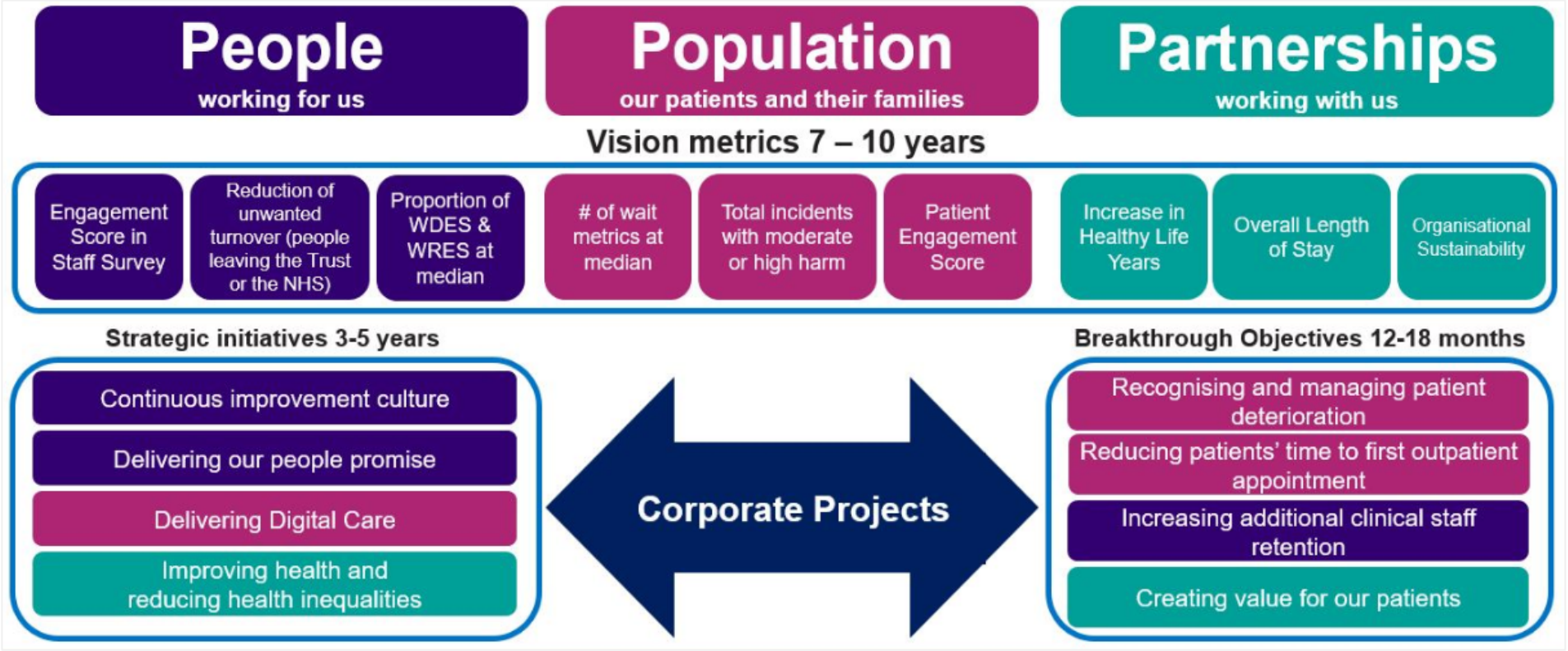
Finance breakthrough objective of *Productivity* remained static at -16% against the 2019/20 equivalent period, sustaining an improving trend. The Trust recorded an in-month control total deficit of £2.9m against an original deficit target of £1.6m - an adverse variance of £1.2m.

Please note that to remove duplication in reporting, performance data relating to maternity services has been removed from this report and is contained within the dedicated Maternity reports that are a standing agenda item at Trust Board

Strategic Priorities

NHS Salisbury NHS Foundation Trust

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



What is an Integrated Performance Report (IPR)

NHS Salisbury NHS Foundation Trust

Our IPR is a summary view of how our Trust is performing against various strategic and operational objectives. It is divided into three sections: Quality of Care, Access and Outcomes, People and Finance and Use of Resources which contain the following within them:

Key Term	Definition
Breakthrough Objective	Trust wide area of focus for the next 12-18 months. We are striving for an improvement of more than 30% in the metrics over this period.
Key Performance Indicator (KPI)	Key metric that is monitored as part of the NHS National Operating Framework and relates to improving patient care and increasing positive outcomes.
Alerting Watch Metric	A metric that has triggered one or more business rules and should be monitored more closely to address worsening performance or celebrate achievement if improving.
Non-Alerting Watch Metric	A metric that we are monitoring but is not a current cause for concern as it is within expected range.

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

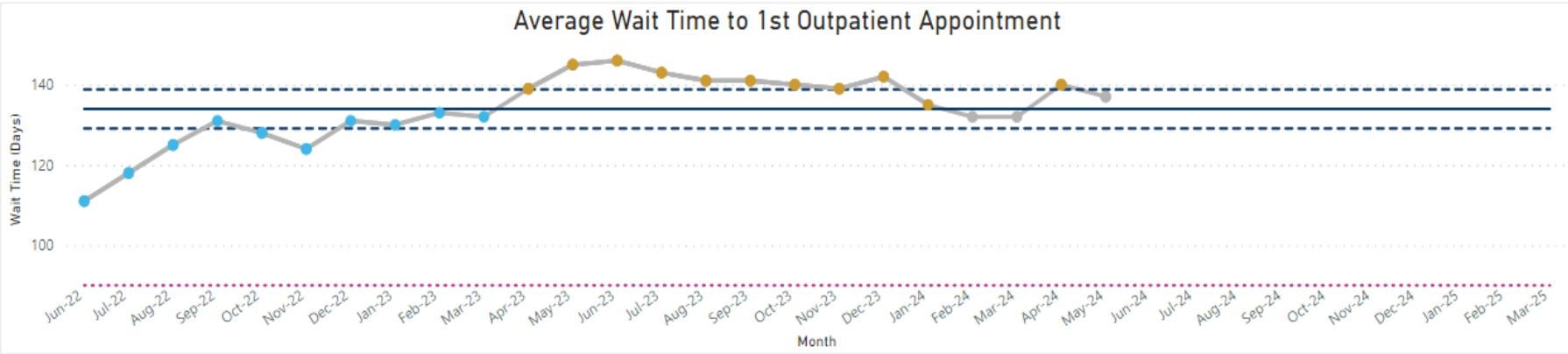
Reducing patients' time to first outpatient appointment

NHS Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because…	SFT has a growing waiting list with increased numbers of patients waiting longer for their care and has not met the 92% RTT 18wk elective treatment target since October 21. A small cohort of specialties account for the majority of the Trust's backlog of patients awaiting a 1st Outpatient appointment. An extended wait for a 1st Appointment places achievement of the 18-week RTT target at risk. It is a poor patient experience to wait longer than necessary for treatment and failure against these key performance standards is a clinical, reputational, financial and regulatory risk for the Trust.

Target: 90 days Performance: 137 days Position: Common Cause



Understanding the Performance

Average wait to first outpatient reduced slightly in month 2 to 137 days. The Women & Newborn Division achieved a reduction of 6 days, Medicine 3 days and both Surgery and CSFS reduced by 1 day.

The specialties with the longest waits are Chemical Pathology (268 days), Oral Surgery (188), Dermatology (171), Orthodontics (171 and Urology (168).
Specialties with the highest number of pathways are ENT, Gynaecology and Trauma & Orthopaedics.

Outpatient activity for first attendances remains under plan with follow ups over plan.

Countermeasure Actions	Due Date
• Each division and speciality has time to first outpatient as a breakthrough objective for 24/25.	March 25
• Trust also relaunched Trust wide improvement programme. To be led by Clinical Director	Oct 24
• Agree Operational lead for outpatient transformation programme (clinical lead agreed in M2).	June 24
• Quantify project support required and request via Corporate Projects Prioritisation Group (CPPG).	June 24
• Investigate significant increase in Chemical Pathology waits from September 23	Oct 25

Risks and Mitigations

Further periods of Industrial Action are scheduled to commence in M3 with the impact of reduced outpatient activity as inpatient and urgent services are prioritised with reduced staffing.

Improvement work requires a focus on administrative processes, workforce challenges and high vacancy levels may mean that work progresses slowly. Project support resource to be requested and escalation of central booking staffing levels.

Activity levels are required to increase to levels set in the plan in order to provide additional capacity – staffing levels affect ability to be responsive and book effectively.

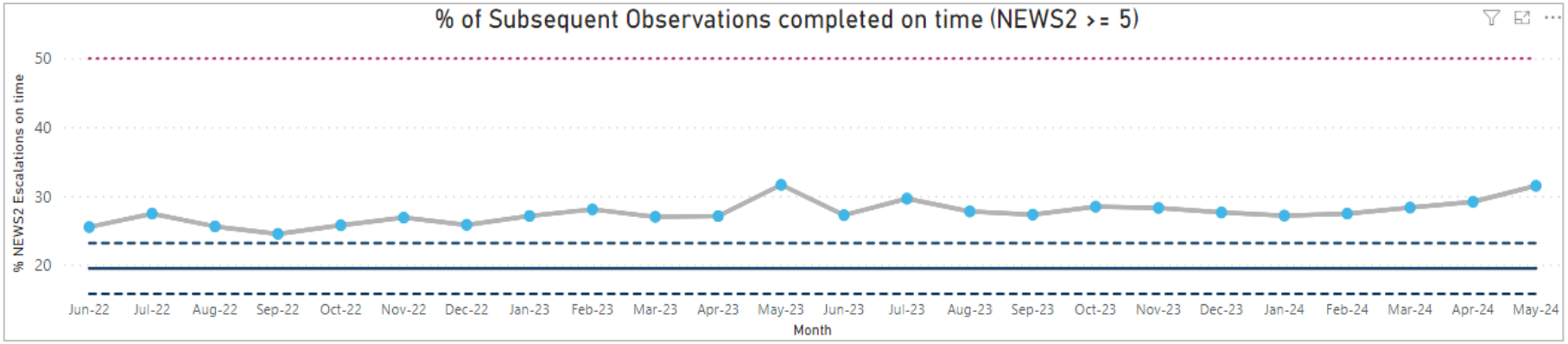
Recognising and managing patient deterioration

Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because…	Improving the early recognition of patient deterioration is a multidisciplinary team activity and comprises of three recognised steps – Record, Recognise and Respond. The first step is regular measurement and recording of clinical observations and in line with recommendations from the *Royal College of Physicians* and *Academy of Medical Royal Colleges*, frequency of these physiological measures is determined by the NEWS2 score. Monitoring trends in both the patient's physiology and NEWS2 score will provide information to the clinical teams to triage workload and to identify potential patients at risk of deterioration. Our aim is to improve upon the current compliance for the recording of these measures with reductions in both mortality, morbidity and late escalations of care.

Target: 50% Performance: 31.5% Position: Special Cause Improvement



Understanding the Performance

RECORD: Timely escalation of deterioration is one of Trust's breakthrough objectives. There is a very slow incremental improvement, 28% to 32% as a result of the work being completed through the divisional teams. The Escalation Working Group discussed the current measure as this is only showing NEWS2 scores of 5 and above, not all observations, which may be impacting on the speed of change.
RECOGNISE: Unplanned admissions to ITU is the agreed measure and is showing a decrease. Further analysis with the critical care team is required and will be included next month.
RESPOND: Manual audit required.

Countermeasure Actions	Due Date
• Re-evaluation of the current improvement measure for RECORD.	19/06/2024
• Pilot undertaking a point prevalence study of frequency and compare results.	24/06/2024
• Analyse admissions data for critical care and cross reference with severity scores on admission.	12/07/2024
• "Go and see" initiative.	Ongoing

Risks and Mitigations

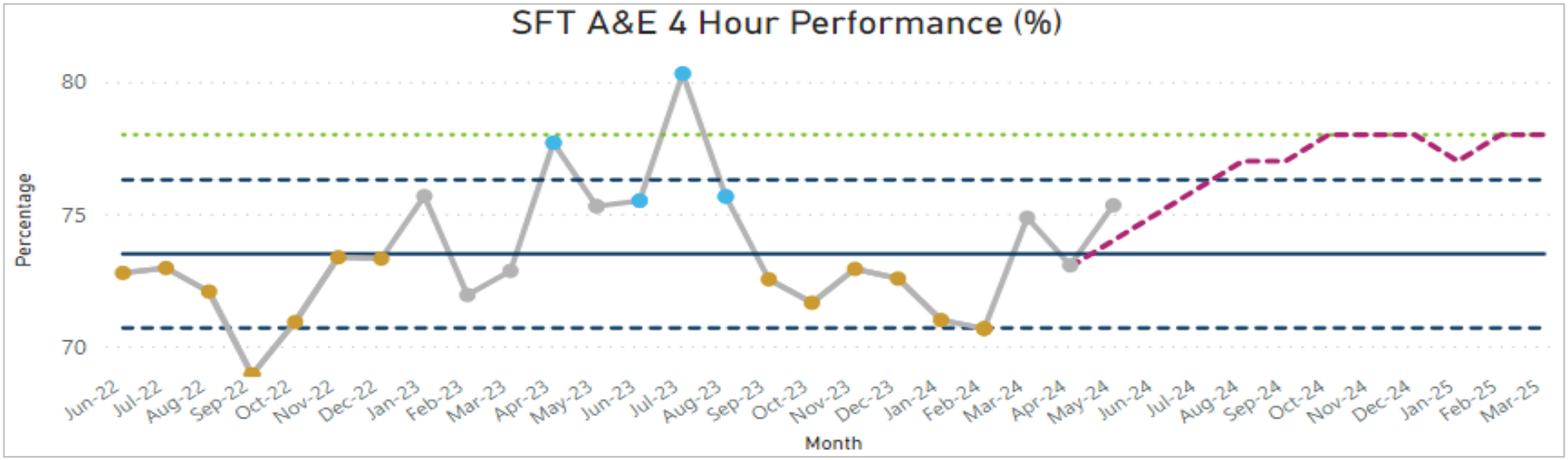
Risk: There is still a risk of unrecognised deterioration which may lead to patient harm.

Mitigation: Whilst we continue to work on understanding all the contributory factors as identified in the focus groups, the following immediate actions have been put in place:

- Training workshops.
- Posters to all ward areas regarding escalation criteria.
- A6 cards for individual staff.

Emergency Access 4-hour standard

Target: 78% Performance: 75.3% Position: Common Cause

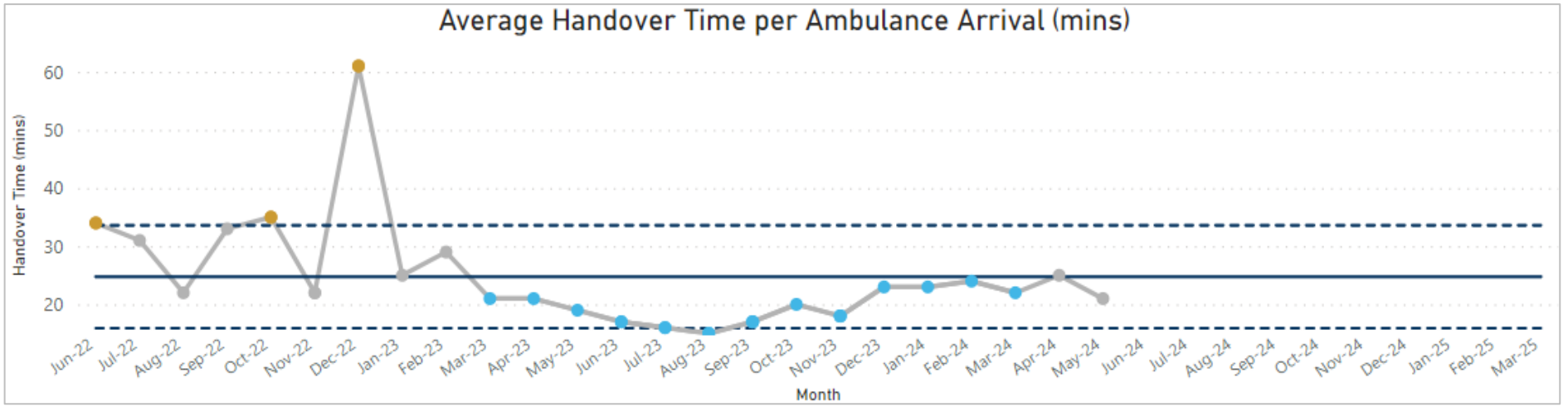


Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
SFT 4-hour performance saw an increase in M2 to 75.3% which is ahead of the trajectory but still within common cause. The Trust saw attendances increase 8.7% in month to 7,366 which is the second highest attendances on record. Of these 4,882 were type 1 through the Emergency Department (ED) which amounts to an average of 157 patients per day. The medical staffing establishment within ED is designed to accommodate an average of 120 per day.	• Full Demand and Capacity review being undertaken. • Continue to reinforce the ring fencing of 4 spaces on Short Stay Emergency Unit (SSEU) to allow for a CDU (Clinical decisions unit) for patients awaiting test results / periods of observation. • 2 x Trainee Advance Clinical Practitioners (ACPs) out to internal advert. • Establish and agree Trust wide Interprofessional Standards • Implement front door streaming model	31/07/2024 Ongoing 14/06/2024 31/07/2024 30/06/2024	• Flow out of the Emergency Department continues to impact both 4-hour and 12-hour performance targets with high bed occupancy levels limiting capacity to see and treat patients. • Using SSEU as a CDU has seen a positive impact on the 4-hour performance target, however this is only successful if there is the capacity to keep these areas as true short stay areas i.e., awaiting transport, awaiting results etc. • Lack of resources to realise improvements. • Operational pressures vs working group engagement.

Ambulance Handover Delays

NHS Salisbury NHS Foundation Trust

Target: 15 minutes Performance: 21 minutes Position: Common Cause

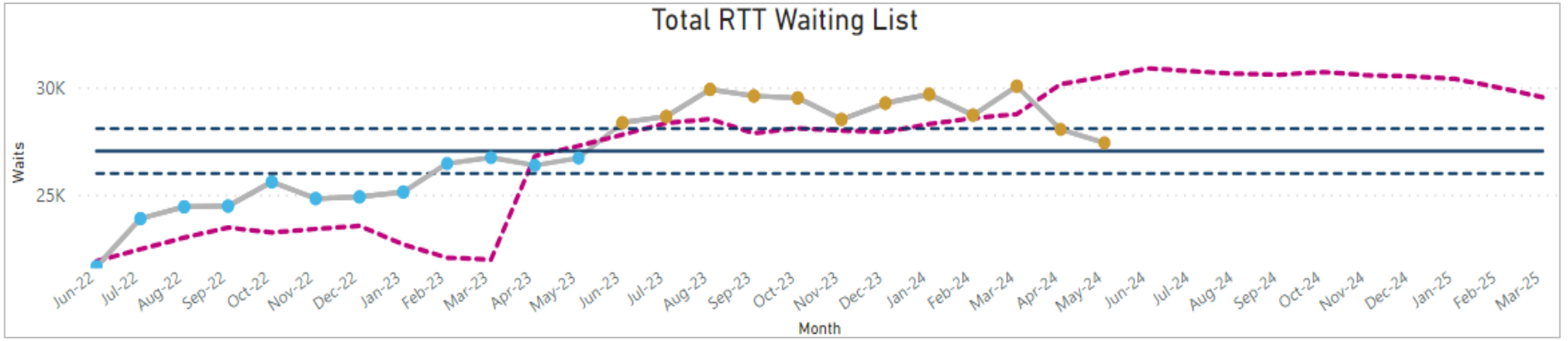


Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Average Ambulance handover performance decreased in M2 to 21mins however the performance has now entered a period of standard variation below the mean. Attendances by ambulance increased slightly to 1,269 which is an average of 40.9 per day vs 40.5 per day in M1. SFT is the top performing Trust in the Southwest and in the top quartile nationally for ambulance handover performance with the average for the Southwest at 57.3mins and for BSW 68.4mins.	• Monthly meetings with the Southwestern Ambulance Services (SWAST) team are continuing improving collaborative working between teams. • Produce Rapid Assessment Treatment and Triage (RATT) paper to support investment to deliver Medical led RATT 12 hours per day. There are limited days where there is a senior decision maker in the RATT area and on those days, it is nurse led. • Review ambulance handover performance based on handover location to understand if areas outside of ED impact performance (AMU, AFU, SAU, Cath Lab etc)	Ongoing 19/07/2024 31/07/2024	• Bottleneck in Rapid Assessment Ambulatory (RAMBO) when multiple attendances arrive consecutively. Mitigated by ensuring ambulances offloaded to any available space when RAMBO full. • Peak handover times are at 15:00 – 17:00 and 21:00 – 23:00 which is linked to times of general poor flow out of the department. • XCAD software data does not always match internal hospital data. Informatics working with SWAST to ensure data matches.

Total Elective Waiting List (Referral to Treatment)

NHS Salisbury NHS Foundation Trust

Target: 30,503 Performance: 27,423 Position: Special Cause Concern



Balancing metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Longest waiting patient	76	75	76	77	243	200	194	153	139	110	94	72	68	73

Understanding the Performance

May saw the Referral to Treatment (RTT) waiting list decrease again to 27,423. This continues to be driven by the weekly Access Meeting where focus is applied to long waits and all elements of waiting list management.

Top 5 specialties with reductions in month were:
1) Gynaecology (-381)
2) ENT (-242)
3) Gastroenterology (-196)
4) Colorectal (-134)
5) Urology (-129)

And Top 3 specialties with growth:
1) Ophthalmology (+181)
2) Rheumatology (+168)
3) Trauma and Orthopaedics (+160)

Countermeasure Actions	Due Date
• Continue weekly Access Meeting to focus on reducing long waits of patients in line with national targets: Zero waiting >65 weeks by the end of September 2024 and Zero waiting >78 weeks as standard.	Ongoing
• Preparation for new ward (Imber) opening in June will support increase of surgical activity and in turn reduce waiting list.	30/06/2024
• Work with Trust CCS software provider to develop reports that better guide waiting list management (e.g. Access Plan visibility).	30/06/2024
• Continue validation programme of reviewing all patients waiting >12 weeks using DrDoctor software.	30/09/2024

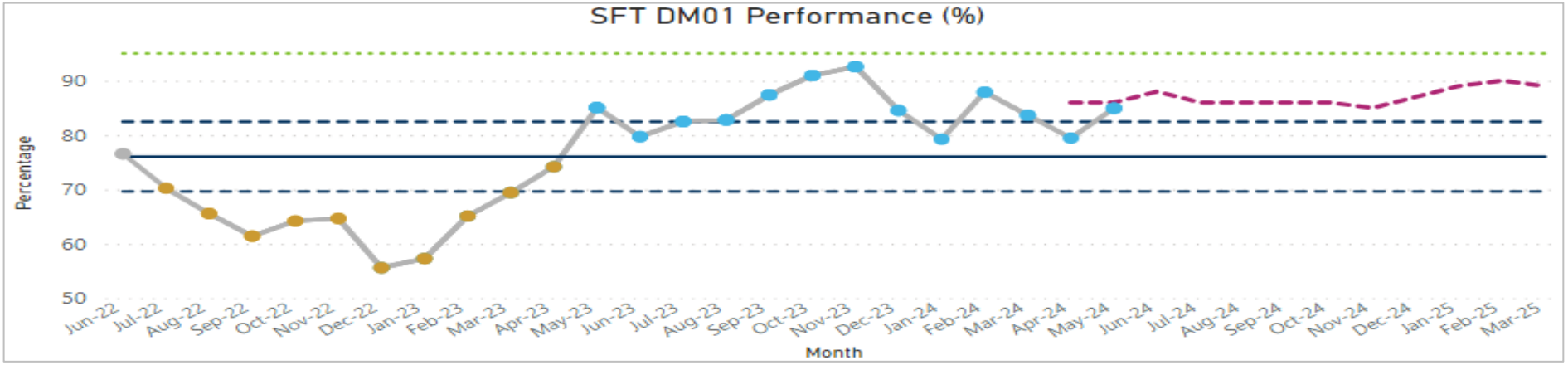
Risks and Mitigations

• The risk of lost capacity owing to any future IA remains.
• Weekly Access Meeting now in place to reduce risk of long waiters and continue drive towards national reduction targets.
• Outpatients programme of work not established and a risk to productivity maximisation.

Diagnostic Waiting Times

NHS Salisbury NHS Foundation Trust

Target: 95% Performance: 84.94% Position: Special Cause Improvement



Please note: Urodynamics and Cystoscopy reporting commenced in April 2024

	%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks
MRI	81.7%	141	Dexa	100.0%	0	Colonoscopy	71.8%	75	Urodynamics	67.2%	20
CT	95.8%	33	Neurophysiology	97.9%	5	Gastroscopy	91.0%	13	Cystoscopy	96.7%	1
Ultrasound	88.7%	214	Echo	63.7%	220	Flexi Sigmoid	69.7%	23	Audiology	81.1%	123

Understanding the Performance

DM01 performance improved in M2, increasing to 84.94% vs. 79.45% in M1. This was primarily due to a significant reduction in the number of breaches in Ultrasound (USS) and MRI with both positions recovering sooner than initially planned. Due to implementation of an enhanced overtime rate within Ultrasound, SFT Sonographers have increased capacity and reduced reliance on outsourcer provision. Breach numbers for M2 as follows:

- Total: 868 vs 1,312 in M1
- MRI: reduced from 267 to 141
- CT: reduced from 38 to 33
- USS: reduced from 534 to 214
- Audiology: increased from 110 to 123
- Cardiology Echo: reduced from 224 to 220
- Endoscopy: increased from 109 to 112

Countermeasure Actions	Due Date
• Increase USS core capacity with use of enhanced overtime rate and continue with recruitment plans	Monthly
• Mitigate CT breaches due to CT replacement project with capacity on mobile scanners as much as possible	August 2024
• Cardiac MRI – explore outsourcing options and review demand and capacity.	July 2024
• Cardiology Echo – continue to maximise capacity as much as possible from within current workforce and deploying insourcing to DM01 activity.	Monthly

Risks and Mitigations

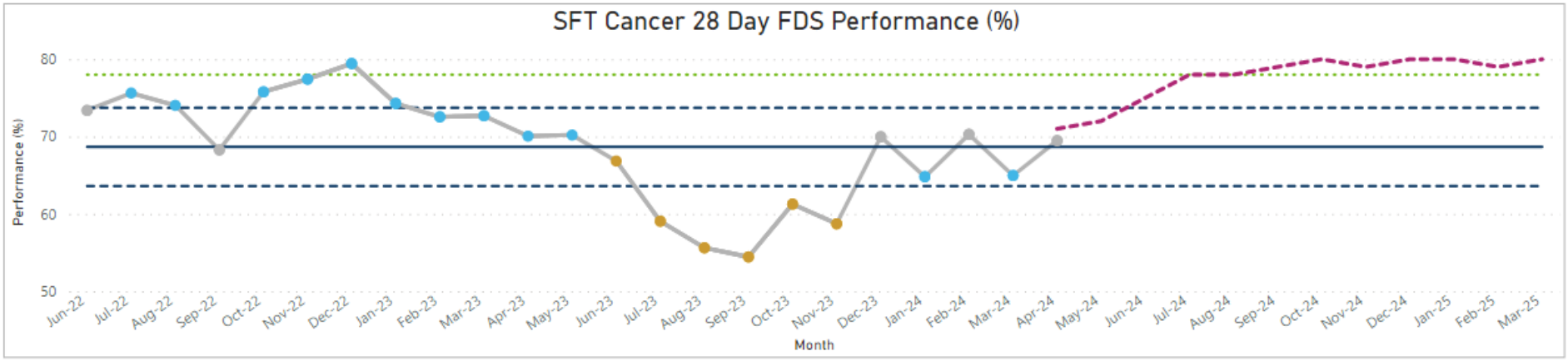
Services remain reliant on internal additional hours and / or locum or insourcing arrangements to meet current demand or to mitigate vacancies within workforce. Enhanced overtime rates have increased uptake of work in house and reduced reliance on external support in USS, explore options for this across other modalties.

CT replacement project is delayed by circa 3 months from original timeline, this is causing risk to waiting times for patients that need their scan on substantive scanner. Mitigate as much as possible with additional lists and ensuring >95% utilisation of main scanner.

Cancer 28 Day Faster Diagnosis Standard

NHS Salisbury NHS Foundation Trust

Target: 78% Performance: 69.5% Position: Common Cause



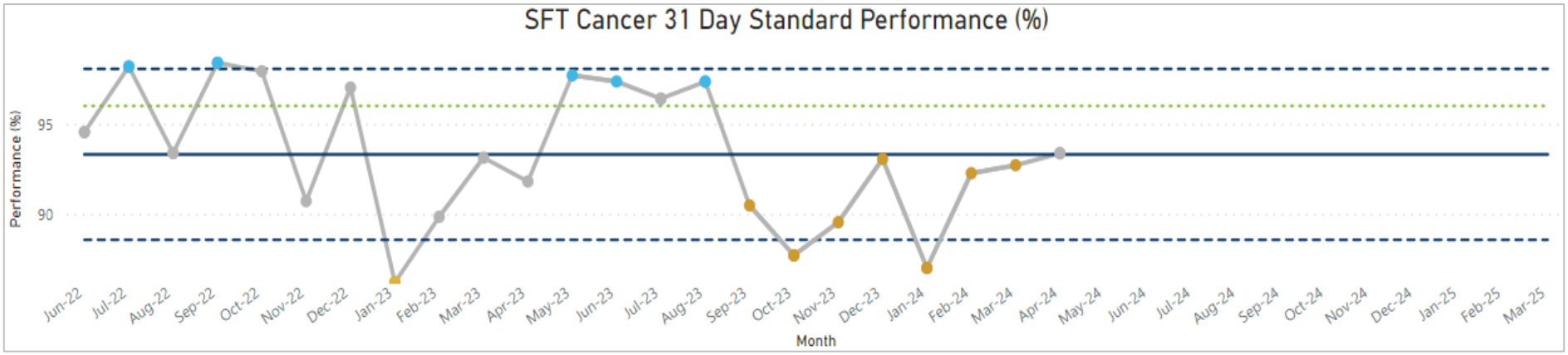
Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
28-day performance improved in M1, reporting a position of 69.5%. The biggest contributors to this were: • Colorectal - 38.2% • Urology - 45.7% • Paediatric - 66.7% • Haematology - 36.4% The tumour sites of Skin, Breast, Upper GI, Lung and Head & Neck all achieved over 78%. Performance continues to be challenged due to clinical delays and pathway complexity, as well as the broader endoscopy capacity constraints across the BSW Bowel Cancer Screening Programme (BCSP).	• Re-invigoration of "Faster Diagnosis Touch-point meetings" for Lower GI, Skin, Urology and Head & Neck. • Restoration of sufficient first appointment capacity for Skin to ensure sustainable delivery of the 28-day position >85% (to support overall Trust delivery at >77% from 2024/25). • Data analysis and development of dashboards against Best Practice Timed Pathway milestones. Project Management Support currently being scoped. • Re-establishment of Cancer Escalation Policy to facilitate faster escalation of delays and potential action in advance of breach dates. • Timed pathway review currently being undertaken	July 24 July 24 August 24 July 24 August 24	Skin service remains vulnerable to demand and capacity issues; daily oversight meetings and early warning on first seen waits through Cancer Improvement Group acting as an alert for improved responsiveness. Resource and capacity within Cancer Services administration team remains insufficient, both in terms of general capacity, as well as skills and expertise. Cancer Services Manager now in post, with a focus on improving data collection processes, including reestablishing expectations around data quality and timely escalation of delays. Re-establishment of Cancer Escalation Policy, will reduce risk to patient breach dates.

Cancer 31 Day Standard

Salisbury NHS Foundation Trust

Target: 96% Performance: 93.4% Position: Common Cause



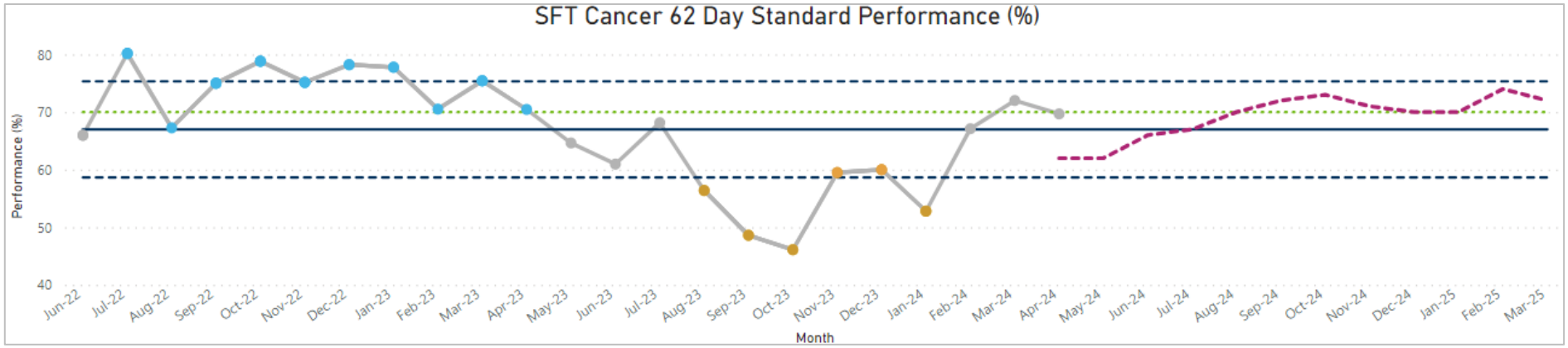
Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
31-day performance improved in M1 to a reported position of 93.41%. This represented 11 breaches of the 167 patients treated. All specialties achieved >96% performance with the exception of the following: • Skin: 82.8% - 10 patients not treated within 31 days of Decision to Treat (DTT) • Urology: 95.7% - 1 patient not treated within 31 days of DTT The Skin position was challenged by reduced capacity within minor ops to meet demand.	• Maintain daily oversight patient tracking meetings in Skin services, led by Operational Manager • Restoration of sufficient minor ops capacity for skin to ensure delivery of the 31-day waiting time. Bid submitted to Cancer Alliance / NHS England for further funding to support insourcing; outcome awaited • Re-establishment of Cancer Escalation Policy, in conjunction with cancer services, operational teams, booking teams and diagnostics to facilitate faster escalation of delays and potential action in advance of breach dates.	Ongoing Ongoing 30/06/2024	Skin service remains vulnerable to demand and capacity issues. Daily oversight meetings and early warning of potential capacity constraints through Cancer Improvement Group act as alert and reduce risk. Resource and capacity within Cancer Services administration team remains insufficient, both in terms of general capacity, as well as skills and expertise. Cancer Services Manager now in post, with a focus on improving data collection processes, including re-establishment of expectations around data quality and timely escalation of breaches. Insufficient Oncology capacity both in terms of nurse capacity to facilitate pre-assessment for chemotherapy within required timeframes, and general outpatient capacity due to demand.

Cancer 62 Day Standard

NHS Salisbury NHS Foundation Trust

Target: 85% Performance: 69.7% Position: Common Cause



Patients waiting over 62 days for treatment	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
	102	109	89	78	102	167	119	87	158	145	117	91	73	76

Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance

62-day performance for M1 reported at 69.6%. 126.5 patients were treated against the 62-day standard in M1, 38.5 of which did not meet the target.

Specialty level performance summary as follows:

- Breast: 51.5% - 8 breaches out of 16.5
- Lower GI: 66.7% - 2.5 breaches out of 7.5
- Gynaecology: 50% - 2 breaches out of 4
- Haematology: 68% - 4 breaches out of 12.5
- Head & Neck: 0% - 0.5 breaches out of 1
- Lung: 52.9% - 4 breaches out of 8.5
- Skin: 81.4% - 8 breaches out of 43
- Upper GI: 80% - 2 breaches out of 10
- Urology: 68.8% - 7.5 breaches out of 24

Countermeasure Actions	Due Date
• Continue / sustain robust patient tracking list meetings, improving their resilience and quality to ensure appropriate action is identified and taken in a timely manner.	Ongoing
• Best Practice Timed Pathway focus for improvement in 28-day performance will have subsequent positive impact on 62-day delivery.	Ongoing
• Re-establishment of Cancer Escalation Policy, in conjunction with cancer services, operational teams, booking teams and diagnostics to facilitate faster escalation of delays and potential action in advance of breach dates.	30/06/2024

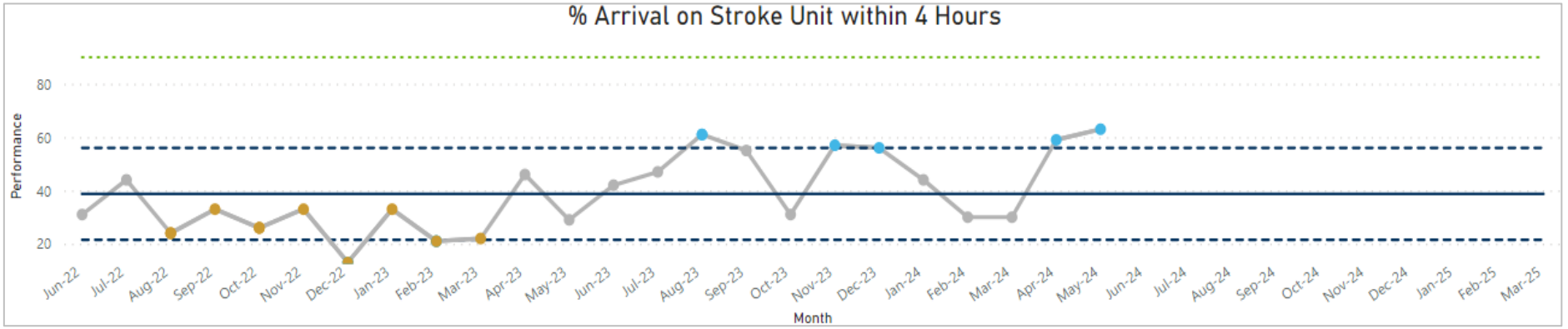
Risks and Mitigations

- Whilst there remains focus on reducing 62-day backlog, 62-day performance compliance will be detrimentally impacted. Nationally, the ask for PTL backlog to reduce to <6.8% of overall PTL size. SFT have applied a stretch target of 6% to each tumour site to support ongoing reduction of patients being treated beyond 62 days of their pathway.

Stroke Care

NHS Salisbury NHS Foundation Trust

Target: 90% Performance: 63% Position: Special Cause Improvement



	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4
SSNAP score	D	C	C	C	B	A	B	C

Understanding the Performance

M2 performance was 63%, which is a 5% increase on M1. This is a modest change felt to be reflective of continuing work on education and training between ED and Stroke team colleagues, as well as expected variation linked to levels of Out of Hours (OOH) patients.

Key themes from the data:

- Delay in initial diagnosis / identification: 8 of the patients who failed to reach the stroke unit within 4 hours presented with obvious stroke symptoms.
- OOH Performance: The large proportion of patients were identified as being OOH. The reason for this is felt to be due to issues with communication between the units, and levels of staff cover.

Countermeasure Actions

Countermeasure Actions	Due Date
• **Awareness of Stroke Targets and Requirements:** It has been identified that awareness is an area of development. The Stroke SOP and SSNAP targets are to be given a focus on future band 6/7 study days. A focus will be on staff working OOH.	01/08/2024
• **Training on non-specific stroke symptoms:** education leads for ED and Stroke to arrange training for triage nurses. This is aimed at addressing delays in identification for all patients.	01/07/2024
• **Stroke B6 nurse liaison with ED:** from this month, 1 Band 6 will be left out of the ward numbers and given responsibility for liaising with ED to address potential stroke patients with a view to reducing communication delays. This will be evaluated in 2 months.	01/08/2024

Risks and Mitigations

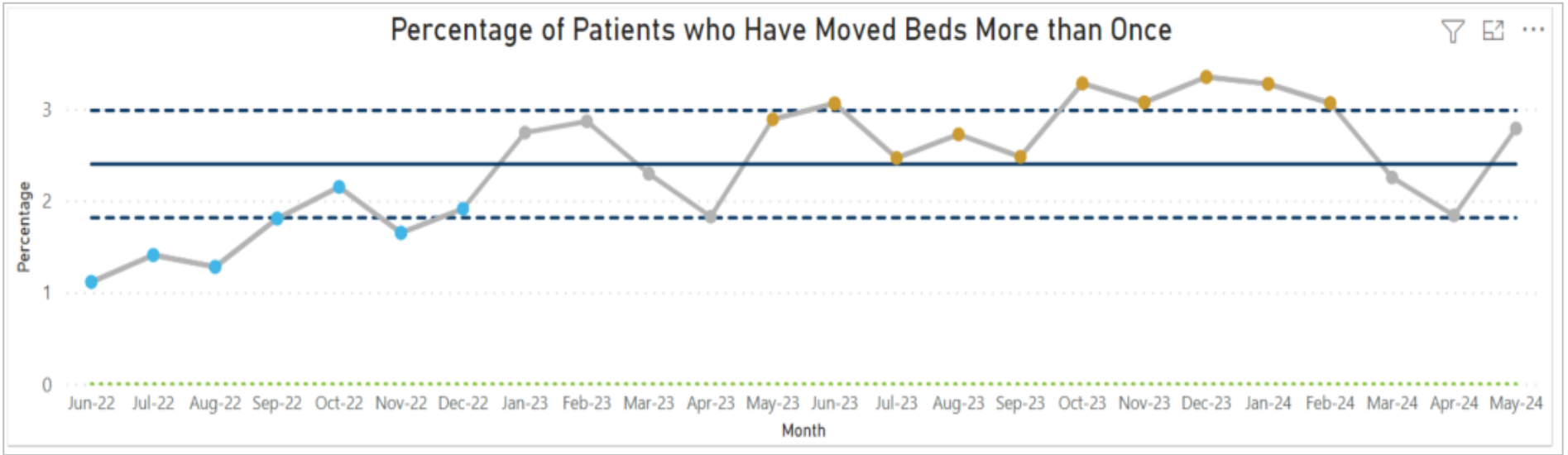
OOH cover represents a source of concern for variation in the Trust's 4 hours performance. A significant driver for this concern are the delays in doctors reviews in this timeframe. Work on improving communication and education to mitigate potential delays is continuing.

Bed Flow / LoS: The Stroke Unit's Length of Stay (LoS) is 16 days. Driver metrics for the unit are before midday discharges, with a view to improving bed flow. A key driver for performance has been identified as Electronic Discharge Summary (EDS) timing. Doctors have been invited to the huddle to identify areas in the process where EDS's have been delayed.

Patient Bed Moves

NHS Salisbury NHS Foundation Trust

Target: 0% Performance: 1.8% Position: Common Cause

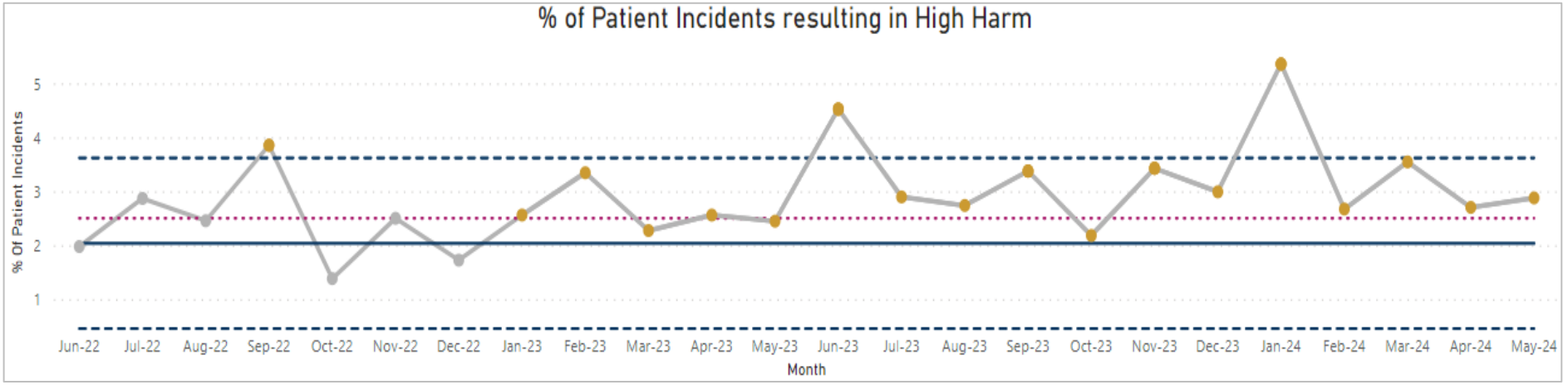


Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
M2 has shown an increase in the percentage of patients who have moved more than once. There have been increased incidences of IPC concerns which have resulted in an increase in patient moves. In line with the escalation policy responding to the operational needs of the trust, the number of escalation beds in use throughout this period has fluctuated. There continues to be an increased demand for medical beds and this impacts the surgical footprint by having a high number of medical outliers moved to create acute capacity.	• Awareness at ward level to understand patient journey and experience, and impact of number of moves patients have been exposed to. • Site team continue to raise awareness and question teams regarding the number of moves • Work with clinical and nursing teams to ensure right patient placement into most appropriate bed.	Ongoing Ongoing Ongoing	OOHs decision making for patient moves continues to generate issues. Ensuring that ward teams have a MDT discussion around most appropriate patient to move into outlying or escalation beds to generate acute capacity is paramount, acknowledging the patient experience. Use of escalation areas as per the SOP for correct placement of patients within escalation areas dependent upon speciality, aiming to reduce ambulance handover delays within our Emergency Department generates an increased risk of moves per patient.

Incidents

NHS Salisbury NHS Foundation Trust

Target: 2.5% Performance: 2.77% Position: Special Cause Concern

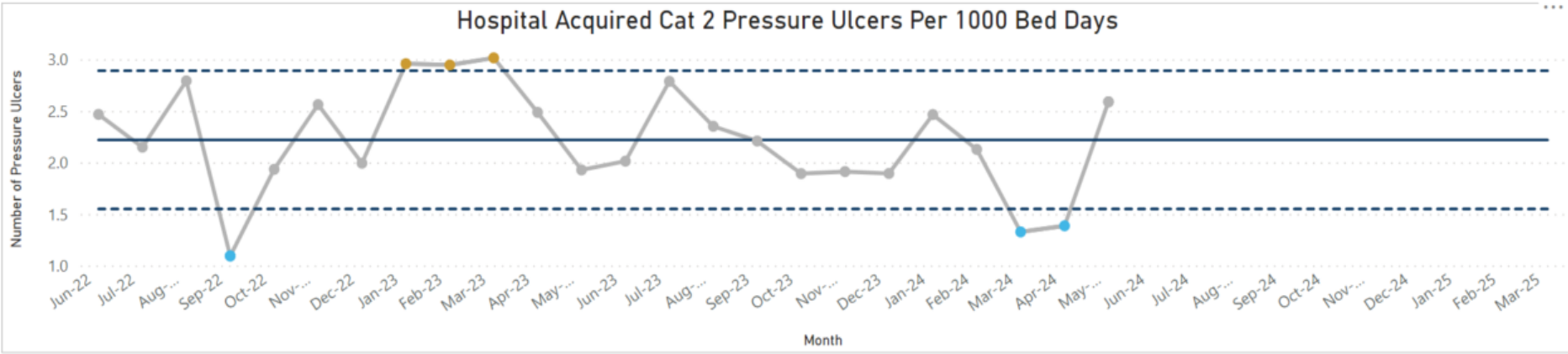


Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
There were 826 incidents reported in May. This rose slightly compared to April (805). There has been a slight fluctuation in the number of incidents reported since the transition to the Learning from Patient safety Events (LFPSE) platform in December, this is being monitored monthly. In May there were: • 22 reported moderate incidents • 1 major reported incident • No reported Never Events To note there may be a slight fluctuation in the actual % of reported incidents' with harm from previous months, due to data validation and conclusions of reviews which occur retrospectively.	• Daily morning huddle across all divisions to discuss previous 24 hours incidents and any immediate actions required. • Weekly Patient Safety Summit (PSS) where all moderate, major and catastrophic graded incidents are discussed • Patient Safety Reviews (PSR) are undertaken for all cases where moderate or above harm has occurred to patients • Consider if information from the PSR immediately identifies an unexpected level of risk or emergent issue/trend and a patient safety incident investigation (PSII) is indicated • Learning from incidents forum monthly.	Ongoing Ongoing Ongoing Ongoing Ongoing	• There are currently 6 Patient Safety Incident Investigations in progress across the Divisions. These are all currently meeting the recommended timeframes and learning will be shared to help mitigate future risks.

Pressure Ulcers

NHS Salisbury NHS Foundation Trust

Target: N/A Performance: 2.59 Position: Special Cause Improvement



Understanding the Performance
Comparing May to April 2024 there has been an increase in Hospital acquired pressure ulcers from 34 to 48, with an increase of total number of patients from 29 to 39 seeing a rise in overall performance of Category 2 at 2.59%. Seven of these incidents were device related across all divisions. **Increases in:** • Category 2 pressure ulcers an increase of 16 • Category 3 pressure ulcers an increase of 4 **Decreases in:** • Category 4 pressure ulcers of 1 • Deep Tissue Injury (DTI) of 3 • Unstageable pressure ulcers of 2 • Moisture Associated Skin Damage (MASD) from 33 to 15 **Note:** Excluding maternity and paediatrics, all HA PU per 1,000 bed days for May = 3.72. This is an increase from April = 2.62.

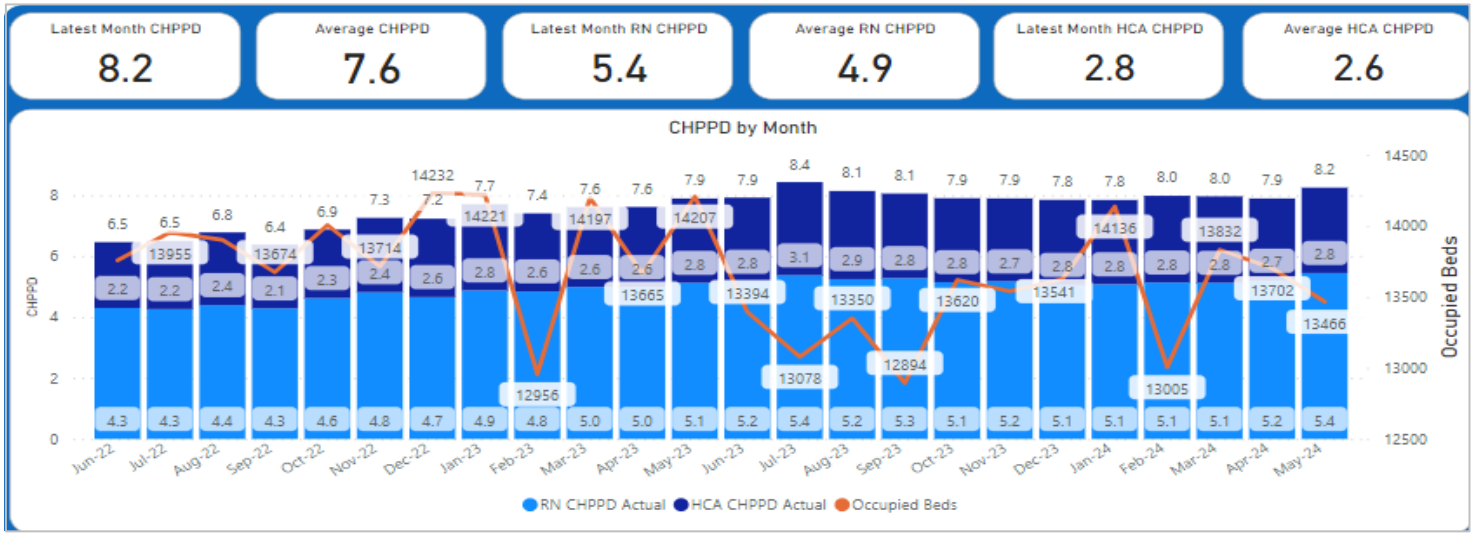
Countermeasure Actions	Due Date
• Continue to review data for pressure ulcers and MASD monthly.	Ongoing
• Ward leaders to ensure TV Link Workers attend the TV study days.	Ongoing
• Wards to utilise Link workers to support with wound care management and prevention of skin / tissue injury.	Ongoing
• Wards to have additional training on VAC dressings	01/10/2024
• Tissue Viability (TV) to work with supplies to review continence products.	01/07/2024
• MASD care pathway to be completed.	30/06/2024
• Trial / evaluation of the Octenisan wash mitts in key areas.	01/07/2024
• aSSKINg care plan short training video to go out to wards.	30/06/2024
• TV Nurses to monitor medical device related pressure ulcers.	01/08/2024

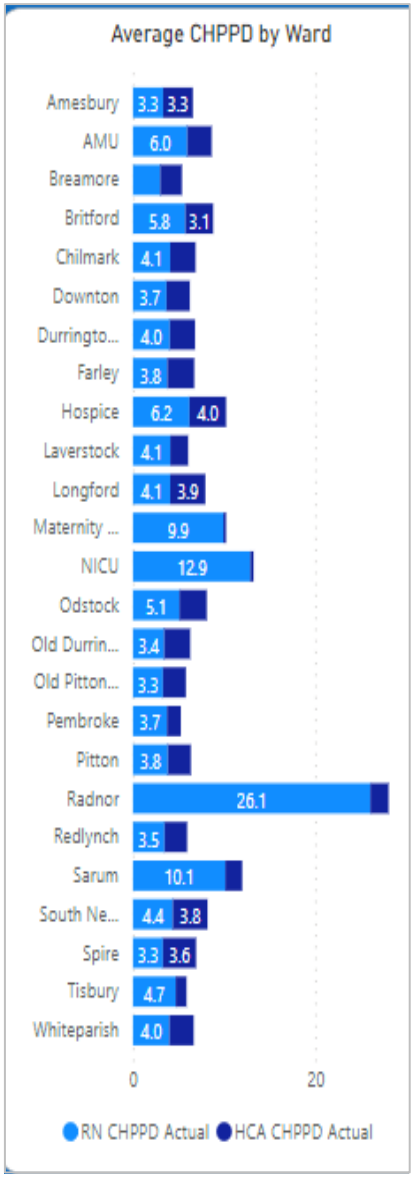
Risks and Mitigations
• Pressure ulcer incidence has for the second month increased.
• MASD incident numbers remain high.
• Resource and capacity within the TV team a risk.
• Increase of education for nursing staff.
• aSSKINg Care Plan replacing the SKIN Bundle.

Care Hours Per Patient Per Day (CHPPD)

Definition: CHPPD (Care Hours per Patient Day) which measures the total hours worked by RNs and HCAs divided by the average number of patients at midnight – and is nationally reported.

NHS Salisbury NHS Foundation Trust



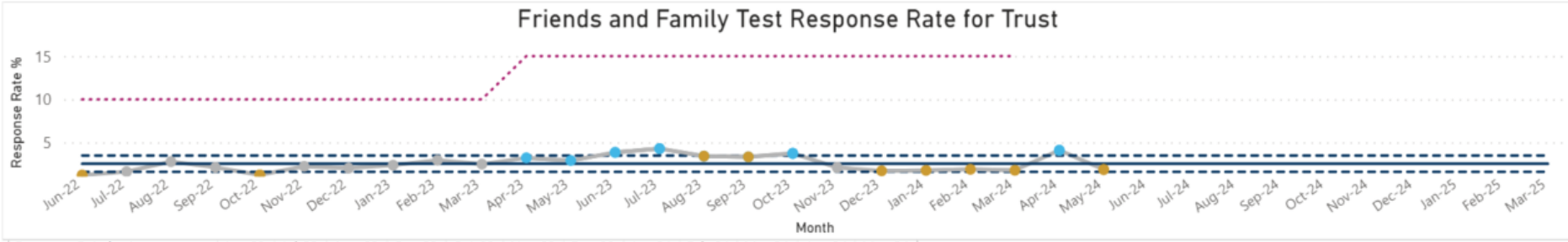


Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
CHPPD 8.2 in month and 7.6 when excluding Critical Care and Maternity. Of note, in month CHPPD in Sarum remains high at 10.01 for Paediatrics. CHPPD has continued to show steady improvement which is reflective of the reduction in vacancies. Current increase is due to staff for Imber ward being recruited but ward not yet open. December 2023 data shows SFT to have lowest CHPPD in BSW and 2nd lowest in the region (8.01 against national average of 9.93). Agency spend on nursing £197k (lowest since June 2022) with main areas of spend specialist: Theatres, ED, ICU and Paediatrics. Bank spend £646k (lowest since December 2022).	• Safer Nursing Care Tool (SNCT) training and data collection (to support establishment setting). • Ward assistant project moved into divisions, remain unfunded. • Business cases for RNDA, Nurse associate to RN business cases approved in principle – remains with exec team for funding. • Trailers now been offered from UKHSA –awaiting delivery date. • Weekly forward review of staffing meeting implemented.	June 24 Complete Sept 23 June 24 Ongoing	Output from annual skill-mix review in budgets but not yet in roster templates or recruited, resulting in temporary spend (risk). Requirement to reduce headcount to 2022/23 staffing (risk). Ongoing turnover rate for HCAs (risk). Ongoing demand for patients requiring RMN support (risk). Increased demand for additional nursing in ED corridor - 5.5wte per week (risk). Domestic and international recruitment campaigns (mitigation).

Friends and Family Test Response Rate

Salisbury NHS Foundation Trust

Target: 15% Performance: 1.9% Position: Special Cause Concern



Response Rate by Area	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
FFT Response Rate - A&E	0.8%	1.1%	0.8%	0.6%	1.0%	0.6%	0.9%	0.7%	0.5%	0.5%	0.7%	0.6%
FFT Response Rate - Day Case	6.4%	6.6%	3.5%	5.8%	4.1%	2.4%	2.5%	3.1%	3.2%	3.3%	2.1%	2.9%
FFT Response Rate - Inpatient	17.1%	28.4%	20.5%	33.7%	24.0%	17.2%	10.2%	19.1%	19.7%	17.2%	22.3%	18.5%
FFT Response Rate - Maternity	0.0%	0.0%	0.9%	1.0%	2.9%	0.9%	0.5%	3.8%	0.0%	3.0%	0.5%	0.0%
FFT Response Rate - Outpatient	2.6%	2.2%	2.2%	2.1%	2.3%	1.3%	1.1%	0.9%	1.0%	0.8%	1.0%	0.9%

Understanding the Performance

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. Weekly emails are sent to leads showing feedback received in the previous week, allowing them to pick up any immediate causes for concern and mitigate these where possible.
Negative feedback should be reviewed by the ward / area regularly and formal reporting bi-annual is provided by PALS, to the Patient Experience Steering Group. FFT response figures have largely increased, and staff are still being encouraged and reminded to offer FFT through the PALS outreach services.

Countermeasure Actions

- The rollout of the digital provider is now live, data collection began on the 1st June 2024. SMS messages are now being sent to all eligible patients attending our maternity services, Outpatients and ED. This is anticipated to significantly improve our response rate. The new online forms have now also gone live. Work is underway to advertise these changes through a new poster and new FFT boards are under design for inpatient (and outpatient) areas. This solution also meets accessibility requirements further increasing access.

Due Date

June 2024

Risks and Mitigations

The new dashboard is already enabling better theming and insights analysis of comments. We are now in a position to analyse and theme comments and will begin showcasing these through the Divisional Governance structures and Patient Experience reports.

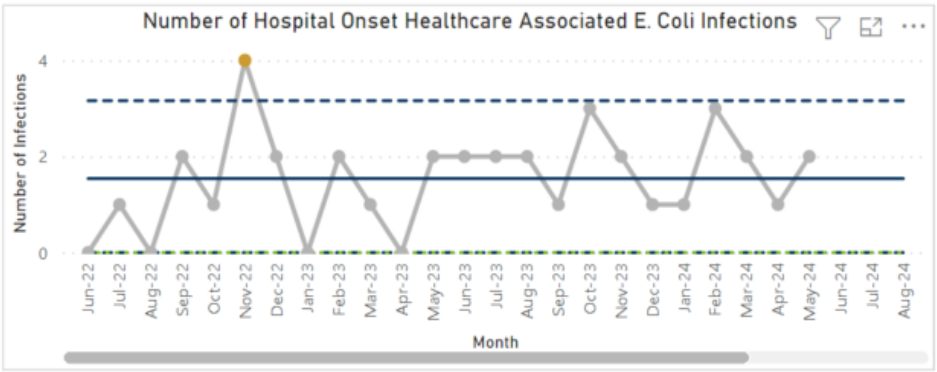
In the last two weeks we have already seen a high increase in feedback received and a positive impact on our response rate targets. The patient experience team will be working with individual clinics and services not included in the new hierarchy data structure, to consider alternative data collection methods for informing service improvements.

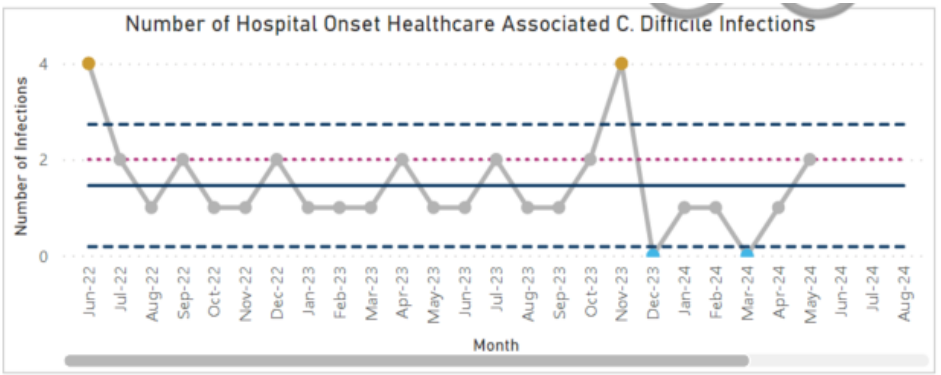
Infection Control

NHS Salisbury NHS Foundation Trust

Position: Common Cause

Position: Common Cause



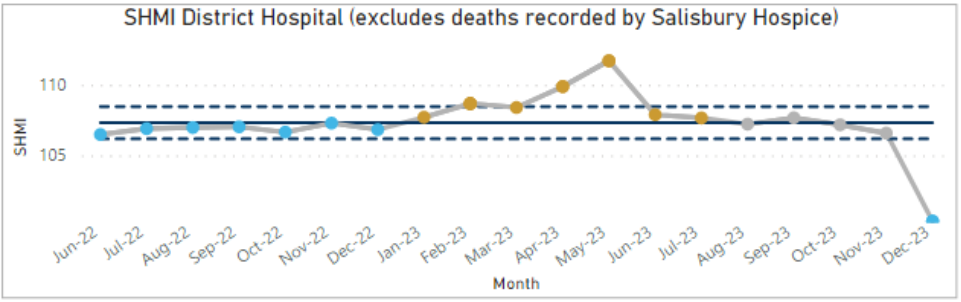


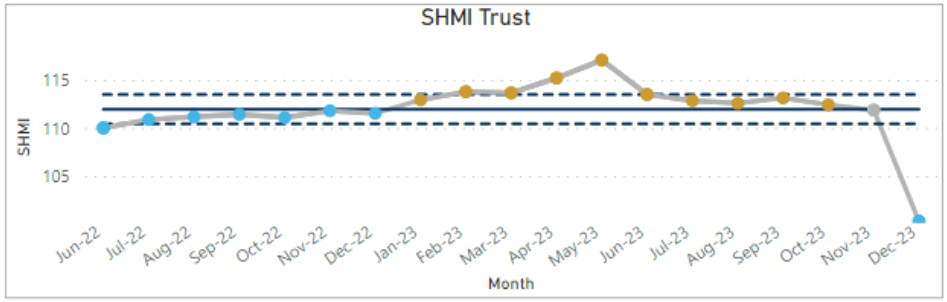
Year	2022-2023	2023-2024	2024-2025
MSSA Bacteraemia Infections: Hospital Onset	10	10	1
MRSA Bacteraemia Infections: Hospital Onset	0	0	0

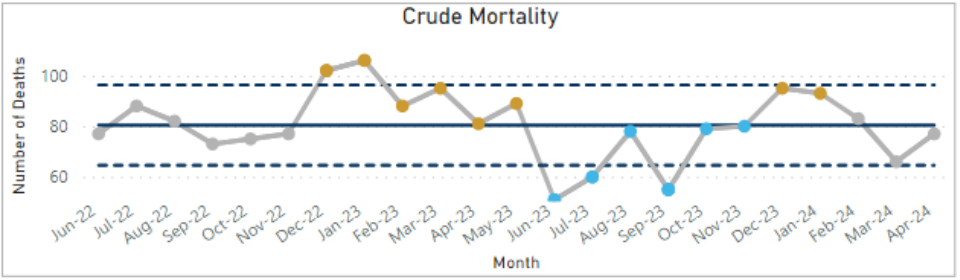
Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
There have been 2 hospital onset healthcare associated (HOHA) reportable *E.coli* bacteraemia infections, compared to one case last month. For HOHA reportable *C.difficile*, there have been 2 cases compared to one case last month. There have been no HOHA *MSSA* bacteraemia infections. A period of increased incidence of *C.difficile* was declared for Sarum Ward following the identification of 3 positive cases. Reviews were undertaken for the positive cases and all the required control measures were implemented. Increased diarrhoeal activity has been experienced across inpatient areas resulting in the closure of bays.	• Completion of required case investigations by clinical areas to identify good practice and any new learning continues within identified timeframes. • From the reviews completed, lapses in care continue to be identified relating to prompt use of the diarrhoea pathway, timely escalation of reviews and delay in sampling. The divisions continue to monitor those areas that have produced action plans and provide updates to the Infection Prevention & Control Working Group (IPCWG). • The Infection Control Nurses (ICNs) continue to undertake targeted ward visits and use educational opportunities with different staff groups.	Monthly Monthly Ongoing	Increased clinical workload for IPC nursing team continues to have an impact on ability to progress other HCAI prevention work. An underlying risk continues to be a potential increase in incidence of reportable healthcare associated infections with poor patient outcomes. As of 1st April 2024, the admission date definition for reporting HCAIs has changed, which may lead to an increase in cases classified as HOHA. Issues with national soap and gel provision from current supplier for the Trust, requiring immediate response from IPC team. This has resulted in an increased workload to an already challenged service. It is anticipated this will be ongoing work. Band 6 nurse continues progressing through their orientation programme.

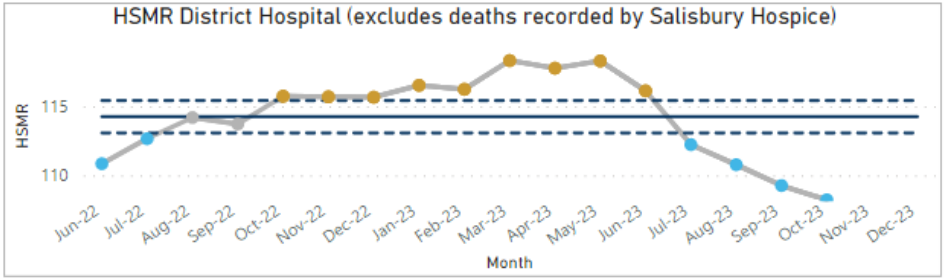
Mortality

Target: N/A Performance: N/A Position: N/A









Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Latest Figures: The Summary Hospital-level Mortality Indicator (SHMI) for the 12-month rolling period ending in December 2023 for Salisbury District Hospital has significantly improved and is now 100.32.* The Hospital Standardised Mortality Ratio (HSMR) for the 12-month rolling period ending in October 2023 for Salisbury District Hospital is 108.23. Both are within the expected ranges. Mortality statistical models compare across all acute hospital Trusts (the majority of which will not contain hospice services), therefore the number of expected deaths at Salisbury NHS Foundation Trust is likely to sit above expected levels.	A revision to the methodology for calculating the SHMI which was anticipated has now come into effect (as per the 12-month rolling SHMI figures from December '23 onwards). - Prior to this, the Trust had already started to seen a positive reduction in both the SHMI and HSMR figures. -8 out of 28 actions related to the recent Board requested mortality insight visit have been completed in full and the progress on these actions continue to be reviewed (with assurances sought) through the Trust's Mortality Surveillance Group (MSG). A new online mortality system to support learning from deaths was launched in March and improvements continue to be made to support good governance.	Ongoing / Bi-monthly review at MSG	The Trust's Mortality Surveillance Group (MSG) meet every two months, and our mortality data is reviewed at this meeting. A representative from our Partner organisation, Telstra Health UK (Dr Foster), is invited to attend to help us to interpret and analyse our mortality data and identify variations in specific disease groups. Where alerts are generated, these are discussed, and a further review of the patient's records may be undertaken.

Watch Metrics: Alerting

NHS Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Ambulance Handovers 60+ mins	57	79	57		0		Special Cause Improving - Below Lower Control Limit	X	48
Beds Occupied %	98.4%	101.3%	96.8%	96.0%	92%		Special Cause Improving - Below Lower Control Limit	X	48
Cancer 2 Week Wait Performance	56.3%	72.6%	%		93%		Common Cause Variation	X	48
Complaints Closed within agreed timescale %	28.0%	47.0%	50.0%	90.0%			Special Cause Improving - Above Upper Control Limit	X	48
ED 12 Hour Breaches (Arrival to Departure)	29	33	26		0		Special Cause Improving - Run Below Mean	X	48
ED Attendances	7411	6722	7366				Special Cause Concerning - Above Upper Control Limit		
Inpatients Undergoing VTE Risk Assessment within 24hrs %	39.9%	42.9%	42.3%		95%		Special Cause Improving - Above Upper Control Limit	X	48
Pressure Ulcers Hospital Acquired Cat 3	1	3	7				Special Cause Concerning - Above Upper Control Limit		
RTT Incomplete Pathways: Total 52 week waits	1033	1139	1069	1000	0		Special Cause Concerning - Above Upper Control Limit	X	17
RTT Incomplete Pathways: Total 65 week waits	9	130	129	98	0		Common Cause Variation	X	9
Total Number of Complaints Received	12	15	30				Special Cause Concerning - Above Upper Control Limit		

Watch Metrics: Alerting

Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Understanding the Performance

In terms of flow bed occupancy remains alerting with continued progress and achievement of 96% in May. Both the number of ambulance handover delays longer than 60 minutes, and patients spending over 12 in the Emergency department (ED) continue to show an improving trend and fall below the lower control limits in the monitoring period (24 months). Conversely the number of total ED attendances remains high, at 5% above plan year to date and 10% higher than the same period in 23/24.

There are continuing signs of slow progress in the VTE Risk assessment within 24 hours (42.3%), and the number of complaints closed within agreed timescale (50%). Both remain some way from target but remain in a stabilised position.

The number of patients waiting less than 2 weeks for their first outpatient remains static at 75% and the number of patients waiting over 62 days remains steady at 76 patients. The number of patients waiting over 52 and 65 weeks continues to reduce but remains slightly higher than plan.

Countermeasure Actions

- Continued tiering meetings with regional NHSE teams focusing on cancer performance.
- Focus with ICB colleagues around understanding increased ED attendances and impact of community/system actions that may support UEC flow.
- Developing an outpatient transformation programme will be critical to reducing elective waiting lists (Referral to Treatment). Clinial lead agreed, operational support and project support to be determined - led by Chief Operating Officer
- Cancer Faster Diagnosis 'Touch point' meetings have had good impact in reducing delays, consideration to be given to rolling out to all specialties
- Best Practice Timed pathways dashboards to be developed – cancer team leading on scoping resource requirements

Risk and Mitigations

Further periods of Industrial Action have been announced for M3 which if they go ahead will impact on elective activity, in particular outpatients.

Volatility in demand for some services – the Skin service and Ultrasound in particular have seen peaks in referrals rates. Close monitoring through daily cancer huddles and radiology weekly waiting list meeting.

High occupancy levels remain challenging and provide poor flow into the hospital from the Emergency Department. New ward (Imber) opening in M3 will increase bed capacity allowing for protection of elective bedded areas.

Watch Metrics: Non-Alerting

Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Average Patients with No Criteria to Reside	73	77	71	75			Special Cause Improving - Below Lower Control Limit	✓	0
Diagnostics Activity	8340	8337	8817	0			Special Cause Improving - Above Upper Control Limit	✓	0
Mixed Sex Accommodation Breaches	0	5	0	0	0		Common Cause Variation	✓	0
Number of High Harm Falls in Hospital	5	3	0	0	0		Special Cause Improving - Run Below Mean	✓	0
Pressure Ulcers Hospital Acquired Cat 2	19	20	36				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 4	0	1	0				Common Cause Variation		
Proportion of patients spending more than 12 hours in an emergency department	0.6%	0.7%	0.5%				Special Cause Improving - Run Below Mean		
RTT Incomplete Pathways: Total 78 week waits	0	0	0	0	0		Special Cause Improving - Below Lower Control Limit	✓	0
Stroke patients receiving a CT scan within one hour of arrival	40.0%	73.0%	63.0%		50%		Common Cause Variation	✓	0
Total Incidents (All Grading) per 1000 Bed Days	52	54	57				Common Cause Variation		
Total Number of Compliments Received	79	28	68				Common Cause Variation		
Total Patient Falls per 1000 Bed Days	6.67	6.69	5.90	7			Special Cause Improving - Below Lower Control Limit	✓	0

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

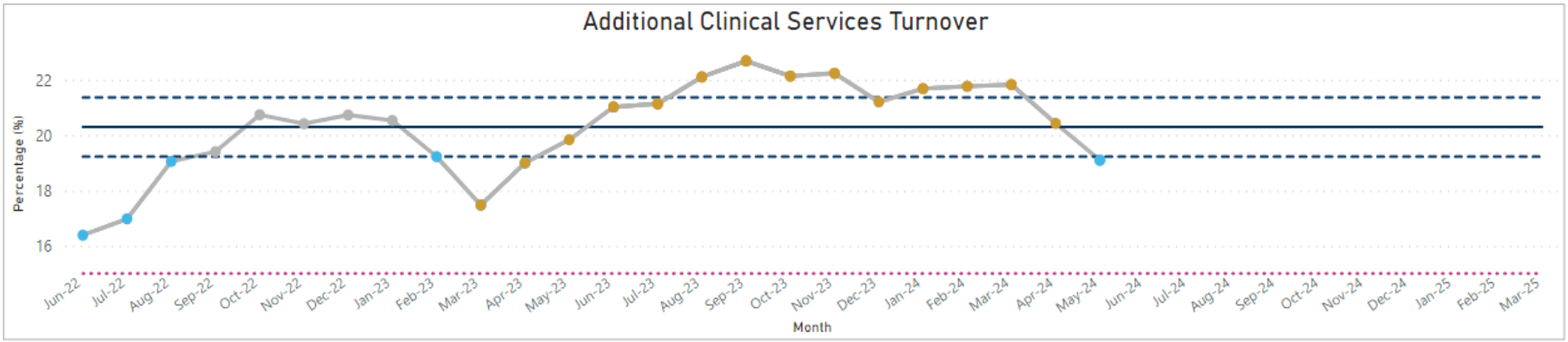
Partnerships

Increasing additional clinical staff retention

Breakthrough Objective

We are driving this measure because…	The breakthrough is on Retention – focus on Healthcare Assistants (HCA) turnover. HCAs have the highest turnover of any staff group at circa 21%. The breakthrough objective is to improve this to a target of 15% turnover by March 2025. SFT currently measures the highest turnover areas by staff group (HCA), length of service and Age of Leavers. We have developed an A3 approach to focus on improving retention in this staff group due to the significant impact this turnover has on direct patient care. This will enable more direct patient care hours due to more available HCAs working each shift.

Target: 15% Performance: 19.1% Position: Special Cause Improvement

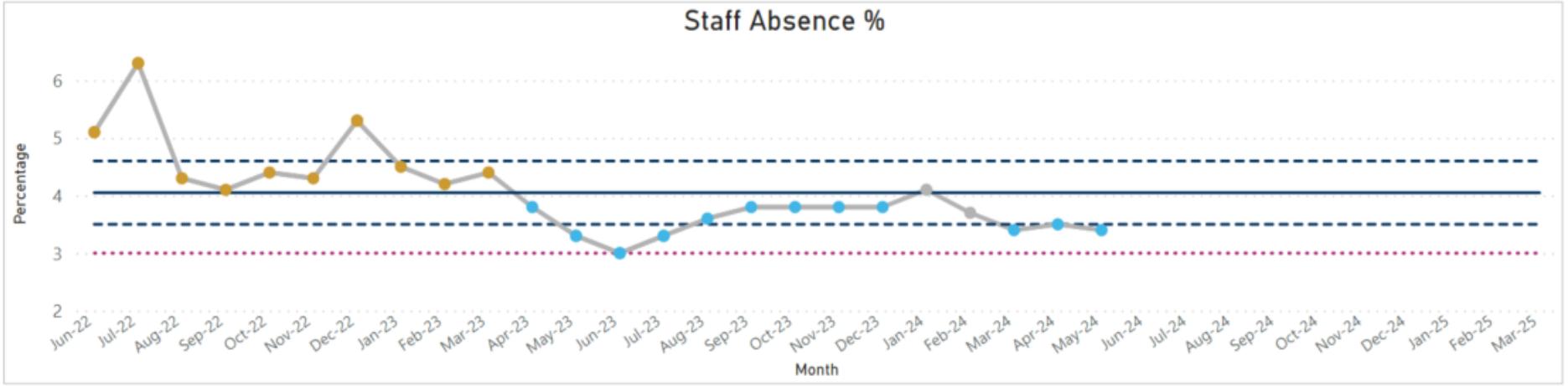


Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
The rate of turnover for Additional Clinical Services (ACS) staff was 19.01% for May and has fallen for the second month since adoption as a breakthrough objective. The overall turnover rate for the Trust sits at 13.49%. Against the divisions, W&NB have the highest turnover at 25.12%. Six staff (4.7 FTE) left the Trust in May 2024, one of which was the conclusion of a fixed term contract. This represents a reduction of 5 FTE compared to the previous month. The long-term trend of c30% of staff giving no reason for leaving has been maintained.	• Review success of HCA preceptorship prog to increase care certificate compliance rates. (HCA retention lead). • New to care HCA tagged at Induction, shadow shifts provided in first 3 months of employment. (HR/HCA retention leads). • HCA 'transfer window' opened on SALI to enable staff to see opportunities in other ward areas. (HCA Retention lead).	Jul 24 May - Sep 24 Aug 24	• Impact of raise of national living wage and delay of pay review body announcement risks loss of staff to other roles. Mitigation to ensure all staff move to Band 3 provision as quickly as possible. • Demand for ACS staff outstrips local supply. Staff at lower pay levels cannot travel. Wider engagement through local schools, colleges and job centres to attract individuals new to care.

Sickness Absence

Salisbury NHS Foundation Trust

Target: 3% Performance: 3.4% Position: Special Cause Improvement

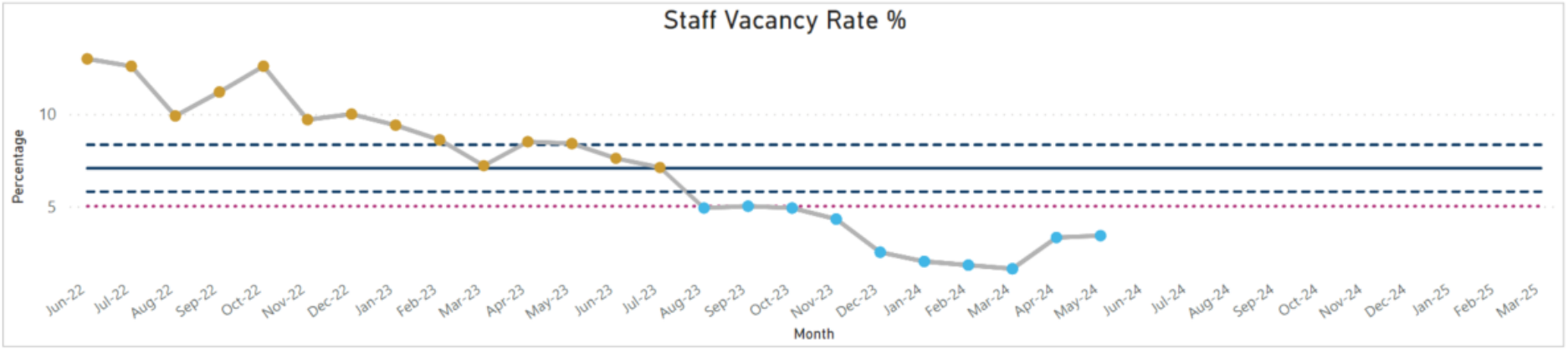


Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Sickness absence has steadied over the last 3 months at an average of 3.44%, below the 12 month average and much lower than 18 month average. Corporate services are the best performing division over the 3 month period, with Surgery and Medicine the worst. Additional clinical services continue to average over 5.5% for the last 3 months, the worst performing staff group, which triangulates with high turnover rates as well. Sickness accounted for 4,167 FTE days lost to the Trust, of which c1/3 were for long term and c2/3 short term absence. Long term absence dropped slightly as a number of days this month. Highest absence rate remains Anxiety / Stress / Depression.	• Line Manager training on Absence Management policy and actions seeking to deliver training opportunities for all LM by year end. sessions programmed through the year, with additional support through breakfast clubs. (Hd ER and Policy) • Reduction of violence and aggression on wards and in ED/AMU, seeking to prevent physical injury and reduce cases of workplace stress and anxiety. 'No excuse for abuse' campaign and training interventions for ward staff planned each month. Excellent feedback so far.	Dec 24 Mar 25	• Availability of instructors and advisers to support training interventions and workplace support to LM. Staff are being trained and recruited to fill vacancies in current team. The ER team has been redesigned to better support the programmed activity.

Vacancies

NHS Salisbury NHS Foundation Trust

Target: 5% Performance: 3.4% Position: Special Cause Improvement



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
A negligible rise of 135 FTE to 137 FTE vacancies in the Trust saw the headline rate stabilise at c3.3% for the second month running, below the Trust target of 5%fr the 10th month running. The highest vacancy rates are in Elderly Medicine and Emergency Medicine, the specialities which generate the highest agency and bank spend.	• Focus attraction campaigns to meet high vacancy and hard to recruit areas. Current focus is Theatres, Emergency Department, Maternity, HCAs and Housekeeping. A campaign has also been launched to attract consultant staff in hard to recruit posts. • Imber Ward recruitment campaign to identify new roles and individuals (internal and external) to resource the new ward. (Head resourcing) • Identification of new areas for apprenticeships through Coventry Programme. Nursing Associate Degree Apprenticeships initial focus.	Aug 24 Jun 24 Sep 24	• Understanding of future resourcing and staff requirements. Workforce trajectory forecasting, seeking to support Divisions and Line Managers with targeted attraction and recruitment campaigns, specifically for hard to fill high value niche posts is a key focus of the recruitment team. • Loss of potential staff through ineffective recruitment and onboarding processes. Implementation of PWC 'overhauling recruitment' programme phase 2 recommendations.

Watch Metrics: Alerting

NHS Salisbury NHS Foundation Trust

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Mandatory Training Rate %	86.3%	86.5%	85.6%	90.0%	85%		Special Cause Concerning - Below Lower Control Limit	X	16
Non-Medical Appraisal Rate %	80.5%	79.1%	78.3%		90%		Special Cause Improving - Above Upper Control Limit	X	48
Staff Turnover (Trust overall)	13.7%	13.5%	13.5%	13.0%			Special Cause Improving - Below Lower Control Limit	X	48

Watch Metrics: Alerting Narrative

NHS Salisbury NHS Foundation Trust

People

Understanding the Performance

Mandatory training remains below target at 85.6% completion. This has been the picture since Feb 23, with the average sitting at around 86%, some 4% below the 90% target. Only facilities have consistently met this target, through the application of significant oversight from their management team.

Medical appraisals have, for the first month since Aug 23, met the 90% target with appraisals in May at 90.6%. The number of medical appraisals out of date greater than 3 months continues to gradually reduce, sitting at 34 in May.

Having seen a rising trend for non-medical appraisals for 8 months, the start of FY 24/25 has seen a drop in completion rates to 78.3% in May. The application of significant oversight is required to reverse this trend moving forward .

Turnover trends at the Trust in the last 4 months have averaged a little over 13.5%, from last years high of 14.5% average. In May the Trust had a drop in net numbers of 4.2 FTE, the first drop in numbers for some months, and likely due to closer scrutiny of recruitment activity in March and April.

Countermeasure Actions

- A review of Mandatory training requirements, aligned to the core skills training framework, and national guidance seeks to better understand the mandated training environment and the time required to complete training. On completion this review identify any changes to the provision and need for statutory and mandatory training in different roles and professions. The review will report in Jul 24.
- Medical appraisals: Clinical directors to maintain positive oversight of appraisals for medical staff, with a focus on appraisals more than 3 months out of date.
- Non-Medical Appraisals: Monthly reconciliation of appraisals with line managers by business partners will continue, with a focus on those staff who have not had an appraisal for more than 15 months. Further analysis of organisational structure to support those managers with a high appraisal burden is ongoing and due to report in Aug 24.
- Turnover: Training and education to improve exit conversations will support further work across the Trust to better investigate the negative reasons for leaving and target these areas to mitigate negative reasons for leaving the Trust.

Risk and Mitigations

- The ability to accurately record and assign statutory and mandatory training to staff is a key function in understanding risk to the Trust from training gaps. A programme of work is underway to improve the MLE system in assigning and identifying staff gaps in training.
- Completion of appraisals remains patchy, and susceptible to interpretation from staff and line managers, leading to incomplete appraisals and lack of effective recording. Having delivered a new, more succinct form, which improved the rate from Sep 23, further work is now being planned to improve training and oversight of appraisals for line managers.
- Loss of staff due to poor reward and recognition is recognised as a risk in the Trust. Work is underway to mitigate this risk through the identification of an Employee Value Proposition, which will seek to identify a framework to better exploit all elements of reward and recognition within the Trust. First elements of this project will be delivered in Q2.

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

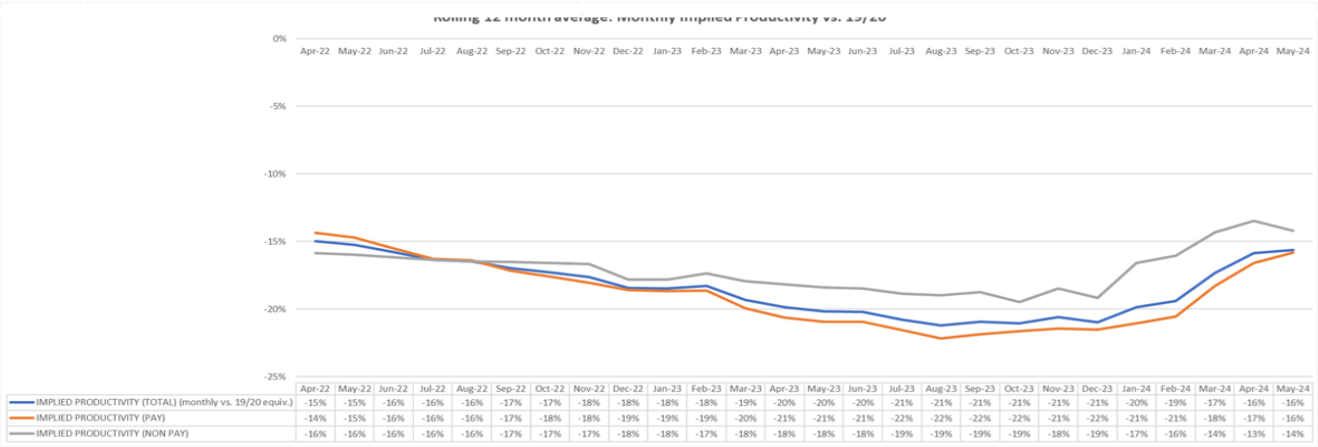
Creating value for our patients

NHS Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because…	Productivity is closely linked to the vision metric of financial sustainability. Since 2019/20 SFT's activity per unit cost has deteriorated leading to challenges of financial sustainability and constraining SFT's ability to invest in service developments and quality initiatives. Through Productivity all front line, clinical support areas and back-office services have the opportunity to affect positive change, either through driving additional activity through a given resource base or through the release or redistribution of excess resource. Divisional proposals for key driver metrics have been agreed and are being measured.

Target: -8% Performance: -16% Position: N/A



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
IMPLIED PRODUCTIVITY (TOTAL) (monthly vs. 19/20 equiv.)	-15%	-15%	-16%	-16%	-16%	-17%	-17%	-18%	-18%	-18%	-18%	-19%	-20%	-20%	-20%	-21%	-21%	-21%	-21%	-21%	-21%	-20%	-19%	-17%	-16%	-16%
IMPLIED PRODUCTIVITY (PAY)	-14%	-15%	-16%	-16%	-16%	-17%	-18%	-18%	-19%	-19%	-19%	-20%	-21%	-21%	-21%	-22%	-22%	-22%	-22%	-21%	-22%	-21%	-21%	-18%	-17%	-16%
IMPLIED PRODUCTIVITY (NON PAY)	-16%	-16%	-16%	-16%	-16%	-17%	-17%	-17%	-18%	-18%	-17%	-18%	-18%	-18%	-18%	-19%	-19%	-19%	-19%	-18%	-19%	-17%	-16%	-14%	-13%	-14%

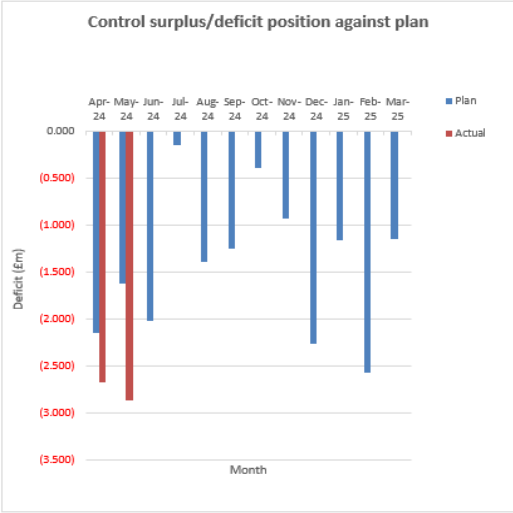
Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
In Month 2 non-pay pressures from Haematology and Oncology drugs and lower pay costs combined with lower levels of Elective inpatients and Outpatients activity than planned but higher A&E and Non-Elective have driven the position. There is an improvement of 1% delivery since March and is largely due to pay and non-pay cost increases being mitigated by A&E and Non-Elective activity increases. The calculation is generated by adjusting Pay and Non-Pay costs for cumulative inflation since 2019/20 and activity valued at a standard rate to provide a monthly Implied Productivity % as a comparator to 2019/20.	• Detailed actions on the response to Division's productivity drivers are detailed within the A3 Productivity countermeasures and discussed at Divisional Performance Reviews (DPRs).	Ongoing	The Finance Recovery Group and Elective Recovery Fund (ERF) / Delivery groups support the savings programme and ERF points of delivery.

Income and Expenditure

Salisbury NHS Foundation Trust

Target: N/A Performance: N/A Position: N/A

	May '24 In Month			May '24 YTD			24-25 Plan
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	25,870	25,547	(323)	51,552	50,687	(865)	
Other Clinical Income	1,251	775	(476)	2,021	1,933	(89)	315,761
Other Income (excl Donations)	3,299	3,044	(254)	6,623	6,221	(403)	43,909
Total income	**30,420**	**29,366**	**(1,054)**	**60,197**	**58,841**	**(1,356)**	**359,670**
Operating Expenditure							
Pay	(19,988)	(20,051)	(63)	(39,868)	(40,538)	(670)	(230,605)
Non Pay	(10,096)	(10,449)	(353)	(20,247)	(20,366)	(119)	(121,968)
Total Expenditure	**(30,084)**	**(30,500)**	**(416)**	**(60,115)**	**(60,904)**	**(789)**	**(352,573)**
EBITDA	**336**	**(1,134)**	**(1,470)**	**82**	**(2,063)**	**(2,145)**	**7,097**
Financing Costs (incl Depreciation)	(1,976)	(1,730)	247	(3,850)	(3,466)	383	(24,102)
NHSI Control Total	**(1,640)**	**(2,864)**	**(1,223)**	**(3,768)**	**(5,529)**	**(1,762)**	**(17,005)**



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
The financial plan submitted to NHS England on 12th June shows a £17m deficit position for the year and includes an efficiency requirement of £21.1m. In month 2 the Trust recorded an in-month control total deficit of £2.9m against an original deficit target of £1.6m - an adverse variance of £1.2m. The deficit position is driven by underperformance on Elective and Outpatients activity and Non Pay pressures from drugs costs.	• Finance recovery groups stood up to review Trust wide workforce actions • National guidance requires all contracts to be signed	June 24 5 July 24	• Pressure on emergency care pathways, particularly in relation to continued levels of patients with no clinical right to reside, as the efficiency plan assumes significant length of stay reductions which will not be realised in full without effective system working. • Delivery of productivity increases which are contingent on both length of stay reductions, staff availability and recruitment. The Trust's £21.1m efficiency savings plan includes more than 40% non-recurrent delivery and signals a risk into 2025/26.

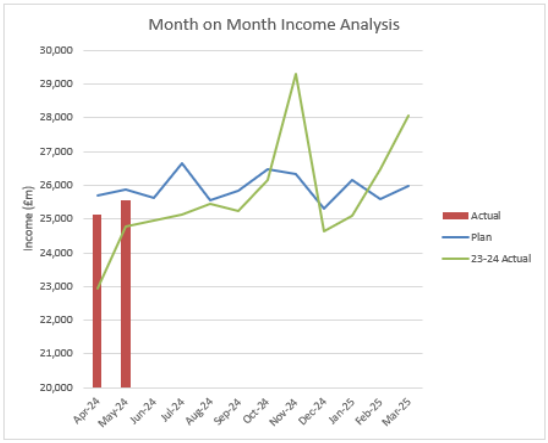
Income & Activity Delivered by Point of Delivery

Salisbury NHS Foundation Trust

Target: N/A Performance: N/A Position: N/A

Income by Point of Delivery (PoD) for all commissioners	May '24 YTD		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	1,997	2,096	99
Day Case	4,057	4,417	360
Elective inpatients	3,518	2,505	(1,013)
Excluded Drugs & Devices (inc Lucentis)	4,561	4,860	299
Non Elective inpatients	13,408	14,149	741
Other	16,713	15,449	(1,264)
Outpatients	7,298	7,211	(87)
TOTAL	51,552	50,687	(865)

SLA Income Performance of Trusts main NHS commissioners	Contract		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	31,206	30,340	(866)
Dorset ICB	5,236	5,178	(58)
Hampshire, Southampton & IOW ICB	4,429	4,258	(171)
Specialist Services	7,065	6,877	(188)
Other	3,616	4,034	418
TOTAL	51,552	50,687	(865)



	Activity YTD			Activity Last Year Actuals	Variance last year
	Plan	Actuals	Variance		
A&E	12,337	13,380	1,043	12,259	1,121
Day case	4,438	4,882	444	4,036	846
Elective	778	607	(171)	513	94
Non Elective	4,769	5,341	572	4,465	876
Outpatients	49,031	48,788	(243)	41,885	6,903

Understanding the Performance

The Clinical income position is below plan year to date with underperformance across all of the main commissioners. This is driven by lower Elective Inpatients and Outpatients activity impacting on the ERF income partially offset by overperformance on Non-Elective and Day cases activity.

The level of uncoded day cases and inpatient spells is 14% in April and 94% in May at the time the activity was taken for reporting purposes.
Activity across all of the main point of delivery was higher in May than April with the exception of Outpatients activity.

Countermeasure Actions

- A3 for main underperforming Surgical Elective specialties.
- National guidance requires all contracts to be signed by 5th July 2024.

Due Date

27 June 24

5 July 24

Risks and Mitigations

Further Industrial action is anticipated by Junior Doctors in June/July. During 2023/24 the impact of Industrial action constrained the elective programme and management capacity to improve productivity.

The Main commissioner contracts have 103% Elective recovery funding (ERF) targets, with Dorset ICB and NHS England Specialised at 102%. Other NHS England ERF contracts targets are yet to be confirmed by NHS England.

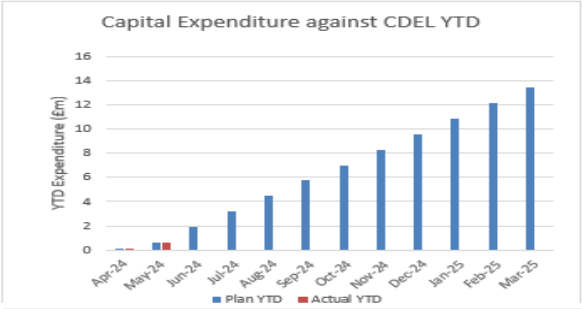
The Trust is maximising activity recording opportunities, productivity improvements and seeking to increase income available through contract negotiations.

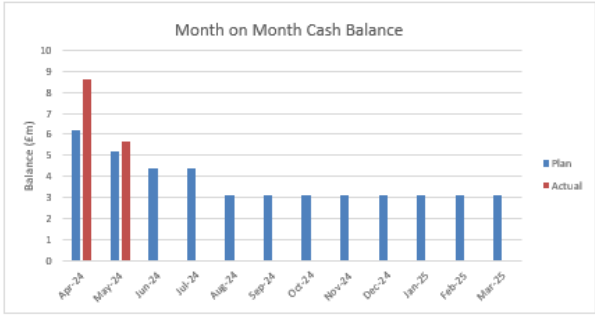
Cash Position & Capital Programme

Target: N/A Performance: N/A Position: N/A

	Closing Balance March 2023 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,954	8,556	602
Debtors	24,999	27,763	2,764
Cash	28,891	5,652	(23,239)
TOTAL CURRENT ASSETS	**61,844**	**41,971**	**(19,873)**
Creditors	(58,026)	(45,706)	12,320
Borrowings	(641)	(631)	10
Provisions	(474)	(431)	43
TOTAL CURRENT LIABILITIES	**(59,141)**	**(46,768)**	**12,373**
TOTAL WORKING CAPITAL	**2,703**	**(4,797)**	**(7,500)**

Schemes	Annual Plan £000s	May '24 YTD Plan £000s	May '24 YTD Actual £000s	May '24 YTD Variance £000s
CDEL Schemes				
Building schemes CIR	3,609	73	73	0
Building projects	2,682	452	452	0
Fire schemes	500	23	23	0
IM&T	6,264	48	48	0
Medical Equipment	393	11	11	0
Total CDEL schemes	**13,448**	**607**	**607**	**0**
National Funding				
Shared EPR - national element	2,231	-		-
Digital Pathology & LIMS	634	39	39	-
Community Diagnostic Centre	1,306	-		-
Sout West Imaging	203	-		
Total National Funding	**4,374**	**39**	**39**	-
GRAND TOTAL	17,822	646	646	0





Payables age profile	Total Payables £'000	0-30 days £'000	31-60 days £'000	61-90 days £'000	90+ days £'000
May-24	**9,256**	8,308	781	141	26
Apr-24	**7,840**	7,266	193	62	319
Mar-24	**11,372**	10,854	168	84	266
Movement vs prev mth	1,417	1,042	589	79	- 293

Understanding the Performance

Capital expenditure on both CDEL and nationally funded projects has been modest in May with £646k incurred mainly on Imber ward and the decarbonisation scheme.

Cash reserves are slightly ahead of plan although revenue support of £2.2m was received in May to ensure a minimum daily cash balance of £1.1m.

Countermeasure Actions

Countermeasure Actions	Due Date
• Quarter 2 revenue support application	June 24
• Capital cash support application Q3	October 24
• Quarters 3 and 4 revenue support application	September 24

Risks and Mitigations

- Supply chain disruption and inflationary pressures remain a significant draw of time on the procurement team. This gives rise to a risk in both lead times and overall procurement capacity.
- The constraint of system capital expenditure limits gives rise to both a mid and long-term risk to the Trust.
- The context of digital modernisation programmes, along with an aging estate and medical equipment means the Trust's five year capital requirement is well in excess of available resources. The Trust seeks to mitigate this risk through bidding for national funds where available.
- The cash support framework and monitoring draws on finance and procurement resources to ensure that payments are made on a timely basis in line with limited cash balances.

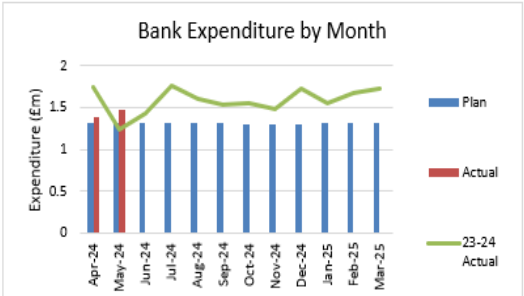
Workforce and Agency Spend

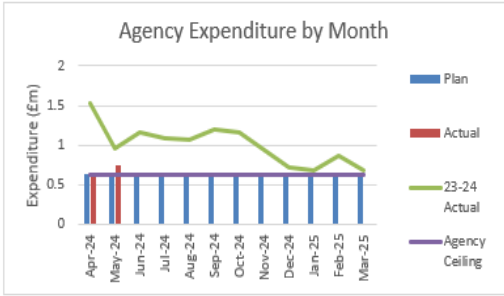
NHS Salisbury NHS Foundation Trust

Target: N/A Performance: N/A Position: N/A

	May '24 YTD Plan £000s	Actual £000s	Variance £000s
Pay - In Post	35,838	36,138	(300)
Pay - Bank	2,628	2,858	(230)
Pay - Agency	1,276	1,385	(109)
Other (eg apprenticeship levy)	126	157	(31)
TOTAL	39,868	40,538	(670)
Medical Staff	9,990	10,986	(996)
Nursing	10,918	10,694	224
Support to Nursing	4,317	3,331	986
Other Clinical Staff	4,715	5,513	(798)
Infrastructure staff	9,805	9,857	(52)
Other (eg apprenticeship levy)	123	157	(34)
TOTAL	39,868	40,538	(670)

	May '24 YTD Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	537.55	521.61	(15.9)
Nursing	1,110.40	1,259.75	149.4
Support to Nursing	701.71	567.51	(134.2)
Other Clinical Staff	450.23	644.96	194.7
Infrastructure staff	1,390.30	1,438.23	47.9
TOTAL	4,190.2	4,432.1	241.9





Understanding the Performance

Pay costs in month were £0.1m above plan and include the planned provision for the Agenda for Change and Consultant pay awards.

The adverse variance is driven by staffing levels in excess of plan, although there has been a reduction since March, with higher levels of supernumerary cover and fill rates in April.

Substantive staff have remained consistent to April's levels in May but there is an over-establishment of 6% due to CIP delivery requirement via headcount. The over-establishment varies across Pay categories with Support to Nursing and Medical Staff under establishe d with all other groups over established.

Countermeasure Actions	Due Date
• Trust wide and Division workforce control panels in place since November	Ongoing
• Finance recovery groups stood up to review Trust wide workforce actions	June 24

Risks and Mitigations

- Staff availability initiatives are in train to mitigate workforce gaps and the need for premium agency and bank, although in the short term it is likely that the Trust will require both.

Appendix

Business rules and Statistical Process Control (SPC) chart guidance

Our Priorities

People

Population

Partnerships

Appendix

Business Rules – Driver Metrics

Salisbury NHS Foundation Trust

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

Appendix

Business Rules – Watch Metrics

Salisbury NHS Foundation Trust

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

Appendix

NHS Salisbury NHS Foundation Trust

Business Rules – Statutory/Mandatory Metrics

These are additional rules only applied to certain metrics that are statutory or mandatory to be monitored at Trust level.
Whether or not a metric has met its target each month will be indicated by a tick or a corss icon in the "Target Met This Month?" column. The number to the right of that indicates how many months in a row the metric has NOT met its target for. Any metric that has met the target in the current reporting month will therefore show a 0 in this column. Different action are suggested depending on hpw many months the target has not been met for. These metrics are assessed against their improvement target, or their national target where no improvement target exists.

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

Appendix

Reading a Statistical Process Control (SPC) Chart

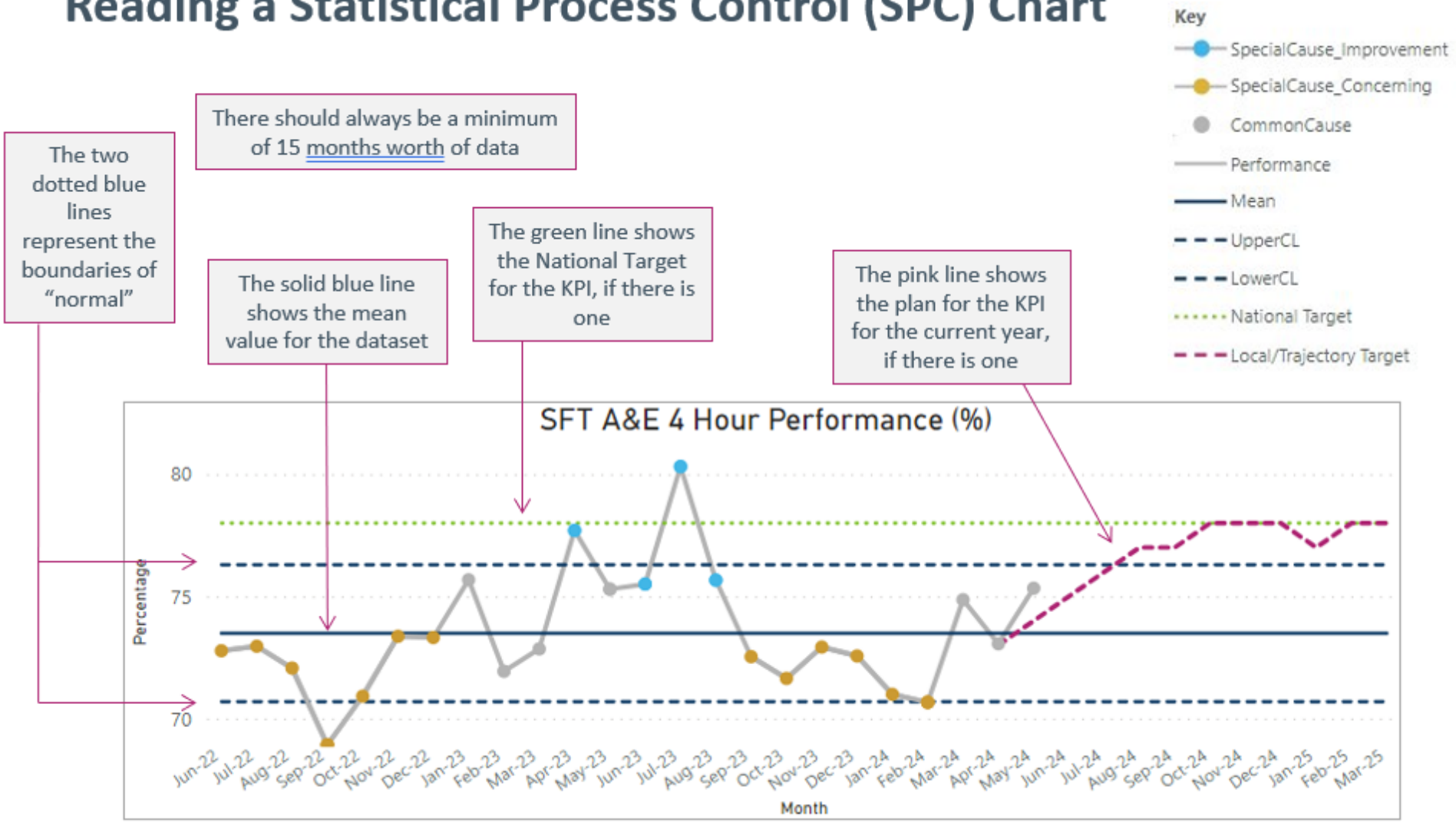
There should always be a minimum of 15 months worth of data

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

The solid blue line shows the mean value for the dataset

The green line shows the National Target for the KPI, if there is one

The pink line shows the plan for the KPI for the current year, if there is one



NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.3
Date of meeting:	4th July 2024		

Report title:	TMC escalation report (covering May & June)			
Status:	Information	Discussion	Assurance	Approval
	x			
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Lisa Thomas, Chief Executive			
Executive Sponsor: (presenting)	Lisa Thomas, Chief Executive			
Appendices	N/A			

Recommendation:

The Board is asked to note the report

Executive Summary:

The Trust management Committee was held on the 22nd of May

The TMC meeting was structured in a new way, trialling starting with the BAF and Corporate risk register as a way to frame the meeting and ensure that the decisions we are taking, and the topics discussed are relevant to the biggest risks in the organisation. This approach will evolve in coming months.

Assure

- The committee received a report on the progress of health inequalities which generated a good discussion about how the Trust might expedite support in some areas, particularly the digital challenges in recording patients with a learning disability.
- The Committee noted the Excellence in Partnership Working document covering working with primary care and to provide guidance and instruction on how best to introduce and embed the principles articulated.

Alert

- Cancer performance was discussed referencing the biggest specialities within challenges. An update on the tiering process was discussed.
- Diagnostics performance had reduced as in the IPR, however recovery plans were in place.
- Financial updates were given highlighting a deficit for April with planned care activity driving the variance.
- Policy compliance was raised as a significant challenge, a summit was to be organised for September to increase compliance.

Advise

- New procedure for Glaucoma patients were approved with the CFO leading the process for ICB approval if over threshold.
- The committee received a report on the benefits realisation of specialty managers
- Helipad policy was signed off

The Trust Management Committee held on the 26th June

Assure

- The committee received a report from the urgent care board updating the transformation programmes.
- The Q4 health and safety report was received which included an update on the violence and aggression and a workforce challenge regarding radiology protection which the CSFS Division are working through.

Alert

- Performance delivery group report highlighted urology is under significant pressure and accounts for the largest 65 week backlog. Further work is ongoing to develop demand and capacity planning to identify actions.

Advise

- The bed escalation plan was approved
- The Committee considered a business case: Acute Pain Team Development, the committee asked for further work in the context of financial challenges and workforce constraints.
- The Committee considered a business case :Endocrine & Diabetes Service Growth, Resilience & Succession Planning, the committee asked for further work in the context of financial challenges and workforce constraints.
- The Committee considered a proposal for Clinical space for Research Hub, this was considered as the right direction for the Trust but further development was required.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.4
Date of meeting:	27th June 2024		

Report from (Committee Name):	People and Culture Committee		Committee Meeting Date:	27 June 2024
Status:	Information	Discussion	Assurance	Approval
	√		√	
Prepared by:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Non-Executive Presenting:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Appendices (if necessary)				

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- The committee were informed that there are several Trust policies (across all policy groups) which have expired. The CEO provided assurance that a summit was being held to review the situation
- The project to transfer medical workforce to the electronic roster programme is taking longer than planned. The CMO and the e-rostering team are working together on this

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- The following items were presented and discussed at this month's meeting:
  - An update was provided into the strategic workforce plan. This will come back to the July committee once purdah is lifted. It was noted that a lot of work has been done in this area but the committee was not yet sighted on this
  - A detailed discussion was held on the latest version of the BAF. It was noted that the BAF is moving to a more cautious risk appetite and the potential risk of the community tender was discussed. Assurance was provided that 22 of the workforce policies were being refreshed, focussing on a restorative culture perspective
  - An update on the BSW people workstream was provided, noting that due to the restructuring at the ICB, there hadn't been much progress to report
  - The improving doctors working lives letter was discussed and a risk assessment against it was provided noting the areas of outstanding actions. Further progress would be provided at a future meeting. The discussion linked this to the Guardian of Safe Working (GOSW) report
  - The new financial year business partner SLA and KPIs were discussed and the Q1 report will be provided to the September committee

To note: The annual review of committee effectiveness was expected in June but has been deferred to July.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- Using the principles of Improving Together, the committee focussed on optimism and curiosity. There was good risk based discussion throughout the meeting
- The workforce planning submissions have been submitted on time

- The Freedom to Speak Up Guarding (FTSU) annual report was discussed, providing good assurance to the committee. The Trust rates highly in terms of the national expectations and the Guardian has been providing help to other Trusts
- The Guardian of Safe Working (GOSW) quarterly report was received. The improvement from the previous report was noted, with the new doctors settling into working at the Trust from their August start
- The risk in relation to staffing has reduced from 20 to 9
- The People Promise workstream continues apace with the retention of the People Promise manager
- Positive shift has been seen in closing all actions bar one in the audit and fraud reports. A new report has been received by the team which will come to the next meeting to be discussed
- The workforce elements of the IPR were discussed. The new format was noted and the positive performance was praised
- This year's tent talks had been very successful with very good attendance

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
• The committee approved the annual FTSU and the GOSW for escalation to the Board

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Public Board	Agenda item:	2.5
	4 July 2024		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	25 June 2024
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Debbie Beaven – Chair of Finance & Performance Committee			
Non-Executive Presenting:	Debbie Beaven			
Appendices (if necessary)	none			

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- **Month 2 Financial Performance** – we are behind plan with two major causes, both of which will be the subject of deep dives in F&P over the next few months.
  - **Activity –** Non elective is 9% above plan and 20% up on last year, for which there is no additional income, but obviously comes with cost and performance implications. The interventions at a system level that should have created a step change improvement have not yet delivered. Primary care has also seen increased activity, to which they have responded. The issue of unfunded demand has been escalated to the ICB, who have asked us to help determine the root cause of demand in the system. The other factor impacting income is a shortfall in elective activity due to theatre utilisation - below plan due to resources in central booking, which is expected to be remedied imminently.
  - **NCTR –** there was some improvement, but it has peaked again.
- **Cash flow –** there is significant stress related to cash flow, which has been escalated to the ICB to seek support.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- **Coding** – there have been resignations in the coding team which could impact the depth and quality of coding until such time as we can fill the vacancies or find a new way of coding e.g. AI, until the EPR (2 years away).
- **Apprenticeships –** Ongoing financial constraints mean we are making short term decisions around the workforce development, which will have a longer term consequence. The Committee expressed a need for a national or regional strategy to develop the future workforce.
- **Risks** – the committee agreed that "deep dives" into each of the "out of tolerance" BAF and CRRs would be a worthwhile exercise; considering the position against our proposed new risk appetite statements (coming to the next Board), exploring how effective mitigation is and how long we can mitigate for before the risks become intolerable. This is in the context of restricted capital including a focus on our critical plant and infrastructure (BAF4) to give assurance that we will not experience a catastrophic failure at any point in the future.

- **Medium Term Financial Strategy –** we were updated on the ICB framework to develop the strategy, with the hope that this will be a two-way collaborative process to improve visibility, partnership effort and socialisation.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- **Cancer –** performance is continuing to improve (using verbal update on May and June performance), which could take us above the threshold to come out of tiering, but only if this were also true for our system partners – as it is a whole system tiering.
- **Digital Progress and SIOR –** there was mixed assurance here, with most programmes are on track, other than EPR, which has been delayed. A joint committee paper will go to the Board. Similarly, with the SIOR, we had reasonable assurance, however, concern was expressed in relation to the use of MFA, and there was some challenge around the penetration testing; the later of which we asked to be detailed more in the next report.
- **Estates Development Plan Governance –** the committee noted the timeline and agreed to add the governance to the F&P workplan.
- **Stroke –** we received a deep dive in the stroke performance and the actions taken to improve the position. We were assured of progress being made, however the best practice of other acutes, using ACPs on the "front door" to identify stroke patients, was suggested as an investment for sustainable improvement, with benefits being in patient outcomes and reduced LoS. Clearly with cost constraints and the "triple lock" position, these are not easy decisions. A strategic conversation across the system is needed to determine the most effective and sustainable long-term model.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.

- None

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.6
Date of meeting:	4th July 2024		

Report from (Committee Name):	Clinical Governance Committee		Committee Meeting Date:	25th June 2024
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	David Buckle			
Non-Executive Presenting:	David Buckle			
Appendices (if necessary)				

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- **Nil**

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- **The medication safety annual report highlighted that the contract with Lloyds Pharmacy was a concern as performance had been poor during the last year. This had resulted in long waits for prescriptions to be processed (a significant quality but not a safety issue) Recent improvement had been noted, but CGC was not fully assured and would continue monitoring.**
- **Not all patients with sepsis are receiving IV antibiotics within an hour. An improving together process is in place to help resolve this matter.**
- **It was noted that 220 patients were waiting more than 6 weeks to have an echocardiogram. CGC has asked for assurance that patients waiting are not put at risk.**

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- **Medicine divisional governance report was informative and gave the committee confidence that clinical governance was in place and effective.**
- **A report on the national patient safety program was received and the Trust is on target with its objectives.**
- **GIRFT six monthly report demonstrates that the trust is broadly delivering the national expectations.**
- **Following the Human tissue authority report, CGC noted that the postmortem corrective plan was making good progress.**
- **The Trust is beginning to see improvement in its SHMI.**

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.

- The IPR, learning from deaths report and the maternity papers have all been considered by CGC in detail.

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.1
Date of meeting:	4th July 2024		

Report tile:	Maternity Quality and Safety Report for Quarter 4 2023/24.			
Status:	Information	Discussion	Assurance	Approval
	X	x	X	
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance 21.06.24 DMT approval e-mail 17.06.24 Clinical Governance Committee -25th June 2024			
Prepared by:	Vicki Marston- Director of Maternity and Neonatal Services.			
Executive Sponsor: (presenting)	Judy Dyos – Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the report, and for its content to be minuted as per CNST requirements ensuring that quarterly oversight of the Quality and Safety Agenda is maintained in addition to the monthly Perinatal Quality Surveillance Model that is reported monthly.

CNST requirements board minutes to note the following:

1. PMRT review to be noted in board minutes.
2. Compliance with labour ward coordinator being supernumerary and women receiving 1:1 care =100%

Executive Summary:

This report will highlight achievements and demonstrate current position against local and nationally agreed measures to monitor maternity and neonatal safety. The purpose of this report is to inform the Salisbury NHS Foundation Trust Board of present and emerging safety concerns.

It will evidence current compliance with national reporting to include Care Quality Commission (CQC), Maternity Incentive Scheme (MIS) and Ockenden 2020 and 2022 recommendations and work towards the 2023 publication of the Three-Year Delivery plan. It will also demonstrate patient experience and feedback and learning.

Clinical outcomes will be reviewed against local and national benchmarks to demonstrate safety in maternity and key improvements and service development will be identified.

This report reflects data from Quarter 4 23/24 with detail highlighted below:

- In Q4 – 1 Stillbirth which will be reviewed via PMRT, with external oversight at the review, to provide additional scrutiny as per process. Overall rate for last 12 months for SFT (to date) is 2.5/1000. National rate 3.9/1000
- 3 reportable Neonatal Deaths.
    - Twins born at 21.5 (non-viable gestation)
    - Baby born at 32 weeks with known congenital anomalies.

  This makes a total of 2 NND > 24 weeks in the last 12 months which equates to 1.1 per 1000 live births. The national neonatal death rate is 1.65 per 1000 live births.
- 1 x Maternity PSII commissioned under the new PSIRF framework.
- Thematic review of all closed SII and CCR's is currently in progress, with external attendance from the Maternity Improvement Advisor working with us from NHSE and LMNS Lead Midwife for BSW, as part of the Maternity Safety Support Programme exit criteria.
- All CNST Training reached 90% compliance in December 2023, however this impacted on other mandatory training rates which has been focussed on during Q4.
    - Challenges in obtaining training compliance for doctors rotating between trusts and training availability to ensure timely updates.
- Challenge with compliance with Saving Babies Lives vs 3 – action plan submitted for extra resource to support the roles and actions that would need to be taken and put into place to move forwards towards compliance.
- 1:1 labour care and supernumerary status of labour ward coordinator maintained 100% of the time in Q4.
- Feedback received via safety champions, FFT, MNVP. Complaints and concerns actioned and fed back to staff and service users.
- Atain rates for SFT for Q4 are 5.2% against a national ambition of <6% and a network ambition of <5%.
- Good progress made with the Maternity Safety Support Programme –Moved to sustainability in March 2024 with a plan to exit during 2024.
- Screening services continue to progress actions following QA visit in September 2022. Out of 44 actions 37 are now closed. The remaining 7 recommendations have been handed to the Screening and immunisations team to continue to monitor.
- Targeted focus on safeguarding supervision, Consultant obstetricians expected to be at 100% in April. Work continues to improve midwifery compliance which is currently at 89% and work around transferring compliance from rotational Doctors.

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

Maternity and Neonatal Services Quality and Safety Report Q4 2023

Women and Newborn Division

Maternity Quality and Safety Report to Board Quarter 4 2023/24

Trust: Salisbury Foundation Trust

CQC Maternity Ratings Inspection 2021	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:
	Requires Improvement	Requires Improvement	Inspected but not rated		Inadequate	

Maternity Safety Support Programme	Select Y / N	Yes

	2023/24											
	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1.Findings of review of all perinatal deaths using the real time data monitoring tool	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Findings of review of all cases eligible for referral to HSIB	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2b. Training compliance for all staff groups in maternity related to the core competency framework (CCF)and wider job essential training	✓	✓	✓	On track for required MIS compliance targets	On track for required MIS compliance targets	On track for required MIS compliance targets	On track for required MIS compliance targets	On track for required MIS compliance targets	Compliant for MIS training compliance not CCF	Compliant for MIS training compliance not CCF	Compliant for MIS training compliance not CCF	Compliant for MIS training compliance not CCF
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3.Service User Voice Feedback	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
4.Staff feedback from frontline champion and walk-abouts	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
6.Coroner Reg 28 made directly to Trust	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
7.Progress in achievement of CNST 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	Reported annually
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (Reported annually)	Reported annually

Contents

1.Executive summary

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the Salisbury Foundation Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. The information within the report reflects actions in line with Ockenden and progress made in response to any identified concerns at provider level.

2.Perinatal Mortality Rate

The following graphs demonstrate how Salisbury Foundation Trust is performing against the national ambition to reduce rates of stillbirths, neonatal and maternal deaths and brain injuries in babies that occur during or soon after birth by 20 per cent by 2020 and 50 per cent by 2025.

In Q4 we have had 1 stillbirth (Excluding MTOP's) as detailed in Figure 2, this makes a total of 5 in the last 12 months, which equates to 2.5 per 1000 births in the last 12 months. The national rate per 1000 births is 3.9 per 1000 with a national ambition to reduce to 2.5 per 1000 births. The stillbirth was reviewed under PSR guidance and presented to Patient Safety Summit. This case was eligible for PMRT review which includes external scrutiny. This case is planned to be reviewed in April.

Figure 1. Stillbirth rate (per 1000 births excluding MTOP's) for Salisbury by calendar year, compared with national rate and ambition by year.

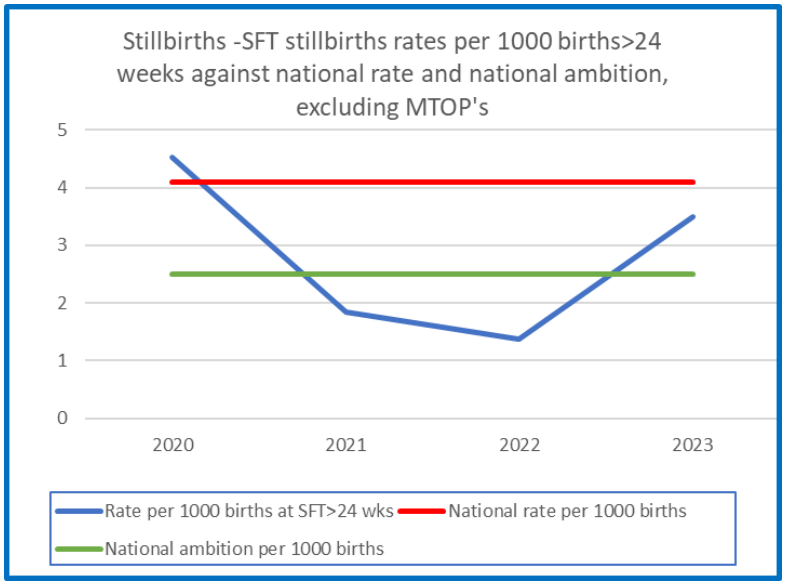
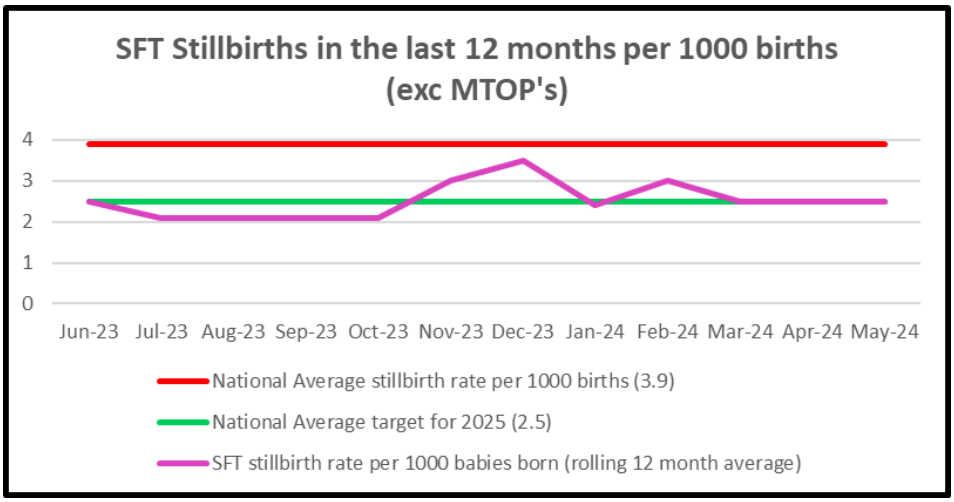


Figure 2. Stillbirth rate (per 1000 births excluding MTOP's) for Salisbury in the last 12 months compared to national rates.



In Q4 Salisbury Foundation Trust had 3 reportable neonatal deaths:

- A set of twins born at extreme prematurity of 21+5 weeks were non-viable and reportable to MBRRACE and CDOP. They were not for PMRT review due to gestation but received a PSR.
- One neonatal death was of a baby born at 32 weeks with known congenital anomalies and expected reorientation to palliative care, reportable to MBRRACE, CDOP and for PMRT review.

This makes a total of 2 NND > 24 weeks in the last 12 months which equates to 1.1 per 1000 live births. The national neonatal death rate is 1.65 per 1000 live births.

Annual local trends by number and rate per 1000 are compared with national rates between 2020-2023 in figure 2. This shows positive progress towards national targets.

Figure 3. Neonatal death rate per 1000 live births > 24 weeks at Salisbury compared with national rate

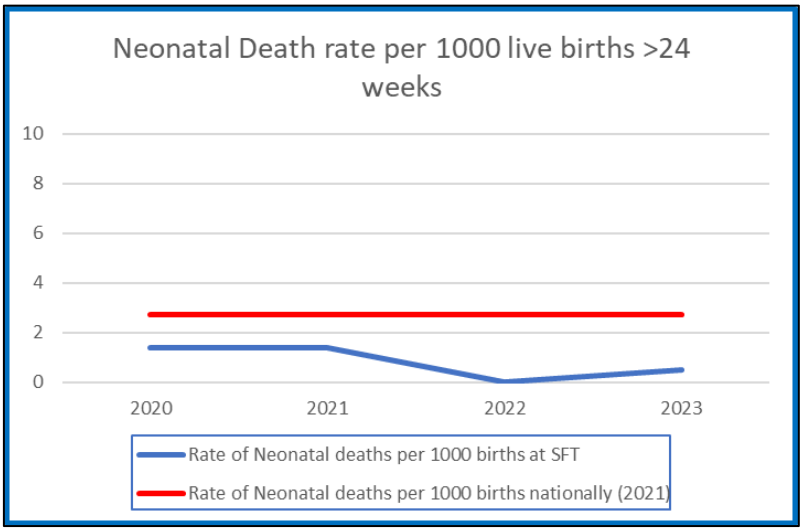
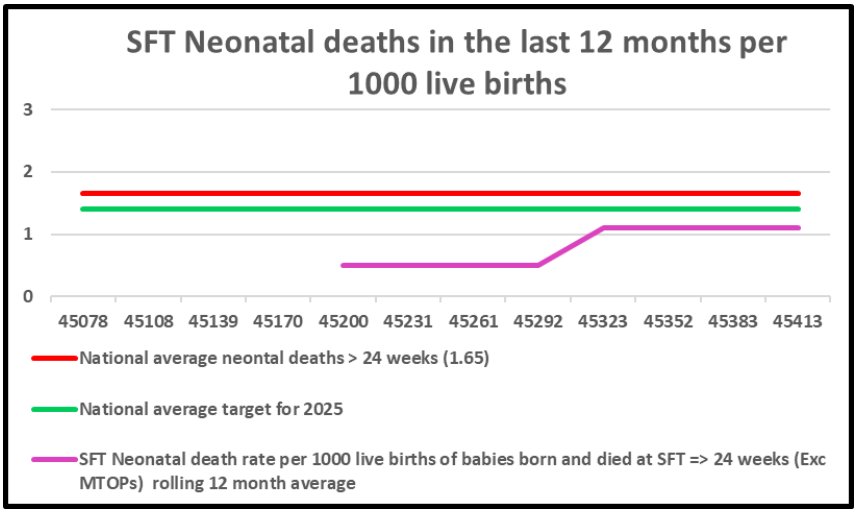


Figure 4. Neonatal death rate per 1000 live births > 24 weeks for Salisbury in the last 12 months



Perinatal Mortality Review Tool (PMRT) Summary Quarter 4 2023/24 (CNST Maternity Safety Action 1)

PMRT was designed and will be developed further with user and parent involvement to support high quality standardised perinatal mortality reviews on the principle of 'review once, review well'.

Introduced in 2018 PMRT is a collaboration led by MBRRACE-UK, who were appointed by the Healthcare Quality Improvement Partnership (HQIP) to develop and establish a national standardised tool building on the work of the DH/Sands Perinatal Mortality Review 'Task and Finish Group'.

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

The PMRT standard is to:
a) Notify all deaths: All eligible perinatal deaths should be notified to MBRRACEUK within seven working days.
b) Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.
c) Review the death and complete the review: For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.
d) Report to the Trust Executive: Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023

During Q4 23/24 4 cases met the criteria for MBRRACE notification and surveillance (2 of these cases were a set of twins) and 2 of these cases met the criteria for PMRT review.

Figure 5. Table showing the number of PMRT reportable perinatal deaths in Q1, Q2, Q3 and Q4

23/24 (excluding terminations for abnormalities)	Q1	Q2	Q3	Q4
Stillbirths (>37+0 weeks)	0	0	0	0
Stillbirths (>24+0 weeks - 36+6weeks)	1	0	3	1
Late miscarriage (22+0 weeks - 23+6weeks)	0	0	0	0
Neonatal deaths <24 weeks	0	0	0	2
Neonatal deaths > 24 weeks	1	0	0	1
Total	**2**	**0**	**3**	**2**

Q4 2023/24 figure 6 (below) highlights outstanding cases to be reviewed by the PMRT group and that they were compliant with the MIS Year 5 CNST standards. The compliance with the MIS (CNST) standards is highlighted as follows: Green represents the standards being completed. Red signifies standard not completed within the reporting time of this quarterly report however, the planned completion dates **will** be reviewed in the specified timeframe to meet MIS standards.

Figure 6. Table showing the MBRRACE reportable cases.

Gest at del	Type of loss	HSIB/ SI/ CR	Parents given MBRRACE/ PMRT	MBRRACE ID	CNST Safety action 1.a) MBRACCE	CNST Safety action 1.a)Survaillanc	CNST Safety action 1.b) Parental engament sought	CNST Safety action 1.c) PMRT	CNST Safety action 1.c) PMRT review meeting	CNST Safety action 1.c) PMRT draft	CNST Safety action 1.c) PMRT report	Grading of care
26+6	SB	No	Yes 3/11/2023	90169	Yes-2/11/2023	Yes- 20/11/202	Yes-20/11/23	Yes 15/12/202	12/01/2024	17/01/2024	17/01/2024	B:B
34+6	SB	No	Yes	90642	Yes 30/11/2023	Yes- 15/12/202	Yes- 11/12/23	Yes 15/12/202	09/02/2024	05/03/2024	05/03/2024	A:A
29+3	MTOP-SB	No	Yes	90990	Yes 21/12/2023	NA	NA	NA	NA	NA	NA	NA
26	SB	No	Yes 22/12/2023	91012	Yes- 22/12/202	Yes - 2.1.24	Yes - 5/1/2024	Yes-23/01/202	08/03/2024	22-Mar	22/03/2024	B:A
21+5	NND x2		Yes - review care (not PMRT <22w)	91250	Yes - 9/1/24	Yes 09/1/24	NA	NA	NA	NA	NA	NA
32+3	NND	No	Yes	91810	Yes-09.02.24	19.02.2024	Yes 15/3/2024	Yes- 22/03/24-	Planned 03/05/20	01/06/2024	01/08/2024	
36+2	SB	No	Yes	91811	Yes-09.02.24	19.02.2024	Yes 08/03/2024	Yes- 22/03/24	Planned 05/04/20	02/05/2024	02/05/2024	

Key: *Grading of care*

A. *No issues identified.*
B. *Issues identified that would not have had an impact on the outcome.*
C. *Issues identified that may have made a difference on the outcome.*
D. *Issues identified that would likely have made a difference to the outcome*

In summary of the above, during Q4 there were 4 MBRRACE reportable cases. Of the 4 cases that met criteria for MBRRACE notification, 2 met criteria for PMRT review. From the reviews, care issues, process and systems changes are identified. Individual action plans are then developed and agreed for cases.

Figure 7: PMRT action plans for each case review of deaths in quarter 4

Action	Implementation plan
This mother presented with reduced fetal movements and scan was indicated but not carried out. •This mother presented with reduced fetal movements, scans and and/or other investigations were indicated but were not caried out •This mother presented with reduced fetal movements, but management was not appropriate and was not in line with national guidance •This mother had a growth restricted baby (defined by estimated fetal weight <10th centile or reduced growth velocity on ultrasound) during her pregnancy and there was a delay in the diagnosis •This mother had oligohydramnios or polyhydramnios during her pregnancy and there was a delay in the diagnosis	Review guidance for fetal surveillance and reduced fetal movements and ensure it is in line with the local FMU trust. Disseminate the learning to ensure pathway for reduced movements at 24-26 weeks is adhered too as per local guideline- Laser, communications to staff, training and education

This mother's progress in labour was not monitored on a portogram	Discuss with staff on bereavement workshops

The Year 5 Maternity Incentive Scheme (MIS) requirements from NHS Resolution (NHSR) recommend using the PMRT tool reporting function to generate reports to share with Trust boards. This report is required to achieve compliance with standard d) and will be submitted to the board on a quarterly basis. A PMRT Board report covering Q1, Q2, Q3 and Q4 23/24 is embedded below for this purpose:

PMRT_BoardReport_
Salisbury NHS Found

3. The number of incidents logged graded as moderate or above.

During Q4 there were 22 incidents recorded as moderate or above. Figure below shows a summary description.

Figure 8. Description of Moderate or above incidents in Q4 2023/24

Incident category and numbers of incidents	Outcome/learning/actions
Unexpected admission to NNU (4)	Reviewed through the MDT ATAIN process and are currently ongoing, PSR's are presented at the weekly Patient Safety Summit. Two of the four incidents were recommended to stay at PSR level, another was recommended for 'after action review' under the new PSIRF policy, and the final case was escalated to MNSI, who triaged and accepted the case.
Shoulder Dystocia (1)	Reviewed using local audit proformas and added to rolling audit for thematic analysis as per PSIRF plan. No omissions in care noted.
OASI injury (9)	Reviewed using local audit proformas and added to rolling audit for thematic analysis as per PSIRF plan. If any concerns or omissions in care these are escalated to PSR and presented to the Patient Safety Summit. All cases reviewed and no omissions in care noted.
Apgar <7 @5 mins (1)	One case reviewed-no immediate safety actions noted-after action review recommended under new PSIRF guidance.
IUD @36/40 (1)	This case involved a multiparous mother who experienced an antepartum stillbirth. Post-mortem and placental histology investigations have been unable to identify a cause of death. PMRT review tool has not identified any concerns or issues with care
Delay in care provision (1)	Delay in providing steroids to mother due to incorrect triage. PSR presented to PSS and influencing human factors noted. PSS team advised midwives reflect upon incident and provide any suggestions for improvements to the triage tools available.
Transfer to Tertiary Unit (2)	• A baby born at 36 weeks was transferred to a tertiary unit for ongoing specialist care (therapeutic cooling). This case was not eligible for MNSI referral but will be investigated as a PSII under new PSIRF guidance. • This case involved a term baby that required transfer to tertiary unit for cooling. This case was eligible for referral to MNSI and has been accepted.
Twin NND (1)	Twins born at <24 weeks gestation with signs of life. PSR presented at PSS, no omissions in care noted - NND due to extreme prematurity.

MCDA Twins- NND(1)	Premature twins born at SFT. Twin 2 had known cardiac anomaly and was transferred following birth and was later repatriated to SFT for palliative care.
21week fetal loss (1)	Missed opportunities to complete the pre-term birth risk assessment. PSR presented to PSS. To amend the VBAC counselling proforma.
19week fetal loss (1)	Pre-term birth risk assessment incomplete for a woman who was low-risk for preterm birth. This did not impact on the outcome. To highlight the importance of the risk assessments and the impact that incomplete risk assessments may have.

4. Maternity and Newborn Safety Investigation (MNSI, formerly HSIB) and Maternity SI's.

Background

The aim of the National Maternity Safety Ambition launched in November 2015 was to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur soon after birth, by 2025. This strategy was updated in November 2017 with a new national action plan called Safer Maternity Care, which set out additional measures to improve the rigour and quality of investigations into term stillbirths, serious brain injuries to babies and deaths of mothers and babies. The Secretary of State for Health asked HSIB to carry out the work around maternity safety investigations outlined in the Safer Maternity Care action plan. However, in October 2023 HSIB was transformed into two bodies the MNSI and Health Services Safety Investigations Body (HSSIB). As part of this transformation the health and social care regulator the Care Quality Commission (CQC) have taken over the HSIB maternity investigations under the newly formed MNSI.

MNSI will continue to undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

Maternal Deaths: Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy

Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.

Early neonatal death: when the baby died within the first week of life (0-6 days) of any cause.

Severe brain injury diagnosed in the first seven days of life, when the baby:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or
- Was therapeutically cooled (active cooling only) or
- Had decreased central tone and was comatose and had seizures of any kind

To meet the requirements against the 7 Immediate and Essential Actions (IEAs) in the Ockenden report all SI's concerning maternity services adhere to the Trusts Incident management Policy. There is also a robust process for reporting cases that meet the criteria for MNSI. There was one case accepted by MNSI in Q4 as detailed above.

Investigation progress update

On 8th January 2024 the Trust moved over to the national PSIRF incident response framework. This report will provide an update on the progress of all ongoing external MNSI/HSIB investigations, any Coroner Regulation 28 notification, Maternity Patient Safety Incident Investigations (PSII's) commissioned during this quarter. There will also be an update on the compliance tracker used by the Trust to monitor and close actions identified during investigations. The table below summarises the progress of MNSI (formerly HSIB) external investigations and notifications.

Figure 9. Progress of HSIB (now MNSI) investigations including any external notifications

Ref	HSIB Reference	Confirmed level of investigation	Date confirmed Investigation	External Notifications and Other Investigations
DATIX 158202 SII587	MI-031767	MNSI Investigation (formerly HSIB)	22/08/23	This case involved a term baby being transferred to a tertiary unit for active cooling. HSIB (now MNSI) have agreed to investigate. Final report has been received with associated actions.
DATIX 163944 Incident Date March 24.	MI-036889	MNSI Investigation (formerly HSIB)	22/05/2024	This case involves a term baby who received therapeutic cooling in a tertiary centre. The case was referred to MNSI as per criteria and has been accepted for investigation.

Coroner Regulation 28 made directly to Trust

There are no Coroner Regulation 28 Reports (prevention of future deaths) in this reporting period.

Maternity Serious Incident Investigations (SII's)

During quarter 4 2023/24 there was one Maternity PSII commissioned under the new PSIRF framework. This was for a 36-week baby born by category 1 emergency caesarean section that required transfer to tertiary unit for therapeutic cooling.

Ongoing SII's and CCRs

At the end of Q4, there were 8 ongoing investigations and 3 for exit which have all breached the 60-day target (from commissioning at the weekly Patient Safety Summit to being presented at the Clinical Risk Group (CRG) meeting). The cases listed below have been subject to regular ongoing escalations to support closure.

Figure 10. Current ongoing incident investigations

SIIs, CRs and LRs In Progress							
ID	Directorate / Ward / Dept	Summary of incident	Incident date	Date commissioned	CRG	Date Due to CCG / 60 days target	Within 60 day target?
SII 574	Maternity	Stillbirth		27/06/2023		**21/09/2023**	
CR 580	WNB	Term admission to NICU	16/07/2023	01/08/2023		**23/10/2023**	
CR 584	Maternity	OASI	3.7.23	8.8.23		**30/10/2023**	
SII586	Maternity	Eclampsia and GA	8.8.23	22.8.23		**13/11/2023**	
SII 587 (HSIB)	Maternity/W&NB	Term baby admitted to NICU and transferred to tertiary unit for cooling	12.8.23	22.8.23		**13/11/2023**	
CR 588	Maternity	Antenatal Pulmonary Embolism at 15 weeks pregnant	31.7.23	29.08.23		**20/11/2023**	
CR 599	Maternity	PPH at Home, did not follow guidelines. C/O IDM	19.9.23	3.10.23		**28/12/2023**	
CR 613	Maternity/W&NB	Eclampsia	19/11/2023	28/11/2023		**26/02/2024**	

Commissioned as PSII					
ID	Directorate / Ward / Dept	Summary of incident	Incident date	Date Discussed at PSS	Progress Notes
162915	WNB	Fetal Bradycardia, Fetal Resus	29/01/2024	06/02/2024	06/02: Commissioned as PSII

Reports for EXIT							
ID	Directorate / Ward / Dept	Summary of incident	Date commissioned	CRG	Date Due to CCG	Within 60 day target?	Progress notes
CR 569	Maternity	Uncrossmatchable Blood - Antibodies	13/06/2023		**08/09/2023**		Post exit changes
CR 579	WNB	Term admission to NICU	18/07/2023		**09/10/2023**		Exit 8.3.24
SII 570	WNB	Retained Swab	13/06/2024	25/04/2024	**08/09/2024**		For exit

Investigation Actions

At the end of Q4 there was significant progress in closing actions. There are ten investigations open across Maternity and Neonatal services of which there are two RAG scored 'red' and thirteen RAG scored as 'amber' with ongoing evidence. There is clear oversight of outstanding actions from Divisional Management Team and support in place to ensure that the progress in closing actions continues.

Figure 11. Compliance Action Tracker demonstrating current completions status on all investigation actions for Maternity (April 2024)

SII/CR No.	Link to Sheet	Directorate	Incident Date	Recommendation RAG Rating (Green = Completion Date, Amber/Red: Target Date)										
				1	2	3	4	5	6	7	8	9	10	11
CR 454	Click	W&NB	December 2021	Q2 23-24	Q2 23-24	Oct 22	Q4 22-23							
SII 489	Click	W&NB	May 2022	Q1 22-23	Dec 22	Q4 22-23	Q4 22-23	Q3 22-23	Q3 22-23					
CR 509	Click	W&NB	July 2022	Q2 22-23	Oct 23	Q2 22-23	Oct 23	Aug 23						
SII 510	Click	W&NB	August 2022	Q1 23-24	Q1 23-24	Feb 23	Q2 23-24	Feb 23	Jan 23	Jan 23	Q1 23-24	Q1 23-24		
CR 512	Click	W&NB	September 2022	Q2 23-24	Jul 23									
CR 514	Click	W&NB	September 2022	Q3 22-23	Jan 23	Q1 23-24	Dec 22	Feb 23	Q2 23-24	Q1 23-24				
SII 537	Click	W&NB	December 22	Jul 23	Jul 23	Jul 23								
CR 540	Click	W&NB	November 2022	Jul 23	Q1 23-24	Sep 23	Jul 23	Jun 24						
SII 555	Click	W&NB	March 2023	Nov 23	Nov 23	Nov 23	Nov 23							
CR 565	Click	W&NB	May 2023	June 24	Dec 24	SMG/Ed.	Compl.							
SII 571	Click	W&NB	May 2022	April 24	June 24	Feb 24	Oct 24							

A thematic review of all closed SII and CCR's is currently in progress, with external attendance from the Maternity Improvement Advisor working with us from NHSE and LMNS Lead Midwife for BSW, as part of the Maternity Safety Support Programme exit criteria. This was commenced and recommended to ensure learning for incidents was being embedded.

5.Continuity of Care

We have no midwifery continuity of carer teams at present. Due to midwifery vacancies and a less experienced workforce, plans to implement this model are paused as per recommendation from NHSE and as advised following the publication of Ockenden. When staffing significantly improves consideration will be given to reviewing a team for continuity of carer in line with national recommendations.

6.Ockenden Report 2020 and 2022 Immediate and Essential Action (IEA) updates

For Ockenden 2020 all outstanding actions had been closed prior to quarter 4.
For the Ockenden Final Actions 2022, there are 15 essential actions, separated into 84 sub actions. Compliance has been assured for 58/84. 0 are awaiting closure, 0 not started and 26 in progress.

Figure 12. Current progress with Ockenden 2022 IEAs

OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
May-24	1	Workforce Planning and Sustainability	0	2	0	5
	2	Safe Staffing	0	2	0	8
	3	Escalation and Accountability	0	0	0	4
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Complaints	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	2	0	5
	8	Complex Antenatal Care	0	4	0	1
	9	Preterm Birth	0	3	0	1
	10	Labour and Birth	0	3	0	3
	11	Obstetric Anaesthesia	0	2	0	5
	12	Postnatal Care	0	3	0	1
	13	Bereavement Care	0	3	0	1
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			↓ 0	26	↓ 0	↑ 58

The multi-disciplinary Ockenden Working Group meets monthly to drive progress on the immediate and essential actions.

7. Training compliance for all staff groups in maternity (related to the core competency framework and wider job essential training)

As part of the Maternity Incentive Scheme (safety standard 8) and Core Competency Framework (CCF) training compliance is monitored monthly. The specified training includes multidisciplinary

obstetric emergencies (PROMPT), newborn life support and fetal monitoring. Within Salisbury, training compliance is also recognised as a divisional driver for Improving Together. We will continue to focus on compliance with 6 key training programmes locally relating to MIS, CCF.

Within the MIS, 3 key areas are identified to achieve training compliance of over 90%:

- PROMPT – Multidisciplinary Obstetric Emergencies
- Newborn Life Support
- Fetal Monitoring

We were able to achieve the required compliance in all 3 areas of training for MIS year 5 as below.

To maintain compliance for MIS year 6 we have a clear trajectory of staff attendance allocated for annual training throughout 2024 prior to the MIS deadline in December 2024.

Figure 13. PROMPT training compliance by staff group as of 01.03.24

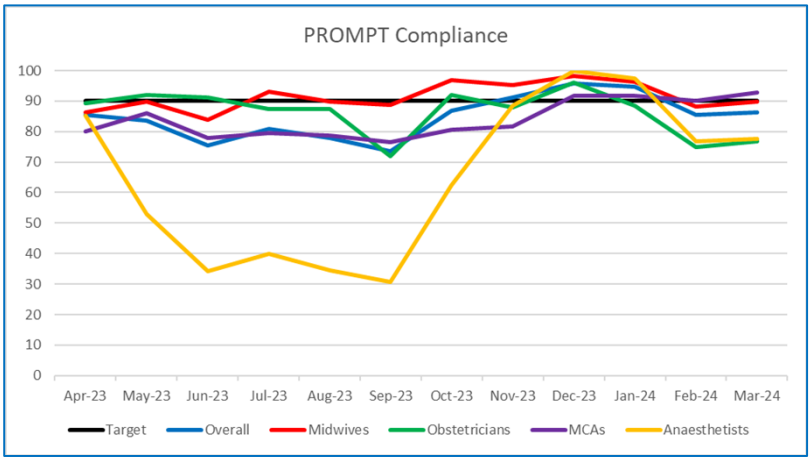


Figure 14. Fetal Monitoring training compliance by staff group as of 01.03.24

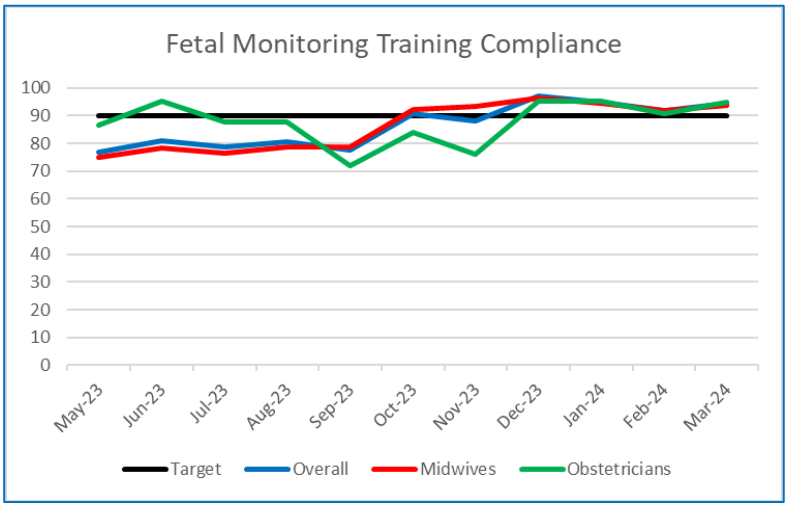


Figure 15. NLS training compliance by staff group as of 01.03.24

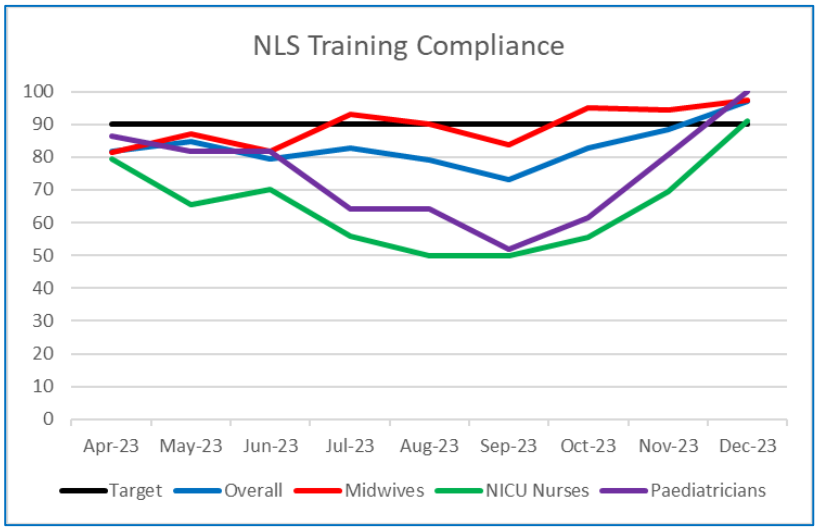
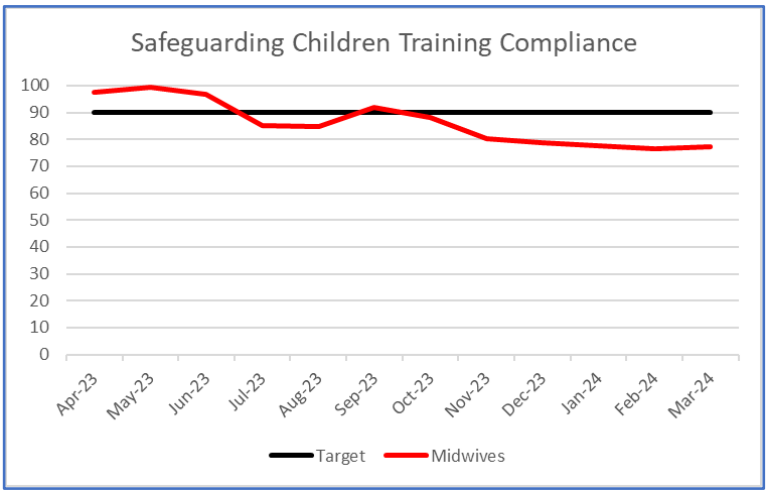


Figure 15. Summary Safeguarding Children Level 3 compliance for Midwives as of 01.03.24.



Although all training compliance was met for the CNST deadline in December 2023, this impacted other rates of compliance for Trust mandatory training, including Safeguarding Children Level 3, negatively. The focus was away from this for the last quarter of the year, so moving forwards, we will be improving Trust-required training compliance alongside the maternity-specific requirements. % A trajectory has been created and additional Safeguarding Level 3 training dates have been created in May 2024 to support this. Whilst Obstetric Consultants are 100% compliant with Safeguarding training, data around junior Doctors compliance for safeguarding is unclear due to the rotation between trusts. Clarification and 'passporting' of training across Wessex is currently being explored to ensure compliance but also avoid repetition when training is still in date.

Industrial action in January impacted the availability for medical staff to attend training and due to the Trust creating additional theatre lists, anaesthetic attendance has dropped. This has been escalated to the surgical divisional leads for a plan in how to release anaesthetists to attend PROMPT.

8. Maternity and Neonatal Safety Champions

In Quarter 4 bimonthly meetings for the Safety Champions continued in accordance with Safety action 9 of the Maternity Incentive Scheme.

Recent highlights have included:

1. Issue of lack of representation in safety champion meetings from MNVP (current MNVP on maternity leave)
2. Lack of devices to access translation services in ANC.

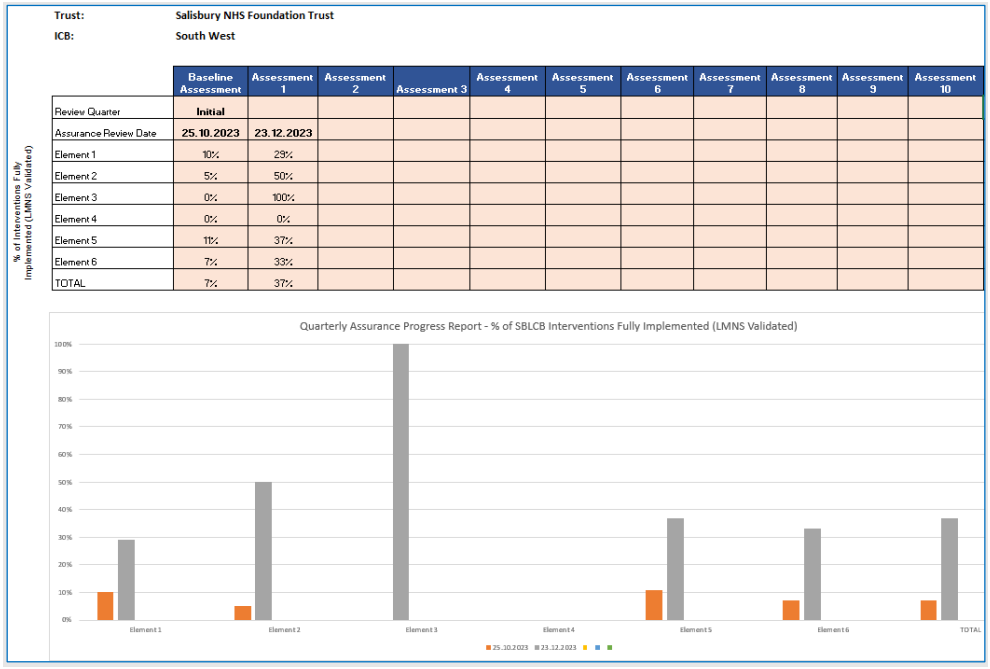
The Maternity and Neonatal Safety Champions Meetings have expanded invitations and now have attendance from across the Neonatal and Maternity workforce from all areas and bandings. This aims to ensure appropriate representation from all areas to ensure concerns and safety issues are escalated form ward to board. It also enables feedback from the safety Champions to be fed back and actions shared to the workforce.
The Executive and Non-executive Safety Champions complete regular walkabouts to give staff opportunity to share any concerns or safety matters.
The monthly meeting also provides opportunity for the perinatal quadrumvirate to share work that is in progress around culture and any support that they require as per CNST Maternity Incentive Scheme Safety Action 9.

9. Saving Babies Lives V3

The Saving Babies Lives Care Bundle version 3 (SBLCBv3) was published on 31st May 2023. The SBLCBv3 represents Safety Action 6 of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme. NHS England have produced an Implementation Tool to assist Trusts in reporting progress to Board and LMNS/ICB.
In addition to the five Elements of the previous care bundle, version three contains an extra element relating to pregnant women with pre-existing diabetes. Saving Babies Lives Version 3 has been challenging to achieve with the new set of requirements (see below). The implementation tool provides detailed minimum requirements and stretch targets for compliance and evidence required. SFT have been working towards the minimum evidence and compliance required with current compliance noted in the figures below.

The figures below show progress that has been assessed by the LMNS from August and December submissions, SFT's self-assessed compliance for these two submissions and then lastly, the most recent 2023 Q4 self-assessed submission which shows reduced compliance from the previous submission.

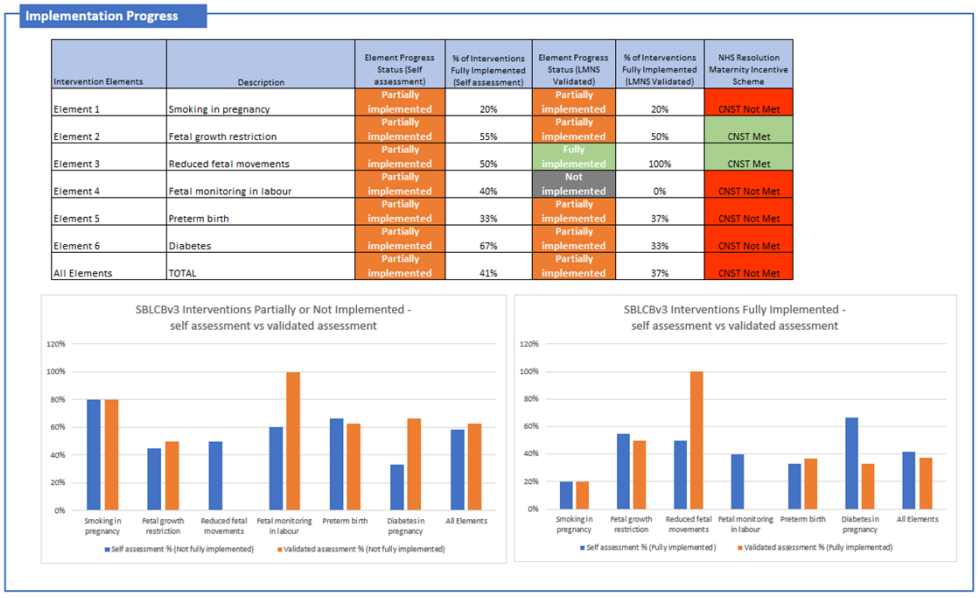
Figure 16 SBLv3 LMNS validated progress at SFT showing 7% compliance with 1st submission (August 2023) and 37% compliance with 2nd submission (December 23).



Trust: Salisbury NHS Foundation Trust
ICB: South West

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5	Assessment 6	Assessment 7	Assessment 8	Assessment 9	Assessment 10
Review Quarter	Initial										
Assurance Review Date	25.10.2023	23.12.2023									
Element 1	10%	29%									
Element 2	5%	50%									
Element 3	0%	100%									
Element 4	0%	0%									
Element 5	11%	37%									
Element 6	7%	33%									
TOTAL	7%	37%									

Figure 17. Compliance with SBLv3 Board Report noting 41% self-assessed compliance vs 37% LMNS validated compliance on 1.12.23 (Q3), SFT's 2nd submission

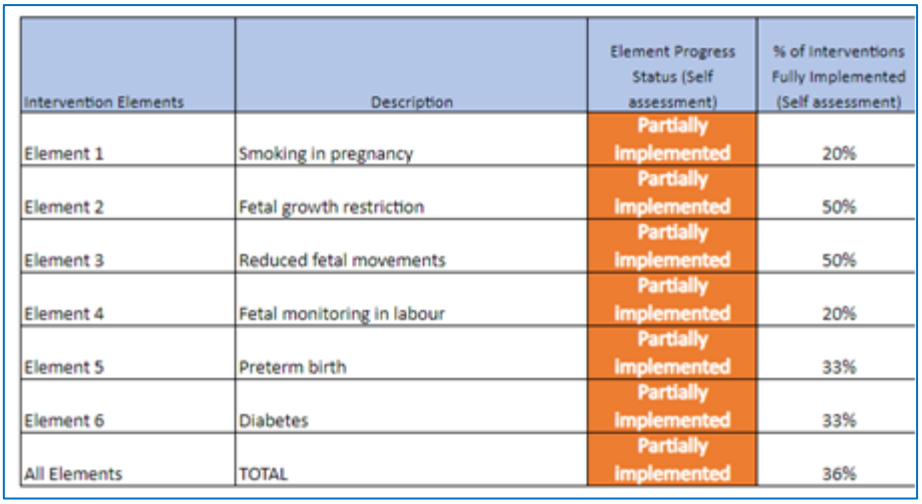


Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	20%	Partially implemented	20%	CNST Not Met
Element 2	Fetal growth restriction	Partially implemented	55%	Partially implemented	50%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	40%	Not implemented	0%	CNST Not Met
Element 5	Preterm birth	Partially implemented	33%	Partially implemented	37%	CNST Not Met
Element 6	Diabetes	Partially implemented	67%	Partially implemented	33%	CNST Not Met
All Elements	TOTAL	Partially implemented	41%	Partially implemented	37%	CNST Not Met

**LMNS validation dates: 1st submission 10.8.23, validation received 25.10.23. 2nd submission 1.12.23 LMNS validation received 19.1.24. (dated 23.12.23)*

Figure 18. Q4 202/324 self-assessed submission to LMNS, showing a reduction in compliance from the previous submission.



Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)
Element 1	Smoking in pregnancy	Partially Implemented	20%
Element 2	Fetal growth restriction	Partially Implemented	50%
Element 3	Reduced fetal movements	Partially Implemented	50%
Element 4	Fetal monitoring in labour	Partially Implemented	20%
Element 5	Preterm birth	Partially Implemented	33%
Element 6	Diabetes	Partially Implemented	33%
All Elements	TOTAL	Partially Implemented	36%

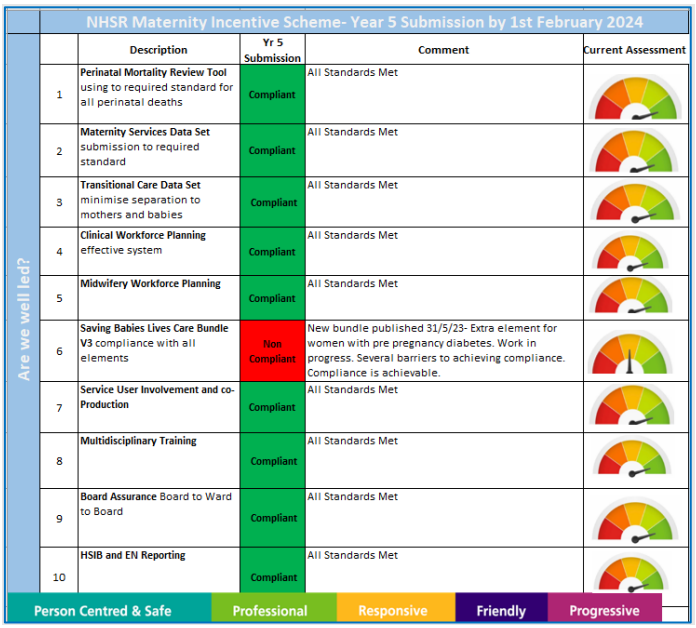
The absence of a fully digitalised clinical information system has meant that the SBL dashboard requires manual data input and, in addition to significant manual audit requirements, this has hindered input and compliance. It is acknowledged that it will improve when Clevermed Badgernet is fully implemented (expected February 2025).
Work has taken place to fill vacancies in key roles (DAU and clinic), as well as recruiting a Quality Assurance Midwife for a 12-month fixed term to provided dedicated support for implementation of SBL. The procurement of digital BP and urine testing devices together with decisions around PLGF testing and funding remain outstanding, all of which result in SFT not following national guidance and impacting on the achievement of SBL. Work continues regarding funding and procurement to achieve this.
It is anticipated that recruitment of a Quality Assurance Midwife will support progress towards compliance and support us to fully commit to the national ambition of reducing stillbirth and improving perinatal outcomes.

10. NHS Resolution Maternity Incentive Scheme (MIS) Year 5 declaration at year end (Q4)

SFT previously self-declared that they were compliant with 5 out of the 10-safety action as defined in the Maternity Incentive Scheme (MIS) year 4 2022/23.
Following focussed work compliance significantly improved for MIS year 5 2023/24 submission and SFT were compliant with 9 out of 10 safety actions.

We were non-compliant with Safety Action 6 Saving Babies Lives but have detailed in the action plan submitted to NHSE the roles and actions that would need to be taken and put into place to move forwards towards compliance. The Figure below shows current progress and projections for this which is an improvement on the previous year 4 submission.

Figure 19. Maternity Incentive scheme (MIS) Year 5 declaration of 9/10 compliance.



NHSR Maternity Incentive Scheme- Year 5 Submission by 1st February 2024

Are we well led?

	Description	Yr 5 Submission	Comment	Current Assessment
1	**Perinatal Mortality Review Tool** using to required standard for all perinatal deaths	Compliant	All Standards Met	
2	**Maternity Services Data Set** submission to required standard	Compliant	All Standards Met	
3	**Transitional Care Data Set** minimise separation to mothers and babies	Compliant	All Standards Met	
4	**Clinical Workforce Planning** effective system	Compliant	All Standards Met	
5	**Midwifery Workforce Planning**	Compliant	All Standards Met	
6	**Saving Babies Lives Care Bundle V3** compliance with all elements	Non Compliant	New bundle published 31/5/23- Extra element for women with pre pregnancy diabetes. Work in progress. Several barriers to achieving compliance. Compliance is achievable.	
7	**Service User Involvement and co-Production**	Compliant	All Standards Met	
8	**Multidisciplinary Training**	Compliant	All Standards Met	
9	**Board Assurance** Board to Ward to Board	Compliant	All Standards Met	
10	**HSIB and EN Reporting**	Compliant	All Standards Met	

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

MIS Year 6 requirements are expected to be published in April 2024

11. Safe Midwifery Staffing

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings. Midwifery staffing is reported separately to the Clinical Governance Committee and Trust Board biannually as well as via monthly perinatal quality slide set report to both committees.

Midwifery Staffing
A bi-annual staffing review paper was submitted to Trust Board as per Maternity Incentive Scheme Safety Action 5 in Quarter 4 2023/24, a further report will be submitted in September 2024 as per requirement. Midwifery vacancies are monitored monthly through Perinatal Quality Slides (reported to Trust Board) and highlighted at Executive performance review monthly.

To ensure continued focus on the staff vacancies across the division, this remains one of our drivers for Improving Together and progress has been significant with recruiting to vacancies.
This staffing challenge is reflected both nationally and in other local units- countermeasures relating to staffing are also monitored weekly through our driver meetings.

Safety metrics are reviewed monthly through the Perinatal Quality Slides (reported to Clinical Governance Committee and Trust Board) and are shown below providing evidence that whilst midwifery staffing remains a challenge measures are in place to maintain a safe service and ensure 1:1 care is maintained for all labouring women.

Figure 20. Current workforce safety metrics for Q4

Measure	Aim	Jan 24	Feb 24	March 24
Midwife to Birth Ratio	1:26	1:25	1:26	1:30
Supernumerary labour ward coordinator status	100%	100%	100%	100%
1:1 care in labour	100%	100%	100%	100%

Whilst midwifery vacancies remain an ongoing challenge, several initiatives have been employed to maintain a safe service as detailed below:

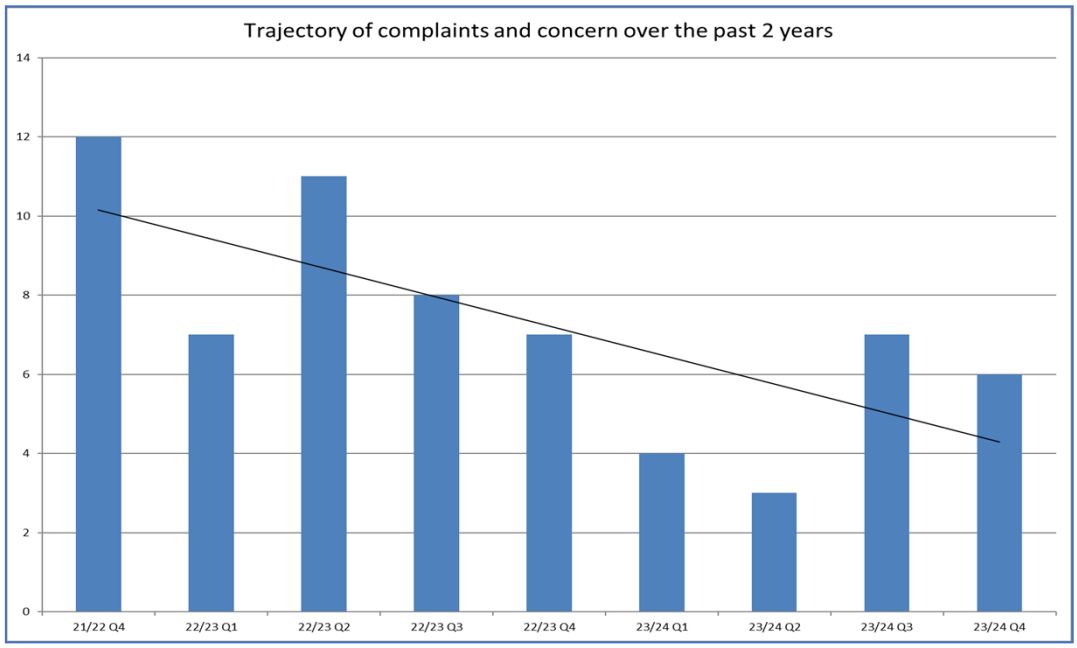
- A robust maternity escalation plan
- Registered General Nurse employed in clinical areas.
- Over recruitment of maternity care assistants
- Engaged in collaboration to recruit International Midwives - we have 7 within the service, all 7 have passed OSCEs, 6 of the 7 midwives have NMC Pin and one is awaiting theirs.
- 2 Maternity care assistants have started a Midwifery apprenticeship and one nurse has commenced a nurse to midwife conversion course.
- Recruitment campaign to include executive agreed incentivised payment once in post.
- Relocation package promoted.
- Flexible working party have reviewed working patterns. Actions identified and instigated to improve work life balance.
- Continue with retention work and input from PMA to support staff.

We have an ongoing recruitment campaign and continue to receive targeted support from the central recruitment team to support us and recruitment is reviewed weekly with the team to ensure timely appointments. We continue to closely monitor staffing daily to ensure a safe service is maintained.

12. Service users and staff feedback, Maternity Voices Partnership Co-production

During this section of the report patient experience via complaints, concerns, enquires, FFT and compliments (including SOX) will be summarised together with current MNVP co-production activity for this quarter.

Figure 21. Summary of complaint, concerns, comments, and enquiries



Although the maternity department ‘s complaints and concerns remain on a downward trajectory, in Q3 an Q4 we have seen a slight increase.

- 2 complaints were logged in Q4 which was the same as in the previous quarter.
- 4 concerns were logged in Q4 which was one less than in Q3.
- 9 complaints and concerns closed in Q4, with a compliance rate to target times at 44%. This is a 44% improvement of the previous quarter.
- 1 concern was escalated in Q4 (from a comment to a concern).
- No complaints were deescalated during this period.

Figure 22. Action from closed complaints and concerns

Location (exact)	Description	Actions	Theme
Postnatal	Poor experience on the postnatal ward	•The Postnatal Ward Manager will work closely with the maternity support workers, to build on their knowledge around basic care needs of the mother and baby. **Pending update.** •To discuss patient's feedback on the annual study days, with the focus on improving the working culture on the Postnatal ward **Update: ongoing.** •To explore ways to protecting a two-person drug round, enabling staff to offer women stronger pain relief more regularly. **Pending update.**	**Nursing Care**
Postnatal	Medication error. Wrong drug chart was amended	•Senior paediatricians are to discuss all babies under enhanced care with the lead midwife on postnatal ward every day, and to be responsible for ensuring timely review of babies on antibiotics. **Update: May 24- the Paediatric clinical leads are looking at safeguarding time to review new-borns on the BMW as part of their work plan.**	**Inappropriate treatment**
Postnatal	Inappropriate behaviour of staff	Notice has been added to the midwives' station as a reminder to staff to ensure all communications are respectful and professional at all times. **Update: completed**	**Attitude of staff - medical**
Antenatal Clinic	Poor internal communication RE scan appointment	Comms have been cascaded RE the new 'No request, No scan' policy. **Update: Completed**	**Lack of communication**
Labour ward	Negligence in labour and aftercare	Second Obstetric opinion sought - case was managed appropriately.	**Neglect**
Postnatal	Concerned RE newborn antibiotics	•Continued to share with staff themes from patient feedback, with a real focus on appropriate communication. **Update: ongoing** •The Neonatal Matron will explore (with the Clinical Lead for the neonatal unit) the escalation process to ensure that parents voices are heard. •MOMA to be completed on the use of prophylactic antibiotics in the new-born. **Update: completed May 24.**	**Insensitive communication**
Postnatal	Concerned RE newborn antibiotics	Not upheld	**Information not given to family**

Maternity Day Assessment Unit	Delay in treatment	•Communicate with staff about correct and full completion of the triage form. **Pending update** •The midwives who triaged your calls, have undertaken a period of professional reflection. **Update: completed**	**Insensitive communication**
Labour ward	Patient's records	No further action as the staff member no longer works for the Trust.	**Unsatisfactory treatment**

Figure 23. Comments opened in Q4

Location (exact)	Description	Outcome	Sub-subject (primary)
Postnatal	Concerned Re management of the Pt's wound infection	Birth reflection appt scheduled	Further complications
Maternity Day Assessment Unit	Poor experience in MDAU.	Local resolution achieved	Nursing Care

Friends and Family Feedback (FFT) Experience Rating

Figure 24. The percentage FFT rated as good or very good by clinical area:

Area	% rated good or very good *(averaged for the quarter)*	
	Q3 2023/24	Q4 2023/24
Antenatal	60%	100%
Community Postnatal	100%	100%
Early Pregnancy Unit (OP)	100%	100%
Homebirth	*No data available*	*No data available*
Hospital Labour Ward	100%	100%
Hospital Postnatal Ward	100%	100%
Infant Feeding Clinic (OP)	100%	100%

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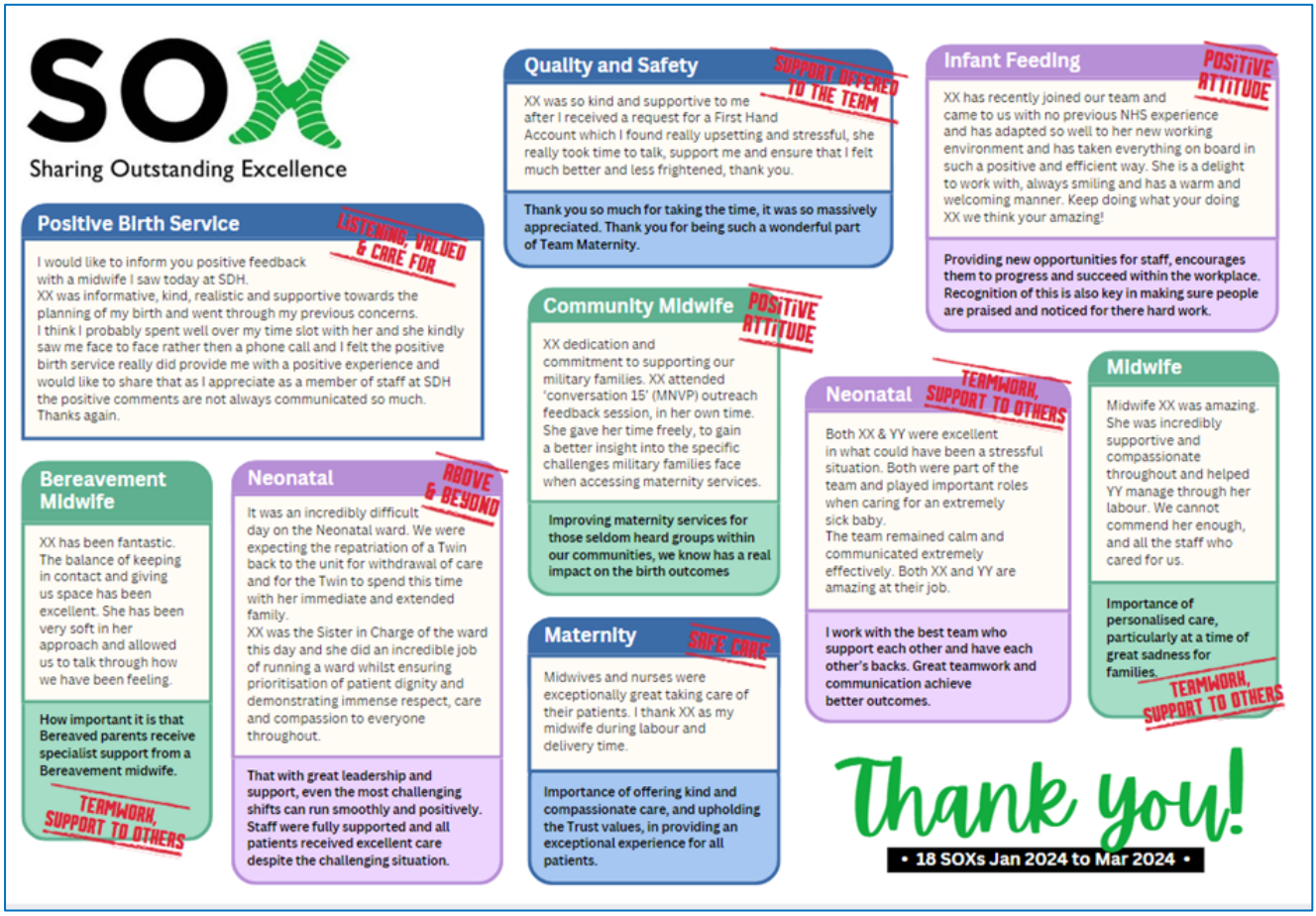
Sharing Outstanding Excellence (SOX) – positive staff feedback
In Q4 we received 18 SOX and themes include 'Support to others and teamwork'. Below is the new infographic shared with staff.

Figure 25. SOX received in Q4.



Patient experience audits and surveys

The postnatal patient experience survey was undertaken between Oct 23 and Feb 24- prior to the introduction of the new mixed postnatal and antenatal ward. 100% of women asked felt that they were supported to bond with their baby, and felt they received enough advice about their baby's wellbeing. However, the survey identified that women's discharges were delayed, due to waiting for the new-born examination. The intention is to reinstate the NIPE clinic, it is hoped this will offer women a prompt service and facilitate a timely discharge home. The link to the full survey results can be found here: PN Survey

MNVP feedback

The top themes of the MNVP feedback includes:

- Personalised care, both positive and negative
- Continuity of care
- Women/ birthing people not feeling /or feeling listen to.

Themes of patient surveys will be monitored via the new complaints, concerns, incidents and litigation triangulation meeting. The full links to the survey results: MNVP Report Feb 24 and MNVP Report Sept 23- Jan 24

Next steps for patient experience

To progress the completion of the 15 steps action plan and monitor the compliance to the national patient experience 2023 work stream.

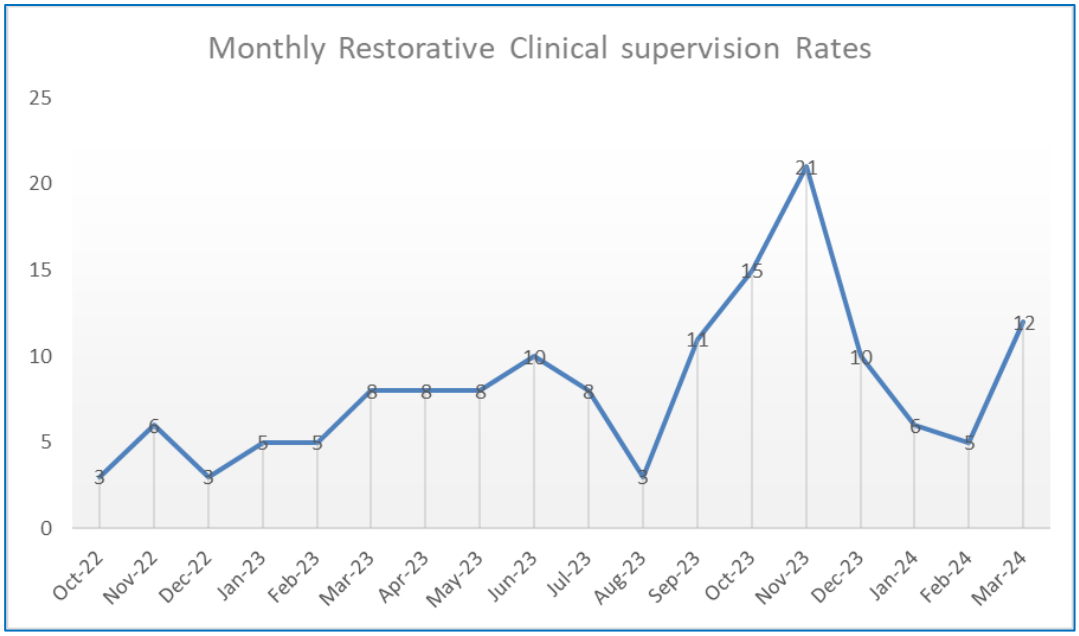
Undertaken a further audit on the experience of women who racialize themselves as black or brown and those from lower social economic groups.
Continue to promote and support the newly formed Triangulation group. With the focus of identifying themes for patient feedback, claims and risks.

13. A-EQUIP model

The Professional Midwifery Advocate (PMA) team are responsible for implementing and deploying the A-EQUIP model (Advocating for Education and Quality Improvement) which supports a continuous improvement process that aims to build personal and professional resilience, enhance quality of care and support preparedness for appraisal and professional revalidation.

PMA Restorative Clinical Supervision (RCS) update
RCS supports the Restorative element of the A-equip model. Through Q4, all Midwives returning from maternity leave, sick leave (> 4 weeks) and all new starters have received an RCS session. Additional RCS support for all NQMW and international midwives has continued through Q4. Secure data is kept on the number of RCS sessions taking place, and themes are collected (whilst ensuring confidentiality is maintained). 23 RCS sessions were carried out in Q4, a decrease from 46 in Q3 which is a decrease of 50%. In Q4 23 sessions carried out, 1 was a midwife returning from long term sick, 2 were returning to work from maternity leave, 2 were new members of staff, 2 were Preceptees receiving RCS as part of their individual preceptee support package and the remaining 16 were Midwives who had a work-related issue they needed support with.

Figure 26. Monthly restorative clinical supervision rates



PMA activity

- Teaching continues around Civility and respect and our Divisional Behaviour Charter, with all our new Midwifery/MCA and Medical staff. This is included on induction and within our PROMPT study day.
- Active Bystander Training has been launched to support the growth of a positive culture within maternity and neonatal. This training has been included in the PROMT mandatory

study day since January 24, as part of a wider session around Civility and positive workplace culture.
- PMA input remains a large part of our Preceptorship support package and includes quarterly 1:1 restorative supervision and teaching on preceptee study days. Topics covered include creating a positive workplace culture, civility and respect, and a session on increasing awareness around psychological health in the workplace, and how to maintain and protect it.
- Production of Wellbeing folders for staff for all staff rest rooms, with information and signposting around physical health, psychological health and menopause.
- A survey around the experience of Equality, Diversity and Inclusion for maternity staff has been designed and will be conducted in April 2024. This survey aims to identify any areas for improvement, to plan and inform ongoing work in this area.

PMA Training
There are 2 Midwives currently undertaking PMA training (funded through NHS England).

PNA/PMA collaborative working.
With 2 nurses from NICU starting PNA training, discussions are underway about how the PMA's and PNA's within Women and Newborn can work together collaboratively to form a larger PMNA team, in support of all maternity and NICU staff.

14.Avoidable Admission into the Neonatal Unit (ATAIN)

The National Ambition
In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on:
- Reducing harm through learning from serious incidents and litigation claims
- Improving culture, teamwork and improvement capability within maternity units.

Why is it important?
There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

All term babies that are required to spend time in the neonatal unit have a formal MDT review via ATAIN meetings. This is a systematic and thematic review, deep diving into the reasons for admissions retrospectively, to identify whether they could have remained on the ward, as opposed to being admitted to the neonatal unit, and observe any themes. This aids learning (via perinatal meetings) and enables a level of scrutiny to ensure that best and most appropriate care is being provided.

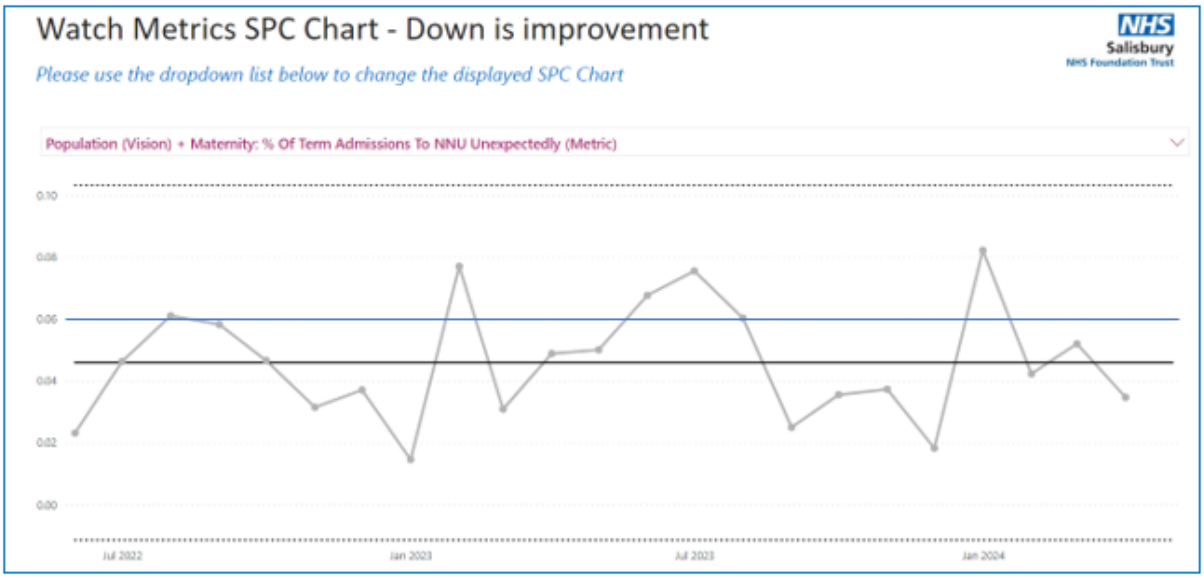
The national ambition is for the percentage of term babies admitted to NICU to be **<6%**, however our local Thames Valley and Wessex (Neonatal) Operational Delivery Network (TVW ODN) aims for a rate of **<5%**.

We are currently awaiting the publication of Q4 ATAIN dashboard data from the TVW ODN.

The current rate in Salisbury is **5.2%** (March 2024) so remains red. Please see TVW ODN ATAIN Dashboard embedded below.

TVW KSS ODN
ATAIN Dashboard 202

Figure 27. % of avoidable term admissions against national target of 6% (noted by blue line).



The majority of ATAIN admissions continue to be respiratory complications associated with birth.

Below is the ATAIN meeting action tracker that has been embedded:

ATAIN ACTION
TRACKER (April) 2024

15.Maternity Safety Support Programme (NHSE)

Formal support from the NHSE programme continues and work remains ongoing with SFTs allocated Maternity Improvement Advisor from NHSE.

Dedicated Project Management support has been provided from the SFT Transformation Team resource and has been extended to support until October 2024. The aim of this introduction is to continue co-ordination of the delivery of the Maternity Safety Support Programme.
Progress has been good and as of March 2024 the Trust has moved into sustainability phase.

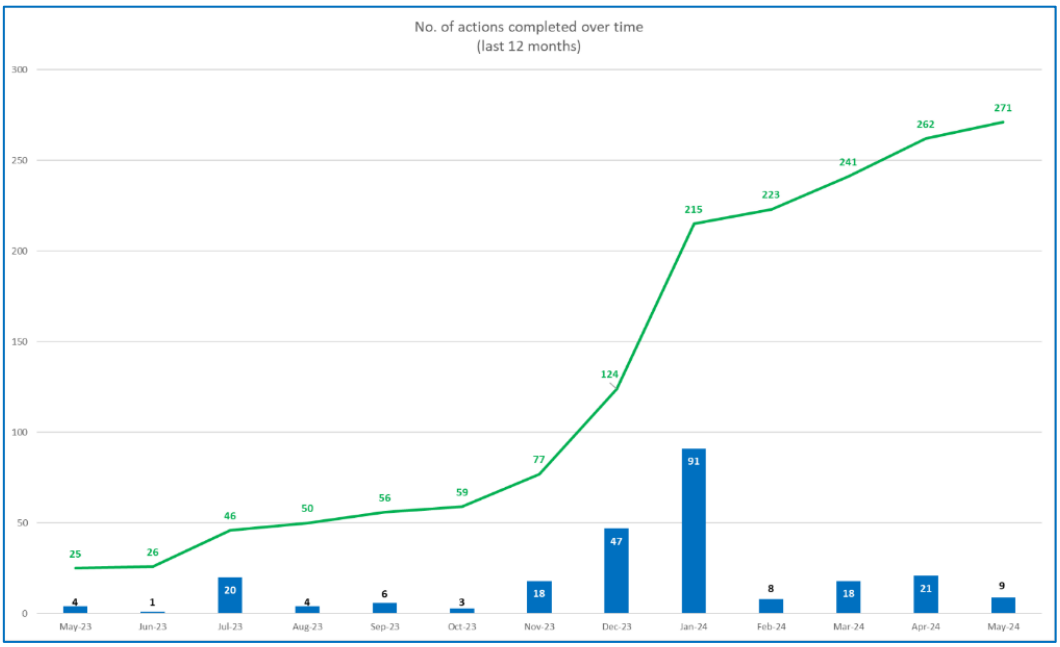
It is expected that in the coming months formal exit from the programme will be achieved.

The benefits will continue to be demonstrated through action progress tracking within the Maternity Improvement Plan.

Maternity Improvement Plan (MIP)
The Maternity improvement plan continues to be worked on with input from the MDT, DMT and our NHS Maternity Improvement Advisor from NHS England. Monthly meetings to monitor progress against the identified actions and feed into the divisional governance process are ensuring progress and improvements are ongoing.

The Director of Midwifery, Clinical Director and Divisional Director of Operations met with LMNS lead Midwife, Regional Chief Midwife and MIA in October 2023 to reset priorities, agree timelines and the exit plan from the programme. The Maternity Improvement Plan provides both a high-level overview of the current situation and demonstrates where focussed resource would deliver value.

Figure 28. Maternity Improvement Plan – monthly progress of actions being closed at end of Q4



16. Risk register highlights

A bi-monthly 'Risk Register Review Meeting' with DMT and lead clinicians/risk owners is held which ensures oversight and timely action completion. Current risk register highlights are identified below.

Figure 29. Current Open Risk register items as of 30.5.24

ID	Title	Rating (current)	Opened
8074	Breaches in 60 day SII and CCR investigation target	12	30/04/2024
7923	Neonatal unit heating	10	08/12/2023
7221	There is a risk of cases with harm not being escalated due to the large backlog of Datix	10	14/02/2022
6412	Potential harm to women and babies through lack of dedicated 2nd obstetric theatre	9	28/04/2020
8060	Non attendance at essential safeguarding child protection and child in need meetings	9	17/04/2024
7894	Delay in first trimester screening bloods reaching the lab in Portsmouth	9	14/05/2024
7733	Lack of Service for Abnormal Placentation	8	15/06/2023
6836	Risk of re-designation of neonatal intensive care service	5	24/02/2021
7109	There is a theorectical risk of infection to women and babies as the Labour Ward birthing pools are over recommended manufacture date	5	15/11/2021
7623	Neonatal ROP	5	02/03/2023
7891	No separate consultant rotas for obstetrics and gynaecology	4	13/11/2023
7999	No dedicated 24/7 obstetric anaesthetist cover.	4	02/10/2023
7860	Neonatal ventilators	3	04/10/2023
8049	Maternity Information syastem back and forward copying issue	2	29/01/2024

17.Safeguarding

Level 3 Safeguarding Children training:
Level 3 Children's safeguarding training figures are improving, the current trajectory evidences that obstetric consultants will be 100% compliant by May and midwives are predicted to be 84% by the 22/5/2024. The outstanding midwives have been rostered onto training days to improve compliance. The Named Midwife for Safeguarding continues to work closely with Named Nurse for Safeguarding to ensure figures are accurate and if concerns are raised these can be resolved quickly.
As per narrative within safeguarding section -Clarification and 'passporting' of training across Wessex is currently being explored to ensure compliance but also avoid repetition when training is still in date.

L3 Adult Safeguarding training:

- This is for B7 and B8 midwives only at present.
- Part 1 is online training and part 2 is face to face ½ day training.
- Compliance is 33% and improving. We are required to provide adult safeguarding supervision and a plan for adult safeguarding supervision training is in development.

Safeguarding Supervision Compliance:
There are now an additional 2 midwives who can provide supervision, this will support compliance (see below). There are four Midwives/nurses who have not completed any sessions. All maternity unit midwives have had safeguarding supervision rostered and can access this remotely.

Figure 30. Safeguarding supervision compliance for Midwives and Nurses

Obstetric Consultants are now being provided with safeguarding supervision sessions by the named midwife for safeguarding. This is taking place quarterly at the clinical governance meeting to support attendance.

Adult safeguarding supervision is currently being reviewed across BSW to ensure we are all in line with recommendations, a meeting is scheduled with safeguarding leads within Banes and Swindon.

Safeguarding themes:
There has been a significant increase in Unborn's subject to child in need plans within the last quarter, see figures in the table below:

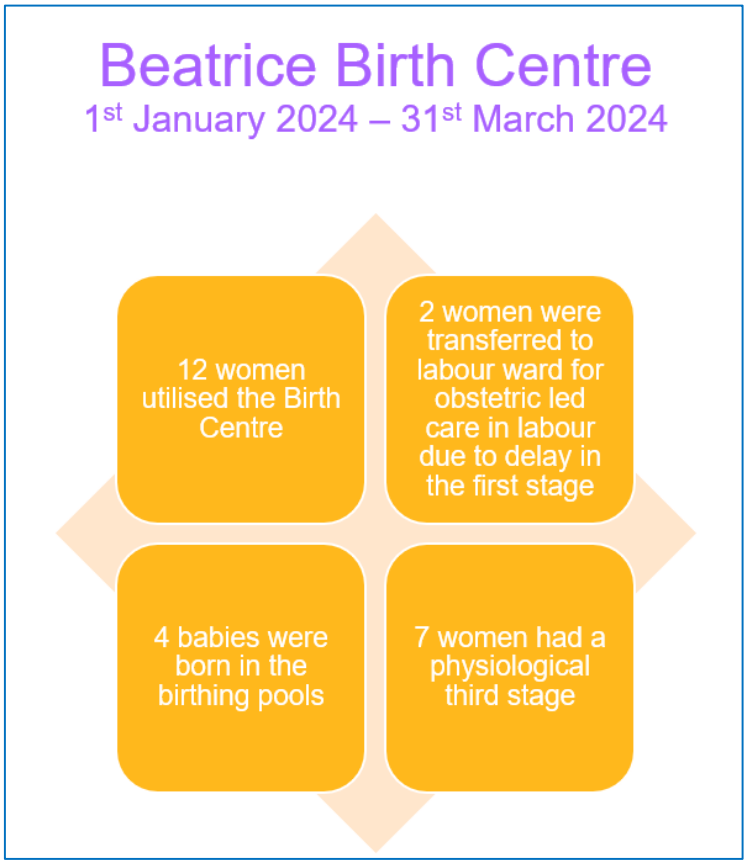
Child protection	7
Child in need	24
Level 2 b	2
ESA (Early support assessment)	5
Awaiting outcome	13

The current theme for legal proceeding includes substance misuse and learning difficulties.

18. Beatrice Birthing Unit

During this quarter 12 women have utilised the Beatrice Birth Centre, which is a slight increase from the previous quarter of 2% of all service users to 2.6%. Of these 12 women 2 were transferred to obstetric led care on labour ward for delay in the 1st stage.

Figure 31. Beatrice Birth Centre summary



19. Screening Services

Six Screening programmes are offered at SDH

- Sickle cell and thalassaemia Screening
- Infectious Diseases in pregnant screening
- Fetal Anomaly Screening
- New-born Hearing Screening
- Newborn and Infant physical examination
- Newborn blood spot screening

This report covers Q2 and Q3 data as per quarterly external reporting submissions as summarised below:

Q1 (April-June)	Data submitted in **September**
Q2 (July-Sept)	Data submitted in **December**
Q3 (Oct-Dec)	Data submitted in **March**
Q4 (Jan-March)	Data submitted in **June** with annual data

There was a second QA visit to the antenatal and newborn screening services at SDH following an initial visit on September 13th, 2022. 44 recommendations were identified following the first visit, with a deadline of May 2023 for a specified proportion of the actions and November 2023 for the remaining actions. 37 of the recommendations have now been confirmed as closed by NHS England quality assurance team the remaining 7 recommendations have been handed to the Screening and immunisations team to continue to monitor. QA have recently sent a letter to the

Directors outlining the remaining open recommendations. There is a plan that is being worked towards for the remaining recommendations to be closed. QA had a positive response to the number of recommendations the screening team have closed to date.

All screening guidelines have now been updated and are all available on microguide.

Incidents / Risks / Screening Incident Assessment Form (SIAF)

All providers of local NHS screening services have a duty to report and manage screening safety incidents in line with 'Managing safety incident in NHS screening programmes' screening safety incidents include;

- Any unintended or unexpected incident(s), acts of commission or acts of omission that occur in the delivery of an NHS screening programme that could have or did lead to harm to one or more persons participating in the screening programme, or to staff working in the screening programme.
- Harm or a risk of harm because one or more persons eligible for screening are not offered screening.

For Q3 SDH has had 1 Antenatal SIAF.

Postnatal SIAF 014136 - A Hearing screener at Salisbury re-screened a baby that had been transferred in from another trust who had already had full screening completed by the trust. An email was sent to the community team prior to the hearing screening advising the community team that the baby required postnatal care. The screening team did not send a hearing proforma as the hearing screening had already been completed. The Hearing screener subsequently went out to see the patient and completed the hearing screen again. Full investigation completed and found the following, the family seen have safeguarding concerns and the Hearing screener attended the property with a midwife for a first visit, no proforma was sent by the screening team when the patient was transferred into SDH as hearing screening had already been completed. the hearing screener did not confirm with the screening team if screening was needed as she saw an opportunity to complete screening for a high-risk family. The hearing screener asked the family to see the notes and red book, but the family were unable to provide any. The hearing screener went through the hearing screening process and both mother and father gave consent. At the end of the visit the hearing screener was handed the red book by the father, and she noted that baby had already been screened. The hearing screener apologized to the family and advised of the repeat screen. The hearing screener did not inform the screening lead, however, on Monday morning when the imports were being managed the mistake was noted by the screening lead and a SIAF was completed as advised by the national team. 16/05/2024 Email sent to National team requesting update on closure date.

Q2&Q3 KPI's

KPI's are used to measure how the 6 antenatal and postnatal screening programmes are performing and give a high-level overview of their quality. They contribute to the quality assurance of the screening programmes.

Figure 32. Q2 (2023) and Q3 (2023) Antenatal and Postnatal screening **KPI improvement areas highlighted in Red** **Q3 KPI's are not published until March.*

KPI Standards	Q2 (2023) July-Sep	Q3 (2023) Oct-Dec	Acceptable threshold	Achievable threshold
ST1: Antenatal screening Coverage	100%		>95.0%	>99.0%
ST2: timeliness of antenatal screening	74.8%	75.0%	>50.0%	>75.0%
ST3: completion of FOQ	92.7%	95.4%	>95.0%	>99.0%

ST4a: timely offer of PND to women at risk of having an infant with SCD or thalassaemia	0 cases	0 cases	To be set	To be set
ST4b: timely offer of PND to couples at risk of having an infant with SCD of thalassaemia	0 cases	0 cases	To be set	To be set
NB2: Avoidable newborn blood spot repeat tests	0.8%	1.3%	<2.0%	<1.0%
SO6: The proportion of first blood spot samples that require repeating due to an avoidable failure in the sampling process.		1.31%	<2.0%	<1.0%
ID1: HIV Coverage	100%	99.3%	>95.0%	>99.0%
ID3: Hepatitis B coverage	100%	99.3%	>95.0%	>99.0%
ID4: Syphilis Coverage	100%	99.3%	>95.0%	>99.0%
FA2: Coverage 20- week screening scan	99.0%	99.6 %	>95.0%	>99.0%
SO4: referral timeliness of information and support	100%	0 cases	>97.0%	>99.0%
NH1: The proportion of babies eligible for newborn hearing screening for whom the screening process is complete < 4 weeks (28 days) corrected age (in services which provide a hospital model – well babies) and neonatal intensive care unit (NICU) babies or by < 5 weeks (35 days) corrected age (in services which provide a community model – well babies). (NH1)	100%	99.3%	>98.0%	>99.5%
NH2: The proportion of babies requiring immediate referral who are brought for an audiological assessment appointment in the required timescale. (NH2)	87.5%	100%	>90.0%	>95.0%
NP1: the proportion of babies eligible for the newborn physical examination who are tested for all 4 components (3 components in female infants) of the newborn examination at ≤ 72 hours of age and have a conclusive result on the day of the report	97.7%	96.9%	>95.0%	>97.5%
NP3: the proportion of babies with a screen positive newborn hip result who attend for ultrasound scan of the hips within the designated timescale.	89.0%	77.9%	>90%	>95%

During Q3 there was a slight decline in the following KPI's **ID1,3 4** (Infectious disease coverage) this was due to patients declining screening, **NH1** (The proportion of babies eligible for newborn hearing screening for whom the screening process is complete < 4 weeks (28 days) corrected age (in services which provide a hospital model – well babies) and neonatal intensive care unit (NICU) babies or by < 5 weeks (35 days) corrected age (in services which provide a community model – well babies) . **NB2** (Avoidable newborn blood spot repeat tests), **NP3** (The proportion of babies with a screen positive newborn hip result who attend for ultrasound of the hips within the designated timescale). Measures have been put in place to bring the KPI's back to the acceptable and achievable threshold and although Q4 KPI's have not yet been submitted improvements have been seen in Q4 for some of the KPI's that were not meeting the acceptable and achievable thresholds during Q2 & Q3.

20. Three Year Maternity & Neonatal Single Delivery Plan

On 30th March 2023 NHS England published its three-year delivery plan for Maternity and Neonatal Services. The plan sets out how the NHS will make maternity and neonatal care safer, more personalized, and more equitable for women, babies, and families.

There are clear actions and objectives defining responsibility for trusts, ICB and NHS England around four themes:

1. ***Listening to Women and Families with compassion***
2. ***Supporting the Workforce***
3. ***Developing and sustaining a culture of safety.***
4. ***Meeting and improving standards and structures.***

SFT have benchmarked their current position and are working through actions on the plan.

21. Recommendation and next steps

The Committee and Board are asked to receive and discuss the content of the report noting the links to NHSR Maternity Incentive Scheme and the below next steps:

- CNST, Ockenden and Maternity Improvement Plan working group meetings continue to ensure traction and movement with ongoing actions.
- Working towards improved SBL compliance and resource to support this.
- Focus on working towards Three-year delivery plan requirements and mapping the additional resources identified to deliver on the plan.
- Continue to focus on additional Divisional priorities for Maternity Services:
    - Recruitment and Retention of workforce
    - Patient involvement and Experience (as per Three Year Delivery Plan and alongside Trust and LMNS priorities)

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.2
Date of meeting:	4th July 2024		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services –April 2024			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance 17.05.2024 DMT Agreed 08.05.2024 CGC 25th June 2024			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 6 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

Executive Summary:

The Maternity Incentive Scheme (safety action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly. The perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance report for SFT for April 2024.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW

Summary:

Staffing:

- Reduction in Midwifery vacancies, although still significant gap in clinical Midwives.

- Midwife to birth ratio 1:32– SFT recommended ratio 1:26 – reflective of Midwifery vacancies and acuity in April
- 1:1 care in labour achieved at all times
- Supernumerary status of labour ward maintained 100% time.

Incidences reported as moderate.

- 2 Incidences reported as moderate.
    - 1 x 3b perineal tears
    - 1 x 3C perineal tears

PMRT

- One review 36.2 Stillbirth of baby. PMRT Grading of care A and A

Training

- Compliance in PROMPT, CTG and NLS training. Target of 90% reached and compliance met as of 1st December 2023. Work continues to improve compliance with other mandatory training.

Service user and staff feedback

- Feedback received from varying sources including MNVP, safety champions, friends, and family survey and PALS

National Guidance

- CNST compliance 9 out of 10 for 2023. MIS year 6 published in April 2024
- Work ongoing to improve compliance with Ockenden 2022 IEA, 26 actions ongoing, 58 actions closed.

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

NHS
Salisbury
NHS Foundation Trust

NHS
Salisbury
NHS Foundation Trust

Perinatal Quality Surveillance

MAY 2024 (April data)

Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

	Target	Threshold			Feb '24	Mar '24	Apr '24	Comment
		Green	Amber	Red				
Midwife to birth ratio	1:28	1:28		>1:26	1:27	1:30	1:32	Increased births from March. Active recruitment continues 3 x MW in April.
Compliance with supernumerary Status of LW Coordinator %	0	0		>1	100%	100%	100%	
1:1 care not provided	0	0		>1	0	0	0	
Confidence factor in BirthRate+ recording	60%	>60%		<50%	79.89	41.67%	83.3%	Percentage of possible episodes for which data was recorded. Audit commended December 23
Consultant presence on LW (hours/week)	40	40			40	40	40	
Daily multidisciplinary team ward round	90%	>90%		<80%	100%	100%	100%	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0		>1	0	0	0	

NHS Salisbury NHS Foundation Trust

Is the standard of care being delivered?

- Supernumerary Labour Ward coordinator status achieved 100% time
- The Midwife to Birth ratio increased in April due to Increased births.

What are the top contributors for under/over-achievement?

- Vacancy rate – steady progress in reducing the vacancy rate (10% in April)
- Maternity leave reducing in May and June. Long term sickness reduced in April.

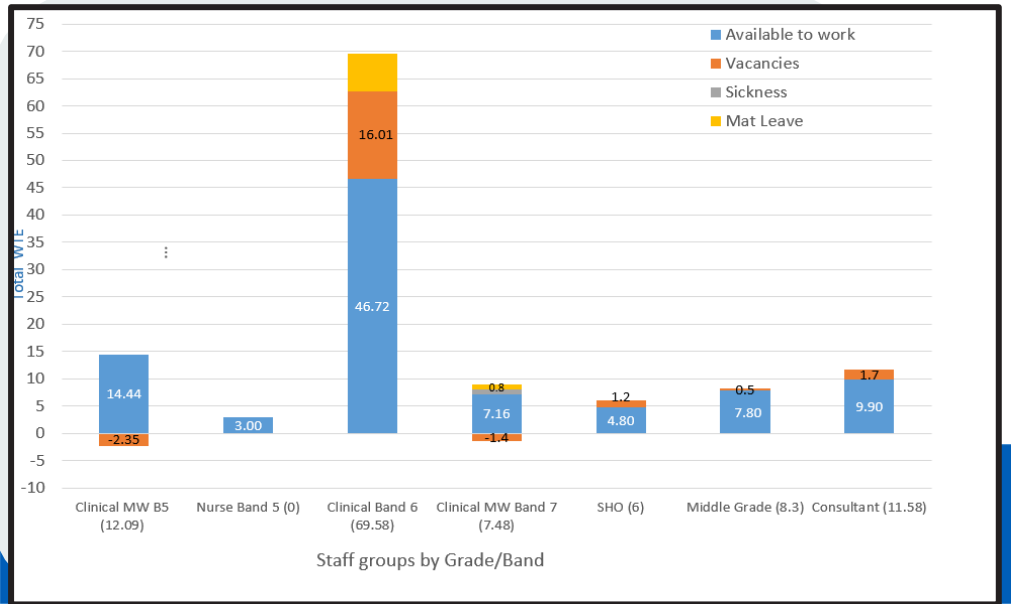
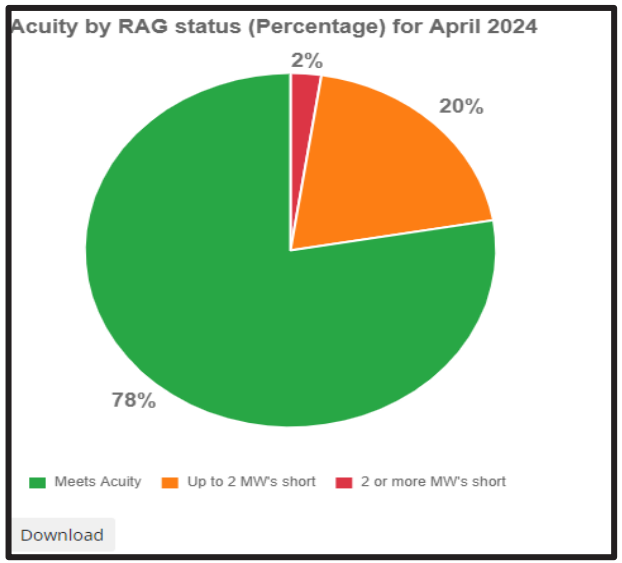
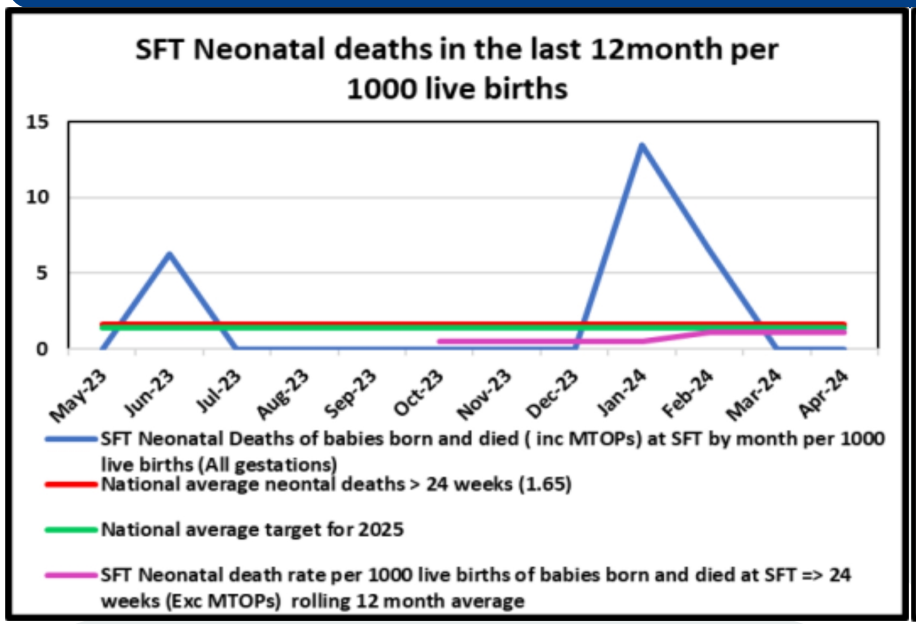


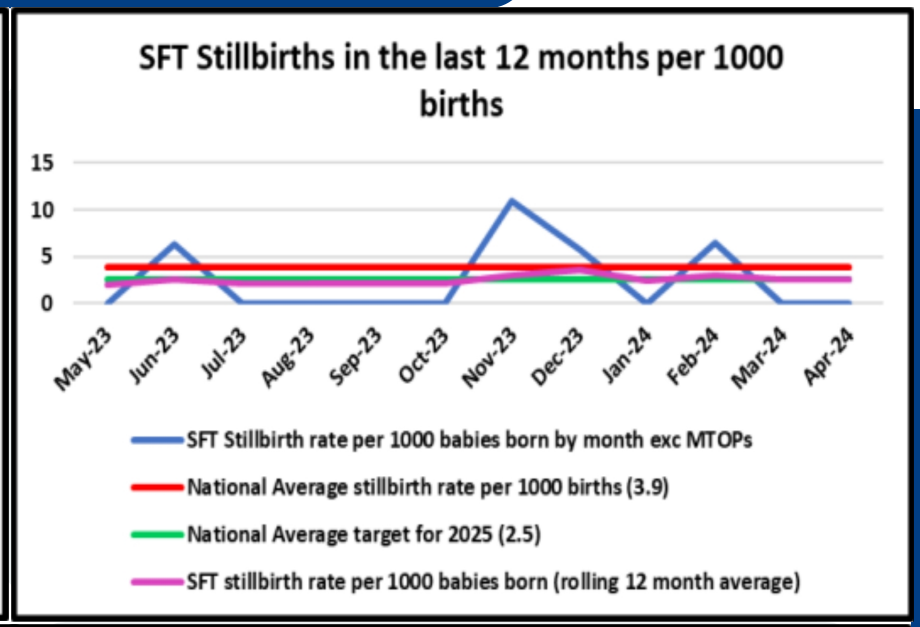
Table 2. Average midwife shift fill rates

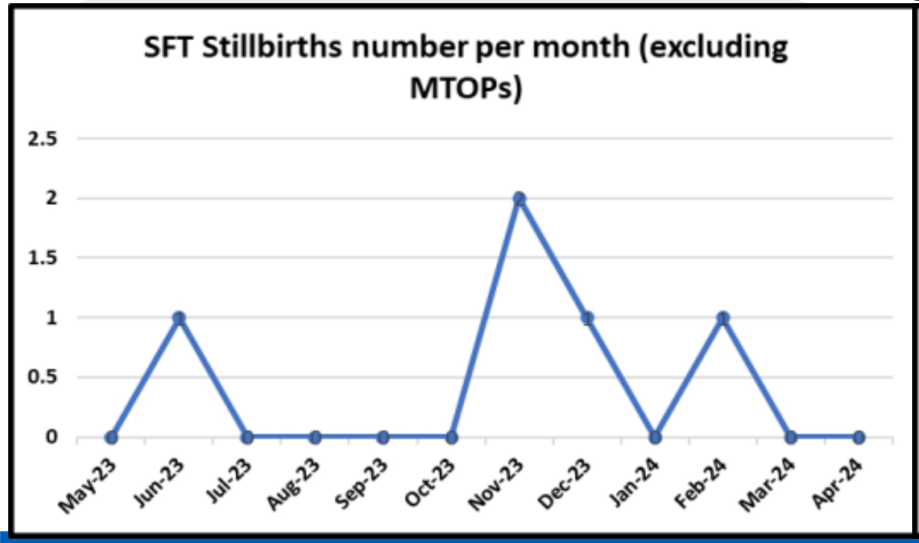
		Feb '24	Mar '24	Apr '24
Midwives	Day	95.2	94.2%	97.2%
	Night	97.8 %	97.9%	99.3%
MCA/MSWs	Day	93.6 %	97%	
	Night	87.2 %	98.4%	

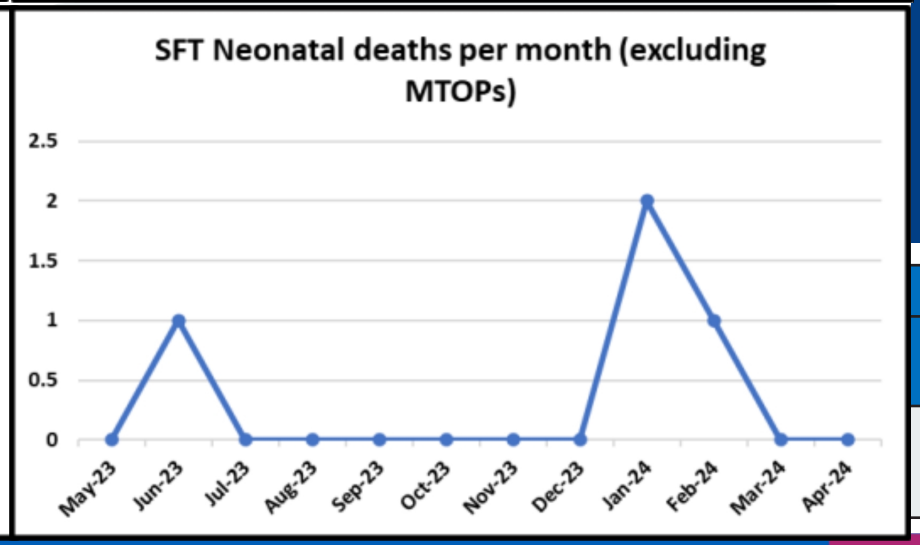


Safe: Perinatal Mortality Review Tool (PMRT)









Salisbury NHS Foundation Trust

- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is MIS Safety Action 1 for year 6. A quarterly update paper is shared with the board. .
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers.
- Still birth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.

- <u>Perinatal deaths for April 2024 :</u>
- One miscarriage at 15+5 weeks gestation
- One MTOP at 19+6 weeks gestation
- One MTOP at 21+6 weeks gestation

PMRT Action Plans for Salisbury Foundation Trust – March 2024 reviews

PMRT case ID	Issue text	Action plan text	Person responsible	Target date
91811	There were no issues with care found that generated an action.			

PMRT grading of care – Key

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
PMRT: 991811 Datix 163122	05/04/2024	Unavoidable death	Stillbirth of baby at 36+2 weeks.	Cause of death-Undetermined PMRT grading of care- A and A **Actions** No actions were generated from this review.	NA	NA

Incidents (Moderate and above)

NHS Salisbury NHS Foundation Trust

New cases for April 24

Case Ref (Datix)	Date	Category	Incident		MNSI Reference	SI? Reference
165183	23/4/24	Moderate	3b tear and MOH 1.7L following svd, delay to theatre	To seek obs opinion		
165313	28/4/24	Moderate	3c following pool birth	No care omissions		

PSRs in April included:

- Difficult extraction
- APGAR of 6 at 5
- Fetal loss at 19+
- Fetal loss at 21 weeks

Ongoing Maternity and Neonatal Reviews

NHS Salisbury NHS Foundation Trust

Ongoing Maternity and Neonatal Reviews and update

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions
155892	18/5/23	Moderate Harm	Unexpected admission to neonatal unit	Shared decision making and escalation training, as well as introduction of updated CTG stickers that give improved information on appropriate actions required. For report share 24/5/24
156305	2/6/23	Moderate	Uncross matchable blood - antibodies	Draft: Develop a system for handover of care for high-risk women expected on LW. Improve communication between lab and community midwife and add antibodies as risk factor on PPH risk assessment tool. Has been through exit. Chasing post exit changes escalated
156497	9/6/23	Never event	Retained swab	Draft: Options to be explored around possibility of purchasing swabs that enable a physical barrier to prevent swabs being left in a cavity. a)Revise the Accountable Items, Swab, Instrument and Sharps Count Policy to ensure this is clearly articulated and the associated flow chart is amended in line with this. b)When revising the policy strengthen action 5.2.2 to reiterate the expectation for clear and timely communication of the swab count prior to closure of a body cavity c)Ensure these changes are communicated to all staff within the operating and 'pseudo' operating departments where this policy has relevance. To review and revise the SOP for Opening a Second Obstetric Theatre and link it to the Obstetric Theatre Operational Policy To include into the current maternity records audit a question on whether there is documented evidence that the need for translation services has been considered on the Delivery Suite for women for whom English is not their first language. The Trust should use a second WHO checklist when a separate and distinct operation is required even if the patient has not left the operating room To support junior medical, midwifery nursing staff by anticipating where unusually pressured situations may arise for example in situations of family conflict, personal / professional boundaries / knowledge / power dynamics. For exit end of May

Ongoing Maternity and Neonatal Reviews (continued)

NHS Salisbury NHS Foundation Trust

Ongoing Maternity and Neonatal Reviews

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions
157595	8/8/23	Moderate Harm	3B tear, tailing growth and mode of birth	Not ready. Draft chase and expected 13/3/24. Report in writing – escalation in progress
157555	8/1/23	Moderate Harm	Term admission	Amend induction of labour guideline AND fetal monitoring guidelines such that both unequivocally state to continue fetal monitoring at minimum 6 hourly intervals. Clarification of whether women partway through induction need evening Obs ward round review as only intrapartum are currently mandated for this. Report out for factual accuracy
158301	8/12/23	Moderate harm	Term Admission, required cooling at tertiary unit	Action plan awaiting CRG review
158202	8/8/23	Moderate harm	Eclamptic seizure at home, admitted to ED - GA	Draft actions: Update pathway and explore options for documentation of administration and escalation. Implementation of case huddles in complex patients with clear SBAR handovers. Clinical teams to be notified and included in future sim scenarios. For chair's final approval
158066	31/7/23	Moderate Harm	PE at 15/40, missed opportunity for LMWH	A failsafe should be introduced to be implemented between appointments with different clinics/specialties to avoid missed appointments and to aid follow up. Appointment letters should be clearer and terminology changed to make it more obvious if a woman is required to see a doctor. High risk VTE women where VTE prophylaxis should br prescribed before 12 weeks should have a timely obstetric consultant appointment in clinic. For CRG
159341	19/9/23	Moderate harm	PPH at home, guidance not followed	Report with legal team
161025	19/11/23	Moderate Harm	Eclamptic seizure	Panel held 19/3/24 - draft complete, for review and amends

Responsive

Salisbury NHS Foundation Trust

MNVP Service User feedback (April 24)

Key achievements and feedback:
No further updates from the MNVP

Identified Areas of Improvement:
No new issues have been identified.

Continued momentum given to previously identified areas of concern, ie themes of complaints and concerns discussed at the annual study days. The PMA lead is undertaking some work with staff around compassionate communication.

Next steps for Progression:

Continue to roll out of personalised care planning training
Finalise the 15 steps and the National Patient Experience Survey 23 action plan.
Commence the Pregnancy patient experience survey- with the focus on hard-to-reach groups.
Update and review the Maternity Website

Safety Champions Staff Feedback

Neonatal:
- AMA – concerns around delays RE Paediatricians arriving on the ward, but this has recently improved. Update will be fed back to the meeting.

Maternity:
- Safety Walkabout feedback – on two occasions both Labour Ward and Postnatal Ward were 1 midwife short, however, fewer admissions meant staffing levels were safe.
- Limescale found in birthing pools which poses infection risk. New process around cleaning the pools has been proposed.
- Concerns raised by consultants re. BadgerNet and potential impact this could have on clinic timings. Consultant advised to visit other Trusts and see how BadgerNet is used. Discussion around curtains being closed or left open on Postnatal Ward. It was reported most patients feedback that they prefer curtains to be closed for privacy.

Family Experience:
- Lack of private spaces for staff to have confidential discussions on DAU, this was raised in a recent complaint.
- Lack of devices for translation services in ANC, specifically mobile phones and iPads –resulting in staff unable to use Language Line. This has been included in BID for BadgerNet. As an interim measure some Ipads will be sourced
- Lack of postnatal obstetric follow up, particularly emergency C-sections.
- Update on concerns surrounding children attending ultrasound scan appointments – It is not a national requirement but a locally agreed guidance. Updates made to the website and ANC appointment letters, to reinforce the current recommendations.

Compliments and Complaints

No complaints or concern have been logged in April 24 for maternity. 7 compliments logged and 3 SOX

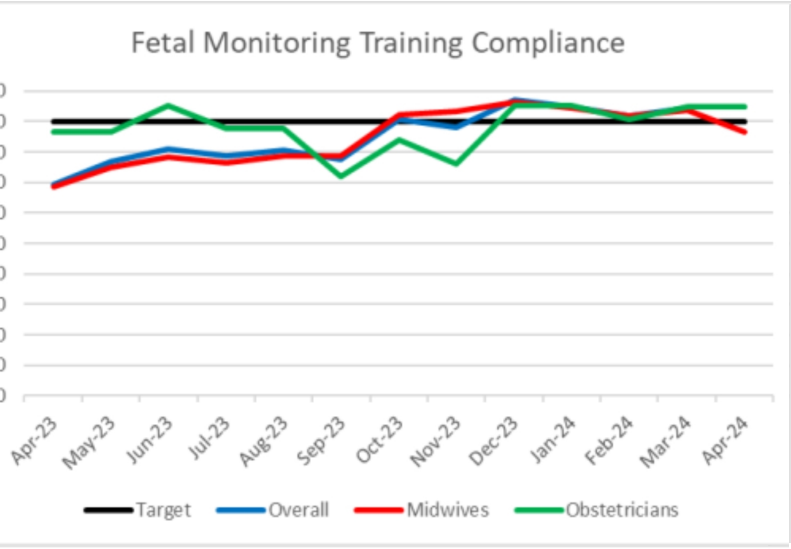
SOX…. **XX was great at covering a busy clinic over this weekend, coping with additional patients arriving without appointments, leading a more junior member of staff and ensuring all work was completed and information disseminated to relevant teams at the end of the working day. Always lovely to work alongside XX.**

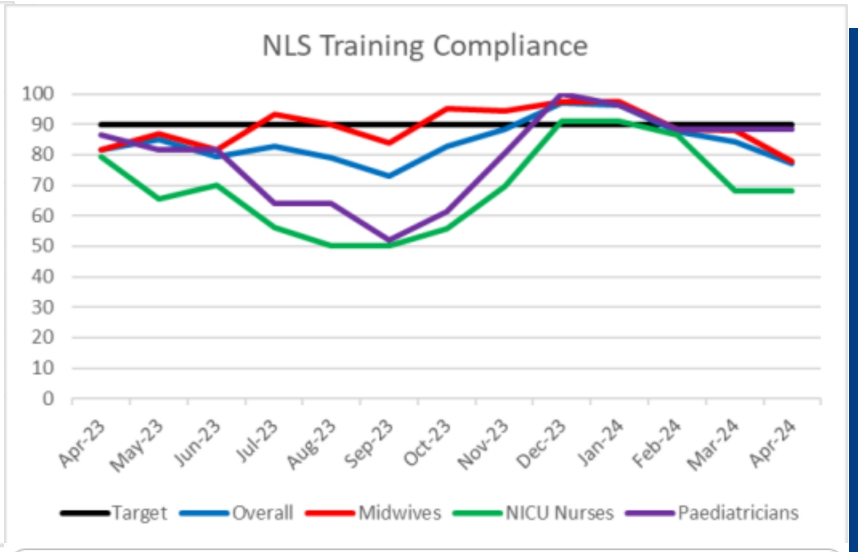
Friends and Family Survey

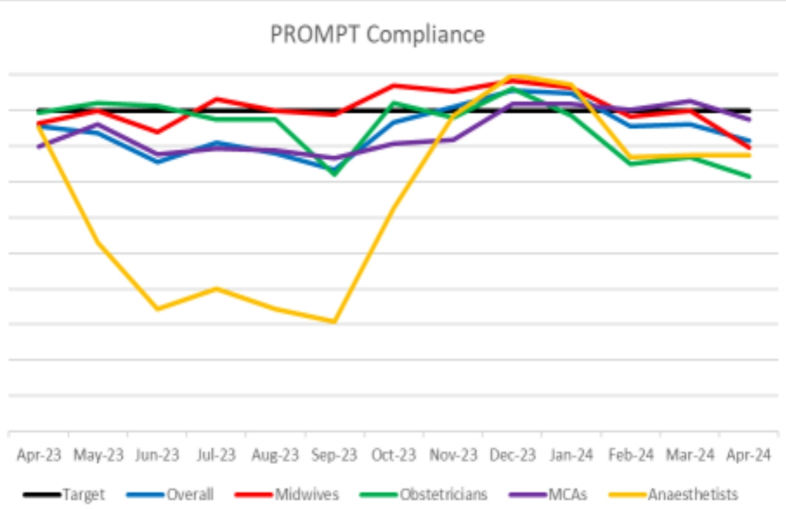
Friends and Family Survey will be going digital for maternity patients. During this transition, no FFT will be reported.

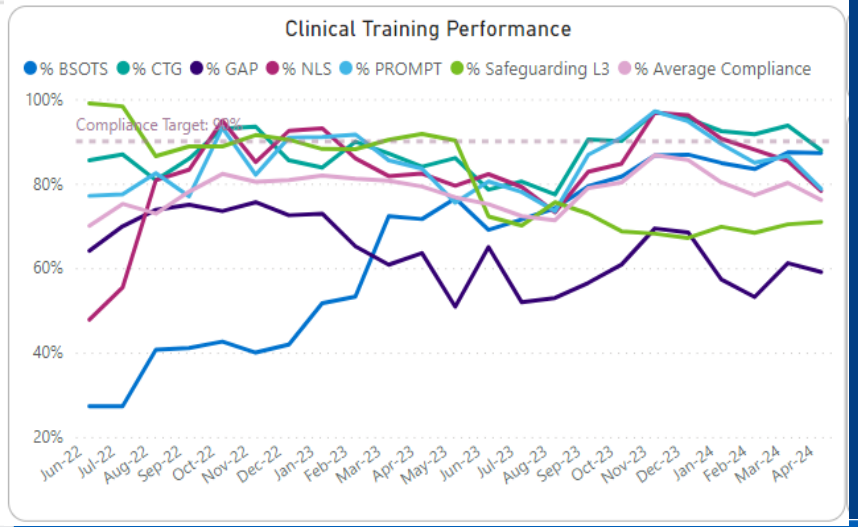
Well-led Training

Salisbury NHS Foundation Trust









Training

CNST requirements for >90% training compliance in all staff groups for NLS, fetal monitoring and PROMPT training achieved in December 2023.

Updated training plan commenced for 2024 to meet new Core Competency Framework Version 2 requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

Countermeasures/action:

- Maternity "training week" to cover all aspects for CCF version 2 and SBLCB version 3 commenced in January 2024 for midwives, MCAs and obstetricians.
- Additional skills sessions available to newly qualified staff and senior students during induction period.
- 10 training dates for each module booked in over 2024 – not during periods of high rates of annual leave
- Rotating obstetric doctors can transfer training compliance of PROMPT and fetal monitoring.

Risks:

- Ongoing medical industrial action has already impacted training in January 2024.
- Influx of new MDT staff in September /October /November.
- Booking of training rooms availability – rooms booked for 2024 in advance but there have been changes to these bookings at short notice impacting training time
- Anaesthetic conflicts of priorities to attend training – no anaesthetic attendance for past 2 months – escalated to surgery divisional lead.
- Please note - No study week in April due to Easter/school holidays.

Compliance to National Guidance

Salisbury NHS Foundation Trust

Table 1. Ockenden 2022

OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
May-24	1	Workforce Planning and Sustainability	0	2	0	5
	2	Safe Staffing	0	2	0	8
	3	Escalation and Accountability	0	0	0	4
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Complaints	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	2	0	5
	8	Complex Antenatal Care	0	4	0	1
	9	Preterm Birth	0	3	0	1
	10	Labour and Birth	0	3	0	3
	11	Obstetric Anaesthesia	0	2	0	5
	12	Postnatal Care	0	3	0	1
	13	Bereavement Care	0	3	0	1
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			↓ 0	26	↓ 0	↑ 58

Ockenden Report

Key Achievements:

- New approach to meetings and actions has secured increase in compliance
- Areas now complete with no outstanding actions are Escalation and accountability, Clinical Governance – Incident Investigation and Complaints, Learning from Maternal Deaths, Supporting Families

Next Steps for Progressions:

- Areas identified for more focus are Complex Antenatal Care, Postnatal Care, Bereavement
- CareData has now been collated to support decision-making and planning of care services for multifetal pregnancies, women with diabetes, and hypertension
- Rollout of TRIM is imminent
- Further work on SOP to satisfy RCOG locum guidance

Maternity Incentive Scheme (CNST)

Key Achievements:

- 9/10 declared for CNST Year 5
- Year 6 commenced in April 2024

Next Steps for Progressions:

- Review at regular touchpoint meetings

Thematic Reviews: Stillbirths and Neonatal deaths -

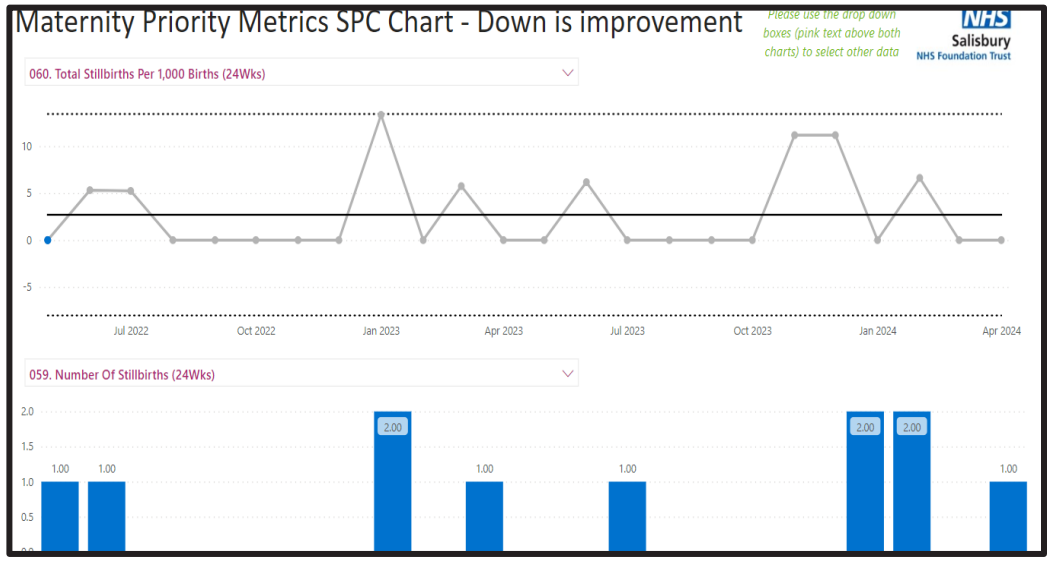


Figure 2 (to the left) shows stillbirths per 1000 births since July 2022 against national average, and stillbirths by number.

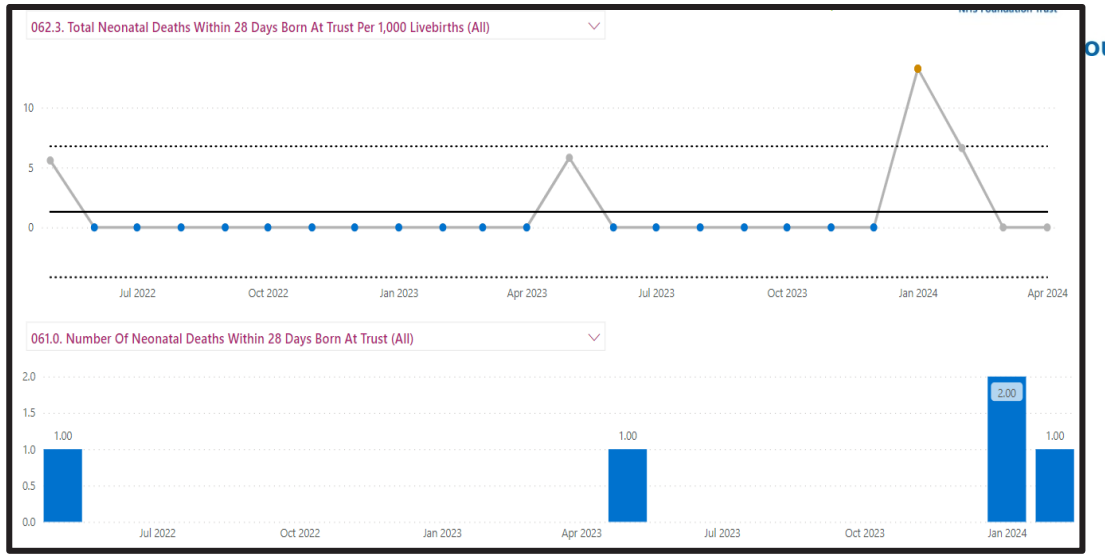


Figure 3 (to the right) shows neonatal deaths >24 weeks per 1000 live births since July 2022 (no data prior to this) against national average and neonatal deaths by number .

Stillbirths – Figure 2

A thematic review of stillbirths Jan 2023-Feb 2024 was undertaken. There were 8 stillbirths in this time period. One was as a result of a MTOP at 29 weeks for fetal anomalies. All mothers were white with English as their first language. 6/7 babies were born on the 0 centile at birth. All of the stillbirths (excluding the case with MTOP) had a review through PMRT.

The PMRT reviews have highlighted the need to undertake review of the fetal surveillance guideline to ensure they are aligned with local guidance and are clear for staff and patients to access and interpret.

Neonatal deaths – Figure 3

A thematic review of neonatal deaths at SFT in the five year period between 2018-2023 was undertaken following the Lucy Letby trail. In this time period there were 4 neonatal deaths over 24 weeks gestation at SFT. One of these babies had a known congenital anomaly not compatible with life. One of these babies was diagnosed with a T18 post birth and care was reorientated to palliative care.

There were no themes found through this review.

All cases were reviewed through appropriate processes which will be continued as a trust, and learning should be shared locally and through the LMNS.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.3
Date of meeting:	4th July 2024		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services –May 2024			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance 21.06.24 DMT Approval by e-mail 17.06.24 CGC 25th June 2024			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 6 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

Executive Summary:

The Maternity Incentive Scheme (safety action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly. The perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance report for SFT for May 2024.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW

Summary:

Staffing:

- Reduction in Midwifery vacancies, although still significant gap in clinical Midwives.

- Midwife to birth ratio 1:28– SFT recommended ratio 1:26 – reflective of Midwifery vacancies and acuity in May
- 1:1 care in labour achieved at all times
- Supernumerary status of labour ward maintained 100% time.

Incidences reported as moderate.

- 6 Incidences reported as moderate.
    - 4 x OASI perineal tears
    - 1x Undiagnosed Bladder exstrophy
    - 1 x Term Admission to Neonatal Unit

PMRT

- One review Neonatal Death at 32.2 weeks. PMRT Grading of care A, A and A – Unavoidable Neonatal Death.

Training

- Compliance in PROMPT, CTG and NLS training. Target of 90% reached and compliance met as of 1st December 2023. Work continues to improve compliance with other mandatory training.
- Concerns around Anaesthetic prompt attendance due to competing priorities and impact this may have on safety and CNST compliance. Trajectory of compliance to be escalated via DPR.

Service user and staff feedback

- Feedback received from varying sources including MNVP, safety champions, friends, and family survey and PALS

National Guidance

- CNST compliance 9 out of 10 for 2023. MIS year 6 published in April 2024 – workstreams allocated with DMT oversight and monthly meetings to ensure progress.
- Concerns around compliance with Saving Babies Lives care bundle and ability to be compliant within reporting period of 2024.
- Work ongoing to improve compliance with Ockenden 2022 IEA, 26 actions ongoing, 58 actions closed.

Thematic Review

- Review of OASI given increase in May. No themes identified however OASI care bundle and education being increased around this.

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

NHS
Salisbury
NHS Foundation Trust

Perinatal Quality Surveillance

JUNE 2024 (MAY DATA)

Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

	Target	Threshold			Feb '24	Mar '24	Apr '24	May '24	Comment
		Green	Amber	Red					
Midwife to birth ratio	1:26	1:26		>1:26	1:27	1:30	1:32	1:28	Lower birth rate this month and more available workforce (reduction in sickness)
Compliance with supernumerary Status of LW Coordinator %	0	0		>1	100 %	100%	100%	100%	
1:1 care not provided	0	0		>1	0	0	0	0	
Confidence factor in Birthrate+ recording	60%	>60%		<50 %	79.89	41.67%	83.3%	75.8%	Percentage of possible episodes for which data was recorded. Audit commended December 23
Consultant presence on LW (hours/week)	40	40			40	40	40	40	
Daily multidisciplinary team ward round	90%	>90%		<80 %	100 %	100%	100%	100%	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0		>1	0	0	0	0	

Salisbury NHS Foundation Trust

Is the standard of care being delivered?

- Supernumerary Labour Ward coordinator status achieved 100% time

What are the top contributors for under/over-achievement?

- Vacancy rate – steady progress in reducing the vacancy rate due to successful recruitment to Band 5 and Band 6 positions

- The Midwife to Birth ratio at target at 1:28 in May due to lower birth rate and more available workforce

Table 1. Total WTE vacancy and availability to work - by role

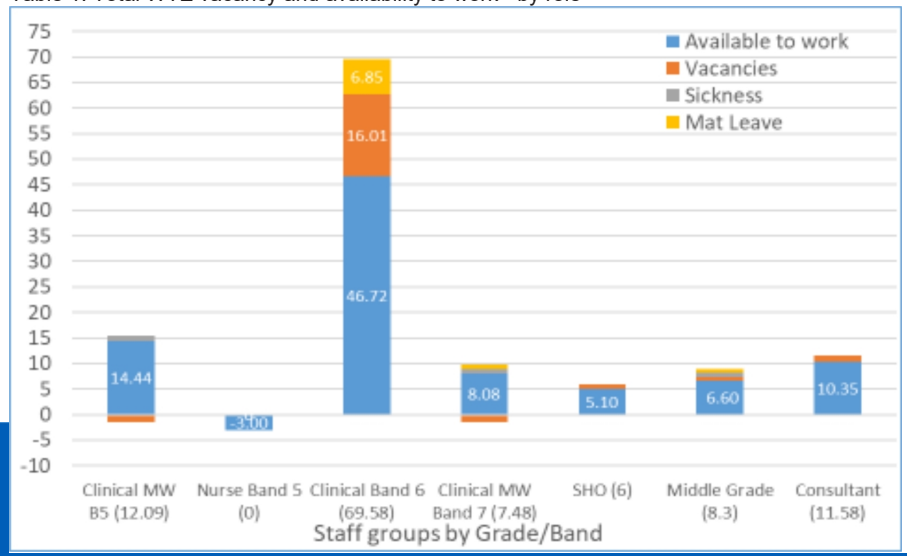
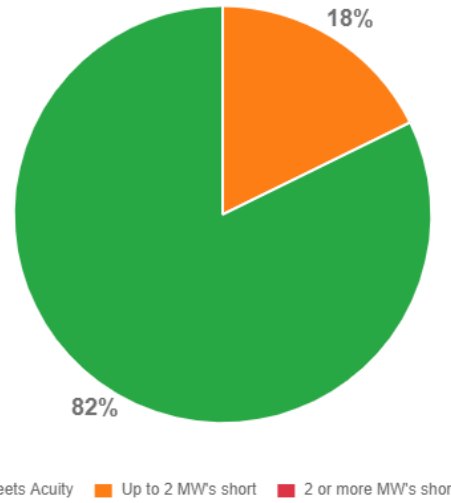


Table 2. Average midwife shift fill rates

		Feb '24	Mar '24	Apr '24	May '24
Midwives	Day	95.2	94.2%	97.2%	97.1%
	Night	97.8%	97.9%	99.3%	98.6%
MCA/MSWs	Day	93.6%	97%	Awaiting data	93%
	Night	87.2%	98.4%	Awaiting data	93%

Table 3. Acuity by RAG vs staffing data



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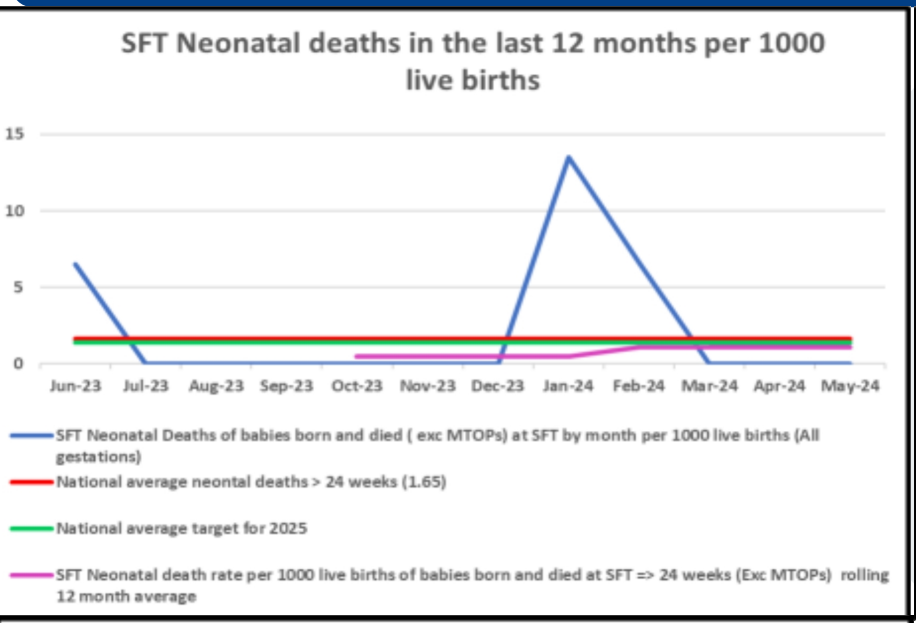
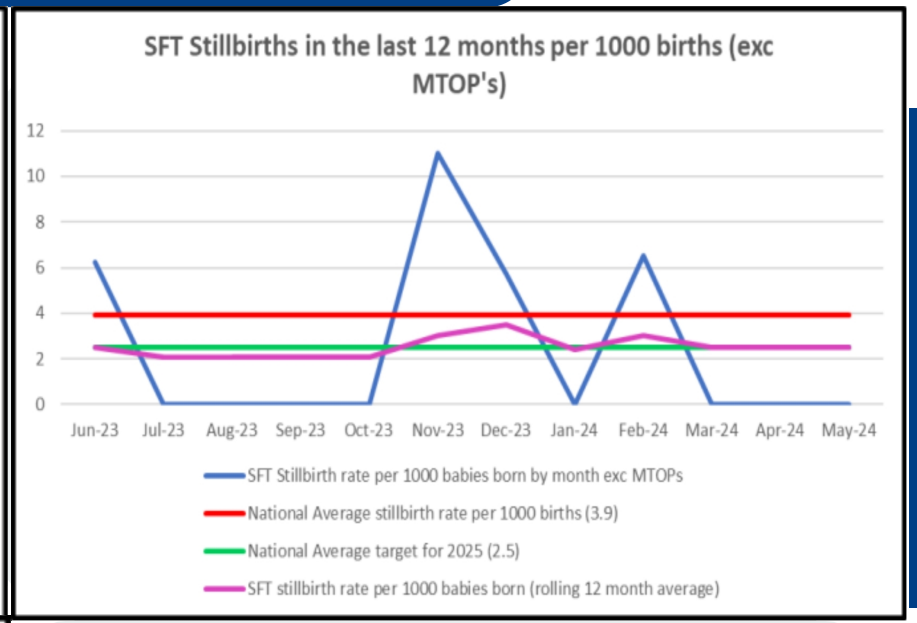
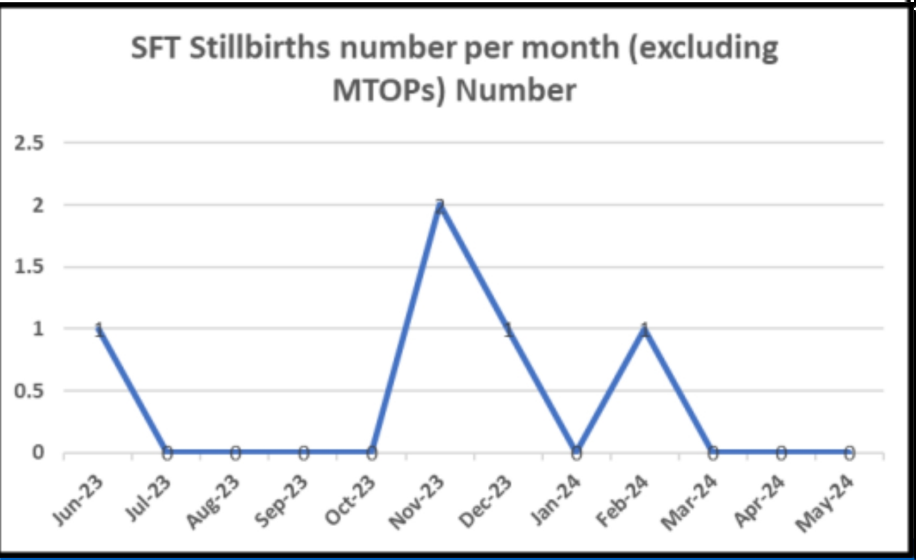
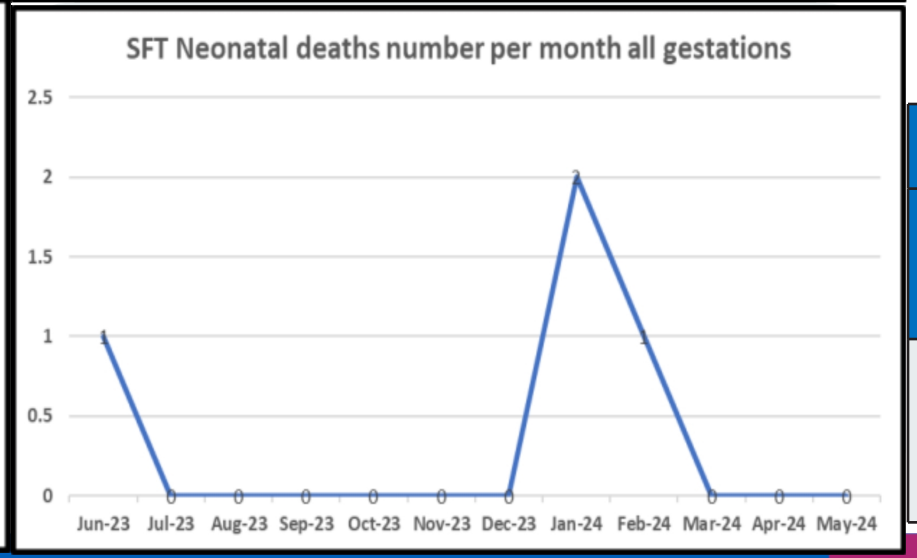








NHS Salisbury NHS Foundation Trust

- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is MIS Safety Action 1 for year 6. A quarterly update paper is shared with the board. .
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers.
- Still birth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.

- Perinatal deaths for May 2024 :
- One missed miscarriage at 17 weeks gestation
- One MTOP at 13 weeks gestation

PMRT Action Plans for Salisbury Foundation Trust – May 2024 review

PMRT case ID	Issue text	Action plan text	Person responsible	Target date
91810	There were no issues with care found that generated an action.			

PMRT grading of care – Key

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
PMRT: 91810 Datix	Date of death- 3/2/24 Date of PMRT review 3/5/24	Unavoidable neonatal death	Neonatal death 32+2	Cause of death- 1. Hypoplastic left heart 2. Prematurity PMRT grading of care- A, A, A **Actions** No actions were generated from this review.	NA	NA

INCIDENTS: DATIX Moderate ≥ Incidents and PSRs

NHS Salisbury NHS Foundation Trust

Incidents in May (moderate harm and above)

Case Ref (Datix no)	Date of incident	Category	Incident summary	Comments?	Commissioned Y / N	MNSI ref no.?	PSII ref no.?
165583	7/5/24	Moderate	3a tear – precipitate birth, found via failsafe as no Datix raised at the time	No care omissions	N	NA	NA
166149	19/5/24	Moderate	3a tear – rapid birth after forewater arm	No care omissions	N	NA	NA
165936	22/5/24	Moderate	3b tear	No care omissions	N	NA	NA
165965	22/5/24	Major	Undiagnosed bladder exstrophy	Ongoing	N	NA	NA
166085	27/5/24	Moderate	3a tear	No care omissions	N	NA	NA
166114	28/5/24	Moderate	Term admission to Neonatal Unit	For PSR	PSR being written.	NA	NA

INCIDENTS: PSII update

Ongoing Maternity and Neonatal Reviews

Salisbury NHS Foundation Trust

	Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions
	156876 SII 574	20/06/2023	Moderate	IUD	Final draft has been circulated for factual accuracy and next steps are for CRG for oversight.
	158202 SII 586	08/08/2023	Moderate	Eclamptic Seizure	Final draft now received after circulating for factual accuracy. To review and next steps for CRG.
	156497 SII 570	9/6/23	Never event	Retained swab	Draft: Options to be explored around possibility of purchasing swabs that enable a physical barrier to prevent swabs being left in a cavity. a)Revise the Accountable Items, Swab, Instrument and Sharps Count Policy to ensure this is clearly articulated and the associated flow chart is amended in line with this. b)When revising the policy strengthen action 5.2.2 to reiterate the expectation for clear and timely communication of the swab count prior to closure of a body cavity c)Ensure these changes are communicated to all staff within the operating and 'pseudo' operating departments where this policy has relevance. To review and revise the SOP for Opening a Second Obstetric Theatre and link it to the Obstetric Theatre Operational Policy To include into the current maternity records audit a question on whether there is documented evidence that the need for translation services has been considered on the Delivery Suite for women for whom English is not their first language. The Trust should use a second WHO checklist when a separate and distinct operation is required even if the patient has not left the operating room To support junior medical, midwifery nursing staff by anticipating where unusually pressured situations may arise for example in situations of family conflict, personal / professional boundaries / knowledge / power dynamics. For exit end of May. Went though exit and some minor post exit changes to make-awaiting return from author.
	158301 SII 587 (HSIB/MNSI)	12/08/2023	Moderate	Term Admission to NICU	Investigated by HSIB now MNSI. Action plan has been formulated and shared with DMT-now for CRG and tripartite meeting with family.
	162915 New Process PSII	29/01/2024	Moderate	Baby transferred to tertiary unit for cooling	Investigation ongoing-currently arranging/holding meetings with staff involved.
	163944 Awaiting SII No (MNSI)	4/3/24	Moderate	Baby transferred to tertiary unit for cooling	Investigation ongoing-currently arranging/holding meetings with staff involved.

CLOSED INVESTIGATIONS: Action progress

NHS Salisbury NHS Foundation Trust

Monthly compliance action tracker update

SII/CR No.	Link to Sheet	Directorate	Incident Date	Recommendation RAG Rating (Green = Completion Date, Amber/Red: Target Date)										
				1	2	3	4	5	6	7	8	9	10	11
CR 454	Click	W&NB	December 2021	Q2 23-24	Q2 23-24	Oct 22	Q4 22-23							
SII 489	Click	W&NB	May 2022	Q1 22-23	Dec 22	Q4 22-23	Q4 22-23	Q3 22-23	Q3 22-23					
CR 509	Click	W&NB	July 2022	Q2 22-23	Oct 23	Q2 22-23	Oct 23	Aug 23						
SII 510	Click	W&NB	August 2022	Q1 23-24	Q1 23-24	Feb 23	Q2 23-24	Feb 23	Jan 23	Jan 23	Q1 23-24	Q1 23-24		
CR 512	Click	W&NB	September 2022	Q2 23-24	Jul 23									
CR 514	Click	W&NB	September 2022	Q3 22-23	Jan 23	Q1 23-24	Dec 22	Feb 23	Q2 23-24	Q1 23-24				
SII 537	Click	W&NB	December 22	Jul 23	Jul 23	Jul 23								
CR 540	Click	W&NB	November 2022	Jul 23	Q1 23-24	Sep 23	Jul 23	Jun 24						
SII 555	Click	W&NB	March 2023	Nov 23	Nov 23	Nov 23	Nov 23							
CR 565	Click	W&NB	May 2023	June 24	Dec 24	SMG/Ed.	Compl.							
SII 571	Click	W&NB	May 2022	April 24	June 24	Feb 24	Oct 24							

Responsive

NHS Salisbury NHS Foundation Trust

MNVP Service User feedback (May 24)

Key achievements and feedback:

The MNVP feedback provided for the Triangulation meeting:

- Raise in induction rate
- Lack of privacy offered to women when undertaking intermate examinations
- Women feeling pressured to discuss contraception prior to discharge

Identified Areas of Improvement:

Continued momentum given to previously identified areas of concern, ie themes of complaints and concerns discussed at the annual study days.

Exploration of translation services- linked project with PALS

Next steps for Progression:

Continue to roll out of personalised care planning training

Finalise the 15 steps and the National Patient Experience Survey 23 action plan.

Commence the Pregnancy patient experience survey- with the focus on hard-to-reach groups.

Safety Champions Staff Feedback

Neonatal:

- Staffing levels are good – 2 nurses completing neonatal course by June 2024.
- To comply with BAPM, the neonatal manager will complete a business case The current ask is for x 1 band 5 nurse and 2 unregistered nurses.
- Unit sustaining 70-80% cot occupancy for last 3-4 years.
- NNAP dashboard spreadsheet and 2023 summary:
  - Deferred cord clamping was good at 76% for 2023.
  - Head scans appear low, but this is because these are sometimes done at term and not recorded on Parental consultation within 24 hours low at 81%.
  - Presence on ward round was good at 97%.
  - Breast feeding has slipped slightly at 60%. GD liaised with Feeding Team and noted they are short staffed.
  - ROP within time was low due to working patterns of our doctors and this is on Risk Register.
  - Number of babies with no invasive respiratory support <32 weeks was 80% and demonstrates less invasive surfactant QI measure is working.
- AMA reported recent security breach in Neonatal unit, which was recorded on new CCTV system. However, there has been an issue with the CCTV - to be escalated in this meeting.

Maternity:

- NIPE clinic staffing has improved.
- The DOM advocated the use of the acuity tool.. It was reported that staffing levels are better however, it was acknowledged that we have a junior midwifery workforce who need more support.
- The Parliamentary report on birth trauma has been recently published – Actions from report fit well with the Three-Year Delivery Plan.

Family Experience:

National Maternity patient experience survey action tracker discussed:

•Advice and information has been provided around birth choices, including personalised care planning and the *My Maternity* booklets which should be ready by end of May.

•Birth reflection service wait times to be reduced by clinical band 7's supporting this service.

•MNVP received feedback re. women wanting to know more about regional anaesthetics. we are now offering bespoke training,.

•Actions re. postnatal education – feedback received regarding inappropriate communication on the ward. MNVP doing ongoing work re. behavioural charter and compassionate communication. Also looking into info shared with women on discharge (envelope with QR codes to relevant support links).

Compliments and Complaints

2 complaints and 1 concern have been logged in May 24 for maternity. 1 compliments logged and 5 SOX

SOX…. **"XX** joined the Trust in November and has made a significant difference in her role already. She has recently supported with a significant data request that was required within a very short timeframe. ".

Friends and Family Survey

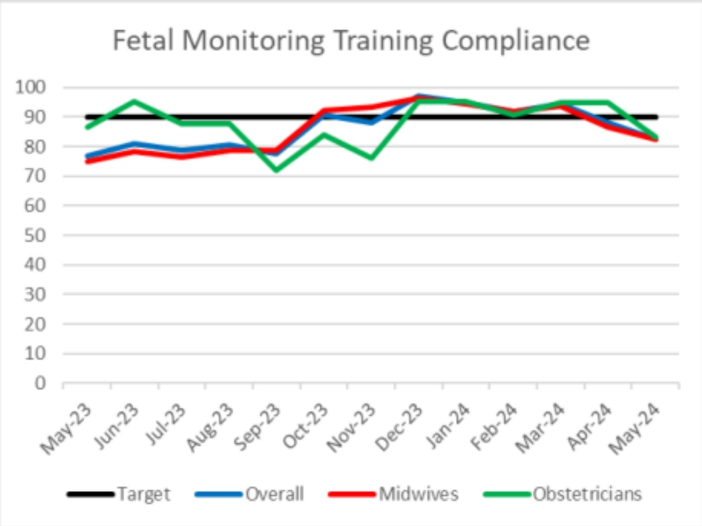
Friends and Family Survey will be going digital for maternity patients. During this transition, no FFT will be reported.

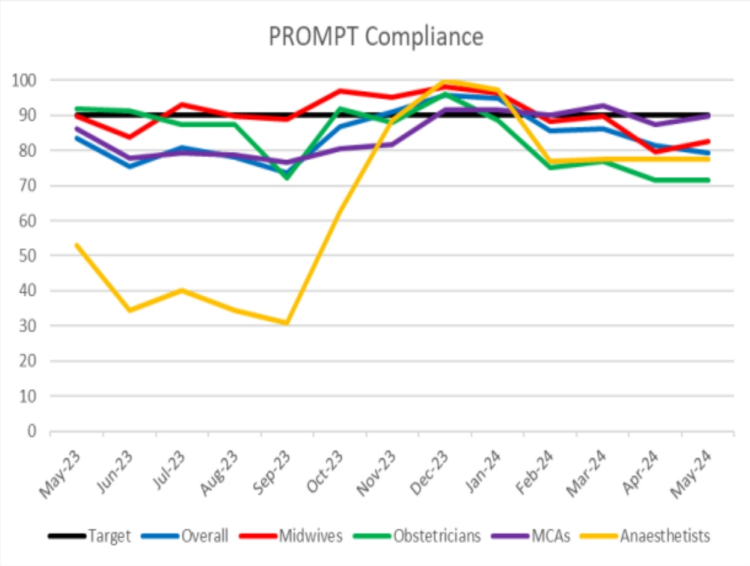
Maternity department has been selected for the initial phase of the roll out.

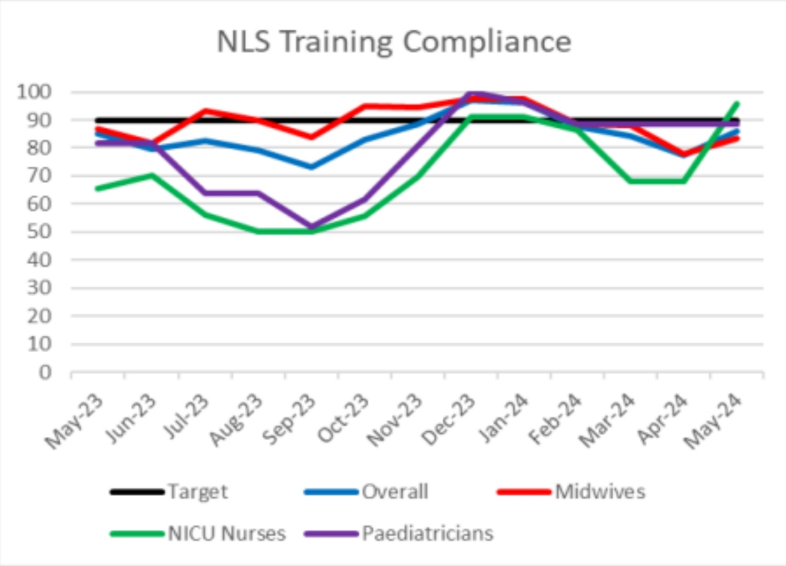
Touch point include:

- Maternity Antenatal (at 20 weeks)
- Maternity Birth (at 7 days)
- Maternity postnatal (at 14 days)
- Maternity community (at 28 days)

Well-led Training







NHS Salisbury NHS Foundation Trust

Training

Updated training plan commenced for 2024 to meet new Core Competency Framework Version 2 requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

Countermeasures/action:

- Maternity "training week" to cover all aspects for CCF version 2 and SBLCB version 3 commenced in January 2024 for midwives, MCAs and obstetricians.
- Additional skills sessions available to newly qualified staff and senior students during induction period.
- 10 training dates for each module booked in over 2024 – not during periods of high rates of annual leave
- Additional PROMPT and fetal monitoring training days created in October due to the ongoing decline of compliance in May for obstetric and anaesthetic groups.
- Rotating obstetric doctors can transfer training compliance of PROMPT and fetal monitoring.
- Additional Level 3 Safeguarding Children date created in May to support midwives to attend.

Risks:

- Influx of new MDT staff in September /October /November.
- Anaesthetic conflicts of priorities to attend training – poor anaesthetic attendance for past 5 months – escalated to surgery divisional lead.
- Please note - No study week in or August due to Easter/school holidays.
- Challenges in gaining accurate safeguarding children compliance rates for Obstetric registrars, SHO's and GP trainees.

Compliance to National Guidance

Table 1. Ockenden 2022

OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
May-24	1	Workforce Planning and Sustainability	0	2	0	5
	2	Safe Staffing	0	2	0	8
	3	Escalation and Accountability	0	0	0	4
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Complaints	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	2	0	5
	8	Complex Antenatal Care	0	4	0	1
	9	Preterm Birth	0	3	0	1
	10	Labour and Birth	0	3	0	3
	11	Obstetric Anaesthesia	0	2	0	5
	12	Postnatal Care	0	3	0	1
	13	Bereavement Care	0	3	0	1
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			↓ 0	26	↓ 0	↑ 58

Ockenden Report

Key Achievements:

- Q&S oversight of Bereavement agreed

Next Steps for Progressions:

- Complex Antenatal Care earmarked for working group to progress solutions

Table 2. CNST Maternity Incentive Scheme – Year 6

NHS Salisbury NHS Foundation Trust

Maternity Incentive Scheme (CNST)

Key Achievements:

- 9/10 declared for CNST Year 5
- Year 6 commenced in April 2024
- Non-compliant at present due to reporting period not ending until end of 2024.

Next Steps for Progressions:

- Review at regular touchpoint meetings
- Recruitment of Assurance Midwife to support

Thematic Reviews: 3rd and 4th degree tear

Salisbury NHS Foundation Trust

January and February 2024 saw an increase in incidences of 3rd degree tears. Across both January and February, seven 3rd degree tears were noted. A cluster review was undertaken, and no themes were identified. The mothers were of varying gestations and parity and all had very different risk factors. Of note only one mother had a low-risk pregnancy but became high risk during labour and birth due to an induction and shoulder dystocia. All babies had varying birth weights, with only one identified as LGA. There were no concerning themes around the practitioners present at the births, each mother was attended by a different member of staff for the birth of her baby, however it was noted that of the seven women, 6 were attended by a Band 5 Midwife. This in itself is not concerning, as we recognise that our workforce is currently quite junior, therefore when allocating staff at handover, Band 5 midwives are usually allocated to labouring women in order to ensure Band 6 staff are available to support the co-ordinator when necessary. No omissions in care were identified around the tears, however incidental findings have been raised and addressed.

March and April saw a reduction in the number of OASI, with two occurring in March and another two in April.

However, May's Datix data shows that four OASI were recorded. A rapid review highlighted no omissions in care for the 3rd degree tears throughout May, however a further thematic review to encompass the new data is underway. Alongside this, we intend to raise this as a theme at daily handovers, to ensure the co-ordinators are aware of the increase in numbers and to offer support to staff around the OASI bundle, which will shortly be reinvigorated through local learning opportunities in the ward areas.

Health Inequalities

Salisbury NHS Foundation Trust

Maternity 3 Year Delivery Plan covers Health Inequalities

- Inclusion Midwife appointed

Workstream starting within LMNS to work through collaborative plan.

Next steps:

- Inclusion midwife to support with improving equity –LMNS funded fixed term post
- Allocation of actions

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board Public	Agenda item:	3.4
Date of meeting:	4 July 2024		

Report title:	Board Assurance Framework (BAF) and Corporate Risk Register (CRR) Report			
Status:	Information	Discussion	Assurance	Approval
		Yes		
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices:	Board Assurance Framework June 2024 Summary CRR Tracker v1 June 2024 Corporate Risk Register June 2024			

Recommendation:

Trust Board are asked to review, discuss and make any recommendations to the following:

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

Specifically, the Board is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current and future risks.
- Review the risks out with tolerance and request any further assurance required in respect of risk mitigation.
- Review the principle strategic risks (BAF) and any associated gaps in control or assurance.
- Discuss alignment with the BSW ICB Board Assurance Framework.
- Consider feedback from the Board Committees.

Executive Summary:

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

There have been changes to the strategic risk profile over the last 5 months with BAF Risk 8 moving within tolerance, one risk de-escalated to the CRR (supply chain) and two new risks (EPR Programme and Board capacity).

There are 3 strategic risks out with tolerance which is comparable to January 2024:

- BAF 4 - Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery. Score unchanged at 16.
- BAF 6 - There is a risk that the Board has limited capacity in terms of time, skills and capacity to effectively oversee the organisation and the delivery of key strategic priorities in 2024/25 **(New risk).**
- BAF 9 - An irreversible inability to reduce the scale of financial deficit. Score unchanged at 16.

The Trust BAF risks align to the ICB risks in relation to staff resource, finance, operational performance and partnership working. There do not appear to be any risks on the ICB BAF which would impact on the Trust which the Trust is not sighted on. Whilst the ICB has a strategic role in health promotion, the Board may want to further consider the ICB risks relating to this and health outcomes and whether these have any bearing on the Trust BAF. The ICB highest scoring risks relate to addressing the financial deficit and recruitment and retention of staff. The financial risk mirrors that of the Trust. The Trust workforce risks have seen notable improvement over the last 12 months and are therefore not reflective of the ICB risk level.

There are 21 risks on the CRR compared to 19 reported in January 2024. There are 2 new risks and 2 risks which have moved within tolerance in addition to improvement in risk score for 3 other risks. Overall, there has been appositive shift in the CRR risk profile.

There are 7 corporate risks out with tolerance compared to 8 at the last report. Risks 5704 and 7574 are now within tolerance. The new risk (8054) is outwith tolerance.

Board Committee Feedback

The BAF and CRR has been considered at Clinical Governance Committee, Finance and Performance Committee and People and Culture Committee with the following proposed changes:

- Revise the risk description for BAF Risk 9 (financial deficit) to align to the ICB BAF risk description and the score will be increased to 20 from 16 given the financial challenges, which also aligns to the ICB BAF.
- Risk 5751 (delayed discharge) to be reviewed to consider the score and whether this is reflective of the current mitigations in place with potential to reduce the current score.
- To hold a separate Board session to consider each BAF risk in the current context with particular focus on controls, assurances and risk tolerance.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	Yes
Partnerships: Working through partnerships to transform and integrate our services	Yes

People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	Yes
Other (please describe):	N/a

Salisbury NHS Foundation Trust

Board Assurance Framework (BAF) and Corporate Risk Register (CRR) Report

Purpose

1.1 The purpose of the report is to provide an updated BAF and CRR providing all relevant information to the Board and Board Committees on the risks to achievement of the strategic objectives and their management.

2 Background

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

3 Summary Strategic Risk Profile

3.1 BAF summary

There have been changes to the strategic risk profile over the last 5 months with BAF Risk 8 moving within tolerance, one risk de-escalated to the CRR (supply chain) and two new risks (EPR Programme and Board capacity).

3.2 BAF Risks Out with Tolerance

There are 3 strategic risks out with tolerance which is comparable to January 2024:

- BAF 4 - Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery. Score unchanged at 16.
- BAF 6 - There is a risk that the Board has limited capacity in terms of time, skills and capacity to effectively oversee the organisation and the delivery of key strategic priorities in 2024/25 **(New risk).**
- BAF 9 - An irreversible inability to reduce the scale of financial deficit. Score unchanged at 16.

All of the above risks have a score greater than 15. These all fall within an open risk appetite and therefore any score over 12 is out with tolerance. The risk tolerance has not identified any unexpected risks out with tolerance and reflect the challenges discussed at Board and Board Committees and evidenced through the Integrated Performance Report metrics and individual reports.

3.3 BAF Risk Profile Changes

- BAF Risk 8 has moved within tolerance based on improvements in length of stay following implementation of SDEC and the Acute Frailty Unit and the anticipated opening of Imber Ward which will support increasing bed capacity.
- BAF Risk 11 has been removed and transferred to the Corporate Risk Register. This is based on the level of supply disruption and severity of the issues having reduced in recent months and an element of resilience has returned in key areas as well as improvements in the wider NHS Supply Chain system. Where possible the Trust has removed its reliance on single source and weekly routines are in place with the procurement clinical specialists in procurement working

with the supply chain effectively to mitigate and substitute known issues. The issues with Stryker have also significantly improved as our major Trauma and Elective supplier.
- BAF risk 1 is a new risk to recognise the forthcoming Electronic Patient Record (EPR) Programme.
- BAF risk 6 is a new risk relating to Board capacity.

3.4 **Alignment with the ICB Board Assurance Framework**

The ICB BAF currently focusses on risks to achieving the strategic objectives from an ICB perspective. The aim is to develop the BAF into a system focussed BAF which articulates risks to achieving the BSW Integrated Care Strategy from a system perspective.

For this report, there has been consideration of the 7 ICB BAF risks, which are unchanged since last reported in September 2023, as follows:

- BSW ICS is unable to create the right conditions and incentives for all BSW residents to stay healthy. Risk score 16.
- BSW ICB does not put reducing inequalities at the heart of all its activities. Risk score 16.
- BSW ICB is unable to meet the additional healthcare demands and deliver our operational plan. Risk score 16.
- BSW ICS is unable to recruit and retain suitably qualified staff. Risk score 20.
- BSW ICB and partner health and care organisations in BSW do not work more effectively in partnership. Risk score 12.
- BSW ICS is unable to reduce its expenditure to address its underlying financial deficit. Risk score 20.
- BSW ICB and partner health and care organisations in BSW do not focus on those things that impact most on health outcomes. Risk score 16.

The Trust BAF risks 5, 7, 8, 9, 10 and 12 align to the ICB risks in relation to staff resource, finance, operational performance and partnership working. There do not appear to be any risks on the ICB BAF which would impact on the Trust which the Trust is not sighted on. Whilst the ICB has a strategic role in health promotion, the Board may want to further consider the ICB risks relating to this and health outcomes and whether these have any bearing on the Trust BAF. The ICB highest scoring risks relate to addressing the financial deficit and recruitment and retention of staff. The financial risk mirrors that of the Trust. The Trust workforce risks have seen notable improvement over the last 12 months and are therefore not reflective of the ICB risk level.

3.5 **CRR summary**

There are 21 risks on the CRR compared to 19 reported in January 2024. There are 2 new risks and 2 risks which have moved within tolerance in addition to improvement in risk score for 3 other risks. Overall, there has been appositive shift in the CRR risk profile.

There are 7 risks out with tolerance compared to 8 at the last report. Risks 5704 and 7574 are now within tolerance. The new risk (8054) is outwith tolerance.

Risks outwith tolerance:

- Risk 7807 (Population): As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff. Score unchanged at 15.

- Risk 7955 (Population): There is a risk that ongoing industrial action compromises the quality and timeliness of patient care, compromises operational effectiveness and impacts on the workforce morale. Score unchanged at16.
- Risk 5751: Risk of patient harm caused by a delayed discharge from hospital. Score unchanged at 15.
- Risk 7308 (Partnership): The financial plan for 2022/23 is a deficit plan with assumed 2.2% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Therefore, there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures. Score unchanged at 20.
- Risk 7734 (Partnership): Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services. Score unchanged at 15.
- Risk 6229 (Population) - The DSU building is 'end of life' and has been identified as priority for replacement. Score is unchanged at 20.
- Risk 8054 (Population): As a result of out-of-date policies there is a risk that mandated processes and procedures may not be followed correctly which may result in compromised quality of care for patients and negatively impact workforce practices. This may result in regulatory action. Score 9. This risk falls under the governance risk type with an assigned cautious risk appetite and therefore is outwith tolerance. **New risk**

New risks since January 2024

There are 2 new risks:

- 8054 (Population): As a result of out-of-date policies there is a risk that mandated processes and procedures may not be followed correctly which may result in compromised quality of care for patients and negatively impact workforce practices. This may result in regulatory action. Score 9. This risk falls under the governance risk type with an assigned cautious risk appetite and therefore is outwith tolerance.
- 7239 (Population): Ad hoc issues within the supply chain resulting in products being out of stock, having longer lead times or with delays in delivery. The challenges come from a number of factors including the impact from the Covid-19 pandemic and EU exit and economic and global disruptions which are all out of the control of our local procurement team and who are often only made aware that a product will be delayed at the last minute. De-escalated from the BAF June 24. Score 9.

Risks removed:

- Nil to note.

Risks with an increased score:

- Nil to note.

Risks with a decreased score:

- Risk 5704 (Population): Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce. There has been ongoing oversight of this service through Clinical Governance Committee and upward reporting to Board. Score 15 to 12 and now within tolerance.

- Risk 7574 (Population): The continued pressure from urgent care flow alongside the increases in length of stay, compromises the ability for the Trust to undertake planned care. Score 15 to 12 and now within tolerance.
- Risk 7309 (Population): The Trust is currently experiencing increased demand and patient acuity across all in-patient areas, at a time of increased nursing sickness, maternity leave, leavers and retirement and reduced recruitment. This causes a shortfall in Care Hours per Patient day (CHPPD), increases risk of burnout for remaining staff, causes delay to flow and discharges and inability to provide required care for all patients. Score 12 to 9.
- Risk 5955 (Population): Insufficient organisation wide robust management control procedures. Score 9 to 6 and at tolerance.
- Risk 7573 (Population): The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services. Score 12 to 9.

4 Summary

There has been an ongoing positive shift in the overall risk profile since January 2024. There have been changes to the strategic risk profile over the last 5 months. There are 3 BAF risks outwith tolerance. There are 21 risks on the CRR compared to 19 reported in January 2024. There has been a positive shift in the CRR risk profile. There are 7 CRR risks out with tolerance.

The changes noted to the BAF and CRR demonstrate that this is a dynamic process and one of continuous improvement. The Board Committees have reviewed and discussed the BAF and CRR and proposed changes.

5 Recommendations

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

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

Specifically, the Board is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current and future risks.
- Review the risks out with tolerance and request any further assurance required in respect of risk mitigation.
- Review the principle strategic risks (BAF) and any associated gaps in control or assurance.
- Discuss alignment with the BSW ICB Board Assurance Framework.
- Agree escalation points for the Trust Board, to include any emerging risk/s or control concerns.
- Consider feedback from the Board Committees.

Fiona McNeight
Director of Integrated Governance

NHS
Salisbury
NHS Foundation Trust

Board Assurance Framework

V1 June 2024

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

An outstanding experience for every patient

Board Assurance Framework

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

Trust Values

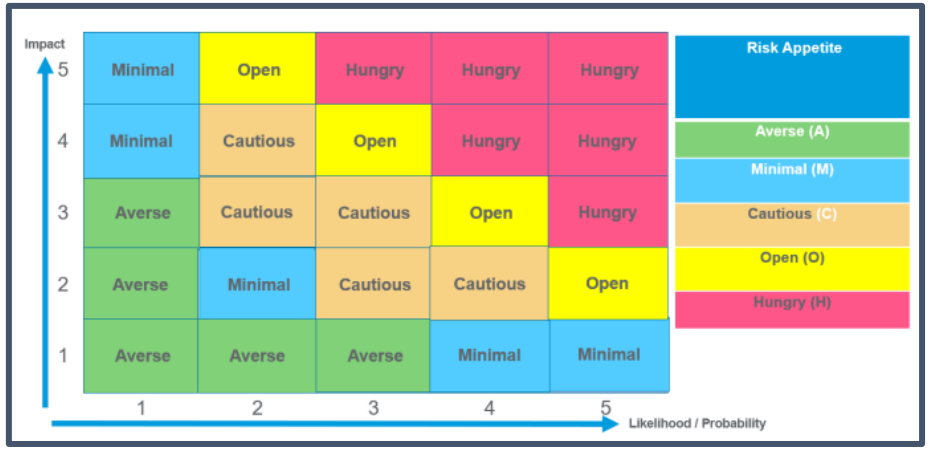
The core values and behaviours to support the achievement of the Trust vision:

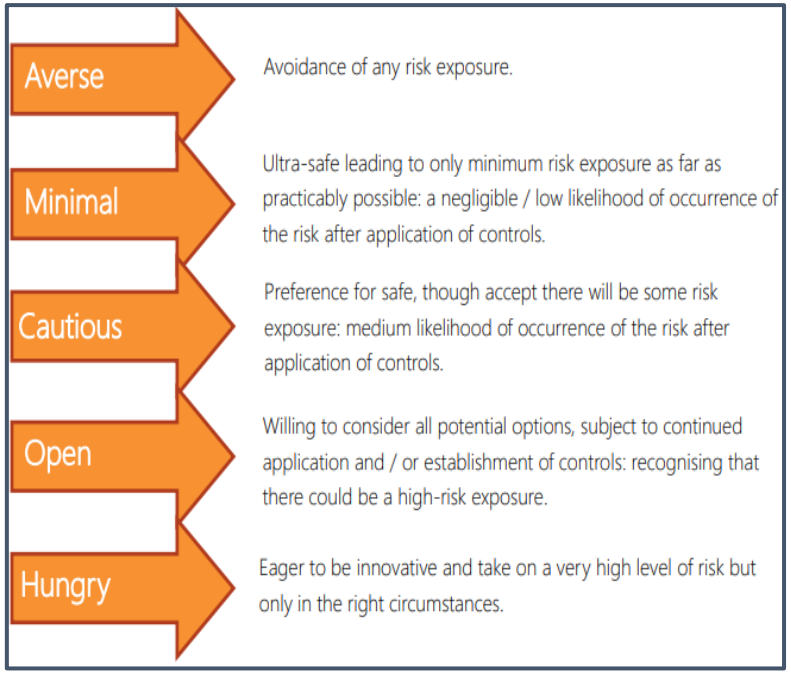
Strategic Priorities

Risk Matrix

Risk Matrix					
Likelihood/ Frequency ↓	Consequence/Impact →				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
5 Almost Certain	Moderate 5	High 10	Significant 15	Significant 20	Significant 25
4 Likely	Moderate 4	High 8	High 12	Significant 16	Significant 20
3 Possible	Low 3	Moderate 6	High 9	High 12	Significant 15
2 Unlikely	Low 2	Moderate 4	Moderate 6	High 8	High 10
1 Rare	Low 1	Low 2	Low 3	Moderate 4	Moderate 5

Risk Appetite





Risk Scores	Risk Appetite Level
15+	Hungry
10-12	Open
6-9	Cautious
4-5	Minimal
1-3	Averse

Risk Tolerance	
within tolerance	
outwith tolerance	

Board Assurance Framework Dashboard

Strategic Risk	Risk Title	Exec Lead	Initial Score	Jan-22	Apr-22	Jul-22	Oct-22	Jan-23	Jun-23	Sep-23	Jan-24	Target
POPULATION - Improving the health and wellbeing of the population we serve												
BAF 2	The scale of and demand for certain Specialist or Sub-Specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service.	Chief Medical Officer	15	10	10	10	10	10	10	10	12	8
BAF 3	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.	Chief Digital Officer	16	12	12	12	12	12	12	12	12	9
BAF 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.	Chief Executive Officer / Director of estates	12	16	16	16	16	16	16	16	16	8
BAF 8	Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.	Chief Operating Officer	20			20	20	20	16	16	16	9

Risk Score Key

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

Board Assurance Framework Dashboard Cont.

Strategic Risk	Risk Title	Exec Lead	Initial Score	Jan-22	Apr-22	Jul-22	Oct-22	Jan-23	Jun-23	Sep-23	Jan-24	Target
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work												
BAF 5	As a result of inadequate nursing staff and additional open capacity there is a risk of poor quality of care and poor patient experience.	Chief Nursing Officer	20			20	20	25	20	16	12	9
BAF 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.	Chief People Officer	20			20	20	20	16	16	12	9
PARTNERSHIPS - Working through partnerships to transform and integrate our services												
BAF 9	An irreversible inability to reduce the scale of financial deficit	Chief Finance Officer	12			12	16	16	16	16	16	9
BAF 10	Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.	Chief executive Officer/ Chief Operating Officer	9			9	9	9	9	9	9	6
BAF 11	Significant failure of supply chain which could result in substantial or prolonged disruption to services.	Chief Finance Officer	12			12	12	12	12	12	12	9
BAF 12	Risk of sustained deterioration across key performance metrics (new risk)	Chief Operating Officer	16				16	16	12	12	12	9

Risk Score Key

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

BAF Risk 1	Delayed or suboptimal deployment of the joint Electronic Patient Record will impact on strategic improvement and impact on the assumed financial benefits to the Trusts operating model		
Strategic Priority	People, Population, Partnership		
Linked Corporate Risks			
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Capacity	Risk Appetite / tolerance	Open

Risk Score 2024/25										
Initial Score	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24				Target score
12						12				6

Context	Controls	Assurance
Becoming a digitally mature organisation with a fit for purpose, integrated Electronic Patient Record is a key enabler of the Trusts strategy. The EPR business case assumes the delivery of significant financial benefits through the reduction of duplication and waste as well as the ability to improve access and reduce variability in outcomes across the BSW acute provider alliance Deployment of a common EPR across three acute Trusts is a complex technical and change management process requiring significant acquisition of skills within our existing workforce and through mew recruitment	Joint Committee to oversee EPR programme at AHA level Digital Steering Group reporting to Trust Management Committee to monitor SFT specific digital programmes SFT board level representation in all key aspects of EPR delivery Delivery partnership with Oracle Health	- Joint committee governance reporting to three boards within AHA - NHSE oversight of EPR programme progress

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
EPR Business case agreed and supported by NHSE and ICS New implementation oversight governance agreed with first Joint Committee taking place in June 24 Programme board reporting on plan in June 24 (plan baselined by external partners)	Digital transformation has a legacy reputational issue within SFT Significant change programme delivery already occurring with SFT and the AHA Current financial and operating context could jeopardise acquisition of key skills or individuals	- Strong executive oversight at all levels of digital governance - Strengthened digital clinal leadership capacity - EPR programme integrated with Improving Together continuous improvement system at AHA and organisational level

BAF Risk 2	The scale of and demand for certain Specialist or Sub-Specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service.
Strategic Priority	Population
Linked Corporate Risks	5704
Executive Lead	Chief Medical Officer
Lead Committee	Finance and Performance
Risk Type	Innovation
Risk Appetite / tolerance	Open

Risk Score 2024/25

Initial Score	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24	Target Score
15	10	10	10	10	10	10	10	12	12	8

Context

Increasing public professional and regulatory requirements resulting in sub-specialisation which is resource intensive and difficult to provide in a Trust of this size.

Sustainable services is a clear priority for BSW ICB, the AHA and the Trust strategy.

The governance mechanism for prioritising fragile services for review and transformation are in place and work is on-going to ensure there is clear alignment of strategy and delivery at organisation and system level.

Current fragile services prioritised for transformation work are orthopaedics, gastro, urology and dermatology.

Controls

Trust contribution into the AHA clinical strategy with set up of oversight Board chaired by the CMO.
Dermatology mutual aid agreement with RUH
GI bleed service being managed in partnership with Bournemouth (UHD)
Reconfiguration of sleep services across BSW – agreed clinical model presented to the AHA Programme Executive. Agreement to proceed to full business case.
External Medical workforce and model of care commissioned work completed- workforce model now feeding into divisional operational planning.
Sleep service contract notice served to Dorset to reduce demand for SFT

Assurance

Internal assurance through service performance and outcome measures.

External assurance through GIRFT and the AHA clinical strategy review monitoring.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Current work to reset priorities and resourcing of AHA clinical transformation projects to ensure faster pace of delivery. The requirement of health and Care legislation to actively collaborate affords an opportunity to redesign services to ensure delivery for the population of BSW as a whole.	Pace of change required for large scale reconfiguration Current fragile services could be at risk of regulatory enforcement action. Risk that patients will not have access to state of the art services Lack of capacity in the sleep service to meet demand.	Clinical governance processes ensure minimum safe standards are maintained. AHA clinical strategy work being led by Chief Medical Officer. Trust leading on reconfiguration of sleep services across BSW. Dermatology and sleep services are subject to working groups as part of the AHA clinical strategy implementation. Commissioned Deputy CMO to undertake review of a sustainable partnership model for GI services (6 month delivery). Insourcing to allow timely diagnosis in skin cancer pathway

BAF Risk 3	Non delivery of programmes within the Digital Plan could result in poor quality services, reputational damage and inability to attract and retain high quality staff		
Strategic Priority	Population		
Linked Corporate Risks	5360 (Cyber)		
Executive Lead	Chief Financial Officer		
Lead Committee	Finance and Performance		
Risk Type	Infrastructure	**Risk Appetite / tolerance**	**Open**

Risk Score 2024/25

Initial Score	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24	Target Score
16	12	12	12	12	12	12	12	12	12	9

Context

The Trust is digitally immature when benchmarked nationally. The Trust's digital plan sets out a significant agenda to improve integration of systems, maximise the existing Electronic Patient Record (EPR) whilst working towards a more sustainable longer term joint approach across the ICS, expanding the use of data and ensuring we have infrastructure that enables us to effective use technology and stay safe.
As technology touches on most transformation programmes, there is insufficient capacity and funding to deliver all that is asked with our appropriate prioritisation. This constraint risks the Trust not being able to maintain all desired level of improvements alongside participating in all local and regional initiatives with peers. Current score remains at 12, EPR funding risk reduced due to FBC approval, however Trust financial position increases risk associated with sufficient funding to deliver wider elements of the Digital Plan.

Controls

Digital Steering Group in place with robust digital governance below this, including programme governance.
BSW shared EPR programme board in place.
Comprehensive clinical digital leadership in place.
Digital Innovation launched to increase digital profile including digital champions and digital superusers to support change and ownership.
Cyber security team set up within IT Operational to manage cyber risk mitigation activities.
Joint CDO, CIO & Deputy CIO across SFT & GWH.

Assurance

Digital Steering Group minutes. Prioritised digital plan for the year agreed
Regular Digital Plan updates to Board committees.
Regular minutes from BSW shared EPR programme board with updated governance being set up.
Rolling cyber desktop exercises results
Fortnightly risk review meetings in place

Progress

What is going well/ Future Opportunities?

Refreshed Digital Plan approved at Trust Board in November 2022.
Shared EPR FBC approved by NHSE in March 2024, with new governance being set up and central programme team recruited.
Fortnightly working group established to build on AHA digital services review, bring ICB into scope. Joint CDO decision remains with CEOs.

What are the current challenges including future risks?

1. Recruitment into shared EPR roles and delivery of programme on time and budget.
2. There remains a large agenda of projects with a digital component which are not resourced, funded or prioritised.
3. Some digital programmes are behind original plans.
4. Lack of funding to deliver full Digital Plan including removing all unsupported technologies.
5. Clinical engagement is limited due to operational pressures.
6. Recruitment and retention of Business Intelligence skills

How are these challenges being managed?

1. Targeted engagement on recruitment with Divisions, revised governance being implemented.
2. Prioritisation of programmes through Corporate Projects Prioritisation Group to ensure the change agenda is realistic and QIAs completed for those unfunded or de-prioritised programmes.
3. Programmes are rebased as part of existing programme governance & strong PMB challenge on delivering against this rebased targets in place. Risk mitigations put in place where appropriate.
4. Seeking opportunities for national funding to support programmes.
5. Clinical leads supporting identifying champions for key activities (Shared EPR, implementation activities). Implementing new communication software to support different digital communication methods.
6. Implementing plan to build resilience with GWH, digital services review

BAF Risk 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.		
Strategic Priority	Population		
Linked Corporate Risks	6229, 7734		
Executive Lead	CEO/ Director of Estates		
Lead Committee	Finance and Performance		
Risk Type	Infrastructure	**Risk Appetite/Tolerance**	**Open**

Risk Score 2024/25

Initial Score	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24	Target Score
12	16	16	16	16	16	16	16	16	16	8

Context

SFT has a substantial estates backlog (£78m – 2024) which impacts service delivery, quality of estate and public/patient experience. Limitations via CDEL and lack of investment capital impact the Trust ability to reduce the estates backlog and creates a corresponding increase in Trust risks; costs to operate and maintain the existing estate, likelihood of future infrastructure and estate failures, compromised service delivery and patient care. Equally environmental sustainability investment is limited reducing the Trust ability to achieve net carbon zero.
Whilst National and/or targeted funding may become available, careful planning and prioritisation of requirements is essential yet remains consistently insufficient to make any marked progress in the reduction of long term risks, or exceed the inflationary rate of change to the backlog value. The clinical strategy and the estates strategy are key long-term plans for the Trust evolution and delivery of effective and reliable services over the next 10 years (and beyond), but require significant investment to achieve.

Controls

6 Facet survey of the whole site completed in 2022, providing an up to date and independent assessment of the campus in accordance with National guidance (NHS Estate Code).
The 6-facet data reviewed annually and adjusted to reflect capital investment made in year and increases due to inflation.
Last annual update May 2024 Quarterly estates reporting to Trust Board. Annual capital plan reviewed via Strategic Capital committee.
Internal audit on management of backlog maintenance completed in 2023 and recommendations completed.
Internal audit on compliance reporting completed in 2024 and recommendations currently being followed through.

Assurance

Significant improvements in estates governance and risk management introduced including the 10-year capital programme compiled, with investment forecasts for estates backlog and a 5-year plan for year on year spend.
Estates compliance status clearly recorded. Majority of targets achieved. One extreme risk outstanding, most highs reduced. Continued progress to mitigate and conclude compliance actions August 2024 before moving to business as usual.

Progress

What is going well /Future Opportunities?

- 10-year capital programme compiled, includes investment forecast for estates backlog. Program subject to annual prioritisation process
- Additional elective ward near to completion (replaces poor condition estate)
- Estates strategy renewal, mobilised with procurement underway. Target completion May 2024.
- Estates strategy update will incorporate Campus project for long term development
- Successful bid for national investment to begin decarbonisation of energy infrastructure, £10m for 2023/24, further bids to be submitted for future years.

What are the current challenges including future risks?

- Insufficient capital. Inflation pressures alone continue to significantly increase backlog value year-on-year
- Competing demands for Trust capital each year.
- Reduction in revenue funding will impact on ability to maintain and repair existing infrastructure.
- Estates backlog value (£78m) is not actual cost to deliver Likely value £124m
- Limited electrical infrastructure on campus impacting future redevelopment opportunities
- Current decarbonisation (Salix) investment does not encompass whole site. Further investment required to realise decarbonisation. Decarbonisation strategy reduces fossil fuel use but increases electrical demand which is a higher cost, Trust utility costs will rise as we become more environmentally sustainable.
- Lack of adequate investment means infrastructure continues to degrade – level of backlog maintenance increases. Cost to maintain Trust estates and infrastructure increases. Infrastructure failure risk increases
- Day surgery unit remains Trust highest priority, with no funding source available.
- Aged areas of the Estate are not fit for purpose or occupation (SFT South and central) but require investment for continued use and are at higher risk of failure.
- Trust 'space' is in high demand and appetite to remove poor quality buildings challenged with space use.
- Clinical strategy limitations inhibit the estates strategy.
- National targeted resources do not address key resilience issues
- Patient environment quality being compromised e.g., spinal unit
- Quality of on-site residential accommodation poor with little investment

How are these challenges being managed?

- Categorisation & prioritisation of Trust capital. Review and prioritisation within Trust framework (alongside digital, medical equipment etc)
- Continued lobbying for major service developments – DSU
- Funding applications made for environmental sustainability and energy decarbonisation (e.g. Salix)
- Estate's strategy procurement documents mobilised
- Board paper planned to present options for on-site residential accommodation
- Investigations into strategic partnership models to allow development and investment of the estate.
- Monthly meetings with regional NHSEI colleagues to highlight priorities and risks
- Continued review of poor-quality accommodation use, identifying opportunities to vacate (e.g remove and dispose archive material) with potential to demolish and remove risk
- Increased scrutiny of estate requests via space allocation committee. Management of space utilisation 'creep'.
- Existing team with Trust support to backfill Director of Estates until permanent solution implemented

BAF Risk 5	As a result of inadequate nursing staff and additional open capacity there is a risk of poor quality of care and poor patient experience.		
Strategic Priority	People		
Linked Corporate Risks	5704, 7039,7573, 7472, 7574,7955		
Executive Lead	Chief Nursing Officer		
Lead Committee	People and Culture Committee		
Risk Type	Capability and skills	**Risk Appetite / tolerance**	**Open**

Risk Score 2024/25

Initial Score	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24		Target score
20	20	20	25	20	16	12	12		9

Context

There has been an improving picture over the last 6 months in addition to no industrial action for the nursing workforce.
Overall, CHPPD has improved
Maternity leave is high due to predominant female workforce.
Retention of HCA workforce continues to be challenging.
Heavy reliance on RMN due to MH needs and unavailability of specialised MH beds. In addition, use of additional staff for enhanced care for complex patients.
Agency spend remains a financial challenge in relation to RMN and RN usage although agency hours has reduced (specifically for specialist areas such as ITU and Paediatrics)
OSCE nurses taking longer to convert since the change to external training provider (from internal provision) although position has improved.
Currently, additional nurses recruited for the opening of the new Imber Ward (and will cover other areas until Imber is officially opened)

Controls

3 x daily staffing meetings and early escalation to agency
Monthly safer staffing meeting
Recruitment events
Apprenticeship to Registered Nurse in place (limited funding)
Successful overseas and HCA recruitment
HCA away days to boost retention
Revised HCA induction and competencies
Risk assessments and SOP in place for boarding
Weekly nursing workforce control meeting chaired by Deputy CNO.
Long line agency for ITU and Sarum to prevent high-cost agency use

Assurance

CHPPD – good levels in all areas
RN vacancy for wards reduced from 14.5% in May, 10% in July and now 3.0% in April 24
Sickness reduction from 9% in December to 6% in March.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
HCA Apprenticeships including Maths and English to attract staff with low educational attainment. HCA support workers in place to support wellbeing and education Partnership working to review future workforce requirements and further opportunities Successful recruitment of RNs in ITU – commencing induction Positive response to paediatric nurse adverts	Overall vacancy rate for HCAs Sickness absence rate across RN and HCA. Staffing demand is likely to increase based on levels of NCTR and Bed capacity modelling which will increase required number of HCA and RN's Retention of current staff Inability to release staff for training	Recruitment events ongoing Revised induction for RNs Utilising Improving Together methodology to focus on improvement areas. Ongoing focus on tissue viability, recognition of deteriorating patients and falls prevention management New to Care HCA Programme

BAF Risk 6	There is a risk that the Board has limited capacity in terms of time, skills and capacity to effectively oversee the organisation and the delivery of key strategic priorities in 2024/25.		
Strategic Priority	People		
Linked Corporate Risks			
Executive Lead	Chief Executive Officer		
Lead Committee	Board of Directors		
Risk Type	Capability and Skills	**Risk Appetite / tolerance**	**Open**

Risk Score 2024/25										
Initial Score	June 24									Target score
16	16									8

Context	Controls	Assurance
The Executive team will have four interim roles (CEO, COO, CFO and CMO) which can limit stability of leadership in year. There is a delay to substantive recruitment due to uncertainty on future governance arrangements in the AHA, the uncertainty could also lead to further attrition of key roles. There are a number of strategic objectives which will render significant leadership capacity including replacement EPR, Community Services tender and financial recovery which dilutes capacity on BAU improvements. Changes in executive team can mean loss of organisational knowledge and experience which in the short term can slow progress or risk delivery which impacts on the reputation of the organisation.	Board oversight of key metrics through IPR AHA Joint Committee on EPR to ensure oversight and shared delivery. Interim mitigation plans enacted for all roles Remuneration committee for oversight of performance. Succession planning in place	- Engine room oversight of breakthrough metrics/strategic initiatives and vision metrics to focus on delivery and risks.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Interim roles predominately held by SFT substantive employees maintaining organisational knowledge. Recruitment plans underway to commence CMO in September 2024.	• Uncertainty about AHA governance structures leading to further attrition in key roles. • Attracting high calibre candidates in context of uncertainty	- Regular executive team development . - Recruitment process planning underway - Board oversight of risks and strategic programme

BAF Risk 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.		
Strategic Priority	**People**	**Risk Score 2024/25**	
Linked Corporate Risks	5704, 7039, 6143, 7573, 7472		
Executive Lead	Chief People Officer		
Lead Committee	People and Culture Committee		
Risk Type	Capability and Skills	**Risk Appetite / tolerance**	**Open**

Initial Score	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24			Target Score
20	20	20	20	16	16	12	12			12

Context

Further industrial action for medical workforce when other professional groups have agreed a National settlement
Quarterly pulse survey is indicating a maintained position against all elements of the People Promise.
There is a National shortage of workforce across a range of professions and BSW mirror the National picture. Attraction to geographical area through recruitment and retention premia, Golden Handshake welcome payment, offer of relocation payment and re-launched 'Refer a friend scheme' has been successful.
Recruitment for opening of the new ward successful and ongoing recruitment for the 3 additional theatres.
Protracted planning process and stretching financial target include a WTE reduction of 220wte.
Tender process for provision of community services would result in TUPE of approx. 1000 staff

Controls

Workforce Control Panel overseeing vacancies
Financial recovery programme –group now meet fortnightly
International RN and Midwife recruitment
HCA recruitment and retention facilitator in post
Staff retention now a breakthrough objective with clear focus
Active update and review of all people policies which are being written and implemented in support of a just and restorative culture.
Workstreams for all 7 elements of the People Promise benchmarked against staff survey
Established leadership development programme plus launch of the people management skills modular programme
Overhaul of recruitment process with emphasis on high impact actions
People Promise Manager retained with an extended portfolio to include widening participation

Assurance

Improving vacancy position – as a result of attraction incentives
Improving pulse survey responses
Maximum take up on the leadership development, wellbeing and appraisal training courses
Time to hire recruitment process – significant reduction in days.
Sickness absence within target through monthly monitoring

Progress

What is going well/ Future Opportunities?

Recruitment & attraction process and practices overhaul in conjunction with PWC – implementation phase completed; moved to phase 2.
Reviewing approach to training needs analysis – appointed to Head of Clinical Learning
Newly forming retention cross-divisional group
Development of a strategic workforce plan
Development of a wellbeing programme of work based on recent survey results.

What are the current challenges including future risks?

1. Increasing retention and reducing turnover
2. Line managers capacity to manage exit interviews and complete appraisals
3. Non-Medical Appraisal compliance – slow improvement
4. Manager's capacity to manage staff wellbeing and career development due to operational pressures.
5. Lack of Strategic workforce planner
6. HHCA retention

How are these challenges being managed?

1. A comprehensive improvement programme against all 7 elements of the People Promise
2. Review of exit interview approach – focus on top contributors identified from A3. Ongoing listening to staff at first 90 days and 1 year anniversary. Hearing it campaign launched
3. Improving line manager training
4. Line managers training course to be launched 2024
5. Interim in post – active monitoring of KPIs at DPR's
6. Breakthrough objective for 24/25

Strategic Priority	Population			**Risk Score 2024/25**									
Linked Corporate Risks	5751, 6143, 7573, 7574,7039			Initial Score	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24			Target score
Executive Lead	Chief Operating Officer													
Lead Committee	Finance and Performance			20	20	20	20	16	16	16	12			9
Risk Type	Capacity	**Risk Appetite / tolerance**	Open										

Context

Our operational context remains challenging with escalation beds , demand for urgent services consistently pressurised, the on-going need to reduce length of time patients are waiting for planned care and staff availability day to day creating significant pressure for the teams. The continued use of escalation capacity compromises efficiency and effectiveness of the operational flow and compromises patient care.

The underlying constraint is insufficient capacity in respect of the skilled workforce required alongside system wide change to respond to an aging population . The ongoing level of patients in the hospital who are medically fit for discharge impact on available beds to see and treat planned care patients.

Controls

SFT Urgent Care Board
SFT Planned Care Board
BSW Urgent Care Board
BSW Urgent Care Tactical
Wiltshire Alliance meetings

Assurance

BSW Virtual ward and care co-ordination centre in place reducing demand on SFT beds and admissions
SDEC model reducing bed occupancy requirements for SFT
Acute Frailty model started August 23 – decreased LOS
Overall bed escalation and bed occupancy has decreased since Q42022/23.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Trust internal programme to reduce bed occupancy including implementation of SDEC, Acute frailty Unit now moved to Durrington and Rambo in ED has had an impact with length of stay for emergency admissions reducing compared to last year by 1 day. Improvement plan developed to help reduce NC2R to 5% of bed base The Trust is opening Imber ward in June 24 which will support increasing bed capacity, enabling further improvements to elective and non elective flow.	The time it takes for Patients to flow out of ED due to bed occupancy remaining higher than national target of 92%. Relatively high NCTR bed occupancy as a result of insufficient community care provision, internal process delays and pathway reconfiguration. Continued escalation into DSU compromising surgery rates and recovery of 2019/20 activity levels On-going high agency usage Continued growth in NEL demand that is higher than forecast/planned	Recruitment into vacant nursing, medical and admin posts in ED ongoing. Daily focus on site flow to maximise bed efficiency Urgent care Board to oversee transformation programme New chair area in DSU to go live in Q4 to help mitigate escalation on planned care activity. Rebasing of the hospital capacity to enable and support improved functionality of key flow components ie reintroducing a discharge lounge.

BAF Risk 9	An irreversible inability to reduce the scale of financial deficit		
Strategic Priority	Partnership		
Linked Corporate Risks	6857, 7308,7734		
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Finance	Risk Appetite / tolerance	Open

Risk Score 2024/25										
Initial Score	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24			Target Score
12	12	16	16	16	16	16	16			9

Context

The Trust has had an underlying deficit greater than 5% of turnover for a number of years. This has led the Trust to be disadvantaged in terms of capital spend due to managing cash flows. Restricted capital expenditure limit is compounded by GWH PFI impact on system allocation.
This position has deteriorated and despite increased funding leading to a requirement for cash support, SFT remains challenged particularly due to high numbers of patients waiting for onward packages of care. The Trust is not alone with BSW ICS reporting an underlying deficit relative to allocation funding.
The inability to deliver a breakeven position risks the ability to deliver safe and effective care and or regulatory action associated with breach of license conditions.

Controls

Ongoing discussions to agree the distribution of centrally held ICB funding by system Chief Finance Officers.
People workstreams are focusing on retention of staff, with planned interventions ranging from the onboarding process through to retire and return conversations. The Trust is targeting a return to 2022/23 workforce numbers.
The BSW-wide procurement workplan levies the ICS spending power to mitigate the impact of inflation.
Breakthrough objective initiatives focus on maximising the clinical outputs of the Trust while maximising the input resource required

Assurance

BSW system 3 year financial plan will act as assurance mechanism

Creating value for the patient: Improving productivity breakthrough objective measurement

Monthly reporting on performance and forecast through financial recovery group

Breakthrough objective measurement via Engine Room

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Focus on increase in productivity to mitigate further decline in financial position and maximise opportunities for ERF. Acute Alliance programme of benchmarking to identify opportunities. LOS reductions having favourable impact on bed base. Work on longer stays on-going.	Identifying CIP plans in context of significant operational challenges. Increasing proportion of savings programme will have to be delivered through clinical service transformation. Adequate cash reserves to service capital programme Medium term financial outlook is uncertain Long term capital programme needs to be assessed against available CDEL and additional funding sources. BSW transformation programme immature and not fully developed.	Improving together programme improving a structured approach to change. Working with ICS to develop BSW sustainability programme. Development of CIP teams within corporate and divisional teams Oversight on delivery of CIP through the Financial Recovery Group Cash flow monitoring and NHSE support in place.

BAF Risk 10	Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.		
Strategic Priority	Partnership		
Linked Corporate Risks	6858		
Executive Lead	Chief Executive Officer		
Lead Committee	Finance and Performance		
Risk Type	Integration & Partnership	Risk Appetite / tolerance	Open

Risk Score 2024/25										
Initial Score	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24			Target Score
9	9	9	9	9	9	9	9			6

Context	Controls	Assurance
The Integrated Care Alliance continues to develop and respond to changing national guidance on role and functions. In turn this places risk to how quickly trusted successful partnership working can enable service integration and delivery. Without partnership working one of SFT's strategic aims of integrating care and partnership working is compromised leading to disjointed services for patients. The community services contract has now gone live which offers both an opportunity and presents a challenge to the integration of services for SFT.	ICB and Wiltshire PLACE with SFT representation Established AHA with SFT representation SFT executive representation within ICS workstreams	Community services delivery plan published

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Work with the Acute Hospital Alliance continues to develop and gather momentum. Acute Alliance Clinical strategy Elective and Urgent care well established forums New Community services implementation plan group Executive Planning	Place based working still in infancy, further work to progress placed based strategy for integrated care, particularly with community services. Challenge to develop relationships across multiple partners at place, including the capacity to influence and support the wide range of groups. Community services tender is 18-month timescale across BSW which impacts on resources and will in the short term potentially slow down integration and change. ICB is currently undergoing a mandated organisational review of form and function. The outcome of this is not yet fully known and this may place additional responsibility on other partners.	The Trust is represented at appropriate meetings at PLACE, Acute Providers and the ICS. Exec team members developing relationships with professional colleagues, attending stakeholder events.

BAF Risk 12	Risk of sustained deterioration across key performance metrics		
Strategic Priority	Population		
Linked Corporate Risks	5751, 7573, 7574, 7039, 7807,7955		
Executive Lead	Chief operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Covid Recovery	Risk Appetite / tolerance	Open

Risk Score 2024/25										
Initial Score	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24				Target score
16	16	16	12	12	12	12				9

Context	Controls	Assurance
There is a risk that all performance targets (Cancer, planned Care, Diagnostic targets) are not improving due to significant gaps in workforce and ongoing industrial action. Due to significant gaps in workforce across a number of functions (e.g Theatres, Diagnostics, central booking) alongside demand being greater than capacity, key performance and quality metrics are showing sustained deterioration. The ongoing impact of industrial action is a significant risk to meeting performance targets due to the level of cancellations.	Planned care and urgent Care boards for transformation BSW Planned Care Board and Elective Recovery group Delivery group monitors performance weekly Cancer improvement group	52/78 week performance is on trajectory although there are emerging risks following further Industrial Action Outsourcing arrangement for additional capacity in Radiology which has improved DMO1 performance significantly in Ultrasound, MRI and CT.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
DM01 improved during Q2& Q3 with additional capacity and focused recovery. Some recovery of long waits for Breast Reconstruction activity reducing the number waiting over 78 weeks. Cancer backlog for skin has reduced with focused funding from Cancer alliance and increased outsourcing.	Number of Patients waiting for planned treatment is increasing Industrial action impacting. Significant issue with Plastic breast reconstruction services due to Consultant capacity. Outpatient waits not reducing in line with expectations – further improvement work targeted to reduce follow up's increase PIFU and improve pathways for patients	Improved governance processes for oversight of performance (delivery group. Cancer improvement group). New process standard work in place from January 2024 Planned Care and Urgent Care SFT Boards in place to support transformation – focus on outpatient in Q4 BSW Urgent care and Planned care boards well established to help support delivery.

ID	Directorate	Opened	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due Date	Action Done Date	Action Lead	Review Date	Rating (target)	Assurance Framework link (AF Risk Ref)	Executive Lead	Risk Owner	Date Escalated to Corporate Risk	Controls in Place	Gaps in Control	Assurance on Controls	Gaps in Assurance
7809	Quality Directorate	17/08/2023	8	There is a risk that the Trust has an unidentified gap in effective clinical care may be the cause of the sustained deterioration in HSMR and SMR. There is a current failure to provide adequate assurance that the change in statistics is not a result of avoidable harm. This may result in reputational risk if unresolved	Cannot believe that this will ever happen again	Major	4	Chair and CEO have requested external review from Regional CMO to provide further assurance of mortality oversight	30/11/2023	29/12/2023	Collins, Peter	30/09/2024	4	Population	Chief Medical Officer	Collins, Peter	17/08/2023	Internal mortality surveillance group External reporting and scrutiny by Telstra (Dr Foster) Mortality data reported monthly through IPR Learning from Deaths Report to Board quarterly. Further assurance papers through CGC and Board, shared with Governors 30/05:Participate in the BSW system mortality group	Nil to note	No consistent concerns in any one diagnostic group. No consistent themes of inadequacy of clinical care from structured judgment mortality reviews All cause mortality (from public health data) suggests a low rate of mortality in SFT catchment area.	Unexplained deterioration in HSMR and HSR which whilst in keeping with a National picture of lack of confidence in current statistical modelling, does not fully explain the sustained SFT trend
								SFT mortality lead to lead work to set up BSW wide mortality meeting to provide further peer learning and assurance	30/11/2023	29/12/2023	Browne, Ben										
								Action plan to be created once formal feedback from NHSE external review on 5th December.	27/02/2024	30/05/2024	Collins, Peter										
508	Organisational Development and People	21/11/2002	8	The absence of a comprehensive Health and Safety Management System for the Trust runs the risk that legislative requirements will not be embedded into the Trust standards to which departments are expected to work. Without those standards, we cannot expect the Trust be be compliant, so the consequences of non-compliance with health and safety law results in Staff and all persons on site at risk of harm and the Trust at risk of prosecution and claims.	Do not expect it to happen again but it is possible	Moderate	6	Trust compliance is assessed on an add hoc basis by Health & Safety. Yearly corporate and self assessment audits are conducted in 2 clinical and 2 non-clinical areas. Compliance results are reported to the H&S Committee, the Workforce Committee and then onto the board.	01/10/2019	08/02/2021	Knight, Paul	31/03/2024	6	Population	Director of Organisational Development and People	Ready, Troy	06/04/2022	Adequate Health & Safety management system is now in place, with an appropriate system of audit & inspection. Policies and standards are in place with a work programme to ensure they are updated where required by the end of the financial year. All staff trained at induction and further training is in place. Individual department specialist training. A process that requires health and safety risk assessments is in place. Health and Safety Manager and Adviser are in place, plus a Manual Handling Adviser. A mechanism of governance is in place through the H&S Committee, which receives reports from relevant officers plus 19 sub-committees. Interim actions are being taken by the Interim H&S Manager to highlight priorities against this risk and to undertake a small number of activity audits to assess compliance. Adverse event reporting and subsequent analysis/investigation. Health and Safety Committee meetings reporting to board. Health and Safety sub-committees reporting to the Health and safety Committee. Controls Assurance. Health and Safety inspections. Union Health and Safety reps in place.	Some policies not yet up-to-date with current legislation, work programme in place as identified in the H&S management system programme of work. At Oct 23 - a list of outstanding policies has been identified, updated and presented to the H&S Committee for approval. Outstanding policies will be updated by the end of November 2023.	Observations of behaviours and standards across the publicly accessible parts of the site indicate a H&S culture that is in need of improvement. Independent reports have highlighted areas for improvement which are being addressed at a senior level. An agreed programme of audit and inspection overseen by the H&S committee. october 23 - An internal audit program is implemented against a published audit program, task analysis are completed against a published schedule and reporting of performance against H&S targets identifies injury trends and allows for action to manage identified risks to the H&S of staff.	Absence of assurance from divisions and departments giving visibility of H&S issues via the H&S committee. Insufficient near-miss reporting on Datix, for example, multiple examples across the campus of lack of control of premises (e.g. loading bay gates left open, fire doors propped open, safety equipment obstructed by inappropriate storage, trip hazards & obstacles in public areas etc). Ensuring compliance with policy & procedures.
								Trust compliance is assessed on an add hoc basis by Health & Safety. Yearly corporate and self assessment audits are conducted in 2 clinical and 2 non-clinical areas. Compliance results are reported to the H&S Committee, the Workforce Committee and then onto the board.	01/10/2019	08/02/2021	Knight, Paul										
								Reviewed the scope of the risk assessment and have not found any significant gaps in our provision of health & safety instruction, training and baseline support.	20/07/2022	06/10/2022	Adams, Peter										
								5/5/22 Recruit permanent H&S Manager. Transparent escalation and communication of the risk in the first instance is intended to draw attention to the work required to create a comprehensive H&S Management System. Recruitment of a permanent H&S Manager is underway whose task it will be to determine the long-term resources required to deliver and maintain (i) the polices and standards that define how the Trust will address H&S compliance, and (ii) the form of the audit system that will measure the gaps between the legal requirements and the Trust's policies and standards; and the gaps between those policies & standards and their implementation by divisions and directorates. In addition the H&S Management system requires support of divisions and directorates in activities such as: H&S Training; risk assessment; and accident investigation; and the administration and contribution to corporate governance activity through the provision of data dashboards, performance reports, attendance and contribution to H&S committee & sub-committees and escalation reports	01/08/2022	07/09/2022	Adams, Peter										
								The polices and standards required by H&S legislation have been identified and a plan of work is being drawn up to resource their implementation, estimated 47 documents requiring 70 days' work. Auditing of activities to assess implementation of legislative requirements is underway and upon the arrival of the new H&S Manager on 1/8/22 a long-term scheme of audit will be devised. Recruitment of a H&S Adviser is underway and consideration of how to resource policy and audit workload in the long term will be led by the H&S Manager.	30/12/2022	06/10/2022	Adams, Peter										
								7 policies approved by OMB 19/7/22	19/07/2022	19/07/2022	Adams, Peter										
								Create a H&SMS that provides measurement, audit and assurance to the Trust Board	30/12/2022	07/06/2023	Ready, Troy										
								Review gaps in current H&S procedures and policies and update where required	30/11/2023	29/12/2023	Ready, Troy										
6858	Finance and Procurement	12/03/2021	9	There is a risk as new models of working emerge the of partnerships between SFT and wider BSW organisations will need to refocus on a new operating model to ensure progress to achieve key objectives. The ICB is currently undertaking of a review of their form and function. The risk will be reviewed when this has been concluded.	May recur occasionally	Minor	6	Executive team participate in Place based leadership development within the ICS to help shape collaborative arrangements. workshop 13th July	31/08/2021	12/10/2021	Thomas, Lisa	02/12/2024	3	Partnerships	Chief Operating Officer	Prosser, Niall	12/03/2021	ICS system planners executive ICS partnership board Acute Alliance member Wiltshire alliance attendance	ICB leading the system development work and havent yet been able too (due to on going consultation) describe their future function. This means there is risk lack of clarity on how the whole system Role and Responsibilities will evolve.	System working reported to Board Transformation programme aligned with ICA in Wiltshire Acute Alliance work programme and reporting to Board. ICS system planners executive ICS partnership board Acute Alliance member Wiltshire alliance attendance	Speed in which changes to patient pathways and models of care is currently slow.
								Trust developing committee in common with Acute Alliance - progress towards provider collaborative in line with national guidance	31/12/2021	11/01/2022	Thomas, Lisa										
								Trust to work in partnership with new emerging leadership structure to develop transformation plans to meet national operating targets.	31/03/2023	13/06/2023	Thomas, Lisa										
								Reviewing Trust wide risk training, aiming to roll out programme to all middle managers	31/03/2020	17/06/2020	Thomas, Lisa										
								Process mapping underway for business critical controls	31/12/2019	16/12/2019	Thomas, Lisa										
								Trust identifying additional procurement training for those areas of non compliance across the organisation. New process targeting individuals starts in November 2019.	29/03/2020	17/06/2020	Willoughby, Kelly										
								Trust developed draft risk training specification for additional support for directorates- view to tender and award before December 2019.	31/12/2020	07/01/2021	Thomas, Lisa										
								Introduce a monthly informatics department management committee that feeds into monthly executive performance reviews	31/10/2019	18/10/2019	Burwell, Jonathan										
								Approval of IT General Controls plan at Informatics DMC and ratify at exec performance review	31/01/2020	02/03/2020	Scott, Andy										
								Approach to testing of backups agreed	20/03/2020	02/03/2020	Cowling, Andrew										
								All IT system contracts reviewed with IAA and IAO confirmed and delivery of duties being monitored	31/12/2020	15/12/2020	Burwell, Jonathan										
				Insufficiently robust management control procedures	again but it is possible	te								on	inance	ork		SFI's standard operating procedures corporate policies (e.g. HR)	-Education and training on management of risk across the organisation.	-Low levels of reported Fraud -low volume of litigation -head of internal audit opinion -Infrequent high risk audit findings	

5955	Finance and Procurement	13/08/2019	15	Insufficiently robust management control procedures across the organisation which pose a financial, reputational, legal and operational/clinical risk.	Do not expect it to happen	Modera	6	Full review of informatics standard operating procedures including putting in place monitoring processes	30/06/2022	06/01/2023	Scott, Andy	31/12/2024	6	Populati	Director of F	Ellis, Ma	13/08/2019	Governance assurance map risk register Leadership development programme in place Regular finance training provided for budget holders		-Infrequent high risk audit findings -Internal audit reports highlighting weaknesses in controls and processes. (Auditors are assured by responsiveness of recomendations)	N/A
								Full implementation of IT general controls framework	31/12/2021	12/03/2021	Scott, Andy										
								Complete a stocktake of all IT operational infrastructure	31/01/2020	02/03/2020	Burwell, Jonathan										
								Implement a robust asset management system	30/10/2020	01/07/2020	Burwell, Jonathan										
								Implement a centralised rolling replacement programme for computers, laptops and iPads	01/04/2020	28/04/2020	Burwell, Jonathan										
								Complete review of IT security policies	30/10/2021	09/12/2021	Burwell, Jonathan										
								Review of existing storage locations of Informatics SOPs to centralise and improve searchability though using modern software such as CITO or Sharepoint	31/08/2021	16/08/2021	Burwell, Jonathan										
								Embed improving together methodology in performance review reporting structure.	31/01/2023	04/05/2023	Ellis, Mark										
								Development of a standard budgetary management and control training pack for leaders and managers	29/12/2023	29/12/2023	Ellis, Mark										
								Financial management responsibilities reflected in managers 'appraisal process	30/06/2024	05/06/2024	Ellis, Mark										
6857	Finance and Procurement	12/03/2021	6	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn meaning the Trust incurs financial losses.	Will probably recur, but is not a persistent issue	Minor	8	continue programme of fraud awareness and prevention with Counter Fraud team	31/03/2022	13/04/2022	Thomas, Lisa	30/06/2025	8	Partnership s	Director of Finance	Ellis, Mark	12/03/2021	budgetary controls internal control procedures in built into financial systems between purchasing and paying training to all staff on induction	Standard operating procedures across the Whole Trust inconsistently applied	Counter Fraud reports budget monitoring reports fraud investigations low level reporting	investigative fraud allegations show sporadic gaps in procedures.
								Address the drivers of fraud- financial wellbeing of staff	30/06/2022	21/06/2022	Thomas, Lisa										
7573	Operations Directorate	16/01/2023	15	The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services.	May recur occasionally	Moderate	9	Urgent and Emergency Care Board established to hold transformation programmes to reduce bed occupancy	29/09/2023	07/09/2023	Thomas, Lisa	30/09/2024	9	Population	Chief Operating Officer	Prosser, Niall	16/01/2023	site report, clinical safety huddle patient safety meeting nurse staffing meetings x2 daily urgent care board	system plans for reduction in NCTR including use of additional bedded capacity	Bed occupancy has started to reduce whiteparish ward closed to enable refurbishment Number of patients in ED waiting for bed overnight reducing	Number of beds open still higher than core bed footprint NCTR remains higher than expected Turnover of staff increasing
								expansion of SDEC to surgery and Gynae specialities to further prevent admissions and need for beds	29/12/2023	15/01/2024	Thomas, Lisa										
								work with BSW on NCTR reduction plan - particularly those waiting for care Act assessment in beds	29/12/2023	15/01/2024	Thomas, Lisa										
								finalise winter plan to optimise flow, including OPEL levels, escalation protocols	31/10/2023	15/01/2024	Thomas, Lisa										
7039	Trustwide	13/09/2021	15	The Trust is currently experiencing increased demand and patient acuity across all in patient services, at a time of increased nursing sickness, maternity leave, leavers and retirements, and reduced recruitment. This increases risk for patient harm, increases risk of burnout for remaining staff, causes delay to flow and discharges, and inability to provide the required care for all patients. Due to national shortfall in nursing and midwifery hours, there is an ongoing risk to recruitment and retention.	May recur occasionally	Moderate	9	Communication and reporting of red flag for staffing regionally to NHSI/E	02/08/2021	02/08/2021	Merrifield, Tracey	31/07/2024	4	Population	Director of Nursing	Hyett, Fiona	01/07/2022	Thrice daily staffing meeting to review allocation of resources and escalation to off cap agencies Rotas completed at six weeks with automatic access to nurse bank and subsequent escalation to nursing agencies at 3 weeks (Tier A) and 3 days (Tier B). Use of nurse bank and temporary staffing Use of supervisory time to support wards Use of RAG safe staffing to guide and inform staffing deployments Availability of matron until 20.00 to support and manage staffing deployments/late sickness calls Use of specialist nurses to support wards	Reduced training and development opportunities. Safe staffing RAG does not account for enhanced care needs. Unpredictable demand for mental health or CAMHS enhanced care leading to use of high cost agency. OSCE nurses are struggling to get their P.I.N within a timely manner due to NMC challenges. Ability to maintain HCA retention.	Reduction in RN vacancy for ward areas to 0. Reduction in Falls with Harm. Improving position in relation to tissue damage. Maintenance of Allocate and safecare data. Use of red flags and professional judgement to escalate and capture concerns and mitigations. Daily staffing summaries shared with operational team Datix reporting 28/05/24: No vacancies for RNs. Maternity recruitment should see vacancies filled by October 24 with the newly qualified midwives. Sickness remains above 6% for nursing and midwifery. HCA vacancy continues to bee a challenge. Breakthrough objective of retention linked to HCA retention due to high turnover. Bank HCAs are used to mitigate risk from a care perspective.	Complaints received regarding to care provision. Sickness above target of 3% (currently at 6% 28/05) Agency spend (although reducing significantly). Failure to escalate deteriorating patients. Increased number of fraud cases in relation to English tests from internationally recruited nurses. (6 cases as of 28/05)
								Explore use of agencies (including off cap) to support block booking	09/08/2021	09/08/2021	Wilding, Mr Henry										
								Explore use of agency HCAs to support wards	20/09/2021	13/12/2021	Wilding, Mr Henry										
								Establish HCA recruitment event - webinar and associated interview dates	30/09/2021	13/09/2021	Holt, Sharon										
								Use of Specialist Nurses/Out patient Nursing to support ward areas	01/11/2021	04/03/2022	Dyos, Judy										
								Development of B2 non-clinical support worker role (housekeeper) to support wards	13/12/2021	13/12/2021	Wilding, Mr Henry										
								Request for use of volunteers from non-patient facing teams to support wards with delivery of meals, answering phone, runner, drink round	01/01/2022	04/03/2022	Wilding, Mr Henry										
								Develop winter incentive scheme for bank workers	01/01/2022	13/12/2021	Ashley, Simon										
								Explore of use of short, fixed term use of over time payments for part time staff.	27/12/2021	04/03/2022	Wilding, Mr Henry										
								Extension of winter incentive scheme until 02/04/22 to support ongoing escalation and acuity	04/03/2022	04/03/2022	Wilding, Mr Henry										
								Develop specific Easter holiday incentive scheme to support and encourage additional shift coverage	08/04/2022	08/04/2022	Wilding, Mr Henry										
								Ongoing use of golden incentive to support short notice sickness/gap	01/09/2022	05/10/2022	Wilding, Mr Henry										
								Revise incentive scheme framework with established triggers and values, and process of sign off	01/08/2022	05/07/2022	Ashley, Simon										
								Review action card/BCP regarding deployment of available resources in times of extemis	31/10/2022	05/10/2022	Cox, Emma										
								Commission task and finish group to explore all options and opportunities to recruit, retain and incentivise additional nursing hours and support	28/10/2022	13/12/2022	Wilding, Mr Henry										
								Recruit substantively to 'allocation on arrival' team to support wards/areas as required	30/11/2022	10/10/2022	Ashley, Simon										
								Develop and recruit to non-clinical support worker role	06/01/2023	14/06/2023	Hyett, Fiona										
								Commission development of and recruitment to the use of a discharge lounge, supporting earlier discharge on the day and release of current nursing hours on wards facilitating TTOs, transport, collections	06/01/2023	13/12/2022	Osman, Laura										
								Recruitment of discharge coordinators to support specific wards, releasing nursing time and availability	30/06/2023	14/08/2023	Dickinson, Jane										
								Temporary staffing winter incentive scheme approved by execs. To go live from 30/12/22	30/12/2022	21/12/2022	Ashley, Simon										
								Implement counter measures that came from the A3 on enhanced care management.	31/10/2023	15/01/2024	Hyett, Fiona										
								Work in partnership with AWP to reduce the use of Mental Health RMNs and improve continuity of care.	31/12/2023	15/01/2024	Hyett, Fiona										
								Delivery of the breakthrough objective in relation to reducing HCA turnover.	28/04/2025		Hyett, Fiona										
								Follow-up of OET fraud investigation with NMC.	31/07/2024		Hyett, Fiona										
								Use of existing PMB groups to address issues on A3 content	22/11/2021	14/01/2022	Cox, Emma										
								SRO leads to prioritise the work and engage with specific task and finish groups	30/11/2021	14/01/2022	Cox, Emma										
								Executive to agree new road map by end of July.	31/07/2022	31/10/2022	Provins, Esther										
								Commence recruitment for Programme Director.	30/08/2022	29/12/2022	Collins, Peter										

7078	Transformation & IM&T	12/10/2021	12	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together work programme deadlines. The impact of this would be a delay in the pace and scale of the rollout of our shared continuous improvement approach across the Trust and within the AHA. This could result in the Trust not being able to improve performance (quality, people, operational & financial) as far as it could have if the programme had stayed on track.	May recur occasionally	Moderate	9	Sustainability workshop completed with Execs and KPMG. Produced roadmap and key area of priorities and assumption in the next 18 months. Detailed roadmaps and requirements to be presented to the Improving Together Programme Board in March 2023.	20/03/2023	09/06/2023	Cox, Emma	30/09/2024	6	People	Chief Medical Officer	Talbott, Alex	13/10/2021	Director of Improvement. Executive oversight of delivery through the monthly Improving Together Board chaired by CEO. Reporting includes progress against the April 2023 to September 2024 roadmap and case studies from across the organisation on the benefit and impact of Improving Together. The Trust Board receive a quarterly board report from the programme board. In preparation for the monthly programme board report and quarterly Trust Board report each of the nine workstreams are reviewed and update by each of the workstream leads (Exec and manager leads). Risks relating to the programme are reviewed on a monthly basis by the Associate Director of Improvement and the Head of the Coach House. This generates new and refresh mitigations as the risk and resultant issues develop month-by-month. E.g. Coach House staffing changes.	05/06/24: Process confirmation of the routine use of Improving Together tools such as the improvement huddle boards and divisional weekly driver meetings. This is beginning to be picked up in Divisional Performance Review meetings and the Executive huddle.	Improvement and the Head of the Coach House. - Reviews of the workstreams against the overall roadmap at the monthly Improving Together Programme Board and the programme board minutes. 05/06/24: Any off-track workstreams have known and owned actions in place to bring them back on-track. - Quarterly reports to Trust Board. - Monthly Engine Room reviews led by the Executives, including quarterly Engine Rooms taking in progress across the four boards: vision metrics, strategic initiatives, breakthrough objectives and corporate projects. -Training continues to be on-trajectory with the Coach House team prioritising training delivery while staffing capacity is constrained. 05/06/24: - Review and monitoring of training place utilisation on a weekly and monthly basis by the Coach House team. - Quarterly maturity self-assessment by the divisional management teams	Behind trajectory of Improver Advanced training - 05/06/24: new training approach using masterclasses now in place to mitigate this. 05/06/24: Process confirmation of the quarterly maturity self-assessment by the divisional management teams - who and how do we review the rationale and accuracy of the self-assessment.
							Recruitment to coach house to cover maternity leave (B6 improvement practitioner) for 6 months	29/09/2023	06/10/2023	Cox, Emma										
							Recruitment of the three B7 rotational Senior Improvement Practitioner roles into the Coach House. Await final approval of the business case at F&P on 26th September 2023.	31/10/2023	02/01/2024	Cox, Emma										
							Review of training delivery approach and programme in order to bring the Trust back on trajectory. This includes learning from the past year of training delivery within current structure	29/02/2024	05/06/2024	Cox, Emma										
							Develop and deliver the next Improving Together sustainability roadmap session on 15th July 2024 to map out the next 18 months of the programme (October 2024 to March 2026).	16/07/2024		Talbott, Alex										
							Socialise and develop the October 2024 to March 2026 roadmap with the deputies, divisions and corporate leads. Develop the workstreams in more detail with the leads and their respective executive sponsors so that come October we can manage against each workstream via the Improving Together Board.	30/09/2024		Talbott, Alex										
7239	Finance and Procurement	10/03/2022	12	All Trusts across the region are experiencing ad hoc issues within the supply chain resulting in products being out of stock, having longer lead times or with delays in delivery. This means the Supply Chain team within Procurement are needing to be reactive to the situation and challenges as they unfold to mitigate these risks which creates additional pressure on the team and, on occasion, can impact operational activity across the Trusts. The challenges come from a number of factors including the impact from the Covid-19 pandemic and EU exit and economic and global disruptions which are all out of the control of our local procurement team and who are often only made aware that a product will be delayed at the last minute.	May recur occasionally	Moderate	9	Dedicated time is allocated on a weekly basis to highlight and review any risks on stock issues across the ICS and the Supply Chain teams are implementing a daily huddle to highlight risks and increase communication. Actions are also underway to understand how we can use the data we have available to help us manage supply chain disruption issues.	27/09/2024		Christoforidis, Stefanos	27/09/2024	6		Director of Finance	Webb, Rob	05/06/2024	As this is a national challenge NHS Supply Chain are continuously reviewing the situation to source alternative products and have invested in more storage space to be able to hold more stock to support local NHS Trusts, therefore reducing the risk of out of stock items and delayed deliveries. Procurement also sit on the Southern Customer Board and have regular routine engagement with NHS Supply Chain so we can keep up to date with challenges as they unfold. To further mitigate the risks and reduce the impact at a local level our supply chains continue to improve their ways of working across the region and have regular routines and communications each week to share information and when needed products to avoid any Trust going out of stock of an item. Procurement have a standard approach across the ICS to finding an alternative product meaning that work isn't duplicated and information can be recorded quickly and efficiently across the 3 Trusts.	With so many orders released and deliveries expected daily we do not have the resource to make sure we are checking that all expected orders have arrived on time or engage with the suppliers to confirm lead-times in order to mitigate this risk further. It is only recently that the volume and frequency of these challenges are having such and impact and so our team are not resourced to be able to support micro management of orders. A robust and formal process to contract manage critical contracts across the ICS is anticipated to reduce the risk of issues in our supply chain. A formal review process is being implemented at SFT shortly with a view that if successful this would be rolled out across GWH & RUH.	Assurance that the current controls are working can be taken from the number of items that do result in being out of stock against the number of stock issues the procurement department are managing on weekly basis. Services are not being disrupted because the Procurement team are working with stakeholders to identify alternative products. Further the Trusts across BSW have greater resilience than if they were working alone as it is easier to see stock available at other locations and share this when needed.	*
8054	Chief Executive	09/04/2024	9	As a result of out of date policies in Microguide, there is a risk that mandated processes and procedures may not be followed correctly which may result in compromised quality	May recur occasionally	Moderate	9	Meeting with all Divisional Management Teams to agree policy management framework	28/06/2024		Nye, Kylie	27/09/2024	6		Director of Integrated	Nye, Kylie	09/04/2024	Microguide system to access all policies and guidelines. Oversight of policy compliance reported to Trust	Microguide system functionality is limited - resource intensive to manage. Consistent ownership and oversight of	Improving picture of compliance with out of date policies No reported incidents relating to out of date	Approx 70-100 out of date policies
							Draft a new policy management framework	28/06/2024		Nye, Kylie										
7946	Transformation & IM&T	02/01/2024	12	As a result of competing priorities, shifting resource plans and sub-optimal scoping of projects there is a risk that transformation programmes and projects will not be delivered to time which may result in the Trust not realising the benefits of the work and delaying the start of new work.	Will probably recur, but is not a persistent issue	Moderate	12	Training refresher on project documentation in the transformation team	29/03/2024	05/06/2024	Arnett, Louise	30/09/2024	9	Population	Director of Transformation	Talbott, Alex	02/01/2024	05/05/24: Transformation programme Boards, including Digital Steering Group (DSG) Resource scheduling bi-weekly meeting Urgent and Emergency Care and Planned Care Boards Small projects Board Corporate Projects Prioritisation Group feeding into the Engine Room Project documentation to support delivery	Capacity and capability to deliver to time 05/05/24: A standardised approach to scoping and scheduling projects with robust SRO engagement with the timeline	Good knowledge of transformation programmes and projects underway 05/05/24: Monthly review of on/off-track to project/programme plan at Transformation team Performance Review Meeting.	Programme slippage Incomplete and sub-standard documentation
							Track project delivery via transformation senior leadership team meeting	29/03/2024	05/06/2024	Talbott, Alex										
							Continue to strengthen the role of Corporate Project Prioritisation Group (CPPG) by ensuring it runs monthly and routing resource requests and major resourcing changes via CPPG.	30/09/2024		Talbott, Alex										
							05/06/24: Implementation of standardised project documentation - including scoping, scheduling and project plan sign off by the SRO.	30/06/2024		Arnett, Louise										
7955		01/01/2024	16	There is a risk that ongoing industrial action compromises the quality and timeliness of patient care, compromises operational effectiveness and impacts on the workforce morale.	May recur occasionally	Major	12	industrial action planning group - focusing on ensuring the hospital remains safe during industrial action and tries to minimise the disruption caused on elective programme.	12/07/2024		Dickinson, Jane	30/09/2024	8		Chief Operating Officer	Prosser, Niall	15/01/2024	EPRR infrastructure IA planning CGC oversight People and Culture committee TMC Pulse survey	Not able to look at longitudinal impact of patients receiving care during strike periods where staffing levels may be different. Minimum staffing levels means cancelling planned patient care due to availability.	Harm related incident reporting low during strike periods sickness levels static and not deteriorating	Patient waiting times increasing in planned care cancelled procedures during strike period cancer performance compromised
							post industrial action review of the impact on elective waiting lists and any potential harm that has been caused	12/07/2024		Dickinson, Jane										
5704	Surgery	31/01/2019	16	A risk that the current lack of substantive Gastroenterology medical and nursing workforce will impact on the ability of the service to deliver sustainable comprehensive safe and effective care to patients.	May recur occasionally	Major	12	Ongoing recruitment drive.	30/09/2019	25/04/2019	Clarke, Lisa	30/09/2024	8	Population	Chief Medical Officer	Collins, Peter	31/01/2019	Sustainable provision of service through use of long-term locums provided by ID Medical. Ongoing recruitment efforts for specialist nursing and unfilled medical posts. May 2023 - New Fixed term gastroenterologist starting end of May 23 August 23 - Deputy CMO commissioned to provide oversight of the service and to describe road map to sustainability through partnership with neighbouring acute Trusts. External support from senior gastroenterologist providing elements of IBD service October 23 - continued support from executive team for improvements with fortnightly assurance meetings. Partnerships with local GP in place and due to commence Nov 23 supporting with specific clinical pathways.	Unsuccessful recruitment to specialist Nurse roles, which has a particular impact on Hepatology and IBD service provision. Until substantive recruitment is complete, off site provision of GI Bleed on-call service will continue. May 2023 - Substantive consultant has handed in notice - leaving end of July 2023. Fixed term consultant going on Mat leave in mid June 2023. Clinical leadership of GI Unit changing hands. June 23 - Resignation of substantive consultant. August 23 - long term capacity and demand planning remains challenging due to non substantive medical workforce October 23 - business case in progress with Southampton hospital to increase support for ERCP / IBD services	Regular contract monitoring meetings with ID Medical. Monitoring of Key Quality Indicators demonstrating a safe service. 3 new substantive GI Consultants in post and providing oversight and assessment of current service performance. Additional service development time has been job planned for the new consultants to support development of the service and increased governance May 2023 - Reduction in Endoscopy long waiters. August 23 - endoscopy performance remains above peer average in BSW. external quality data does not suggest the Trust is an outlier. October 23 - Reduction in long waiters for both gastro and endoscopy through focussed attention on waiting lists 30/05:Current substantive Gastroenterologist as clinical lead for service.	Service is not meeting all required performance standards but this is understood and related to post-Covid elective recovery challenges. No service specific concerns identified currently. New consultants are uncovering new risks as they explore the service but action plans are being developed and will be raised as new specific risks. May 2023 - With fluctuation in staffing levels in endoscopy and gastro over the last 6 months there has been an impact on waiting list levels. Mitigations are in place to regain control June 23 - Risk to service provision around ERCP, inflammatory bowel disease, and nutrition. August 23 - as June update. All subject to ongoing work overseen by Deputy CMO
							Continual clinical prioritisation to ensure that high risk areas are covered.	01/04/2019	17/04/2019	Clarke, Lisa										
							Continuing insourcing of private provider to endoscopy.	30/06/2019	25/04/2019	Vandyken, Mrs Ali										
							Quantification and mitigation of the risk to bowel scope.	01/04/2019	17/04/2019	Vandyken, Mrs Ali										
							Tender for elements of the Gastroenterology service.	01/04/2019	17/04/2019	Stagg, Andrew										
							Monthly update to F&P Committee and CGC.	10/05/2019	25/04/2019	Hyett, Andy										
							Presentation of gastro strategy to Finance and Performance Committee.	31/05/2019	12/06/2019	Hyett, Andy										
							Put together a workshop with CDs and Clinical Leads to discuss options for service provision.	01/10/2019	22/10/2019	Hyett, Andy										
							Continue conversations and meetings with alternative NHS providers for likely future joint partnership for delivery of service	30/09/2019	29/08/2019	Henderson, Dr Stuart										
							Medical Director to link with other STP partners around system wide solution.	31/12/2019	21/02/2020	Blanshard, Dr Christine										
							Case for change to develop a GI unit to be completed	31/12/2019	04/03/2020	Hyett, Andy										
							New GI unit to be launched on 1st April	01/04/2020	07/05/2020	Hyett, Andy										
							To recruit medical and nursing staff for the GI Unit	28/06/2024		Insull, Victoria										
							Confirm Southampton will be able to take over full responsibility for the GI Bleed out of hours service.	23/04/2021	23/04/2021	Branagan, Mr Graham										
							Secure support for existing junior doctors	30/07/2021	31/08/2021	Branagan, Mr Graham										
							Ongoing regular review of workforce strategy in GI unit	01/12/2021	20/12/2021	East, Rachael										
							Recruitment to Nutrition Service Vacancy required.	31/01/2022	28/03/2022	East, Rachael										
							Develop joint governance meeting between medicine and surgery	31/08/2023	20/11/2023	East, Rachael										

								Recruitment of new clinical lead for GI Unit	31/05/2023	22/06/2023	Stephens, Mr Paul										
								CMO to report outcome of GI services review once complete.	30/09/2024		Murray, Dr Duncan										
								Surgical division to provide assurance report on oversight of operational delivery and any impacts to quality to CGC on 27th June 2023.	27/06/2023	13/07/2023	East, Rachael										
								Intensive support meetings to commence fortnightly from 24th July.	24/07/2023	17/08/2023	East, Rachael										
								GI Unit enhanced support programme ongoing to identify strategic aims for 24/25 to address stats and service	28/06/2024		Insull, Victoria										
7574	Operations Directorate	16/01/2023	15	The continued pressure from urgent care flow alongside the increases in length of stay, compromises the ability for the Trust to undertake planned care.	Will probably recur, but is not a persistent issue	Moderate	12	Outpatient transformation programme request for additional support - to ensure progress in reducing patients waiting, reduction in follow ups and increased in PIFU	29/09/2023	07/09/2023	Thomas, Lisa	30/08/2024	9	Population	Chief Operating Officer	Prosser, Niall		delivery Group IPR EPR meetings with Divisions Planned care board Theatre productivity programme BSW Elective Care Board N	Impact of NCTR patients on available bed capacity no real reduction in time to first outpatient appointment risking 78 WW	Longer waits over 78 weeks 104 week waits on trajectory growth in waiting list fairly stable	some specialities under pressure for 52 benchmark lower for productivity that comparable Trusts can't achieve 2019/20 levels of activity due to bed capacity
								Work with Wiltshire Alliance to reduce NCTR impacting on elective beds through the development of virtual wards, discharge hub and pathway changes for non bedded capacity.	29/09/2023	07/09/2023	Thomas, Lisa										
								planned care board to focus on outpatients for the next three months in line with NHS letter 2/8	30/12/2023	15/01/2024	Thomas, Lisa										
								winter plan includes expansion within DSU for chairs to mitigate against winter escalation	29/12/2023	15/01/2024	Thomas, Lisa										
								New ward opens with new timetable for April/May 2024 to increase planned care capacity	30/04/2024		Thomas, Lisa										
7472	Organisational Development and People	12/10/2022	16	As a result of staff absences, continued poor retention of existing staff and ineffective & inefficient recruitment activity to fill vacancies in a timely manner, there is a risk that SFT is unable to manage service provision and operate a safe hospital.	May recur occasionally	Major	12	Staff resource plans identified and agreed with Divisional Management Teams.	31/03/2024	12/06/2024	Crowley, Ian	30/09/2024	9	People	Director of Organisational Development and People	Whitfield, Melanie	12/10/2022	Monthly analysis of Workforce Data against Staffing Availability levels People Promise elements delivered to improve retention Targeted attraction and recruitment campaigns against identified priority vacancies. Line management training to support delivery of Career and well being conversations. Divisional and trust workforce control panels. First 90 day and 1 year anniversary feedback events. Hearing it campaign. We have a specialist interim involved in resource planning and strategic workforce management. AHA clinical strategy to meet long term NHS workforce plan targets Quarterly nursing safe staffing meetings. Nursing skills mix bi-annual reviews.	Resources to deliver the NHS Widening participation agenda. Line management confidence to manage absence and grievance procedures. Insufficient wellbeing and career conversations. Further review of exit process and appraisals are required	Improving KPIs for vacancy rate, time to hire, and sickness absence control - maintaining though not improving staff retention. Positive trend on quarterly pulse survey.	Lack of alignment between budgeted FTE and the establishment recorded per service function and/or division - this is one of six improvement projects in our financial recovery. Number of days absence/time lost due to short intermittent periods of absence being effectively managed. Control and effective management of temporary staffing numbers.
								Mechanism to manage career pathways and career conversations delivered.	14/01/2023	07/06/2023	Crowley, Ian										
								Delivery of the widening participation initiative.	31/07/2024		Crowley, Ian										
								Recruitment processes optimised (pwc recommendations implemented).	30/04/2023	07/06/2023	Crowley, Ian										
								Movers and leavers project delivered.	31/07/2024		Crowley, Ian										
								People Promise actions for this year to be delivered.	31/03/2024	12/06/2024	Crowley, Ian										
								Health and Well-being plan delivered.	30/09/2023	17/09/2023	Crowley, Ian										
								Exit and appraisal policy review and application.	31/03/2024	12/06/2024	Whitfield, Melanie										
								12/06: Ongoing delivery of all elements of the People Promise.	31/10/2024		Whitfield, Melanie										
								12/06: Conclude the line management skills build pilot in July and launch trustwide.	30/09/2024		Crowley, Ian										
7734	Finance and Procurement	16/06/2023	15	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Will undoubtedly recur, possibly frequently	Moderate	15	2024/25 medical equipment brought into 2023/24 as backfill against estates program slippage.	31/03/2024	05/06/2024	Ellis, Mark	31/03/2025	8	Resources	Director of Finance	Ellis, Mark	21/09/2023	- capital control group priorities capital programme - monitor Datix incident reporting related to infrastructure and equipment.	- financial constraints on ability to address whole scale estate risk. - unclear regional/national process for emergency capital bids	- incident reporting highlighting areas of concern - sub groups maintain 5 year capital plans providing visibility of programme deliverables and gaps	- increasing level of maintenance required - increasing number of incidents of operational disruption particularly in day surgery
								24/25 Capital monitoring in place. Ongoing processes. Board reporting continues, including specific updates on digital & estates.	31/12/2024		Ellis, Mark										
7807		16/08/2023	20	As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff. This also	Will undoubtedly recur, possibly frequently	Moderate	15	Agree an approval algorithm for mental health 1 to 1 support with AWP.	28/02/2024		Osman, Laura	31/03/2024	12	Population	Director of Nursing	Murray, Dr Duncan	16/08/2023	Daily review of mental health needs across the organisation and identify staffing requirements. Use of agency RMNs. As required Meetings with key agency to discuss	Availability of adult mental health beds and tier 4 CAMHS beds. Inconsistent standards of agency RMN skills and knowledge.	Improved partnership working leading to better therapeutic input. Recent audit 28/05/24 demonstrated good compliance with Mental Health Act.	Long length of stay for mental health patients requiring community or MH inpatient facilities. Increase number of incidents reported in relation to mental health patients. Impact on estates having to be adapted to maintain
								Ongoing collaboration with partners at ICS and regional level related to Mental Health Provision.	31/03/2024		Murray, Dr Duncan										
5751	Operations Directorate	11/03/2019	15	Risk of patient harm caused by patients remaining in hospital when their clinical need does not require this (no right to reside). This risk is caused by capacity/resource constraints in out of hospital care.	Will undoubtedly recur, possibly frequently	Moderate	15	Winter director managing Trustwide ECIST actions.	01/05/2019	12/06/2019	Hyett, Andy	31/07/2024	12	Population	Chief Operating Officer	Prosser, Niall	11/03/2019	Site and Flow meetings 3x a day. Specific medicine ward level discharge meeting Daily reporting and monitoring. System escalation plan revised and approved. Patient flow score card monitoring delivery of KPIs. Expert panel which reviews all patients with LoS over 7 days with CTR. Monthly urgent care board which the COO attends. Deputy Chief Operating Officer role in place. No right to reside is an approved breakthrough objective as part of the Improving Together Programme Improved data quality Improved use of e-Whiteboards on wards.	Reporting of timelines in patients journeys challenging with current IT systems. - capacity gap in Council for domiciliary care which means significant shortage of available care hours.	There is currently increased system visibility. Good visibility of patients waiting on different pathways which is recognised by all across the system.	Understanding of discharge process at ward level (nursing and medical) is inconsistent. Use of e-whiteboards although improved is still inconsistent with no training delivered to new starters.
								Winter Director coordinating trajectory for delivery of DTOC target.	01/05/2019	12/06/2019	Hyett, Andy										
								Trust actions being led by COO and Medicine CD and managed through weekly delivery meeting and monthly PMB.	01/05/2019	12/06/2019	Hyett, Andy										
								Weekly expert panel meeting to challenge discharge pathways chaired by CCG director of quality.	01/05/2019	12/06/2019	Hyett, Andy										
								Trust implementing discharge PTL	01/07/2019	04/09/2019	Hyett, Andy										
								Escalation to EDLDB non delivery of trajectory	01/07/2019	04/09/2019	Hyett, Andy										
								Mitigation actions being prepared to mitigate lack of capacity in the community.	01/08/2019	04/09/2019	Hyett, Andy										
								All providers required to present their winter plans to EDLDB in September.	30/09/2019	22/10/2019	Hyett, Andy										
								Business case to expand ESD service going to TMC in September and COO and DoF meeting Wiltshire Health and Care to align services	30/11/2019	10/12/2019	Hyett, Andy										
								CEO DOF and COO representing SFT at system wide winter summit on 25th October 2019.	31/10/2019	10/12/2019	Hyett, Andy										
								COO representing Trust at Regional Workshop w/b 9th December	14/12/2019	04/03/2020	Hyett, Andy										
								System wide actions to be monitored through the ED local delivery board.	01/04/2020	28/04/2020	Hyett, Andy										
								COO escalating the need for an ED LDB risk log reflecting the risks carried by each provider organisation.	19/12/2019	04/03/2020	Hyett, Andy										
								Risk to be captured on newly developed ED Local Delivery Board Risk Register.	31/03/2020	28/04/2020	Hyett, Andy										
								Action plan to be developed for 2021 by Urgent Care Board.	31/03/2021	04/05/2021	Hyett, Andy										
								Reinstate the challenge of stranded patients by the Medical Director by the end of October.	01/11/2020	20/10/2020	Hyett, Andy										
								Development of Transformation Programme for improved Discharge processes.	31/05/2021	28/06/2021	Hyett, Andy										
								Agreement of system escalation triggers.	31/05/2021	28/06/2021	Hyett, Andy										
								Review of bed modelling in light of increased urgent and elective activity.	31/05/2021	30/06/2021	Humphrey, Kieran										
								Agreement of Improvement Trajectory with system partners.	30/07/2021	08/10/2021	Hyett, Andy										
								Delivery of the Transformation Improvement Plan.	30/11/2021	30/12/2021	Wood, Paul										
								Delivery of the BSW Urgent Care Board discharge improvement plan which the Trust is contributing to	31/10/2022	11/10/2022	Thomas, Lisa										
								Trust working with BSW on delivery of 57 additional community beds at South newton from November.	30/11/2022	28/12/2022	Thomas, Lisa										

							Trust developing winter plan for implementation focusing on pathway 0 patients to maximise available bed capacity	31/10/2022	28/12/2022	Thomas, Lisa										
							Discharge Hub being established at SFT to support efficient and effective discharge process and improve partner working	29/09/2023	14/08/2023	Cavill, Emma										
							SFT to complete bed modelling and potential pathway improvements with Wiltshire Place colleagues	30/11/2023	15/01/2024	Thomas, Lisa										
							Further engagement with system partners to understand their actions	25/09/2024		Cavill, Emma										
5360	Transformation & IM&T	28/02/2018	15	Risk of a cyber or ransomware attack, resulting in the potential loss of IT systems, compromised patient care and financial loss.	May recur occasionally	Catastrophic	02/10/18 IT Technical group on 8/10/18 to discuss what Anti virus software should be purchased	10/10/2018	14/12/2018	Noble, Bob	30/08/2024	8	Population	Director of Finance	Burwell, Jonathan	11/02/2020	- Information Security Team in place to proactively manage CareCERT compliance - Microsoft Defender Endpoint (MDE) is installed to monitor the Microsoft Windows operating system on a PC or laptop to identify any abnormalities and take immediate action to stop issues identified spreading - NESSUS vulnerability scanning in place - Industry standard firewalls have been installed (Watchguard) - Trust compliant with DSPT which is Cyber essentials equivalent - IT Health Assurance Dashboard (ITHAD) provides compliance monitoring, in particular CareCERT compliance. Cynerio for Medical Device monitoring in place. - SIEM, Password monitoring solution and PAM products implemented. - All devices on supported version of Windows (Windows 10 version 21H2).	- A number of outstanding devices for Critical CareCERT. Log4j critical careCERT is a significant wide ranging risk that is considered. - A number of MDE alerts in last 12 months related to staff clicking on phishing emails.	SFT Informatics CareCERT Alert Dashboard in place as part of ITHAD. Informatics Tech Group oversees progress in CareCERT compliance, patching monitored and wider cyber activities. IT Health dashboard in place and reviewed Tech Group using this operationally Quarterly digital update to F&P. Board agreed moderate risk appetite for cyber security risk in 2021. IG, DP and Cyber related Policies in place and up to date. Rolling progress of desktop exercises to test business continuity plans and preparedness	Poor recent phishing exercise results.
							Technical Group made decision to extend current product. Quotes being obtained for 1, 2 and 3 year extension.	28/02/2019	20/02/2019	Noble, Bob										
							Review of practicalities of getting ransomware with financial controller.	24/07/2019	09/09/2019	Burwell, Jonathan										
							Development of Cyber Essentials plus plan to support achievement of the standard by 2021	17/01/2020	03/02/2020	Carman, Mr Stephen										
							Review of options for SIEM automated logging and impact of this on resource	31/03/2020	28/04/2020	Carman, Mr Stephen										
							Business case to TMC for agreement of option, associated resources an risk management	18/03/2020	28/04/2020	Carman, Mr Stephen										
							Windows 10 migration complete	31/03/2022	13/04/2022	Arnold, Jon										
							Cyber essentials plus accreditation achieved	30/06/2021	09/07/2021	Carman, Mr Stephen										
							Completion of outstanding penetration test actions prior to moving into cyber essentials plus plan	28/02/2020	17/03/2020	Burwell, Jonathan										
							Implementation of SIEM solution with regional leads	30/06/2020	10/07/2020	Carman, Mr Stephen										
						15	ATP to be installed on Servers	31/12/2020	08/01/2021	Gibson, Richard										
							External CORS review to be undertake to support progress review	31/01/2021	24/02/2021	Burwell, Jonathan										
							Test implementation of IT Health Assurance Dashboard	31/05/2021	09/07/2021	Burwell, Jonathan										
							Review of proposed actions outlined by NHSD cyber team and CORS assessment to develop a 2021/22 updated cyber plan.	30/07/2021	12/10/2021	Gibson, Richard										
							Implementation of offline backup storage	21/12/2021	12/01/2022	Gibson, Richard										
							Completion of KPI report for Cyber	17/09/2021	12/10/2021	Badham, Gareth										
							Completion Log4j Critical CareCERT mitigations that are currently available.	30/03/2023	22/05/2023	Gibson, Richard										
							Implement Privileged Access Management solution	30/03/2024	09/05/2024	Gibson, Richard										
							Rollout of SpecOps	16/12/2022	16/12/2022	Gibson, Richard										
							Procure a solution to monitor networked medical devices	31/03/2023	22/05/2023	Gibson, Richard										
							Undertaken awareness of Metacompliance training, focusing on Phishing	30/10/2023	30/10/2023	Gibson, Richard										
							Review of additional actions required to increase cyber preparedness	30/07/2024		Burwell, Jonathan										
							Action plan to improve awareness of phishing attacks and retraining of those who failed recent test	31/08/2024		Gibson, Richard										
7308	Finance and Procurement	19/04/2022	15	The financial plan for 2024/25 is for an underlying deficit plan with assumed 6% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Ongoing industrial action has the potential to affect both activity levels and management capacity to deliver required improvement programmes. Cash balances have depleted and the Trust is engaged in NHSE cash support process.	Will undoubtedly recur; possibly frequently	Major	20	Grip and Control processes reviewed in all Divisions to ensure robust financial governance	29/07/2022	11/10/2022	Thomas, Lisa	30/09/2024	9	Partnerships	Director of Finance	Ellis, Mark	19/04/2022	Cash flow forecasting -- monitoring reports to F&P - SFI's ensuring strong financial governance - budget signed off for April 2024/25 based on internal assumptions - ICB transitional funding agreed. - Weekly agency usage monitoring - Fortnightly financial recovery group chaired by CEO - Enhanced vacancy control and temporary staffing process - System investment triple lock	- Delivery of 6% CIP dependent on external action - Uncertain impact of winter pressures, staffing gaps, and effects of industrial action	2023/24 efficiency plan delivered in full (5%) Improving Together methodology being used to underpin 24/25 programme. Continued upward trajectory in Trust productivity calculation. 16 theatres fully operational.	Ongoing agency bookings Pay overspend Low theatre utilisation. Forecasted £17 million deficit.
							Divisions asked to identify full CIP and or productivity plans to ensure they manage within Budget for 2022/23	29/07/2022	11/10/2022	Thomas, Lisa										
							Deployment of winter plans.	30/11/2022	15/12/2022	Ellis, Mark										
							Seeking support for unfunded pressures from the ICB and SpecCom.	31/01/2023	31/03/2023	Ellis, Mark										
							Review of agency booking process.	31/01/2023	31/03/2023	Whitfield, Melanie										
							3-year forecast being undertaken in Q1, including risks and impact on cash flow.	29/09/2023	29/12/2023	Ellis, Mark										
							Identification of additional savings opportunities managed through Divisions with oversight from FRG.	31/12/2024		Ellis, Mark										
							Organisation wide communications strategy for financial recovery	30/09/2024		Ellis, Mark										

6229	Surgery	04/03/2020	12	[07/07/2023 12:00:42 Laurence Arnold] The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures. Failure of the air handling unit is becoming a regular occurrence, this in turn affects the overall environment, prevents activity from taking place owing to infection control policies and results in cancellations of elective procedures. Incidents relating to the building condition are increasing and impacting on patient safety, care and experience. Regular problems with maintaining temperatures safely - theatre F particularly difficult. Air handling plant is sub-optimal for the needs of the facilities. Poor environment for staff - lack of wellbeing facilities. Results in inconvenience for patients - cancellations, and being moved to main theatres. The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures.	Will undoubtedly recur, possibly frequently	Major	20	DSU risk escalated to wider stakeholders to ensure remains priority scheme for BSW and South West Region	13/06/2023	13/06/2023	Arnold, Laurence	31/10/2024	4	Population	Chief Operating Officer	O'Keeffe, John	13/01/2023	[07/07/2023 12:00:42 Laurence Arnold] None ad hoc nature of issues results in limitations around mitigations. Staff manage individual cases and issues None ad hoc nature of issues results in limitations around mitigations.	[07/07/2023 12:00:42 Laurence Arnold] Substantial capital investment is required - the whole facility needs to replacing, necessitating national capital funding. Funding for new DSU.	None Constant lobbying being undertaken to attempt to secure funding.	[07/07/2023 12:00:42 Laurence Arnold] Problems persist - Roof leaks, heating failures and significant investment identified in the critical plant survey (2020). Regular failure in AHU's resulting in patient cancellations Roof leaks, heating failures and significant investment identified in the critical plant survey (2020). Regular failure in AHU's resulting in patient cancellations

Corporate Risk Register Summary - June 2024 v1

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Oct-22	Jan-23	Jun-23	Sep-23	Jan-24	Jun-24	Target
Risk Detail				Score Trend							
POPULATION - Improving the health and wellbeing of the population we serve											
5704	Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce	Chief Medical Officer	31-Jan-19	16	9	9	15	15	15	12	6
5751	Risk of patient harm caused by a delayed discharge from hospital.	Chief Operating Officer	11-Mar-19	16	20	20	20	15	15	15	12
7039	The Trust is currently experiencing increased demand and patient acuity across all in-patient areas, at a time of increased nursing sickness, maternity leave, leavers and retirement and reduced recruitment. This causes a shortfall in Care Hours per Patient day (CHPPD), increases risk of burnout for remaining staff, causes delay to flow and discharges and inability to provide required care for all patients	Chief Nursing Officer	01-Jul-22	15	20	15	15	12	12	9	4
5360	Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss	Chief Finance Officer	11-Feb-20	15	10	10	10	10	10	10	8
5955	Insufficient organisation wide robust management control procedures	Chief Finance Officer	13-Aug-19	15	9	9	9	9	9	6	6
7946	As a result of competing priorities, shifting resource plans and sub-optimal scoping of projects there is a risk that transformation programmes and projects will not be delivered to time which may result in the Trust not realising the benefits of the work.	Chief Medical Officer/Director of Transformation	02-Jan-24	12					12	12	9

508	The absence of a comprehensive Health and Safety Management System for the Trust runs the risk that legislative requirements will not be embedded into the Trust standards to which departments are expected to work. Without those standards, we cannot expect the Trust be compliant, so the consequences of non-compliance with health and safety law results in Staff and all persons on site at risk of harm and the Trust at risk of prosecution and claims.	Chief People Officer	30-Jun-21	16	12	12	9	9	6	6	6
6229	The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures. Failure of the air handling unit is becoming a regular occurrence, this in turn affects the overall environment, prevents activity from taking place owing to infection control policies and results in cancellations of elective procedures. Incidents relating to the building condition are increasing and impacting on patient safety, care and experience	Chief Operating Officer	02-Jan-23	12		20	20	20	20	20	4
7573	The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services.	Chief Operating Officer	16-Jan-23	20		20	20	15	12	9	12

7574	The continued pressure from urgent care flow alongside the increases in length of stay, compromises the ability for the Trust to undertake planned care.	Chief Operating Officer	16-Jan-23	15		15	15	15	15	12	12
7807	As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff.	Chief Nursing Officer	16-Aug-23	20				20	15	15	12
7955	There is a risk that ongoing industrial action compromises the quality and timeliness of patient care, compromises operational effectiveness and impacts on the workforce morale.	Chief Operating Officer	01-Jan-24	16					16	16	8
8054	As a result of out of date policies there is a risk that mandated processes and procedures may not be followed correctly which may result in compromised quality of care for patients and negatively impact workforce practices. This may result in regulatory action. **New Risk**	Director of Integrated Governance	09-Apr-24	9						9	6
7809	There is a risk that the Trust has an unidentified gap in effective clinical care may be the cause of the sustained deterioration in HSMR and SMR. There is a current failure to provide adequate assurance that the change in statistics is not a result of avoidable harm.	Chief Medical Officer	17-Aug-23	8				8	4	4	4
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work											

7472	As a result of unmanageable staff absences, poor retention of existing staff and ineffective recruitment activity to fill vacancies, there is a risk that SFT is unable to manage service provision and operate in a safe hospital	Chief People Officer	12-Oct-22	16	16	16	16	16	12	12	6
7078	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together Programme deadlines	Chief Medical Officer	13-Oct-21	12	12	9	6	9	9	9	6
PARTNERSHIPS - Working through partnerships to transform and integrate our services											
6857	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn resulting in the Trust incurring financial losses **Risk tolerated**	Chief Finance Officer	12-Mar-21	6	8	8	8	8	8	8	8
6858	There is a risk as new guidance and models of working emerge, the immaturity of partnerships between the Trust and wider BSW organisations will impact on progress to achieve key objectives	Chief Operating Officer	12-Mar-21	9	9	9	9	9	9	9	6
7239	Ad hoc issues within the supply chain resulting in products being out of stock, having longer lead times or with delays in delivery. The challenges come from a number of factors including the impact from the Covid-19 pandemic and EU exit and economic and global disruptions which are all out of the control of our local procurement team and who are often only made aware that a product will be delayed at the last minute **De-escalated from BAF June 24**	Chief Finance Officer	10-Jun-24	12						9	6
7734	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Chief Finance Officer	16-Jun-23	15			15	15	15	15	8

7308	The financial plan for 2022/23 is a deficit plan with assumed 2.2% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Therefore there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures.	Chief Finance Officer	12-Mar-21	15	12	16	20	20	20	20	9

Risk Score Key

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

Risk Appetite

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board Public	Agenda item:	3.5
Date of meeting:	4 July 2024		

Report title:	Risk Appetite Definitions			
Status:	Information	Discussion	Assurance	Approval
		•		x
Approval Process: (where has this paper been reviewed and approved):	Content agreed with subject matter experts			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices				

Recommendation:

Trust Board to review and approve:

- The risk category definitions.
- The risk appetite scale definitions.
- The proposed overall risk appetite for the 5 Level 1 risk types.
- The proposed risk appetite for each of the 24 risk categories.

Executive Summary:

Following the Board Risk Appetite Development session in February 2024, risk category definitions and risk appetite scale definitions have been developed with the subject matter experts for 3 of the 5 risk types: workforce risks, operational risks and clinical risks. For each risk type and category there is a proposed risk appetite.

The estates risk has been broken down further to 6 categories and the Head of Estates is working on a single definition which will be presented in September.

The financial risk and external risk definitions will now be drafted and presented to Trust Board in September 2024. Once approved, the risk appetite framework will be finalised and presented to Trust Board in October 2024 for final approval.

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

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

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Virtual Meeting Etiquette:

- Mute microphones when not speaking (to minimise background noise)
- Turn cameras off – unless speaking (to maximise call quality)
- Please use the *Raise Your Hand* to ask a question
- Please note, this event will be recorded

Risk Appetite Definitions
July 2024

Fiona McNeight

Director of Integrated Governance

Background

Salisbury NHS Foundation Trust

- Board development session in February 2024.
- Agreement to develop definitions for each risk category and risk appetite scale and present to Trust Board for approval in a phased approach (outlined on next slide) with final approval in October 2024.

Timeline

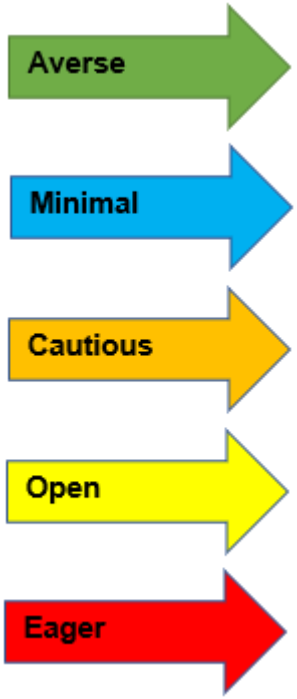
NHS Salisbury NHS Foundation Trust

Risk Type	Timescale	Board Approval
Workforce Risks	31 May	July 2024
Operational Risks	31 May	July 2024
Clinical Risks	17 June	July 2024
Financial Risks	30 June	September 2024
External Risks	31 July	October 2024 (final approval)

Risk Appetite scales

Salisbury NHS Foundation Trust

Based on risk appetite guidance provided within the ‘Orange Book’.



Avoidance of risk and uncertainty is key objective

Preference for safe options leading to only minimum risk exposure: low likelihood of occurrence of the risk after application of controls

Preference for safe options though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls

Willing to consider all options and choose one that is most likely to result in successful delivery; recognise that there could be a high-risk exposure

Willing to be innovative and take on a very high level of risk but only in the right circumstances

Risk Appetite scales

Salisbury NHS Foundation Trust

Consequence	1	2	3	4	5
5	Minimal	Open	Eager	Eager	Eager
4	Minimal	Cautious	Open	Eager	Eager
3	Averse	Cautious	Cautious	Open	Eager
2	Averse	Minimal	Cautious	Cautious	Open
1	Averse	Averse	Averse	Minimal	Minimal

Likelihood

Risk Scores	Risk Appetite Level
15+	Eager
10-12	Open
6-9	Cautious
4-5	Minimal
1-3	Averse

Approved Risk Categories

Salisbury NHS Foundation Trust

Defined 5 risk types (known as Level 1 Risk Types) – principal risks which arise from the nature of the Trust's operating environment

Defined 24 Risk Categories (known as Level 2 Risk Categories) – each aligned to one of the 5 Risk Types. These have been determined through aligning the Corporate Risk Register risks to a broader, industry-recognised Risk Category.

Definitions

Salisbury NHS Foundation Trust

Definitions have been drafted by the subject matter experts for each risk type and risk appetite scale with a proposed risk appetite (outlined in red on each scale)

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Workforce Risks

Workforce Supply

NHS Salisbury NHS Foundation Trust

Definition

The Trust has sufficient staff numbers, with the right skills mix, in the right locations to deliver an effective and safe service to patients

Adverse	Minimal	Cautious	Open	Eager
We prioritise patient safety and quality of care, thus we have a low tolerance for understaffing and will invest in recruiting additional staff even if it means higher short-term costs.	We have a low tolerance for gaps in specialist care and will ensure we have a sufficient number of specialist staff in each department to provide high-quality, expert care	We aim to maintain optimal staffing levels and are willing to accept some temporary understaffing during peak periods if it is balanced by efficient use of current resources and temporary staff	We will maintain a balanced mix of specialist and generalist staff, accepting that some departments may need to rely on generalists during peak times	We are prepared to operate with minimal staffing levels to reduce costs, accepting the potential for increased workload on existing staff and a possible impact on service delivery

Workforce Deployment

NHS Salisbury NHS Foundation Trust

Definition

The Trust is able to flexibly deploy the right staff to the right areas, enabling SFT to generate efficiencies and innovation.

Adverse	Minimal	Cautious	Open	Eager
We have a low tolerance for rigid role definitions and will invest heavily in cross-training programs to ensure staff can be deployed flexibly across different functions and departments as needed	We will use temporary and agency staff to supplement our workforce during peak periods, balancing the need for flexibility with the importance of continuity in patient care	We will support some level of cross-training to allow staff to cover critical roles, accepting that not all staff will be interchangeable across all functions	We will adopt flexible staffing practices to a reasonable extent, accepting occasional shortfalls or overstaffing during non-peak periods to manage costs and efficiency	We will limit cross-training initiatives, accepting the risk that staff may not be able to easily switch roles or departments in response to changing needs

Workforce Performance

NHS Salisbury NHS Foundation Trust

Definition

Staff are sufficiently trained to deliver in their role, and that they are performing and delivering to required standards

Adverse	Minimal	Cautious	Open	Eager
We have no tolerance for skill gaps among staff and will invest heavily in ongoing training and development programs to ensure all staff are highly skilled and up-to-date with the latest medical practices and procedures	We are willing to tolerate some skill gaps among staff, for short periods of time, but seek to provide opportunities for training and education at the earliest opportunity	We support regular training and development but are willing to prioritize certain key areas over others based on strategic importance and available budget	We are willing to accept limited skill gaps in non-mandated areas, where cover can be provided by external agencies and temporary staff solutions	We will limit investment in training and development to essential compliance and regulatory requirements, accepting that some skill gaps may persist among staff

Workforce Retention

NHS Salisbury NHS Foundation Trust

Definition

The Trust does all it can to retain staff by seeking to improve the staff experience, which in turn enables high quality patient care. As such the Trust does all it can to reduce turnover across the Trust.

Adverse	Minimal	Cautious	Open	Eager
We have no tolerance for high staff turnover and burnout, and will implement robust well-being programs and deliver competitive benefits to retain staff and maintain high morale	High levels of turnover will not be tolerated, and staff burnout will be contained through the implementation of effective well-being programs and focussed interventions on staff areas which have moderate to high levels of turnover	We will implement well-being measures and deliver benefits, accepting some level of turnover as inevitable, but ensuring critical roles are retained through a keen focus on areas of concern and high and increasing turnover turnover	We will implement well-being measures and deliver benefits, accepting some level of turnover as inevitable, but ensuring critical roles are retained through a keen focus on areas of concern and high and increasing turnover	We will focus on cost containment, accepting higher turnover and some level of staff dissatisfaction, with a focus on filling critical roles as needed.

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Operational Risks

Business Continuity Risk

Salisbury NHS Foundation Trust

Definition

To ensure the Trust has effective processes (Business Continuity Plans or BCP) in place for maintaining continuity of key services in the face of disruption from identified local risks, these are in line with the Civil Contingencies Act 2004 and Health and Care Act 2022. This will range from extreme shortages in staff groups to Major Mass Casualty planning.

Adverse	Minimal	Cautious	Open	Eager
The Trust invests in the ability to understand its BCP in detail and is unwilling to accept any risks in relation to gaps in plans. The financial implications of securing full BCP that are all tested to cover all situations at all times are accepted.	The Trust seeks to provide adequate BCP to ensure patient safety and constitutional standards are met at a Trust level where possible, with minimal areas of risk gaps in plans and audit of plans.	The Trust will ensure that BCP and testing is focused on areas most at risk from the impact of any incident and areas that are most likely to be impacted. Accepting the risk that some areas will not be compliant.	The Trust is willing to tolerate reduce levels of compliance with BCP and testing, accepting the risk that significant numbers of areas may not be fully compliant with BCP.	The Trust does not prioritise regular reviews of BCP plans does not seek assurance by way of testing and responds reactively to incidents in a manner that it deems appropriate.

Health and Safety Risk

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Definition

To ensure the Trust has a structured health and safety management system that enables the Trust, and accountable officers, to demonstrate actions that eliminate or reduce the risk to the health and safety of staff, visitors and contractors as far as is reasonably practicable.

Adverse	Minimal	Cautious	Open	Eager
Any risk to the H&S of staff, or others, that is high or above (risk score of 8–25) will result in tasks being ceased, an action plan developed and immediate steps taken to ensure the safety of staff, and others, before a task recommences.	Where the consequence of harm is high (risk score 8-12), the Trust will not prioritise cost, and will accept an impact on the service where necessary, to reduce the consequence and likelihood of harm.	The Trust accepts other priorities may take precedence over high and moderate risks (8-14) and resources may be allocated according to other risks. The Trust will prioritise specific risks, such as violence and aggression, where practical or cost-effective solutions are available	The Trust will monitor low (1-3) or moderate (4 -6) risks, where cost effective and practical solutions are available, until greater priorities are managed and resources are freed to reduce the risk to the health and safety of staff, or the risk score changes.	The Trust will accept risks to the H&S of staff, and others, where the consequence of harm is low (risk score of 1-3) or moderate (4 -6) and where there are no practical or cost-effective solutions available to reduce the risk.

Information Governance (IG) Risk

Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has the right processes and systems for collecting, storing, managing and maintaining information (including archiving and deleting) in all its forms in order to support business needs and comply with regulations.

Adverse	Minimal	Cautious	Open	Eager
The Trust will adhere to national IG best practice guidance to the letter, regardless of any operational or clinical benefit. IG and data protection (DP) risks identified will need to be fully mitigated before any data is shared and/or contracts are signed. Staff cannot work unless they are IG training compliant.	Wherever possible, the Trust will adhere to national IG/DP best practice. IG risks in contracts and data sharing agreements must be minimal for it to be acceptable to the Trust. Wherever possible all data stored adheres to the data retention policy.	The Trust will ensure IG training is prioritised and mandated for all. Mitigations to risks identified in IG and DP reviews will be carefully considered and an informed judgement will be taken on a case by case basis. Invariably the risk the Trust will accept is low.	Whilst IG training is mandated, the Trust will willing to accept lower compliance. IG and DP risks are identified, reviewed on a case by case basis but IG is prioritised lower that operational/clinical risk mitigation. Data stored adheres to the data retention policy only in high risk areas.	The Trust will predominantly prioritise data sharing for clinical and operational benefits above IG legislation, accepting the risk of potential legal/regulatory action. IG Training and effective data management is not a Trust priority and not mandated.

Information Security Risk

Salisbury NHS Foundation Trust

Definition

To ensure that the management of information security is designed to protect confidential, private and sensitive information or data from unauthorised access, use, misuse, disclosure, destruction, modification or disruption.

Adverse	Minimal	Cautious	Open	Eager
Cyber is a high priority for Trust to invest in risk mitigations, accepting the increase in financial risk at all times. The Trust will prioritise patching and the application of restrictions to support cyber security, even when it may impact operational or clinical practice.	Cyber is a high priority for Trust to invest in risk mitigations, invariably accepting the increase in financial risk. Security patching will be a priority and restrictions to support cyber security will be applied where it does not significantly impact operational or clinical practice.	The Trust will invest to reduce the risk of cyber attack where it is practical to do so. The trust will balance the need for cyber restrictions With the wider risk of the organisation, adhering to cyber policy and practices, wherever practically possible.	The Trust is willing to reduce restrictions supporting cyber security for the wider benefit of the organisation. Adherence to cyber related policies and practices remains important but not essential.	The Trust will seek to only invest in cyber security when there is funding available, accepting the risk otherwise of not doing so. Adherence to cyber policy and practices are encouraged but not treated as a priority. The Trust accepts the risk of regulatory action.

Information Technology Risk

Salisbury NHS Foundation Trust

Definition

To ensure the Trust has appropriate processes in place to manage the use, ownership operation, involvement, development and adoption of IT to prevent unplanned business disruption.

Adverse	Minimal	Cautious	Open	Eager
Investing in technology is a high priority, regardless of whether there is financial return on investment (RoI) or not. There is eagerness to be lead technological innovation piloting, accepting the associated risks. The replacement of aging software and hardware is prioritised ahead of almost anything else.	The Trust will prioritise operational/clinical benefits over financial RoI when investing in technology. There is interest in exploring technological innovation, at times being at the forefront of this. The Trust will, accept small pockets of aging technology, however will adhere to national expectations on digital maturity.	The Trust will consider business cases that balances the financial risks of technology investment with the operational/clinical benefits. Technological innovation will be on a fast follower basis only. The Trust will have a higher level of aging technology, accepting the risks/disbenefits to the organisation.	Investment in technology, without a clear financial RoI is rare. The Trust will support Technological innovation trials where there is high risk needing mitigation. The Trust will ensure there is no regulatory action but will otherwise accept the risks associated with increasingly aging technology.	The Trust will invest in technology only where it is essential to do so, and only when there is a deliverable financial RoI. The default will be to not participate in Technological innovation pilots. The Trust accepts the risks associated with having extensive aging technology, including regulatory action.

Estates Governance Risk

Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has the right processes and systems for collecting, storing, managing and maintaining Estates information (including archiving and deleting) in all its forms in order to support business needs and comply with regulations.

Adverse	Minimal	Cautious	Open	Eager
The Trust will adhere to national best practice guidance to the letter, regardless of any operational or clinical benefit. Risks identified will need to be fully mitigated.	Wherever possible, the Trust will adhere to national best practice. EG risks in contracts and data sharing agreements must be minimal for it to be acceptable to the Trust. Wherever possible all data stored adheres to the data retention policy.	The Trust will ensure All Estates staff are trained in EG procedures. Mitigations to risks identified will be carefully considered and an informed judgement will be taken on a case by case basis. Invariably the risk the Trust will accept is low.	Whilst EG training is mandated, the Trust will willing to accept lower compliance. EG risks are identified, reviewed on a case by case basis but EG is prioritised lower that operational/clinical risk mitigation. Data stored adheres to the data retention policy only in high risk areas.	The Trust will predominantly prioritise data sharing for operational benefits above legislation, accepting the risk of potential legal/regulatory action. EG Training and effective data management is not a Trust priority and not mandated.

Estates Professional Support Risk

Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has the technical and professional support across a range of specialist services. This support should be embedded in the structure and responsibility framework of the organisation to ensure an adequate approach for each of the areas covered by the healthcare specific technical engineering guidance. In order to support business needs and comply with regulations.

Adverse	Minimal	Cautious	Open	Eager
The Trust will adhere to national best practice guidance regardless of any cost. A full complement of external consultants Authorising Engineers, Approved and competent persons will be employed and responsible for only one discipline. Staff cannot work or be engaged unless they are fully competent.	Wherever possible, the Trust will adhere to national best practice. A full complement of Authorising Engineers, Approved and competent persons will be employed but can be responsible for two disciplines. Staff cannot work or be engaged unless they are fully competent. All project work will utilise external consultants	Wherever possible, the Trust will adhere to national best practice. A full complement of Authorising Engineers, Approved and competent persons will be employed but can be responsible for numerous disciplines. Staff cannot work or be engaged unless they are competent. Most project work will utilise external consultants	Wherever possible, the Trust will aim for national best practice. Some Authorising Engineers, Approved and competent persons will be employed based on the risk level but can be responsible for numerous disciplines. Staff should be competent. Some project work will utilise external consultants	If possible, the Trust will adhere to national best practice. No Authorising Engineers Approved and competent persons will be employed but can be bought in for specific tasks. Any Staff can work or be engaged no matter their competence. Occasionally project work will utilise external consultants

Estates Design & Installation Risk

NHS Salisbury NHS Foundation Trust

Definition

The engineering services of a healthcare facility support the delivery of patient care and help to maintain a healing and safe environment. At all stages of planning, design, operation and maintenance of healthcare engineering services, attention should be given to the level of care that the service supports. This will define the resilience and reliability that needs to be provided to ensure patient safety.

Adverse	Minimal	Cautious	Open	Eager
The Trust will adhere to national best practice guidance to the letter, regardless of any operational or clinical benefit. All designs will be based upon HBN standards with no mitigations allowed. External consultants will be used at all stages supported by a fully staffed in house team. regardless of the cost.	Wherever possible, the Trust will adhere to national best practice. regardless of any operational or clinical benefit. All designs will be based upon HBN standards with minimal mitigations allowed. External consultants will be used for most stages supported by an in-house team. With defined costs	Wherever possible, the Trust will adhere to national best practice. All designs will be based upon HBN standards with some mitigations allowed. External consultants will be used for some stages supported by an in-house team. With defined costs	Wherever possible, the Trust will adhere to national best practice. Some high profile/risk designs will be based upon HBN standards with major mitigations allowed. External consultants will be used for initial stages only supported by an in-house team. With defined costs	Wherever possible, the Trust will adhere to national best practice. Designs will be based on the most cost effective manner with no regard to NHS guidance. External consultants may be used for initial stages supported by an in-house team. With defined costs

Estates Maintenance Risk

NHS Salisbury NHS Foundation Trust

Definition

This should take into account the critical nature of the healthcare services to be supported, the staff and resources required to be available for maintenance, and the range of engineering services to be supported.

Adverse	Minimal	Cautious	Open	Eager
The Trust will adhere to national best practice guidance to the letter, regardless of any operational or clinical benefit. All assets will be fully maintained and replaced in a timely manner. There will be a full complement of trained in house staff supported by external contractors with no budget limits.	Wherever possible, the Trust will adhere to national best practice. All assets will be risk assessed and maintenance schedules produced. Assets will be replaced in a timely manner. There will be a full complement of trained in house staff supported by external contractors with no budget limits.	Wherever possible, the Trust will adhere to national best practice. High priority assets will have maintenance schedules produced and will be replaced in a timely manner; others will run to fail. There will be a partial complement of trained in house staff supported by external contractors with defined budget limits.	Wherever possible, the Trust will adhere to national best practice. Some assets will have maintenance schedules produced and will be replaced when funding allows others will run to fail. There will be a partial complement of trained in house staff supported by external contractors with lower defined budget limits.	Occasionally the Trust will adhere to national best practice. No assets will be maintained be replaced they fail . There will be no in house staff the trust will rely on external contractors with defined budget limits.

Estates Backlog Maintenance Risk

NHS Salisbury NHS Foundation Trust

Definition

It is essential that the physical condition of the NHS estate is accurately assessed and maintained to ensure it is fit for purpose and safe for patients and staff. Backlog Maintenance is the cost to bring estate assets that are below acceptable standards in terms of their physical condition or do not comply with mandatory fire safety requirements and statutory safety legislation (as they apply to the built environment) up to an acceptable condition.

Adverse	Minimal	Cautious	Open	Eager
The Trust will adhere to national best practice guidance to the letter, regardless of any operational or clinical benefit. A full survey will be carried out each year by external consultants. Costs identified will be fully funded within our CDEL envelope.	Wherever possible, the Trust will adhere to national best practice. A 50% site survey will be carried out annually by external consultants as well as a 50% paper-based review. Significant & High-risk costs identified will be fully funded within our CDEL envelope.	Wherever possible, the Trust will adhere to national best practice. A 20% site survey will be carried out annually by external consultants as well as an 80% paper-based review. Statutory costs identified will be fully funded Significant & high risk prioritised within our CDEL envelope.	Wherever possible, the Trust will adhere to national best practice. A 100% paper-based review by internal staff will be carried out . Statutory costs identified will be fully funded Significant & high risk prioritised within our CDEL envelope.	The Trust will not adhere to national best practice. No review will take place and an estimate will be submitted as part of our national return obligation. Statutory costs will be met but others noted as a risk and dealt with when they fail.

Estates Information Technology Risk

Salisbury NHS Foundation Trust

Definition

To ensure the Trust has appropriate processes in place to manage the use, ownership operation, involvement, development and adoption of EIT to prevent unplanned business disruption.

Adverse	Minimal	Cautious	Open	Eager
Investing in technology is a high priority, regardless of whether there is financial return on investment (RoI) or not. There is eagerness to be lead technological innovation piloting, accepting the associated risks. The replacement of aging software and hardware is prioritised ahead of almost anything else.	The Trust will prioritise operational/clinical benefits over financial RoI when investing in technology. There is interest in exploring technological innovation, at times being at the forefront of this. The Trust will, accept small pockets of aging technology, however will adhere to national expectations on digital maturity.	The Trust will consider business cases that balances the financial risks of technology investment with the operational/clinical benefits. Technological innovation will be on a fast follower basis only. The Trust will have a higher level of aging technology, accepting the risks/disbenefits to the organisation.	Investment in technology, without a clear financial RoI is rare. The Trust will support Technological innovation trials where there is high risk needing mitigation. The Trust will ensure there is no regulatory action but will otherwise accept the risks associated with increasingly aging technology.	The Trust will invest in technology only where it is essential to do so, and only when there is a deliverable financial RoI. The default will be to not participate in Technological innovation pilots. The Trust accepts the risks associated with having extensive aging technology, including regulatory action.

NHS
Salisbury
NHS Foundation Trust

Clinical Risks

Infection Prevention and Control Risk

Salisbury NHS Foundation Trust

Definition

To ensure the Trust has appropriate processes in place to avoid healthcare associated infections and preventable harm.

Recommended status – minimal or averse

Averse	Minimal	Cautious	Open	Eager
The Trust will adhere to all national IPC guidance regardless of any cost. A full complement of IPC team members will be employed, supported by link professionals across the divisions. IPC team members will have completed all required training. Link professionals attend 100% training sessions	Wherever possible, the Trust will adhere to national IPC guidance. A full complement of IPC team members will be employed, supported by link professionals. IPC team members will have completed all required training. Link professionals attend 80% training sessions External support may be required from UKHSA, or system partners	Wherever possible, the Trust will adhere to national IPC guidance. A full complement of IPC team members will be employed, supported by link professionals. IPC team members will have completed 75% required training/have experience in IPC. Link professionals attend 60% training sessions. External support is required from UKHSA, or system partners	The Trust will aim to meet national IPC guidance. A full complement of IPC team members maybe be employed, supported by link professionals. IPC team members will have completed 50% required training/have some experience in IPC. Link professionals attend 40% training sessions. External support will be required from UKHSA, or system partners	The Trust will aim to meet minimum national IPC guidance. A full complement of IPC team members maybe employed, supported by link professionals. IPC team members will have completed 0-50% required training/have some/no experience in IPC. Link professionals attend 20% training sessions. External support will be required from UKHSA, or system partners

Patient Experience

NHS Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has accessible, diverse and equitable means by which our service users, their carers and visitors can share their experiences openly and honestly, with assurances that these are embraced and seen as opportunities for improvement.
The Trust accepts that despite the priority of a person-centred patient experience, this may at times be compromised in favour of delivering safe and effective care.

Averse	Minimal	Cautious	Open	Eager
The Trust will strictly adhere to national patient experience targets (complaints standards, national surveys and Friends and Family Feedback) and will ensure we comply with or exceed minimum targets. The Patient Experience team will be at full complement to deliver on these targets. Patient experience may only be compromised in favour of delivering safe and effective care, when any mitigations will be established.	The Trust will adhere to national patient experience targets, (complaints standards, national surveys and Friends and Family Feedback). The Patient Experience team will be at full complement to deliver on these targets The Trust accepts patient experience may be compromised in favour of delivering safe and effective care, but anything fundamentally detrimental to patient experience will be mitigated.	The Trust will aim to exceed minimum national patient experience targets and aim to prioritise a person-centred patient experience. Local improvements made as a result of complaints and triangulation of data established through trusted patient engagement forums, (including Friends and Family Testing and National Surveys) is prioritised. Improvements are driven in balance with delivering safe and effective care,.	The Trust will aim to exceed national patient experience targets and will prioritise a person-centred patient experience. This will include some risk exposure through organised, trusted patient engagement opportunities such as patient panels, Patient Safety Partners and Patient Stories. Using these forums to openly expose inefficiencies and drive improvement (where possible) with the same priority as delivering safe and effective care.	The Trust will exceed national patient experience targets and strictly adhere to a person-centred patient experience. Exposing itself to pro-active patient engagement and involvement across a diverse range of communities and our local community. This may include proactive duty of candour where necessary. Improvements are driven with the same priority as delivering safe and effective care.

Patient Safety and Outcomes

NHS Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has systems and processes in place to deliver safe, timely and effective care to our patients.

Averse	Minimal	Cautious	Open	Eager
The Trust will strictly adhere to all evidence based processes, policies and procedures to deliver the highest possible standards of care at all times. Workforce standards will meet minimum requirements to deliver the care. Mitigations will be robust to ensure care is optimal at each point of contact. Patient safety will take priority over financial and patient experience targets.	The Trust will adhere to evidence based processes, policies and procedures as far as possible. Workforce standards may not always meet optimal levels but any gaps will be mitigated to ensure patient safety is prioritised. Preferred care options may not be possible due to financial constraints. Care outside the accepted footprint will be minimised and mitigated.	The Trust supports evidence based best practice but balances this with financial stability. Patient safety and effective outcomes are prioritised with a balance achieved between these, patient experience and financial responsibility. Patients will be cared for within the budgeted footprint of the Trust where possible.	The Trust supports evidence based best practice but balances this with financial stability and an appetite for cautious research projects. Patient safety and effective outcomes are prioritised with a balance achieved between these, patient experience, research objectives and financial responsibility. Patients may need to be cared for in corridors or other escalation areas to meet targets.	The Trust supports evidence based best practice but balances this with financial stability and an appetite for ambitious research projects. Patient safety and effective outcomes are prioritised with a balance achieved between these, patient experience, research objectives and financial responsibility. Patients may need to be cared for in corridors or other escalation areas to meet targets.

Research

NHS Salisbury NHS Foundation Trust

Definition

To ensure that the Trust deliver Research safely to patients, providing adequate oversight and complies with Regulations. To provide legal ownership of Trust generated research and in improve the health of the community.

Adverse	Minimal	Cautious	Open	Eager
Research studies delivered to patients or using patients' data require appropriate National Regulatory Approvals. Regulatory non compliance is a legal and reputational risk to the Trust. The Trust ensures that appropriate governance and oversight frameworks arein place to ensure that all research delivered to its patients have the appropriate ethical , legal , regulatory complaint.	The Trust Research department conducts comprehensive feasibility and risk assessment during the planning and set up stage of all sponsored research projects as well as robust local multi disciplinary feasibility assessments to all hosted research projects to identify risks and develop mitigating strategies. Relevant central and specialised Trusts departments such as Pharmacy, Radiology or Information Governance work closely with the Trust Research department to identify and mitigate risks	The research department workforce is monitored on an ongoing basis to ensure that all the Trust and Healthcare worker Statutory training and certification is up to date. In additional all Research staff hold a Good Clinical Practice (GCP) certificate and have bi-yearly training to ensure that these are up to date. Research staff attend National Institute for Health Research (NIHR) training as well as research study specific training prior to delivering any Research study in the Trust.	The Trust holds the research department to account in ensuring that all Trusts generated research have the appropriate sponsor oversight and monitoring during the life span of the study. The research department is continuously developing and maintaining SOPs , assurance systems and ensure that the research processes adhere to protocols and ICH GCP standards.	The Trusts Research Department collaborates with other NHS R&D departments, Education Partners , Industry Partners and other regional and national organisation to share best practices and resources . The Trusts Research department seeks support from research networks and consortia to enhance research quality , mitigate risks, identify training needs and collaborate on providing best care and making research safe and accessible to the community.

Capacity Planning Risk

Salisbury NHS Foundation Trust

Definition

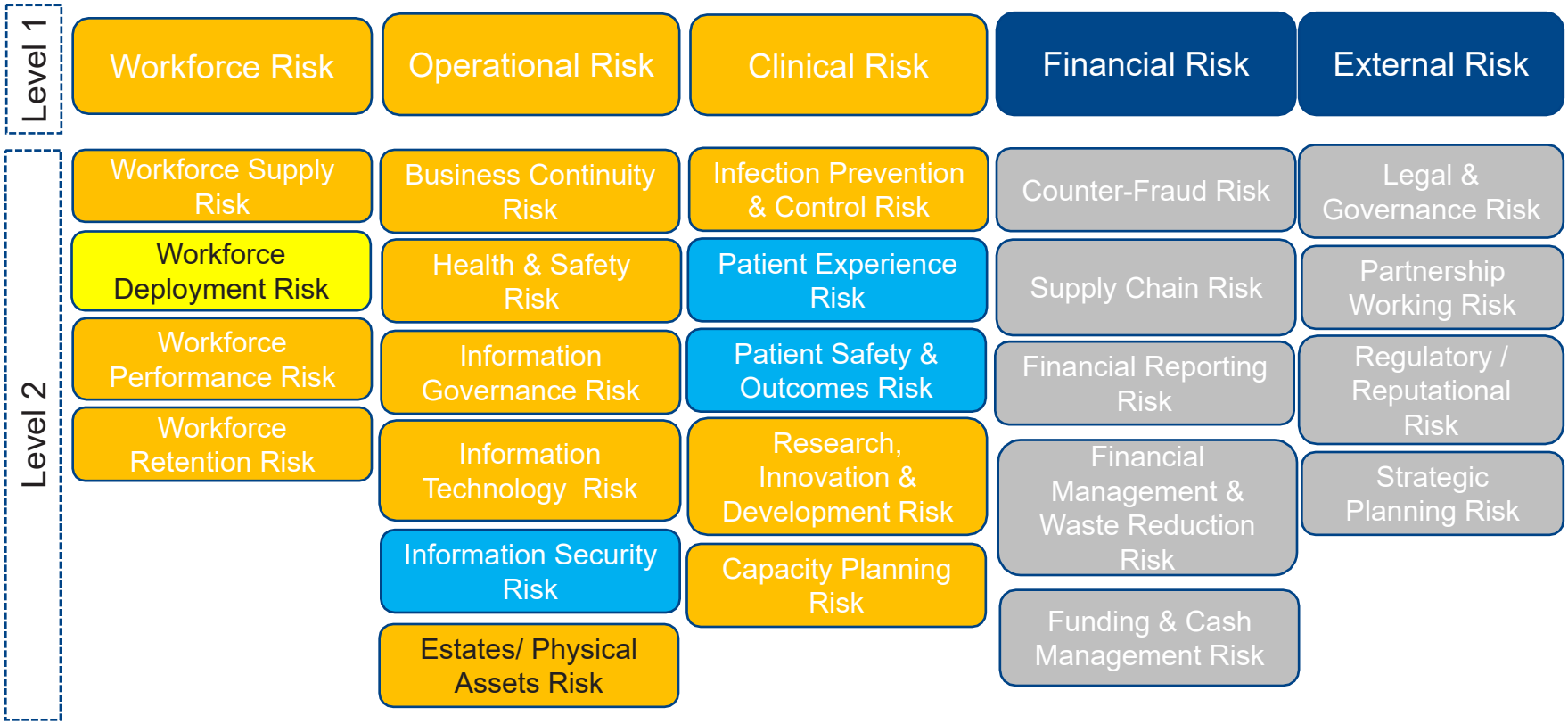
To ensure the Trust has effective processes in place for planning and providing capacity to treat elective, non-elective, and clinically urgent patients to maintain patient safety and meet constitutional standards.

Adverse	Minimal	Cautious	Open	Eager
The Trust invests in the ability to understand its capacity in detail and is unwilling to accept any risks in relation to capacity. The financial implications of securing adequate capacity to meet all constitutional standards and maintain patient safety at all times are accepted.	The Trust seeks to provide adequate capacity to ensure patient safety and constitutional standards are met at a Trust level where possible, with minimal areas of risk or capacity gaps.	The Trust will ensure that capacity is planned to meet the demand for elective and non-elective (acute) admissions to our hospitals, managing this risk to provide safe treatment and care to our patients.	The Trust is willing to tolerate reduce levels of performance against some constitutional standards in order to prioritise clinically urgent patients.	The Trust does not prioritise regular reviews of demand versus capacity and responds reactively to peaks in demand. The Trust is willing to accept low compliance to constitutional standards, prioritising clinically urgent patients.

Risk Types & Risk Categories

Based on Government's 'Orange Book'

Salisbury NHS Foundation Trust



Risk Appetite Levels:

Averse | Minimal | Cautious | Open | Eager

Report to:	Trust Board (Public)	Agenda item:	3.6
Date of meeting:	04 July 2024		

Report tile:	Patient Experience Report – Q4 2023/24			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Patient Expereince Steeering Group – 29th May 2024 Scheduled for Trust Board – 4th July 2024 Clinical Governance Committee 25th June 2024			
Prepared by:	Victoria Aldridge - Head of Patient Experience			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			
Appendices (list if applicable):	APPENDIX 1: Cancer Patient Public Voice Partners update Feb 24 APPENDIX 1a: Patient Public Voice for Cancer Services - Patient Story Mar 24 APPENDIX 2: MNVP Feedback Jun – Aug 2023 APPENDIX 3: Patient Experience - F2 Core Teaching Presentation January 2024 APPENDIX 4: KPMG Management Action Plan v1.4 APPENDIX 6: FFT Feedback – Sample Q4 APPENDIX 7: Your Views Matter – Bereavement Survey Annual Report 2023/24			

Recommendation:

This report is for assurance and noting by the Committee.

Executive Summary:

This report provides summary and insights drawn from the various methods by which our patients feedback on our services. This includes analysis of complaints, concerns, compliments, Friends and Family Testing and any National surveys reported during Q4 of 2023-24.

To summarise the contents of this paper:

Complaints/concerns/compliments and enquiries:

The number of formal complaints made in Q4 has remained consistent (n~44) when compared with Q3 (n~45).

There were 58 concerns logged in Q4, again, consistent with Q3 (n~60).

The total number of complaints and concerns received for 2023/24 is higher/less than 2022/23 (n~60) and (n~60) respectively.

A total of 490 comments/enquiries were logged by the PALS team in Q4, these are seeing a continued increase quarter on quarter this year. This is a further peak when comparing both 23/24 and 22/23 reporting.

222 compliments were recorded on Datix this quarter across the Trust (less than last quarter), however this is attributed to a backlog with recording with PALS. There have been a total of 888 compliments logged this year across the Trust. This is new for 2023/24, therefore no historic data to compare.

For Q4 the two most common high-level themes for complaints across the Trust were the same as those seen in both Q3 and Q2. These were in relation to **Patient Care** (41%) and **Communication** (29%). The third most prevalent theme was new, 9% accounting for **Appointments, including delays and cancellations**. Within these themes **unsatisfactory treatment, lack of** or **insensitive communication and delays with receiving appointments** came out as the highest sub-categories (see Tables 1.1a-1.2c).

Overdue complaints continue to be a challenge for the Trust as a whole, we continue to fall short of the 90% Improving Together target set. PALS have targeted support to individual departments and specialities where challenges are being recognised. Focuses on early intervention and resolution continue to be promoted.

The number of reopened complaints/concerns has increased slightly this quarter. For 2023/24 the Trust has had an average 8% of the total complaints/concerns received, reopen. Patient Experience Quality Priority Targets for 2024/25 would like to see this reduce to less than 5%.

Friends and Family Test (FFT) Trust wide average response rate for Q4 has continued to drop again this quarter, with a total of 2,042 responses received. This has reduced the response rate to 1.8% (of eligible population). FFT experience ratings have decreased slightly to 97%. The project to launch a digital provider is scheduled for Go Live on the 3rd of June 2024, this is anticipated to address the response rates as well as provide data insights with themeing and analysis capability.

Local Surveys:

Real-time feedback (RTF) remains a standing item for discussion at the PESG. Overall good satisfaction rates, though some issues still noted around noise at night and understanding of and involvement with discharge plans. High levels of satisfaction related to being treated with dignity and respect and cleanliness of the ward areas. A total of 102 surveys were completed during this quarter and an average overall satisfaction rating of 81.6% was achieved.

Your Views Matter Annual Report has noted a slight decrease in the overall experience ratings in Q4 compared with the Q3 data. 77% of those surveyed rated their overall experience as Good or Very Good, compared with 81% last quarter. Poor experience ratings have increased slightly on last quarter going from 8% up to 13% as a result. However, the average experience rating for 2023/24 is 76%, higher than the average for 2022/23 (70%). Positive experiences noted related to the Bereavement and Medical Examiners Offices, negative comments and patient letter to evidence poor experience of facilities.

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

Salisbury NHS Foundation Trust

Patient Experience - Patient Feedback
Q4 Report 2023/24

Purpose of paper

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

This paper will also outline the other methods of patient feedback that the Trust collects, and as these processes develop will seek to triangulate these various data sets to provide balanced insight to how patients experience our hospital.

Background

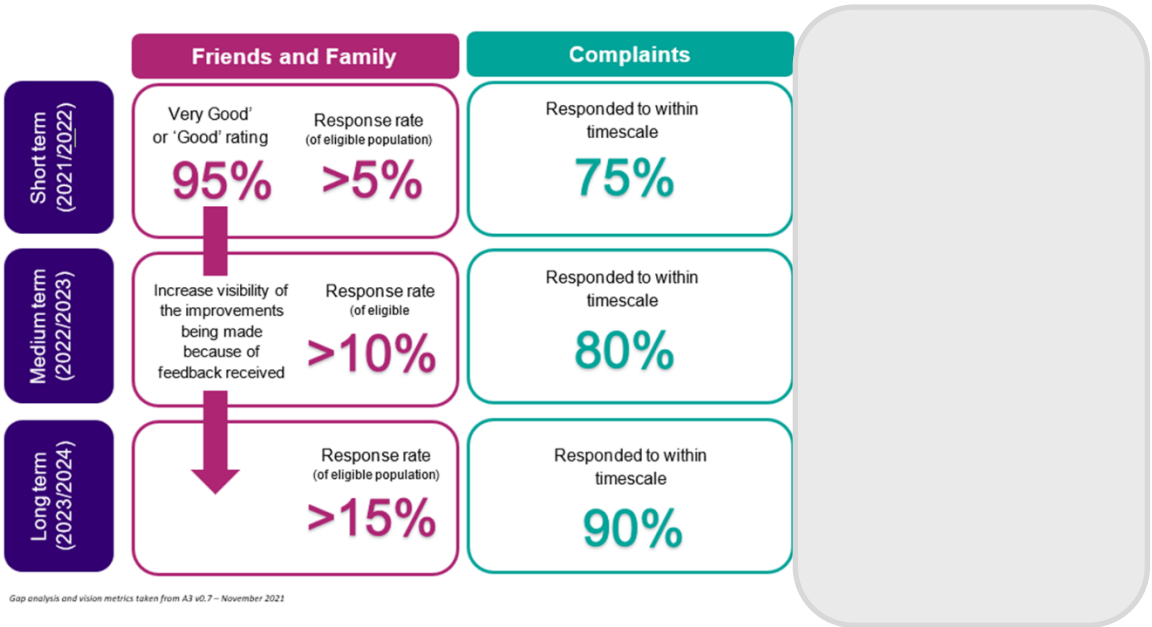
Patient experience is defined as “the sum of all interactions, shaped by an organisation’s culture that influence patient perceptions across the continuum of care”. Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and feedback is an imperative. This includes learning from feedback and in transparency and honesty on when healthcare goes wrong.

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 concerns and complaints are welcomed and learnt from. This can also be said of the many compliments received that far outweigh these complaints and concerns. Compliments can also help improve practice by allowing good practice to be disseminated and shared where possible.

Below is a summary of the Improving Together metrics originally developed in 2021 with a 3-year plan. Friends and Family Testing and Complaints are covered in this Patient Experience report. Progress against the Patient Engagement objectives are covered separately under the Patient Engagement annual report.

These metrics are currently under review and will be produced under a new A3 “Patient Engagement Score”. This will be introduced through the annual patient engagement report in Q1 of 2024/25.

Patient Experience – Improving Together Summary



Improving the health and well being of the Population we serve

Contents

1. Complaints, Concerns and Compliments - Trust Overview

There were a total of 7 items of feedback posted on the NHS Website* in Q4.

Average rating on responses: ★★★★★

	Positive	Neutral	Negative	Average star rating
Q4 23/24	2	1	0	★★★★★
Q3 23/24	6	1	0	★★★★★
Q2 23/24	2	0	2	★★★
Q1 23/24	4	0	0	★★★★★
Total / Average	14	2	2	★★★★½

*All feedback is available here: Ratings and reviews - Salisbury District Hospital - NHS (www.nhs.uk)

Summary of these comments are demonstrated in this wordcloud:

Patient Activity

Table 1.1 shows the breakdown for patient activity across the Divisions and total for the Trust. This is used to calculate feedback on a per 1,000 basis within this report (see Figure 1.1). The Trust is seeing a higher level of patient activity compared with last quarter, and this is significantly higher than this same period last year.

Table 1.1 – Patient activity

Patient Activity by Division / Quarter	Clinical Support and Family Services	Medicine	Surgery	Women & Newborn	Total
Q4 2023 - 24	36,547	37,402	41,456	4,576	119,981
Q3 2023 - 24	33,495	35,002	41,789	4,471	114,757
Q2 2023 - 24	33,871	34, 921	39, 997	4,330	113,119
Q1 2023 - 24	35,540	34, 554	40, 495	4, 206	114, 795
Q4 2022-23	*34,107*	*28,406*	*35,310*	*3,795*	*101,618*

Compliments

Compliments are sent directly to the Chief Executive, PALS or via the SOX inbox and are acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment the PALS team complete a SOX which is sent to the SOX administrator for formal recognition. Whilst compliments continue to be retained locally within the department areas, the

PALS team have been working to promote the importance of sharing these to allow for more formal reporting. This ensures for more robust reporting and changes to the Datix system now allow for theming of compliments to enable reporting alongside complaints and FFT.

Further analysis of compliments is included within the individual Division's reports.

Complaints and Concerns

Figure 1.1 Total Number of Complaints, Concerns, Compliments and FFT per 1,000 of Trust activity

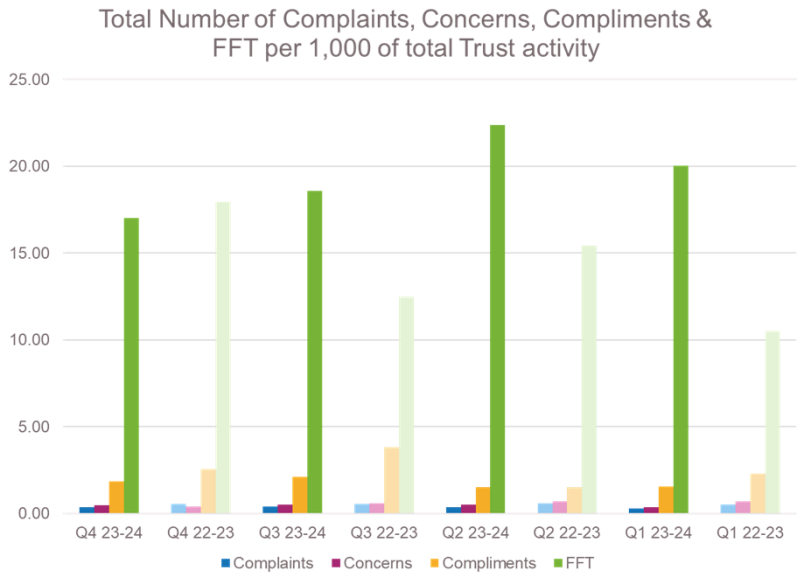


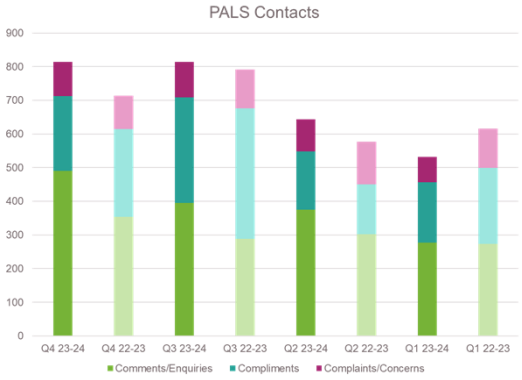
Figure 1.1 shows a slight decrease in the total number of both complaints and concerns received for Q4, in comparison with Q3. These numbers continue to remain overall lower when comparing the same period last year *(opaque graphs show 2022/23 reporting)*. FFT feedback has decreased again slightly this quarter, but annual comparison remains largely higher when compared with the same periods last year.

Compliment numbers have continued to fluctuate, as we balance the continued promotion of formally recording these with PALS and the resources needed to undertake this. At the time of writing this report, the previously reporting **44** compliments which were outstanding for logging have been included in the reporting for Q4. There is estimated to be a similar number again this quarter to have experienced delayed logging.

In Q4 the PALS department logged 490 comments/enquiries. 95 more than in Q3.

This equates to an average of 4.1 contacts per 1,000 patient activity across the Trust. These contacts are in addition to the complaints, concerns and compliments.

Figure 1.1a Total Number of Complaints & Concerns, Comments/enquiries, and Compliments logged by PALS with quarter comparisons 2022/23 – 2023/24



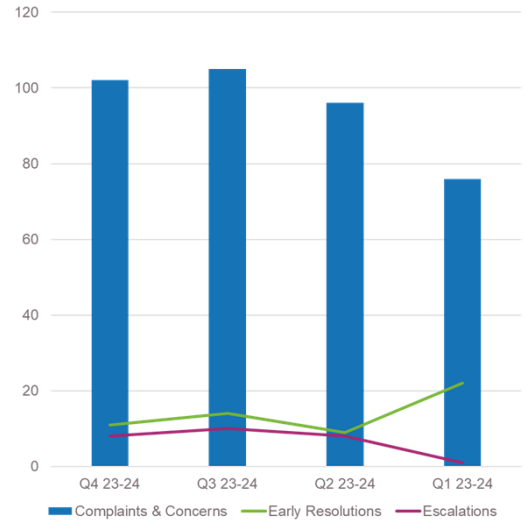
During Q4 there were a total of 102 complaints and concerns logged (105 in Q3).

Figure 1.1a demonstrates the steady increase in contacts for the PALS department, particularly for comments and enquiries.

Complaints and concerns however, have been comparatively lower when compared with the same time periods last year (pink opaque graphs).

Changes to the complaints process over the past 6-12months coupled with targeted work through PALS to adopt the PHSO principles on **early resolution** of complaints continues to be emphasised.

Figure 1.1b Total Number of Complaints & Concerns, Early resolutions, and Escalations

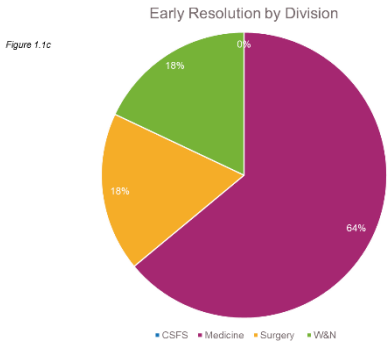


Changes to the Datix system implemented in Q1 now enables reporting on the number of complaints/concerns that have been deescalated following early intervention and/or resolution. 11 of the 102 were considered to achieve an earlier resolution than anticipated in Q4.

8 of the 102, were noted to have escalated from a comment or enquiry into a concern or complaint.

Figure 1.1b shows how this correlates with previous quarters.

Figure 1.1c shows how the de-escalated complaints/concerns were distributed across the Trust.



Medicine continues to work hard this quarter to adopt the principles around early resolution and de-escalation, and this is evidenced by the highest proportion of these 11.

Table 1.2 below shows the themes for complaints received in Q4 (trust wide). Highlighted are the top three most prevalent themes. **Communication** and **Patient Care** are consistent themes with the previous quarter, however **Appointments including delays and c cancelations** is a new theme. These top three themes are further broken down into sub-categories for deeper analysis in Tables 1.2a, 1.2b and 1.2c.

Table 1.2 Raw data - Themes from Q4 Complaints/concerns

	CSFS	Medicine	Surgery	Women & Newborn	Non-clinical	Total by theme	% of total by theme
Access to treatment or drugs			4	1		5	5%
Admissions, discharge and transfers		4	2			6	6%
Appointments including delays and cancellations		**1**	**8**			**9**	**9%**
Clinical Treatment						0	0%
Commissioning Services						0	0%
Communications	**2**	**14**	**5**	**8**	**1**	**30**	**29%**
End of Life Care		1	1			2	2%
Facilities Services					1	1	1%
Other			1			1	1%
Patient Care	**4**	**12**	**24**	**1**	**1**	**42**	**41%**
Prescribing errors		1				1	1%
Privacy, dignity & wellbeing	1					1	1%
Values and behaviours (Staff)		1	3	1		5	5%
Total by Division	**7**	**34**	**48**	**11**	**3**		
Divisions Total	**102**						

The following tables show a further breakdown for these three themes across the Trust.

Unsatisfactory treatment was the highest sub-category under **Patient Care** (see Table 1.2a). This was the same for Q3.

Insensitive or **lack of communication** were again the highest causes for complaints under the **Communications** category (see Table 1.2b).

Appointments including delays and cancelations is a new theme for Q4. With **Appointment procedures and delay in receiving appointment** featuring as the highest causes under this category (see Table 1.2c).

Table 1.2a

Patient Care	42	41%
Assistance not given	1	2%
Correct diagnosis not made	5	12%
Delay in making diagnosis	2	5%
Falls	1	2%
Further complications	8	19%
Harm	1	2%
Inappropriate treatment	2	5%
Neglect	1	2%
Nursing Care	3	7%
Pain management	2	5%
Meal not available	1	2%
Unsatisfactory treatment	**15**	**36%**

Table 1.2b

Communications	30	29%
Delay in receiving/sending information	2	7%
Information not given to family	2	7%
Information not given to patient	1	3%
Insensitive communication	**12**	**40%**
Lack of communication	**10**	**33%**
Wrong information	3	10%

Table 1.2c

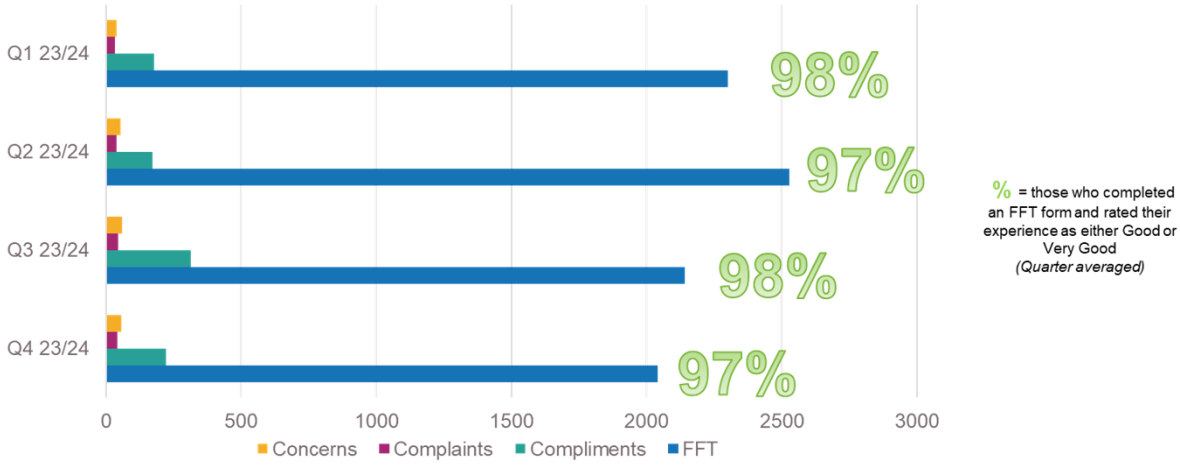
Appointments, including delays and cancellations	9	9%
Appointment system - procedures	**4**	**44%**
Delay in receiving appointment	**4**	**44%**
Unsatisfactory Outcome	1	11%

Further analysis of these themes is reported within the Divisional reports.

Complaints and concerns continue to be small in number when compared with the number of Friends and Family Test (FFT) feedback received across the Trust and satisfaction rates associated with these. This comparison is demonstrated in Figure 1.2.

This demonstration represents the proportion of good or very good experiences (as rated by our service users) and how vast this is in comparison to the number who have raised a complaint or concern. This has however seen a slight decrease in satisfaction this quarter. This data is significant in demonstrating (by the proportions of feedback) that overall patient experience is positive.

Figure 1.2 – Reiterates the FFT feedback rates compared with complaints, concerns and compliments (based on a per 1,000 patient activity) but also demonstrates the patient experiences rates obtained from these.



Overdue Complaints

The Trusts Improving Together Target for response to complaints within their agreed timescale is set at 90%. As a Trust we continue to struggle to achieve this, despite individual areas regularly achieving this. Overdue complaints will therefore continue to be a focus for the Patient Experience Quality Priorities going into 2024/25.

There are various factors that can influence the inability to achieve the timescale for response.

PALS continue to work with individual areas to understand these challenges and to help improve processes to help mitigate where possible.

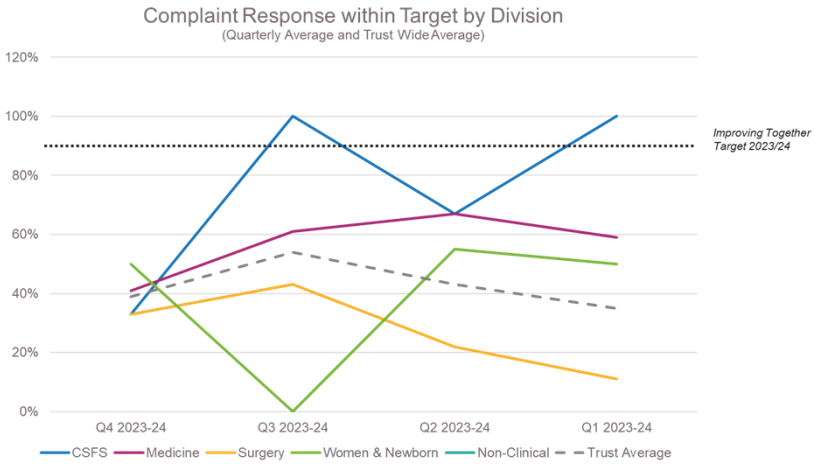
This target continues to be monitored via the Integrated Performance Report (IPR) as a watch metric.

Monthly live data is also monitored via the Patient Experience Steering Group, and the tracking of this target through this forum is being demonstrated in Figure 1.3.

At Division level, we are seeing varied compliance to this target. This is largely impacted by operational pressures, along with complexity and the number of complaints requiring response within similar timeframes. There is still some work to be done with some staffing groups and speciality areas to demonstrate the benefits of early resolution, particularly when operational pressures can make these harder to prioritise.

PESG overdue complaints reporting from December 2023 started to focus on which areas were struggling the most with overdue responses, this was to help highlight their need for more support or escalate if needed. In addition, PALS continue to work closely with individual areas supporting with response writing where this is also causing delays. To date, additional support has been provided to Day Surgery Unit, ED, Ophthalmology Gynaecology, Gastroenterology and Amesbury Ward.

Figure 1.4 – Complaints closed within Target (by Division and Trust Total)



Three of the Divisions have seen a downward turn in this target this quarter, Women & Newborn have improved on their Q3 position going from 0% to 50%.

For the reasons outline above, the fluctuations are demonstrated in Figure 1.4.

(see Section 3 Division Summaries – Complaints, Concerns and Compliments) for more detailed breakdowns for each Division.

Reopened Complaints

Figure 1.5 – Number of re-opened complaints or concerns

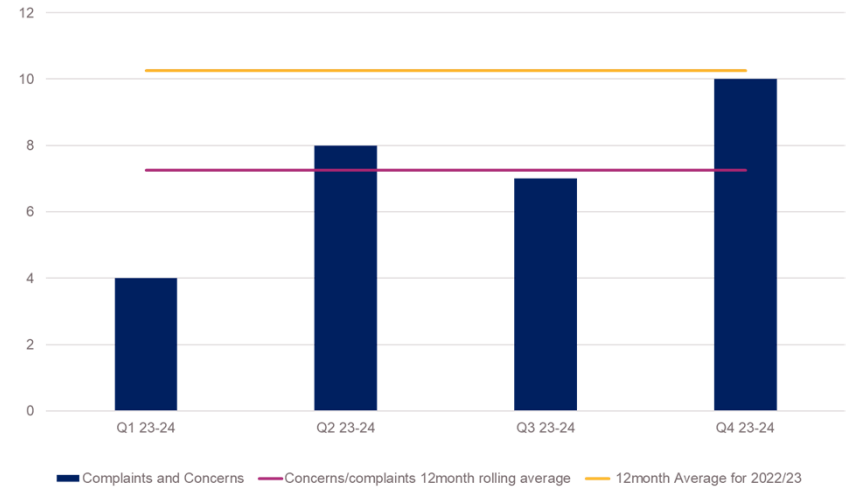


Figure 1.5 shows the number of reopened complaints and concerns (in total), compared with previous quarters.

The yellow lines shows the average for 2022/23 acting as a benchmark.

The pink line is a calculated average for 2023/24.

The number of reopened complaints and concerns has increased this quarter, topping this year. However, it maintains lower than the 2022/23 average, indicating a higher success rate of first time resolution.

For those which have reopened the reasons were varied with no clear themes. The PALS team and the Division Leads continue to work hard to realise the benefits of concluding investigations with complaint meetings. Where written responses are required ensuring these address all the points raised, contain empathetic apologies, are factually accurate and demonstrate lessons learnt are continually emphasised as the key principles.

Reopened complaints will be incorporated into the Patient Experience Quality Priorities for 2024/25 as a measure of the quality of resolution.

2. Learning from Patient Experience

Patient Stories

For February's Patient Experience Steering Group (PESG) a patient representative from the Patient and Public Voice Partnership (PPV). The PPV is the Trust's patient panel for Cancer Services. Peter was invited to attend in person to talk about his experiences of prostate cancer care at the Trust.

He gave a balanced comparison of the care he received some years ago when first diagnosed, comparing this with his experiences of other hospitals and other departments within the hospital that he had experienced more recently.

Peter is an avid member of the PPV and the work of this group was also showcased as part of this agenda item. The group has been active since August 2023 and had held 6 meetings to date. Common themes were determined based on the collective experiences of the group, which were exchanged at their first meeting:

Theme 1: Communication and information – for which a co-designed information pack at diagnosis has been developed. Along with a successful application for a Macmillan Information Hub to be located on Level 3 in the Summer of 2024.

The PPV have also helped to design the Trusts new Cancer Services website.

Theme 2: Outpatient environment – The group are currently collaborating to improve signage and consider appropriate artwork in corridors and clinic rooms.

Theme 3: Prostate Pathway Changes

- Changes to pathways to include; telephone triage, earlier MRI screening, CNS appointments as well as biopsy-treatment appointments.
- Improved information at the time of appointment and development of online patient information.
- Recruitment of Urology-Oncology Clinical Nurse Specialist (CNS) to support patients treated in Oncology supported by Urology team.
- Environment review planned with ArtCare to review options to improve the Urology Centre.

See Appendix 1 for full details.

Peter's patient story was also invited to present to Trust Board on the 7th March 2024 – see Appendix 1a.

Patient Experience Division Presentations

We continue to develop the agenda of the Patient Experience Steering Group to ensure there are equal opportunities for sharing patient experiences seen through DMT's and Clinical Governance Sessions. Throughout Q4, complaints and FFT data from Q3 was shared at Divisional Governance sessions as an opportunity to share patient experience data with front-line teams and encourage reflections on what mitigations could be considered to change poor experiences and replicate those things which are being done well.

In return, Divisions have been attending the Patient Experience Steering Group to reflect on this data and also provide updates on any areas of focus which they are pursuing informed in part, by this data.

Table 1.3 – Q1 Patient Experience data presented to Divisions during this quarter

Division	Data presented to Division	Division update to PESG
Surgery	*17th April 2024. *Reschedule from 17th January 2024	24th January 2024
CSFS	25th March 2024	28th February 2024
Medicine	27th February 2024	28th February 2024
Women & Newborn	22nd February 2024	28th March 2024
Facilities (Food & Nutrition /PLACE)		24th January 2024

Facilities Update to PESG (24th January 2024):

Celebration of various SOXs received across the Division. The success of the Salisbury Food Festival was reflected on from October. The Trust has replaced the Gold Tray system with a new Red Tray System as agreed by the Food & Nutrition steering group. This launched on the 6th November 2023, during 'Malnutrition Awareness Week'. Speech & Language Therapy (SaLT) and Dietetics teams visited wards to support this launch and the awareness week. New red trays will be sent up to wards in the meal trolleys (instead of the old gold trays) and they need to be used as a tool for ward staff, to support patients at mealtimes.

Parking was discussed at length and measures to alleviate the pressures on capacity were outlined, including the success of the Staff Park and Ride Service. 80 staff have joined the scheme so far, with great engagement and feedback.

Current workplans were outlined:

- Catering – Implement National Standards *(Funding TBC)*
- Catering – New digital menu – due for completion in May 2024
- Laundry – Tender Awarded (4/12/23) - *spec includes changes*
- Car Parking – New digital pay station added to car park 8
- Car Parking – New Park and Ride Service for staff (January 2024)
- Housekeeping – Implement New Standards - *year 2 of 3*
- Helipad replacement – on target for completion - 31/03/24
- Non-Urgent Patient Transport – Contract extended until 31/01/25
- Portering – Benefits Realisation – Review to be undertaken
- Sustainability – 'Green Plan' update due for publication in Feb 2024

Surgery Update to PESG (24th January 2024):

The Division are actively reviewing their feedback over the last two quarters, Friends and Family feedback responses have improved, with utilisation of the ward assistants prompting completion of these. But this is anticipated to reduce as three have left and are not being replaced.

Compliments – highest number for the following areas: Radnor, Odstock and Britford.

Complaints/concerns within orthopaedics, DSU and Gastroenterology during Q1 and 2 were noted to be higher than in other areas.

Improvements being carried out in the DSU environment, including a new floor which makes it much brighter and look less dated. Work to improve showers etc noted as well. The step-down unit to improve flow has been helpful with the patient journey through here, however it is felt that the volume of patients in this areas can mean that this can feel chaotic from a patient's perspective.

There has been lots of input from DMT in relation to gastroenterology, there is an accreditation inspection scheduled looking at gastroenterology and endoscopy overall.

On the whole, feedback is positive, with the division receiving over 90% of those surveyed using FFT rating their experience as good or very good.

The division continues to have a high volume of complaints and concerns, but this was not felt to be out of keeping given the size and complexity of the Division. There has been more of an increase in concerns than complaints, and there has been concentrated efforts to close older complaints. There was an influx of complaints and concerns in December and early January, where an additional 20 complaints and concerns came in. There were some significantly overdue cases, but there was celebrated success having closed down the oldest, from April 2023. The Division acknowledged still falling short of the Trust target for closure within timescale (currently only 50%), they are trying to improve on this.

The complexity of surgery complaints means they often involve a range of different departments and this in itself can create delays, there has been an increase of complaints about appointments and procedures being cancelled, and that has likely been an impact of industrial action. The DMT has identified a new driver, focusing on the perspectives of patients coming out of ICU, projects such as patient diaries, and being aware of the psychological impact on patient was also outlined.

CSFS Update to PESG (28th February 2024):

Focus at the moment on celebrating successes and achievements highlighted included:

- Promoting learning and positivity within the Division through sharing patient and staff stories, or service spotlight.
- Working closely with PALS to ensure new staff in post are trained to manage patient complaints / concerns.
- Head of patient experience provides regular updates at Divisional governance meetings and promotes the variety of PALS work (it's not just complaints)
- Showcasing patient experience groups (Spinal, Cancer services)
- Increased number of staff and teams trained in improving together across the division
- Score card agreements completed for paediatrics, spinal, radiology and therapies
- Spinal including patient voice (through patient panel) in driver metric discussions
- EOLC – facilitate communication course continues to have good engagement and uptake.
- Listening event planned for the end of March.

Outpatient feedback: Parking – access to spaces and not being able to park also charges. Food choices: feedback from parents is that the menu is not always child friendly. Waiting times are also a theme. Noted

improvements to complaints response times. Workstreams to ensure patients are kept up to date with waiting lists an delays.

Outlined challenges with patients with additional needs on Paediatric ward, as children's mental health up 300% since Covid. And increased referrals for end-of-life care.

Medicine Update to PESG (28th February 2024):

Focus on positive outcomes. Celebrating successes of staff, showcasing feedback and SOX awards.

Outlined the new learning from incidents forum meetings, these are continuing to develop and have good staff engagement, these have also welcomed Patient Safety Partners to be in attendance.

Areas of challenge included communicating sensitive and bad news in an appropriate place and being discharged without appropriate follow up.

Looking to improve discharge checklists, which would have scope to be standardised throughout hospital.

Improvements to AMU and waiting times were celebrated.

Women & Newborn Update to PESG (28th March 2024):

The divisional update was deferred until April, so will feature in the Q1 2024/25 report. However, the feedback from the Maternity and Neonatal Voice Partnership was circulated to the membership, a copy of this can be found in Appendix 2.

In addition, PESG also had updates from; the End of life care team and summaries from the first meetings of both the Stoma and Colostomy focus groups.

3. Training & Development for Staff

The Patient Experience Team and PALS continue to work with Division leads and staffing groups to ensure staff are understand the complaints process and the role of PALS within this.

Training packages were delivered in January 2024 as part of the F2 Core Teaching programme. See Appendix 3.

Further training is scheduled for May for the staff as part of the new Imber Ward launch in the late Spring.

4. Process reviews, audits and policies

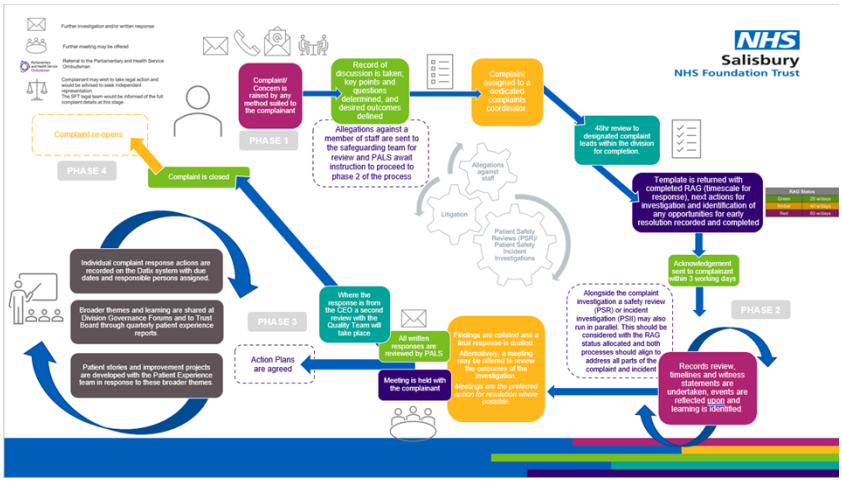
KPMG Internal Complaints Audit 2023

In September 2023 the complaints process was subject to an internal audit with KPMG. A random sample of 15 complaints received between 1st January 2023 - 30th September 2023 were reviewed in detail by external auditors throughout October and November 2023. The complaints process was scrutinised through a series of interviews with key staff including the Head of Patient Experience, PALS Lead and Complaints Coordinators. In addition, interviews with the Leads for Medicine, Women & Newborn and Surgery were also conducted.

The findings were outlined in the Q3 Patient Experience Report. As a further update, this action plan is now fully completed and recommended changes implemented. A copy of the completed action plan can be found in Appendix 4.

New Managing Concerns and Complaints Policy

The Trust has revised its complaints policy in line with the KPMG recommendations. This was ratified with the Patient Experience Steering Group in March 2024 and approved at Clinical Management Board in April 2024.



The Trust has developed its core principles for receiving and responding to complaints and concerns based on PHSO Framework and learning taken from complaints. These are:

- **Listen, understand and value** - Listening with empathy and without judgement, taking the time to understand what the issues are and what resolution should look like. Thanking the complainant for raising their issues.
- **Early resolution** – Considering what information or action can be taken or sourced now.
- **Meaningful apology** – Saying sorry where it's appropriate is always the right thing to do. A meaningful apology is about demonstrating actions and learning has been taken to prevent this from happening again.
- **Clear and thorough** – Ensuring to address all of the points raised. Being clear and simple with language and open and accountable with our accounts and findings. Avoiding the use of jargon or acronyms without clear explanation.

The purpose of this policy is to describe the processes by way that the Trust manages all feedback in accordance with these principles. This policy supersedes the previous Trust policy – *[Handling Comments, Concerns, Complaints and Compliments Policy - Aug 2020].* Link to the new policy can be found in the link within Appendix 5.

5. Division Summaries – Complaints, Concerns and Compliments

Non-Clinical Divisions (Facilities, Quality, Trust Offices, Corporate etc.)

3 complaints/concerns were recorded for **non-clinical** divisions in Q4. All of these were for facilities, and 2 of these related to car parking (lack of spaces and charges).

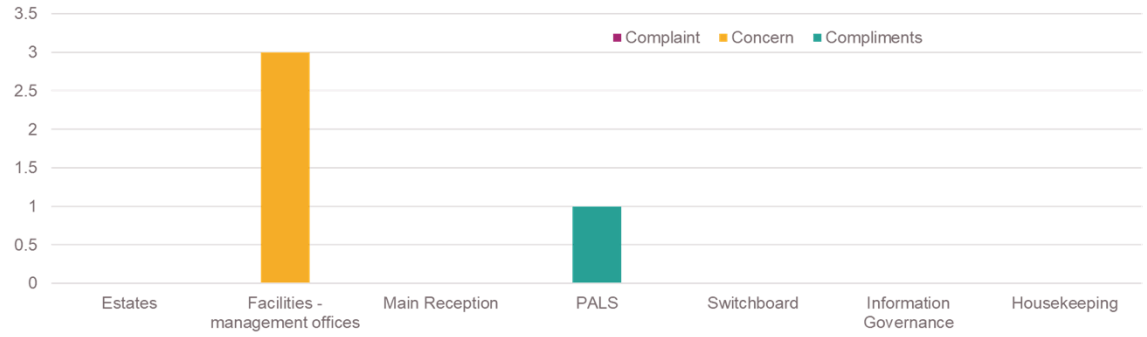
There were a total of 38 comments/enquiries logged in Q4 (12 more than in Q3) of which 24% were related to requests for further information, and 15% described as lack of communication. 37% of these enquiries were related to Central Booking and 24% for Medical Records.

Compliments – Non-Clinical Divisions (Facilities, Trust Offices, Corporate etc.)

There was only 1 compliment recorded on Datix for non-clinical divisions across Q4 and this was for PALS.

Figure 5.0 shows the location of complaints, concerns and compliments by area:

Figure 5.0 – Location of complaints, concerns and compliments by area



Clinical Support and Family Services (CSFS)

- There were a total of 7 complaints and concerns received during Q4 (same as Q3)
- The division achieved a 33% response rate for response to complaints and concerns during this period (100% achieved in Q3)
- 0 complaints/concerns were reopened (this has retained for the whole of 2023/24).
- 13 compliments were formally logged on Datix (19 in Q3).

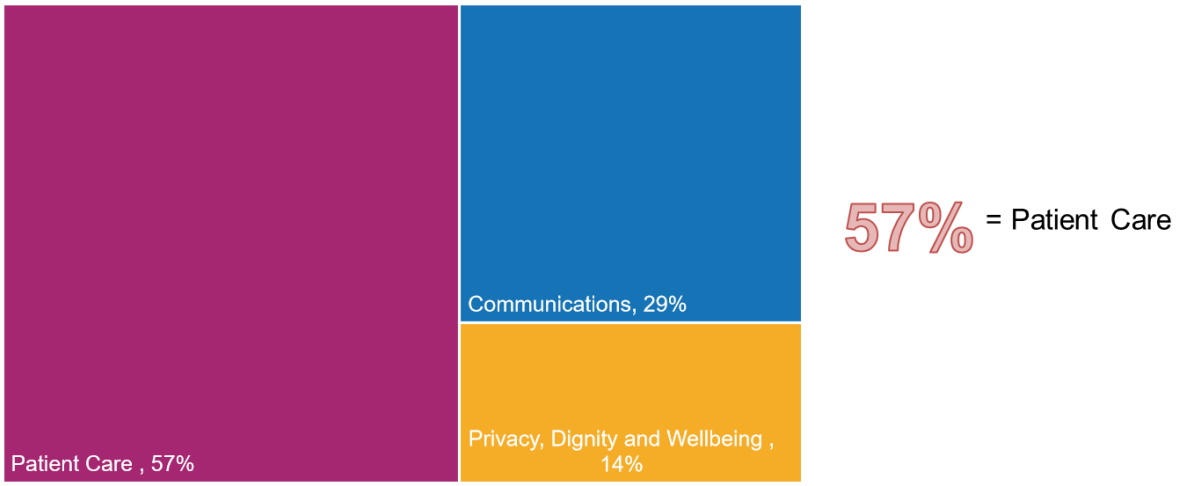
Table 5.1 Summary of number of received, reopened and response within timeframe – annual summary and quarterly averages.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

	Q1 23-24	Q2 23-24	Q3 23-24	Q4 23-24	Annual Summary	Quarterly average for 23/24
Complaints	▲ 2	▶ 2	▲ 5	▼ 3	12	3
Concerns	▼ 2	▲ 5	▼ 2	▲ 4	13	3
Compliments	▼ 8	▼ 5	▲ 19	▼ 13	45	11.25
FFT Responses	▲ 403	▼ 315	▼ 241	▼ 176	1135	283.75
Re-opened complaints/concerns	▶ 0	▶ 0	▶ 0	▶ 0	0	0
% closed complaints responded to within agreed timescale	▲ 100%	▼ 67%	▲ 100%	▼ 33%	Total patient activity for 2023/24	75%
Complaints closed in this quarter	1	3	3	3		3
Complaints by Division activity (per 1,000)	▼ 0.06 (35,540)	▶ 0.06 (33,871)	▲ 0.15 (33,495)	▼ 0.08 (36,547)	139,453	Average quarterly activity for the Division
Concerns by Division activity (per 1,000)	▼ 0.06 (35,540)	▶ 0.15 (33,871)	▼ 0.06 (33,495)	▲ 0.11 (36,547)		34,863
Compliments by Division activity (per 1,000)	▲ 0.23 (35,540)	▼ 0.15 (33,871)	▲ 0.57 (33,495)	▼ 0.36 (36,547)		

Figure 5.1 demonstrates the most prevalent high-level themes for opened complaints during Q4.

Figure 5.1 – Summary of themes for CSFS Complaints and Concerns – Q4 2023/24



This quarter **communication** and **patient care** remain consistent themes from Q3 and Q2. **Privacy, dignity and wellbeing** is new, but only equates to 1 complaint.

Within these themes the following tables shows a sub-category breakdown for further context of these complaints:

Table 5.1a

Patient Care	**4**	**57%**
Further complications	1	25%
Neglect	1	25%
Pain management	1	25%
Unsatisfactory treatment	1	25%

Table 5.1b

Communications	**2**	**29%**
Insensitive communication	1	50%
Lack of communication	1	50%

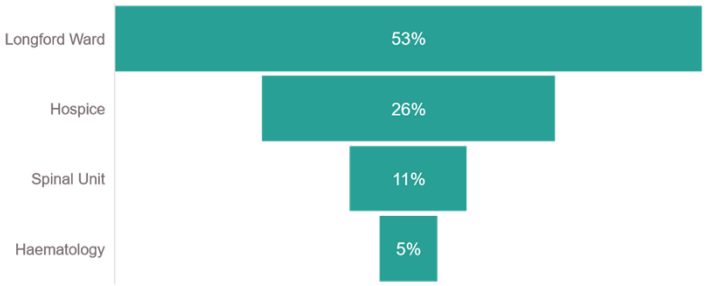
Table 5.1c

Privacy, dignity and wellbeing	**1**	**14%**
Data Protection	1	100%

Compliments – Clinical Support and Family Services

Figure 5.2 – CSFS Compliments breakdown

There were a total of 13 compliments for CSFS across Q4. This is fewer than previous quarters and all have been logged on Datix. Figure 5.2 shows a breakdown of where the compliments were received:

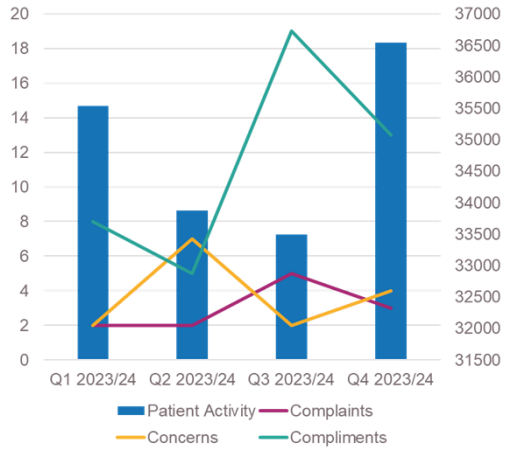


Radiology, Spinal Unit and the Hospice were noted to be consistent with compliments again this quarter compared with Q3. Pathology outpatients achieved the highest proportion of complaints for the Division.

Figure 5.2a is a word cloud summarising key themes from this compliments.

Figure 5.3 shows correlation of number of complaints, concerns and compliments by patient activity for Clinical Support & Family Services**.**

Figure 5.3 – CSFS patient activity correlation with feedback

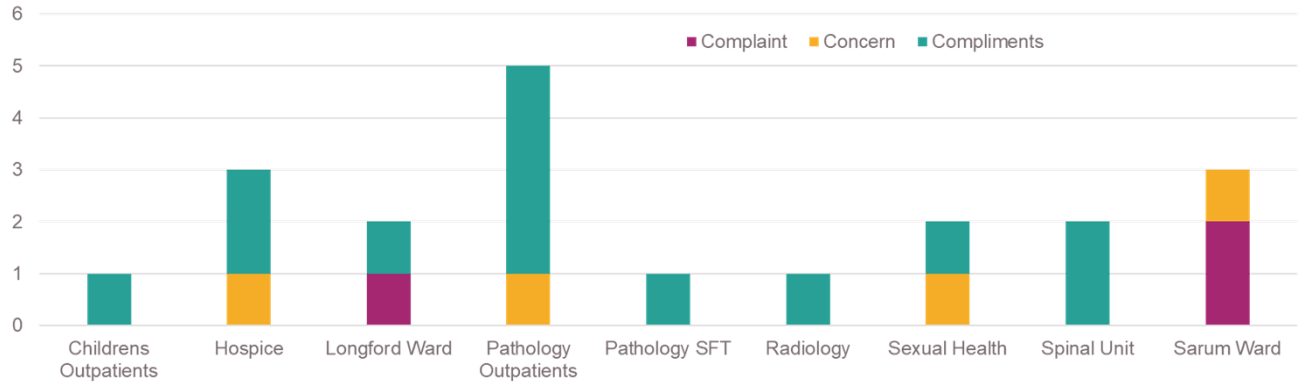


The Division has seen a similar total number of logged complaints and concerns over the past three quarters, despite a significant increase in patient activity in this last quarter.

Compliments recorded this quarter have significantly decreased further work continues to ensure all departments within the Division are sharing these with PALS for recording on Datix.

Figure 5.4 shows the location of complaints, concerns and compliments by area:

Figure 5.4 – Location of complaints, concerns and compliments by area



Women and Newborn

- There were a total of 11 complaints and concerns for Q4 – one less than Q3.
- 8 complaints were closed in Q4; 50% of these were within the agreed timescale. This is a significant increase on the 0% achieved in the previous quarter.
- 1 complaint was reopened.
- 36 compliments were formally logged on Datix.

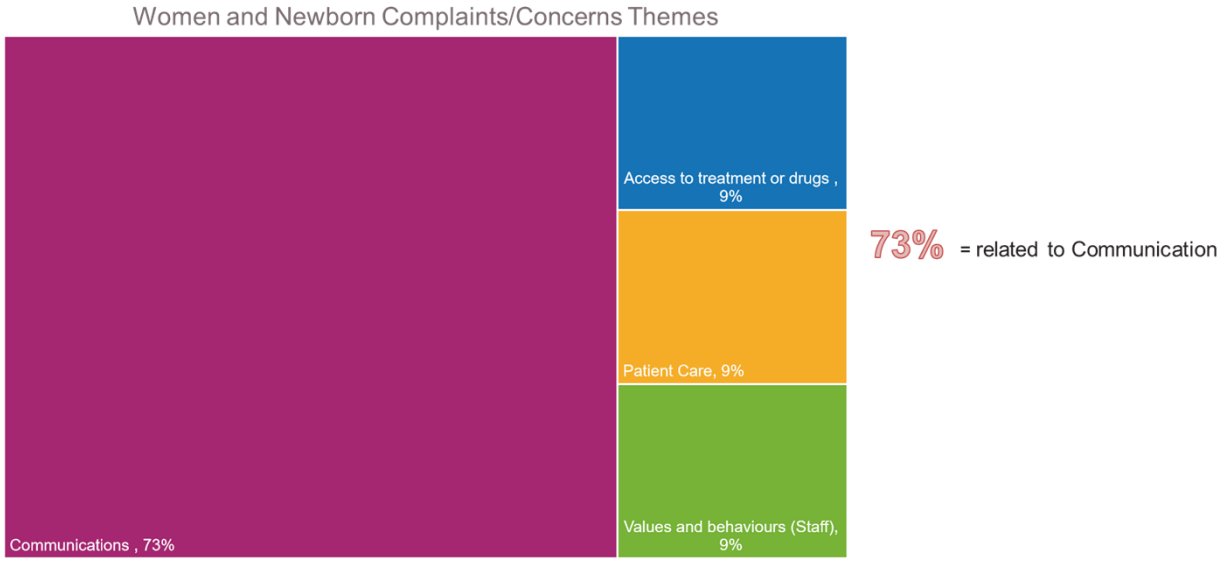
Table 5.2 Summary of number of received, reopened and response within timeframe – annual summary and quarterly averages.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

	Q1 23-24	Q2 23-24	Q3 23-24	Q4 23-24	Annual Summary	Quarterly average for 23/24
Complaints	▼ 3	▲ 4	▲ 6	▼ 4	17	4.25
Concerns	▶ 3	▲ 8	▼ 6	▲ 7	24	6
Compliments	▲ 68	▼ 16	▼ 4	▲ 36	114	28.5
FFT Responses	▼ 50	▼ 18	▲ 38	▼ 28	132	33
Re-opened complaints/concerns	▼ 0	▲ 1	▲ 2	▼ 1	4	0.5
% closed complaints responded to within agreed timescale	▼ 60%	▼ 55%	▼ 0%	▲ 50%	Total patient activity for 2023/24	39%
Complaints closed in this quarter	4	11	2	8		6
Complaints by Division activity (per 1,000)	▼ 0.71 (4, 206)	▲ 0.92 (4, 330)	▲ 1.34 (4, 471)	▼ 0.87 (4, 576)	17,583	Average quarterly activity for the Division
Concerns by Division activity (per 1,000)	▼ 0.71 (4, 206)	▲ 1.85 (4, 330)	▼ 1.34 (4, 471)	▲ 1.53 (4, 576)		4,396
Compliments by Division activity (per 1,000)	▲ 13.7 (4, 206)	▼ 3.70 (4, 330)	▼ 0.89 (4, 471)	▲ 7.87 (4, 576)		

Figure 5.5 – Summary of themes for W&N Complaints and Concerns – Q4 2023/24

Communication remains the highest theme for complaints this quarter, and consistent with Q3. With **values and behaviours of staff**, **access to treatment or drugs** and **patient care** seeing a much lower theme prevalence. **Access to treatment or drugs** is a new theme for this year for this Division.



Within these themes, **insensitive communication** made up 63% of those categorised under **communication**. Whilst **lack of communication, wrong information or information not given to family** made up 13% (respectively). Tables 5.2a, shows the sub-category breakdown for further context of this theme.

Table 5.2a

Communications	**8**	**73%**
Information not given to family	1	13%
Insensitive communication	**5**	**63%**
Lack of communication	1	13%
Wrong information	1	13%

Compliments – Women & Newborn

Figure 5.6 – W&NB Compliments breakdown

There was a total of 30 recorded compliments for W&N across Q4, that were all formally recorded on Datix.

Figure 5.6 shows a breakdown of where the compliments were received.

Figure 5.6a is a word cloud to summarise these compliments

Figure 5.6 – W&NB compliments location

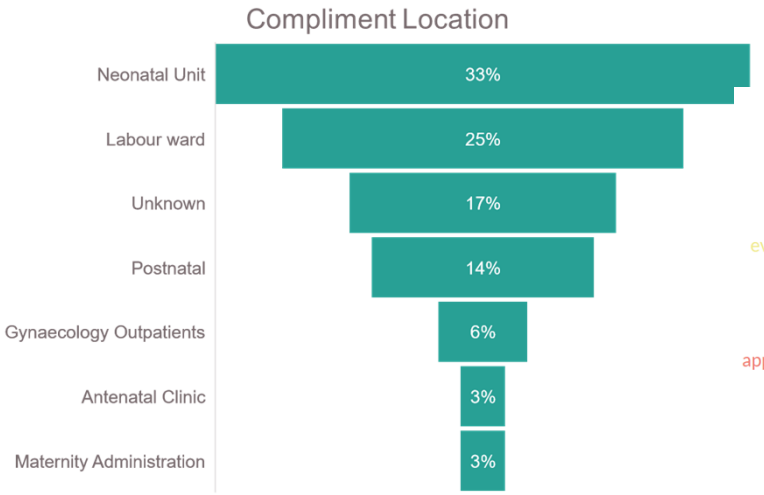
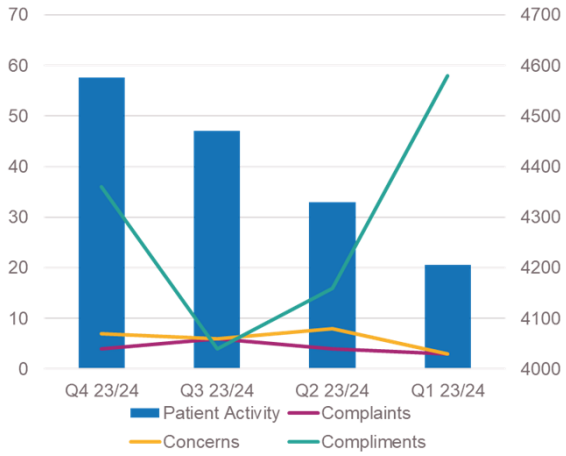


Figure 5.6a – W&NB compliments word cloud

Figure 5.7 shows correlation of number of complaints, concerns and compliments by patient activity for Women and Newborn

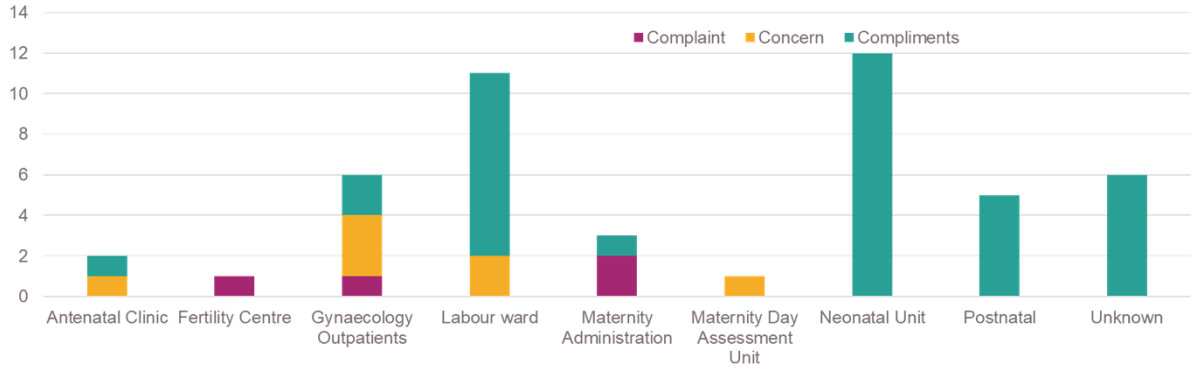


The Division saw an increase in patient activity this quarter and this has grown steadily over the past 12months.

Compliments recorded this quarter has increased compared with the previous quarters, the Division are working hard to ensure these are more actively recorded and celebrated.

Figure 5.8 shows the location of complaints, concerns and compliments by area:

Figure 5.8 – Location of complaints, concerns and compliments by area



Medicine

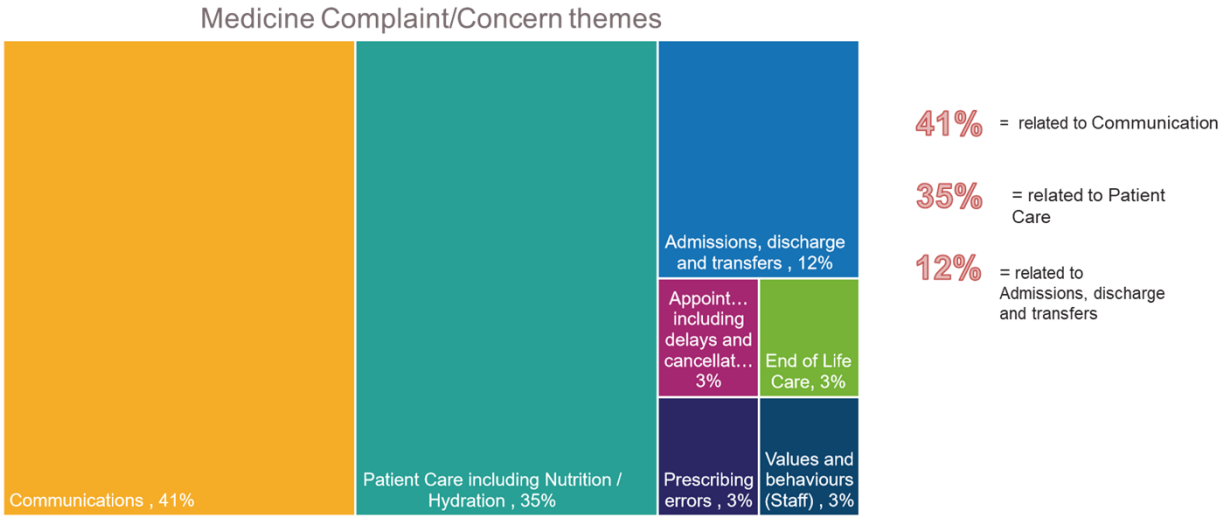
- There were a total of 34 complaints and concerns for Q4, this is a slight decrease on the total number seen for Q3 (n~36).
- 79 compliments were formally logged on Datix. This is less than Q3 and some of this is owed to delays with recorded compliments on the Datix system.
- 17 complaints were closed in Q4; with 41% being responded to within the agreed timescale. This is a reduction on Q3 however, the division continues to demonstrate a commitment to meet the 90% Improving Together Target.
- 4 complaints/concerns reopened this quarter, 3 more than Q3.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

Table 5.3 Summary of number of received, reopened and response within timeframe – annual summary and quarterly averages.

	Q1 23-24	Q2 23-24	Q3 23-24	Q4 23-24	Annual Summary	Quarterly average for 23/24
Complaints	▼ 12	▲ 18	▼ 15	▶ 15	60	15
Concerns	▼ 17	▲ 20	▲ 21	▼ 19	77	19
Compliments	▼ 51	▲ 101	▲ 169	▼ 79	400	100
FFT Responses	▲ 573	▲ 935	▼ 799	▲ 864	3171	792.75
Re-opened complaints/concerns	▼ 2	▶ 2	▼ 1	▲ 4	9	2.25
% closed complaints responded to within agreed timescale	▲ 59%	▲ 67%	▼ 61%	▼ 41%	Total patient activity for 2023/24	57%
Complaints closed in this quarter	22	15	18	17		18
Complaints by Division activity (per 1,000)	▼ 0.35 (34, 554)	▲ 0.52 (34, 921)	▼ 0.43 (35, 002)	▼ 0.40 (37, 402)	141,879	Average quarterly activity for the Division
Concerns by Division activity (per 1,000)	▼ 0.49 (34, 554)	▲ 0.57 (34, 921)	▲ 0.60 (35, 002)	▼ 0.51 (37, 402)		35,470
Compliments by Division activity (per 1,000)	▼ 1.45 (34, 554)	▲ 2.89 (34, 921)	▲ 4.83 (35, 002)	▼ 2.11 (37, 402)		

Figure 5.9 – Summary of themes for Medicine Complaints and Concerns – Q4 2023/24



For comparison, all three of the top themes noted for Q3 remained consistent again this quarter. **Communication** has however replaced **Patient Care** as the most prevalent theme. We saw a new emerging theme related to **admission, discharge and transfers** in Q3 and this has continued into Q4, although at a slightly reduced proportion.

Lack of communication and insensitive communication were the most prevalent sub-themes under **Communication** accounting for 71% of these complaints. Patients being **unsatisfied with treatment** remained the most significant sub-theme under **Patient Care** again this quarter, accounting for 58% of these. Being unsatisfied with arrangements is a new sub-category theme under **admission, discharge and transfers** this quarter, accounting for 75% of these.

Tables 5.3a, b and c show a breakdown of all the sub-categories for further context of the themes from these complaints:

Table 5.3a

Communications	**14**	**41%**
Delay in receiving/sending information	1	7%
Information not given to family	1	7%
Information not given to patient	1	7%
Insensitive communication	**4**	**29%**
Lack of communication	**6**	**43%**
Wrong information	1	7%

Table 5.3b

Patient Care	**12**	**35%**
Assistance not given	1	8%
Falls	1	8%
Further complications	1	8%
Inappropriate treatment	2	17%
Unsatisfactory treatment	**7**	**58%**

Table 5.3c

Admissions, discharges & transfers	**4**	**12%**
Discharge procedures	1	25%
Unsatisfactory arrangements	**3**	**75%**

Compliments - Medicine

There was a total of 79 compliments logged for Medicine on Datix for Q4, this was noted to be significantly lower than previous quarters, the Division have worked hard to include PALS in sharing of their compliments, some of this loss in activity is owed to delays with recording by PALS.

Figure 5.10 shows a breakdown of where the compliments were received:

Figure 5.10 – Medicine Compliments breakdown

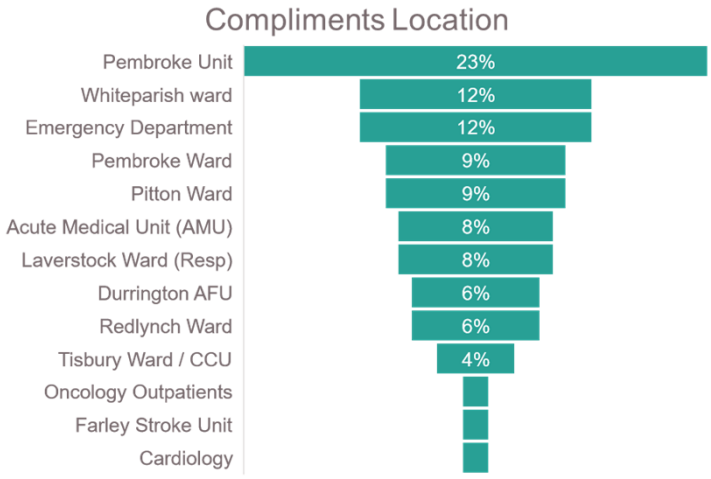


Figure 5.10a is a word cloud to summarise these compliments

Figure 5.10a – Word cloud

Figure 5.11 shows correlation of number of complaints, concerns and compliments by patient activity for Medicine.

Figure 5.11 – Complaints, concerns and compliments correlation with patient activity

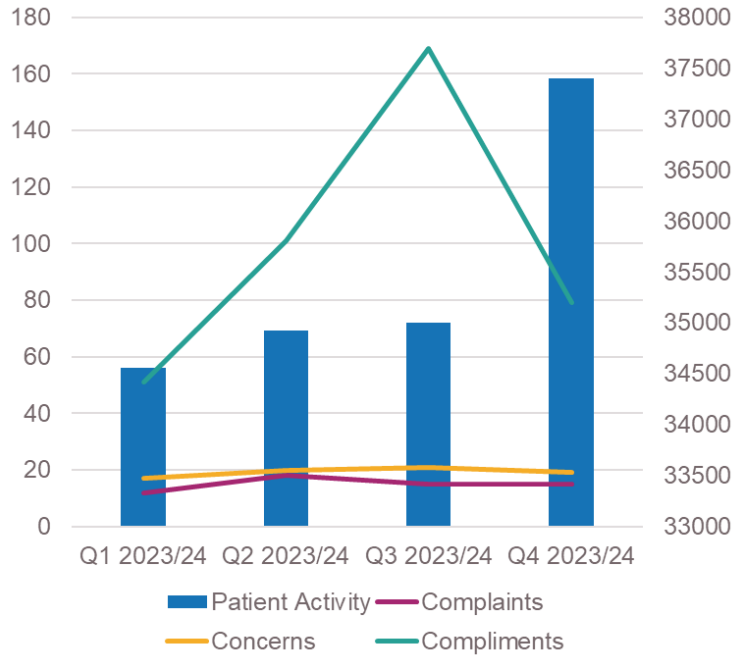
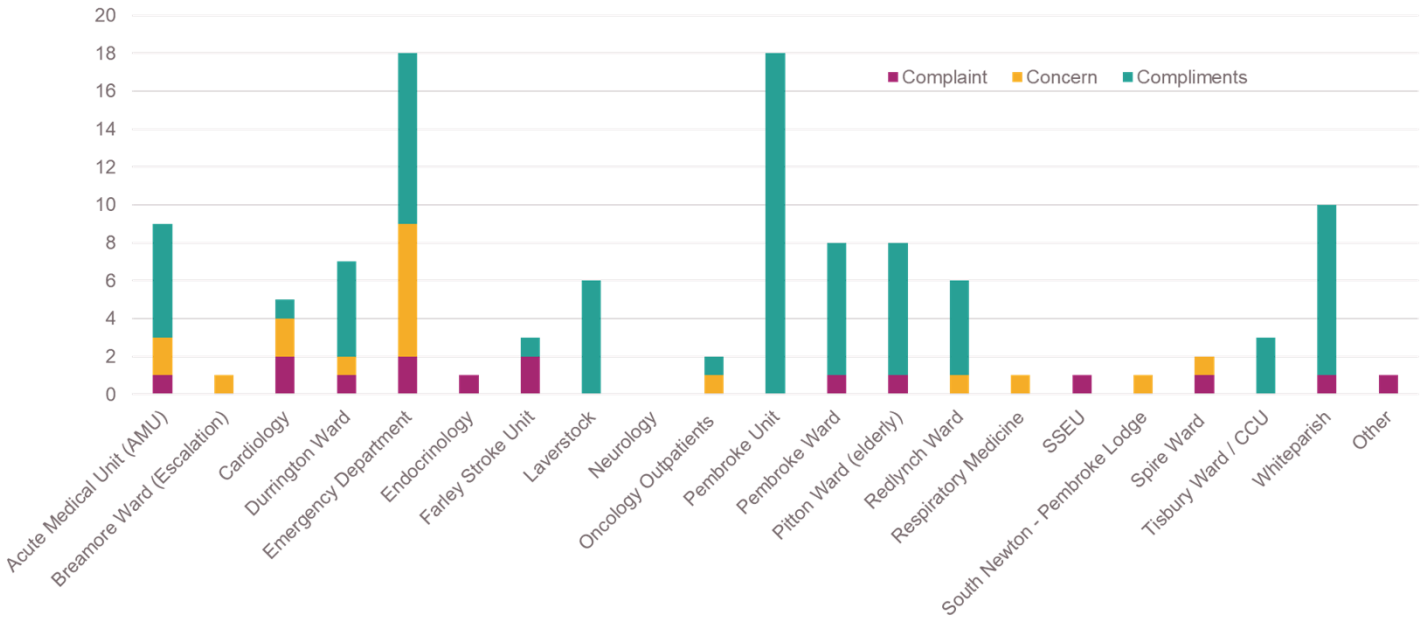


Figure 5.11 is demonstrating a decrease in the number of concerns and complaints compared with previous quarters, this is also against a landscape of increasing patient activity.

Figure 5.12 shows the location of complaints, concerns and compliments by area:

Figure 5.12 – Location of complaints, concerns and compliments by area



Surgery

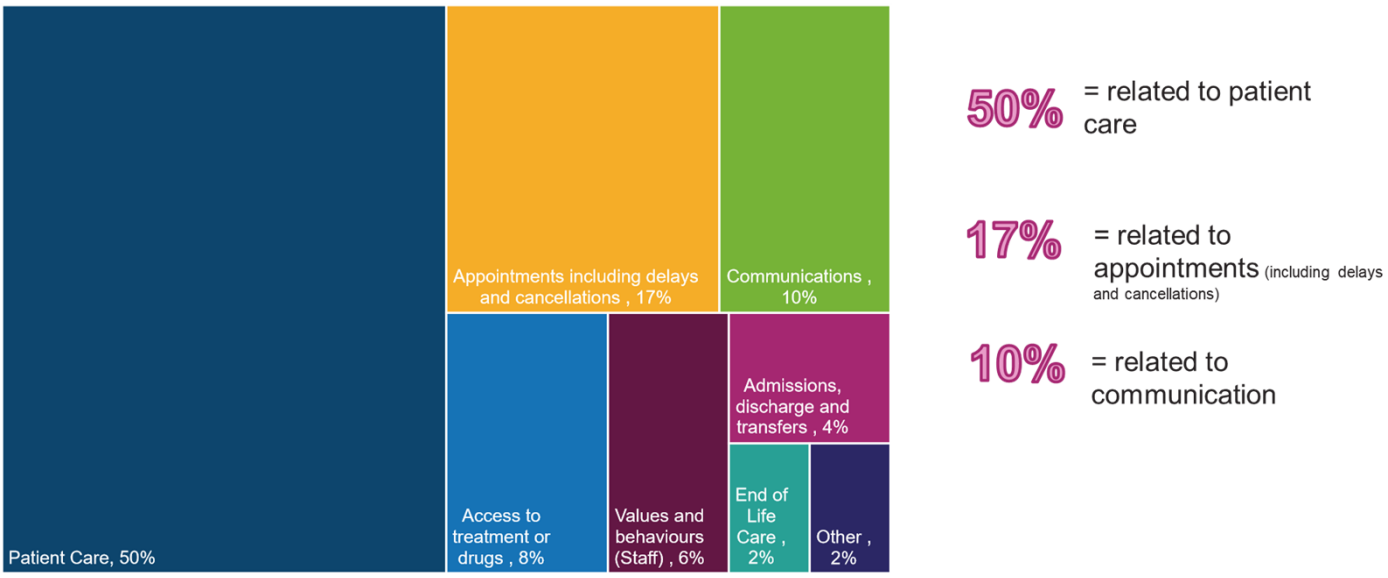
- There were a total of 47 complaints and concerns for Q4, an increase of 1 from Q3.
- 18 complaints were closed in Q4, 4 more than Q3. 33% of these were on target compared with 43% in Q3.
- 5 were reopened this quarter, an increase of 1 from the previous quarter.
- 92 compliments were logged this quarter. A slight decrease on Q3.

Table 5.4 Summary of number of received, reopened and response within timeframe – annual summary and quarterly averages.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

	Q1 23-24	Q2 23-24	Q3 23-24	Q4 23-24	Annual Summary	Quarterly average for 23/24
Complaints	▲ 18	▼ 16	▲ 17	▲ 22	73	18.25
Concerns	▲ 19	▲ 23	▲ 29	▼ 25	96	24
Compliments	▼ 62	▼ 51	▲ 111	▼ 92	316	79
FFT Responses	▲ 1,275	▼ 1,261	▼ 1,057	▼ 968	968	1140.25
Re-opened complaints/concerns	▼ 2	▲ 5	▼ 4	▲ 5	5	4
% closed complaints responded to within agreed timescale	▼ 11%	▲ 22%	▲ 43%	▼ 33%	Total patient activity for 2023/24	27%
Complaints closed in this quarter	27	27	14	18		22
Complaints by Division activity (per 1,000)	▼ 0.44 (40,495)	▼ 0.40 (39,997)	▲ 0.41 (41,789)	▲ 0.53 (41,456)		Average quarterly activity for the Division
Concerns by Division activity (per 1,000)	▼ 0.47 (40,495)	▲ 0.58 (39,997)	▲ 0.69 (41,789)	▼ 0.60 (41,456)		
Compliments by Division activity (per 1,000)	▼ 1.53 (40,495)	▼ 1.28 (39,997)	▲ 2.66 (41,789)	▼ 2.22 (41,456)		

Figure **5.13 –** Summary of themes for Surgery Complaints and Concerns – Q4 2023/24



For comparison, two of the top themes common for Q3 remained consistent again this quarter. **Patient care** and **Appointments (including delays and cancellations).** Communication is a new emerging theme this quarter, the first time for this Division this year.

Further complications and being **unsatisfied with treatment** were the combined most prevalent sub-theme under **Patient Care** accounting for 50% of these complaints. **Appointment system - procedures** was the most significant sub-theme under **Appointments** accounting for 50%. **Insensitive communication** had the most significant proportion of those categorised under **communication**, accounting for 40% of these.

Within these three most prevalent theme(s), the following tables show the full sub-category breakdown for further context of the themes of these complaints:

Table 5.4a

Patient Care	**24**	**50%**
Correct diagnosis not made	5	21%
Delay in making diagnosis	2	8%
Further complications	**6**	**25%**
Harm	1	4%
Nursing Care	3	13%
Pain management	1	4%
Unsatisfactory treatment	**6**	**25%**

Table 5.4b

Appointments	**8**	**17%**
Appointment system - procedures	**4**	**50%**

Delay in receiving appointment	3	38%
Unsatisfactory Outcome	1	13%

Table 5.4c

Communications	**5**	**10%**
Delay in receiving/sending information	1	20%
Insensitive communication	**2**	**40%**
Lack of communication	1	20%
Wrong information	1	20%

Compliments – Surgery

Figure 5.14 – Surgery Compliments breakdown

There was a total of 92 compliments for Surgery for Q4, slightly lower than last quarter.

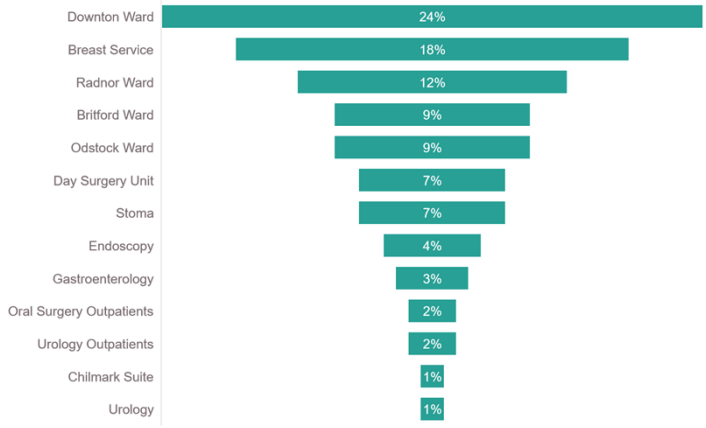


Figure 5.14 shows a breakdown of where the compliments were received, there are consistencies noted again this quarter from the previous quarter with Odstock and Britford for inpatient areas and Urology and Breast Services for outpatients. Downton received the highest proportion of these compliments.

Figure 5.14a is a word cloud to summarise these compliments

Figure 5.14a compliments word cloud

Figure 5.15 shows correlation of number of complaints, concerns and compliments by patient activity for Surgery.

Fig 5.15 Activity compared with Complaints, Concerns and compliments

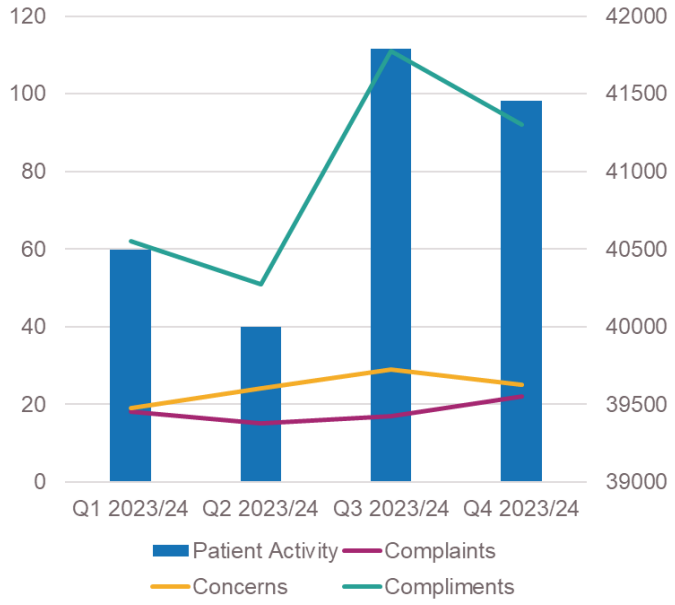


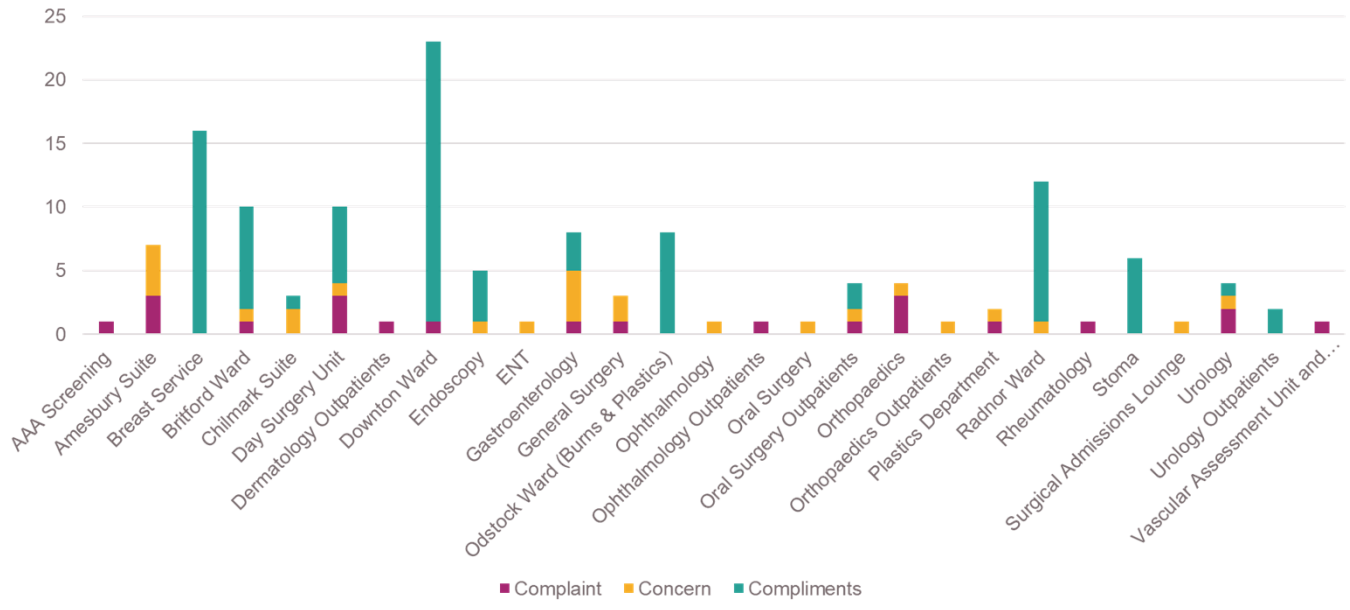
Figure 5.15 is demonstrating a slight decline in the number of recorded concerns, and a small increase in complaints.

This division has been actively engaged in adopting the principles for de-escalation of complaints and utilising opportunities for earlier resolution.

Compliments have decreased slightly this quarter, this however, could be in part owed to some delays with PALS recording.

Figure 5.16 shows the location of complaints, concerns and compliments by area:

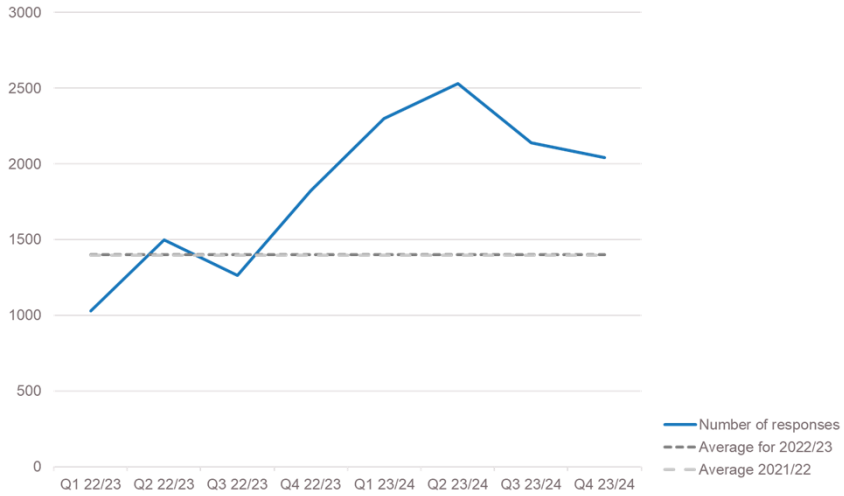
Figure 5.16 – Location of complaints, concerns and compliments by area



6. Friends and Family (FFT)

Response Rates

Fig 6.1 Number of FFT responses, broken down by quarter with historic averages



A total of **2,042** patients provided feedback through the paper form for the Friends and Family Test (FFT) in Q4. This has been the lowest uptake seen so far this year, for which no clear reason has been determined.

This response rate however continues to be higher than the calculated quarter averages for the previous 2 years (as demonstrated by the grey dotted lines in Fig 6.1)

97% Of those surveyed rated their experience of our hospital as Good or Very Good (average for Q4 2023-24)

1.8%* Response rate (*of eligible population and averaged for Q4 2023-24)

A selection of the comments received from both inpatient and outpatient areas across the Trust can be found in Appendix 5.

The target response rate continues to be significantly below our Improving Together target of >15% of eligible patients for 2023/24, however the Trust remains consistent in accomplishing its other target of achieving a >95% satisfaction rate.

Table 6.1 summarises the response rates in accordance with patient activity.

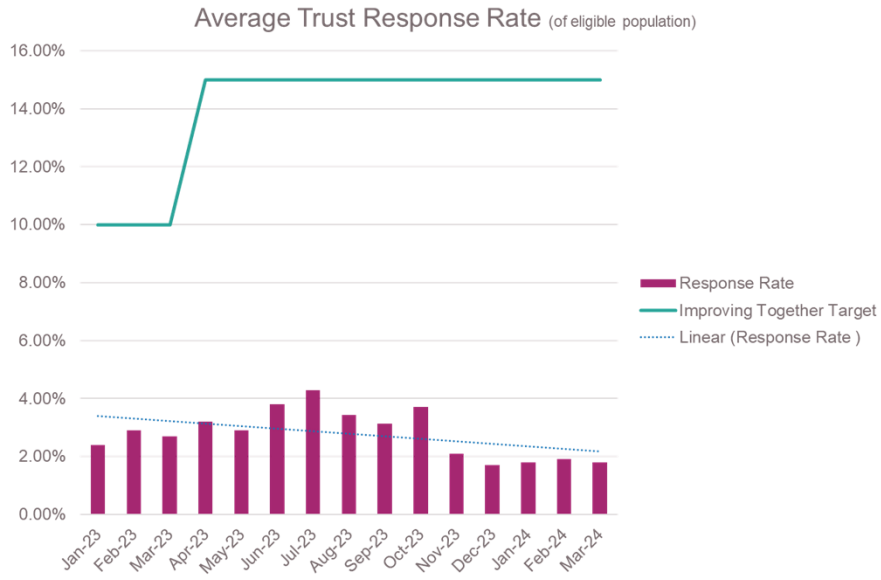
Table 6.1 Response rate across the Trust by per 1,000 patient activity – rolling annual comparison

	Q1 23-24	Q2 23-24	Q3 23-24	Q4 23-24	Annual Summary
Across all Directorates	▲ 20.0 (114, 795)	▲ 22.36 (113, 119)	▼ 18.66 (114, 757)	▼ 17.00 (119, 981)	**19.5 (462, 652)**

Benchmarking against Improving Together Targets

As Figure 6.2 demonstrates - we continue to be far from our **Improving Together** targets as we go into 2023/24.

Figure 6.2 – Response rate (based on eligible population) – Trust wide



15%
Response rate target
(2023/24)

Response rates after Christmas have slowly increased, but this quarter has failed to achieve response rates resembling the peaks in July and October.

The Trust continues to have only one collection method for FFT, with use of the online form also seeing very small engagement.

However, changes with the digital system as anticipating to significantly increase these response rates once they Go live. See Friends and Family Test Digital Go Live.

We continue to regularly promote positive feedback received via FFT through weekly social media plugs under "*#ThankyouThursday*" and "*#FeedbackFriday*" hashtags. Examples take from January, February and March 2024:

Friends and Family Test – Digital Go Live

The digital FFT project is fully underway is scheduled for launch on the 3rd June 2024. This transition is anticipated to have the following benefits realisation:

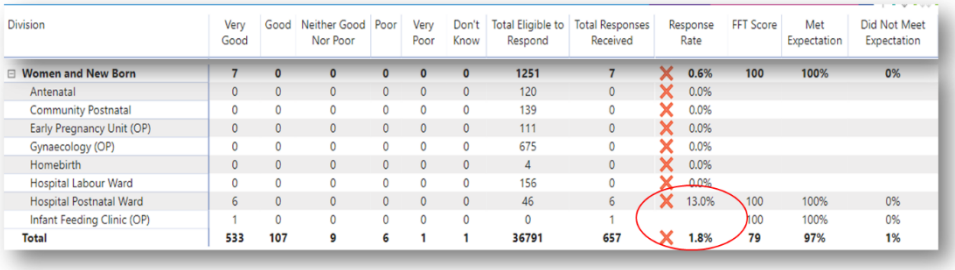
- ✓ Increased response rates to FFT
- ✓ Diversifying methods for access (including, online, SMS, over the phone to make this more accessible to difficult to reach areas of the Trust)

- ✓ Increased accessibility and inclusivity (sight impairments, languages and additional demographic options)
- ✓ Robust analysis of data for insight
- ✓ More opportunities to triangulate themes

There have been some challenges with the implementation of this new digital element which as resulted in a loss of feedback from specific clinics when we transition over. This loss is a result of these needing to be absorbed into their specialities to ensure response rates can be accurately captured. This project has highlighted this to be an historic issue owed to the eligible population being unreliably tracked through to some clinic's touchpoints. Previously in Power BI these have been reported as responses received, but no response rate, consequently impacting negatively on the Trust's overall performance.

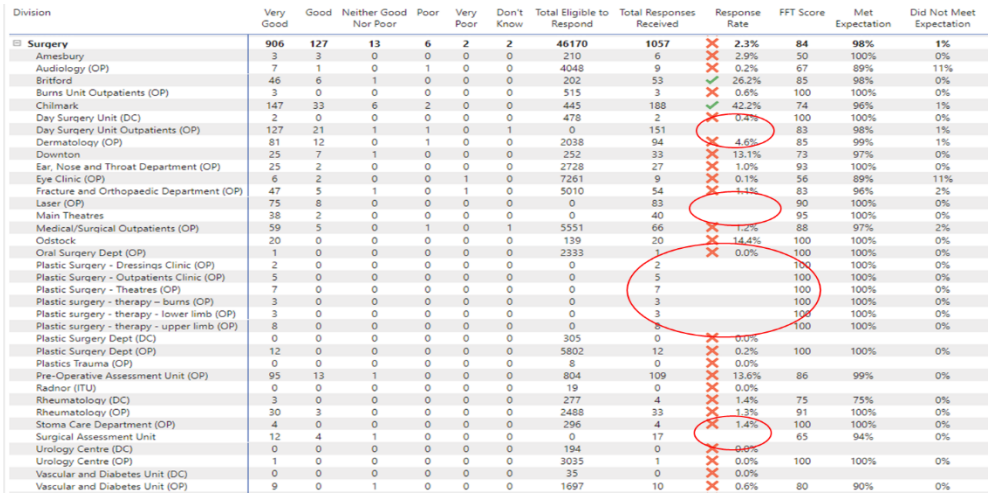
Figures 6.3 and 6.4 demonstrate this.

Figure 6.3 Power Bi extract FFT under reporting example for W&N



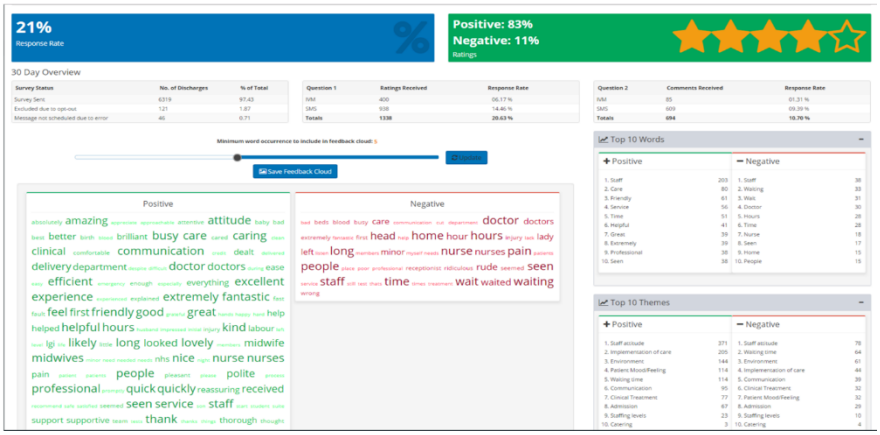
Division	Very Good	Good	Neither Good Nor Poor	Poor	Very Poor	Don't Know	Total Eligible to Respond	Total Responses Received	Response Rate	FFT Score	Met Expectation	Did Not Meet Expectation
Women and New Born	**7**	**0**	**0**	**0**	**0**	**0**	**1251**	**7**	**0.6%**	**100**	**100%**	**0%**
Antenatal	0	0	0	0	0	0	120	0	0.0%			
Community Postnatal	0	0	0	0	0	0	139	0	0.0%			
Early Pregnancy Unit (OP)	0	0	0	0	0	0	111	0	0.0%			
Gynaecology (OP)	0	0	0	0	0	0	675	0	0.0%			
Homebirth	0	0	0	0	0	0	4	0	0.0%			
Hospital Labour Ward	0	0	0	0	0	0	156	0	0.0%			
Hospital Postnatal Ward	6	0	0	0	0	0	46	6	13.0%	100	100%	0%
Infant Feeding Clinic (OP)	1	0	0	0	0	0	0	1		100	100%	0%
Total	**533**	**107**	**9**	**6**	**1**	**1**	**36791**	**657**	**1.8%**	**79**	**97%**	**1%**

Figure 6.4 Power Bi extract FFT under reporting example for Surgery



Division	Very Good	Good	Neither Good Nor Poor	Poor	Very Poor	Don't Know	Total Eligible to Respond	Total Responses Received	Response Rate	FFT Score	Met Expectation	Did Not Meet Expectation
Surgery	**906**	**127**	**13**	**6**	**2**	**2**	**46170**	**1057**	**2.3%**	**84**	**98%**	**1%**
Amesbury	3	3	0	0	0	0	210	6	2.9%	50	100%	0%
Audiology (OP)	7	1	0	1	0	0	4048	9	0.2%	67	89%	11%
Britford	46	6	1	0	0	0	202	53	26.2%	85	98%	0%
Burns Unit Outpatients (OP)	3	0	0	0	0	0	515	3	0.6%	100	100%	0%
Chilmark	147	33	6	2	0	0	445	188	42.2%	74	96%	1%
Day Surgery Unit (DC)	2	0	0	0	0	0	478	2	0.4%	100	100%	0%
Day Surgery Unit Outpatients (OP)	127	21	1	1	0	1	0	151		83	98%	1%
Dermatology (OP)	81	12	0	1	0	0	2038	94	4.6%	85	99%	1%
Downton	25	7	1	0	0	0	252	33	13.1%	73	97%	0%
Ear, Nose and Throat Department (OP)	25	2	0	0	0	0	2728	27	1.0%	93	100%	0%
Eye Clinic (OP)	6	2	0	0	1	0	7261	9	0.1%	56	89%	11%
Fracture and Orthopaedic Department (OP)	47	5	1	0	1	0	5010	54	1.1%	83	96%	2%
Laser (OP)	75	8	0	0	0	0	0	83		90	100%	0%
Main Theatres	38	2	0	0	0	0	0	40		95	100%	0%
Medical/Surgical Outpatients (OP)	59	5	0	1	0	1	5551	66	1.2%	88	97%	2%
Odstock	20	0	0	0	0	0	139	20	14.4%	100	100%	0%
Oral Surgery Dept (OP)	1	0	0	0	0	0	2333	1	0.0%	100	100%	0%
Plastic Surgery - Dressings Clinic (OP)	2	0	0	0	0	0	0	2		100	100%	0%
Plastic Surgery - Outpatients Clinic (OP)	5	0	0	0	0	0	0	5		100	100%	0%
Plastic Surgery - Theatres (OP)	7	0	0	0	0	0	0	7		100	100%	0%
Plastic surgery - therapy - burns (OP)	3	0	0	0	0	0	0	3		100	100%	0%
Plastic surgery - therapy - lower limb (OP)	3	0	0	0	0	0	0	3		100	100%	0%
Plastic surgery - therapy - upper limb (OP)	8	0	0	0	0	0	0	8		100	100%	0%
Plastic Surgery Dept (DC)	0	0	0	0	0	0	305	0	0.0%			
Plastic Surgery Dept (OP)	12	0	0	0	0	0	5802	12	0.2%	100	100%	0%
Plastics Trauma (OP)	0	0	0	0	0	0	8	0	0.0%			
Pre-Operative Assessment Unit (OP)	95	13	1	0	0	0	804	109	13.6%	86	99%	0%
Radnor (ITU)	0	0	0	0	0	0	19	0	0.0%			
Rheumatology (DC)	3	0	0	0	0	0	277	4	1.4%	75	75%	0%
Rheumatology (OP)	30	3	0	0	0	0	2488	33	1.3%	91	100%	0%
Stoma Care Department (OP)	4	0	0	0	0	0	296	4	1.4%	100	100%	0%
Surgical Assessment Unit	12	4	1	0	0	0	0	17		65	94%	0%
Urology Centre (DC)	0	0	0	0	0	0	194	0	0.0%			
Urology Centre (OP)	1	0	0	0	0	0	3035	1	0.0%	100	100%	0%
Vascular and Diabetes Unit (DC)	0	0	0	0	0	0	35	0	0.0%			
Vascular and Diabetes Unit (OP)	9	0	1	0	0	0	1697	10	0.6%	80	90%	0%

Figure 6.5 Example FFT Dashboard under the new digital solution



Going forward, it is anticipated this loss of granular level feedback will be offset by the improve response rate and accuracy of reporting. In addition, theming and analysis can be undertaken at Specialty level, Divisional level and comparatively across Outpatients, Inpatients, ED and Maternity. This will enable FFT to become are more reliable method of triangulation with complaints, Real Time Feedback (RTF) and national surveys. (Figure 6.5 is an example dashboard)

FFT can the be used as an insights tool to drive/evidence areas for improvement for Improving Together initiatives.

The loss of this granular level feedback, also poses an opportunity for individual services and clinics to consider alternative, more bespoke and appropriate ways to measure their service's performance and to develop local service improvement action plans. These services have been contacted directly with this offer by the Patient Experience Team.

From the 3rd of June all patients over 16, not admitted as an inpatient or who have passed away will receive an SMS asking about their experience. SMS will go out approximately 3 working days after being seen and are free of charge to the patient.

New online forms will also launch, with three variations, one for children, one standard survey and one for those with Learning Disabilities. Posters with QR codes to access the online form will be available across the Trust.

7. Patient and Public Feedback – Local Surveys

Real-Time Feedback (RTF)

The aim of RTF is to give a "real-time" view of a patients perspective of their care.

Real-time feedback is not currently undertaken within the maternity inpatient areas or on Sarum ward. Surveys are taken at the patients bedside and results are sent to ward leads within one week of these being completed for reflection.

The survey mirrors the focuses of the National Inpatient survey and includes questions to assess the following areas: Admission to hospital, the ward environment, Doctors & Nurses, care and treatment, operations and procedures, leaving hospital, respect & dignity and overall experience.

Real-time feedback (RTF) has maintained consistency throughout Q4 owed to the efforts of volunteers, governors and work experience students.

RTF is now regularly presented to the Patient Experience Steering Group, reflecting on the data from the previous month. Summary of analysis to date:

Table 7.1 Number of inspections and locations visited

Month	Total number of surveys	Number of inpatient areas visited	Wards surveyed	Average Score
January	31	6	Britford, Laverstock, Longford, Pitton, Tisbury, Whiteparish	80.9%
February	36	12	Amesbury, Breamore, Chilmark, Downton, Durrington, Farley, Laverstock, Odstock, Pitton, Redlynch, Sarum*, Spire	85.2%
March	35	8	Amesbury, Chilmark, Durrington, Odstock, Pitton, Radnor, Redlynch, Spire	78.4%
Total	**102**	**17**		81.6%

**RTF being undertaken on Sarum was in error, RTF is not used in Paediatric wards.*

Table 7.1a January 2024 breakdown:

	Area	
1	Britford	86.6
2	Laverstock	90.5
3	Longford Ward	59.5
4	Pitton	91.3
5	Tisbury	85.7
6	Whiteparish	67.9

Table 7.1b February 2024 breakdown:

	Area	
1	Amesbury	85.3
2	Breamore	85.9
3	Chilmark	88.5
4	Downton	71.7
5	Durrington	88.5
6	Farley	96.4
7	Laverstock	90.9
8	Odstock	94.7
9	Pitton	92.6
10	Redlynch	84.1
11	Sarum	100.0
12	Spire	59.6

Table 7.1c March 2024 breakdown:

	Area	
1	Amesbury	75.4
2	Chilmark	73.8
3	Durrington	81.6
4	Odstock	84.4
5	Pitton	81.7
6	Radnor	86.5
7	Redlynch	78.8
8	Spire	70.9

Tables 7.2, 7.3 and 7.4 shows the breakdown of average response to specific questions:

Table 7.2 highest scoring questions:

Question Text	Category Name	Answer score (%)	Responded Answers
How would you describe the trust and confidence you have in those involved in your care?	Clinicians	91.7	102
How would you describe the level of assistance you receive for basic care such as eating, drinking and washing?	The hospital and ward	91.8	85
How would you rate the level of privacy when being examined or treated?	Your care and treatment	93.5	100
Have you felt treated with dignity and respect during your stay?	Respect and dignity	94.1	101
How would you rate the cleanliness of the ward you are in?	The hospital and ward	96	101
Are you receiving enough to drink?	The hospital and ward	100	7
Do you feel safe?	Overall Experience	100	7
Do you feel comfortable?	Overall Experience	100	7
Are you receiving enough to eat?	The hospital and ward	100	7

Table 7.3 adequately scoring questions:

Question Text	Category Name	Answer score (%)	Responded Answers
Do you feel Anxious?	Respect and dignity	71.4	7
How would you describe the numbers of medical staff on duty during your stay?	Clinicians	75	102
How would you describe your involvement with decisions around your care and treatment?	Your care and treatment	75.8	97
How well have medical staff explained things to you?	Clinicians	80.7	101
How well did the staff explain how you might feel following your operation or procedure?	Operations and procedures	81.3	32
How would you describe the quality and selection of dietary options available to you?	The hospital and ward	81.8	96
How would you describe your pain management?	Your care and treatment	82.7	52
Overall, how would you rate your experience so far with the hospital?	Overall Experience	88.6	101

How would you rate your overall wait time for your admission to hospital?	Admission to hospital	89	91

Table 7.4 lowest scoring questions:

Question Text	Category Name	Answer score (%)	Responded Answers
Is there noise at night from other patients?	The hospital and ward	16.7	6
Is there noise at night from staff?	The hospital and ward	16.7	6
Do you feel Bored?	Respect and dignity	28.6	7
Is there noise at night from Equipment or machines?	The hospital and ward	33.3	6
How would you describe the quality of written information provided about your operation or procedure?	Operations and procedures	50	26
How would you describe your understanding or involvement with your discharge plan?	Leaving hospital	56.3	71
How would you describe the noise level on the ward at night?	The hospital and ward	61.5	100

Your Views Matter Bereavement Survey – Annual Report 2023/24

Overall, there has been a slight decrease in the overall experience ratings in Q4 compared with the Q3 data. 77% of those surveyed rated their overall experience as Good or Very Good, compared with 81% last quarter. Poor experience ratings have increased slightly on last quarter going from 8% up to 13%. However, the average experience rating for 2023/24 is 76%, higher than the average for 2022/23 (70%).

Response rates were noted to have increased from Q3 (going up to 38% from 36% this quarter). This is against an increased survey rate, with 69% of bereaved families agreeing to receiving this survey, compared with 53% in Q3. This gives a total average response rate for 2023/24 of 54%, compared with 41% for 2022/23.

9 survey participants requested a call-back from PALS, 3 of these went on to record a formal complaint or concern.

There annual review of themes from this survey concludes positive experiences of both the Bereavement and Medical Examiner's Offices. There are negative themes around communication and suitability of the facilities for end-of-life care.

From the 1st April 2024 the YVM survey will be replaced for 9months by the NACEL survey and reporting will be undertaken via a dashboard. This is to allow for national benchmarking to take place for this period and YVM is anticipated to resume for the final quarter of 2024/25.

Full report can be found in Appendix 7.

8. Patient and Public Feedback – National Surveys

Scheduled Reporting of Surveys

Children and Young People Survey 2023 – will be reported in (TBC) 24/25

National Inpatient Survey 2023 – will be reported in (TBC) 24/25

APPENDIX 1: Cancer Patient Public Voice Partners update Feb 24

See attachment.

APPENDIX 1a: Patient Public Voice for Cancer Services - Patient Story Mar 24

See attachment.

APPENDIX 2: MNVP Feedback Jun – Aug 2023

See attachment.

APPENDIX 3: Patient Experience - F2 Core Teaching Presentation January 2024

See attachment

APPENDIX 4: KPMG Management Action Plan v1.4

See attachment.

APPENDIX 5: Managing Concerns and Complaints Policy – Mar 24

Link to Microguide.

APPENDIX 6: FFT Feedback – Sample Q4

See attachment.

APPENDIX 7: Your Views Matter – Bereavement Survey Annual Report 2023/24

See attachment.

NHS
Salisbury
NHS Foundation Trust

Cancer Patient and Public Voice

Luke Curtis, Lead Cancer Nurse February 2024

Cancer Patient and Public Voice

Salisbury NHS Foundation Trust

- The Cancer Patient and Public Voice was created in August 2023
- Initial meeting to share stories
- Themes captured
- Action plan
- Terms of Reference co-produced
- 5 meetings to date

Theme 1- Communication and Information

Salisbury NHS Foundation Trust

Communication and Information

- Giving information sensitively whether good or bad news
- No or little information given at diagnosis
- No or little information given about effects of treatment
- A card with key people details would help
- Lack of information about support
- Useful to have access to online leaflets
- Difficult to contact Oncology
- A care plan
- Language in letter confusing
- Blood results

"I felt like I had lost control so needed some control over treatment through information. Knowledge is power."

Theme 1- Communication and Information- CPES

NHS Salisbury NHS Foundation Trust

Question Number	Scored Question Text	No. of responses	Unadjusted Trust Score	National
Q52	Patient has had a review of cancer care by GP practice	277	22.4%	20.6%
Q53	After treatment, the patient definitely could get enough emotional support at home from community or voluntary services	49	36.7%	31.1%
Q58	Cancer research opportunities were discussed with patient	171	40.4%	43.1%
Q48	Patient was definitely able to discuss options for managing the impact of any long-term side effects	229	52.0%	53.2%
Q51	Patient definitely received the right amount of support from their GP practice during treatment	165	58.2%	44.7%
Q47	Patient felt possible long-term side effects were definitely explained in a way they could understand in advance of their treatment	261	58.2%	59.0%
Q23	Patient could get further advice or a second opinion before making decisions about their treatment options	122	59.0%	52.0%
Q49	Care team gave family, or someone close, all the information needed to help care for the patient at home	186	59.1%	57.9%

Theme 1- Communication and Information- CPES

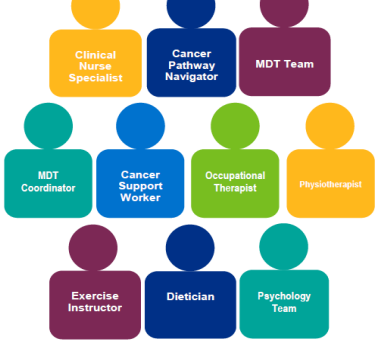
NHS Salisbury NHS Foundation Trust

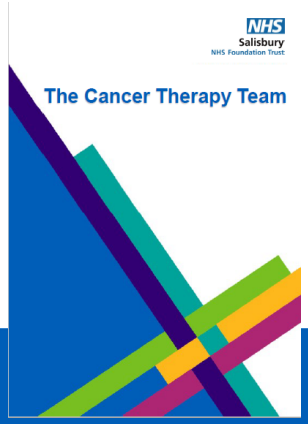
Question Number	Scored Question Text	No. of responses	Unadjusted Trust Score	National
Q55	Patient was given enough information about the possibility and signs of cancer coming back or spreading	242	63.2%	62.4%
Q50	During treatment, the patient definitely got enough care and support at home from community or voluntary services	109	63.3%	51.3%
Q32	Patient's family, or someone close, was definitely able to talk to a member of the team looking after the patient in hospital	88	63.6%	65.7%
Q35	Patient was always able to discuss worries and fears with hospital staff	104	67.3%	64.2%
Q45	Patient was always offered practical advice on dealing with any immediate side effects from treatment	260	68.1%	69.3%
Q33	Patient was always involved in decisions about their care and treatment whilst in hospital	108	68.5%	69.5%
Q42_4	Patient completely had enough understandable information about progress with hormone therapy	58	69.0%	72.5%
Q29	Patient was offered information about how to get financial help or benefits	132	72.0%	67.5%
Q24	Patient was definitely able to have a discussion about their needs or concerns prior to treatment	262	72.1%	71.1%
Q34	Patient was always able to get help from ward staff when needed	109	72.5%	72.6%
Q41_4	Beforehand patient completely had enough understandable information about hormone therapy	60	73.3%	78.8%

Theme 1- Communication and Information

NHS Salisbury NHS Foundation Trust

Information Pack at Diagnosis





Co designed with the PPV group

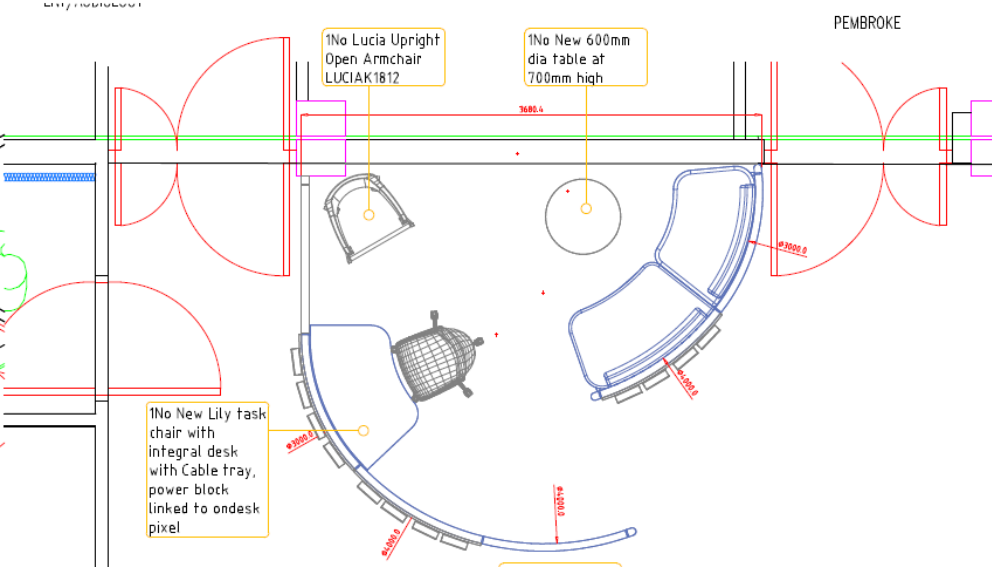
Theme 1- Communication and Information

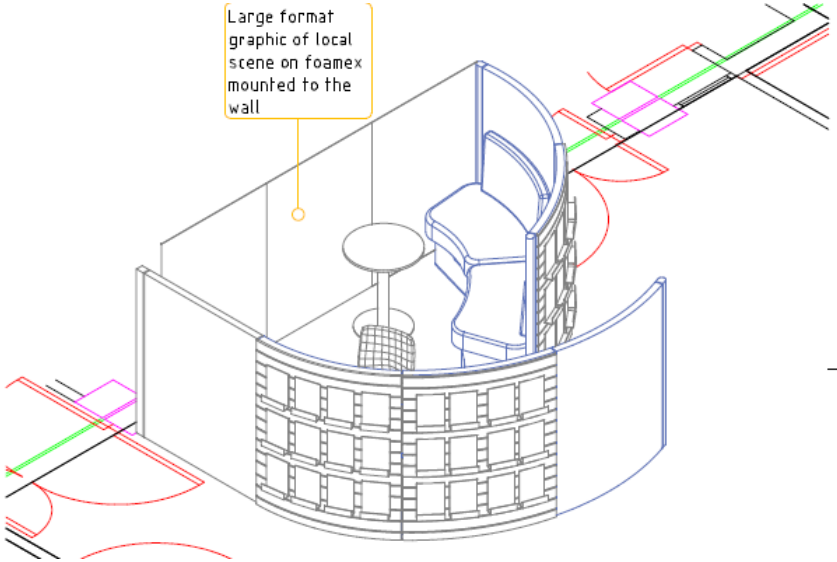
Salisbury NHS Foundation Trust

The Macmillan Information Hub

Opening Spring 2024- Monday to Friday

Co designing images for use in the hub

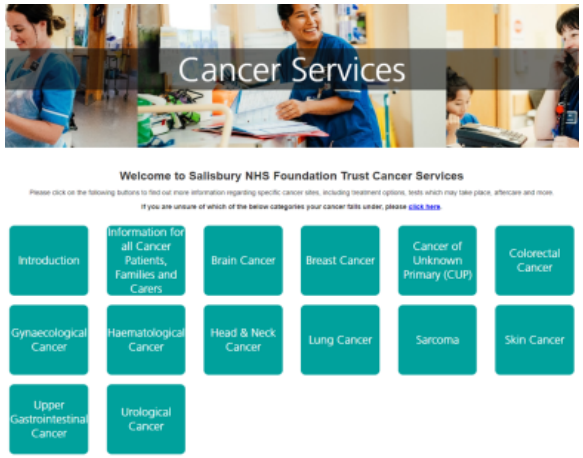


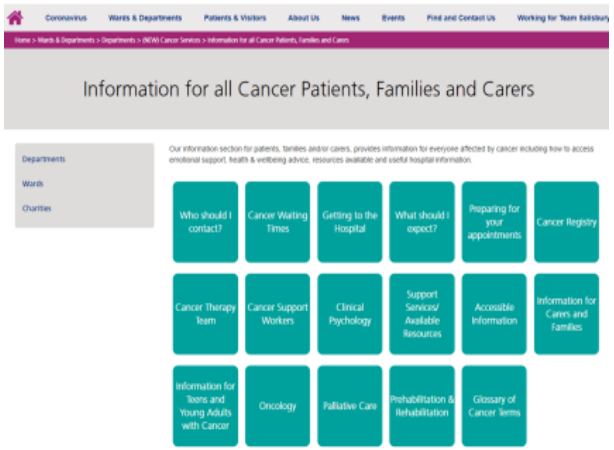


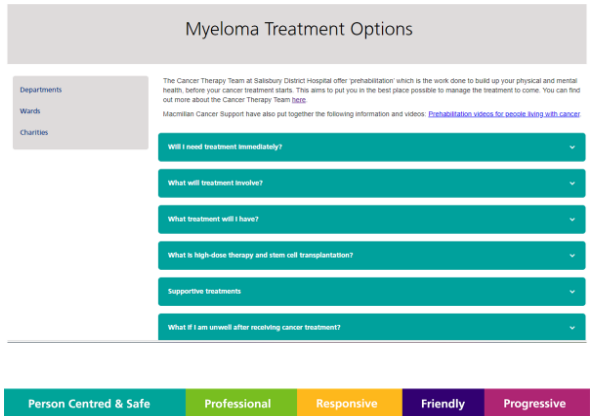
Theme 1- Communication and Information

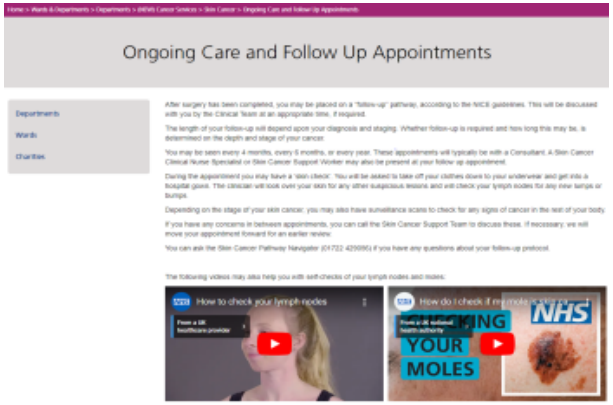
NHS Salisbury NHS Foundation Trust

The Cancer Website









[(NEW) Cancer Services]

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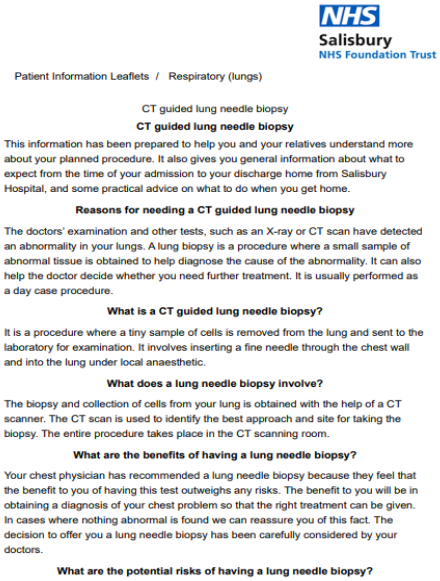
Theme 1- Communication and Information

NHS Salisbury NHS Foundation Trust

Cancer Information Leaflets

From



NHS Salisbury NHS Foundation Trust

Patient Information Leaflets / Respiratory (lungs)

CT guided lung needle biopsy

CT guided lung needle biopsy

This information has been prepared to help you and your relatives understand more about your planned procedure. It also gives you general information about what to expect from the time of your admission to your discharge home from Salisbury Hospital, and some practical advice on what to do when you get home.

Reasons for needing a CT guided lung needle biopsy

The doctors' examination and other tests, such as an X-ray or CT scan have detected an abnormality in your lungs. A lung biopsy is a procedure where a small sample of abnormal tissue is obtained to help diagnose the cause of the abnormality. It can also help the doctor decide whether you need further treatment. It is usually performed as a day case procedure.

What is a CT guided lung needle biopsy?

It is a procedure where a tiny sample of cells is removed from the lung and sent to the laboratory for examination. It involves inserting a fine needle through the chest wall and into the lung under local anaesthetic.

What does a lung needle biopsy involve?

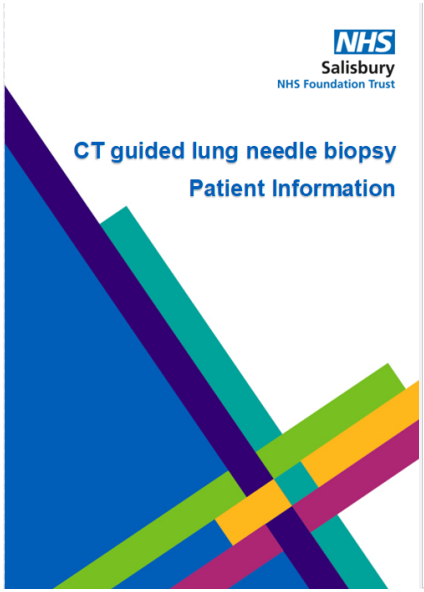
The biopsy and collection of cells from your lung is obtained with the help of a CT scanner. The CT scan is used to identify the best approach and site for taking the biopsy. The entire procedure takes place in the CT scanning room.

What are the benefits of having a lung needle biopsy?

Your chest physician has recommended a lung needle biopsy because they feel that the benefit to you of having this test outweighs any risks. The benefit to you will be in obtaining a diagnosis of your chest problem so that the right treatment can be given. In cases where nothing abnormal is found we can reassure you of this fact. The decision to offer you a lung needle biopsy has been carefully considered by your doctors.

What are the potential risks of having a lung needle biopsy?

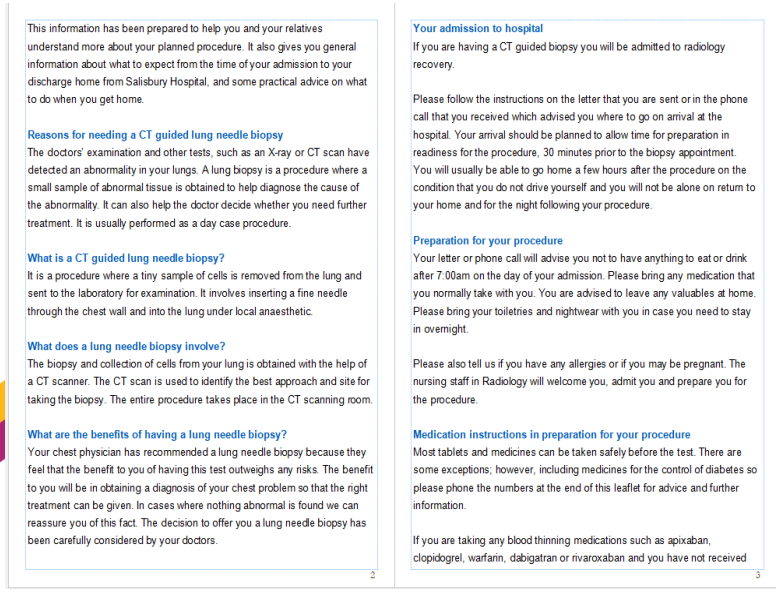
To



NHS Salisbury NHS Foundation Trust

CT guided lung needle biopsy

Patient Information



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2

Your admission to hospital

If you are having a CT guided biopsy you will be admitted to radiology recovery.

Please follow the instructions on the letter that you are sent or in the phone call that you received which advised you where to go on arrival at the hospital. Your arrival should be planned to allow time for preparation in readiness for the procedure, 30 minutes prior to the biopsy appointment. You will usually be able to go home a few hours after the procedure on the condition that you do not drive yourself and you will not be alone on return to your home and for the night following your procedure.

Preparation for your procedure

Your letter or phone call will advise you not to have anything to eat or drink after 7:00am on the day of your admission. Please bring any medication that you normally take with you. You are advised to leave any valuables at home. Please bring your toiletries and nightwear with you in case you need to stay in overnight.

Please also tell us if you have any allergies or if you may be pregnant. The nursing staff in Radiology will welcome you, admit you and prepare you for the procedure.

Medication instructions in preparation for your procedure

Most tablets and medicines can be taken safely before the test. There are some exceptions; however, including medicines for the control of diabetes so please phone the numbers at the end of this leaflet for advice and further information.

If you are taking any blood thinning medications such as apixaban, clopidogrel, warfarin, dabigatran or rivaroxaban and you have not received

3

Co designed with PPV group

Theme 1- Communication and Information

Salisbury NHS Foundation Trust

My Medical Record

- Live for Colorectal
- Near go live for Prostate and Breast

Theme 1- Communication and Contacting the Hospital

Salisbury NHS Foundation Trust

A single phone line for Oncology and Haematology

Main line- Hello and welcome to the Oncology and Haematology service. Press 1 if you are unwell and need to speak to a Nurse. Press 2 for Pembroke Ward, Press 3 for the Oncology Team, Press 4 for the Haematology team.										
1	2	3- Press 1 for treatment appointments, Press 2 for outpatient appointments or to speak to a secretary, press 3 for the Oncology Navigator, press 4 for Pembroke Suite				4-Press 1 for treatment appointments, Press 2 for outpatient appointments, press 3 for the Haematology Secretary, press 4 for the Haematology Navigator mor Clinical Nurse Specialists, press 5 for Pembroke Suite				
Urgent Advice Line	Pembroke Ward	Oncology				Haematology				
01722 341930		1	2	3	4	1	2	3	4	5
Can we have a queue	Ward	Schedulers-Treatment	Follow up Appointment/Secs	Navigator	Pembroke Suite	Schedulers-Treatment	Follow Up appointment	Secs	CNS/Navigator	Pembroke Suite
Press 1 if have a tempature- move to frount of queue	5070	3169	2785	3732	5075	3169	4020	5197	5936	5075
		3731	4225	Hunt 2785 and 4225	5076	3731		5421	4625	5076
		Answer phone	Hunt 3732	Answer phone		Answer phone		Hunt 5936	Hunt 5197/5421	
			Answer phone					Answer phone	Answer phone	

Theme 2- The Environment

NHS Salisbury NHS Foundation Trust

Pembroke Environment Feedback

Number of concerns raised about the environment in Outpatient and the Ward

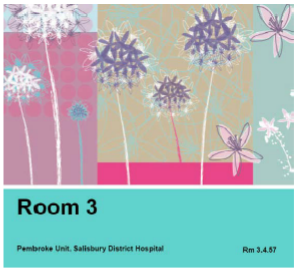
- Unwelcoming- "It needs to feel like we are cared about."
- No waiting areas in outpatient
- No Quiet in Oncology Outpatients
- Poor signage
- Haematology patients waiting with all patients waiting for bloods
- No windows on Pembroke Ward in some bays and SW- "A Prison Cell"
- Bay and SW 7 near Tug ramp - "Like sleeping next to a train track"
- Temperature and noise of air-conditioning

Theme 2- The Environment

Salisbury NHS Foundation Trust

Outpatient Environment

Improving signage



Art work in corridors
and clinic room based on Wilton House

Next PPV meeting- Artcare to engage with group to create design and patient journey infographic.

Theme 2- The Environment

NHS Salisbury NHS Foundation Trust

Future Plans

- Exploring options of a New Cancer Centre
- Air conditioning sensors to be upgraded

Theme 3- Prostate Changes

NHS Salisbury NHS Foundation Trust

- Urology Lead Nurse attended PPV group.
- Changes to pathways- Telephone Triage- MRI- CNS appointment- Biopsy- Treatment appointment.
- Improved information- At appointment and developing online patient information.
- Recruitment of Urology-Oncology Clinical Nurse Specialist to support patients treated in Oncology supported by Urology team.

Environment work with ArtCare on potential options to improve Urology Centre.

Future Work

NHS Salisbury NHS Foundation Trust

- Shift to What Matters to me conversations- SWAG strategy
- Care plans for patients at start of treatment
- Treatment Summaries at the end of treatment
- Ensure CNS support at key times- medical work/medical model by CNS making the gap worse
- Visibility of blood tests in a way the patient understands what is normal for them
- Oncology text reminders for Outpatient appointments
- Support groups
- Communication training- Advance Communication

Peter's Story

NHS Salisbury NHS Foundation Trust

The Travails of a Prostate Cancer Patient

- Some Statistics
- My Experiences at Salisbury
- What would help
- The Positives that give me hope
- Conclusion / overall reflection

- Salisbury

Peter's Story - Background

Salisbury NHS Foundation Trust

- Every year: ~393,000 new all Cancer cases
- 2016-18:
  - 55.920 new annual Breast Cancer Cases
  - 11,499 deaths from Breast Cancer
- 2017-19:
  - 52,254 new annual Prostate Cancer cases
  - 12,039 Deaths from Prostate Cancer

- Salisbury

Peter's Story – My Experiences

Salisbury NHS Foundation Trust

2007 (May): Diagnosed

Recommended Watchful Waiting but my choice

2007 (Dec): Discharged

Competence to manage Watchful Waiting?

2008 (June): Back to Hospital

2008 (Sept): Prostatectomy – supposedly nerve sparing

Side effects

Longevity – unacceptable statement

2009 (Jan): Radiotherapy & Antiandrogen

2013: Bilateral Mastectomy (Gynaecomastia)

2020: To Oncology: Androgen Deprivation Therapy +Antiandrogen

2023: Phase 1 Trial Royal Marsden

2023 (Aug): Chemotherapy

2024 (Feb): Back to Royal Marsden for a Whole Body MRI

Peter's Story – What would help?

NHS Salisbury NHS Foundation Trust

- Care plan – from diagnoses – onwards
- Support Groups – in Hospital & external
- Contact Data Cards (eg: Oncology & Support numbers)
- Address Financial support, Nutrition and Exercise
- Blood test results to patients and GP and in a better format
- A 'My Salisbury' Communication System
- **Oncology** – Change the perception
- Add wall coverings
- Water machine
- Information Leaflets
- No narrow corridor waiting and improved reception area

Peter's Story – The Positives that give me Hope!

Salisbury NHS Foundation Trust

- Patient Experience Groups
- Urology Improvements
- Breast Cancer Care
- Plastic and Burns Department
- Openness to Improvements
- Salisbury

Peter's Story – Reflections

Salisbury NHS Foundation Trust

- A challenging journey
- I should never have got here!
- Is Prostate Cancer/Oncology an embarrassment to Salisbury?
- Royal Marsden was a revelation
- Small changes can make a big difference
- Real hope for the future
- Salisbury

MNVP FEEDBACK
Salisbury & Wiltshire Overview

Feedback from survey monkey & local engagement
June - Aug 23

Relating to care given by maternity services from Salisbury Foundation trust
& Community teams including Health Visiting

Personalised Care

Key Praise

Parents reported all risks and benefits were explained at their level of understanding and their wishes were listened to.

Areas of Concern

- Confusion and poor communication between Midwives and Consultants
- Parents felt risks and benefits weren't explained clearly or could have been better

Opportunities for Action

To ensure risks & benefits are being explained clearly

Consultant Led Care

Key Praise

"High quality care and observation from GROW pathway at antenatal clinics"

Parent appreciated consultants matter of fact conversation - was not blunt but gave the facts and their opinion and engaged in discussion over the options available to them.

Areas of Concern

- Parents reported feeling "railroaded" in to making decisions about their birth.
- No conversation, no respect for womens choices, very opinionated.

Opportunities for Action

Personalised care training for Doctors to ensure all families are treated with consistent personalised care

Antenatal

Key Praise

Parents impressed with level of information and interaction from sonographer during scans

Areas of Concern

- A number of women have been sent for growth scans for disparity between growth scan measurement and fundal height measurement or are still having fundal height measured when on a growth scan pathway.
- Hospital staff attending appointments are being asked work related questions.

Opportunities for Action

- Parents would like in-person antenatal classes
- Reminder to book 16 week Midwife appointment as some parents report not knowing they needed to

Health Visiting & GP

Areas of Concern

- Parents reported "poor" care from Health Visitors due to lack of information and support with feeding advice
- Parents reached out to Health Visitor & GP when new to the area as didn't feel herself. Received unprofessional advice from GP and didn't hear back from the Health Visitor

Opportunities for Action

- To ensure a robust pathway in place for parents reaching out for advice with mental health concerns

Labour & Birth

Key Praise

- Parents using the birth centre had really positive experience, but wish more people were able to utilise it

Areas of Concern

- Behaviour in the birth room - parents reported a lack of dignity in the care they received, experienced disagreements between staff members, felt nobody wanted to help them, they were a burden due to short staffing issues

Opportunities for Action

- Midwives & Doctors to be mindful of how vulnerable women are in labour

Infant Feeding

Areas of Concern

Parents feel the Infant Feeding Team could be more supportive when other teams (HV & GP) are involved. Parents need reassurance they're doing ok when under pressure from other services.

Postnatal

Areas of Concern

Parents feel ignored, they feel that postnatal ward was noisy, busy and unorganised.
Discharge very slow and unorganised; staff don't seem to know what families are waiting for

Opportunities for Action

Parents said they would have liked more home comforts, more regular check ins, offers of a cuppa.
They don't feel comfortable ringing the bell constantly and don't always like the curtain being pulled round, especially when they're immobile, post-surgery.
Parent want to feel more human, to be encouraged to mobilise

NICU

Key Praise

The NICU staff were caring and supportive, parents felt confident with them caring for their babies and gave great advice that Midwives often miss.

Opportunities for Action

A daily ward round from NICU nurses on postnatal ward for transitional care/light therapy babies to ensure both Mums and babies needs are being met.

Bereavement

Areas of concern

Families felt unsupported during times of increased emotion, when surrounded by lots of staff.

Opportunities for Action

- Parents feel that postnatal support could be more personalised as they don't benefit from having the same conversation at each contact.
- Access to bereavement suite from maternity theatre

No exact demographics due to the nature of how thefeedback has been collected
Majority of births from 2022 & 2023 and current pregnancies

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Patient Experience

Introduction to Complaints

January 2024

Victoria Aldridge - Head of Patient Experience

Session key points

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- ✓ Complaints - exemptions, our pledge and resolution first
- ✓ Common themes for complaints
- ✓ SFTs current complaints process
- ✓ Reflecting on your experience with complaints
- ✓ Reopened complaints
- ✓ Saying sorry, Do’s and Don'ts!
- ✓ Tips for managing a complaint
- ✓ PALS – we are more than just complaints!
- ✓ Key contacts

The NHS pledge to complaint and redress

Salisbury NHS Foundation Trust

Source: NHS Constitution for England

Complainants are treated with courtesy and receive appropriate support throughout the handling of a complaint; and that the fact that they have complained will not adversely affect their future treatment

When mistakes happen or if patients are harmed while receiving health care they receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma they have experienced, and know that lessons will be learned to help avoid a similar incident occurring again

The organisation learns lessons from complaints and claims and uses these to improve NHS services

Who can raise a complaint?

NHS Salisbury NHS Foundation Trust

- ✓ Patients
- ✓ Carers/relatives
- ✓ Visitors
- ✓ MP, acting on behalf of and by instruction from a constituent.
- ✓ Members of hospital staff and other health professionals including the General Practitioner may also complain about aspects of a patient's care or raise it through the **Freedom to Speak Up: Raising Concerns Policy**.
- ✓ Commissioners
- ✓ Advocacy Service on behalf of a patient.

Complaints are exempt from the investigation process when they are…

Salisbury NHS Foundation Trust

- about private treatment;
- have already been investigated;
- where legal action has already been started;
- about data subject requests under the Data Protection Act 2018;
- relating to requests under the Freedom of Information Act 2000;
- Complaints over 12months old*

Resolution first.
We encourage complainants to…

Salisbury NHS Foundation Trust

Raise their concern as soon as possible after the event has occurred

Talk it through with those involved with their care in the first instance

If raising a concern on behalf of someone else, ensure they have the appropriate consent in place

Be clear about what they want as an outcome

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Why do people complain?

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How would receiving a complaint make you feel?

Reflection point

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Think about a time when you have had to make a complaint yourself

What made it a poor experience for you?

What made it a positive experience?

What are the most common themes for complaints?

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Patient Care

Values and behaviours of staff

Communication

Access to treatment

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Reality does not always meet expectations

Current Complaint Process

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Complaint comes in

Record of discussion taken, key points and defining of outcomes

48hr template sent to Division leads.

Template is returned with RAG response, next actions for investigation and identification of early resolution

Investigations and statements are undertaken, learning identified and response drafted/ meeting arranged

Holding letter may be sent with extended timeframe if RAG response time is exceeded

Actions and responses are reviewed by PALS and response has second review with the Quality Team

Outcome of investigation and a response is provided to complainant

Meeting may be arranged instead of response letter to discuss and address the points of the complaint

RAG Status	
Green	25 w/days
Amber	40 w/days
Red	60 w/days

The complainant is not satisfied

What happens next?

NHS Salisbury NHS Foundation Trust

Meeting may be offered

Parliamentary and Health Service Ombudsman

Referral to the Parliamentary and Health Service Ombudsman

Complainant may wish to take legal action and would be advised to seek independent representation.
The SFT legal team would be informed of the complaint details at this stage

Saying sorry…

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- ✓ Is always the right thing to do
- ✓ Is not an admission of liability
- ✓ Acknowledges that something could have gone better
- ✓ Is the first step to learning from what happened and preventing it recurring

Source: NHS Resolutions – publication 2018

Do's and Don't's

Source: NHS Resolutions – publication 2018

NHS Salisbury NHS Foundation Trust

Do say:

- ✓ I'm sorry … happened
- ✓ We're truly sorry for the distress caused
- ✓ We're sorry, we have learned that…

Don't say:

- ✗ I'm sorry you feel like that
- ✗ We're sorry if you're offended
- ✗ I'm sorry you took it that way
- ✗ We're sorry, but...

Principles for successful complaints management

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Listen, understand and value

Early resolution

Communication

Meaningful apology

Comprehensive and comprehensible

Ask for help!

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Empathy – our ability to understand someone else's point of view

PALS Services
we are so much more than just complaints !

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Patient clothing & TV cards – provided by the Stars Appeal

Friends and Family Tests (FFT)

Message to a loved one

Virtual visiting

Patient engagement initiatives

Accessibility and Interpreting Services

PALS Outreach Services

Lost property

Real-time Feedback (RTF)

Your Views Matter Bereavement survey

Hearing Aid Batteries

Insurance forms

Patient Stories

Compliments

Local and National Surveys

Any questions?

NHS
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2023-24 KPMG Internal Complaints Report – Management Actions Tracker

Associated file(s) location: W:\Chief-Executive-Directorate\Customer Care\Complaints Internal Audit\2023

Finding	Management Action	Evidence to confirm implementation	Owner and Due date	Progress update and RAG Status
2.1 Divisional Guidance documents (Medium) Currently there is no requirement for Divisions to produce complaints management guidance for division-specific procedures.	1. Produce a template for Division level guidance for managing complaints, including key areas such as allocating investigating managers, internal timelines, and Division-level reporting requirements. 2. Communicate deadlines for responding to complaints within divisions to those involved. 3. Set a minimum expectation for monitoring of complaints data within divisions.	1. Division guidance document template. 2. Communication of deadlines: guidance to be included with the Divisional guidance and complaints policy. 3. Agreed minimum reporting at divisional level governance.	Victoria Aldridge – Head of Patient Experience 29/02/2024	**Complete** Sections added as follows to the updated complaints policy. Policy approved at PESG (26th March 2024) and ratified at Clinical Management Board (17th April 2024): 1. Divisions have developed additional guidance documents to outline their individual processes where these are in addition to the PALS complaint process. These have been added as appendices to the new complaints policy. **Evidence:** Microguide link to appendix 11a. 2.Communication of deadlines explicitly referenced in the new policy *"Complaints pathway and investigation process"*. 3. New section added to the complaints policy – *"learning from complaints".* **Evidence:** Microguide link to full policy for evidence of points 2 and 3.

2.2 Sharing lessons learned and good practice (Medium) There are limited forums for sharing lessons learned and/or good practice from complaints.	1. Publish trust-wide lessons learned on the intranet on a regular basis. 2. Include trust-wide lessons learned from complaints within the quarterly patient experience report. 3. Include discussion of lessons learned from complaints across the Trust, and sharing of best practice, within divisional forums.	1. Trust-wide lessons learned from complaints published in a newsletter on the intranet. 2. Lessons learned included in the quarterly patient experience report. 3. Evidence of discussion of lessons learned and best practice in divisional forums.	Victoria Aldridge – Head of Patient Experience 30/06/2024	**Complete** New section *"learning from Patient Experience"* has now been added to the Patient Experience quarterly reports (starting from Q2 2023/24, most recent finalised report included for evidence) – **Evidence:** Section 2 of the attached paper Patient Experience - Patient Feedback Rep Evidence of Patient Experience presentations for Divisional forums (quarterly basis) – new template developed. **Evidence:** PESG Presentation Template - v1 March2 Ongoing work to develop a digital format (i.e. newsletter or page on SaLi intranet) for sharing Trust-wide lessons learnt. Currently included in complaints training for B7's, F2's and consultants.

2.3 Re-opened complaints (Medium) The complaints policy does not include the process for managing re-opened complaints.	Update the Handling Comments, Concerns, Complaints and Compliments Policy to include a section on managing re-opened complaints.	1. Updated Handling Comments, Concerns, Complaints and Compliments Policy including re-opened complaints	Victoria Aldridge – Head of Patient Experience 29/02/2024	**Completed** "*Reopened complaints*" section added to the updated complaints policy. Policy approved at PESG (26th March 2024) **Evidence:** Microguide link to full policy for evidence
2.4 Accuracy of response times (Medium) Complaints response times are being calculated from the date of entry to Datix, instead of the date of receipt.	Add a section into the Datix complaints record to record the date of receipt and use this to calculate deadlines.	1. Dates of receipt are recorded for complaints in Datix.	Sophie Brookes – PALS Lead 31/01/2024	**Completed** Additional field added to Datix . This is referenced for completion in the new policy under *"record keeping"*. **Evidence:** Microguide link to full policy for evidence
2.5 Completeness of meeting records (Low) Records are not retained for all meetings used to resolve complaints.	Produce a template for recording outputs from meeting-based complaint resolutions, include this as an appendix to the policy and circulate to Divisions.	1. Meeting record template to be used for patient complaints.	Sophie Brookes – PALS Lead 29/02/2024	**Completed** Appendix added to the updated complaints policy. Policy approved at PESG (26th March 2024) **Evidence:** Microguide link to appendix 12.
2.6 Record of joint investigations (Low) There is currently no requirement to retain evidence of each stage of the complaint management process when a joint-Trust complaint is being led by the other Trust.	Retain evidence of the response to complaints where these are being led by another Trust.	1. Cross-Trust complaints responses are recorded, guidance and templates to be added to the Trusts main complaints policy .	Sophie Brookes – PALS Lead 31/03/2024	**Completed** Section "cross boundary complaints management" added to the updated complaints policy. Policy approved at PESG (26th March 2024) **Evidence:** Microguide link to full policy for evidence Previous similar policy has been archived, incorporated into the new policy for ease of reference and to prevent missed information.

Friends and Family Feedback
Women & Newborn Comments Q4

NHS Salisbury NHS Foundation Trust

Community Postnatal

The staff were so polite and friendly. They also took great care of me and my newborn.

Gynaecology

Everyone was kind and put me at ease when I was very nervous.

Labour Ward

Midwives and nurses were exceptionally great taking care of their patients. I thank Melissa Green as my midwife during labour and delivery time.

Antenatal

Staff were friendly and polite.

Early Pregnancy Unit

Staff have excellent patient service.

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

Friends and Family Feedback

CSFS Comments Q4

NHS Salisbury NHS Foundation Trust

CT/MRI

The service from all staff was exceptional. Very kind, caring and professional

DEXA Clinic

Excellent staff. No waiting. Very efficient.

Pathology Reception

Receptionists are very jolly, kind and helpful. Not long too wait.

Orthotics

Friendly receptionist and other staff. They always do their best.

Wessex – Lower Limb

The team are friendly and fully invested in giving the best quality care all the time.

Moire Fringe

Friendly, helpful and easy to ask questions. Excellent service.

Sarum

Staff very kind and listened when we had concerns/ideas about our treatment.

Neurophysiology

Everyone was friendly, confident and engaging.

Wessex – Chronic Pain

Sharing the experience with like-minded people and learning new things and knowing I am not alone.

Wessex – Upper Limb

Kind supportive service, tailored to my injuries. Rehab was varied, fun, pushed me to achieve my best. Everyone was amazing!

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

Friends and Family Feedback
Surgery Inpatient Comments Q4

NHS Salisbury NHS Foundation Trust

Amesbury

Very good meals. Efficient medication. Taken care of by caring nurses.

Chilmark

Everything. They were extremely nice. Thank you very much.

Odstock

All the staff were wonderful and looked after me so well. Everything was explained to me at every stage of my treatment.

Downton

The staff have been caring and attentive which made such a difference in my time here.

Britford

The staff are all caring and listen to you. They attend to you as soon as possible.

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

Friends and Family Feedback
Surgery Outpatient Comments Q4

NHS Salisbury NHS Foundation Trust

Audiology

Very helpful when I needed to arrange initial appt. Thank you. Equally thorough and helpful consultation.

Dermatology

DTC nurses. Professional, attentive and knowledgeable staff that know their field of expertise. Empathetic to my son as he is young and not fully understanding.

DSU

The care and information provided once I arrived at the day surgery unit was good.

Burns

Was on time. Nurses knew details/history beforehand. Provided with correct advice/supplies needed for the wound. Physio appt was very helpful. Really caring people.

Fracture & Orthopaedics

The doctor was very reassuring, confidence building, clear information re progress given. Responded to all questions clearly.

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

Friends and Family Feedback
Outpatient Comments continued …

Salisbury NHS Foundation Trust

Laser

On time, lovely staff, treated with respect and always a good service. Thank you

Rheumatology

Fantastic staff. I couldn't have asked for any better. Pain free for me, first time for me. Dr Smith spent so much time to help me, fabulous.

Oral Surgery

Very fast to be seen. Exceptional consultant. Very efficient service.

Med/Surg OP

The staff were very helpful and the reception was equally good i.e. showing me where to go.

Main Theatres

Everyone was very friendly and helpful. There was no delay. Everything was explained clearly. A good experience.

Plastic Surgery

Excellent care, explanation of treatment, very empathetic caring nurse.

Friends and Family Feedback
Medicine Inpatient Comments Q4

NHS Salisbury NHS Foundation Trust

Breamore

Nurses are great and helpful. Cleanliness is exceptional.

Durrington

Excellent happy staff. Great jobs they all do, wouldn't want to go anywhere else.

Cardiac Suite

Nothing seemed too much hassle and always treated with a smile.

AMU

Beautiful lovely service of the staff. Always smiling and taking care of all the patients.

ED

Nurses and doctors were welcoming, professional and caring. Staff were always trying to make us as comfortable as possible.

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

Friends and Family Feedback
Medicine Inpatient Comments Q4

NHS Salisbury NHS Foundation Trust

Farley

Excellent care from medical staff. Friendly and open. Nurses' brilliant.

Redlynch

All staff at all levels very respectful and gentle. Always asking by name if a procedure is ok. Very attentive and professional whilst being very kind. Food very good and hot.

Pitton

A lovely hospital. Staff excellent. The care and hard work you all do is amazing. So happy the care you all did for looking after mum.

Nunton Day

Kind staff. Attentive. Safe and clean. No complications.

Tisbury

The nurses in this ward are excellent.

Whiteparish

Everything about staying was okay, no improvements to be made.

Laverstock

Every staff member was very welcoming and cheerful. Nothing was too much trouble, ever.

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

Friends and Family Feedback
Medicine Outpatient Comments Q4

NHS Salisbury NHS Foundation Trust

Cardiac Investigations

The sonographer explained all procedures clearly and was kind and reassuring about what was happening.

Cardiac Rehabilitation

Welcoming and friendly. Exercising at your pace. Comfortable to ask questions.

Report to:	Patient Experience Steering Group	**Agenda item:**	4.2
Date of Meeting:	29 May 2024		

Report Title:	**Your Views Matter – Bereavement Survey Annual Report 2023/24**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x	x	x	
Approval Process (where has this paper been reviewed and approved)	Mortality Surveillance Group (11th June 2024) - (Q4 data extracts included in Learning from Deaths Report) Scheduled for presentation at End of Life Care Steering Group – date *TBC*.			
Prepared by:	Victoria Aldridge - Head of Patient Experience			
Executive Sponsor (presenting):	Angie Ansell – Deputy CNO			
Appendices (list if applicable):	Appendix 1: Patient Experience Letter to CEO – December 2023			

Recommendation:
This report is asked to be noted by the steering group and feedback on the contents and focuses of the report. For note - elements of this report are extracted for inclusion within the quarterly Learning from Deaths Report, presented to the Mortality Surveillance Group.

Executive Summary:
Overall, there has been a slight decrease in the overall experience ratings in Q4 compared with the Q3 data. 77% of those surveyed rated their overall experience as Good or Very Good, compared with 81% last quarter. Poor experience ratings have increased slightly on last quarter going from 8% up to 13%. However, the average experience rating for 2023/24 is 76%, higher than the average for 2022/23 (70%). Response rates were noted to have increased from Q3 (going up to 38% from 36% this quarter). This is against an increased survey rate, with 69% of bereaved families agreeing to receiving this survey, compared with 53% in Q3. This gives a total average response rate for 2023/24 of 54%, compared with 41% for 2022/23. 9 survey participants requested a call-back from PALS, 3 of these went on to record a formal complaint or concern. There annual review of themes from this survey concludes positive experiences of both the Bereavement and Medical Examiner's Offices. There are negative themes around communication and suitability of the facilities for end-of-life care. From the 1st April 2024 the YVM survey will be replaced for 9months by the NACEL survey and reporting will be undertaken via a dashboard. This is to allow for national benchmarking to take place for this period and YVM is anticipated to resume for the final quarter of 2024/25.

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

Your Views Matter - Bereavement Survey
Annual Report - 2023/24

Background

The Your Views Matter Bereavement survey was established in 2019 and was created to capture the views and experiences of bereaved relatives. This is an opportunity for families to feedback their experiences about the support they themselves received and the end of life care their loved one was given during their last days of life in Salisbury Hospital. Whilst the feedback is anonymous, relatives are able to name individuals they would like to acknowledge and thanked for making a difference. Likewise, where the experience was less than satisfactory those completing the survey also have the option to enclose their contact details and be followed up by the PALS team.

Metric Data

During Q4 of 2023-24 the Trust saw 242 deaths (12 less than Q3 22/23), of which 69% (n~167), were sent a bereavement survey after follow-up with the Medical Examiner's Office. This is a significant increase on the percentage of surveys sent in Q3 (53%).

For comparison, on total average of 54% of bereaved families were sent the YMV survey in 2023/24.

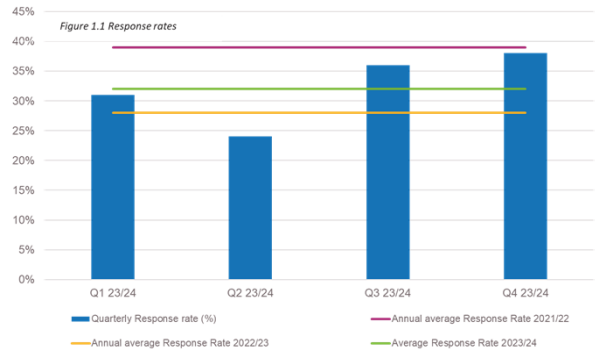


Figure 1.1 shows the response rates by quarter for 2023/24, with a comparative average annual response rates for the two previous years.

The green line shows the calculated average response rate for 2023/24 for further comparison.

In Q4 **77%** (n~49) of those surveyed rated their overall experiences with the Trust's end of life care as **good/very good**. This is a slight *decrease* on Q3. This takes the average **good/very good** to **76%** for 2023/24, 6% higher than the average for 2022/23.

In Q4 **13%** (n~8) rated their overall experience as **poor/very poor**, this is higher than Q3. This takes the average **poor/very poor** to 13% this year this is the same average as that for 2022/23.

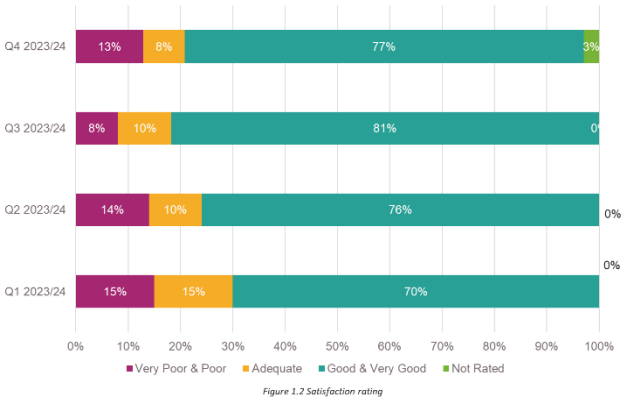


Figure 1.2 Satisfaction rating

Insights and Analysis (annual review)

In total, for 2023/24 there were 910 deaths, 135 less than 2022/23. There were 495 surveys sent this year. We were able to achieve an average sampling of 54% of bereaved families. This is higher than 2022/2023 (41%).

The average response rate achieved for 2023/24 is 32%. This is higher than 2022/2023 (28%).

For 2023/24, it averaged **76%** of those surveyed rated their experience as **good or very good** (n~127).

Of those who rated their experience as good or very good – the following further breakdowns are noted:

- **81%** (n~103) were able to talk with doctors and nurses involved in their loved one's care (in person) before their death. A further **17%** (n~21) were able to do so either in person and or over the phone.
- **87%** (n~111) were clearly communicated with that their loved one may die.
    - Of these **99%** (n~110) felt that this news was broken to them in a sensitive and caring way.
- **77%** (n~98) felt hospital was the right place for their loved one to pass away.
    - **66%** (n~84) felt that room in which they spent their last days or hours in was appropriate.
- **65%** (n~82) received support from either the EOLC team, hospital palliative care team (or both) during their final admission to hospital.
    - **90%** (n~74) of those, rated the support given to the patient as Good/Very Good.
    - **100%** (n~82) of those, rated the support given to loved ones as Good/Very Good.
- **42%** (n~53) received support from the chaplaincy services.
    - **85%** (n~45) rated this service as either Good or Very Good
- **93%** (n~118) did not have any outstanding questions following the death of their loved one.

Figure 1.2a Satisfaction rating ward breakdown (Good/Very Good)

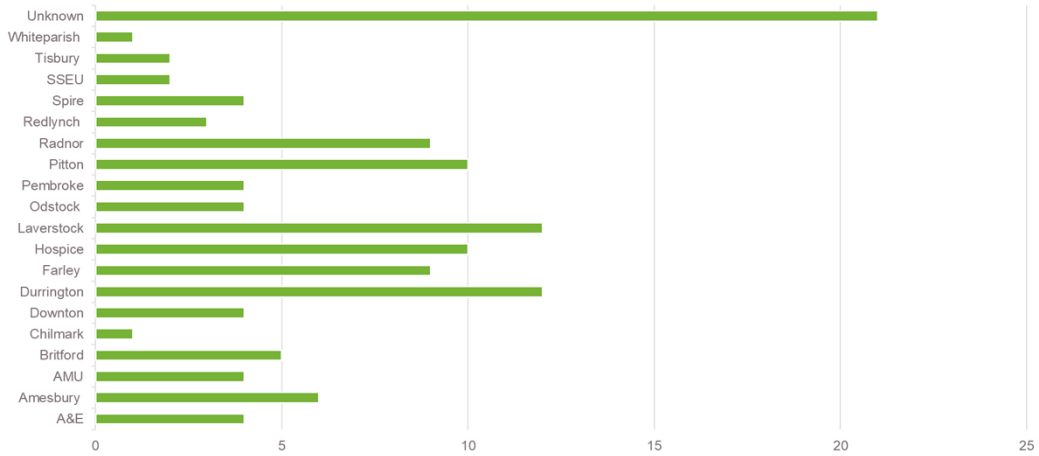


Figure 1.2a shows the satisfaction rating (good/very good) by ward/area.

In total, **13%** of those surveyed rated their experience as **poor or very poor** (n~20).

Of those who rated their experience as poor – the following further breakdowns are noted:

- **60%** (n~12) did not have an advanced care plan in place.
    - A further **10%** (n~2) did not know where there was a plan in place.
- Of those that had an advanced care plan in place **67%** (n~8) felt that this plan was taken into account by the medical team when their loved one was admitted to hospital.
- **45%** (n~9) requested further contact by PALS, **3** of these, have since resulted in a formal concern/complaint being raised.

Figure 1.2b Satisfaction rating ward breakdown (Poor/Very

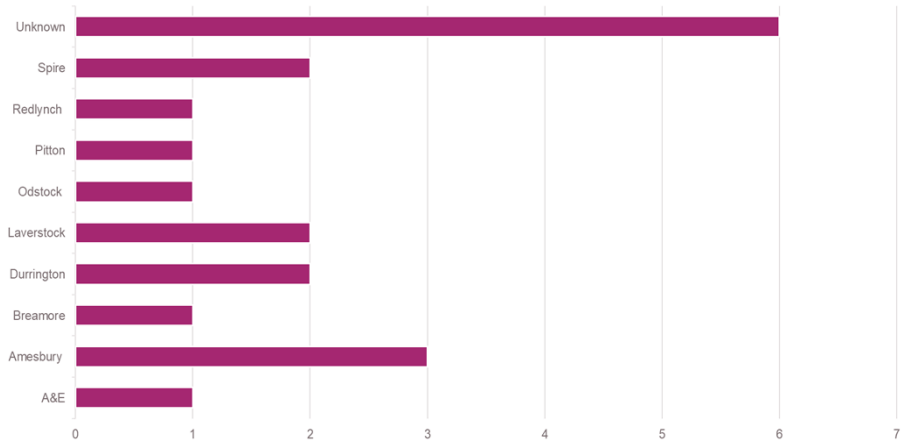


Figure 1.2b shows the wards/areas where there was an overall rating of poor or very poor experience.

Table 1.1 summarises complaints/concerns logged by PALS during 2023/24 where the location is the same as those wards in Figure 1.2b.
For context, the majority of these concerns **were not related to end-of-life care explicitly** and this information is presented as a means by which to triangulate our feedback. This information

is included to consider any common themes within these areas which may add some context to the bereavement survey experiences.
The number of A&E complaints is not felt to have any correlation with the bereavement survey findings, as only one death occurred in this area during this period. Spire, Pitton and Amesbury have the highest number of complaints for this period, and Amesbury and Spire had marginally lower levels of patient experienced reported through this survey.

Table 1.1 Summary of complaints/concerns for 2023/24 by ward

Ward	Number of complaints/concerns	Top three most prevalent themes
Spire	11	Unsatisfactory treatment, insensitive communication
Redlynch	6	Communication
Pitton	9	Unsatisfactory treatment/arrangements, communication
Odstock	1	*No themes*
Laverstock	2	*No themes*
Durrington	7	Unsatisfactory treatment, discharge procedures
Breamore	10	Unsatisfactory treatment, discharge procedures, lack of communication
Amesbury	7	Unsatisfactory treatment, nursing care
A&E	39	Insensitive or lack of communication, attitude of staff (medical)
Total		**92**

Figures 1.3 to 1.6 show the overall ratings in the key areas of patient experience for Q4:

- Relief of symptoms
- Communication
- Compassion and Dignity
- Support for loved ones

Figure 1.3 Relief of Symptoms

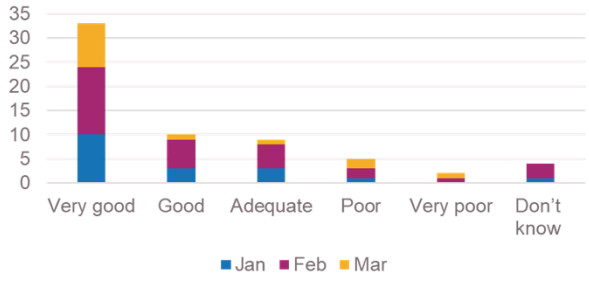


Figure 1.4 Communication

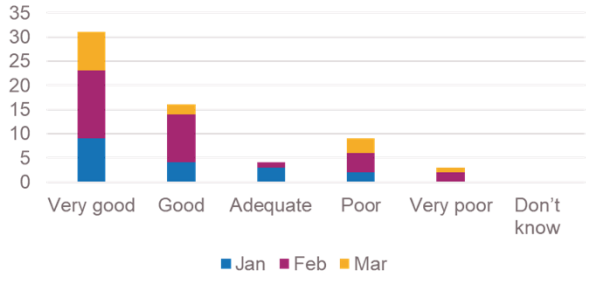


Figure 1.5 Compassion & Dignity

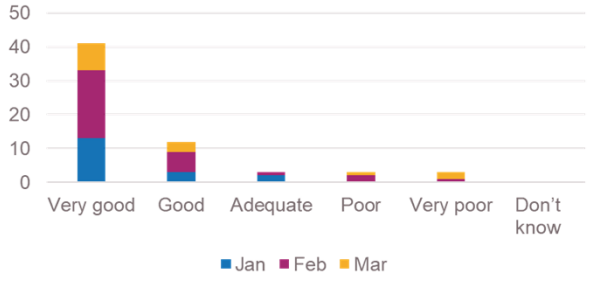
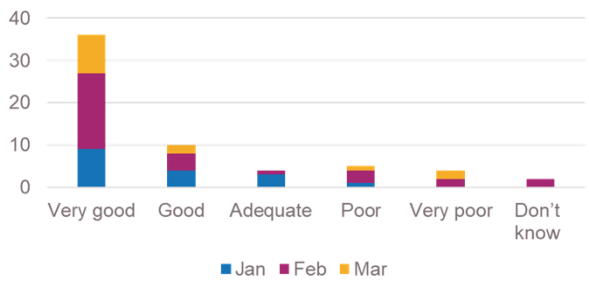
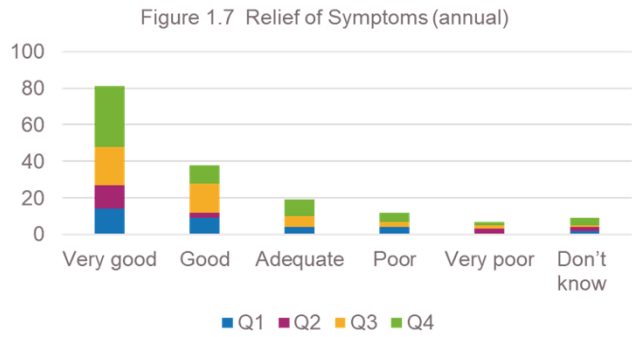
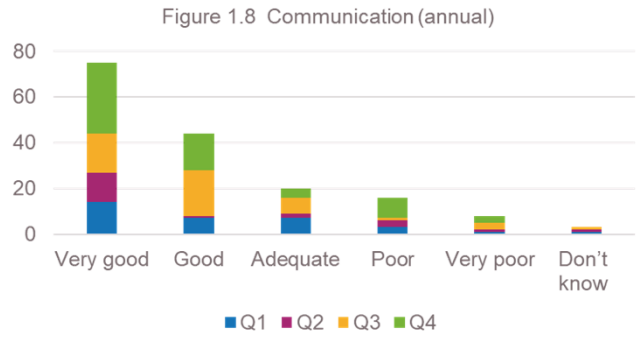


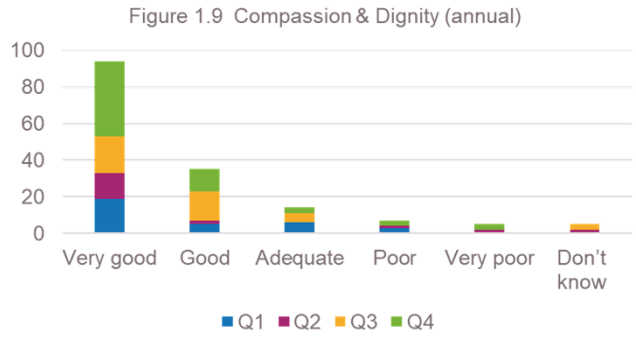
Figure 1.6 Support for loved ones

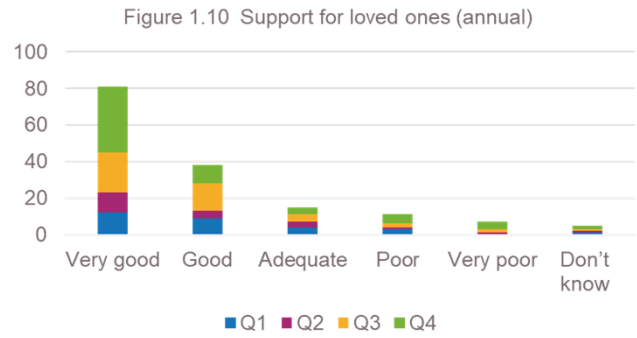


Figures 1.7 – 1.10 demonstrate the ratings for these areas in total for 2023/24.









All four areas have a significant proportion of overall good/very good experience rating. Communication, however, does have the highest proportion of poor/very poor ratings (Figure 1.8) when compared with the other three areas. This is consistent with complaint themes Trust wide and a prevalent theme for several of the wards in Table 1.1.

Correlation with Complaints

In 2023/24 there were a total of **3** complaints related to end-of-life care. All three were themed as ***poor communication***. 1 of these occurred in Q1 and 2 in Q3.

The Trust continues to support the Communications Course for Ward Staff in an attempt to mitigate this theme. This course has been developed in house and covers skills including (but not be limited to):

- telephone communication with relatives
- escalation of a sick patient
- non-verbal communication
- De-escalation skills and use of empathy to aid communication
- Supporting tender conversations
- Breaking bad news
- Importance of positive feedback and self-care

This training is delivered using professional actors, participants will participate in scenarios based on real life experiences. In 2023/24 there were a total of 10 dates offered for this training and a total of 98 members of staff have attended this, this year. The course achieves an average 60% fulfilment rate.

There are 11 further training dates currently scheduled for 2024/25.

Medical Examiner's Office and Bereavement Office

It has been noted this year a continued positive theme in relation to experience of the Medical Examiners Office and Bereavement Office.

There were a total of 80 individual comments related to the Bereavement Office and 77 in relation to the Medical Examiner office. These are positive comments. A summary of these collated in the following word clouds*

**The size of the word indicates how many times this word was used within these comments.*

Figure 1.7a Comments on Medical Examiner's Office

Figure 1.7b Comments on Bereavement Office

However back in Q1, there was a total of 8 negative comments made in relation to access to both of these offices out of hours and the subsequent poor experience associated with initial contact being through an answer machine.

Further investigation concluded this to be a exceptional and largely owed to the limited resourcing of the service (not covered during bank holidays), coupled with the impact of the additional holidays that occurred during this short period. This would have inevitably impacted the accessibility of these services during that time.

(depiction of most prevalent words used in the negative comments are show in Fig 1.7c)

Figure 1.7c Negative comments made on both the Bereavement Office and Medical Examiner's Office.

Other noted themes

Of the 132 responses received to the question *"..was the room/ward in which they spent their last days or hours appropriate?"* 38% said "no" or "don't know".

There has been a notable theme around the these are summarised as being to due:

- Unavailability of the hospice
- Unavailability of private side rooms

Leading to:

- Lack of privacy and dignity

- High noise levels
- Limitations with visiting (lack of appropriate furniture to aid long-stay visiting)
- Insensitivity

At the end of Q3, a letter was received by the Chief Executive from a family member who had died in October 2023 (see Appendix 1). This accompanied a YVM completed survey.
It was agreed with the recipient to include this within the YVM annual report as qualitative evidence of the impact on patient experience that we have seen with this theme over the past 12months.

There is a wider project currently being feasibility assessed to consider a new cancer unit development to increase availability of more private spaces. This is currently at the very early stages of discussion and there will be supported needed from our hospital charity for a dedicated fund-raising effort.

In the short-term, a funding application through the Stars Appeals has been successful in purchasing 34 reclining chairs, this was a joint application from the End of Life Care team, Patient Experience Team and Carers Leads to allow for short term improvements to this theme. The aim was to reduce the limitations and improve the comfort of those staying with a loved one at this crucial time. There will be an allocation of 2 recliner chairs per inpatient ward, with the first phase to commence with Amesbury, Durrington, Laverstock and Pitton in May 2024.

Future Reporting

From the 1st April 2024 the YVM survey will be replaced for 9months by the NACEL survey and reporting will be undertaken via a dashboard. This is to allow for national benchmarking to take place and YVM is anticipated to resume for the final quarter of 2024/25.

Correlations with this report and overall report presentation will therefore be limited and subject to change.

Report written by Victoria Aldridge - Head of Patient Experience

Appendix 1

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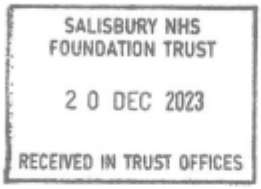

The Chief Executive
Salisbury NHS Foundation Trust
Trust Offices
Salisbury District Hospital
Salisbury
Wiltshire
SP2 8BJ

18th December 2023

To Stacey Hunter

RE: [redacted]
Patient ID: [redacted]

I am writing to you to fulfill the final promise that I made to my wonderful Father, [redacted], who passed away on the [redacted] October 2023 at 10.45am on Pembroke Ward at Salisbury District Hospital.

My Father was admitted to your hospital by ambulance on Tuesday 26th September 2023 suffering with breathing difficulties and an infection. He spent 17hours in resus, most of which was waiting for a bed space, and due to that lengthy wait he developed a sore on his bottom. At approximately 16.00hrs he was finally admitted to Pembroke Ward.

The Staff on Pembroke Ward are worth their weight in gold, working under extremely challenging and difficult conditions and I cannot thank them enough for the care they gave my Father in his final days. However, that is where any praise I can offer ends.

The conditions on Pembroke ward are, in my opinion, absolutely appalling. To put patients in side rooms, with absolutely no view of the outside world reaches far beyond unacceptable. Most days, my Father was unable to depict day from night and this caused him an overwhelming amount of undue anxiety and distress. For a ward that treats patients who are seriously ill and who often spend their final hours there, I would expect the facilities and the outlook to be far better. The rooms in which he spent his final days are in my opinion little more than prison cells.

My Father spent the last days of his life, bed bound, frightened and experiencing panic attacks, a symptom which he never suffered from previously, which lead to him having an unwitnessed fall hours before he passed away. Even though he was incredibly unhappy with the conditions in which he was staying, he was continuously told that there was no where else for him to go. I am of the opinion that this is entirely unacceptable and, a breach of his basic human rights. I also believe that this was a major contributing factor in his death and I believe he gave up fighting his illness as a result.

Had my Father been given a bed space with a window and a view to the outdoors he may have stayed with us a while longer, and I am of no doubt that he certainly would have been happier and far less distressed in his dying days. I now have to live with the fact that my beloved father spent the final days of his life desperately unhappy and traumatised. This was not the man I knew and loved. My Father was happy, carefree, always singing or telling a joke and a man that enjoyed being outside. It is heart breaking to know that he passed away in such immense distress and without the simple and basic expectation of a window with a view.

No words of apology or condolence can excuse or rectify the suffering that my father experienced and that our family have and are still experiencing. Action is the only possible comfort that can even attempt to heal our broken hearts and the knowledge that no other patient or family has to suffer in the way that we are.

I fully appreciate the financial and structural limitations that the NHS faces and the staff come to work every day and perform countless miracles. However, to place seriously ill and end of life patients in a ward without windows, so that they cannot see the outside world, is inexcusable. Simply having a window could have made all the difference to my father in his final days and hours, it would have lifted his spirits and improved his mental health which could have given us a precious few more days with him. I strongly suggest you take a more holistic approach regarding the care of your seriously ill patients and I urge you to consider this approach for the sake of future patients and their families.

Yours sincerely,

[redacted]

Daughter of the late [redacted]

Cc Victoria Aldridge, PALS sft.pals@nhs.net

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.7
Date of meeting:	4th July 2024		

Report tile:	Q4 Learning from Deaths Report 2023-24 Appendix A – Changes to SHMI Methodology			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	Mortality Surveillance Group Clinical Governance Committee 25/6/2024			
Prepared by:	Mr Charles Ranaboldo, Trust Mortality Lead Dr Ben Browne, Associate Medical Director			
Executive Sponsor: (presenting)	Dr Peter Collins, Chief Medical Officer			

Recommendation:

The paper is to provide assurance that the Trust is learning from deaths and making improvements.

Executive Summary:

Summary:

- The Trust have been notified that there will be a revision to the methodology for calculating both the HMSR and SHMI. These changes are likely to come into effect during the early part of the next financial year and further details on this will be supplied in subsequent reports. In the meantime, the Trust have been seeking further details about the changes and how this will impact our figures [**NB.** the latest SHMI figures have subsequently been released since the Q4 learning from deaths report was first published – the latest rolling 12-month figures are those ending in December '23 and now include the revised methodology. The SHMI figures have seen a positive reduction and further information about this is available in the latest IPR. Attached (as an appendix to this report) is also a summary of the changes to this methodology.

- Our overall position as a statistical outlier is improving. HSMR is now at national median.

- The mortality data suggests that we are a statistical outlier for patients who are admitted at the weekend and out of hours. Further assurances and understanding of the data are therefore being sought through the Trust's mortality surveillance group and through our partners at Telstra U.K (Dr Foster).

- The report from the recent mortality insight visit form NHSE has been reviewed and actioned. The Trust mortality surveillance group is providing the oversight for delivery of these actions. At the time of publication 8 out of 28 actions had been completed in full, with others are in progress. [**NB.** The Trust's MSG met in June 2024 and 19 out of 28 actions have now been completed, with 9 still in progress].

- The new online mortality system is now live within AMaT (Audit Management and Tracking) and is being utilised for recording mortality reviews and learning from deaths.

- There have been some new additions to the learning from deaths report this quarter, reflecting recommendations/feedback from the mortality insight visit. For instance, inclusion of a section on litigation, complaints related to end-of-life care, and a summary of national audits related to mortality which has been included in the appendices.

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

CLASSIFICATION: UNRESTRICTED

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QUARTER 4 2023/24 LEARNING FROM DEATHS REPORT

June 2024

A summary document outlining the learning from deaths at Salisbury NHS Foundation Trust during the fourth financial quarter of 2023/24. Data correct as of 05.06.2024 [unless otherwise stated in the report]

GLOSSARY OF TERMS

CHARLSON COMORBIDITY INDEX (CCI) SCORE
The Charlson Comorbidity Score is a method of measuring comorbidity. It is a weighted index that predicts the risk of death based on the number and severity of 19 comorbid conditions.

CUSUM
A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues. The CQC monitor CUSUM's at a 99.9% threshold to determine outliers.

HSMR
The Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity.

ME
Medical examiners (MEs) are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. The purpose of the medical examiner system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths, ensure the appropriate direction of deaths to the coroner, provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased, improve the quality of death certification, and improve the quality of mortality data. The Medical Examiner (ME) system was introduced in April 2020 and was established in the Trust by August 2020.

MSG
The Mortality Surveillance Group (MSG) meets bi-monthly and is responsible for reviewing deaths to identify problems in care and commissioning improvement work, to reduce unwarranted variation and improve patient outcomes. To identify the learning arising from reviews and improvements needed.

PALS
The Patient Advice and Liasion Service (PALS) offers confidential advice, support and information on health-related matters and they provide a point of contact for patients, their families and their carers. A complaint is an expression of dissatisfaction made to an organisation, either written or spoken, and whether justified or not, which requires a formal response from the Chief Executive. A concern is a problem raised that can be resolved/responded to by the clinical or non-clinical teams concerned. Concerns include issues where the patient/family member has said that they don't want to make a formal complaint.

PSIRF
Patient Safety Incident Response Framework

RESPECT
The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) provides a personalised recommendation for an individual's clinical care in emergency situations whether they are not able to make decisions or express their wishes.

SFT
Salisbury NHS Foundation Trust.

SHMI
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. It covers in-hospital deaths and deaths that occur up to 30 days post discharge for all diagnoses excluding still births. The SHMI is an indicator which reports on mortality at trust level across the NHS in England and it is produced and published as an official statistic by NHS Digital.

SII
Serious Incident requiring Investigation.

SJR
The Structured Judgement Review (SJR) is a process for undertaking a review of the care received by patients who have died.

Salisbury NHS Foundation Trust

SMR

A calculation used to monitor death rates. The Standardised Mortality Ratio (SMR) is the ratio of observed deaths to expected deaths, where expected deaths are calculated for a typical area with the same case-mix adjustment. The SMR may be quoted as either a ratio or a percentage. If the SMR is quoted as a percentage and is equal to 100, then this means the number of observed deaths equals that of expected. If higher than 100, then there is a higher reported mortality ratio.

SOX

Sharing Outstanding Excellence (SOX) is a method of paying a compliment to a team or a member of staff. It is a way of learning from when things go well.

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Learning from Deaths Report – Quarter 4

Purpose and Background

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. 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.

Executive Summary

- The Trust have been notified that there will be a revision to the methodology for calculating both the HMSR and SHMI. These changes are likely to come into effect during the early part of the next financial year and further details on this will be supplied in subsequent reports. In the meantime, the Trust have been seeking further details about the changes and how this will impact our figures.
- Our overall position as a statistical outlier is improving. HSMR is now at national median.
- The mortality data suggests that we are a statistical outlier for patients who are admitted at the weekend and out of hours. Further assurances and understanding of the data are being sought through the Trust's mortality surveillance group and through our partners at Telstra U.K (Dr Foster).
- The report from the recent mortality insight visit form NHSE has been reviewed and actioned. The Trust mortality surveillance group is providing the oversight for delivery of these actions. So far 8 out of 28 actions have been completed in full, and others are in progress.
- The new online mortality system is now live within AMaT (Audit Management and Tracking) and is being utilised for recording mortality reviews and learning from deaths.

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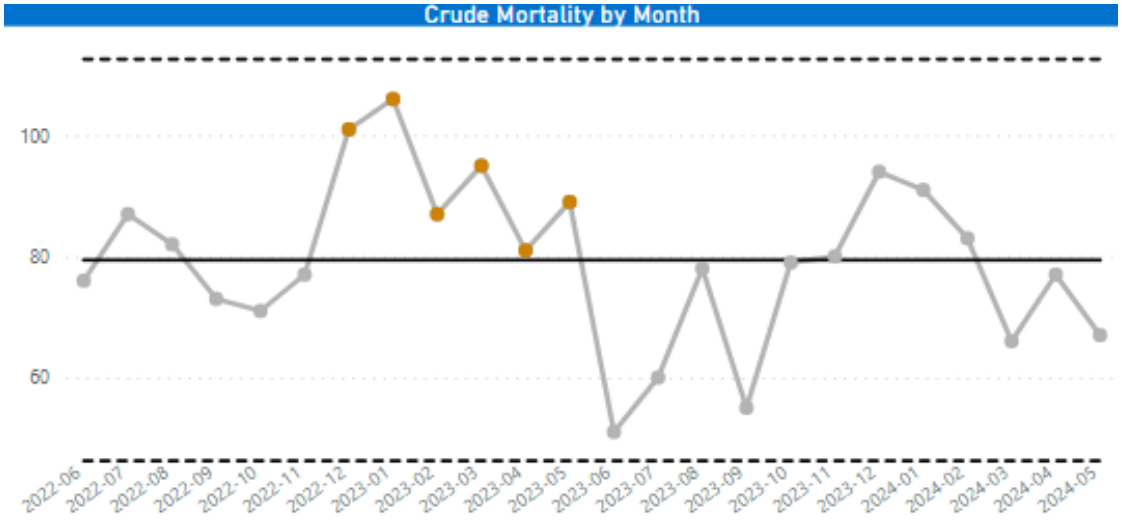
1. Learning from Deaths in Q4

Headline Data for the 2023-24 financial year

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
Inpatient Deaths (inclusive of Emergency Department and Hospice)	221	193	254	242	910
1st Scrutinised by the Medical Examiner	203	187	248	241	879
Additional reviews (Structured Judgement Reviews) completed	0	0	2	1	3
Structured Judgement Reviews undertaken related to deaths during 2023/24	59	37	36	51	183
Structured Judgement Reviews undertaken related to deaths during 2022/23	35	16	90	44	185
Patient deaths judged more likely than not to have been due to problems in the care provided to the patient (Hogan Score)	<5	<5	<5	<5	<5

The hospital mortality group (MSG) met on 20th February 2024 in Quarter 4 (Q4), where learning, improvement themes and actions arising from mortality diagnosis group alerts and individual case reviews were discussed. The learning outlined in this report reflects a summary of the key highlights (reflecting on the year as a whole and more specifically Q4), and the information reviewed and discussed at the MSG.

1.1. Data Overview



The graph above has been obtained from our Power-Bi data dashboard. It shows the number of deaths occurring in SFT as reported monthly.

Below average numbers were observed between June to October 2023. The mortality rate increased during quarter 3 (Q3) and during the month of December, before dropping back down to below average towards the end of quarter 4 (Q4). These numbers remain comparable/lower than the figures seen in 2022/23. The graph and table on the next page provide a further breakdown of these figures.

Salisbury
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Mortality Overview

Total Deaths as Reported by the Medical Examiner: Jun-22 - Apr-24

Mortality Overview: Jun-22 - Apr-24

Year-Month	Total Deaths as Reported by the ME	Deaths Reviewed by the ME	SJRs Requested by the ME	ED Deaths	Hospice Deaths	Covid19 as Primary Cause of Death (1a)	Total Stillbirth Deaths	Late Miscarriage 22 - 23+6 Weeks	Stillbirths >24+0 - 36+6	Stillbirths >37+0	Total Neonatal Deaths	Total Maternal Deaths	Total Learning Disability Deaths	Total Serious Mental Illness Deaths
2024-04	77	76	7	5	6	0	0	0	0	0	0	0	1	1
2024-03	66	66	4	2	9	1	0	0	0	0	0	0	0	0
2024-02	83	82	4	6	15	0	1	0	1	0	1	0	2	0
2024-01	93	93	2	6	11	3	0	0	0	0	2	0	1	0
2023-12	95	92	4	7	16	0	1	0	1	0	0	0	0	0
2023-11	80	78	10	4	10	4	2	0	2	0	0	0	1	1
2023-10	79	78	6	3	12	3	0	0	0	0	0	0	1	3
2023-09	55	54	1	2	15	1	0	0	0	0	0	0	0	1
2023-08	78	75	6	2	17	1	0	0	0	0	0	0	0	2
2023-07	60	58	5	1	13	0	0	0	0	0	0	0	1	1
2023-06	51	49	1	0	9	0	1	0	1	0	1	0	0	0
2023-05	89	80	8	3	15	2	0	0	0	0	0	0	4	0
2023-04	81	74	6	3	17	3	0	0	0	0	0	0	0	0

Salisbury NHS Foundation Trust

Learning Continued:

1.2. End of Year Summary

Most deaths that occur at Salisbury NHS Foundation Trust are reviewed (scrutinised) by the Medical Examiner shortly after death. An internal review (known as a structured judgement review) may be requested should there be potential learning identified following the death of a patient. This could be identified through a review of the medical records or following consultation with the relatives or carers of the bereaved. In addition to cases flagged up by the Medical Examiner, reviews may be commissioned or undertaken by clinical specialties through peer learning and/or at Mortality and Morbidity meetings.

The number of Structured Judgement Reviews undertaken related to deaths during 2023/24 was 185, and this represents approximately 20% of all deaths. This is in addition to almost 100% of inpatient deaths being scrutinised by the Medical Examiner prior to a Structured Judgement Review being requested.

The Trust's Mortality Surveillance Group has continued to meet every two months and our mortality data is reviewed at this meeting. A representative from our Partner organisation, Telstra Health U.K. (Dr Foster) is invited to attend to help us interpret and analyse our mortality data and identify any variations in specific disease groups. Where alerts are generated, these are discussed, and a further review of the patient's records may be undertaken.

During 2023/24, a Board requested mortality insight visit took place due to concerns about Salisbury NHS Foundation Trust being a statistical outlier for their reported mortality statistics. Formal feedback from this visit was received in February 2024, and this included some positive feedback and some areas for development and improvement. An action plan has been developed and delivery of these actions are being overseen by the Trust's mortality group. Early signs suggest that our mortality statistics (SHMI and Hospital Standardised Mortality Ratios (HSMR)) are starting to improve.

Other Learning from Deaths Developments

A new electronic system to manage mortality reviews and learning from deaths was launched in March 2024. The procurement of this closely mirrored that of clinical audit, as the same system is being used to manage both processes using two separate modules. One of the key benefits of the system is to enable real-time reporting and sharing of learning, and to increase visibility of this data. Eliminating paper reporting forms is reducing the administrative burden and is also ensuring that more resources are channelled into learning and the delivery of actions. Our policy and processes have been revised to reflect the improvements being made.

In 2023/24 we completed the development of our in-house mortality dashboard (using the Power-Bi platform). This is now providing the Trust with new data intelligence, and this data is being routinely reviewed at mortality meetings. This data has also been made accessible to all our staff.

Medical Examiner Update

Preparations for the community ME roll-out remain ongoing and we have continued to make progress in this area. Our medical examiners are now operating within most of our local GP surgeries. The community medical examiner roll-out is expected to become statutory by September 2024, and the date for this was recently revised by NHSE (previously April 2024).

Key Highlights:

- The Trust's Mortality Surveillance Group has continued to meet every two months for assurance purposes.
- A Board requested mortality insight visit took place during 2023/24 which provided positive feedback and some suggested areas for improvement. Actions related to this remain ongoing (further information outline further on in this report).
- A new electronic system for managing mortality reviews and learning from deaths was launched during 2023/24.
- A BSW Integrated Care Board-wide mortality group was established to help consider shared opportunities for improvement across our wider population.
- A mortality dashboard was launched (using the latest Power-Bi software) to provide new and improved data insights. The data is now regularly being reviewed at mortality meetings.
- A new Trust mortality lead was appointed during 2023/24 to help support the Trust with its learning from deaths.

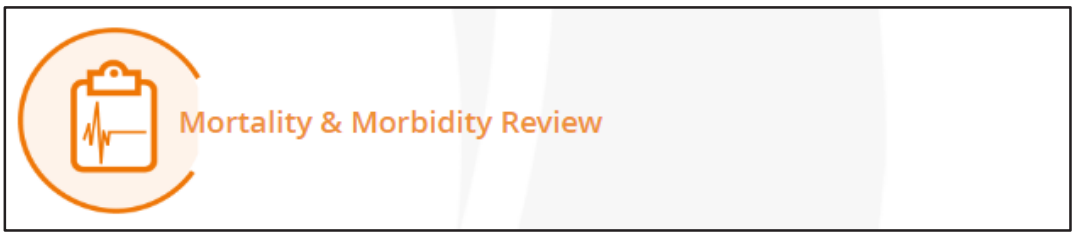
1.3. Summary of Specific Learning and Actions Taken in Q4

1.3.1. **Insight Visit from NHSE:** This has been reviewed under the following domains: Strategy, Systems & Process, Training, Data and Governance.

1.3.2. 28 action points identified. 8 items have been completed, 6 are in discussion including factoring family views, M&M & SJR policy review, and the inclusion of litigation metrics. The remainder (14) actions or work streams are in place. The review and oversight of these actions is taking place at the Trust's mortality surveillance group. As part of recommendations, there have also been modifications to this month's learning from deaths report with inclusion of a section on litigation, further details about complaints and a summary of national audit outcomes contained in the appendices of this report.

1.3.3. **MaMR (Mortality and Morbidity Review) rollout**: This is our new platform which was launched in March 2024 and is supporting our learning from deaths (module within AMaT). This is being utilised for recording the outcomes of ME reviews, triggered SJRs and incorporates the capacity to include all other mortality reviews using the online Trust checklist, which includes data-fields compatible with SJR output for overall assessment of care, quality of end-of-life care (EoLC), and the learning points and actions arising from them. Learning point categories are also compatible with the new patient safety incident response framework (PSIRF), allowing overall learning form adverse events and mortality to use the same parameters. Key elements are as follows:

- Log of reviews due and completed.
- Log of further reviews requested.
- Learning points and actions, all in a standardised interrogable format.
- Detailed customised reports for individual specialty M&M meetings.



1.3.4. At the time of writing, within MaMR 15 learning points have been identified: 10 categorised as positive and 5 as negative. As this becomes embedded in the Trust's learning culture it will allow the underlying picture to be understood and any repeated shortcomings to be rectified. The learning will continue to be regularly reviewed and discussed at the Trust's mortality surveillance group.

1.3.5. Since the launch of MaMR:

- *Total deaths:208*
- *Total reviewed (ME):198 (95%)*
- *Number of primary reviews requested by ME:23*
- *Primary reviews:22 (11%)*
- *Number of further reviews requested by specialities:4*
- *Number of secondary reviews requested by specialities:1*

Actions are being taken to increase the number of primary reviews being undertaken, and further effort is required to drive through the change in culture to make this both useful to and valued by clinical staff.

1.3.6. **AKI audit**: Prompted by an alert generated by Telstra U.K. (Dr Foster) in 2023/24, a review of 27 cases was undertaken, plus a more detailed review of the records of patients who deceased within 72 hrs of admission. The findings revealed good overall levels of care (average reviewer score of 4.0/5) and delivery of EoLC. An audit against national guideline adherence undertaken by our risk team was satisfactory overall but did identify the need to improve uptake of urinalysis testing (important in identifying kidney problems such as glomerulonephritis). It was also identified that the uptake of our acute kidney injury (AKI) proforma needs some improvement. Our matron for quality and safety is now helping to support with the delivery of these actions.

1.3.7. **Cancer of Colon**: The have been two separate Telstra U.K. alerts - 18 observed vs 10.5 expected (Nov 21 – Oct 22), and second alert in September 2023. Most of these deaths occurred in the hospice. A case-note review has been requested and the initial findings suggest that these are expected deaths due to recurrent disease or disease progression.

1.3.8. **Septicaemia alert**: This was a new alert triggered in 2024 and a case note review is being undertaken. Mortality linked to sepsis may be flagging a wider problem within the Trust for the recognition and prompt treatment of patients with suspected sepsis, and therefore a review of these cases will help to inform learning. Recognition of the deteriorating patient has been selected as one of the Trust's breakthrough objectives for next year as part of the Improving Together programme.

1.4. End of Life Care

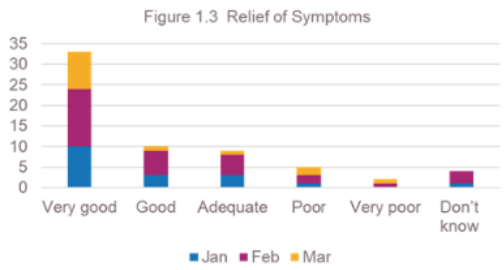
1.4.1. The Your Views Matter Bereavement survey was established in 2020 and was created to capture the views and experiences of bereaved relatives. This is an opportunity for families to feedback their experiences about the support they themselves received and the end of life care their loved one was given during their last days of life in Salisbury Hospital. Whilst the feedback is anonymous, relatives can name individuals they would like to acknowledge and thank for making a difference. Likewise, where the experience was less than satisfactory those completing the survey also have the option to enclose their contact details and be followed up by the PALS team.

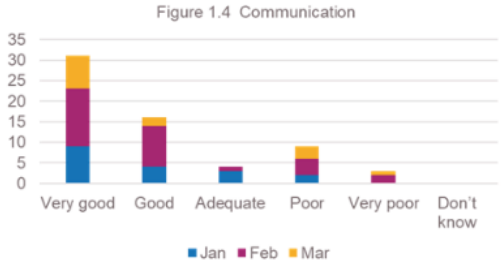
1.4.2. Your Views Matter Bereavement survey was posted to 167 families in Q4 with their consent, 64 (38%) responding. This is a significant increase on the response rate observed during both Q2 and Q3. An average annual response rate of 32% for 2023/24 was achieved, which is noted to be higher than the average response rate seen for 2022-2023 (28%) and much closer to the average response rates previously seen for 2021/22 (39%).

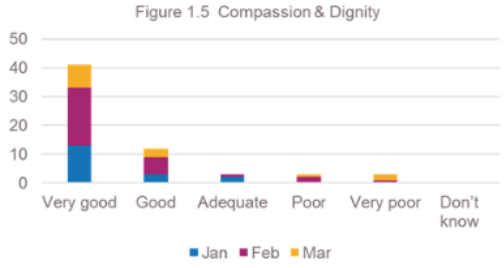
1.4.3. 77% of respondents rated the overall end of life care as good or very good, compared to 81% in the last financial quarter. Respectively, poor/very poor ratings increased to 13%.

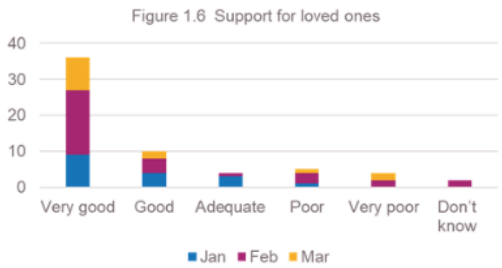
1.4.4. 9 survey participants requested a call-back from PALS, 3 of these was logged as a formal complaint. This was an increase in comparison to Q3 for the number of call-backs made by PALS and subsequent conversion to concern/complaint.

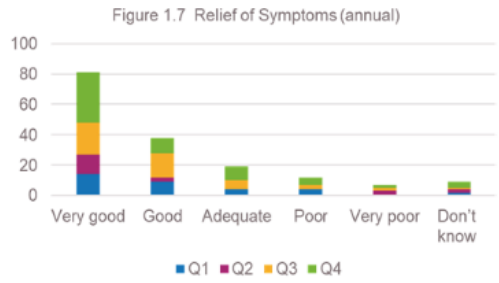
Figures 1.3 to 1.10 show the overall ratings in the key areas of patient experience.

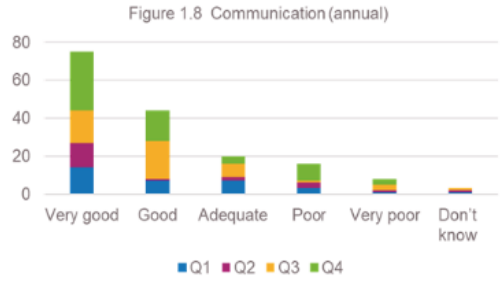


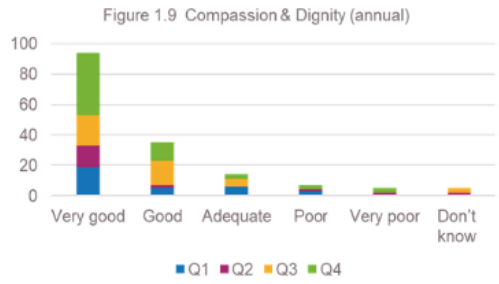


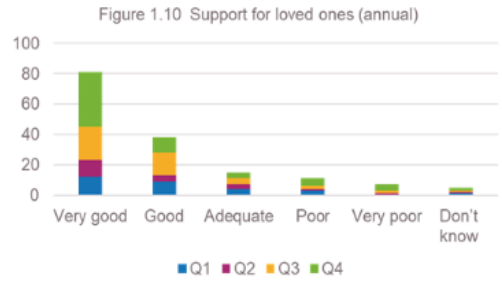












1.4.5. Overall, all four focus areas are rated as good or very good. Compassion and dignity continue to be areas of positive patient experience, as is support for loved ones.

1.4.6. Communication is the area with the highest proportion of poor/very poor ratings (see figure 1.8) when compared with the other three areas on annual collation of feedback. This is noted to be consistent with complaint themes (Trust wide).

The table below shows the overall satisfaction rating from the bereavement survey results

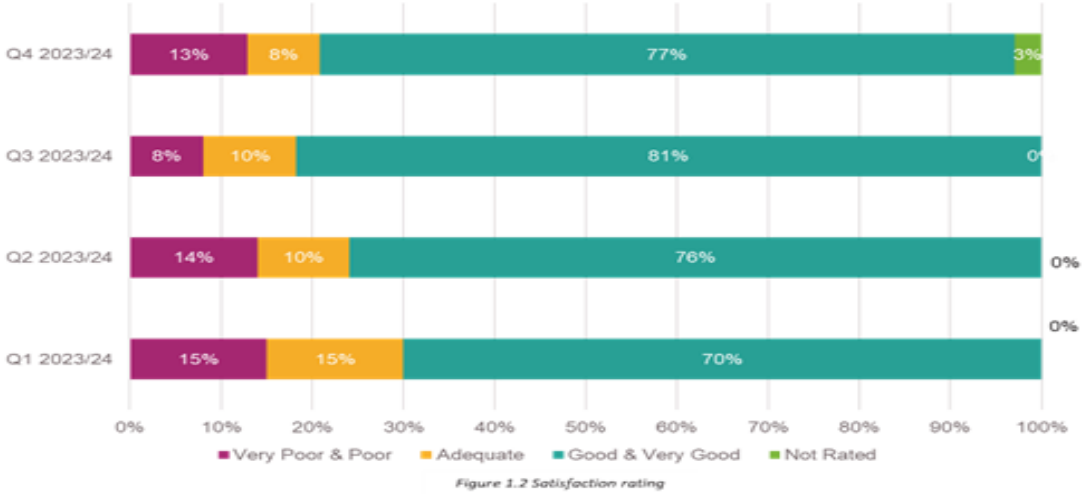


Figure 1.2 Satisfaction rating

EOL Care – Learning and Complaints?

1.4.7. In 2023/24 there were a total of 3 complaints related to end-of-life care. All three were themed as poor communication. One of these occurred in Q1 and two in Q3. 'Communication' has the highest proportion of poor/very poor ratings (see figure 1.8) when compared with the other three areas on annual collation of feedback.

1.4.8. The Trust continues to support the *Communications Course for Ward Staff* in responding to this feedback. This course has been developed within the Trust and continues to be evolved based on real-life experiences. The skills covered include (but not be limited to):

- Telephone communication with relatives
- Escalation of a sick patient
- Non-verbal communication
- De-escalation skills and use of empathy to aid communication
- Supporting tender conversations
- Breaking bad news
- Importance of positive feedback and self-care

1.4.9. This training is being delivered using professional actors, and attendees participate in scenarios based on real life experiences. In 2023/24 there were a total of 10 dates offered for this training and a total of 98 staff members have attended this. The course achieves an average of 60% fulfilment rate. There are 11 further training dates currently scheduled for 2024/25.

1.4.10. Of the 132 responses received to the question, 'was the room/ward in which your loved one spent their last days or hours appropriate?', 38% had responded with no/don't know.

The environment has been a notable theme, and the responses were linked to either unavailability of the hospice and limited availability of private side rooms on the ward. This in turn can lead to lack of privacy and dignity, higher noise levels, limitations with visiting (and lack of furniture to aid long-stay visiting), and an insensitive environment for both the patient and the family.

1.4.11. There is a long-term project currently being feasibility assessed to consider a new cancer unit in a bid to not just improve facilities but also to increase the availability of more private spaces. This is currently at the very early stages of review, and it is anticipated that there will be a need for dedicated fund raising in collaboration with our hospital charity should this be deemed viable.

1.4.12. In the short-term, a funding application through the *Stars Appeals* has been successful in purchasing 34 reclining chairs. This was a joint application from the End-of-Life Care team, Patient Experience Team, and Carers Leads to allow for short term improvements in response to this theme. The aim is to improve the comfort of those staying with a loved one at this crucial time. There will be an allocation of 2 recliner chairs per inpatient ward, with the first phase to commence with Amesbury, Durrington, Laverstock, and Pitton wards in May 2024.

1.5. Medical Examiners (MEs)

1.5.1. The ME system was introduced to ensure excellence in care for the bereaved and learning from deaths to drive improvement. The Medical Examiners aim to scrutinise all acute hospital deaths, and a local network of MEs exists to share learning and provide an independent review facility if needed.

1.5.2. 10 Structured Judgement Reviews were requested by the Medical Examiners in Q4 out of a total of 241 patients cases reviewed. Overall, 99.6% of all patients who died whilst under the care of SFT were subject to a Medical Examiner review during Q4.

1.5.3. A small number of reviews were requested under our mandated categories of patients with a learning disability/autism (no. =3) in Q4. As per recent changes (to improve scrutiny and learning from these case types), these cases will be subject to a mortality review (using the validated SJR method) and will also be reviewed by our learning disability/autism nurse for a specialist review of potential learning. This is in addition to the learning disability /autism cases that continue to be submitted to the national LeDer programme (NHS England » Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) .

1.5.4. The requests (identified through ME screening) continue to be categorised into problem themes and stage of care (see table below). Some requests can fall into multiple categories. Where requests do not fit into any of the categories below, this may be because the ME has requested a review for a specific group of patients, e.g., where a serious mental illness or learning disability has been identified but no obvious problems in care were identified during their initial screening. This process of tracking and reviewing the learning and actions will improve now that the online mortality platform has been successfully launched.

Examiner Requested Reviews, Month: Jan-March 2024 (Q4)

Type of problem	*Stage of Care* →								
	Admission and initial assessment (first 24 hours)	Ongoing care	Care during a procedure	Perioperative/procedure care	End of life care (or discharge care)	Concerns about over all care	2023/24 YTD	2022/23 YEAR TOTAL	2021/22 YEAR TOTAL
Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)	1				1		3	7	17
Problem with medication / IV fluids / electrolytes / oxygen							3	5	3
Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)		3					9	8	7
Problem with infection control							1	0	0
Problem related to operation/invasive procedure (other than infection control)							2	2	4
Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)						1	7	7	13
Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR))							0	0	0
Problem of any other type not fitting the categories above						5	33	26	24
2023/24 YTD	2	8	1	1	2	44			
2022/23 YEAR TOTAL	6	15	0	0	5	30			
2021/22 YEAR TOTAL	9	24	3	3	4	25			

1.6. Litigation

1.6.1. **New Enquiries from the Coroner during Q4:** During this reporting period, there were four new enquiries from the coroner concerning the deaths of patients known to SFT. Statements were requested in three of those cases, and the final case was a request for records only.

1.6.2. **Inquests concluded in Q4 from previous reporting periods:** Three inquests were concluded in this quarter. Statements were provided by SFT in all three cases. One case was dealt with as read only (no witness called) and witnesses from SFT were called in the other two. SFT was an interested party in two of the three cases.

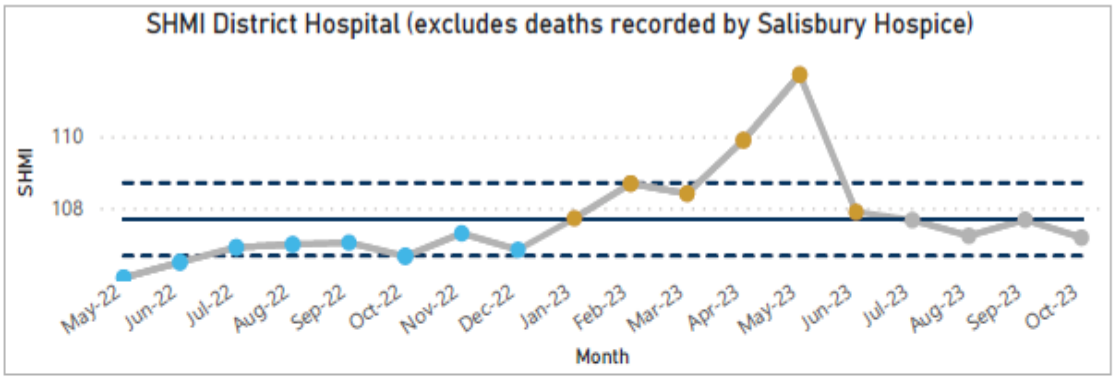
1.6.3. There were no jury cases, and no Prevention of Future Death reports were issued.

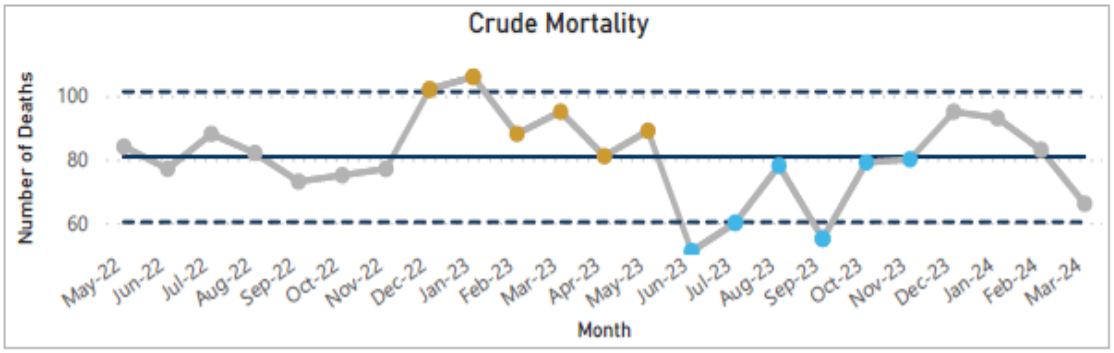
NHS Salisbury NHS Foundation Trust

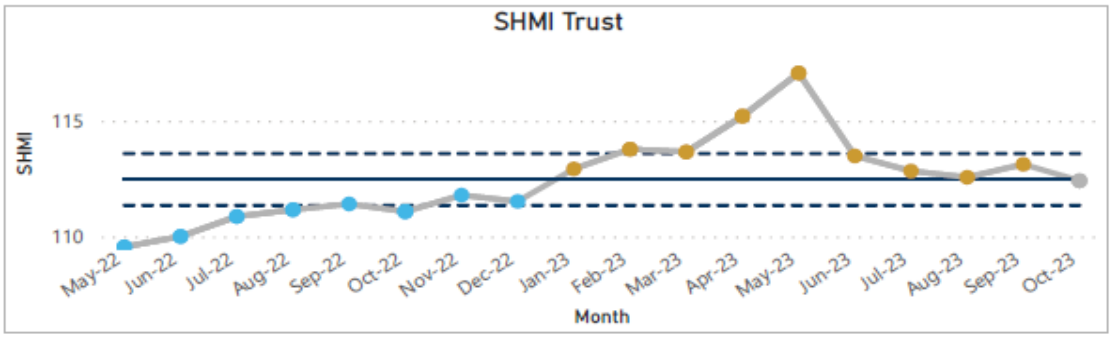
APPENDICES – Mortality Supplementary Data

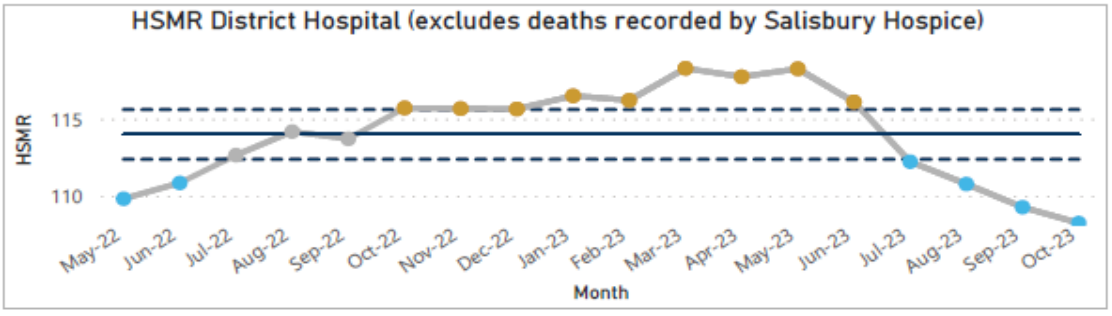
1. HSMR and SHMI Rolling 12-month Trends

1.1. A two-month time lag has been applied to the HSMR data to improve the accuracy of data for the 12-month period. This is due to a potential coding backlog for the two most recent months of discharge data. Therefore, the latest HSMR is for the 12-month rolling period ending in October 2023. Both the HSMR and SHMI have seen a positive decline lately.

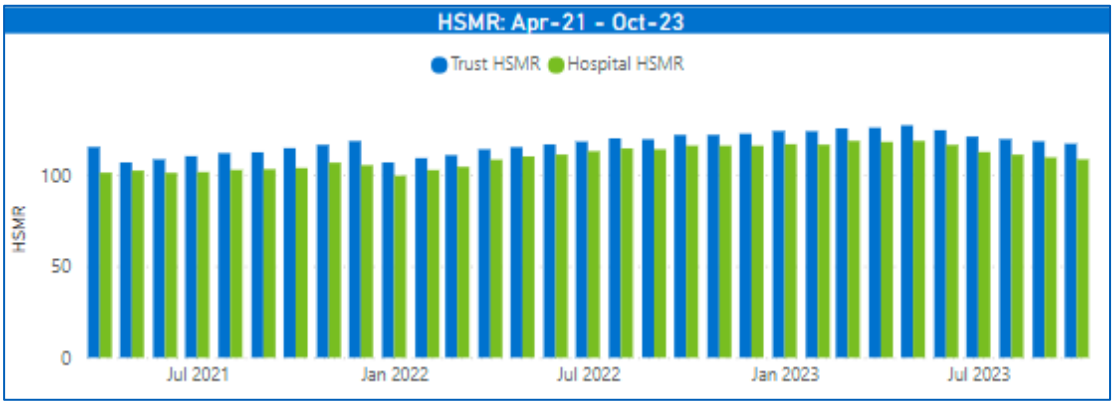


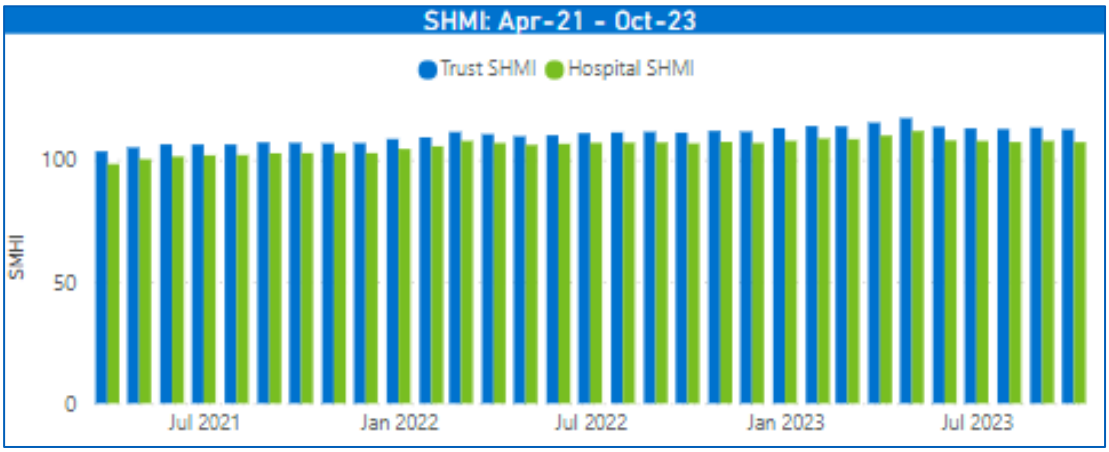






1.2. HSMR and SHMI reported as bar charts





NHS Salisbury NHS Foundation Trust

Latest SHMI data supplied by Telstra U.K. (Dr Foster) - 12 Month Period Ending in December 2023

SHMI - Summary Hospital Mortality Indicator

Period: Jan 23 - Dec 23

Provider: RNZ - SALISBURY NHS FOUNDATION TRUST

Region: SOUTH WEST

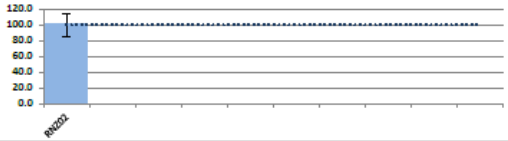
Click to enable bespoke peer

SHMI - Published (With Over Dispersion)

* click group name to filter; click header title to clear

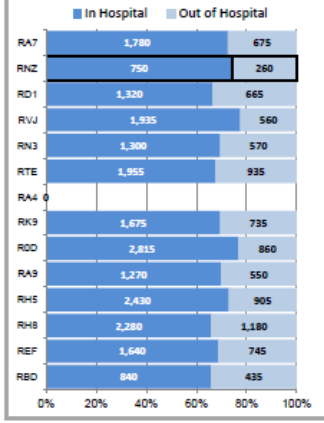
	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RBD	Dorset County Hospital NHS Foundation Trust	29,690	1,275	1,150	125	110.90	88.58	112.89
REF	Royal Cornwall Hospitals NHS Trust	64,180	2,385	2,290	95	104.17	89.20	112.10
RH8	Royal Devon University Healthcare NHS Foundation Trust	95,815	3,460	3,643	-185	95.04	89.45	111.79
RH5	Somerset NHS Foundation Trust	80,555	3,335	3,260	75	102.28	89.40	111.85
RA9	Torbay And South Devon NHS Foundation Trust	40,660	1,820	1,870	-50	97.27	89.06	112.29
R0D	University Hospitals Dorset NHS Foundation Trust	95,100	3,675	4,235	-560	86.82	89.51	111.72
RK9	University Hospitals Plymouth NHS Trust	75,025	2,410	2,240	170	107.65	89.19	112.12
RA4	Yeovil District Hospital NHS Foundation Trust	0	0	0	0	0.00	0.00	0.00
RTE	Gloucestershire Hospitals NHS Foundation Trust	98,680	2,895	2,530	365	114.37	89.27	112.02
RN3	Great Western Hospitals NHS Foundation Trust	60,555	1,870	1,820	50	102.70	89.04	112.31
RVJ	North Bristol NHS Trust	95,590	2,495	2,655	-160	94.02	89.30	111.99
RD1	Royal United Hospitals Bath NHS Foundation Trust	60,310	1,985	2,090	-105	94.83	89.14	112.18
RNZ	Salisbury NHS Foundation Trust	32,330	1,015	1,010	5	100.32	88.41	113.11
RA7	University Hospitals Bristol And Weston NHS Foundation Trust	103,650	2,455	2,665	-210	92.09	89.30	111.99
Group		932,140	31,075	31,460	-385	98.78		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
SALISBURY DISTRICT HOSPITAL	32,330	1,015	1,010	100.32	86.76	115.26

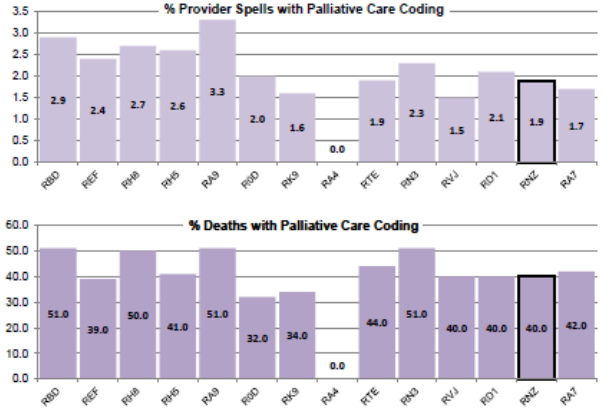


SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	65	50.00	134.21	74.01 135.12
Cancer of bronchus, lung	20	20.00	100.76	62.89 159.00
Secondary malignancies	15	25.00	52.29	67.04 149.18
Fluid and electrolyte disorders	15	15.00	98.44	56.07 178.33
Acute myocardial infarction	15	25.00	62.01	67.99 147.09
Pneumonia	135	140.00	95.35	82.59 121.08
Acute bronchitis	10	15.00	67.59	59.01 169.47
Gastrointestinal haemorrhage	15	15.00	94.06	59.02 169.42
Urinary tract infections	20	20.00	89.25	63.00 158.72
Fracture of neck of femur (hip)	25	25.00	90.17	68.39 146.22

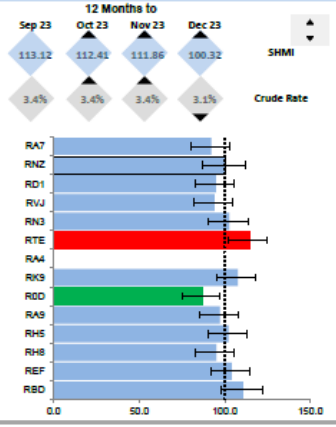
Deaths: In / Out Hospital



% Palliative Care Coding



Trend / Rate



SHMI Group - With 95% CI (Dr Foster)

SHMI Group	Obs	Exp	SHMI	Low / High
(113) Other connective tissue disease	20	10	200.00	122.11 308.90
(75) Chronic obstructive pulmonary disease and bronchiectasis	40	25	160.00	114.29 217.88
(42) Mental retardation, Senility and organic mental disorders	30	20	150.00	101.18 214.14
(66) Acute cerebrovascular disease	70	65	107.69	83.95 136.07
(92) Biliary tract disease	15	10	150.00	83.89 247.42
(65) Congestive heart failure, nonhypertensive	40	35	114.29	81.64 155.63
(77) Aspiration pneumonitis, food/vomitus	20	20	100.00	61.06 154.45
(124) Intracranial injury	15	15	100.00	55.93 164.93

* Dr Foster "SHMI Group" values based on published, rounded values with 95% CI's

HEALTH | dr foster

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Version: 1.2

Retention Date: 31/12/2039

Salisbury NHS Foundation Trust

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Salisbury NHS Foundation Trust

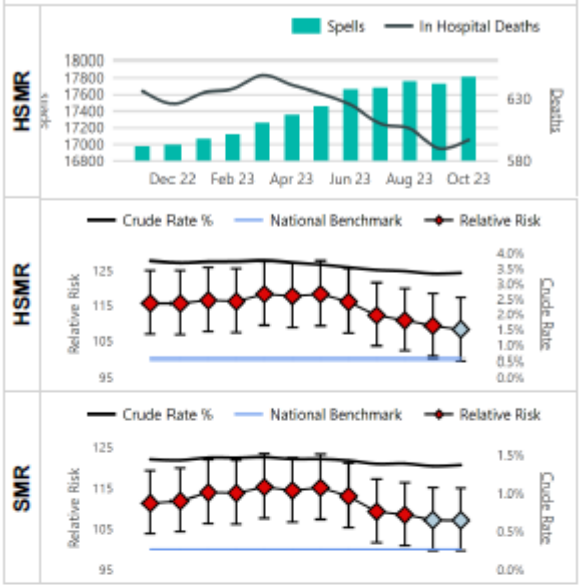
HSMR for the 12 Month Period Ending in October 2023 for Salisbury District Hospital [Excludes Hospice Data]

dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Oct-2023 as at 15/04/2024

SALISBURY NHS FOUNDATION TRUST - SALISBURY DISTRICT HOSPITAL (RNZ02)

Rolling 12 month trends



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	33	18.1	182.0	125.3	
Other psychoses	1	5	1.3	381.4	122.9	
Senility and organic mental disorders	2	22	11.6	190.2	119.2	
Septicaemia (except in labour)	1	52	34.2	152.0	113.5	
Other connective tissue disease	1	13	6.5	198.5	105.6	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	33	18.1	182.0	125.3	
Other psychoses	1	5	1.3	381.4	122.9	
Senility and organic mental disorders	2	22	11.6	190.2	119.2	
Septicaemia (except in labour)	1	52	34.2	152.0	113.5	
Other connective tissue disease	1	13	6.5	198.5	105.6	
Aspiration pneumonitis, food/vomitus	1	23	16.8	136.7	86.6	

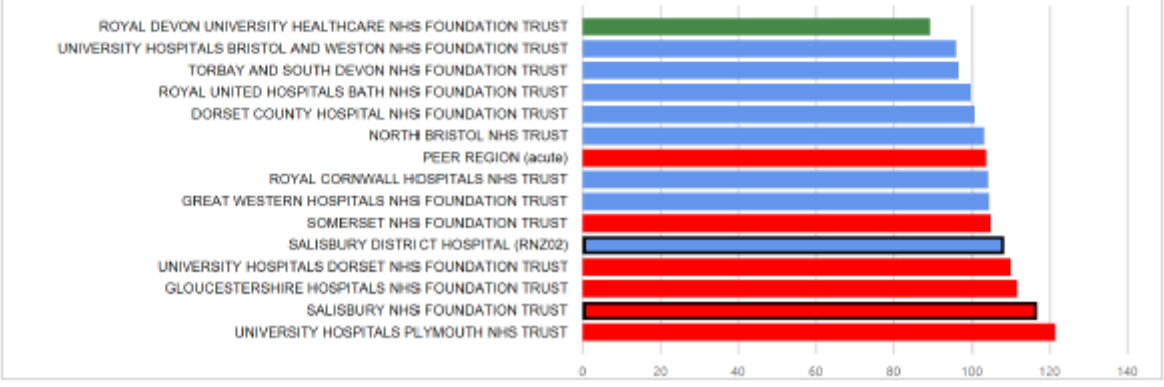
CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	1	33	18.1	182.0	125.3	
Senility and organic mental disorders	1	22	11.6	190.2	119.2	
Other connective tissue disease	1	13	6.5	198.5	105.6	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR	108.2	116.8	103.8	98.9
SMR	107.1	116.2	103.3	98.8
Non-elective (HSMR)	108.4	115.8	103.7	98.6
Weekday, emergency (HSMR)	103.0	110.7	101.7	97.2
Weekend, emergency (HSMR)	125.7	132.1	110.8	102.9
Saturday, emergency (HSMR)	126.4	128.5	111.4	102.4
Sunday, emergency (HSMR)	124.6	135.9	109.9	103.4
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)	41.9%	51.9%	42.7%	43.3%
% Non-elective spells with palliative care (HSMR)	4.2%	5.7%	4.8%	5.0%
% Spells in Symptoms & Signs chapter	7.5%	7.5%	6.7%	6.4%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	48.2%	47.5%	42.7%	41.3%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	12.2%	12.7%	15.2%	16.1%
% Non-elective spells in Risk Band (0-10%) (HSMR)	87.6%	86.2%	85.6%	84.8%

HSMR Peer Comparison



Salisbury NHS Foundation Trust

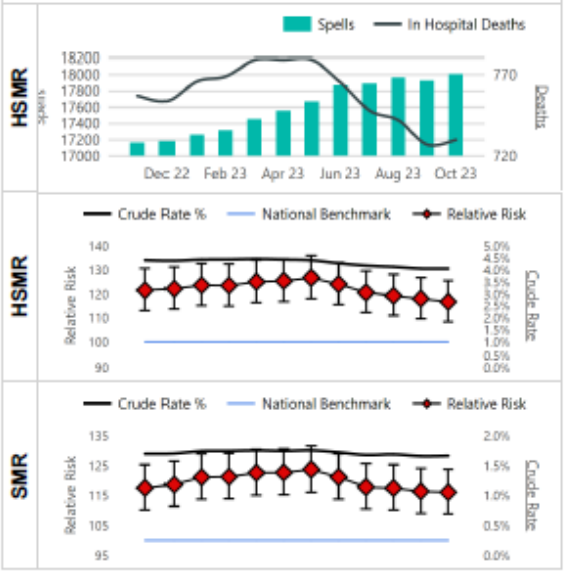
HSMR for the 12 Month Period Ending in October 2023 for SFT [Includes Hospice Data]

dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Oct-2023 as at 15/04/2024

SALISBURY NHS FOUNDATION TRUST - All Sites

Rolling 12 month trends



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	34	19.0	178.9	123.8	
Other psychoses	1	5	1.3	381.4	122.9	
Nonspecific chest pain	0	3	0.5	589.7	118.5	
Senility and organic mental disorders	2	22	11.7	188.7	118.2	
Other connective tissue disease	1	15	7.3	204.3	114.2	
Septicemia (except in labour)	1	53	35.0	151.6	113.5	
Secondary malignancies	1	25	15.2	164.6	106.5	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	34	19.0	178.9	123.8	
Senility and organic mental disorders	2	22	11.7	188.7	118.2	
Other connective tissue disease	1	15	7.3	204.3	114.2	
Septicemia (except in labour)	1	53	35.0	151.6	113.5	
Secondary malignancies	1	25	15.2	164.6	106.5	
Aspiration pneumonitis, food/vomitus	1	23	16.8	136.7	86.6	

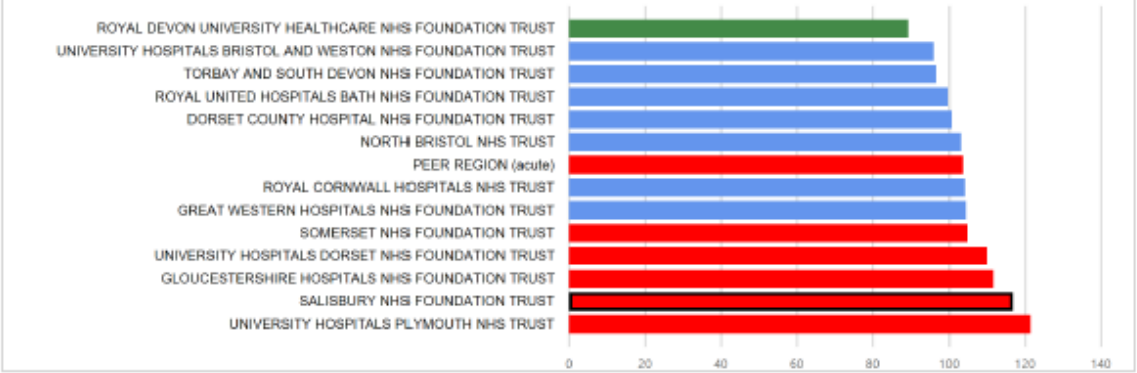
CUSUM 99.8% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	1	34	19.0	178.9	123.8	
Senility and organic mental disorders	1	22	11.7	188.7	118.2	
Other connective tissue disease	1	15	7.3	204.3	114.2	
Secondary malignancies	1	25	15.2	164.6	106.5	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR		116.8	103.8	98.9
SMR		116.2	103.3	98.8
Non-elective (HSMR)		115.8	103.7	98.6
Weekday, emergency (HSMR)		110.7	101.7	97.2
Weekend, emergency (HSMR)		132.1	110.8	102.9
Saturday, emergency (HSMR)		128.5	111.4	102.4
Sunday, emergency (HSMR)		135.9	109.9	103.4
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)		51.9%	42.7%	43.3%
% Non-elective spells with palliative care (HSMR)		5.7%	4.8%	5.0%
% Spells in Symptoms & Signs chapter		7.5%	6.7%	6.4%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)		47.5%	42.7%	41.3%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)		12.7%	15.2%	16.1%
% Non-elective spells in Risk Band (0-10%) (HSMR)		86.2%	85.6%	84.8%

HSMR Peer Comparison

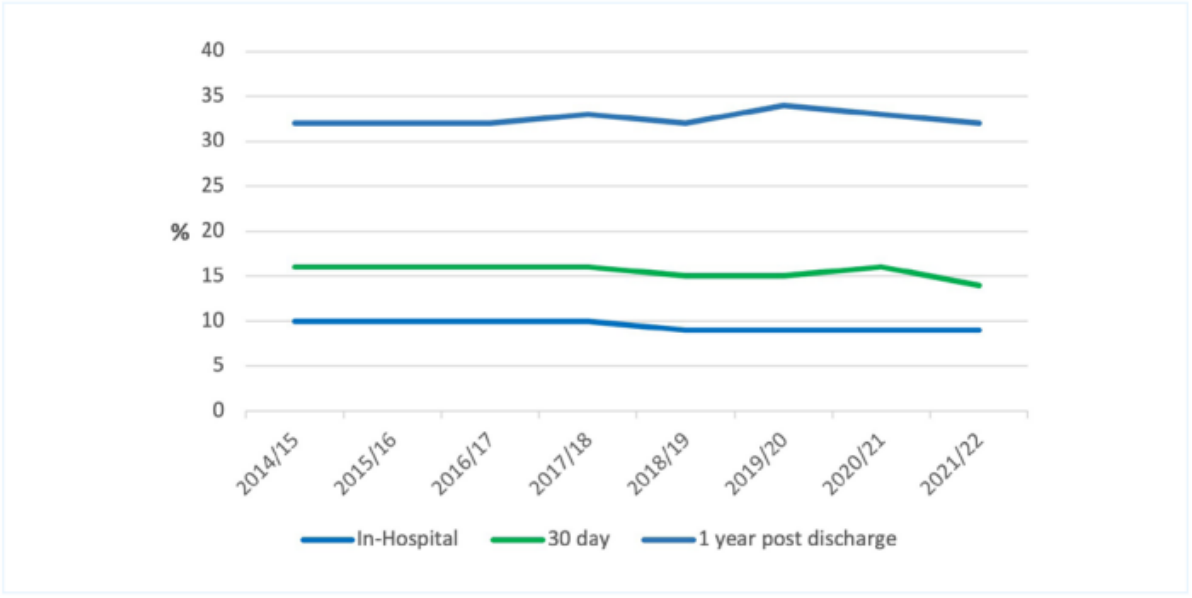


Annual Summary of National Audits / Other Indicators of Care

2.1. National Heart Failure Audit **(NHFA) 2022/2023 data**

- In-patient mortality increased from 9% in 2021/22 to 11% in 2022/23.
- 30-day mortality reduced from 14% to 13%.
- 1-year post discharge mortality has decreased to 30% from 32% in 2021/22.

Figure 2.6: Inpatient, 30-day and 1-year post admission mortality (%) of HF patients in England and Wales, 2014/15 - 2021/22 [NHFA data]



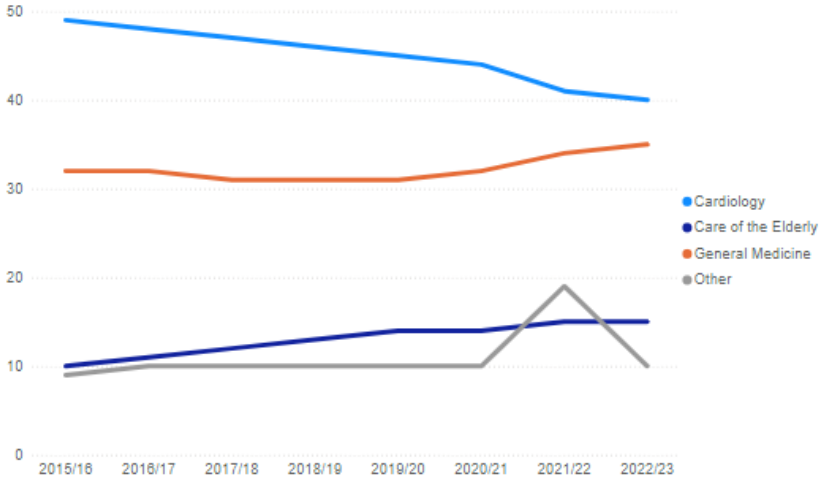
The proportion of patients being admitted to Cardiology wards is falling

The audit target is that 60% of all patients admitted with heart failure (HF) should have their care on a cardiology ward.

Instead of improving, this has been deteriorating gradually and in 2022/23 only 40% of HF patients were cared for on a cardiology ward.

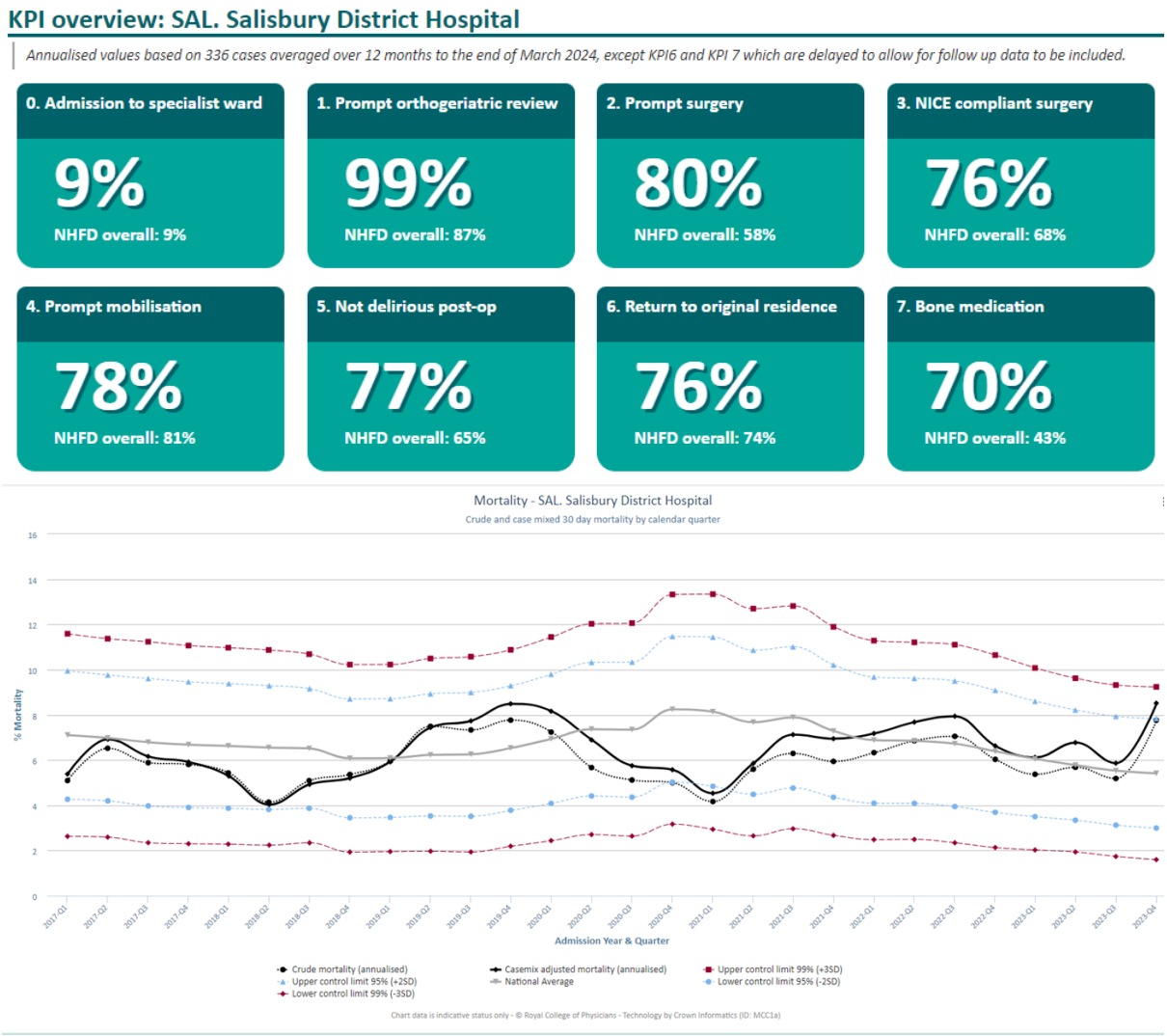
This is of concern since patients with HF are amongst the highest risk patients admitted to hospital and their care is demonstrably improved under cardiology care. Access to protected beds for these patients is essential.

Percentage of HF patients receiving care in different types of ward (2022/23)



2.2. **Falls & Fragility Audit Programme (FFFAP) National Hip Fracture Database 2022** (NHFD) - data April 2021 - March 2022

Data from 1Jan – 31 Dec 2022 showed that a number of people who died in the month following a hip fracture has reduced to 6.2% from 10.9% since 2007. However, the report also demonstrated that it took longer for patients to reach a ward where the best chance of recovery is. Also. fewer patients received prompt surgery to repair their broken hip by the day after they presented to hospital.



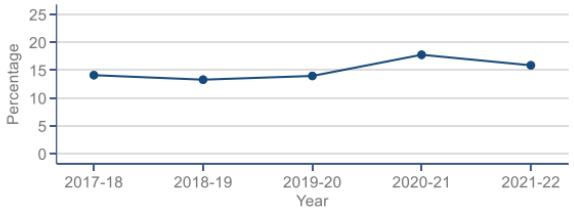
This clinically led, web-based audit of hip fracture care and secondary prevention qualifies each patient for best practice tariff of £1335 when criteria are met. Salisbury contributed 303 patients to this audit. SFT performed well in the main KPIs as they have been consistently over several years. Mortality is lower than the national average and SFT recently began joint clinical governance meetings with ortho-geriatrics, orthopaedics, and anaesthetics.

2.3. **ICNARC Case Mix Programme** – 2023 (data 2021-2022)

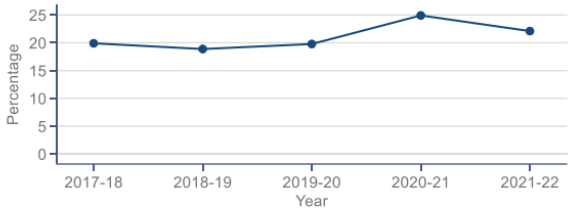
Key statistics from the Case Mix Programme: 1 April 2021 to 31 March 2022

Unadjusted outcomes – trends and survival

Critical care unit mortality*

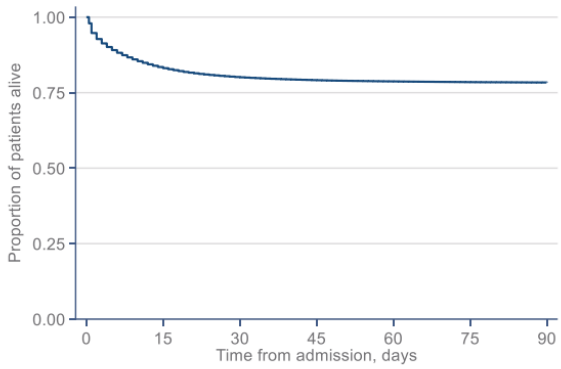


Acute hospital mortality*



*Excluding readmissions to the same critical care unit of the same patient within the same acute hospital stay

Survival (K-M plot)

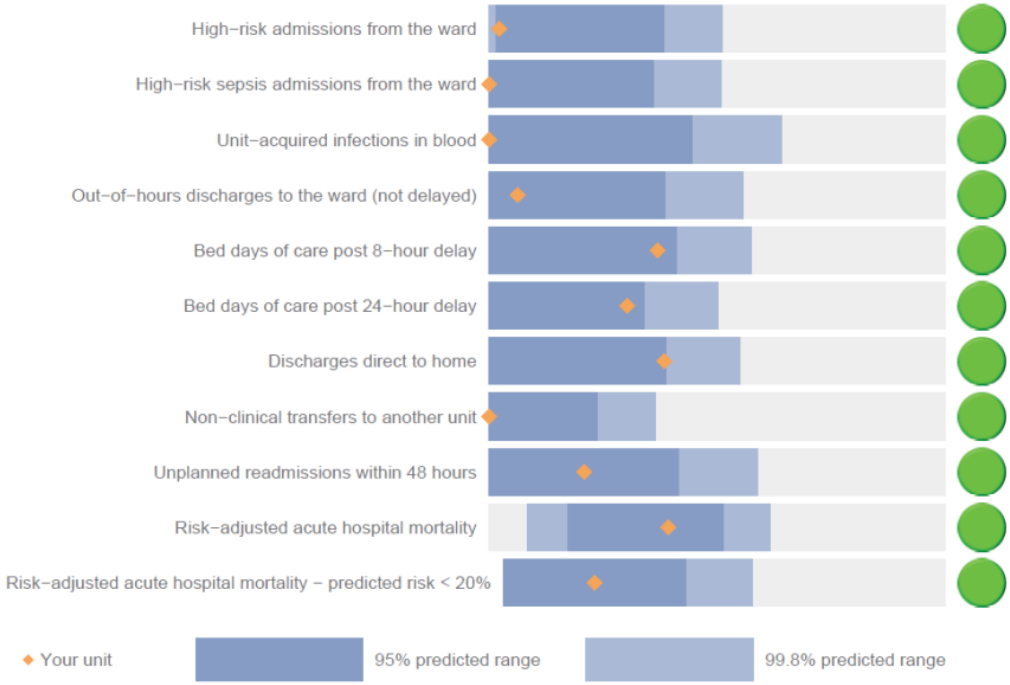


Explanation

- The Kaplan-Meier (K-M) plot shows the proportion of patients that remain alive by the number of days following admission to the critical care unit
- Patients discharged from acute hospital before 90 days are assumed to have survived to 90 days

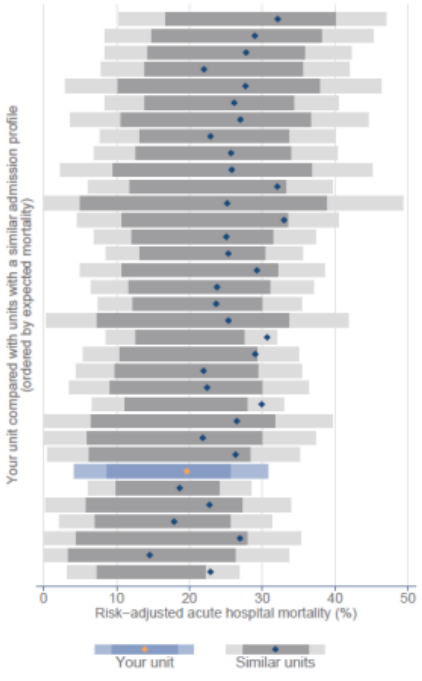
Salisbury District Hospital, Radnor Ward
Quarterly Quality Report: 1 April 2021 to 31 March 2022

Quality indicator dashboard

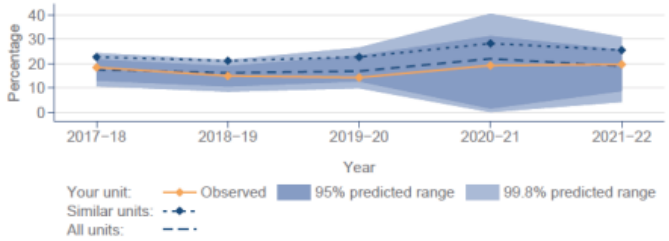


Salisbury District Hospital, Radnor Ward
Quarterly Quality Report: 1 April 2021 to 31 March 2022

Risk-adjusted acute hospital mortality



	N	Eligible	Observed percentage	Expected percentage	95% predicted range	99.8% predicted range
Quarter 1	121	109	19.3	16.0	(8.9, 22.7)	(5.7, 27.2)
Quarter 2	131	120	18.3	17.1	(4.9, 28.8)	(0.0, 36.5)
Quarter 3	121	111	18.0	16.3	(3.1, 29.0)	(0.0, 37.4)
Quarter 4	104	98	23.5	19.9	(10.6, 28.7)	(6.2, 34.5)
Full year	477	438	19.6	17.3	(8.7, 25.6)	(4.2, 30.8)



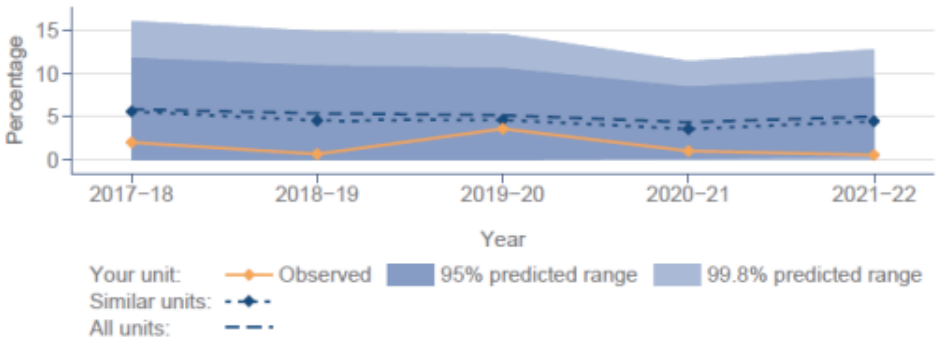
Definition

- Eligible: All critical care unit admissions, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
- Observed percentage: The percentage of eligible admissions that died before ultimate discharge from acute hospital
- Expected percentage: The expected percentage of acute hospital deaths among eligible admissions, calculated as the mean predicted risk of death from the ICNARC$_{H-2018}$ model for eligible admissions to your unit
- Predicted range: We expect a unit's observed percentage to lie within the 95% predicted range 19 times out of 20 and within the 99.8% predicted range 998 times out of 1000

Salisbury NHS Foundation Trust

High-risk admissions from the ward

	N	Eligible	Observed percentage	Expected percentage	95% predicted range	99.8% predicted range
Quarter 1	121	39	0.0	5.0	(0.0, 11.8)	(0.0, 17.5)
Quarter 2	131	54	1.9	4.8	(0.0, 10.4)	(0.0, 14.8)
Quarter 3	121	54	0.0	5.0	(0.0, 10.7)	(0.0, 15.4)
Quarter 4	104	34	0.0	6.2	(0.0, 14.1)	(0.0, 20.5)
Full year	477	181	0.6	5.0	(0.4, 9.6)	(0.0, 12.8)



SFT's local data in this audit are within the 95% predicted range for both risk-adjusted mortality and key quality indicators. The low mortality rate was attributed from relatively low admission from wards of patients from high-risk patients, which suggests that these acute cases were recognised, assessed, and managed timely before further deterioration. Also, there was no critical care-acquired infection and there was no non-clinical transfer despite large proportion at national level during winter COVID.

11.5% of our patients were discharged direct to home, however, 7.5% of beds were occupied due to delayed discharges (>8 hours), whilst 5% were due to prolonged discharges for >24 hours respectively. Current local actions are underway to improve discharge of patients who do not require critical care within 4 hours after being deemed wardable.

2021 winter COVID was included in this data.

2.4. **National Audit of Care at the End of Life** (2022/2023 report)

The National Audit of Care at the End of Life (NACEL) aims to promote quality improvement in patient outcomes, and, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality.

Key Findings at National level

Priority 1: *Recognizing the possibility of eminent death.* The possibility that the patient may die within the next few hours/days was recognised in 87% of cases audited; this was consistent with 2021.

Results from the Quality Survey show that 13% of families and those important to the dying patient strongly disagreed or disagreed with the statement 'staff communicated sensitively with the dying person' (11% in 2021).

Priority 2: *Communication with dying person.* There was little improvement in the recording of conversations with families and others in 2022 when compared to 2019, with continued high compliance on the recording of conversations about the possibility that the person might die and on the individualised plan of care. Improvement is required on documenting discussions about the risks and benefits of hydration and nutrition options with families and others. This was reported in around a half of cases.

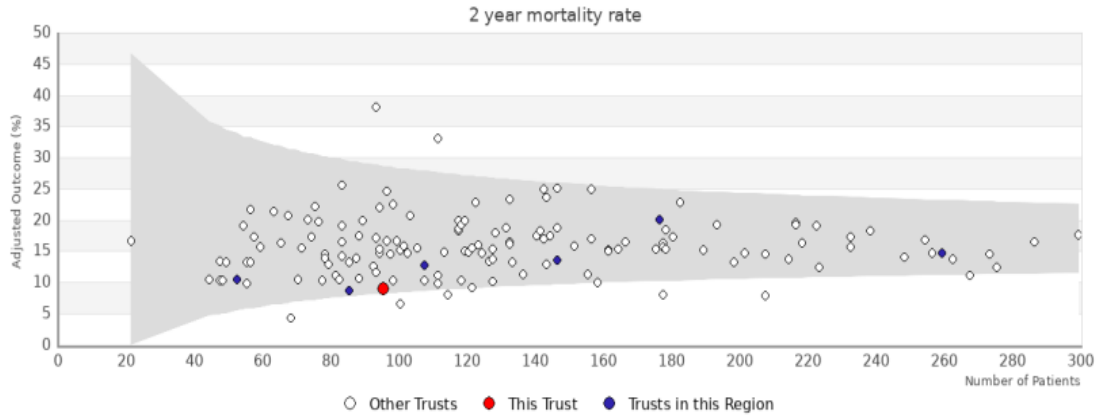
Priority 3: *Communication with families and others.* From the Quality Survey, 26% of respondents felt they would like to have been more involved in the person's care compared to 23% in 2021.

Priority 4: *Involvement in decision making.* A quarter of cases had a documented discussion about the extent to which the patient wished to be involved in their care and 62% had no discussion documented but a reason recorded. This suggests earlier action is required once uncertain recovery is identified to avoid missed opportunities to involve patients, and those important to them.

Priority 5. *Individualised plan of care.* Third round findings from the Case Note Review showed similar results for the existence of an individualised plan of care, 73% of cases compared to 71% in 2019, suggesting this is an ongoing area for improvement.

Overall, SFT remained above (2-6% higher) the national benchmark in five priorities for care and the NICE standards and guidelines on end-of-life care for adults.

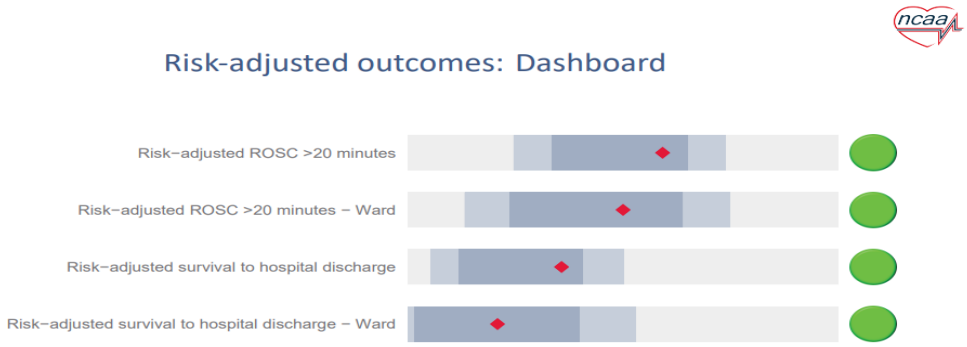
2.5. **National Bowel Cancer audit** (data April 2021 – 31 March 2022) Annual report 2023.



Trust	Number	Adjusted	Observed
Salisbury NHS Foundation Trust	95	9%	9.9%
Other trusts within the region: Somerset, Wiltshire, Avon & Gloucestershire			
Gloucestershire Hospitals NHS Foundation Trust	259	14.6%	11.9%
North Bristol NHS Trust	107	12.8%	11.9%
Royal United Hospitals Bath NHS Foundation Trust	146	13.6%	13.9%
Somerset NHS Foundation Trust	85	8.8%	8.6%
University Hospitals Bristol and Weston NHS Foundation Trust	176	20%	17.4%
Yeovil District Hospital NHS Foundation Trust	52	10.5%	10%

The funnel plots above show trust risk-adjusted outcomes only for 2-year mortality (2021-2022). Other outcomes are not outlier-reported because they are measured on patients diagnosed and/or treated during the COVID-19 pandemic. The funnel regions represent the 95 % limit and the 99% limit for trusts compared to the national average. SFT (in red) was within the 95% limit, and therefore not considered a potential outlier.

2.6. Cardiac Arrest Audit – Latest report 07 July 2022 [data: April 2021- March 2022]



Salisbury District Hospital
NCAA Report: 1 April 2021 to 31 March 2022
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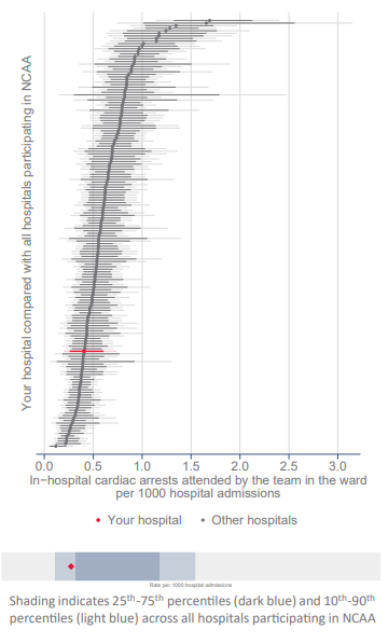
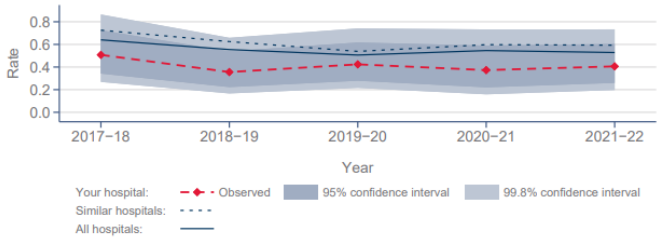
Date of report: 06/07/2022
©Resuscitation Council (UK) & ICNARC



	Hospital admissions	Eligible team visits	Rate per 1000 hospital admissions	95% confidence interval	99.8% confidence interval
Quarter 1	14568	8	0.55	(0.24, 1.08)	(0.14, 1.45)
Quarter 2	14953	3	0.20	(0.04, 0.59)	(0.01, 0.87)
Quarter 3	15057	7	0.46	(0.19, 0.96)	(0.10, 1.30)
Quarter 4	14538	6	0.41	(0.15, 0.90)	(0.08, 1.24)
Full year	59116	24	0.41	(0.26, 0.60)	(0.20, 0.73)



Definition

- Hospital admissions: Total includes elective, non-elective and day cases (excludes babies born in your hospital and neonates)
- Eligible team visits: All reported in-hospital cardiac arrests in a ward attended by the team
- Observed rate: The total number of cardiac arrests in a ward attended by the team divided by the total number of admissions to your hospital multiplied by 1000 to give a rate per 1000 hospital admissions
- Confidence interval: Reflects the degree of uncertainty surrounding your observed rate, given the total number of admissions to your hospital

Salisbury District Hospital
NCAA Report: 1 April 2021 to 31 March 2022
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Date of report: 06/07/2022
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The graph (above and left) represents the number of in-hospital cardiac arrest calls attended by the team per 1,000 admissions for all adult cases in acute secondary care. SFT (in red), is on the lower zone of chart, which suggests there was a relatively lower occurrence of in-patient cardiac arrest in 2021/22. The table to the right provides actual number of arrest calls per quarter. The graph below the table shows a marked reduction in cardiac arrest since 2017/18 and remained static since 2021/21.

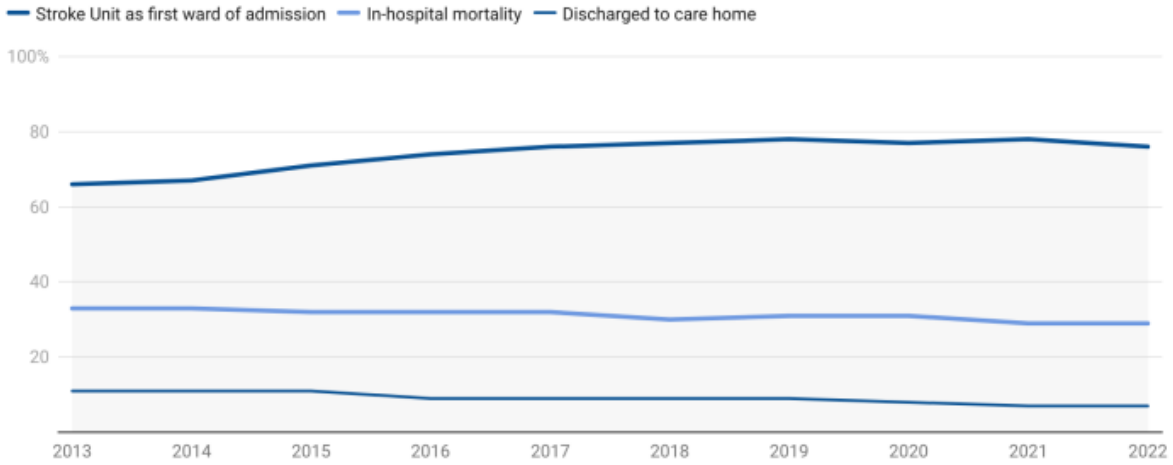
2.7. **Sentinel Stroke National Audit Programme** (SSNAP)

SSNAP collect information about care provided to stroke patients from the arrival time up until 6 months after having stroke. Performance indicators are assessed based on 10 aspects of care.

The latest report which covers October – December 2023, showed that SFT meets the highest standards (level A-D) for almost all patients. In particular, SFT has been doing well in brain scanning (48% of patients within 1 hours, 95% within 12 hours; median scan time less than 60 mins) , thrombolysis and MDT working (Speech and Language Therapy, Physiotherapy and Occupational therapy) amongst other trusts in the region.

Intracerebral haemorrhage

Outcomes for intracerebral haemorrhage patients (2013-2022)



The graph above shows that outcomes for patients with intracerebral haemorrhage (comprises 12% of all stroke admissions) have improved over the past 10 years. This includes a reduction in in-hospital mortality from 2013 to 2022 which occurs in parallel with an increase in the proportion of these patients directly admitted to a stroke unit from 66% in 2013 to 76% in 2022.

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NHS Foundation Trust

* * * * * * END OF REPORT* * * * * *

SHMI Old and New Models

	SHMI (original)	SHMI (new model – May 24)
Methodology derived by	NHS Digital	NHS England
Frequency	Monthly (from May '19), approx. 5 months time lag	Monthly (from May '19), approx. 5 months time lag
Coverage	In-hospital deaths plus deaths up to 30 days post discharge All diagnosis groups excluding still births Day cases and regular attenders are excluded	In-hospital deaths (HES) plus deaths up to 30 days post discharge (ONS) All diagnosis groups excluding still births COVID-19 spells included from September 21 only Day cases and regular attenders are excluded Hospice sites are excluded
Diagnosis	Smaller CCS groups are joined together and no subgroups are used. Primary diagnosis - is identified from episode 1 or 2 – if episode 1 is not a robust diagnosis code (i.e. not a residual or X Y Z code), episode 2 will be used if it is robust. If not, episode 1 will be used.	Smaller CCS groups are joined together and no subgroups are used. R69 – Invalid/null coding for diagnosis is within a stand alone SHMI group Primary diagnosis - is identified from any episode containing a robust diagnosis code (i.e. not a residual or X Y Z code) - COVID 19 identified in primary diagnosis position sits in a stand alone SHMI group
Assignment of deaths	Deaths that happen post-transfer count against the transfer hospital (acute non-specialist trusts only)	Deaths that happen post-transfer count against the transfer hospital (acute non-specialist trusts only)
Casemix adjustment	8 factors: diagnosis, age, sex, method of admission, Charlson comorbidity score, month of admission, year, birthweight (for individuals aged <1 year in perinatal diagnosis groups)	8 factors: diagnosis, age, sex, method of admission, Charlson comorbidity score (5 bands), month of admission, year, birthweight (for individuals aged <1 year in perinatal diagnosis groups)
Palliative care	Not adjusted for in the model	Not adjusted for in the model

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.8
Date of Meeting:	04 July 2024		

Report Title:	**Director Of Infection Prevention and Control, annual report**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	IPC Commitee			
Prepared by:	Fiona McCarthy Lead Nurse Infection Prevention Judy Dyos Chief Nursing Officer			
Executive Sponsor (presenting):	Judy Dyos, Chief Nursing Officer			
Appendices (list if applicable):	Appendix A Infection Prevention & Control – Annual Action Plan 2023/2024 Appendix B Bacteraemia's - all cases are reportable to UK Health Security Agency (UKHSA) Appendix C Tendable Infection Prevention & Control (IPC) Inspection Compliance scores for Quarters 1 & 2 of 2022/23			

Recommendation:
The Trust Board are asked to note the Trust's performance regarding Infection prevention in this annual report

Executive Summary:
The purpose of this annual DIPC Report is to summarise the work undertaken at Salisbury NHS Foundation Trust (SFT) and inform the Trust Board of the progress made against the 2023/24 Annual Action Plan, to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices. The action plan focuses on the Trust achieving the standards identified in *'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (revised July 2015),* to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible. For the reported period, the Trust has experienced the following cases • Five COVID-19 outbreaks affecting inpatient areas • One *Carbapenemase Producing Enterobacteriaceae* (CPE) outbreak in surgery • One *Clostridioides difficile (C.difficile)* outbreak in surgery • Significant amounts of work have been completed and remain ongoing for antibiotic stewardship, decontamination, cleaning services, water, and ventilation safety.

However, it is important to note that the following risks to delivery were identified:

- The trust was identified as a high outlier for mandatory surgical site infection surveillance (SSIS) for the category of repair of neck of femur (NOF) surgery and completion of deep dive work by the division. Since then, significant work has been undertaken which includes theatre cleaning review, patient decontamination review and new filters in theatres. Additionally, NHSE were invited to the trust to undertake a critical friend review. No cases have been reported in Q4 since the work.
- Continued challenges to achieving hand hygiene assessment compliance despite new process being undertaken.

Additionally, the clinical teams have managed cases of Pertussis (Whooping Cough), Hepatitis A, Norovirus, Tuberculosis, Methicillin Sensitive Staphylococcus aureus(MSSA) and Methicillin Resistant Staphylococcus aureus (MRSA), E Coli and Klebsiella . None of which were deemed an outbreak or were related cases.(i.e.. not cross infected in hospital)

Anti-microbial stewardship has returned to twice weekly reviews and a new dashboard has been developed to assist with this important work.

Water safety continue to be a challenge due to the poor infrastructure of many areas of the hospital and aged pipework however good processes are in place for testing and treatment .

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

DIRECTOR OF INFECTION PREVENTION AND CONTROL

ANNUAL REPORT

April 2023 – March 2024

JUDY DYOS
Director of Infection Prevention and Control (DIPC)

May 2024 (Final draft v.1)

CONTENTS

APPENDICES

1. INTRODUCTION

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is delegated to the Director of Infection Prevention & Control (DIPC) who is the Chief Nursing Officer.

The DIPC Reports together with the monthly Integrated Performance Reports (IPR) are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of this annual DIPC Report is to summarise the work undertaken at Salisbury NHS Foundation Trust (SFT) and inform the Trust Board of the progress made against the 2023/24 Annual Action Plan (Appendix A), to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The action plan focuses on the Trust achieving the standards identified in *'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (revised December 2022),* to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible.

For the reported period, the Trust has experienced a difficult twelve months for infection prevention and control, which has involved:

- Five COVID-19 outbreaks affecting inpatient areas
- One *Carbapenemase Producing Enterobacteriaceae* (CPE) outbreak in surgery
- One *Clostridioides difficile (C.difficile)* outbreak in surgery
- Significant amounts of work have been completed and remain ongoing for antibiotic stewardship, decontamination, cleaning services, water, and ventilation safety.

However, it is important to note that the following risks to delivery were identified:

- The trust was identified as a high outlier for mandatory surgical site infection surveillance (SSIS) for the category of repair of neck of femur (NOF) surgery and completion of deep dive work by the division. Since then, significant work has been undertaken which includes theatre cleaning review, patient decontamination review and new filters in theatres. Additionally, NHSE were invited to the trust to undertake a critical friend review. No cases have been reported in Q4 since the work.
- Continued challenges to achieving hand hygiene assessment compliance despite new process being undertaken.

2. GOVERNANCE ARRANGEMENTS

The work towards achieving the objectives of the Annual Action Plan 2023/24 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) and onto the Clinical Governance Committee (CGC), which completes the governance arrangements.

3. INFECTION PREVENTION & CONTROL ARRANGEMENTS

A comprehensive infection prevention and control service is provided Trust wide. The Infection Prevention and Control (IPC) team provides a liaison and telephone consultation service for all inpatient and outpatient services, with additional arrangements for seven-day service cover by an Infection Control Nurse (ICN) during declared Norovirus outbreaks and other clinical activity exceptions.

The IPC team currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 3.0 whole time equivalent (w.t.e) ICNs and secretary (0.6 w.t.e). In addition, there are 3 Consultant Microbiologists, one of whom is the Deputy ICD and one of whom is the Trust Antimicrobial Stewardship Lead. (*Of note: For 5 months of the reported period, there continued to be a 1.0 w.t.e vacancy for a Band 6 ICN. A secondment position was accepted by an internal nursing staff member in February 2023, which ended at the beginning*

of May due to unforeseen circumstances. Following an extensive recruitment exercise, a Band 6 ICN commenced within a substantive role from October 30th).

4. ASSURANCE ACTIVITIES

The IPCC monitors the action plan on behalf of the Trust Board, which is achieved through the following actions:

- Agree an annual infection control programme and monitor its implementation
- Oversee the implementation of infection control policies and procedures
- Monitor and review the incidence of HCAI
- Develop and review information regarding infection prevention and control
- Monitor the activities of the Infection Prevention and Control Team
- Benchmark the Trust's delivery of control of infection standards in various accreditation systems, and against Care Quality Commission (CQC) Regulations
- Monitor the implementation of infection prevention and control education
- Receive regular updates from the Antibiotic Reference Group (ARG)
- Receive regular updates from the IPCWG
- Monitor compliance and formal reporting on *Legionellosis* and *Pseudomonas* water management, via the Water Safety Group (WSG)
- Receive regular reports from the Decontamination Working Group (DWG)
- Receive regular reports from the Ventilation Safety Group (VSG)
- Receive regular reports from the Facilities Division regarding cleaning programmes.

5. HEALTHCARE ASSOCIATED INFECTION (HCAI) STATISTICS AND SURVEILLANCE

The Trust is required to report any HCAI outbreaks externally as a serious incident (SI). An outbreak is defined as the occurrence of two or more related cases of the same infection over a defined period. When a HCAI outbreak is declared, the Trust initially reports the outbreak to the relevant Integrated Care System (ICS) and other regulatory bodies, e.g., NHS England (NHSE), within 2 working days.

The Trust is also required to record these incidents on the strategic executive information system (STEIS) in line with the *Serious Incident Framework: Supporting learning to prevent recurrence (NHSE, March 2015)*, and the *Public Health England (PHE) HCAI: Operational Guidance & Standards for Health Protection Units (HPUs) (July 2012),* PHE now UK Health Security Agency (UKHSA) from 1st October 2021.

In January 2024, the Trust implemented the *Patient Safety Incident Response Framework (PSIRF) (NHSE, 2022),* which replaces the *Serious Incident Framework (2015)* and makes no distinction between 'patient safety incidents' and Serious Incidents'.

During 2023/24, the Trust has had **no** declared internal outbreaks of:

- Viral gastroenteritis (Norovirus)
- *Staphylococcus aureus*, including Methicillin Resistant *Staphylococcus aureus* (MRSA)
- Methicillin Sensitive *Staphylococcus aureus* (MSSA)
- Invasive Group A Streptococcus (iGAS)
- Multi-drug resistant Acinetobacter baumannii (MDRAB)
- Chickenpox (Varicella zoster)
- Extended Spectrum Beta Lactamase (ESBL) producers, including *Klebsiella Pneumoniae*
- Pertussis
- Respiratory Syncytial Virus (RSV)
- Influenza ('flu)
- Vancomycin Resistant Enterococcus (VRE)
- Tuberculosis (TB).

Additional information regarding alert organisms can be accessed from the UKHSA website:
UK Health Security Agency - GOV.UK (www.gov.uk)

The ICNs provide clinical teams with infection control advice, support, and education on a daily basis to all inpatient and outpatient areas. The management of patients admitted with suspected and known alert organisms is discussed, and risk assessments undertaken. The Isolation Risk Assessment Tool (IRAT), Flowchart for the Management of Inpatients with Diarrhoea, and Diarrhoea Pathway have been developed and implemented to assist staff competency and confidence in the management of cases.

The availability of sideroom facilities across the Trust site to isolate infected patients can be limited at times when demands on bed capacity are high. In such instances, risk-based decisions are necessary. Patients with alert organisms can be safely managed either within cohort bays, or isolation nursed in a bedspace. The ICNs continue to review patients nursed in siderooms to prioritise high risk patients. Information and guidance are communicated to and discussed with, the ward nursing and medical teams, including the Clinical Site Coordinators (as necessary). Additional written documentation is provided to support staff in the ongoing management of these patients.

5.1 SARS-CoV (COVID-19)
During 2023/24, the Trust continued to experience COVID-19 activity, and the ICNs worked closely with the divisions and Clinical Site Team around COVID-19 management. All newly identified COVID-19 positive cases for inpatients were discussed at the Virtual Board Round (VBR) meetings. This group is chaired by the Deputy DIPC, with core attendance including Consultant Microbiologists, ICNs, and divisional representatives. All cases are reviewed to ensure the correct management and classification of positive cases; the management of any identified patient contacts; and consideration of any potential links between positive cases. Staffing continues to be an agenda item at the VBR meetings, with attendees reporting any identified trends or concerns around respiratory illnesses (including COVID-19) related staff sickness for discussion. Any matter deemed to require escalation from the VBR group is taken by the chair to the existing IPC groups and Operational Working Group (OWG) accordingly.

Following the publication of updated national guidance, key practice changes implemented during quarter 1 of 2023/24 included policy revisions for COVID-19 testing for patients and staff. The Trust also stepped back from the requirement for staff and visitors to wear surgical face masks (FRSM) across most areas of the hospital. Criteria was set out for when the wearing of surgical face masks was still required, with the continued focus on protecting those identified as most vulnerable/high-risk, and also allowing staff a personal preference to continue to wear a surgical face mask if they wish to do so.

5.2 COVID-19 outbreak prevention and management
During quarter 1 of 2023/24, it was necessary for the Trust to implement the planned outbreak response process, with the declaration of five COVID-19 outbreaks for inpatient areas within the medical division, and at the South Newton Hospital site (SFT beds). **Table 1** *below provides a breakdown of information:*

Ward/ Department	Hospital onset definite healthcare associated (15 or more days after admission)	Total number of positive patients (linked to outbreak)	Total number of staff members positive (linked to outbreak)	Date outbreak declared by the Trust	Date outbreak closed by the Trust at OMG *(date NHSE portal updated)*
Durrington Ward	5	20	0	05.04.23	01.06.23 *(07.06.23)*
Nadder Ward *(South Newton)*	7	7	0	14.04.23	18.05.23 *(19.05.23)*
Breamore Ward	8	9	0	28.04.23	12.06.23 *(15.06.23)*
Redlynch Ward	4	16	0	28.04.23	12.06.23 *(15.06.23)*
Whiteparish Ward	4	7	0	03.05.23	12.06.23 *(15.06.23)*

(Table 1)

For these outbreaks, the Outbreak Management Group (OMG) was formed with review meetings held throughout. The meetings were well attended by all required individuals and departments within the Trust and by representatives from UKHSA and Bath and North East Somerset (BaNES), Swindon and Wiltshire (BSW) Integrated Care Board (ICB). The OMG ensured that appropriate arrangements were in place to care for the affected patients and staff, instigating and monitoring the effectiveness of the control measures implemented in containing the spread of infection.

Spire Ward continued to be utilised as a COVID-19 positive cohort area, with positive cohort bays also created at different times on Breamore, Redlynch and Whiteparish Wards. The impact on service delivery was constantly reviewed, to aid the release of available beds in the positive cohort bays to enable patient flow and increase capacity. Key staff were involved and communication to all relevant groups, including patients, relatives, carers, and staff completed as appropriate. The production and distribution of meeting notes and actions was facilitated by the ICNs.

The outbreaks were reported externally to the NHS Outbreak System on the Insights Platform for NHSE within the expected reporting timeframes (within 24 hours of declaration). Updates were reported on the same system when additional cases were identified and/or following an outbreak management review meeting. A further notification was made on the same system at the ending of an outbreak, defined as when there had been no confirmed cases with onset dates in the 28 days since the last positive result.

For the declared COVID-19 outbreaks, application of the national COVID-19 case definitions to these 59 patient cases classifies 28 as hospital onset; definite healthcare associated. The Trust recognises that where any infections are classified as hospital onset healthcare associated then there is clearly scope for learning, and that this is the same for COVID-19 infections.

During this outbreak period, the ICNs have worked additional hours to provide extra support and oversight of the outbreak areas. This has also been necessary to complete the required outbreak management administration tasks for external reporting on the NHSE outbreak portal. *(Of note: the external outbreak reporting portal closed at the end of quarter 4 of 2023/24).*

No new COVID-19 outbreaks were declared for the Trust during quarters 2, 3 or 4 of 2023/24 across inpatient areas. However, six clusters of cases were identified for Downton, Durrington, Laverstock, Redlynch, Pitton and Longford Wards. These were reviewed by the VBR group with appropriate Post Infection Reviews (PIR) requested for completion by the divisions. During September 2023, COVID-19 positive cohort bays were created at different times on Laverstock, Durrington, Redlynch and Longford Wards. This led to the initiation of the established escalation plan by the medical division instigated with two cohort bays created on Spire Ward.

5.3 Respiratory Illnesses including Influenza

During 2023/24, there have been cases of Influenza A and B and Respiratory Syncytial Virus (RSV) identified for both adults and children admitted to the Trust. The patients were nursed under isolation precautions, with no onward transmission or links identified.

The IPCWG have reviewed the Seasonal Illness Plan to ensure that this reflects the updated management agreed for the various aspects covered by the document. Following final approval by the IPCC, the Seasonal Illness Plan was cascaded and made available centrally for all staff to access.

The numbers of respiratory illnesses experienced in the Trust continued at a low level throughout quarter 2. From mid-September onwards, numbers of COVID-19 cases reported in the hospital started to increase. This reflected a similar pattern reported by the other acute providers across the BaNES and BSW region. There were no outbreaks of respiratory illnesses declared for the Trust during quarter 4, and as the quarter progressed, respiratory illness cases were on an overall downwards trajectory.

5.4 Carbapenemase Producing Enterobacteriaceae (CPE) outbreak

During quarter 2 of 2023/24, there has been one outbreak of CPE declared by the Trust for the surgical division, involving Odstock Ward and Main Theatres. Initially a period of increased incidence (PII) was declared on 27th July when two patients were identified to have the same organism (*Klebsiella pneumoniae* New-Delhi mellato beta-lactamase (NDM-1) Carbapenemase gene detected). An outbreak was declared on 4th August following the outcome of typing received.
The Trust outbreak management policy was followed with the inclusion of the UKHSA representatives and BSW IPC Lead who provided additional support and guidance. This included considerations for the Trust to explore to ensure adherence to best practice for the management a CPE. The outbreak was declared over on 5th September with ongoing monitoring of actions via the IPCWG. Throughout the outbreak period, the ICNs and ICD provided continued management advice and support to the surgical division, including for personal protective equipment (PPE) and with environmental cleaning.

During January 2024, an IPC Clinical Advisor for NHSE Southwest completed a review of practices in Main Theatres at the request of the DIPC. The scope of the review focused on IPC practices, cleaning and decontamination processes within the environment, leadership, training and education provision. Terms of reference (ToR) were developed and agreed for the visit by the DIPC, Divisional Head of Nursing (DHoN) for Surgery and the Lead IPC Nurse. A report was produced and from review of these findings, an action plan will be generated and presented by the division at the CGC during quarter 1 of 2024/25.

5.5 *Clostridioides difficile (C.difficile)* outbreak
During December 2023, an outbreak of *C.difficile* was declared retrospectively for the previously reported period of increased incidence (PII) for Britford Ward, Surgical Assessment Unit (SAU) and Downton Ward following enhanced fingerprinting testing results. Following review by the IPCWG, no additional actions were required to be implemented *(see section 6.4.1).*

5.6 Norovirus (viral gastroenteritis)
During 2023/24, the Trust has experienced a continued level of activity associated with patients experiencing diarrhoea and/or vomiting. This included patients admitted with symptoms of diarrhoea and/or vomiting and isolated in a sideroom from admission, and patients who were nursed in a bay environment and developed symptoms during their admission period. It was necessary to close bays at different times during quarter 2, with closures across the medical and surgical divisions.

During January 2024, one medical ward (Laverstock Ward) was closed with symptoms of diarrhoea and/or vomiting reported for patients, staff members and visitors. Separate review meetings were held with the DIPC and Deputy DIPC, divisional and ward team representatives to review and progress resolution. This aided discussions for overall management decisions and monitoring and consideration of service provision.

5.7 *Hepatitis A*
During quarter 4 of 2023/24, the IPC team were notified of 2 unrelated cases of acute *Hepatitis A*, for patients admitted to Sarum Ward (paediatrics) and Pitton Ward (adult medicine). Following the initial investigation into the paediatric case, the DIPC instigated a meeting to review the required actions by the Trust and ensure their implementation, with the advice and support of the UKHSA. Learning was identified for the Sarum Ward team with improving IPC practices and ensuring completion of the ward team cleaning task lists.

5.8 Candida auris
During December 2023, an inpatient on Odstock Ward was confirmed to have *Candida auris* identified from a tissue sample. During their admission, the patient had been moved from a bay into a sideroom facility for isolation precautions for another alert organism. The timeline of the patient's journey in the hospital was reviewed by the ICD and ICNs, and working with the surgical division actions were implemented. This included enhanced PPE requirements, the isolation and screening of any identified contact patients, and additional environmental cleaning of specific rooms/areas. A total of 2 patients were isolated and screened for *Candida auris*, and from the screens completed, the organism was not found.

The ICD received confirmation from another Trust that the patient with *Candida auris* was already known to have both *Candida auris* and CPE positive results earlier in the year (from testing completed at that hospital).

It was not clear however, what information was provided when the patient was originally referred to SFT, and therefore the ICD instructed that this was to be investigated by the Plastics Team.

During quarter 3, the ICNs were also notified of other patients needing isolation and screening for *Candida auris*. One patient had been transferred to SFT as a known contact of a *Candida auris* positive case at another hospital. Another patient was transferred to SFT from a different hospital and identified by the ICD to require *Candida auris* screening. These were unrelated patients, and from the screening completed, *Candida auris* was not found.

5.9 *Staphylococcus aureus*
During the quarter, the ICNs have supported the surgical division with their investigation of five *Staphylococcus aureus* infections reported for patients having undergone orthopaedic surgery. The *Staphylococcus aureus* isolates available were sent for typing at the External Reference Laboratory, and the results show they are all different strains. Following several meetings, actions have been identified and the formation of a working group convened during quarter 4 of 2023/24 to address these factors and establish strategies to mitigate those factors within the control of the Trust.

5.10 Pulmonary Tuberculosis (TB)
When informed of a patient with a suspected diagnosis of Pulmonary TB, management advice for isolation precautions and the wearing of PPE has been provided by the ICNs. During quarter 3 of 2023/24, two patients with a known/recent diagnosis of Pulmonary TB were admitted as inpatients at different times, additional support was provided to the relevant teams (these were unrelated cases). This included instructions provided by the ICD to the Respiratory Team, with follow up undertaken by the ICNs and input from the Trust Fit Testing Team.

During quarter 4 of 2023/24, a patient was identified to have potentially Multidrug Resistant TB, the ICD provided management advice internally, and also notified the required external agencies of the result. The patient had previously attended the Emergency Department (ED), and separately as an outpatient when the sample was taken (not admitted). Follow up with the relevant teams was undertaken by the ICNs.

5.11 Measles
In response to national UKHSA alerts and NHSE guidance released during quarter 4 of 2023/24, the Trust formed a Measles Preparedness Group with the membership of key personnel. Response action cards were developed to ensure the appropriate measures implemented for a suspected or confirmed case attending SFT. Internal messaging continues to raise awareness for staff. There have been no inpatient cases identified.

5.12 *Bordetella Pertussis* (Whooping Cough)
During quarter 4 of 2023/24, UKHSA released guidance on the management of pertussis following a re-emergence of cases in England.

During March 2024, the Lead Nurse for IPC was contacted by the Regional Health Protection Unit (HPU) team regarding a staff member with suspected pertussis listed as working at the Trust. This information was communicated to the ICD and Occupational Health (OH) Department for further clarification and follow up. The DIPC instigated review meetings with the appropriate key personnel to ensure that the required actions were completed.

6. MANDATORY SURVEILLANCE
Alert organism and alert condition surveillance data is collected and used by the Trust to detect outbreaks and monitor trends. It is a mandatory requirement for NHS Acute Trusts to report Methicillin Resistant *Staphylococcus aureus* (MRSA) and Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias, and *Clostridioides difficile* infections to the Department of Health (DH) via the HCAI Data Capture Site (DCS) system, hosted by UKHSA (*Mandatory enhanced MRSA, MSSA and Gram negative bacteraemia, and Clostridioides difficile infection surveillance Protocol (version 4.4) updated December 2021).*

(Of note: No final comparative MRSA, MSSA, E.coli, Klebsiella spp. and Pseudomonas spp. BSI incidence by Acute Trust data for 2023/24 has been available to access, but this information will be included within the next update report).

6.1 Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias
During 2023/24, there has been one community onset; healthcare associated MRSA bacteraemia case reported by the Trust. The Trust's MRSA hospital onset case target for 2023/24 is zero.

A Post Infection Review (PIR) meeting was held to discuss the case and support the completion of the required documentation. An action plan was developed by the medical division to capture the identified learning with improving compliance with established policies for MRSA screening and treatment, and the recognition of signs of wound infection and appropriate escalation when needed. These actions are ongoing and will be monitored by the IPCWG.

6.2 Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias
During 2023/24, there have been 12 unrelated healthcare associated MSSA bacteraemia cases, of which 2 cases were community onset and 10 cases were hospital onset. For the hospital onset cases, the sources of infection were identified as:

- Endocarditis (2 cases), with associated clinical infection unknown
- Endocarditis (2 cases), with no associated clinical infection
- Surgical site infection (1 case), with associated clinical infection of leg ulcers
- PVC related (1 case), with no associated clinical infection
- Psoas abscess (1 case), with associated clinical infection unknown
- Unknown/unclear source (3 cases); one of these patients had an associated clinical infection of lower respiratory tract.

Post infection reviews were requested to be completed by the ward teams. For those reviews completed, key learning identified the requirement for continued monitoring of all invasive devices by staff, adherence to the relevant Trust policies relating to the taking of blood cultures and skin disinfection/decontamination and maintaining the required care documentation.

(Of note: Currently, there is no national guidance for data definition of MSSA bacteraemia cases for reduction targets to be set. UKHSA are collating data which may function as a baseline for trajectory setting in the future. Therefore, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the MSSA bacteraemia cases recorded within the Trust. This allows the cases to be classified as either hospital onset or community onset).

6.3 Gram-negative organism bloodstream infections (GNBSIs)
The increase in gram negative organism bacteraemia infections is a national concern and mandatory surveillance of *Escherichia coli (E.coli), Klebsiella species (spp.)* and *Pseudomonas aeruginosa* bacteraemias continues. This reporting at the Trust now requires enhanced investigation and data entry onto the UKHSA DCS website. This work is undertaken by the ICNs.

A national action plan 'Tackling antimicrobial resistance 2019 – 2024' (January 2019) advises that work should continue to reduce healthcare associated GNBSIs, adopting a systematic approach to preventing infections and delivering a 25% reduction by 2021/22 with a full 50% reduction by 2023/24.

6.3.1 *Escherichia coli (E.coli)*
Following the identification of a positive blood culture result for *E.coli,* a Consultant Microbiologist completes a UKHSA mandatory enhanced surveillance form. In consultation with the relevant clinician, key patient factors are considered in order to establish if the case is likely to be healthcare related. However, it may not be possible to determine.

During 2023/24, there have been 42 unrelated healthcare associated *E.coli* bacteraemia cases, of which 21 cases were community onset, and 21 cases were hospital onset. Of the 21 hospital onset cases identified, an unknown or no underlying focus of infection was identified for six cases, and the remaining 15 cases had a source of infection identified. Of these unrelated 15 cases, the sources of infection were:

- Lower urinary tract (11 cases)
- Hepatobiliary (2 cases)
- Gastrointestinal or intraabdominal collection (1 case)
- Bone and joint (with prosthetic material, 1 case).

The Trust will continue to work closely with local community and hospital partners to reduce the incidence of *E.coli* bloodstream infections (BSIs) for the whole health economy, with the initial focus on reducing those infections related to urinary tract infection (UTI). In addition, as usual activity levels resume, the ICNs will continue to work collaboratively with the relevant ICBs who are leading on achieving this Quality Premium guidance.

The Trust's *E.coli* case threshold for 2023/24 is no more than 33 healthcare associated cases (*as detailed in the Official NHS Standard Contract 2023/24 document (version 1) updated 26th May 2023 https://www.england.nhs.uk/publication/minimising-clostridioides-difficile-and-gram-negative-bloodstream-infections/).*

6.3.2 *Klebsiella spp.* and *Pseudomonas aeruginosa*

During 2023/24, there have been 14 unrelated healthcare associated *Klebsiella spp.* bacteraemia cases, of which 6 cases were community onset and 8 cases were hospital onset. There have been 8 unrelated healthcare associated *Pseudomonas aeruginosa* bacteraemia cases, of which one case was community onset and 7 cases were hospital onset.

The Trust's *Klebsiella spp.* case threshold for 2023/24 is no more than 10 healthcare associated cases and for *Pseudomonas aeruginosa,* no more than 10 healthcare associated cases (*as detailed in the Official NHS Standard Contract 2023/24 document (version 1) updated 26th May 2023).*

Further information relating to official statistics and benchmarking of performance can be found at:
Statistics at UKHSA - UK Health Security Agency - GOV.UK (www.gov.uk)

6.4 *Clostridioides difficile (C.difficile) Infection*

The control of this infection is managed by the combination of adherence to the correct infection control practices, environmental cleaning, equipment decontamination and prudent antibiotic stewardship.

The Trust continues to apply Department of Health (DH) guidance for *C.difficile* testing and all *C.difficile* positive stool samples that test toxin positive are reportable to UKHSA. For 2019/20, changes were made to the *C.difficile* reporting algorithm. This included the addition of a prior healthcare exposure element for community onset cases and reducing the number of days to apportion hospital onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.

For 2023/24, the *C.difficile* case threshold objective set for the Trust by NHSE is no more than 22 healthcare associated reportable cases. Guidance for testing and reporting *C.difficile* cases remained unchanged, and the safety and care of patients remains our concern and priority.

During 2023/24, the Trust has reported 23 healthcare associated *C.difficile* cases to UKHSA, of which 7 cases were community onset and 16 cases were hospital onset. Incident investigations are conducted for all hospital onset cases using a 'SWARM' approach. This process is facilitated by the ICNs with the relevant clinical leader and divisional Matron to assess whether there were any lapses in quality care provided to the patient and whether this contributed to the case. In addition, the ICNs review the community onset cases to establish whether any lapses in care occurred during their previous hospital admission (in the preceding 4 weeks).

From the completed incident investigations for the hospital onset cases, lapses in care were identified. Key learning has included improvements required for the use of the Diarrhoea Pathway, instigation of isolation nursing and closure of bays, timeliness of sampling symptomatic patients, and timeliness of clinical reviews for these patients. (*Of note: From an ICB perspective, the appeals process is not in place anymore and the fines associated are no longer in existence and third-party arbitration not in place. Apportion categories are being reviewed nationally and may change or disappear next year 2024/25).*
In addition, the ICNs have completed extra investigations for the *C.difficile* cases identified within the community setting, where these patients have previously had a recent inpatient episode of care at the Trust. This has resulted in the implementation of enhanced environmental cleaning of identified clinical areas.

6.4.1 Periods of increased incidence (PII) of *C.difficile*

During quarters 1 and 2 of 2023/24, there were no PIIs of *C.difficile* declared within the Trust. During quarters 3 and 4 of 2023/24, a total of 5 unrelated PIIs of *C.difficile* were declared for the Trust across the medical and surgical divisions (detailed in **Table 2** below).

Date PII declared	Area *(number of positive cases in brackets)*	Ribotyping results	Final outcome
18.10.23	Pembroke Ward (2 cases)	1 case = 012 1 case = 020	Remained a PII – not linked cases.
09.11.23	Spire Ward (3 cases)	1 case = 029 2 cases = 014	• Enhanced fingerprinting testing completed for the 2 cases identified as 014; outcome = not identical cases • Remained a PII – not linked cases.
13.11.23	Britford Ward, SAU & Downton Ward, (3 cases)	1 case = 003 2 cases = 002	• Enhanced fingerprinting testing completed for the 2 cases identified as 002; outcome = identical cases • Reviewed by the IPCWG on 12.12.23 when this PII was declared retrospectively as an outbreak of *C.difficile.*
30.11.23	Pitton Ward (2 cases)	1 case = 081 1 case = 002	Remained a PII – not linked cases.
02.02.24	Redlynch Ward (3 cases)	1 case = 014 1 case = C.difficile not able to be grown from sample sent to Reference Laboratory 1 case = insufficient amount of sample remaining, unable to send to Reference Laboratory for ribotyping.	Remained a PII.

(Table 2)

In response to each of the declarations, measures were instigated, and included increased monitoring and practice checks; completion of an antibiotic stewardship audit; ribotyping of identified positive stool samples (completed at the External Reference Laboratory); and additional daily enhanced cleaning of the areas by Housekeeping. A DATIX report was generated for each PII to ensure escalation to the Patient Safety Summit Group (PSSG). Each PII of *C.difficile* was monitored by the IPCWG, with the divisions required to feedback and provide updates to this group.

Please see Appendix B for the Infection Prevention & Control 'Dashboard' for 2023/24 for further detail of HCAI data.

6.5 BSW Collaboratives

During 2023/24, representatives from the Trust have attended a newly formed BSW ICS HCAI and Infection Prevention Management (IPM) collaborative. These partnership meetings are held quarterly and enable a system wide approach to monitor and improve IPC for the populations of BSW. The meetings provide an opportunity for thematic reviews of HCAI data and shared learning from communicable disease incidents, with outcomes fedback to the IPCWG.

6.6 NHS Standard Contract 2023/24

Table 3 below summarises the threshold levels for the Trust's count of healthcare associated (i.e., hospital onset healthcare associated (HOHA) and community onset healthcare associated (COHA)) cases for 2023/24 (*as detailed in the Official NHS Standard Contract 2023/24 document; Minimising Clostridioides difficile and Gram-negative bloodstream infections (version 1) updated 23rd May 2023).*

Organisation code	Name	Case thresholds for 2023/24			
		C.difficile	*E.coli*	*P.aeruginosa*	*Klebsiella spp.*
RNZ	Salisbury NHS Foundation Trust	22 ↓	33 ↓	10 ↓	10 ↓

(Table 3)

6.7 Surgical Site Infection Surveillance (SSIS)

The ICNs and IPC team secretary coordinate data collections for the national SSIS programme of various surgical procedures, which are applicable to the Trust. For the mandatory surveillance of SSI following orthopaedic surgery, Trusts must participate in a minimum of one surveillance period in at least one category of orthopaedic procedures during a financial year. The Trust complies with this annual requirement to undertake SSIS. Active data collection for the category of repair of neck of femur (NOF) surgery has continued during 2023/24.

(Of note: additional reporting information was included within the previous six-monthly update report for quarters 3 and 4 of 2022/23 where final cohort numbers were confirmed).

- Final data collection for quarter 1 of 2023/24 was reconciled within the required timeframe. A total of 61 cases entered onto the national database, with no SSIs identified.
- Final data collection for quarter 2 of 2023/24 was reconciled within the required timeframe. A total of 51 cases entered onto the national database, with one organ/space (joint or bursa) SSI.
- Final data collection for quarter 3 of 2023/24 was reconciled within the required timeframe. A total of 49 cases entered onto the national database, with no SSIs identified.
- Data collection continued in quarter 4 of 2023/24, with final records to be entered onto the national database and submitted for reconciliation by the end of quarter 1 of 2024/25.

The IPCC have acknowledged that SFT trigger as a high outlier for repair of NOF surgery SSI risk with the expectation that UKHSA will provide formal notification to the organisation (as per protocol). Actions have already been identified within the orthopaedic team including additional auditing of practices. This follows on from the review of the *NICE Guidance (NG) 125 (for surgical site infections: prevention and treatment)* facilitated by the surgical divisional Matron with progress updates provided at the IPCWG. This audit work will be repeated by the division. The DIPC commissioned the surgical division to undertake a review of all the SSI case investigations for 2022/23 and produced a report for presentation at the IPCC.

(Of note: It has been noted that on reconciliation of data, the number of patients included within the reporting periods, have reduced from those first identified. This is a result of the clinical code allocated to the operation, being different from those being included within this category of surveillance, as set out by UKHSA).

Formal reports outlining progress with SSIS have been presented at the IPCC meetings and disseminated to relevant Trust personnel.

6.8 MRSA screening

The Trust has continued to report MRSA screening rates for all elective and emergency admissions to ensure continued improvement in reducing infections. These screening compliance rates are monitored by the Divisional Management Teams (DMTs) and reported as a quality performance indicator. The IPC team secretary undertakes a monthly emergency admission MRSA screening audit, and a quarterly elective admission MRSA screening audit.

Feedback is provided to DMTs about compliance rates and any identified missed screens for follow up actions. For 2023/24, the Trust compliance rates for MRSA emergency screening ranged from 88.16% - 93.23%. For MRSA elective screening, the Trust compliance rates ranged from 58.33% – 73.58%. However, it must be acknowledged that the number of elective patients within the elective screening cohorts remains exceptionally small.

Outcomes of any follow up of actions undertaken by the clinical divisions are included within their current reporting processes and to include any shared learning. The current Trust screening policy exceeds the requirements outlined within the Department of Health guidance published in 2015 and continues following further review by the Trust.

6.9 Infection in Critical Care Quality Improvement Programme (ICCQIP)
From April 2017, the Trust has participated in the surveillance of bloodstream infections in patients attending the Intensive Care Unit (ICU) and Neonatal Unit (NNU). There had been a delay in the ICU data being uploaded onto the national database within the required timeframes. This work was completed by the end of quarter 2 of 2023/24 following reactivation of database accounts for one of the ICU Matrons. From the data submitted so far, report updates have been provided by UKHSA and cascaded to the area leads.

6.10 Private Healthcare Information Network (PHIN)
The Trust continues to complete mandatory reporting externally regarding private patients via PHIN. In relation to infection prevention and control, this involves the IPC team secretary undertaking monthly cross checking of a dedicated SharePoint database of private patients. If it is identified that a patient has a HCAI that is externally reportable (as per national mandatory reporting definitions), then this is added to the SharePoint database for the relevant patient, for submission to PHIN by the Trust. From the data provided to the ICNs for review, there have been no externally reportable infection alert organisms identified for this patient group during 2023/24.

7. HAND HYGIENE

Fifty-six areas (including wards and departments) across the four clinical divisions carry out a monthly audit of hand hygiene compliance in their area against the World Health Organisation's (WHO) '5 moments for Hand Hygiene'.

The Trust target for hand hygiene compliance rates is >85%, with formal reporting by the divisions of measures implemented to improve non-compliance. When compliance is poor, the ICNs support individual clinical areas and staff groups promoting patient safety and hand decontamination. The audit results continue to be disseminated according to staff groups for each area. This action has provided evidence to strengthen the feedback process for the divisions to take the necessary action.

During 2023/24, audits have been completed by the external auditor (Healthcare Support Manager from GOJO Industries) for a total of 16 clinical areas (22 audits completed). Non-compliance of staff with IPC practices were observed, with feedback provided either at the time of the audit to the relevant nurse in charge or through cascade of audit findings via email. The clinical divisions have been undertaking some peer cross auditing within their areas and specialities to further validate audit processes.
Detailed analysis was undertaken to identify the key areas of non-compliance, which were predominantly staff missing moment number 1, handwashing before patient contact and moment number 5, handwashing after contact with patient surroundings and following removal of gloves. The results were reported via the DIPC, and the IPCC and feedback was provided to the clinical leaders and DMTs to address the shortfall in practice. Additional education and support have been provided by the ICNs to staff groups focusing on these audit findings.

For the internal hand hygiene audits completed, the overall average compliance rate for 2023/24 ranges from 69.29% - 100%. It should be noted that completion of these audits has been variable across all divisions, which the divisions have reported as being due to reduced staffing levels and ongoing operational/bed capacity challenges.

The 'Red, Amber and Green' (RAG) rating for the hand hygiene compliance audits continues and includes actions to be identified for areas that do not achieve the 'pass threshold' of 85% or show improvements. This RAG rating was further revised, and the impact of these measures being monitored by the IPCWG, DMTs and Patient Led Assessment in the Clinical Environment (PLACE) Steering Group. *(Of note: during 2023/24, there have been eight PLACE Steering Group meetings held (April, June, August, September, October, November, February and March).*

8. ANTIBIOTIC STEWARDSHIP

Key successes for 2023/24

8.1 Commissioning for Quality and Innovations (CQUINs)

- The Trust has undertaken a national antimicrobial CQUIN03: Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria. The Trust has achieved full compliance for the financial year. No further CQUIN schemes have officially been released/communicated with the pharmacy Antimicrobial Stewardship (AMS) team and unofficially it has been communicated that the IVOS CQUIN has been paused for 2024/2025.
- The AMS Microbiology Consultant and Lead Pharmacy Technician are continuing to undertake the IVOST CQUIN of their own accord (with no Trust financial implication) from 04/2024 onwards, despite the pause stated above. As Q1 of 2024/2025 is still being undertaken, no IVOST data has been published.

8.2 Guidance Development

A full review of all policies in the antimicrobial section of Microguide has been completed. Antibiotic guidance will now be classified into body systems and is currently live and published. Guidance on Bronchiectasis treatment has now been completed and ratified. Haematology has developed a patient group directive (PGD) for nurses to rapidly administer Tazocin® to neutropenic patients being admitted into hospital. The policy does require minor changes but will then be taken to Drug & Therapeutics Committee (DTC) for ratification.

8.3 Antimicrobial Stewardship (AMS) Ward Rounds for quarters 3 and 4 of 2023/24

A review of AMS ward round data (**Table 4** below) indicates the following for each month:

Month	Number of patients seen	Number of interventions made
October 2023	183	54
November	274	72
December	127	23
January 2024	171	41
February	65	17
March	66	23

(Table 4)

(Of note: Data for February and March 2024 is pending as there has been significant team annual leave, sickness, and unavailability due to workload).
Subjectively, most interventions made, involved stopping IV antibiotics, prompt IV to PO antibiotic switches, and reviewing antibiotics due to treatment efficacy.

8.4 Antibiotic Reference Group (ARG) Action plan for 2023/24

- Microguide updating has been completed and information placed into body systems. The Lead Antimicrobial Pharmacist is monitoring feedback from staff at present.
- Treatment guidance for measles has been completed and will be sent to the next DTC.
- Publishing of COVID interim guidance to be prioritised due to increasing COVID cases and release of the official NICE TA.

8.5 Challenges

8.5.1 Risk Management

- The Pharmacy AMS team have identified several DATIX reports relating directly to antibiotics. Incidents involved incorrect antibiotic prescribing, incorrect antibiotic administration, prescribing an antibiotic with a known allergy status, and missed doses of antibiotics. These DATIXs will continue to be reviewed and brought to ARG.
- From January 2024, there have been 33 DATIX reports relating directly to antibiotics. 32 incidents were classified as low risk/no harm except for 1 DATIX which was listed as minor harm involving antibiotic omission. The AMS team is going to perform targeted education and training to the wider pharmacy team and specific ward teams.
- There is still considerable staffing pressure within the pharmacy department/AMS team due to vacancies, however this has improved slightly. Three to four new clinical staff members have been recruited, therefore this situation should improve in the coming months. New staff will be starting in August and September 2024 but will still have to be trained for clinical ward cover, therefore no deadline/estimation can be given.

8.5.2 Electronic Prescribing and Medicines Administration (ePMA)
A programme has now been created and is being used to identify patients on IV antibiotics for AMS ward round data collection, however the programme must be tested for data quality and accuracy which is still ongoing. The Lead Antimicrobial Pharmacist is hoping this will be completed in April - June 2024.

9. AUDIT

The ICNs have not undertaken any formal policy audit during 2023/24 due to staffing resources and increased clinical workload but have been involved in supporting identified clinical areas to complete the Tendable inspections for infection prevention and control. This process ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust. (*Of note: these inspections include policy practice standards as part of audit criteria).*

Any observations/findings are fedback verbally to the clinical leader/nurse in charge at the time with instruction to access the results report to identify any required actions. The results are also available for the HoN and Matrons to access (via the application), with formal reports fedback via the PLACE Steering Group. (*Completion of these audits has been in addition to the 'spot checks' and observational practice audits undertaken by the ICNs during clinical visits to ward areas*).

When required, the HoNs, Matrons and clinical leaders have completed additional Tendable quick COVID-19 assessment inspections within identified clinical areas. These focus on monitoring and assurance around several measures, including signage, provision of hand hygiene opportunities, provision of PPE and observations of PPE practices, and adherence with the current COVID-19 management pathway. The ICNs have continued to support the areas and staff with addressing any concerns arising from these inspections. For 2023/24, the overall average IPC compliance scores reported have ranged from 90% - 94% for those audits completed.

Please see Appendix C for further details, the results continue to provide transparency across a number of IPC indicators at practice level.

10. EDUCATION AND TRAINING ACTIVITIES

Education and training continues to be an important part of the work of the IPC team. Mean compliance scores for 2023/24 were 76% for staff completion of hand hygiene assessments and 92% for staff completion for IPC computer-based learning (CBL) package *(LEARN data accessed 06.04.2024).*

The low hand hygiene assessment compliance is an ongoing concern. In response, the ICNs have continued to focus on the promotion of different working opportunities for staff to complete their hand hygiene assessment. This has included arranging extra sessions within specific work areas and enabling identified staff to be trained to undertake hand hygiene assessments. Furthermore, the clinical divisions facilitated the completion of hand hygiene assessments for staff by utilising an ultra-violet (UV) light box for rotation through

their divisional areas and departments. In addition, the ICNs continue to work with the Education Department to improve compliance for staff completing these mandatory training modules.
As requested by the DIPC, the hand hygiene assessment trial (previously discussed in 2022/23), has been slowly progressed by the divisions within inpatient areas. This is an alternative to using the UV light box to assess hand hygiene technique, where the clinical leader (Band 7) assesses staff members washing their hands using soap and water. Progress with this work has been reported to the IPCWG, with the agreement for further roll out within surgery and implementation across the medical division.

The ICNs have contributed to formal and informal teaching sessions within clinical areas and other Trust departments. Several of the core infection prevention and control sessions have been delivered for different staff groups, in addition to specific topic requests. The ICNs have also met with small groups and teams or on a one-to-one basis, to provide guidance and aid improved understanding of policies and practices. There has been a continued focus on promoting learning through the daily clinical visits undertaken by the ICNs.

Formal 'virtual' meetings with the Infection Control Link Professionals (ICLPs) group have been held during 2023/24. Communications via e-mail and through discussions with various ICLPs as part of both routine and additional visits undertaken by the ICNs to clinical and non-clinical areas have continued. Details of education opportunities provided are available from the ICNs.

11. DECONTAMINATION

11.1 Key success stories of 2023/24

- Work to refurbish Sterile Services Limited (SSL) commenced in April 2023, starting with the flexible endoscope reprocessing area. The old equipment has been removed and five new machines installed, validated and are now fully operational.
- Centralised decontamination records owned by the Trust, but pre-dating SSL, need to be kept for a further 8 years. The existing database was no longer viable due to the age of the operating system, so the information has been transferred to a new database. This improves data security and enables access should a future request for historical information be received.
- A Trust wide audit of ultrasound probe decontamination has been completed, identifying good compliance overall. There are a couple of locations which would benefit from further review regarding probe use to establish whether there are opportunities to improve practice further.
- A revised SOP for decontamination of Theatre equipment and environment was approved at the Decontamination Working Group (DWG) in quarter 3 of 2023/24.
- A device to provide automated decontamination of invasive ultrasound probes has been procured for Fertility. This is the result of a long piece of work to resolve the fast-paced clinical demands with a device which offers assurance and Best Practice for our patients. We now have a total of eight machines on site supporting invasive scanning teams.
- Collaboration and team working across departments, professions and organisations minimised the effects to patients when a critical piece of decontamination equipment failed in the Sterile Services Unit during quarter 3 of 2023/24. Business continuity plans were utilised for a period of three weeks and a report identifying learning points has been written by the Head of Emergency, Preparedness, Resilience and Response (EPRR) Team.
- The Trust's Authorised Person (AP) for Decontamination (D) in training has successfully completed their last courses and continue to be mentored by our Authorised Engineer (AE) for Decontamination (D) whilst gaining more experience but expect to be formally appointed in 2024/25.

11.2 Progress on actions during 2023/24

- Discussions to confirm the revised formats of both the Decontamination and Creutzfeldt-Jakob disease (CJD) policies has taken place. Work has commenced on the Decontamination policy, with plans to present an initial draft for discussion at the DWG during quarter 1 of 2024/25. It is hoped the policy will be sub-divided into clinical and engineering elements to assist navigation and ease of use for the relevant teams. The CJD policy re-write is being led by one of the Consultant Microbiologists, with the Decontamination Lead (DL) supporting. Flow-chart style appendices have been added to

focus on ease of use for clinical staff. It is anticipated that the final policy will be presented to IPCC for approval July 2024.

- The transition of the decontamination audits onto an electronic platform, Tendable, has stalled slightly but this has given opportunity to further refine the questioning. Once live, the audit process will capture evidence against the IPC Board Assurance Framework (BAF), national patient safety alerts and Health Technical Memorandum (HTM) standards.
- Theatre cleaning process are being reviewed to ensure appropriate device and environmental decontamination takes place. This work is being led by the Theatre Matron, supported by the DL and Lead IPC Nurse, and monitored via the Decontamination Working Group.
- Progress has been made on the project to introduce a specialist scope storage unit in Urology Outpatients to support the flexible cystoscope list. Agreement on a suitable location for the cabinet has been reached from a compliance perspective, but it requires identifying alternative storage for the department's consumable items, which is yet to be agreed.
- New Laboratory autoclaves, installed during quarter 4 of 2022/23, continue to be unreliable. A working group has been set up, led by the Laboratory Manager and supported by the Decontamination Lead, ETS, procurement and senior laboratory staff to escalate the situation within NHS Supply Chain and to the manufacturer. Initial offers of restitution have been deemed unacceptable so this work will continue.

11.3 Key challenges for Quarters 1 and 2 of 2024/25

- The Joint Advisory Group on GI Endoscopy (JAG) accreditation assessment for Endoscopy Services was completed in January 2024. There were some concerns identified relating to decontamination which will need to be addressed with an action plan.
- Ongoing refurbishment of SSL at a time when operational activity is increasing continues to be a challenge. The end of quarter 4 of 2023/24 and into quarters 1 and 2 of 2024/25, is a critical phase where capacity is reduced whilst work focuses on the instrument washers, clean room (where instrument trays are laid out and wrapped) and autoclaves. This will have an impact on production, though steps are being taken to keep disruption to a minimum. The risk assessment associated with the refurbishment work has been reviewed and increased to reflect the challenges of this current phase.

12. CLEANING SERVICES

This section summarises the key components of the Trust's cleaning programme, to ensure the provision of a safe and clean environment for patients and their relatives, visitors and staff. The following areas of work are managed by the Housekeeping Department and Facilities Directorate.

12.1 Patient Led Assessment of the Care Environment (PLACE) internal audits

The Trust has undertaken a programme of PLACE audits which commenced in June 2023 to undertake approximately 60 internal PLACE audits over the remaining year. From February 2024, 9 audits have been completed to date with a further 44 planned for the coming year. The result of each PLACE assessment is submitted to the Health and Social Care Information Centre using the PLACE 'Lite' tool and discussed with ward leaders at the monthly PLACE Steering Group meetings.

12.2 National PLACE

The National PLACE inspection took place on October 26th 2023, with results *(published early 2024)* shown below in **Table 5**:

Cleanliness – 98.74%	Privacy, dignity and wellbeing – 86.94%
Combined food – 87.14%	Condition, appearance and maintenance – 95.39%
Organisation food – 92.71%	Dementia – 81.74%
Ward food- 85.44%	Disability – 79.89%

(Table 5)

12.3 Deep clean programme/rapid response team

The deep clean programme commenced in April 2023 with a plan to deep clean every sideroom, bedspace and outer area over the coming year. The programme was successfully completed ahead of schedule, with the 2024/25 plan commencing in April 2024.

12.4 Improvement Work Over the past 6 months

Recruitment drives of group interviews, working alongside human Resources (HR) to attract new cleaning assistants continues.

Tables 6 *and* ***7*** *below from the past 2 years indicating the increased activity during the pandemic.*

2023/24 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTIONS	882	850	735	656	666	810	934	884	1055	995	988	785	**10240**
ENHANCED HRS	95.50	104	53.5	57.75	64	83.25	69	81.25	117.75	108.75	108.7	83.5	**1027**
DOUBLE CLEANS HRS	10	33	61.5	70.25	49.25	59.25	54	67.75	56.25	98	72	103	**735.25**
BIOQUELL	0	31	37	54	59	45	56	74	62	59	113	66	**656**

(Table 6)

2022/23 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTIONS	1305	741	855	1176	717	687	807	755	1262	1017	980	837	**11139**
ENHANCED HRS	66.50	50	73	112.75	102	63.25	87.5	104.25	79.75	138.75	103.	124	**1104.75**
DOUBLE CLEANS HRS	42.25	50.25	64.25	84.75	51.25	50	17.5	24	53	44.25	30	23.75	**535.25**
BIOQUELL	34	47	32	30	42	33	27	46	43	35	44	20	**433**

(Table 7)

12.5 Successes from the past 12 months

- Housekeeping were successful in achieving approval for a New Deputy Housekeeping Manager position and the successful applicant commenced in post early December 2023.
- Reached 99.8% or above each month for our key performance indicators linked to the operational response times in starting a clean within 3 hours.
- Successfully recruited 35 Cleaning Assistants (vacancies and new standards).

12.6 Challenges for Quarters 1 and 2 of 2024/25

Housekeeping is working towards the new National Cleaning Standards including key elements, task lists, risk categories, audit requirements over a phased rolling implementation period. It is not known whether any funding will be released delaying the implementation until 2026.

13. WATER SAFETY MANAGEMENT

This section summarises the water safety management precautions that the Trust has taken during 2023/24. The Trust manages the safety of water systems in line with the Health Technical Memorandum (HTM) 04-01 (Pt B) Safe Water in Healthcare Premises and HTM 04-01 (Pt C) Pseudomonas (guidance for augmented care units), together with the technical guidance document HSG274 part 2.

To assist the management process in respect of the water systems across the site, regular meetings of teams (SOM and AP water) from ETS and FES Ltd (PFI maintenance contractor) are held monthly, to review progress with PPM's and actions in respect of water safety.

The Trust continues to keep the domestic hot water temperature elevated above 65°C as a precaution in the challenge of Legionella control. The water systems within hospitals are complex; therefore, the testing and controls we have in place are designed to mitigate the risks to our patients and staff.

Emergency review meetings *(see* **Tables 8** and **9** *for Legionella, listing counts reported >1000 cfu/l*) and high counts for Pseudomonas (**Tables 10** and **11**) have taken place in the Trust as a result of the sample results, the actions and results of the ongoing checks have been circulated to senior members of the Trust in a series of emails as events occur, and as regular reports to the Water Safety Group (WSG) and IPCC. Actions taken have included the cleaning and disinfection of outlets, with temperature checks and increased flushing where necessary.

Annual sampling (routine) is due to commence in June 2024, these routine samples will be taken along with additional samples of outlets that have high counts that are being manged with the use of Point of Use (POU) filters (PAL).

Legionella results for Quarters 1 and 2 of 2023/24						
	Ward/Department	LG Ref	Location	Action plan	Test result as of 27/07/2023	
					Pre	Post
1	ED	33	Majors' cubicle 11	PAL filter fitted. Clear result resample.	<20	<20
2	AMU	60	Sink Room 2.2.22	PAL filter fitted. Clear result resample.	<20	<20
3	SSEU	31	SSEU Nurse Base	Fit PAL, clean disinfect and resample.	<20	600
4	Tisbury CCU	112	Bay 2 WHB	PAL fitted; system chlorinated as part of works on Whiteparish Ward. Resample.	54000	6200
5	Pathology Labs	93	Blood Room	PAL fitted, resample.	7000	3800
6	Block 05	119	Room 6 WHB	Outlet tap replaced; additional samples required.	3800	1000
7	ENT	13	3.04.14	Resample and investigate temperature/circulation issues.	100	5800
8	ENT	15	3.04.24	Resample and investigate temperature/ circulation issues.	<20	800
9	L3 Laboratories	87	3.14.37	Fit PAL, investigate issues with system (temperature/circulation).	8000	800
10	L3 Laboratories	88	3.14.17A	Fit PAL, investigate issues with system (temperature/circulation).	3100	100
11	L3 Laboratories	92	3.15.13	Fit PAL, investigate issues with system (temperature/circulation).	5400	1800
12	L4 Laboratories	103	4.14.27	Lack of use? Take additional sample from outlet 4.14.18.	21000	2200
13	L4 Laboratories	104	4.14.12	Fit PAL, investigate issues with system (temperature/circulation).	31000	2100
14	Spire Ward		2.10.19	PAL fitted, outlet disinfected and resampled.	9600	?

(Table 10)

Legionella results for Quarters 3 and 4 of 2023/24						
	Ward/Department	LG Ref	Location	Action plan	Test result as of 20/03/2024	
					Pre	Post
1	Tisbury CCU	112	Bay 2 WHB	PAL fitted, system has been chlorinated as part of the works on Whiteparish Ward, resample.	54000	6200
2	Pathology Labs	93	Blood Rm	PAL fitted, resample.	7000	3800
3	Block 05	119	Room 6 WHB	Outlet tap replaced, additional samples required.	3800	1000
4	ENT	13	3.04.14	Resample and investigate temperature/circulation issues.	100	5800
5	ENT	15	3.04.24	Resample and investigate temperature/circulation issues.	<20	800
6	L3 Laboratories	87	3.14.37	Fit PAL, investigate issues with system (temperature/circulation).	8000	800
7	L3 Laboratories	88	3.14.17A	Fit PAL, investigate issues with system (temperature/circulation).	3100	100
8	L3 Laboratories	92	3.15.13	Fit PAL, investigate issues with system (temperature/circulation).	5400	1800
9	L4 Laboratories	103	4.14.27	Lack of use? Take additional sample from outlet 4.14.18.	21000	2200
10	L4 Laboratories	104	4.14.12	Fit PAL, investigate issues with system (temperature/circulation).	31000	2100

(Table 11)

13.2 Pseudomonas

Pseudomonas sampling has been completed on Radnor Ward and the Neonatal Unit (NNU), further routine sampling to be scheduled for Pembroke Unit, Sarum and Odstock Wards. The SFT Estates Team are working with the PFI provider on options for transferring the testing for Pseudomonas to be included as part of the maintenance contract. See **Tables 12** and **13** below for results.

Pseudomonas results for Quarters 1 and 2 of 2023/24						
	Ward/ Department	PS Ref	Location	Action plan	Test result as of 18/07/2023	
					Pre	Post
1	Odstock Ward	197	SHW 4.11.20	Remedial works required; PAL fitted.	>100	
2	Odstock Ward	200	SHW 4.11.21	Remedial works required; PAL fitted.	100	
3	Odstock Ward	209	SHW 4.11.39	Remedial works required; PAL fitted	79	
4	Odstock Ward	216	SHW 4.11.33	Remedial works required; PAL fitted	>100	
5	Odstock Ward	231	SHW 4.11.41	Remedial works required. PAL fitted	>100	
6	Odstock Ward	244	SHW 4.11.53	Remedial works required. PAL fitted	>100	
7	Sarum Ward	109	SHW 4.06.08	Remedial works required. PAL fitted	>100	99
8	Sarum Ward	112	SHW 4.06.09	Remedial works required. PAL fitted	>100	3
9	Sarum Ward	139	SHW 4.06.32	Remedial works required. PAL fitted	>100	15

(Table 12)

Pseudomonas results for Quarters 3 and 4 of 2023/24						
	Ward/ Department	PS Ref	Location	Action plan	Test result as of 20/03/2024	
					Pre	Post
1	Odstock Ward	197	SHW 4.11.20	Remedial works required, PAL fitted.	>100	
2	Odstock Ward	200	SHW 4.11.21	Remedial works required, PAL fitted.	100	
3	Odstock Ward	209	SHW 4.11.39	Remedial works required, PAL fitted.	79	
4	Odstock Ward	216	SHW 4.11.33	Remedial works required, PAL fitted.	>100	
5	Odstock Ward	231	SHW 4.11.41	Remedial works required. PAL fitted.	>100	
6	Odstock Ward	244	SHW 4.11.53	Remedial works required. PAL fitted.	>100	
7	Sarum Ward	109	SHW 4.06.08	Remedial works required. PAL fitted.	>100	99
8	Sarum Ward	112	SHW 4.06.09	Remedial works required. PAL fitted.	>100	3
9	Sarum Ward	139	SHW 4.06.32	Remedial works required. PAL fitted.	>100	15

(Table 13)

Pseudomonas sampling is due in April 2024 and Sarum and Odstock Wards will be completed as a priority as high as being manged in this area with the use of POU Filters (PAL).

13.3 Pool Water Quality

No positive results requiring remedial action reported in this period.

13.4 Achievements of 2023/24

- The main pool in the Leisure Centre has now been fitted with an Ultraviolet (UV) system, the x 3 pools across the SFT estates are now all fitted with supplementary control to maintain water quality.
- Good water quality for leisure and hydro pools supported by regular testing of the water quality by UKHSA.
- Completion of routine Legionella and Pseudomonas testing and development of subsequent action plans.
- Maintenance and monitoring of the temperature of the main circulated hot and cold-water systems across the SFT Estate.
- No hot water generation/storage temperature excursions.

- Flushing compliance improved for Priority 1 areas from 79% to 80.5%; and Priority 2 areas from 94% to 95%.
- Estates have recruited a new Band 5 specialist to manage water safety at an operational level. This post will assist in the delivery of key PPMs, deliver all action plans related to water safety and manage the Estates Team who complete flushing in clinical areas.
- Delivery of PPMs in respect of water safety, to include tank cleaning, thermostatic mixing valve (TMV) maintenance and temperature monitoring of storage and sentinel outlet temperatures.
- The formation of Water Safety Ops Group, which will focus on the delivery of PPMs, action plans and actions from the Authorised Engineer (AE) water audit and site water risk assessment.

13.5 Key Focus for Quarters 1 and 2 of 2024/25

- Maintaining the level of flushing compliance for Priority 1 and 2 areas to circa 75%.
- Delivery of actions from the AE water audit and site water risk assessment.
- Engagement of key members (DIPC, Consultant Microbiologist, ICNs) of the WSG in supporting action plans and quarterly meetings of the WSG.
- Completion of Pseudomonas testing (6 monthly) for the augmented care wards (Neonatal Unit (NNU), Radnor (ITU), Odstock, Sarum and Pembroke Wards).
- Flushing compliance of the augmented care wards – these wards should be flushing daily by the ward teams.
- Introduction of a managed service for all water sampling.

14. SPECIALIST VENTILATION

This section summarises the actions/precautions that the Trust has taken during 2023/24 in relation to the critical ventilation systems.

The Trust manages the safety of ventilation systems in line with the HTM 03-01 and operates a permit to work system to ensure that approval has been sought by the key stakeholders (e.g. Theatres, Pharmacy and Laboratories) of the system prior to its isolation.

To assist in the management of ventilation a quarterly meeting (Ventilation Safety Group) is held, the core members of this group include IPC, a Microbiologist and key stakeholders.

14.1 Achievements of 2023/24

- Verifications completed on ventilation systems within Medical Outpatients Department (OPD) (Block 98) and Breast Care (Block 91), this process should be completed annually to ensure that the air change rate and balance of the system is in line with the recommendations of HTM 03-01.
- Annual planned preventive maintenance (PPM) completed on Theatres 1 to 8, Day Surgery Unit (DSU) Theatres A, B, C, D and E, Cardiac Catheterisation Laboratory and Medical OPD.
- Replacement of motor and fan pulleys on Pharmacy Aseptic air handling unit (AHU) to reduce belt wear and reliability of the ventilation for this critical system.
- Tender and contract awarded to progress the fire damper testing across the SFT estate, 1044 dampers have now been tested, 740 have passed, 82 have failed and 220 were unable to be tested due to lack of safe access. The completion of remedial and ensuring suitable access is available will be a priority during quarters 3 and 4 of 2023/24.
- Annual local extract ventilation (LEV) testing was completed for LEV systems in Medical Engineering, Estates, Orthotics and Wessex Rehabilitation workshop systems. Remedial actions have been identified from the reports and relevant departments have been informed. Three new LEV equipment have been installed in the Orthotics Department, which resolved the issues highlighted in the annual LEV testing and Health & Safety (H&S) audit.
- Pressure stabilizers installation has been completed in Main Theatres. The new stabilizers have replaced units that were circa 30 years, and these were not operating correctly which impacted the performance of the ventilation systems.
- Bi-annual service completed on ultra clean ventilation (UCV) in Main Theatres 2, 5, 6 and 7 and Theatre 6 UCV canopy motors replaced with new by Howarth on 28th and 29th February 2024.

- The annual PPM has been completed on the AHUs serving Mortuary, Main Theatre core areas, east areas, and Pharmacy Aseptic suite.
- The Annual Fire Damper Testing of the ventilation ductwork has been completed for the year and was carried out by Gemini which had started on 3rd July 2024. Currently most of the dampers have been tested, some could not be tested due to access issues. Some dampers will need to be repaired/replaced which have been identified and will be taken up depending on the availability of budget and risk rating. Dampers have been tested in SDH North, Block 99, Block 98, and Block 93. The first phase of remedial works has been completed, and for additional remedial works quotes have been requested. The plan is to tender for the pending remedial works and a 5-year fire damper testing contract. It has also been identified that many extract ducts will require cleaning. There will be additional budget required for this to be done.
- Quarterly meetings being held of the VSG, these meetings are well attended and have representation from IPC, a Microbiologist and Pharmacy and Theatres as key stakeholders.

14.2 Key Focus for Quarters 3 and 4 of 2023/24

- Current status is all critical AHUs PPM is done but for it to be done to include 40 point check for critical systems as per the guidance in HTM 03-01. Additional labour resource has been identified but need to send them on Competent Person (CP) training for ventilation and then need to ring fence to carry out PPM and other ventilation works only.
- Delivery of all remedial works post the fire damper testing process. First phase of remedial works has been completed. Pending works are to be completed once new contract is in place, planned for quarters 1 and 2 of 2024/25.
- Secure capital funding for the replacement of the pressure stabilizers in Theatres A, B, C, D, E and F in DSU.
- Plan and deliver a ventilation duct cleaning programme. It is evident from the survey completed for the fire dampers this is urgently required especially for critical systems e.g. Main Theatres. Funding of £50k is allocated in this year's capital budget for this and the plan is to start the procurement process as soon as possible.
- Review of capital projects to include SSL and Imber Ward to ensure these systems have been installed in accordance with HTM 03-01, can be maintained and verified in line with guidance.
- Train two members of the Estates Team to enable them to work on AHUs and be appointed as ventilation CPs.
- Form a new operational working group to drive actions related to ventilation highlighted in the AE's audit and to review compliance with PPM.

15. CONCLUSION

This annual DIPC Report has provided the Trust Board with evidence of the measures in place that have made a significant contribution to improving infection prevention and control practices across the Trust. The report has detailed the progress against the Action Plan for 2023/24 in reducing HCAI rates for the Trust.

For quarters 1 and 2 of 2024/25, the key ambitions for the Trust will include:

- Ongoing focus on the reduction of all reportable HCAIs and ensure preventable infections are avoided
- Continued reinforcement to improve compliance with hand hygiene practices and behaviours
- Maintaining achievements with antimicrobial stewardship
- Sustain progress with contingency planning and improvement plans for decontamination services
- Maintaining progress with education, training and audit relating to infection control practices and policies
- Monitor and manage water and ventilation safety
- Maintaining a clean and safe environment for patients and staff through the Trust Housekeeping service.

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- Clare Goodyear, Trust Decontamination Lead and Medical Device Safety Officer (Section 11)
- Michelle Sadler, General Manager, Facilities and Amanda Urch, Head of Housekeeping and Portering (Section 12)
- Terry Cropp, Technical Services Manager, Estates Department (Sections 13 and 14)

APPENDIX A

Infection Prevention & Control – Annual Action Plan 2023/24

Please note: The numbering **does not** depict the order of priority for the Trust but reflects the numbered duties within the Hygiene Code.

Domain and Key Actions	Who By	Status
1 Management, Organisation and the Environment **1.1 General duty to protect patients, staff and others from HCAIs** **1.2 Duty to have in place appropriate management systems for Infection Prevention and Control**		
Continue to promote the role of the DIPC in the prevention & control of HCAI	CEO	Continuous
DIPC as Chair of the Infection Prevention & Control Committee (IPCC)	CEO	In place
Lead infection prevention & control in the Trust and provide a six-monthly public report to the Trust Board	DIPC	In place
Monitor and report uptake of mandatory training programme	IPCT	In place
Continue contribution to implementation of the Bed Capacity Management policy	DIPC	In place
Ensure a programme of audit (incorporating Saving Lives High Impact Interventions) is in place to systematically monitor & review policies, guidelines and practice relating to infection prevention & control	IPCWG/IPCC	Monthly
Continue to review staffing levels via Workforce Planning	Deputy CNO	Continuous
Complete bedpan washer replacement and dirty utility room upgrade programme within the Trust (for inpatient clinical areas), including the Spinal Unit.	DIPC	Complete
1.3 Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks		
Maintain the role of DIPC as an integral member of the Trust's Clinical Governance & risk structures (including Assurance Framework)	CEO	Continuous
Ensure active maintenance of principle risks relating to infection prevention and control, and that the system of Root Cause Analysis (RCA) is used to review risks relating to these	DIPC/ICD/ICNs	In place
Active Surveillance & Investigation:		
Continue implementation of mandatory Surveillance Plan for HCAI & produce quarterly reports for IPCC	IPC team	In place
Review implementation of 'alert organism' & 'alert condition' system	ICD/Microbiologists	Continuous
Use comparative data on HCAI & microbial resistance to reduce incidence & prevalence	ICD/Microbiologists	In place
Promote liaison with UK Health Security Agency (UKHSA) for effective management & control of HCAI.	DIPC/ICD/ICNs	Continuous

Domain and Key Actions	Who By	Status
1.4 Duty to provide and maintain a clean and appropriate environment for health care		
Ensure maintenance and monitoring of high standards of cleanliness via policy management and audit, and environmental audits	DIPC/Housekeeping Manager	Monthly
Review schedule of cleaning frequency and standards of cleanliness, making them publicly available	DIPC/Housekeeping Manager/Matrons	Monthly
Ensure adequate provision of suitable hand washing facilities, hand products/alcohol gel and continued implementation of 'WHO - Five Moments' and use of 'CleanYourHands' resources	ICNs	Continuous
Continue IP&C involvement in overseeing all plans for construction & renovation	Head of Estates	Continuous
Ensure effective arrangements are in place for appropriate decontamination of instruments and other medical devices/equipment	DIPC/Decon. Lead	Continuous
Ensure the supply and provision of linen and laundry adheres to health service guidance	Head of Facilities	Continuous
Ensure adherence to the uniform and Bare below the elbow (BBE) policies and workwear guidance through audit and formal reporting via the PLACE Steering Group meetings.	DIPC/HoNs/Matrons	Continuous
1.5 Duty to provide information on HCAIs to patients and the public **1.6 Duty to provide information when a patient moves from one health care body to another** **1.7 Duty to ensure co-operation**		
Ensure publication of DIPC report via the Trust website	DIPC	6 monthly
Review Bed Capacity Management policy & documentation to ensure communication regarding an individual's risk, nature and treatment of HCAI is explicit	DIPC	Completed
Include obligations under the Code to appropriate policy documents.	DIPC	Ongoing
1.8. Duty to provide adequate isolation facilities		
Continue implementation and monitoring of the Isolation policy and monitoring of practice via audit.	HoNs/Matrons/ IPC team	Ongoing
1.9. Duty to ensure adequate laboratory support		
Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation.	ICD/Microbiologists/ Laboratory Manager	Continuous

Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control		
Core policies are:		
Standard infection control precautions	ICNs	In place
Aseptic technique	ICNs	In place
Major outbreaks of communicable infection (Outbreak policy)	ICNs	In place
Isolation of patients	ICD	In place
Safe handling and disposal of sharps	H&S Lead	In place
Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries	ICNs	In place
Management of occupational exposure to BBVs and post exposure prophylaxis.	H&S & OH Lead	In place
Closure of wards, departments and premises to new admissions (Outbreak & Capacity Management)	IPC team	In place
Disinfection policy	Facilities GM	In place
Antimicrobial prescribing	ICD/Lead Pharmacist	In place
Mandatory reporting HCAIs to Public health England (PHE)	ICD	In place
Control of infections with specific alert organisms; MRSA and *C.difficile*	IPC team	In place
Additional policies:		
Transmissible Spongiform Encephalitis (TSE)	ICD/Decon. Lead	In place
Glycopeptide Resistant Enterococcus (GRE)	ICD	Included in
Acinetobacter species	ICD	Isolation
Viral Haemorrhagic fever (VHF)	ICD	Policy
Prevention of spread of Carbapenem resistant organisms	ICD	In place
Diarrhoeal infections	ICD	In place
Surveillance	ICNs	In place
Respiratory viruses (RSV)	NNU Lead	In place
Infection control measures for ventilated patients	ITU Lead/Matrons	In place
Tuberculosis	ICD	In place
Legionellosis risk management policy and procedures, including pseudomonas	Head of Estates	In place
Strategic Cleaning Plan & Operational Policy	Facilities GM	In place
Building & Renovation – Inclusion of Infection Control within Building Change, Development & Maintenance	Head of Estates	In place
Waste Management Policy	Waste Manager	In place
Linen Management Policy	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	Decon. Lead	In place

Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonably practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs		
Ensure all staff can access relevant Occupational Health & Safety Services (OHSS)	Head of OD&P & OH Lead	Continuous
Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place	OH Lead	Continuous
Continue the provision of infection prevention and control education at induction	IPC team	Continuous
Continue the provision of ongoing infection prevention and control education for existing staff	IPC team	Continuous
Continue recording and maintaining training records for all staff via the MLE	Education Dept.	Continuous
Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and objectives of all staff	DIPC/DMTs	In place
Enhance and monitor the role of the Infection Control Link Professionals.	HoN/Matrons/ICNs	Continuous

NHS Salisbury NHS Foundation Trust

APPENDIX B (2023/2024)

Clinical Divisions	Inpatient areas/wards	*Clostridioides difficile* - all cases (reportable and not reportable)		Bacteraemias - all cases are reportable to UK Health Security Agency (UKHSA)															Outbreak declared	PII declared	Hand Hygiene (mean %)	
				MRSA			*MSSA*			*E.coli*			*Pseudomonas aeruginosa*			*Klebsiella sp.*						
		Hospital onset healthcare associated	Community onset healthcare associated	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	See main repot for details	PII of C.difficile		
Clinical Support & Family Services	Sarum Ward (inc. Children DAU)	1						1	3	1				1		1					↓99.31%	
	Hospice Unit																				→100%	
	Longford Ward						1			2						1					↑95.04%	
	CS&FS Totals:	**1**					**1**	**1**	**3**	**3**				**1**		**2**						
Women & Newborn	Labour Ward										1										↑100%	
	Neonatal Unit																				↓92.44%	
	Post-natal Ward																				↑100%	
	W&N Totals:										**1**											
Medicine	AMU (inc. SDEC)	2	2		1			1	1		4	7					4	2			↓69.29%	
	Breamore Ward						1			2						1					↑87.73%	
	Durrington AFU	1					1			1		1						1			↑77.80%	
	ED (inc. SSEU)		1 + 2						24	1	13	52			2		1	13			↓89.36%	
	Farley Ward	1 + 1					1			4											↑91.55%	
	Laverstock Ward	1					1			1			1								↓88.80%	
	Pembroke Ward	1 + 1								2	1	1	1			1	1			18.10.23	↓95.77%	
	Pembroke Suite		1																		→100%	
	Pitton Ward	4																		30.11.23	↓76.16%	
	Redlynch Ward	2 + 1	1				3						1							02.02.24	↑87.82%	
	Spire Ward	3 + 2					1			2			2			1				09.11.23	↑93.83%	
	Tisbury CCU	1 + 1											1								↓77.70%	
	Whiteparish Ward	1					1														↑95.28%	
	Nunton Unit																				→100%	
	Medicine Totals:	**11 + 12**	**2 + 5**		**1**		**9**	**1**	**25**	**13**	**18**	**61**	**6**		**2**	**3**	**6**	**16**				
Surgery	Amesbury Suite	2							1	1		2									↓85.33%	
	Britford Ward	2 + 1	1								2	3				1		3	C.difficile#	13.11.23	↑89.75%	

	(inc. SAU)																				
	Chilmark Suite	2																		↓81.07%	
	Day Surgery Unit											1								↓94.57%	
	Downton Ward	1 + 2								2		1				1			C.difficile#	13.11.23	↓74.13%	
	Odstock Ward	2 + 4								1									CPE		↑92.12%	
	Radnor Ward								1	1			1			1					↓98.66%	
	Surgery Totals:	**5 + 11**	**1**						**2**	**5**	**2**	**7**	**1**			**3**		**3**				
Additional info: Other *C.difficile* samples, e.g. GP, other Emergency Assessment, OPD, Mortuary, Private or Community Hospitals			**5 + 3**						**1* 1^**			**3***										

***C.difficile*: All SFT samples including inpatient and outpatient areas, GP and other e.g., Emergency Assessment** *C.difficile* **reportable** cases = **red** *C.difficile* **not** reportable cases = **blue**

(C.difficile# refers to an initial PII of C.difficile declared for the surgical division, affecting Downton Ward, Britford Ward and SAU in November 2023, with the PII later regraded as an outbreak)

Bacteraemia classification codes:

- Hospital onset healthcare associated, is shown as Hospital onset HA
- Community onset healthcare associated, is shown as Community onset HA
- Community onset community associated, is shown as Community onset CA
- A number followed by * indicates that the location of the patient(s) when the blood culture sample was taken = Salisbury Dialysis Unit
- A number followed by ^ indicates that the location of the patient(s) when the blood culture sample was taken = Newhall Hospital outpatient

Outbreak code: CPE is Carbapenemase Producing Enterobacteriaceae outbreak declared

Hand hygiene scoring:

	Score 85% and above
	Score 61% - 84%
	Score 60% and below

(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

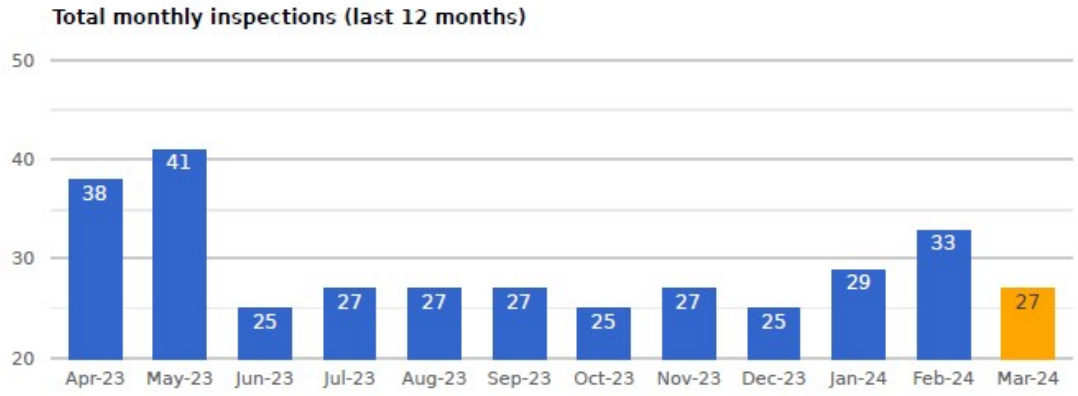
Mean hand hygiene compliance for the beds previously utilised by SFT at South Newton Hospital during Q1 and Q2 of 2023/24 = Nadder Ward 85%; Pembroke Lodge 80.95%

Salisbury NHS Foundation Trust

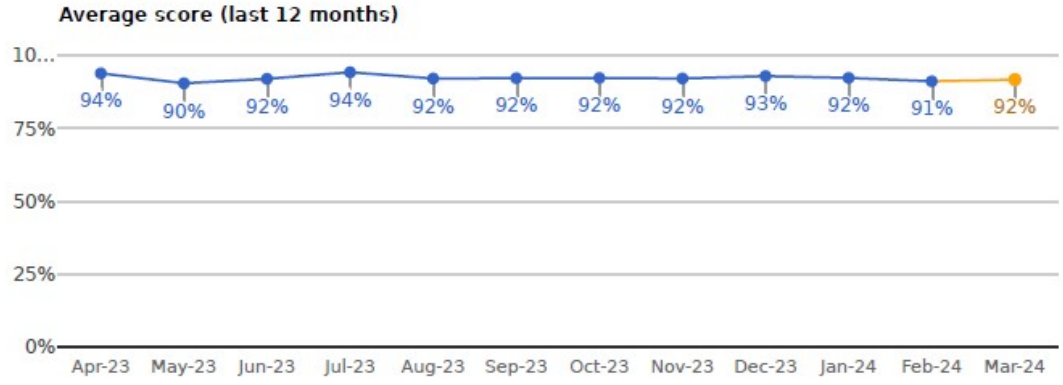
APPENDIX C

Tendable Infection Prevention & Control (IPC) Audit Inspection Summary for April 2023 – March 2024

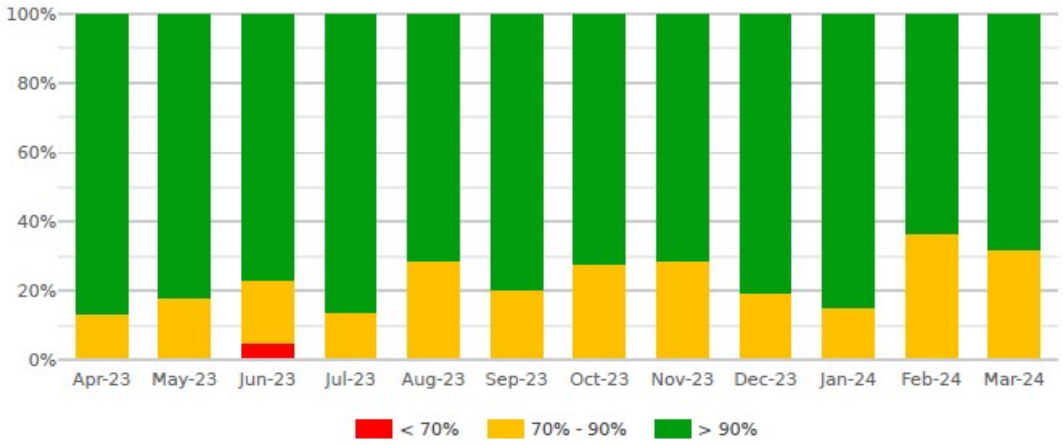
Overall



The average score across the organisation this month was 92%.



Distribution of scores (last 12 months)



Highest Scoring Clinical Areas

Rank	Area	Score this month	Score last 12
1	Sarum	100% (1)	99% (12)
2	Longford Ward	98% (1)	94% (12)
3	Radnor	98% (1)	98% (12)
4	Day Surgery Unit	97% (1)	99% (12)
5	Hospice	96% (1)	97% (13)

Lowest Scoring Clinical Areas

Rank	Area	Score this month	Score last 12
18	Laverstock	85% (1)	86% (28)
19	Whiteparish	85% (1)	91% (14)
20	Durrington	82% (1)	92% (15)
21	ED	82% (1)	83% (11)
22	Downton	75% (1)	90% (19)

Numbers in brackets show number of inspections score is calculated from.

(Information taken from Tendable Board IPC report (generated 19.04.2024)

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.9
Date of Meeting:	04 July 2024		

Report Title:	Q4 Incident reporting and risk report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	CMB CGC 25/6/2024			
Prepared by:	Kim Melbourne Deputy Risk Manager Judy Dyos, Chief Nursing Officer			
Executive Sponsor (presenting):	Judy Dyos, Chief Nursing Officer			
Appendices (list if applicable):				

Recommendation:
The report aims to inform the committee of the process and data related to incident reporting and the management of the risk registers over the quarter 3 period of 2023.

Executive Summary:

This report provides the overarching data for incident reporting over a 12 months period moving to the data for Q4. The report then provides the risk register information and the plans to resolves outstanding risk held at service level that require review.

Assurance

- All Datix incidents undergo a robust quality check to ensure accuracy of reporting utilising a Standard operating procedure process to reduce unwarranted variation
- The data shows that Incident reporting has remains consistent throughout the last year, there has been a spike in moderate incidents in January 2024 however this may be due to reclassification of incidents.
- Themes and trends continue to be analysed and moving forward will form the intelligence for the yearly PSIRF plan. There are several workstreams (e.g. Deteriorating patient and pressure ulcer working group) in the trust which look at the current top categories of reported incidents.
- For quarter 4 there were 2367 incidents reported throughout the trust, only 3.16% of these were moderate or above harm. This is a slight decrease from Quarter 3 of 3.6% These incidents continue to be scrutinised through the weekly patient summit with executive oversight.

- There has been just under a 50% reduction in the number of red open actions in the compliance report since Quarter 3.

Alerting

- There are a high number of open risks at service level that require review, a targeted piece of work is now being undertaken with risk team member assigned to divisional teams. A more prescriptive process has been put in place to assist divisional colleagues.
- Duty of candour compliance has been challenging due to the length of time reporting take but the move the Patient Safety Reviews(PSR) under PSIRF should help to resolve this

Advising

- There have been 4 never events from April 2023-March 2024.

Retained swab at LSCS
Retained mouth prop (Child dental extraction)
Wrong site surgery
Wrong biopsy site

- There was 1 SII commissioned at the beginning of January prior to the transition to PSIRF.
- 4 PSIIs have been commissioned since the transition to PSIRF. 2 of these are related to the latter 2 never events and 2 and linked to local PSIRF priorities.

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

Risk Management Report

Salisbury NHS Foundation Trust

Quarter Four (Jan, Feb and March 2024)

Kim Melbourne

Overview

Salisbury NHS Foundation Trust

This report has been written by the Risk Management team for SFT to detail the current trust position in relation to the following:

Annual data

- Incident Reporting Overall Profile
- Total Annual moderate/Severe Incidents
- Total Annual Incidents by Category
- Breakdown of Annual data (April 23– April 24)

Q4 Data

- Total Reported Incidents in Q4
- Total Q4 Incidents by Category
- Breakdown of Moderate incidents in Q4
- Serious Incident Investigations (SII) and Clinical reviews (CR) in Q4/ Never Events
- SII/CR Action Compliance and Deep Dives
- Risk Registers
- Duty of Candour (DoC)

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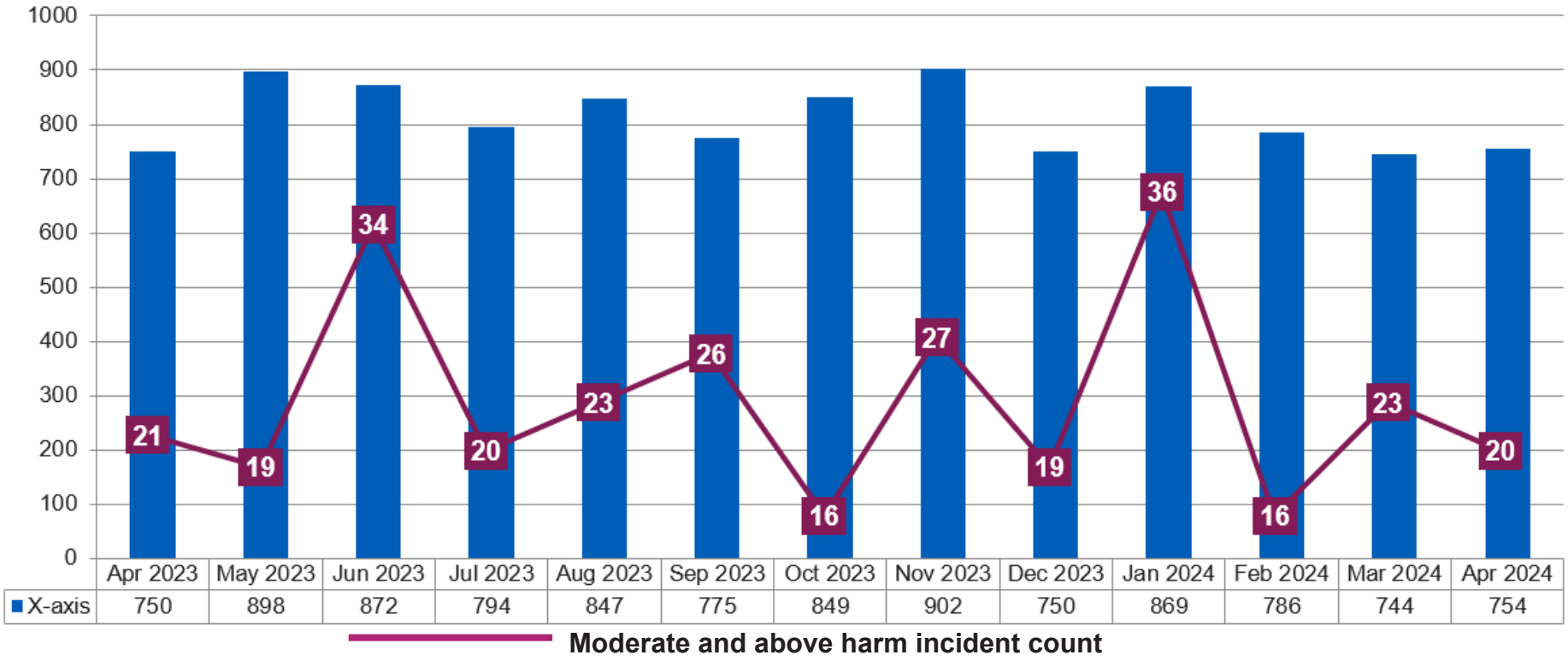
Annual Review of Incidents 2023 - 2024

Incident Reporting Overall Profile

In December 2023, the trust switched to the Learning From Patient Safety Events (LFPSE) system for reporting our patient safety incidents to the national platform, this has replaced the National Reporting Learning System (NRLS). Datix remains the system in place for reporting events. The graph below shows that our reporting culture has remained consistent throughout the last financial year.



	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024
X-axis	750	898	872	794	847	775	849	902	750	869	786	744	754

Moderate and above harm incident count

There is an increase in the number of moderate and above incidents in Jan 2024. A small number of these were maternity incidents that had been reported in retrospect. There are no other identifiable themes or trends.

Total Annual moderate/Severe Incidents

Each moderate and above case is scrutinised through the weekly patient summit with executive oversight and commissioning of further review if necessary.

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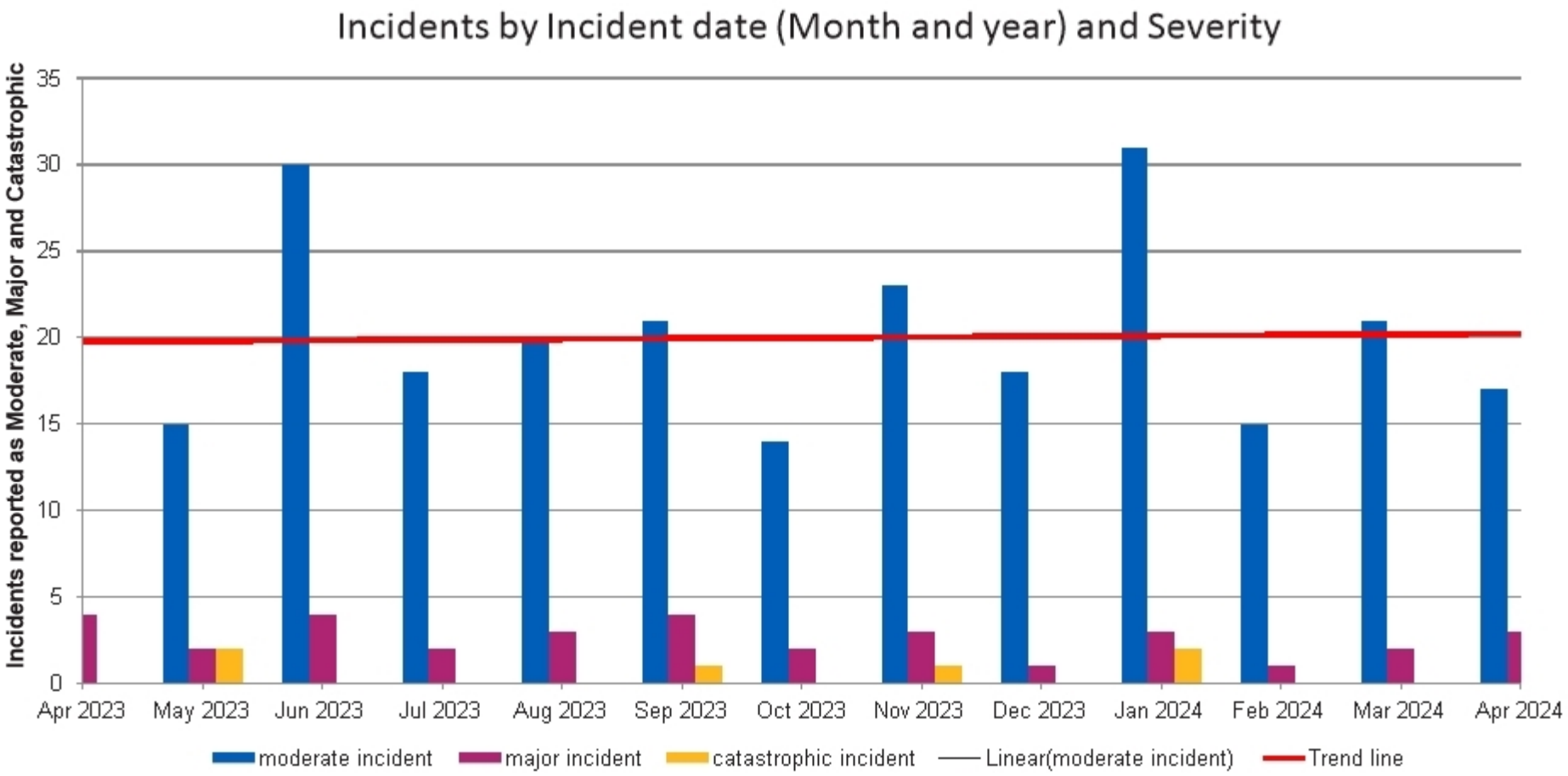
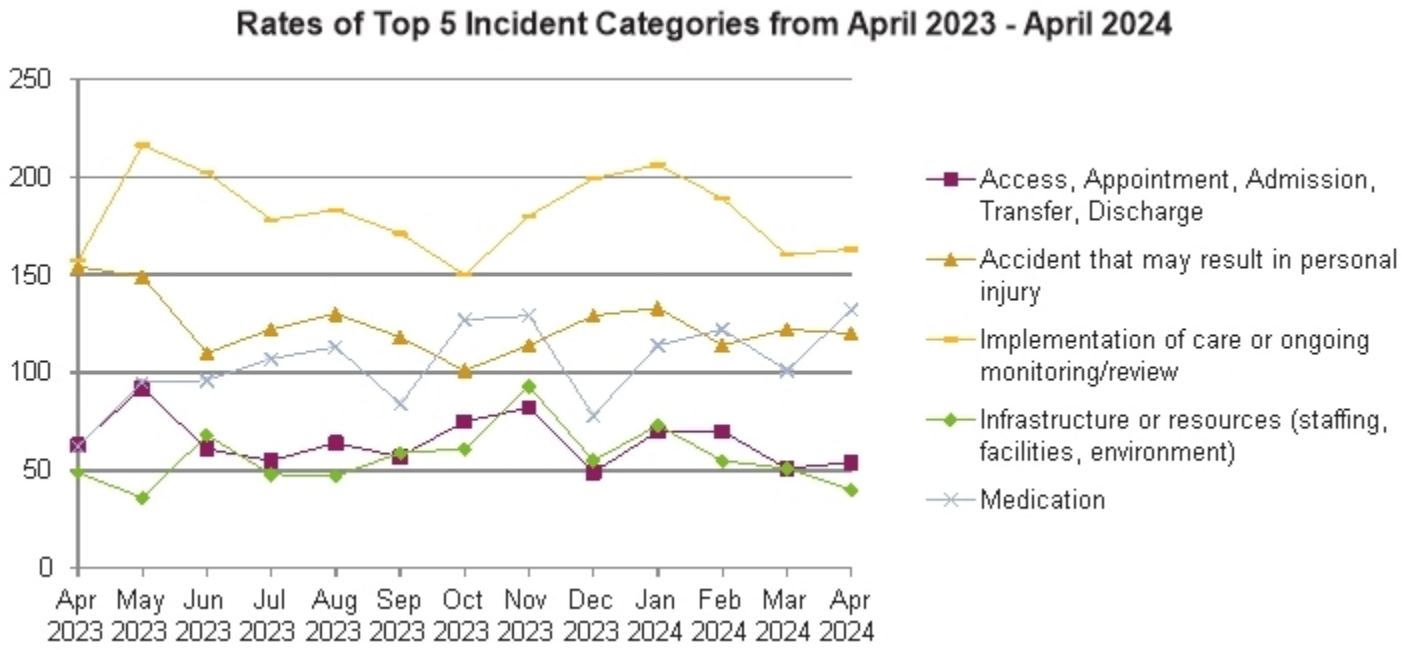


Total Annual Incidents by Category



The above run chart demonstrates 13 months of reported incidents and will be further broken down into quarter 4 later in the report.

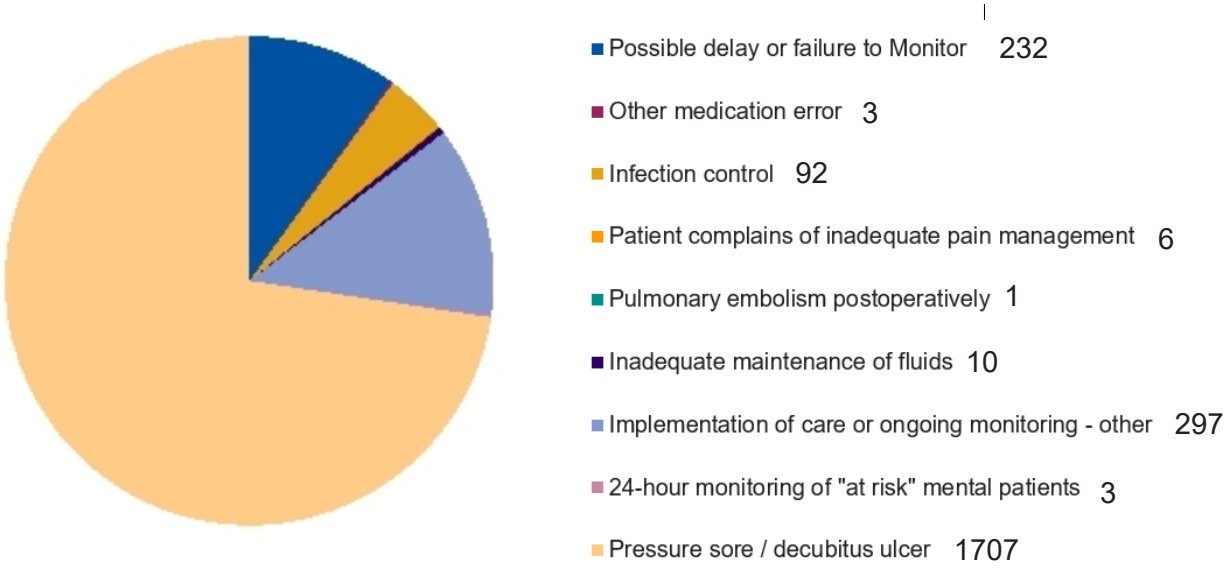
The highest reported incident type is implementation of care or ongoing monitoring/review, this includes all reported pressure ulcers. The following slides will breakdown each incident category.

There are several ongoing workstreams and breakthrough objectives that are In place that include:

- The Deteriorating Patient
- Pressure Ulcers
- IPC working group
- Falls Working group
- VTE working group

Breakdown of Annual data (April 23 – April 24)

Implementation of care or ongoing monitoring (2,354)



This chart shows implementation of care broken down into subcategories, the highest being pressure ulcers, 588 of these were present on admission to hospital and 613 were hospital acquired. The TV team undertake a more in-depth review and cleanse the number formally reported via the IPR, numbers reduce as staff reporting may be duplicated as patient moves through services and may include tissue damage that is not pressure related such as vascular issues (e.g. leg ulcers). The trust has a workstream for pressure ulcers implementing a new assessment form and charting processes

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Quarter 4 Incidents (Jan, Feb, March 2024)

Total Reported Incidents in Q4

In quarter 4 there were a total of 2367 incidents reported, the below table breaks this down by month.

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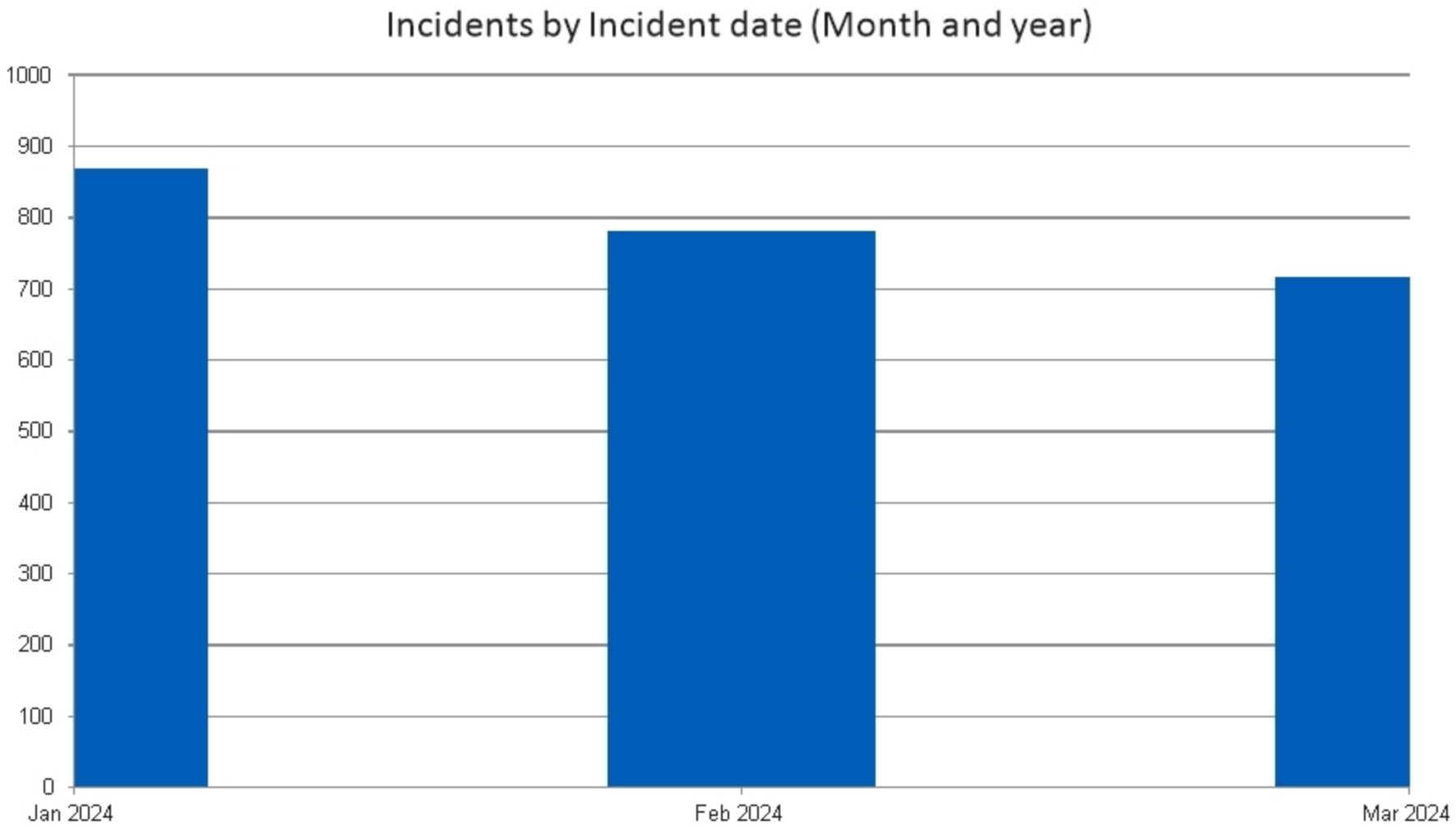
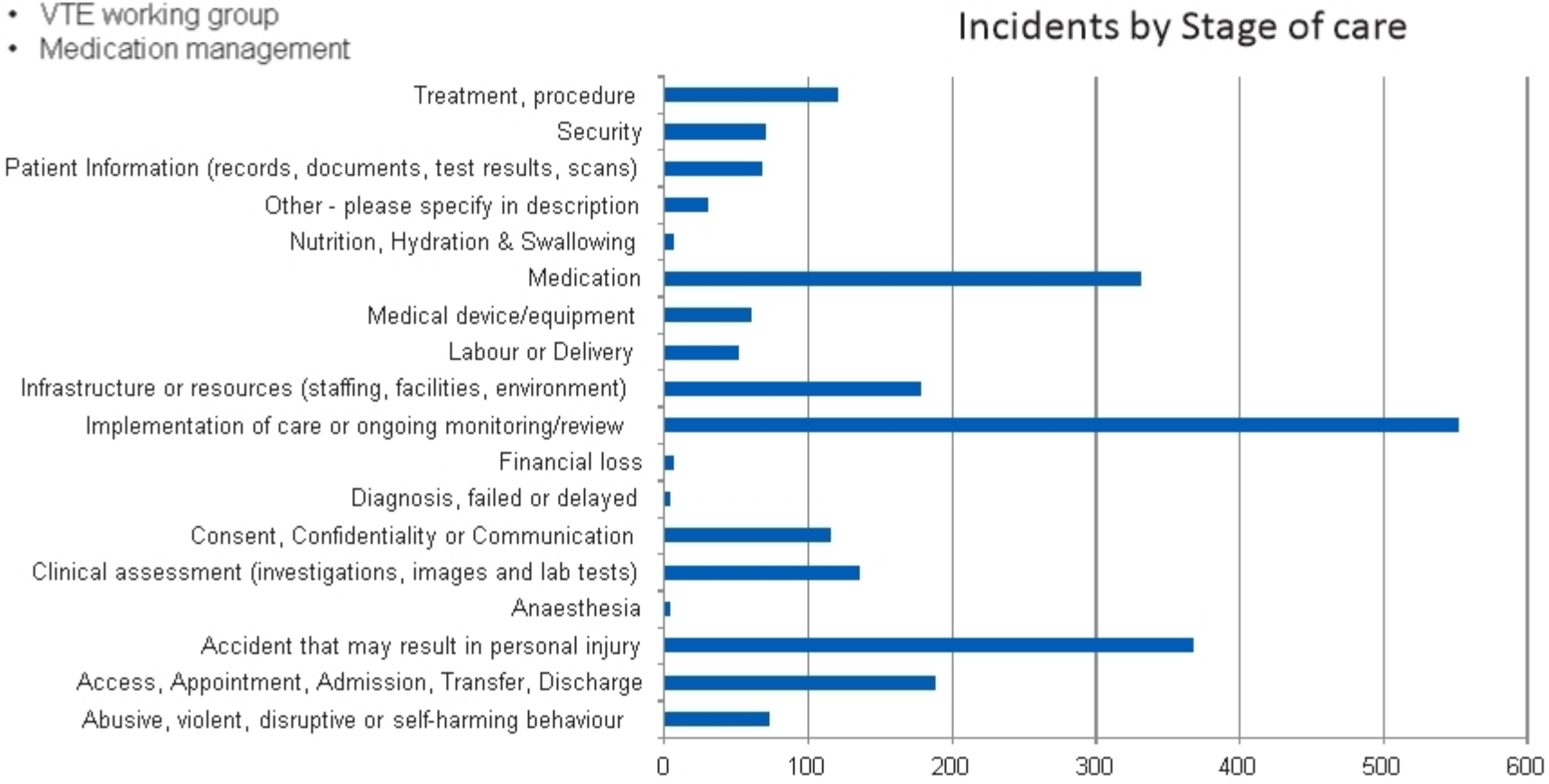


Total Q4 Incidents by Category

Similarly to the Annual picture, the highest reported incident type in Q4 is implementation of care or ongoing monitoring/review

There are several ongoing workstreams and breakthrough objectives that are in place to focus on the areas identified in the data, these include:

- Recognising the deteriorating patient (Breakthrough objective 24/25)
- Pressure damage reduction
- IPC working group
- Falls Working group
- VTE working group
- Medication management

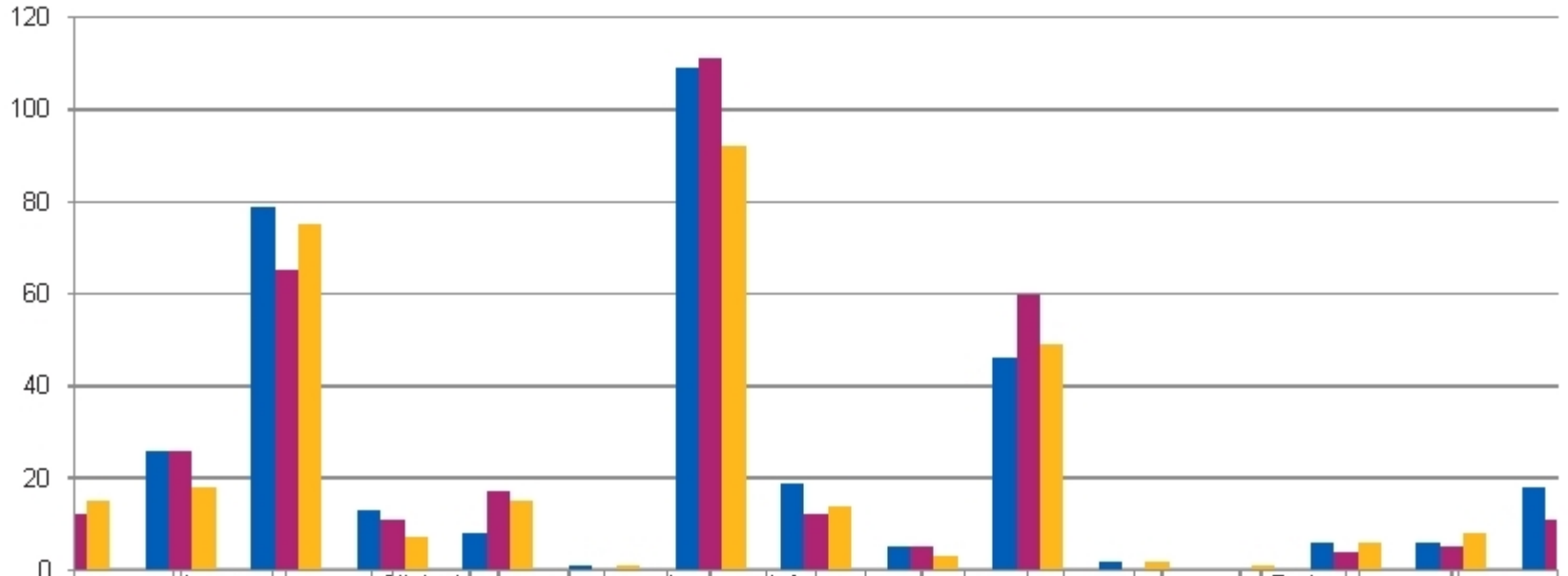


Breakdown of Q4 (Jan 24 – March 24)

Medicine Divisional Themes and Trends

Salisbury NHS Foundation Trust

This chart shows the themes and trends of incidents in the medicine division for Quarter 4.



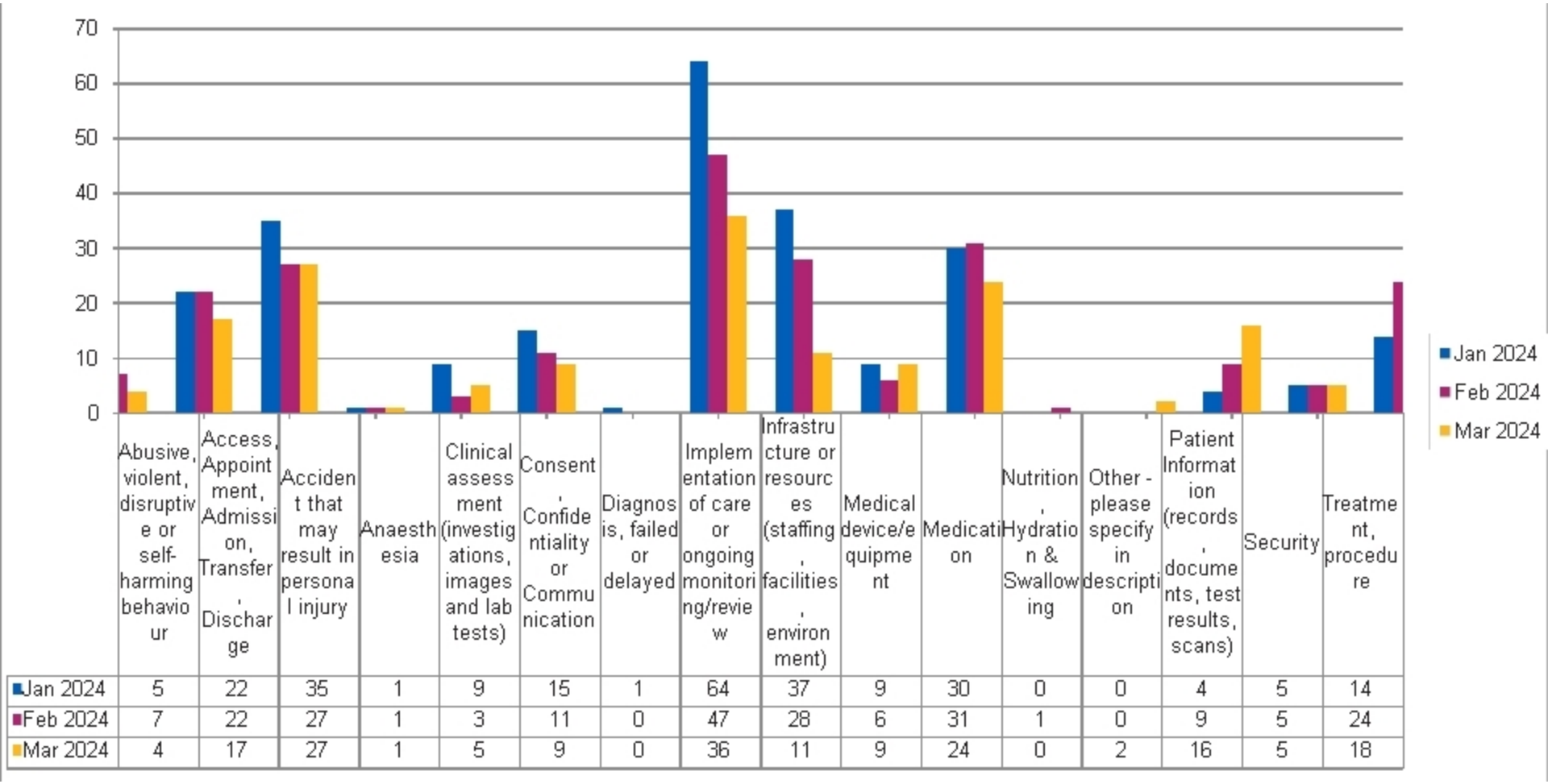
	Abusive, violent, disruptive or self-harming behaviour	Access, Appointment, Admission, Transfer, Discharge	Accident that may result in personal injury	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Implementation of care or ongoing monitoring/review	Infrastructure or resources (staffing, facilities, environment)	Medical device/equipment	Medication	Nutrition, Hydration & Swallowing	Other - please specify in description	Patient Information (records, documents, test results, scans)	Security	Treatment, procedure
Jan 2024	19	26	79	13	8	1	109	19	5	46	2	0	6	6	18
Feb 2024	12	26	65	11	17	0	111	12	5	60	0	0	4	5	11
Mar 2024	15	18	75	7	15	1	92	14	3	49	2	1	6	8	11

Breakdown of Q4 (Jan 24 – March 24)

Surgery Divisional Themes and Trends

Salisbury NHS Foundation Trust

This chart shows the themes and trends of incidents in the surgery division for Quarter 4.



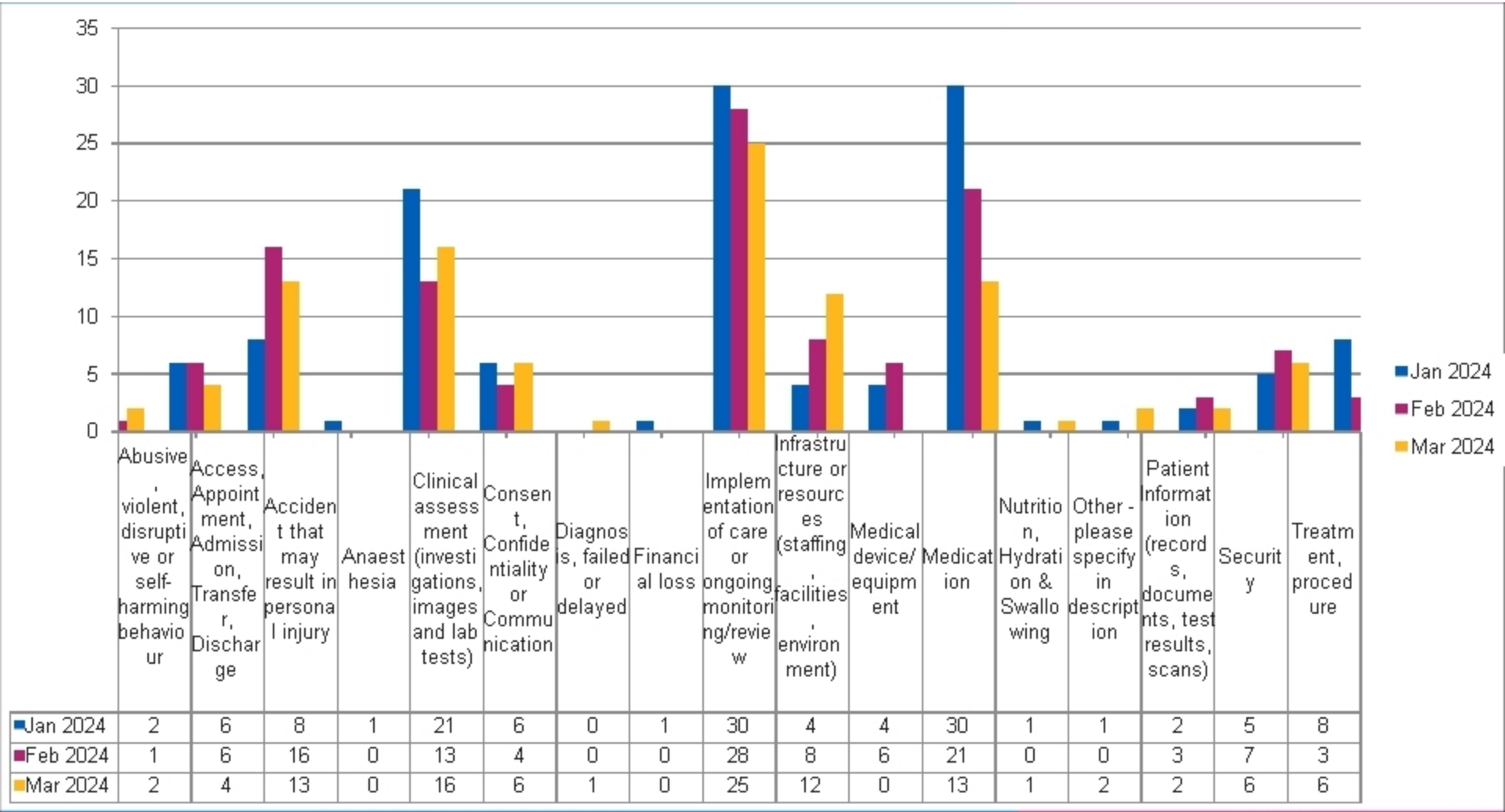
	Abusive, violent, disruptive or self-harming behaviour	Access, Appointment, Admission, Transfer, Discharge	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Implementation of care or ongoing monitoring/review	Infrastructure or resources (staffing, facilities, environment)	Medical device/equipment	Medication	Nutrition, Hydration & Swallowing	Other - please specify in description	Patient Information (records, documents, test results, scans)	Security	Treatment, procedure
Jan 2024	5	22	35	1	9	15	1	64	37	9	30	0	0	4	5	14
Feb 2024	7	22	27	1	3	11	0	47	28	6	31	1	0	9	5	24
Mar 2024	4	17	27	1	5	9	0	36	11	9	24	0	2	16	5	18

Breakdown of Q4 (Jan 24 – March 24)

CSFS Divisional Themes and Trends

Salisbury NHS Foundation Trust

This chart shows the themes and trends of incidents in the CSFS division for Quarter 4.



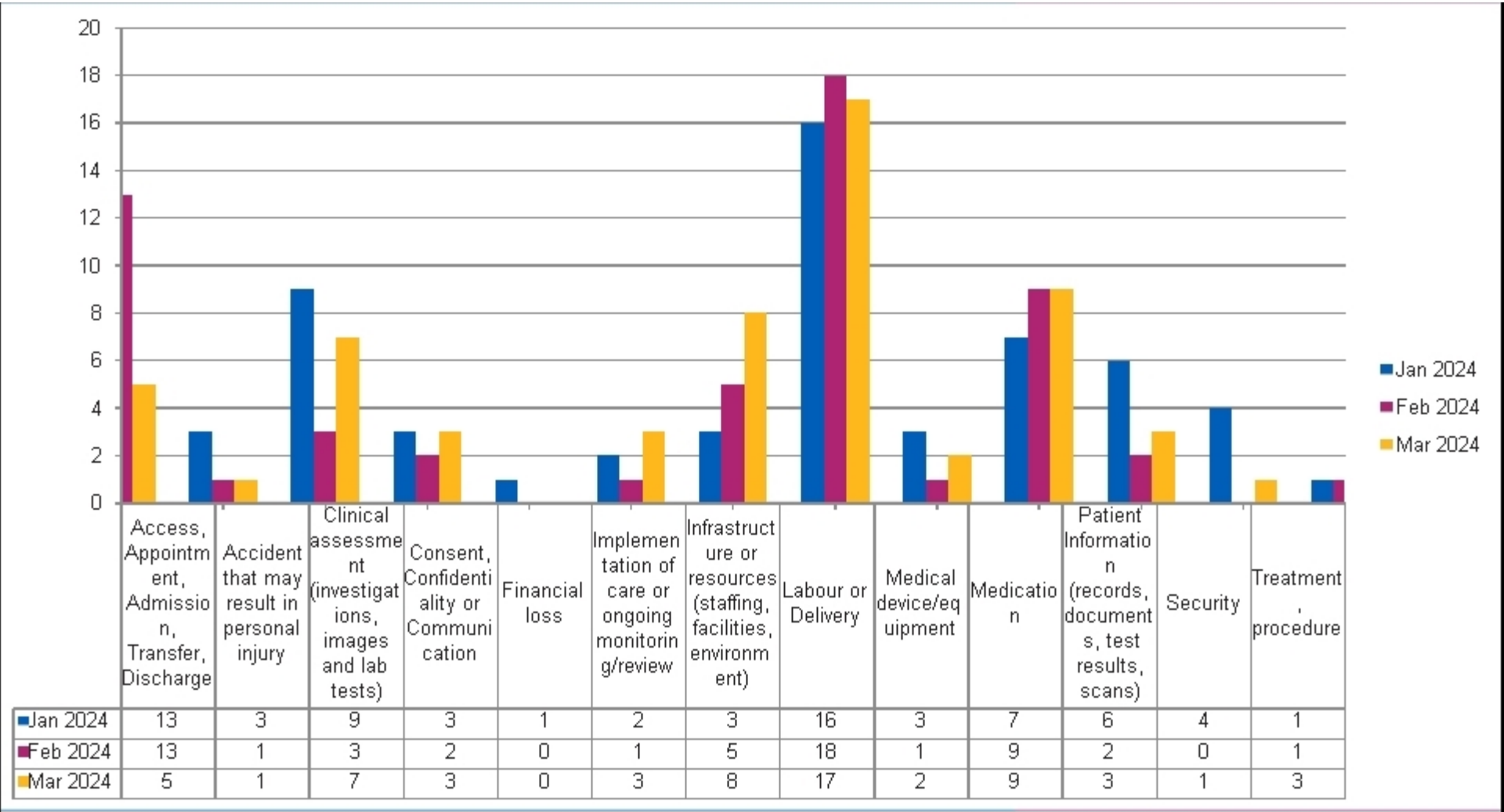
	Abusive, violent, disruptive or self-harming behaviour	Access, Appointment, Admission, Transfer, Discharge	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Implementation of care or ongoing monitoring/review	Infrastructure or resources (staffing, facilities, environment)	Medical device/ equipment	Medication	Nutrition, Hydration & Swallowing	Other - please specify in description	Patient Information (records, documents, test results, scans)	Security	Treatment, procedure
Jan 2024	2	6	8	1	21	6	0	1	30	4	4	30	1	1	2	5	8
Feb 2024	1	6	16	0	13	4	0	0	28	8	6	21	0	0	3	7	3
Mar 2024	2	4	13	0	16	6	1	0	25	12	0	13	1	2	2	6	6

Breakdown of Q4 (Jan 24 – March 24)

WNB Divisional Themes and Trends

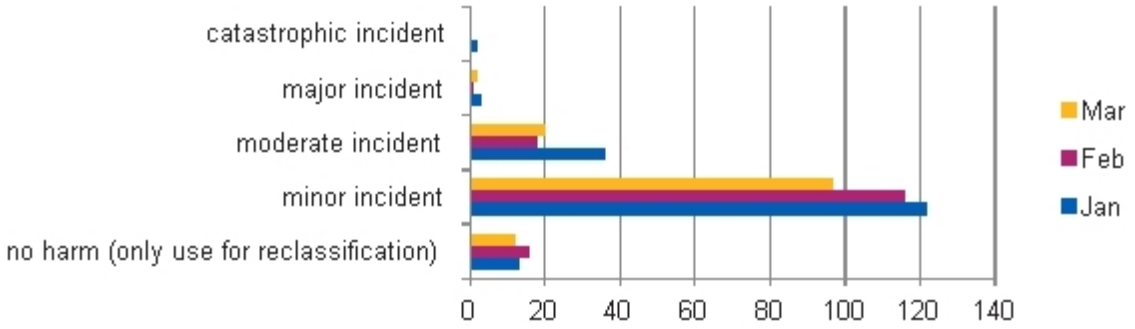
Salisbury NHS Foundation Trust

This chart shows the themes and trends of incidents in the women and new-born division for Quarter 4.

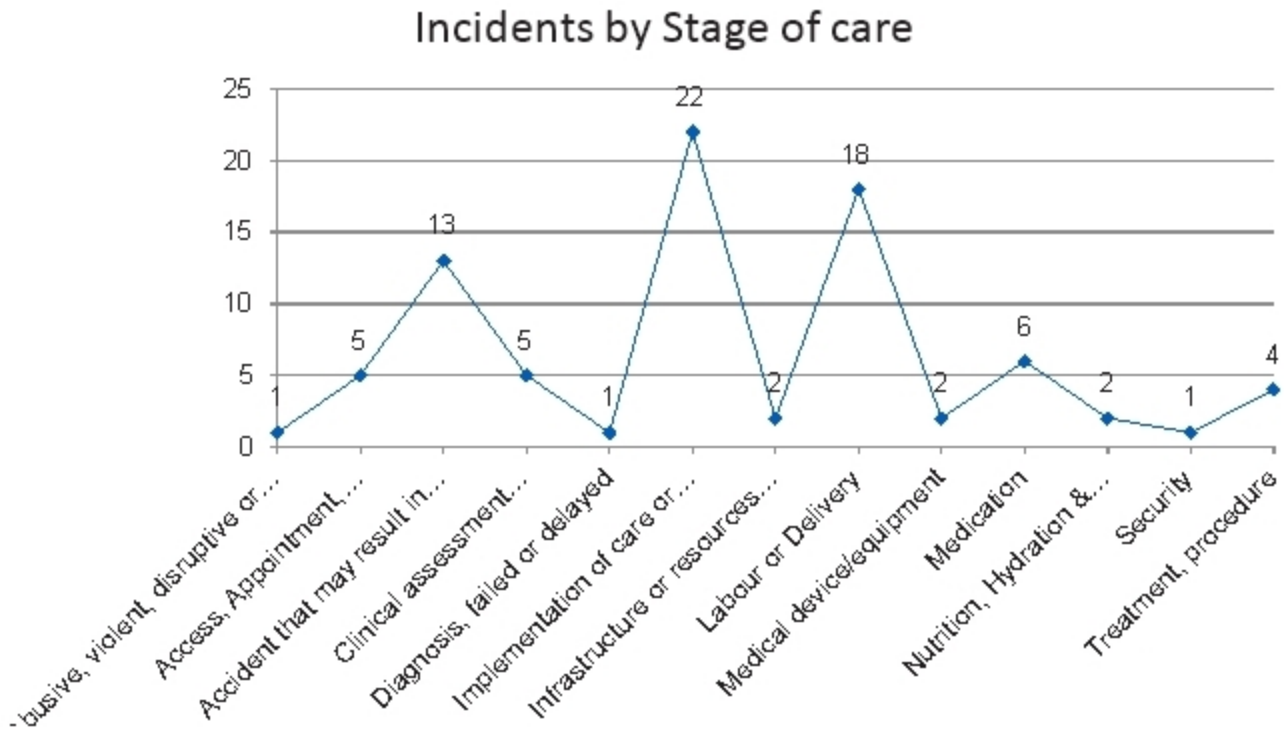


	Access, Appointment, Admission, Transfer, Discharge	Accident that may result in personal injury	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Financial loss	Implementation of care or ongoing monitoring/review	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Patient Information (records, documents, test results, scans)	Security	Treatment, procedure
Jan 2024	13	3	9	3	1	2	3	16	3	7	6	4	1
Feb 2024	13	1	3	2	0	1	5	18	1	9	2	0	1
Mar 2024	5	1	7	3	0	3	8	17	2	9	3	1	3

Breakdown of Moderate incidents in Q4



Of the 2367 incidents reported, only 82 of these were moderate or above harm which is on average 3.46% of incidents.
This has reduced from 3.6% in Q3.



This separates the moderate and above incidents into categories, the next slide will break this down further.

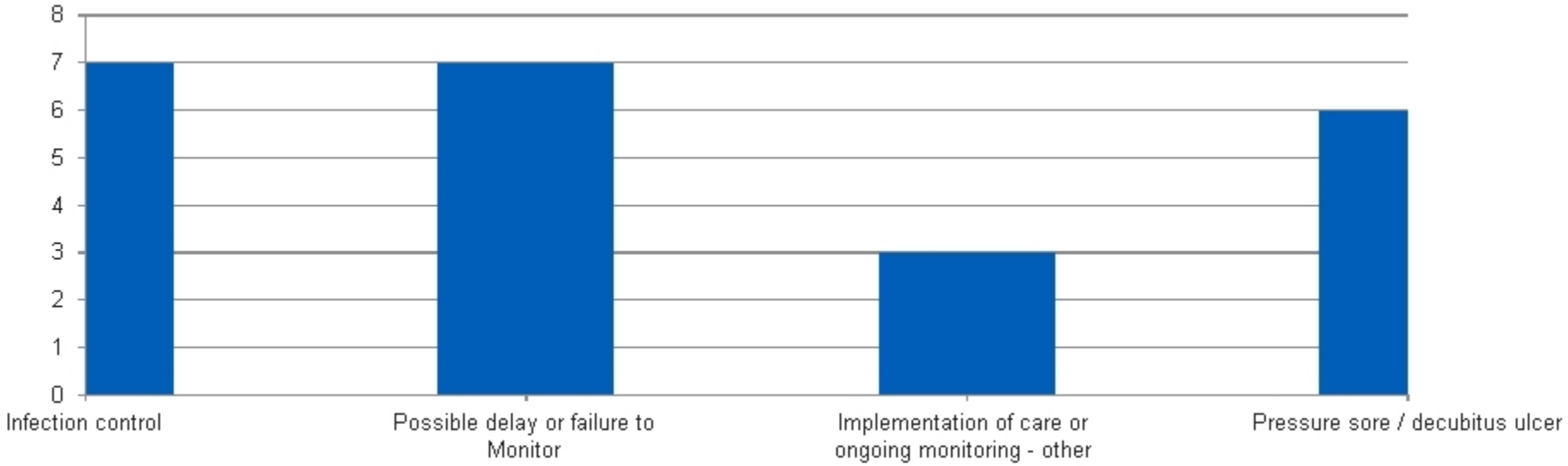
Continued Breakdown of Moderate incidents in Q4

The highest reported moderate incident category is Implementation of care or ongoing monitoring, the graph below breaks this down into subtypes of the incident.

Infection control is the most common moderate incident that is reported, The IPC team work to national reporting standards and we benchmark well against other trusts.

Delay or failure to monitor is an area of focus for the trust currently and is one of our breakthrough objectives.

Pressure sores have been a focus of ours for some time, ongoing work includes; the TVN lead is bringing in a new aSSKINg bundle for the assessment of patient skin and there is new body maps being introduced throughout the trust.



Serious Incident Investigations (SII) and Clinical reviews (CR) updates in Q4

Salisbury NHS Foundation Trust

1 SII was commissioned in January prior to going live with PSIRF at the beginning of Quarter 4 (Jan 8th).

We will continue to work towards closing all the ongoing SII/CRs over the coming months. All panels from these reviews have been held

We have commissioned 4 PSIIs- 2 are never events, and 2 are linked to local PSIRF priorities.

PSII 1 – Cooled Baby
PSII 2 – Wrong site surgery (Never Event)
PSII 3 – Ophthalmology
PSII 4 - Wrong biopsy site (Never Event)

To Note- from April 2023- March 2024 the Trust has had 4 never events

- Retained swab at LSCS
- Retained mouth prop (Child dental extraction)
- Wrong site surgery
- Wrong biopsy site

SII/CR Action Compliance and Deep Dives

As this table shows, there are currently 80 outstanding actions across the 4 clinical divisions. This is almost a **50 % reduction** in the number of red open actions (176) since Quarter 3.

Directorate	Open actions
CSFS	12
Medicine	43
Surgery	15
Women and Newborn	10

The Risk Management Team have been working collaboratively with the divisional teams and a high number of actions have been closed.

Whilst we continue to work towards closing the current SII/CRs new actions will be added, however new actions are carefully considered to establish whether the actions can be fed into existing workstreams.

Traditionally we aim to hold a deep dive meeting for each clinical division every 3 months. The Divisional Management Teams, Executives and Risk Management attend to go through their Risk Registers and Compliance with open actions. All Divisions are in date with their deep dive MDT meeting.

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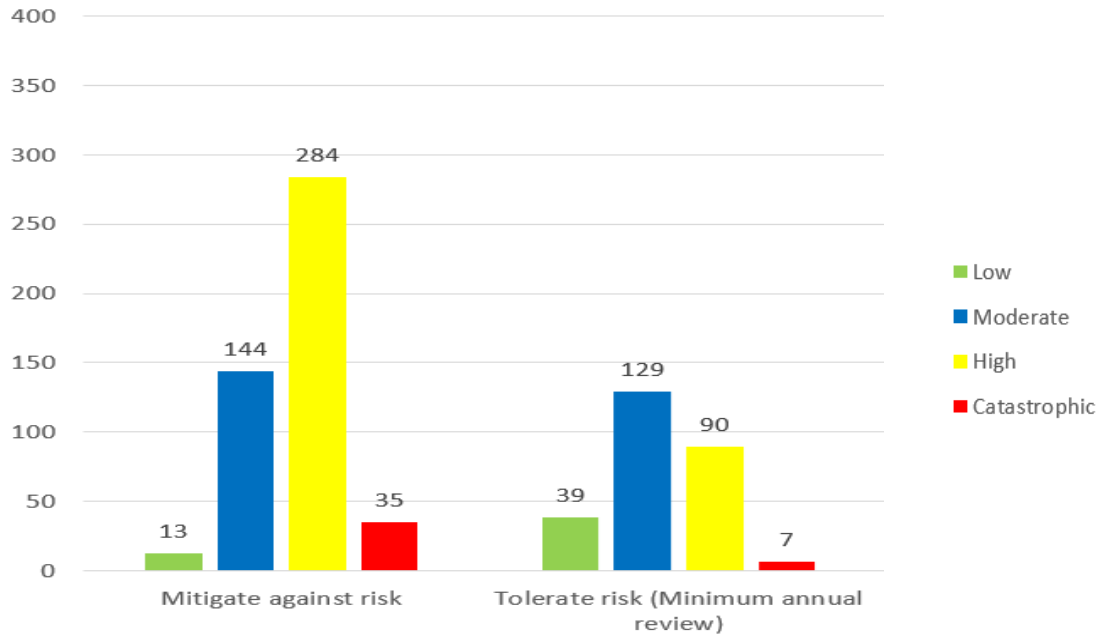
Risk Registers

Divisional and Service Level Risk Registers

Salisbury NHS Foundation Trust

- As of April 2024 there are 748 open risks throughout the trust, of these 265 are being tolerated while 476 are being mitigated.
- The risk team aim to run quarterly deep dives into the divisional risk registers with the CNO and CMO but there is less robustness about the processes being undertaken at service level, this has been reviewed in an external audit by KPMG and we await the outcomes but to note targeted work is planned .
- Following the approval of the Trust risk management strategy the risk team have assigned a staff member to each division to assist them with management of the risk register at a service level. They are providing a more detailed process of review to aid the divisional teams. This will clarify the steps in the review process including how to assess the score, the time frames and the mitigating actions.
- There is now Increased visibility of risk team who are working with the individual areas to make sure their risk registers are up to date and accurate.



Duty of Candour (DoC)

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Duty of candour is a three stage process that requires initial information sharing of any moderate or above incident review. Stage 2 is that a letter to the person that has been involved detailing the review work and this needs to be uploaded to Datix to be counted in the percentage data, the final stage is the sharing of the review outcomes. The length of time it taking to undertake those reviews impacts the stage 3, the move to PSIRF and the use of Patient Safety Reviews will speed up all aspects of this and should positively impact the DOC processes
A DoC tracker has been incorporated into the weekly Patient Safety Summit meeting which keeps track of compliance. The table outlines a significant increase in stage 1 and 2 DoC being completed since its implementation.

This will in the future be added to the Deep Dive agendas in place of the current SII/CR action tracker which will eventually dissolve due to PSIRF, the work the Risk team are doing to distribute the actions into the existing workstreams will support this.

Q4 (Jan-March 2024)		
	Compliance against total cases	Compliance Percentage
Stage 1 Compliance	56/71	79% (-2%on Q3)
Stage 2 Compliance	49/70	70% (+6%)
Stage 3 Compliance	38/69	55% (+10%)

In Conclusion…

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- All Datix incidents undergo a robust quality check to ensure accuracy of reporting utilising a Standard operating procedure process to reduce unwarranted variation .
- The data shows that Incident reporting has remains consistent throughout the last year, there has been a spike in moderate incidents in January 2024, but no specific themes or trends have been identified within this number.
- Themes and trends continue to be analysed and moving forward will form the intelligence for the yearly PSIRF plan. There are several workstreams (e.g. Deteriorating patient and pressure ulcer working group) in the trust which look at the current top categories of reported incidents.
- For quarter 4 there were 2367 incidents reported throughout the trust, only 3.16% of these were moderate or above harm. These incidents continue to be scrutinised through the weekly patient summit with executive oversight.
- Progress has been made with each division to start their Learning from Incidents forums.
- There has been a nearly 50% decrease in the number of open red actions in the compliance report since Quarter 3.

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Appendices

Medicine Highest Rated Risks
January 2024

Salisbury NHS Foundation Trust

The highest rated risks in the Medicine Division at 05/02/2024 are:

ID	Title	Location (exact)	Rating (current)	Escalation status
7435	Time to Initial Assessment/Safety of the waiting room in ED	Emergency Department	16	Divisional Governance Committee Risk Register

Mitigating
Action plan in place. There are 12 actions, 7 of which are complete the other five are ongoing and require review.

ID	Title	Location (exact)	Rating (current)	Escalation status
7852	Ongoing risk of patient disease relapse whilst awaiting admission to UHS for transplant	Haematology	16	Divisional Governance Committee Risk Register

Mitigating
Action plan in place. There is 1 action ongoing and requires review.

ID	Title	Location (exact)	Rating (current)	Escalation status
7958	High number of vacancies in Staffing for older persons Therapy	Durrington AFU	15	Divisional Governance Committee Risk Register

Mitigating
Action plan in place. There are 2 actions, 2 of which are complete the other 2 are within their review date.

ID	Title	Location (exact)	Rating (current)	Escalation status
7935	Non escalation of abnormal NEWS2 observations	Medicine Directorate Management offices	15	Divisional Governance Committee Risk Register

Mitigating
Action plan in place. There is 1 action ongoing and is within its review date.

ID	Title	Location (exact)	Rating (current)	Escalation status
7862	Rising new patient long waiters in Respiratory consultant clinics	Respiratory Medicine	15	Divisional Governance Committee Risk Register

Mitigating
Action plan in place. There is 1 action ongoing and is within its review date.

Surgery Highest Rated Risks
January 2024

Salisbury NHS Foundation Trust

The highest rated risks in the Surgery Division at 05/02/2024 are:

ID	Title	Location (exact)	Rating (current)	Escalation status
6229	Risk of DSU - Estate Infrastructure failure	Day Surgery Unit	20	Divisional Governance Committee Risk Register

Tolerating, within its review date.

ID	Title	Location (exact)	Rating (current)	Escalation status
7931	Lack of appropriate electrical power infrastructure in the theatres.	Main Theatres	20	Divisional Governance Committee Risk Register

Mitigating
No action plan in place currently, within review date.

ID	Title	Location (exact)	Rating (current)	Escalation status
6907	SSL in BCP mode and MI declared in this status	Main Theatres	15	Divisional Governance Committee Risk Register

Mitigating
No action plan in place currently.

ID	Title	Location (exact)	Rating (current)	Escalation status
7917	Fire risk in Main Theatres corridors	Main Theatres	15	Divisional Governance Committee Risk Register

Mitigating
Action plan in place. There are 7 actions, 3 of which are complete the other 4 are due review.

ID	Title	Location (exact)	Rating (current)	Escalation status
7096	Lack of resilience in the ERCP service.	GI Unit	15	Divisional Governance Committee Risk Register

Mitigating
Action plan in place. There are 3 actions, 1 of which are complete the other 2 are due review.

CSFS Highest Rated Risks
January 2024

Salisbury NHS Foundation Trust

The highest rated risks in CSFS Division at 05/02/2024 are:

ID	Title	Location (exact)	Rating (current)	Escalation status
7455	Blood360 Kiosk becoming increasingly unstable and taken out of use	Blood Issue Room	20	Divisional Governance Committee Risk Register

Mitigating
Action plan in place. There are 6 actions, 4 of which are complete the other 2 are ongoing and require review.

ID	Title	Location (exact)	Rating (current)	Escalation status
7893	Lloyds returning their outpatient contract	Pharmacy	16	Local Management

Mitigating
Action plan in place. There is 1 action ongoing and requires review.

ID	Title	Location (exact)	Rating (current)	Escalation status
7939	Pathology/Pharmacy Stores - Inadequate controls for waste, fire, storage and awareness/procedure	Pathology Stores	16	Local Management

Mitigating
Action plan in place. There are 4 actions ongoing, and they are within their review date.

ID	Title	Location (exact)	Rating (current)	Escalation status
7751	Aria - E-prescribing system upgrade	Pharmacy	16	Divisional Governance Committee Risk Register

Mitigating
Action plan in place. There is 1 action ongoing and requires review.

W&NB Highest Rated Risks
January 2024

Salisbury NHS Foundation Trust

The highest rated risks in Women and New-born Division at 05/02/2024 are:

ID	Title	Location (exact)	Rating (current)	Escalation status
6773	transfusion training competencies do not meet the minimum requirements of the blood policy of 85%	Labour ward	12	Local Management

Mitigating
Action plan in place. There are 6 actions, all of which are complete.

ID	Title	Location (exact)	Rating (current)	Escalation status
7454	Lack of space in dewar room in Fertility Clinic	Fertility Centre	12	Local Management

Mitigating
Action plan in place. There are 3 actions, 2 of which are complete the other 1 is ongoing and within its review date..

ID	Title	Location (exact)	Rating (current)	Escalation status
7860	Neonatal ventilators	Neonatal Unit	12	Local Management

Mitigating
No action plan in place.

ID	Title	Location (exact)	Rating (current)	Escalation status
7894	Delay in first trimester screening bloods reaching the lab in Portsmouth	Antenatal Clinic	12	Local Management

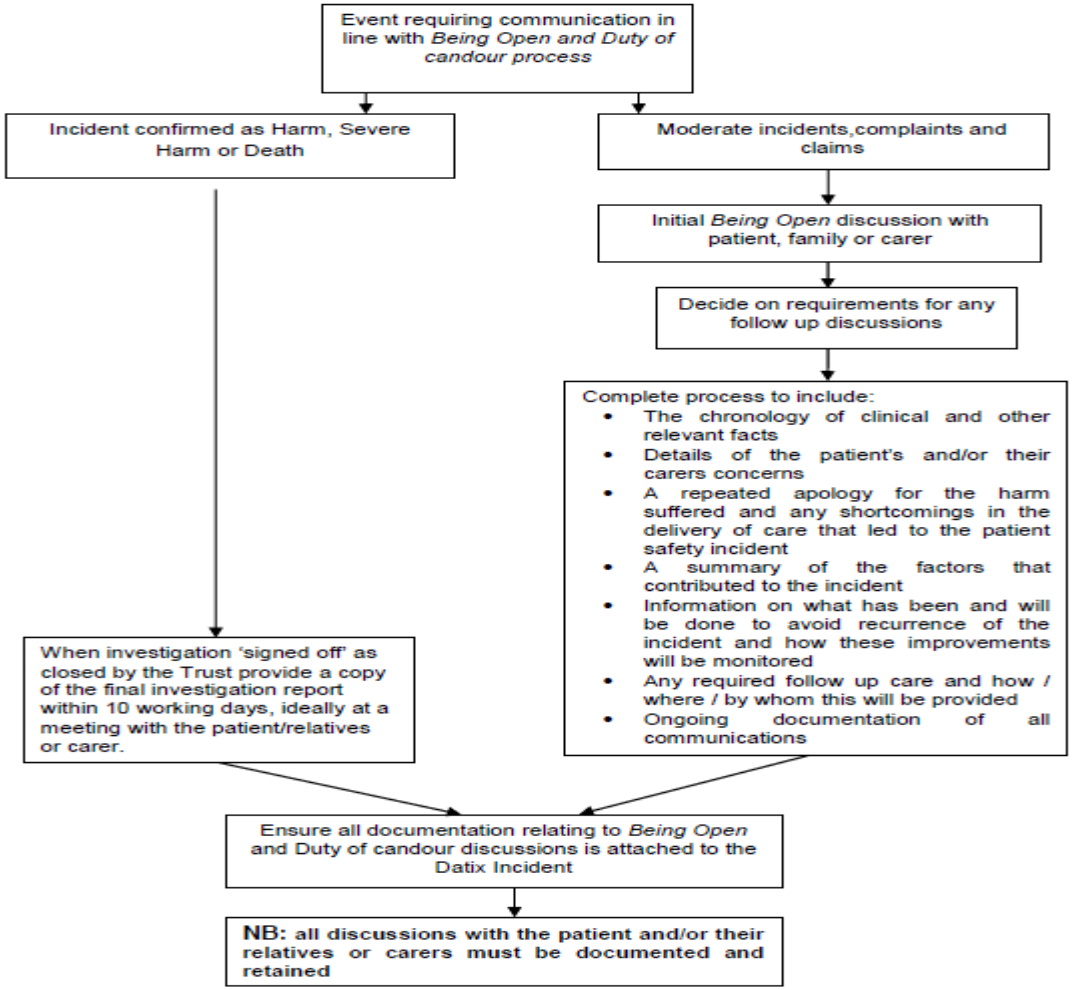
Mitigating
Action plan in place. All actions are complete, within its review date.

ID	Title	Location (exact)	Rating (current)	Escalation status
7913	Babies not being vaccinated within 28 days for BCG	Postnatal	12	Local Management

Mitigating
Action plan in place. There are 2 actions which are ongoing and require review.

DOC guide (Lifted from DOC policy)

Salisbury NHS Foundation Trust



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Report to:	Trust Board (Public)	Agenda item:	4.1
Date of meeting:	4th July 2024		

Report title:	Care Quality Commission Update June 2024			
Status:	Information	Discussion	Assurance	Approval
	Yes		Yes	
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee 25 June 2024			
Prepared by:	Alison Montgomery Fiona McNeight			
Executive Sponsor: (presenting)	Judy Dyos			
Appendices	Appendix 1 – Presentation: CQC Single Assessment Framework and new approach to monitoring and regulation Appendix 2 – Surgery core service self-assessment findings presented to TMC			

Recommendation:

For CGC to note the changes to CQC monitoring and regulatory approach and feel assured by work in progress to socialise the approach and to support the core services in being CQC prepared.

Executive Summary:

There have been no inspections since 2021. The CQC have introduced a new Single Assessment Framework, which is currently being used to assess one of our core services, namely Maternity. The framework is being socialised across the organisation and a CQC page has been set-up on SALi.

Some core services are being supported to undertake a self-assessment of must dos and should dos from a range of CQC reports for learning purposes and to prompt improvement where required. This methodology has received some positive feedback.

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

Salisbury NHS Foundation Trust

Care Quality Commission (CQC) Update June 2024

1 Purpose

1.1 The purpose of this report is to provide the Clinical Governance Committee with an update on what we are doing at the Trust to help ensure CQC preparedness.

2 Background

2.1 The Trust, as a provider, was last inspected in November/December 2018, with a report published in March 2019 demonstrating a change in rating from requires improvement to good. In 2021 our Maternity and Spinal Services were inspected, both receiving a rating of requires improvement. Improvement plans have been progressed and closed. There have been no further inspections. It should be noted that our Maternity Service is currently undergoing an assessment using the CQC new Single Assessment Framework (SAF).

The CQC have been developing a new monitoring and regulatory approach which has now been rolled out. The new SAF is a framework that applies to all providers, local authorities and systems and used from registration through to maintenance of registration. The framework continues with the 5 key questions (safe, effective, caring, responsive and well-led), the 4-point ratings scale (outstanding, good, requires improvement, inadequate) also remains. New to the framework are Quality Statements, which replace key lines of enquiry (KLOEs) and are described as commitments that providers, commissioners and system leaders should live up to. There are 6 categories for evidence collection, which will be scored to make CQC judgements more structured and consistent. The number of evidence categories and the sources of evidence will vary depending on service or model, the level of assessment and whether the assessment is for an existing service or at registration. The framework provides a range of information to be assessed about providers flexibly and frequently and ratings can be updated at any time. Assessment will no longer be tied to set dates or driven by previous ratings. This will help CQC respond more flexibly to changes in risk and help decide which services to visit. The SAF will facilitate production of shorter, simpler reports showing the most up-to-date assessment.

3 What we are doing at the Trust

3.1 Socialising the new SAF

Work is ongoing to socialise the new SAF across the organisation. To date a presentation (see Appendix 1) has been given at the Trust Management Committee (TMC), all of the Divisional Governance meetings and to 6 out of 11 core services. A CQC page has been set-up on SALi and information is available for staff via this link:

http://intranet/quality/clinical-governance/care-quality-commission-cqc/

3.2 Core service self-assessments against must dos and 'should dos' in recent CQC reports

Facilitated by the Head of Compliance, the Surgical Core Service undertook the above in Autumn 2023 and presented their findings to the TMC in January 2024 (see Appendix 2). There was positive feedback from this exercise and, reassuringly, the team did not uncover anything that they weren't already aware of. The process is that the Head of Compliance randomly selects a number of reports (6 – 8), ranging from inadequate to outstanding and reviews for key themes in must dos and 'should dos'. This information is provided to the core service, who undertake their self-assessment against the themes and are then given an opportunity for a 'check and challenge' meeting with the Director for Integrated Governance and Head of Compliance prior to attending TMC.

The Medical Core service commenced this exercise in early 2024 and will present to TMC in the near future. They have already had a 'check and challenge' session, which was very informative and again the feedback was positive about the process and reassuring in that they also reported that they did not uncover anything that they weren't already sighted on. At the request of the Medicine DMT, information has been provided to them to share with Urgent and Emergency care, so that they can undertake the exercise.

Of note, the same exercise was started for Maternity Service early 2024 (prior to the assessment notification) but interestingly there appeared to be nothing mentioned more than once across the reports, so it was difficult to pick-up real themes, so essentially, they were just provided with a list of must dos and 'should dos' but grouped under headings.

4 Summary

4.1 There have been no inspections since 2021. Our Maternity Service is currently undergoing an assessment using the new SAF. There is good progress with socialising the new SAF across the organisation and the development of a CQC page on SALi. Some core services are being supported to undertake a self-assessment for the purposes of learning and improvement where required.

5 Recommendations

5.1 For CQC to note the changes to CQC monitoring and regulatory approach and feel assured by work in progress to socialise the approach and to support the core services in being CQC prepared.

Alison Montgomery
Head of Compliance

NHS Salisbury NHS Foundation Trust

Report to:	Clinical Governance Committee	Agenda item:	2.1
Date of meeting:	25 June 2024		

Report title:	Well-Led Areas for Improvement Progress Report			
Status:	Information	Discussion	Assurance	Approval
			x	
Approval Process: (where has this paper been reviewed and approved):	Nil			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			

Recommendation:
To note the progress made against the areas for improvement identified as part of the external well-led developmental review in 2023.

Executive Summary:
Following a BSW competitive tender process, AQUA were appointed to deliver an external well-led developmental review. The Trust review took place April – June 2023. As part of the tender process, the 3 Acute Trusts commissioned a shared learning report which is anticipated Autumn 2024 once RUH review has concluded. Key development themes were identified for each Key Line of Enquiry (KLOE) from the findings of the review and there was Executive agreement to the key development themes and delivery workstreams in November 2023. This was presented to Trust Board in December 2023 and the proposed improvement themes were approved. It was agreed that there would be a bi-annual progress report to Board. Progress has been made across all identified improvement areas as outlined in the report with on-going work being addressed within current programmes of work.

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

Salisbury NHS Foundation Trust

Well-Led Progress Report

Purpose

1.1 The purpose of the report is to provide assurance of progress against the areas for improvement identified through the AQUA External Well-led Review concluded in June 2023.

2 Background

2.1 Following a BSW competitive tender process, AQUA were appointed to deliver an external well-led developmental review. The Trust review took place April – June 2023. As part of the tender process, the 3 Acute Trusts commissioned a shared learning report which is anticipated Autumn 2024 once RUH review has concluded.

Key development themes were identified for each Key Line of Enquiry (KLOE) from the findings of the review and there was Executive agreement to the key development themes and delivery workstreams in November 2023. This was presented to Trust Board in December 2023 and the proposed improvement themes were approved. It was agreed that there would be a bi-annual progress report to Board.

Progress against each of the improvement themes is noted below (Appendix 1 outlines the review findings).

3 Improvement theme progress

3.1 KLOE 1: Leadership Capacity and Capability

There were 6 approved areas for improvement:

- NED skillset review and consideration of an Associate NED model – this was completed as part of the recent NED recruitment and 2 NEDs were appointed as Associate NEDs in addition to a substantial NED position.
- Board Committee escalation process and review of escalation templates – this has been completed and the 3A (Alert, Assure and Advise) model has been implemented.
- Strengthen Divisional Governance arrangements – the Director of Integrated Governance has been working with the Divisional Management Teams (DMT) and attending Divisional Governance meetings to support standardisation of meeting agendas and content. The Divisional Governance meeting standard agenda template has been revised. Specialty performance reviews are now being tracked with oversight at the Divisional Performance Reviews (DPR). Deep dives of the Divisional Risk Registers continue with the Chief Medical Officer and Chief Nursing Officer. The Divisional Performance Reviews (DPR) have been reviewed and Leader Standard Work has been implemented for the development of the DPR packs. An Internal Audit of Divisional risk management, completed in May 2024, provided an overall assessment of 'partial assurance with improvements required'. Areas for improvement related to Divisional oversight of specialty risks registers, consistency of risk reporting at the DPRs, review and updates to risks on Datix and risk management training. Recommendations are being implemented to agreed deadlines.
- Structured Board Development Programme – this work is on-going. Board development days are being structured to prioritise key risk discussions.

- Board visibility – a revised Leading through Go and See Programme is under development to be implemented by September 2024 and will incorporate the Board Safety Walkabouts. There have been Improving Together Board development sessions in April 2023 and June 2024 focussed on Go and See. Executives are undertaking Go and See's regularly.
- Talent Management and Succession Planning approach – NHS England and CQC identified talent management as one of its key strategic objectives. Throughout the course of 2023/24 the Trust Management committee have discussed and agreed:

1. The Trust definition of our approach to talent, which included the following four guiding principles:
   - Everyone should be able to have a fulfilling career.
   - Everyone should be able to access the right development opportunities for them.
   - Everyone has talent.
   - Inclusion underpins the strategy.

   Definition:

   "At SFT we have an inclusive approach to talent. We believe that everyone in our organisation is talented. We will therefore support everyone to reach their potential, whatever their characteristics, grade, or professional group. We will provide our leaders and managers with tools to support them to develop all their people to be the best that they can be at work and provide individuals with development opportunities to support them to reach their potential."

2. That the proposed elements of the talent strategy should be: talent management, talent development and succession planning which provides a robust approach to succession planning, talent acquisition, identification, and development without bias.

   TMC agreed a more inclusive approach to talent management in that everyone has their own strengths and weaknesses and that everyone has potential to add value in their own unique way.

   That the talent development encompasses all the Trust's activities and initiatives that support employee learning and growth with an ambition for every employee to have a clear pathway to expand their skillset, advancing within the organisation, and achieving their professional ambitions.

   The Trust approach to succession planning is the process of identifying and developing potential future leaders or senior managers, as well as individuals who could fill other business-critical positions, either in the short or the long term. The approach would begin with the Executive Directors and their immediate reports, before cascading to the direct reports team and other service critical roles in the Directorates and Divisions.

   Examples of recent talent management and talent development activity in the Trust include: leadership development for the divisional clinical directors, building trust and increasing collaboration across Executive direct reports, increasing awareness of Board role requirements through two cohorts of shadow board.

3. Our Trust talent objective to ensure all employees have the right skills to embrace significant organisational change, through embedding a culture of ownership, empowerment and decision making at all levels of the organisation, so that we may have:
   • Flexible, resilient individuals who are ready for the next challenge.
   • A Trust that is an Employer of Choice for talented individuals.
   • Employees who are not only skilled for the present but for the future.
   • A Trust that can respond quickly, effectively and fairly to changing circumstances.

   Adopted an evidence based option to rate behaviour and potential, which is currently been used in the talent and succession planning for the direct reports to the Executive team.

   The final papers outlining the approach informed by this first experience of application, also including the approach to identify key/ critical roles in the leadership and management teams, will be presented for discussion and agreeing at OD and P Board and People Committee in July.

   The Exec team have concluded the 360 feedback pilot which will be evaluated with consideration to further cascade across the senior leadership team at a minimum

   The annual appraisal form and process has been refreshed once and is to be refreshed again to include reference to the values within the context of the leadership behaviours and the process aligning strategy / individual and team objectives / talent development and succession planning will be made more explicit; design and launch later this year

3.2 KLOE 2: Vision and Strategy

There were 2 approved areas for improvement:

- Divisional 5-year plans – There is now a structured approach to clinical divisional annual planning. As part of Improving Together each division agrees with the executive their 4 to 6 key areas for improvement each year in a process known as the scorecard agreement. This process recognises our teams cannot focus on everything and so seeks to give them clarity on their priorities within the scope of the resources available. The scorecard agreement also includes the confirmation of a range of watch metrics – areas of work which continue on a business as usual basis and are therefore not expected to generate significant improvement. Additionally, at the specialty level within Divisions, clinical and operational leaders are engaged in a process of 'responding' to the Trust master strategy with their 3, 5 and 10 year plans.

- Health inequalities reporting and awareness – Health Inequalities annual report presented at Clinical Management Board (CMB) in April 2024 and Trust Management Committee (TMC) in May 2024. There is currently a broad range of activity being supported by the Trust and our staff to reduce health inequalities. Several staff members are closely involved in this work and have been very proactive at addressing issues of inequality, e.g., by addressing a specific health which was identified during their interaction with patients and staff.

  Given the broad range of activity already taking place, there is currently consideration of a small number of priorities to address in addition to core business as usual. These should be driven by the Trusts Improving Together programme and 'A3' thinking. Cardiovascular disease is one of the top contributors to our crude mortality rates and our population health data suggests that management of hypertension, lipid control, and diabetes could be a few specific areas of focus. A workshop took place on 13th June to help us undertake an in-depth review of this data in collaboration with our community partners.

3.3 KLOE 3: Clear roles and responsibilities and systems of accountability

There were 4 approved areas for improvement:

- Divisional accountability – the Integrated Governance and Accountability Framework was revised in April 2024. The DPR meeting and performance packs have been revised to enhance oversight and accountability. The packs are now being replicated for the performance meetings with the specialties (SLT's) and are in the process of being rolled out.
- Quality of Board and Board Committee papers – 2 NHS Provider report writing sessions have been held for Executives, NEDs and Senior Managers. There is Executive approval of Board and Board Committee papers prior to publication.
- Review of the Governor observer at Private Board – this is complete. There is no longer a Governor observer at Private Board as agreed with the Lead and Deputy Lead Governor and the Chair.
- Policy compliance – there has been regular reporting to Trust Management Committee of policy compliance. This is improving incrementally but compliance remains a concern. The risk is now recorded on the Corporate Risk Register and the CEO has scheduled a Policy Summit on 3rd September where all outstanding policy owners will be required to attend.

3.4 KLOE 4: Culture of high quality care

There were 2 approved areas for improvement:

- Freedom To Speak Up Guardian (FTSUG) reporting – The identified increase in FTSU reporting has been investigated and follows the national trajectory for speaking up cases reported nationally (post Lucy Letby). There is focus on the timeliness of responses to concerns raised. This is currently challenged by the lack of resources within the employee relations department to support concerns raised by staff who then use the FTSU route. FTSUG and ambassadors have commenced walkabouts to raise awareness and increase staff engagement, supported by Listening Events held with the FTSUG and CPO out of hours to increase access by all staff. There is a new refreshed policy and strategy. Following the successful visit to the Tent Talks at SFT in July 2023, The National Guardian, Jayne Chidgey-Clark, commented on the positive engagement that the Board had with FTSU and the desire to improve, reflect and learn from concerns raised. She was also satisfied with the quality, content and governance of FTSU Reports, and in particular the attention given to ensuring that all colleagues especially from diverse backgrounds, do speak up. This puts SFT in a strong position with the National Guardian Office focus for 2024-25 being Inclusion.
- Staff survey action planning – Divisions presented their staff survey action plans to TMC in April 2024 and Corporate Services in May.

3.5 KLOE 5: Appropriate and accurate information being effectively processed, challenged and acted on

There was one approved area for improvement:

- Board cyber and digital awareness – there was a Board development session held in February 2024. The subsequent discussion on risk appetite also covered cyber elements with a draft proposed set of statements sent to Finance and Performance Committee for consideration.
  A cyber security framework is being finalised outlining the approach SFT takes on cyber, its current performance and areas for improvement. This is for annual review and sign off by the Board with the report going to Finance and Performance Committee in September 24 and onward to Trust Board.
  There have been rolling activities to raise awareness around digital/cyber in conjunction with communications. Bi-monthly reports on the Shared EPR programme will come to Trust Board from the EPR Joint Committee (next meeting is July 2024).

3.6 KLOE 6: Clear effective processes for managing risk, issues and performance

There were 3 approved areas for improvement:

- Alignment of the Board Assurance Framework (BAF) to the ICB BAF – this is now included in the BAF reports to Board and Board Committees on a bi-annual basis.
- Quality Impact Assessment (QIA) Process – the QIA policy has been revised and there is now oversight of the QIAs at Clinical Management Board (CMB). This work is ongoing to ensure sustainability of oversight.
- Review of risk appetite – there was a Board development session in April 2024. Risk categories and definitions are currently being worked through as an action from the Board development session. This is being presented to the Board in July and September 2024 with a view to establish a risk appetite framework once all risk categories and levels definitions have been approved by the Board.

3.7 KLOE 7: Patient, public and external partner engagement

There were 2 approved areas for improvement:

- Structured approach to co-production – the Trust has introduced patient panels in cancer services and spinal services. There has been recent patient involvement in a recent recruitment panel (cancer matron). The Readership Group reviews patient literature prior to publication. The Trust now has 2 Patient Safety Partners involved in the patient safety agenda and representing the patient perspective. Recent focus groups have been held with patients for stoma, breastcare and colostomy services.
- Staff engagement – the Trust now has an Engagement Group leading on staff engagement. There are a number of activities to support staff engagement including:
    - 'Hearing It' is a chance for any colleagues to feedback to the CEO about their experiences of working at SFT. Feedback is collated into themes.
    - At 100 days and one year new starters are invited to meet with the CPO and DCPO to talk about how their first months / year have gone. Going forwards new starters are signposted to these meetings on arrival as part of the My First 90 days package.
    - Staff Council is a new membership forum designed to support retention and support people to discuss the People Promise and how the elements impact on them and their work and is in the process of being established.

  Staff screens (in some staff rooms) and public screens have been installed across the Trust to communicate key information. Tent Talks were held in June for the second year with excellent attendance. The Employee Value Proposition and SOX recognition framework is in the process of being reviewed as part of the wider Board visibility programme. 30 members of staff have currently come forward in the response to become NHS Ambassadors.

3.8 KLOE 8: Robust systems and processes for learning, continuous improvement and innovation

There were 3 approved areas for improvement:

- Organisational learning (complaints, incidents & mortality reviews) – There has been a refresh of the Clinical Governance half days as shared learning events. The weekly patient Safety Summit lends itself to shared learning for those incidents graded moderate and above. A communications plan is under development to support shared learning across the organisation. Shared learning forums have been introduced into the clinical divisions which incorporate a cross divisional forum.
- Growing commercial based research – the Trust is prioritising commercial research studies and is in the process of building this portfolio. Commercial research is also a National priority. The research department presented at the recent EDGE Conference (International research conference).
- Lived experience into Improving Together – staff stories now incorporated into the monthly Improving Together Board.

4 Summary

4.1 There has been progress made against all identified areas for improvement following the external well-led developmental review in 2023 with on-going work being addressed within current programmes of work.

5 Recommendations

5.1 To note the progress made against the areas for improvement identified as part of the external well-led developmental review in 2023.

Fiona McNeight
Director of Integrated Governance

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Virtual Meeting Etiquette:

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CQC Single Assessment Framework and new approach to monitoring and regulation

Alison Montgomery

Head of Compliance

January 2024

Current status

Salisbury NHS Foundation Trust

Date of last inspection and ratings for core services

Dec 2015	Nov/Dec 2018	Mar 2021	Oct 2021
Medical Care – *Good* Children & Young People – *Requires improvement* End of Life Care – *Good* Outpatients – *Good* Diagnostic Imaging – *Good* Gynaecology – *Good*	Urgent & Emergency Care – *Good* Surgery – *Good* Critical Care – *Outstanding* Provider Well-led and Use of Resources – *Good* Overall Provider rating improved to – *Good*	Maternity – *Requires improvement* Spinal Services – *Requires improvement* *No change in Provider rating*	Maternity (against WN actions) – *Requires improvement* *No change in Provider rating*

What's changing?

NHS Salisbury NHS Foundation Trust

Multiple assessment frameworks	Single assessment framework
Ongoing monitoring and with inspections scheduled according to previous rating	Ongoing assessment of quality and risk
Evidence gathered during onsite inspection (single point in time)	Evidence gathered at multiple points in time (not just through inspection)
Judgements and ratings decisions made using ratings characteristics	Teams assign score to evidence
Narrative inspection report	Ratings updated; short narrative published

What is the Single Assessment Framework (SAF)?

NHS Salisbury NHS Foundation Trust

- A framework that applies to all providers, local authorities and systems
- It focuses on what matters to people who use health and social care and their families and is designed to help CQC provide an up-to-date view of quality
- It covers all sectors, service types and levels – from initial registration moving on to continuous monitoring and regulation
- The framework continues with:
  - 5 key questions (safe, effective, caring, responsive and well-led)
  - 4-point ratings scale (outstanding, good, requires improvement and inadequate)
- New to the framework are:
  - 34 Quality ('We')statements which replace key lines of enquiry (KLOEs)
  - 6 evidence categories

Quality Statements

Salisbury NHS Foundation Trust

- Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as 'We' statements, they show what is needed to deliver high-quality, person-centred care. They are pitched at the level of *'good'*
- They derived from 'I' statements – statements that reflect what people have said matters to them when accessing healthcare and are written from the perspective of the patient
- They show how services and providers need to work together to plan and deliver high-quality care
- They relate directly to the regulations – regulations CQC would consider in their judgements
- An example of a safe quality ('We') statement:
  - **Learning culture**
    We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
    - **Related regulations**

      Regulation 12: Safe care and treatment

      Regulation 16: Receiving and acting on complaints

      Regulation 17: Good governance

      Regulation 20: Duty of Candour

Evidence categories

Salisbury NHS Foundation Trust

- Designed to help bring structure and consistency to CQC assessments. There will be a scoring* system for evidence provided for each quality ('We') statement

- They show the types of evidence CQC use to understand the quality of care being delivered against the quality statement

- The evidence categories are:

People's experience of health and care services	**Observation**
Feedback from staff and leaders	**Processes**
Feedback from partners	**Outcomes**

- Different evidence categories will be used for sector groups/services and whether the assessment is for an existing service or at registration

- CQCs new Portal will enable us to share evidence more frequently but the process for this has not yet been made clear. Quality of evidence and collation will be key

*(*CQC scoring: 4 = evidence shows exceptional standard/3 = evidence shows a good standard/2 = evidence shows some shortfalls/1 = evidence shows some significant shortfalls)*

Using the SAF for the first assessment

NHS Salisbury NHS Foundation Trust

- Each quality statement will need to have a score applied to it
- Quality statements to be assessed will be selected based on national priorities, set by type of service and consideration of the information held about the service
- CQC will collect evidence and score all the relevant evidence categories
- This means the score for the selected quality statements will be entirely based on the new assessment
- For the remaining quality statements, CQC will base the scores on their current published rating for the relevant key question for a service

Example of calculating the first score – using SAFE key question for Surgery at SFT

Salisbury NHS Foundation Trust

- There are 8 quality statements for the SAFE key question
- The first 4 quality statements are assessed by looking at and scoring evidence from all the relevant evidence categories to give a score for each quality statement (new assessment)
- The SAFE key question for Surgery is *Good (Nov 19),* therefore the last 4 quality statements are automatically given a score of 3*, based on current published rating
- Scores for all 8 quality statements are added together and a calculation applied to help determine the overall new rating for SAFE for Surgery

*(*CQC scoring: 4 = key question rated as outstanding/3 = key question rated as good/2 = key question rated as requires improvement/1 = key question rated as inadequate)*

Summary of the new framework

NHS Salisbury NHS Foundation Trust

- Five key questions and ratings remain the same
- Quality ('We') statements focus on specific topics under the key questions
- Six new evidence categories aligned to the new quality statements – evidence is scored to make judgements more consistent and structured *(quality of evidence and collation will be key)*
- Site visits (inspections) will be focused and support gathering evidence, rather than being primary way to collect evidence as before
- CQC will not necessarily have to inspect to re-rate a service and a Trust can be re-rated at any time
- Quicker and more responsive assessments and ratings; shorter and simpler reports that show most up-to-date assessment

Roll-out of the SAF

Salisbury NHS Foundation Trust

- Planned for November 2023 – rolled out regionally, starting with providers in the South of England
  - (*For hospitals – CQC currently testing SAF on selected independent hospitals, assessing targeted key questions and quality statements*)
- Assessments will be scheduled by considering factors such as the level of risk – hence not all providers will have an immediate assessment
- Any assessments will use the new SAF

HOWEVER

- Until providers are notified or told otherwise, CQC are continuing with their current methods to monitor, assess and rate

Resources:

Our new approach to assessment - Care Quality Commission (cqc.org.uk)

http://intranet/quality/clinical-governance/care-quality-commission-cqc/

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Well-Led Developmental Review

Areas for Development

KLOE 1 : report findings

NHS Salisbury NHS Foundation Trust

KLOE 1 Leadership, Capacity and Capability

Key Development Themes

↑ Board Stability and Capacity

The underlying narrative behind each of the Board appointments is compelling but the number of changes may prompt a challenge in respect of Board stability. NED preparedness for regulatory questions varied considerably.

Development –

- *There may be value in periodically undertaking a stocktake of priorities, individual portfolios, major change programmes against individual and collective board capacity. Whilst key to this is appointment to interim vacancies, consideration can also be given to Associate NED roles.*
- *Regulatory challenge development is recommended to present the Trust in the best light (for board and divisional leadership). This preparation needs to be underpinned by mentoring and strong Trust-focused evidence base.*
- *Provide a single positive narrative for Board members in respect of recent appointments to ensure a consistent response to this challenge.*
- *Review the balance of executive capacity and engagement with external partnership commitments recognising that partners may be better placed to lead on some external programmes.*

↑ Talent Management and Succession Planning

An environment has been created where talent and succession discussions can take place, but the next step is to build a more cohesive and embedded approach.

Development-

- *Undertake a structured approach to building Trust-wide talent management and succession planning arrangements.*
- *Increased access to NED perspective and board as part of the leadership development programme. Consideration of operating this programme as an AHA to increase perspective and system context.*

↑ Board Visibility

There are some good examples of leadership visibility, but it is variable and there is opportunity for senior leaders to be clearer about their individual and collective approach to visibility.

Development-

- *Progress the Board Safety Walkround review and incorporate consideration of improved clinician engagement, timing and organisation.*
- *Full Board consideration of a more structured approach to visible, sustainable, compassionate, inclusive and effective leadership*
- *Review the totality of executive external partnership commitments.*
- *Enable wider engagement of senior leaders with Non-Executive directors*

↑ Divisional Leadership (refer also to other sections re divisional developments)

There is some variation in respect of having the right blend of capacity, skills, and experience across divisions.

Development-

- *Assessment of divisional capacity (and leadership gaps) aligned to roles, responsibilities, and scale.*
- *Support for divisional tri-team level development recognising their formation as a group.*
- *Continued focus and increase of cross divisional working and engagement, to continue to increase appreciation (and group resolution) of pressures and challenges. In addition, there was stakeholder appetite for more shared peer learning and sharing opportunities at operational level.*
- *Board line of sight to divisional leadership and performance is an area that needs to be kept under review, Including board exposure and NED visibility with divisions.*
- *There is opportunity to increase empowerment of divisional teams through defined earned autonomy (including defined exit criterion from intensive support). This would benefit releasing executive capacity for system work.*
- *Better engagement with the Local Maternity System is required so there is a shared understanding of any concerns. The Maternity Improvement Plan has had a number of iterations and there may be value in the Maternity Improvement Group being more evidently Board-led.*
- *Explore whether there are synergies across CSFS disparate services and whether opportunities of grouping services in such a division have been fully exploited.*
- *Supporting the development of governance maturity and embeddedness across divisions.*

KLOE 2 : report findings

NHS Salisbury NHS Foundation Trust

KLOE 2
Trust Vision and Strategy

Key Development Themes

↑ Strategy Development

There is a clear strategy, set of priorities, vision and values. Improving Together has helped socialise all these elements.

Development

- *The level of collaboration and engagement in developing strategy was not always seen as positive across the divisions. The engagement approach should be reviewed when the strategy is next refreshed.*
- *Produce a narrative on how all the underpinning strategies and initiatives fit together.*
- *Align the monitoring of strategy delivery to provide transparency.*
- *Application of a structured approach to Divisional annual planning and 5-year planning.*

↑ Business Cases

Board oversight of business cases and the tracking and monitoring of strategic business cases was not well understood.

Development

- *The approach to business cases should be reviewed.*

↑ Clinical Strategy

The lack of a clinical strategy for the Trust is considered to be a gap.

Development

- *A Board focus upon the need for all clinicians to be able to connect with, and exercise influence over, the pan-AHA clinical strategy.*

↑ Health Inequalities

There is good work in train on health inequalities but there was little leadership knowledge of context and strategic intent.

Development

- *Shared narrative is required so leaders (at corporate and divisional levels) can explain what health inequalities are, the data that is being looked at and what action the Trust might be taking alone or with partner agencies.*

KLOE 3 : report findings

NHS Salisbury NHS Foundation Trust

KLOE 3 Roles, Responsibilities and System Accountability

Key Development Themes

↑ Board and Committee Developments

Improvements to the consistency of committee papers

Not all papers were clear in terms of their purpose, what the committee was expected to do, where the paper had previously been and where it was going next. Some papers were not in a format that easily enabled holding to account on delivery, risks, mitigations, and timeframes for the impact of those mitigations. On occasion papers are late.

Development

- *Programme of work to improve the format, timeliness and writing of committee papers.*

Strengthen escalation processes

Chairs' reports are discursive and assurance escalation is not easily visible at Board. Referrals across committees could be strengthened.

Development –

- *This could be strengthened by structuring in a triple "A" format: Advise, Alert and Assure*
- *Embed reflection on the need to cross refer to other committees in committee agendas.*

Consistent challenge and contribution

Executive and non-executive contributions were not always evenly spread across attendees leading to some voices not being heard.

Development

- *Consideration of whole-Board development programme incorporating unitary Board principles, appreciative enquiry and effective challenge.*

Policy Compliance

As a key part of governance structures and regulatory oversight, it is important to maintain the focus on addressing the backlog of policies due for update.

Development

- *Ensure Board and committee line of sight on tracking policy compliance.*

↑ Board Openness

Whilst public openness is encouraged, Governor's observation of the private board is not standard practice and due to confidentiality can lead to additional meetings being required.

Development

Another option is to exclude governors from Part 2 of the Board but strictly limit what goes into Part 2 and have as much in the open part of the Board as possible. This helps to allay governor concerns that they are missing key issues and can be supplemented by the Chair providing the agenda and a summary of what has been discussed. Also, this needs to be seen alongside other opportunities the governors have to observe the NEDs e.g. COG, other committees of the Board.

KLOE 4 : report findings

Salisbury NHS Foundation Trust

KLOE 4
Culture

Key Development Themes

↑ Refer to KLOE 2 Health Inequalities

↑ Staff Feedback

Developments

- *Sustained focus on staff led improvement in Staff Survey results particularly amongst nursing, midwifery and BAME staff*
- *Opportunities for better communicating the improvements that have been made in response to the survey results.*
- *Sustained focus on completion of appraisals and emphasis on their value-add.*

↑ Equality and Diversity

Developments

- *Improved knowledge and use of EDI data to drive change.*

↑ Challenged Services

Developments

- *Working with system partners to assess the viability and ongoing sustainability of challenged services.*

↑ Safety Culture

Developments

- *Embed and sustain changes e.g., theatres consent.*
- *Focus upon learning from incidents and planning e.g., liberty protection standards and PSIRF implementation.*
- *Simplify lengthy and over-engineered processes where possible e.g., incident investigation process.*

↑ Freedom to Speak Up

Developments

- *Investigate and act upon the 50% increase in issues raised with the FTSU Guardian and monitoring of timely feedback to staff (in accordance with internal policy).*
- *Review divisional level access to FTSU.*
- *As part of the review of staff survey performance, review timeliness of FTSU responses.*

↑ Patient, Service User and Family Engagement

Developments

- *Embed coproduction as a norm across the organisation aiming for evidence of consistent codesign and coproduction.*
- *Include service users and carers in Improving Together training and delivery of Trust improvement work. (see KLOE 8)*
- *Consider whether the description of coproduction could be strengthened by reference to health inequalities and EDI and by demonstrating how the Trust will engage and coproduce with different sub-populations.*

KLOE 5 : report findings

Salisbury NHS Foundation Trust

KLOE 5 Information

Key Development Themes

↑ Digital Strategy

Development

- Assessment of the capacity of staff to address EPR and other digital priorities, change programmes and alignment to Improving Together
  - *Prioritisation of digital projects/initiatives recognising the impact of the EPR programme (i.e., staffing capacity and capability).*
- Funding, limitations to revenue and capital allocation
- Evidence of lessons learnt from other organisations.

↑ Information Governance

Development

- *Increased board cyber and digital awareness*

KLOE 6 : report findings

Salisbury NHS Foundation Trust

KLOE 6
Managing Risk and Performance

Key Development Themes

↑ Risk Appetite

Risk appetite is at an early stage of development and needs to become part of the discussions at all levels of governance.

Development-

- *Progress the risk appetite work that has been started and incorporate into committee operation and Board decision-making.*

↑ Board Assurance Framework

The format, content and utilisation of the BAF can be improved particularly with regard to separating controls and assurances, trajectories for improvement and connection to deep dives.

Development-

- *A development programme to refresh the BAF would be timely.*

↑ Top Risks

There is some inconsistency in how the Trust's top risks are described by leaders.

Development-

- *A narrative in advance of any regulatory visit (linked to any BAF development work) should set out key risks for leaders at all levels.*

↑ Quality Impact Assessment

Visibility and consistent understanding of QIA processes needs leadership attention.

Development-

- *Further communication and engagement on QIA arrangements is important.*
-

↑ Performance

There is opportunity to further refine the use of SPC reporting.

- *Consider implementing hybrid SPC aligned to RAG ratings and better utilisation of trajectories, taking account of planned improvements, actions, and investments. Using longer time series where the data is available, helps with seasonal variation. Also suggest the application of the special cause rules could more effectively drive the narrative / analysis / action. Narrative can be observational: if you're using an SPC and the data falls within levels of expected variation then the narrative should conclude levels are as expected, no further analysis is needed and no further actions being undertaken. The trajectories for improvement could be better described and monitored.*
- *There was an appetite for expanding the system to facilitate pathway information (in and out of hospital).*
- *Increased ability for the divisions to interrogate data. The business cases for the EPR and a new maternity system were recognised as opportunities to strengthen information and the ability to share data across providers.*
- *There are concerns that indicators that are not breakthrough measures have a reduced focus which can lead to failure to identify early warnings. This places significant reliance on the operational and divisional teams operating effective governance processes.*

KLOE 7 : report findings

Salisbury NHS Foundation Trust

KLOE 7 Engagement

Key Development Themes

System Engagement

Development

- *The Trust were recognised internally and by system partners as having a significant presence across system initiatives. There was in some internal and external courts a perception that this required rebalancing and a reduction in dominance to facilitate an improved internal focus.*
  - *There is an opportunity to redistribute responsibilities across partners e.g., medical leadership.*
- *There was a perception from partners that within a system context the Trust could be more open and inclusive.*

Service Provision Partnerships

Development

- *Wiltshire Health and Care (WH&C) partnership has a contract extension to 2024:*
  - *System based decisions regarding the provision and commissioning approach for community care will be required. It was understood that there were tensions between the organisations regarding the future model.*
  - *It was understood that the partnership would be financially challenged in 2024 regarding pay award funding.*
  - *It was understood by partners that Salisbury saw direct management the community health service delivery as part of their ongoing viability.*
  - *Viability could be compromised subject to the contractual arrangements (i.e., current block arrangements).*
- *Stakeholders noted an opportunity to risk share more equitably particularly between the Trust and Wiltshire Council where relationships 'could be better.'*
- *The provision of mental health services by different adult and CAMHS providers outside the AHA presents some challenges particularly with out of hours responsiveness.*

Staff Engagement and Communication

Development

- *The Communications Team is built on freelance staffing which impacts team and staff development. A business case has been submitted to develop as substantive.*

Service User and Carer Engagement

Development

- *Ensure a robust approach to service user and carer engagement becomes the norm and that there is evidence of coproduction in all innovation and continuous improvement work.*

KLOE 8 : report findings

Salisbury NHS Foundation Trust

KLOE 8
Learning and Improvement

Key Development Themes

↑ Building Capability

Development

- *Consider how to train lived experience partners in Improving Together as part of the Coach House team. There may be the opportunity to learn from the work of other providers e.g., Leeds Teaching Hospital QI Partner model.*
- *Review involvement of Deputy Directors who feel that with their responsibilities for operational delivery, they are a critical layer to involve as soon as possible.*

↑ Deployment / Operating System

Development

- *Include people with lived experience in Improving Together in a far more intentional way scaled across the Trust, trained in the IT method to participate in operational improvement teams.*
- *It may be possible to strengthen the link between Improving Together and implementation of the NHS Safety Strategy to maximise resource investment.*

↑ Impact

Development

- *The impact narrative could be strengthened and aligned with the Trusts strategic priorities.*
- *The Improving Together work is portrayed as primarily training rather than impactful. Stronger evidence albeit in pockets could be prepared in readiness for regulatory conversations.*

↑ Learning Organisation

Development

- *There is opportunity to strengthen whole organisation learning. It was anticipated that PSIRF will support this improvement.*
- *There needs to be increased understanding of the division's role in sharing learning from deaths across specialties and across divisions.*
- *Mortality surveillance group includes representatives from the divisions. Further clarity is required on attendees' role to ensure consistent sharing of information.*

↑ Clinical Audit and Mortality

Development

- *Align audits to the Improving Together initiative.*
- *There is no easy way to theme (free test field) learning from case note review on the current system.*
- *Increased understanding of the division's role in sharing learning from deaths across specialties and across divisions*
- *Clarify role of attendees at Mortality Surveillance Group to ensure consistent sharing of information across departments/ specialties.*

Salisbury NHS Foundation Trust

Trust Management Committee

Surgery Core Services

Self assessment against CQC ‘must do’s’ and ‘should do’s’.

24th January 2024

Surgery Core Service – Self Assessment

Salisbury NHS Foundation Trust

Selected CQC ‘must do’s and should do’s’ themes that were selected for self assessment were:

Microsoft Word Document

Safe Storage	Medication Safety
Environment	Managing Incidents / risk
Equipment / Consumables	Patient Safety
Record Keeping	Access / discharge
Infection Control	Documentation
Staff	Complaints
Training	Strategy

Assessment was carried out in 5 surgical wards, main theatres and day surgery unit.

Surgery Core Service – Self Assessment

Salisbury NHS Foundation Trust

Findings

Assessment showed that there were common findings in all ward areas relating to:

- Safe Storage of cleaning fluids and hazardous substances.
- COSHH data base to be reviewed
- Patient notes trolleys left unlocked by all staff even when challenged.
- Drug trolley security.
- Decluttering of patient environments
- Storage challenges and not storing boxes on the floor.
- Dementia friendly environments
- Sharps bins not closed / secured
- Tendable audits completed but action plans not always generated

Surgery Core Service – Self Assessment

Salisbury NHS Foundation Trust

Findings

- Orientation form for temporary staff or redeployed staff not used.
- Appraisals – trajectory in place.
- Expiry date for medication not checked
- Learning from incidents
- Completion of patient assessments and re assessments within time frame particularly for nutrition and hydration.
- VTE assessment within 24 hours of admission
- Safeguarding documentation and compliance with checks not completed
- Whiteboards not updated daily.
- Complaints to be answered within timeframe.

Surgery Core Service – Self Assessment

Salisbury NHS Foundation Trust

Findings specific to Theatres / DSU

- Planned preventative maintenance for operating theatres not carried out yearly.
- Failing infrastructure of DSU building
- Training and support for care of children in DSU
- WHO surgical safety check list ongoing work
- Surgical Site Infection ongoing work

Surgery Core Service – Self Assessment

NHS Salisbury NHS Foundation Trust

Positive Findings:

- Discharges before 14.00 is a driver metric for Chilmark and discussed at daily huddle.
- Matron oversite of rosters and use of professional judgement.
- Theatre Utilisation is a watch metric for DMT and discussed at theatre SLT meeting.
- DSU reconfiguration of reception completed which includes a dedicated children's waiting area and two assessment rooms.
- A3 completed for IPC and Consent checking process completed .
- Robust investigation of surgical site infections and other infections within Division completed.

Surgery Core Service – Self Assessment

Salisbury NHS Foundation Trust

Challenges

- Engagement from all members of the MDT, view of medical and therapy staff not included.
- Acknowledgement of time required to complete action plan based on self assessment for individual wards to provide evidence of rectifying issues.
- Sharing of learning and trends reaching all teams.
- Completion of ongoing work within theatres.

Surgery Core Service – Self Assessment

Salisbury NHS Foundation Trust

Next Steps

- SLT meetings to include governance and quality audits for discussion and learning.
- Process for sharing of learning from incidents at ward level to be developed.
- Matrons to continue quality rounds to include peer auditing and to monitor progress of action plans for ward areas.
- Working with housekeeping to ensure cleaning compliance.
- Matron for Paediatrics to review support and training for adult nurses looking after children in DSU.
- Feedback at Divisional Governance Meeting.
- To share common findings with other Divisions.

Surgery Core Service – Self Assessment

Salisbury NHS Foundation Trust

Questions

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.1
Date of meeting:	4th July 2024		

Report title:	Estates Department Quarterly Update – July 2024			
Status:	Information	Discussion	Assurance	Approval
	x		x	
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	John O'Keeffe – Head of Estates Edmund Ellert – Head of Estates Capital Tom Sneddon – Interim Deputy Head of Estates			
Executive Sponsor: (presenting)	Mark Ellis – Chief Financial Officer (John O'Keeffe – Head of Estates)			
Appendices	Appendix A – Estates Report June 2024			

Recommendation:

Trust Board is asked to note the content of the paper summarising the work of the Estates Department, consisting of Estates Technical Services (ETS) and Capital Projects teams during the last quarter, including current and ongoing risk positions.

Executive Summary:

Staff position two vacancies and one position on hold until justified as required.

Our work on compliance and estates risks continues to reduce both volume and classification of risks. We now have one extreme risk (Estates CAFM System) and eleven high risks remaining, which have continued beyond our target of the end of the 2023/24 financial year due to funding (implementation of a new CAFM system) and volume of works. We are now targeting closure and removal of the high risks by September 2024 by means of mitigating and reducing risks so that only medium and low remain. At this stage we will cease reporting and continue as business as normal.

Overall, we have now reduced the total number of estates risks from 383 to 123. (- 260)

		Extreme		High		Moderate		Low		Total	
This Period	**Remaining** (by **Current** Risk Score)	1	⟺	11	-1 ↓	106	-6 ↓	5	⟺	123	-7 ↓
Previous Period	**Remaining** (by **Current** Risk Score)	1		12		112		5		130	

The chimneys structural integrity continues to be monitored while investigating methods to stabilise and also returning to the market to tender for replacement.

Our MLE compliance has increased to 93% (up from 89%) we are confident our compliance rates will remain in this area.

Our department appraisal rates are currently 87%

The capital team have been allocated £6.791k of CDEL in 24/25; as well as going some way to reduce the backlog maintenance position, it provides budgets to conclude The Elizabeth Building/Imber Ward as well as the decarbonisation project, including the geothermal feasibility.

The decarbonisation project is progressing well with the final connections shortly to be made. Final commissioning has been delayed from the end of March to July due to electrical infrastructure issues.

Progress on the new Estates strategy has slipped due to challenges around staff engagement. The engagement requirements have been re-planned however, target completion for the project has slipped from end March to June 2024.

Imber Ward is close to handover despite numerous challenges and delays, Bam as main contractor is on schedule to achieve sectional completion of Imber Ward on Monday 17th June 2024. Early access for Trust staff has been available since the end of May, allowing the Trust to commence commissioning, clinical ward setup and training as well as installations by ArtCare, thereby enabling first patients to be admitted from Tuesday 18th June.

Replacement of CT 1 & 2 Scanners will be delayed due to structural engineers determining the floor slab unable to take the weight of the new heavier scanners. Mitigation works identified and currently being worked through. CT2 will be installed by the end of June.

The Head of Estates has concerns on the impact of the Trust financial position and the requirement for CIP targets and staff reduction directly impacting on the work that has taken place over the last three years to address the historic Estates challenges and issues. This will be monitored and escalated if appropriate.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	x
Partnerships: Working through partnerships to transform and integrate our services	x
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	x
Other (please describe): Long term strategic and sustainable benefits for the SFT campus, supporting the effective delivery of health services.	x

NHS Salisbury NHS Foundation Trust

Appendix A – Estates Report – June 2024

1.0 Introduction

This is a quarterly update to Trust Board for activity within the Estates Technical Services (ETS) and Capital Project teams from 1st March 2024 – 31st May 2024.

2.0 Staff

Our staffing levels have worsened slightly since the last report. We have recruited to the Senior Estates Officer position and the shared Energy Officer; however, one member of staff has resigned and we have an additional two vacancies including the transfer of residential maintenance to Estates. Our aim is to maintain a core team of internal resources and therefore reduce our requirement to use external contractors, who are approximately twice as expensive.

We continue meetings with our people business partner and recruitment team to discuss vacancies which currently stand at 2.6 WTE role. We attend the Weekly Divisional Workforce Control Panel (Corporate) meetings as required to discuss and manage vacancies appropriately, two vacancies approved.

Our latest staff position is below.

March 2024	No.	Notes
Estates Posts	40.1	Includes vacancies.
Vacancies	2.6	B2 Mechanical Assistant - approved. B3 Residential handyperson (0.6WTE) – on hold B5 Multiskilled craftsperson – approved
Sub Total	37.5	
Bank Staff	3	2 x Flushers 1 x Admin
Estates Officer Operations	1	Agency Cover

Our MLE compliance has increased to 93% (up from 89%). Whilst our compliance position remains high, there has been a reduction in several mandatory training areas, many are the result of training now becoming due. Staff are being reminded the importance of mandatory training and supported to undertake their training in reasonable time.

Top Level by Training Title

KEY:	0-79%	80-84%	85-100%

Report database last refreshed on 07/06/2024 at 03:34:32

Training Title	Number complete	Number incomplete	Number in target group	Compliance
Adult Basic Life Support 122014	0	1	1	%
Data Security Awareness 122014	36	4	40	90%
Equality and Diversity 122014	40		40	100%
Fire Safety 122014	36	4	40	90%
Hand Hygiene Assessment 122014	38	2	40	95%
Infection Control 122014	39	1	40	98%
Moving and Handling 122014	37	3	40	93%
Prevent - 122014	38	2	40	95%
Safeguarding Adults Level 2 - 122014	3		3	100%
Safeguarding Children Level 1 122014	27	4	31	87%
Safeguarding Children Level 2 122014	1		1	100%
Overall:	**295**	**21**	**316**	93%

3.0 Compliance

We continue our trajectory of closing and mitigating risks from the Estates compliance report. The table below indicates we are now reduced to one (1) extreme risk, although as previously highlighted some of our mitigation actions do transfer risks into lower rating categories as we work toward concluding them. There has also been a further reduction of one (1) high risk and seven (7) overall closures in this period. We have seen an overall reduction in risks and continue toward our target which was to close all extreme and the majority of high risks while converting the remaining moderate and low risks to *business as usual*, which will follow by the closure of the compliance report. However, some high risks will remain until late 2024.

		Extreme	High	Moderate	Low	Total
Initial Risks	**Initial Risks**	286	95	2	0	383
	Closed (by **Initial** Risk Score)	181	71	1	0	253
	Remaining (by **Initial** Risk Score)	105	24	1	0	130
Risk Changed/Moved	**Risk Mitigated** (+/-) due to mitigation in place	-285	-84	104	5	-260
This Period	**Added** in this reporting period.	0	0	0	0	0
	Remaining (by **Current** Risk Score)	1	11	106	5	123
At last report	**Remaining (by Current Risk Score) at last report**	1	12	112	5	130
	Change during reporting period	0	-1	-6	0	-7

We have extracted the final extreme and high risks from the compliance report to the table below and provided a narrative previously.

ID	Source of Risk Data	Risk
197	PAM Audit	Estates and Facilities Operational Management/ Maintenance: CAFM and PPM regime's inadequate

Risk 197

Estates CAFM system not fit for purpose – **1x risk**

Update to last report: The bids received on the CAFM procurement have been assessed and moderated. Concerto came out as the preferred platform. The recommendation report has been shared to seek the capital funding to implement the platform with the preference to place orders and start within this financial year. Work is also being done now the cost is understood how to absorb the ongoing cost into the Estates budget. A full business case is required, and we are currently working on that.

The implementation cost that is required for this year is £64,500, with an ongoing annual cost of £65,000. The procurement is tested for a 7-year contract.

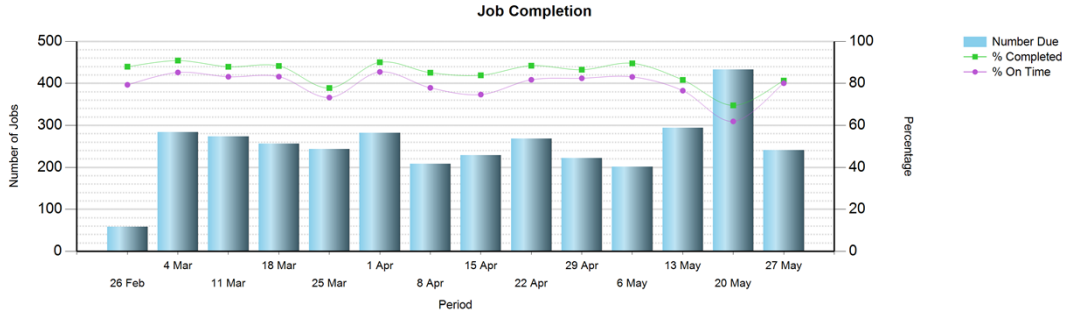
Although we are on track to close or mitigate the bulk of the high-risk actions, there are eleven actions that will still be outstanding until mid-2024 . They are:

ID	Source of Risk Data	Risk	Update
16	AE Audit	Switchgear not worked or inspected periodically	With the fixed-wiring testing yet to be completed, a separate preventive maintenance (PPM) regime has been created and is underway to thermal image all switchgear for assurance of correct operation. This will allow the risk of the action to be brought down until the fixed-wiring testing is complete, at which point the action can be closed. **Closure Target – September 2024**
56	AE Audit	Fire Damper maintenance	With the survey work now finished and remediation of faulty dampers in progress, completion of the action is anticipated by August 2024, barring budgetary constraints. **Closure Target – September 2024**
87	Other	HTM 06-23 Periodic Inspection and Testing - New contract in place, but not yet used, last undertaken 2013, reports of outstanding C1 and C2 from then	Fixed wiring testing is complete in the residence's south and most central areas. While some testing has begun in the north block, approximately 30% of the site remains untested. This will be completed within the current financial year, as progress awaits confirmation of the capital budget allocation. Additionally, any code FL, C1, or C2 remediation is being addressed as encountered. **Closure Target – September 2024**
106	Other	32-09 Hot Water Cylinders - No Practice in place	Progress on this action has been delayed due to higher-risk actions taking priority. The preventive maintenance plan (PPM) is currently being developed and implemented, however, resource availability for its execution depends on estates operations capacity. **Closure Target – September 2024**
134	Other	102-04 Window Restrictors - No Practice in place	We encountered issues with the survey contractor due to inaccurate reporting and inconsistencies in their findings. The contractor has agreed to revisit the site commencing the week of April 22nd to address any outstanding problems. Upon completion, remediation of identified non-compliances will be undertaken. **Closure Target – August 2024**
147	Other	HTM 06-18 Busbar System and Cables - No annual non-intrusive checks or 10 yearly full service taken place	The primary method for identifying and mitigating risk was the fixed wiring inspection. Due to delays with the inspection, a temporary reporting form has been implemented for ETS electrical staff. This ongoing measure allows them to report on the condition of equipment and identify any non-compliances. Once all busbars have been inspected, either through the estates PPM task or the fixed wiring inspection, this action will be closed. **Closure Target – September 2024**
150	Other	44-08 Electrical Installation – Generally - No practice in place - RCD and AFDD	Pending completion of fixed wiring inspection - see ID 87 **Closure Target – September 2024**

151	Other	44-09 Three Phase Circuits - No practice in place - RCD and AFDD	Pending completion of fixed wiring inspection - see ID 87 **Closure Target – September 2024**
161	Other	HTM 02-20 Oxygen Systems - No Risk Assessment carried out on Oxygen system with yearly review	The newly appointed Senior Estates Officer (Mechanical) is tasked with completing this within the next quarter. **Closure Target – July 2024**
215	PAM Audit	Medical Gas Systems/Resilience, Emergency & Business Continuity Planning: BCP / Procedure to be developed	Due to resource limitations and prioritisation of higher-risk actions, completion of this task has been deferred to the next quarter. **Closure Target – July 2024**
371	AE Audit	RP Water not adequately trained in pool specific safety	Training was pending confirmation of the new fiscal year budget and available funds. **Closure Target – September 2024**

4.0 Estates Maintenance

The data for March 2024 – May 2024 is shown below. (Data is shown for full month activity).



This quarter

Job Type Summary

	Due	Cancelled	Completed	On Time
ECO	231	0	230	227
HELPDESK	2112	30	1801	1703
PPM	1149	5	902	805
Total	3492	35	2933	2735

Previous quarter

Job Type Summary

	Due	Cancelled	Completed	On Time
ECO	178	0	177	175
HELPDESK	1959	20	1663	1491
PPM	1201	1	980	848
REMEDIAL	1	0	1	1
Total	3339	21	2821	2515

The data shows a continued high volume of helpdesk jobs raised (logged calls for maintenance actions across the estate) although data for planned maintenance (PPM) and Helpdesk are consistent with previous 3-month reporting periods The data shows we carry out more reactive than planned works and we should be aiming for the opposite situation.

During this period the number of emergency call outs was 231. As with previous report periods, some analysis of the increased numbers is in progress, although given the estates backlog continues to increase at a rate faster than it can be reduced, the failure rate of the estate is equally likely to increase particularly whilst the Trust resources to maintain the estate remain constant or potentially reduce.

5.0 Capital Delivery

The capital team have been allocated £6.791k of CDEL in 24/25; as well as going some way to reduce the backlog maintenance position, it provides budgets to conclude The Elizabeth Building/Imber Ward as well as the decarbonisation project, including the geothermal feasibility.

Imber Ward

Despite numerous challenges and delays, Bam as main contractor is on schedule to achieve sectional completion of Imber Ward on Monday 17th June 2024. Early access for Trust staff has been available since the end of May, allowing the Trust to commence commissioning, clinical ward setup and training as well as installations by ArtCare, thereby enabling first patients to be admitted from Tuesday 18th June. The contractor made considerable progress in recent weeks, with on average having approx. 120 workers onsite per day working between 6am and midnight. The main cause of delay to the project has been connection of an incoming mains supply; however, concerted efforts facilitated a schedule of key activities to be achieved, resulting in SSE being able to make the connection to the new HV substation on 6th June.

The Trust also worked with BAM to agree access to host a private viewing of Imber Ward for Stars Appeal on Friday 7th June and was also open to the public on Saturday 8th June. The following is a word cloud of feedback received from the Open Day:

Works will continue after sectional completion, including the external cladding and external areas through to the end of July, the estimated date of practical completion. Costs received for an enhanced external landscape design exceed the budget, so discussions are underway to secure alternative funding which will potentially see this delivered later under a separate contract.

Salix decarbonisation

As part of the £10m Salix funded decarbonisation scheme, various net zero carbon works have been carried-out across the estate, including photo voltaic panels, replacement glazing, thermal upgrades to building fabric. The main elements of equipment are the air source heat pumps which are in the process of being commissioned, this will continue through to the end of July. The Trust's 12% capital contribution to the Salix funding help commission a geothermal feasibility study; the supplier GT Energy and the Trust have now secured the consent of landowners for seismic surveys which will enable a planning application to be submitted later in the year and the feasibility study completed by the end of the financial year.

Estates Strategy

The consultant team appointed to undertake the Estates Strategy are finalising their Stage 3 report; they will require some consultation before concluding their report, which they aim to issue in mid-June in line with the summary programme.

Multi-flue Chimneys

We have previously reported the age of the energy centre chimneys and associated risks, with a requirement for replacements. The current decarbonisation project and future geothermal facility will ultimately reduce the number of gas-fired boilers required on the estate, thereby reducing the number of boiler flues. It is hoped there will only be a need for a single chimney rather than the two currently in situ. Mitigations are ongoing to regularly monitor the condition of the chimneys and actively looking to appoint a specialist consultant to provide further advice on the design of the chimneys and alternative options which may potentially extend their life before re-tendering for the full replacement.

Replacement of CT1 & CT2 scanners

The Trust has taken delivery of CT1 & CT2 scanners which are being stored on site until enabling works have been completed. Structural strengthening works are required to the Level 3 floor slab due to the increased weight of the latest scanners. Works to CT2 are almost complete and the scanner will be installed by the end of June; Radiology have asked for a 2-month period before CT1 enabling works commence.

24/25 Capital Allocation

The following funding has been allocated to the Building and Infrastructure Group:

CDEL	£'000's
Imber Ward	£1,500
Energy Centre Flues	£1,219
CDEL Salix – seismic studies	£930
CT building works	£404
Installation of Fluoroscopy C Arm	£200
Other <£100k	£180
Lift Refurbishment	£700
Fire compartmentation	£300
Other <£300k	£1,358
Total BIG	**£6,791**

National Funding	£'000's
Community Diagnostic Centre	£1,306
Total BIG	**£1,306**

6.0 Governance and Risks

As noted previously the BSW commitment to invest in the EPR system over the next 3-years has resulted in significantly reduced capital availability. Whilst our requirements for 5-year (and beyond) capital investment are now well documented (and tabled regularly via the relevant committees) we expect a combination of reduced investment for 2024-2027 and a resulting very high demand for capital allocation in 2027-28, alongside IT and Medical Equipment requirements, to increase the Trust risks further and the backlog maintenance position to worsen.

The chimneys structural integrity continues to be monitored while investigating methods to stabilise and returning to the market to tender for replacement.

New risks identified within this report.

	Risk	Action
	None	

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.1
Date of meeting:	4th July 2024		

Community Diagnostic Centre Business Cases	annual board report and statement of compliance (Responsible Officer and Revalidation for Doctors and Dentists)			
Status:	Information	Discussion	Assurance	Approval
				X
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Zoe Cole (Associate Medical Director and Appraisal Lead) Mark Pountney (Appraisal and Revalidation Administrator)			
Executive Sponsor: (presenting)	Peter Collins, Chief Medical Officer			

Recommendation:

- To receive approve the annual NHS England assurance document regarding the Responsible Officer function for Medical appraisal and revalidation.
- To approve the signing of the statement of compliance

Executive Summary:

NHS England require the Chief Medical Officer to prepare an annual report assuring the board that the processes required for effective revalidation of doctors. The Responsible Officer is accountable for the processes to allow any doctor with a prescribed connection (doctors whose main work is with the Trust and who are not in a formal training programme) to collect the required information to allow for revalidation on a 5 yearly cycle.

There are no significant gaps in assurance against the key lines of enquiry

The reporting period for 2023/24 has resulted in a period of continuity post pandemic. During this period there were 335 prescribed connections. The completed (298), approved exceptions (16) and missed appraisals (3) add up to 317. 18 prescribed connections as of 31st Mar 24 were not due an appraisal until the 2023-24 cycle, mainly due to relatively late trust start dates.

Whilst we see that 22% of doctors appraisals are overdue on date of appraisal only 9% have been overdue for more than 3 months. Most of these appear to be the junior trust grades who have shorter contracts and need more help to understand the appraisal system requirements outside of deanery posts.

No new referrals to the GMC were made by the RO in this reporting period. 3 notifications of doctors who are currently employed by the Trust with ongoing investigations instigated elsewhere were received -Each of these had individual consideration by the CMO to ensure that the necessary oversight and restrictions were in place to maintain patient Trust and Safety.

This year has seen the introduction of a consistency panel to ensure that actions taken by the RO in regards to concerns raised against doctors are treated fairly and in a consistent manner and not subject to bias.

Work over the next year will include whether we continue with Premier IT and whether we jointly precure with RUH. Further work with the GMC regional team into supporting doctors and difficulty and behaviour is planned.

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

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.2 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Dr Peter Collins is the nominated responsible officer and has received appropriate training. He attends the regional updates regularly. Dr Zoe Cole is the appraisal lead and also attends the RO updates. She is planning on formal training in case of unexpected CMO absence. Dr Duncan Murray Deputy CMO is to attend RO training in 25/25

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes All non deanery doctors that are employed for more than 6 months are provided with access to an electronic system provided by Premier IT. The license for Premier IT was renewed for a further year and we are currently working through with procurement and potential to include RUH The trust funds an appraisal administrator to help keep track of appraisal and help support both doctors and the responsible officer in facilitating revalidation

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

The Chief medical officer and appraisal and revalidation administrator update a list of connected medical practitioners on a quarterly basis and this is triangulated with electronic staff records, HEE information under the oversight of the trusts medical workforce group.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Policies associated with medical workforce are reviewed and updated through the trusts Joint Local Negotiating committee. Recent reviews/ rewrites that have been completed include study leave and professional leave policy (now merged) and job planning policy. All other policies have been reviewed by our solicitors and deemed as being compliant with regulatory and legal requirements and are therefore in date. We have plans to review MHPS/managing concerns, annual leave, acting down and additional payments within the next 12-18months

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

No recent review has taken place but we are aware that the South West NHS team are currently organising reviews within the region.

Discussion and advice has been sought re appraisal and revalidation within the BSW and the South West region

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

All fixed term doctors within the organisation who are expected to remain at the trust for 6 months or longer are offered an appraisal. For those who are in training this is usually their educational supervisor. Appraisal output forms are generated using Premier IT.

Continued training and revaluation for those that are appraising these locally employed doctors is ongoing.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

There is a mechanism for all doctors to undergo formal appraisal with access to the trusts electronic system Premier IT. Sufficient numbers of appraisers are trained and updated and provided with SpA time recognised to allow appraisers to perform this duty. Appraisals are now audited using the premier IT ASPAT facility.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

There is a mechanism to remind doctors that there appraisal is overdue. An email is end out immediately after their appraisal is overdue reminding them that this is a mandatory requirement of their contract. A sterner email is sent from the lead appraiser at 3 months overdue if still not completed. If there is still no engagement despite warnings then this is escalated to the responsible officer.

Some of our appraisal dates have been reset to account for the pandemic.

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

An updated appraisal policy was agreed by the Joint Negotiating Committee and the trusts internal governance processes in 2021

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Sufficient numbers of appraisers are trained and updated and there is sufficient SPA time recognised to allow appraises to perform this duty

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

The appraisal lead is responsible for annual updates to all appraisers. She has looked into additional external training at a cost of around £84 per head which RUH uses however there is no funding to specifically facilitate this New appraisers are trained via Miad Healthcare and certification is essential. There is yearly quality assurance process using the ASPAT audit tool to provide both assurance and feedback to appraisers.

As part of the South West network face to face meetings have restarted having been online since the pandemic. There has been validation form lead appraisers over output forms specifically using the audit tool we are now using.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: The appraisal assurance process described above has been reported to the board via the annual ROs report Action from last year:

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2024	335
Total number of appraisals undertaken between 1 April 2023 and 31 March 2024	298
Total number of appraisals not undertaken between 1 April 2023 and 31 March 2024	19
Total number of agreed exceptions	16

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: ensure a consistency panel (ROAG) is in place to assist the RO with decision making for doctors who have had concerns raised about them.

Comments: The Terms of reference and standard work for the concerns about doctors consistency panel have been agreed and the first quarterly meeting occurred in 2024. No new referrals to the GMC were made by the RO in this reporting period. 3 notifications of doctors who are currently employed by the Trust with ongoing investigations instigated elsewhere were received -Each of these had individual consideration by the CMO to ensure

that the necessary oversight and restrictions were in place to maintain patient Trust and Safety.

Action for next year: Embed and improve the effectiveness of the consistency panel and ensure that there is an annual assessment of protected characteristic data. Ensure reporting to board of the process and outcomes for all concerns raised.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

All doctors receive email confirmation of actions taken. Doctors are involved in deferment decisions usually by direct correspondence with this chief Medical Officer. Non engagement decisions are only considered after at least one formal meeting with the chief medical Officer.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

There is effective clinical safety and governance structure with well attended meetings and evidence of positive assurance in all significant domains such as audit, medicines management, mortality and morbidity and incident reporting.

The governance structure feeds into clinical effectiveness, patient safety and patients experience. Divisions have their only governance structure which links into these three main themes and seek assurance through regular senor leadership meetings with departments and wards. The head of clinical effectiveness and associate medical director have helped support this.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

There are mechanisms in place for the reporting and escalation of concerns about doctors from a number of routes (performance concerns, involvement in serious incidents staff or patient concerns or complaints, freedom to speak up guardian reports and doctors 360 feedback) with a new MHPS consistency panel which started in April 24 to escalate concerns to the RO.

Information on serious incidents and complaints is provided to doctors to use at the time of appraisal and forms part of their input form.

The current update of managing concerns form medical and dental staff policy will be setting up of a consistency panel to ensure the fair treatment of all doctors

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

There is a current process described in the trusts managing concerns about medical or dental staff policy which has been updated to ensure it includes elements of compassion and just culture

The management of serious concerns can be discussed with the local GMC ELA officer who provides meetings and updates to trust.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Reporting of concerns raised about doctors or dentists in the trust are collated by the Chief medical Officer and Deputy Medical Director. There are regular meetings with the trusts ELA to ensure external triangulation and consistency. Learning from these events is shared at the regional RO updates.

There is now a quarterly consistency panel (April 24) to support the Chief Medical Officer in agreeing an appropriate and consistent response to any performance or conduct concerns that are raised about doctors

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Information transfer requests are responded to by a combination of Medical HR, appraisal leads/ administrator as well as the CMO if there is active or prehistoric concerns re an individual practitioner.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

The trust has a policy in place for the reporting and investigation of concerns raised by practitioners regarding any form of discrimination or bias.

The CMO has accountability for assuring the board that all processes managing doctors (including recruitment, job planning management of conduct or capability concerns and career progression) are fair and free from bias

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

There are a robust set of pre-employment checks that is carried out on all doctors employed by the trust in line with GMC guidance. Oversight is provided by the trust's medical workforce group with assurance to trust board.

Section 6 – Summary of comments, and overall conclusion

The reporting period for 2023/24 has resulted in a period of continuity post pandemic. During this period there were 335 prescribed connections. The completed (298), approved exceptions (16) and missed appraisals (3) add up to 317. 18 prescribed connections as of 31st Mar 24 were not due an appraisal until the 2023-24 cycle, mainly due to relatively late trust start dates. Whilst we see that 22% of doctors appraisals are overdue on date of appraisal only 9% have been

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

overdue for more than 3 months. Most of these appear to be the junior trust grades who have shorter contracts and need more help to understand the appraisal system requirements outside of deanery posts. This was the first full appraisal year since the MAG forms had been phased out with all new starters now offered a Premier IT account.

Appraisal audit is done using the ASPAT tool as part of premier IT system which is used by many of our colleagues in the South West is validated.

Regular appraisal update is provided the trust and there is training from the South West team to the RO and lead appraiser. The GMC has provided training to support the new good clinical practice professional standards.

Work over the next year will include whether we continue with Premier IT and whether we jointly precure with RUH. Further work with the GMC regional team into supporting doctors and difficulty and behaviour is planned.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

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NHS Salisbury NHS Foundation Trust

Report to:	Public Board (public)	Agenda item:	6.2
Date of meeting:	4/07/2024		

Report title:	Health and Safety Q4 Report – Annual Performance Report			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):	Health and Safety Committee and Trust Management Committee			
Prepared by:	Troy Ready, Health & Safety Manager			
Executive Sponsor: (presenting)	Melanie Whitfield, Chief People Officer			

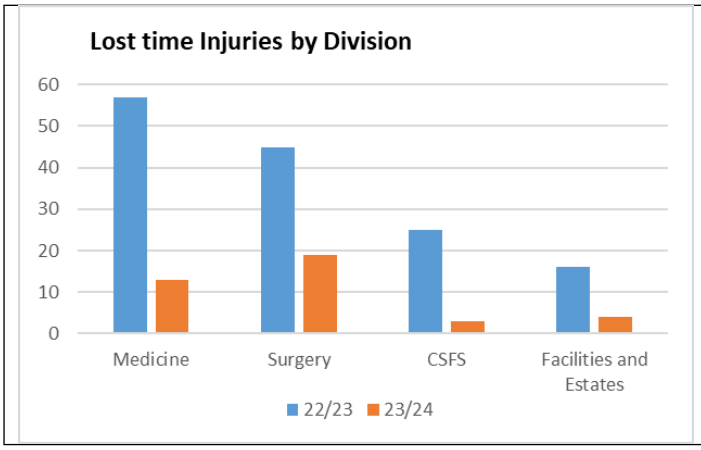
Recommendation:

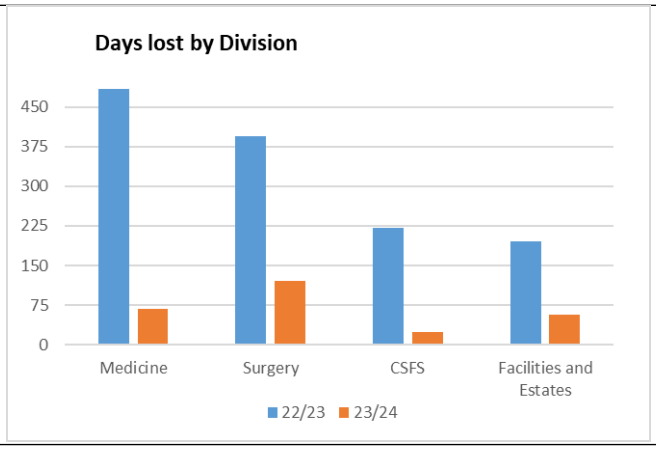
The Public Board is asked to note the contents of the annual H&S report. Specifically the improved performance against 23FY and the areas of focus for the ongoing managing of risks to the H&S of individuals exposed to the activities across the Trust.

Executive Summary:

Annual H&S Report FY24

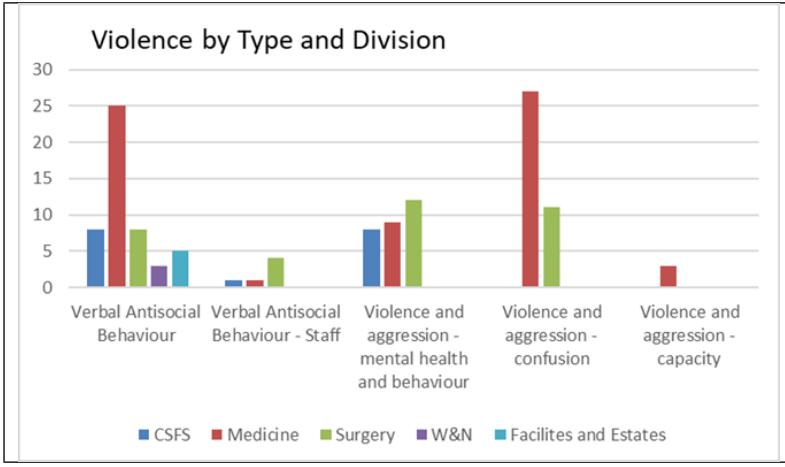
The annual H&S report for the 24FY shows a significant reduction in the number of Datix reports, the number of lost time injuries and the amount of time lost due to injuries. Injury reports fell from 549 in FY23 to 387 in FY24 whilst the grapsh below show performance in the past 2 FY's





Of the 380 incidents reported, violence and aggression accounts for 31% of all reports. This is down from 51% in FY23. Of note here is the conflation of confusion with violence and aggression. 135 datix reports were submitted for patients who were shouting and disturbing others, pulling out cannula's, repeatedly pressing call bells without being in need of assistance, or wandering without risk to self. There was no evidence of reported violence, yet a Datix report would be submitted and / or security would be asked to supervise the patient. Had such reports been kept within the report, there would be 527 datix reports and

violence and aggression would account for 50% of all datx reports. But where violence and aggression is evident the graph below shows the type of incident and numbers by Division.



Classification	Incidents Reported
Antisocial behaviour (non violent)	48
Violence and aggression – confusion	27
Violence and aggression – mental health / behavioural	19
Antisocial behaviour between staff	8
Violence and aggression – capacity	3

In order to improve the management of violence and aggression a number of key actions were implemented or commenced:

1. The VP&RWG is now co-chaired by the Deputy Head of Nursing and the Health and Safety Manager, with Executive Director sponsorship provided by the Chief People Officer and became a sub committee of the H&S committee, with a focus on understanding the risk to the H&S of staff and developing initiatives to reduce the risk of harm,

2. The Trust wide strategy to reduce the risk of violence and aggression was developed to include:

    a. Updating the Trust Violence Reduction Policy. The Policy has been developed after wide consultation and is due to be finalised in the coming months with guidance on managing the response to violence and aggression, reinforcing the use of red and yellow cards and reviewing the use of body worn cameras.

    b. Developing an awareness program titled ‘No Excuse for Abuse’. Work continues on developing a campaign to promote this initiative.

3. Implementing the Design Councils ‘Reducing Violence and Aggression in A&E Through a Better Experience’ program. This action sits with the ED team and should be completed within the next 6 – 8 weeks. The expectation of this program is to explain the ED journey and reduce the anxiety and uncertainty that comes with waiting in ED.

4. Delivering external Management of Violence and Aggression and Breakaway Training. Further training has been secured for the 2025FY and will allow for 250 staff to be trained in addition to the 85 staff already trained since January 2024. This can be contrasted with training over previous where the uptake was minimal. Changes to the course and content have marked an effective change.

The H&S team has worked throughout the year to improve the response to injury reports by contacting staff within 24 hours of submitting a Datix report. Work has expanded to escalate incidents directly to Matrons and Divisional Heads of Nursing to ensure management engagement from the Division. The response to staff injured continues and is well received.

Measuring and responding to injuries is one aspect of H&S activity. The arguably more relvant part is to prevent injuries occuring in the first place. In this regard the H&S team continued to undertake risk activity

against a published schedule of audit and taks analysis. During the 24FY, the H&S team has conducted H&S audits in:

- Estates Technical Services,
- Emergency Department,
- Acute Medical Unit,
- Longford Ward,
- Pitton Ward,
- Radnor, and
- Main Theatres.

Each audit identified actions. Many were managed locally with the ward managers though a small number of risks were escalated for Divisional Management Team or Executive awareness. In a similar way, the H&S Team published a calendar of task reviews within departments to understand the manner in which work is conducted and determine if risks are effectively managed. Task analysis have been completed in kitchens, biomedical engineering, estates and medical devices, portering and medical engineering.

Triangulation of Corporate Services Information

Efforts to triangulate information between HR, H&S, Occupational Health, F2SU, PALS and the Legal team remains a work in progress. This Group was organised towards the later part of the 2023 calendar year and is very much in its infancy but has the potential to identify issues not readily identified in isolation. A key objective of the group is to identify any Trust wide themes or flag specific departments that require greater support. One such example of how this group would work can be seen in theatres where a number of issues were identified in isolation but ultimately led to a H&S audit, the development of a behavioural charter, to work with clinical teams on civility and an exec walk around to assess some of the issues raised. This triangulation group would be expected to understand what these issues are, expedite actions sooner and will act as a function of the We Are Safe and Health Committee being established in the 24/25FY.

Priorities for FY25

Continue the implemtation of H&S against ISO45001

The H&S team will continue to implement H&S against the standard adopt by the Trust in FY23. H&S plans have been developed to ensure risk activity and hazard management continues, reporting against performance indicators will continue and a review of performance against the standard will continue. Key activities will include supporting departments with the development of local risk assessments.

Auditing and Risk Activity

Update the audit calendar that is due to end in October 2024 and continue the internal audit program. This will include training members of the H&S team to gain auditing competencies and participate in the internal audit program.

Continue Violence Prevention and Reduction Work

The Violence Prevention and Reduction Policy was approved in June 2024. The H&S team will continue to support the reduction of violence and aggression across the Trust. This includes ensuring strong attendance at violence prevention and breakaway training, responding to incidents reported by staff, developing local violence prevention key workers and ongoing communication prgrames that reduce the risk of violence towards staff in high risk areas.

Traffic Management Review

The H&S Manager has commenced a review of traffic management across the Trust, specific to 2 areas; the use of tugs, and the movement of traffic in the u-shaped road adjacent to the laundry, entrance to Springs, and Energy Centre. The H&S Manager is working with Estates and Facilities to map out changes and is providing updates to the H&S and Sustainability Committees.

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

HEALTH AND SAFETY PERFORMANCE REPORT

QUARTER 4 – ANNUAL REPORT

2024FY

Salisbury NHS Foundation Trust

1. Injury Performance Measures

Throughout the year there has been a sustained reduction in the amount of time lost and the frequency of lost time injuries and the overall annual performance reflects this. Year on Year highlights include:

- A fall in the overall number of incident reports from 549 to 387.
- A fall in the number of lost time injuries reported from 143 to 39.
- A fall in the number of days lost due to work related injuries from 1,296 to 287 days.
- LTIFR tracking lower from 15 to 3.
- LTFR is also tracking lower from 10 to 2.

As seen in the table below reduced injury rates are seen across all Divisions:

	Lost Time injuries			FTE Days Lost		
Division	**22/23**	**23/24**	**YoY**	**22/23**	**23/24**	**YoY**
Medicine	57	13	↓77%	484	68	↓85%
Surgery	45	19	↓58%	394	121	↓69%
CSFS	25	3	↓88%	222	24	↓91%
Facilities and Estates	16	4	↓75%	196	57	↓71%

Such significant reductions in the number of incident reports, lost time injuries and days lost due to work related injuries were not expected within a 12 month period of time. There are a number of suggestions as to why this may be so:

1. Absence due to infectious disease in FY2022 and FY2023 fell significantly in FY2024. It is presumed staff absences due to work related Covid accounted for significantly higher work related injuries and absence from work in the previous years. In FY2024 there was no evidence of work related infectious disease being reported, and

2. The H&S team has been tasked with responding to all incident and injury reports submitted on Datix within 24 hours. The purpose of which is to improve the initial support to staff, to signpost staff to the available support services where necessary, commence an investigation into underlying causes, determine if an injury has resulted in lost time and ensure there is an early and sustainable return to work. Early engagement, action and support is known to be a key driver in staff returning to work and reducing time lost. The H&S team reaching out to staff in a timely manner demonstrates a level of staff support that was not always available and encourages a return to work. Of the 365 incidents reported on Datix in 2024FY, the H&S team responded to 91% of all reports (301) within 24 hours.

3. It is becoming apparent that a significant number of datix reports are classified under violent and aggressive behaviour where there is no evidence of violence and aggression. 135 Datix reports were submitted for patients who were shouting and disturbing others, pulling out cannula's, repeatedly pressing call bells without being in need of assistance, or wandering without risk to self and being told to return to bed. There was no evidence of reported violence, yet a Datix report would be submitted and / or security would be asked to supervise the patient. Datix reports submitted for disturbance, but not violence or aggression, were removed from injury statistics in this

report and will not be included in future H&S reports. Had such reports been kept within the report, there would be 527 datix reports (10% reduction in datix reports).

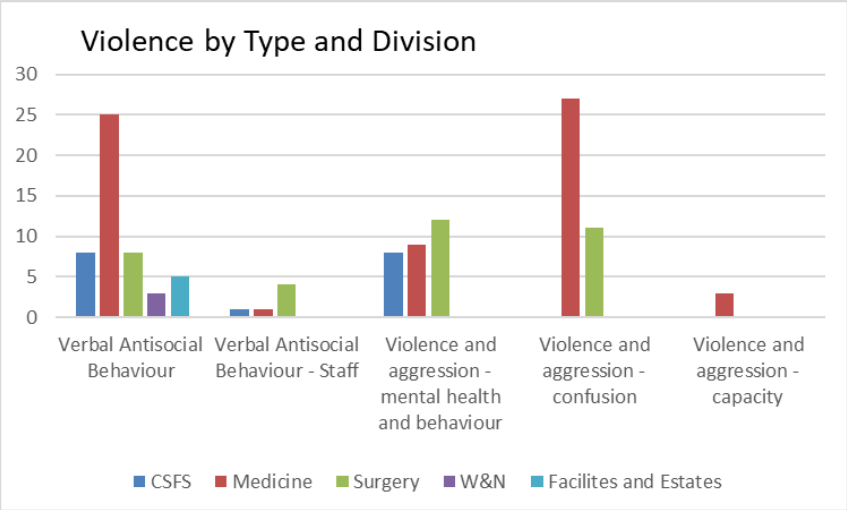
Notwithstanding the above, it was still necessary to consider the likelihood of systemic errors in reporting given the significant reductions. Expanded Datix reports were utilised to consider all non-patient related injuries, cross referenced with wider business intelligence reports and back dated to look for previously unknown injuries. There remains a risk that injuries, and absences, are not reported on Datix and work-related injuries therefore not identified. But in all likelihood staff on work-related long-term absence know to submit a retrospective Datix report for continuation of pay. A back dated review of Datix reports and time lost identified 3 additional injuries that accounted for 15 days lost and none of the injuries fell under the scope of reportable injuries to the Health and Safety Executive (HSE).

2. Performance Against 2023FY Key Objectives

From the 2023FY Annual Report a number of formal actions were identified for the 2024FY. These included the following:

2.1 Improve the Management of Violence and Aggression in Medicine

The number of type of datix reports associated with violence and aggression, by Department, is seen in the table below.



It was noted in 2023FY, and remained so in the 2024FY, that violence and aggression towards staff is the most reported incident and injury. It was identified early on in the year that violence and aggression was not limited to the Medicine Division and there was a need to expand the management of violence and aggression across the entire Trust, especially Surgery and CSFS.

The Violence Prevention and Reduction Working Group (VP&RWG) has been a key driver of initiatives to improve the management of violence and aggression, initiatives that continue into the 2025FY. Some of these key actions include:

1. The VP&RWG is now co-chaired by the Deputy Head of Nursing and the Health and Safety Manager, with Executive Director sponsorship provided by the Chief People Officer.

2. The VP&RWG became a sub committee of the H&S committee, with a focus on understanding the risk to the H&S of staff and developing initiatives to reduce the risk of harm,

3. Developing a Trust wide strategy to reduce the risk of violence and aggression. This plan included:

    a. Developing an awareness program titled ‘No Excuse for Abuse’. There was a delay in developing this campaign due to the time taken to attempt to utilise Trust employees as part of the campaign. This proved difficult and the campaign is

currently with communications team partners to develop posters, web materials and information for electronic communication boards within the Trust.

b. Updating the Trust Violence Reduction Policy. The Policy has been developed after wide consultation and is due to be finalised in the coming months with guidance on managing the response to violence and aggression, reinforcing the use of red and yellow cards and reviewing the use of body worn cameras.

4. Implementing the Design Councils 'Reducing Violence and Aggression in A&E Through a Better Experience' program. This action sits with the ED team and progress continues on developing a suite of posters to explain the ED journey and reduce the anxiety and uncertainty that comes with waiting in ED.

5. Delivering external Management of Violence and Aggression and Breakaway Training. Further training has been secured for the 2025FY and will allow for 250 staff to be trained in addition to the 85 staff already trained since January 2024. This can be contrasted with training over previous where the uptake was minimal. Changes to the course and content have marked an effective change.

2.2 Assess Manual Handling Practices on Longford Ward and Theatres

Injury analysis from FY2023 showed manual handling within Theatres and Longford Ward led to a significant number of injuries. The H&S Manager in consultation with Department Matrons and Ward Leaders identified the following:

Longford Ward – There was a need for local department specific manual handling training on commencing on the unit to be reintroduced. Such training had ceased in the years prior but was considered valuable in teaching staff the skills required to move and handle spinal patients. This training recommenced in November 2023.

Theatres – There has been significant work undertake to manage the risks of manual handling injuries that often occurred due to the handling of surgery trays and a local theatres risk assessment was conducted by the H&S Manager. Tray sizes have been modified, lifting equipment is available, strong team lifting practices are evident and scrub staff rotate during a theatre list. But the lack of storage for surgical equipment means there is a greater need to reach above shoulder height, bend below hip height and handle equipment in a way that gives rise to an increased risk of injury. Until the issue surrounding the lack of storage is addressed, the risk of manual handling in theatres continues.

2.3 Commence Audit and Task Analysis Activity

A scheduled calendar of department audit activity was published in late 2022. Since then, the H&S Manager has conducted H&S audits in the following areas:

- Estates Technical Services,
- Emergency Department,
- Acute Medical Unit,
- Longford Ward,
- Pitton,
- Radnor, and
- Main Theatres.

Each audit identified a number of actions. Many were managed locally with the ward managers though a small number of risks were escalated for Divisional Management Team or Executive awareness. Following up the effectiveness of actions from each audit, as well as continuing to audit departments against the current calendar, remains an ongoing action for the H&S Manager. In a similar way, the H&S Team published a calendar of task reviews within departments to understand the manner in which work is conducted and determine if risks are effectively managed. Task analysis have been completed in kitchens, biomedical engineering, estates and medical devices.

Actions for 2025FY
1. Continue to follow up actions from audits to ensure risks are managed and continue with the audit schedule. 2. Train members of the H&S team to gain auditing competencies and participate in the internal audit program.

2.4 Increasing the H&S Team Involvement in the Management of Work Related Injuries
The perception of clinical staff is how the Trust prioritises the safety of patients over the safety of staff. There is little evidence to suggest this is the case, but it is the perception of some staff. Yet there was a need to increase the engagement with staff who submit a Datix report. Initially, this was a pastoral response to check in with staff, signpost as required to the relevant wellbeing supports and conduct a simple investigation using a H&S team investigation template.

In doing so staff were being heard, listened to, understood and simple actions being developed to prevent recurring injuries. All critical functions in understanding, and improving the H&S culture within the Trust, but also critical to reducing the length of time staff have off work. As noted above, it is becoming standard practice for staff to be contacted by the H&S team within 24 hours of a datix report. It is therefore not uncommon for an injured worker to state to the H&S team that they "knew [the H&S team] would be in touch" and universal feedback from staff includes statements such as:

- "Thank you so much for your help & support",
- "Thanks for checking up", and
- "Thank you so much! I really appreciate it!".

But pastoral care by the H&S Team can only go so far. There was a need to ensure effective learning from incidents occurs and demonstrated support from Divisional Management. Guidance on Managing Anti-Social Behaviour was developed by the VP&RWG that outlined Divisional Management engagement with injured staff. The H&S team has commenced escalating injury reports to Matrons and Divisional Heads of Nursing in line with this guidance and staff are seeing increased divisional management response within a much quicker timeframe.

Action for 2025FY
Key actions for the 2025FY include the need to: 1. Injury investigation training has commenced in April and will be rolled out during the year. Training will be based on the principles of safety investigations utilised by the Patient Safety Incident Response Framework (PSIRF) common to all investigations. 2. Injuries, or risks, of moderate harm to staff, will be investigated by the H&S team and reviewed by a Staff Injury Review Panel convened with clinical staff to understand Trust wide learning from an investigation and communicate amongst Divisions. 3. Identify, train and mentor Violence Prevention Key Workers

2.5 H&S Performance Measures for 2025FY
The use of positive and negative performance indicators helps drive continuous improvement in H&S management systems. The H&S Manager will continue measuring time lost and injuries but will look to addition indicators to measure H&S activities. Performance measures will include:

- Reducing the number of lost time injuries
- Reducing the amount of days lost
- 95% attendance at violence prevention training

- 95% completion of scheduled ward inspections
- Continue H&S audits against published audit schedule

attendance at training, auditing and inspections is realistic and achievable. But whilst it is preferable to have tangible, realistic and measurable performance indicators, the results between 2023FY and 2024FY vary so considerably that it is not practical to suggest a specific reduction in time lost injuries and days lost. Trends will be compared against prior year performance to ensure reductions occur with a plan to identify sustainable targets in 2026FY.

In addition to the above, the H&S Manager will continue to develop the knowledge and competency of the H&S team using external training provides during the year to ensure the H&S team complete training that will expand the capacity of the team to conduct audits, task analysis activity and robust investigations.

3. Injury by Classification

Incidents and Injuries by Classification	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**
	79	**85**	**102**	**104**	**387**
Violence and aggression	25	29	38	30	122
Damage, unsafe equipment, or environment	12	14	11	12	49
Slip and trips	6	11	13	15	45
Manual handling	3	12	12	14	41
Exposure to sharps	8	9	9	11	37
Struck by a moving object	8	5	6	9	28
Biological, Radiation or chemical exposure	5	4	5	6	20
Struck an object	4	3	2	4	13
Heat / Cold Exposure	2	2	1	4	9
Laceration	2	-	3	4	9
Chemical	3	1	1	2	7
Fall	-	2	1	2	5
Other	1	1	-	-	2

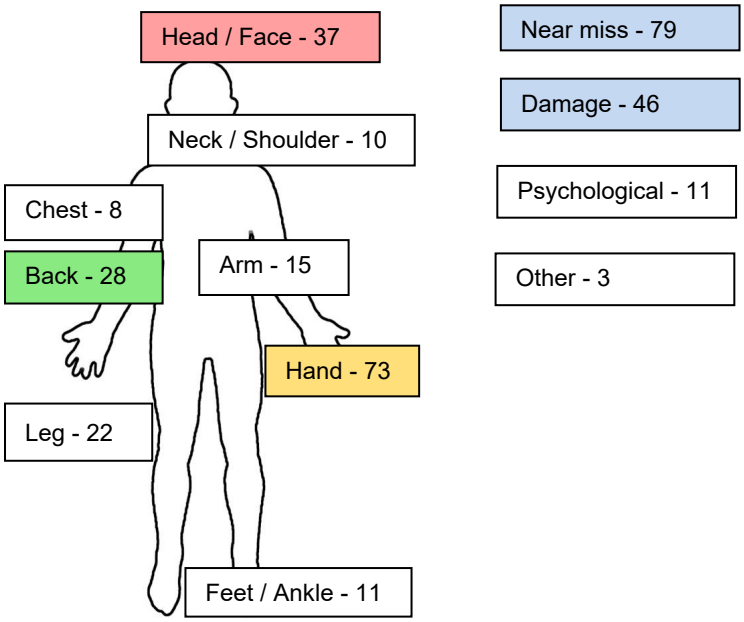
79 of the above reports were near misses related.

Even with reports of nonviolent confusion removed from results, violence and aggression towards staff remains, for the second consecutive year, the most commonly submitted Datix report. Where violence and aggression accounted for over 50% of all datix reports in 2023FY, it was 29% in 2024FY (had episodes of confusion been included, violence and aggression would account for over 65% of all datix reports). The number of incidents related to violence and aggression are broken down into the following categories:

Classification	Number of Incidents Reported
Antisocial behaviour (non violent)	48
Violence and aggression – confusion	27
Violence and aggression – mental health / behavioral	19
Antisocial behaviour between staff	8
Violence and aggression – capacity	3

The actions identified above, and the activity of the Violence Prevention and Reduction Working Group, is expected to reduce the frequency of violence, aggression and antisocial behaviour, reduce the consequence of violence and aggression and improve the response to staff exposed to such events.

3.1 Injuries by Body Location



3.2 Injury Analysis

The relatively small number of lost time injuries for the year, and the significant reduction in the overall number of incidents, is surprising in such a small space of time.

The nature and location of injuries reported in 2024FY reflect the prevelance of violence and aggression towards staff. Being punched, or struck, in the face and being scratched, pinched and bitten on the hands / arm were the most reported injuries. All of which points to staff being in close proximity to confused and delirious patients and not identifying the risk of being struck hit, pinched or scratched. The external violence prevention and reduction training teaches those targeted Band 3, Band 4 and Band 5 staff members how to identify and manage the risk of harm due to confusion and delirium and mental health.

The low number of injuries to the back and shoulders is a testiment to the amount of work put into reducing manual handling injuries. Radnor as the intensive care unit is the one area where manual handling injuries continue because of the nature of bending forward and moving sedated patients. Yet, musculoskeletal injuries are the cause of significant time off work at the Trust, but this is not reflected in the number of Datix reports. Audit discussions have identified that staff will have a day off work as a result of aches and strains from manual handling and moving but do not always report this on Datix and as such abscences will not be identified as being work related.

3.3 Triangulating Corporate Services Information

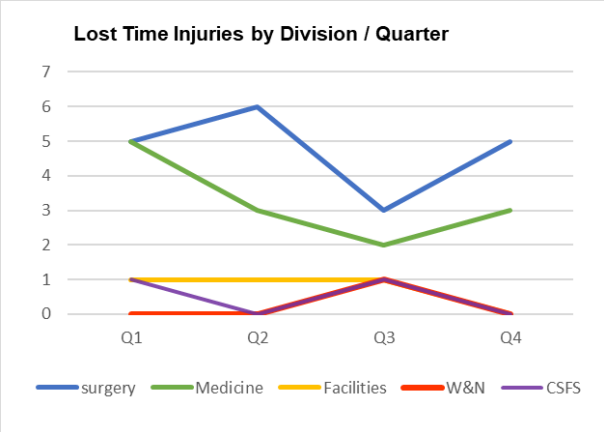
Efforts to triangulate information between HR, H&S, Occupational Health, F2SU, PALS and the Legal team remains a work in progress. This group is expected to identify or flag departments where evidence of reports or concerns across multiple reporting lines such as H&S, employment or safeguarding issues can identify wider need for action. This Group was organised towards the later part of the 2023 calendar year and very much in its infancy but has the potential to identify issues not readily identified in isolation of each work group or function.

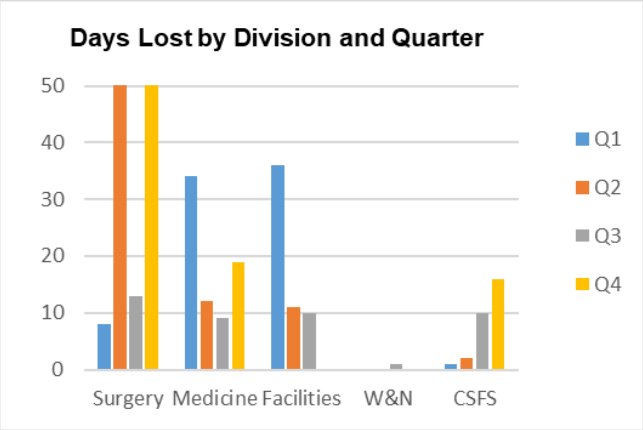
This group will meet quarterly to identify any themes for consideration and exploration and will report to the We Are Safe and Health Committee being established in the 24/25FY. One such example of how this group would work can be seen in theatres where a number of issues were identified in isolation but ultimately led to a H&S audit, the development of a behavioural charter, to work with clinical teams on civility and an exec walk around to assess some of the issues

raised. This triangulation group would be expected to understand what these issues are and expedite such actions sooner.

Action for 2025FY
The reporting of injuries and abscences from work will be picked up by a working group comprised of the H&S Manager, Head of Occupational Health, Head of Employee Relations and the Freedon to Speak Up Guardian to triangulate injury and absence data to determine the extent of under reporting.

4. Injury Performance Measures
Time lost injuries and days lost by Division and quarter are seen in the table below:





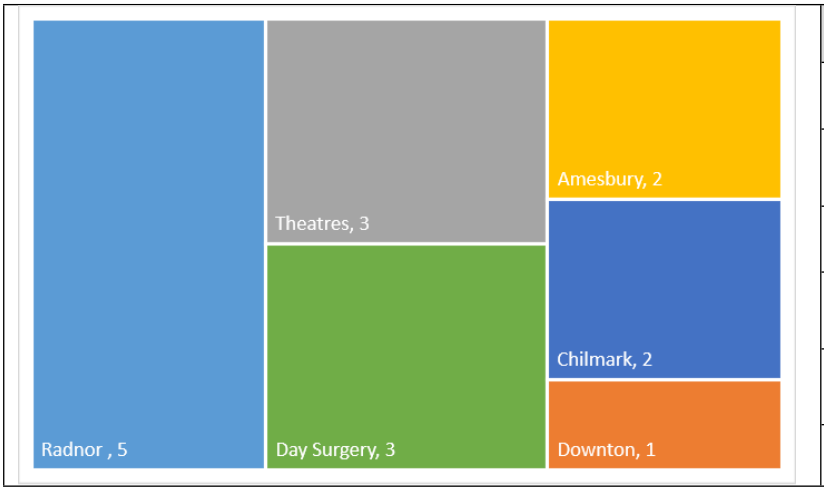
It is difficult to draw conclusions or identify trends by time lost or injuries because the numbers of injuries in 2024FY were relatively modest and 1 injury can skew results considerably between quarters. The increase in time lost within CSFS was the result of 1 injury having time off that overlappled Q3 and Q4, whilst time lost in Facilities in Q1 was the result of 1 injury sustained during security training.

Further analysis is seen below:

Injury and Frequency Rates by Division										
	Days Lost	YTD	LTI	YTD	LTIFR	YTD	LTFR	YTD	RIDDOR	YTD
Estates & Facilities	0	57	0	4	-	6.1	-	6.5	-	2
Surgery	51	121	5	19	5.4	5.8	2.0	3.1	1	2
Medicine	19	68	3	13	5.2	5.5	2.5	2.3	-	1
W&N	0	1	0	1	-	1.7	-	0.1	-	-
CSFS	16	24	0	3	-	0.9	2.0	0.6	1	1
Corporate	0	6	0	1	-	0.8	-	0.2	-	-
Total	**38**	**270**	**9**	**38**	**2.6**	**2.9**	**1.1**	**1.8**	**2**	**6**

Definitions:
Days lost are the accumulated total of days lost because staff are unfit to work due to work related injury reported in that quarter.
Lost Time Injury Frequency Rate (LTIFR) measures work related hours lost per 1,000,000 hours.
Lost Time Frequency Rate (LTFR) measures work related hours lost per 10,000 hours.
RIDDOR is an incident that must be reported to the Health and Safety Executive

4.1 Surgery - Lost Time Injuries and Days Lost



Days Lost by Department	
Radnor	46
Downton	31
Theatres	23
Day Surgery	12
Amesbury	6
Chilmark	6

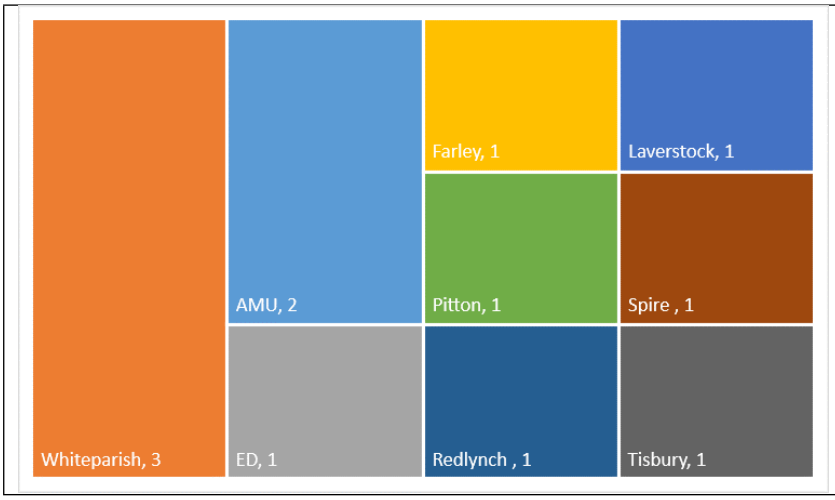
Within Radnor Ward 4 of the 5 lost time injuries were the result of manual handling. In much the same way Longford staff are exposed to increasingly hazardous manual handling due to paralysis of limbs, ICU patients are sedated and also difficult to move and handle. The recent audit of Radnor Ward did not identify any specific manual handling issues that can be readily actioned. Beds and adjustable, team lifting is available, handling and moving equipment is available and staff undergo manual handling training. There is however constant reaching forward, and over, the patient to interact with drains, intravenous access, suctioning and medications to name just a few and even when beds are raised there is still the element of reaching that puts a strain on the back.

In Theatres (inc Day Surgery) 3 of the 6 lost time injuries were the result of walking into objects and hitting hands. The most serious injury was the result of an external slip trip whilst walking to the car park.

Whilst Downton Ward only had the one lost time injury it was the most significant across the Surgical Division and resulted in a reportable injury to the HSE, a graduated return to work program and ongoing support from the Occupational Health Team. The details of which relate to a bariatric patient and a unique situation that offers little learning opportunity.

4.2 Medicine - Lost Time Injuries and Days Lost

Days Lost by Department	
AMU	23
Whiteparish	13
ED	12
Farley	6



Tisbury	6
Laverstock	5
Pitton	5

As noted above, there are a significant number of Datix reports associated with patients who are confused and agitated being reported as violent or aggressive behaviour. Whilst the reporting of incidents and near misses are encouraged, many incidents do not relate to health and safety or even safety related near misses. Whilst there were 58 incidents of violence and aggression associated with verbal or physical abuse reported in the Medical Division, there were more than 250 incidents of verbal disruption, individuals voicing frustrations, trying to abscond or displaying medically related agitation that posed no obvious risk to staff or patients.

The external violence and aggression training addresses this issue by trying to understand this behaviour and that such behaviour is not indicative of violent behaviour but other motivators. A message echoed by the Trust Dementia Lead during internal training.

This is in contrast with ED and AMU, where reports of violence and aggression and more specifically staff being struck, kicked and bitten by patients who display mental health and the rise in antisocial behaviour from patients and next of kin. There is a need to look at ways to improve Datix reporting associated with near misses though. Most reports formed occur only when someone is injured or exposed to a particularly difficult situation.

4.3 CSFS
Only 2 lost time injuries were reported across CSFS. Both related to lifting and handling injuries one on Longford Ward the other on the Palliative Care Unit.

4.4 Women and Newborn
There was only one lost time injury reported within W&N and this resulted in 1 day lost.

4.5 Corporate
There was only one lost time injury reported within the Corporate Division and this resulted in 6 day lost.

4.6 Facilities and Estates
Many of the injuries sustained related to cleaners slips and falls. Foot stools are available and approriate to reach equipment and materials are stored in a way to reduce the need to use footstools and elephants feet. As noted above, the one injury that led to extended time off was the result of security training. Given the amount of cleaning, distances walked and items handled by the cleanign staff each year, there are very limited trends or actions available to reduce the few injuries that have occurred during the year.

No injuries were reported from the Estates Technical Team (ETS), but there is ongoing consultation on the management of ETS risks across the Trust. The H&S Manager and Head of ETS have a scheduled quarterly meeting to discuss the ETS risk register, understand actions outstanding / completed, and track progress against remaining actions. During the course of the year the number of extreme risks have been reduced to one, with significant actions taken to reduce the risk identified with the chminey and work continues to update. The one remaining extreme risk in ETS relates to the Computer Aided Facility Management (CAFM) software used to manage planned and reactive maintaince programs

across the Trust and is noted below. The additional 12 high risks asscoiated with ETS activity are reported in the ETS Board Report and not duplicated here.

5. Risks

Outside the risks managed locally by each Division are a number of risks, specific to the H&S of staff, that remain under review by the H&S team. These are listed below.

Division	Description	Risk Rating	Actions
Trustwide	A collision may occur as a result of tugs operating in pedestrian areas.	6	H&S Manager and Waste Team Leader to investigate alternative routes of travel for tugs.
Facilities	Vehicles enter the area between the Waste Transfer Store and Procurement Store / Estates Store where staff are moving goods and bins around. Staff at risk of being struck.	8	CCTV cameras installed, barriers in place and warning signage present.
CSFS	The flammable waste area used to store Pathology and Pharmacy waste has built up to unsafe levels.	8	Volumes now removed but to H&S Team to assess removal processes.
Medicine	Staff at risk of harm due to violent or aggressive patients. Particularly on Farley Stroke Unit, Whiteparish, Spire, AMU, ED Durrington and Pitton Wards.	15	Security, training, 1:1 care, VERA, patient care plans, work of the Violence Prevention Group
Surgery	As a result of the storage of equipment in corridor there is restricted emergency egress in theatres	15	All fire doors and extinguishers have been cleared of obstructions, desktop exercise, weekly walk and training for all band 6's and 7's. A wider review of storage and office space is being considered
Estates	CAFM system not fit for purpose	15	Updated CAFM system identified and capital funding bid underway to secure new software.

Actions for 2025FY
The H&S Manager will review risks on a scheduled basis and present updates on risks to the H&S committee each quarter.

6. Further Risk and Hazard Management

6.1 Nitrous Oxide (N_2O) Exposure Testing Update

In response to the NHSE publication on the risk to long term exposure to low levels of N_2O the H&S Team in consultation with Medical Gases Group and Chief Pharmacist have identified a cohort of staff using N_2O and agreed on a testing regime that includes but is not limited to Maternity, Theatres, Endoscopy Suite and ED Minors. An assessment of the risk of exposure due to the ventilation, access to open air and frequency of use determined there is no need to undertake testing of staff in minors or the plaster clinic.

The Health and Safety Executive (HSE) published exposure rates at 100 parts per million (ppm) over a period of 24 hours that is averaged over 8 hours. This is known as a time weighted average (TWA). There is no minimum peak exposure rate published by the HSE. The following results were recorded:

<u>Day Surgery Recovery</u>

Testing was undertaken in Day Surgery Recovery in response to staff concerns about potential exposure to Entonox from patients recovering post surgery. 3 days of testing did not detect any nitrous oxide from expired air in recovery.

<u>Day Surgery Theatre</u>

Testing was conducted with a consultant anaesthetist administering N_2O for paediatric surgery. The time weighted average was measured at 8ppm. Further testing on 2 other occasions did not return results greater than this and subsequent testing is not required.

Endoscopy
Testing was conducted in Endoscopy suite across a variety of different patient lists, targeting patients seeking to avoid the recovery times associated with sedation. Testing was conducted in February and March 2024 and returned TWA results of no greater than 1.3ppm. Further testing is scheduled towards the end of the 2025FY.

Midwifery
Testing was conducted with 12 midwives' nurses between November and March where results were seen to vary considerably but within the TWA limits, but for 1 midwife. Testing with the midwife was repeated and anomalies found in the use of the testing equipment that rendered results inaccurate. Further testing of midwives will continue monthly throughout the year.

6.2 Traffic Management Review
The H&S Manager has commenced a review of traffic management across the Trust, specific to 2 areas:

1. the use of tugs, and
2. the movement of traffic in the u-shaped road adjacent to the laundry, entrance to Springs, and Energy Centre.

The H&S Manager will present papers on the management and control of both risks in the coming months to further reduce the risk of injury and damage to people and equipment.

Report written by

Troy Ready

Health and Safety Manager

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.1
Date of meeting:	04 July 2024		

Report title:	Register of Seals			
Status:	Information	Discussion	Assurance	Approval
	✓			
Approval Process: (where has this paper been reviewed and approved):	Approved by Lisa Thomas, Chief Executive and Mark Ellis, Chief Finance Officer			
Prepared by:	Sasha Godfrey, EA and Board Support Officer			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			

Recommendation:

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.

Executive Summary:

To report entries in the Trust's Register of Seals since the last report to Board in March 2024.

None of the signatories who witnessed the fixing of the seal of Salisbury NHS Foundation Trust had an interest in the transactions they witnessed.

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

No.	Date signed in Register	Approval Details	Held on file with:	Signature one:	Signature Two:
374	14 March 2024	Lease relating to land for electricity sub station at SFT	Laurence Arnold	Mark Ellis	Not required
375	3 May 2024	Lease for part of Highfield House, Fordingbridge	Laurence Arnold	Lisa Thomas	Mark Ellis
376	19 June 2024	Contract and transfer 16 Woodlea Grange, Alderbury	Lawrence Arnold	Mark Ellis	Lisa Thomas

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.2
Date of meeting:	4th July 2024		

Report title:	Non-Executive Director Responsibilities			
Status:	Information	Discussion	Assurance	Approval
	x			
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Ian Green, Chairman			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices				

Recommendation:
The Board to note the new Non-Executive Director responsibilities.

Executive Summary:
Due to the change over of Non-Executive Directors some adjustments to committee allocations have been made, these changes will take place in September.

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

NHS
Salisbury
NHS Foundation Trust

	Trust Board	Audit	Finance and Performance	Clinical Governance	People and Culture	Charitable Funds	Remuneration Committee
Ian Green	Chair					Chair	✓
Michael von Bertele	✓	✓			✓		✓
Richard Holmes	✓	Chair	✓				✓
Debbie Beaven	✓		Chair	✓		✓	✓
Eiri Jones	✓	✓			Chair		✓
David Buckle	✓			✓		✓	✓
Rakhee Aggarwal	✓				✓		Chair
Kirsty Matthews	✓	✓			✓		✓
Paul Cain	✓		✓	✓			✓
Anne Stebbing	✓			Chair		✓	✓