# Bundle Trust Board Public 11 January 2024

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates
*December SOX of the month –*
*December Patient Centred SOX –*

1.2 10:10 - Staff Story

1.3 Welcome and Apologies

1.4 Declaration of Interests, Fit & Proper / Good Character

1.5 10:30 - Minutes of the previous meeting
*Minutes attached from the meeting held on 7th December 2024*
*For approval*
1.5 Draft Public Board mins 7 December 2023

1.6 Matters Arising and Action Log
1.6 January 2024 Public Board Action Log

1.7 10:35 - Chair's Business

1.8 10:40 - Chief Executive Report
*Verbal update by Stacey Hunter*

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:50 - Integrated Performance Report to include exception reports
*Presented by Peter Collins*
*For assurance*
2.1a IPR Cover Sheet - Trust Board 2023-12
2.1b Integrated Performance Report Jan 24 FINAL

2.1.a 11:20 - Outcome of Mortality Review
*Verbal update from Peter Collins*

2.2 11:25 - Audit Committee – 12 December
*Presented by Richard Holmes*
*For assurance*
2.2 Audit Committee Escalation Report December 2023

2.2.a 11:30 - Short term changes to SFI's for Procurement Recommendation Report approvals for capital from 1 December 2023 – 31 March 2024
*Presented by Mark Ellis*
*For approval*
2.2a Q4 SFI capital procurement SFI ammendments
2.2a Trust Standing Financial Instructions

2.3 11:35 - Charitable Funds Committee – 12 December
*Presented by Ian Green*
*For assurance*
2.3 charitable funds escalation report

3 FINANCIAL AND OPERATIONAL PERFORMANCE

3.1 11:40 - Quarterly Strategy Update
*Presented by Lisa Thomas*
*For assurance*
3.1a 2024-01-11 Quarterly-Strategy-Update Cover-Sheet
3.1b 2024-01-11 Quarterly-Strategy-Update

3.2 11:50 - Estates Technical Service Update
*Presented by Brian Johnson*
*For assurance*
3.2 ETS Report to Board January 2024

3.3 12:00 - Planning Update
*Verbal update by Lisa Thomas*

4 STRATEGY AND DEVELOPMENT

4.1 12:05 - Improving Together Quarterly Update Report Q3
*Presented by Peter Collins*
*For assurance*
4.1 Improving Together Quarterly Trust Board Report_Jan 2024

5 PEOPLE AND CULTURE

5.1 12:15 - Health and Safety Quarterly Report
*Presented by Melanie Whitfield*
*For assurance*
5.1a H&S Cover Sheet Jan Public Board
5.1b HS Report Q2

5.2 12:25 - Medical Education Performance Annual Report
*Presented by Peter Collins*
*For assurance*
5.2a PCC -Medical Education Annual Report Cover Sheet
5.2b Annual Medical Education Report 2022-2023

5.3 12:35 - BREAK

6 GOVERNANCE

6.1 13:05 - Emergency Preparedness, Resilience and Response Annual Assurance Statement and Compliance
*Presented by Lisa Thomas*
*For assurance*
6.1a Cover Sheet EPRR Annual report 2023
6.1b EPRR Annual Report 2023 Version 1.0 Draft

6.2 Register of Seals – no new seals added since last report

7 QUALITY AND RISK

7.1 13:15 - Director of Infection Prevention Control
*Presented by Judy Dyos*
*For assurance*
7.1a Front sheet DIPC report jan 2024
7.1b DIPC Report 6 monthly Update 2023-24 (Draft v.1)
7.1c Copy of SFT IPC BAF Q2 of 2023-24 (v.1 March 2023) Draft v.1 (Updated 01.12.23)

7.2 13:25 - Quarterly Learning from Deaths Report
*Presented by Peter Collins*
*For assurance*
7.2a Q2 2023-24 Learning from Deaths Report Cover Sheet
7.2b CGC Q2 LFD Report 2023-24v1.0

7.3 13:35 - CNST Declaration sign-off
*Agreed the CNST Declaration sign off report to go to Trust Board first and then CGC retrospectively - report to follow on 9 January 2024*
*Presented by Judy Dyos*
*For assurance*
7.3a Front Sheet CNST Board Report year 5
7.3b CNST MIS Year 5 Board self certification report January 2024
7.3c Board Declaration form - CNST Jan 2024

7.4 13:55 - Perinatal Quality Surveillance Report – December (November data)
*Agreed the Perinatal Quality Surveillance Report to go to Trust Board first and then CGC retrospectively*
*Presented by Judy Dyos*
*For assurance*
7.4a Front sheet Perinatal quality surveillance December (November Data)
7.4b Perinatal Surveilance reporting December - November data

8 CLOSING BUSINESS

8.1 14:05 - Any Other Business

8.2 14:10 - Agreement of Principal Actions and Items for Escalation

8.3 14:15 - Public Questions

8.4 Date next meeting

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 7 December 2023, 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 (Via Teams) |
| Rakhee Aggarwal (RA) | Non-Executive Director |
| Stacey Hunter (SH) | Chief Executive Officer |
| Judy Dyos (JDy) | Chief Nursing Officer |
| Mark Ellis (ME) | Chief Finance Officer |
| Peter Collins (PC) | Chief Medical Office |
| Lisa Thomas (LT) | Chief Operating Officer |
| Melanie Whitfield (MW) | Chief People Officer |

**In Attendance:**

| | |
|---|---|
| Kylie Nye (KN) | Head of Corporate Governance (minutes) |
| Fiona McNeight (FMc) | Director of Integrated Governance |
| Jayne Sheppard (JS) | Lead Governor (observer) |
| Victoria Aldridge (VA) | Head of Patient Experience |
| Chris Prentice (CP) | Volunteer and Chair of the Spinal Patient Panel (Item TB1 07/12/1.2) |
| Jane Podkolinski (JP) | Governor (observer) |
| Frances Owen (FO) | Governor (observer via Teams) |
| Vicky Marston (VM) | Director of Midwifery |
| Louise Couzens (LC) | Clinical Commissioning Group (observer) |
| Louise Drayton (LD) | Performance Manager (Shadow Board Observer) |
| Kate Jenkins (KJ) | Clinical Psychologist (Shadow Board Observer) |
| Bernie Dunn (BD) | Divisional Head of Nursing, Surgery (Shadow Board Observer) |
| Jo Underwood (JU) | EA to Peter Collins and Judy Dyos (Observer) |
| Gary Rouse (GR) | System C Connecting Care (observer) |

**ACTION**

**TB1 07/12/1** **OPENING BUSINESS**

**TB1 07/12/1.1** **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:

**October SOX of the month** – Bibin George, Housekeeping and the Peter Gillam Team

**October Patient Centred SOX** – Britford and Stoma and Eddison Riviera, Nathan Noble and Rogeme Platino, Radiology

**November SOX of the month** – Neil Marshall and Tom Ranaboldo, Orthopaedics

**November Patient Centred SOX** – Pathology Reception and Phlebotomists

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

**TB1 07/12/1.2** **Patient Story**

VA welcomed Chris Prentice (CP), Chair of the Spinal Patient Panel who had joined the meeting to provide his story on spinal rehabilitation and implementation of a 'Patient's Forum'. CP presented slides which summarised the setup of the group, the objectives, aims and progress and noted that the current projects were selected based on common experiences of the group themed as:

- Improving patient information (pre and post admission)
- Maximising opportunities for self-rehabilitation
- Patient experience of facilities (i.e., noise, toilets)

The three headline projects of the group are:

- **Gait Walker -** Trials have been held and more are planned. The Head of Physiotherapy has said that there is optimism that a viable unit can be found and deployed. Further trials due in the next few weeks
- **Toilet safety grab rails -** Project currently about to enter trials
- **Bone conduction hearing aids** - Currently under test in the Ophthalmic Unit at SDH

**Discussion:**
IG thanked CP for his comprehensive presentation, his time as a volunteer and sharing his lived experience.

SH noted that for the vast majority of people who find themselves needing care, there is a distinct motivation to want to improve the service for others. This is a resource the Trust does not always make use of. The Trust need to consider how do we work with and challenge our professional groups to encourage this different way of doing things. The partnership between clinicians and patients is key to improving patient services and quality of care.

CP further noted that the profile of the unit had changed in the past. The unit now receive more elderly patients than they used to but the facilities are not aligned to their requirements. There is a requirement for investment. Additionally, the NHS culture is risk averse and he suggested the Trust should try to be risk aware but continue to push forward to overcome barriers.

The Board recognised the continued importance to hear from either staff or patients at the start of the Board to help set the context.

The Board thanked CP for his story.

VA and CP left the meeting.

**TB1 07/12/1.3** **Welcome and Apologies**

IG welcomed everyone to the meeting and noted RA was joining the meeting via Teams.

IG noted that as part of the Improving Together Programme, he had considered the standard work discussed at the Board Development Day. He noted that this standard work will be gradually implemented at Board to support effective and strategic discussion.

**TB1 07/12/1.4** **Declarations of Conflicts of Interest**

There were no declarations of conflict of interest pertaining to the agenda. However, the following items were noted:

- SH noted her standing declaration in relation to being an Integrated Care Board (ICB) Member, noting that there was no conflict of interest with any of the agenda items at the meeting.

**TB1 07/12/1.5** **Minutes of the Part 1 (Public) Trust Board meeting held on 5th October 2023**

IG presented the public minutes from 5th October 2023 and the following was noted:

- On pg. 14, the third bullet point should read “1:1 care”.
- On pg. 14 in the maternity and neonatal Bi-annual staffing report, there is reference to an evidence-based process which should be named as Birth rate +.
- Pg. 16 EJ noted that the sentence around physicians associates and the GoSW did not read well. PC to check wording and update.
- Pg, 18 the 3rd bullet should read “not representative of the wider local community”.

Subject to these amendments, the minutes were agreed as a correct record of the meeting.

**TB1 07/12/1.6** **Matters Arising and Action Log**

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

**TB1 05/10/5.5 Maternity and Neonatal Bi-Annual Staffing Report**
JDy noted that this is related to the continuity of carer model which the Trust is unable to fulfil until the maternity department have adequate staffing. JDy noted that this is being added to the risk register and quality impact outcomes were being reviewed. IG noted this action was to remain open until the risk assessment comes back through the Board.

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

**TB1 07/12/1.7** **Chair’s Business**

IG noted the following key points:

He had attended numerous meetings since the last Board and spent an interesting unannounced visit in the Trust on Saturday which was welcomed by colleagues. IG reported that this visit did not highlight any difference in culture. IG noted that NEDs have been discussing increasing their level of exposure in relation to these visits.

IG explained that the Trust has agreed to delay recruitment of CEO to allow conversations to take place around potential opportunities for different approach to leadership. A number of meetings have taken place over the course of the last few weeks with no further conclusions so we have been asked if the Board is content to extend a pause on recruitment until January 2024. IG noted that this requires the Board's approval.

**Discussion:**
The Board discussed the other acute Trusts with SH noting that the same request is going to Great Western Hospitals NHS Foundation Trust's (GWH) Board.

EJ noted that there was a robust interim appointment in place and was therefore content to support.

RA supported the recommendation but queried if the move of the two Trusts in Bristol to one joint CEO and Chair is, or will impact the leadership decision between the three NHS Trusts. IG noted this has not been considered within the BSW system. This is a further temporary pause to allow conversations to take place. The solution proposed will be a decision of the Board.

DBe supported, noting that December is a bad time to start recruitment.

**Decision:**
The Board approved the proposal to pause CEO recruitment to January pending further discussions.

**TB1 07/12/1.8** **Chief Executive's Report**

SH presented her CEO report and highlighted the following key points:

- SH and IG had attended an NHS Providers conference in November and received a session from Margaret Heffernan in relation to 'wilful blindness'. SH encouraged the Board to seek out the highlights of this session, noting the need to reflect on culture as a Board and to the theme of what more and different can be done to minimise risks.
- The Trust has received the announcement of further Industrial Action (IA) which will take place leading up to Christmas. This is a key concern and it will be challenging to secure cover. Key escalations are being put in place to manage this situation. SH proposed that the Trust provides the Board with additional assurance around IA and the risks. PC will be requesting redeployment of staff which requires a sensitive balance but it is key to keep essential services as safe as possible. This will also impact financial recovery which was predicated on no further IA. There is recognition that financial positions will change based on IA likely to happen in December and January.
- SH highlighted that whilst under pressure, the work our teams are doing is having a positive impact and this should be recognised.

- SH thanked F&P Committee, ME and the finance team for their efforts in supporting the Trust's financial plans in the last month, noting that ME would provide a brief update later in the meeting.
- Some of the work from the Integrated Care Alliance has progressed and the Board will start to receive more information on this.
- We're in a formal procurement process regarding the Community Services Tender. LT to update further in the private meeting.
- The Acute Hospital Alliance (AHA) work is progressing and is summarised in the appended report.

**Discussion:**
DBe noted the wording needed to be amended from "the cancer waiting times remains cancelled" to "challenged".

DBe referenced staff welfare noting that it is generally minority groups who suffer the most and asked if there is there any additional effort to support them. KJ explained that funding was received the previous year to add specific interventions to support ethnic minority groups. The Trust ran workshops to understand the key concerns, including social space for those who live onsite. A well-being session is now included in OCSE training. The Trust have also introduced a better welcome package based on feedback from overseas staff. There is also a refreshed network and a mentoring system is under development. The Trust's Head of Equality, Diversity and Inclusion (EDI) is also focused on the wellbeing of overseas staff. For all BAME staff there is a QR code for the wellbeing portal which can now be translated into over 200 different languages. The team continue, through the network to gain feedback so we are able to react dynamically.

EJ was pleased to note the request for Christmas gifts for the hub for staff, recognising that this is a challenging time for a number of people.

DBe referenced the AHA briefing and the joint committee and asked what the governance or escalation route is if it is not working effectively. The Board noted that work is underway around delegated authority for that body e.g., around budget controls which will come back to Board. The expectation is the committee will have one executive and one non-Executive from SFT. DBe asked the executive to consider the assurance reports into various committees. IG referenced the Shared Electronic Patient Record (EPR) programme, noting that a joint committee will mitigate the risk highlighted around convoluted governance arrangements. This simplifies the approach but for it to work it must be really clear with transparent reporting lines. The Board noted that PC and the Chief Information Officer (CIO) Jon Burwell, are working on the line of sight of internal capacity to deliver the EPR programme.

TB referenced the announcement this week from the government regarding immigration policy. TB asked when the Board could expect to get a further update on this from the Trust's perspective. SH noted that this policy announcement has been made prior to any written guidance and therefore NHS Employers will be seeking the clarification around this policy change. MW noted the Trust will establish an understanding of the Trusts staff position and how this might impact them and discuss this at the Staff Network.

The report was noted.

**TB1 07/12/2** **ASSURANCE AND REPORTS OF COMMITTEES**

**TB1 07/12/2.1** **Clinical Governance Committee – 31 October and 28 November**

IG thanked the Chairs of Committee for their escalation reports and asked the Board to take the papers as read. IG asked the chairs to highlight only the key escalation points.

DBu presented the report, providing a summary of escalation points from the meetings held on 31st October and 28th November 2023. DBu noted that there were no key areas of concern to highlight but clarified that the Trust was not an outlier in relation to the Annual Cancer Survey and the Trust's response rate was 63%.

The report was noted.

**TB1 07/12/2.2** **Finance and Performance Committee – 31st October and 28th November**

DBe presented the report, providing a summary of escalation points from the meeting held on 31st October and 28th November 2023. DBe asked for the report to be taken as read and highlighted the key points as follows:

- Despite financial performance and year end projections, the determination to reach the CIP targets should be commended. The Committee receive thorough reports around what has been delivered and the gaps in relation to CIPs.
- In November, the Committee challenged the shift in run rate, and good assurance was received around identified schemes to deliver.
- The Sterile Services Critical Incident was discussed at November's Committee with assurance provided around mitigating actions.
- There have been many discussions in the last few months around the Trust and system financial challenges which ME will pick up in the next item.

**Discussion:**
EJ noted that there is more robust data and a shift in reporting which has supported the process in comparison to previous years

The report was noted.

**TB1 07/12/2.2a** **Current Financial Position Update**

ME noted that the Trust's financial position is £6.3 off plan, indicating an £8.1m deficit. Since the last F&P Committee in November there has been feedback from a national meeting where it was noted that BSW carries a high level of risk and therefore the ability to improve is based on this sensitive risk profile.

There was a discussion regarding the potential difficult decisions that might need to be taken. There is a challenge for the system to reduce the deficit of £9.9m. However, the actions in place e.g., focus on temporary and agency staffing and the divisional actions to address run rate hold a level of risk. Additionally, the numbers are contingent on no further IA. ME noted that the level of strike action is likely to be more than the Trust's assumption. Another

key risk is the vulnerability of the estate which has also been escalated. The Trust plans to have more theatre capacity open but this could be constrained by the ability to use the estate in winter alongside availability of beds which is impacted by IA.

IG summarised that the conversations at Board and F&P have indicated our position has a high level of risk and therefore there is an agreement that the Trust will not realistically be able to deliver any further to reach a system breakeven.

**Discussion:**
DBe supported the view that to push further would result in the risks being significantly higher and the Board could not assure itself on the Trust's ability to deliver.

SH noted her concerns around the external workforce control measures that the Trust were being asked to fulfil and explained that she is working with MW to manage this issue. SH outlined the situation in relation to workforce, acknowledging the challenge around the Trust's headcount increase.

ME noted that where there are national funding business cases going through, there is heightened review and oversight of these.

Additionally, the Trust has received the letter for Q2 segmentation reporting we are now in segment 3. There are three areas of concern. However, what has deteriorated is our 62-day cancer performance, which means we have an enhanced element of oversight which means greater scrutiny from NHSE. The letter indicated that the exit criteria would be confirmed at a later date.

LT positively reported that the 62-day cancer backlog had been cleared.

DBe referenced the estate issues and asked for an update on the Sterile Services incident referenced in her escalation report. LT reported that the critical incident has ended and the Trust only cancelled 11 patients despite the level of disruption caused. There will be a reflection session and lessons learnt will feedback through F&P Committee.

**TB1 07/12/2.3** **Trust Management Committee – 22nd November**

LT presented the report, providing a summary of escalation points from the meeting held on 22nd November 2023. The report was taken as read.

**Discussion:**
EJ noted it was positive to see the Standing Operating Procedure (SOP) around additional capacity and grip.

The report was noted.

**TB1 07/12/2.4** **People and Culture Committee – 26th October and 30th November**

EJ presented the report which provided a summary of escalation points from the meeting held on 26th October and 30th November 2023. EJ asked for the report to be taken as read and highlighted the following key points:

- Both meetings were positive but acknowledged the challenges around workforce is one of our biggest risks and there is working ongoing around retention.

**Discussion:**
SH acknowledged the issues raised around parking. SH noted that the car parking strategy will be refreshed. However, more immediately we are looking at the criteria for fines as many people have been in touch to complaint. The Head of Facilities is going to review first to get assurance we are not fining people unnecessarily. There will be Trust-wide comms as soon as IR clarifies the facts/issues. This will be covered in January's CEO report.

MW noted that the Staff Survey response rate has been tracking 10% above the national returns. There has been a lot of work to encourage response rates so it's good to see a positive return.

RA highlighted from October's meeting, the Freedom to Speak Up Guardian and the amount of work undertaken by this service. RA noted a robust discussion at Shadow Board about the Patient Safety Incident Response Framework (PSIRF) plan and policy and if there might be any impact on how people react and report safety related issues. The Board noted that PSIRF encourages a just and learning culture and should be a more complementary way of learning.

The report was noted.

**TB1 07/12/2.5** **Integrated Performance Report (IPR) (M7)**

JDy presented the Integrated Performance Report which provided a summary of October 2023 performance metrics. JDy noted that there was a new approach to presenting the IPR through the implementation of Standard Work. JDy noted that following key points:

- The time to first outpatient (OP) appointment metric continues to be a struggle, which is contributed by a small number of specialities, including General Surgery and Gastroenterolgy.
- The number of falls has continued to reduce and is currently tracking below the mean. The countermeasure which is the most impactful has been the use of 'Baywatch'.
- In terms of deteriorating metrics, October's report highlights the issue around the 62 days cancer standard position (although noted by LT that this has now been resolved).
- Total Trust Referral to Treatment (RTT) performance has deteriorated over the past few months with October reporting 59.1% against 61.3% in August.
- Bed moves have declined to a worse position but have been tracking above the mean for the last 7 months. The last month or so this has been largely due to ward openings and relocations.
- Agency spend has reduced in the last month but is still tracking significantly above the 3.7% target. The countermeasures for this are focused workforce control processes at a Divisional level.
- Financial measures have already discussed above.

**Discussion:**

The Board had a detailed discussion around the new approach of presenting the IPR, noting the logical process and focus on key metrics and countermeasures.

The Board discussed time to first OP appointment, noting that implementation of the Improving Together (IT) methodology has reinforced the work at speciality and looking at the aggregate performance does not quite show the improvements made. There is focused work and also a need to look at balancing measures in relation to urgent and follow ups. The Cancer position has improved and this will be reported in future IPRs. IG thanked LT for this assurance.

IG referenced the key areas highlighted as part of JDy's summary and asked the Board if this reflected the key concerns highlighted in the Board Committee meetings. The Board noted that through the discussion at Committees the meetings address all the points raised but perhaps in a less structured way. DBe suggested that it would be helpful for executive summary to follow a similar structure.

EJ thanked JDy for the update, noting that the approach to presenting focuses the mind on key issues. EJ noted that the Breakthrough Objective around agency is small quantum of the efforts and work discussed at People and Culture Committee so it does not reflect all the underlying work. EJ noted she would reflect how to enhance the golden thread from Committee to Board.

JDy reflected that the presentation approach set out in the standard work did not allow for recognition of positive work, e.g., DM01, ambulance handovers etc and noted the importance of good news stories.

RA noted a disconnect in the clear links between the work at Committee and Board. SH suggested aligning the discussion to the overall strategic planning framework (SPF), not just the breakthrough objectives. SH noted that the two areas of focus at the Committees should be the BAF and the IPR. DBe noted that there is a space for good news stories and/or assurance that activities are working effectively.

The Board discussed the outcome of the Aqua well-led review, acknowledging the suggestion that a narrow focus on breakthrough objectives could instigate other performance issues being missed. The Board agreed on the approach but noted there is further work to create a more holistic view of performance.

PC explained that the executives explore good news in the Executive Performance Review Meetings (EPRMs). The assurance work is referenced through the vision metrics and linking to the assurance Committee. PC noted that he would include assurance around strategic intent in the Q3 Improving Together report.

The Board discussed balancing metrics and performance oversight. RA queried if the Board needs to consider how interdependencies come together more visually. PC suggested visiting the Engine Room with Committee members to understand the golden thread from ward to Board. Additionally, although attention is not directly focused on watch metrics, there is a role for

assurance committees to ensure they are comprehensive and right metrics to provide assurance.

MvB referenced risks and issues, noting that the discussion does not always link back to the BAF. The IPR is not clear in the narrative around how the Trust is addressing risk.

KJ referenced positive assurance, noting how important it is for people on front line to understand what is going well and how they have contributed to the bigger picture re what is going well.

EJ reflected that she sat on all three Board Committees, noting her preparation for discussion was made much easier with the new style IPR.

DBe noted that in another Trust she works in, the BAF is at beginning of every committee and then evaluated in terms of risk improvement. This is a useful exercise and could be beneficial to SFT's Board Committees.

IG thanked everyone for their input and asked for continuous reflection on the IPR as the report develops.

The report was noted.

**TB1 07/12/2.5a** **Mortality Review Update**

PC noted that the review had been undertaken on Tuesday 5th December. The focus was on a wider remit around governance around quality. They have focused on areas of good practice and areas which required an improved focus.

The high-level assurance received on the day was that there were no significant concerns that quality of care was impacting mortality numbers. The written outcome letter will come back to Clinical Governance Committee (CGC). There are also 27 key actions which will come back through CGC.

**Discussion:**
RH asked if there were any expected areas of focus as part of the initial feedback. PC noted that there were no surprises but a different focus, particularly around the impact of coding and how to solve that. This was about wider clinical documentation and relationship between clinical staff and coders.

SH noted that there were suggested improvements around how hospice deaths are being recorded. This was not something the executive were aware of but they have suggested we do a specific piece of work around how they are being coded. DBu queried if they were reviewing capacity of coding and quality. SH explained that there are challenges in both timeliness and depth of coding.

The update was noted.

**TB1 07/12/3** **STRATEGY AND DEVELOMENT**

**TB1 07/12/3.1** **Implications for SFT on Major Conditions Strategy**

IG presented the report which was included in the Board papers for information. The report outlined the NHS Providers briefing on the new DHSC 'Major Conditions Strategy'

The report was noted.

**TB1 07/12/3.2** **Digital Plan Update**

ND presented the report which summarises the progress against the Trust's digital plan over the last 12 months. ND highlighted the following key points:

- Shared EPR programme - the full business case (FBC) requires regional and national approval. However, it is acknowledged further to the recent financial discussions the regional financial position may affect this.
- The three Trusts are implementing BadgerNet. ND noted that there is an opportunity to collectively implement, however this could possibly delay progress.
- The main risks to the plan are available funding and the capacity of staff to engage in the digital agenda, in particular the Shared EPR programme. Where staff need to be released to support priority digital programmes, any associated risks from doing this will be clearly identified and escalated through Trust governance for consideration.

**Discussion:**
IG thanked JB and RK for pulling the report together. IG referenced the 'project and planned work progress', noting that some have dates and some do not. IG asked for all to have dates for consistency. **ACTION: JB** **JB**

DBe noted the huge investments going into digital interventions, which will have had benefits and impact assessed. DBe asked how the Board will be assured on effective implementation, i.e., are these projects delivering and did we meet the results we wanted to.

EJ referenced the point made regarding BadgerNet implementation in Maternity, noting that any further delay would have an impact on patient safety. EJ asked for further assurance that there would not be any further delay. ND provided an update on the meeting held on 6/12 regarding BadgerNet, noting that the funds have been approved and project managers appointed. The discussion on this call had been around a joint procurement process. JDy noted that the preference is not to take a joint approach as SFT will the Maternity CNST (Clinical Negligence Scheme for Trusts) and saving babies lives. This is business critical and therefore it is the Trust's wish to have BadgerNet in place as soon as possible. The Board noted that SFT is under a national intensive support programme for maternity and therefore do not have the flexibility to delay any further.

The Board discussed funding for EPR, as a query was raised if funding is not approved. SH noted that there have been many meetings to discuss this programme moving forward. It is acknowledged that a delay cannot be accepted and therefore we cannot afford to pause. ND discussed the other options if the project does not receive funding. As discussed, we have not managed to reduce the system £9.9m deficit and have been asked to look at

improving benefits in EPR business case. There is not an opportunity to deliver any further savings and the reality is SFT have to replace the EPR system. This might be delayed into Q1, which will mean we could carry on all our preparation.

PC referenced the breadth of programmes and each requires clinical engagement / leadership and non-clinical resource and we should not underestimate the impact on productivity in relation to the amount of time it takes for successful implementation.

The report was noted.

**TB1 07/12/4 QUALITY AND RISK**

**TB1 07/12/4.1 In-Patient Survey Results – deferred from October**

JDy presented the report which had been considered at CGC. JDy noted that there were some areas of deterioration with themes around lack of explanation for changing wards and patient's home situations not being considered. The Trust falls within the average range when compared to national data and there is further work to be done to achieve higher level of feedback.

**Discussion:**
SH noted her concerns as SFT had one of the lowest performance ratings as a result of this service in the Southwest. The Trust need to consider its priorities in terms of this feedback, including if there are any areas of focused support required. SH noted that the executives will discuss over the next few weeks but noted that it does not represent the efforts of colleagues.

RH noted it would be helpful to liaise with those nearby Trusts who have performed better to learn from them in terms of best practice.

MvB noted that this was a survey from a snapshot in time but is useful feedback. He suggested that the Trust add its own questions as it is a good way of tailoring feedback and is an opportunity to learn from inpatients. JDy noted that this feedback is from last year and it is important to recognise that further interventions have been implemented since then so it is expected this will be reflected in this year's survey results.

KJ noted that, as highlighted at Shadow Board, communication is raised as an issue repeatedly and whilst there are many interventions, there is more that needs to be done as it has not improved as an overall theme. KJ noted Royal Devon have scored well and there might be learning.

The Board discussed some observations from the Shadow Board as it was noted that it was unclear what the paper was trying to achieve at Board vs CGC. SH noted that the report was required to be received at Board-level as it is fundamental to core business but recognised the need to be clearer in terms of actions. KJ questioned the use of the term statistical significance in the report and JDy noted that those terms are added by the survey facilitators.

DBu referenced the issues these surveys can present but highlighted that they are useful benchmarks to understand what patients are telling us about

the services we provide. From a NED perspective, have we heard the patient voice and is there an appropriate response.

In terms of next steps, JDy has met with VA and discussed the Improving Together work and how this links to streams of work including, assistance with hydration, working through discharge process and the nursing contribution to Trust Strategy.

RA noted that the discussion at Shadow Board referenced the co-creation of actions with our patients. The discussion was related to what the Trust should be doing in terms of communications development rather than the focus that is currently in existence. JDy explained that in previous reports we have shared the communications programme and that will go some way to responding to that ask. However, noted that in the Engine Room, collaborative working, and this approach to care in terms of measuring and monitoring was discussed as a Vision Metric going forward.

The report was noted.

**TB1 07/12/4.2** **Patient Experience Report Q1**

The Board noted this report was deferred to March as it reports to CGC first and there is no meeting in December. SH noted that this needs to be addressed for next year.

**TB1 07/12/4.3** **Quarterly Risk Report Card**

The Board noted this report was deferred to March as further work was required to implement the Improving Together methodology.

**TB1 07/12/4.4** **Patient Safety Incident Response Framework (PSIRF) Plan and Policy**

FMc presented the report noting that PSIRF is going live in January so requires approval. This has been through and supported at TMC and the weekly executive team meeting.

FMc noted that the policy and plan have been updated but not included in the papers. Therefore, she asked if colleagues would review in the next 10 days to gain Non-Executive Director approval.

**Discussion**:
EJ noted that she has read the documents, noting that the plan is live and user friendly and follows the national template well.

FMc noted that she has been chairing the PSIRF implementation group, and the process has been led by Risk. As the Trust moves through the implementation process the policy and plan may have to be amended. The process mapping work has been useful and data analysis, which is how the 5 local priorities were identified, alongside the national priorities. The Trust has appointed two learning response leads full time to take forward the investigation.

LD queried if any risk had been raised regarding the time is takes to report due to the burden of the process. JDy explained that PSIRF should reduce the burden as the teams currently produce multiple-page Serious Incident

reviews and create multiple action plans. PSIRF will ensure there is one overarching action plan and it will be less onerous. FMc noted it will remove the threshold of harm which will place more focus on the learning from high volume, low harm incidents.

KJ welcomed the move to this approach and addressing the low hard but high-volume incidents. There was a lot of positive discussion about this at Shadow Board and there were suggestions of training for managers regarding compassion in their response to these incidents being raised. PC noted that the Board should be aware of the different perspectives of the Shadow Board and feed that into wider communications if it is felt appropriate.

SH welcomed the implementation of PSIRF which is long and will hopefully address the industry around SIs failure to undertake thematic analysis. This is about implementing a just and restorative culture.

**Decision:**
IG recommended that this was agreed in principle subject to feedback by 22nd December to FMc via email. Delegation of consideration of changes would be to IG and SH. **ACTION: ALL** **ALL**

**TB1 07/12/4.5** **External Well Led Development Review**

FMc presented the External Well led Developmental Review which also outlined the key themes for development. The following key points were noted:

- The review was between April-June this year and the executives had an away day in September to understand the outcome of review and this was also presented to the Board in October. The executive team have re-reviewed the report.
- Key development themes have been identified for each Key Line of Enquiry (KLOE) from the findings of the review and are outlined in the slides including current workstreams to address improvement. Any further action required has been identified. It has been recognized that there are current programmes of work in place to address the key areas for development without the requirement to create additional workstreams.
- Once the areas for development have been approved by the Board, these will be disseminated to the relevant workstreams to implement. Oversight of progress will be through progress reports to Board by the Director of Integrated Governance in addition to information reported through the committee governance structure.

**Discussion:**
The Board noted that the full report went to the Council of Governors in November for oversight and assurance.

The Board discussed how they would gain assurance around implementation of the key recommendations. It was noted that assurance would be escalated upwards from divisional governance meetings via the Executive Performance Review Meetings (EPRMs). To pull all of this together LT noted that she had suggested an annual or bi-annual review of a strategic service map including the divisions and Board to look back at the previous year, with a focus on the actions going forward. It was acknowledged that this does create work for

colleagues but there are tangible benefits in having these conversations. The Trust is working on a date in January/February but will depend on availability.

IG summarised that the actions are being built into existing workstreams. The Board will receive a 6-monthly update on progress as part of a consolidated report. KN to add to the Board cycle of business. **ACTION: KN.** **KN**

**TB1 07/12/4.6** **Maternity and Neonatal Quality and Safety Report Quarter 2**

VM joined the meeting to present the Q2 report which outlined the CNST requirements, PMRT review and compliance with labour ward coordinator being supernumerary and women receiving 1:1 care, which was currently at 100%.

Additionally, the Board are asked to note and challenge compliance with national reporting to include the CQC, Maternity Incentive Scheme (MIS) AND Ockenden 2020 and 2022 recommendations, acknowledging the work towards the 2023 publication of the three year delivery plan.

The following positive points were noted:

- Positive patient feedback in Q2.
- Still birth and neonatal death rate was nil in Q2.
- Ockenden audit actions will all be closed by the end of Q3.
- Good progress towards CNST against the MID year 5 requirements.

Focus for improvement is on:

- The maternity safety support programme has moved at pace in last 8 weeks to close actions as work continues to exit from the plan.
- In Q2 we have had some training compliance issues, relating to IA and prioritising care.
- There have been challenges in meeting compliance and full implementation with saving babies lives care bundle.

**Discussion:**
IG noted that it was good to see progress. He referred to Figure 15 and asked if the next report could demonstrate the timelines around those areas which are non-compliant. This was accepted.

The Board discussed the team's cautiousness in terms of delivery against CNST. VM and AK noted that their approach is to be overly cautious in assessment and challenging themselves to be realistic in terms of delivery. SH acknowledged the lack of control in relation to external factors and the cautious approach as the department is under scrutiny. However, SH suggested reviewing how we respond to CNST requirements in comparison to our neighbouring acute Trusts, as a useful mechanism to see if the team is over cautious. VM noted that the Trust is hoping to exit the MIP in March 2024. There is a clear plan to exit which has been agreed with the Maternity Improvement Advisor (MIA).

EJ and JDy meet regularly to discuss progress in Maternity. EJ noted that the team have made great progress and advised that there will be a reinspection by CQC and the evidence of improvement will be there. EJ noted that the MIS 5 requirements were changed significantly but the team know their position and what is required. Additionally, the Insight visit raised no concerns.

IG thanked the team for the report noting the alignment to the NHSR Maternity Incentive Scheme and the next steps detailed in the report.

**TB1 07/12/4.7** **Perinatal Quality Surveillance Report October (September data)**

VM presented the September report which was produced 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. The Board noted that this report had been discussed at November's CGC meeting.

VM noted that all three Boards (including RUH and GWH) now receive the same report, with the same information for consistency.

VM summarised the key points noting the challenges and mitigations detailed within the report to address concerns.

The Board noted the discussion that had taken place at CGC and noted the report.

**TB1 07/12/4.8** **Perinatal Quality Surveillance November (October data)**

VM presented the October report which was produced 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. The Board noted that this report had been discussed at November's CGC meeting.

VM noted that whilst staffing remains a challenge, the department has received eight new starters and these posts are currently supernumerary so their induction can be effective.

There were 4 incidences reported as moderate. Of these three were related to anal sphincter injury. These have been reviewed and there are no themes.

In terms of feedback, the 15 Steps in Maternity' have been completed by MNVP and service users in October, feedback received and action plan codesigned.

**Discussion:**
SH noted the positives in seeing international midwives coming through training. SH asked if there was any learning. VM noted the challenges in terms of linking International Nurses and OSCEs. The team are looking to get funding for practice educator for international midwives. Additionally, as escalated before, some colleagues have been waiting to receive their pins from the NMC. One midwife has been waiting 8.5 months and this has been escalated.

The Board discussed the domestic pipeline and midwifery apprenticeships with a query if there were plans to increase numbers. The Board noted that the Trust was offered two places through the university, which was non-negotiable. The team have already asked to increase this next year but this will be reliant on funding.

The Board noted the discussion that had taken place at CGC and noted the report.

**TB1 07/12/4.9** **ATAIN Action Plan**

VM presented the paper which asked the Board to sign off the ATAIN action plan as per CNST safety action 3, note progress of actions and provide any challenge for ATAIN process.

**Decision:**
The Board signed off the action plan and progress against actions.

**TB1 07/12/4.10** **Maternity and Neonatal Training Needs Analysis (TNA)**

VM presented the report which asked the Board to note the contents of the Training Needs Analysis which has been provided for information and assurance processes.

To demonstrate compliance with the Maternity Incentive scheme the Board is asked to note the specific expectations in relation CNST – Safety Action 8 of implementing version 2 of the core competency framework.

**Discussion:**
SH noted the limited action Board could take in relation to these documents, as there was not the expertise across the Board as to the quality of the TNA. SH questioned the value of having the Board review this, suggesting that it did not demonstrate effective governance.

EJ noted that this had been raised with regional midwife with the question posed as to what good assurance looks like from a national perspective. Everyone needs to be clear about what the ask is.

Noted the contents of TNA and SEE papers. Safety action 8.

Thanks to teams.

**TB1 07/12/5** **CLOSING BUSINESS**

**TB1 07/12/5.1** **Any Other Business**

KJ noted that she had attended the last Shadow Board and noted the positive feedback from the facilitator who had recognised everyone's development. KJ thanked the Board for the opportunity.

IG thanked Shadow Board colleagues for their feedback.

RA noted that as chair of Shadow Board she'd had a really good experience and offered her support to future cohorts.

**TB1 07/12/5.2** **Agreement of Principle Actions and Items for Escalation**

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

- It will be decided whether any additional assurance re IA will be required between now and the new year will be fed back outside the Trust Board.

- There are issues with car parking which have been acknowledged and further communications has now been published today.

- The Board has had a good conversation around financial recovery and the level of risk that continues to exist in financial plan.

- The Board had a good strategic conversation around the IPR which worked well.

- The digital plan highlighted gaps in progress and resource but reiterated the requirement for the implementation of BadgerNet.

- The PSIRF Plan and policy has been circulated and FMc would like feedback by 22nd December 2023.

**TB1 07/12/5.3** **Public Questions**

IG noted the following public question recently received:

*Many years ago, I had an operation at Salisbury District Hospital. The hostile atmosphere amongst the ward staff was evident. Having discussed this with a member of the then board, I was told the ward staff had no knowledge that this was impacting on patient wellbeing.*

*Approximately twenty years on, I have been made aware that a negative atmosphere appears to still exist at Salisbury District Hospital. I am well aware of the potential stress involved with working in the NHS (although I am not sure that is the same case at corporate level). Therefore, I would like you to address my following concerns at your next board meeting:*

- *Is this negativity due to an embedded culture at SDH?*
- *Does this permeate top down through the hospital?*
- *How much does this impact on staff morale and staff turnover?*
- *What is being done to rectify it?*

*I will read the minutes with interest.*

*Yours sincerely*

*Mrs M Jones*

**The Trust reply:**
The Board would like to thank Mrs Jones for the enquiry which always provide an opportunity for reflection, though we are naturally sorry to hear she had a poor experience when she had an operation 20 years ago.

Having a positive and patient focused culture is important to us and included in our Trust values of: person centred and safe, professional, responsive, friendly, and progressive. Our vision which underpins our strategy is to

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

We seek feedback from a range of sources and our patient feedback is relatively positive regarding our culture within the Trust although we are not complacent. A sample of recent feedback from our Friends and Family test, Inpatient Wards – Oct/Nov 2023:

Tisbury
*"Lovely ward. Lovely staff. The way they treat us patients and the way they treat each other. Teamwork. Humour too!"*

Main Theatres
*"Great to see such good teamwork, and personal service particularly from Mini! Thanks."*

Britford
*"All staff were very caring and professional. Some went beyond this. SDH is a nice hospital! Britford staff are a credit to the hospital."*

Themes from our complaints are regularly reviewed and reported to various committees within the Trust and also to our divisions as part of their Governance structures. We continue to work on developing our intelligence in how we correlate these themes with other sources of patient feedback and also feedback from our staff (i.e., Friends and Family tests and Freedom to Speak Up etc.). There have been no noted themes over the past 12 months attributable to staff culture specifically that have been directly raised by patients and correlated with a negative impact on their experience. However, we are very clear of the connections between staff experience (both positive and negative) and how this impacts our services and subsequently the experience of our patients hence, our continued efforts to triangulate this information.

There is also significant research and evidence in support of the criticality of developing our NHS people and the impact on the quality of patient care. Salisbury is one of 23 vanguard People Promise sites which supports our focus on continually improving the staff experience.

Over this past year our quarterly pulse survey scores have shown a marked improvement in staff engagement, as we have increased our professional development learning provision, increased our range of wellbeing support, invested in our staff networks with a focus on promoting an inclusive, supportive, and compassionate work culture and continued our recognition of all staff through – SOX awards to large scale events. In this year's annual all staff survey we are showing a 10% increase on both the number of staff who have completed the survey and above the national average. Staff feedback is critical to help us focus and refresh on matters that are important to them.

In your question to Board Mrs Jones, you state you have been made aware that a negative culture exists within the Trust. We would welcome further details so that we can look into any specific issues.

**Feedback and reflection of the meeting.**

IG asked the Board to reflect on the meeting and the following points were noted:

- Move the IPR before Committee escalation to support more effective discussion. (*Actioned for January's agenda*).
- ME noted that the IPR and IT standard work does not reflect the 3 'A's model from the escalation reports. He also recognised the distinction of the standard work approach from the IPR cover sheet. IG noted it would be useful if the narrative followed a similar approach as it would facilitate thinking through the key issues. LT noted that she would work with the team on this but acknowledged that it will be a challenge due to the level of input from different sources.
- EJ noted she would support the other NEDs being more involved in the maternity discussions.
- FMc supported the BAF being presented at every Committee to cross reference with matters raised at the meeting.
- IG noted the external influences on the Board agenda, in particular the level of maternity documents received at the Board. The Board noted the impact on good governance when receiving papers which require subject expert interpretation and scrutiny.

**TB1 07/12/5.4** **Date of Next Public Meeting**

The next Public Trust Board meeting will be held on 11th January 2024, in the Board Room, Salisbury NHS Foundation Trust

**TB1 07/12/6** **RESOLUTION**

**TB1 07/12/6.1** 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 | No progress made/ 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 07/09/4.3 Perinatal Quality Surveillance Monthly Report | 12/01.2024 | Vicky Marston, VM | IG asked VM to provide feedback to the board in a few months' time on sustaining a cultural improvement journey in Maternity | **January's meeting** | N | 2 |
| Trust Board Public | Sasha Grandfield | TB1 07/09/5.4 Health and Safety Annual Report and Q1 | 12/01/2024 | Melanie Whitfield, MW | IG requested the next report contain more details on the support available to staff and added a trajectory showing if incidents were getting better or worse would also be helpful. | **January's meeting** | N | 2 |
| Trust Board Public | Sasha Grandfield | TB1 05/10/4.1 Improving Together Quarterly Update Report Q2 | 12/01/2024 | Alex Talbott, AT<br>Peter Collins, PC | EJ asked if the next report could include who we have trained and how many should we train and the narrative on if we are training the right people | **January's meeting** | N | 2 |
| Trust Board Public | Sasha Grandfield | TB1 05/10/5.5 Maternity and Neonatal Bi-Annual Staffing Report | ~~07/12/2023~~<br>12/01/2024 | Judy Dyos, JDy | SH requested a documented risk assessment around why the Trust do not have a continuity of carer model. | **JDy noted that this related to the continuity of carer model which the Trust is unable to fulfil until the maternity department have adequate staffing. JDy noted that this is being added to the risk register and quality impact outcomes were being reviewed. IG noted this action was to remain open until the risk assessment comes back through the Board.** | N | 2 |
| Trust Board Public | Sasha Grandfield | TB1 07/12/3.2 Digital Plan Update | 26/03/2024 | Jon Burwell, JB | IG referenced the 'project and planned work progress', noting that some have dates and some do not. IG asked for all to have dates for consistency. | To be incorporate into the digital updates which go to F&P Committee in March | N | 4 |
| Trust Board Public | Sasha Grandfield | TB1 07/12/4.4Patient Safety Incident Response Framework (PSIRF) Plan and Policy | 22/12/2023 | All NEDs | Patient Safety Incident Response Framework Policy and Plan to be circulated and all to feedback to Fiona McNneight by 22nd December | To be closed at the next meeting. | N | 3 |
| Trust Board Public | Sasha Grandfield | TB1 07/12/4.5 External Well Led Development Review | 12/01/2024 | Kylie Nye, KN | IG summarised that the actions are being built into existing workstreams. The Board will receive a 6-monthly update on progress as part of a consolidated report. KN to add to the Board cycle of business. | Cycle of business to add an update to July and December's 2024 Board meetings | N | 3 |

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 2.1 |
| Date of meeting: | 11th January 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report tile: | Integrated Performance Report | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | | | Yes | |
| Approval Process: (where has this paper been reviewed and approved): | Lisa Thomas, Chief Operating Officer | | | |
| Prepared by: | Adam Parsons, Operational Performance Lead | | | |
| Executive Sponsor: (presenting) | Peter Collins, Chief Medical Officer | | | |

## Recommendation:

The Trust Board are asked to note the Trust's operational performance for Month 8 (November 2023).

## Executive Summary:

Breakthrough Objectives

- *Wait to First OP Appointment* remained static at 131 days, holding its improved position from earlier in the year.
- *Bed Occupancy* rose slightly to 99% rose slightly with an increase in NCTR patients to an average of 79 and volume of ED attendances, which remain higher than this time last year.
- Patient *Falls* increased in month to 6.82 although remains below the target (7) for a third month in a row.
- Staff Availability measured by *Agency Spend* reduced significantly to lowest point in over a year at 5%.

Deteriorating Performance

- Cancer *31-day* and *62-day Standard* performance both continued decline to 87.7% and 46.1% respectively due to known limitations in capacity that are being addressed. Notes: Cancer data is one month behind, therefore improvement resulting from additional insourced capacity expected to show from M9. Also, national Cancer Wait Times (CWT) standards changed in October 2023 to combine previous multiple standards for 31-day and 62-day together into three overall standards for 28-day Faster Diagnosis Standard (FDS), 31-day and 62-day.

Alerting Metrics

- *Mixed Sex Accommodation* breaches increased again in November to 29 aligned with flow issues and evidenced through entering OPEL 4 escalation.
- The number of patients waiting longer than *78-weeks* for elective treatment increased to 33, although 18 are booked and good work to improve overall long waits position continues.
- ED *12-hour breaches* increased to 52 despite improvements in *4-hour performance* and *Ambulance Handover*, highlighting capacity challenges.
- *Complaints Acknowledged* within timescale decreased sharply to 35% and operational pressures associated with time of year are a contributory factor. This decline in activity is scheduled for discussion at January's Patient Experience Steering Group (PESG).

NHS
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NHS Foundation Trust

| 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): | ☐ |

# Integrated Performance Report

NHS
Salisbury
NHS Foundation Trust

## November 2023

# Summary

# November 2023

Salisbury NHS Foundation Trust

November saw the Trust experience increasing pressure across all areas, particularly the front door where ED attendances continued to be higher than this time last year and test capacity to the limit, resulting in entering the highest level of escalation (OPEL 4) at times and opening of escalation areas. Despite these severe challenges, Emergency Department (ED) performance against 4-hour standard and average Ambulance Handover times commendably improved to 72.9% and 18 minutes respectively which is testament to the positive impact the Rapid Assessment Treat and Triage (RATT) service change has made.

Given the higher patient volumes, the breakthrough objective of Bed Occupancy increased to 99% and a rise in No Criteria to Reside (NCTR) patients to average of 79 intensified the challenged capacity situation, demonstrated by ED 12-hour breaches increasing to 52 as the Trust couldn't easily move patients from ED to inpatient wards. However, it is pertinent to highlight the significant improvement reduced overall Length of Stay (LoS) to 8.6 days (from 10 days this time last year) has had on minimising the need for beds beyond those within the Trust.

Despite the capacity challenges quality related metrics overall were positive, particularly the Stroke 4-hour performance which improved back to recent familiar territory of 57% and contributed to the outstanding achievement of being awarded Grade A for Q2 from the Sentinel Stroke National Audit Programme (SSNAP).

Patient Bed Moves More than Once reduced to 3% and Serious Incidents remained static at 2 to sustain positivity in the face of challenges. However, Mixed Sex Accommodation breaches increased to 29 indicative of flow issues and the breakthrough objective of patient Falls also increased to 6.82 although remains under target for third month in a row.

Diagnostics continue to perform remarkably well against DM01 6-week standard and sustained improvement again to 92.6% which remains above recovery target of 85% by year end set by NHSE. Cancer performance was mixed, with expected deterioration, resulting from challenges in the Skin pathway, against 31-day and 62-day standards offset by improvement in 28-day Faster Diagnosis standard (FDS) to 61.2% resulting from internal work to increase capacity. Outsourced additional capacity to address wider performance in place and will show from November (Note: Cancer always reporting one month behind – October in this report).

The breakthrough objective of reducing Wait Time to 1st Appointment held static at 131 days and positively, overall RTT Waiting List reduced again for the third month in a row to 28,511.

The final breakthrough objective relating to staffing availability measured by Agency Spend reduced significantly from 6.1% to 5% and the Vacancy Rate also improved again further below the target to 4.3%.

Finance recorded an Income and Expenditure control total surplus in month of c£3.0m against a target of c£0.8m - a favourable variance of c£2.2m. The year-to-date position is driven by supernumerary cover for new and overseas staff, the costs of providing enhanced care to patients, the residual gap on pay awards and increased costs of elective and non-elective activity mitigated by confirmed Industrial action funding.

# Vision

To provide an outstanding experience for our patients, their families and the people who work for and with us.

NHS Salisbury NHS Foundation Trust

**People**
working for us

**Population**
our patients and their families

**Partnerships**
working with us

## Vision metrics 7 – 10 years

- Engagement Score in Staff Survey
- Reduction of unwanted turnover (people leaving the Trust or the NHS)
- Proportion of WDES & WRES at median
- # of wait metrics at median
- Total incidents with moderate or high harm
- Patient Engagement Score
- Increase in Healthy Life Years
- Overall Length of Stay
- Matrix Measure

### Strategic initiatives 3-5 years

- Continuous improvement culture
- Delivering our people promise
- Delivering Digital Care
- Improving health and reducing health inequalities

**Corporate Projects**

### Breakthrough Objectives 12-18 months

- Reducing Falls
- Reducing time to first outpatient appointment
- Staff Availability
- Bed Occupancy

# 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 that are set as part of the recently updated strategy. 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 | Area of focus for the whole organisation for the next 12-18 months. We are striving for an improvement of 30%+ in these metrics over this period. |
| Key Performance Indicator | Key metric that is monitored as part of NHS National Operating Framework for 2022/23 and heavily 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 analyse worsening performance, or achievement celebrated if performing is 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. |

# Business Rules - Driver Metrics

| 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 |

# Business Rules - Watch Metrics

| 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.<br><br>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.<br><br>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:<br>- 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.<br><br>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 |

# 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 cross 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 actions are suggested depending on how 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<br>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 |

NHS
Salisbury
NHS Foundation Trust

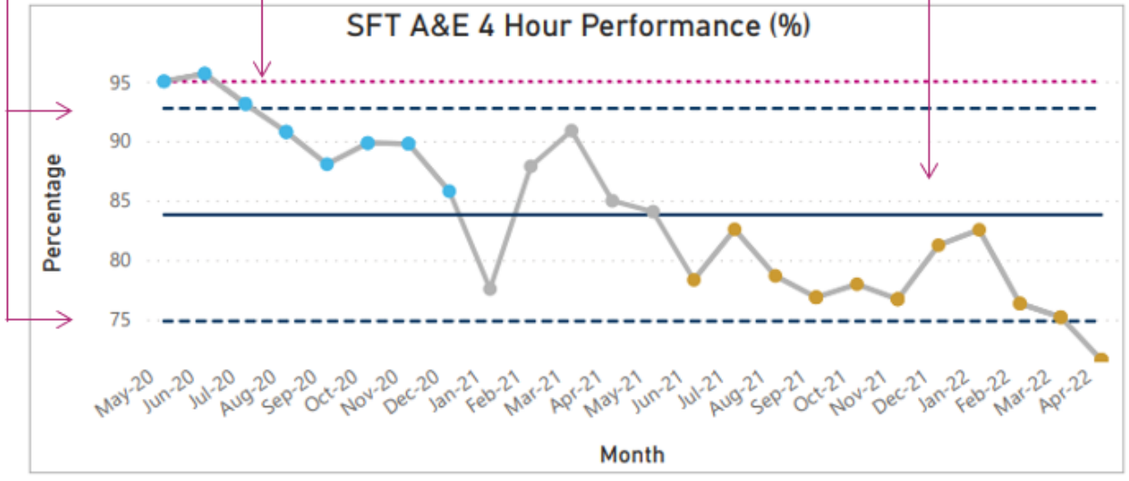
# Reading a Statistical Process Control (SPC) Chart

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

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

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

The solid grey line shows the mean value for the dataset




**Blue** markers indicate that there has been a marked improvement in performance, meeting Business Rules 1-3

**Orange** markers indicate that there has been a marked decline in performance, meeting Business Rules 4-6

**Grey** markers show normal behaviour with no significant cause for variation

# Part 1: Quality of Care, Access and Outcomes

## Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

**Our Priorities**

**Population**

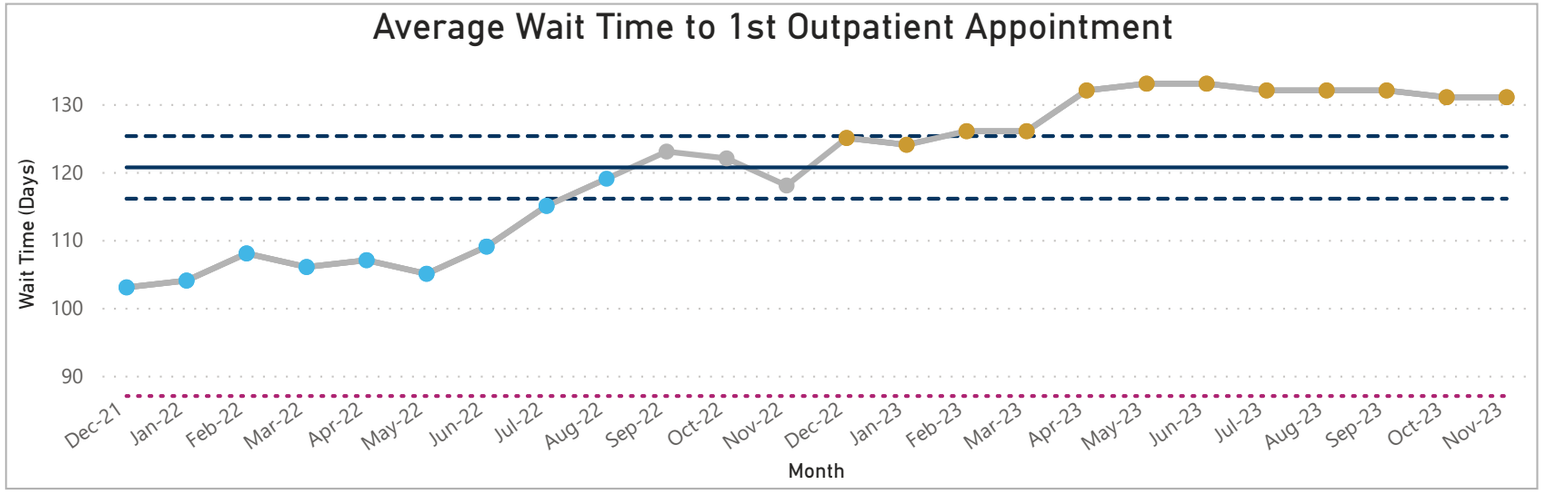
**Partnerships**

**People**

# Reducing Patient Waiting Times

## Target 87 days

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.

Dated: April 2022

## Understanding the performance

The performance data shows a stable performance between October and November at 131 days. The time to 1st appointment has now been broadly static since a peak across May and June at 133, following a consistent deterioration from Nov 21 to May 23, and has only varied by a single day since July. This should be viewed in context given the monthly LoSs of capacity / activity from the Industrial Action (IA) over the last 10 months. Unfortunately, despite the settlement reached with Consultant staff, given the recent declarations from Junior Doctor representatives, it is highly likely that the consequence of IA will continue to effect performance going forwards.

There is now evidence that the Improvement huddles within Plastics, ENT and Cardiology are having a beneficial effect with ENT falling 6 days, Plastics 5 days and Cardiology 16 days since October's performance reporting.

However, overall, only Surgery as an aggregated Division reduced their overall wait (down circa 1.5 days), with Women and New Born deteriorating 6.5 days (driven by Gynaecology), Medicine 3 days (driven by a sharp deterioration in Respiratory of 38.5 days) and CSFS 6.5 days. The position remains driven broadly by a small number of key specialties: Respiratory (179), Oral (165), Gastroenterology (163), General Surgery (157), Gynae (137). ENT (143) and Plastics (144) are also significant contributors but continue to see reductions in wait times with the impact of the huddles.

The Trust's focus remains on seeing patients in line with NHSE requirements. The impact of the IA has and will effect those patients with less clinical risk and therefore waiting longest.

## Actions (SMART)

- Changing primary care referral practices escalated to System and ICB colleagues, including commissioners for action.
- Weekly review of undated longest waiting patient by specialty with specific review on those patients awaiting 1st OPA.
- Cardiology Improvement huddles have reviewed clinic structure to enable protection of New patient appointment slots. Focused action is predicted to drive down routine wait times to 4 weeks by Oct 24.
- Plastics and ENT Improvement huddles both have Time to 1st OP Appointment as a driver to focus on reduction of wait times. Their actions include: Waiting List validation, clinically appropriate discharge of long-wait patients and clinic template reviews.
- Further rollout of specialty huddles (training and support required) to contribute to reduction in Time to 1st OP Appointment in align with Improving Together approach.
- Trust progress against long waiting patients including those awaiting 1st Appointment to continue to be monitored weekly and to be reported to the CEO and COO via weekly summary updates.
- Patients to continue to be booked in line with NHSE recommendations, with weekly validation of long waiting patients. Specialty Managers and DDO's of challenged key specialties have been supplied with historic trajectories and booking performance to assist forward planning.
- Demand and Capacity support to Plastics and Gynaecology to be concluded, with further specialties to follow.

## Risks and Mitigations

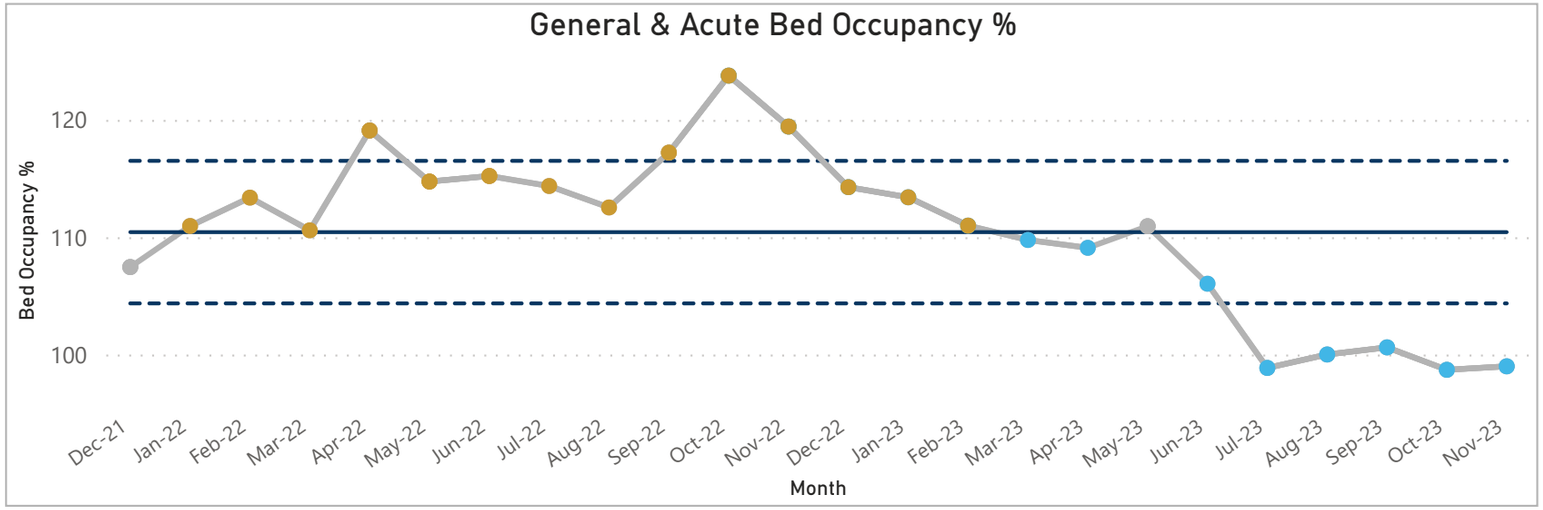
Limitations continue in relation to the Trust's ability to comprehensively map demand and capacity at a subspeciality / pathway level, however the performance team are supporting this work with the Divisions and specialities. Resource limitations at both DMT and Speciality level have been raised and a paper proposing enhanced Divisional structures has been drafted to be discussed at TMC.

Staffing pressures exist across a number of specialities not least Dermatology and Plastics which present a potential individual speciality pressure into next financial year. Plastics have recruited in the interim to a Micro Plastics Fellow and Locum Consultant post in Plastics, and has commenced an insourcing relationship with an external body '18wks' which is addressing the long waits in Dermatology. 18wks limited have been engaged to support further work across Plastics / Dermatology to improve the Skin cancer pathways.

# Optimising Beds

**Target 92%**

Breakthrough Objective




## We are driving this measure because...

Bed occupancy is used as a driver metric as it is closely linked to length of stay.

Lower bed occupancy generally is associated to optimised clinical practice and lower lengths of stay, the combination of the two are known to demonstrate good outcomes and patient experience. An additional positive consequence is also lower temporary staffing costs.

Dated: April 2022

## Understanding the performance

Bed occupancy has remained fairly static, seeing a slight increase to 99%.
However Non-Elective (NEL) and Elective Length of Stay (LoS) have increased in Medicine by half a day but have positively decreased in Surgery by 2 days; NEL LoS has also dropped slightly. This shows a picture of improving LoS but an increase in the number of patients in beds. The numbers of patients going through Same Day Emergency Care (SDEC) on a zero day length of stay for Medical patients has increased again.
Acute Frailty Unit (AFU) is showing an increase in LoS, however the number of readmissions have dropped significantly to 11%.
No Criteria to Reside (NCTR) numbers rose in November with the average number of patients rising from 70 in Oct to 79 in Nov, however bed days lost decreased slightly.
LoS from admission to being fit to be discharged continues to decrease and has decreased again in month by half a day.
System partners continue to to see an increase in demand for P1 placements and are struggling to meet demand.
The proportion of patients being discharged between midday and 5pm has increased, the numbers leaving before midday remains disappointingly low at 10%.
Overall numbers of discharges for the month have risen slightly this month and are significantly greater than has been seen through most of Q2.

## Actions (SMART)

Work continues with specialist Surgical teams to establish SDEC pathways for Trauma and Orthopaedics, Head and Neck etc.
AFU was successfully relocated to the Durrington footprint.
Ongoing work with Radiology to ensure that NEL pathways are supported with the capacity that is required and that pathways are appropriate.
Discharge Hub - WH&C are recruiting into vacant posts for SFT inreach, Local Authority are still under going a restructure.
Discharge process working group established. Two forums set up to meet F1 and F2 junior doctors to talk through the challenges they have on a daily basis and try to understand why discharge planning does not have a priority for them - this has needed to be moved to January.
Reset week being planned for early December, focus again will be discharge, doing tasks that are not usually BAU, such as OOA transport requests being managed by the transport office rather than the ward staff. Feedback to be given in M9.

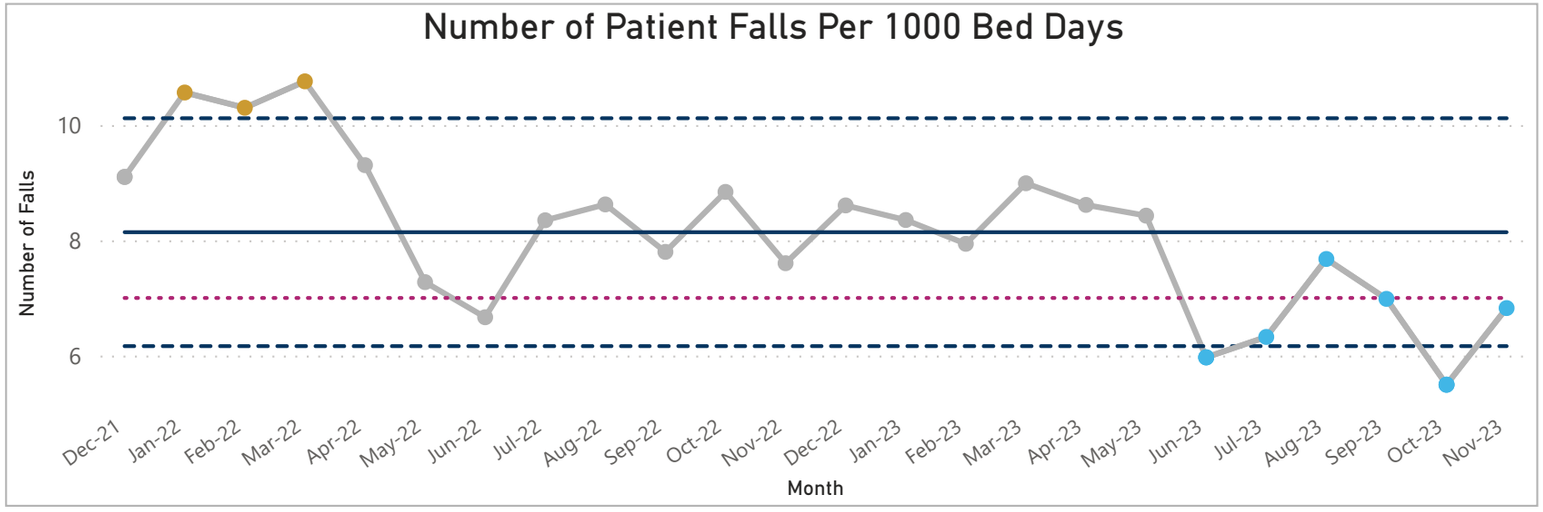
## Risks and Mitigations

An increase in Infection Prevention Control (IPC) challenges such as COVID or other will impact the ability to keep escalation areas closed. IPC will also impact staff available to work.
As winter approaches, operational challenges related to capacity are expected to increase - winter planning is under way.
Ongoing industrial action from various professional groups and unions reduces staff capacity to focus on the QI work

# Reducing Patient Harm

## Target 7

Breakthrough Objective




### We are driving this measure because...

Falls are the most frequent adverse event reported in hospital. The Trust continues to report a high level of falls per 1000 bed days with a significant spike over the last 12 months to 10.2 falls per 1000 bed days during the COVID-19 pandemic. The average nationwide falls data shows a rate of 6.7 falls per 1000 bed days and so this spike in combination with the increasing trend of all falls within SFT, is a concern which requires concentrated effort to address and improve.

Dated: April 2022

### Understanding the performance

In November, falls increased from 5.49 to 6.9 per 1000 bed days, which is just below the target of 7. However, this has improved from 7.5 in November 2022.

There were 3 inpatient falls with moderate or above harm:
1 x Subdural haemorrhage
2 x Fractured Neck of Femurs
Unfortunately, this has risen from only 1 moderate or above harm fall in October. However, it is still an improvement compared to 5 falls with moderate harm or above in September.
Falls audit data shows that 86% of wards (that have submitted) have improved their compliance with risk assessments being in date. However, only 75% wards have a 90% and above rate of implementing accurate interventions. Which has significantly decreased from 90% last month.

The falls team has increased to two which has improved the ward coverage, with the ability to review all patients that have fallen to ensure accurate documentation and implementation of appropriate interventions.

### Actions (SMART)

We are working with ED to implement the new 'Think Yellow Scheme', which involves providing yellow socks and blankets to patients at high risk, to become easily identifiable. This has shown a significant decrease in other settings. The new ED falls risk assessment has been finalised and will be trialled.
Bay watch continues to be in use on Amesbury, Farley and Spire wards. Falls on Amesbury have slightly decreased from 6 falls in October to 5 in November and on Farley, with 8 falls in October to 7 falls in November. We are encouraging further wards to implement, providing them with the necessary information.
Research found that 20 patients fell from their beds since August. We are currently developing a bed safety assessment which will help staff to identify the safest bed choice for their patients.
75% of wards have improved their Laying and Standing Blood Pressure (L&S BP) compliance in November, with targeted training for required areas.
Research looking at common themes for falls in the last few months completed and actions that can be implemented to reduce has been sent to all ward managers for circulation to all staff. We are going to make this a quarterly task. This research found that 16 patients fell from chairs since August. New chairs will be introduced next year to address.
Improvement huddles paperwork has been amended; this will be circulated once written up.
We are in discussion with the Pharmacy team to carry out falls training with pharmacy staff from next year.
A national target that all patients who have a falls risk assessment as an inpatient should have an eye test will be addressed by new multifactorial assessment in the new year which incorporates a visual check.

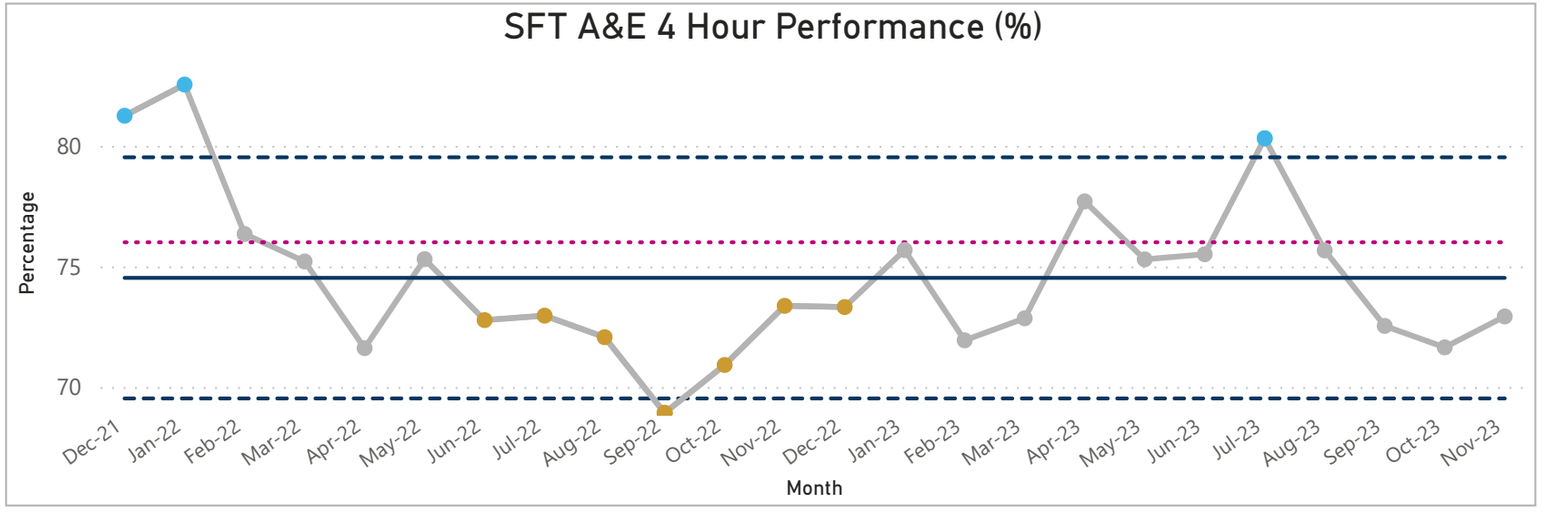
### Risks and Mitigations

The winter months have consistently shown a rise in falls, with falls reduction training being rolled out in December, The Think Yellow Scheme and risk assessment improvement in ED, the push for Bay Watch, new Bed Safety Assessment and visual check, we hope to reduce the number of falls over the winter period.
Improvement has been seen in L&S BP compliance but it is still not quite where we would like it to be, this will be covered in training.

National Key Performance Indicators

# Emergency Access (4hr) Standard

**Target 76%**




| | |
|---|---|
| Performance Latest Month: | 72.9% |
| Attendances: | 6323 |
| >12 hrs in ED Breaches: | 52 |

## Understanding the performance

Attendances in M8 reduced by 148 to 6,323 compared with 6,471 in M7 but remain higher than this time last year and the 4-hour standard performance improved just slightly back up to 72.9% from 71.6% in M7.

Acuity of patients increased to offset attendance reduction, with 55 Category 1 against 52 in M7 and there was only a slight drop in Category 2 from 444 to 439.

M8 has again seen an increase in the number of 12-hour breaches, 52 compared to 42 in M7. This is indicative of the difficulties the Trust continues to experience relating to flow. Type 1 4-hour performance saw a slight improvement from 59.6% in M7 to 60.8% M8.

Spaces lost per day to patients with a Decision to Admit (DTA) further deteriorated by 0.1 to 6.0, this loss of space amounts to the capacity to see 84 patients being lost. Flow out of the department continues to be the biggest contributory factor to the failure of the 4-hour and 12-hour standard performance.

Average time to initial assessment and treatment both improved which may, in part be due to the introduction of the new Rapid Assessment Treat and Triage / Rapid Ambulatory services (RATT / RAMBO) process on 13th November.

## Actions (SMART)

Nursing Recruitment currently stands at:

Band / Current / Vacancy / Plan
7 / 1.08 / 0.61 / New starter end Jan 24
6 / 4.79 / 4.98 / New starters Dec-Feb 2024
5 / -0.81 / N/A / Awaiting skill mix approval to Continue recruit
HCAs / 3.68 / N/A / Interviewing Dec and Jan as part of Trust recruitment

The current Matron for ED will be leaving the Trust in Feb 24, an advert for their replacement is due out mid December.
There is a consultant interview 19/12/23 for a substantive post to fill one of the 1.95 WTE vacancies.

On 13th November the pilot to stream and RATT patients at the front door started. This has demonstrated a positive impact for time to first assessment and time to treatment, however, the lack of flow out of the department has curtailed the full impact due to patients waiting for admission remaining in Majors spaces and therefore needing to hold patients in ambulatory areas.

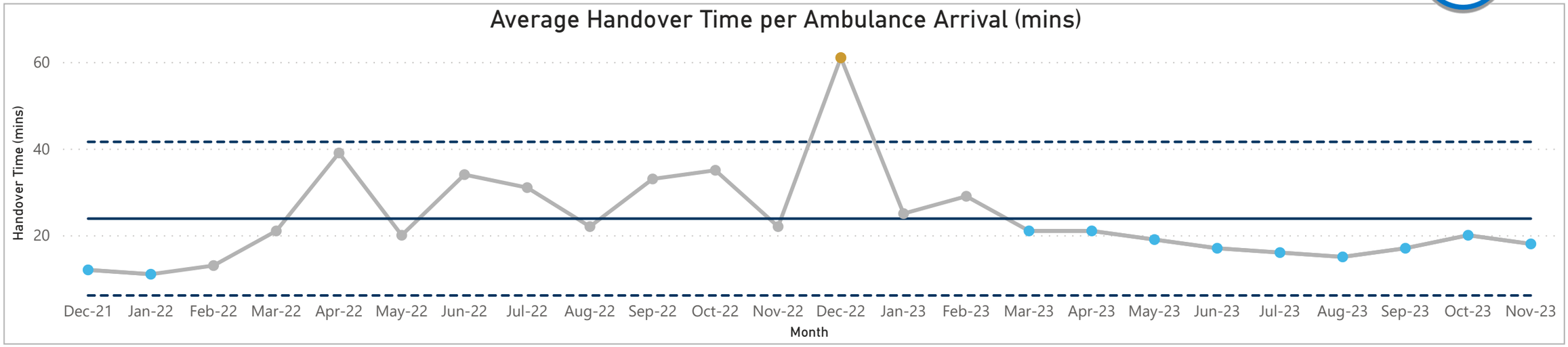
## Risks and Mitigations

Timely flow out of the Department continues to impact 4-hour and 12-hour standard performance targets with high bed occupancy levels across the Trust continuing.

RATT / RAMBO process to continue and evolve as necessary to maintain related improvements.

# Ambulance Handover Delays

National Key Performance Indicators




## Understanding the performance

Attendances by ambulance in M8 increased to 1,269 compared to 1,202 in M7 although average handover time improved to 18 minutes. Patients off loaded within target times as follows:

- 82% of patients <15 minutes (improved from 81%)
- 88% of patients <30 minutes (improved from 81%)
- 94% of patients <60 minutes (improved from 93%)

Despite attendances increasing this performance improvement reflects the positive impact the new Rapid Assessment Treat and Triage (RATT) service model of care has made.

## Actions (SMART)

Regular meetings with the SWAST team restarted in M8 which should help improve more collaborative working with both teams initially concentrating on the role of the Hospital Ambulance Liaison Officer (HALO) within ED.

Continue evolving RATT service model as necessary to maintain improvements.

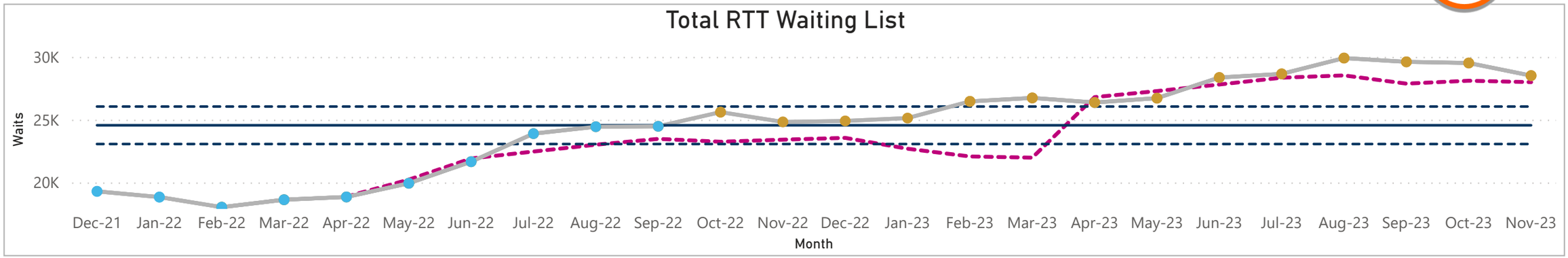
New handover recording system to be implemented by SWAST in M9 with the aim of improving accuracy of handover time.

## Risks and Mitigations

The pilot to stream and RATT patients at the front door started with the arrival of patients by ambulance midway through M8 and although there have been teething problems and new processes for staff, the safety of patients has significantly improved with all arrivals having a fast initial assessment by a senior decision maker.

# Total Elective Waiting List (Referral to Treatment)

National Key Performance Indicators




| Month | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Longest Waiting Patient (Weeks) | 83 | 85 | 73 | 75 | 76 | 75 | 76 | 77 | 243 | 200 | 194 | 153 |

## Understanding the performance

The Total RTT Waiting List (WL) size position at the end of November was 28,511 which is a decrease of 1,005 from October and third monthly reduction, but remains behind plan.

Despite this third monthly decrease, there continues to be a limited number of specialties that account for a disproportionate percentage of the WL increase since April 2022. The top five specialties with the greatest increase respectively are: Gynaecology (1st), Urology (2nd), Plastics (3rd), ENT (4th), and General Surgery (5th). They collectively account for 53.81% of the increase in WL size since April 2022.

Work to reduce the number of Breast DIEP long waiters has continued with longest waits being reduced from 243 weeks in August to 153 weeks in November.

Given the 10 months of IA, a growth in the WL size has not been entirely surprising, and so to have three months of reductions is relatively pleasing.

## Actions (SMART)

The largest proportion of the WL remains within the non-admitted pathways. There are a number of specialities with large increases in WL size over the last year, including a number of specialities with considerable operational and staffing pressures, e.g. Plastics and Gynaecology.

A number of actions are planned to continue through December including:

- Monitoring of long waits to continue with a mirrored process for the 65ww target as was implemented for the 78ww in 2022/23.
- Adoption of GIRFT Further / Faster principles
- Breast DIEP WL reduction.
- Locum Consultant in Gynaecology.
- Dermatology insourcing to continue as per business case.
- Additional Plastics 2ww insourcing to continue to support both Cancer performance and 65ww clearance.
- Develop plans to improve clinical engagement in OPD transformation via Planned Care Board.
- Completion of the RTT module for CCS tool to allow for enhanced validation and WL data quality.

## Risks and Mitigations

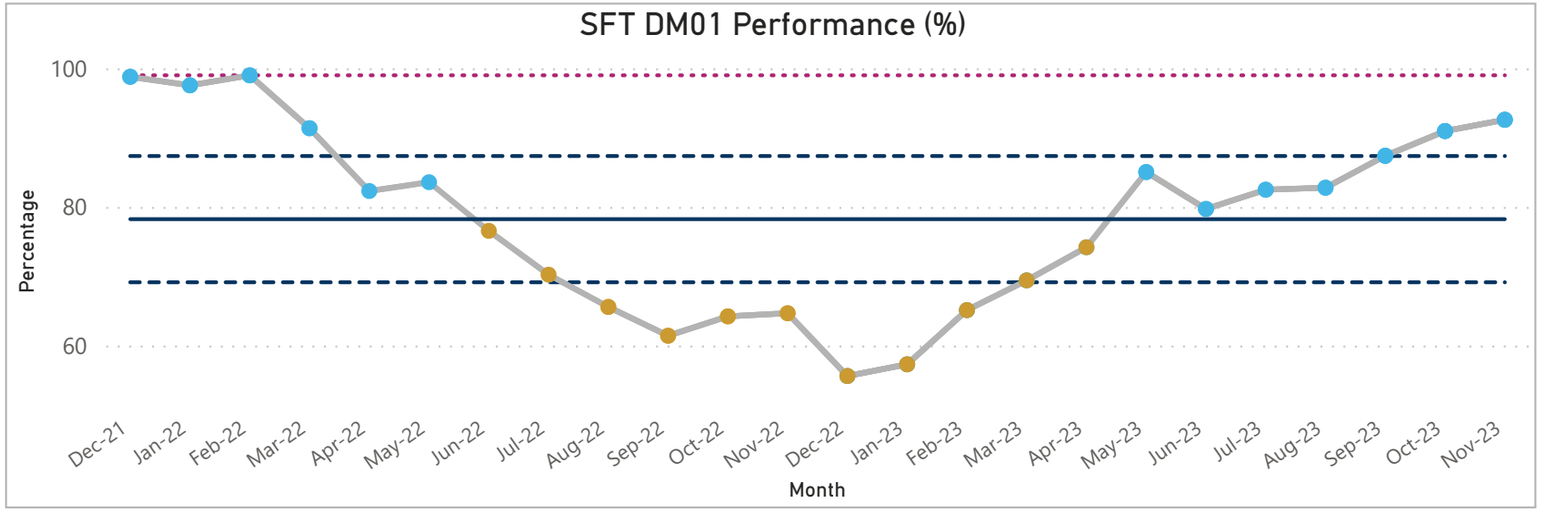
The risk of lost capacity owing to IA remains given the recently announced additional action for both December and January. Whilst mitigations are in place to support safety for those most clinically urgent patients, it is unlikely that the volume of activity affected cannot be entirely mitigated, and many plans have now been stretched beyond that for which they were designed with the ongoing elevated risk to the 65 week clearance for year end.

Support into operational teams to enhance level of focus on the non-admitted pathways, through further OPD workshops and weekly huddles in line with Improving Together methodology to continue through the remainder of Q3 and into Q4.

# Diagnostic Wait Times Performance (DM01)

**Target 99%**

National Key Performance Indicators




Performance Latest Month: 92.6%

Diagnostic Activity: 7438

| | Performance | Breaches | | Performance | Breaches |
|---|---|---|---|---|---|
| MRI | 92.3% | 42 | CT | 98.7% | 9 |
| US | 96.9% | 63 | DEXA | 100.0% | 0 |
| Audio | 79.6% | 115 | Cardio | 84.8% | 79 |
| Neuro | 100.0% | 0 | Colon | 76.3% | 49 |
| Flexi Sig | 76.8% | 13 | Gastro | 90.9% | 12 |

## Understanding the performance

DM01 performance continued to improve in M8, increasing to 92.59% vs M7 performance of 90.96%.

The number of patients impacted by breach of the 6 week standard in M8 was 382 patients as compared to 385 patients in M7, acknowledging that the increase in overall performance to 92.59% as a result of increased WL size from 4,257 in M7 to 5,153 in M8 (see risk section).

MRI remained stable at 42 breaches, Ultrasound Scan (USS) increased from 20 breaches to 60 breaches (see risk section), Audiology continues their improvement trajectory with 115 breaches in M8 and Endoscopy remain relatively stable at 74 breaches although a slight reduction from 87 breaches in M7. The number of breaches within Cardiology Echo increased for a second month from 53 patients to 79 (see risk section).

## Actions (SMART)

1) Insourcing arrangement within USS to continue for at least the next 6 months into M3 of next financial year.
2) Approval of Recruitment and Retention Premium (RRP) for USS via CSFS DMT (12/12/23).
3) Continuation of incentivised overtime in Audiology through remainder of financial year (as a minimum).
4) Cardiology team to scope options to restore performance (or as a minimum retain current levels). Action to be discussed at Delivery Group throughout M9.

## Risks and Mitigations

There is a risk to M9 performance associated with USS capacity in month. There has been a reduction of insourcing availability combined with a reduction in substantive workforce WTE as a result of Lead Sonographer resignation (a replacement has been appointed, pending start dates). Circa 400 breaches in December are expected - this has been mitigated as much as possible with the insourcing capacity available and with overtime within the team. The Team will be working on a recovery plan for M10 to restore performance quickly.

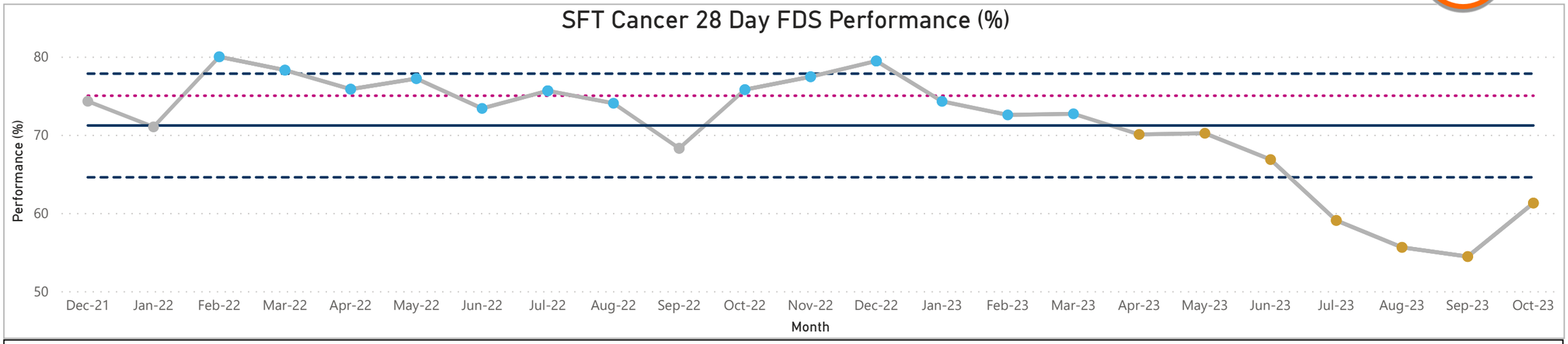
There is risk within Cardiology workforce to be able to sustain or improve the DM01 performance in Echo. Locum and overtime is already being utilised. The Medicine Division are working on options for how DM01 performance can be sustained.

The increased WL size in M8 compared to M7 is a signal of numbers of patients waiting longer to be booked and correlates with the risks now presenting in M9 for USS and Echo. USS performance is monitored weekly by the CSFS DDO via Radiology Waiting Times Access Group Meeting and Echo performance through the Medicine Division and via Delivery Group on a weekly basis.

# Cancer 28 Day Faster Diagnosis Standard Performance

**Target 75%**

National Key Performance Indicators




*Please note: Cancer Wait Times (CWT) standards changed in October 2023 to combine previous multiple standards for 31 Day and 62 Day together into three overall standards for 28 day FDS, 31 day and 62 day.*

## Understanding the performance

The Trust did not meet the 28-day Faster Diagnosis Standard (FDS) in October reporting at 61.27%. Specialty summary of performance as follows:

Breast - 95.3% (improvement from 91.7% in M6)
Upper GI - 82.7% (improvement from 72.9% in M6)
Head & Neck - 76.1% (improvement from 69.6% in M6)
Lung - 68.3% (deterioration from 82.8% in M6)
Gynaecology - 58% (improvement from 49.1% in M6)
Urology - 46.5% (deterioration from 52.4% in M6)
Lower GI - 45.7% (improvement from 37.6% in M6)
Haematology - 33.3% (deterioration from 50% in M6)
Skin - 16.6% (improvement from 15.5% in M6)

Improvements noted in a number of specialties and in some cases (Gynaecology) due to focused attention having been given to Waiting List (PTL) management and processes. Deterioration in Lung, Haematology and, in part Urology due to sickness absence and delayed data recording (work to rectify this in M8 has been completed although remains a risk).

Of note, whilst there remains <75% achievement in many specialties, historically the high volume of Skin pathway patients has supported overall achievement of the Trust performance.

## Actions (SMART)

1) Continued insourcing provision within Dermatology pathway across M8-10 to increase capacity and reduce first seen waiting time and then improved 28-day performance within M10/M11.

2) Continued scrutiny and oversight of PTL tracking and PTL meeting process by DDO for CSFS to ensure weekly tracking and management of patient pathways.

3) Relaunch of cancer improvement huddle, engagement with Divisions during M9 and launch mid M10 with Improving Together methodology in mind.

4) Lower Gastrointestinal (LGI) recruitment into Clinical Nurse Specialist (CNS) workforce to support early diagnosis processes etc. Workforce provision to increase from M11.

## Risks and Mitigations

Capacity within Skin pathway will continue to pose risk to the 28-day position for the specialty and the Trust up to end of M10 as a minimum. The insourcing arrangement is and will continue to support with recovery of this.

Inability to run fully service engaged PTL meetings continues to be a challenge and risk to tracking, although this is improving in some areas (Urology, Gynaecology, Head and Neck, Breast). Multi Disciplinary Team (MDT) Coordinator absences in Cancer Services is causing challenge to some of this. Recruitment into vacancies is ongoing and process standard work also being developed to support PTL meetings.

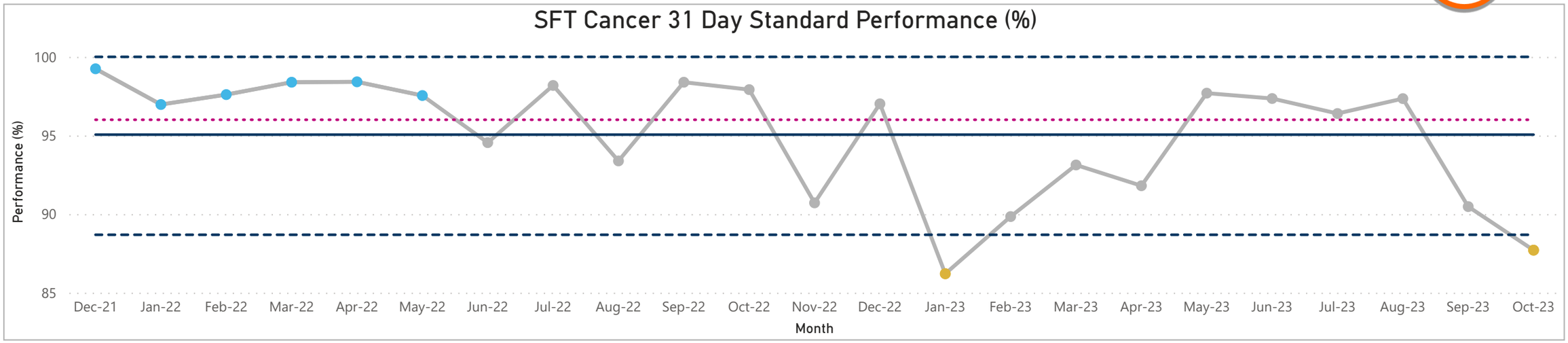
A vacancy in Cancer Services Manager for January to March will also add pressure although will be mitigated from within the Division.

First seen waits continue to be extended in LGI which means patients are then consequently more likely to breach the 28-day standard (due to lack of conclusion on their diagnosis). Increased oversight of this through relaunched cancer improvement huddle will provide weekly mitigation to resolve.

# Cancer 31 Day Standard Performance

**Target 96%**

National Key Performance Indicators




*Please note: Cancer Wait Times (CWT) standards changed in October 2023 to combine previous multiple standards for 31 Day and 62 Day together into three overall standards for 28 day FDS, 31 day and 62 day.*

## Understanding the performance

31-day performance for October has been reported at 88.2% against the 93% standard and represents a deterioration in performance as compared to M6.

The number of patients impacted by a breach in this performance standard as 15 patients, breakdown as per the below.

Skin x 11
Urology x 2
Breast x 1
Haematology x 1

The high volume of breaches in the skin pathway links with the overall capacity issues within the service and an improvement plan is in place to restore performance across all of the cancer standards with addtional insourcing capacity across M8-M10.

## Actions (SMART)

1) Insourcing arrangement within Skin across M8-10 to increase capacity for first assessment and then consequential treatments.

2) Continued escalation of potential breaches at Waiting List (PTL) meetings and via routes from MDT Coordinators and bookings teams to flag issues for early resolution.

## Risks and Mitigations

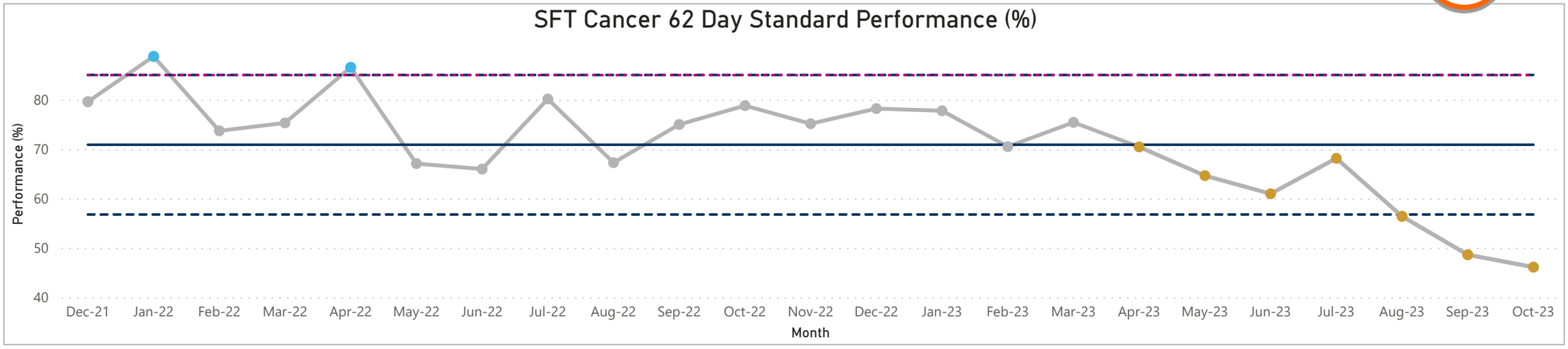
High conversion rate being seen from first assessment to treatments within the skin pathway, thus requiring more insourcing capacity than initially anticipated. Additional minor ops clinics (funded by NHSE) being scheduled for M10.

Some lack of attendance and engagement at PTL meetings is resulting in escalation of concerns not being promptly acted upon. Director of Clinical Support and Family Services (CSFS) division is working on improving the engagement within teams and the process standard work required for a functioning PTL and tracking process.

# Cancer 62 Day Standard Performance

**Target 85%**

National Key Performance Indicators




*Please note: Cancer Wait Times (CWT) standards changed in October 2023 to combine previous multiple standards for 31 Day and 62 Day together into three overall standards for 28 day FDS, 31 day and 62 day.*

## Understanding the performance

The Trusts performance against the 62-day standard was reported at 46.11% against the 85% standard and represents a further deterioration in performance as compared to M6 of 49.3%. The breakdown of breaches are shown below:

Skin x 13
Urology x 8
Colorectal x 5
Upper GI x 4
Head and Neck x 3
Gynaecology x 2
Haematology x 1.5
Lung x 1.5

The main themes for breach reasons were:

Elective Capacity x 13.5 (majority of which were in the Skin pathway)
Complex Diagnostic Pathways x 8.5
Healthcare Initiated Delay x 7.5

## Actions (SMART)

1) Insourcing arranagement within Skin pathway to increase capacity for first seen assessment and then treatments - by reducing wait to first seen there will be consequential improvement in 28-day and 62-day performance. Insourcing is due across M8-10 and reportable improvement expected M10-M11.

2) New Haematuria pathway within Urology will commence in November which will provide expedited access to first assessment and diagnostics for suspected bladder cancer patients.

3) Breach reviews being shared with operational teams to learn from causes to scope opportunities for improvement (monthly).

4) Cancer improvement huddle process to be relaunched during M10 to enable improved engagement with esclations for Waiting List (PTL) meetings and opportunities to resolve potential breaches within their target times.

5) Radiology escalation process shared with team members. This will enable clinically urgent images required for Multi Disciplinary Team (MDT) discussion to be escalated and ensure timely treatment planning.

## Risks and Mitigations

The capacity issues within the skin pathway will continue to impact performance across M8-M10 but improvements thereafter are anticipated assuming all insourcing that is planned is delivered.

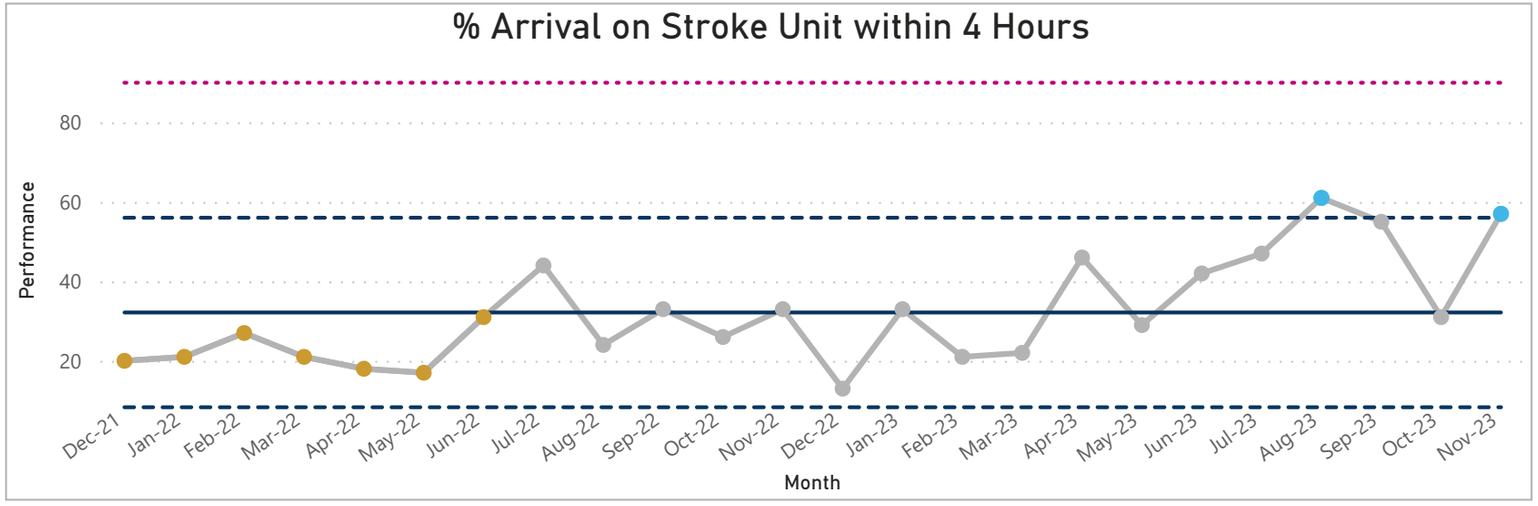
Inability to run fully service engaged PTL meetings continues to be a challenge and risk to tracking although this is improving in some areas (Urology, Gynae, Head and Neck, Breast). MDT Coordinator absences in Cancer Services is causing challenge to some of this. Recruitment into vacancies is ongoing and Clinical Support and family Services (CSFS) Director continues to engage with relevant operational teams to bring together team approach to PTL meetings. Process standard work also being developed.

A vacancy in Cancer Services Manager for January to March will also add pressure to this although will be mitigated from within the Division.

# Stroke Care

**Target 90%**

National Key Performance Indicators




**SSNAP Case Ascertainment Grade**

Highest Level = Grade A
Lowest Level = Grade E

| Fyear | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| 2021-2022 | | | C | C |
| 2022-2023 | D | C | C | C |
| 2023-2024 | B | A | | |

## Understanding the performance

The national target for patients admitted to the stroke unit within 4 hours is 90%. November end performance (based on discharged patients) was 57% and improved from 31% in October.

Q2 (July-Sept 23) SSNAP performance improved to an A. This is huge improvement from "C" to "A" in the last year. This is largely as a result in improvements in the 4-hour performance but has also due to improved "specialist assessment" which has moved from D to B and in "Multi Disciplinary Team (MDT) working". Consultants are now seeing patients within an hour of arrival, and the nursing team completing the swallow assessment within 4 hours.

Out of the 35 patients discharged in November, 15 did not make it to the unit within target. Of these, 15 patients were admitted outside of the 4 hour window, 14 were brought in by ambulance and one walked into ED. 2 patients had non-specific symptoms whilst 13 were suspected as having had a stroke. November's data identified that 13 out of 15 of those who attended ED were out of hours.

The 4-hour performance metric forms part of the wards Improving Together clinical scorecard and has introduced a monthly admissions target of 70% of patients to be admitted within 4 hours. November's end of month performance for admissions finished at 69% compliance against this target.

## Actions (SMART)

For the month of November, the stroke unit undertook a trial using a Band 6 nurse to track patients through ED. This had a positive effect on our performance and received excellent feedback from ED. This will be reviewed as to how this can be implemented in the longer term plan for staffing.
Meeting to be arranged with clinical site and ED matron to discuss effective communication going forward as this is main issue identified through Improving Together for our Out of Hours (OOH) patients.
Poster with red phone and Nurse in Charge (NIC) bleep number to be put in Resus so it can be a prompt and easily seen.
Nurses working OOH to have more education on the importance of targets and checking Lorenzo for suspected cases.
Boarding areas are now being utilised effectively when appropriate which has had a positive outcome on 4-hour performance.

Future actions:
November discharged patients review shows the biggest contributing factor to delays relate to OOH issues. A root cause analysis is to be developed with the team in line with Improving Together methodology. Early countermeasures for patients admitted in November but not yet discharged are:
• Improved communication processes between ED and Stroke Unit. ED will be invited to attend the Stroke unit huddles to facilitate.
• Further education will be given to the teams to ensure they are proactively using the SOP issued in April.
• Further support and mentoring of senior staff taking the ward overnight to proactively look for patients who may be potential cases.

## Risks and Mitigations

Although boarding is effective it can put extra pressure on the staff and patients can board for longer than expected. With bay window boarding it can delay medication due to no power supply and an example of this is a patient prescribed Infection Prevention Control (IPC) such as Flowtrons for Venous Thromboembolism (VTE) prevention.
High admission numbers throughout October and November having an impact on our bed capacity throughout November with an average LoS of 19 days.

# Maternity

Are We Safe?

| 01/11/2023 | <- Reporting Month (Input the first of the REPORTING month) | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | RAG rating calculation | | | | | RAG rating | | | Rolling 6 months | | | | | | |
| SFT Assurance Dashboard | Guidance | Standard | RAG Target 2021-22 Q4 | R | Red | G | Green | Red | Green | Improvement Direction | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Rolling 6m average |
| Perinatal Morbidity and Mortality (M&M) | Number of late fetal losses (22+0 to 23+6 weeks excl TOP) | | | NA | >= | 2 | = | 0 | >= 2 | = 0 | Down | 0 | 0 | 0 | 1 | 0 | 0 | 0.166667 |
| | Number of stillbirths (> + 24 weeks excl TOP) | | | NA | | | | | NA | NA | Down | 1 | 0 | 0 | 0 | 0 | 2 | 1 |
| | Number of neonatal deaths : 0-28 days | | | NA | | | | | NA | NA | Down | 1.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 |
| | Number of neonatal deaths : 0-28 days per 1,000 Live (Reg) Births | ONS | 2.7 per 1000 live births | NA | >= | 2.8 | <= | 2.6 | >= 2.8 | <= 2.6 | Down | 6.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.0 |
| | Medical termination over 24 +0 registered | | | NA | NA | NA | NA | NA | NA | NA | Down | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Maternal M&M | Number of Maternal Deaths | | | NA | | | | | NA | NA | Down | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Number of Maternal Deaths per 100,000 Maternal Deaths | ONS | 9.1 per 100,000 women who | NA | >= | 9.2 | <= | 9.0 | >= 9.2 | <= 9 | Down | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | Number of women requiring admission to ITU | 6 month SFT rolling | | NA | >= | 2 | = | 0 | >= 2 | = 0 | Down | 1 | 0 | 1 | 0 | 1 | 0 | 0.5 |
| Insight | Datix incidence SII | 6 month SFT rolling | | 0 | >= | 1 | = | 0 | >= 1 | = 0 | Down | 2 | 0 | 2 | 0 | 0 | 0 | 0.7 |
| | HSIB referrals | 6 month SFT rolling | | 0 | >= | 1 | = | 0 | >= 1 | = 0 | Down | 0 | 0 | 1 | 0 | 1 | 0 | 0.3 |
| | HSIB/NHSR/CQC or other organisation with a concern or request | 6 month SFT rolling | | 0 | >= | 1 | = | 0 | >= 1 | = 0 | Down | 0 | 1 | 1 | 0 | 0 | 1 | 0.5 |
| | Coroner Reg 28 made directly to trust | 6 month SFT rolling | | 0 | >= | 1 | = | 0 | >= 1 | = 0 | Down | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 |
| Workforce | Obstetric cover - labour ward | RCOG guidence | | 40 | <= | 39 | >= | 40 | <= 39 | >= 40 | Up | 40 | 40 | 40 | 40 | 40 | 40 | 40 |
| | Midwife to Birth ratio | RCM;NHSR;BR + | 1.26 | 1.29 | >= | 1.28 | <= | 1.26 | >= 1.28 | <= 1.26 | Down | 1.29 | 1.30 | 1.30 | 1.29 | 1.35 | 1.28 | NA |
| | Midwifery vacancy rate (black= over establishment; red =under | | | NA | >= | 1 | | NA | >= 1 | NA | Down | 23.0 | 23.9 | 23.3 | 22.2 | 15.7 | 13.9 | NA |
| | Provision of 1 to 1 care in established labour (%) | NICE, RCM, MIS | 100% | 100 | <= | 94 | >= | 100 | <= 94 | >= 100 | Up | 100 | 100 | 100 | 100 | 100 | 100 | NA |
| | Datix relating to workforce | 6 month SFT rolling | | NA | >= | 2 | = | 0 | >= 2 | = 0 | Down | 1 | 2 | 3 | 0 | 0 | 0 | 1 |
| | Compliance with supernumery status of the LW coordinator - % | NICE;RCM;NHSR | 100% rostered | 100 | <= | 94 | >= | 100 | <= 94 | >= 100 | Up | 100 | 100 | 100 | 100 | 100 | 100 | NA |
| | Numbers of times maternity unit on divert | 6 month SFT rolling | | NA | >= | 2 | = | 0 | >= 2 | = 0 | Down | 0 | 0 | 1 | 0 | 0 | 0 | 0.2 |
| Involvement | Service user feedback : Number of Compliments | 6 month SFT rolling | | 9 | | NA | >= | 9 | NA | >= 9 | Up | 3 | 1 | 0 | 28 | 3 | 1 | 6 |
| | Service user feedback : Number of Complaints | 6 month SFT rolling | | NA | >= | NA | <= | NA | NA | NA | Down | 0 | 1 | 0 | 1 | 0 | 2 | 0.7 |
| | Number of SOX | 6 month SFT rolling | | 8 | | NA | >= | 8 | NA | >= 8 | Up | 7 | 9 | 10 | 5 | 6 | 0 | 6 |

## Understanding the performance

0 datix' relating to workforce.
2 x Stillbirths in November - 1 x 26 weeks pregnant 1 x 34.5 weeks pregnant.
Neonatal death of a baby in June* with a congenital abnormality that was incompatible with life (*NB artificially inflated rate as figure per 1,000 births).
Midwife to birth ratio remains above SFT individualised recommended rate of 1:26, despite this 1:1 care in labour maintained.

## Actions (SMART)

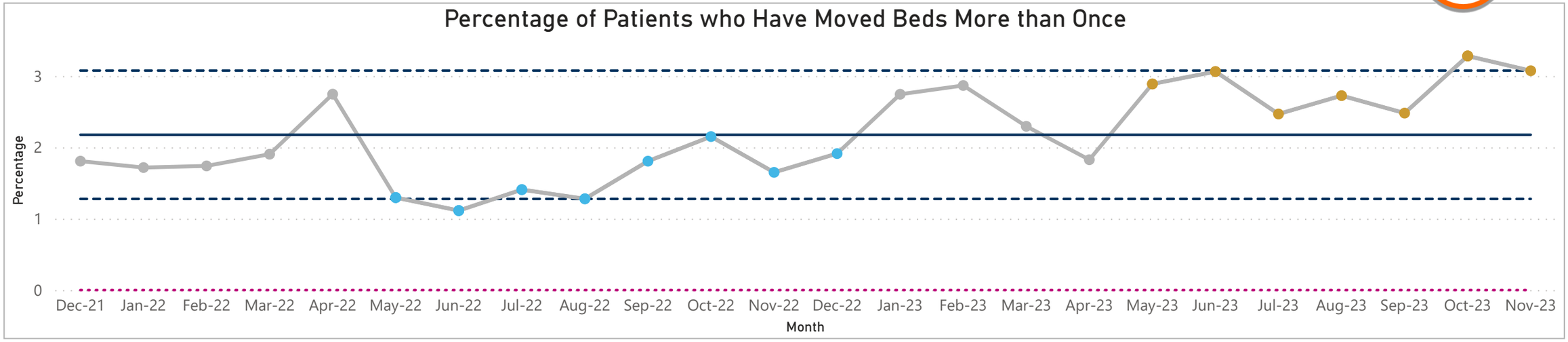
Both stillbirths reviewed at 72 hour review, will be investigated accordingly and have been notified to Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE).
Targeted recruitment drive in place with welcome incentive.
4 new Midwives started in November.
2 Preceptee Midwives starting over the next 2 months.
3 International Midwives still awaiting NMC PINs.

## Risks and Mitigations

Midwifery staffing remains a risk, long line agency usage ceased 26.11.23, due to improved vacancy rate.
Escalation policy followed to ensure one to one and safe care maintained.
Maternity care assistants supporting with non midwifery care.
Registered nurses employed within maternity services, supporting with non midwifery specific roles, e.g., working alongside midwives in postnatal care.

# Patients Who Have Moved Beds More Than Once

Are We Safe?




## Understanding the performance

This month has seen the percentage of patients moved more than once has decrease slightly but remains significantly higher in comparison to the same period last year. The Trust had a high number of escalation beds being used, which has an impact on the percentage of moves per patients. To be able to backfill the escalation beds with the most clinically appropriate patients often results a numerous move of multiple patients. The number of Medical patients within the Trust throughout November has increased dramatically, resulting in usage of some Surgical beds and ultimately impacting the moves a patient experiences through necessity. The pressure on bedding speciality patients within SSEU for prolonged periods continues and the use of Interventional Radiology as an escalation area has contributed to the decrease in the performance.

## Actions (SMART)

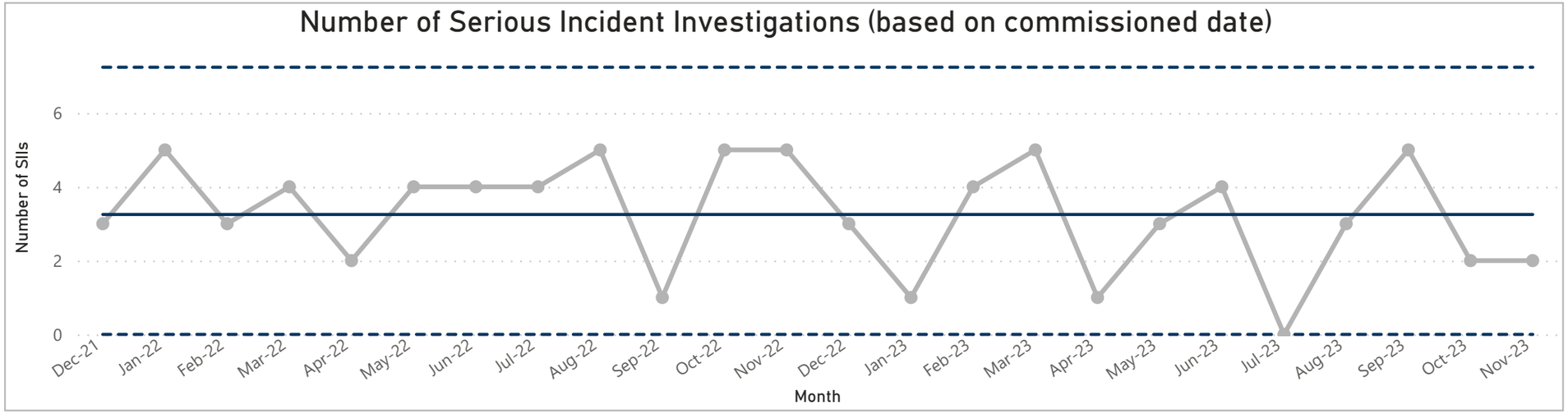
Ongoing work with AFU continues to see some positive reduction in LoS. There is still some work to be carried out to ensure that patients reach the AFU in a timely manner, and this work is ongoing with the working group, sharing concerns and positive outcomes for the patients. There is continued work with the early identification and triaging of the patients being admitted via ED / AMU / SDEC / SAU to ensure patients are transferred to the right ward on the first move.

## Risks and Mitigations

The increased use of escalation is to balance the risk across the Trust especially unblocking capacity at the front door. To accommodate patients' needs in clinical speciality when the hospital is full requires prioritisation and movement. There is a plan as per the escalation SOP that we ensure the correct placement of outlying patients. There are mitigations in place to ensure that each division have a list of appropriate names to move to the escalation areas. This continues to be an area that we need to reduce the number of escalation beds in use. Ongoing work with system partners to improve flow out of the hospital of complex discharges.

# Incidents

Are We Safe?




| Fyear | Never Events |
|---|---|
| 2021-2022 | 3 |
| 2022-2023 | 0 |
| 2023-2024 | 2 |

## Understanding the performance

There were 2 serious Incident Investigations (SIIs) commissioned in November:

SII 610 - NEWS 2 not acted upon
SII 611 - Delay in diagnosis

## Actions (SMART)

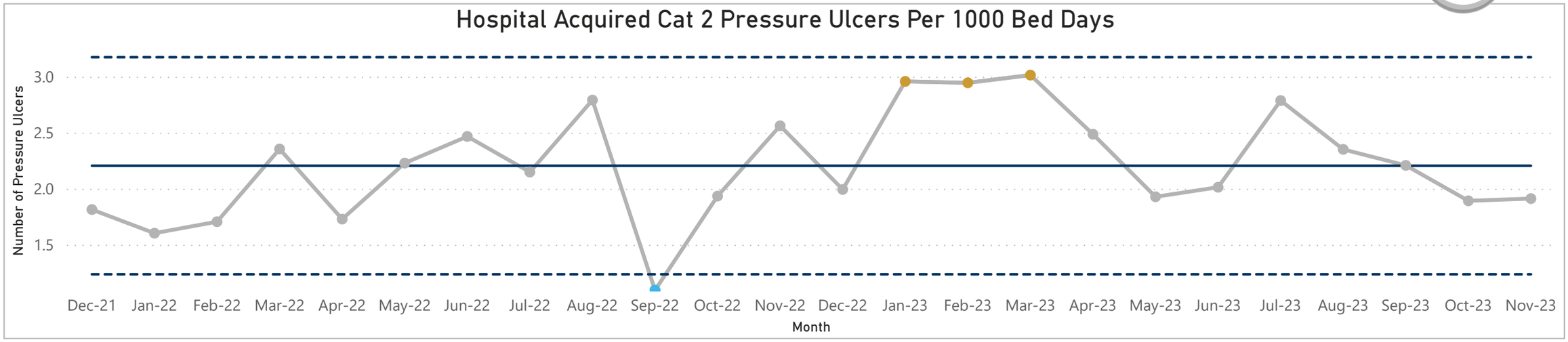
Investigate SIIs as per Trust policy, with those detailed underway and to continue through the month.

## Risks and Mitigations

Once an incident has been identified and a 72-hour report completed, it is established whether there are any immediate safety actions that need to be implemented or escalated straight away. On completion of the report, learning is cascaded through the intranet, Clinical Governance sessions, Patient Safety Steering group and dissemination to relevant staff via area leads.

# Pressure Ulcers

Are We Safe?




## Understanding the performance

44 Hospital acquired Pressure Ulcers (PUs) in November. This is an increase in numbers from October.

• 27 Cat 2 PUs – 6 of these were device related. This is the same number of PU2 as October but with an increase in device related PUs.
• We have seen 10 Deep Tissue Injuries (DTIs) this month which is a 50% increase in wounds compared to October. There have been 4 Unstageable PUs this month which is still an increase from October. None of these are device related.
• We have seen two hospital acquired PU4s in November, both from the surgical division. No Hospital acquired PU3s this month.
• We have seen a reduction in PUs from the Medical wards this month, indicating an increase from the Surgical wards as CSFS remains similar in their numbers.
• There is also a slight increase in patients with hospital acquired Moisture Associate Skin Damage (MASD) this month. This increase in numbers is seen in surgical and CSFS wards. There is a reduction in MASD from the Medical wards.

50 Present on admission PUs in November 2023.
24 Present on admission MASD in November 2023.

## Actions (SMART)

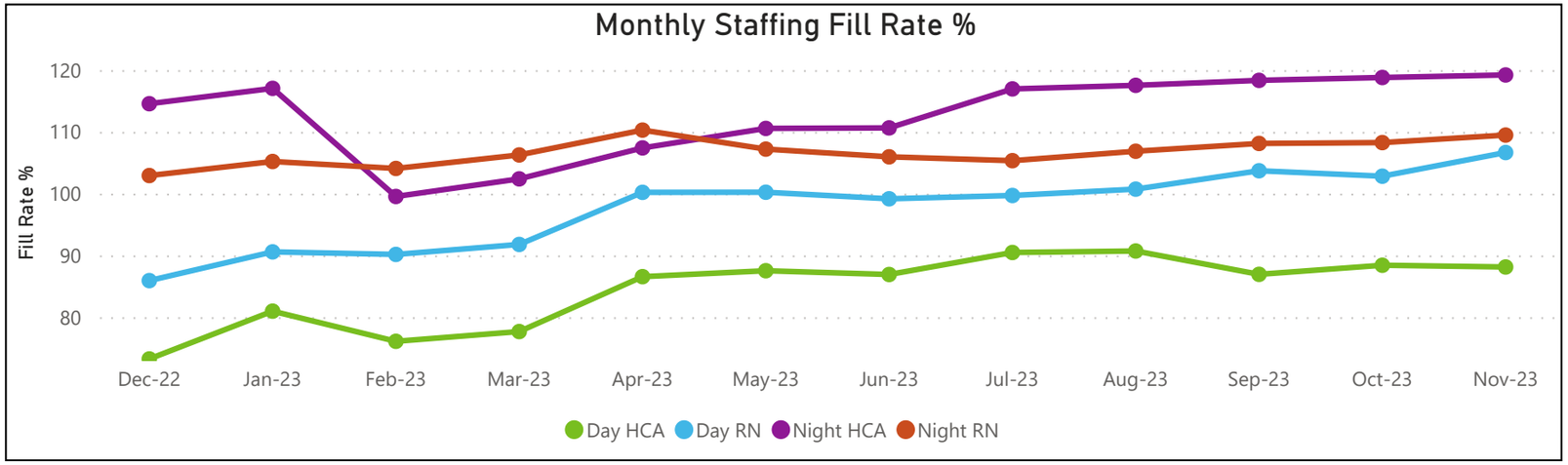
• This month we saw the Tissue Viability Nursing (TVN) team out on the wards educating the staff about the worldwide STOP the pressure ulcer day. They were able to talk to staff about the new equipment that the hospital will be receiving to aid in patient pressure relief. This was also a great opportunity to show the staff the new aSSKINg PSR paperwork that will replacing the current skin bundles and will hopefully be rolled out in the New Year.
• The new repose trolley toppers for ED are now in place and being used. These toppers are a unique device that stays with the patient and offers an effective pressure redistribution with a safer lateral transfer. The staff in the department have all received training and education on how to use them.
• Our A3 work is continuing across all the divisions this month.
• TVN staff are continuing to deliver teaching through out the hospital to all members of staff.
• Surgical wards have completed pressure ulcer prevention audits which is part of a CQUIN work for the month of November.

## Risks and Mitigations

This month Tissue Viability have seen a reduction in capacity due to a full time member of staff taking on a part time secondment. This has meant we have had a 15-hour reduction in TVN staff hours. The remaining workforce have increased their hours to cover 10 of the reduced hours, but this still leaves the service short by 5 hours every week while the secondment continues.
• There has been no outpatient PU clinics available this month due to having no Plastic consultant. TVN are still waiting for a replacement to cover their previous consultant who has taken a sabbatical year off. This has therefore seen an increase in waiting times for patients in the community to be reviewed for potential surgery.

# Nurse Staff Fill Rate

Are We Safe?




| Ward | Day RN | Night RN | Day HCA | Night HCA |
|---|---|---|---|---|
| Amesbury | 107% | 100% | 85% | 103% |
| AMU | 100% | 105% | 70% | 101% |
| Breamore | 156% | 143% | 56% | 210% |
| Britford | 98% | 101% | 98% | 100% |
| Chilmark | 102% | 104% | 78% | 95% |
| Downton | 104% | 145% | 96% | 115% |
| Durrington | 111% | 104% | 84% | 109% |
| Farley | 100% | 100% | 102% | 136% |
| Hospice | 98% | 101% | 104% | 150% |
| Laverstock | 129% | 146% | 73% | 85% |
| Longford | 98% | 109% | 93% | 102% |
| Maternity | 89% | 96% | | |
| NICU | 100% | 98% | 45% | |
| Odstock | 130% | 101% | 96% | 145% |
| Pitton | 115% | 113% | 76% | 113% |
| Radnor | 93% | 97% | 88% | 84% |
| Redlynch | 119% | 118% | 112% | 120% |
| Sarum | 104% | 119% | 95% | |
| Spire | 147% | 122% | 98% | 197% |
| Tisbury | 100% | 105% | 83% | 113% |
| Whiteparish | 128% | 136% | 94% | 100% |

## Understanding the performance

All 4 markers continue to remain broadly static, normal variation. HCA day rate fill still under 100% - driven by areas such as critical care who only have 1 HCA which they do not replace if unfilled, HCA vacancies and unfilled additional duties added for specials at ward level. If unfilled on roster but were required they remain to demonstrate need was required but shift not filled.

Care Hours Per Patient Day (CHPPD) 7.9 in month (slight decrease) and 7.4 when excluding critical care and maternity.

## Actions (SMART)

Safer Nursing Care Tool (SNCT) completed in 6 wards in November.

Ward assistant project – KPIs from matrons awaited (data being collated).

IEN Recruitment – Sri Lanka visit completed, 15 nurses offered posts, ongoing project to establish future partnership working.

Business cases for RNDA, Nurse associate to RN business cases approved in principle but being taken to system financial recovery group – remains with Exec team to update.

First appointments made under Return to Practice business case.

Trailers obtained to use as training hub to bring OSCE training back in house (saving £800 per candidate) – expected launch in October – still awaiting trailers but change in process commenced.

Work on A3 for enhanced care ongoing.

Ongoing work with partners on opportunity for mental health support worker to replace some RMNs – led by AWP.

## Risks and Mitigations

Ongoing turnover for HCAs and RNs exceeds starters (risk).

Increase demand for patients requiring RMN support (risk).

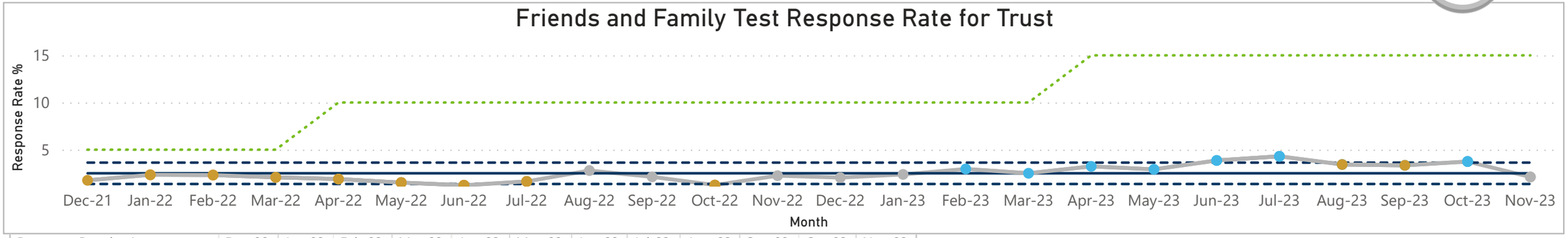
Additional beds utilised which are reliant on temporary workforce and not in establishment (risk).

Domestic and international recruitment campaigns (mitigation)

OD&P led work on retention, turnover and inclusion (mitigation and risk).

# Friends and Family Test Response Rate

Our Care




| Response Rate by Area | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FFT Response Rate - A&E | 0.3% | 0.8% | 1.6% | 1.0% | 0.6% | 0.6% | 0.8% | 1.1% | 0.8% | 0.6% | 1.0% | 0.6% |
| FFT Response Rate - Day Case | 1.4% | 0.3% | 2.0% | 2.5% | 3.4% | 4.2% | 6.4% | 6.6% | 3.5% | 5.8% | 4.1% | 2.4% |
| FFT Response Rate - Inpatient | 5.8% | 11.5% | 13.0% | 3.2% | 14.5% | 12.9% | 17.1% | 28.4% | 20.5% | 33.7% | 24.0% | 17.2% |
| FFT Response Rate - Maternity | 2.6% | 2.2% | 3.7% | 1.4% | 0.0% | 0.5% | 0.0% | 0.0% | 0.9% | 1.0% | 2.9% | 0.9% |
| FFT Response Rate - Outpatient | 2.0% | 2.0% | 2.2% | 2.1% | 2.5% | 2.3% | 2.6% | 2.2% | 2.2% | 2.1% | 2.3% | 1.3% |

## 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. It's a quick and anonymous way to give views after receiving NHS care or treatment Areas are encouraged to offer feedback forms to patients at discharge or during their stay. 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. This remains the sole method of obtaining responses and this will mean inevitable fluctuations in activity.

Cards have gone to all areas and offer free postage. Gender options have also now been extended in line with national guidance.

## Actions (SMART)

Delay in the rollout of digital provider was taken in November 2022, postponing this until December 2023.

This solution would facilitate an SMS option in a bid to increase responses rates, particularly in Outpatient areas and ED. It would also meet accessibility requirements with a new online form and digital dashboard. Interim actions were taken to develop the digital dashboard. This will be loaded with retrospective data to allow insight and analysis of FFT comments. This will not have any impact on response rates. This month we saw a high response rate across

Inpatient, Day case and Outpatient areas and hope this will continute to improve monthly.

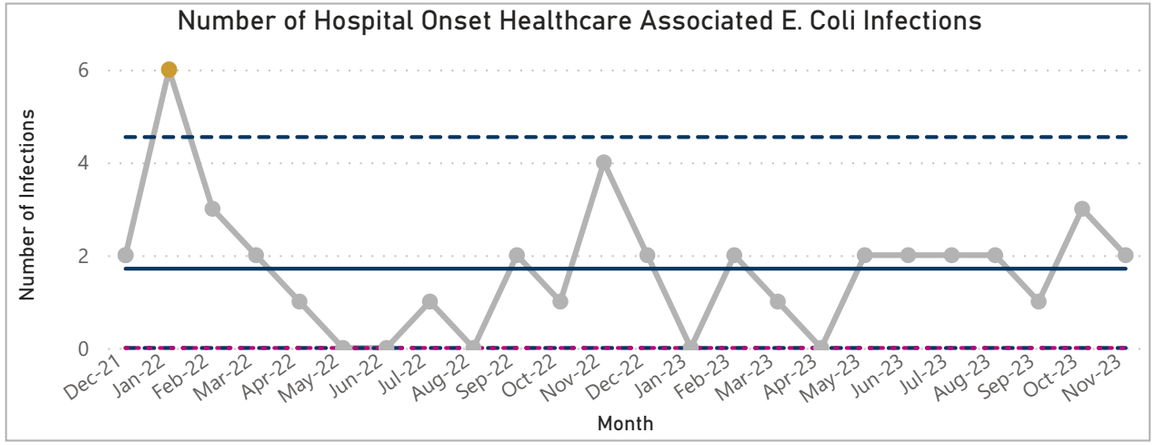
Concentrated efforts to promote adoption of FFT has been communicated via PALS outreach visits, helping to demonstrate to staff the importance of promoting this to patients as a way to hearing their views and gathering feedback on their services.

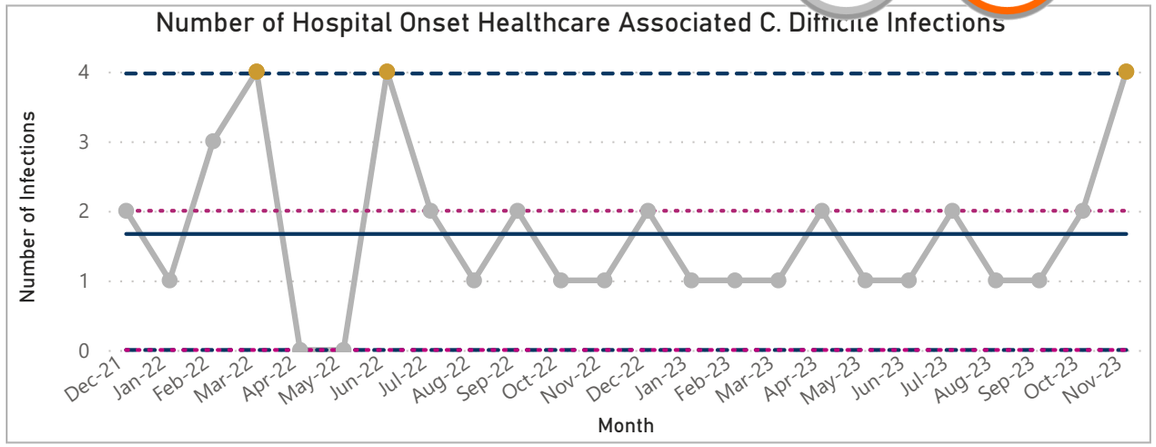
## Risks and Mitigations

We anticipate that the new dashboard will further increase this as we will be in a position to draw themes and insights from these comments. We are currently working with the new digital provider on the data analysis dashboard and we hope to be in a position to analyse and theme the comments we collected during Q1 and Q2 showcasing these through the Divisional Governance structures and Patient Experience reports. These mitigations are unlikely to have any impact on response rates but will significantly improve our data quality and therefore the insights we draw from this feedback. We hope to have the dashboard populated and begin extractions from this Autumn, and plan to introduce this reporting within the Patient Experience Reporting from Q3. Response rates are noted to have reduced this month, this could be owed to a delay in collation of the FFT cards owed to volunteering resource not being available for data entry (they were on holiday). This is a known risk to the data collection and entry, this delay in response input cannot be mitigated until the new digital provider is fully adopted where these gaps can be supplemented with a courier service collection and data entry services, which they also provide.

# Infection Control

Are We Safe?




## Understanding the performance

There has been 2 hospital onset healthcare associated reportable E.coli bacteraemia infections, and 4 hospital onset healthcare associated reportable C.difficile cases this month.
There has been no hospital onset healthcare associated MSSA bacteraemia infections this month.
Of note; there has been one community onset healthcare associated MRSA bacteraemia case.
A further three periods of increased incidence (PII) of C.difficile were declared during the month for 2 Medical wards and the Surgical unit.
The Infection Control Nurses (ICNs) continue to undertake targeted ward visits and use educational opportunities with different staff groups.

| Year | 2021-2022 | 2022-2023 | 2023-2024 |
|---|---|---|---|
| MSSA Bacteraemia Infections: Hospital Onset | 12 | 10 | 5 |
| MRSA Bacteraemia Infections: Hospital Onset | 0 | 0 | 0 |

## Actions (SMART)

Advancement with an alternative approach for staff in ward areas to complete hand hygiene education and assessments continues within surgery and has commenced in medicine under the direction of the Operational Matrons.
Completion of required case investigations by clinical areas to identify good practice and any new learning continues. SFT IP&C team facilitate this process so that areas can take ownership and progress any actions or identified learning (including sharing good practice).
Of the reviews completed, lapses in care have been identified. The divisions are monitoring those areas that have produced action plans. 'Share & Learn' meetings continue, using the new divisional format.
Involvement with BSW collaborative workstreams. Feedback communicated from sessions has been shared at the SFT Infection Prevention & Control Working Group as part of a standing agenda item.

## Risks and Mitigations

Slow progress with rolling out the alternative hand hygiene assessment method within Medicine.
New Band 6 nurse continues their orientation programme.
Ongoing clinical and non-clinical workload for IPC nursing team continues to have an impact on ability to progress other HCAI prevention work e.g. policy reviews / development, and innovation activities.
An underlying risk continues to be a potential increase in incidence of reportable healthcare associated infections with poor patient outcomes. (Of note: Trust trajectories for 2023/24 were published in May 2023).

# Mortality

Are We Safe?

| Metric Name | Dec-21 | Jan-22 | Feb-22 | Mar-22 | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Crude Mortality | 94 | 86 | 84 | 84 | 88 | 84 | 77 | 88 | 82 | 73 | 75 | 77 | 102 | 106 | 88 | 95 | 81 | 89 | 51 | 60 | 78 | 55 | 79 | 80 |
| HSMR District Hospital (excludes deaths recorded by Salisbury Hospice) | 105.02 | 99.28 | 102.37 | 104.12 | 108.04 | 109.81 | 110.84 | 112.65 | 114.18 | 114.57 | 116.02 | 115.93 | 115.08 | 115.20 | 114.30 | 115.64 | 114.45 | 114.55 | 112.14 | | | | | |
| HSMR Trust | 118.21 | 106.53 | 108.89 | 110.50 | 113.70 | 114.89 | 116.37 | 117.91 | 119.69 | 120.07 | 121.88 | 121.84 | 121.67 | 122.37 | 121.63 | 122.44 | 122.18 | 123.04 | 120.16 | | | | | |
| SHMI District Hospital (excludes deaths recorded by Salisbury Hospice) | 102.70 | 104.38 | 105.48 | 107.66 | 106.81 | 106.05 | 106.48 | 106.90 | 106.98 | 107.03 | 106.65 | 107.29 | 106.83 | 107.71 | 108.68 | 108.40 | 109.89 | 111.72 | 107.89 | | | | | |
| SHMI Trust | 106.77 | 108.47 | 109.13 | 111.34 | 110.43 | 109.56 | 110.01 | 110.87 | 111.16 | 111.41 | 111.08 | 111.79 | 111.52 | 112.92 | 113.77 | 113.65 | 115.19 | 117.05 | 113.48 | | | | | |

*Please note: The data has been supplied by Telstra Health UK (Dr Foster) and a 2-month lag has been applied to the HSMR figures to allow for coding. It should be noted that 'expected' ranges are based on the 95% confidence intervals applied by Dr Foster, however the published SHMI figures from NHS Digital are based on 98% confidence intervals. This intended to be a more sensitive indicator in order to provide the trust with an early warning for potential areas to review. Please also be aware that historical data can change month on month due to updated figures in Telstra Health as a result of latent coding.*

***Key:** Red = Statistically higher than expected*

## Understanding the performance

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.

The SHMI for the 12 month rolling period ending in June 23 for Salisbury District Hospital is 107.89.

The HSMR for the 12 month rolling period ending in June 23 for Salisbury District Hospital is 112.14.

## Actions (SMART)

Low coding of comorbidities may be resulting in a higher-than-expected number of deaths. We are prioritising coding of patients who die and improving coding of patients' comorbidities.
The Trust Board have commissioned an NHS England external review of our mortality governance processes to ensure that we are taking all reasonable steps to understand and act on the significant and sustained change seen in the Trust's statistical mortality model benchmarking. This review took place on 05/12/2023 and initial verbal feedback suggested that no significant clinical risk to patients cared for by SFT had been identified. A number of recommendations have been made including clinical and coding teams working closely together to ensure that data quality is improved. Better coding data should give a more accurate assessment of any excess mortality and help focus improvement work on processes and pathways that reduce harm.
Once a formal report has been received the Chief Medical Officer will present an initial action plan to Trust Board.

A data insight report is provided by Dr Foster and reviewed at each Mortality Surveillance Group (MSG) meeting and contains peer comparison data. There have been no obvious patterns or themes suggesting significant deficiencies in care from recent reviews although a general increased in patient frailty at the point of admission has been noted. A regional mortality summit has been established to help provide us with further context in regards to our mortality data. Data suggests that there is a lower overall mortality rate for the region as a whole when compared to national figures.

## Risks and Mitigations

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 in order 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

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 | 128 | 133 | 95 | | 0 | | Special Cause Improving - Run Below Mean | X | 32 |
| Cancer 2 Week Wait Performance | 66.6% | 62.0% | 70.0% | | 93% | | Special Cause Concerning - Run Below Mean | X | 32 |
| Complaints Acknowledged within agreed timescale % | 48.0% | 60.0% | 35.0% | 90.0% | | | | X | 32 |
| ED 12 Hour Breaches (Arrival to Departure) | 36 | 43 | 52 | | 0 | | Special Cause Improving - Run Below Mean | X | 32 |
| ED Attendances | 6480 | 6471 | 6323 | | | | Special Cause Concerning - Run Above Mean | | |
| Inpatients Undergoing VTE Risk Assessment within 24hrs % | 33.5% | 33.6% | 32.7% | | 95% | | | X | 32 |
| Mixed Sex Accommodation Breaches | 19 | 22 | 29 | 0 | 0 | | Special Cause Improving - Run Below Mean | X | 15 |
| Number of High Harm Falls in Hospital | 6 | 2 | 3 | 0 | 0 | | Common Cause Variation | X | 15 |
| Pressure Ulcers Hospital Acquired Cat 4 | 0 | 0 | 2 | | | | Special Cause Concerning - Above Upper Control Limit | | |
| RTT Incomplete Pathways: Total 52 week waits | 1291 | 1259 | 1155 | 775 | 0 | | Special Cause Concerning - Above Upper Control Limit | X | 11 |
| RTT Incomplete Pathways: Total 65 week waits | 300 | 296 | 258 | 85 | 0 | | Special Cause Concerning - Above Upper Control Limit | X | 3 |
| RTT Incomplete Pathways: Total 78 week waits | 15 | 20 | 33 | 0 | 0 | | Special Cause Improving - Run Below Mean | X | 4 |

# Watch Metrics: Alerting Narrative

Quality of Care, Access and Outcomes

## Understanding the performance

A range of access metrics continue to alert in relation to Cancer, Emergency Department and Referral to Treatment.
Cancer performance data is always one month behind due to reporting timeframes and so the data displayed is reflective of October. Performance against the 2 week wait standard is no longer reported externally due to changes made by NHSE in relation to cancer reporting, but we continue to monitor our performance against this as we recognise the importance of seeing patients referred on a suspected cancer pathway quickly, leading to cancer being ruled out or treatment options being discussed as early as possible. The pathway under most pressure continues to be the Skin.

The number of patients waiting over 78 weeks for elective treatment has increased further to 33, with the majority waiting for treatment in the Plastics service. There has been a reduction in the number of patients waiting over 52 and 65 weeks, but both remain over plan due at least in part to the Industrial Action (IA) throughout the year.

Pressure in flow is evident in the watch metrics with an increase in the number of patients in the department for longer than 12 hours and an increase in the number of instances patients were located in mixed sex accommodation. There was improvement however in the number of ambulances waiting over 60 minutes to handover patients to the Emergency Department which is reflective of the changes to the assessment process in the department.

## Actions (SMART)

A recovery plan is in place for the skin cancer pathway, with an insourcing arrangement in place from November, and expectation that the performance against the cancer standards will improve to above target by the end of the financial year.

Further actions in relation to Emergency Department, Ambulance Handovers and Elective Waiting Lists are detailed on the relevant key performance indicator slides in this report.

## Risks and Mitigations

Following a pause further IA has now been confirmed for December and January, and this will put considerable pressure on the ability to run a full programme. As expected priority will be to maintain emergency and urgent activity with disruption expected to routine activity.

Staffing pressures exist across a number of specialities not least Dermatology and Plastics which present a potential individual speciality pressure into next financial year. Insourcing arrangements have been procured to provide support to Dermatology and Skin services which are having impact.

# Watch Metrics: Non-Alerting

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 | 86 | 83 | 79 | 105 | | L | Special Cause Improving - Below Lower Control Limit | ✓ | 0 |
| Cancer Patients with a decision to treat waiting > 62 days | 167 | 119 | 87 | 92 | | L | Special Cause Improving - Below Lower Control Limit | ✓ | 0 |
| Diagnostics Activity | 7206 | 7438 | 7438 | 7065 | | H | Special Cause Improving - Run Above Mean | ✓ | 0 |
| Neonatal Deaths Per 1000 Live Births | 0 | 0 | 0 | | 0 | | Common Cause Variation | ✓ | 0 |
| Pressure Ulcers Hospital Acquired Cat 2 | 30 | 27 | 27 | | | | Common Cause Variation | | |
| Pressure Ulcers Hospital Acquired Cat 3 | 1 | 0 | 0 | | | | Common Cause Variation | | |
| Proportion of patients spending more than 12 hours in an emergency department | 0.8% | 0.9% | 1.2% | | | L | Special Cause Improving - Run Below Mean | | |
| Serious Incident Investigations | 5 | 2 | 2 | | | | Common Cause Variation | | |
| Stillbirths Per 1000 Total Births | 0 | 0 | 11 | | | | Common Cause Variation | | |
| Stroke patients receiving a CT scan within one hour of arrival | 73.0% | 62.0% | 57.0% | | 50% | H | Special Cause Improving - Run Above Mean | ✓ | 0 |
| Total Incidents (All Grading) per 1000 Bed Days | 57 | 60 | 63 | | | | Common Cause Variation | | |
| Total Incidents Resulting in High Harm (Mod/Maj/Cat) % | 3.6% | 2.2% | 2.8% | | | | Common Cause Variation | | |
| Total Number of Complaints Received | 16 | 17 | 22 | | | | Common Cause Variation | | |
| Total Number of Compliments Received | 13 | 29 | 66 | | | | Common Cause Variation | | |

# Part 2: People

## Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

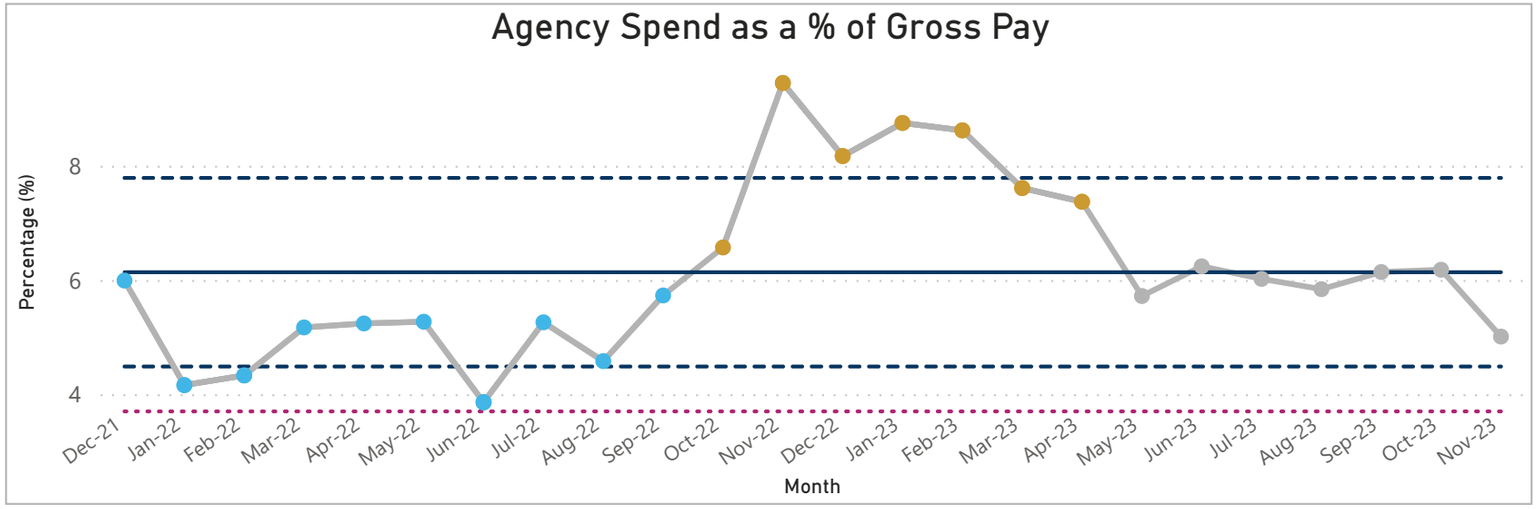
Partnerships

People

# Staffing Availability

## Target 3.7%

Breakthrough Objective




### We are driving this measure because...

Insufficient substantive clinical staff are available to meet safe staffing levels. The Trust is currently unable to consistently meet Green staffing levels across all shifts and for a significant number of shifts has to resort to the use of expensive agency staff, which has led to an unsustainable overspend. Agency spend against total staff pay costs is currently averaging 5.9% against a 3.7% target and rising.

Dated: April 2022

### Understanding the performance

Agency spend reduced below £1M for the first time since May 23 and to its lowest level this financial year. The spend was £939K and represented a 4.8% cost against substantive pay. With absence static this month and only modest drops in vacancies and turnover, the reduced proportion of cost has likely been achieved through reducing demand by improved management processes.

Nursing spend reduced by £5K to £517K representing c55% of all Agency spend. Medical costs have dropped to 25% of spend at c£246k, lower than the 6 month average. A reduction in spend on corporate areas has raised the overall % contributions of Medical and Nursing staff despite reduced total spend. All divisions have shown a decrease in agency spend with medicine below 10% at 8.4 %. Theatres was the highest spending speciality this month at c£140k, accounting for 15% of all agency spend.

### Actions (SMART)

Temporary Staffing Grip and Control. Grip and control of Temporary staffing appears to be influencing spend, despite moving into the winter period, cost has reduced. Further work is being developed to manage medical spend and to align agency rates across the region.

Establishment Control: Establishment control work continues, with a reconciliation expected by end Dec 23. This work will then be established as a routine part of divisional management meetings aligned through Finance and HR Business Partners (BPs).

Bank Staff: Recruitment campaign to improve Nurse and HCA staff bank numbers remains live.

### Risks and Mitigations

Corporate Risk – Sustainable Workforce
Mitigations:

Line Managers insufficiently trained to support people promise and absence management initiatives – Leaders training now established at 2 levels, with management training interventions designed and in place.

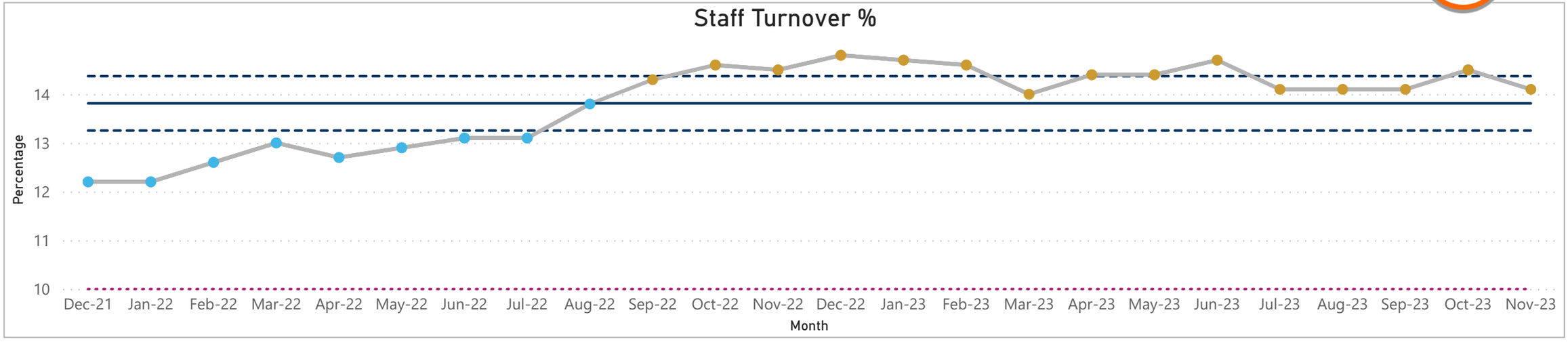
Temp staffing 5 point plan seeks to address weaknesses in the process and controls of temp staffing, as well as managing Agency costs through increasing Bank staff numbers and a negotiation of improved contracts with agency providers.

Establishment Control project timelines are tight and require detailed engagement from DMT, Finance BP and OD&P BP. The new timetable has just been released seeking to establish a reconciled position by Dec 23.

# Workforce - Turnover

**Target 10%**

People




## Understanding the performance

Turnover has reduced slightly to 14.05% this month. Staff numbers overall increased this month by 12.8 FTE, but 34.11 FTE staff left the Trust in November. Next months figures (Dec) historically demonstrate a greater number of leavers than starters, due to the Christmas holidays and therefore it is likely that turnover will increase next month.

All Divisions remain above the Trust target of 10%. Women & New-Born (19.39%) remain the division with the highest proportional turnover although only one person left the division in November. Across the various staff groups, turnover rates remain largely unchanged, with Nursing at 11.5% and additional clinical services the highest at 22%

Of the 43 individuals to leave the Trust this month, 25% left to improve their work / life balance and 7 retired from the NHS.

## Actions (SMART)

The Action plan to address issues identified in WRES/WDES and Gender Pay Gap reports is being developed. This will include looking at areas to improve performance at interview and improve the upwards trends against reporting of incidences of bullying harassment and discrimination for those staff with protected characteristics.

The national retention toolkit has been released and actions assessed against this toolkit to support line managers with a particular focus on those in their first 2 years of service and under 30. This work is complemented by 100 day and 1-year sessions for staff organised by OD&P.

Wellbeing survey data is being analysed and actions will be discussed at the next Health and Wellbeing Committee in December.

## Risks and Mitigations

Corporate Risk – Sustainable Workforce.
Mitigations:

Improved toolkits to support Line Managers to deliver appraisals and other conversations have been delivered.

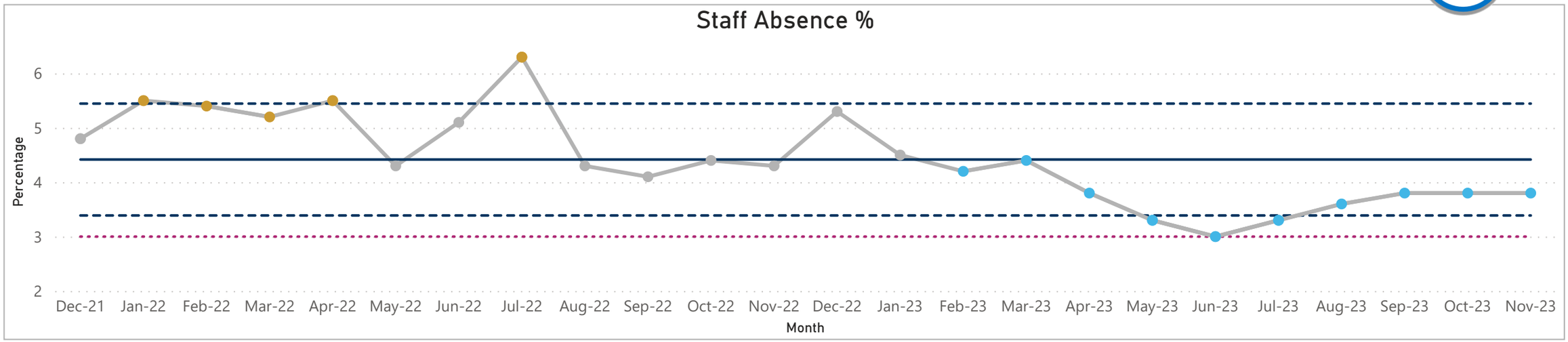
Divisional Staff Survey Action Plans

Line Manager Training interventions

# Workforce - Sickness

Target 3%

People




## Understanding the performance

Sickness absence has now been maintained at 3.8% for a three-month period, despite the onset of winter pressures.

Surgery remains the worst performing division at 4.04% sickness, however the Corporate area has dropped this month to 3.3% and is the best performing division. Absence rates in the Estates and Ancillary team and Additional clinical services groups remain the highest at 6.14% and 5.68% respectively.

Sickness accounted for 4,350 FTE days lost to the Trust, of which 2952 were for short term absence. Long term absence has been consistent in the last quarter at an average of 1420 days each month. Short term absence continues to be dominated by short bouts of absence for anxiety, stress and depression and coughs /colds / flu which account for more than double the days lost in Aug 23.

## Actions (SMART)

Absence Management: A second round of staff briefings is underway to explain the implementation and policy relating to reasonable adjustments, aimed at getting staff with long term sickness back to work.

The first 'we are safe and healthy' working group took place in early December, which has identified a mechanism to triangulate Trust wide data which contributes towards a richer picture to support managers in relation to absence management.

The prevention of violence and aggression within the Trust remains a focus, seeking to prevent physical injury, but also aiming to reduce cases of workplace stress and anxiety for those working in high prevalence situations.

## Risks and Mitigations

Corporate Risk – Delivery of OH service
Mitigations:

Increased counselling and physio hours have been agreed and staff recruited for the counselling post. Delivery of an initial health intelligence capability is planned for Summer 23.

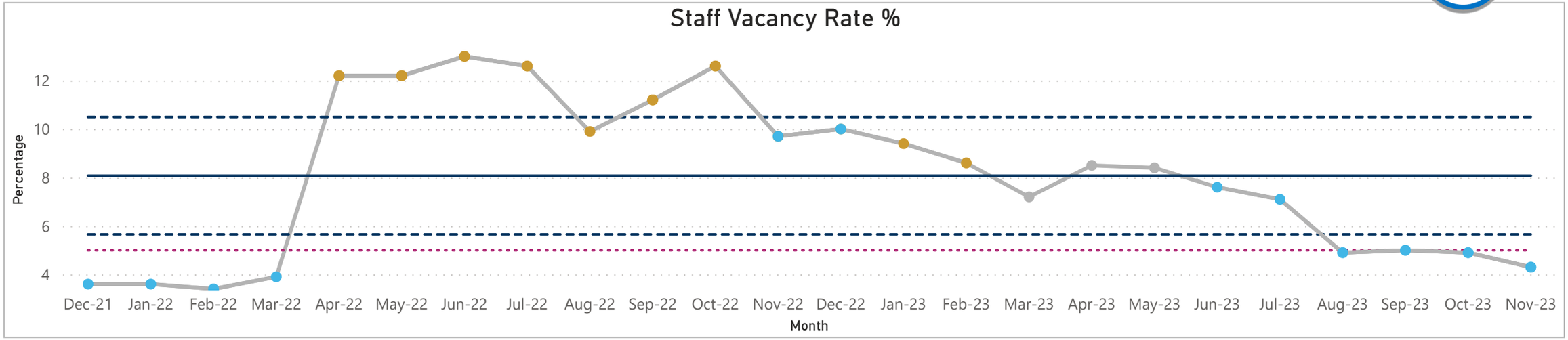
Corporate Risk – Sustainable Workforce
Mitigations:

The HRA team has been reduced by 50% (4 FTE) due to promotion, resignation and maternity leave – this will generate a short-term impact on outputs for the Team.

# Workforce - Vacancies

Target 5%

People




## Understanding the performance

Vacancy rates remain below target at 4.56% in November. This equates to 183 FTE vacancies across the Trust.

Vacancy numbers have fallen across all staff groups with Infrastructure Staff (84) and Nursing (80) the highest staff group rates. Theatres remain the service with the highest vacancies, predominately within Nursing staff, and there are campaigns in place to continue to close this gap.

## Actions (SMART)

The clear identification of vacancies against funded establishment remains the key challenge to management of effective campaigns to deliver new staff. This is ongoing work as part of 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.

The focus of Advertisement campaigns remains Theatres, The Emergency Department, Maternity, HCAs and Housekeeping.
Recent activity has also focussed on delivery of additional bank staff for nursing and HCA.

A business case has been agreed to support return to practice for nurses.
Business cases to support degree apprenticeships for nursing and to enable additional training to allow those overseas staff with nursing qualifications to practice in the UK are pending decisions at system level.

## Risks and Mitigations

Corporate Risk – Sustainable Workforce
Mitigations:

Resourcing Plans delivered.
Implementation of PWC 'overhauling recruitment' recommendations to generate more efficient processes.
Recruitment campaigns are being refreshed.
Communication of single version of recruiting picture across the Trust.
Creation of career pathways and improved career structures to better advertise roles and opportunities.

# Watch Metrics: Alerting

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 % | 87.3% | 86.8% | 86.5% | 90.0% | 85% |  | Special Cause Concerning - Decreasing Run | X | 10 |
| Medical Appraisal Rate % | 86.2% | 82.7% | 85.9% | 90.0% | |  | Common Cause Variation | X | 3 |
| Non-Medical Appraisal Rate % | 64.5% | 70.2% | 75.1% | 86.0% | |  | Special Cause Improving - Above Upper Control Limit | X | 32 |

# Watch Metrics: Alerting Narrative

People

## Understanding the performance

Mandatory training activity remains above national target, but below the Trust's improvement target of 90%. There has been a very slight reduction in performance by 0.3% this month. Women and New-Born and the Corporate area (less facilities) remain the lowest performing divisions at 83 and 81% respectively. Only facilities are above the improvement target requirement, at 96% completion.

Data for medical appraisals was not available for this report.

Non-Medical appraisals continue to demonstrate distinct improvement, with a 75% completion rate in November. This is a 15% rise in 3 months and indicates that the new appraisal format, and concerted effort from line managers to address the issue is paying dividends.

## Actions (SMART)

Mandatory Training: A busy operational period in the hospital has seen training activity reduce – key to maintaining training currency is the ability for line managers to release staff to attend training. Trust wide comms will continue to remind all staff of their responsibilities, alongside specific updates to line managers from the MLE system, identifying staff who are out of date. The Education team will offer additional support to those corporate areas struggling to complete training, and the HRBP for corporate will continue to remind managers and staff of the requirements.

Non-Medical Appraisals: Instructions on how to record appraisals on ESR have been published and training offered to line managers to support data capture. The ESR support team remain available to support line managers with uploading appraisal data into ESR. Monthly reconciliation of appraisals with line managers by business partners is also having a positive effect.

## Risks and Mitigations

Corporate Risk - Sustainable Workforce.
Retention Mitigations:

People Promise Projects, Appraisal Project, Development and Delivery of Leadership Training Modules for line managers.

# Part 3: Finance and Use of Resources

## Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

Partnerships

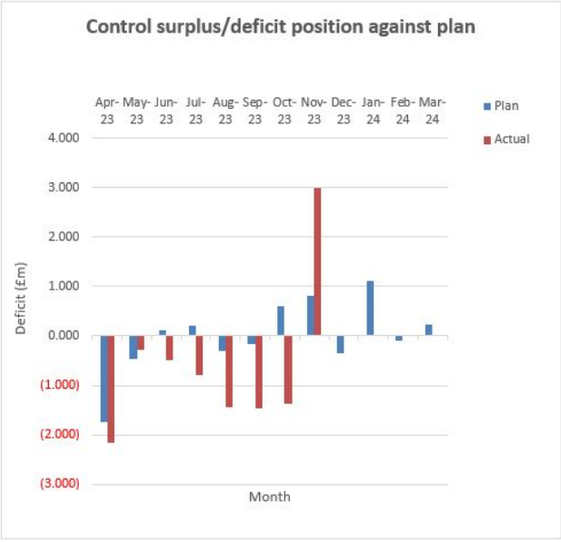
People

# Income and Expenditure

**Income & Expenditure:**

Finance and Use of Resources

| | November '23 In Month | | | November '23 YTD | | | 23-24 |
|---|---|---|---|---|---|---|---|
| | Plan £000s | Actual £000s | Variance £000s | Plan £000s | Actual £000s | Variance £000s | Plan £000s |
| **Operating Income** | | | | | | | |
| NHS Clinical income | 25,370 | 29,303 | 3,933 | 198,324 | 203,986 | 5,662 | 275,490 |
| Other Clinical Income | 751 | 506 | (245) | 5,998 | 10,182 | 4,184 | 9,478 |
| Other Income (excl Donations) | 3,559 | 3,941 | 382 | 24,423 | 27,729 | 3,306 | 59,621 |
| **Total income** | **29,680** | **33,750** | **4,070** | **228,745** | **241,896** | **13,152** | **344,589** |
| **Operating Expenditure** | | | | | | | |
| Pay | (17,866) | (19,671) | (1,805) | (142,217) | (155,825) | (13,608) | (212,809) |
| Non Pay | (9,422) | (9,396) | 26 | (74,734) | (77,628) | (2,894) | (112,722) |
| **Total Expenditure** | **(27,288)** | **(29,067)** | **(1,779)** | **(216,951)** | **(233,454)** | **(16,503)** | **(325,531)** |
| | | | | | | | |
| **EBITDA** | **2,392** | **4,683** | **2,291** | **11,794** | **8,443** | **(3,351)** | **19,058** |
| Financing Costs (incl Depreciation) | (1,587) | (1,687) | (100) | (12,702) | (13,424) | (722) | (19,058) |
| **NHSE Control Total** | **805** | **2,996** | **2,191** | **(908)** | **(4,981)** | **(4,073)** | **0** |




## Understanding the performance

The financial plan submitted to NHS England on 4 May shows a breakeven control total position for the year. The 2023/24 financial arrangements have moved to the 2023/25 NHS payment scheme with fixed and variable elements of an Aligned Payment Incentive (API) arrangement following the transitional arrangements from COVID block payments in 2022/23. Although the majority of the Trust's NHS contractual income base is fixed, the guidance allows for additional income to be earned through the variable element of the API and the Elective Recovery Fund (ERF) from commissioners. SFT has not assumed any ERF income within the 2023/24 plan as the Trust's planned activity levels do not meet the

In Month 8 the Trust recorded a control total surplus of c£3.0m against a target of c£0.8m - a favourable variance of c£2.2m. This is mainly due to Industrial Action (IA) funding in month.

The year to date position is driven by supernumerary cover for new and overseas staff, the costs of providing enhanced care to patients, the residual gap on pay awards and increased costs of elective and non elective activity mitigated by confirmed IA funding.

## Actions (SMART)

The 2023/24 plan includes an efficiency requirement of £15.3m and the Financial recovery group was established in April, as a sub committee of the Finance and Performance committee, to provide scrutiny and support to the savings programme.

## Risks and Mitigations

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 and the recruitment of staff. The Trust's forecast of £15.3m efficiency savings includes more than 27% non recurrent delivery and signals a risk if further recurrent efficiencies cannot be identified. Actions are ongoing to identify additional schemes.

# Income & Activity Delivered by Point of Delivery

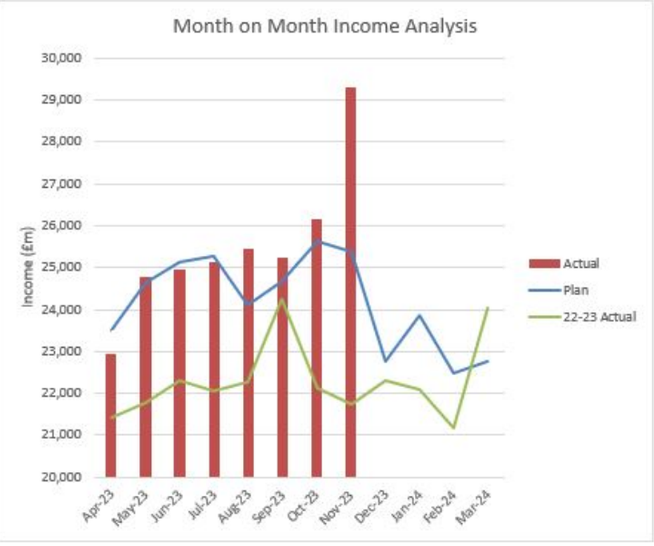
**Clinical Income:**

Finance and Use of Resources

| Income by Point of Delivery (PoD) for all commissioners | Nov 23 Year to Date (YTD) Plan (YTD) £000s | Actual (YTD) £000s | Variance (YTD) £000s |
|---|---|---|---|
| A&E | 7,140 | 7,851 | 711 |
| Day Case | 15,017 | 14,335 | (682) |
| Elective inpatients | 9,507 | 9,957 | 450 |
| Excluded Drugs & Devices (inc Lucentis) | 16,048 | 17,432 | 1,384 |
| Non Elective inpatients | 52,755 | 51,452 | (1,303) |
| Other | 73,195 | 75,952 | 2,757 |
| Outpatients | 24,662 | 27,007 | 2,345 |
| TOTAL | 198,324 | 203,986 | 5,662 |

| SLA Income Performance of Trusts main NHS commissioners | Contract Plan (YTD) £000s | Actual (YTD) £000s | Variance (YTD) £000s |
|---|---|---|---|
| BSW ICB | 121,878 | 127,307 | 5,429 |
| Dorset ICB | 19,512 | 19,357 | (155) |
| Hampshire, Southampton & IOW ICB | 16,835 | 16,627 | (208) |
| Specialist Services | 27,026 | 28,077 | 1,051 |
| Other | 13,073 | 12,618 | (455) |
| TOTAL | 198,324 | 203,986 | 5,662 |

| | Activity YTD Plan | Actuals | Variance | Activity Last Year Actuals | Variance last year |
|---|---|---|---|---|---|
| A&E | 49,267 | 49,264 | (3) | 48,841 | 423 |
| Day case | 15,973 | 16,118 | 145 | 15,142 | 976 |
| Elective | 2,192 | 2,175 | (17) | 2,273 | (98) |
| Non Elective | 18,377 | 18,714 | 337 | 17,865 | 849 |
| Outpatients | 170,354 | 184,098 | 13,744 | 169,230 | 14,868 |




## Understanding the performance

The Clinical income position is above plan year to date due to BSW ICB overperformance which includes £2.6m of Industrial Action (IA) funding in month and overperformance on Outpatient first attendances and procedures, Elective Inpatients, Advice and Guidance and Radiology from the use of independent sector providers for MRI and CT activity and Specialist services overperformance on High cost drugs and devices and Chemotherapy activity. This is offset by underperformance on the Dorset and Hampshire ICB contracts and other NHS England contracts.

The level of uncoded day cases and inpatient spells is 25% in October and 92% in November at the time the activity was taken for reporting purposes. September's activity was fully coded at the SUS submission.

Activity was higher in November than October across all the main points of delivery with the exception of A&E attendances.

## Actions (SMART)

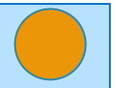
The contracts with ICBs and NHS England remain under negotiation at this stage. Several contract schedules have been agreed with commissioners with discussions progressing on the finance schedules with BSW and Dorset ICBs. Further guidance is anticipated around Dental commissioning arrangements including revised ICB allocations and detailed ERF calculations.

## Risks and Mitigations

The impact of IA has constrained the elective programme. Additional guidance has been received which reduces the ERF target by 4% in total across all commissioners and a funding allocation of £2.6m to mitigate the impact of Industrial action to October. All commissioner contracts, excluding BSW ICB, are now required at 99% of 2019/20 Elective activity levels. The Trust is seeking to mitigate the impact by maximising activity recording opportunities and via the contract negotiations.

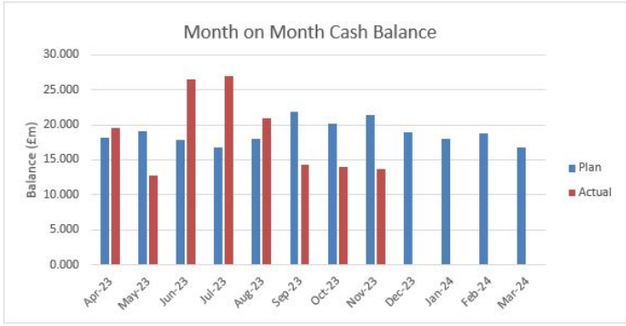
# Cash Position & Capital Programme

**Capital Spend:** 

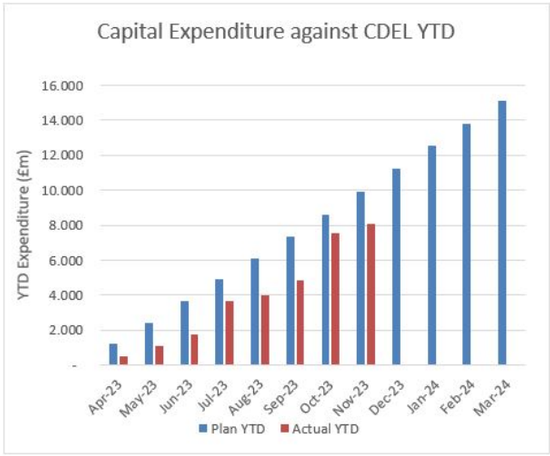
**Cash & Working:** 

Finance and Use of Resources

| | Closing Balance March 2023 £000s | Current Month Balance £000s | Actual In Year Movement £000s |
|---|---|---|---|
| Inventories (Stock) | 7,954 | 8,491 | 537 |
| Debtors | 24,999 | 26,306 | 1,307 |
| Cash | 28,891 | 13,699 | (15,192) |
| **TOTAL CURRENT ASSETS** | **61,844** | **48,496** | **(13,348)** |
| Creditors | (58,026) | (50,355) | 7,671 |
| Borrowings | (641) | (632) | 9 |
| Provisions | (474) | (449) | 25 |
| **TOTAL CURRENT LIABILITIES** | **(59,141)** | **(51,436)** | **7,705** |
| **TOTAL WORKING CAPITAL** | **2,703** | **(2,940)** | **(5,643)** |




| Payables age profile | Total Payables £'000 | 0-30 days £'000 | 31-60 days £'000 | 61-90 days £'000 | 90+ days £'000 |
|---|---|---|---|---|---|
| Nov-23 | **10,204** | 8,882 | 224 | 542 | 556 |
| Oct-23 | **5,883** | 4,423 | 599 | 456 | 406 |
| Sep-23 | **5,536** | 4,514 | 505 | 61 | 456 |
| *Movement vs prev mth* | *4,321* | *4,459* | *(375)* | *86* | *150* |




| Schemes | Annual Plan £000s | November '23 YTD Plan £000s | November '23 YTD Actual £000s | November '23 YTD Variance £000s |
|---|---|---|---|---|
| **CDEL Schemes** | | | | |
| Building schemes CIR | 2,785 | 1,862 | 861 | 1,001 |
| Building projects | 6,201 | 4,145 | 3,632 | 513 |
| IM&T | 3,432 | 2,110 | 1,645 | 465 |
| Medical Equipment | 2,698 | 1,804 | 494 | 1,310 |
| **Total CDEL schemes** | **15,116** | **9,920** | **6,632** | **3,288** |
| **National Funding** | | | | |
| New Elective Ward TIF | *11,952* | *4,299* | *4,299* | *0* |
| Salix Decarbonisation | *10,005* | *3,437* | *3,437* | *0* |
| Shared EPR - national element | *3,760* | *0* | *0* | *0* |
| Digital Pathology | *1,053* | *534* | *534* | *0* |
| Pathology LIMS | *310* | *110* | *110* | *0* |
| SW Imaging (ATVS) | *174* | *2* | *2* | *0* |
| **Total National Funding** | **27,254** | **8,382** | **8,382** | **0** |
| **Great Western Hospitals transaction** | | | | |
| Medical Equipment - Surgical robot | | | **1,431** | **(1,431)** |
| **GRAND TOTAL** | **42,370** | **18,302** | **16,445** | **1,857** |

## Understanding the performance

In month 8 there has been limited expenditure on CDEL Schemes of £0.5m and £1.7m on the Elective ward scheme. Forecast expenditure by capital sub group continues to be reviewed each month at the Trust Capital Control Group to ensure full allocations will be spent by the year end. Specific projects, including Salix, do have expenditure profiles weighted towards the end of the year and actions will to taken to maximise the funding in year and manage any slippage. Cash reserves are now c£7.0m below plan following the reductions in creditors, increases in debtors and the year to date deficit of c£5.0m.

## Actions (SMART)

The Trust will be actively seeking opportunities for additional capital funds as they arise. Monthly review of the cash position and forecast to ensure that sufficient funds are available to meet payments as they arise and that working capital funding is in place as early as possible to mitigate cash requirements. A revenue support application of £6m was submitted to NHS England on 30th November 23 for the remainder of 2023/24.

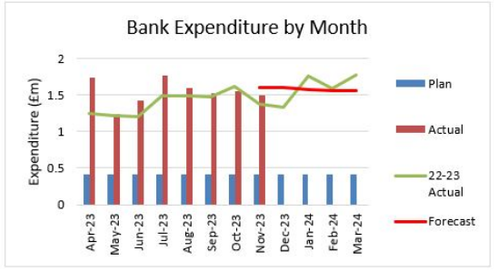
## Risks and Mitigations

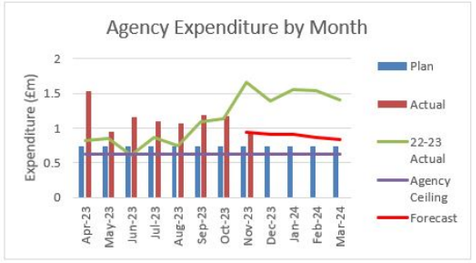
Additional capital pressures are emerging in year and such risks will have to be managed within the overall capital envelope if additional funding cannot be secured. The Trust received confirmation of the BSW ICB Capital leases allocation of £6.1m on 30/11/23 against a plan of £12.5m, with £5m anticipated for SFT. The Trust is expecting to submit a request against a provider contingency allocation for Capital leases funding to purchase a CT scanner and C-arm equipment on a leased basis. The constraint of both available cash and 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 ageing estate and medical equipment means the Trust's five year capital requirement is well in excess of available resources. The Trust seeks to in part mitigate this risk through the proactive bidding for national funds where available. 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.

# Workforce and Agency Spend

**Pay:**

Finance and Use of Resources


| | November '23 YTD Plan £000s | Actual £000s | Variance £000s |
|---|---|---|---|
| Pay - In Post | 132,709 | 133,836 | 1,127 |
| Pay - Bank | 3,394 | 12,357 | 8,963 |
| Pay - Agency | 6,115 | 9,088 | 2,974 |
| Other (eg apprenticeship levy) | | 544 | 544 |
| **TOTAL** | **142,217** | **155,825** | **13,609** |
| Medical Staff | 37,321 | 41,169 | 3,848 |
| Nursing | 37,177 | 41,691 | 4,515 |
| Support to Nursing | 10,167 | 14,100 | 3,932 |
| Other Clinical Staff | 20,107 | 20,448 | 342 |
| Infrastructure staff | 37,445 | 37,873 | 428 |
| Other (eg apprenticeship levy) | | 544 | 544 |
| **TOTAL** | **142,217** | **155,825** | **13,609** |

| | November '23 YTD Plan WTEs | Actual WTEs | Variance WTEs |
|---|---|---|---|
| Medical Staff | 470.9 | 522.7 | 51.8 |
| Nursing | 1,149.9 | 1,206.1 | 56.2 |
| Support to Nursing | 521.4 | 624.4 | 103.0 |
| Other Clinical Staff | 643.9 | 638.9 | (5.0) |
| Infrastructure staff | 1,484.7 | 1,427.9 | (56.8) |
| **TOTAL** | **4,270.7** | **4,419.9** | **149.2** |

## Understanding the performance

Month 8 was a marginal change of £40k to the Month 7 position. Pay costs remain consistently above plan with an adverse variance to plan in month of c£1.8m and c£13.6m YTD. There was a modest increase in Substantive offset by a reduction in Agency costs in month. The pay position includes the cumulative pay savings target at month 8 of c£6.7m of which c£3.7m has been delivered to date. Staff unavailability reduced by 63 WTE in November mainly within clinical areas. The average unavailability was 23.7% (24.9% in October) which disproportionately impacts areas delivering clinical activity.

Substantive vacancies across the Trust have remained at 4% in November with the highest proportion of vacancies remaining within the Consultant, Nursing and midwifery and NHS Infrastructure groups. The unfilled rate has remained at 3%, mainly across Consultant and Infrastructure groups.

## Actions (SMART)

Detailed actions on the response to the Trust's workforce challenges are set out in the People section of the IPR. These focus on establishment, recruitment, staff availability, temporary staffing and sickness.

## 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. Industrial Action (IA) has driven the increased costs of cover and Time off in lieu (TOIL).

# Data Sources: Narrative and Breakthrough Objectives

Understand the Data

| Metric Type | Metric Name | Data Source | Executive Lead | Data Quality Rating |
|---|---|---|---|---|
| Breakthrough Objective | Beds Occupied % | Lorenzo via Trust Data Warehouse | Lisa Thomas | Medium |
| Breakthrough Objective | Staffing Availability | Oracle | Melanie Whitfield | High |
| Breakthrough Objective | Total Patient Falls per 1000 Bed Days | DATIX Team | Judy Dyos | High |
| Breakthrough Objective | Wait time to first OPA (non-admitted) | Lorenzo via Trust Data Warehouse | Lisa Thomas | High |
| Narrative | Ambulance Handover Delays >30 mins as a % of all handovers | Lorenzo via Trust Data Warehouse | Lisa Thomas | High |
| Narrative | Average Ambulance Handover Time | Lorenzo via Trust Data Warehouse | Lisa Thomas | High |
| Narrative | C Difficile Hospital onset Healthcare associated | Infection Control Team | Judy Dyos | High |
| Narrative | Cancer 28 Day Faster Diagnosis Standard | Cancer Services | Lisa Thomas | High |
| Narrative | Cancer 31 Day Performance Overall | Cancer Services | Lisa Thomas | High |
| Narrative | Cancer 62 Day Standard Performance | Cancer Services | Lisa Thomas | High |
| Narrative | Cat 2 Pressure Ulcers per 1000 Bed Days | Tissue Viability team | Judy Dyos | High |
| Narrative | DM01 Performance | Trust Data Warehouse | Lisa Thomas | High |
| Narrative | E Coli Hospital onset Healthcare associated | Infection Control Team | Judy Dyos | High |
| Narrative | ED 4 Hour Performance | Lorenzo via Trust Data Warehouse | Lisa Thomas | High |
| Narrative | Friends and Family Test Response Rate - All Trust | Trust Data Warehouse | Judy Dyos | High |
| Narrative | Patients moved more than once % | Lorenzo via Trust Data Warehouse | Judy Dyos | High |
| Narrative | Staff Sickness Absence % | Health Roster | Melanie Whitfield | High |
| Narrative | Staff Turnover | ESR | Melanie Whitfield | High |
| Narrative | Stroke: % Arrival on Stroke Unit within 4 hours | Stroke Team | Peter Collins | Medium |
| Narrative | Total Waiting List | Lorenzo via Trust Data Warehouse | Lisa Thomas | High |
| Narrative | Vacancies | ESR | Melanie Whitfield | High |

# Data Sources: Watch Metrics (1)

Understand the Data

| Metric Type | Metric Name | Data Source | Executive Lead | Data Quality Rating |
|---|---|---|---|---|
| Watch | Ambulance Arrivals | Lorenzo via Trust Data Warehouse | Lisa Thomas | High |
| Watch | Ambulance Handovers 15-<30 mins | SWAST AR119 report | Lisa Thomas | High |
| Watch | Ambulance Handovers 30-<60 mins | SWAST AR119 report | Lisa Thomas | High |
| Watch | Ambulance Handovers 60+ mins | SWAST AR119 report | Lisa Thomas | High |
| Watch | Average hours lost to Ambulance Handover delays per day | Lorenzo via Trust Data Warehouse | Lisa Thomas | High |
| Watch | Average Patients with No Criteria to Reside | e-whiteboards via Trust Data Warehouse | Lisa Thomas | Medium |
| Watch | Cancer 2 Week Wait Breast Breaches | Cancer Services | Lisa Thomas | High |
| Watch | Cancer 2 Week Wait Breast Den | Cancer Services | Lisa Thomas | High |
| Watch | Cancer 2 Week Wait Breast Num | Cancer Services | Lisa Thomas | High |
| Watch | Cancer 2 Week Wait Breast Performance | Cancer Services | Lisa Thomas | High |
| Watch | Cancer 62 Day Screening Den | Cancer Services | Lisa Thomas | High |
| Watch | Cancer 62 Day Screening Num | Cancer Services | Lisa Thomas | High |
| Watch | Cancer 62 Day Screening Performance | Cancer Services | Lisa Thomas | High |
| Watch | Cancer 62 Days Standard Den | Cancer Services | Lisa Thomas | High |
| Watch | Cancer 62 Days Standard Num | Cancer Services | Lisa Thomas | High |
| Watch | DM01 Waiting List Volume | Trust Data Warehouse | Lisa Thomas | High |
| Watch | ED 12 Hour Breaches (Arrival to Departure) | Lorenzo via Trust Data Warehouse | Lisa Thomas | Medium |
| Watch | ED Attendances | Lorenzo via Trust Data Warehouse | Lisa Thomas | High |
| Watch | MSSA Bacteraemia Infections: Hospital Onset | Infection Control Team | Judy Dyos | High |
| Watch | RTT Incomplete Pathways: Total 104 week waits | Lorenzo via Trust Data Warehouse | Lisa Thomas | High |
| Watch | RTT Incomplete Pathways: Total 52 week waits | Lorenzo via Trust Data Warehouse | Lisa Thomas | High |
| Watch | RTT Incomplete Pathways: Total 78 week waits | Lorenzo via Trust Data Warehouse | Lisa Thomas | High |
| Watch | Stroke patients receiving a CT scan within one hour of arrival | Stroke Team | Peter Collins | Medium |
| Watch | Stroke: % Bedside Swallow Assessment within 4 hours | Stroke Team | Peter Collins | Medium |

# Data Sources: Watch Metrics (2)

Understand the Data

| Metric Type | Metric Name | Data Source | Executive Lead | Data Quality Rating |
|---|---|---|---|---|
| Watch | Inpatients Undergoing VTE Risk Assessment within 24hrs % | Lorenzo via Trust Data Warehouse | Peter Collins | High |
| Watch | Mandatory Training Rate % | MLE | Melanie Whitfield | High |
| Watch | Medical Appraisal Rate % | ESR | Melanie Whitfield | High |
| Watch | Mixed Sex Accommodation Breaches | Site Team | Judy Dyos | Low |
| Watch | Neonatal Deaths Per 1000 Live Births | E3 via Trust Data Warehouse | Peter Collins | High |
| Watch | Non-Medical Appraisal Rate % | ESR | Melanie Whitfield | High |
| Watch | Number of High Harm Falls in Hospital | DATIX | Judy Dyos | High |
| Watch | Pressure Ulcers Hospital Acquired Cat 2 | Tissue Viability team | Judy Dyos | High |
| Watch | Pressure Ulcers Hospital Acquired Cat 3 | Tissue Viability team | Judy Dyos | High |
| Watch | Pressure Ulcers Hospital Acquired Cat 4 | Tissue Viability team | Judy Dyos | High |
| Watch | Proportion of patients spending more than 12 hours in an emergency department | Lorenzo via Trust Data Warehouse | Lisa Thomas | High |
| Watch | Serious Incident Investigations | DATIX | Judy Dyos | High |
| Watch | Stillbirths Per 1000 Total Births | E3 via Trust Data Warehouse | Peter Collins | High |
| Watch | Total (Excess) Bed Days from NC2R to Discharge - Internal Reasons only | e-whiteboards | Lisa Thomas | Medium |
| Watch | Total Incidents (All Grading) per 1000 Bed Days | DATIX | Judy Dyos | High |
| Watch | Total Incidents Resulting in High Harm (Mod/Maj/Cat) % | DATIX | Judy Dyos | High |
| Watch | Total Number of Complaints Received | PALS Team | Judy Dyos | High |
| Watch | Total Number of Compliments Received | PALS Team | Judy Dyos | High |
| Watch | Trust Performance RTT % | Lorenzo via Trust Data Warehouse | Lisa Thomas | High |

# Data Sources: Other Metrics (1)

Understand the Data

| Metric Type | Metric Name | Data Source | Executive Lead | Data Quality Rating |
|---|---|---|---|---|
| Other | Cancer 2 Week Wait Breaches | Cancer Services | Lisa Thomas | High |
| Other | Cancer 2 Week Wait Den | Cancer Services | Lisa Thomas | High |
| Other | Cancer 2 Week Wait Num | Cancer Services | Lisa Thomas | High |
| Other | DM01 Breaches: Audio | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Breaches: Cardio | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Breaches: Colon | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Breaches: CT | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Breaches: DEXA | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Breaches: Flexi Sig | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Breaches: Gastro | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Breaches: MRI | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Breaches: Neuro | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Breaches: US | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Performance: Audio | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Performance: Cardio | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Performance: Colon | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Performance: CT | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Performance: DEXA | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Performance: Flexi Sig | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Performance: Gastro | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Performance: MRI | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Performance: Neuro | Trust Data Warehouse | Lisa Thomas | High |
| Other | DM01 Performance: US | Trust Data Warehouse | Lisa Thomas | High |
| Other | Longest Waiting Patient (Weeks) | Lorenzo via Trust Data Warehouse | Lisa Thomas | High |
| Other | Day HCA | Health Roster | Melanie Whitfield | High |
| Other | Day RN | Health Roster | Melanie Whitfield | High |

# Data Sources: Other Metrics (2)

Understand the Data

| Metric Type | Metric Name | Data Source | Executive Lead | Data Quality Rating |
|---|---|---|---|---|
| Other | Maternity: Compliance with supernumery status of the LW coordinator % | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: Coroner Red 28 made directly to trust | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: DATIX incidents moderate harm (not SII) | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: DATIX incidents SII | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: DATIX relating to workforce | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: HSIB referrals | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: HSIB/NHSR/CQC or other organisation with a concern or request | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: Midwifery vacancy rate | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: Minimum safe staffing in maternity services; Obstetric cover | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: Minimum to birth ratio | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: Number of DATIX incidents - moderate or above | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: Number of SOX | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: Number of times maternity unit on divert | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: Number of women requiring admission to ITU | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: Progress in achievement of 10 safety actions (CNST) | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: Provision of 1 to 1 care in established labour (%) | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: Service user feedback: number of complaints | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: Service user feedback: number of compliments | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: Training compliance - MDT Prompt % | Maternity Dept | Judy Dyos | Medium |
| Other | Maternity: Medical termination over 24+0 registered | E3 via Trust Data Warehouse | Peter Collins | Medium |
| Other | Maternity: Number of late fetal losses (22+0 to 23+6 weeks excl TOP) | E3 via Trust Data Warehouse | Peter Collins | Medium |
| Other | Maternity: Number of Maternal Deaths | E3 via Trust Data Warehouse | Peter Collins | Medium |
| Other | Maternity: Number of neonatal deaths (0-28 days) | E3 via Trust Data Warehouse | Peter Collins | Medium |
| Other | Maternity: Number of stillbirths (>+24 weeks excl TOP) | E3 via Trust Data Warehouse | Peter Collins | Medium |
| Other | SSNAP Case Ascertainment Audit | Stroke Team | Peter Collins | High |

# Data Sources: Other Metrics (3)

Understand the Data

| Metric Type | Metric Name | Data Source | Executive Lead | Data Quality Rating |
|---|---|---|---|---|
| Other | Crude Mortality | Medical Examiners | Peter Collins | High |
| Other | FFT Response Rate - A&E | Trust Data Warehouse | Judy Dyos | High |
| Other | FFT Response Rate - Day Case | Trust Data Warehouse | Judy Dyos | High |
| Other | FFT Response Rate - Inpatient | Trust Data Warehouse | Judy Dyos | High |
| Other | FFT Response Rate - Maternity | Trust Data Warehouse | Judy Dyos | High |
| Other | FFT Response Rate - Outpatient | Trust Data Warehouse | Judy Dyos | High |
| Other | HSMR Trust | Telstra Health | Peter Collins | High |
| Other | MRSA Bacteraemia Infections: Hospital Onset | Infection Control Team | Judy Dyos | High |
| Other | Never Events | DATIX | Judy Dyos | High |
| Other | SHMI Trust | Telstra Health | Peter Collins | High |

# Data Sources: Other Metrics (4)

Understand the Data

| Metric Type | Metric Name | Data Source | Executive Lead | Data Quality Rating |
|---|---|---|---|---|
| Other | Add: impact of donated assets | Finance Division | Mark Ellis | High |
| Other | Financing Costs | Finance Division | Mark Ellis | High |
| Other | Income by PoD: A&E Actual | Finance Division | Mark Ellis | High |
| Other | Income by PoD: A&E Plan | Finance Division | Mark Ellis | High |
| Other | Income by PoD: Daycase Actual | Finance Division | Mark Ellis | High |
| Other | Income by PoD: Daycase Plan | Finance Division | Mark Ellis | High |
| Other | Income by PoD: Elective IP Actual | Finance Division | Mark Ellis | High |
| Other | Income by PoD: Elective IP Plan | Finance Division | Mark Ellis | High |
| Other | Income by PoD: Excluded Drugs & Devices Actual | Finance Division | Mark Ellis | High |
| Other | Income by PoD: Excluded Drugs & Devices IP Plan | Finance Division | Mark Ellis | High |
| Other | Income by PoD: Non Elective IP Actual | Finance Division | Mark Ellis | High |
| Other | Income by PoD: Non Elective IP Plan | Finance Division | Mark Ellis | High |
| Other | Month on month I&E Surplus/(Deficit) Actual | Finance Division | Mark Ellis | High |
| Other | Month on month I&E Surplus/(Deficit) Plan | Finance Division | Mark Ellis | High |
| Other | NHS Clinical income | Finance Division | Mark Ellis | High |
| Other | NHS Clinical income Plan | Finance Division | Mark Ellis | High |
| Other | Non Pay | Finance Division | Mark Ellis | High |
| Other | Other Clinical income | Finance Division | Mark Ellis | High |
| Other | Other Clinical income Plan | Finance Division | Mark Ellis | High |
| Other | Other income (excl donations) | Finance Division | Mark Ellis | High |
| Other | Other income (excl donations) Plan | Finance Division | Mark Ellis | High |
| Other | Pay | Finance Division | Mark Ellis | High |
| Other | Share of Gains on Joint Ventures | Finance Division | Mark Ellis | High |
| Other | Surplus/(Deficit) | Finance Division | Mark Ellis | High |

# Data Sources: Other Metrics (5)

Understand the Data

| Metric Type | Metric Name | Data Source | Executive Lead | Data Quality Rating |
|---|---|---|---|---|
| Other | Activity by PoD: A&E | Finance Division | Mark Ellis | High |
| Other | Activity by PoD: Day case | Finance Division | Mark Ellis | High |
| Other | Activity by PoD: Elective | Finance Division | Mark Ellis | High |
| Other | Activity by PoD: Non Elective | Finance Division | Mark Ellis | High |
| Other | Activity by PoD: Outpatients | Finance Division | Mark Ellis | High |
| Other | Capital Expenditure: Building Projects Actual | Finance Division | Mark Ellis | High |
| Other | Capital Expenditure: Building Projects Plan | Finance Division | Mark Ellis | High |
| Other | Capital Expenditure: Building Schemes Actual | Finance Division | Mark Ellis | High |
| Other | Capital Expenditure: Building Schemes Plan | Finance Division | Mark Ellis | High |
| Other | Capital Expenditure: IM&T Actual | Finance Division | Mark Ellis | High |
| Other | Capital Expenditure: IM&T Plan | Finance Division | Mark Ellis | High |
| Other | Capital Expenditure: Medical Equipment Plan | Finance Division | Mark Ellis | High |
| Other | Income by PoD: Other Actual | Finance Division | Mark Ellis | High |
| Other | Income by PoD: Other Plan | Finance Division | Mark Ellis | High |
| Other | Income by PoD: Outpatients Actual | Finance Division | Mark Ellis | High |
| Other | Income by PoD: Outpatients Plan | Finance Division | Mark Ellis | High |
| Other | Month on month cash balance | Finance Division | Mark Ellis | High |
| Other | Month on month Income Analysis Actual | Finance Division | Mark Ellis | High |
| Other | Month on month Income Analysis Plan | Finance Division | Mark Ellis | High |
| Other | SLA Income: BSW CCG | Finance Division | Mark Ellis | High |
| Other | SLA Income: Dorset CCG | Finance Division | Mark Ellis | High |
| Other | SLA Income: Hampshire, Southampton and IoW CCG | Finance Division | Mark Ellis | High |
| Other | SLA Income: Other | Finance Division | Mark Ellis | High |
| Other | SLA Income: Specialist Services | Finance Division | Mark Ellis | High |

# Data Sources: Other Metrics (6)

Understand the Data

| Metric Type | Metric Name | Data Source | Executive Lead | Data Quality Rating |
|---|---|---|---|---|
| Other | Agency total Actual | Finance Division | Mark Ellis | High |
| Other | Agency Total Plan | Finance Division | Mark Ellis | High |
| Other | Bank total Actual | Finance Division | Mark Ellis | High |
| Other | Bank total Plan | Finance Division | Mark Ellis | High |
| Other | Capital Expenditure: Additional funds approved in year Actual | Finance Division | Mark Ellis | High |
| Other | Capital Expenditure: Additional funds approved in year Plan | Finance Division | Mark Ellis | High |
| Other | Capital Expenditure: Medical Equipment Actual | Finance Division | Mark Ellis | High |
| Other | Capital Expenditure: Other Actual | Finance Division | Mark Ellis | High |
| Other | Capital Expenditure: Other Plan | Finance Division | Mark Ellis | High |
| Other | Month on Month CAPEX Actual | Finance Division | Mark Ellis | High |
| Other | Month on Month CAPEX Plan | Finance Division | Mark Ellis | High |
| Other | Month on Month total pay Actual | Finance Division | Mark Ellis | High |
| Other | Month on Month total pay Plan | Finance Division | Mark Ellis | High |

NHS Salisbury NHS Foundation Trust

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|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 2.2 |
| Date of meeting: | 11 January 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report from (Committee Name): | Audit Committee | | Committee Meeting Date: | 12 December 2023 |
| Status: | Information | Discussion | Assurance | Approval |
| | | | x | |
| Prepared by: | Richard Holmes (Audit Committee Chair) | | | |
| Non-Executive Presenting: | Richard Holmes | | | |
| 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.**

- None noted

**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 Trust's Counter Fraud Auditors advised that, other than cybercrime, the most significant risk factors associated with Fraud are management of Conflicts Of Interest, and identification and prevention of Mandate Fraud, and that these areas would continue to be a key focus for their work with SFT into the future.

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

- The Audit Committee was reassured to receive a report demonstrating that the volume and value of contracts awarded non-competitively by single tender (Single Tender Action – STA) was continuing to reduce. In 2018/19, 178 STAs were approved at a value of £10.1m, reducing to 71 STAs at a value of £2.8m being approved in 2022-23. The numbers continue to fall in 2023-24. STAs can be used reactively to respond to operational priorities, and for continuation of service from existing providers at contract end. The Audit Committee reviewed a sample of Recommendation Reports for individual STAs approved this year.

- The Audit Committee was reassured that the newly appointed External Auditors (Deloitte LLP) had been engaging with the Trust to ensure effective planning for the year end audit to meet the deadline of 30 June 2024. **Post meeting note**: Initial inertia with the previous incumbents to handover earlier years' Audit information to support the planning process has now been overcome.

(cont'd.)

The Audit Committee were advised that no substantive new reporting obligations or changes to audit practice are in place for this reporting year.

- The Committee received the first two Internal Audit reports and the first two Counter Fraud Audit reports from KPMG LLP, the newly appointed auditors, and were reassured to note that all give significant assurance and each identifies improvement opportunities. In line with comments noted above, the two Counter Fraud audits covered Conflicts of Interest and Mandate Fraud.

- The Committee took the opportunity, with its new external partners, to reflect on how the Audit Committee could add real practical value to the Executive team, as well as providing assurance on the systems of internal control to the Board. The general opinion of the Meeting was that the Audit Committee operated professionally and was broadly effective. Third party input was for Audit Committee to focus on risk management and risk appetite as distinct from risk identification and risk evaluation, to dovetail Audit Committee business, eg Deep Dives, clearly into the Trust's strategic priorities, and to ensure that it operated an effective mechanism to pass information between itself and other Board Committees.

  There was also a feeling that Audit Committee should focus on organisational culture as well as organisational process, and encourage bringing an Internal Audit process mindset to in-house control activities, through the application of Improving Together principles.

  The Committee will consider these points in future meetings.

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

- The Audit Committee received and recommends to the Board the approval of a paper that proposes short term changes to Standing Financial Instructions (SFIs) for the procurement of capital items up to a value of £350k during the period between 1 January 2024 and 31 March 2024.

  This will enable agile, light touch, decision making should opportunities for capital investment be offered to the Trust during the lead-in to year end.

  The approach proposed is in line with that adopted during the last quarter of the previous year.

  In discussion, KPMG observed that it was not usual practice for organisations temporarily to amend SFIs, and challenged the Trust to consider whether or not this agile approach should be integrated into SFIs permanently. This will be considered by the Executive.

| 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: | 2.2a |
| Date of meeting | 11 January 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report title: | Short term changes to SFI's for Procurement Recommendation Report approvals for capital from 1 December 2023 – 31 March 2024. | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | | | | x |
| Approval Process: (Where had this paper been reviewed and approved) | This is paper is presented to Trust Board having been discussed, challenged and recommended for approval at Audit Committee in December 2023 | | | |
| Prepared by: | Rob Webb – Director of Procurement | | | |
| Executive sponsor: (presenting) | Mark Ellis - CFO | | | |
| Appendices | N/A | | | |

## Recommendation

Due to the amount of capital projects being managed through the procurement service across the ICS and changes to the prioritisation of the capital plan on where money will be spent in the next 4 months and the potential last minute annual availability of funding, procurement are seeking approval for a short term flexibility to the procurement section of the SFIs supported by the Audit committee to be approved by Trust Board around:

1. Approving that at the discretion of the Director of Procurement a recommendation report does not need to be written for capital purchases that are placed via the NHS Supply Chain capital and equipment framework up to a value of £350k which is the Director of Procurement current sign off level. For audit purposes all capital purchases utilising this route would have purchase orders which reference approval against 7.12e within the SFIs. Any capital order above this value or outside of an ordering route via NHS Supply Chain will follow the current approval processes. For the avoidance of doubt this is just capital and will not be applicable for revenue contracts during this period such as maintenance. A retrospective procurement recommendation report would be written to capture any transactions processed via this approach or a light touch report as shown in Appendix 1 drafted to cover the purchase for audit and compliance purposes.

2. For capital purchases that are required due to late availability of funding or late changes in the capital plan that need to be made for year end, that fall outside NHS Supply Chain procurement routes as mentioned in step one, but can be procured compliantly to both SFIs and Public Contract Regulations via a direct award. It is proposed that procurement, at the discretion of the Director of Procurement, can utilise the light touch recommendation report form to record the assurance of the purchase up to £350k. This will enable faster turnaround of procurement requirements from the requirement to the approval of the contract to proceed and the order being placed rather than writing a full recommendation report but still hold the required information for audit and compliance an example report of the light touch template and what it requested is contained in Appendix 1 and offers flexibility in the speed of approach that procurement can turn projects during end of year capital.

3. That the option, if approved by the CFO, of Chairman's action supported by 2 NEDS can be taken and used for contract recommendation report approval for capital order values of £750k and above outside of F&P and Trust Board if the timing is such that

there is a critical reason (such as lead time for equipment) for ensuring approval between committees to place orders. This would then be reported at the next meeting.

## Executive Summary

Currently procurement has completed the procurement process and placed orders for 70% of the 2023/24 capital programme it can currently influence at this time so is in a better position than it has been in the past and this request is not for the reason of being behind plan but is requested as part of proactively planning based on experience of what frequently happens in the final 3 months of the year.

Traditionally at this time of the year annually the capital programme is often changed or reprioritised as additional last minute funding becomes available to be spent compliantly by the Trust in line with Standing Financial Instructions and Public Contract Regulations by the 31 March.

This creates a significant challenge for procurement to turn around procurements in very short time periods. However in acting in a proactive way to address this to enable us to move through the programme efficiently as and when any unforeseen opportunities materialize for additional capital purchases or changes to the capital plan, procurement have proposed some slight changes to the procurement process under the SFIs that will enable us to move at pace where required due to the annual recurring challenges to the capital plan in the final quarter of the financial year. These changes are at the discretion of the Director of Procurement to use where lead times and procurement processes need to be shortened whilst maintaining compliance and audit provisions and the CFO for values that would traditionally come to F&P for sign off.

This approach worked well in 2023/24 as procurement, capacity is pushed to the limit at this time of year across the ICS to give flexibility to manage the programme while staying in line with agreed SFI's. Some lessons learnt from last year were:

- Programme was delivered in full for year end with orders being placed in a timely way
- The procurement capacity could be juggled to meet all priorities
- No need for further additional temporary resource to manage the programme
- The flexibility to the rules were only used at the discretion of the Director of Procurement and only up to his level.
- The main volume of activity is for purchases between £10k and £300k
- Only having NHS SC frameworks covered by the route is limiting when both Estates and also IT have last minute requirements which we could not use this proposed flexibility for. Therefore this year are proposed to widen slightly.
- The requirement was only used by exception last year (twice) and is not the normal route but only used for unforeseen circumstances or reasons
- The reference in the Buyers note around compliance to 7.12e allows us to track and audit all orders placed under this route.

The normal recommendation report process takes time to write and document and is a critical part of the governance process. However to help deliver some level of flexibility to move the programme forward without creating unnecessary risk, procurement would like to ask that as last year some flexibility is offered under the Trust Standing Financial Instructions to the requirement of a recommendation report between January 2024 – March 2024 to enable procurement exercises to move through where lead times are critical.

Under the Trust SFI's procurement will write a recommendation report for anything over £25k. With so many supply chain challenges in all areas and fluctuating lead times with capital purchases we need to be as efficient and flexible as possible to ensure orders are placed in good time but effective governance is followed.

Therefore it is proposed that the following changes are agreed to enable more flexibility for procurement to enable the delivery of the capital programme at SFT and manage any unforeseen last minute availability of funding

1. Approving that at the discretion of the Director of Procurement a recommendation report does not need to be written for capital purchases that are placed via the NHS Supply Chain capital and equipment framework up to a value of £350k which is the Director of Procurement current sign off level. For audit purposes all capital purchases utilising this route would have purchase orders which reference approval against 7.12e within the SFIs. Any capital order above this value or outside of an ordering route via NHS Supply Chain will follow the current approval processes. For the avoidance of doubt this is just capital and will not be applicable for revenue contracts during this period such as maintenance. A retrospective procurement recommendation report would be written to capture any transactions processed via this approach or a light touch report as shown in Appendix 1 drafted to cover the purchase for audit and compliance purposes as discussed at the Audit Committee in December 2023.

2. For capital purchases that are required due to late availability of funding or late changes in the capital plan that need to be made for year end that fall outside NHS Supply Chain procurement routes as mentioned in step one but can be procured compliantly to both SFIs and Public Contract Regulations via a direct award procurement, at the discretion of the Director of Procurement can utilise the light touch recommendation report form to record the assurance of the purchase up to £350k. This will enable faster turnaround of procurement requirements from the requirement to the approval of the contract to proceed and the order being placed.
3. That the option, if approved by the CFO, of Chairman's action supported by 2 NEDS can be taken for contract recommendation report approval for capital order values of £750k and above outside of F&P and Trust Board if the timing is such that there is a critical reason (such as lead time for equipment or availability) for ensuring approval between committees to proceed with placing orders. Any action taken using this step would then be reported at the next meeting.

| 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): | |

Appendix 1 – please note example shown is fictious and GWH and is for illustrative purposes only of how the report works and is set out. (Document also included on iBabs).

# Procurement Approval Document for up to £350k

- In line with Trust Standing Financial Instructions, where the value of a proposed purchase **exceeds** the Trust SFI threshold for **Director of Procurement (£350k excl. VAT at SFT & GWH and £350k Incl. VAT for RUH)** approval, a full recommendation report needs to be completed.

| **1. TRUST DETAILS** | Complete all fields in this section. | **Please confirm if the procurement is a ONE-OFF PURCHASE, is RETROSPECTIVE and / or an STA / STW is being requested** | **RETROSPECTIVE** | **ONE OFF PURCHASE** | **STA / STW** |
|---|---|---|---|---|---|
| | | | **YES** ☐<br>**NO** ☒ | ☐ | ☐ |

| **TRUST** | SFT ☐ | GWH ☒ | RUH ☐ | WHC ☐ | BSW ICB ☐ | **FINAL APPROVAL REQUIRED FROM** | |
|---|---|---|---|---|---|---|---|
| **PROCUREMENT MANAGER** | Lauren Smith | | **PROCUREMENT LEAD JOB TITLE** | | Procurement Manager | **DDOP ☐** | **DOP ☒** |
| **DIVISION/S** | **SFT**<br>CORPORATE ☐<br>CS AND FS ☐<br>FACILITIES ☐<br>MEDICINE ☐<br>SURGERY ☐<br>WOMAN AND NEWBORN ☐ | | **GWH**<br>CORPORATE, ESTATES AND FACILITIES ☐<br>INTEGRATED AND COMMUNITY CARE ☐<br>Medicine ☒<br>SURGERY WOMENS AND CHILDRENS ☐ | | **RUH**<br>CORPORATE DIVISION ☐<br>FACILITIES DIVISION ☐<br>FAMILY AND SPECIALIST ☐<br>SERVICES DIVISION ☐<br>MEDICAL DIVISION ☐<br>SURGICAL DIVISION ☐<br>SULIS HOSPITAL ☐<br>WEAHSN ☐ | **WHC**<br>WHC - CLINICAL ☐<br>WHC - NON-CLINICAL ☐ | **ICB**<br>ICB ☐ |

| **2. PROCUREMENT DETAILS** | Complete all fields in this section. The cost should **INCLUDE the total cost with maximum extension.** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **ACTIVITY TITLE** | The supply of 2 ultrasound machines with maintenance | | **CONTRACT REFERENCE** | G/12076/CAP /LS/423 | | | | | |
| **GOODS/SERVICE or WORKS?** | GOODS ☒<br>SERVICES ☒<br>WORKS ☐ | **INITIAL TERM START DATE** | On delivery (4-6 week lead time) | **INITIAL TERM END DATE** | **5 years from delivery** | **EXTENSION PERIODS** | **n/a** | **END TERM DATE INCL. EXTENSIONS** | **5 years from delivery** |
| **PROPOSED SUPPLIER(s)** | MIS Healthcare | | | | | | | | |
| **TOTAL PROCUREMENT VALUE (inc. any extension option)** | **TOTAL CONTRACT VALUE EXCL. VAT** | £165,490 | | **TOTAL CONTRACT VALUE INCL. VAT** | £192,836<br>(VAT is reclaimable on maintenance) | | | | |

# Procurement Approval Document for up to £350k

**PROJECT TEAM / WHO HAS BEEN INVOLVED**

*Must include stakeholders, finance, capital stakeholders where appropriate and enabling stakeholders i.e. IT/IG Infection control*

***Stakeholders to sign here to reflect their approval and support.***

| TRUST | NAME | JOB TITLE | SIGNATURE | DATE | COMMENTS |
|---|---|---|---|---|---|
| **GWH** | Lauren Smith | Procurement manager | | | |
| **GWH** | Stewart Thompson | Trust Equipment Manager | | | |
| **GWH** | Anil Lall | Capital Account | | | |
| **GWH** | Julia Cherrill | Lead Sonographer | | | |
| **GWH** | Virginia Harriss | Finance Business Partner | | | |

| | |
|---|---|
| **THE RECOMMENDATION** | This contract recommendation report is seeking approval from Director of Procurement and Commercial Services to award a contract to MIS Healthcare via NHS Supply Chain framework agreement for Ultrasound Scanners and associated options and related services for the provision of Two Ultrasound scanners with maintenance, for an initial period of 5 years, with no options to extend. |
| **WHAT IS THE REQUIREMENT** | Replacement of 2 ultrasound scanners in the scanning depart at GWH which have reached end of life. |
| **WHY THE REQUIREMENT IS NEEDED** | To release operational or commercial benefits ☐<br>Current equipment has reached end of life ☒<br>Existing contract is expiring ☐<br>A business case has been approved ☐<br>Support transformation / strategic change in the division ☐<br>The requirement is on the capital programme ☒ |
| **KEY DRIVERS AND OBEJCTIVES** | To create a cash releasing saving ☐<br>To mitigate risk to a disruption of patient care and / or services ☒<br>To support delivery of the capital programme ☒<br>To improve services and / or patient care ☒<br>To support the strategic direction of the division / Trust / ICS ☐ |

# Procurement Approval Document for up to £350k

| **3. COMPLIANCE** | | | |
|---|---|---|---|
| **IS THE CONTRACT VALUE OVER PCR THRESHOLD?** | YES ☒<br><br>NO ☐ | | |
| **ROUTE TO MARKET TO COMPLY WITH TO PCR** | Full PCR Compliance Tender ☐<br>Through framework that offers compliance to PCR ☒<br>Local tender ☐<br>Made compliant via a VEAT ☐<br>Made compliant via specific Regulations (explain below) ☐<br>PCR not applicable (explain below) ☐ | **COMPLIANCE TO SFI'S** | Appropriate level of competition ☐<br>Where competition need not apply, and a waiver is not required, confirm the specific SFI **section reference below** ☒<br>Through and STA / STW ☐<br>SFI's are not applicable ☐ |
| **ADDITIONAL INFORMATION TO SUPPORT COMPLIANCE TO PCR** | Direct award via NHS SC, providing standardisation to Samsung model brought last year. | **ADDITIONAL INFORMATION TO SUPPORT COMPLIANCE TO SFI'S** | 2.8.13f |

| **4. PROCUREMENT PROCESS ADOPTED** | Select the appropriate process adopted for this procurement activity from the options below. | | | | | |
|---|---|---|---|---|---|---|
| **Local** | | **Framework** | | **Direct Negotiation** | | **Other** |
| **Request for Quotation** | **Local Tender** | **Mini competition** | **Direct award** | **Sole Supply** | **Bespoke Technical / Clinical Requirement** | **PCR / Other (please detail below (6.1)** |
| ☐ | ☐ | ☐ | ☒ | ☐ | ☐ | ☐ |
| **Summary of process / framework used and why** | Direct award via NHS SC framework 2021/S 000-007768, providing standardisation to Samsung model brought last year. | | | | | |

| **5. ADDITIONAL GOVERNANCE** | | | |
|---|---|---|---|
| **DECLARATION OF INTEREST** | Has a declaration of interest form been completed by all members of the project team?<br><br>Yes ☒<br>No ☐ | | |

# Procurement Approval Document for up to £350k

| | | | |
|---|---|---|---|
| **INFOMRATION GOVERNANCE** | Is personal data being processed as part of this contract and therefore a Data Protection Impact Assessment is required to be completed?<br><br>Yes ☐<br>No ☒ | Has a (DPIA) form been completed and approved?<br><br>Yes ☐<br>No ☐ | Is a DTAC required and been completed and approved?<br><br>Yes ☐<br>No ☐ |
| **IT** | Does the purchase include Software that requires integration with the IT network?<br><br>Yes ☐<br>No ☒ | Are IT aware and have approved the implementation? | Please detail any additional network considerations: |
| **IFRS16** | Is IFRS16 applicable to this procurement?<br><br>Yes ☐<br>No ☒ | | |
| **IR35** | Is IR35 Applicable to this procurement?<br><br>Yes ☐<br>No ☒ | | |

| **6. CONTRACT MANAGEMENT** | | | | |
|---|---|---|---|---|
| **CONTRACT MANAGEMENT** | What is the contract classification?<br><br>Gold ☐<br>Silver ☐<br>Bronze ☐<br>N/A ☒ | how often will the contract meetings take place?<br>Monthly ☐<br>Bi monthly ☐<br>6 monthly ☐<br>Annually ☐<br>N/A ☒ | How involved does the stakeholder need to be?<br>High ☐<br>Medium ☐<br>Low ☐<br>N/A ☒ | What will the role of the stakeholder be?<br>R- Responsible ☐<br>A - Accountable ☐<br>C - Consulted ☐<br>I – Informed ☐<br>N/A ☒ |
| **KEY PERFORMANCE INDICATORS (KPIS)** | Are KPI's included in the contract?<br><br>YES ☐<br>NO ☒ | If yes, how will the supplier be held to account? | | |

# Procurement Approval Document for up to £350k

| | | |
|---|---|---|
| **SOCIAL VALUE** | Briefly describe how social value has been considered in the procurement process. | NO, this wasn't captured in this process ☒ |
| **SUSTAINABITY** | As part of the procurement, has consideration been given to procure with sustainably responsible suppliers?<br>YES ☐<br>NO, this wasn't captured in this process ☒ | If yes, has the supplier committed to support the Trust to meet NHS Commitments to reach Net Zero by 2045?<br>YES ☐<br>NO, this wasn't captured in this process ☒ |

| **7. EVALUATION CRITERIA** | | | | | |
|---|---|---|---|---|---|
| **TECHNICAL WEIGHTING PERCENTAGE** | **60%** | | | | |
| **FINANCIAL WEIGHTING PERCENTAGE** | **40%** | | | | |
| **TOTAL** | **100%** | | | | |
| **EVALUATION CRITERIA BREAKDOWN** | | | | | |
| **Supplier** | **Technically Compliant** | **Technically score?** | **Financial Score** | **Overall Score** | **Ranking** |
| MIS Healthcare | Yes | 60% | 40% | 100% | 1 |

| **8. FUNDING SOURCE** | Confirm where any funding is coming from – if relevant please detail the date of any Trust Investment Committee approval within funding notes. | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Trust Revenue** | ☒ | **Ext. income (rev.)** | ☐ | **Trust Capital Funding** | ☒ | **Charitable Funding (capital)** | ☐ | **Specific PDC Funding (capital)** | ☐ | **Funding Not Specified** | ☐ |
| **FUNDING NOTES** | Revenue budget for the maintenance aspect<br>Capital funding for the purchase of the equipment. | | | | | | | | | | |

| **BREAKDOWN OF CONTRACT SPEND CAPITAL & REVENUE** | |
|---|---|
| **CAPITAL** | **GWH** |
| **CAPITAL BUDGET AVAILABLE** | £192,000 |
| **COST OF ACQUISITION INCL. VAT** | £164,088 |
| **VARIANCE TO BUDGET INCL. VAT** | £27,912 |

# Procurement Approval Document for up to £350k

| | |
|---|---|
| **SAVING / COST PRESSURE** | Cost Avoidance |
| **RECURRENT / NON RECURRENT** | **Non Recurrent** |
| **REVENUE** | |
| **CURRENT ANNUAL BUDGET EXCL. VAT** | £1,780 |
| **PROPOSED ANNUAL SPEND EXCL. VAT** | £7,187 |
| **FINANCIAL IMPACT PER ANNUM INCL. VAT** | £5,407 |
| **SAVING / COST PRESSURE** | Cost Pressure |
| **RECURRENT / NON RECURRENT** | Recurrent |
| **CURRENT REVENUE BUDGET OVER LIFE OF CONTRACT EXCL. VAT** | £8,900 |
| **PROPOSED REVENUE SPEND OVER LIFE OF CONTRACT INCL. VAT** | Year 1 = £0 (Warranty)<br>Year 2 = £7,187<br>Year 3 =£7,187<br>Year 4 = £7,187<br>Year 5 = £7,187<br>Total = 28,748 |
| **WHOLE LIFE COST INCL. VAT** (VAT is reclaimable on maintenance) | £192,836 |

| **9. RISKS** | |
|---|---|
| **RISKS** | **MITIGATION** |
| 1. Capital funding must be spent (delivered and invoiced) by 31st March 2024 | 1. Current lead time is 4- 6 weeks |
| **2.** | **2.** |
| **3.** | **3.** |

# Procurement Approval Document for up to £350k

| **10. ADDITIONAL INFORMATION** | You may use this section to provide additional information and to **insert any appendices** referenced.<br>Section headings are provided as a guide, but you only need to complete where needed and relevant. |
|---|---|

- **Baseline spend / benchmarking** – (Details of existing costs and any comparison exercise conducted.)
- **Supplier & market review** – (Details of suppliers approach and why, selection criteria and market review/conditions.)
- **Appendices**

| **11 . COMPETITIVE PROCEDURE STA/STW** | When the rec report is accompanied by an STA authorisation to waive competitive procedure process, select the reason from then options below and add a summary justification below.- if the process is not being waived this section does not need to be completed | |
|---|---|---|
| **Extreme Urgency** | **Renewal with existing supplier / Interim arrangement** | **Retrospective Request** |
| ☐ | ☐ | ☐ |
| Where a delay in ordering could create issues with supply or delays in patient treatment. | Where changing supplier could create issues with supply or increased costs (e.g. switching IT network supplier), or this is an interim arrangement while a full procurement process is undertaken. | The goods / service already received. The justification will need to explain why approval was not possible before goods were ordered / works commenced. |
| Embedded STA /STW | | |

# Procurement Approval Document for up to £350k

This recommendation is supported by the stakeholders and has been signed by procurement and the stakeholder representatives below in recognition of this proposal to award.

In accordance with Trust Standing Financial Instructions the **Choose an item.** is requested to approve the award of this contract on behalf of **Choose an item.**

| Approval | Name | Signature | Date | Comments |
|---|---|---|---|---|
| **Procurement Lead** | **Lauren Smith** | | | |
| **Director of Procurement and Commercial Services** | **Rob Webb** | | | |

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 2.3 |
| Date of meeting: | 11th January 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report from (Committee Name): | Charitable Funds Committee | | Committee Meeting Date: | 12/12/23 |
| Status: | Information | Discussion | Assurance | Approval |
| | | | x | |
| Prepared by: | Ian Green, Chair | | | |
| Non-Executive Presenting: | | | | |
| 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.** |
| • **Statutory Accounts will need to be considered and approved by the Board meeting a corporate trustee. The committee reviewed the accounts with the auditor present at the committee and recommends their approval** |
| **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 charity remains healthy with assets of £14.7 million with approximately £ 8 million being unrestricted**<br>• **The charity doesn't currently have an income budget. This will be rectified for the start of the new financial year.** |
| **ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.** |
| • **Charity operation/governance - further work needed to obtain assurance regarding the on-going governance and operation of the charity to align with the Trust's strategy** |

| **Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.** |
|---|
| • Approval of statutory accounts (by the Board acting as corporate trustee) |

| 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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| | | | |
|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 3.1 |
| Date of meeting: | 11th January 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report title: | Quarterly Strategy Update | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | X | | X | |
| Approval Process: (where has this paper been reviewed and approved): | | | | |
| Prepared by: | Tony Mears, Associate Director of Strategy | | | |
| Executive Sponsor: (presenting) | Lisa Thomas, Chief Operating Officer & Deputy CEO | | | |

## Recommendation:

That the Board **note** progress made against the three 'P' priorities, and the associated 'vision metrics'. Including the allocation of project support / resource.

That the board **note** the completion of response submission by all clinical specialties to the main Trust strategy, the structure of those responses, and the next steps.

## Executive Summary:

In the previous quarter we have continued to make progress on our strategy deployment. This takes place through two principal routes – the 'Improving Together' methodology and service strategy responses. This allows us to foster both top down strategy deployment and bottom up service led engagement in how to bring our strategy to life.

The vision metrics are measuring our progress over 10 years and so significant movement isn't expected but progress is underway and the executive team also monitor and challenge this every quarter in 'Engine Room' strategy deployment sessions.

The service strategy response have been submitted and cross-cutting Trust leaders have scrutinised first cut analysis. Deeper analysis is underway and will be brought as a full report to board in February along with a showcase event for board that will provide the opportunity to engage directly with specialties.

| 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): | |

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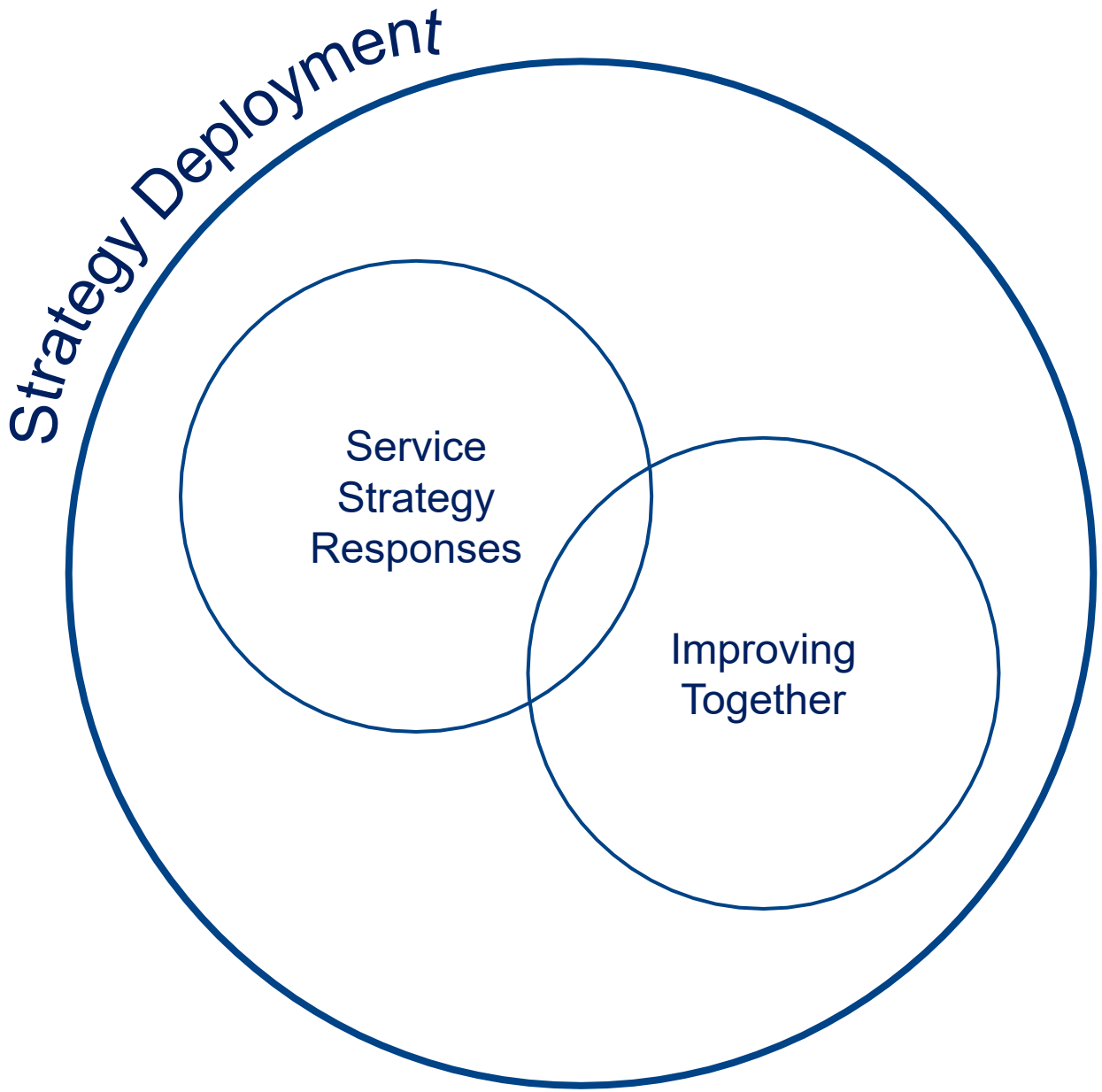
# Quarterly Strategy Update

Our Strategy 2022-26

IMPROVING together




How do our services help us deliver our strategy? What does it mean to them?

Service Strategy Responses

Operationalising our strategy from board to ward.

Improving Together

# Our Priorities & Progress Against Vision Metrics

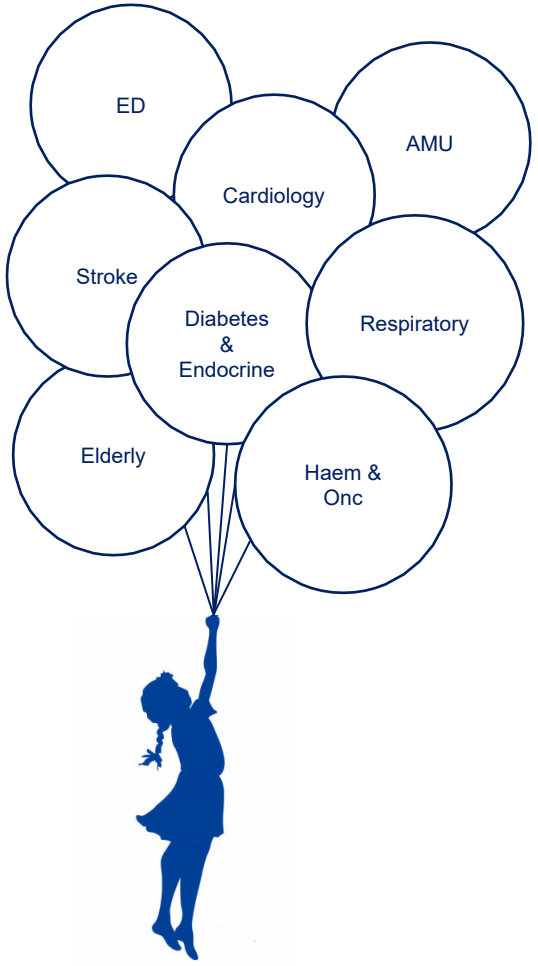
| | | |
|---|---|---|
| ***People*** | Proportion of WDES & WRES at median | Ongoing development of masterclasses and workshops to develop line managers knowledge and skills are key identified actions for commencement in 2024. |
| | Reduction of unwanted turnover | Further understanding of the root causes for staff turnover and 'highest contributors' have been identified, with further targeted focus work underway using 'Go and See' methodology. |
| | Engagement score in staff survey | Publication of the people survey results are imminent with improvement on our previous score expected. |
| ***Population*** | Patient engagement score | Further review of this metric has been undertaken in the last 3 months, with improvements in data collection methods being identified to ensure accessibility across all areas of the Trust. |
| | Total incidents with moderate or high harm | Cleansing of harm data by risk (staff vs patient harm) is being completed. Triangulation to staff survey results and FFT feedback will be considered as part of this review. Strong progress on 'falls' with attention now turning to the next top contributor to harm. |
| | # of wait metrics at median | Theatre utilisation has increased, diagnostic activity has increased due to deployed CDC capacity, and DNA rates have been reduced. |
| ***Partnerships*** | Organisational Sustainability | The A3 thinking for this is in first draft stage and encompasses all the elements we need to be a truly sustainable organisation: finance, environmental, and our role as an anchor institution. |
| | Overall length of stay | Identification and understanding of the variability of inpatient ward processes has gained momentum, with an increased number of wards running improvement huddles to generate ideas for improvement and reviewing existing ways of working. In addition, the Discharge hub is running - including weekly reviews of no criteria to reside status. |
| | Increase in healthy life years | We have steered £0.8m of ICB funding toward our data led priority areas and continue working closely with partners at place. A showcase of ongoing work is planned for Spring 2024. |

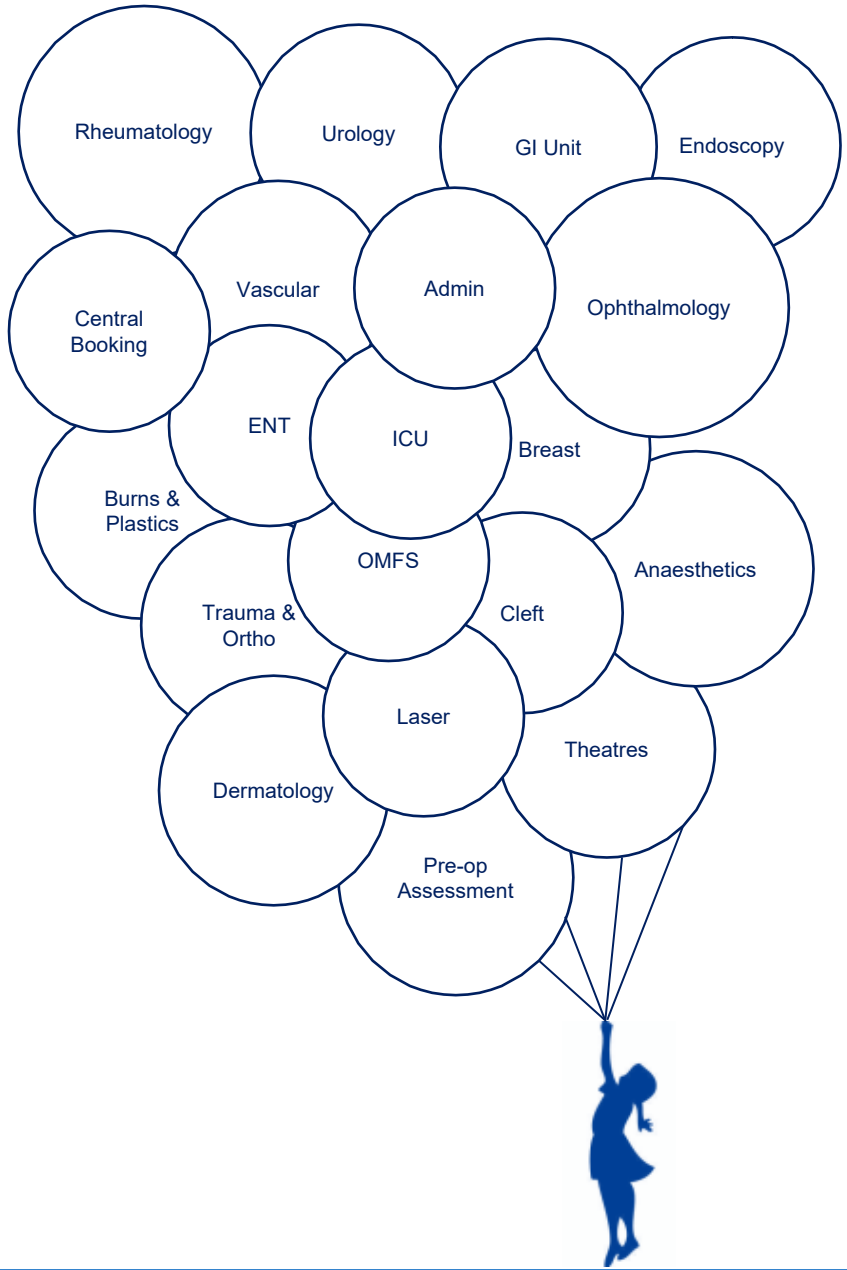
# Projects Supporting Strategy Deployment

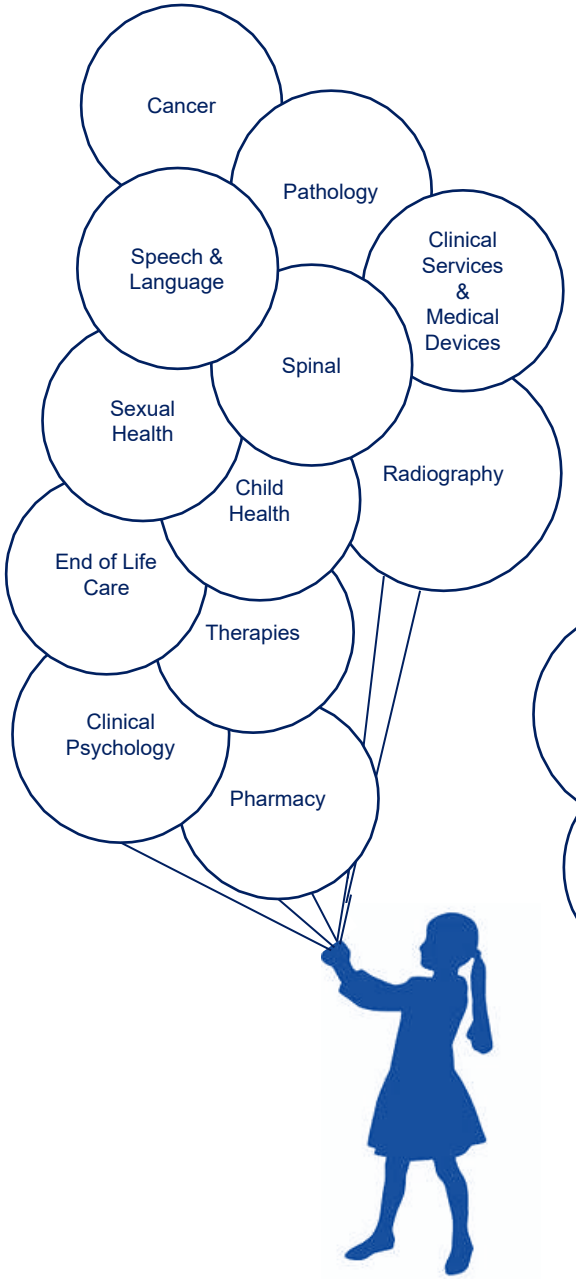
| MISSION CRITICAL | Filter Priority |
|---|---|
| **Strategic Initiatives** | |
| Electronic Prescribing and Medicines Administration (EPMA) | Delivering Digital Care |
| RPA automation (robotic process automation) | Delivering Digital Care |
| Pathology LIMs | Delivering Digital Care |
| Paperlite Discharges in Lorenzo | Delivering Digital Care |
| BSW Shared EPR | Delivering Digital Care |
| Graphnet Integrated Care Record | Delivering Digital Care |
| Maternity EPR | Delivering Digital Care |
| Health Inequalities Portfolio Oversight | Improving Health and Reducing Health Inequalities |
| People Promise | Creating a sustainable workforce |
| **Mandated/time Sensitive** | |
| Data Warehouse | Mandated |
| Server Refresh | Mandated |
| Additional ward (new build) | Mandated & Vision Metric: Timely access to care |
| Additional ward (operationalisation) | Time sensitive & Vision Metric: Timely access to care |

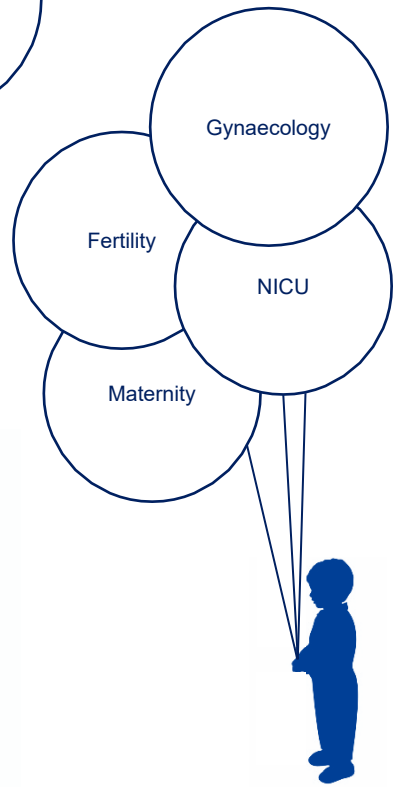
| IMPORTANT | Filter Priority |
|---|---|
| **Breakthrough Objectives** | |
| Outpatient Huddles | Time to 1st OPD |
| Outpatients Cinnapsis Advice & Guidance | Time to 1st OPD |
| Dr Doctor : digital letters | Time to 1st OPD |
| Dr Doctor : digital assessments | Time to 1st OPD |
| IECCP Outpatients | Time to 1st OPD |
| Paperlite e-documentation (phase 2) | Falls |
| E-rostering and medical rostering | Staff Availability |
| Overhauling recruitment | Staff Availability |
| ESR establishment | Staff Availability |
| SDEC (same day emergency care) | Bed Occupancy |
| **Mandated/Time sensitive** | |
| Patient Safety Incident Framework (PSIRF) | Mandated & Vision Metric : incidents of harm |
| Multi-Factorial Authentication (MFA) | Mandated |
| Maternity Improvement Plan | Time Sensitive |
| Gastro Intervention | Patient Safety |
| Mortality system | Patient Safety |
| PACs | Delivering Digital Care SI |
| Paperlite (other) | Delivering Digital Care SI |
| Friends and Family test text messaging | Vision metric: patient engagement score |

# Service Strategy Responses



# Service Strategy Response Structure

- Service level SWOT analysis
- Current service demand and capacity
- Patients of today and in the future
- Service level 10-year vision
- Service level priorities 1, 3-5, 7-10 years
- How and with whom the response was developed
- Service level activity to deliver the 3 Ps
- Workforce
- Estate
- Digital
- Equipment
- National Context inc Model Hospital and GIRFT
- Upcoming regulatory changes
- ICS, AHA, and Wessex elements
- Service risks
- Service interdependencies

# Next Steps

***Broader Analysis***

***Board Showcase***

***Board Paper***

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Our **Strategy** 2022-26

# IMPROVING together

Service | Teamwork | Ambition | Respect

Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | Trust Board (Public) | **Agenda item:** | 3.2 |
| **Date of Meeting:** | 11 January 2024 | | |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Estates Technical Services Quarterly Update – January 2024 | | | |
| **Status:** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | x | | x | |
| **Approval Process** (where has this paper been reviewed and approved) | | | | |
| **Prepared by:** | Brian Johnson, Director of Estates<br>John O'Keeffe – Head of Estates<br>Edmund Ellert – Head of Capital<br>Tom Sneddon – Interim Deputy Head of Estates | | | |
| **Executive Sponsor** (presenting): | Brian Johnson, Director of Estates | | | |
| **Appendices** (list if applicable): | Appendix A – Estates Technical Services Report January 2024 | | | |

| **Recommendation:** |
|---|
| Trust Board is asked to note the content of the paper summarising the work of the Estates Technical Services (ETS) and Capital Projects teams during the last quarter, including current and ongoing risk positions. |

| **Executive Summary:** |
|---|
| Our staff position remains good and we have now reduced vacancies to 2.5 WTE. We have no long-term absences.<br><br>Our MLE compliance has reduced slightly from previous quarter, to 89% due to new starters but this will be addressed during January and we are confident our compliance rates will move back to the very high levels previously sustained.<br><br>Our department appraisal rates are currently 87%, a slight reduction on previous quarter.<br><br>Our work on compliance and estates risks is continuing to reduce volume and classification of risks. We now have three extreme risks remaining and have made progress toward closing one risk, reducing the ratings of the remaining two.<br><br>Overall we have now reduced the total number of estates specific risks from 383 to 175. |

| | | Extreme | High | Moderate | Low | Total |
|---|---|---|---|---|---|---|
| **This Period** | **Remaining** (by **Current** Risk Score) | 3 | 104 | 61 | 7 | 175 |

We are maintaining our planned trajectory to close all extreme and high risks by year-end, reduce any residual risks to medium or low categorisation. This will prompt us to close the compliance action plan and convert the remaining items to business as usual within the department. This has been an extensive program of work over the last 2-years within the team.

Our Capital delivery program continues at pace to deliver £30m via 42 individual projects, within this financial year. The decarbonisation project is progressing well with the completion of new windows and fabric improvements. New large scale heat pumps have been delivered and roof level photo voltaic panels are installed across the estate.

Progress on the new Estates strategy is good, although we are working with clinical colleagues to ensure engagement with our consultant team to ensure inclusion of all relevant data and content, as this aspect has slipped slightly. We are currently confident of recovering this slippage and it has not yet impacted our overall program.

Lastly, the Director of Estates is leaving the Trust at the end of February having supported SFT for 2-years. Reporting will continue to F&P committee and Trust Board on a quarterly basis. Discussions are in progress with executive colleagues regarding continuity of leadership and reporting for the Estates and Capital teams.

| **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)** – Long term strategic and sustainable benefits for the SFT campus, supporting the effective delivery of health services. | ☒ |

**Appendix A – Estates Technical Services Report – January 2024**

## 1.0 Introduction

This is the quarterly update to Trust Board (Public) for activity within the Estates Technical Services (ETS) and Capital Project teams.

## 2.0 Staff

Our staffing levels have improved again since the last report. We have recruited to the Multi Skilled Band 5 position. This will provide more internal resources and continue to allow a reduction in the use of external contractors.

We continue meetings with our people business partner and recruitment team to discuss vacancies which currently stand at 2.5 WTE roles (3.5 WTE last report). We have been invited to the new Weekly Divisional Workforce Control Panel (Corporate) meetings to discuss and manage vacancies appropriately.

The deputy estates officer operations role has been running for a number of months now and has helped with the effective day-to-day operational side of the department and the role is now being considered for permanent funding (was the only post not previously approved within our 2023-24 business planning and estates business case).

Our latest staff position is below.

| Description | No. | Notes |
|---|---|---|
| **Estates Posts** | **38.5** | **Includes vacancies.** |
| Vacancies | 2.5 | Band 7 Senior Estates Officer (Mechanical/Electrical) – Currently out to advert<br>B2 Mechanical Assistant – Currently in the recruitment pipeline.<br>B5 Energy manager. (part-time 0.5) working in collaboration with RUH for a joint post. Interviews taking place in January. |
| **Sub Total** | **36** | |

Our MLE compliance remains high at 89% (95% last report), but hand hygiene is below target due to the availability of courses (an issue relevant to the whole organisation, not specific to Estates).

Our new starters and the Christmas period has seen a slight drop in compliance but we are confident this will be addressed and we will return to the very high levels of compliance consistently delivered over the last year.

Estates mandatory training includes requirement for our staff to complete Level 2 Safeguarding and Life Support training courses. We are checking the relevance of this to our staff and discussing with the MLE team. (Note: Estates staff do complete Level 1 Safeguarding training).

## Top Level by Training Title

| KEY: | 0-79% | 80-84% | 85-100% |
|---|---|---|---|

Report database last refreshed on 02/01/2024 at 03:35:39

| Training Title | Number complete | Number incomplete | Number in target group | Compliance |
|---|---|---|---|---|
| Adult Basic Life Support 122014 | 1 | | 1 | 100% |
| Equality and Diversity 122014 | 31 | | 31 | 100% |
| Fire Safety 122014 | 26 | 5 | 31 | 84% |
| Hand Hygiene Assessment 122014 | 22 | 9 | 31 | 71% |
| Infection Control 122014 | 28 | 3 | 31 | 90% |
| Information Governance 122014 | 28 | 3 | 31 | 90% |
| Moving and Handling 122014 | 27 | 4 | 31 | 87% |
| Prevent - 122014 | 29 | 2 | 31 | 94% |
| Safeguarding Adults Level 2 - 122014 | 2 | | 2 | 100% |
| Safeguarding Children Level 1 122014 | 27 | | 27 | 100% |
| **Overall:** | **221** | **26** | **247** | 89% |

Appraisal rates for the estates team are currently at 87% (previously reported 89%). We have some new starters showing as out of date which we believe to be a system error.

### 3.0 Compliance

Overall we continue our trajectory of closing and mitigating risks from the Estates compliance report. The table below indicates we are now reduced to three (3) extreme risks, although as previously highlighted some of our mitigation actions do transfer risks into lower rating categories as we work toward concluding them. We have seen an overall reduction in risks and continue toward our year end trajectory which is to close all extreme and high risks and convert the remaining moderate and low risks to *business as usual*, with closure of the compliance report activity.

| | | Extreme | High | Moderate | Low | Total |
|---|---|---|---|---|---|---|
| **Initial Risks** | **Initial Risks** | 286 | 95 | 2 | 0 | 383 |
| | **Closed** (by **Initial** Risk Score) | 149 | 58 | 1 | 0 | 208 |
| | **Remaining** (by **Initial** Risk Score) | 137 | 37 | 1 | 0 | 175 |
| **Risks Changed/Moved** | **Risk Mitigated** (+/-) due to mitigation in place | -283 | 9 | 59 | 8 | -207 |
| **This Period** | **Added** in this reporting period. | 0 | 0 | 0 | 0 | 0 |
| | **Remaining** (by **Current** Risk Score) | 3 | 104 | 61 | 7 | 175 |
| | | | | | | |
| **Change during reporting period** | | -2 | -48 | 10 | 4 | -36 |

The remaining three extreme risks from the compliance report are extracted below with a corresponding narrative.

| ID | Source of Risk Data | Risk |
|---|---|---|
| 41 | AE Audit | Pressure Systems in operation beyond their inspection date |
| 249 | PAM Audit | Pressure Systems/ Maintenance: PPM regime's slipped and resolution required |
| 197 | PAM Audit | Estates and Facilities Operational Management/ Maintenance: CAFM and PPM regime's inadequate |

**Risk 41**
During the reporting period, equipment beyond inspection dates have been reviewed and assessed.

41 pressure system assets were scheduled for inspection with the insurance inspectors, with 14 reported compliant with PSSR); 1 asset was reported to have a defect which has now been resolved.

26 assets were rated not accessible (or not located) on the day of inspection and have been subject to further review. A number have been identified as obsolete and should be removed from our written scheme, with the remainder identified and subject to a re-visit from the insurance inspector during January.

This risk cannot yet be fully closed and is pending a second inspection visit, although we will target closure of this extreme risk by late January/early February.

**Risk 249**
Planned preventative maintenance (PPM) regimes had previously slipped, this was partly due to a lack of suitably qualified staff appointed as Competent Persons (CPs) and Authorised Persons (APs) able to undertake the planned maintenance.

We have completed external training of Competent and Authorised Persons (CPs and APs). Maintenance of pressure systems equipment that was recorded as slipped are now being maintained on a reactive basis.

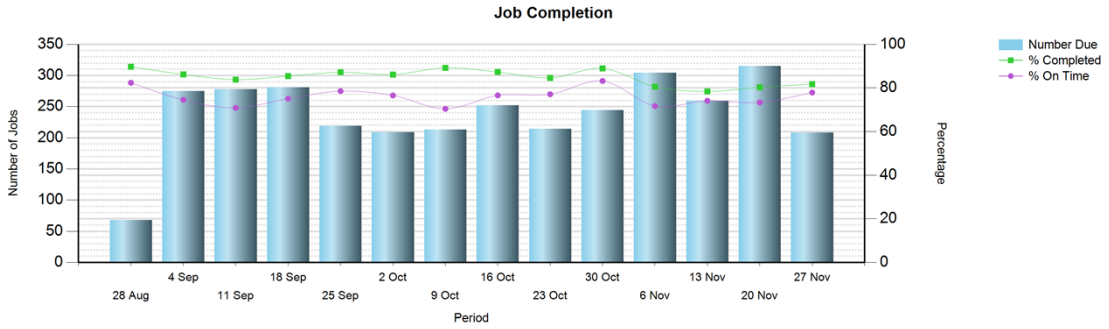
We will complete the formal appointment records of CPs and APs in the coming weeks, and this activity in combination with the reactive maintenance will reduce the risk from extreme to moderate.

**Risk 197**
As noted previously, the Estates CAFM system is life expired and no longer supported. Current database content is insufficient for comprehensive planned maintenance of assets and we are progressing procurement activity with the open market to seek a replacement system.

Specification and procurement work has progressed in combination with the RUH as we are looking to purchase a single new system that will enable coverage of both Trust Estates. We are meeting with prospective bidders in mid-January and target end of financial year (March 2023) to complete the procurement exercise and submit a report to the Trust with final recommendations.

As previously reported, mitigations are already in place via the extension of the Shire system from the RUH to improve operational management of estates planned maintenance of the Salisbury campus. We are reviewing current mitigations to determine if this permits the existing extreme rating to be reduced, although the risk is likely to remain as High or moderate until a replacement CAFM system can be implemented.

**4.0 Estates Maintenance**
The data for September - November 2023 is shown below. (Data is shown for full month activity. Due to data *lag* December data is not yet available).




**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** |

During this quarter, we are consistent with quantity of planned maintenance activity (PPM) with emergency call outs (ECO) increasing by 27% and helpdesk calls reducing by 15%.

We previously highlighted the demands on emergency and reactive call-outs to blocked drainage. Despite implementing a 5-point response plan and increasing comms we are not seeing any reduction in blocked drains primarily caused by flushed wipes.

**5.0 Capital Delivery**

The capital team are now entering the final quarter of a very challenging year, delivering more than £30m of construction works, including £22m of external funding with the additional pressure to ensure all monies are drawn down.

The main contractor delivering the new Ward has encountered many challenges since starting on site early in 2023, but the Estates team have risen to the challenge and are on course to accept handover of the 24 beds by the end of March this year. Imber Ward is expected to be open to patients in early May following a period of commissioning and fitting out equipment as well as clinical staff becoming familiar with their new environment. External landscaping will continue separately through to early summer as the team are working with the contractor for this to be delivered as part of a social value initiative.

As part of the £10m Salix funded decarbonisation scheme, various net zero carbon works are underway across the estate. Photo voltaic panels are being installed on the roofs of numerous buildings, with the south facing roofs of SDH North receiving the most panels and will be the last to be completed. Replacement windows and insulation have been installed to Odstock Leisure Centre and the Spinal Unit, where air source heat pumps will also be commissioned with additional units serving the energy centre.

The Trust's 12% capital contribution to the Salix funding is commissioning a geothermal feasibility study; unfortunately, this has encountered a problem as the Trust has been unable to secure the consent of landowners for our contractor to undertake seismic surveys within the proposed timeframe. As the study won't be complete until midway through the next financial year there will be some slippage in the capital spend profile.

We have previously reported the age of the energy centre chimneys and associated risks, with a requirement for replacements. The current decarbonisation project will reduce the number of gas fired boilers in operation on campus and this will equally reduce the quantity of boiler flues, resulting ultimately in a requirement for one chimney rather than the two currently in situ. Mitigations are in place to regularly monitor the condition of the chimneys and we are undertaking non-destructive testing to gain further data on the condition of the chimneys.

The Trust has now placed orders for the replacement of both CT 1 & CT2, this is later than originally planned due to internal decision making whether to purchase or lease the equipment. Estates are liaising with the PFI to ensure completion of the enabling works allowing CT2 to be installed in this financial year, whereas the enabling works for CT1 will carry-over into 24/25.

The consultant team appointed to undertake the Estates Strategy have made good progress, although engagement with clinical divisions has been compromised by the lack of availability of staff which will cause a slight delay to circulation of the final report.

Following the refurbishment of the Douglas Arter Centre (DAC), we continue to review the process of space allocation to reduce the risks associated with re-occupying vacant space, particularly within areas of SFT South. The accommodation in this area of the estate is particularly poor and we are seeking to vacate further and undertake demolitions at the earliest opportunity, reducing both backlog and risk from our estate.

Otherwise, progress is well underway with delivery of the remainder of the CDEL allocation across the Trust estate which has various challenges. The refurbishment of Whiteparish ward was completed to programme in early October and the discharge lounge for Day Surgery Unit was also completed just before Christmas.

The following lists all projects in progress and due for completion in year. Project status is regularly reviewed via the capital group;

**Project Name**

Operational Requirements
Traffic Management consultant
PSDS Phase 3 Capital Contribution
New gas rig and meter to feed site
Electrical remedials following EICR
Fixed Wiring Testing
Nurse Call replacement
Standby generators
Lift replacement/repairs
Energy Centre Flues
UPS replacement
UPS system replacements
Water tank replacement and upgrade
Air handling unit - ultraclean
Theatre 8 SDH North - bring back into use
CT pipework replacement
Screening to chiller compound & controls
Replacement gas rig
Cardiac Cath lab cooling

- Theatre ventilation (pressure stabilisers)
- Oncology nurse call
- Theatre lights
- Fire Door Replacement SDH North
- Fire stopping - remedial from survey (year 1)
- Fire stopping - SDH North
- Carpenter workshop machinery
- Flooring issues
- Spinal walk way Side protection
- Window restrictors - asset list and assessment
- Fire Alarm refurbishment
- SDH North Fire Strategy
- Emergency light fittings
- Bollards
- Replacement roller shutter door R&D entrance
- Cardiology Move to Physiology
- CT Scanner Works
- Whiteparish ward refurbishment
- Estates Strategy - design development
- Elective Ward Decant
- DSU Discharge lounge
- CDC Salisbury Spoke project
- MRI L3
- Helipad - VAT cost

With the BSW commitment to invest in the EPR system over the next 3-years, as previously reported capital availability will become highly constrained. 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. Clearly some difficult decisions lay ahead regarding allocation of capital and our ability to maintain a safe estate.

In response to a reduction of estates capital over the next 3-years, consideration is being given to resource requirements. During the new financial year we will also undertake a wholesale review of capital project systems and processes to improve the delivery of capital allocations, year-on-year.

We are currently undertaking additional diligence on the planning and forecasting of our estates backlog works, to ensure transparency of the backlog program alongside the 5-year capital program.

**6.0 Governance and Risks**

As noted above, the BSW commitment to invest in the EPR system over the next 3-years will result 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.

No new risks are identified within this report.

| | **Risk** | **Action** |
|---|---|---|
| | None this report | |

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 4.1 |
| Date of meeting: | 11 January 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report tile: | Improving Together Quarterly Report to Trust Board | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | Yes | Yes | Yes | No |
| Approval Process: (where has this paper been reviewed and approved): | Reviewed and approved at December's Improving Together Programme Board | | | |
| Prepared by: | Alex Talbott, Associate Director of Improvement<br>Emma Cox, Head of Continuous Improvement and Coach House | | | |
| Executive Sponsor: | Peter Collins, Chief Medical Officer | | | |

## Recommendation:

**Assure** – This report is to assure the Trust Board of our progress in developing Improving Together across the Trust.

## Executive Summary:

In quarter 3 of 23/24 we have seen our Improving Together approach continue to grow in use and impact across teams who have been trained and those who are yet to be trained. Work to expand the reach of the training courses by increasing the maximum capacity of our courses is helping introduce more teams to the approach. Concurrently routines at executive and divisional level have been strengthened via focused work on the monthly Executive Performance Review (EPR) meetings and the weekly divisional driver meetings.

During this quarter we have seen the ability for the divisional management teams to teach and lead their teams in improvement increase, with a positive impact on the benefits seen from our improvement work across the Trust. This paper highlights a range of examples of the benefits we are seeing and how change at a team and pathway level is improving Trust-wide performance, patient care and patient outcomes.

The three main points for the Board to note are:

1. **Training:** The training trajectory for Improver Standard is on-track. Improver Advanced is off-track by two teams. Improver Leader is off-track against our 16 team target for November 2023 by three specialities, with plans in place to bring it back on-track by February 2024. A review of the training programme is underway to evolve our approach based on experience and feedback so far, particularly looking at how Improver Advanced works. This review will be presented at the Improving Together Programme Board in February 2024.
2. **Maturity:** Divisional self-assessment and Trust self-assessments have been completed during the quarter. Divisional assessments show improvement and increasingly routine use of the tools, with structured conversations and the strategic filter being areas for development. The Trust self-

assessment has highlighted patient involvement and co-production of improvements as the key area of development. This has been put forward as a focus for Improving Together work across the AHA.

3. **Investment**: Recruitment has been successful into the Coach House and Organisational Development & Leadership roles approved in October as part of the Improving Together business case. Colleagues start dates range from November 2023 to February 2024. There is one outstanding vacancy which is expected to be filled by April 2024. No further funding has been agreed for consultancy support and so the KPMG contract is being closed. Mitigations are in place to minimise the impact of the removal of KPMG's role as strategic partner and critical friend to our deployment of Improving Together.

| 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 |

## 1 Purpose

The purpose of this paper is to provide the Trust Board with a summary of the current position of the Improving Together roadmap and a review of the impact using Improving Together is having on our People, Population and Partnerships.

## 2 Background

The Improving Together programme is the how of how we will achieve our strategy. It links together improvement tools, with the behaviours needed to support a culture of continuous improvement and an operational management system (OMS) to form a golden thread from ward to board.

It is the shared improvement approach used across the Acute Hospital Alliance in the BSW system.

## 3 Benefits realisation from using Improving Together across the Trust

As the use of the Improving Together approach spreads within the Trust we are seeing increasing examples of how the approach is driving continuous improvement in our services. Six of these are summarised below, with further details provided in Appendix 2.

A consistent lesson learnt across these examples of improvements is that getting the mix of resources and leadership right is crucial to driving the improvements. For example, the support of project managers, dedicated clinical (doctor, nurse and AHP) leadership focused on continuous improvement and the inclusion of multi-disciplinary team members in training has underpinned the benefits highlighted here and in Appendix 2.

**Cardiology: Time to first OPA**
Pre-improvement: 133 days
Post-improvement: 121 days (9% improvement)
Trajectory to a 4 week wait: October 2024.

**SDEC: Bed day reductions**
Cost savings Since 27th March 2023: £517,000
Consultants working group across divisions to improve patient pathways.

**£1,193,537 cost savings**

**Surgical SDEC: ED arrival to SAU admission**
Time from ED Arrival to SAU 2022/23 - 715 mins 2023/24 - 471 mins. An improvement of more than 4hrs (244 mins).

**Acute Frailty Unit: Length of stay reductions**
Cost savings since 31st July 2023: £678,537
Consultants working group across divisions to improve patient pathways.

**Stroke Unit performance:**
SNNAP score rated A in Q2 for the first time.
Statistically significant improvement in arrival on the stroke unit within 4hrs – special cause improvement, outside the upper control limit.

**Financial Management Team:**
After 13 incremental improvements, the team are now able to consistently report the financial position for pay two working days earlier than six months ago.

## 4 NHS Impact: Trust and system self-assessments

In October, the NHS Impact team removed the ask to submit Trust self-assessments against the five components of continuous improvement. However, this work was strongly encouraged by NHS Impact and we have continued to use the self-assessment at Salisbury as part of Improving Together. In October 2023 the Improving Together Programme Board reviewed and confirmed the Trust's initial self-assessment, which is summarised in Appendix 1.

Acute Hospital Alliance colleagues have followed a similar approach and the work is now being drawn together across the BSW system via the BSW Community of Improvement Practice. This work assimilates both NHS Impact and NHS Aqua assessments and has identified the following top three opportunities for development:

1. Patient and public involvement in continuous improvement
2. Common and shared approaches to training people in continuous improvement
3. Supporting the development of shared data analysis capacity, skills and systems.

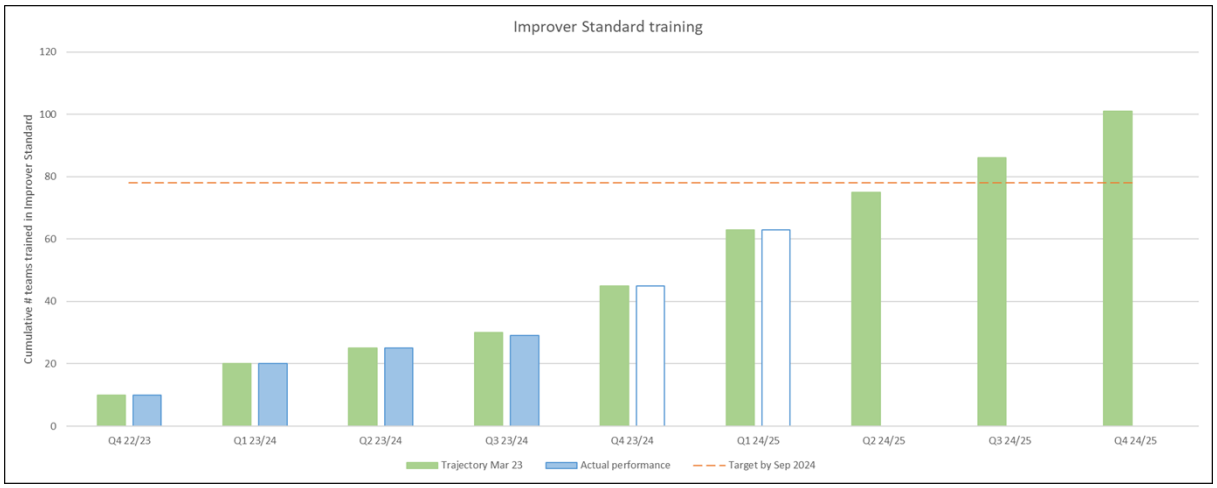
## 5 Training rollout: Numbers and fill rates

Training is a key way to develop and support a workforce who are confident in using continuous improvement as part of their daily work. The table and charts below set out the training numbers for 23/24 Q3 and forecasts for Q4 and Q1 of 24/25. Demand remains high for Improver Standard training, with courses fully booked to the end of the financial year. Booking for Improver Advanced training in Q4 is paused due to a low number of teams who are ready to progress from Improver Standard. Experience within the Coach House over the last two years, tells us teaching more tools to teams who are not ready can be counterproductive. In response to this, a review of the training design and delivery is underway to continue to respond to the needs of colleagues and the organisation and achieve the agreed training trajectories.

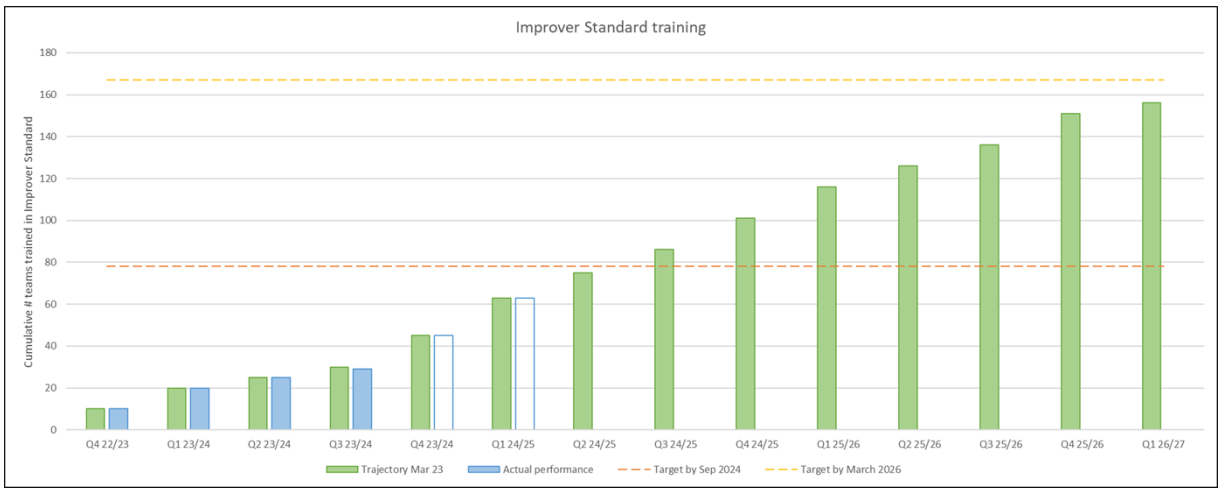
| Course | Individuals trained to date | Teams trained to date | Percentage fill rate of next course (based on 25 places per course) | Number of teams represented at next course |
|---|---|---|---|---|
| Improver Standard | 187 | 29 | January: 168% | January: 7 (5 new) |
| Improver Advanced | 56 | 14 | February: 0% | February 0 |
| Improver Leader | 130 | 39 | January: 108% | January: 9 (4 new) |

Work is being started to be able to display these data by division and speciality, so that we may review the 'heatmap' of training through the organisation and introduce more visual management of these data.

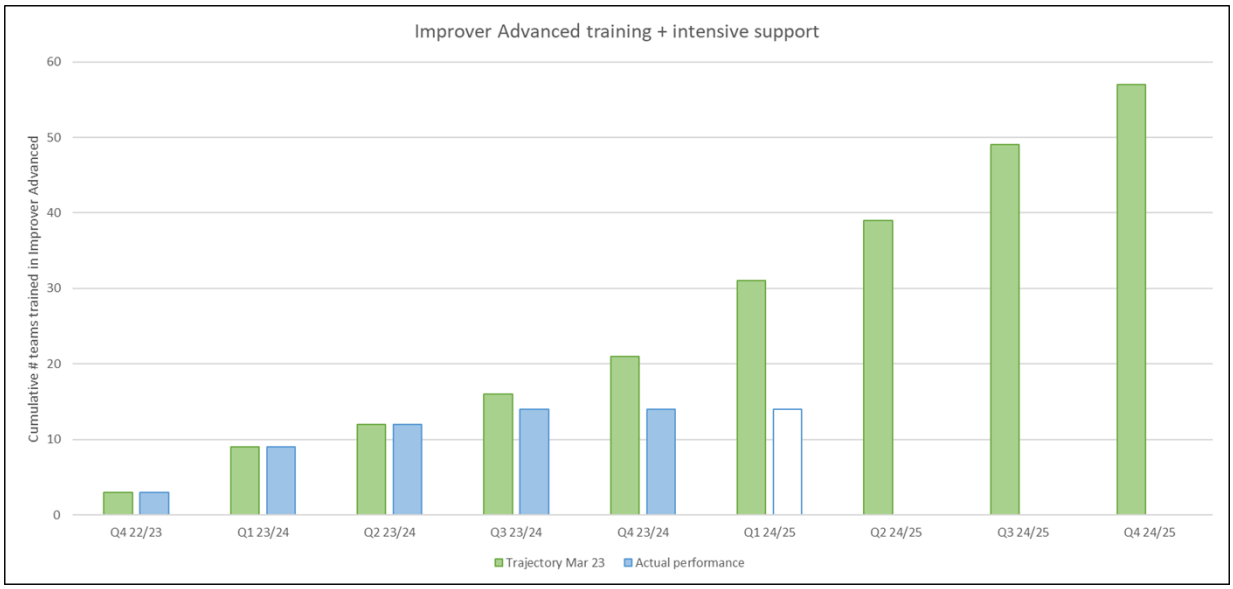
The following charts show the performance against the roadmap trajectory for each course (the unfilled bars reflect our projected performance for the next two quarters).




The forecast outturn for July 2024 is 69 teams trained, which is on-track with our trajectory.

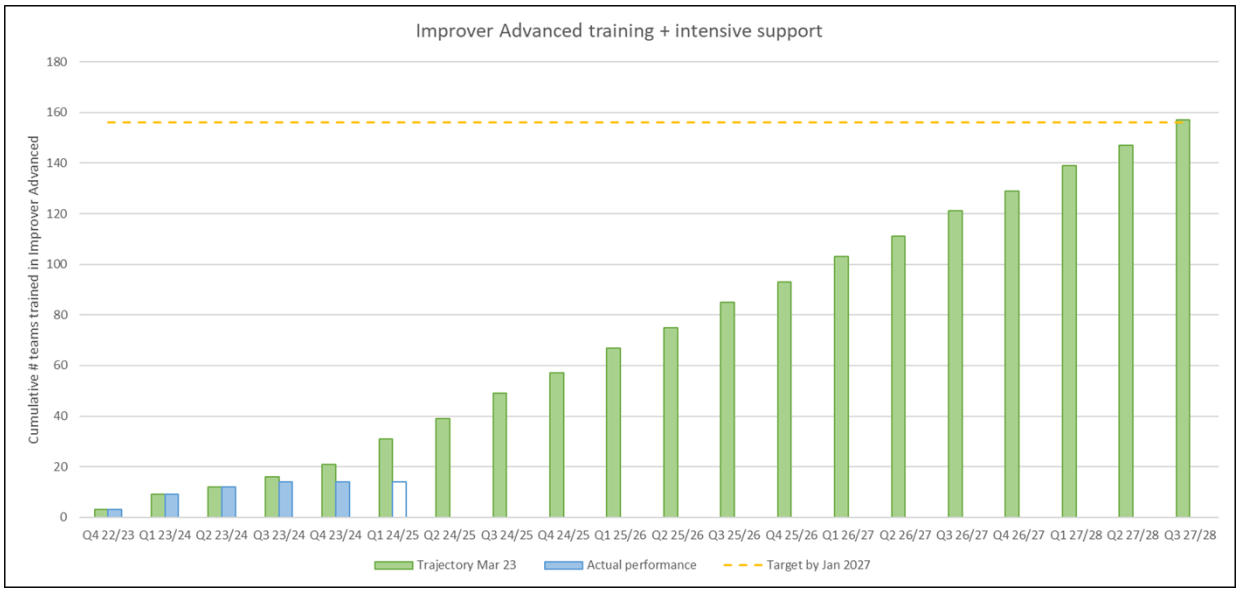


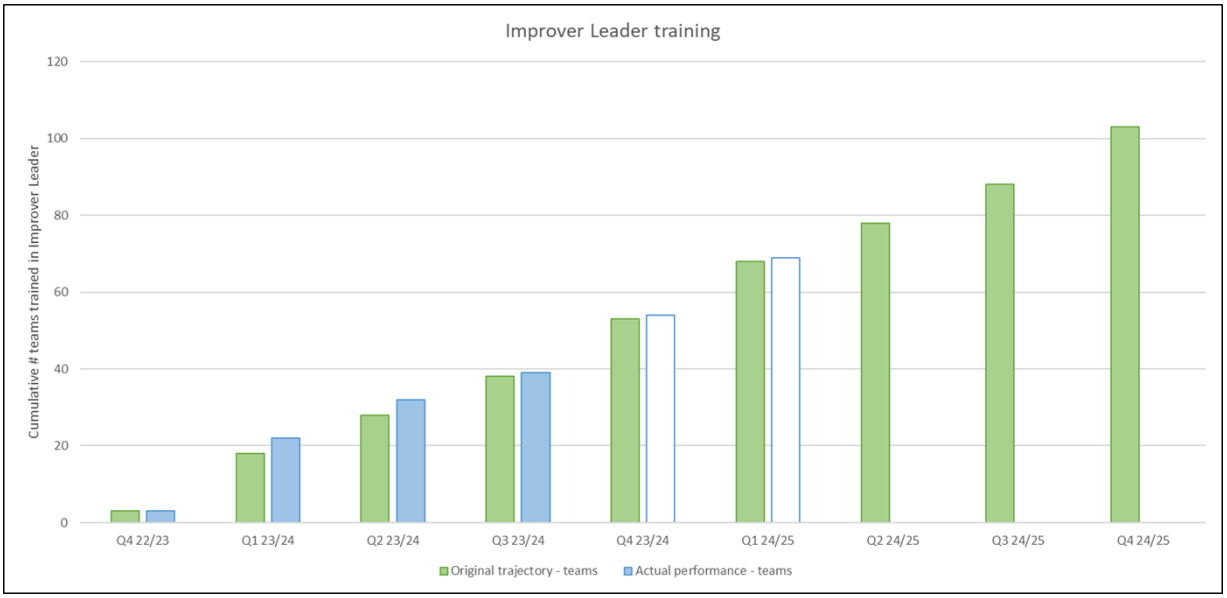

The current trajectory is for representatives of 100% of teams to have attended Improver Standard by end of Quarter 1, 2026.




Improver Advanced is currently off track by two teams, due to lower uptake of the course by new teams in Oct/Nov and pressures on individual teams preventing full completion of the training. A review is in progress to understand whether the time commitment of three days

can be condensed, alongside the content and approach to delivery. As part of this review, we will assess the forecast training trajectory numbers and work to ensure we can achieve the target of 100% of teams trained to Improver Advanced level by Q3 of 2027. The review will consider and ensure that our approach reflects the needs to engage and train up teams who are top contributors to the trust's priorities whilst also working with those who wish to embed continuous improvement in their teams.




Improver Leader training remains on track for overall numbers. This course is for leaders of teams and specialties, with a particular focus on teams who are undertaking the Improver Standard training. Representatives from 17 teams were trained during Q3 23/24.

However, we had a target of training 16 speciality triumvirates in Improver Leader by the end of November. A total of 13 specialties have been fully trained (all three of the triumvirate trained), with 29 specialties (66% of the total number of specialities) having at least two members of the triumvirate trained. A total of 98% of operational leads – those in senior management roles across the divisional management teams – 62% of nursing leads, and 39%

of clinical/service leads (this figure includes AHPs who are part of a specialty triumvirate) have been trained in Improver Leader.

Based on bookings to date, the target of having 16 speciality triumvirates trained will be met in February 2024. Conversations with key individuals are ongoing, and training spaces are being prioritised for them.

| | Number of the triumvirate trained (out of 3) | | | |
|---|---|---|---|---|
| **Specialty tris trained to date** | **3/3** | **2/3** | **1/3** | **0/3** |
| Medicine division | 3 | 3 | 3 | 0 |
| Surgery division | 1 | 11 | 7 | 0 |
| CSFS division | 6 | 1 | 2 | 3* |
| Women & Newborn division | 3 | 1 | 0 | 0 |
| **Total** | **13** | **16** | **12** | **3** |

*these are smaller specialties, with a single specialty lead, rather than a triumvirate

## 6 Developing maturity in the use of improving together methodology

The quarterly maturity assessment continues to be used by the divisions to self-assess their maturity, with time scheduled at Sharing It sessions to review and discuss those scores and identify areas of opportunity for further training/reflection/focus.

A new teams maturity assessment has been developed by the Coach House and is being tested in two clinical and one non-clinical teams. It is anticipated this revised self-assessment will start to be used by more teams in early 2024, with scores presented at Programme Board and reported in the next Trust Board quarterly report.

In October's report, the identified areas of focus were linked to A3 thinking and undertaking go and sees. This quarter's self-assessments show all clinical divisions are beginning to mature in their use of A3 thinking and increasing the number of go and sees they are undertaking. These two tools are beginning to become part of the division's daily and weekly routines.

| Key | |
|---|---|
| Level 0 - Not started | Level 3 – Maturing |
| Level 1 – Aware | Level 4 - Mastering |
| Level 2 – Developing | |

The maturity assessment is not a 'marking of your homework'. It represents a structured reflection on where our teams are strongest and where we should focus our energies to develop our understanding and use of the Improving Together approach.

| Framework | Tool | Behaviour | Execs (Dec 23) | Divisions (Dec 23) | Specialty | Frontline (Dec 23) |
|---|---|---|---|---|---|---|
| Align | Scorecard | Focus | 2 | 3 | 2* | 2 |
| | Strategic Filter and SDM | | 2 | 1 | 0 | NA |
| Enable | Monthly routines (Performance/Executive Review Meeting + A3 Summary) | Humility Curiosity A3 Thinking Go, See, Listen, Learn, Respect | 3 | 3 | 0 | 1 |
| | Weekly Routines (Weekly Driver meetings, Go & | | 2 | 3 | 0 | NA |

| | | | | | | |
|---|---|---|---|---|---|---|
| | See, OMS Exec routines, weekly Exec huddles) | | | | | |
| | Daily routines (Improvement Huddles, Performance and improvement boards) | | N/A | N/A | N/A | 2 |
| | Process and Leader Standard Work | | 2 | 2 | 0 | 2 |
| | Process Confirmation | | 2 | 2 | 0 | 1 |
| | Structured Conversation | | 1 | 2 | 0 | 1 |
| Improve | A3 | A3 Thinking | 3 | 3 | 1 | 2 |

*Based on the reported use of scorecard agreements in divisional maturity self-assessments.

**Key areas to note from the divisions' self-assessments:**

- Increasing use of Process Standard Work across identified teams/services
- A general improvement in the use of A3 thinking across divisions, with this becoming a common language and approach to help understand the problem and drive improvement in priority areas
- Increased number of scorecard agreements happening across divisions at the speciality layer
- Refreshed driver meetings have improved participation and attendance - introducing Leader Standard Work has ensured a consistent approach
- Continuing to progress to embed go & sees within divisions and specialities – including joint Executive and Divisional go and sees. In addition, recognition that Go and See's help support process confirmation.

**Key areas of focus to support maturity in Q4:**

- Continuing to embed Leader Standard Work as individuals and within the divisional management team
- New Operational Managers to attend training in February 2024
- Further reflection on the new Trust's Leadership Behaviour Framework, acknowledged that continued practice at a divisional level is required throughout Q4
- Continued development and amendment of speciality performance review meetings, speciality drivers and adoption of Improving Together principles at speciality level
- A focus on supporting speciality leadership triumvirates with scorecards and scorecard agreements
- Structured conversations are least developed and is an area to develop as we enter 2024/25.

There are 15 areas now actively using Improvement Huddles, an increase from the 11 reported in the previous Trust Board report. Four of those areas have commenced using the improvement huddle board before attending training, these areas are ED, Plastic outpatients, ENT and Laverstock. Discussions with those teams to attend training are underway. To enable colleagues who work from home to participate, two teams have adopted a virtual improvement board, following the same standard work as a physical board.

## 7 April 2023 to September 2024: 18-month roadmap for the programme

A deep-dive review of all of the workstream roadmaps was undertaken in November. This review identified the main areas of opportunity and support required to maintain delivery of planned activities are linked to: identification of benefits, successes and case studies and strengthening collaboration and cross-divisional working between trained and non-trained teams. Both of these areas of work are being prioritised with support from our communications and finance colleagues and via the monthly cross-divisional meetings such as Sharing It, Urgent Emergency Care Board, Planned Care Board and Improving Together Programme Board.

Two of the nine workstreams are reporting off-track against the roadmap in December. These are the Business Intelligence (BI) workstream and the Executive and Board Leadership Behaviours workstream. For BI vacancies are the key issue and actions and mitigations are being reviewed and completed by the Head of Informatics to minimise impact on progressing key workstream actions and BI Business Partner support to the divisions. For the Executive and Board Leadership Behaviours workstream planning on how to include our leadership behaviours framework into executive development days is a key next step. The second overdue action is on how best to process confirm Board members' go & sees. Guidance from those who have been sustaining a go & see approach for multiple years is being sort and this will be brought back to Executives and then the Board in the New Year.

As part of our Improving Together Programme Board teams who have been trained and are using the approach are invited to give their feedback and review what has worked well and what could be improved in our training and support. So far this year the following teams have presented:

- Ophthalmology
- Gynaecology
- Chilmark ward
- Transformation team
- Spinal Unit
- Cardiology
- Junior Doctors.

## 8 Refreshing the Strategic Planning Framework for 24/25

Work is underway with the Executive and operational leads for each of our nine Vision Metrics to identify the options for 24/25's Breakthrough Objectives. An initial check and challenge session of nine possible breakthrough objectives with the Executive has taken place and A3 thinking is now being used to further define the leading options.

The plan is for the Trust Board to receive a report in January 2024 setting out the work, ahead of the executives and divisional management teams completing their scorecard agreements in February and March. The refreshed Breakthrough Objectives will cascade into the rest of the organisation via the scorecard agreements and a range of corporate and divisional communication channels.

## 9 Finance

### KMPG consultancy

The contract with KPMG is now in the process of being closed as we have come to the end of the original funding. A request for an extension of funding to cover support into 24/25 and 25/26 was not approved by the regional team. The impact and mitigation of this is described below:

| Impact | Mitigation |
|---|---|
| Removal of coaching for improvement support to senior leaders from KPMG. | The Chief Medical Officer and Associate Director of Improvement will undertake the role of Improvement Coach with 23 senior colleagues, utilising the online Catalysis Academy programme of modules. This will start in February 2024. |
| Review of the training programme to ensure fidelity to the methodology. | The Coach House team are undertaking a review of training and internal and system partners will act as the team's critical friends. |
| One of the three AHA workshops planned to cover how our shared continuous improvement approach can best be designed and enabled at the AHA level is unfunded. | Two of the three workshops remain funded. The AHA Improvement Leads are working to determine how this changes the scope and scale of the work in the two workshops with funded consultancy input. |

**Coach House budget for 24/25**

As part of budget setting the Coach House budget have been decoupled from the wider Transformation Team budget. This will improve our ability to monitor and report on the specific spend against our improvement training and improvement coaching programme.

**Additional investments in 23/24 and 24/25**

**Coach House**

The three (2.93 WTE) rotational Senior Improvement Practitioner roles in the Coach House have been recruited. All three staff will be in post by February 2024 and work in the Coach House for 12 months. Colleagues are joining the team from the CSFS and Surgery divisions. In all three cases, colleagues will spend time delivering the Coach House training and coaching programmes and directly supporting their 'home' teams in initiating, developing and embedding continuous improvement. This approach will help ensure their learning and new improvement knowledge is being taken back into their divisions and teams as early as possible during the rotation.

The in-year and 24/25 costs of these roles are detailed below:

**23/24:** £31k (compared to £83k in the business case)

**24/25 (FYE):** £161k (compared to £165k in the business case)

**Organisational Development (OD) and Leadership**

Two of the three additional posts have currently been recruited with 1.0 WTE OD and Leadership Lead starting on the 4th Dec 2023 and the second WTE starting on the 19th Feb 2024. Due to delays in our matching working group the Project Support Officer role won't be matched until 9th Jan 2024 and therefore may not be in post until April 2024.

- This investment in the team is helping increase capacity to develop current and future leaders at all levels, increasing the number of delegates through our programmes from 144 to 280 per year. This also includes rolling out and embedding our new leadership

behaviours framework and 360 feedback tool and intensive support to teams in the Trust.

The in-year and 24/25 costs of these roles are detailed below:

**23/24:** £29k (compared to £71k in the business case)

**24/25 (FYE):** £160k (compared to £142k in the business case due to business case modelling costs at the mid-point of AfC bands)

### Communications

The portion of the business case included £50k of non-pay spend. In the YTD £22k of that has been spent. This is supporting strategy and Improving Together communications work. Across the Trust such as the branding of entrance ways and training collateral.

## 10 Recommendations

The board is asked to note:

1. The progress on delivery of the improving together programme and its impact
2. The current maturity assessment of key elements of continuous improvement

**Alex Talbott**
**Associate Director of Improvement**

**Appendix 1: NHS Impact self-assessment for SFT:**

| Ref | Theme | SFT Assessment |
|---|---|---|
| 1 | Board and executives setting the vision and shared purpose | Progressing |
| 2 | Improvement work aligned to organisational priorities | Progressing |
| 3 | Co-design and collaborate - celebrate and share successes | Spreading |
| 4 | Lived Experience driving this work | Developing |
| 5 | Pay attention to the culture of improvement | Progressing |
| 6 | What matters to staff, patients and carers | Developing |
| 7 | Enabling staff through a coaching style of leadership | Progressing |
| 8 | Enabling staff to make improvements | Developing |
| 9 | Leadership development strategy | Progressing |
| 10 | Leadership Values and behaviours | Developing |
| 11 | Leadership acting in partnership | Progressing |
| 12 | Board development to empower collective QI leadership | Progressing |
| 13 | Go and see visits | Progressing |
| 14 | Improvement capacity and capability building strategy | Progressing |
| 15 | Clear improvement methodology training and support | Progressing |
| 16 | Improvements measured with data and feedback | Progressing |
| 17 | Co-production | Developing |
| 18 | Staff attend daily huddles | Developing |
| 19 | Aligned goals | Spreading |
| 20 | Using the management system for planning and understanding status | Progressing |
| 21 | Using the management system to respond to local, system, and national priorities | Developing |
| 22 | Using the management system to integrate QI into everything we do | Progressing |

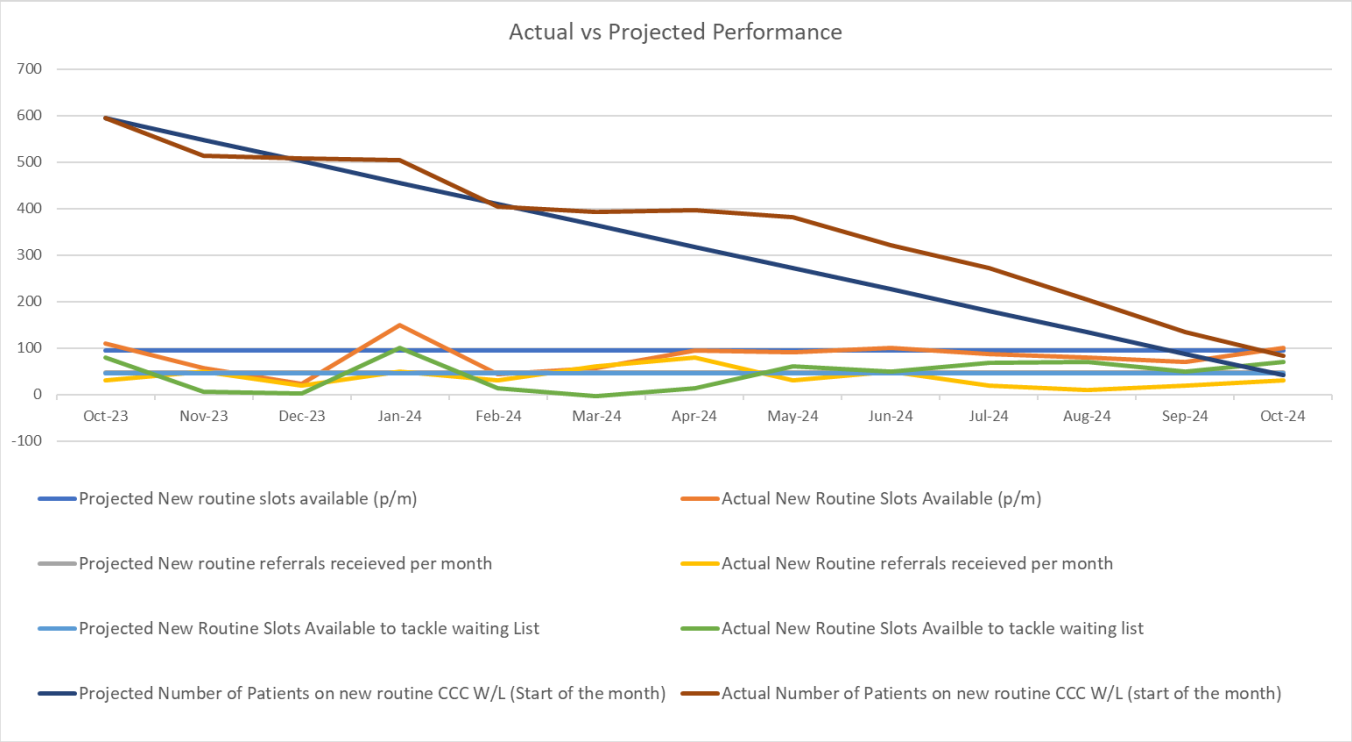
**Appendix 2:** Improving Together Benefits Realisation and case studies

The range of benefits and improvements described here all have a direct impact on patient care, be that wait times and or the clinical quality and outcomes we deliver for our patients. In turn we are seeing this boost staff engagement and morale in the teams highlighted below.

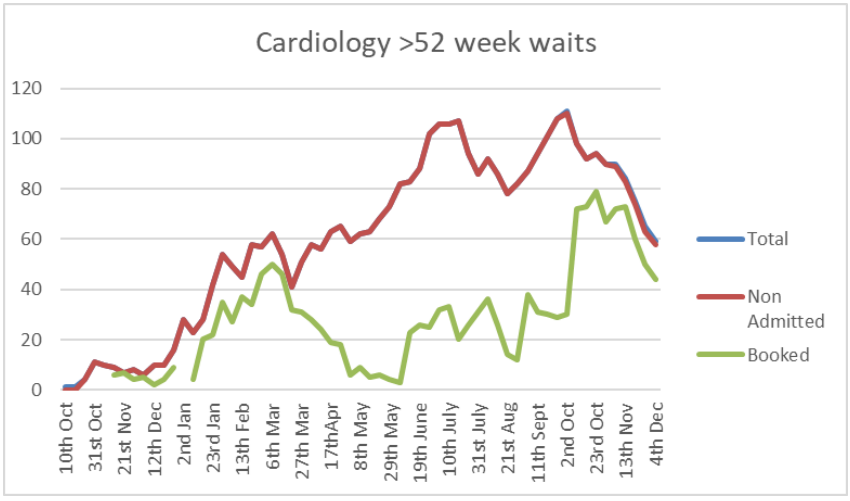
### Cardiology: Time to first outpatient appointment

In June the Cardiology team started using improvement huddles, before attending training in September. The Cardiology huddles are led predominately by the Cardiology secretaries, and they have been instrumental in driving the huddles and improvement in outpatient wait times. The team report seeing an improvement in teamwork with a variety of staff groups attending the improvement huddle. The secretaries have also designed a newsletter that is sent out to the whole department following the Tuesday morning huddle. This ensures teams members across the department can keep up to date with the challenges and successes of the work.

The focus on improving the number of new appointment slots has meant the team are now projecting a four week wait by October 2024 in the Combined Cardiology Clinic.




Cardiology are now showing steep improvement in reducing the numbers of patients who are at risk of breaching a 52+ week wait for their outpatient appointment by 31 March 2024.



**A summary from the Urgent and Emergency Care Board: High level project performance over the last 12 Months.**

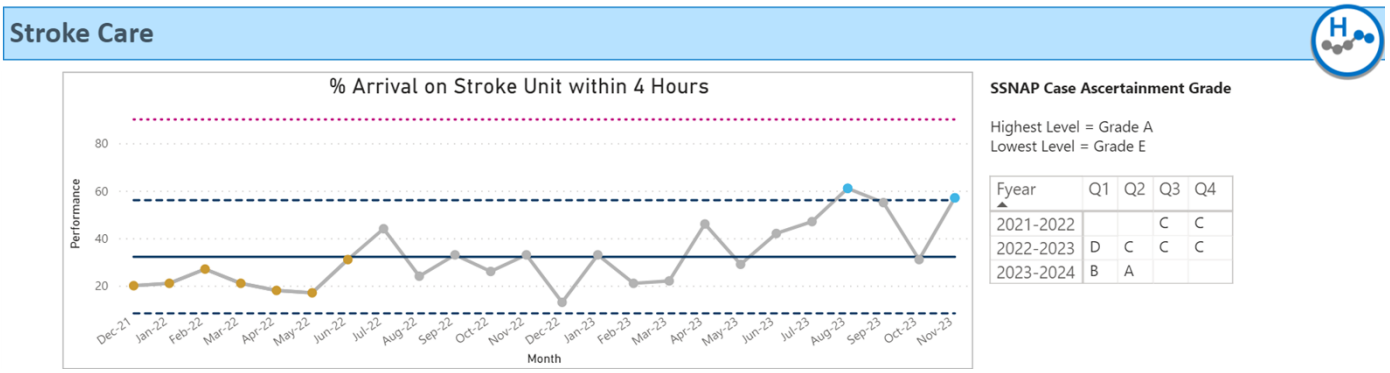
**Key data and achievements:**

- Medical EM Zero-day LoS Dec 2022 - 21.97% - October 2023 29.14% - Improvement 7.17 points = 32.63% Improvement
- Surgical EL Day case rate % Dec 2022 - 90.43% - October 2023 90.66% - Consistent performance
- Non-Elective Length of Stay Nov 2022 - 9.8 days Nov 2023 7.8 days - Improvement 2 days = 20% improvement
- SDEC Cost savings Since Launch on 27th March 2023: £517,000
- Frailty Cost savings since 31st July 2023: £678,537
- Total saving SDEC and Frailty working group = a £1,193,537 saving for the Trust through improved ways of working
- We have seen a y-o-y reduction in total ambulance handover time lost of 1 hour 44 mins between November 2022 and November 2023
- Consultants working group across divisions to improve patient Pathways from ED to support patient admissions to the right specialty to improve patient experience and getting the patients to the right specialty quicker.
- Project Manager - Networking with RUH Bath and GWH Swindon to share learnings / Experiences / Ideas / Solutions / Best Practise.

**Reductions in length of stay (LoS) have led to a reduction of 35 beds being open.**

From the work done across patient pathways, the Trust's overall LoS has reduced by 1.2 days year-on-year, a reduction of 9%. This is equivalent to 35 ward beds. This has supported the refurbishment of Whiteparish and the closure of beds at South Newton along with continuing use of the discharge lounge.

**Stroke care: SNNAP A rating and improvements in arrival on the stroke unit within 4 hours**




| Fyear | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| 2021-2022 | | | C | C |
| 2022-2023 | D | C | C | C |
| 2023-2024 | B | A | | |

In Q2, July, August, September, the Stroke Unit achieved their first SNNAP score rating of A. This was after significant focus from the team on their improvement huddle driver of the 4 hour standard (ensuring patients get to the stroke unit within 4 hours). Further work is now building on that to sustain the A rating and 4 hour standard performance in Q3.

**The Financial Management team**
The Financial Management team have made 13 incremental changes to their month end accounts reporting timetable by using Improving Together methodology and toolkits to drive through process improvements and increase efficiencies during this tightly constrained time period.

The team are now consistently able to **report the financial position for pay 2 working days earlier than 6 months ago**. This frees up time to provide more detailed analysis to the organisation and improve the quality of the forecasting, driving forward more value adding activities and supporting the Trust with robust information, ideas and monitoring to help promote sustainable financial recovery.

This has been delivered through **regular huddles, A3 thinking and process mapping**, and focus on a limited number of targeted countermeasures each month. The team are also proud of the achievement and are using it as a steppingstone to further improvements which will have tangible benefits to themselves and the wider organisation.

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Public Trust Board | Agenda item: | 5.1 |
| Date of meeting: | 11 January 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report tile: | Health and Safety Report – Q2 | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | X | | X | |
| Approval Process: (where has this paper been reviewed and approved): | Trust Management Committee (TMC) | | | |
| Prepared by: | Troy Ready – Health and Safety Manager | | | |
| Executive Sponsor: (presenting) | Melanie Whitfield – Chief People Officer | | | |

## Recommendation:

The Public Trust Board is requested to note the escalation report from the November TMC. No issues are raised for action or approval.

## Executive Summary:

The H&S Manager presented the half year H&S report to TMC in November. Highlights from the H&S report are seen below:

**Advise**

Work continues to finalise the Trust strategy on reducing and preventing violence. This includes considering how the Emergency Medicine Team, in consultation with the H&S team, can utilise the Design Council toolkit to reduce violence and aggression through improved communication and signposting in ED. Training on reducing and managing the risk of violence and aggression is due to commence in January and the violence prevention and reduction policy is awaiting input from Children and Adolescent Mental Health Service (CAMHS) and Mental health Liaison Service (MHLS) before finalisation. After consultation through TMC, H&S Committee and Violence Prevention and Reduction Working Group the 'No Excuse For Abuse' campaign has been agreed and work is underway to develop posters that involve staff images.

**Assure**

The H&S management structure has been developed and the implementation of auditing, reporting and task analysis is starting to provide evidence of trends that enable corrective actions to be implemented. For example, the causes for manual handling injuries in spinal unit have been identified and local actions have been developed to reduce the likelihood or consequence of injuries. A similar review of theatres will be completed by the end of November.

All outstanding H&S procedures have now been reviewed updated and finalised. Scheduled audits are completed, task analysis are completed as scheduled and staff injuries are being investigated by the H&S team to better understand causation and corrective actions.

**Alert**

There was an increase in manual handling injuries as a result of what was described by individuals as controlled falls (the practice of assisting patients to the floor as they fall). This is not a practice supported by

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NHS Foundation Trust

| |
|---|
| the manual handling lead and is not trained at the Trust. Evidence suggests falls assessments are being completed and the response is seemingly a natural instinct. |

| 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): | |

# Q2 HEALTH AND SAFETY PERFORMANCE REPORT
# HALF YEAR REVIEW 2023/24

Salisbury NHS Foundation Trust

## 1. Report Summary

There has been continued progress in the management of H&S across the Trust in Q1 and Q2. Highlights of which include:

- Lower injury rates (quarter comparison) from Q1.
  - The number of lost time injuries fell 27% from 13 in Q1, to 10 in Q2. A significant percentage fall but only a modest fall in actual numbers.
  - LTIFR is tacking lower from 5 to 3.9.
  - LTFR remains steady at 2.3.
- An agreed Trust strategy to manage violence and aggression has been published.
- The H&S Team responding to all Datix reports related to staff injury and incident.
- Implementation of risk activity such as auditing and task analysis by the H&S team
- Hazard management activity, including nitrous oxide exposure and noise levels.

The H&S management system has only been in place for 10 months and whilst preventative actions have been developed, there is no demonstrable measurable improvements to date. This is not to say benefits will not flow, nor suggest H&S is not being managed in a strategic or planned manner. Meaningful reports to identify trends by location, causation and consequence in a meaningful way have not been previously available. Quarter on Quarter and Year on Year comparisons by Division will be provided once the Trust has 12 months of comparable data.

That said, measuring current performance can be undertaken by way of H&S actions that promote H&S improvements. In this manner, the H&S continues to undertake audits, task analysis and improving the response to reported injuries. Anecdotally, staff are making positive statements about the increased engagement in H&S and actions are identifying gaps in the management of H&S that would otherwise increase the risk of injury.

## 2. Half Year Health and Safety Report

The following report provides performance against objectives, describes the nature of injuries reported in the first 6 months of the financial year and actions to be taken during Q3.

### 2.1 Injury Statistics

| Number of Injuries by Type | Q2 | YTD |
|---|---|---|
| | 58 | 113 |
| Violence and aggression | 21 | 46 |
| Manual handling | 11 | 14 |
| Near miss | 11 | 11 |
| Slip and trips | 5 | 11 |
| Struck by a moving object | 3 | 11 |
| Exposure to sharps | 6 | 9 |
| Struck an object | 2 | 4 |
| Chemical | 1 | 4 |
| Heat / Cold Exposure | 2 | 2 |
| Fall | 2 | 2 |
| Other | 1 | 2 |
| Radiation | - | 2 |
| Laceration | - | 1 |

Q2 saw an increase in:

1. Needlestick injuries undertaking phlebotomy, or surgical procedures. These will be further investigated to identify any root cause.

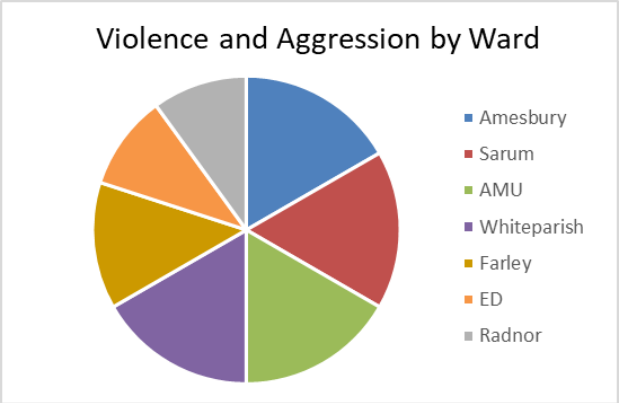
2. Manual handling injuries, especially reports referring to controlled falls. In discussions with the Manual Handling Lead, controlled falls is not a practice taught, or encouraged, across the Trust. The process is to encourage people to slide down against a fixed object such as a wall. This is difficult in practice where patients are not near a fixed object to slide down, and where staff reflexively hold and assist a patient about to fall as opposed to letting a patient fall.

3. Near miss reports. Most near misses were reported by the Portering and Waste Teams who identified sharps in waste bins, or overflowing waste disposal in theatres.

| Action for Q3 |
|---|
| The H&S Manager will consult with the medical and surgical divisions to determine if there is an increase in falls, consider falls assessments and the practice of managing falls to avoid injury to both staff and patients. |

### 2.2 Violence and Aggression

| | |
|---|---|
| **Physical act** | **30** |
| Confusion | 17 |
| Antisocial | 2 |
| Mental health | 1 |
| Damage | 10 |
| **Verbal abuse** | **11** |
| Confusion | 6 |
| Antisocial | 8 |
| Mental Health | 4 |
| Between staff | 2 |




Violence and aggression continues to be the most reported cause of injury and incident. The Trust Violence Prevention and Reduction Strategy will be finalised in Q3 and the H&S Team has started implementing elements of this strategy.

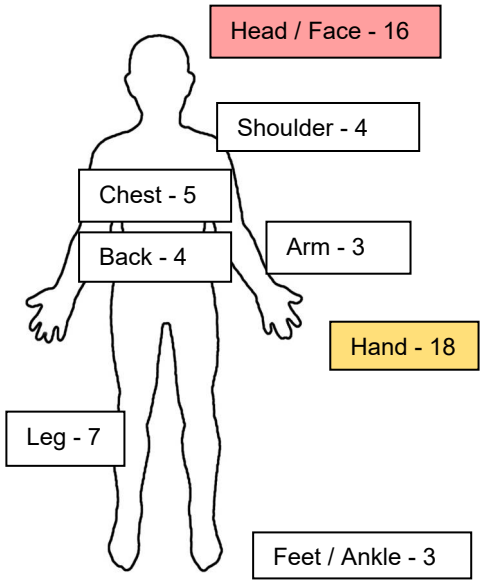
### 2.3 Injury Performance Measures

| Injury and Frequency Rates by Division | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Days Lost | YTD | LTI | YTD | LTIFR | YTD | LTFR | YTD | Near Miss | YTD | RIDDOR | YTD |
| **Estates & Facilities** | 11 | 49 | 1 | 4 | 6.5 | 9.8 | 5.4 | 11.5 | 3 | 3 | 1 | 2 |
| **Surgery** | 49 | 57 | 5 | 10 | 6.9 | 7 | 5.1 | 3.0 | 3 | 3 | 1 | 1 |
| **Medicine** | 12 | 42 | 3 | 7 | 5.7 | 6.6 | 1.7 | 3.0 | 2 | 2 | - | 1 |
| **W&N** | - | - | - | - | - | - | - | - | - | - | - | - |
| **CSFS** | - | 3 | - | 1 | - | 0.9 | - | 0.2 | 3 | 3 | - | - |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Corporate** | 6 | 6 | 1 | 1 | 2.4 | 1.2 | 1.1 | 0.5 | - | - | - | - |
| **Total** | 78 | 157 | 10 | 23 | 3.9 | 4.5 | 2.3 | 2.3 | 11 | 11 | 2 | 4 |

**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
Near Miss is an incident that did not result in harm to staff.

## 2. Injuries by Body Location




**Head and face injuries**

Of the 12 head and face injuries reported in Q1, 9 were the result of being struck by patients. In Q2, 4 injuries to the face and head were reported, 2 were the result of walking into objects. 1 was the result of confused patient and the fourth was a chemical splash in the eye that was treated immediatetly.

**Hand injuries**

Where all hand injuries in Q1 were due to staff hitting hands on fixed objects, there were 9 hand injuries reported in Q2. 6 of which were related to sharps injuries during surgical procedures or taking bloods.

### 2.5 Injury Analysis

The number of days lost, and the frequency of injuries that resulted in time lost is steady across Q1 and Q2. With 78 incidents reported in Q2 (against 79 in Q1) and 10 lost time injuries (against 13 in Q1). Encouragingly, 11 near misses were reported in Q2 (against 4 in Q1).

As noted in the Report Summary above, the H&S team is responding to staff who report incidents and injuries, and are being seen to respond to incidents. A common response from staff when approached by the H&S Team is: “I did not realise anyone received these reports and haven’t had this response before”. Responding to, and trying to normalise this reponse is an important step in improving a H&S culture. The initial focus of the H&S team is to support staff and utilise a H&S Team investigation template to formalise investigations. Such steps have allowed the H&S team to take the following steps to support staff:

- Assessing workstations and making reasonable adjustments to the workplace to allow people with disabilities and injuries to perform the inherent requirements of a role without risk of injury,
- Referring hazard controls to departments for action. For example undertaking work with Estates and Medical Engineering to improve exhaust and ventilation systems from the use of hazardous chemicals,
- Refering individuals to occupational health for physical, mental and wellbeing support or to pastoral services where warranted.

Whilst it is necessary to normalise reporting of incidents, and for staff to expect a response to an injury report, it is more important to understand what happened, identify causation and lessons learned. It is clear from a review of incidents on Datix, and discussions with staff investigating Datix reports, there is a lack of knowledge on incident investigations, a lack of understanding of root cause theory / contirbuting factors and causation. As an example, the

learning documented from one injury report on Datix cited: “dementia patients are unpredictable”. H&S auditing supports this with very few ward staff responsible for investigating injuries having had any training on root cause investigation or explaining any confidence in undretaking an investigation.

| **Action for 2024** |
| --- |
| Whilst the H&S Team has developed a local injury investigation tool to improve the documentation of investigations, clinical staff need training on root cause investigations. A recommendation to the H&S Committee is for the H&S Manager to develop an investigation training course that can be added to MLE as a training module and delivered against a published training calendar. Staff spoken to express an appetite to learn this skill and would value any training available. Doing so is expected to improve outcomes of investigations, understand root cause and identify lessons learned that can be shared with local staff, without relying upon the H&S team. |

## 3. Key Risks Defined as by the Health and Safety Executive and Risk Register

### 3.1 Manual Handling

The Annual H&S Report identified manual handling injuries on the spinal unit as an outlier to the overall Trust manual handling performance. An action from Q1 was for the H&S Manager to liaise with the Manual Handling Lead to investigate local spinal manual handling training and to undertake a H&S audit of the Spinal Ward.

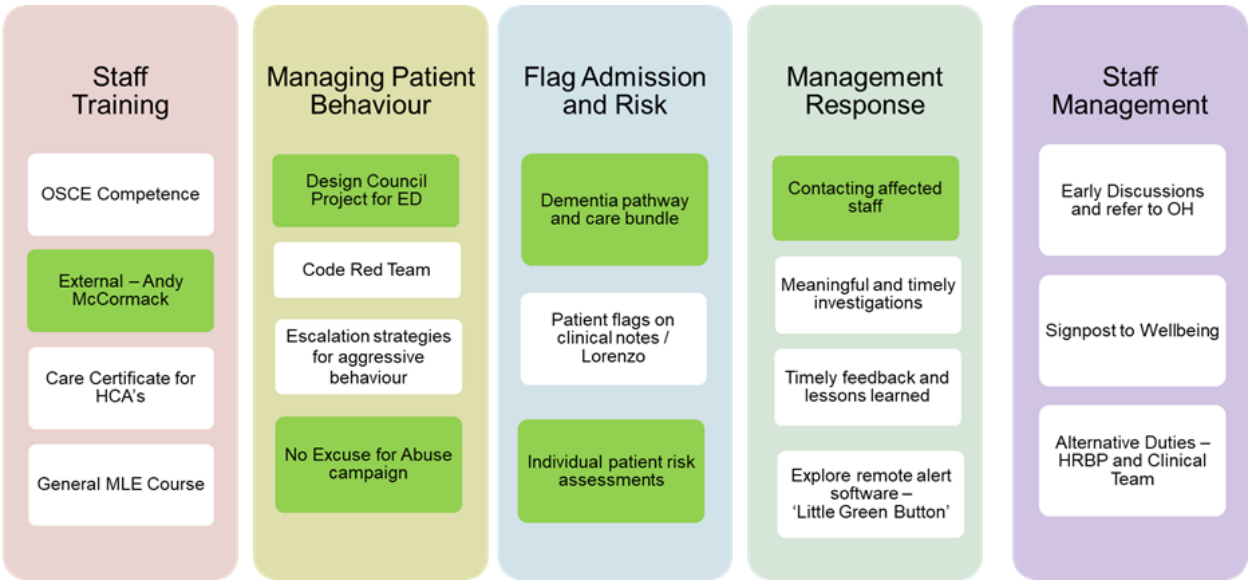
It was identified how the Trust provides specialised spinal training to staff at Band 5 or above, training that includes head holds and log rolls. This technical spinal training is distinguishable from the repetitive nature of manual handling associated with the lifting and handling of patient’s limbs to undertake activities of daily living for spinal patients. The spinal training is not available to Band 3 and Band 4 staff who perform the majority of patient handling on the spinal unit and in any event training is of a technical nature rather than teaching strategies that reduce or improve the amount of lifting for spinal patients undergoing long term rehabilitation.

The H&S audit conducted on the spinal unit identified much of the training provided to new starters is through a buddy system provided staff who may have been on the ward for many years, or just as likely by staff who have themselves been on the unit for a short space of time. In consultation with the Manual Handling Lead the Spinal Unit has a number of manual handling key workers who can train staff on lifting and handling specific to risks associated with spinal patients as part of a formal manual handling competency completed during local induction.

| **Action for 2024** |
| --- |
| The spinal unit will develop a competency based manual handling program to be developed and implemented by those manual handling key workers on the ward. This competency will be reviewed by the Manual Handling Lead before implementation. The scope of which would be expected to communicate strategies and tools to reduce the impact of manual handling on staff. |

### 3.2 Violence and Aggression

A review of all risks rated as high on the Trust Risk Register identifies 3 risks related to violence and aggression. The Q1 H&S Report provided an overview of the Trust wide approach to managing violence and aggression proposed by the Violence Prevention and Reduction Working Group. From the image below, a number of highlighted actions have commenced and will be implemented in Q3 and Q4. Doing so is expected to reduce this risk.




There are a number of key actions to be implemented in Q3. These are:

### 3.2.1 External Training

The current training provided to staff on managing violence and aggression is a 2 day externally facilitated course that provides general overview of confusion and mental health to understand why patients become aggressive, whilst the second day focuses on the use of restraint and hold techniques that include taking patients to a safe position on the floor. The training has generally been poorly attended, was seen to focus on security and staff felt uncomfortable being trained on restraint and holding patients.

Training has been amended to provide 2 separate training streams, has been reduced to a one-day course, eliminates the element of restraint and hold but introduces staff to skills required to remove themselves from a sitaution where they are being held by a patient. Training has been scheduled monthly from January (this ensures dates are scheduled and study days are allocated to staff ahead of roster deadlines to ensure staff are released for training).

1. The first day is specific to confusion, dementia and delirium and is being developed in consultation with the Trust H&S Manager and Trust Dementia Lead. The first course is scheduled for January and is being delivered to 14 HCA, Band 4 staff and OSCE nurses who work on Durrington, Redlynch, Pitton and Spire wards.

2. The second stream is specific to antisocial behaviour and the skills necessary to deesclate behaviour that is not the result of confusion, delirium or lack of capacity. The course is also scheduled for January and is being delivered to 14 staff on AMU, Sarum and Radnor wards.

### 3.2.2 Design Council and Awareness Campaign

The Violence Prevention and Reduction Working Group in consultation with the Emergency Medicine Team has identified the campaign tag 'No Excuse for Abuse'. A design template for posters has been drafted and is currently in consultation with stakeholders before being published and posted within ED and AMU.

In addition, the Emergency Medicine Team in consultation with the H&S team is assessing the Design Council of Englands strategy and toolkit, used by a number of NHS Trusts, to reduce violence and aggression through improved communication and signposting processes.

### 3.2.4 Violence Prevention and Reduction Policy

The current Violence Prevention and Reduction Policy has been updated with a focus on steps to manage violent and aggressive behaviour, preventative steps and how to manage escalating behaviour. This policy is being reviewed by the Emergency Management Team, Violence Prevention and Reduction Working Group and other stakeholders.

| **Actions for 2024** |
| --- |
| 1. Publish No Excuse for Abuse Posters in ED and AMU<br>2. Make decision on adopting Design Council tools<br>3. Finalise the Violence Prevention and Reduction Policy |

## 4. H&S Activity – Auditing and Task Analysis

As a result of the Annual H&S Report, the decision was made to expand the auditing within Medicine to include Pitton and the Spinal Ward in addition to audits completed in ED. This is a change to the published calendar that was looking to commence audits in CSFS. The change in audit locations was the result of the annual H&S report identifying higher injury rates on Pitton and Longford wards therefore shifting priorities based on a known risk profile.

Audits have been completed and common gaps identified include:

**Risk Assessments** - Whenever clinical staff are asked about risk assessments, the immediate response relates to the various patient specific assessments completed for to prevent or manage the risk of falls, venous thrombosis, nutrition and reduced mobility. Each of which go to reducing the risk of harm not only to patients, but also to staff. But there is no knowledge of risk assessments related to manual handling, reducing violence, fire or hazardous substances. Risk assessments identified were in response to an incident on the ward, or a risk documented on Datix.

There is rarely any evidence of risk assessments available to demonstrate how risks are identified, assessed and controlled locally. The H&S team has completed a number of risk assessments for wards or divisions that need to be reviewed locally with a program of work, completed in consultation with the H&S Team to complete risk assessments to demonstrate how risks to the H&S of staff are being managed. The H&S Team will liaise with divisions to create timeframes for completion.

**Lack of Manager Training for Nursing Staff –** Senior Sisters explained how they were required to undertake investigations of injuries, and manage absences but did so without completing a formal training program and lacked both knowledge and confidence in undertaking either task. One example offered across a number of wards was how an individual knew it was important to speak to staff who were off work as a result of an injury, but would contact staff only when they had returned to work. Whilst staff were good intentioned, the lack of knowledge around timely contact and the ability to promote an early return to work is lost on many managers.

**Investigations, Causation and Lessons Learned** – When asked about investigation training staff referred to completing Datix training on MLE and learning how to complete the Datix fields, rather than how to conduct an investigation and root cause analysis. In turn, this led to a review of investigations completed on Datix and lessons learned from staff injuries. Many were incomplete and where completed, the lessons learned, as stated above, where not practical and root cause was not identified.

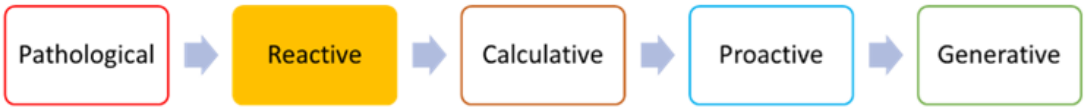
## 5. Risk Register

### 5.1 Health and Safety Management System

The Trust documented the risk of a lack of H&S management system on the Trust Risk Register over 18 months. This time last year the Trust had minimal performance measures, was partially unaware of the consequence or frequency of injuries by causation, there was no audit program, few risk assessments, no routine response to injuries and only a superficial understanding of H&S performance.

By the end of Q2, there are agreed goals and objectives, performance reports, an understanding of consequence and frequency of injuries, a standard response to injuries, a program of audit and risk activity, strategies to manage the risk of violence and aggression and greater consultation with clinical and non clinical areas. All of which is evidence of a H&S management system being developed and implemented and justification for the reduction of the risk to the target score and therefore closing.

But it is important to note whilst there is evidence of a H&S management system, it is one very much in its infancy. The current risk to the Trust is not the absence of a H&S management system, but that H&S management system is not yet embedded across the Trust. This is not to suggest this risk should remain on the Trust Risk Register, but to inform the Trust there is still much to do to embed this H&SMS across the Trust as we aim to move from a reactive to calculative management system as outlined in the H&S plan for 2023/24.




### 5.2 Risk Register

5.2.1 Extreme Risks

There are 3 risks specific to the H&S of staff, rated as extreme, all of which relate to ETS and the end of life of buildings, the need for backlog maintainence and critical plant and building infrastructure failure.

| Datix No | Risk Description | Action |
|---|---|---|
| 6229 | The day surgery unit is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous roof leaks and delayed / cancelled procedures. | The DSU strategy to maintain and repair falls under a schedule of works and the wider estates strategy. |
| 5664 / 7573 | The Trust commissioned a survey in February 2018 to establish the backlog liability of the Trusts Estate and risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery. | It is noted this risk forms part of the Board Assurance Framework Risk 4 reported in July 2023. |
| 7490 | A recent inspection of the main chimneys highlighted structural issues and are at risk of failure. | An independent structural engineer has been engaged and structural diagnositic tests are being conducted and reported through F&P Committee and to the Board. |

### 5.2.2 High Risks

There are 27 risks specific to H&S matters across the Trust rated as high risk. 17 of these risks relate to the consequences of the maintainence and infrastructure risks 5664 / 7573 identified within Estates. The remaining disticnt risks are listed below:

| ID | Directorate | Location | Description | Risk | Controls in place |
|---|---|---|---|---|---|
| 7689 | CSFS | Medical Engineering | There is a risk of injury to a person walking through car park to Medical Engineering building when the area is full of cars/vans that restrict access. | 9 | Signage markings and fencing has been erected to reduce the risk. |

| | | | | | |
|---|---|---|---|---|---|
| 7856 | CSFS | Orthotics | Following an inspection hazards identified include lack of sufficient ventilation and extraction against dust and fumes from substances used in a workshop | 9 | Stand alone extraction is used for router, kitchen style wall extraction fan and quotes have been sourced for extraction and ventilation |
| 7602 | CSFS | Sarum Ward | There is an increase in the amount of CAMHS inpatients receiving longer term treatment both that create a risk of self harm, damage and injury to staff. | 8 | Each patient has individual risk assessment, CAMHS referral, supervision and reduce ligature points in room. |
| 6955 | Facilities | Waste Area | There is a risk a member of staff is struck by a passing vehicle or that Trust or Contractor Assets are damaged | 8 | Procurement Team put a sign across the road, install witches hat, CCTV cameras. |
| 7841 | Medicine | Emergency Department | ED has not provided emergency response training for over 18 months. within ED. There is a risk of patient and staff harm and delay to treatment if a CBRN incident were to occur. | 10 | Emergency plans are in place, equipment is checked and staff are aware of procedures. |
| 7797 | Medicine | Laverstock Ward | There are 4 trollies that block exits due to lack of alternative storage space on the ward. There is a risk of obstruction of fire exits in the event of a fire, putting staff and patients at risk. | 12 | Fire Warden reviewing location of trolleys |
| 7695 | Medicine | Emergency Department | The ENP department is an isolated area of the ED, There is a risk of physical/verbal aggression from members of the public configuration can lead to staff being caught between a threatening patient and an accessible exit point to raise find a place of safety. | 9 | Security procedures in place and procedures in place to ensure staff are not working in isolation until after midnight, exit strategies for consultation rooms and buzzers available to alert staff. |
| 5812 | Medicine | All | There is a risk of violence and aggression in the workplace from both patients, relatives or visitors towards staff and other patients. | 10 | Violence Prevention and Reduction Group is developing a Trust wide strategy to reduce this risk. |
| 6492 | Surgery | Day Surgery Unit | Due to the lack of required structural integrity in theatre A and B, there is a risk that the Trust is non compliant with Laser legislation | 9 | Mobile screen, signage and estates work to install signage, lighting and barriers. |
| 3129 | Surgery | Vascular Assessment Unit | Risk of RSI to sonographers due to job role. | 12 | Ergonomic equipment is available include beds chairs and there is job rotation available to avoid repetition. |

## 6. Further Hazard Management

### 6.1 Nitrous Oxide Exposure Testing Update

In response to the NHSE publication on the risk to long term exposure to low levels of nitrous oxide ($N_2O$), 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.

Testing equipment has been purchased and equipment has been shared with both maternity and anaesthetics. The equipment provider did not provide software required to download the results. This is being chased by the Trust and testing will commence when software is available and installed.

### 6.2 Noise Testing

The Q1 H&S report identified anecdotally high levels of noise within corridors and the potential risk to operators of tugs towing cages throughout a shift. Noise is measured by peak levels and time weighted average over an 8 hour period (TWA). For the purpose of understanding noise baseline noise is recorded at 70dBA (a standard vacuum cleaner) and an increase of 5dBA doubles the volume of the noise heard.

A TWA of 85dBA requires the Trust to:

- Manage the noise at the source wherever possible,
- Provide staff with training about hearing damage and protection,
- Provide workers with suitable hearing protection, which must be worn, and
- Carry out regular monitoring of the noise levels to ensure they have not increased.

Noise levels were recorded by the H&S team during Q2. The intention was to measure noise created by tugs towing various trolleys and cages at locations between the link bridge and Hedgerows, including the central corridor. The H&S team in consultation with the Waste Management Team measured the noise of various trolleys and cages being towed by a tug. Results for peak noise levels are below:

| Location | Type of trolley | Peak Noise Level (dBA) | | |
|---|---|---|---|---|
| | | At 1m | 5m | 10m |
| North corridor along IT entrance | Multiple plastic waste trolleys | 85 | 82 | - |
| | Metal cage | 85 | 83 | - |
| | Electric bed mover | 68 | - | - |
| Central corridor | Multiple various trolleys | 96 | 94 | 90 |
| | Metal cage | 88 | 86 | 83 |
| | Plastic waste trolley | 86 | 84 | 83 |
| | Tug only | 64 | - | - |
| | Kitchen trolley | 77 | - | - |
| | Electric bed mover | 71 | - | - |

- At **96dBA** staff towing metal cages can only be exposed to 35 minutes of noise before reaching a TWA of 85dBA. At 90dBA, staff can be exposed to 2 hours 40 minutes before reaching a TWA of 85dBA.

- At **88dBA,** staff towing multiple plastic waste trolleys can do so for 4 hours before reaching TWA of 85dBA.

- At **86dBA**, staff towing trolleys can do so for 6.5 hours before reaching the TWA of 85dBA. There is enough inherent rotation, gaps and breaks in the day where staff towing plastic waste trolleys are not required to wear hearing protection or requires the Trust to take action to reduce the source of noise.

Noise is significantly greater in the central corridor due to the condition of the floor, varied floor angles, holes in the floor and a lack of noise insulation. This is also true of the central carousel tugs use to navigate between floors of the main hospital building. Despite noise levels, there is no risk of hearing damage to staff, patients, visitors or others. Pedestrians are not exposed to noise long enough and because tugs operate at lower speed and on vinyl flooring within the main hospital noise is lower than 80dBA. It is worth noting the noise created within the carousel does impact on the patient and visitor experience, especially for patients adjacent to the carousel on Pembroke Ward.

Where elevated noise levels are identified it is the specific vibration of metal on metal created from towing metal cages. Reducing the level of risk at the source of the noise, rather than relying upon the use of hearing protection, is the preferred choice of risk control published in the HSE's risk management guidelines. There has been a previous concern raised that the use of hearing protection will reduce the ability of drivers to hear pedestrians, but at 88 – 96 dBA, it is unlikely staff can currently hear pedestrians over the noise of the cages.

There are a number of different cages across the Trust. These include:

1. Supply chain cages used to transport goods to wards are not owned, or controlled, by the Trust and belong to a pool of cages used across multiple NHS Trusts. The H&S Team assessed supply chain cages and can see they have plastic covers in key areas to reduce the volume of noise created. Most inspected were in good condition and made less noise than other trolleys on site.

2. Porters use a number of Trust owned cages that evidence metal rubbing on metal and causing noise greater than 85dBA. Some have broken welds that are being repaired but in consultation with the Portering Team self joining rubber tape has been applied to contact points and at first glance has reduced the level of noise significantly without increasing the risk of manual handling injuries. The Portering team are assessing the noise and use of modified trolleys to see if the changes are effective and practical.

3. The Waste team use a variety of trolleys, cages and low loaders to transport goods. Large waste bins are not owned by the Trust and those that are owned by the trust are made from heavy duty plastic with rubber covers to reduce noise. The Waste team also use a number of older trolleys, that whilst not owned by the rust are in circulation across the campus. These older cages often seen used have broken welds and loose metal connections that cause metal to contact metal and create the excess noise recorded.

| **Action for 2024** |
| --- |
| There is a pool of older cages used by departments to transfer items and waste. The H&S team will investigate the use of heavy duty rubber tape to insulate cages at contact points attempt to reduce the level of noise for cages not part of the NHS Supply Chain pool, explore an inspection program for cages and explore practices to reduce the number of large waste trolleys being towed at once. |

### 6.3 H&S Procedures

At the beginning of Q1 there was a substantial number of H&S procedures for review, rewrite or development. The final 6 procedures related to H&S that remained outstanding were approved at the November H&S committee. There are no further outstanding H&S policies that need approval. The Violence Prevention and Reduction Policy is undergoing a significant rewrite to reflect changes in practice but remains within date.

Report written by

Troy Ready

Health and Safety Manager

October 2023

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 5.2 |
| Date of meeting: | 11 January 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report title: | Medical Education Annual Report | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | | | X | |
| Approval Process: (where has this paper been reviewed and approved): | People and Culture Committee 30 November 2023 | | | |
| Prepared by: | Emma Halliwell, Director of Medical Education | | | |
| Executive Sponsor: (presenting) | Emma Halliwell, Director of Medical Education | | | |

**Recommendation:**

The People and Culture Committee (P&CC) is asked to **note** the annual report from the medical education director.

**Executive Summary:**

It is a relief to be able to report this year that the worst of the Covid-19 pandemic appears to be behind us. However, its impact coupled with relentless clinical pressures, and a prolonged period of industrial unrest, means it remains a difficult time for all those working in the health sector. The Medical Education Team's priority continues to be to provide an excellent educational and training environment in Salisbury, despite these challenges, whilst supporting the well-being and development of both trainees and trainers alike.

It is therefore exceedingly pleasing to report that we received the best GMC survey results we have had in recent years. Not only have our benchmarking figures improved, but our 'overall satisfaction' ranking both nationally and regionally has shown marked improvement; we now sit second in the Wessex region. This is a testament to the hard work and dedication of all those involved in medical education in the Trust at all levels, and I extend my thanks to them all.

Our undergraduate team led by Dr. Annabel Harris, Associate Clinical Sub-Dean, received excellent feedback from a recent quality visit from Southampton University Medical School. As medical student numbers expand the team is working with the university to see if we can support more student placements, specifically year 3 attachments in surgery.

Our first cohort of Physician Associate students have graduated from Bournemouth University. The Trust approved a business case to employ qualified PAs last spring and we will have four in post by the end of the autumn. Dr. Gail Ng, PA Lead, is supporting these newly qualified individuals through a preceptorship programme, which mirrors one that has been established in Poole for several years.

The expansion of the Foundation Programme is now complete, so we have 33 F1s and 33 F2s in post as of August 2023. Dr. Georgina Morris, Foundation Programme Director, has worked hard with individual departments to ensure that this expansion contains quality educational post with appropriate supervision. The medical education foundation role has also been embedded and is proving an excellent experience for the individual F2, as well as providing invaluable support to the Trust's simulation team. Whilst not strictly within the timeframe of this report, it would be remiss of me not to mention a recent visit from the Foundation School from which we have received some excellent verbal feedback, and so we are looking forward to the final written report.

Ms. Rashi Arora continues to play a vital role as SAS and LED Development Lead. The establishment of a recognised CESR group within the Trust is in its infancy, but gaining traction, and is a priority area for us over the next 12 months.

There have also been some excellent SAS and LED development days, including a 'Design your own Study Day' competition, which have had inspiring feedback. We are grateful to Emma Freeman, Medical Education Manager, for all her support and enthusiasm in organising these.

Aware of the challenges that International Medical Graduates face when new to the NHS, and in light of recent GMC guidance, I am delighted to report that we have appointed Dr. Julie Onslow as our IMG Lead. Julie is an experienced educator and an Associate Dean in Wessex, so her knowledge and experience will be invaluable. She is currently working alongside medical HR and departmental educators to assess our current induction provision and how this needs to be developed going forward.
We have become more aware of the pressures that supervisors are under in the last year and I am pleased that we have been able to offer extra training days to support them in their role. These have been run both 'in house' and by an external provider, and have universally received very good feedback. They have also proven to be an excellent opportunity to spend time together as an educational faculty.

The entire medical education team were delighted when the simulation department won a 'Staff Achievement Award' last year. It was a tangible way to recognise all Claire Brattle has done to develop this team over a number of years, and she should be proud of it. Simulation is become a bigger part of medical and non-medical curricula for all learners at all levels. The Trust has recognised this and approved a business case to expand the team, so they can meet this increasing demand.

Our medical education administration team goes from strength to strength. Emma Freeman, Medical Education Manager, is showing great leadership and initiative, and I would like to thank her personally for all the support she gives me. Anna Thorne (nee Spicer), Foundation Programme Coordinator, has become an expert in her field and was singled out by the Foundation School for particular recognition during their recent visit. Rebecca Henderson, Medical Education Administrator, continues to ably support our medical and PA students, as well as the GP VTS trainees. We would like to develop other areas further e.g. widening participation, clinical attachments, work experience etc., but cannot do so without an expansion within this administration team, as they are running at (over) full capacity. The other challenge in this regard is the space available in the Education Centre to support such expanded education and training.

It remains a privilege to be Director of Medical Education in Salisbury. The wider educational fraternity continue to go 'over and above' what is necessary to support, educate and train our trainees. I remain grateful for all their expertise and enthusiasm, as well as the support they give me in fulfilling my role.

| 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

# Director of Medical Education
# Annual Medical Education Report
# August 2022 to August 2023

**Produced by:** **Dr. Emma Halliwell, Director of Medical Education**

**October 2023**

## Acknowledgements

Ms. Rashi Arora, Specialty and Associate Specialist, and Locally Employed Doctor Development Lead

Dr. Annabel Harris, Associate Clinical Sub-Dean

Dr. Georgina Morris, Foundation Programme Director

Dr. Ellen Neale, GP Vocational Training Scheme Programme Director

Dr. Gail Ng, Physician Associate Lead

Dr. Julie Onslow, International Medical Graduate Lead

Members of the Medical Education Training Committee

Administrative Staff, Medical Education Department, Education Centre

## Distribution List

Ms. Stacey Hunter, Chief Executive, Salisbury NHS Foundation Trust

Dr. Paul Sadler, Post-Graduate Dean, Health Education Wessex

Dr. Peter Collins, Chief Medical Officer, Salisbury NHS Foundation Trust

All members of the Medical Education Training Committee (METC)

All members of People and Culture Committee

Posted on the Medical Education page of the Trust Intranet

# Executive Summary

It is a relief to be able to report this year that the worst of the Covid-19 pandemic appears to be behind us. However, its impact coupled with relentless clinical pressures, and a prolonged period of industrial unrest, means it remains a difficult time for all those working in the health sector. The Medical Education Team's priority continues to be to provide an excellent educational and training environment in Salisbury, despite these challenges, whilst supporting the well-being and development of both trainees and trainers alike.

It is therefore exceedingly pleasing to report that we received the best GMC survey results we have had in recent years. Not only have our benchmarking figures improved, but our 'overall satisfaction' ranking both nationally and regionally has shown marked improvement; we now sit second in the Wessex region. This is a testament to the hard work and dedication of all those involved in medical education in the Trust at all levels, and I extend my thanks to them all.

Our undergraduate team led by Dr. Annabel Harris, Associate Clinical Sub-Dean, received excellent feedback from a recent quality visit from Southampton University Medical School. As medical student numbers expand the team is working with the university to see if we can support more student placements, specifically year 3 attachments in surgery.

Our first cohort of Physician Associate students have graduated from Bournemouth University. The Trust approved a business case to employ qualified PAs last spring and we will have four in post by the end of the autumn. Dr. Gail Ng, PA Lead, is supporting these newly qualified individuals through a preceptorship programme, which mirrors one that has been established in Poole for several years.

The expansion of the Foundation Programme is now complete, so we have 33 F1s and 33 F2s in post as of August 2023. Dr. Georgina Morris, Foundation Programme Director, has worked hard with individual departments to ensure that this expansion contains quality educational post with appropriate supervision. The medical education foundation role has also been embedded and is proving an excellent experience for the individual F2, as well as providing invaluable support to the Trust's simulation team. Whilst not strictly within the timeframe of this report, it would be remiss of me not to mention a recent visit from the Foundation School from which we have received some excellent verbal feedback, and so we are looking forward to the final written report.

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Our medical education administration team goes from strength to strength. Emma Freeman, Medical Education Manager, is showing great leadership and initiative, and I would like to thank her personally for all the support she gives me. Anna Thorne (nee Spicer), Foundation Programme Coordinator, has become an expert in her field and was singled out by the Foundation School for particular recognition during their recent visit. Rebecca Henderson, Medical Education Administrator, continues to ably support our medical and PA students, as well as the GP VTS trainees. We would like to develop other areas further e.g. widening participation, clinical attachments, work experience etc., but cannot do so without an expansion within this administration team, as they are running at (over) full capacity. The other challenge in this regard is the space available in the Education Centre to support such expanded education and training.

It remains a privilege to be Director of Medical Education in Salisbury. The wider educational fraternity continue to go 'over and above' what is necessary to support, educate and train our trainees. I remain grateful for all their expertise and enthusiasm, as well as the support they give me in fulfilling my role.

**Dr. Emma Halliwell**
**Director of Medical Education**

# 1.0 Introduction

This report gives an overview of medical education in Salisbury NHS Foundation Trust (SFT) for the past 12 months from August 2022 until August 2023. These activities are assessed against our strategic objectives which are as follows:

## Objectives

1. Maintain accreditation of training
2. Accreditation of Medical student and Dental student placements via university medical schools.
3. Maintain a strong educational environment for doctors.
4. All Educational and Clinical Supervisors to be accredited in line with GMC requirements and trainees only allocated to those supervisors fully recognized.
5. Keep the Trust management informed of national policy pertaining to doctors in training and the impact these polices will have on service delivery.
6. Feed into the Trust's clinical governance framework to ensure patient safety.
7. Provide supportive pastoral care and personal development opportunities, including career guidance information, whilst promoting equality and diversity
8. Medical Education incorporated into Directorate Annual Plans
9. Ensure good quality Trust and Departmental Induction with appropriate evaluation of these.
10. Quality of training maintained in light of the European Working Time Regulations (EWTR) plus changes that result from trainee reductions, The Shape of Training, Broadening the Foundation Programme and the new Junior Doctors contract implemented from October 2016 and renegotiated 2019.
11. Ensuring trainees feel valued and are an integral part of the Trust.

All these objectives have proven particularly challenging this year due to the ongoing pressure on service delivery, alongside the current industrial unrest. The Trust has aimed to minimise any negative impact on both training and well-being, but its effects are likely to pertinent for the foreseeable future.

## 2.0 The Medical Education Department

*The Medical Tutors are:*

| | |
|---|---|
| Dr. Emma Halliwell | Director of Medical Education (DME) |
| Ms. Rashi Arora | SAS and LED Development Lead |
| Dr. Annabel Harris | Associate Clinical Sub-Dean (ACSD) |
| Dr. Georgina Morris | Foundation Programme Director (FPD) |
| Dr. Ellen Neale | GP Vocational Training Scheme (GPVTS) Programme Director |
| Dr. Gail Ng | Physician Associate (PA) Lead |
| Dr. Julie Onslow | International Medical Graduate (IMG) Lead |

*The Education Centre is based on Level 5 of the hospital. The Medical Education Team is as follows:*

| | |
|---|---|
| Mrs. Emma Freeman | Medical Education Manager |
| Mrs. Rebecca Henderson | Medical Education Administrator and PA to the Associate Clinical Sub Dean |
| Mrs. Anna Thorne (nee Spicer) | Medical Education Administrator, Foundation Programme Co-ordinator, and PA to DME and FPD |

## 3.0 Quality Assurance Methods

The standards and outcomes for postgraduate medical education and training are set by the General Medical Council (GMC).

These standards form the basis for monitoring and implementing education and training of medical staff at Salisbury Foundation NHS Trust. Quality Assurance processes are in place in order to monitor and support the development of medical education both at a local and regional level (Health Education England - Wessex). These processes are usually augmented by the annual GMC trainees and trainers' survey, and triggered visits from the various 'schools' to programmes at the Trust when issues arise.

The Director of Medical Education is required to complete an 'annual return' to HE Wessex as part of the Quality Assurance process.

# 4.0 Accreditation of Medical Training Posts

### *4.1 Foundation Programme*

Recruitment

Salisbury continues to be a popular hospital for trainees to undertake the Foundation Programme. We continue to be able to recruit a good standard of trainees from medical schools through the national competitive entry process. For August 2022, we brought forward 6 additional posts (2 rotations x 3 x 4 months) that were originally planned to commence from August 2024 (see below) to cater for an expanded national waiting list. All of these extra posts were recruited to and will form part of our ongoing standard 2 year Foundation Programme rotations going forwards. We therefore had 33 F1s starting with us in August 2022 (compared with 25 in Aug 2021 when there were 2 unfilled 'extra' posts), and 21 in previous years). In addition, we had 2 'out of sync' F1s on extended training post-ARCP.

The expansion was originally planned nationally by UK Foundation Programme to start from August 2024 (with increased numbers of UK Medical Graduates finishing their studies over the next 3 years). However, it has been brought forward due to unprecedented numbers of eligible International Medical Graduates (IMGs) applying to the UK Foundation Programme at F1 level (having provisional rather than full GMC registration) and being added to the general recruitment pool.

As a result of the above, 7 of our new F1s were IMGs. This is far higher than our usual intake and resulted in complexities, beyond our and the doctors' control. For example, 3 were unable to start during the usual induction period (end of July 2022) because of delays in obtaining visas (the situation in Ukraine had exacerbated this situation by creating extra applications for visas). This resulted in staggered starts over an 8-week period. 4 had not had opportunity to take the Prescribing Skills Assessment which resulted in need for extra supervision when prescribing and being doubled up on rotas for several months. Despite these initial challenges, I'm very pleased to report that all have settled in well and all of our F1s have now successfully passed through their ARCPs and moved to F2 posts.

Regarding F2s, in August 2022 we had 26 in standard rotational posts (having been F1s in Salisbury), 1 extra as a long-standing transfer from Jersey, and 2 out of sync (maternity leave, extended training). In view of the additional posts recruited to in August 2021 at F1, we made the decision not to take any 'stand-alone F2s'. The F2 posts from the previous 'stand-alone' rotations were used in creating new standard rotational posts.

From August 2023, we will have 33 F2s, and anticipate 33 standard F2 posts in the Salisbury Foundation Programme in the longer term. These will incorporate 2 additional Psychiatry posts (external to SFT in Fountain Way) as there is a requirement for community posts, plus 2 additional posts in Medicine at SFT.

Specialised Foundation Post in Medical Education

I am pleased to report that from August 2021, one of our 2-year Foundation Programme rotations now includes a new Foundation Education Fellow post, the first in Wessex, which is an exciting development. The appointee is part of the highly competitive Specialised Foundation Programme (which contains Research-

focused placements, Education and Leadership streams). The Salisbury SFP post-holder receives additional training and experience related to Medical Education, for example involvement in Simulation and placement-based Medical Student and Physician Associate teaching and spends 4 months equivalent time during F2 doing this role alongside training in the Emergency Department (in practice this was delivered 50:50 over 8 months). Feedback from the initial post holder, Dr. Grace Whyman, was very positive. The UK Foundation Programme held a 'Sharing best practice day' in Birmingham in May 2023. Grace presented a poster on 'Standardising informal near-to-peer medical student teaching.'

The Foundation Programme 2021 Curriculum

The Foundation Programme curriculum, which underpins the training and professional development of newly graduated doctors, relaunched for the first time in five years in summer 2021. The curriculum sets out a holistic approach to care including physical health, mental health and social health, and the skills required to manage this in both acute and community settings and for patients with chronic conditions. Foundation doctors must demonstrate that they are competent in initial assessment and management of patients under supervision. Other capabilities are focused on areas such as communication and consultation skills, teamwork, reflective practice, patient safety, quality improvement and teaching. The curriculum provides a framework for educational progression that will help them achieve these skills and supports them through the first two years of professional development after graduation from medical school.

In conjunction with the above, Dr. Annabel Harris, ACSD, and I co-developed and facilitated a series of six workshops for F1s and F2s aimed at developing skills and confidence with teaching and delivering constructive feedback (called the 'Foundations of Teaching' programme). This was inspired by the 'Teaching Tomorrow's Doctors' Course run by Southampton Medical School for clinicians delivering Medical Student teaching. We are indebted to Jacquie Kelly, Faculty Development Lead at Southampton Medical School, for her advice and for allowing us to use some of their resources.

Well-being

We continue to strive to ensure that our Foundation Doctors are supported pastorally as well as clinically to provide the best care for patients. The Foundation Programme expansion opened up possibilities for working differently and improving workload and supervision during weekend working in Medicine and H@NT surgical cover. A working group was established in 2021 through the H@NT Board to develop ideas, act on trainee feedback, and look to implement changes. From April 2023, all F1s (on both Medicine and Surgical Rotas) now do night cover, so there are now 2 F1s on nights routinely (previously there was just one F1, taken from the Surgical Rota).

The Junior Doctors' kitchen area on Level 5 is now well-utilised, with 24-hour access. Dr. Grace Whyman and Dr. Niamh Toner, joint Mess Presidents, have continued to develop the Mess environment and the programme of Mess Events in 2022/23 was diverse and very well-received. The Second Mess Formal Event in July 2023 at the Guildhall was a fantastic occasion attended by over 80 people.

I am greatly indebted to Dr. Emma Halliwell as DME, and all the Foundation Training Clinical and Educational supervisors, and want to thank them for their ongoing support. I'd also like to thank Anna Spicer who joined us in July 2021 as Foundation Programme Coordinator and is now well-established in this role. I'm also very

pleased to have the support of Emma Freeman, Medical Education Manager, who joined the SFT Medical Education team in Spring 2022 having previously been a Midwife and an experienced member of the Practice Education team.

**Dr. Georgina Morris**
**Foundation Programme Director**

***4.2 General Practice Training***

Overall, 2022-2023 has been another successful year for GPVTS training at Salisbury District Hospital.

We have some trainees who require additional support for a variety of reasons, and we continue to greatly appreciate the positive culture of open communication between ourselves and the Trust, which we have jointly cultivated, to enable these trainees to be best supported whilst they undertake their hospital posts.

Teaching

Attendance levels have been good, and trainees have again provided positive feedback on the half day monthly ST1&2 teaching schedule which continues to be delivered virtually. May I take this opportunity to express my thanks to those departments who have contributed to this virtual teaching schedule and more widely to the departments for enabling trainee attendance.

Recruitment

All GPVTS posts were successfully filled at recruitment for August 2023 commencement onto the 24:12 GP training programme. All trainees entering the GPVTS training who graduated from a non-UK Medical school have been contacted by myself prior to August 2023 and their past NHS working experience explored and this information shared with the Trust.

The challenges of LTFT doctors as well as the 24:12 training programme regarding hospital posts remain.

I would like to express my thanks and gratitude to administration team at SDH, for their ongoing administration support and assistance with the mid Wessex GPVTS trainees.

**Dr. E Neale**
**GP & Mid-Wessex TPD (Salisbury ST1&2)**

### *4.3 Medical Posts within Salisbury NHS Foundation Trust*

Trainee posts numbers within SFT for the last few years are as follows:

| | 2018-2019 | 2019-2020 | 2020-2021 | 2021-2022 | 2022-2023 |
|---|---|---|---|---|---|
| F1 | 21 | 21 | 28 | 27 | 33 |
| F2 | 22 | 28 | 29 | 29 | 29 |
| Core Trainees | 101 | 99 | 38 | 40 | 33 |
| GP VTS | | | 18 | 16 | 15 |
| Specialty trainees | | | 50 | 46 | 57 |
| Locally employed doctors | 25-40 | 35-55 | 72 | 54 | 45 |
| **Total** | **169-184** | **183-203** | **215** | **212** | **212** |

In addition, the Trust currently employs 38 SAS doctors.

The table above clearly shows the expansion in the Foundation Programme, which has been reflected nationally to accommodate the increasing number of medical students. This has been beneficial to Salisbury as it had been recognised regionally for years that the Trust was 'under Foundation doctored' compared to other hospitals of equivalent size.

The number of our other doctors in training (Core trainees, GP VTS and Specialty trainees) has remained more or less static over the last five years. The main variation in numbers is the size of the locally employed doctor cohort.

Expansion of specialty training is happening nationally and we are already been asked to 'bid' for extra posts, which will usually (but not always) be Trust-funded. The DME is working with CDs to identify LED posts that might be suitable for conversion to training posts, which will ensure cost neutrality for the Trust.

# 5.0 Accreditation of Student Placements

### *5.1 Medical student placements*

This report pertains to medical students present in Salisbury, mostly from Southampton Medical School, and is covering the academic year 2022-2023.

It has been another successful year for Salisbury NHS Foundation Trust and medical student education. This has been due to the ongoing dedication, flexibility and positive attitude of all staff at all levels. This year has not been without its hiccups, but these have been overcome. I remain hugely thankful for all those that have helped and supported myself and the medical students this last year.

QAE visit from Southampton

Southampton came to visit us for a QAE inspection December 2022. They were highly complementary about the education faculty here and the facilities. They thought the teaching provided was excellent and the attention given to well-being and pastoral care was very positive. Recommendations and requirements for this trust to work on were:

1) Providing all students with their ACC assessors at the start of their placements - this has already been actioned and will happen for the 2023-24 year.
2) The Trust team needs to look at education space to ensure that teaching spaces are not compromised by clinical commitments - this has been escalated to the DME and the Trust executives to look at.
3) To continue to review the WiFi provision - lots of work has happened with this and it is also part of a bigger Trust wide project. Hopefully this will improve the WiFi in the medical students' accommodation for those starting in 2023-2024.
4) It is recommended that the team consider the use of F1 mentors where possible- This has already been implemented across the final year modules and is in place for the 2023-24 start.

Teaching provided

As well as the formal teaching programme that we provide the medical students, the 'junior doctors' undergraduate education group maintained their high standards this year. Junior doctors provided simulation teaching, a mock OSCE and evening regional teaching - a collaboration between us and Dorchester. The teaching program, simulation and mock OSCE went down well with the students and received excellent feedback. They also delivered assistantship teaching sessions and case-based teaching regional sessions which were also well received.

Dr. Morris and I delivered our second 'Foundations of Teaching' course which had top reviews again. This consisted of 6 evening sessions on 'how to teach' for junior doctors. We also created a new course- 'Senior Educators half day' which was aimed at consultants and senior locally employed doctors and taught on medical student assessments, giving feedback and on clinical reasoning teaching. This was run in June and received very positive feedback.

Medical student numbers

Through our doors we hosted 12 final year medical students for 6 months. Throughout the year we also saw 11 x 4$^{th}$ year students in O&G, 8 x 4$^{th}$ years in child health and 23 x 4$^{th}$ year students in acute care modules. We also had 24 students doing their assistantships with us.

We hosted 10 student selected units and electives here in plastics (x2), emergency medicine (x1), anaesthetics (x3), child health (x2), radiology (x1) and ENT (x1). It was great to see people offer to help with this and I know that the students and the university were happy with these placements.

Staffing

This was the first complete year that was done by Rebecca Henderson as our administration lead for medical students. She has been outstanding and is an huge asset to the department and Trust, with fantastic support and leadership from Emma Freeman. Dr. Temitayo Gandon and Dr. Sophie Moloney-Geany have also successfully completed their first years as module leads in child health and O&G respectively. They have slotted well into their new roles and have been great - thank you. Dr. Chris Pandya has become clinical lead and so has stepped down from his role as subject lead for medicine. For the new cohort of students starting in August 2023-24, Dr. Matt Hill (locally employed doctor on AMU) is the new subject lead for Medicine and Chris will deputise for him when needed.

I would like to thank all the subject leads and administration staff for all they have done for the students this last year.

Many thanks to Rebecca Henderson and Emma Freeman, Dr. Georgina Morris, Dr. Emma Halliwell, Claire Levi and the undergraduate faculty, the teaching block/rotation leads, and everyone involved in providing high quality supervision and teaching to the medical students 2021-2022.

**Dr. Annabel Harris**
**Associate Clinical Sub-Dean**

### *5.2 Physician Associate students*

Background

This is the second year that SFT have had Physician Associate (PA) students from Bournemouth University. We had a total of seven students in 2022/2023.

They were split into General Medicine/ Acute and Emergency Medicine, Paediatrics, Surgery and Obstetrics and Gynaecology.

Summary report 2022/2023

Another exciting and challenging year for the students and for me as it was the first year having students in Paediatrics, Obstetrics/Gynaecology and Surgery.

A special thank you to Ms. Moloney-Geany, Obstetrics/Gynaecology Consultant, who set up an amazing induction/ welcome day for the PA students. I know that the students were very impressed and one of them is keen to return and work with the team in the future.

The Paediatric team were also truly amazing and welcoming. I know that the students enjoyed being there. A big thank you to Dr. Gandon, Paediatric Consultant, who settled the students in.

A further thank you to Mr. Saboor Ghauri, Dr. Tom Jackson, Dr. Russell Mellor, Dr. Toby Black, Dr. Anna Barton, Dr. Danielle Bagg and Dr. Andy Nash for their support through the last year.

I am pleased to say that a business case (as mentioned in last year's report) to have four qualified Physician Associates was put in following our first successful year having PA students. We interviewed 12 candidates in March 2023, and I am delighted to say that we have appointed four qualified Physician Associates, two of whom started their preceptorship year in Emergency Medicine and Acute Medicine in July. I am also pleased that one of the appointed PAs is one of our first PA students in the Trust from 2021.

The Future

The Trust vision is to have 20 qualified Physician Associates in 5 years. I can definitely see a challenging few years ahead. I have great hopes that the qualified PAs will develop a good training programme for the student PAs over the next couple of years and this will hopefully attract more PAs to SFT.

**Dr. Gail Ng**
**Physician Associate Lead**

# 6.0 Strengthen the Education Environment

### *6.1 SAS and Locally Employed Doctors*

This report provides an overview of the SAS and LED education initiatives at SFT over the past 12 months, spanning from August 2022 to August 2023. These activities have been evaluated against our strategic objectives, which focus on promoting development opportunities aligned with service requirements, individual experiences, and career aspirations. The report aims to underscore our commitment to nurturing the SAS and Locally Employed Doctor (LED) cohort, with a specific emphasis on supporting their growth and advancement, including those aspiring to join the GMC specialist register through the CESR route.

SAS/LED Education Administrative Support

Efforts have been dedicated to maintaining an up-to-date SAS and LED database, with valuable administrative support from Emma Freeman, Medical Education Manger. This arrangement has laid the groundwork for a well-structured SAS education framework. As of June 2023, our database encompasses 37 SAS and 59 LEDs within the SFT community.

Activities for SAS Group

1. SAS Advocate Role: A strategic position designed to enhance the well-being of SAS Doctors has been proposed in the latest contract. This strategic position is distinct from the SAS tutor role and has already received approval from the Trust. The upcoming recruitment process for this role signifies a proactive step towards fostering better support for SAS doctors.

2. Training Needs Analysis: An evaluation questionnaire (TNA) was distributed to all SAS doctors, yielding a response rate of 33%. The TNA revealed a list of courses that piqued the interest of our SAS Doctors. This data-driven approach will help tailor training initiatives to better match the interests and needs of SAS doctors.

3. SAS Courses Organized at SFT:

    - 15th March 23 - Preparation for CESR Study Day: Virtual training, delivered by Resconsortium, attended by fourteen participants.
    - 1st April 23 - Present with Impact (Day 1): Face-to-face workshop, delivered by Dendritic Ltd, attended by eight participants.
    - 23rd March 23 - Patient Safety with Human Factors: Virtual training, delivered by Resconsortium (cancelled as clashed with relaunch of Trust Patient safety processes. To be rescheduled)
    - 15th September 23 - Train with Impact (Day 2): Face-to-Face workshop, delivered by Dendritic Ltd (rescheduled due to IA)
    - 31st May 23 - DIY Study Leave Day Competition: An engaging competition was launched, inviting SAS doctors to submit their proposals for study day topics and designs of their choice. The application submission deadline is set for 11th August. All entries will receive personalized support and mentoring, with the results announcement scheduled for 25th August 2023.

4. Well-being support: Our commitment to supporting doctors' well-being remains steadfast. The SAS Christmas event on 1st December 2022 provided a platform for open discussions on SAS challenges and issues, sharing examples of the importance of personal & professional well-being. SAS Doctors enjoyed painting Christmas pottery & sharing pizza with enthusiasm and engagement.

5. Deanery-Promoted Courses and Educational Activities: SAS Doctors have capitalized on Deanery-funded activities and courses, with regular dissemination of course information facilitated by Emma Freeman.

6. SAS Professional Fund: There have been issues around the delivery of these funds to the Trusts on a national level. Finance team is working diligently to identify the money trail.

Activities for LED Group

1. LED Appraisal and Revalidation Advice Sheet: An advice sheet, formulated through collaborative efforts between Trust appraisal and Education Teams, was developed last year. The topic of LED appraisal has become a recurrent theme in the Appraisal Refresher Course, reinforcing key points.

Activities for CESR Group

1. CESR Trainees Group: Dr. Frederick Gleadowe, SAS Doctor ED, has assumed the role of the new CESR Representative. He established a WhatsApp group comprising doctors keen on pursuing the CESR route at SFT. A registration system is under development to identify interested doctors, streamlining resource allocation. Concurrently, collaborative endeavours are underway, involving the Regional SAS Tutor and Wessex SAS Tutor group, to institute a regional support network for CESR.

**Ms. Rashi Arora**
**Trust Training and Development Lead for SAS and LEDs**

### *6.2 International medical graduates*

Salisbury hospital welcomes all international medical graduates. I have been appointed as a lead for all our IMG doctors new to the Trust. I have set up a specific E-mail for all queries with regards our IMG colleagues - SFT.IMGHUB@nhs.net

A handbook that offers advice with regards accommodation, clinical competencies and supervision, career development, childcare, banking, childcare links, registration with a local general practitioner and where to obtain provisions are available. This guidance will cover local religious groups, places to meet, local attractions, and green spaces soon.

Welcome posters are being developed for distribution.

For each new cohort of IMG doctors we envisage early engagement with a named Educational Supervisor and a buddy to help with the practicalities of living in the UK. We aim to guide them through the GMC learning and responsibilities. Each doctor will have a bespoke plan for shadowing and talked through how to ask for help within their department and other hospital settings.

We shall recommend the Health Education Wessex course for IMG Induction in the initial stages and then the Leadership course after this.

**Dr. Julie Onslow**

**International Medical Graduate Lead**

### *6.3 Medical Education Training Committee (METC)*

This committee includes medical tutors, specialty education leads (College Tutors), staff from Medical Education and Medical Personnel. During the past 12 months the Committee met on 6 occasions and, as in previous years, has been proactive in its approach to sharing information and implementing changes to medical education and training. These meetings also provide a forum for the educational faculty to be made aware of concerns and issues in the various departments with regards to training.

The Medical Education and Training Committee reports to the OD and People Management Board and the minutes of meetings held are therefore submitted here for review and, if necessary, action.

### *6.4 Quality Assurance Monitoring Data*

Local processes to quality assure in addition to the annual GMC survey of trainees include:

1. Local (optional) survey of trainees who started in August 2022 will be undertaken to establish their views of the induction process, educational and clinical supervision and overall support provided by senior members of the Trust.
2. Annual feedback sessions with both the Foundation Year 1 and Foundation Year 2 doctors – summarised and distributed as appropriate by the FPD.
3. Formal feedback from GP VTS trainees at the end of each year - forwarded to the individual departments.
4. Formal evaluation of the main August induction – **Appendix B**
5. Regular departmental visits by the DME to meet with trainees and discuss their training experience.

### *6.5 Educational Supervision*

All Educational Supervisors in Wessex are required to have undertaken 'The Essentials' course. This is the 2-day course run by HE Wessex that equips Educational Supervisors for their role. Currently this is running as a combination of E-learning and face-to-face tutorials. Once accredited, trainers recognised for these roles are now identified on the GMC register.

The process for maintaining recognition as a trainer is based upon a requirement to undertake 10 hours of educational CPD (8 hours of which has to be face-to-face) within a five-year period. A more robust system is now in place whereby HE Wessex send reminders to supervisors when their recognition is due to expire.

There are many examples of what could be classed as CPD e.g. equality and diversity training, attendance at ARCP panels, career guidance, exam support, supporting trainees through SIIs etc. Several 'Trust Refresher' courses have been facilitated by an increasing number of senior educationalists at SFT, which can form part of the face-to-face element. The two that have been run over the last 12 months had good attendance and received excellent feedback – **Appendix C**

We have used some extra funding we received from HE Wessex (study leave underspend) to increase the CPD offering for our Educational Supervisors. An external company called 'Doctors Training' ran a very well-received course in July on 'Supporting your trainee to Improve Self Care, Manage Stress and Enhance Resilience'. It was an excellent educational day and benefited from supervisors having time away from the hospital to network as well. A further course looking at supervision of IMGs, LTFT and LEDs is planned for November.

Once all the CPD requirements have been met, an individual's training role is discussed at their appraisal, after which a signed form is sent to HE Wessex to confirm that the trainer has met the requirements for ongoing recognition.

### *6.6 Medical Education Budgets*

The department is supported by the following budgets:

- Medical Education Director (Infrastructure)
- Specialty Doctors' Training
- Study Leave (held centrally by HE Wessex and reimbursed to SFT)
- Undergraduate Tariff form Southampton University (formerly SIFT)

The responsibility for these budgets lies with the DME.

The annual Undergraduate Tariff business plan, which outlines how around £550,000 will be spent, is drawn up by the DME and then approved by the Chief Medical Officer. This is used to support medical students with accommodation, travel, administrative support and well-being initiatives. It is also used to develop/train our medical educators. In addition, funds have been allocated for the purchase of the following items of equipment:

- Histopathology – textbooks
- ITU – ultrasound for line insertion/echos/chest scans
- Maxillo-facial – laptop
- Ophthalmology – teaching microscope
- Paediatrics – portable laptop and monitor for simulations
- Plastics – hand model
- Simulation – junior manikin
- Up-to-Date

### *6.7 Revalidation for Trainees*

The GMC revalidation process for secondary care and doctors in training has been in place since 2012, which requires each doctor to revalidate on a 5-yearly cycle. The Postgraduate Dean for HE Wessex (Dr. Paul Sadler) is the Responsible Officer for all doctors in training.

The Trust reports on every trainee involved in an SII or Clinical Review, or named in a Complaint. This information is collated by the DME and returned to the HE Wessex in the requested format known as an exception report (not to be confused with exception reports introduced as part of the Junior Doctors' Contract). We continue to collate this information every 4 months, with the DME meeting formally with the Head of Risk Management, Patient Safety Facilitator, Clinical Governance Lead for Maternity and the Head of Customer Care to review the information required to generate the required reports.

All trainees about whom an exception report is completed are informed of this and sent a copy of the information submitted. These reports feed into the ARCP process, where information should triangulate with the self-reported incidents on the trainee's Form R.

## 7.0 Strengthen the Education Environment within the Health Community

The IT and audio-visual systems in the Lecture Theatre, and other rooms, in the Education Centre have been upgraded, which has been well overdue. This is now an attractive and interactive environment to hold educational sessions. It is hoped that some more of the 'furnishings and fittings' will be replaced in the coming year, which will enhance the area immensely.

It is pleasing that, after the pandemic, more 'external' courses have been undertaken – anaesthetic and ophthalmology regional teaching, GP training days etc.

However, the issue in plain sight is that the Education Centre capacity is at its limits, and this is hindering our desire to expand educational opportunities. It has been necessary to hire other venues at times, with the associated cost and lack of flexibility. There is also a lack of private space for 1:1 conversations. It is becoming a real bottleneck in the provision of the education requirements for our trainees, as well as our ability to support their well-being. With the political agenda moving towards widening participation in medicine, the Trust will need to act to address this in order for Salisbury to maintain its educational reputation.

## 8.0 Inform Trust Management of National Policy

The Medical Education and Training Committee (METC) is a cohesive and functional group as it provides a forum for cascading information out to Departments and trainees within SFT via the Educational Leads. The DME reports to the People and Culture Committee in order to continue to highlight the impact of national directives regarding education and training, and recruitment issues on service delivery and safe patient care. Finally, the DME meets every other month with the Chief Medical Officer to discuss issues that have arisen at Deanery, Trust and trainee level.

## 9.0 Clinical Governance Framework

The DME receives clinical review reports involving trainees and has regular communications with the Head of Risk Management. The Trust completes exception reports, which are forwarded to the HE Wessex, on all trainees involved in SIIs and Clinical reviews and named in Complaints (please see section on Revalidation for Trainees). This work has ensured close working with the Risk Departments for both maternity and the overall Trust.

Salisbury's inter-professional Healthcare Improvement Programme (HImP) is a well-established course to help Foundation Doctors learn basic, non-clinical skills by undertaking service improvement projects. The programme is currently led by Dr. Seb Gray and Louise Arnett, Head of Service Improvement. During the last year, this programme has been aligned with the Trust's 'Improving Together' initiative. It is hoped that this will (amongst other benefits) improve the sustainability of the projects undertaken as this has always been a challenge for HImP.

## 10.0 Careers Advice and Pastoral Care

Career support and pastoral care from the DME, FPD, and College/Specialty/GP and Tutors continues to ensure that trainees receive appropriate and timely assistance and guidance throughout the duration of their time in Salisbury.

Career guidance for Foundation Trainees takes place in both years of the Foundation Programme. There are 2 generic career guidance sessions, with additional specific sessions on interview preparation and applying for GPVTS in Foundation Year 2.

With the ongoing clinical pressures and current industrial unrest, the need for pastoral care and well-being support remains in forefront of everyone's mind.

The DME and FPD continue to provide pastoral care for trainees who require additional support for reasons both within and outside the working environment. As a rule, the FPD mainly supports the Foundation Doctors as issues regarding their welfare are usually escalated in that direction. The DME usually does the same for trainees above Foundation level, but not exclusively so. Both are supported in this regard by an excellent network of departmental educational leads and medical education staff.

Referrals from the Trust to the Wessex PSWU (Professional Support and Well-Being Unit) for the few trainees needing higher level of support, are usually made by educational supervisors, in discussion with the departmental educational leads. However, they are always done with the knowledge and support of the DME.

Unfortunately, finding an appropriate site for the promised rest area (funded via the BMA money from several years' ago) has been challenging. As a result, we are investigating an alternative approach of putting recliners etc. in areas already used by junior doctors as offices during the day.

The Mess continues to be a well-used area and the events held on a regular basis are well-attended. The resurrection of this has been a huge asset in supporting well-being across all our training grades.

## 11.0 Trust and Departmental Inductions

The new Foundation Year 1 doctors had a week of shadowing, funded nationally, as usual. This allowed the new doctors to undergo the same level of induction as their more senior colleagues who arrived a week later, whilst addressing areas that were particularly important at the start of their medical careers. They completed an AIM (Acute Illness Management) course and had the opportunity to 'find their feet' on the wards by working alongside the outgoing F1s. It is recognised that a longer shadow week would be preferable, but this is currently not supported by UKFPO. With the revision of curricula that are due at medical school, this may be achieved in the next few years by a longer 'assistantship' attachment, happening at the end of medical school, but at the hospital that the students have been assigned to for their Foundation programme.

48 new doctors joined the Trust on Wednesday 2nd August 2022, all receiving a mandatory induction followed by their departmental inductions. The Medical Education staff are to be commended for all their hard work in ensuring that everything ran smoothly.

Regular monthly inductions (of up to 20 doctors) follow a similar format but are often held in an alternative venue to the Education Centre and are run by Medical HR.

It is an aspiration for the Medical Education team to take the lead in running all the doctors' inductions throughout the year, with support from Medical HR, but there is a need to expand the team before they are able to take on the extra work.

Formal evaluation of the F1 shadow week and the main August induction was undertaken and as stated in paragraph 6.3 is attached to this document in **Appendix B**

## 12.0 Challenges for 2023/2024

- Working alongside the Trust and HE Wessex to support training, education and well-being of our doctors in training within the national environment of prolonged industrial action with its associated challenges.
- Ensuring the emphasis on trainee well-being is maintained and initiatives to improve the lives of doctors in training completed in a timely manner.
- Continuing to ensure that all Named Clinical and Educational Supervisors who are GMC accredited trainers maintain this accreditation and encourage more consultants to take up these supervisory roles, including by offering training to further their own professional development.
- Support Named Clinical and Educational Supervisors to ensure they have adequate time in their job plans, which is ring-fenced, to support the doctors in training.
- Continuing to work with the Trust so that, even when vacancies in a rota are at the level that the viability of a rota is jeopardised, the impact on the quality of education provided and the time available by senior doctors to train is minimised.
- Ensuring full implementation of the self-development time for trainees at all levels and locally employed doctors as they transition onto their new contract.
- Working with trainees, supervisors, the GoSW and Trust management to ensure that issues raised by doctors in training through exception reports are appropriately addressed and sustainable solutions put in place to resolve recurrent concerns.
- Supporting departments where there have been concerns about training and supervision raised by trainees at their ARCPs or via the GMC survey.
- Support the increasing cohort of Foundation doctors, and their supervisors, to ensure they integrate into teams and become a valuable part of the workforce.
- Looking to continue to develop our SAS and Locally Employed Doctor cohort and, specifically, how we can support and develop these individuals, including those wanting to join the GMC specialist register via the CESR route.
- Continuing to develop our Physician Associate students programme and support those qualified Physician Associates through their preceptorship year.
- Developing support mechanisms for International Medical Graduates starting in the Trust in line with GMC guidance.
- Considering how we widen our remit to meet the challenge of the national 'widening participation', clinical attachments, work experience etc., and the need to increase administration and education centre space capacity to support this.

## 13.0 References

The following documentary evidence supporting this report is held in the Medical Education Department:

- Medical Education Strategic Plan: 2022-2023
- Evaluation of locally organised teaching
- Nationally analysed formal assessment of feedback from medical students on placement
- Feedback and analysis from the medical students of the local teaching sessions
- Evaluation forms received from shadowing week and induction August 2022
- Study leave database – Accent
- METC agenda and minutes
- Junior Doctors Induction and H@NT course programmes
- Website documentation
- Archives retained according to local policy

# Appendix A

## GMC Survey 2023

## Salisbury NHS Foundation Trust

## Background

The yearly, national GMC trainee and trainer survey has taken place again in 2023 and the results were released in July.

## Caveats

### Response rate

There was a similar response rate nationally to 2022:

73% trainee response (76% 2022)

37% trainer response (34% 2022)

However, the response rate was lower regionally and locally:

64% Wessex trainee response (68% Salisbury trainees)

36% Wessex trainer response (36% Salisbury trainers)

This was despite a high profile and active campaign to ensure as many people as possible completed the survey.

### Locally

Results are not reported if less than three responses to questions, so ability to look at individual departments/training programmes is more limited, especially when looking at the smaller departments. In additional, if only a few trainees in a department/programme respond the results can easily be skewed (positively or negatively) by an outlier. This means that the results for a hospital like Salisbury can potentially be less representative of the communal experience of all trainees within a particular area and more difficult to interpret.

## Results

Results are benchmarked against other Trusts across the country. If the score is significantly negative or positive compared to the national average, the box is highlighted red or green. Where it is negative or positive but shares a confidence interval with the national average, the box is highlighted pink or light green.

The survey also asked questions about patient safety and undermining behaviour, allowing free text comments.

A trainer survey runs alongside the trainee survey.

**Benchmarking results for SFT**

There were insufficient trainees in a programme, or responses from those that are, for the results to be reported in the following programmes:

GP VTS – emergency medicine, obstetrics and gynaecology, paediatrics

Also – acute internal medicine, cardiology, general internal medicine, haematology/oncology, histopathology, intensive care medicine, ophthalmology, otolaryngology, palliative medicine

| **Specialty** | **Programme** | **Green flags** | **Red flags** |
|---|---|---|---|
| Anaesthetics | Core | 0 | 0 |
| | Specialty | Facilities | 0 |
| Emergency medicine | F2 | 0 | Workload |
| | ACCS | Overall satisfaction<br>Handover<br>Adequate experience<br>Feedback | 0 |
| General practice | F2 | 0 | 0 |
| Medicine | F1 | Facilities | 0 |
| | F2 | 0 | 0 |
| | IMT year 1 | 0 | Workload |
| Obstetrics and gynaecology | Specialty | Workload<br>Teamwork<br>Supportive environment | 0 |
| Paediatrics | Specialty | Reporting systems<br>Supportive environment<br>Induction<br>Educational governance<br>Regional teaching | 0 |
| Plastic surgery | Specialty | 0 | Clinical supervision out of hours |
| Radiology | Specialty | Reporting systems<br>Teamwork<br>Supportive environment<br>Induction<br>Educational governance | 0 |
| Surgery | F1 | Clinical supervision out of hours | 0 |
| | F2 | 0 | 0 |
| | CST | Educational governance | Clinical supervision out of hours |
| | Specialty | Workload<br>Rota design | 0 |
| **Total** | | **23** | **4** |

These results are reported as by programme, rather than by specialty, as the former cover very small cohorts of trainees and therefore are more liable to be skewed.

When the results are interrogated by specialty, other aspects particularly to note:

**Acute internal medicine:** 5 green flags

**Paediatrics:** 6 green flags

**Urology:** 8 green flags

**Geriatric medicine:** 2 red flags

**Gastroenterology:** 2 red flags

**Overall satisfaction ranking**

The survey also provides ranking of hospitals for 'overall satisfaction'. This year Salisbury was ranked 133/356 acute Trusts nationally and 2nd in Wessex (2022: 234/363 nationally and 7th in Wessex).

**Patient safety and undermining behaviour**

There were one free text comments about the workload, lack of beds and impact on training in ED, leading to concerns about patient safety.

**Trainer results**

These results were only available for a small number of specialties, which is consistent with the last few years.

| Specialty | Green flags | Red flags |
|---|---|---|
| Anaesthetics | Support for training<br>Resources for training | 0 |
| Emergency medicine | Rota issues | 0 |
| General surgery | Supportive environment<br>Professional development | 0 |
| Obstetrics and gynaecology | 0 | 0 |
| Plastic surgery | Appraisal<br>Resources to train | 0 |
| Trauma and orthopaedic surgery | Supportive environment<br>Support for training | 0 |
| Urology | Appraisal | 0 |
| **Total** | **10** | **0** |

**Comments**

The GMC survey continues to be regarded as the most valuable tool there is for assessing the quality of training of posts nationally. However, when there are only a small number of respondents in a programme it is relatively easy for the results to be biased by the responses of just one trainee in a positive or negative way. This is compounded where there are several 'neutral' or 'average' responses or if the particular programme

concerned is one of a limited number in the country, due to the way results are analysed and compared. The falling response rate across the country that we have seen in the last few years seems to have stabilised a little this year. In Salisbury the response rate to the trainee survey has increased a little, whilst that of the trainer survey has decreased. There still remains concern at local, regional and national level that some of the questions asked are ambiguous and would be better answered with a 'yes' or 'no' rather than a graded response.

Even though the GMC survey does not always give us the full picture, it does identify areas where there are significant concerns and where training is clearly excellent. The results give a guide as to where work needs to be done to improve the quality of the posts and also where there is good practice that should be shared more widely.

I am pleased to report that our results from the GMC survey this year have shown noticeable improvement on previous years – namely 23 green flags (15 in 2022) v 4 red flags (8 in 2022). It has been particularly pleasing to see a marked uplift in our ranking for overall satisfaction at both a national and regional level - 133/356 acute Trusts nationally and 2$^{nd}$ in Wessex (2022: 234/363 nationally and 7$^{th}$ in Wessex).

Looking at some specific areas, both Paediatrics and Radiology are to be commended for their excellent results – 5 green flags and 0 red flags in both cases when analysed by programme. We have expanded the number of Radiology STs that we train here (on honorary contracts from Southampton) and so it is the first time that there has been data for department, as they had more than the minimum 3 trainees respond. It is therefore reassuring to know that we now have tangible evidence, rather than just anecdotal, that we are giving the trainees a very good educational experience whilst they are with us.

The paediatric results by specialty were also excellent (6 green flags), as were urology (8 green flags) and acute internal medicine (5 green flags). AMU should be highly commended for their excellent results at a time when their clinical environment has been extremely challenging.

The results for Plastic Surgery (1 red flag after 4 red flags in 2022) reflect the work and input of both the Lead Clinician and Educational Lead, for which I am grateful. However, the ongoing red flag for clinical supervision out of hours has surprised all three of us. We asked for feedback specifically about this from the trainees when we met for an education review, and they all said they had no issues. We will have to revisit this with them again to see if it reflects an ongoing pattern, a specific incident or concerns about a specific trainer.

There has been a challenging clinical and educational environment in the Gastroenterology department in recent years, due to a lack of permanent staff. This has eased somewhat, but the results (2 red flags by specialty) probably reflect the ongoing fluid situation. This is slowly improving, and we now have trainers in the department that are fully engaged with the educational requirement of their trainees, so I would hope that there will be an improvement in the results next year.

The patient safety issue that was reported was about the lack of beds in the hospital, leading to an increased workload in ED which was felt to impact on the training experience. At the time 25% of beds at Salisbury were occupied by patients medically fit for discharge, which inevitably had a knock-on effect. The Trust has been actively addressing mechanisms to facilitate discharge of these 'long stayers'. In the last few months, AMU have institute a SDEC unit, which means most medical patients now bypass ED, improving flow. I am confident that ED has a robust and well-regarded teaching programme in place, and actively release trainees for core teaching (e.g. F2 teaching).

These results have been discussed with educational leads for the various departments in order to facilitate further reflection and discussion.

My final reflection is that this survey was undertaken at the beginning of what has now proven to be long industrial action by our trainees. Whilst recognising that the grievance the doctors have is with the government, not the Trust, it will be interesting to see if their current disquiet with their working environment comes through in the 2024 survey.

**Dr Emma Halliwell**

**Director of Medical Education**

**Salisbury NHS Foundation Trust**

**August 2023**

# Appendix B

## EVALUATION OF F1 SHAOW WEEK

| Induction – Wednesday 26th July 2023 | High 5 | 4 | 3 | 2 | Low 1 |
|---|---|---|---|---|---|
| How did you find the initial welcome talks (from the Chief Executive Officer, Chief Medical Officer, Director of Medical Education and Freedom to Speak Up Guardian)? | 3 | 1 | | | |
| Do you have any comments about the initial welcome talks?<br>• A run down of things like annual leave and rota's would have been helpful. Or a deeper dive into how the hospital runs logistically. | | | | | |
| How did you find the Top Tips for F1s? | 1 | 2 | 1 | | |
| Do you have any comments about the Top Tips for F1s?<br>• No clarity on on-call shifts. Would've appreciated practical advice on F1.<br>• This was useful, perhaps more structure to the session."<br>• I liked our small group discussions which continued during the lunch time. | | | | | |
| How did you find the Blood Transfusion talk? | 2 | 2 | | | |
| How did you find the Foundation Programme Director session? | 3 | 1 | | | |
| Do you have any comments about the Foundation Programme Director session?<br>• I think an introduction to Horus would be useful at this stage. | | | | | |
| How did you find the Guardian of Safe Working video? | 3 | | 1 | | |
| Do you have any comments about the Guardian of Safe Working video?<br>• A summary slide would be useful.<br>• Felt she is very approachable. | | | | | |
| How did you find the Bereavement/Coroners Officers session? | 2 | 1 | 1 | | |
| How did you find the H@NT introduction? | 2 | 1 | | 1 | |
| Do you have any comments about the H@NT introduction?<br>• I think examples of calls/what to do would be nice. | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| How did you find the HIMP introduction? | 3 | 1 | | | |
| How did you find your IT induction overall? | 2 | 1 | 1 | | |
| Do you have any comments about your IT induction?<br><br>• Fine but too much time allocated.<br>• Some of them were repetitive and I don't think I remember everything in the session, but I will try to learn more on wards.<br>• Sufficient time wasn't provided to complete all the training during the time slot but it was very useful.<br>• Really useful. | | | | | |
| The Trust is now live with EPMA across the Inpatient settings in the Trust. IT included learning for EPMA as part of your induction. How confident are you in using EPMA in your role? | 1 | 2 | 1 | | |
| Do you have any comments about EPMA?<br><br>• Wasn't aware we had one. | | | | | |
| How did you find the Resuscitation training? | 4 | | | | |
| Do you have any comments about Resuscitation training?<br><br>• First time to see the mechanical compression! | | | | | |

# EVALUATION OF AUGUST INDUCTION

**18 responses**

Average rating based on 1-5 scoring (1 – worst; 5 -best)

**Please rate the pre induction communication**
4.33 average rating
Comments:

*"Information sent out a long way in advance, really useful for planning day. "*
*"Email sent with the outline of the day."*
*"Well organized and clear, thank you. "*

**Please rate the pre induction arrangements regarding ID badge, Smart card & Car parking**
4.44 average rating
Comments:

*"All present and ready to go on day one. "*
*"Clear and simple processes which could be improved by the use of electronic forms instead of word / pdf attachments. "*

**Please rate the welcome from Stacey Hunter CEO, Dr Peter Collins CMO & Dr Emma Halliwell DME**
4.33 average rating
Comments:

*"Good overview from Dr Halliwell "*
*"Introduction helpful "*

**Doctors Mess representatives**
4.28 average rating
Comments:

*"Felt slightly less relevant. "*

**Freedom to Speak up/ Equality, diversity & Inclusion/ Wellbeing team.**
4.50 average rating
Comments:

*"Good overview of services. "*

**Guardian of Safe working - Dr Rowena Staples (Video)**
4.56 average rating
Comments:

*"Thank you for taking the time to prepare the video. The message was clear and supportive. "*

**Blood transfusion training**

2.61 average rating

Comments:

*"Covered predominantly online via MLE. Yet to complete, due to too much mandatory online training. "*

*"Not done on the day"*

**Talk from Director of Medical Education**

4.39 average rating

Comments:

*"Good overview of SL provision. "*

*"Thank you for setting clear expectations and frank support. I was very impressed that newly rotating doctors were not rostered for out of hours shifts".*

**Was the IT training session?**

| Too long | Too short | Just right | Other |
|---|---|---|---|
| 3 | 2 | 10 | 3 |

**Did the classroom IT training equip you for your first clinical shift?**

| Yes | No | Other |
|---|---|---|
| 10 | 4 | 4 |

Comments:

*"Excellent troubleshooting "*

*"Too much IT training covered on MLE with little time to practice this during the IT training session. IT session covered how to log into each software".*

*"The IT systems in Salisbury are the most complicated I have ever worked with compared to 5 other hospitals in this region. Thankfully, the IT team are helpful".*

**Resuscitation Training**

4.67 average rating

Comments:

*"Well run, not overly long. "*

*"Covered the basics."*

*"Good session"*

**Do you have any suggestions for us to improve on future inductions?**

*"A 2-day induction would be more helpful to give more time to navigate through MLE. The MLE training has taken more than 0.5 day allocated for SDT time".*

*"Whilst IT advances are to be welcome; they have made the transition to new trusts far more challenging, and it takes longer for new and rotating doctor."*

**What did you like least about the induction?**

*"Mess talk was a little less relevant. "*
*"The little time given to complete mandatory MLE teaching - I am having to complete this in my own time outside of work. Induction felt very rushed. "*
*"Despite a good induction, I did not feel adequately prepared for the clinical environment. I think this is a growing problem for all hospitals".*

**What did you like most about the induction?**

*"Well organised, published well in advance. "*
*"The food given on induction. The staff wellbeing talk was also helpful."*
*"There was a very friendly, welcoming, valuing atmosphere and the hospitality provided supported this. The attendance of the rota managers at the induction"*

**How friendly were the staff?**

| Extremely friendly | Very friendly | Somewhat friendly | Not so friendly | Not at all friendly |
|---|---|---|---|---|
| 11 | 7 | 0 | 0 | 0 |

**Any other comments or suggestions.**

*"Knowing the induction schedule in advance really makes you feel like a valued member of the workforce, reduced the inevitable prestart anxiety."*
*"A very shortened induction, with subjects e.g., fire safety being transferred to MLE which take more time to complete on MLE than it would to deliver face-to-face"*
*"Thank you"*

# Appendix C

## EVALUATION TRUST REFERSHER COURSE

## 9th November 2022

**Facilitators:** **Katharine Backhouse, Aisling Coy, Claire Page**

**Collated feedback:** **8/8 respondents**

**Content**

| Poor | Satisfactory | Good | Very good |
|---|---|---|---|
| | | 3/8 | 5/8 |

**Delivery**

| Poor | Satisfactory | Good | Very good |
|---|---|---|---|
| | | 2/8 | 6/8 |

**Any topics covered particularly well?**

- LED's – our group particularly wanted to discuss this & was well covered in each section.
- Available support.
- Differential attainment & bias.
- Well facilitated discussions on trainees that are struggling.
- Summary on SDT useful
- Discussion around LEDs particularly helpful.
- Yes, feasible to include LEDs as part of a common standard.
- LEDs

**Any topics that could have been covered better?**

- No

**Any topics that should have been covered but weren't?**

- Issues around neurodiversity

**Was 4 hours for this refresher?**

| Too short | About right | Too long |
|---|---|---|
| | 8/8 | |

**Any other suggestions or comments?**

- Good course. Knowledgeable faculty. Thanks!
- Perhaps more time for discussing difficult in managing trainees
- Excellent!

**EVALUATION TRUST REFERSHER COURSE**

**26th November 2023**

**Facilitators:** **Adam Hughes, Gail Ng, Claire Page**

**Collated feedback:** **11 respondents**

**Content**

| Poor | Satisfactory | Good | Very good |
|---|---|---|---|
| | | | 11/11 |

**Delivery**

| Poor | Satisfactory | Good | Very good |
|---|---|---|---|
| | | 1/11 | 10/11 |

**Any topics covered particularly well?**

- 'Trainee in need'
- Useful tips and tricks on ES/CS meetings
- All – good discussion
- Very simplified and useful
- Trainees in difficulty and steps to remedy
- Trainees in difficulty
- Trainee in need/ needing support
- Trainees and awkward conversations
- Everything

**Any topics that could have been covered better?**

Nil

**Any topics that should have been covered but weren't?**

- Trainer welfare

**Was 4 hours for this refresher?**

| Too short | About right | Too long |
|---|---|---|
| | 9 | |

**Any other suggestions or comments?**

- Useful to meet and collate with colleagues
- Lovely to interact with other specialties
- Time to stop and think – thank you!
- Very good session covering practical aspect of AES role.
- Thank you
- Thanks for biscuits!
- Thank you

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 6.1 |
| Date of meeting: | 11 January 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report tile: | Emergency Preparedness Resilience & Response (EPRR) | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | | | ✓ | |
| Approval Process: (where has this paper been reviewed and approved): | No other forum | | | |
| Prepared by: | Steve Court – Head of EPRR | | | |
| Executive Sponsor: (presenting) | Lisa Thomas – Chief Operating Officer/EPRR Accountable Officer | | | |

## Recommendation:

The Trust Board is asked to support the ongoing work required to fulfil our EPRR duties and responsibilities, and to sign off this annual EPRR assurance report as part of the NHSE assurance process.

**Purpose of Report:**

To provide assurance to the Trust Board as part of the National EPRR Assurance process.

The Trusts self-assessment against the National EPRR Core Standards has been confirmed by NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB) and approved by NHSE, as delivering Substantive assurance.

This report, through a summary of EPRR activity, including the assurance process and training and exercising demonstrates our compliance.

**Background:**

The Trust is defined as a category 1 responder under the Civil Contingencies Act and is subject to civil protection duties discharged through the EPRR assurance process.

## Executive Summary:

Based on the National RAG status for EPRR compliance SFT has been rated by NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board and NHS as 'Substantive' compliant for this year. As a category One responder we are meeting our civil protection duties under the Civil Contingencies Act (2004).

Substantive compliant means that arrangements are in place that appropriately addresses all but one of the core standards that the organisation is expected to achieve to the minimum level. The only core standard which has been identified as partially compliant is Domain 10, Standard 10, which requires having trained staff for Chemical, Biological, Radiological & Nuclear (CBRN) on each roster within ED or available from other departments so there is cover 24/7, 365 days a year.

| 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): | |

# Emergency Preparedness Resilience & Response (EPRR) Annual Report 2023

## 1. Purpose

This paper provides an annual report on the Trust's emergency preparedness in order to meet our statutory requirements of the Civil Contingencies Act (CCA) (2004) and the NHS England Emergency Preparedness Resilience and Response (EPRR) Framework 2022 and NHS England Business Continuity Framework.

## 2. Background & Statutory Framework

The Civil Contingencies Act outlines a single framework and establishes clear roles and responsibilities. SFT are defined as a category 1 responder in the CCA 04 and is subject to the following civil protection duties:

- Assess the risk of emergencies occurring and use this to inform contingency planning.
- Put in place Emergency Plans.
- Put in place Business Continuity Arrangements.
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- Share information with local responders to enhance co-ordination.
- Co-operate with other local responders to enhance coordination.

## 3. National EPRR Framework & Core Standards

The NHS England EPRR Frameworks contain principles for health emergency planning for the NHS in England and the NHS Core Standards for EPRR provides the minimum standards that an NHS organisation must meet.

It is expected that that the level of preparedness will be proportionate to the role of the organisation and the services provided:

- SFT must meet the minimum core standards and provide evidence these standards are being met.
- SFT must identify an Accountable Office (Chief Operating Officer) who is responsible for ensuring these standards are met.

## 4. NHS Bath and North East Somerset, Swindon and Wiltshire EPRR Assurance process 2022-23

The responsibility for undertaking the local assurance process for SFT was undertaken by the NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB) in conjunction with NHSE. SFT provided the ICB with a core standard spreadsheet with each standard RAG rated with supporting evidence for those standards requested by the ICB.

Our self-assessment stated (September 2023): As part of the national EPRR assurance process for 2022/23, Salisbury NHS Foundation Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against the core standards which are applicable to the organisation, Salisbury NHS Foundation Trust:

The ICB conducted the 'confirm and challenge' meeting on 3rd November 2023, with Rachael Backler, AEO, Louise Cadle, Head of Emergency Preparedness Resilience and Response & Deputy AEO and Tracey Merrifield, EPRR Manager, all from NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board. In attendance from SFT, Lisa Thomas, Chief Operating Officer; Jane Dickinson, Deputy Chief Operating Officer and Steve Court, Head of EPRR.

The outcome letter detailed SFT progress: Not yet received.

The final outcome letter with the final compliance rating for SFT for EPRR Core Standards 2022/23 based on the National RAG status for EPRR compliance has not yet been formally received.

SFT Is compliant with 98% of the Standards - the overall rating is '**Substantive'.**

See figure 1 below for compliance levels:

| **Overall EPRR assurance rating** | **Criteria** |
|---|---|
| Fully | The organisation is 100% compliant with all core standards they are expected to achieve.<br>The organisation's Board has agreed with this position statement. |
| Substantial | The organisation is 89-99% compliant with the core standards they are expected to achieve.<br>For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. |
| Partial | The organisation is 77-88% compliant with the core standards they are expected to achieve.<br>For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. |
| Non-compliant | The organisation compliant with 76% or less of the core standards the organisation is expected to achieve.<br>For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.<br>The action plans will be monitored on a quarterly basis |

Figure 1:

## 5. Training & Exercising

Statutory requirement set out that the Trust will undertake:

- Live Exercise – Every 3 years (if there hasn't been an incident which required a full response from the organisation)

- Table Top Exercise – Yearly
- Communication Test – Every 6 month

A variety of training and exercising and live events have taken place in the last year, despite the ongoing Incident response to COVID-19.

See tables below in relation to training and awareness and exercises and live incidents:

**Training August 2022 – to date**

- DipHEPRR Unit 8 Plan, Conduct and Evaluate EPRR Exercises, 18/01/2023, 1 x EPRR Officer
- CBRN & PRPS, 12/01/2023 (x 1), 19/04.2023 (x 1), 13/07/2023 (cancelled due to Industrial Action)
- Duty Manager on-call training, 27/01/2023 (x 1), 21/04/2023 (x 1)
- Executive on-call training, 30/03/2023 (x 1)
- Multi-Agency Operational Training, 20/04/2023 (x 2)
- New Loggist training, 08/06/2023 (x 1)
- Loggist refresher training, 20/07/2023 (cancelled due to industrial action)

**Exercising Schedule – dates planned**

| Live Exercises | Table Tops | Communications Test | Training |
|---|---|---|---|
| CBRN exercise "Pluto" 20/6 | Planned Business Continuity exercises throughout the year with divisional teams | Everbridge MI Cascades adhoc – no notice (ICB) | CBRN & PRPS 15/01 (monthly from Feb, dates to be confirmed) |
| | | Internal Cascade – Feb & July 2024 (no confirmed date) | Senior Emergo Instructor 09/01 |
| | | | Loggist (monthly from Feb, dates to be confirmed) |
| | | | Principles in Health Command 30/04, 07/05, 26/06, 01/08, 06/11 |
| | | | NPAG 27/02, 30/04, 23/07, 01/10 |

**6. Exercises and Live Incident including internal incident responses - September 2022 to date.**

**Exercises**

| Name of Exercise | Type of Exercise | Date & Timings | Exercise Lead | Participants |
|---|---|---|---|---|
| SWASFT & NHSE SW Mass Casualty | Regional Mass Casualty Tabletop | 09/03/2023 | SWASFT & NHSE Regional Team | 7 SFT staff |

| | | | | |
|---|---|---|---|---|
| SWASFT & NHSE SW Comms | Communications Exercise | 30/05/2023 | SFT EPRR Team | 1 SFT Staff |
| SFT Comm's | Communications Exercise | 13/07/2023 | SFT EPRR Team & Ops team | 6 SFT Staff |
| SFT Shelter & Evacuation | SFT Tabletop Exercise | 21/09/2023 | SFT EPRR Team & Directorate Reps | 8 SFT Staff |

**Incidents**

| Incident | Audience/Description | Date | Learning Outcomes |
|---|---|---|---|
| COVID-19 Response | Trust wide | Jan 2020 - to date | • Numerous clinical & operations processes changed |
| Industrial Action (Nurses, BMA) | Trust wide | Dec 2022 – to date | • Clear battle rhythm.<br>• Templates for submissions.<br>• SOP's to support planning.<br>• Senior Divisional leads developing managers.<br>• Robust communications with Trust staff. |
| IT Outage affecting intranet | Trust wide | 07/07/2023 | • IT will discuss with the contractor around risk assessment |
| Skip fire outside main entrance | Main Entrance & Level 3 administration block | 07/07/2023 | • Broadcast to all that smoking is prohibited in site.<br>• Skips are located 6m away from any building and it has a cover. |
| Water leak | SFT North Block | 11/07/2023 | • RTS to look if the tank can be re-filled more quickly. The fault was with an old valve |
| Cyber attach against Electronic Care Records (e-PRC) | Emergency Department (SWASFT) information for patients arriving at ED | 18/07/2023 | • Good partner support from IT as a new way of informing ED about patient arrivals was identified by SWASFT and we helped GWH to have it set up. |

| | | | |
|---|---|---|---|
| Telephone Outage (national provider) | Trust wide | 29/08/2023 | • Hold back on calling a Tactical response meeting as once it was set up, the issue had been resolved. |
| Power outage | Trust wide | 14/10/2023 | • To keep the MRI's in good working condition until new equipment is in-place<br>• Understand what other patient services are running (vaccine centre due to be open on Sunday 15th Oct) |
| ED Ceiling water leak | Emergency Department | 20/10/2023 | • ED identified new routing for patients within the department for patient safety. |
| Cyber attack | Trust wide | 26/10/2023 | • IT to review Business Continuity Plans. |
| ETS member drilling through pipeline in Theatres | Theatres | 14/11/2023 | • ETS to review work booked out of hours and to liaise with those departments affected.<br>• Clear escalation process for Out of hours significant works on site to include the Clinical Site team.<br>• Work in theatres not to go ahead when there are patients having procedures. |
| SSL RO Failure | Trust wide | 15/11/2023 | • Clear understanding of contract arrangements<br>• Escalation of incident<br>• Business Continuity plan review to highlight triggers for escalation.<br>• Wider SII being conducted. |
| PAC's failure | Trust wide | 27/11/2023 | • Radiology organised a workaround quickly to prevent any service disruption. |

| | | | |
|---|---|---|---|
| | | | • Business Continuity Plans used to support data migration. |
| Power outage | Trust wide | 08/12/2023 | • ETS to update of what has happened in as soon as possible. |

All exercises and live events are debriefed so lessons learnt, and action plans can be captured, and plans updated/modified as required.

The EPRR Team have been involved with other aspects of response for the Trust which include:

- New generator Project – We have coordinated the planned work with SFT estates team and departments so clear communications are used and changes in location of patient services for that day.
- High Voltage shutdown – Agreed response with clear communications to all areas affected and set up mini response team on the day. (No issues identified)
- Storm Ciaran – supported the communications to Trust staff and highlighted risk to the site for equipment that may come loose due to high winds.
- Reset Week – supported the site team with the organisation of the week.
- Head of EPRR facilitated an IT tabletop exercise for GWH.
- Head of EPRR facilitated and supported the Isle of Man with a live Mass Casualty exercise.

## 7. Partnership Working

Externally the Trust is embedded in multi-agency planning through the Wiltshire & Swindon Local Health Resilience Partnership LHRP. This ensures a proactive and coordinated approach to planning and sharing of best practice. The Trust participates on a regular basis on the Everbridge SWAST communications cascade as well as regular Health Community Response Plan activities, and actively works on the LHRP task and finish groups where appropriate and works with partners with the coordinated planning of the modular response tool iRespond which has been implemented across the health economy in Wiltshire, the work of the LHRP has all been completed via face to face and virtually. SFT have also been supporting GWH and Gloucester Hospitals with sharing of documentation to ensure a consistent approach across partner organisations.

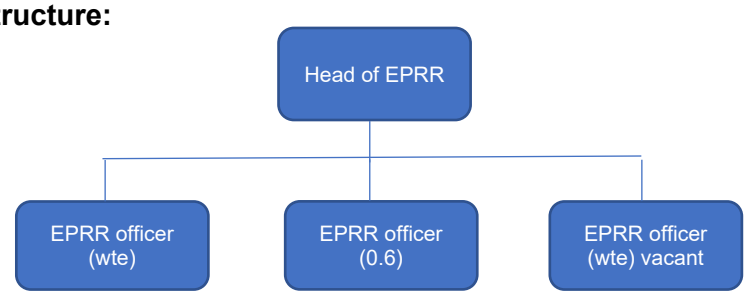
This partnership working has been strengthened further with the multi-agency partnership working during the continued response to COVID-19, where partners have worked together and forged greater relationships with partners.

## 8. Developments to consider for 2024.

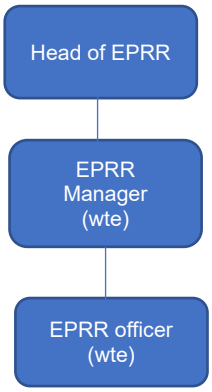
As the EPRR portfolio continues to expand, we need to consider the longer-term development of the EPRR Team, and how we continue to support the organisation and use our skills to enhance and further embed the EPRR culture across the Trust. The goal for the EPRR Team will always be, to be the best we can and aspire to ‘Gold’ standards and not to simply achieve the minimum required, this drive is enhanced by working with partners and colleagues who are professional and aspire to support the Trust and the wider community.

As the team have lost an officer it is a good time to look at the structure so what has been proposed and agreed, is to recruit a EPRR Manager to support staff progression and succession planning, and to take on the responsibility of the portfolio when the Head of EPRR is away. There is an anticipation that one of the two EPRR officers currently employed will be successful in being recruited to this new position.

**Current Structure:**




**Proposed Structure:**




The EPRR team are supporting the Emergency Department with organising CBRN training as there has been a large turnaround of staff so having a trained person on shift 24/7 has become a challenge. To support mitigation, we are looking to train the site team as they are on duty all day, every day.

To support the EPRR portfolio a 3 year strategy document is being written to identify the department a clear focus of what we want to achieve and how we intend of making this progression.

National Power Outage planning will continue going into 2024 and further training with support from the ICB and partners to develop our Tactical & Strategic Commanders so they are confident to respond to anything which may happen.

## 9. Identified Gaps in EPRR portfolio & Next Steps

| Gaps | Action | Date |
|---|---|---|
| Instigate a switchboard automated procedure for our internal cascade procedures | Netcall project started so looking for testing in early 2024 | 2024 |
| In a mass casualty type MI response, ED currently no | ED have found a solution so exercising is required | Work progressing with ED – early 2024 |

| | | |
|---|---|---|
| robust process for unidentifiable patients | | |
| Maintain compliance against the core standards and improve on these minimum standards | To ensure we maintain full compliance at the next Core Standards ICB Confirm and Challenge meeting | August 2024 |
| Continue to build on the links with the Wessex network of the LHRP, to ensure a consistent approach for response to an incident linking the Trauma Centre and Units and to build on the relationships and sharing with MTW | Continued participation in regional exercising, building on links with partners at other organisations | 2024 |
| Emergo Table top Trust - Wide | | TBC (late summer, early autumn) |

**10. Summary**

Based on the National RAG status for EPRR compliance SFT has been rated by NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group and NHS England as 'Substantive". As a category One responder we are meeting all but one of our civil protection duties under the Civil Contingencies Act (2004) but have a robust plan to ensure the element identified, is managed.

**11. Recommendation**

The Trust Board is asked to support the ongoing work required to fulfil our EPRR duties and responsibilities, and to support the work required within the EPRR portfolio as we transition into the Integrated Care System (ICS) Structures in 2024 and to approve this Substantive compliance statement by signing off this annual EPRR assurance report as part of the NHS England assurance process.

Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Report to:** | Trust Board (Public) | **Agenda item:** | 7.1 |
| **Date of Meeting:** | 11th January 2023 | | |

| | | | | |
|---|---|---|---|---|
| **Report Title:** | Director of Infection Prevention & Control (DIPC)<br>6th monthly update April-September 2023 | | | |
| **Status:** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | | | X | |
| **Prepared by:** | Fiona McCarthy Lead Nurse, Prevention and Control Nurse, Infection Prevention & Control Team | | | |
| **Executive Sponsor (presenting):** | Judy Dyos, Director of Nursing and DIPC | | | |
| **Appendices (list if applicable):** | Appendix A IPC Board Assurance document | | | |

**Recommendation:**

The Board is asked to:

1. Note the report, and the performance against Infection Prevention and Control requirements for the year.

2. Minute/document that the Board continues to acknowledge their collective responsibility as described within the DIPC report and confirm receipt of assurance on IPC actions and controls for the year.

**Executive Summary:**

The purpose of the annual DIPC Report is to inform the Trust Board of the progress made against the annual plan and 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' (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.

This report takes the opportunity to celebrate the successes and highlights the challenges of managing infection risk in an acute hospital trust. Overall, the Trust continues to benchmark well against the common HCAIs as demonstrated in this report but has had some challenges in this period.

During April-September 2023 the Trust has had **no** declared internal outbreaks of:

- *Clostridioides difficile* (*C.difficile*)
- 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).

Significant amounts of work have been completed and remain ongoing for antibiotic stewardship, decontamination, cleaning services, water, and ventilation safety.

For the reported period, the Trust has experienced some challenges which has involved:

- Five COVID-19 outbreaks affecting inpatient areas
- One *Carbapenemase Producing Enterobacteriaceae* (CPE) outbreak in surgery

It is important to note that the following risks to delivery were identified:

- Trust 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.

IPC BAF Appendix A
This is the most recent IPC Board Assurance Report updated in December. Salisbury Foundation Trust is compliant with 54 of 61 key lines of enquiry and partially compliant with 7. Work is ongoing to achieve full compliance in all areas, all of which that have full processes in place but adherence remains ongoing work.

KQI 2.5 has moved from non-compliant to full compliance as there is now evidence of a programme of planned preventative maintenance (PPMs) for buildings and care environments.

KQI 3.4 has moved from partial compliant to compliant due to twice weekly antimicrobial rounds .

| **Board Assurance Framework – Strategic Priorities** | Select as applicable |
|---|---|
| **Local Services -** We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do | ☒ |
| **Specialist Services -** We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population | ☒ |
| **Innovation** - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered | ☐ |

| | |
|---|---|
| **Care** - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm | ☒ |
| **People** - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams | ☐ |
| **Resources -** We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources | ☐ |

NHS
Salisbury
NHS Foundation Trust

# DIRECTOR OF INFECTION PREVENTION AND CONTROL

## 6 monthly update

## April 2023 – September 2023


**JUDY DYOS**
**Director of Infection Prevention and Control (DIPC)**

**December 2023 (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 Key Quality Performance Indicators (KQPI) Report 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 six monthly 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 challenging six months for infection prevention and control, which has involved:

- Five COVID-19 outbreaks affecting inpatient areas
- One *Carbapenemase Producing Enterobacteriaceae* (CPE) 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:

- Trust 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
- Continued low 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 Team (IPCT) 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 IPCT currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 2.0 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 Lead. (*Of note: For 5 months of the reported period, there has 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 will commence 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, and must undertake an investigation and submit a formal written report within 45 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 (NHS England, 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.

During quarters 1 and 2 of 2023/24, the Trust has had **no** declared internal outbreaks of:

- *Clostridioides difficile* (*C.difficile*)
- 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 quarters 1 and 2 of 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 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).

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.

No new COVID-19 outbreaks were declared for the Trust during quarter 2 of 2023/24 across inpatient areas. However, five clusters of cases were identified for Downton, Durrington, Laverstock, Redlynch and Longford Wards. These were reviewed by the VBR group with appropriate Post Infection Reviews (PIR) requested for completion by the divisions. During September, 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 quarter 1 of 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 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.

**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.

**5.5 Norovirus (viral gastroenteritis)**
During quarters 1 and 2 of 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.

## 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 4.3) updated January 2020).*

**6.1 Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias**
During quarters 1 and 2 of 2023/24, there have been no hospital or community onset MRSA bacteraemia cases reported by the Trust. The Trust's MRSA hospital onset case target for 2023/24 is zero. Information from the BSW ICS HCAI report for quarter 2 of 2023/24 show SFT performs well for MRSA rates against the other local acute Trusts.

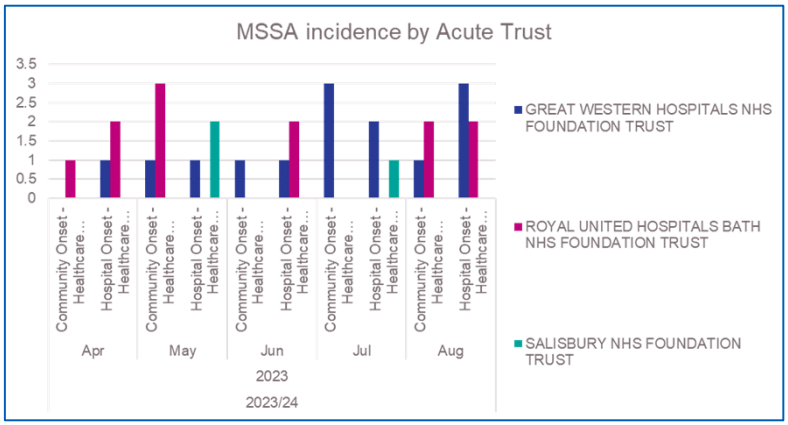
**6.2 Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias**
During quarters 1 and 2 of 2023/24, there have been 7 unrelated healthcare associated MSSA bacteraemia cases, of which 2 cases were community onset and 5 cases were hospital onset. For the hospital onset cases the sources of infection were identified as:

- Endocarditis (2 cases), with associated clinical infection unknown
- Surgical site infection (1 case), with associated clinical infection of leg ulcers
- Unknown/unclear source (2 cases).

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).*

***Table 2** below demonstrates that SFT performs well against local case numbers.*




*(Table 2 Trust MSSA data)*

**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)***

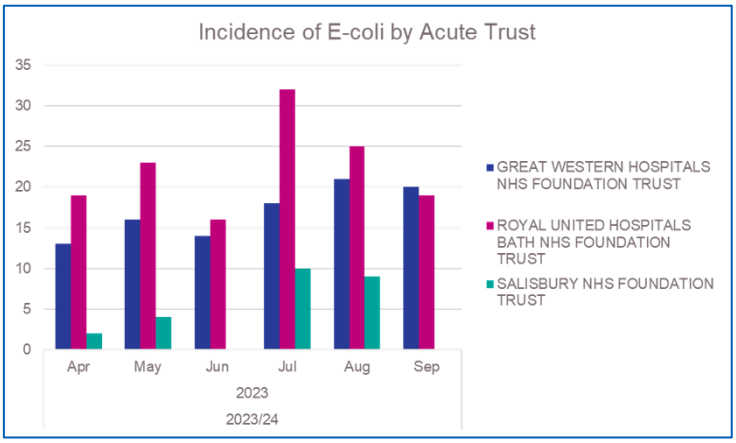
Following the identification of a positive blood culture result for *E.coli,* a Consultant Microbiologist completes a UKHSA mandatory enhanced surveillance form. In consultation with the relevant clinician, key patient factors are considered in order to establish if the case is likely to be healthcare related. However, it may not be possible to determine.

During quarters 1 and 2 of 2023/24, there have been 15 unrelated healthcare associated *E.coli* bacteraemia cases, of which 6 cases were community onset, and 9 cases were hospital onset. Of the 9 hospital onset cases identified, an unknown or no underlying focus of infection was identified for two cases, and the remaining 7 cases had a source of infection identified. Of these unrelated 7 cases, the sources of infection were:

- Lower urinary tract (5 cases)
- Hepatobiliary (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/).*




*(Table 3 Trust E.coli data)*

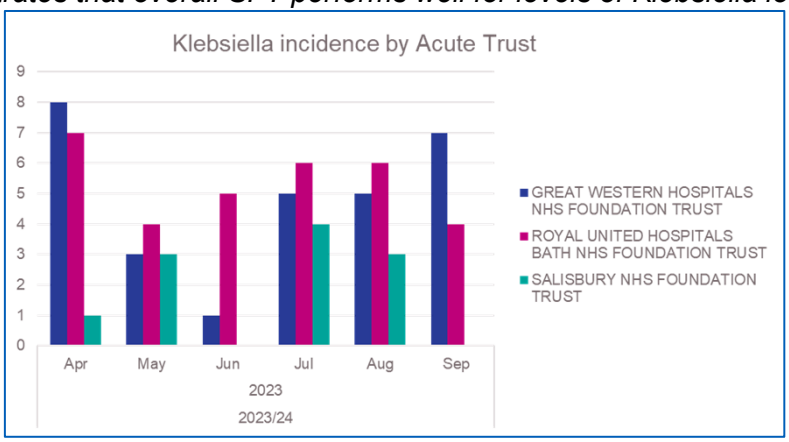
### 6.3.2 *Klebsiella spp.* and *Pseudomonas aeruginosa*

During quarters 1 and 2 of 2023/24, there have been 7 unrelated healthcare associated *Klebsiella spp.* bacteraemia cases, of which 2 cases were community onset and 5 cases were hospital onset. There have been 3 unrelated healthcare associated *Pseudomonas aeruginosa* bacteraemia cases, of which all 3 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)

***Table 4*** *below demonstrates that overall SFT performs well for levels of Klebsiella locally.*




*(Table 4 Trust Klebsiella spp. data)*

### 6.4 *Clostridioides difficile (C.difficile) Infection*

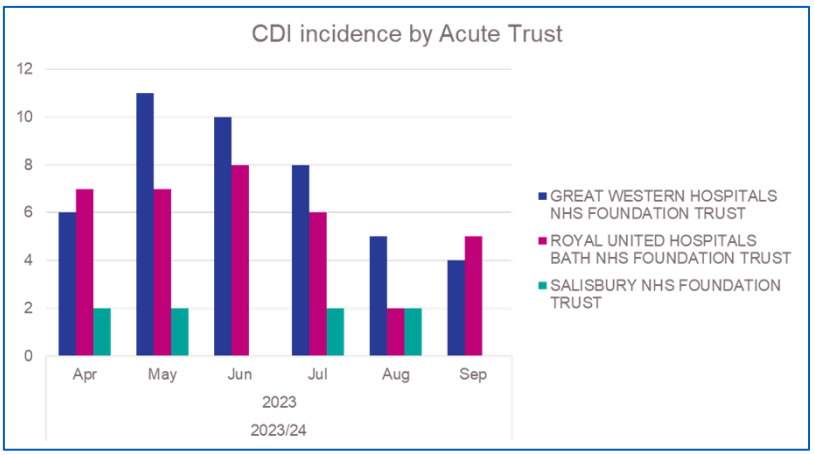
The control of this infection is managed by the combination of adherence to the correct infection control practices, environmental cleaning, equipment decontamination and prudent antibiotic stewardship.

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 quarters 1 and 2 of 2023/24, the Trust has reported 9 healthcare associated *C.difficile* cases to UKHSA, of which one case was community onset and 8 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).

***Table 5*** *overleaf demonstrates that SFT performs well against other Trusts in BSW.*




*(Table 5 Trust C.difficile data)*

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.

Please see Appendix B for the Infection Prevention & Control 'Dashboard' for quarters 1 and 2 of 2023/24 for further detail of HCAI data.

**6.5 BSW Collaboratives**
During quarters 1 and 2 of 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 6** 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 6)*

**6.7 Surgical Site Infection Surveillance (SSIS)**
The ICNs and IPCT 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 quarters 1 and 2 of 2023/24.

***Additional reporting for information:***
*For quarter 3 of 2022/2023, there were 5 additional surveillance cases to add to the reconciled cohort. These were identified from data collection forms found on the Orthopaedic Unit. Unfortunately, these patients were not listed when the final coding report was run by the IP&CT Secretary. UKHSA have been informed and these patients were added to the final cohort: Total number of patients = 61).*

Final data collection for quarter 4 of 2022/23 was reconciled within the required timeframe set by UKHSA. There were a total of 59 cases entered onto the national database, with one organ/space SSI identified. *(Of note: There are 4 additional surveillance cases to add to this reconciled cohort. These were identified from data collection forms found on the Orthopaedic Unit. Unfortunately, these patients were not listed when the final coding report was run by the IP&CT Secretary. UKHSA have been informed and these patients were added to the final cohort: Total number of patients = 59).* The patient was re-admitted to the Trust and returned to Theatre. The relevant orthopaedic surgeon, who was listed for this patient has provided detailed information regarding intra-operative and post-operative care for this case. The Ward Nursing Team completed a timeline/summary of the admission period for this patient.

Final data collection for quarter 1 of 2023/24 was reconciled within the required timeframe. There were a total of 61 cases entered onto the national database, with no SSIs identified.

Data collection continued in quarter 2 of 2023/24, with final records to be entered onto the national database and submitted for reconciliation by the end of quarter 3 of 2023/24.

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 NG125 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 produce 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 KQPI. The IPCT 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 quarters 1 and 2 of 2023/24, the Trust compliance rates for MRSA emergency screening ranged from 88.16% - 92.41%. For MRSA elective screening, the Trust compliance rates ranged from 62.5% – 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 has 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 IPCT 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 quarters 1 and 2 of 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 quarter 1 of 2023/24, audits have been completed by the external auditor (Healthcare Support Manager from GOJO Industries) for a total of 8 inpatient areas. Non-compliance of staff with IPC practices were observed, with feedback provided at the time of the audit to the relevant nurse in charge. 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 quarters 1 and 2 of 2023/24 ranges from 71.56% - 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 quarters 1 and 2 of 2023/24, there have been four PLACE Steering Group meetings held (April, June, August and September).*

## 8. ANTIBIOTIC STEWARDSHIP

**Key successes for Quarter 1 and 2 of 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 continues to perform well in quarter 2 achieving the compliance required for full payment. The Antimicrobial Stewardship Team (AMS) has managed to reduce non-compliance by 50% in comparison to quarter 1.

| *Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarter 1 compliance | | | Quarter 2 compliance | | | Quarter 3 compliance | | | Quarter 4 compliance | | |
| 24.88% (54/217) | | | 12.22% (33/270) | | | | | | | | |
| Apr 2023 | May 2023 | June 2023 | July 2023 | Aug 2023 | Sept 2023 | Oct 2023 | Nov 2023 | Dec 2023 | Jan 2024 | Feb 2024 | Mar 2024 |
| 16.67% *(3/18)* | 26.79% *(30/112)* | 24.14% *(21/87)* | 13.04% *(9/69)* | 11.93% *(21/176)* | 12% *(3/25)* | | | | | | |

* Lower % = better performance

*(Table 7)*

### 8.2 Guidance Development

A full review of all policies in the antimicrobial section of Microguide has been undertaken and almost completed. Antibiotic guidance will now be classified into body systems with a soft launch mentioned via communications due soon.

Guidance on Bronchiectasis treatment has now been completed and will be taken to Drug & Therapeutics Committee for ratification in January 2024.

### 8.3 Antibiotic Reference Group (ARG) Action plan for 2023/24

- The Influenza and COVID vaccination campaign has started. Electronic Prescribing and Medicines Administration (ePMA) has been configured to prescribe vaccines for inpatient cohorts. The Lead Antimicrobial Pharmacist is looking to increase awareness of this through pharmacy and Trust communications.
- Micro-guide updating is nearly complete with a view to update presentation of Microguide into body systems.
- Publishing of COVID interim guidance to be prioritised due to increasing COVID cases.
- Influenza treatment guidance review is ongoing and will be complete in December 2023.

### 8.4 Challenges

**CQUIN actions for Quarters 3 and 4 of 2023/24**

The AMS and audit team have identified key prescribers and themes for non-compliance. The AMS team will continue with informal education and discussions with colleagues whilst on the ward round to target and limit non-compliance within the CQUIN.

**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.

**ePMA**
Identification of patients on IV antibiotics for AMS ward round review still requires considerable personnel time (approximately 3 to 4 hours/week) to collect data manually. Progress is being made as the Lead Antimicrobial Pharmacist has been in contact with the Database Warehouse Team to resolve the issue.

**Total antibiotic consumption**
Total Antibiotic consumption within the Trust has increased by 5.5% within the last 6 months. Wards with the biggest antibiotic consumption were within the surgical directorate. The ARG are beginning to implement plans to try and reduce consumption as part of the NHS contract.

**Pharmacy staff resources**
There is still considerable staffing pressure within the pharmacy department due to vacancies. Consequently, the Lead Pharmacist Antimicrobials and HIV time and role has been reduced (to cover these vacancies) to approximately 0.2 to 0.4 w.t.e. Pharmacy will have additional staff vacancies in the near future due to retirement and long-term leave, therefore this will not be resolved soon.

## 9. AUDIT

The ICNs have not undertaken any formal policy audit during quarters 1 and 2 of 2023/24 due to staffing resources and increased clinical workload but have been involved in supporting identified clinical areas to complete the Tendable inspections *(formerly Perfect Ward Application)* 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 Heads of Nursing (HoN), 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 quarters 1 and 2 of 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 IPCT. Mean compliance scores for quarters 1 and 2 of 2023/24 were 82% for staff completion of hand hygiene assessments and 94% for staff completion for IPC computer-based learning (CBL) package *(LEARN data accessed 06.10.2023).*

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 progressed by the surgical division 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 in 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 quarters 1 and 2 of 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 in Quarters 1 and 2 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.

### 11.2 Progress on actions during Quarters 1 and 2 of 2023/24

Discussions to confirm the revised formats of both the Decontamination and Creutzfeldt-Jakob disease (CJD) policies has taken place. The decontamination policy will be split, with one part focussing on the engineering and regulatory requirements and the other part covering the clinical content. The CJD policy re-write is being led by one of the Consultant Microbiologists, with the Decontamination Lead (DL) supporting, and will focus on ease of use for clinical staff.

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.

### 11.3 Key challenges for quarters 3 and 4 of 2023/24

The introduction of a device to undertake high level decontamination of invasive ultrasound probes into the Fertility clinic remains unresolved but needs completion. The Gynaecology Matron is leading this work.

Undertaking the refurbishment of SSL at a time when operational activity is increasing will continue to be a challenge. This next phase will see work to replace the instrument washer-disinfectors and autoclaves. Associated environmental and engineering changes to the department will be carefully managed to minimise operational disruption and clinical impact.

New Laboratory autoclaves were installed in quarter 4 of 2022/23, but the new machines have proved unreliable. Their reliability is being challenged with the manufacturers and the work is being led by Estates Technical Services (ETS) and supported by Procurement and the Laboratory Manager.

## 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. We plan to undertake approximately 60 internal PLACE audits over 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, it felt like a positive day and results will be published early 2024.

### 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, we are currently on track to complete this work by May 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 in preparation of the implementation of the new cleaning standards and vacancies. Reached 99.6% or above each month for our KPIs linked to the operational response times in starting a clean within 3 hours.

***Tables 8, 9** and **10** below and overleaf from the past 3 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 | | | | | |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ENHANCED HRS | 95.50 | 104 | 53.5 | 57.75 | 64 | 83.25 | 69 | 81.25 | | | | | |
| DOUBLE CLEANS HRS | 10 | 33 | 61.5 | 70.25 | 49.25 | 59.25 | 54 | 67.75 | | | | | |
| BIOQUELL | 0 | 31 | 37 | 54 | 59 | 45 | 56 | 74 | | | | | |

*(Table 8)*

| 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 9)*

| 2021/22 MONTH | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | TOTALS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| POST INFECTIONS | 1076 | 934 | 850 | 1106 | 1105 | 1127 | 1180 | 1114 | 1386 | 1322 | 1436 | 1807 | **14443** |
| ENHANCED HRS | 67.75 | 67.50 | 50 | 66.5 | 70.75 | 70.25 | 73.50 | 71 | 65.50 | 86.50 | 124.75 | 113.75 | **927.75** |
| DOUBLE CLEANS HRS | 104 | 84.75 | 79.5 | 88.0 | 93.25 | 60.50 | 44.75 | 35.75 | 50.50 | 91 | 51 | 65.75 | **846.75** |
| BIOQUELL | 39 | 40 | 38 | 61 | 56 | 49 | 36 | 35 | 60 | 40 | 38 | 51 | **543** |

*(Table 10)*

### 12.5 Challenges for the coming 6 months

Housekeeping is working towards the new National Cleaning Standards including key elements, task lists, risk categories, audit requirements over a phased rolling implementation period.

Recruitment remains a challenge due to a reduction in applicants and the incentives associated with clinical posts (Healthcare Assistants). Recruitment is required to undertake the new Cleaning Standards and we are working with HR and recruitment agencies to support this recruitment drive.

### 12.6 Successes from the past 6 months

Housekeeping have been successful in achieving approval for a New Deputy Housekeeping Manager position. The Interviews for this position have taken place, and the successful applicant is due to start early December 2023.

## 13. WATER SAFETY MANAGEMENT

This section summarises the water safety management precautions that the Trust has taken over quarters 1 & 2 of 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 (RP and dRP 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 **Table 11** for Legionella, listing counts reported >1000 cfu/l*) and high counts for Pseudomonas *(**Table 12**)* 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.

### 13.1 Legionella

| Legionella | | | | | | |
|---|---|---|---|---|---|---|
| | Ward/ Department | LG Ref | Location | Action plan | Test result as of 27/07/2023 | |
| | | | | | Pre | Post |
| 1 | Emergency Department | 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 | Short Stay Emergency Unit (SSEU) | 31 | SSEU Nurse Base | Fit PAL, clean disinfect and resample. | <20 | 600 |
| 4 | Tisbury CCU | 112 | Bay 2 WHB | PAL fitted; system has been chlorinated as part of the works on Whiteparish Ward. Resample. | 54000 | 6200 |
| 5 | Pathology Laboratory | 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 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.

| Pseudomonas | | | | | | |
|---|---|---|---|---|---|---|
| | 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)*

**13.3 Pool Water Quality**

No positive results requiring remedial action reported in this period.

**13.4 Achievements for Quarters 1 and 2 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.
- 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.
- Development of a new Band 5 post to manage water safety at an operational level to ensure flushing is completed, records are maintained, and action plans associated with high counts for Legionella and Pseudomonas are delivered.
- Flushing compliance for Priority 1 areas at 79% and Priority 2 areas at 94%.

**13.5 Key Focus for Quarters 3 and 4 of 2023/24**

- Maintaining the level of flushing compliance for Priority 1 and 2 areas to circa 75%.
- Develop and deliver an action plan related to the actions identified from the site water risk assessment, this will be the key focus of the new Band 5 water safety.
- 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 wards and annual testing for Legionella.

- Introduction of a managed service for all water sampling.

## 14. SPECIALIST VENTILATION

This section summarises the actions/precautions that the Trust has taken over quarters 1 and 2 of 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 Quarters 1 and 2 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.
- Survey completed of all the pressure stabilizers in the Main and DSU Theatres has indicated that most of them will need to be replaced. Budget approval (capital) has been received for the same and the plan is to replace all the pressure stabilizers in SDH North in February/March 2024.
- 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

- Completion of PPMs to include 40-point check for critical systems as per the guidance in HTM 03-01.
- Delivery of all remedial works post the fire damper testing process.
- Plan and deliver the replacement of the faulty pressure stabilisers in Main Theatres.
- Plan and deliver a ventilation duct cleaning programme, it is evident from the survey completed for the fire dampers this urgently required especially for critical systems e.g. Main Theatres.
- Review of capital projects involving the replacement of air handling systems to include and Sterile Services Limited (SSL) and the new elective ward.

## 15. CONCLUSION

This six monthly 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 2023/24, 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.

## 16. ACKNOWLEDGEMENTS

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**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**<br>**1.1 General duty to protect patients, staff and others from HCAIs**<br>**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 | IPCT | 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**<br>**1.6 Duty to provide information when a patient moves from one health care body to another**<br>**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/ IPCT | 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) | IPCT | 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* | IPCT | 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 | IPCT | Continuous |
| Continue the provision of ongoing infection prevention and control education for existing staff | IPCT | 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 |

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APPENDIX B (Q1 and Q2 of 2023/2024)

| | | *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.* | | | | | | |
| **Clinical Divisions** | **Inpatient areas/wards** | Hospital onset healthcare | Community onset healthcare | Hospital onset HA | Community onset | Community onset | Hospital onset HA | Community onset | Community onset | Hospital onset HA | Community onset | Community onset | Hospital onset HA | Community onset | Community onset | Hospital onset HA | Community onset | Community onset | See main repot for details | PII of C.difficile | | |
| **Clinical Support & Family Services** | Sarum Ward (inc. Children DAU) | 1 | | | | | | 1 | 2 | 1 | | | | | | 1 | | | | | 100% | |
| | Hospice Unit | | | | | | | | | | | | | | | | | | | | 100% | |
| | Longford Ward | | | | | | | | | | | | | | | | | | | | 92.36% | |
| | **CS&FS Totals:** | **1** | | | | | | **1** | **2** | **1** | | | | | | **1** | | | | | | |
| **Women & Newborn** | Labour Ward | | | | | | | | | | | | | | | | | | | | 95% | |
| | Neonatal Unit | | | | | | | | | | | | | | | | | | | | 97.50% | |
| | Post-natal Ward | | | | | | | | | | | | | | | | | | | | 99.07% | |
| | **W&N Totals:** | | | | | | | | | | | | | | | | | | | | | |
| **Medicine** | AMU (inc. SDEC) | 2 | 2 | | | | | 1 | 1 | | 3 | 3 | | | | | 2 | | | | 96.11% | |
| | Breamore Ward | | | | | | 1 | | | 2 | | | | | | 1 | | | | | 81.84% | |
| | Durrington Ward | 1 | | | | | | | | 1 | | | | | | | | | | | 73.72% | |
| | ED (inc. SSEU) | | 1 | | | | | | 14 | | 3 | 26 | | | | | | 8 | | | 93.02% | |
| | Farley Ward | | | | | | 1 | | | 2 | | | | | | | | | | | 85.74% | |
| | Laverstock Ward | | | | | | 1 | | | 1 | | | | | | | | | | | 92.01% | |
| | Pembroke Ward | | | | | | | | | | | 1 | | | | 1 | | | | | 100% | |
| | Pembroke Suite | | | | | | | | | | | | | | | | | | | | 100% | |
| | Pitton Ward | 2 | | | | | | | | | | | | | | | | | | | 81.79% | |
| | Redlynch Ward | 1 | 1 | | | | 1 | | | | | | | | | | | | | | 83.41% | |
| | Spire Ward | 1 + 1 | | | | | 1 | | | | | | 2 | | | | | | | | 71.56% | |
| | Tisbury CCU | 1 | | | | | | | | | | | 1 | | | | | | | | 86.35% | |
| | Whiteparish Ward | | | | | | | | | | | | | | | | | | | | 94.84% | |
| | Nunton Unit | | | | | | | | | | | | | | | | | | | | 100% | |
| *South Newton* | Nadder Ward | | | | | | | | | | | | | | | | | | | | 85% | |
| *South Newton* | Pembroke Lodge | | | | | | | | | | | | | | | | | | | | 80.95% | |
| | **Medicine Totals:** | **5 + 4** | **4** | | | | **5** | **1** | **15** | **6** | **6** | **30** | **3** | | | **2** | **2** | **8** | | | | |

| | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Surgery** | Amesbury Suite | 1 | | | | | | | | 1 | | 1 | | | | | | | | | 88.49% | |
| | Britford Ward (inc. SAU) | 1 | 1 | | | | | | | | | 3 | | | | | | 2 | | | 88.16% | |
| | Chilmark Suite | 1 | | | | | | | | | | | | | | | | | | | 88.50% | |
| | Day Surgery Unit | | | | | | | | | | | | | | | | | | | | 94.99% | |
| | Downton Ward | 1 | | | | | | | | | | | | | | 1 | | | | | 77.43% | |
| | Odstock Ward | 2 + 2 | | | | | | | | 1 | | | | | | | | | CPE | | 82.19% | |
| | Radnor Ward | | | | | | | | | | | | | | | 1 | | | | | 98.69% | |
| | **Surgery Totals:** | **3 + 5** | **1** | | | | | | | **2** | | **4** | | | | **2** | | **2** | | | | |
| **Additional info: Other *C.difficile* samples, e.g. GP, other Emergency Assessment, OPD, Mortuary, Private or Community Hospitals** | | | **1 + 2** | | | | | | **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**

**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

**Outbreak codes:** C19 is COVID-19 outbreak declared; 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)

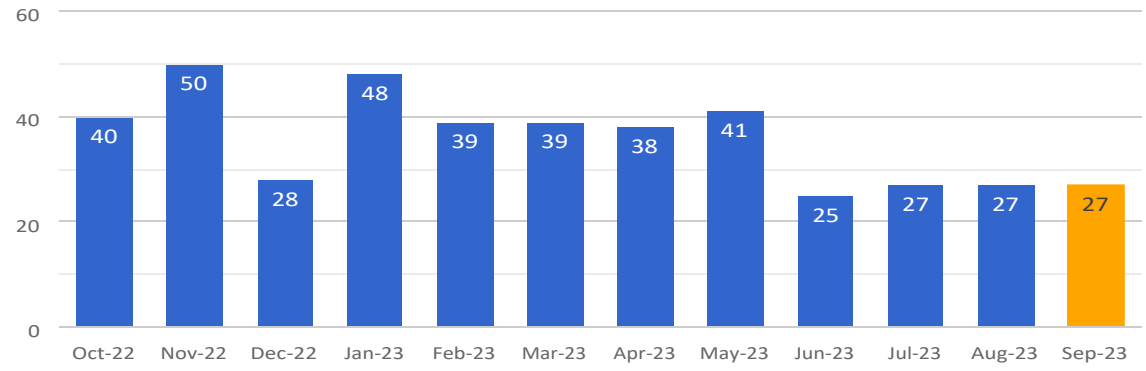
Salisbury NHS Foundation Trust

**APPENDIX C**

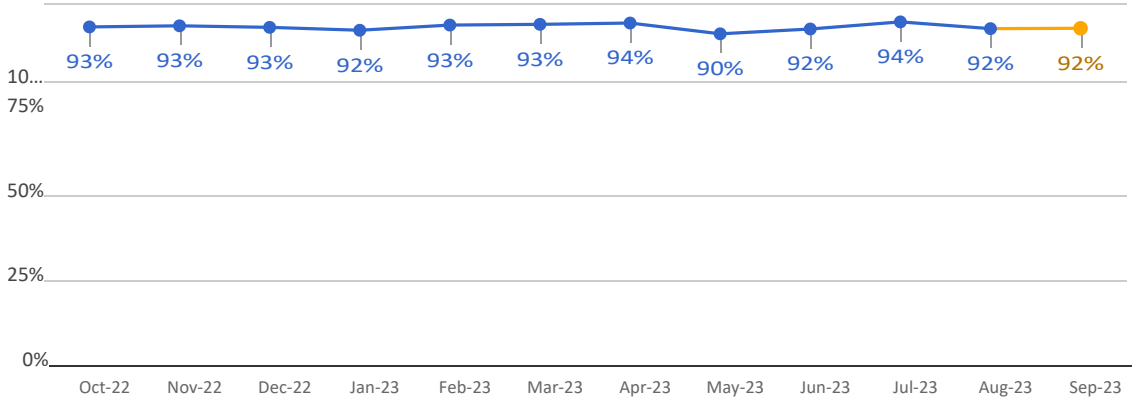
# Tendable Infection Prevention & Control (IPC) Audit Inspection Summary including Quarters 1 & 2 of 2023/24

## Overall

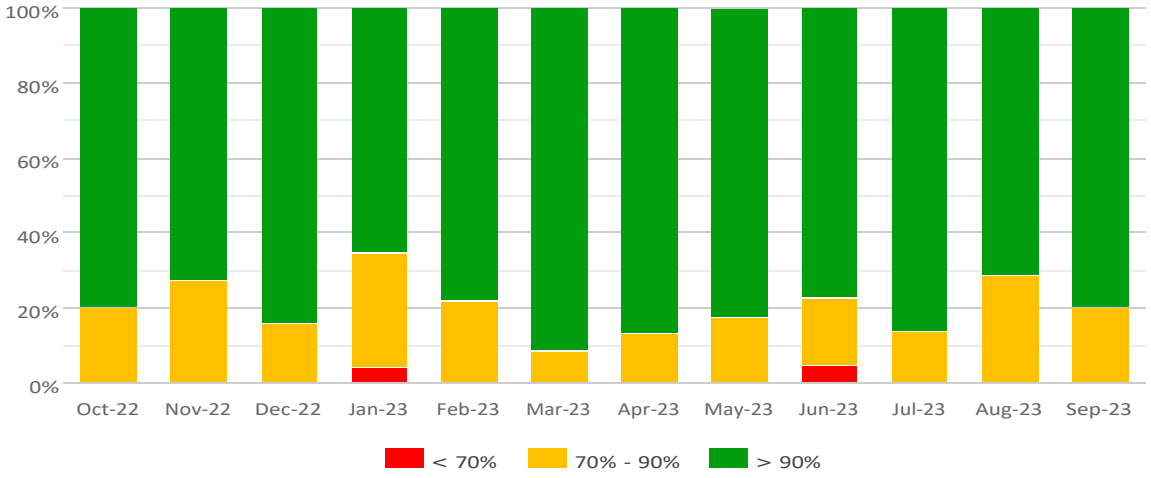
**Total monthly inspections (last 12 months)**




**Average score (last 12 months) across the organisation**



**Distribution of scores (last 12 months)**




## Highest Scoring Clinical Areas

| Rank | Area | Score this month | Score last 12 |
|---|---|---|---|
| 1 | Britford Ward | 100% (1) | 93% (16) |
| 2 | Day Surgery Unit | 100% (1) | 97% (19) |
| 3 | Radnor Ward | 100% (1) | 97% (11) |
| 4 | Sarum Ward | 100% (1) | 99% (12) |
| 5 | Chilmark Suite | 98% (1) | 91% (13) |

## Lowest Scoring Clinical Areas

| Rank | Area | Score this month | Score last 12 |
|---|---|---|---|
| 16 | Spire Ward | 90% (1) | 94% (13) |
| 17 | Durrington Ward | 89% (1) | 93% (21) |
| 18 | Longford Ward | 88% (1) | 92% (13) |
| 19 | Downton Ward | 84% (3) | 89% (25) |
| 20 | Farley Ward | 76% (1) | 92% (20) |

***(Information taken from Tendable Board IPC report (generated 01.10.2023)***

# National Infection Prevention and Control Board Assurance Framework

Version 1.0 March 2023

Publication approval reference:

# Introduction

The National Infection Prevention and Control board assurance framework ('the framework') is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The framework is for use by all those involved in care provision in England and can be used to provide assurance in NHS settings or settings where NHS services are delivered. This framework is not compulsory but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place).

The purpose of the framework is to provide an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

The aim of this document is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures.

The framework should be used to assure the executive board or equivalent, directors of infection prevention and control, medical directors, and directors of nursing of the assessment of the measures taken in line with the evidence based recommendations of the NIPCM (or whilst the NIPCM is being implemented) including the relevant criterion outlined in the Health and Social Care Act 2008: code of practice on the prevention and control of infections. The outcomes can be used to provide evidence to support improvement and patient safety. The adoption and implementation of this framework remains the responsibility of the **organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined.

If the criterion is not applicable within an organisation or setting for example, ambulance services then select not applicable option.

# Links

NHS England » National infection prevention and control manual (NIPCM) for England

Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)

# Legislative framework

The legislative framework required to protect patients, service users, staff and others from avoidable harm in a healthcare s etting is detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections, the duty of care and responsibilities are set out in the Health and Safety at Work Act 1974, and associated regulations for employers and employees.

Local risk assessment processes are central to protecting the health, safety and welfare of patients, service users, staff an d others under relevant legislation. This risk assessment process (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings) has been designed to support services in identifying hazards and risks, and includes guidance on measures that should be maintained to improve and provide safer ways of working by balancing risks appropriately. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work using the risk assessment process and the organisation's governance processes.

# Links

Health and Social Care Act 2008: code of practice on the prevention

Health and Safety at Work etc. Act 1974

Primary care, community care and outpatient settings

Acute Inpatient areas

Primary and community care dental settings

# Instructions for use

The adoption and implementation of the National Infection Prevention and Control Board Assurance Framework remains **the responsibility of the organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined in the Act.

The Board Assurance Framework worksheet is ordered by the ten criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop down list. Specifically: not applicable, non-compliant, partially compliant, compliant.

Once options have been selected a summary plot for each criteria is generated automatically, which are displayed in the corresponding worksheet. The overall RAG status for an organisation/provider across all ten criteria is shown in plots under the summary worksheet.

**N.B.** Use of the framework **is not compulsory** but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place). In addition, not all of the criteria outlined in the framework will be relevant or applicable to all organisations or settings.

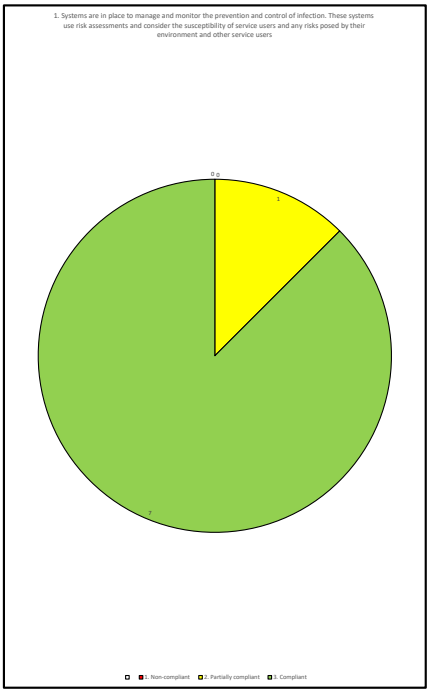
***Please note: Specific URL's referred to in the document can be accessed via the ' Hyperlinks included in the BAF' tab. Or alternatively, can be accessed by***

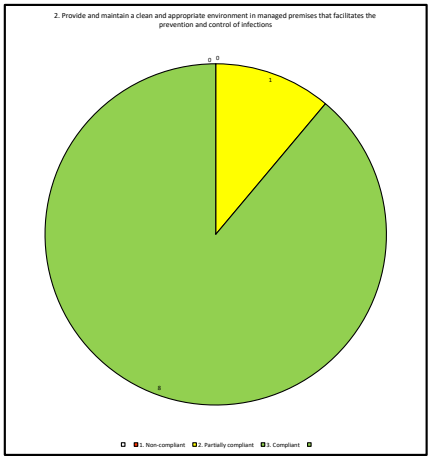
# Links

| | |
|---|---|
| **Section 1** | |
| **1.4** | NIPCM |
| **1.6** | NICPM |
| | Primary care, community care and outpatient settings, |
| **1.8** | Acute inpatient areas |
| | Primary and community care dental settings |
| **Section 2** | |
| **2.1** | National cleanliness standards |
| **2.2** | Patient-Led Assessments of the Care Environment (PLACE) |
| **2.4.1** | HTM:03-01. |
| **2.4.2** | HTM:04-01 |
| **2.5** | HBN:00-09 |
| **2.6** | HTM:01-04 |
| | NIPCM |
| **2.7** | HTM:07:01 |
| | HTM:01-01 |
| **2.8** | HTM:01-05 |
| | HTM:01-06 |
| **Section 3** | |
| **3.2** | UK AMR National Action Plan |
| **3.3** | UK AMR National Action Plan. |
| | NICE Guideline NG15 |
| **3.4** | TARGET |
| | Start Smart, Then Focus |
| **Section 5** | |
| **5** | NIPCM |
| **Section 6** | |
| **6.2** | Roles and responsibilities |
| **Section 7** | |
| **7** | NIPCM |
| **Section 9** | |
| **9** | UKHSA |
| | A to Z Pathogen |
| | NIPCM |

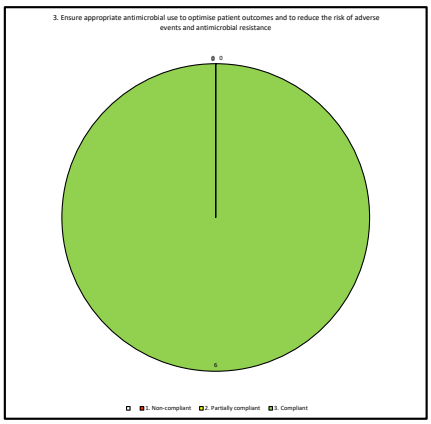
# Infection Prevention and Control board assurance framework v0.1

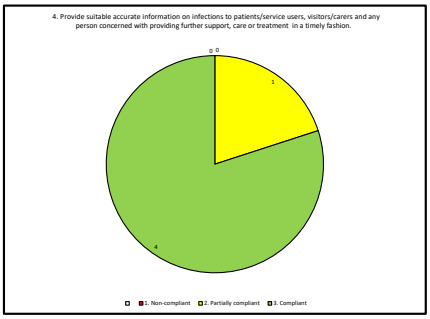
| | Key Lines of Enquiry | Evidence | Gaps in Assurance | Mitigating Actions | Comments | Compliance rating |
|---|---|---|---|---|---|---|
| **1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them** | | | | | | |
| **Organisational or board systems and process should be in place to ensure that:** | | | | | | |
| **1.1** | There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team. | Infection Prevention & Control Committee (IPCC) meetings held quarterly, with DIPC reports to Trust Board six monthly. *Divisional feedback: Divisional Heads of Nursing (DHoN) attendance at IPCC meetings. IPC moderate harm incidents discussed at Patient Safety Summit weekly then disseminated through Divisional Governance meetings.* | | | *Divisional feedback: Discussed at IPC steering group which Matrons for each division attends. Surgery Division: identified Divisional IPC lead. Matrons attend Infection Prevention & Control Working Group (IPCWG) Meetings. DHoN attends IPCC.* | 3. Compliant |
| **1.2** | There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission. | Reporting and monitoring via IPCWG and IPCC meetings. Membership includes representation from all clinical divisions. *Divisional feedback: IPC moderate harm and above incidents discussed at Patient Safety Summit weekly.* | | *Divisional feedback: Moderate DATIX highlighted by Risk Team for investigation, 72 hour report and discuss at Patient Safety Summit.* | | 3. Compliant |
| **1.3** | That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone. | Risk assessments in place. Approved through Trust governance processes/policies. Risk assessments completed on DATIX system. Any new risks identified are escalated via the normal Trust governance processes. Continued microbiologists and IPC Nursing Team advice on infectious agents. *Divisional feedback: All staff know how to complete DATIX. Risk assessments completed as required.* | Potential for risk assessments becoming out of date. | Discussions and monitoring via existing Trust processes (IPCWG to IPCC). *Divisional feedback: SWARM processes and learning and actions shared with teams.* | *Divisional feedback: Incidents are reviewed and discussed operationally as required. Medicine feedback: IPC incidents discussed as when they occur. SWARM process employed as required.* | 3. Compliant |
| **1.4** | They implement, monitor, and report adherence to the NIPCM. | Existing IPC Trust policies and National IPC Manual (NIPCM) are available to all staff via Microguide. Tendable inspections/audits in place as per standard operating procedure (SOP). Ward area reviews for policy practice compliance including ad.hoc 'spot checks' by Divisional and Speciality Matrons and IPC Nursing Team. Additional monitoring of practice compliance when periods of increased incidence (PIIs) identified. IPC Board Assurance Framework (BAF) document submitted quarterly to Trust Board and IPCC, following completion by participants of the IPCWG. | | | | 3. Compliant |
| **1.5** | They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level. | Mandatory surveillance and reporting of alert organisms completed via Trust policy existing/established processes. Completion of investigations (post infection reviews (PIRs) and SWARMs) and divisional reporting slides. Virtual Board Rounds (VBR) continue for COVID-19 reporting and monitoring. Outbreak Management Review meetings as required; external reporting completed. Tendable inspections increased if an area has a declared outbreak. DIPC reports to Trust Board six monthly. *Divisional feedback: Elective and emergency MRSA screening monitored and fedback via DHoNs. Surgical site infection surveillance (SSIS) undertaken for repair of neck of femur orthopaedic patients.* | *Divisional feedback - Surgery: lack of centralised action tracker for actions generated from C.difficile and other post infection reviews. Challenging to evidence and closed actions.* | | *Divisional feedback: Outbreaks discussed at Capacity meetings ad monitored via Virtual Board Round (VBR) with divisional teams/representation.* | 3. Compliant |
| **1.6** | Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM. | Tendable inspections/audits in place as per existing SOP and other infection control reviews. *Divisional feedback: IPC & Hand Hygiene audits completed at least monthly via Tendable with Matron oversight if action plans required.* | | Existing IPC Trust policies. | | 3. Compliant |
| **1.7** | All staff receive the required training commensurate with their duties to minimise the risks of infection transmission. | Mandatory training module e-learning (LEARN) available. IPC policies in place. Tendable IPC inspections and hand hygiene practice compliance audits. *Divisional feedback: Initial training at Induction with mandatory annual updates. Focused training following any outbreaks or incidents.* | Hand hygiene assessment compliance across all divisions not at the expected level (>85% compliance). | New approach agreed by the DIPC for ward senior leadership teams to assess hand hygiene practices within the clinical environments to improve compliance. | *Divisional feedback: Training accessed via MLE and induction to ward, also additional training as result of action plan as required.* | 2. Partially compliant |
| **1.8** | There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings) | Risk assessments in place. Approved through Trust governance processes/policies. Risk assessments completed on DATIX system. Any new risks identified are escalated via the normal Trust governance processes. | *Divisional feedback - Surgery: Knowledge limitations of ward leads and nurse in charge cohorts, further training on both risk assessment and mitigation required.* | | *Divisional feedback: RCA completion with IPC team as a result of infection on ward.* | 3. Compliant |
| **2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections** | | | | | | |
| **System and process are in place to ensure that:** | | | | | | |
| **2.1** | There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place). | Housekeeping Department monitor standards of environmental cleanliness. Currently working towards the new 2021 National Cleaning Standards and currently evidence the 2008 standards. Business case approved by Trust Board for additional cleaning hours. | Funding has been secured over a 3 year implementation period for the new standards. Variable/low staffing levels impacting cleaning schedules due to ongoing vacancies. Ongoing clutter on wards and lack of storage areas resulting in challenges with accessing areas to clean. | Derogation against the new cleaning standards has been awarded by NHS England until April 2025. We will then apply for further derogation until the new standards are implemented. An action plan has been shared with NHS England and identifies that the new cleaning standards will be implemented before or on the 1st January 2026. Continue with current cleaning schedules and frequencies. Prioritise with support of the IPC Nursing Team. Approval at IPCC. | | 3. Compliant |
| **2.2** | There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board. | Annual national PLACE inspection completed with patient assessors and volunteers. These are communicated within the quarterly cleanliness report to Trust Board (via DIPC), with an action plan. The Trust also undertakes a year long PLACE 'Lite' programme, with findings discussed at the monthly PLACE Steering Group. | | | | 3. Compliant |
| **2.3** | There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards. | Clear guidelines with two cleaning task lists (CTLs); one for Housekeeping Staff and one for ward teams/staff to complete on a weekly basis. The Housekeeping CTLs are reviewed and signed off weekly by the Housekeeping Management Team. Decontamination Policy covers medical devices and patient care equipment. | Ward team/staff CTLs should be signed off weekly by the Ward/Clinical Lead and reviewed by the division (e.g. Matrons and/or Heads of Nursing (HoNs), however there are gaps in this sign off process. Decontamination Policy due for review. | Review identified as action for Decontamination Lead and monitored via Decontamination Working Group (DWG) action tracker. | | 3. Compliant |
| **2.4** | There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01 | There are Water Safety and Ventilation Working Groups set up and well attended. There are policies and the new draft Water Safety Plan is out for consultation. Ventilation systems are maintained and verified in accordance to HTM and an annual audit is conducted by the Authorised Engineer (AE). There is a current water safety risk assessment in place and actions being worked through. | Water Safety Plan out for consultation before final document produced. | Existing water safety plan in place. | | 3. Compliant |
| **2.5** | There is evidence of a programme of planned preventative maintenance (PPMs) for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09 | PPMs are in place for building maintenance and IPC are included for new builds/refurbishments. | Funding and staff resources restricts PPM coverage. | Contractors used when possible. | | 3. Compliant |
| **2.6** | The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM. | Linen and laundry is kept in a dedicated linen cupboard/covered trolley and is topped up by our Contractors twice per day. Linen usage is also reviewed at the monthly PLACE Steering Group and within the internal PLACE 'Lite' inspections. Key performance indicators (KPIs) are also reviewed every month. Linen Policy in place for users. | | | | 3. Compliant |
| **2.7** | The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal. | Policy in place. Practices monitored via auditing processes, with reporting at Waste Management Group. | SFT not fully implemented tiger waste stream within clinical areas. | Work plan identified for implementation, with support of IPC and Health & Safety Committee. | | 3. Compliant |
| **2.8** | There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06. | Instrument (HTM 01-01) and endoscopic (HTM 01-06) reprocessing undertaken centrally in SSI, who are audited by BSI (last audit Nov 22 - compliant with one minor comment) . Concerns or issues around central re-processing reported via Datix or SSI Synergy Trak and trends reported, monitored and discussed at DWG. Automated HLD of invasive ultrasound probes in place in many areas with manual wipe system in place where unavailable (due to device incompatibility or low usage making automated system inappropriate). | Some local SOPs for areas with specific needs undertaking Local decontamination of devices are due for review. Difficult to evidence decontamination in general areas or for general devices (such as Obs machines) as no requirements for device traceability linked to decontamination processes. | SOPs are presented/agreed at DWG. Decontamination audit via Tendable app in draft which will improve evidence/compliance capture going forward. | HTM 01-05 (Primary Care Dental) not applicable at SFT. | 2. Partially compliant |

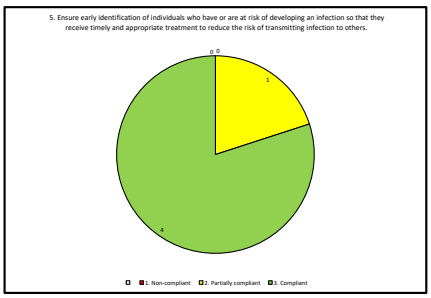


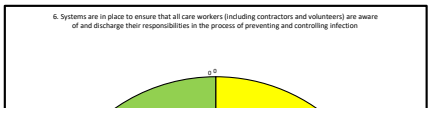



| | | | | | | |
|---|---|---|---|---|---|---|
| **2.9** | Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations. | Training records for Catering staff and training recorded on the MLE for ward based clinical staff. | Not all clinical staff who serve or prepare food for patients have completed the basic Food Hygiene MLE training. | Each inpatient ward has at least one member of staff who has been trained. Ward based catering facilities (kitchen/food storage areas) are routinely inspected by the Catering Manager. Facilities are provided to store food in line with Food Hygiene Regulations, for a maximum of 30 minutes, in line with Trust policy. | | 3. Compliant |
| **3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance** | | | | | | |
| **Systems and process are in place to ensure that:** | | | | | | |
| **3.1** | If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated. | There is a nominated Antibiotic Pharmacist supported by Consultant Microbiologist and Pharmacy Technician which as a team undertake weekly antibiotic stewardship (AMS) ward rounds. Furthermore, weekly MDT Diabetic Foot ward rounds are undertaken. Additionally, the AMS team also attend a monthly C.difficile ward round. AMS currently undertaking IVOST COUIN. | The AMS ward round cannot cover all areas/ward of the hospital due to time restraints. The whole AMS team cannot commit to every ward round involved with the AMS service but to mitigate this a member of the team will try to make an attendance. | Using electronic prescribing and drug charts to provide a targeted approach to AMS ward rounds. The implementation of a antibiotic filter programme is being created to facilitate identification of patients on IV antibiotics. | Nil | 3. Compliant |
| **3.2** | The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals. | The IPCC receives a quarterly and bi-annual report on the activities and work performed by the Antimicrobial Reference Group (ARG). Additionally, an antimicrobial report is also created for Medicine Assurance for the Clinical Governance Group. | Reports only cover activities within the last quarter or last 6 months. | Key issues on AMS activities are discussed every 6-8 weeks at ARG. | Nil | 3. Compliant |
| **3.3** | There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR Action Plan. | The board executive responsible for AMS as set out in the UK AMR Action Plan is the DIPC. | Nil | The DIPC has oversight over antimicrobial stewardship, via ARG feeding into the Infection Prevention & Control Committee (IPCC). | Nil | 3. Compliant |
| **3.4** | NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools [TARGET] are implemented and adherence to the use of antimicrobials is managed and monitored:<br>•To optimise patient outcomes.<br>•To minimise inappropriate prescribing.<br>•To ensure the principles of Start Smart, Then Focus are followed. | Targeted C.difficile round.<br>Daily ICU ward round. Within critical care, drug charts are embedded with AMS principles.<br>IPCC report (quarterly) and DIPC report (bi-annual) completed by the Antimicrobial Pharmacist to provide assurance to the board regarding total antimicrobial prescribing, and use of broad- spectrum antibiotics.<br>Antimicrobial Review Group (ARG) reviews antibiotic policies in light of national and international guideline changes or emergence of new evidence. Also reviews drug safety incidences where antibiotics are involved.<br>Microguide provides antimicrobial guidance (regularly reviewed by ARG).<br>Antibiotic stewardship included in the Foundation Teaching Program. | Time and staffing constraints in conducting C.difficile round especially within Pharmacy at present due to limited clinical staff.<br>C.difficile cases reviews not completed in a timely manner due to staff and time constraints<br>No formal education of medical staff beyond FY2.<br>Limited access to nursing teaching program. | Continuation of AMS round twice weekly.<br>Monitoring C.difficile incidence occurs regularly and the AMS team conduct ad hoc rounds where feasible. | Nil | 3. Compliant |
| **3.5** | Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including:<br>•Total antimicrobial prescribing.<br>•Broad-spectrum prescribing.<br>•Intravenous route prescribing.<br>•Treatment course length. | IPCC (quarterly), DIPC (bi-annual) and Medicines Assurance reports completed by the Antimicrobial Pharmacist to provide assurance to the board regarding antimicrobial prescribing.<br>Antimicrobial Review Group (ARG) reviews antibiotic policies in light of national and international guideline changes or emergence of new evidence. Also reviews drug safety incidences where antibiotics are involved. | Reporting created retrospectively and does not cover all wards within SDH. | Nil | Nil | 3. Compliant |
| **3.6** | Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors) | Microguide section on antibiotics is being updated by Microbiology Consultant and Pharmacy.<br>Antimicrobial guidance is being renewed and created to aid and support adherence to proactive.<br>The AMS team is contactable and offers support on a daily basis in working hours. | Microguide updating is progressing at the pace that staffing, workload and time pressures allow. There is a suitable time gap between guidance creation and implementation into practice. Support from AMS team only available when staff are available. | Continuation of AMS round twice weekly. Monitoring C.difficile incidence occurs regularly and the AMS team conduct ad hoc rounds where feasible. Microbiology and Pharmacy advice and support on AMS available in working hours. Additionally, SDH has a live version of micro/infection guidance. | Nil | 3. Compliant |
| **4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion** | | | | | | |
| **Systems and processes are in place to ensure that:** | | | | | | |
| **4.1** | Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs. | Information available on Trust website, including visiting information and potential restrictions.<br>Patient information leaflets available. | *Divisional feedback - Surgery: Limited evidence. Information leaflets available but failure to capture the delivery to patients. Medicine - not aware of requirement.* | *Divisional feedback: Translation service available for patients where English is not first language. Specialist nurse available for individual patient needs.* | | 3. Compliant |
| **4.2** | Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (e.g. digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate. | Regular review of information available and accessible formats e.g. website, leaflets undertaken within the Trust. | *Divisional feedback: Unsure if available in other formats e.g. e-format/audio.* | | | 3. Compliant |
| **4.3** | The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR. | In place. Regular review of information and any changes in practice undertaken by the ARG and IPCWG. | | | | 3. Compliant |
| **4.4** | Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include:<br>•Hand hygiene, respiratory hygiene, PPE (mask use if applicable)<br>•Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (e.g. cleanliness)<br>•Explanations of infections such as incident/outbreak management and action taken to prevent recurrence.<br>•Provide published materials from national/local public health campaigns (e.g. AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections. | *Divisional feedback - Surgery: Posters and leaflets available and risk assessments completed when required.*<br>Existing IPC Trust policies in place. Posters and patient information resources available. Adherence to national and local public health campaigns e.g. Antibiotic Awareness week, Global Hand Hygiene Day and IPC awareness/focus weeks. | *Divisional feedback - Surgery: Documentation of actions.* | | *Divisional feedback: Communications campaign utilised to cascade information about national and local public health campaigns.* | 3. Compliant |
| **4.5** | Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users. | *Divisional feedback - Surgery: Cannulation pathways and VIP scores; documentation audits, and other Tendable audits. Sbar handover porcesses being reintradiced to ensure safe handover of vital information* | *Divisional feedback - Surgery: Variable compliance with audits.* | SBAR handover | | 2. Partially compliant |
| **5.Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.** | | | | | | |
| **Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:** | | | | | | |
| **5.1** | All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission. | *Divisional feedback: Admission screening for MRSA (elective and emergency), timely stool sampling, etc. Review of microbiology alerts on Lorenzo system. MRSA screening programme for all inpatients. CPE monitoring for appropriate patients.* | | | | 3. Compliant |
| **5.2** | Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes. | *Divisional feedback: Use of Isolation Risk Assessment Tool (IRAT), daily monitoring of sideroom facilities/usage by Matrons. Discussed at ward rounds with escalation to IPC Team for advice.* | *Divisional feedback: effective documentation and delay in sampling or failure to sample.* | | *Divisional feedback: Daily discussion with IPC team and ward team. On ward safety brief.* | 2. Partially compliant |
| **5.3** | The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct manageement/placement. | *Divisional feedback: Transfer of care forms on discharge to other care facilities and SBAR handovers between wards. Alerts on Lorenzo electronic system. Clinical Site Managers (CSM) handover for inter-hosoital transfers.* | *Divisional feedback: Effective communication and documentation.* | | | 3. Compliant |
| **5.4** | Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival. | Agreed messaging/posters in place. | Inappropriate removal of IPC signage by staff to display other key messages. | | | 3. Compliant |
| **5.5** | Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures. | *Divisional feedback: Completion of investigations (post infection reviews and SWARMs) and divisional reporting slides; completion of clinical reviews (as appropriate), and PII monitoring. Report via Patient Safety Summit and divisional governance structure.*<br>PII investigations meetings and Outbreak Management Review meetings as required; external reporting completed. IPCC meeting quarterly and DIPC reports to Trust Board. | | | | 3. Compliant |
| **6.Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection** | | | | | | |
| **Systems and processes are in place to ensure:** | | | | | | |
| **6.1** | Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting. | Mandatory training module e-learning (LEARN) available. New starter checklists for IPC available. | Less than 100% compliance with LEARN completion and failure to utilise checklists in all areas. | | | 3. Compliant |
| **6.2** | The workforce is competent in IPC commensurate with roles and responsibilities. | Compliance with IPC practice audit results e.g. hand hygiene, use of PPE. | Variation in compliance percentages identified in IPC audits. | Peer/cross auditing within the clinical divisions and increased frequency of auditing when non-compliance evident. | | 2. Partially compliant |



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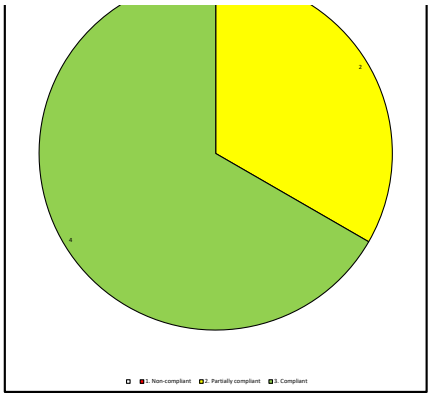
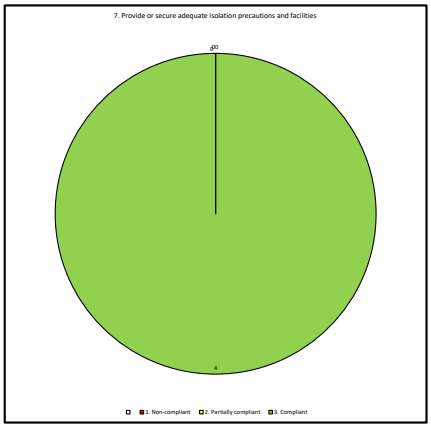
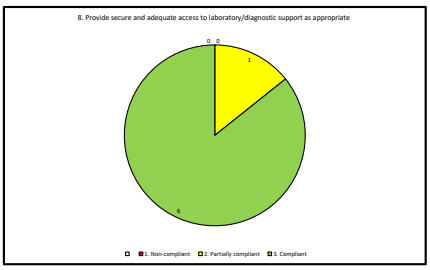
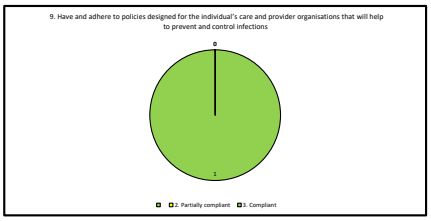
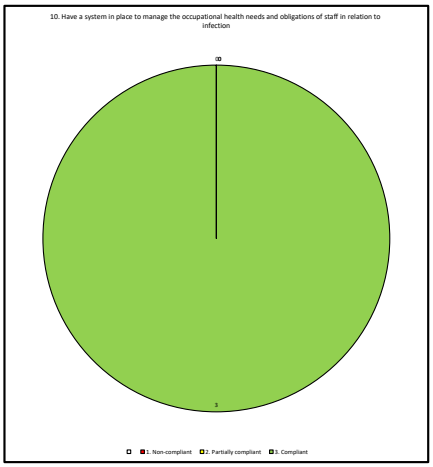
| 6.3 | Monitoring compliance and update IPC training programs as required. | Area leads monitor compliance with e-learning via LEARN (MLE reports). | Area leads need to tailor checklists to their specialist areas to ensure they meet the requirements of each speciality e.g. Theatres, ICU, burns/plastics and orthopaedics. **Fit testing** - training information added manually once employee is seen in the department. LEARN/MLE will not record/account for change in staff members facial features, teeth removal and weight loss, so the recall is 2 yearly regardless. | Reminders automatically for fit testing are generated until compliance is added. | | 3. Compliant |
| 6.4 | All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE. | All patient facing staff are captured at Induction and a Fit Testing appointment made. RPE training and advice given at Fit Test appointment. *(Of note: PPE training not given by Fit Testing Team. Instructions for PPE donning and doffing within existing Trust policy/action card).* | If appointment not attended, no RPE training will take place within the Fit Testing Department. | Ward/area leads to ensure/push fit mask refresher training and monitor compliance.<br>Use of personal risk assessments. | | 2. Partially compliant |
| 6.5 | That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept. | An 8.00hrs - 16.00hrs, Monday to Friday Fit Testing service is available for staff to access, plus nights and weekends if wards or departments need these times. All patient facing staff are invited for their Fit Test and the department follows the Trust policy of x2 fitted masks for each employee.<br>All records are given to the employee. All records are held on ESR, LEARN/MLE and a database is held for those that are not contracted. | Cannot always identify staff if names are not on induction list or contracted staff do not contact us. Messaging clear in daily bulletin/communications. | | *Divisional feedback: Staff are fit tested on induction and this is recorded on allocate. Fit test team available for advice.* | 3. Compliant |
| 6.6 | If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently. | Competency sign off for clinical procedures following training completion.<br>*Divisional feedback: Specific competency and Expanded Practice process as required.* | *Divisional feedback: Staff compliance and competency.* | Divisional feedback: Ward/Clinical Leads aware of staff. | *Divisional feedback: Training provided as required relating to procedure and assessment document completed. Depending on procedure may be agreed by Expanded Practice Group.* | 3. Compliant |
| **7. Provide or secure adequate isolation precautions and facilities** | | | | | | |
| **Systems and processes are in place in line with the NIPCM to ensure that:** | | | | | | |
| 7.1 | Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status. | Existing IPC policies in place including Isolation Risk Assessment Tool to aid patient assessment and requirement for isolation facility/sideroom. Daily sideroom reviews undertaken by the divisional Matrons with support from the IPC Nursing Team (as required). Completion of admission screens for alert organisms as per established policies (e.g. MRSA, CPE, etc).<br>*Divisional feedback: Assessment completed on admission or in Emergency department or Pre-Operative Assessment unit (POAU). Clinical Site Team aware when transfer into hospital.* | Availability of isolation facilities/sideroom due to capacity challenges and patient compliance. *Divisional feedback: Information not given.* | Unable to enforce isolation nursing with patients - appropriate information/advice given. *Divisional feedback: SBAR handover.* | | 3. Compliant |
| 7.2 | Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if:<br>•Single rooms are in short supply and if there are two or more patients with the same confirmed infection.<br>•There are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk. | Existing IPC policies in place and established sideroom priority list available (within the Trust Bed Management Policy (access via Microguide) and Seasonal Respiratory Illnesses guide). Escalation of isolation requirements for cohort nursing agreed in Trust preparedness plan e.g. winter plan. Additional advice and support available from the Microbiologist and IPC Nursing Team.<br>*Divisional feedback: Discuss with Clinical Site Team.* | | | | 3. Compliant |
| 7.3 | Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required. | Isolation policy in place, with established signage for source isolation nursing available. | *Divisional feedback: Staff compliance and knowledge.* | *Divisional feedback: Matron checks.* | Review of isolation signage underway, following discussion at IPCWG meeting to include revised PPE and waste management information. | 3. Compliant |
| 7.4 | Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions. | Policy in place and transfer of care letter. Use of SBAR handover to ensure cascade of management requirements.<br>*Divisional feedback: Discussion at daily Capacity meetings and plan to move patient if clinically required.* | | | *Divisional feedback: Discussed with Divisional Teams and Clinical Site Team at daily Bed Capacity Meetings if clinical transfer required.* | 3. Compliant |
| **8.Provide secure and adequate access to laboratory/diagnostic support as appropriate** | | | | | | |
| **Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:** | | | | | | |
| 8.1 | Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system. | Training and competency records for BMS and MLA staff are in place. | Awaiting visit from UKAS. | | We have approached UKAS to come to visit but have not received a date from them yet. | 2. Partially compliant |
| 8.2 | Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary. | Process in place. | | | | 3. Compliant |
| 8.3 | Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems. | Antenatal and General Laboratory are monitored on a monthly basis. These are available in the user handbook and are in line with the IDPS. | | | | 3. Compliant |
| 8.4 | Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation. | Policies in place. | | | The Laboratory will test what samples sent but do not make the decision on what tests are requested. | 3. Compliant |
| 8.5 | Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols. | Policies in place. | | | | 3. Compliant |
| 8.6 | There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens. | We would support with outbreak investigation and transport of specimens depending on the pathogen, risk assessments and available information. | | | | 3. Compliant |
| 8.7 | There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance. | We would support with outbreak investigation and transport of specimens depending on the pathogen, risk assessments and available information. | | | | 3. Compliant |
| **9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections** | | | | | | |
| 9.1 | Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider. | Existing IPC Trust policies and National IPC Manual are available to all staff via Microguide. Additional monitoring of practice compliance when periods of increased incidences (PIIs) and outbreaks identified. Outbreak Management Review meetings as required; external reporting completed. | | | | 3. Compliant |
| **10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection** | | | | | | |
| **Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:** | | | | | | |
| 10.1 | Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment. | Trust pregnancy risk assessment is completed by managers and sent to OH as per policy. All other illnesses which would be increased risk - OH would be involved via management referral route. | The risk is managers not referring on. | | | 3. Compliant |
| 10.2 | Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting. | Contamination policy, which advices OH or Emergency Department for out of hours. Reporting is via DATIX and then followed up by OH or Health & Safety. | | | | 3. Compliant |
| 10.3 | Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs). | All staff complete a PPQ and we assess their vaccine requirements. If vaccines are required we invite them for an OH appointment. If they DNA 3 times we inform their recruitment they haven't attended OH. For EPP staff – we require evidence of Hepatitis B, Hepatitis C and HIV 1 & 2 identified validated samples before health clearance is provided. Once we have this evidence, we will clear them. | | | | 3. Compliant |



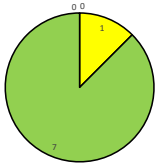



1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

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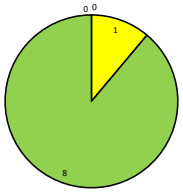
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

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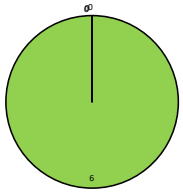
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

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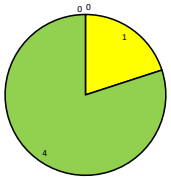
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment in a timely fashion.

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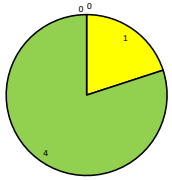
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.

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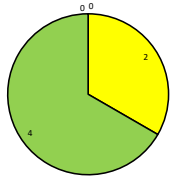
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

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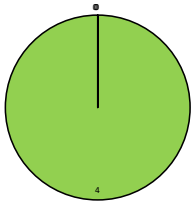
7. Provide or secure adequate isolation precautions and facilities

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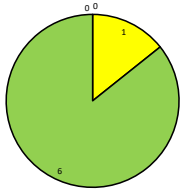
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate

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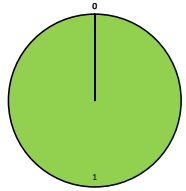
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

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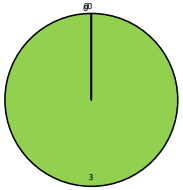
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

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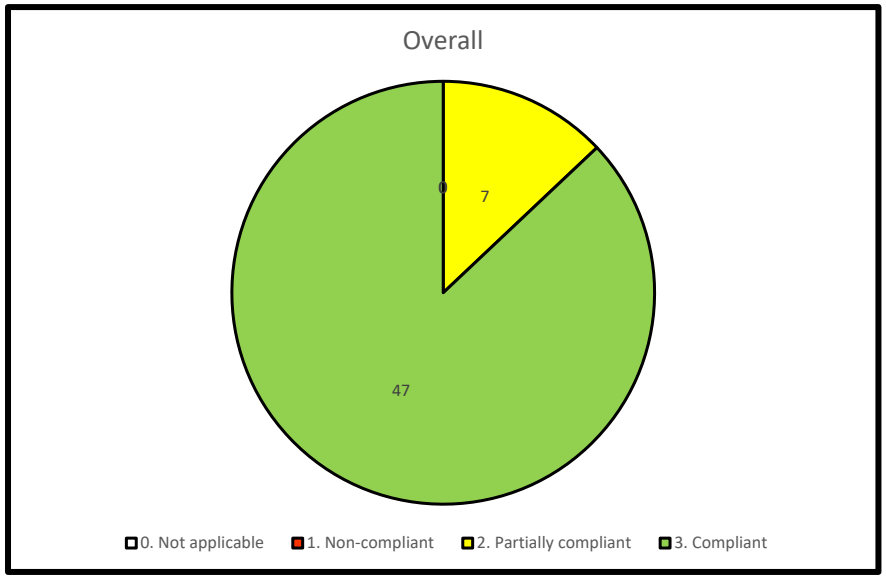
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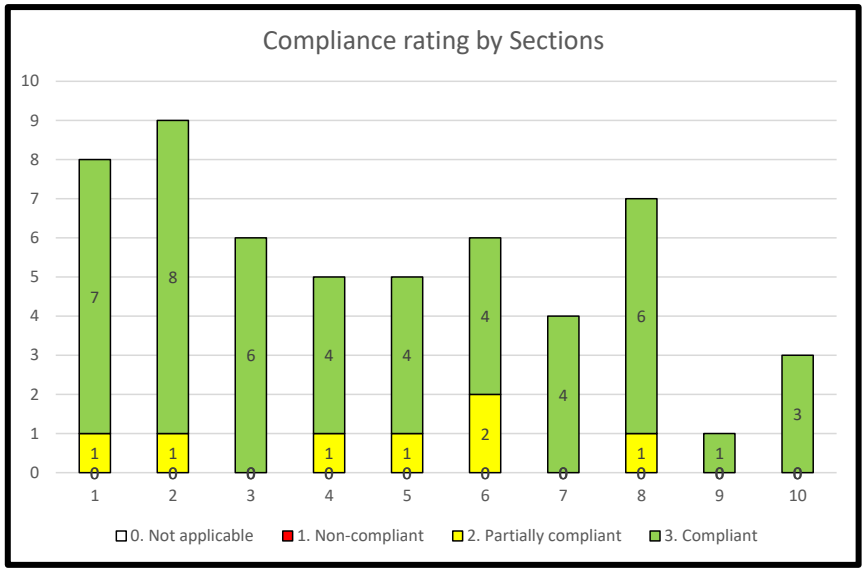
Compliance rating by Sections
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0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant

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| Report to: | Trust Board (Public) | Agenda item: | 7.2 |
| Date of meeting: | 11 January 2024 | | |

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|---|---|---|---|---|
| Report tile: | Q2 Learning from Deaths Report 2023-24 | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | Yes | Yes | Yes | |
| Approval Process: (where has this paper been reviewed and approved): | Mortality Surveillance Group<br>Clincal Governance Committee 28 November 2023 | | | |
| Prepared by: | Dr Ben Browne, AMD/Head of Clinical Effectiveness | | | |
| 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:

The Trust MSG met on 12th September 2023 in Quarter 2 (Q2), where learning, improvement themes and actions arising from mortality diagnosis group alerts and individual case reviews were discussed. Please also refer to the Q2 **Summary of Learning** (outlined on pages 3-5 of the report).

There were 193 inpatient deaths in Q2 (inclusive of patients who died in either the Emergency Department or Hospice).

**During Quarter 2 there was/were:**

- 2 deaths where COVID-19 was the primary cause of death (recorded as 1a on the death certificate)
- No stillbirths
- No maternal deaths
- 1 death reported in a patient with a learning disability
- 4 deaths in patients considered to have a serious mental illness

- A total of 187 deaths were scrutinised by the Medical Examiners in Quarter 2 (97% of all inpatient deaths), an increase from 92% in the previous Quarter
- 12 Structured Judgement Reviews (SJRs) were requested

**End of Life Care**

The Your Views Matter Bereavement survey aims to capture the views and experience of bereaved families.

**During Quarter 2:**

- 88 families gave consent for the Trust's Your Views Matter bereavement survey to be posted.
- A response rate of 24% (n~ 21) was achieved.

- 76% of respondents rated the overall end of life care as good or very good.

**National Benchmarks**

**Latest SHMI (as reported by NHS Digital at the time of publication):**

- The Trust SHMI is **1.1705** for the twelve-month period ending in May 2023 and is statistically higher than expected. When comparing SHMI by site, Salisbury District Hospital is **1.1172** and Salisbury Hospice is **2.3794.**
- The SHMI is within the expected range when our hospice data is removed.

**HSMR:**

- 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 May 2023.***

  - The HSMR (relative risk) for the Trust for the twelve-month period ending in May 2023 is **123.0** and is statistically higher than expected (114.5 – 132.0, 95% confidence limits).
  - The HSMR (relative risk) for Salisbury District Hospital (excludes hospice data) for the twelve-month period ending in May 2023 is **114.5** and is statistically higher than expected (105.7 – 123.7).
  - Weekday HSMR is **116.5** and weekend HSMR is **140.8**. Both are statistically higher than expected. For Salisbury District Hospital (excludes hospice data) this is **108.6** and **133.0** respectively. Weekend HSMR is statistically higher than expected. Weekday figures fall to within the expected range with the hospice figures excluded.

| 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 |

NHS
Salisbury
NHS Foundation Trust

# QUARTER 2 2023/24 LEARNING FROM DEATHS REPORT

November 2023

A summary document outlining the learning from deaths at Salisbury NHS Foundation Trust during the second financial quarter of 2023/24. Data correct as of 12.11.2023 [unless otherwise stated in the report]

*Dr Ben Browne - Head of Clinical Effectiveness*
*Mr Richard Cole*

# 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.

## 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.

**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.

# 1. Purpose

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

# 2. Background

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

# 3. Summary of Learning in Q2

The Trust MSG met on 12th September 2023 in Quarter 2 (Q2), where learning, improvement themes and actions arising from mortality diagnosis group alerts and individual case reviews were discussed. Further work is underway to introduce the new mortality review platform (MaMR) alongside the Trust's Clinical Audit system (AMaT) which itself went live in September 2023. The output from any mortality reviews included in this platform is being designed with an emphasis on learning points and actions taken as a result, all of which will be in a categorised or themed format for the purpose of future analysis, for example in response to a new Alert received from Dr Foster / Telstra UK. It is expected that this mortality module will go live in early spring 2024.

## 3.1. SJRs and The Medical Examiner System

In Q2 there were 193 deaths (inclusive of the hospice and ED). Of these, 187 cases were scrutinised by the MEs (97%) with 12 Structured Judgement Reviews (SJRs) requested by the MEs (6.4%). This was a similar percentage to that observed during Q2 in 2022/2023, the majority being indicated for issues in the "other" category. The categorisation of type of problem triggering the SJR is being addressed in the new mortality management platform whereby any learning or actions arising from reviews will be categorised or themed more precisely.

To enhance the SJR process for Learning Disabled (LD) and autism mortality cases (approximately 4 per year) the LD & autism lead nurse and audit facilitator have been working together to ensuring as far as possible that these are completed together with a key specialist (or their deputy), and within the six-month period allowed for submission following death.

## 3.2. Serious Incidents Requiring Investigation (SIIs)/ Case Reviews

An SII was discussed at the MSG in relation to a patient who sadly died in an ambulance after arriving at the hospital. This occurred during one of the busiest times in the hospital's history. The emergency department (ED) have subsequently made changes in practise to ensure that there is a consultant or senior decision-making conversation about all patients arriving by ambulance as soon as possible and to ensure that they are prioritised appropriately.

## 3.3. Bereavement

Your Views Matter Bereavement survey were posted to 88 families in Q2 with their consent, 21 (24%) responding. This was a lower response rate compared to the previous two years, but satisfaction was reported as good or very good in 76%. This is an increase on Q1 and Q4, and higher than the annual average for 2022/23 (70%). Poor/Very Poor and adequate ratings have subsequently reduced this quarter.

There were some negative themes around facilities and appropriateness of the room or ward where someone dies again this quarter. However, these were noted to be much fewer than previous quarters and there were also positive examples shared where staff behaviours and access to additional facilities (such as reclining chairs to allow loved ones to stay with the patient) made these end-of-life experiences easier for the loved ones.

## 3.4. Formal Alerts and Reports

The Trust Board have commissioned a review of our mortality governance processes to ensure that we are taking all reasonable steps to understand and act on the significant and sustained change seen in the Trust's statistical mortality model benchmarking. Low coding of comorbidities may be resulting in a higher-than-expected number of deaths, and we are therefore prioritising coding of patients who die and improving coding of patients' comorbidities. A regional mortality summit is also being established to help provide us with further context regarding our mortality data.

The Charlson co-morbidity scores are one of the three case-mix factors which are provided directly by SFT into the Dr Foster/Telstra UK mortality model. It is important that these co-morbidities are coded as accurately as possible because they influence "expected" mortality, and, if cases are being allocated to zero co-morbidities (because some are being missed in the coding process), there is a risk of SFT mortality metrics being moved towards or into the statistical outlier intervals. The latest Dr Foster/Telstra UK Report confirmed that for the twelve months to May 2023: 50.2% of our deaths had zero Charlson co-morbidity score (HSMR) compared to a figure of 41.6% nationally. Similarly, only 11.9% had co-morbidity scores greater than or equal to 20, compared to the national figure of 15.9%. One priority of our approach to the Dr Foster/Telstra UK reports includes reviewing the accuracy of comorbidity score attribution, as outlined in previous Learning from Death reports, which have included various actions such as allowing increased access to records for coders, whereby it will be the local policy at SFT to use the Integrated Care Record (ICR) within the Electronic Patient Record (EPR) to extract information regarding patient co-morbidities (accessing the active problems, past problems, medication, and lifestyle sections will help to determine appropriate codes). The coding team have also started to set up an ongoing audit for deceased patients with zero Dr Foster/Telstra UK comorbidities, to cover all diagnosis

groups. This is running from April 2023 and is intended to become a regular process once the coding for a month is complete, so that any errors can be corrected before they get to Dr Foster/Telstra UK.

Learning opportunities arising from the significant accumulation of mortality review 'Checklists' (the level of mortality review scrutiny below formal SJRs) have led to further improvements, including the addition of delayed discharge as a data-item and the inclusion of the initials of a second consultant as well as the original admitting one. This is relevant if during the admission most of the care occurs under a second or principal consultant who is not the admitting one. These are being incorporated into the new MaMR platform for the initial Checklist reviews. By bringing in a standardised dataset for all specialties participating in mortality reviews, we will in future be able to respond immediately to any alerts by analysing the relevant admission diagnostic group data already captured prospectively. Similarly, we will be able to analyse by specialty and trust-wide for common themes or types of problems with care.

Recent examples of learning points and actions arising from these Checklist reviews include: Reviewing signage on entry to wards relating to visiting rules, highlighting how multiple transfers to different wards in patients with delirium is not in patients best interest (raised to DMT level), recognising how patients assessed as being high risk of falls and confusion should be considered for one-to-one supervision (highlighted in an M&M learning points document circulated to medical teams), ensuring that referrals to sub-specialties occur and if not, a reason is documented in the notes and, finally, that ReSPECT forms are countersigned by a consultant (both also highlighted with an M&M learning points document circulated to medical teams).

A Higher-level review previously carried out by the Trust Mortality Lead (TML) together with the Acute Kidney Injury (AKI) Lead of those cases which triggered a Dr Foster/Telstra UK Alert included the case-notes available of the ten patients who died within 72 hrs of admission; the overall cohort of 27 cases having revealed no patterns of concern and good adherence to best practice in end-of-life care. This higher-level review led to several actions including highlighting deficiencies in completion of fluid charts and food charts. These themes were presented at the Patient Safety Steering Group on 4 Oct 2023. Further training is considered to be essential for all staff and a further action is now also under way to review the accuracy of Charlson co-morbidity scoring in the early <72-hour AKI mortality subgroup.

An alert relating to 'cancer of colon' cases (18 deaths vs 10.5 expected), discussed at the 11 Apr 2023 MSG, led to a communication with the colorectal team. A total of 12 cases of the 18 in the cohort were subsequently identified as palliative care-related, and the other cases could not therefore in themselves have triggered an alert statistically. An unrelated "cleaning up" of palliative care coding exercise revealed that one death had not been allocated the Z51.5 (palliative care code) in the original data submitted to Dr Foster/Telstra, but the model does not allow for retrospective corrections to be made. The Dr Foster/Telstra UK report after that (29 Aug 2023) generated a new alert in this same diagnosis group, 18 deaths vs 10.6 expected (coincidentally almost the same as the earlier one, but confirmed to apply to a different cohort), and for this reason a review of coding accuracy has been requested. It should be noted that whilst the model does adjust for specialist palliative care within the general hospital population nationally, it cannot consider if patients are within a palliative care unit or hospice, where the majority of patients are on an end-of-life pathway. Cancer of colon is no longer an alert in the latest Dr Foster/Telstra UK report covering the 12 months up to May 2023, and dated Oct 2023.

Dr Foster/Telstra UK, at our request, include in their reports analysis of six key diagnosis risk groups (Acute and unspecified renal failure, Pneumonia, non-hypertensive Congestive cardiac failure, Acute cerebrovascular disease, Fractured neck of femur and Septicaemia (non-labour). The relative risk according to the rolling 12-month trends for five of the six lies within the normal range (95% confidence intervals) with Septicaemia (non-Labour) having become higher than expected (54 v 34.7 expected) in the latest year to May 2023 report. This will likely require a review of coding as the next step (see graph on the final page of this report).

## 4. Mortality Data

| Categories | Quarter 1 2023/24 | | | | Quarter 2 2023/24 | | | |
|---|---|---|---|---|---|---|---|---|
| | April | May | June | Q1 Total | July | August | September | Q2 Total |
| All inpatient Deaths (inc. ED and Hospice) | 81 | 89 | 51 | **221** | 60 | 78 | 55 | **193** |
| Deaths Reviewed/Scrutinised by the ME | 74 | 80 | 49 | **203 (92%)** | 58 | 75 | 54 | **187 (97%)** |
| SJRs requested by ME | 6 | 8 | 1 | **15** | 5 | 6 | 1 | **12** |
| ED Deaths | 3 | 3 | 0 | **6** | 1 | 2 | 2 | **5** |
| Hospice Deaths | 17 | 15 | 9 | **41** | 13 | 17 | 15 | **45** |
| Covid-19 as Primary cause of death (recorded as Covid 1a) | 3 | 2 | 0 | **5** | 0 | 1 | 1 | **2** |
| Stillbirths (>37+0 weeks) | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** |
| Stillbirths (>24+0 weeks – 36+6 weeks) | 0 | 0 | 1 | **1** | 0 | 0 | 0 | **0** |
| Late Miscarriage (22+0 weeks – 23+6 weeks) | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** |
| Neonatal Deaths | 0 | 0 | 1 | **1** | 0 | 0 | 0 | **0** |
| Maternal Deaths | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** |
| Learning Disability Deaths* | 0 | 4 | 0 | **4** | 1 | 0 | 0 | **0** |
| Serious Mental Illness* | 0 | 0 | 0 | **0** | 1 | 2 | 1 | **4** |

**as reported/identified by the Medical Examiner*

# 5. Medical Examiner (ME) and Structured Judgement Reviews (SJR)

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.

- **12 Structured Judgement Reviews were requested by the Medical Examiners in Q2.**

The requests (identified through ME screening) are categorised into problem themes and stage of care (see table below). Please note that some requests may occasionally 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.

| *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*** | ***7*** | ***17*** |
| Problem with medication / IV fluids / electrolytes / oxygen | | | | | *1* | | ***1*** | ***5*** | ***3*** |
| Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE) | *1* | | | | | | ***3*** | ***8*** | ***7*** |
| Problem with infection control | | | | | | | ***0*** | ***0*** | ***0*** |
| Problem related to operation/invasive procedure (other than infection control) | | *1* | | *1* | | | ***2*** | ***2*** | ***4*** |
| Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes) | | | | | | | ***2*** | ***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 | | | | | | 7 | ***18*** | ***26*** | ***24*** |
| 2023/24 YTD | *1* | *3* | *0* | *1* | 1 | 21 | | | |
| **2022/23 YEAR TOTAL** | ***6*** | ***15*** | ***0*** | ***0*** | ***5*** | ***30*** | | | |
| **2021/22 YEAR TOTAL** | ***9*** | ***24*** | ***3*** | ***3*** | ***4*** | ***25*** | | | |

# 6. Your Views Matter Survey & End of Life Care

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.

In Q2, 88 families gave consent for the Trust's Your Views Matter bereavement survey to be posted. Achieving a response rate of 24% (n~ 21). This is a reduction on Q1 and is also noted to be lower than the average response rate seen for 2022-2023 (41%) and average response rate for 2021/22 was 39%.

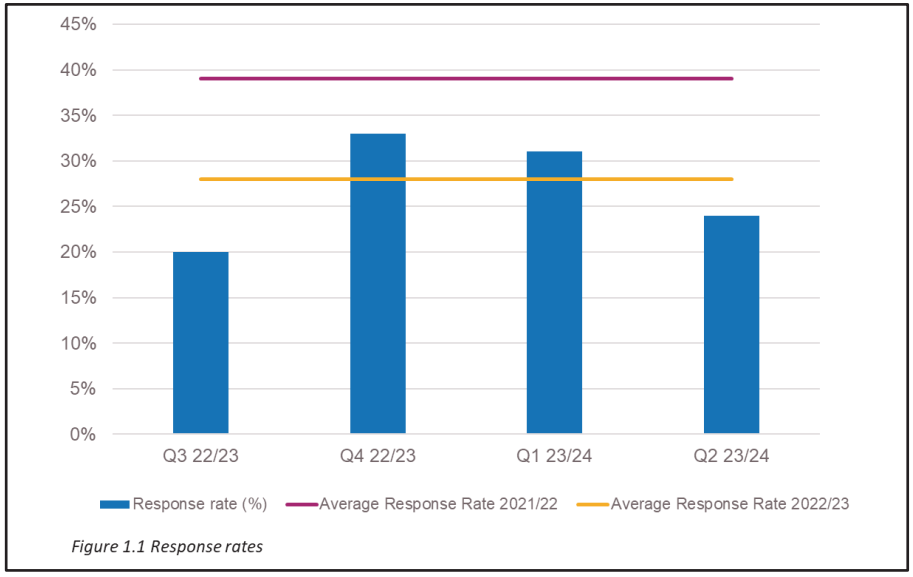



*Figure 1.1 Response rates*

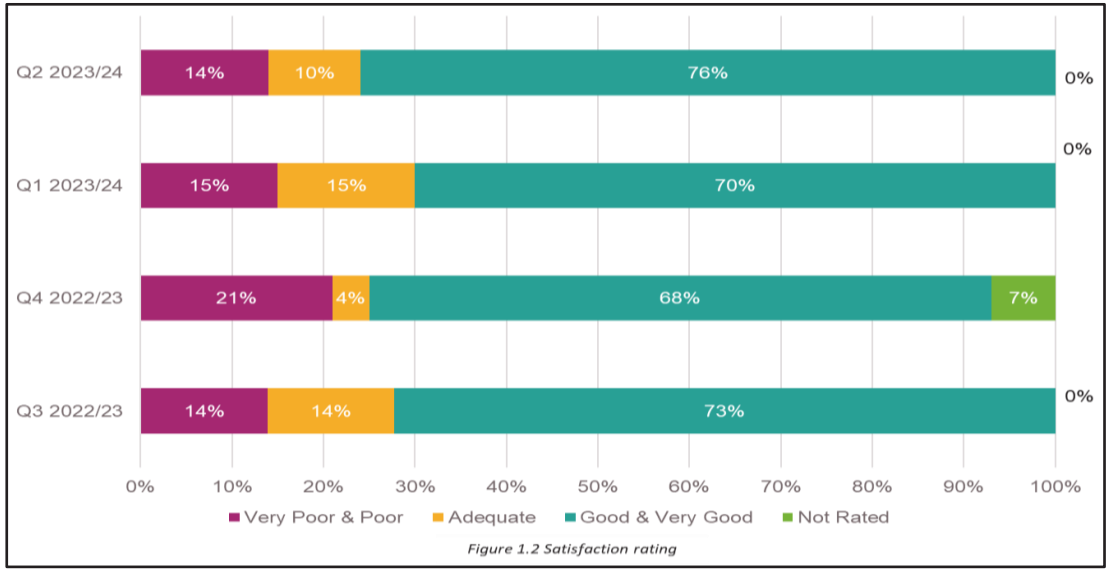
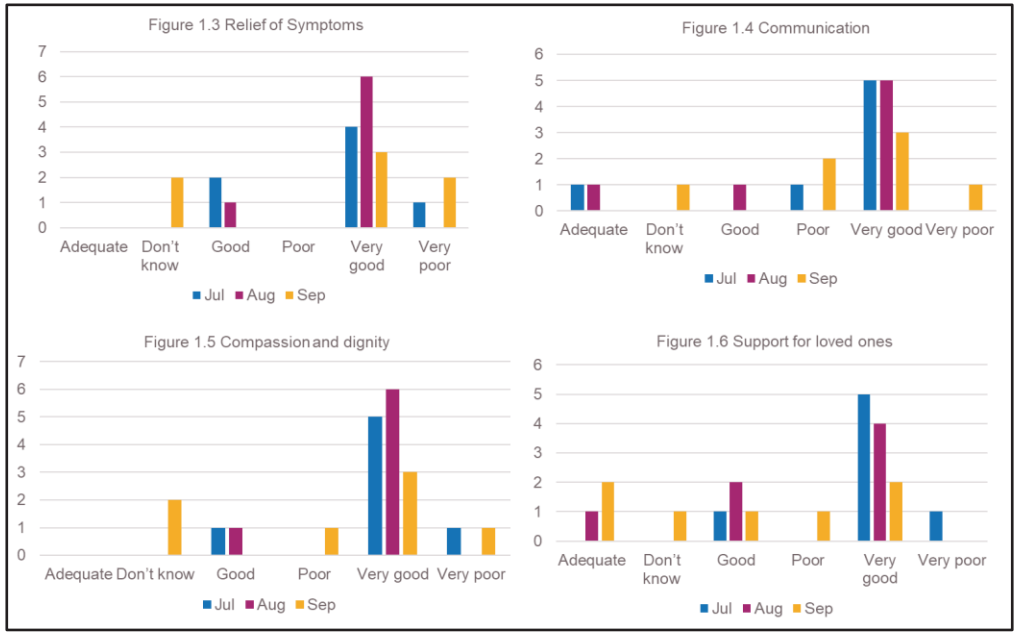



*Figure 1.2 Satisfaction rating*

- 76% of respondents rated the overall end of life care as good or very good. This is an increase on Q1 and Q4, and higher than the annual average for 2022/23 (70%). Poor/Very Poor and adequate ratings have subsequently reduced this quarter.
- **Figures 1.3 to 1.6** (below) show the overall ratings in the key areas of patient experience (Relief of symptoms, Communication, Compassion and Dignity, Support for loved ones)
- 5 survey participants requested a call-back from PALS, 1 of these was noted to be a previously logged complaint with PALS that was still under investigation at the time of receiving the completed bereavement survey. This is a noted increase on Q1 for the number of call-backs made by PALS. There were no notable correlations with complaint themes this quarter.
- There were some negative themes around facilities and appropriateness of the room or ward where someone dies again this quarter. However, these were noted to be much fewer than previous quarters and there were also positive examples shared where staff behaviours and access to additional facilities (such as reclining chairs to allow loved ones to stay with the patient) made these end-of-life experiences easier for the loved ones.
- There continued to be most positive comments in relation to both the bereavement and medical examiner's office this Quarter.



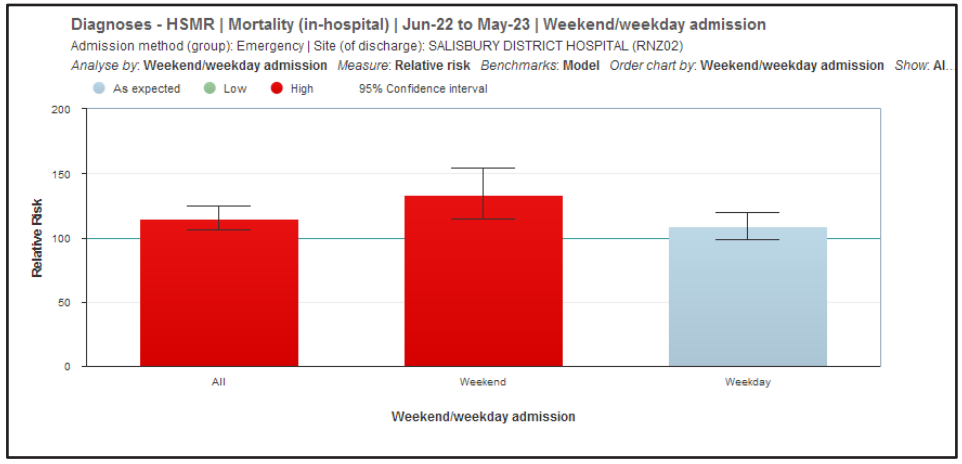

# 7. Mortality Benchmarking

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 May 2023.

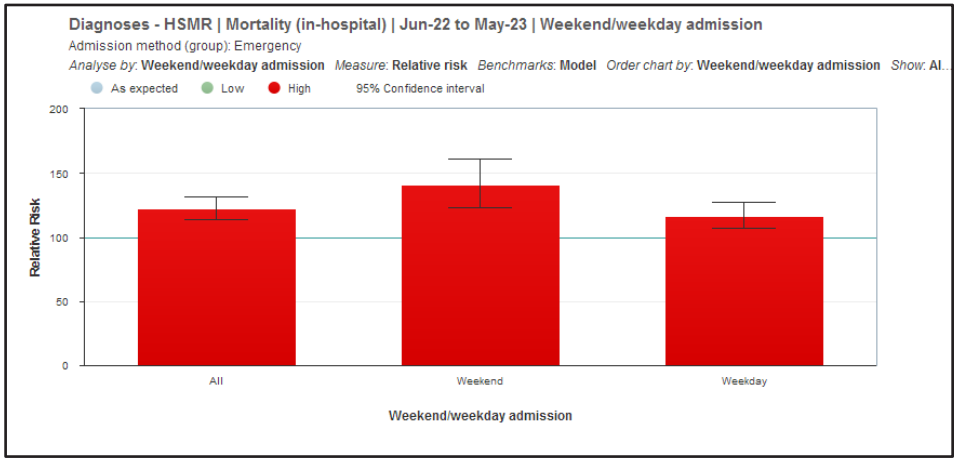
## 7.1. Summary - HSMR rolling 12-month trend to May '23

- The HSMR (relative risk) for the Trust for the twelve-month period ending in May 2023 is **123.0** and is statistically higher than expected (114.5 – 132.0, 95% confidence limits).
- The HSMR (relative risk) for Salisbury District Hospital (excludes hospice data) for the twelve-month period ending in May 2023 is **114.5** and is statistically higher than expected (105.7 – 123.7).
- Weekday HSMR is **116.5** and weekend HSMR is **140.8**. Both are statistically higher than expected. For Salisbury District Hospital (excludes hospice data) this is **108.6** and **133.0** respectively. Weekend HSMR is statistically higher than expected. Weekday figures fall to within the expected range with the hospice figures excluded.

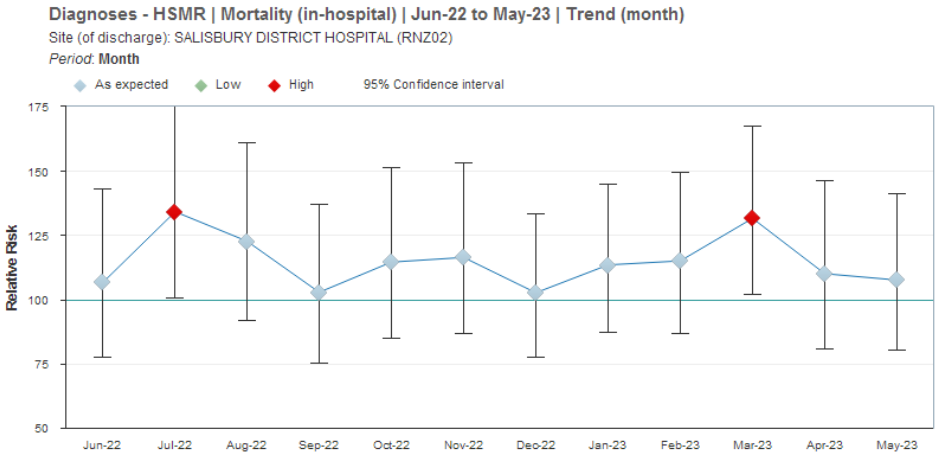
### Weekend/Weekday HSMR [Excluding Hospice Data]




### Weekend/Weekday HSMR [Inclusive of Hospice Data]



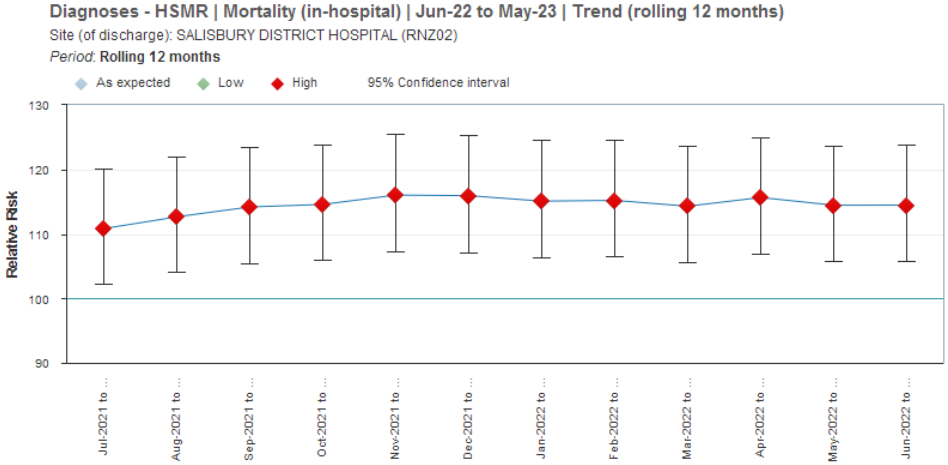
## Salisbury District Hospital HSMR [Excludes Hospice Data] – Monthly Trend



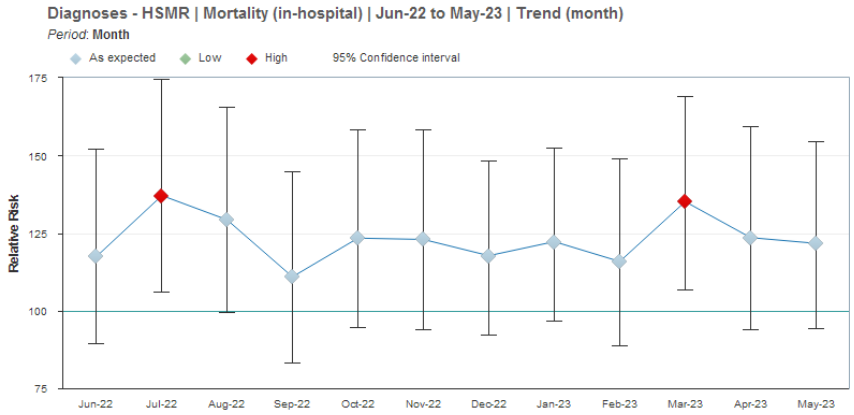

### Monthly HSMR Figures

When reviewing the previous 12-month's data monthly, July-22 & March-23 figures were those which were statistically higher than expected.

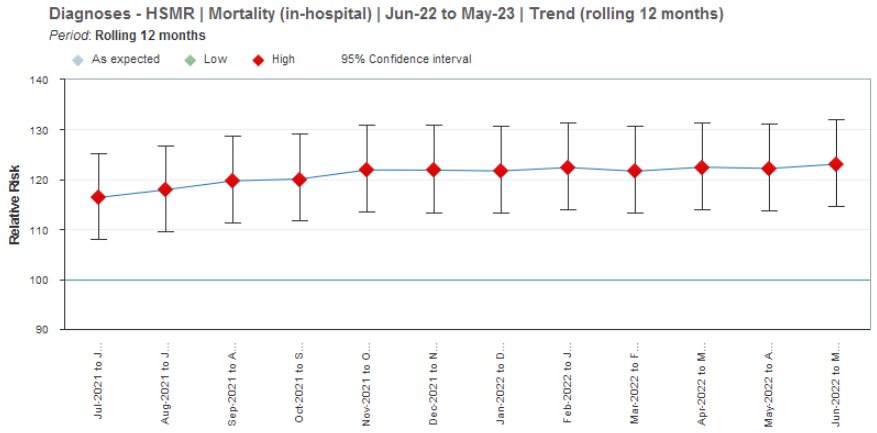
## Salisbury District Hospital HSMR [Excludes Hospice Data] – Rolling 12-Month Trend



## Trust HSMR [Includes Hospice Data] – Monthly Trend



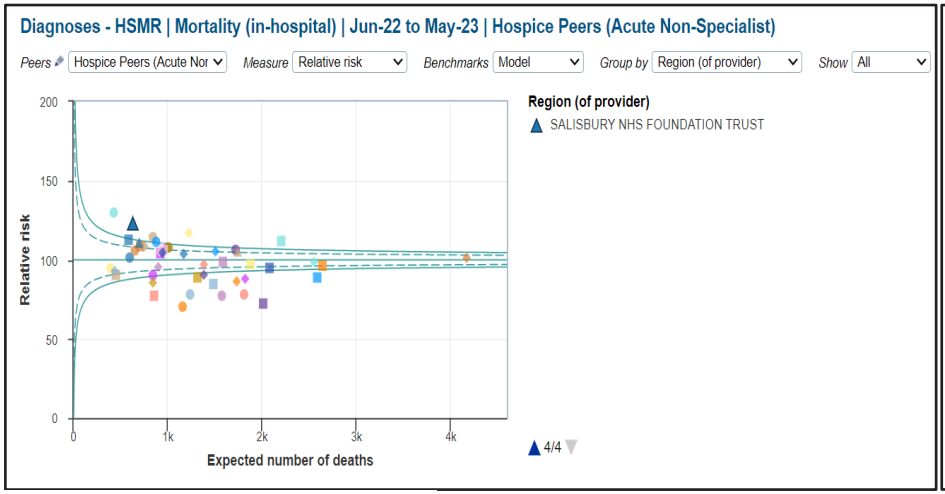

## Trust HSMR [Includes Hospice Data] – Rolling 12-month Trend



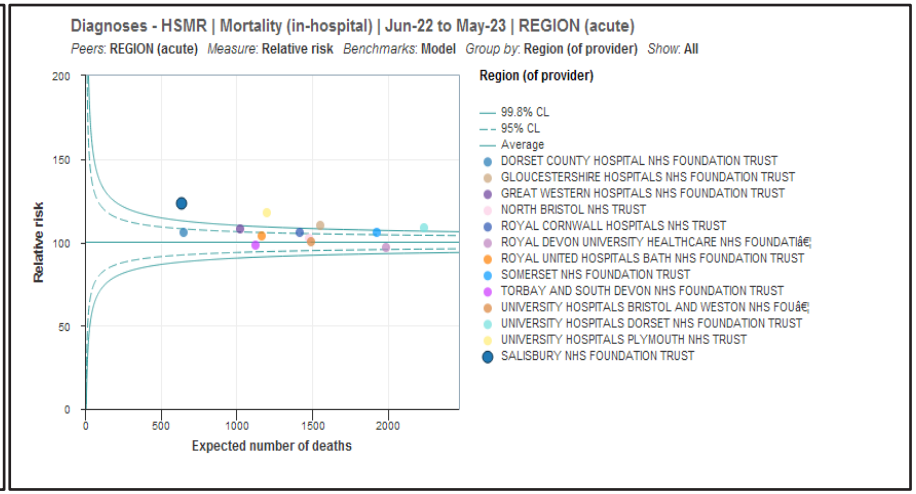
Salisbury NHS Foundation Trust

## Trust HSMR [Includes Hospice Data] Peer Comparison Rolling 12-month Trend.

### Hospice Peers




### Regional Acute Trusts




Region (of provider)

99.8% CL
95% CL
Average
AIREDALE NHS FOUNDATION TRUST
BARNSLEY HOSPITAL NHS FOUNDATION TRUST
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST
BOLTON NHS FOUNDATION TRUST
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
CROYDON HEALTH SERVICES NHS TRUST
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST
EAST CHESHIRE NHS TRUST
FRIMLEY HEALTH NHS FOUNDATION TRUST
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST
HARROGATE AND DISTRICT NHS FOUNDATION TRUST
HOMERTON HEALTHCARE NHS FOUNDATION TRUST
IMPERIAL COLLEGE HEALTHCARE NHS TRUST
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST
LEWISHAM AND GREENWICH NHS TRUST
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
NORTH WEST ANGLIA NHS FOUNDATION TRUST
NORTHAMPTON GENERAL HOSPITAL NHS TRUST
ROYAL BERKSHIRE NHS FOUNDATION TRUST
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST
THE ROTHERHAM NHS FOUNDATION TRUST
THE ROYAL WOLVERHAMPTON NHS TRUST
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST
UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST
WEST SUFFOLK NHS FOUNDATION TRUST
WHITTINGTON HEALTH NHS TRUST
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST
WYE VALLEY NHS TRUST
YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST

## 7.2. Summary Hospital-Level Mortality Indicator (SHMI) for April 2022 – May 2023

The SHMI is an indicator which reports on mortality at Trust level across the NHS in England and it is published as an official statistic by NHS Digital. The latest available data is published in this report.

- The Trust SHMI is **1.1705** for the twelve-month period ending in May 2023 and is statistically higher than expected. When comparing SHMI by site, Salisbury District Hospital is **1.1172** and Salisbury Hospice is **2.3794.**
- The SHMI is within the expected range when our hospice data is removed.

| Site code | Site name | Provider spells | Observed deaths | Expected deaths | SHMI value |
|---|---|---|---|---|---|
| RNZ02 | Salisbury District Hospital | 31,445 | 1,000 | 895 | 1.1172 |
| RNZ78 | Salisbury Hospice | 125 | 95 | 40 | 2.3794 |

- The tables in the supplementary data pack show additional data for SFT as a breakdown for specific conditions for the twelve-month period ending in May 2023.

## 7.3. Alerts

- All new alerts continue to be discussed at the Trust MSG meeting where a further review or investigation into deaths may be requested. A representative from Telstra Health U.K (Dr Foster) attends and provides a regular report of our mortality data and all new alerts. A member of the Trust Information Services team and/or coding department have been attending to help further our understanding of the data.

Salisbury NHS Foundation Trust

# 8. Supplementary Data

## SHMI Data for the 12 Month Period Ending in May 2023

**SHMI - Summary Hospital Mortality Indicator**

**Period: Jun 22 - May 23**

Provider: RNZ - SALISBURY NHS FOUNDATION TRUST

Region: SOUTH WEST

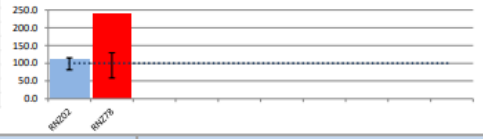
Click to enable bespoke peer

**SHMI - Published (With Over Dispersion)**

** click group name to filter; click header title to clear*

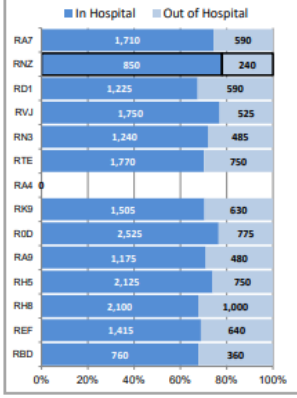
| | Provider | Denominator | Obs | Exp | Obs-Exp | SHMI | Low | High |
|---|---|---|---|---|---|---|---|---|
| RBD | Dorset County Hospital NHS Foundation Trust | 25,835 | 1,120 | 1,005 | 115 | 111.57 | 88.09 | 113.52 |
| REF | Royal Cornwall Hospitals NHS Trust | 58,845 | 2,055 | 2,065 | -10 | 99.54 | 88.79 | 112.62 |
| RH8 | Royal Devon University Healthcare NHS Foundation Trust | 87,310 | 3,100 | 3,200 | -100 | 97.01 | 89.04 | 112.30 |
| RH5 | Somerset NHS Foundation Trust | 75,525 | 2,875 | 2,980 | -105 | 96.50 | 89.01 | 112.35 |
| RA9 | Torbay And South Devon NHS Foundation Trust | 35,850 | 1,655 | 1,625 | 30 | 101.97 | 88.61 | 112.86 |
| R0D | University Hospitals Dorset NHS Foundation Trust | 87,965 | 3,300 | 3,795 | -495 | 86.91 | 89.12 | 112.21 |
| RK9 | University Hospitals Plymouth NHS Trust | 67,640 | 2,140 | 1,985 | 155 | 107.71 | 88.77 | 112.65 |
| RA4 | Yeovil District Hospital NHS Foundation Trust | 0 | 0 | 0 | 0 | 0.00 | 0.00 | 0.00 |
| RTE | Gloucestershire Hospitals NHS Foundation Trust | 93,680 | 2,520 | 2,280 | 240 | 110.49 | 88.86 | 112.53 |
| RN3 | Great Western Hospitals NHS Foundation Trust | 54,935 | 1,725 | 1,615 | 110 | 106.79 | 88.60 | 112.86 |
| RVJ | North Bristol NHS Trust | 90,230 | 2,275 | 2,350 | -75 | 96.90 | 88.88 | 112.51 |
| RD1 | Royal United Hospitals Bath NHS Foundation Trust | 56,480 | 1,815 | 1,850 | -35 | 98.17 | 88.71 | 112.72 |
| RNZ | Salisbury NHS Foundation Trust | 31,570 | 1,095 | 935 | 160 | 117.05 | 87.99 | 113.65 |
| RA7 | University Hospitals Bristol And Weston NHS Foundation Trust | 92,530 | 2,300 | 2,420 | -120 | 95.02 | 88.90 | 112.49 |
| Group | | 858,395 | 27,975 | 28,105 | -130 | 99.54 | | |

| Site - All Diagnosis | Den | Obs | Exp | SHMI | Low | High |
|---|---|---|---|---|---|---|
| SALISBURY DISTRICT HOSPITAL | 31,445 | 1,000 | 895 | 111.72 | 84.35 | 118.56 |
| SALISBURY HOSPICE | 125 | 95 | 40 | 237.94 | 70.53 | 141.79 |

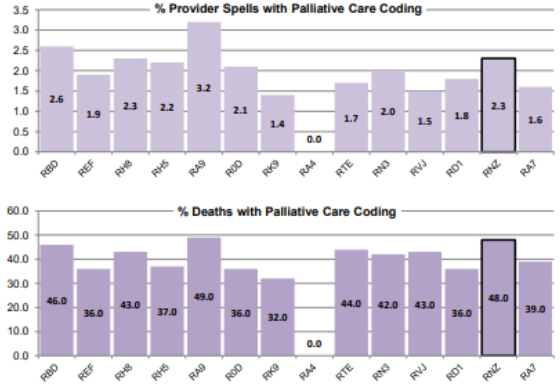



| SHMI Group | Obs | Exp | SHMI | Low / High |
|---|---|---|---|---|
| Septicemia (except in labour), Shock | 55 | 40.00 | 133.28 | 73.03 136.93 |
| Cancer of bronchus, lung | 35 | 25.00 | 138.03 | 66.98 149.31 |
| Secondary malignancies | 35 | 30.00 | 131.19 | 68.78 145.39 |
| Fluid and electrolyte disorders | 15 | 10.00 | 124.91 | 56.18 177.98 |
| Acute myocardial infarction | 15 | 20.00 | 73.28 | 64.84 154.22 |
| Pneumonia | 135 | 135.00 | 103.22 | 81.48 122.73 |
| Acute bronchitis | 10 | 10.00 | 90.87 | 56.93 175.65 |
| Gastrointestinal haemorrhage | 15 | 15.00 | 89.38 | 59.81 167.18 |
| Urinary tract infections | 15 | 20.00 | 70.59 | 60.48 165.34 |
| Fracture of neck of femur (hip) | 20 | 25.00 | 79.26 | 67.01 149.23 |

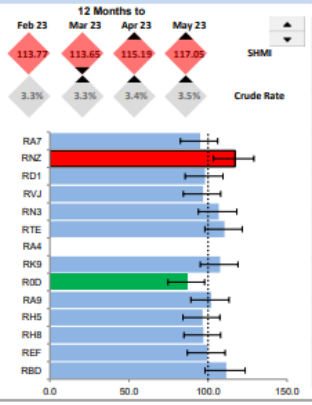
**Deaths: In / Out Hospital**




**% Palliative Care Coding**




**Trend / Rate**




**SHMI Group - With 95% CI (Dr Foster)**

| SHMI Group | Obs | Exp | SHMI | Low / High |
|---|---|---|---|---|
| (42) Mental retardation, Senility and organic mental disorders | 30 | 15 | 200.00 | 134.91 285.52 |
| (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 |
| (77) Aspiration pneumonitis, food/vomitus | 30 | 20 | 150.00 | 101.18 214.14 |
| (65) Congestive heart failure, nonhypertensive | 40 | 30 | 133.33 | 95.24 181.57 |
| (66) Acute cerebrovascular disease | 65 | 55 | 118.18 | 91.21 150.64 |
| (89) Intestinal obstruction without hernia | 15 | 10 | 150.00 | 83.89 247.42 |
| (8) Cancer of oesophagus | 15 | 10 | 150.00 | 83.89 247.42 |

** Dr Foster "SHMI Group" values based on published, rounded values with 95% CI's*

Salisbury NHS Foundation Trust

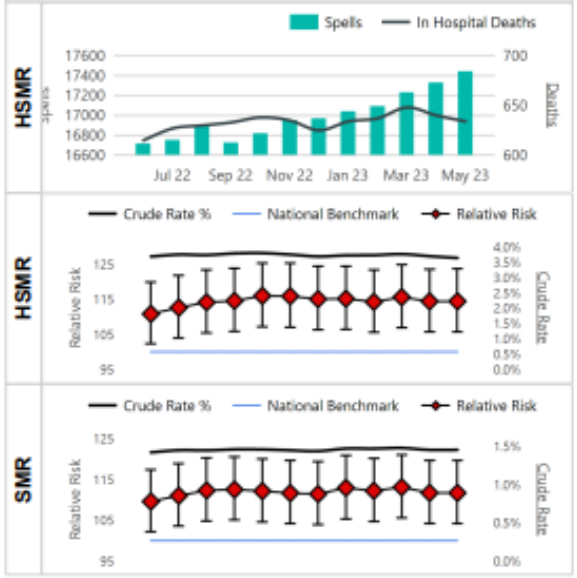
## HSMR for the 12 Month Period Ending in May 2023 for Salisbury District Hospital [Excludes Hospice Data]

HEALTH | dr foster. HEALTHCARE INTELLIGENCE PORTAL

**Mortality Summary for 12 months to May-2023 as at 02/11/2023**

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 |
|---|---|---|---|---|---|---|
| Syncope | 1 | 4 | 0.8 | 476.0 | 128.0 | |
| Chronic obstructive pulmonary disease and bronchiectasis | 1 | 32 | 18.0 | 178.0 | 121.8 | |
| Senility and organic mental disorders | 2 | 25 | 14.0 | 178.8 | 115.7 | |
| Crushing injury or internal injury | 0 | 7 | 2.6 | 269.5 | 108.0 | |
| Septicemia (except in labour) | 0 | 50 | 34.8 | 143.6 | 106.6 | |
| Other connective tissue disease | 1 | 14 | 7.4 | 188.9 | 103.2 | |
| Aspiration pneumonitis, food/vomitus | 0 | 30 | 19.8 | 151.1 | 102.0 | |

| CUSUM 99% Threshold (Top 6) | CUSUM | Obs | Exp | RR | LCI | Trend |
|---|---|---|---|---|---|---|
| Syncope | 1 | 4 | 0.8 | 476.0 | 128.0 | |
| Chronic obstructive pulmonary disease and bronchiectasis | 1 | 32 | 18.0 | 178.0 | 121.8 | |
| Senility and organic mental disorders | 2 | 25 | 14.0 | 178.8 | 115.7 | |
| Other connective tissue disease | 1 | 14 | 7.4 | 188.9 | 103.2 | |
| Pneumonia | 1 | 130 | 118.6 | 109.6 | 91.6 | |
| Chronic ulcer of skin | 1 | 5 | 2.4 | 205.5 | 66.2 | |

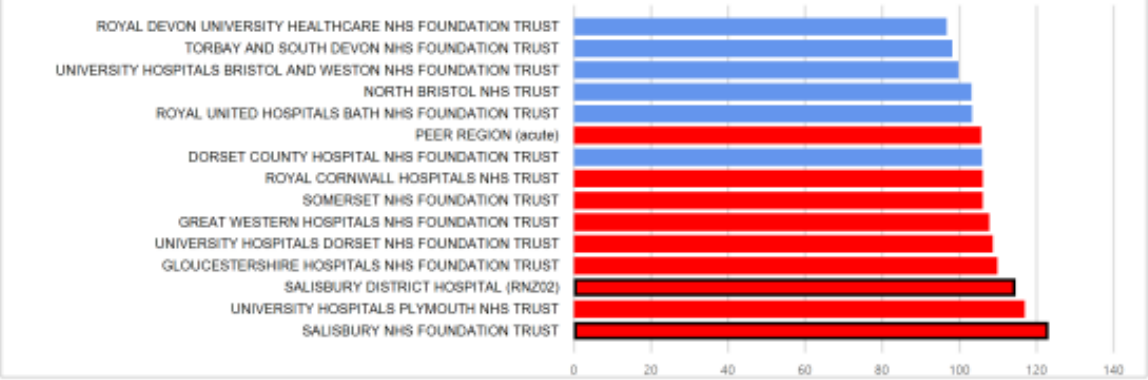
| CUSUM 99.9% Threshold (Top 6) | CUSUM | Obs | Exp | RR | LCI | Trend |
|---|---|---|---|---|---|---|
| Chronic obstructive pulmonary disease and bronchiectasis | 1 | 32 | 18.0 | 178.0 | 121.8 | |
| Senility and organic mental disorders | 1 | 25 | 14.0 | 178.8 | 115.7 | |
| Other connective tissue disease | 1 | 14 | 7.4 | 188.9 | 103.2 | |

| Patient Safety Indicators | Obs | Exp | RR | LCI | Trend |
|---|---|---|---|---|---|

### Mortality Influencers

| Performance | Site | Trust | Peer | National |
|---|---|---|---|---|
| HSMR | 114.5 | 123.0 | 105.8 | 99.9 |
| SMR | 111.7 | 120.5 | 105.1 | 99.9 |
| Non-elective (HSMR) | 114.6 | 122.3 | 105.7 | 99.6 |
| Weekday, emergency (HSMR) | 108.6 | 116.5 | 103.5 | 98.2 |
| Weekend, emergency (HSMR) | 133.0 | 140.8 | 112.9 | 104.0 |
| Saturday, emergency (HSMR) | 132.5 | 140.8 | 113.8 | 103.2 |
| Sunday, emergency (HSMR) | 132.7 | 140.0 | 111.8 | 104.7 |
| **Coding/Casemix** | **Site** | **Trust** | **Peer** | **National** |
| % Non-elective deaths with palliative care (HSMR) | 41.2% | 51.7% | 41.4% | 41.7% |
| % Non-elective spells with palliative care (HSMR) | 4.3% | 6.0% | 4.8% | 5.0% |
| % Spells in Symptoms & Signs chapter | 7.3% | 7.3% | 6.7% | 6.1% |
| % Non-elective spells with Charlson comorbidity score = 0 (HSMR) | 50.2% | 49.5% | 42.9% | 41.6% |
| % Non-elective spells with Charlson comorbidity score = 20+ (HSMR) | 11.9% | 12.4% | 15.2% | 15.9% |
| % Non-elective spells in Risk Band (0-10%) (HSMR) | 86.9% | 85.3% | 84.4% | 83.8% |

### HSMR Peer Comparison



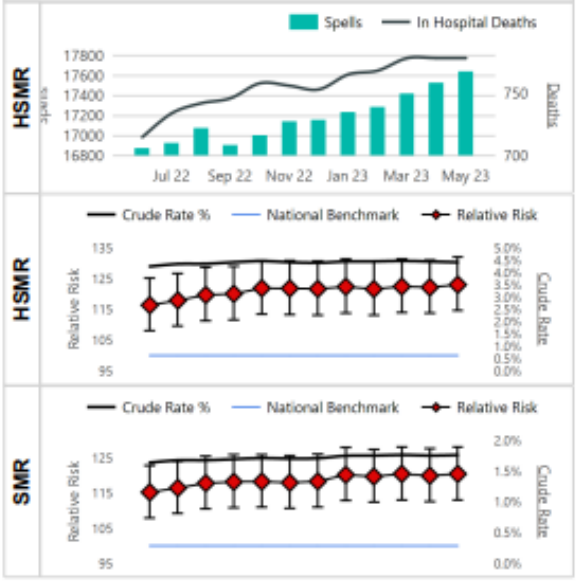
## HSMR for the 12 Month Period Ending in May 2023 for SFT [Includes Hospice Data]

HEALTH | dr foster. HEALTHCARE INTELLIGENCE PORTAL

**Mortality Summary for 12 months to May-2023 as at 02/11/2023**

SALISBURY NHS FOUNDATION TRUST - All Sites

### Rolling 12 month trends




### Diagnosis Groups

| Relative Risk Alerts (Top 10) | CUSUM | Obs | Exp | RR | LCI | Trend |
|---|---|---|---|---|---|---|
| Syncope | 1 | 4 | 0.8 | 476.0 | 128.0 | |
| Chronic obstructive pulmonary disease and bronchiectasis | 1 | 33 | 18.6 | 177.5 | 122.2 | |
| Senility and organic mental disorders | 2 | 25 | 14.0 | 178.8 | 115.7 | |
| Secondary malignancies | 2 | 28 | 16.4 | 171.0 | 113.6 | |
| Septicemia (except in labour) | 0 | 53 | 36.4 | 145.5 | 108.9 | |
| Other connective tissue disease | 1 | 15 | 7.8 | 193.1 | 108.0 | |
| Crushing injury or internal injury | 0 | 7 | 2.6 | 269.5 | 108.0 | |
| Aspiration pneumonitis, food/vomitus | 0 | 31 | 20.6 | 150.6 | 102.3 | |

| CUSUM 99% Threshold (Top 6) | CUSUM | Obs | Exp | RR | LCI | Trend |
|---|---|---|---|---|---|---|
| Syncope | 1 | 4 | 0.8 | 476.0 | 128.0 | |
| Chronic obstructive pulmonary disease and bronchiectasis | 1 | 33 | 18.6 | 177.5 | 122.2 | |
| Senility and organic mental disorders | 2 | 25 | 14.0 | 178.8 | 115.7 | |
| Secondary malignancies | 2 | 28 | 16.4 | 171.0 | 113.6 | |
| Other connective tissue disease | 1 | 15 | 7.8 | 193.1 | 108.0 | |
| Pneumonia | 1 | 136 | 121.6 | 111.9 | 93.9 | |

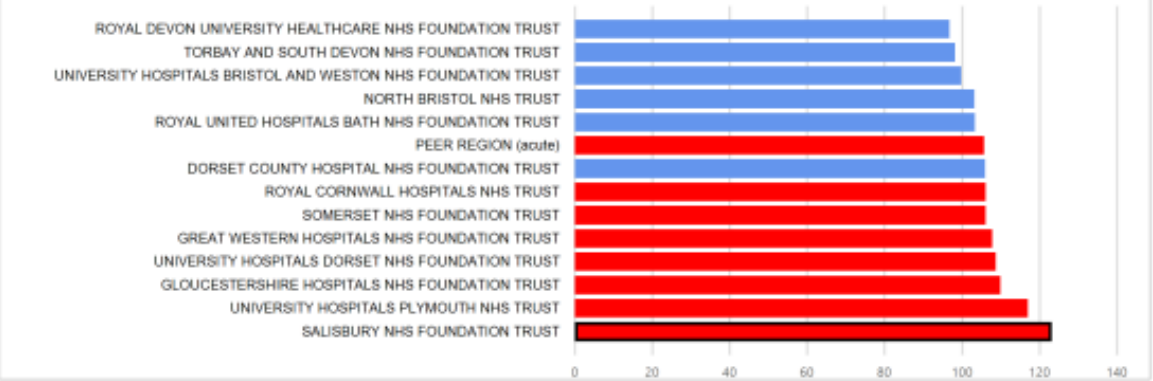
| CUSUM 99.9% Threshold (Top 6) | CUSUM | Obs | Exp | RR | LCI | Trend |
|---|---|---|---|---|---|---|
| Chronic obstructive pulmonary disease and bronchiectasis | 1 | 33 | 18.6 | 177.5 | 122.2 | |
| Senility and organic mental disorders | 1 | 25 | 14.0 | 178.8 | 115.7 | |
| Secondary malignancies | 1 | 28 | 16.4 | 171.0 | 113.6 | |

| Patient Safety Indicators | Obs | Exp | RR | LCI | Trend |
|---|---|---|---|---|---|

### Mortality Influencers

| Performance | Site | Trust | Peer | National |
|---|---|---|---|---|
| HSMR | | 123.0 | 105.8 | 99.9 |
| SMR | | 120.5 | 105.1 | 99.9 |
| Non-elective (HSMR) | | 122.3 | 105.7 | 99.6 |
| Weekday, emergency (HSMR) | | 116.5 | 103.5 | 98.2 |
| Weekend, emergency (HSMR) | | 140.8 | 112.9 | 104.0 |
| Saturday, emergency (HSMR) | | 140.8 | 113.8 | 103.2 |
| Sunday, emergency (HSMR) | | 140.0 | 111.8 | 104.7 |
| **Coding/Casemix** | **Site** | **Trust** | **Peer** | **National** |
| % Non-elective deaths with palliative care (HSMR) | | 51.7% | 41.4% | 41.7% |
| % Non-elective spells with palliative care (HSMR) | | 6.0% | 4.8% | 5.0% |
| % Spells in Symptoms & Signs chapter | | 7.3% | 6.7% | 6.1% |
| % Non-elective spells with Charlson comorbidity score = 0 (HSMR) | | 49.5% | 42.9% | 41.6% |
| % Non-elective spells with Charlson comorbidity score = 20+ (HSMR) | | 12.4% | 15.2% | 15.9% |
| % Non-elective spells in Risk Band (0-10%) (HSMR) | | 85.3% | 84.4% | 83.8% |

### HSMR Peer Comparison

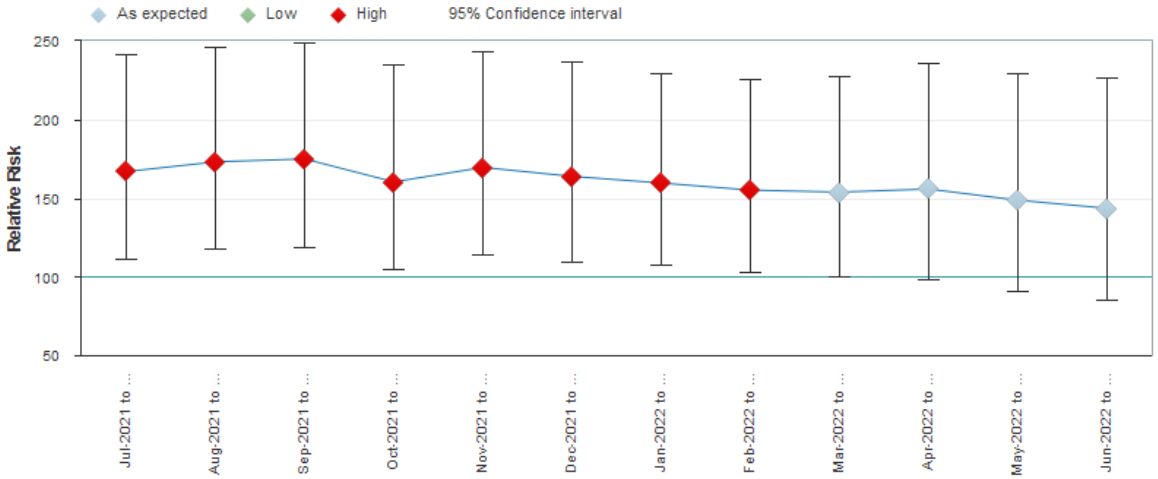


## 12-Month Trends in Relative Risk for High-Risk Diagnosis Groups

**Acute and unspecified renal failure | Mortality (in-hospital) | Jun-22 to May-23 | Trend (rolling 12 months)**

Diagnosis group: Acute and unspecified renal failure

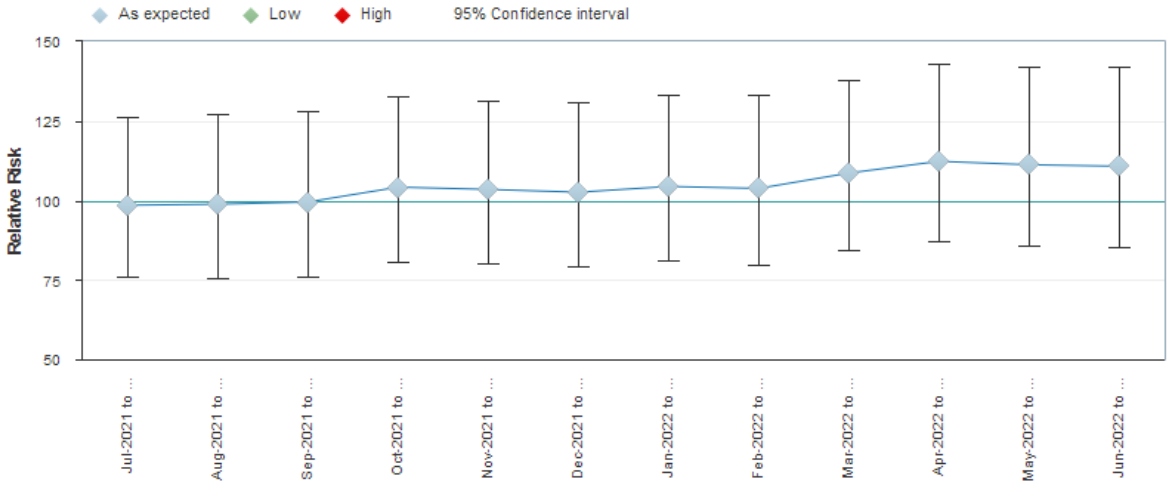
*Period*: **Rolling 12 months**




**Acute cerebrovascular disease | Mortality (in-hospital) | Jun-22 to May-23 | Trend (rolling 12 months)**

Diagnosis group: Acute cerebrovascular disease

*Period*: **Rolling 12 months**

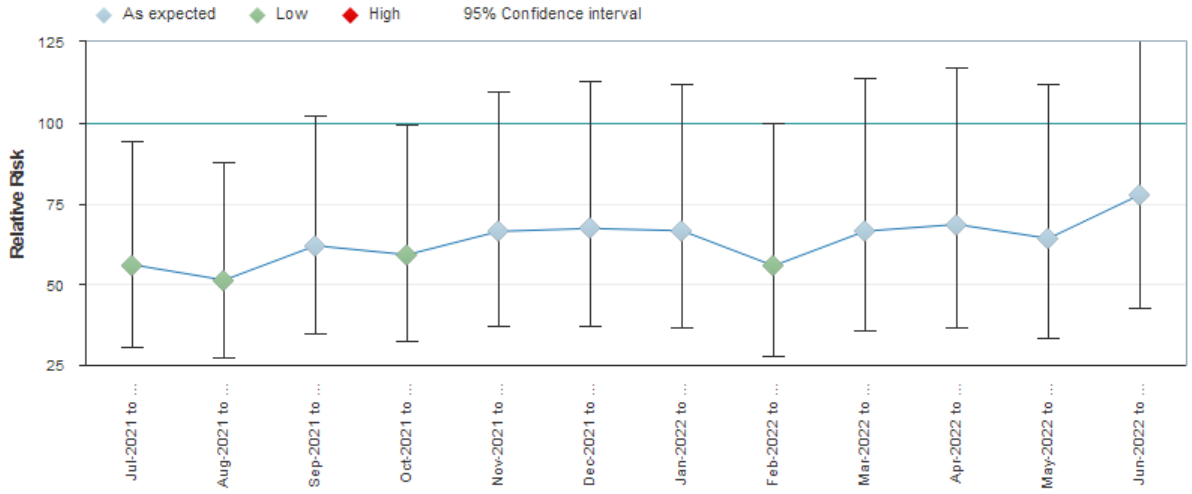


Salisbury NHS Foundation Trust

**Acute myocardial infarction | Mortality (in-hospital) | Jun-22 to May-23 | Trend (rolling 12 months)**

Diagnosis group: Acute myocardial infarction

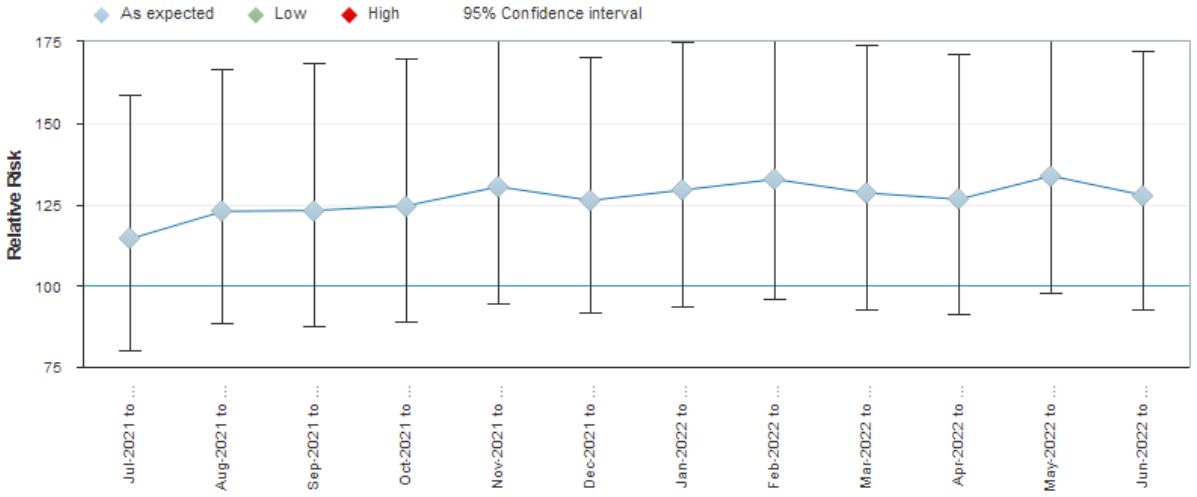
*Period*: **Rolling 12 months**




**Congestive heart failure, nonhypertensive | Mortality (in-hospital) | Jun-22 to May-23 | Trend (rolling 12 months)**

Diagnosis group: Congestive heart failure, nonhypertensive

*Period*: **Rolling 12 months**

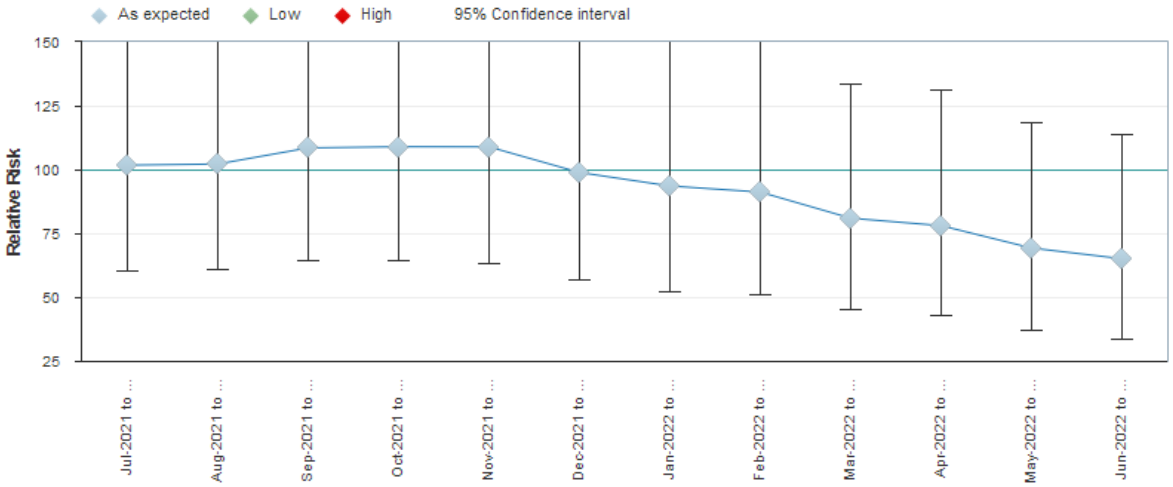


NHS
Salisbury
NHS Foundation Trust

**Fracture of neck of femur (hip) | Mortality (in-hospital) | Jun-22 to May-23 | Trend (rolling 12 months)**

Diagnosis group: Fracture of neck of femur (hip)

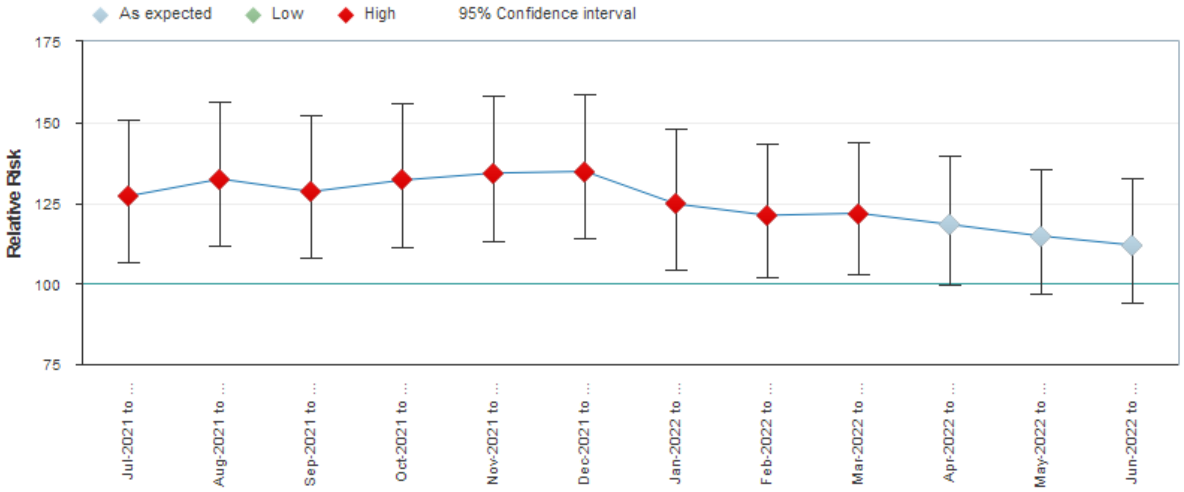
*Period*: **Rolling 12 months**

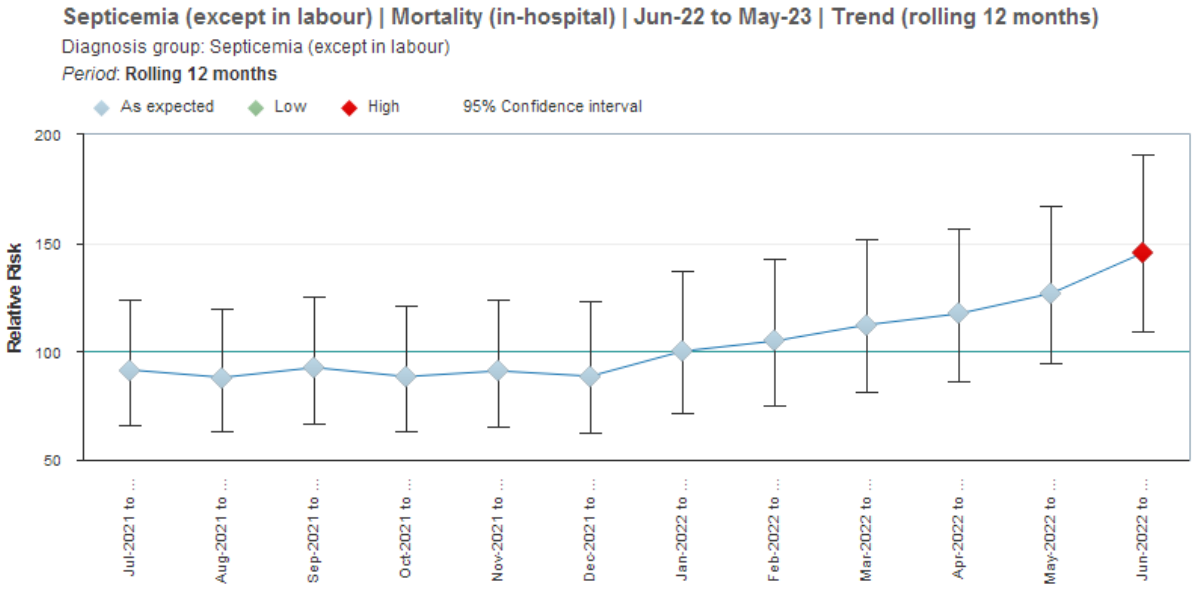



**Pneumonia | Mortality (in-hospital) | Jun-22 to May-23 | Trend (rolling 12 months)**

Diagnosis group: Pneumonia

*Period*: **Rolling 12 months**






* * * * * * END OF REPORT* * * * * *

NHS Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 7.3 |
| Date of meeting: | 11th January 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report tile: | Salisbury NHS Foundation Trust Maternity Self Certification NHS Resolution Maternity Incentive Scheme, Board Assurance Report - January 2024 | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | | | x | x |
| Approval Process: (where has this paper been reviewed and approved): | Approved by Divisional Management Team –remotely 5/1/2024 | | | |
| 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 requirements as set out by NHSE CNST Maternity Incentive Scheme Year 5 and consider the information and evidence provided in the enclosed report evidencing compliance with **9 out of the 10** Safety Actions.

As per guidance from NHSE:

- The Trust Board must then give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. If the form is signed by another Trust member this will not be considered
- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution
- The Board declaration form must be then sent to NHS Resolution nhsr.mis@nhs.net between 25 January 2024 and 1 February 2024 at 12 noon.

## Executive Summary:

The Clinical Negligence Scheme for Trusts (CNST) is a scheme for handling clinical negligence claims against NHS Trusts. The Trust pays an annual premium to the CNST scheme, plus an additional amount towards the Maternity Incentive Scheme (MIS). The Maternity Incentive Scheme (MIS) establishes 10 safety actions to support safer maternity care. Trusts that can demonstrate that

they have achieved all 10 safety actions in full recover the additional 10% of the maternity contribution charged under the scheme, plus a share of the monies paid into the scheme by the hospitals that did not achieve.

Trusts are required to report compliance with MIS by 1 February 2024 at 12 noon using the Board declaration form, published on the NHS Resolution website.

Salisbury NHS Foundation Trust Maternity and Neonatal Services are declaring compliance with 9 out of 10 Safety Actions for year 5 of the scheme.

The Divisional Triumvirate comprising of the Director of Midwifery, Clinical Director and Divisional Director of Operations are satisfied that the evidence provided demonstrates achievement of nine of the ten maternity safety actions and meets the required safety actions sub-requirements as set out in the safety actions and technical guidance document included in the MIS document.

In addition, the NHSE Maternity Improvement Advisor allocated to Salisbury NHS Foundation Trust, Chief Nursing Officer and LMNS lead Midwife (as designated deputy for ICS AO, on AO's for ICS instruction), have all reviewed the detailed evidence and agreed that it meets the requirements for the standards for which compliance is being declared (9 out of 10 Safety Actions).

It is recommended for the Board to note the contents of the report and formally record to the Trust Board minutes compliance with the following:

- Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team at a minimum of quarterly (a minimum of two in the reporting period) and that any support required of the Board has been identified and is being implemented.
- Compliance to short term locum usage
- Compliance to Long term locum guidance (ROCG) and action plan to address gap in compliance.
- Action plan to address shortfall in compliance to the RCOG guidance on compensatory rest.
- Compliance of consultant attendance for the clinical situations listed in the RCOG workforce document.
- Availability of Obstetric anaesthetic cover in line with ACSA standard 1.7.2.1
- Action plan to address lack of compliance to BAPM standards for Neonatal Medical workforce.
- Action plan to address lack of compliance to BAPM standards for Neonatal Nursing workforce.
- Using the CNST NHSR Safety Action Board Notification template, Salisbury NHS Trust can demonstrate compliance to Safety Action 4 as per Appendix 7.

NHS
Salisbury
NHS Foundation Trust

| 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 | |
| Other (please describe): | |

# Salisbury NHS Foundation Trust Maternity Self Certification
# NHS Resolution Maternity Incentive Scheme,
# Board Assurance Report
# January 2024

## 1. Introduction

The Clinical Negligence Scheme for Trusts (CNST) is a scheme for handling clinical negligence claims against NHS Trusts. The Trust pays an annual premium to the CNST scheme, plus an additional 10% towards the Maternity Incentive Scheme (MIS).

The Maternity Incentive Scheme (MIS) establishes 10 safety actions to support safer maternity care.

Trusts that can demonstrate that they have achieved all 10 safety actions in full recover the additional 10% of the maternity contribution charged under the scheme, plus a share of the monies paid into the scheme by the hospitals that did not achieve to help to make progress against actions they have not achieved.

The Divisional Triumvirate comprising of the Director of Midwifery, Clinical Director and Divisional Director of Operations are satisfied that the evidence provided to demonstrate achievement of nine of the ten maternity safety actions meets the required safety actions sub-requirements as set out in the safety actions and technical guidance document included in the MIS document.

This report has been reviewed and ratified by the Women and Newborn (WNB) Divisional Management Team. The NHSE Maternity Improvement Advisor allocated to Salisbury NHS Foundation Trust, Chief Nursing Officer and LMNS lead Midwife, (as designated deputy for ICS AO, on AO's for ICS instruction). have reviewed the detailed evidence and agreed the evidence meets the requirements for the standards for which compliance is being declared.

In January 2023 the Maternity service at Salisbury NHS Foundation Trust (SFT) was successful in achieving compliance in 5 of the 10 criteria for NHS Resolution (NHSR), Clinical Negligence Scheme for Trusts (CNST).

As of February 2024, Salisbury NHS Foundation Trust are declaring compliance with **9 out of 10** safety actions for submission for year 5 of the NHS Resolution (NHSR), Clinical Negligence Scheme for Trusts (CNST).

## 1.1 Maternity incentive scheme year Five: Conditions

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (nhsr.mis@nhs.net) by **12 noon on 1st February 2024** and must comply with the following conditions:

a) Trusts must achieve all ten maternity safety actions.

b) The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services

c) The 'Board Declaration Form' must be signed and dated by the Trust Chief Executive to confirm the following:

•The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.

•There are no reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g., Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before 1 February 2024

• The Trust Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. If the form is signed by another Trust member this will not be considered.

• In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution

• Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also

be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

• The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.

• NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions, then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.

• NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution

## 1.2 Evidence for submission

• The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested as explained above.

• Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.

• The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.

• Trusts will need to report compliance with MIS by 1 February 2024 at 12 noon using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.

• The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) of Clinical Commissioning Group/Integrated Care System.

• Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.

• The Board declaration form will be available on the MIS webpage at a later date.

• Trusts are reminded to retain all evidence used to support their position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described above) it must be made available as it was presented to support Board assurance at the time of submission.

### 1.3 Timescales and appeals.

• Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution nhsr.mis@nhs.net prior to the submission date.

• The Board declaration form must be sent to NHS Resolution nhsr.mis@nhs.net between 25 January 2024 and 1 February 2024 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from submission date.

• Submissions and any comments/corrections received after 12 noon on 1 February 2024 will not be considered.

• The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.

• There are two possible grounds for appeal: - alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation - technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.

• NHS Resolution clinical advisors will review all appeals to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.

• Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.

• Further detail on the results publication, appeals window dates and payments process will be communicated at a later date.

## 1.4. For Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 1 February 2024 to NHS Resolution nhsr.mis@nhs.net. The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the action plan template which will be provided within the Board declaration form. Action plans should not be submitted for achieved safety actions.

## 2. MIS Year 5 Criteria Safety Actions

**Table 1 below describes the ten safety actions and provides overall current compliance for SFT.**

**Table 1.**

| Criteria for Maternity CNST | | RAG SCORING |
|---|---|---|
| 1 | Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? | |
| 2 | Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? | |
| 3 | Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? | |
| 4 | Can you demonstrate an effective system of clinical workforce planning to the required standard? | |
| 5 | Can you demonstrate an effective system of midwifery workforce planning to the required standard? | |
| 6 | Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three? | |
| 7 | Listen to women, parents and families using maternity and neonatal services and coproduce services with users | |
| 8 | Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? | |
| 9 | Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues? | |
| 10 | Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to | |

## 3. Analysis

### 3.1 Safety action 1:

### Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

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'.

The PMRT has been designed to support the review of the care of the following babies:

- All late fetal losses 22+0 to 23+6
- All antepartum and intrapartum stillbirths
- All neonatal deaths from birth at 22+0 to 28 days after birth
- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

| | |
|---|---|
| **Required standard** | a) All eligible perinatal deaths should be notified to MBRRACEUK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death. |
| | b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards |
| | c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 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 to the draft report stage within four months of the death and published. within six months. |
| | d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023 |
| **Minimum evidential requirement for trust Board** | Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see note below about the introduction of the NHS single notification portal).<br>The PMRT must be used to review the care and reports should be generated via the PMRT.<br>A report should be received by the Trust Executive Board each quarter from 30 May 2023 that includes details of the deaths reviewed, any themes identified and the consequent action plans.<br>The report should evidence that the PMRT has been used to review |

| | |
|---|---|
| | eligible perinatal deaths and that the required standards a), b) and c) have been met.<br>For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review. |

The maternity service can confirm that the PMRT is used in review processes.

1. It should be noted that from the 30 May 2023 there were 6 eligible cases requiring notification to MBRRACE. These were all reported within 7 working days.

2. There were 4 cases where surveillance information was to be completed within one month. This was completed within the one-month timeframe. The further 2 cases were notification only as medical termination of pregnancies.

3. For 100% of all deaths of babies (4 babies) who died in our Trust from 30 May 2023, the parents' perspectives of care were sought, and they were given the opportunity to raise questions.

4. 100% of all eligible deaths within the MIS timeframe of babies suitable for review using PMRT (2 babies) had the PMRT review commenced within two months of the death. The further 2 cases will have the PMRT review started within the 2-month timeframe however this goes out of the 7th of December 2023 deadline for MIS.

5. 100% of all eligible deaths within the MIS timeframe of babies suitable for review using PMRT (2 babies) had the PMRT review draft report completed and generated by the tool within the 4-month timeframe. The further 2 cases will have the PMRT review draft report generated by the tool within the 4-month timeframe following the PMRT review however this goes out of the 7th December 2023 deadline for MIS.

6. 100% of all eligible deaths within the MIS timeframe of babies suitable for review using PMRT (2 babies) had the PMRT report published and generated by the tool within the 6-month timeframe. The further 2 cases will have the PMRT report published and generated by the tool within the 6-month timeframe following the PMRT review however this goes out of the 7th of December 2023 deadline for MIS.

7. Quarterly reports have been submitted to the Trust Executive Board in the Quarterly Quality and Safety Report and include details of all death reviewed and consequent action plans.

8. Quarterly reports have been discussed with the Trust maternity safety and Board level Safety champions.

| Date of delivery | Date of diagnosis | Gestation at diagnosis | Gestation at delivery | Type of loss | Consultant | Post mortem/ placental histology | HSIB/ SI/ CR | Parents given MBRRACE/ PMRT information and Duty of Candour | MBRRACE ID | CNST Safety action 1.1) MBRACCE notification within 7 working days | CNST Safety action 1.2)Survaillance completed within 1 month | CNST Safety action 1.3) Parental engament sought | CNST Safety action 1.4) PMRT commenced within 2 months | CNST Safety action 1.5) PMRT review meeting within 4 months | CNST Safety action 1.5) PMRT draft report within 4 months. | CNST Safety action 1.6) PMRT report published within 6 months |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 07/06/2023 | MTOP | 21+3 | 21+3 | MTOP- NND | SMG | Genetics | No | Discussed reporting | 87885 | Yes-9/6/23 | NA | NA | NA | NA | NA | NA |
| 20/06/2023 | 17/06/2023 | 27+0 | 27+3 | SB | KEB | PM and Genetics | CR | Yes- 23/6/2023 | 88068 | Yes-21/6/23 | Yes 26/6/2023 | Yes- sent t | Completed 7/8/23 | 23/09/2023 | 03/10/2023 | 03/10/2023 |
| 31/05/2023 | NND 27/06/20 | NND 27 days | 37+ | NND | JBF | Genetics following | CR | Discussed 03/07/20 | 88241 | Yes- 3/7/2023 | Yes 11/07/2023 | Yes- none | Completed 14/7/23 | 28/08/2023 | 03/10/2023 | 17/10/2023- |
| 22/09/2023 | MTOP | Fetocide 22+1 | 22+3 | MTOP | KEB-UHS fol | PM and Genetics | No | Discussed reporting | 89523 | Yes -22/09/2023 | NA | NA | NA | NA | NA | NA |
| 01/11/2023 | 30/10/2023 | 26+4 | 26+6 | SB | SMV | PM and Genetics | No | Yes 3/11/2023 | 90169 | Yes-2/11/2023 | Yes- 20/11/2023 | Yes | Yes 15/12/2023 | 01/03/2024 | 01/03/2024 | 01/05/2024 |
| 24/11/2023 | 22/11/2023 | 34+4 | 34+6 | SB | SMV | PM and Genetics | No | Yes | 90642 | Yes 30/11/2023 | Yes- 15/12/2023 | Yes | Yes 15/12/2023 | 24/03/2024 | 24/03/2024 | 24/05/2024 |

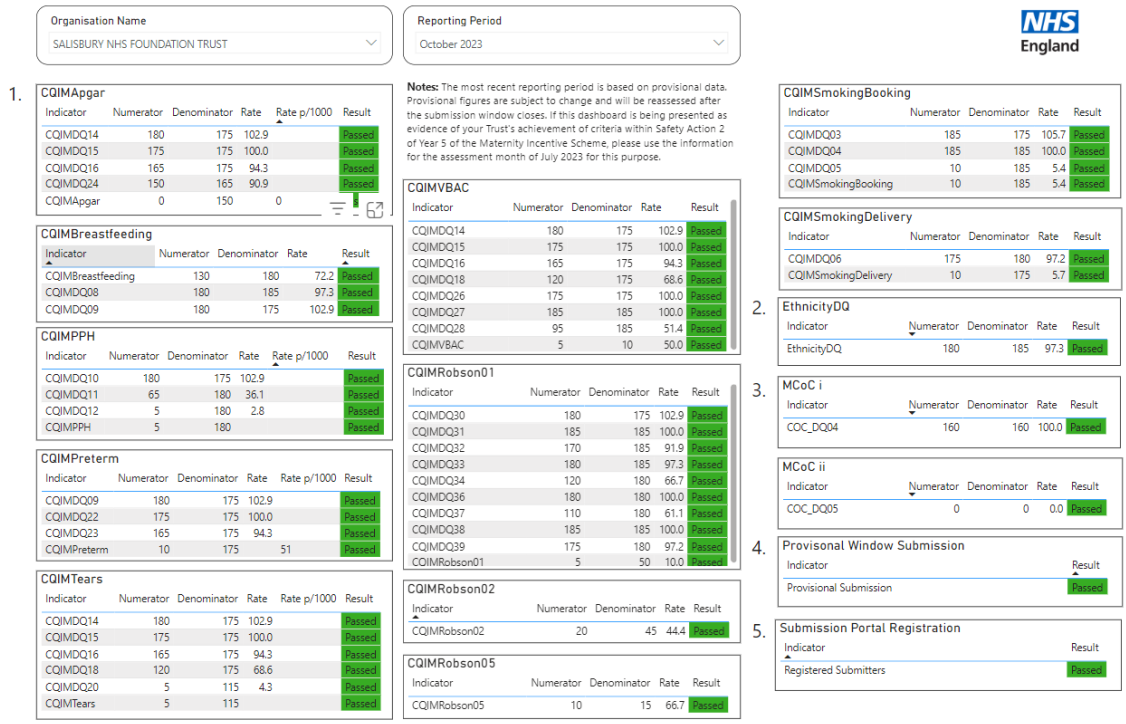
**Salisbury NHS Foundation Trust are declaring full compliance with safety action 1.**

## 3.2 Safety action 2:

### Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

| | |
|---|---|
| Required standard | This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. |
| | 1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023.<br>2. July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)<br>3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:<br>Midwifery Continuity of carer (MCoC)<br>Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable.<br>i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.<br>ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.<br>These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation.<br>Final data for July 2023 will be published in October 2023.<br>If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information).<br>4. Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023. 5. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust. |
| Minimum evidential requirement for trust Board | The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria |

1. SFT have passed 11 out of 11 Clinical Quality Improvement Metrics (CQIMs) associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023.



Organisation Name: SALISBURY NHS FOUNDATION TRUST

Reporting Period: October 2023

NHS England

1.

**CQIMApgar**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMDQ14 | 180 | 175 | 102.9 | | Passed |
| CQIMDQ15 | 175 | 175 | 100.0 | | Passed |
| CQIMDQ16 | 165 | 175 | 94.3 | | Passed |
| CQIMDQ24 | 150 | 165 | 90.9 | | Passed |
| CQIMApgar | 0 | 150 | 0 | | |

**CQIMBreastfeeding**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMBreastfeeding | 130 | 180 | 72.2 | Passed |
| CQIMDQ08 | 180 | 185 | 97.3 | Passed |
| CQIMDQ09 | 180 | 175 | 102.9 | Passed |

**CQIMPPH**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMDQ10 | 180 | 175 | 102.9 | | Passed |
| CQIMDQ11 | 65 | 180 | 36.1 | | Passed |
| CQIMDQ12 | 5 | 180 | 2.8 | | Passed |
| CQIMPPH | 5 | 180 | | | Passed |

**CQIMPreterm**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMDQ09 | 180 | 175 | 102.9 | | Passed |
| CQIMDQ22 | 175 | 175 | 100.0 | | Passed |
| CQIMDQ23 | 165 | 175 | 94.3 | | Passed |
| CQIMPreterm | 10 | 175 | | 51 | Passed |

**CQIMTears**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMDQ14 | 180 | 175 | 102.9 | | Passed |
| CQIMDQ15 | 175 | 175 | 100.0 | | Passed |
| CQIMDQ16 | 165 | 175 | 94.3 | | Passed |
| CQIMDQ18 | 120 | 175 | 68.6 | | Passed |
| CQIMDQ20 | 5 | 115 | 4.3 | | Passed |
| CQIMTears | 5 | 115 | | | Passed |

**Notes:** The most recent reporting period is based on provisional data. Provisional figures are subject to change and will be reassessed after the submission window closes. If this dashboard is being presented as evidence of your Trust's achievement of criteria within Safety Action 2 of Year 5 of the Maternity Incentive Scheme, please use the information for the assessment month of July 2023 for this purpose.

**CQIMVBAC**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ14 | 180 | 175 | 102.9 | Passed |
| CQIMDQ15 | 175 | 175 | 100.0 | Passed |
| CQIMDQ16 | 165 | 175 | 94.3 | Passed |
| CQIMDQ18 | 120 | 175 | 68.6 | Passed |
| CQIMDQ26 | 175 | 175 | 100.0 | Passed |
| CQIMDQ27 | 185 | 185 | 100.0 | Passed |
| CQIMDQ28 | 95 | 185 | 51.4 | Passed |
| CQIMVBAC | 5 | 10 | 50.0 | Passed |

**CQIMRobson01**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ30 | 180 | 175 | 102.9 | Passed |
| CQIMDQ31 | 185 | 185 | 100.0 | Passed |
| CQIMDQ32 | 170 | 185 | 91.9 | Passed |
| CQIMDQ33 | 180 | 185 | 97.3 | Passed |
| CQIMDQ34 | 120 | 180 | 66.7 | Passed |
| CQIMDQ36 | 180 | 180 | 100.0 | Passed |
| CQIMDQ37 | 110 | 180 | 61.1 | Passed |
| CQIMDQ38 | 185 | 185 | 100.0 | Passed |
| CQIMDQ39 | 175 | 180 | 97.2 | Passed |
| CQIMRobson01 | 5 | 50 | 10.0 | Passed |

**CQIMRobson02**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMRobson02 | 20 | 45 | 44.4 | Passed |

**CQIMRobson05**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMRobson05 | 10 | 15 | 66.7 | Passed |

**CQIMSmokingBooking**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ03 | 185 | 175 | 105.7 | Passed |
| CQIMDQ04 | 185 | 185 | 100.0 | Passed |
| CQIMDQ05 | 10 | 185 | 5.4 | Passed |
| CQIMSmokingBooking | 10 | 185 | 5.4 | Passed |

**CQIMSmokingDelivery**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ06 | 175 | 180 | 97.2 | Passed |
| CQIMSmokingDelivery | 10 | 175 | 5.7 | Passed |

2. **EthnicityDQ**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| EthnicityDQ | 180 | 185 | 97.3 | Passed |

3. **MCoC i**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| COC_DQ04 | 160 | 160 | 100.0 | Passed |

**MCoC ii**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| COC_DQ05 | 0 | 0 | 0.0 | Passed |

4. **Provisonal Window Submission**

| Indicator | Result |
|---|---|
| Provisional Submission | Passed |

5. **Submission Portal Registration**

| Indicator | Result |
|---|---|
| Registered Submitters | Passed |

2. In July 2023 97.3% of women booked in the month contained valid ethnic category (Mother).
3. SFT can confirm to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:
    - Midwifery Continuity of carer (MCoC)

    As SFT has suspended all MCoC pathways criteria ii is not applicable.
4. The trust made the MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.
5. SFT has 2 people working in the trust who are registered to submit MSDS data to SDCS Cloud.

**Salisbury NHS Foundation Trust are declaring full compliance with safety action 2.**

### 3.3 Safety action 3:

### Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

| | |
|---|---|
| **Required standard** | a) Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.<br><br>b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director, or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.<br><br>c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway. |
| **Minimum evidential requirement for trust Board** | Evidence for standard a) to include:<br><br>Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where:<br>• There is evidence of neonatal involvement in care planning<br>• Admission criteria meets a minimum of at least one element of HRG XA04<br>• There is an explicit staffing model<br>• The policy is signed by maternity/neonatal clinical leads and should have auditable standards.<br>• The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.<br><br>Evidence for standard b) to include:<br><br>• Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks.<br>• Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks. 21<br>• Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan.<br>• Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan<br><br>Evidence for standard c) to include:<br><br>Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring.<br>OR<br><br>An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation. |

Discussion

a) A local policy has been in place since CNST year 4. It has been updated this year, reviewed through maternity governance and signed off by the DOM, CD, clinical leads for neonatology and obstetrics. Quarterly audits of compliance are completed and discussed at Divisional Clinical governance committee.
b) The Trust continues with monthly meetings to review all term admissions to the neonatal unit with a focus on reducing separation of primary carers and babies. The ATAIN action plan which addresses the findings has been signed off by the quadrumvirate, discussed at divisional governance and presented to LMNS/ICB and Trust board.
c) Admission to TC at SFT included 34+0 babies from June 2023 and in this time 2 of our 34+0 babies have been cared for in a transitional care setting with primary care by their parent. The data of these babies is included in the TC audit data.

**Salisbury NHS Foundation Trust are declaring full compliance with safety action 3**

## 3.4 Safety action 4:

### Can you demonstrate an effective system of clinical workforce planning to the required standard?

| | |
|---|---|
| **Required standard** | a) Obstetric medical workforce<br>1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:<br>a. currently work in their unit on the tier 2 or 3 rota<br>or<br>b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)<br>or<br>c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.<br><br>2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-termlocums-in-mate.pdf<br><br>3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-compensatory-rest.pdf<br><br>4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 26 ‘Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology’ into their service https://www.rcog.org.uk/en/careerstraining/workplace-workforce-issues/rolesresponsibilities-consultant-report/ when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further nonattendance.<br><br>b) Anaesthetic medical workforce A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)<br><br>C) Neonatal medical workforce The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements have not been met in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN). |

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|---|---|
| | d) Neonatal nursing workforce The neonatal unit meets the BAPM neonatal nursing standards.<br><br>If the requirements have not been met in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed 27 and include new relevant actions to address deficiencies.<br><br>If the requirements had been met previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies.<br><br>Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN). |
| **Minimum evidential requirement for trust Board** | **Obstetric medical workforce**<br>1) Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses.<br><br>Information on the certificate of eligibility (CEL) for short term locums is available here: www.rcog.org.uk/cel This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk) A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk<br><br>2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS.<br><br>3.) Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working 28 as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.<br><br>NB. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing \| RCOG<br><br>4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.<br><br>**Anaesthetic medical workforce** The rota should be used to evidence compliance with ACSA standard 1.7.2.1.<br><br>**Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).<br>**Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress |

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| | against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN) |

**Obstetric workforce**

**1) Short Term Locum usage**

An audit of compliance with our Medical HR colleagues was completed for the time period 1st March 2023 - 31st August 2023. The audit demonstrated that during this period, 19 (short term) middle grade locum shifts were required, 6 Doctors completed these shifts, 5 of these Doctors were Salisbury NHS Foundation Trust employed Doctors and 1 of these Doctors was a locum, not employed at Salisbury NHS Foundation Trust at the time of undertaking the shifts. The Doctor was however working in their local unit (within the Wessex area) on their Tier 2 or 3 rota and therefore 100% compliant with the criteria described above.

The audit has been shared with Trust Board level safety champions and the LMNS.

**2) Long Term Locum usage**

During the time period 1st March 23-31st August 23 the trust has utilised 3 long term middle grade locum doctors. An audit, found in appendix 2, against the RCOG guidance, demonstrates compliance to the following standards:

| Standard | Compliance % |
|---|---|
| Standard 1 Locum doctor CV reviewed by consultant lead prior to appointment | 100 |
| Standard 2 Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment | 66.6 |
| Standard 3 Departmental induction by consultant on commencement date | 33.3 |
| Standard 4 Access to all IT systems and guidelines and training completed on commencement date | 100 |
| Standard 5 Named consultant supervisor to support locum | 100 |
| Standard 6 Supernumerary clinical duties undertaken with appropriate direct supervision | 66.6 |
| Standard 7 Review of suitability for post and OOH working based on MDT feedback | 100 |
| Standard 8 Feedback to locum doctor and agency on performance | 66.6 |

As the department was not fully compliant with the guidance on long term locum usage an action plan has been developed at the end of this section. The audit has been shared with Trust Board level safety champions and the LMNS.

### 3) Compensatory Rest

An audit of compliance was completed, this demonstrated 82.2% compliance to the BMA/RCOG guidance. There were 5 occasions where the non-resident consultant did not have the adequate rest period before commencing normal duties the next day. A Standard Operating Procedure (SOP) has been developed regarding compensatory rest in line with the BMA/RCOG guidance, and an action plan to address the lack of compliance can be found at the end of this section. The audit has been shared with Trust Board level safety champions and the LMNS.

### 4) Consultant Attendance

For the period 30th May – 7th December there were 28 cases meeting the criteria above. The audit demonstrates 93% compliance to the standard.

There are 2 cases where it is not documented that the Consultant was in attendance, however on both occasions it is documented that the cases were discussed with the Consultant on-call or covering labour ward that day. Both cases were discussed after the event using the 72-hour review process.

**Anaesthetic workforce**

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and has clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they are able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. The rota is fully compliant to Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1.

**Neonatal Medical Workforce**

The neonatal unit does not meet the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. The Trust has accepted that our small unit is staffed safely with our current staffing structure described below and furthermore is aware of the likely future redesignation of the neonatal unit to a level 3 unit.

| **Salisbury paediatric staffing model October 2023** | |
|---|---|
| Tier 1 | *GPVTS ST1/2 or F2 or trust grade SHO* |
| Tier 2 | *paediatric ST3-8 or consultant out of hours (shared with general paediatric service)* |
| Tier 3 | *Consultant cover* |
| **Monday – Fri 09.00- 17.00** | |
| Tier 1 | *1 doctor on rota for NICU / PNW / Births* |
| Tier 2 | *joint cover for NICU / maternity and general paediatrics (minimum 1 doctor)* |
| Tier 3 | *Consultant in hospital cover* |
| **Monday - Friday 17.00-21.00** | |
| Tier 1 | *1 doctor joint cover NICU and general paediatrics.* |
| Tier 2 | *1 doctor joint cover NICU and general paediatrics (usually ST3-8)* |
| Tier 3 | *Consultant on call cover* |
| **Monday - Friday 21.00-09.00 and weekends 24 /7** | |
| Tier 1 | *1 doctor covering NICU and general paediatrics.* |
| Tier 2 | *1 doctor covering NICU and general paediatrics. At night this is most likely to be covered by a consultant but there are some registrar night shifts and some consultant long day shifts at the weekend* |
| Tier 3 | *Consultant on call cover for both areas* |

To meet the current standard, we would require a tier 1 doctor to cover the neonatal unit exclusively rather than our current model of having them split across paediatrics.

This was discussed and reviewed at the Trust Board in September 2022 and the mitigations of non-compliance were supported by the board at this time. There have been no further changes to the model or mitigations and no clinical incidents, datix events or concerns regarding non-availability of a Tier 1 doctor for the neonatal unit due to them covering neonates and paediatrics.

A staffing paper will be submitted to board in 2024 to consider options of achieving BAPM compliance. The compliance data to this standard has been shared with the LMNS and the Neonatal Operational Delivery Network (ODN).

## Neonatal nursing workforce

The nursing workforce review was completed in September 2023 using the Workforce calculator seen below. This demonstrates that the unit is not compliant to the BAPM standards and requires additional nursing workforce. The requirement would be an additional 0.77wte registered nurse and 2.09wte non-registered nurse. There are mitigations in place for increasing the number of nurses who are QIS trained, 1.45wte are in training currently.

| | FUNDED September 23 | IN POST September 23 | Calculated requirement (from tool) | Variance |
|---|---|---|---|---|
| Total direct care nurses | 21.69 | 20.48 | 24.55 | 2.86 |
| Total registered nurses (band 5 and above) | 20.89 | 19.88 | 21.66 | 0.77 |
| of which QIS | 13.65 | 13.65 | 15.16 | 1.51 |
| Total Non QIS | 7.24 | 6.23 | 6.50 | -0.74 |
| Total Non Reg | 0.80 | 0.60 | 2.89 | 2.09 |
| % REGISTERED NURSES QIS QUALIFIED | | 68.7% | 70.0% | |

An action plan to address the shortfall can be found at the end of this section, this has been shared with The LMNS and the Neonatal Operational Delivery Network (ODN).

### ACTION PLAN SAFETY ACTION 4

| Area | Action | Owner | Deadline | Current progress made | RAG Rating |
|---|---|---|---|---|---|
| **Short Term Locum usage** | **SOP required to ensure standardised process for employing Short Term Locum use within the Maternity Service** | Yazmin Faiza<br><br>Clinical Lead Obstetrics | 31/01/24 | In progress | **Date in future** |
| **Long Term Locum usage** | **SOP required to ensure standardised process for employing Short Term Locum use within the Maternity Service. To ensure that Certificate of Eligibility compliance is included within the medical HR process** | Yazmin Faiza<br><br>Clinical Lead Obstetrics | 31/01/24 | In progress | **Date in future** |
| **Compensatory Rest** | **Benchmarking against other units of a similar size using same or similar on-call model.** | Yazmin Faiza<br><br>Clinical Lead Obstetrics | 31/03/24 | Not yet started | **Date in future** |
| | **Discussion with the LMNS regarding the compensatory rest guidance and adherence to this across the 3 acute trusts within the system** | Yazmin Faiza<br><br>Clinical Lead Obstetrics | 28/02/24 | Not yet started | **Date in future** |

| | | | | | |
|---|---|---|---|---|---|
| | **Re-Audit of compliance in 6 months** | Yazmin Faiza<br><br>Clinical Lead Obstetrics | 31/03/24 | Not yet started | **Date in future** |
| **Neonatal Medical workforce** | **Neonatal medical workforce paper to be presented to board to reflect workforce models available to demonstrate compliance to BAPM standards.** | Jim Baird<br><br>Neonatal Clinical Lead | 31/03/24 | Not yet started | **Date in future** |
| **Neonatal Nursing workforce** | **Neonatal Nursing workforce paper to be presented to board to seek approval of additional registered and non-registered posts as per the workforce calculation tool.** | Geoff Dunning, Neonatal Matron / Vicki Marston Director of Maternity and Neonatal Services | 31/03/24 | Not yet started | **Date in future** |

## Salisbury NHS Foundation Trust are declaring full compliance with safety action 4.

## 3.5 Safety action 5:

## Can you demonstrate an effective system of midwifery workforce planning to the required standard?

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|---|---|
| **Required standard** | a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.<br><br>b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.<br><br>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.<br><br>d) All women in active labour receive one-to-one midwifery care.<br><br>e) 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. |
| **Minimum evidential requirement for trust Board** | The report submitted will comprise evidence to support a, b and c progress or achievement.<br><br>It should include:<br><br>• A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.<br><br>• In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.<br><br>• Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.<br><br>• The plan to address the findings from the full audit or tabletop exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners<br><br>• Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.<br><br>o The midwife to birth ratio<br><br>o The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. |

| | |
|---|---|
| | • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward coordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls. |
| **What is the relevant time period?** | 30 May 2023 – 7 December 2023 |

Birth rate plus was last reported fully in December 2019, however it was recalculated in 2021, following a review of the data. Midwifery staffing budget currently reflects the establishment calculated as of 2021and is compliant with the standard above – We are currently repeating the full birthrate plus assessment and expect the full report shortly.

a) Six monthly staffing reports to CGC and Trust board have been submitted with evidence of birthrate+ calculation. Trust board have previously agreed to fund establishment in line with this calculation and this is reflected in our budget.

b) The midwife on the labour ward is supernumerary and this is audited in real time using the acuity tool every 4 hours. Each occasion when this has been breached is reviewed, reported via datix and it has been only sporadic and not a recurrent event.

c) All women in labour within our Trust receive 1:1 midwifery care. This is evidenced by data extracted fomr the acuity tool which reviews labour ward activity 4 hourly and captures any incidences where 1:1 care is not achieved.

d) The supernumerary status of the labour ward co-ordinator and midwife to birth ratio are included in each six-monthly maternity staffing report. All reports are discussed thoroughly at CGC and noted in escalation to Trust board. They are also reported monthly in the perinatal Quality Slides which are shared with and reported to Clinical Governance Committee, LMNS Board and Trust Board for full scrutiny.

**Salisbury NHS Foundation Trust are declaring full compliance with safety action 5.**

### 3.6 Safety action 6:

### Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

| | |
|---|---|
| **Required standard** | 1)Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.<br><br>2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool. |
| **Minimum evidential requirement for trust Board** | 1) The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024.<br><br>A new implementation tool is now available to help maternity services to track and evidence improvement and compliance with the requirements set out in version three. The tool is based on the interventions, key process and outcome measures identified within each element, and is available at https://future.nhs.uk/SavingBabiesLives<br><br>Providers should use the new national implementation tool to track compliance with the care bundle and share this with the Trust Board and ICB.<br><br>To evidence adequate progress against this deliverable by the submission deadline in February, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. These percentages will be calculated within the national implementation tool.<br><br>2) Confirmation from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust, using the implementation tool and includes the following:<br><br>• Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.<br><br>• Progress against locally agreed improvement aims.<br><br>• Evidence of sustained improvement where high levels of reliability have already been achieved.<br><br>• Regular review of local themes and trends with regard to potential harms in each of the six |

| | |
|---|---|
| | elements.<br><br>• Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts |

The Saving Babies lives care bundle version was published in June 2023 and provides evidence based best practice, for providers and commissioners of Maternity care across England with an aim to reduced perinatal mortality.

It brings together six elements of care:

1. Reducing smoking in pregnancy
2. Fetal Growth: Risk assessment, surveillance, and management
3. Raising awareness of Reduced Fetal Movements
4. Effective Fetal Monitoring
5. Reducing preterm Birth
6. Management of pre-existing diabetes in pregnancy

**Table 2.- Compliance with the 5 elements**

August 10th self-assessment submission and LMNS validated assessment 31.10.23:

| 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) |
|---|---|---|---|---|---|
| Element 1 | Smoking in pregnancy | Partially implemented | 30% | Partially implemented | 10% |
| Element 2 | Fetal growth restriction | Partially implemented | 55% | Partially implemented | 5% |
| Element 3 | Reduced fetal movements | Not implemented | 0% | Not implemented | 0% |
| Element 4 | Fetal monitoring in labour | Not implemented | 0% | Not implemented | 0% |
| Element 5 | Preterm birth | Partially implemented | 44% | Partially implemented | 11% |
| Element 6 | Diabetes | Partially implemented | 33% | Not implemented | 0% |
| All Elements | TOTAL | Partially implemented | 40% | Partially implemented | 7% |

1st Dec self-assessment submission (Smoking self-assessment lower than August submission re 1.8 & 1.9 staff training changed from fully implemented to partially implemented). This training is now added to all new starter inductions and as part of CCF2 ratified in Maternity Governance on 6.10.23. Still awaiting LMNS feedback on our Dec 1st submission:

| 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% | Not implemented | 0% | CNST Not Met |
| Element 2 | Fetal growth restriction | Partially implemented | 55% | Not implemented | 0% | CNST Not Met |
| Element 3 | Reduced fetal movements | Partially implemented | 50% | Not implemented | 0% | CNST Not Met |
| Element 4 | Fetal monitoring in labour | Partially implemented | 40% | Not implemented | 0% | CNST Not Met |
| Element 5 | Preterm birth | Partially implemented | 33% | Not implemented | 0% | CNST Not Met |
| Element 6 | Diabetes | Partially implemented | 67% | Not implemented | 0% | CNST Not Met |
| All Elements | TOTAL | Partially implemented | 41% | Not implemented | 0% | CNST Not Met |

The Trust has not yet fully implemented every element of the saving babies lives care bundle.

Two quarterly improvement meetings have been held with the ICB (LMNS), using the new national implementation tool with assessment of current compliance against the element and progress has been evidenced as can be seen from the tables of compliance below. We continue to progress and work towards compliance, with support and oversight from the ICB and LMNS.

**Salisbury NHS Foundation Trust are NOT declaring full compliance with safety action 6.**

## 3.7 Safety action 7:

### Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

| | |
|---|---|
| **Required standard** | 1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023). Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.<br><br>2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.<br><br>3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions. |
| **Minimum evidential requirement for trust Board** | Evidence should include:<br>• Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff.<br><br>• Evidence that MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.<br><br>• The MNVP's work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it.<br><br>• Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses.<br><br>• Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality. |
| **What is the relevant time period?** | Trusts should be evidencing the position as 7 December 2023 |

Our mechanisms for service user feedback are through the family experience midwife and includes:

A Maternity Neonatal Voices Partnership (MNVP) group which is a conduit between service users and maternity and neonatal services and works collaboratively within the LMNS.

The MNVP meets with services within the LMNS and the MNVP Chair is represented on the operational and board LMNS meetings which are monthly and attended by SFT representatives from the maternity unit. The MNVP reflects the experiences of the local community but remains independent and accessible to all sections of the community. Within the maternity incentive scheme period the MNVP have worked collaboratively with SFT to co-produce the local maternity service and the local MNVP representative meets monthly with the Family Experience Midwife to facilitate this. Examples of this work are:

- Increasing women's choice of place of birth- our birth centre has been open for over a year, and MNVP have been involved with co-production of broadening the criteria for birthing on our birth centre
- Involvement of MNVP with gaining feedback from service users of the BAME community and those living in socially deprived areas
- Attendance at local governance and safety champion meetings
- Involvement of updating our website
- Working with the Family Experience Midwife around complaints and compliments from users.
- Using social media
- Feedback to SFT from users
- Allowing birth partners on postnatal ward overnight
- Supporting the development of staff training for personalised care as per the Core Competency Framework v3
- Reviewing service user written information such as our induction of labour leaflet

The LMNS has signed off the MNVP work programme which also includes prioritisation around feedback and access for minority groups.

All above standards and requirements have been met and evidence provided.

**Salisbury NHS Foundation Trust are declaring full compliance with safety action 7.**

### 3.8 Safety action 8:

### Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

| | |
|---|---|
| **Required standard and Minimum evidential requirement** | 1.A local training plan is in place for implementation of Version 2 of the Core Competency Framework.<br><br>2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.<br><br>3.The plan is developed based on the "How to" Guide developed by NHS England. |
| **What is the relevant time period?** | 12 consecutive months should be considered from 1st December 2022 until 1st December 2023 to ensure the implementation of the CCFv2 is reported on and, an appropriate timeframe for trust boards to review.<br><br>It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e Diabetes. 90% compliance is required for all elements that featured in CCFv |

a) A local 3-year training plan detailing the introduction of the six core modules of the Core Competency Framework Version 2 has been commenced, and updated in 2023, with all training being delivered to staff by August 2024.

b) Compliance with PROMPT for 12 consecutive months from 1st December 2022 to 1st December 2023, is shown in table 3. 90% or more of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day, that includes maternity emergencies and with one scenario being conducted in the clinical area.

**Table 3.**

| MDT PROMPT TRAINNG | |
|---|---|
| Staff group | Compliance |
| Midwives | 98.17% |
| MCA's | 91.67% |
| Obstetricians – consultants | 90.91% |
| Obstetricians – other grades | 100% |
| Obstetric Anaesthetists - consultants | 100% |
| Obstetric Anaesthetists – other grades | 100% |

c) Compliance with fetal monitoring as of December 1st 2023, is shown in table 4. We have achieved compliance for the training requirements of fetal monitoring for 2023.

**Table 4.**

| Fetal monitoring | |
|---|---|
| Staff group | Compliance |
| Midwives | 96.33% |
| Obstetricians - consultants | 100% |
| Obstetricians – other grades | 100% |

d) Compliance with newborn life support training as of December 1st 2023, is shown in table 5. We have achieved compliance in NLS training.

**Table 5.**

| Newborn Life support | |
|---|---|
| Staff group | Compliance |
| Midwives | 97.25% |
| Neonatal nurses | 90.91% |
| Paediatricians - consultants | 100% |
| Paediatricians – other grades | 100% |

The new MIS Year 5 requirement is that Resus Council trained instructors must deliver all in-house NLS training. We are currently not able to provide this due to the lack of RC instructors at Salisbury. We currently only have 4 RC instructors across the division, to provide the training for over 150 staff. Our mitigation plan, as outlined by MIS, is that we have 1 RC instructor returning from maternity leave in December and a further 2 more midwives nominated to commence RC instructor training in 2024. This training can take up to 6-9 months to complete. However, due to the challenges of not being able to meet the MIS requirements this year, this has been escalated to our Divisional Management Team to be escalated to Trust board and our LMNS. Due to a lack of RC instructors in the LMNS also, as a minimum, our NLS training is delivered by staff who have attended RC NLS course in the last 4 years, as confirmed as mitigation in the guidance from MIS.

**Salisbury NHS Foundation Trust are declaring full compliance with safety action 8.**

## 3.9 Safety action 9:

## Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

| | |
|---|---|
| **Required standard** | a All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.<br><br>b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.<br><br>c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures. |
| **Minimum evidential requirement for trust Board** | .<br>**Evidence for point a) is as per the six requirements set out in the Perinatal Quality Surveillance Model and specifically:**<br><br>• Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues.<br><br>• Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs).<br><br>• To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.<br><br>**Evidence for point b)**<br><br>• Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaints data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. This should continue to be undertaken quarterly as detailed in MIS year 4. These discussions 60 must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.<br><br>**Evidence for point c):**<br><br>Evidence that the Board Safety Champions have been involved in the NHS England Perinatal Culture and Leadership Programme. This will include:<br><br>• Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available.<br><br>• Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team at a minimum of quarterly (a minimum of two in the reporting period) and that any support required of the Board has been identified and is being implemented. |

| What is the relevant time period? | **Time period for points a and b)**<br><br>• Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action should be in place based on previous requirements. The expectation is that if work is still in progress, this will have been completed by 1st December 2023.<br><br>• The expectation is 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 are continuing to take place at Board level monthly. If for any reason they have been paused, they should be reinstated no later than 1 July 2023.<br><br>• The expectation is for ongoing engagement sessions with staff as per year 4 of the scheme. If for any reason these have been paused, they should be recommenced no later than 1 July 2023. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions.<br><br>• Progress with actioning named concerns from staff engagement sessions are visible to both maternity 61 and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than the 17th of July 2023.<br><br>• Evidence that a review of the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting by 17th July 2023. At least one additional meeting must have been undertaken before the end of the year 5 scheme demonstrating oversight of progress with any identified actions from the first review as part of the PSIRF plan. This should continue to be undertaken quarterly as detailed in MIS year 4.<br><br>**Time period for points c)**<br><br>• Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available no later than 1 August 2023.<br><br>• Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of quarterly and that any support required of the Board has been identified and is being implemented. There must have been a minimum of 2 meetings held by 1 February 2024 |
|---|---|

A non-executive safety Champions continues to work alongside the Executive Safety Champion to address quality issues, they meet bi-monthly as part of the safety champions forum as well as being present monthly at Trust Board and reviewing perinatal Quality in both forums, including review of the minimum data set monthly at trust board.

The quarterly quality & safety reports to Trust board and the monthly Perinatal Quality Slide sets report on all of the agreed metrics in this action. Board safety champions undertake a walk round of the department bimonthly to hear any concerns raised by staff relating to safety issues. Progress on actions from walk abouts and staff feedback is collated and reviewed and has been made available to staff in 'you said, we did' format on the NNU and on Labour Ward.

The Trust has reviewed it's claims scorecard alongside incident and complaint data and at least twice in the MIS reporting period at a Trust level quality meeting. This data is reviewed quarterly at Divisional Governance and escalated upwards from this here.

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 are continuing to take place at Board level monthly and are all incorporated into the Perinatal Quality Surveillance slides presented by the Director of Midwifery monthly at Trust Board.

Both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available to them, both registered pre-1 August 2023 as per requirements.

As per CNST MIS requirements the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of quarterly and that any support required of the Board has been identified and is being implemented. There have been 2 meetings held by 1 February 2024 as required, one on 21 November 2023 and one 8th January 2024.

**Salisbury NHS Foundation Trust are declaring full compliance with safety action 9.**

### 3.10 Safety action 10:

### Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

| | |
|---|---|
| **Required standard** | A) Reporting of all qualifying cases to HSIB/ MNSI from 6 December 2022 to 7 December 2023.<br><br>B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until 7 December 2023.<br><br>C) For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:<br><br>i. the family have received information on the role of HSIB//MNSI and NHS Resolution's EN scheme; and<br><br>ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Reg |
| **Minimum evidential requirement for trust Board** | Trust Board sight of Trust legal services and maternity clinical governance records of qualifying HSIB//MNSI/EN incidents and numbers reported to HSIB//MNSI and NHS Resolution.<br><br>Trust Board sight of evidence that the families have received information on the role of HSIB/MNSI and EN scheme.<br><br>Trust Board sight of evidence of compliance with the statutory duty of candour. |
| **What is the relevant time period?** | Reporting to HSIB – from 6 December 2022 to 7 December 2023<br><br>Reporting period to HSIB and to NHS Resolution – from 6 December 2022 to 7 December 2023 |

A. All qualifying cases for the qualifying timeframe were reported to the health care safety investigation branch (HSIB). There were 4 cases, two have been accepted by HSIB (term latent phase still-birth and a term baby requiring therapeutic cooling following labour and birth) two were rejected when clinical information was reviewed by HSIB.

B. One of the two cases under investigation by HSIB was eligible for reporting to ENS and this has been notified. The other was a stillbirth so did not meet criteria for reporting. In addition, within this year we have reported the case that was identified as outstanding from last years MIS submission. The ENS reporting has a single point of failure currently as completed by Trust legal services however we developed further failsafe procedures and have a master investigation tracker (as per evidence bundle) to track cases that are referred, investigated and eligible to reporting for both HSIB and ENS.

C.

i. Families receive written information regarding HSIB (now MNSI) and ENS. Both the letter templates, redacted copy of the letter sent and postage tracking details are

included in the evidence bundle for the one family that met HSIB and ENS criteria. *The reporting wizard for ENS is completed by the head of litigation as per email and NHSR have confirmed current eligible reported cases (see redacted emails in evidence bundle).

ii. Duty of candour compliance is confirmed.

**Salisbury NHS Foundation Trust are declaring full compliance with safety action 10.**

## 4. Conclusion

The Trust board is asked to review the content of this report and note compliance with 9 of the 10 Safety actions.

All evidence has been collated and reviewed by the Divisional triumvirate of Director of Midwifery, Clinical Director, and Divisional Director of Operations. In addition, it has been reviewed by the Maternity Improvement Advisor allocated to SFT from NHSE as part of the Maternity Safety Support Programme, the Chief Nursing Officer for SFT and the LMNS Lead Midwife (as allocated by, and deputising for, the Chief Nurse for the ICB) to ensure complete scrutiny and transparency around evidence provided to support SFT's compliance.

The CEO is requested to sign the Board declaration form prior to submission to NHS resolution.

NHS Resolution

# Section A : Maternity safety actions - Salisbury NHS Foundation Trust

| Action No. | Maternity safety action | Action met? (Y/N) |
|---|---|---|
| 1 | Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard? | Yes |
| 2 | Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? | Yes |
| 3 | Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies? | Yes |
| 4 | Can you demonstrate an effective system of clinical workforce planning to the required standard? | Yes |
| 5 | Can you demonstrate an effective system of midwifery workforce planning to the required standard? | Yes |
| 6 | Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three? | No |
| 7 | Listen to women, parents and families using maternity and neonatal services and coproduce services with users | Yes |
| 8 | Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? | Yes |
| 9 | Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues? | Yes |
| 10 | Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023? | Yes |

# Section B : Action plan details for Salisbury NHS Foundation Trust

**An action plan should be completed for each safety action that has not been met**

## Action plan 1

| | | | |
|---|---|---|---|
| **Safety action** | Q6 SBL care bundle | **To be met by** | Q4 = 2024/25 |
| **Work to meet action** | *We require further capacity to deliver the elements of Saving Babies Lives Care bundle version 3. There is a requirement for further leadership and capacity within the team, with a Senior clinician being required to have ownership and support more junior members of the team with development of all elements and requiremnts of the care bundle. We would aim to do this with a Senior Quality Assurance Midwife role (1 FTE* | | |
| **Does this action plan have executive level sign off** | Yes | **Action plan agreed by head of midwifery/clinical director?** | Yes |
| **Action plan owner** | *Vicki Marston Director of Maternity and Neonatal Services and Abi Kingston Clinical Director* | | |
| **Lead executive director** | *Yes* | | |
| **Amount requested from the incentive fund, if required** | *£184,844.00* | | |
| **Reason for not meeting action** | *We have been challenged by implementation for a multitude of reasons. We are currently on the Maternity Safety Support Programme and have had significant change across all levels of the leadership and non-clincial team over the past 12 months with a junior (developing) and new workforce requiring support. There has been some challenge in clarity about actions in SBL vs3, some challenge in understanding of the* | | |
| **Rationale** | *The Senior Quailty Assurance Role will provide senior ownership and experience to ensure progress and support with implementation of the bundle with an overall aim for safer care, improved outcomes and compliance.The Specialist Diabetic Midwife will support implemenation and work clinically to improve care and outcomes. The workstream requires operational and transformational/infromatics support to enable audits to* | | |
| **Benefits** | *Benefits will be compliance and progress against the care bundle. A Senior Quality Assurance 1.0 FTE Band 8a (Saving Babies Lives) Midwife will ensure that we have the right staff in the right roles to support learning and development around SBL, as well as benchmarking and working closely with our LMNS to progress our compliance - ensuring women in our care are receiving care that is aligned to the bundle. This will also* | | |
| **Risk assessment** | *Non compliance with the safety action leading to poor outcomes for mothers and babies, and lack of progress and development for the service.* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | Through regular SBL meetings, Audit, and oversight through Governance | Director of Midwifery and Clinical Director | Monthly - commencing Q1 24/25 |

## Action plan 2

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

## Action plan 3

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

## Action plan 4

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

## Action plan 5

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

## Action plan 6

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

## Action plan 7

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

## Action plan 8

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

## Action plan 9

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

## Action plan 10

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

## Maternity Incentive Scheme - Board declaration form

| | |
|---|---|
| **Trust name** | **Salisbury NHS Foundation Trust** |
| **Trust code** | **T398** |

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

| | Safety actions | Action plan | Funds requested | Validations |
|---|---|---|---|---|
| Q1 NPMRT | Yes | | - | |
| Q2 MSDS | Yes | | - | |
| Q3 Transitional care | Yes | | - | |
| Q4 Clinical workforce planning | Yes | | - | |
| Q5 Midwifery workforce planning | Yes | | - | |
| Q6 SBL care bundle | No | Yes | 184,844 | |
| Q7 Patient feedback | Yes | | - | |
| Q8 In-house training | Yes | | - | |
| Q9 Safety Champions | Yes | | - | |
| Q10 EN scheme | Yes | | - | |
| **Total safety actions** | **9** | **1** | | |
| **Total sum requested** | | | **184,844** | |

**Sign-off process confrming that:**

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2023/24) or the previous financial year (2022/23)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.
* If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

| | |
|---|---|
| **Electronic signature of Trust Chief Executive Officer (CEO):** | |
| **For and on behalf of the Board of** | Salisbury NHS Foundation Trust |
| **Name:** | |
| **Position:** | |
| **Date:** | |

| | |
|---|---|
| **Electronic signature of Integrated Care Board Accountable Officer:** | |
| **For and on behalf of the board of** | Salisbury NHS Foundation Trust |
| **Name:** | |
| **Position:** | |
| **Date:** | |

Salisbury NHS Foundation Trust

| | | | |
|---|---|---|---|
| Report to: | Trust Board (Public) | Agenda item: | 7.4 |
| Date of meeting: | 11th January 2024 | | |

| | | | | |
|---|---|---|---|---|
| Report tile: | Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services –November 2023 | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | x | x | x | |
| Approval Process: (where has this paper been reviewed and approved): | Agreed by DMT 07.12.23<br>Divisional Governance 15.12.23 | | | |
| Prepared by: | Vicki Marston –Director of Midwifery and Neonatal Services | | | |
| Executive Sponsor: (presenting) | Judy Dyos - Chief Nursing Officer | | | |

## Recommendation:

The committee 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 5 – 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 November 2023.

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 of 14.34 (establishment 90.6)
- Vacancies and maternity leave mitigated by bank and long line agency usage.

- Agency use continued until end November 2023 to maintain safe staffing.
- Midwife to birth ratio 1:28
- 1:1 care in labour achieved at all times
- Supernumerary status of labour ward maintained 100% time.

**PMRT**

- 1 PMRT review in November.

**Incidences reported as moderate.**

- 7 Incidences reported as moderate.
    - 2 Stillbirths
        - 1 x 26 gestation – 72-hour review showed no omissions in care, however for PMRT review as per criteria.
        - 1 x 34 gestation – Known small for gestational age, having increased surveillance with fetal medicine unit. No omissions in care noted at 72-hour review. For PMRT as per reporting criteria.

**Training**

- Compliance shows slight increase in PROMPT, CTG and NLS training, Plan in place throughout to continue with trajectory to reach 90% target. Target reached and compliance met as of 1st December.

**Service user and staff feedback**

Current Local patient surveys ongoing:

- Postnatal care
- AN and PN screening service survey
- Maternity's new website (launched Oct 23)
- NNU family experience.
- Bereavement survey
- Feedback re – Requirement for design of a more robust pathway for parents reaching out for advice around mental health concerns.

| 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

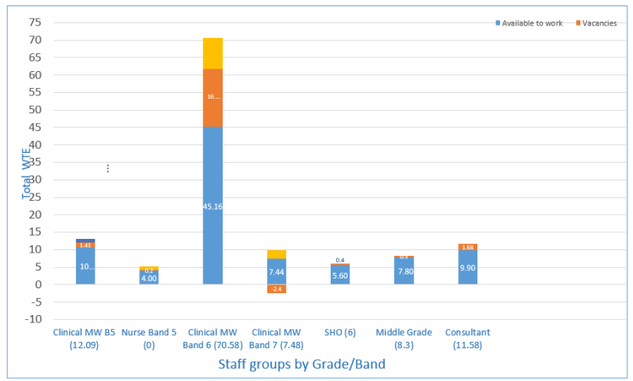
# Perinatal Quality Surveillance Integrated Performance Report

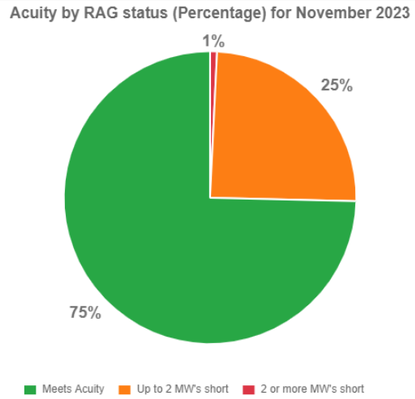
## November Data 2023

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

# Maternity & Neonatal Workforce -

| | Target | Threshold | | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Comment |
|---|---|---|---|---|---|---|---|---|
| Midwife to Birth Ratio | 1:26 | =<1:26 | >1:26 | 1:30 | 1:29 | 1:30 | 1:28 | |
| 1:1 Care | 100% | 100% | 100% | 100% | 100% | 100% | 100% | |
| Consultant Presence in Delivery Suite (Hrs per week) | 40 | =>40 | <40 | 40 | 40 | 40 | 40 | |
| Supernumerary Status of Delivery Suite Coordinator | 100 % | 100 % | 100 % | 100 % | 100 % | 100 % | 100% | |
| Confidence factor in Birthrate+ recording | | | | | | | Yes | Audit be commenced November 2023 |
| Daily multidisciplinary team ward round | | | | | | | 100% | Audit to be commenced Nov 23 |
| Consultant non-attendance when clinically indicated (in line with RCOG guidance) | 0 | | | 0 | 0 | 0 | 0 | To be monitored via datix reporting |




- **OVERVIEW**

**Key Achievements:**

- Out of 7 international midwives who have joined the trust all have now passed their OSCE. 3 are awaiting NMC PINS.
- Supernumerary status of coordinator maintained and achieved 100% of time
- 1:1 care achieved 100% of time
- Reduction in Midwifery vacancies, 1 new preceptee miwife starting in November.
- 1 starting in January.

**Next Steps for Progression:**

- Continue with targeted recruitment campaign
- 2 x places secured on Nurse to Midwife conversion course. Commencing Jan ’24, training funded by HEE.
- 2 MSW candidates confirmed for Midwifery apprentice course in January

**Key Risks:**

- Vacancy rate of 15.25 WTE Midwives leading to challenges in maintaining fill rates
- Challenge in supporting well-being of staff whilst staffing levels are low but mitigating this and ensuring safety by use of escalation policy and ensuring midwives are rostered where acuity dictates the need is.

# Perinatal Mortality Review Tool (PMRT)

**Background Narrative & Identified Issues:**

- *Figure 1: Shows live data for perinatal losses reportable to MBRRACE 1/1/2023- 24/11/23 form MBRRACE data tool. To show the trend of the year. (Excluding MTOP's, data only given up to last loss)*
- *Table 1: Shows PMRT reviews completed in November 2023, note this case was reviewed by HSIB and the PMRT review did not take place until the HSIB final report was published.*
- *Table 2:Shows actions generated from PMRT reviews completed in November 2023*

**Number of babies who died in November that meet PMRT review criteria:**

*2*

**Improvement Actions & Timescales:**

Improvements in escalation when concerns with fetal monitoring.

Improvements in ensuring the correct follow up tests are undertaken.

**Themes in issues:**

None

**Figure 1. Live data for perinatal losses reportable to MBRRACE 01/01/2023- 24/11/23**

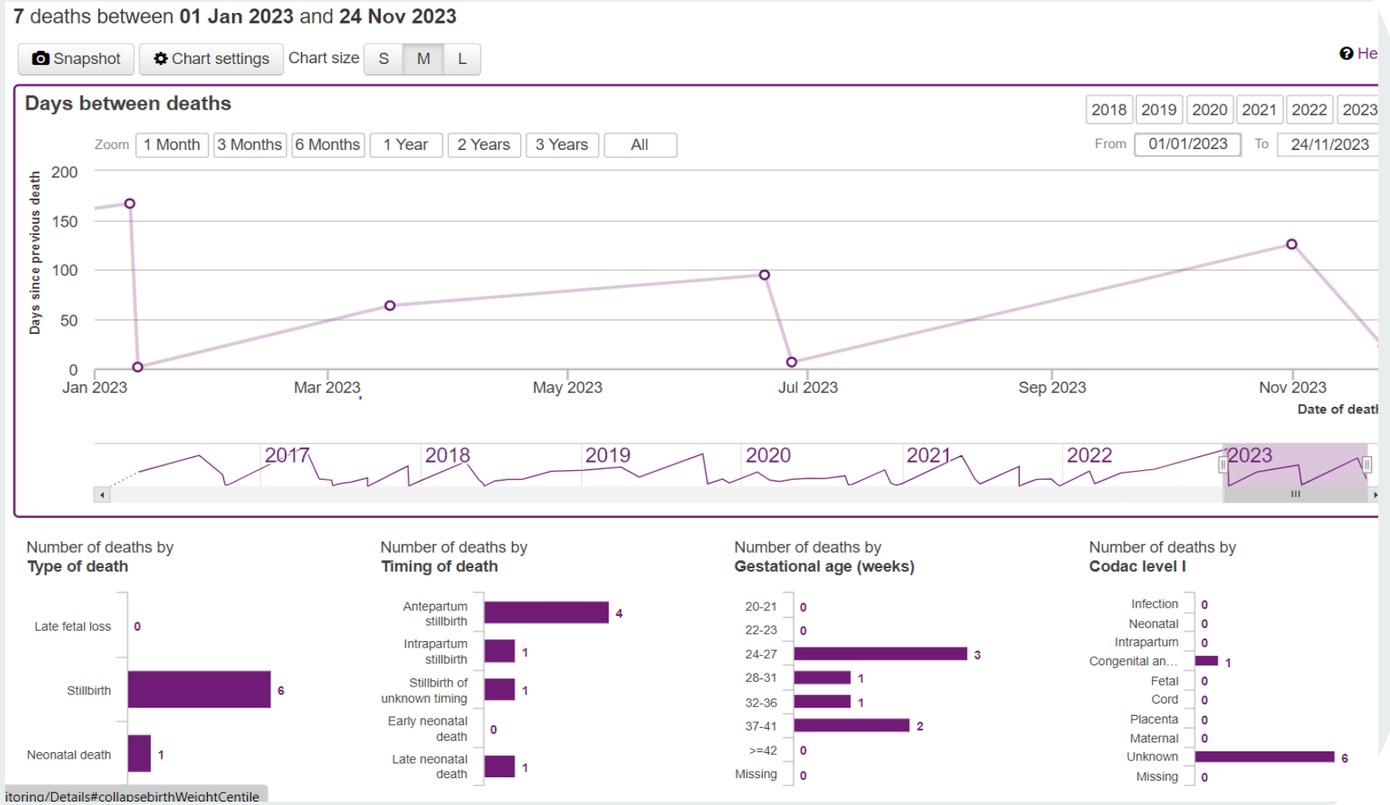



**Table 2- PMRT Actions from review the reporting month 2023**

| Action | Implementation plan |
|---|---|
| The fetal heart monitoring in the latent phase of labour was not carried out correctly | Embedded in HSIB recommendations |
| During this mother's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out | Embedded in HSIB recommendations |
| Appropriate action was not taken when fetal heart rate abnormalities were identified during the latent phase of labour- | Embedded in HSIB recommendations |
| Although indicated this mother was not offered a Kleihauer test- | Make this section separate from the other bloods on checklist-Discuss at Bereavement Workshops |
| Although indicated this mother was not offered infection screening for herself and her baby | Request for fetal swabs added to the stillbirth checklist |

**Table 1: PMRT reviews completed during the reporting month**

| Date of delivery | Gestation at delivery | Type of loss | MBRRACE ID | PMRT multidisiplinary review date | Grading of care |
|---|---|---|---|---|---|
| 17/03/2023 | 39+3 | Stillbirth | 86616 | 10/11/2023 | Upto the point the baby had died- C- issues may have made a difference to the outcome |
| | | | | | After the baby had died- B- issues identified would have made no difference to the outcome of the mother. |

# Incidents & Investigations
# DATIX SUMMARY

| Case Ref (Datix) | Date | Category | Incident | Outcome/Learning/Actions | HSIB Reference | SI Reference |
|---|---|---|---|---|---|---|
| 160481 | 01.11.2023 | Moderate | Shoulder dystocia and term admission to NICU | Shoulder dystocia reviewed. Recognised quickly and appropriate response/managed well. Presented at PSS as part of rolling updates of shoulder dystocia cases. No omissions or concerns re: care. Admission to NICU to be reviewed as part of ATAIN process. | NA | NA |
| 160564 | 01.11.2023 | Moderate | 26+6 Stillbirth | Initial 72hr review revealed no omissions in care that would have had a direct impact on the outcome for this mother, however there will also be a full PMRT review-this is currently pending. | NA | NA |
| 160856 | 14.11.2023 | Moderate | Collapsed pre-conception care patient in ante-natal clinic | Case is currently pending review. | NA | NA |
| 161025 | 19.11.2023 | Moderate | Antenatal patient attended ED after experiencing eclamptic seizures at home and in ambulance | This case was presented at PSS and has been commissioned as CCR. | NA | CCR-Not STEIS'd |
| 161099 | 22.11.2023 | Moderate | Scar dehiscence noted at LSCS | Case is currently pending review. | NA | NA |
| 161129 | 22.11.2023 | Moderate | IUD at 34/40 | Case is currently pending review. | NA | NA |
| 161364 | 30.11.2023 | Moderate | 3rd degree tear | Case is currently pending review. | NA | NA |

## New Serious Incidents (November 2023)

Following recommendations made in the Ockenden Report all cases referred to HSIB will be reported as a Serious Incident (SI).

| Case Ref (Datix) | Date | Category | Incident | Outcome/Learning/Actions | HSIB Reference | SI Reference |
|---|---|---|---|---|---|---|
| **NO NEW SII** | | | | | | |

# 72-hour Incident Reviews

## Completed Maternity & Neonatal 72-hour Reviews (Nov 23)

| Case Ref (Datix) | Date | Category | Incident | Outcome/Learning/Actions | HSIB Reference | SI Reference |
|---|---|---|---|---|---|---|
| 160564 | 01.11.2023<br>Presented at PSS<br>14.11.2023 | Moderate | 26/40 Stillbirth | At initial 72hr review no omissions in care identified, however for final review at PMRT-Datix to remain open until completed. | | |
| 160367 | 29.10.2023<br>Presented at PSS<br>17.11.2023 | No harm | Patient experienced 3rd degree tear and later reported numbness/weakness in leg and foot. | 3rd degree tear sutured in theatre as soon as was practicable. Had appropriate care and follow up. Had prompt, good follow up in relation to the numbness/weakness which was not felt to have been caused by any omissions in care. No concerns identified. | NA | NA |
| 160529 | 15.11.2023<br>Presented at PSS<br>21.11.2023 | No harm | Mother received accidental bolus of oxytocin infusion | The bolus received was calculated and was found to be such an amount that would have been extremely unlikely to have had any impact on the outcome for this mother. There has been incidental learning from this case which will be disseminated via Q&S and Education teams. | NA | NA |
| 161025 | 19.11.2023<br>Presented at PSS<br>28.11.2023 | Moderate | Mother experienced eclamptic seizure at home and in ambulance en route to hospital. | Commissioned as clinical review. | NA | NA |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Maternity Safety Support Programme** | Yes | **CQC Ratings** | TBC | **Maternal Deaths** | Nil | **Concerns or requests from national bodies** | Nil | **Coroners Regulation 28** | Nil |

# Ongoing Investigations

## Maternity & Neonatal Investigations (September)

| 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? | Progress Notes |
| CR 565 | Maternity/W&NB | Uexpected admission to neonatal unit | 18/05/2023 | 30/05/2023 | | **22/08/2023** | | Draft report received. Action plan meeting arranged. CRG in Jan. |
| CR 569 | Maternity | Uncrossmatchable Blood - Antibodies | 02/06/2023 | 13/06/2023 | | **08/09/2023** | | Draft report to CRG 14/12. |
| SII 570 | Maternity | Retained Swab | 09/06/2023 | 13/06/2023 | | **08/09/2023** | | External chair. Panel 16.10.23 (originally 5.9.23). Report in writing. Chased to request ETA on draft report. |
| SII 571 | Maternity | Placenta Acreta | 25/05/2023 | 20/06/2023 | | **14/09/2023** | | Panel 16.11.23. Report in writing. |
| SII 574 | Maternity | Stillbirth | | 27/06/2023 | | **21/09/2023** | | Panel 14/8/23. Report returned to author for final amendments. CRG in Jan. PMRT review complete. |
| CR 579 | WNB | Term admission to NICU | 20/04/2023 | 18/07/2023 | | **09/10/2023** | | Draft report to CRG 14/12 |
| CR 580 | WNB | Term admission to NICU | 16/07/2023 | 01/08/2023 | | **23/10/2023** | | Panel on 16.10.23. Report in writing. Deadline given of 4th December for draft report. |
| CR 584 | Maternity | OASI | 3.7.23 | 8.8.23 | | **30/10/2023** | | Reschedule panel date (due to change in chair and change in commitments). Originally set for 16.10.23. Still no panel chair and escalated for support. Trialing new process until PSIRF is implemented and arrangements change. |
| SII586 | Maternity | Eclampsia and GA | 8.8.23 | 22.8.23 | | **13/11/2023** | | External chair. Panel on 2.11.23. Report in writing. |
| 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** | | Draft report received 23/11 - to send to staff for factual accuracy checking |
| CR 588 | Maternity | Antenatal Pulmonary Embolism at 15 weeks pregnant | 31.7.23 | 29.08.23 | | **20/11/2023** | | Panel 31.10.23 (moved from 11.10.23). Report in writing - support with draft. |
| CR 599 | Maternity | PPH at Home, did not follow guidelines. C/O IDM | 19.9.23 | 3.10.23 | | | | Awaiting panel date. FHA requested. |

| Reports for EXIT | | | | | | | |
|---|---|---|---|---|---|---|---|
| ID | Directorate / Ward / Dept | Summary of incident | Date commissioned | CRG | Date Due to CCG | Within 60 day target? | Progress notes |
| | | | | | | | |
| | | | | | | | |

| SIIs, CRs and LRs Signed off - share (Stage 3) duty of candour | | | | | | | |
|---|---|---|---|---|---|---|---|
| ID | Directorate / Ward / Dept | Summary of incident | Incident date | Date Signed Off | Duty of Candour Update | Report share | |
| | | | | | | | |

Following recommendations made in the Ockenden Report all cases referred to HSIB will be reported as a Serious Incident (SI).

Data correct as of 5.12.23 (finalised with Trust PSS group). The data in the preceding month may have changed due to this being reported weekly via Trust Risk team and being updated and agreed locally

# Investigation Actions

## Compliance Tracker

**W&NB SII / CR Open Compliance Matrix**

| 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 472 | Click | W&NB | February 2022 | Q1 22-23 | Oct 22 | Oct 22 | Q3 22-23 | Q3 22-23 | | | | | | |
| SII 477 | Click | W&NB | April 2022 | Q1 22-23 | Q2 23-24 | Jan 23 | Q4 22-23 | Q4 22-23 | Q4 22-23 | Q3 22-23 | Q4 22-23 | Q1 23-24 | | |
| SII 489 | Click | W&NB | May 2022 | Q1 22-23 | Dec 22 | Q4 22-23 | Q4 22-23 | Q3 22-23 | Q3 22-23 | | | | | |
| SII 506 | Click | W&NB | March 2021 | CSFS | Jun 23 | Q1 23-24 | CSFS | | | | | | | |
| CR 509 | Click | W&NB | July 2022 | Q2 22-23 | Oct 23 | Aug 23 | Oct 23 | Aug 23 | | | | | | |
| SII 510 | Click | W&NB | August 2022 | Q1 23-24 | Q1 23-24 | Feb 23 | Q2 23-34 | Feb 23 | Jan 23 | Jan 23 | Q1 23-24 | Jan 23 | | |
| CR 512 | Click | W&NB | September 2022 | Sept 23 | 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 | | | | |
| CR 527 | Click | W&NB | October 2022 | Q1 23-24 | Q1 23-24 | Jun 23 | Q2 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 | | | | | | | |

| Colour Code | | |
|---|---|---|
| No Evidence | Evidence of Progress | Evidence of Completion |

** Action tracker held corporately and reported via Trust Risk Team. Data in preceding and current month maybe the same or have changed due to Trust reporting mechanisms and due to cases being removed once all actions completed. Current tracker received on 13th November **(above)** -

# Feedback – Staff & Service Users

## MNVP Service User Feedback

**Key Achievements & Positive Feedback:**

**Feedback from MNVP survey and local engagement March- May 23 and June –Aug 23**

**Personalised care :**Parents reported all risks and benefits were explained at their level of understanding and their wishes were listened to.

**Feedback on PN care:**

**"Midwives amazing, checked Mum and baby regularly"**

**Identified Areas of Improvements:**

- Better understanding and information sharing RE personalised care.
- To ensure a robust pathway in place for parents reaching out for advice with mental health concerns

**Next Steps for Progressions:**

**Review the action from both survey, meetings to be arranged with the various leads.**

## Safety Champions Staff Feedback

**Key achievements & positive Feedback:**

***"I am writing to express my gratitude and that of my wife, for the exceptional care we received in your department following the birth of our second son. He was born through c-section on XX October and we were both humbled by the kindness and dedication of your staff. From the midwives XX and XX who attended us, the surgeon and XX the anaesthetist we were always supported and in good hands. Even the choice of music in theatre was top notch! We have had two children delivered at SDH as your team continue to inspire and deliver in every sense".***

**Identified Areas of Improvements:**

Update on CNST submission

National Maternity Survey action plan 2022 presented, actions completion on target.

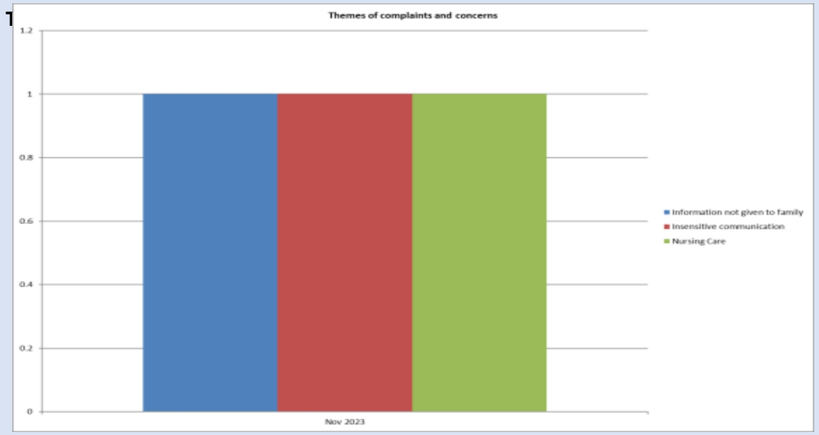
**Next Steps for Progressions:**

Look at how we can share the results of the SCORE Survey results with our community colleagues.

## Compliments & Complaints

**Themes & Trends: Nov 23**

**Complaints :2**
**Compliments :1**
**Concern: 1**
**Comments: 3**




## Friends & Family Survey

**Key Achievements:**

**FFT feedback – 2 responses received in Nov 23**
**AN feedback rate: very poor**
**Community and postnatal feedback: Very good.**

**Identified Areas of Improvements:**

Continue to promote FFT . Look at funding to support additional FFT cards.

Review ANC feedback with the clinical leads

**Next Steps for Progressions:**

All leads have been asked to locate the current FFT cards are offer them to women who access their department/ inpatient aeras

**Current Local patient surveys ongoing :**

- Postnatal care
- AN and PN screening service survey
- Maternity's new website (launched Oct 23)
- NNU family experience.
- Bereavement survey

**Completed National /local surveys:**

- Pregnancy journey survey- with the focus on women in low social economic groups, Black, Asian and ethnic minority groups. Action plan completed

# Compliance across National Guidelines – Ockenden

## OCKENDEN 2020 Report

| | Current Rag Status /Action No | Immediate & Essential Action | Number of actions under each heading rated | | |
|---|---|---|---|---|---|
| | | | RED | AMBER | GREEN |
| Nov-23 | 1 | Enhanced Safety | 0= | 0= | 3= |
| | 2 | Listening to Women & Families | 0= | 0= | 1= |
| | 3 | Staff Training & Working Together | 0= | 0= | 3= ↑ |
| | 4 | Managing Complex Pregnancy | 0= | 0= | 3= |
| | 5 | Risk Assessment Through Pregnancy | 0= | 0= | 2= |
| | 6 | Monitoring Fetal Wellbeing | 0= | 0= | 8= ↑ |
| | 7 | Informed Consent | 0= | 0= | 3= ↑ |
| | | TOTAL | 0 | 0 | 5↑ |

**Ockenden 2020 Report**

**Key Achievements:**
Now fully compliant with Ockenden 2020
Can now be removed

## OCKENDEN 2022 Report

| | Current Rag Status /Action No | Immediate & Essential Action | Number of actions under each heading rated | | |
|---|---|---|---|---|---|
| | | | RED | AMBER | GREEN |
| Oct-23 | 1 | Workforce Planning & Sustainability | 0= | 3= | 4= |
| | 2 | Safe Staffing | 0= | 6= | 4= |
| | 3 | Escalation & Accountability | 0= | 3= | 2= |
| | 4 | Clinical Governance - Leadership | 0= | 3= | 4= |
| | 5 | Clinical Governance - Incident Investigation & Complaints | 0= | 4= | 2= |
| | 6 | Learning From Maternal Deaths | 0= | 2= | 0= |
| | 7 | Multidisciplinary Training | 0= | 6= | 1= |
| | 8 | Complex Antenatal Care | 2= | 2= | 1= |
| | 9 | Preterm Birth | 2= | 2= | 0= |
| | 10 | Labour & Birth | 4= | 2= | 0= |
| | 11 | Obstetric Anaesthesia | 0= | 3= | 0= |
| | 12 | Postnatal Care | 0= | 4= | 0= |
| | 13 | Bereavement Care | 0= | 4= | 0= |
| | 14 | Neonatal Care | 3= | 2= | 1= |
| | 15 | Supporting Families | 0= | 3= | 0= |
| | | TOTAL | 11 | 48 | 19 |

**Ockenden 2022 Report**

**Key Achievements:**
- Nearly all actions are in progress

**Next Steps for Progressions:**
- Working groups are continuing to be established
- Neonatal team working on neonatal and preterm birth guidance
- Anaesthetists working on guidance in relation to anaesthetic staffing

**Key Risks to Full Compliance:**
- None

# Compliance across National Guidelines – MIS

## CNST/Maternity Incentive Scheme (MIS)

| | NHSR Maternity Incentive Scheme- Year 5 Submission by 1st February 2024 | | | |
|---|---|---|---|---|
| | Description | Yr 4 Submission | Comment | Current Assessment |
| Are we well led? | 1 **Perinatal Mortality Review Tool** using to required standard for all perinatal deaths | Compliant | No issues identified or anticipated |  |
| | 2 **Maternity Services Data Set** submission to required standard | Compliant | No issues identified or anticipated |  |
| | 3 **Transitional Care Data Set** minimise separation to mothers and babies | Non Compliant | Plan in place to achieve compliance |  |
| | 4 **Clinical Workforce Planning** effective system | Non Compliant | Work in progress. Compliance is achievable. |  |
| | 5 **Midwifery Workforce Planning** | Compliant | No issues identified or anticipated |  |
| | 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 | No issues identified or anticipated |  |
| | 8 **Multidisciplinary Training** | Non Compliant | Work in progress. Compliance is achievable. |  |
| | 9 **Board Assurance** Board to Ward to Board | Non Compliant | Awaiting ratification of new Maternity Governance Framework. Proposed changes to trust policy *Accountability and Integrated Governance Framework* Compliance is |  |
| | 10 **HSIB and EN Reporting** | Non Compliant | Awaiting ratification of new Maternity Governance Framework. Compliance is achievable. |  |
| | Person Centred & Safe | Professional | Responsive | Friendly | Progressive |

### CNST / Maternity Incentive Scheme (MIS)

**Key Achievements:**
- Nearly all actions are nearing completion
- CNST meeting on 08/11/23 confirmed good progress with all actions

**Key Risks to Full Compliance:**
- Progress continues with all actions at steady pace with continual review of guidance for any new evidence required

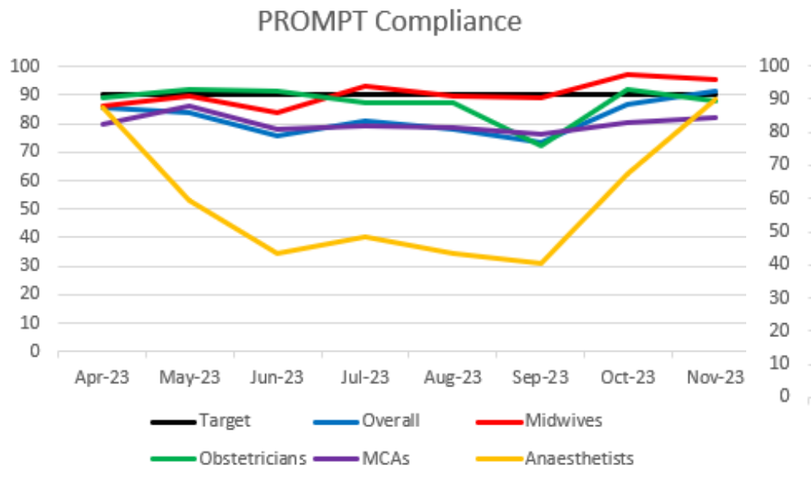
## Maternity 3 Year Single Delivery Plan

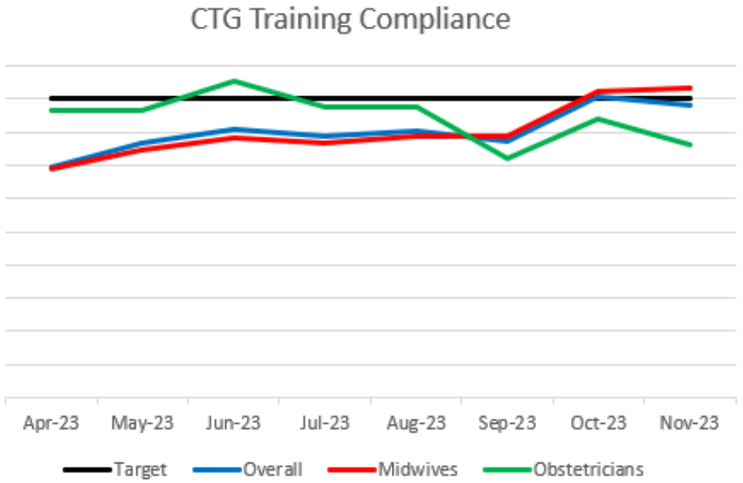
### Maternity 3 Year Single Delivery Plan

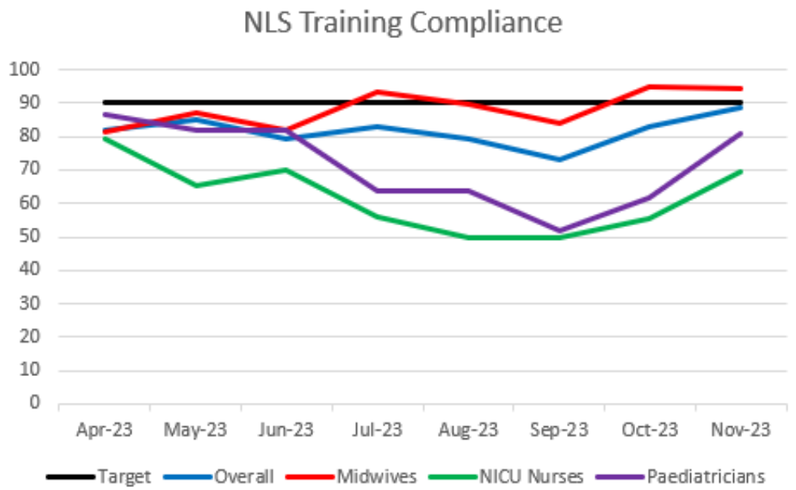
Plan reviewed by Divisional Triumvirate, some actions already in progress following staff survey and already being progressed through Improving together methodology.

Plan to utilise Improving together methodology to focus and prioritise actions from the plan.

# Training & Education




**Background Narrative & Identified Issues:**

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

•PROMPT – Multidisciplinary Obstetric Emergencies

•Newborn Life Support

•Fetal Monitoring - New Obstetric trainees have started at the trust and are non-complaint as have not yet had their training but are all allocated for training in November so we will reach 90% by 1st December

In Maternity Incentive Scheme year 5, the data needs to be further stratified to be compliant with safety standard 8. This includes staff groups and grades individual compliance with above training modules. We have included this data to continue monitoring compliance during MIS year 5.

**Improvement Actions & Timescales:**

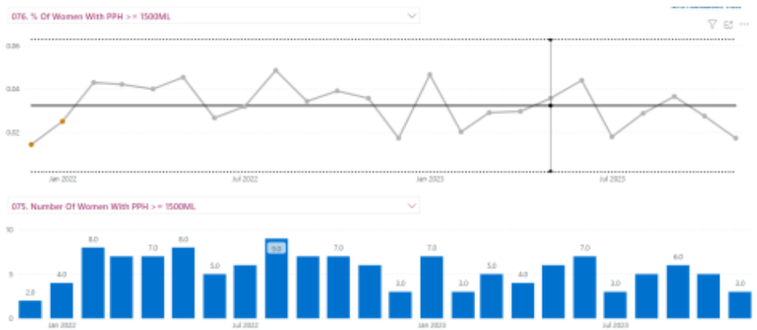
- Deadline for MIS compliance 1st December – plan in place to meet this.
- NLS compliance for Neonatal and Paediatric staff escalated to each department for plan – extra NLS sessions created.

**Risks:**

- Lack of RC-trained instructors for NLS updates – mitigated as provided by RC attenders.

# Ongoing Themes

## % and number of women with PPH >1500ml




**Theme – PPH rate above national rate**

**Key Achievements:**

- SFT had a higher PPH rate (above national target) which is mirrored across the LMNS. This is being monitored and has seen a reduction in rate over the last two reporting months.

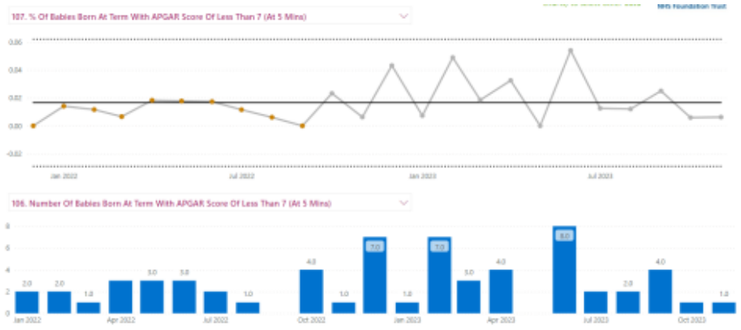
**Next Steps for Progressions:**

- A thematic review needs to take place and has been delayed due to competing work priorities. PPH >1500mls cases

**Countermeasures:**

- To await thematic review and to include use of PPH Risk assessment tool.

## % and number of babies born at term with APGAR of less than 7 at 5 mins




**Theme - % and number of babies born at term with APGAR of less than 7 at 5 minutes**

**Key Achievements:**

- SFT did have a persistently higher % of term babies with low APGARS than national target. This is being monitored and has seen a reduction in rate over the last two reporting months.

**Next Steps for Progressions:**

- A thematic review has been commenced and this has been delayed due to competing priorities. It is been scheduled for later this month.

**Countermeasures:**

- To await thematic review results and to include use of PPH Risk assessment tool

# Health Inequalities

**Maternity 3 Year Delivery Plan covers Health Inequalities**

**Action plan has been drafted**

**Next steps:**
- Job matching and advertising for an inclusion midwife to support with improving equity –LMNS funded fixed term post
- Allocation of actions