Bundle Trust Board Public 6 May 2021

1	OPENING BUSINESS
1.1	10:00 - Presentation of SOX certificates *Presented by Nick Marsden*
1.2	10:05 - Staff Story - helping out on Pitton Ward *Nicolas Jones, Staff Grade Surgeon* *Carlos Lopez, Charge Nurse*
1.3	Welcome and Apologies *Apologies received from Peter Collins*
1.4	Declaration of Interests
1.5	10:25 - Minutes of the previous meeting *Minutes attached from previous meeting held on 8th April 2021* *For approval* 1.5 Draft Public Board mins 8 April 2021 1.docx
1.6	10:30 - Matters Arising and Action Log 1.6 Public Trust Board action log.pdf
1.7	10:35 - Chairman's Business *Presented by Nick Marsden* *For information*
1.8	10:40 - Chief Executive Report *Presented by Stacey Hunter* *For information* 1.8 CEO Board Report April for May final.docx
1.9	10:50 - Care Quality Commission focused inspection of the maternity and spinal departments - 31st March 2021 *Presented by Stacey Hunter* *For information* 1.9 20210401 FU letter Salusbury NHS Trust.pdf
2	ASSURANCE AND REPORTS OF COMMITTEES
2.1	11:00 - Clinical Governance Committee - 27 April *Presented by Eiri Jones* *For assurance* 2.1 Escalation report - from April CGC to May Board 2021.docx
2.2	11:05 - Finance and Performance Committee - 27 April *Presented by Paul Miller* *For assurance* 2.2 Final version - Board - Finance and Performance Committee escalation paper 27th April 2021.docx
2.3	11:10 - Trust Management Committee - 28 April *Presented by Stacey Hunter* *For assurance* 2.3 TMC Escalation report.docx
2.4	11:15 - People and Culture Committee - 29 April *Presented by Michael von Bertele* *For assurance* 2.4 P&C Escalation report - April 2021.docx
2.5	11:20 - Integrated Performance Report (M12) to include exception reports *Presented by Lisa Thomas* *For assurance* 2.6a 060521 IPR cover Board.docx 2.6b IPR May 2021 DRAFT excl benchmarking.pdf
3	FINANCIAL AND OPERATIONAL PERFORMANCE
3.1	11:30 - Review and Agreement of Corporate Objectives 2020/21 2021/22

Presented by Lisa Thomas
For approval

3.1a 210506 Corporate Priorities Cover.docx

3.1b Corporate Objectives 2021 review.docx

4 CLOSING BUSINESS

4.1 11:40 - Agreement of Principle Actions and Items for Escalation

4.2 11:45 - Any Other Business

4.2.1 NHSI Self-Certification (FT4, G6, CoS7)

Presented by FMc

4.2.1 Corporate Governance Statements Cover sheet F&P April 2021.docx

4.2.1b Appendix 1_ Provider Licence Self Certification Proposed Response_2020_21.docx

4.2.1c Appendix 2_ Provider Licence Conditions.docx

4.3 11:50 - Public Questions

4.4 Date next meeting

Date of next Public meeting 8th July 2021

5 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

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

Present:

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

In Attendance:

Kylie Nye (KN)	Corporate Governance Manager (minutes)
Fiona McNeight (FMc)	Director of Corporate Governance
Esther Provins (EP)	Director of Transformation
Paul Wood (PW)	Interim Director of Transformation
Kat Glaister (KG)	Head of Patient Experience (for item TB1 8/4/1.2)
John Mangan (JM)	Lead Governor (lead observer)
Kevin Arnold (KA)	Governor (observer)
Jennifer Lisle (JL)	Governor (observer)
Mark Wareham (MW)	Staff Side Representative (observer)

ACTION

TB1 8/4/1 OPENING BUSINESS

TB1 8/4/1.1 Presentation of SOX (Sharing Outstanding Excellence) Certificates

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

- Tanya Angel, Stoma Care Department - Living Our Values SOX.
- The Ophthalmology Team – Karinya Lewis, Jackie Haugh and Julie Edwards, April SOX of the Month

NM congratulated the members of staff who had received a SOX award and the Board noted the great effort from staff during what has been a challenging time.

TB1 8/4/1.2 Patient Story

KG joined the meeting to present the joint patient and staff story. KG explained that this story had been recorded as part of the work to review the virtual appointments in Outpatients. The story focused on a patient who attended virtual appointments with her parents. The story indicated a positive experience from the patient, who felt more relaxed in a known environment and the parents also found it convenient from a practical and logistical perspective.

Discussion:

- NM thanked KG and the family for sharing their story and asked about overall feedback in relation to virtual outpatient appointments. KG explained that there have been approximately 2000 people who have provided feedback and it has been overwhelmingly positive. The negative feedback is related to those people who live in areas with poor internet signal. KG noted that this feedback will be included in future patient experience reports.
- NM further asked how much of the feedback relates to the positives of virtual consultations due to Covid-19 rather than the overall convenience of not having to come into the Trust, i.e. once the prevalence of Covid-19 falls will people prefer face to face consultations. KG noted that a large number of people have highlighted the convenience of not having to find childcare cover, take time off work and find and pay for a parking space. This indicates that Covid-19 is not the fundamental reason for people preferring virtual appointments.
- PC referred to mitigating the digital inequalities that some patients face. KG explained that those who are unable are offered face to face or telephone appointments. There has been no feedback to PALS relating to exclusion by using a digital platform.
- EJ noted that during Covid-19 loneliness has increased and KG explained that feedback has indicated patients prefer video appointments to telephone due to the better interaction when you can see the person.
- EP reminded the Board that the team is in the process of reviewing clinics to see which could be virtual consultations by default. Individual preferences regarding appointments will still be taken into account.
- JDy noted that from a personal perspective the virtual consultations do provide flexibility. However, a concern to consider is the potential lost opportunity for safeguarding oversight for children. PM noted that safeguarding was discussed at the last CGC and each situation should be carefully reviewed in terms of context and the stage of the patient pathway.

KG left the meeting.

TB1 8/4/1.3 Welcome and Apologies

NM welcomed everyone to the meeting and noted that no apologies had been received.

TB1 8/4/1.4 Declarations of Conflicts of Interest

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

TB1 8/4/1.5 Minutes of the part 1 (public) Trust Board meeting held on 4th March 2021

NM presented the minutes which were agreed as an accurate record of the meeting held on 4th March 2021.

TB1 8/4/1.6 Matters Arising and Action Log

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

- **TB1 05/11/3.1 The People Plan** – It was agreed that this would be picked up in the IPR going forward. Item closed.
- **TB1 14/1/4.5, TB1 4/3/1.6, TB1 4/3/2.1 Maternity Ockenden Review** - The team is awaiting feedback from the regional/ national consideration of all Trust submissions.
- **TB1 14/1/5.1 Equality and Diversity Seminar** – This has been scheduled for August. Item closed.
- **Trust Management Committee** – The report on this month's agenda includes a lot more detail. Item closed.

All other matters arising were either on a future agenda or closed.

TB1 8/4/1.7 Chairman's Business

NM highlighted the following key points:

- The Trust is now looking to the future and starting to focus on various non-Covid-19 issues facing the organisation.
- The Trust currently has one Covid-19 occupied bed and with this reduction in prevalence of the pandemic, the organisation can start to plan for the year ahead and beyond.
- NM took the opportunity to highlight the fantastic job of all staff over the last 12 months.

TB1 8/4/1.8 Chief Executive's Report

SH presented the report and highlighted the following key points:

- In relation to the Trust's staff vaccination rate the overall rate for permanent staff is at 84%. The information provided is also broken down to provide visibility of the rates for BAME (Black, Asian, Minority and Ethnic) colleagues which does indicate lower uptake in some of those groups. Line managers are in the process of having 1:1 supportive conversations for those who have declined the vaccination to ensure they have had the opportunity to have the information required. Nationally, half of the people who have

these 1:1 discussions decide that they will have a vaccination and it is hoped this will be the case at Salisbury.

- SH referred to the recent press regarding the Astrazeneca vaccine and noted that for all vaccinations, for a vast majority of people, the benefits outweigh the risks. There is ongoing work and the guidance now states that those aged 29 years and under should be offered a different vaccination. Fiona Hyett, the vaccination team and Occupational Health are on hand to have conversations with those who do feel anxious about having the vaccine and it is the Board's view that the vaccine has had a positive impact, saving thousands of lives and reducing hospital admissions.
- There has been national planning guidance and the Board and leadership teams are now focusing on the reset on quality and experience for patients, financial recovery and a continued focus on health and wellbeing and ensuring staff are rested.
- There was an unannounced visit from the Care Quality Commission (CQC) on 30th March to the Trust's Maternity and Spinal departments. The Trust will await the formal report which will come to this meeting in due course. SH thanked colleagues in Spinal, Maternity and divisional management teams for their hard work.

TB1 8/4/2 ASSURANCE AND REPORTS OF COMMITTEES

TB1 8/4/2.1 Clinical Governance Committee – 30 March

EJ presented the report, providing a summary of escalation points from the meeting held on 30th March:

- The focus for this month's Covid-19 update was the potential quality impact of the work to recover and restart services.
- The Committee received a presentation from the Clinical Lead for Paediatrics to provide an update on progress since the last CQC inspection where the service was rated "requires improvement". EJ noted the improvements with no specific concerns apart from the provision of CAMHS (Children and Young People's Mental Health Services) which is a national issue.
- The draft quality account was presented and whilst this is now not a mandated document, the Committee agreed it was good practice to complete. The report outlined good progress made in priorities despite a challenging year and also highlighted areas where further work is required.

Discussion:

- NM noted that he had recently chaired the Children's Quality and Safety Board and the CAMHS issue and the impact on Sarum Ward was discussed. This is a national problem but it will be a challenge for a number of organisations. The Board discussed the impact on the ward

and PM suggested that the Clinical Strategy will have to be broader as there is a need to look at pathways in the context of the ICS (Integrated Care System).

- DB noted that CAHMS referrals have increased year on year and agreed with PM that this would need to be resolved in a broader context with an understanding of the mental health long term plan.
- SH noted that she would raise the issue of a leadership gap in relation to paediatric care at ICS level at the next BSW Executive meeting.
- JDy explained that managing mental health appropriately required a wide variety of people who need to work together. There is also a requirement to look at education and services available to be able to move forward and change approach.
- AH explained that there is a weekly sit-rep of the patients on the paediatric ward as CAMHS covers a wide variety of patients. This data will inform improvements in patient pathways.
- RA agreed with JDy and explained that there is a lack of services and Covid-19 has impacted on people's mental health. There is no coherent pathway for people and parents and there is a lack of process and system. EJ explained that this had been discussed at CGC and paediatricians are working with specialist services ensuring a child's stay in acute care is therapeutic, which is a positive development. EJ noted that as a system there is a responsibility to drive demand for equitable provision to this area.

TB1 8/4/2.2 Finance and Performance Committee – 30 March

P Miller provided a summary of escalation points from the Finance and Performance Committee held on 30th March:

- The key challenge is increased waiting lists in key areas across the organisation. The positive is that the challenges are well known and the organisation is clear on what is required. It is clear from national guidance that it is of great importance that the Trust recovers its operational performance during 2021/22 back to pre-Covid levels.
- The Committee supported the approval of three contracts which are on the private Board agenda for final ratification.

TB1 8/4/2.3 Trust Management Committee – 31 March

SH provided a summary of escalation points from the Trust Management Committee held on 31st March:

- For the first two meetings of the year TMC had reduced the scope of the meeting due to Covid-19 and operational pressures. This was the first full meeting of 2021.
- The Interim Head of Midwifery bought a review of midwifery

workforce which responds to a number of pieces of work which have been ongoing. This included the structure of leadership roles with the business case requesting £500k additional funding. TMC supported the business case but questioned the consultant midwife post because in the time available there had not been time to explore the benefits and added value. This will come back to the Committee once further work has been done. This is a fundamental milestone in the ongoing work in Maternity.

Discussion

- PM noted that further to the feedback from the last Board meeting the report is very helpful and provides insight into what was discussed at TMC. PM referred to the midwifery review and asked if it went through the normal governance processes and if it reviewed the impact on the working lives of existing staff. SH explained that these changes will not impact on those existing roles. What will change is the opportunity for career development and restructure in the department. Any impactful change will be reviewed at Board level.
- SY supported Stacey's comments on the maternity review and NM took the opportunity to welcome SY to the Trust Board.
- The Board discussed staff feeling represented at a higher level and that there has been little guidance about the role of a consultant midwife. RA suggested the executive think about what it wants its workforce to look like in the future and how staff want to feel about their value within the hospital.
- PC agreed that it is important when people do feel like they are not represented. The Board and leadership teams need to help medical and non-medical staff groups to show that what was formerly a hierarchical structure has changed.
- JDy noted that how the Trust works across the ICS will influence the development of opportunities within maternity.
- EP explained that a BSW Academy paper had been added to the papers for information. This has been to all Board Committees and was for noting. A further update will come to the Board. The paper was noted.

TB1 8/4/2.4 People and Culture Committee – 25 March

NM provided a summary of escalation points from the People and Culture Committee held on 25th March:

- The Committee agreed the People and Culture Terms of Reference.
- Best Place to Work has been progressing throughout the pandemic and the rolling programme of events for phase 2 commences this month. NM noted that the Board will be involved to review opportunities and challenges going forward.
- There has been considerable work on the People Plan

internally and a great focus on the Health and Wellbeing Board reviewing how the Trust's efforts meet the needs of staff.
- Work continues across all Divisions on hard to recruit posts; focus is currently on Radiographers, Consultant Histopathologists and Consultant Dermatologists.

Discussion:
- PM referred to the hard to fill posts and asked if they are not filled for a length of time what is the mitigation. PC explained that the Trust look to other staff groups to carry out some of these functions. SH stated that workforce planning in relation to the medical workforce does need to improve and SH has asked SY to ensure this is one of her priorities.

TB1 8/4/2.5 Audit Committee – 18 March

PK provided a summary of escalation points from the Audit Committee held on 18th March 2021.

- The Committee agreed its Terms of reference.
- The Executive presented a paper to the Committee to provide assurance and rationale behind the assumption of a going concern basis for the upcoming annual report. It is required that the Board consider and approve this matter for each reporting cycle. The paper demonstrated that the Trust was compliant with the government's interpretation of going concern as it relates to NHS Trusts, including the qualifications recommended to highlight the Trust's ongoing requirement for financial support.
- The Committee reviewed the BAF process and was content with the progress. The Committee discussed horizon scanning and the Committee concluded that the processes being used were appropriate for the Trust's needs.
- The draft opinion from the Head of Internal Audit was reviewed and in summary, during a difficult year the Trust has maintained a level of internal control. Good practice has been observed and there were one or two concerns which require further action.
- The Committee received final reports for four internal audit investigations. By far the most significant was the report into Key Financial Controls, within which there were two findings rated as high risk relating to control processes within Pharmacy. The Local Counter Fraud specialist noted that shortcomings on controls would be mitigated.
- In a private session at the end of the meeting, the Committee received a paper from LT recommending extension of the PWC contract by one year, as originally provided for in the tender process.

TB1 8/4/2.6 Charitable Funds Committee – 18 March

NM provided a summary of the escalation points from the meeting held on 18th March:

- The Committee received an update on the new governance arrangements, including the investment committee which proved to be working well.
- The Committee approved funding of £200k for the newly refurbished Maternity Unit.
- The Committee agreed the next steps would include a strategy workshop to ascertain the charities future direction and prioritisation of fundraising objectives.

Discussion:

- DB noted that as a member of the Committee the changes that have been made are positive and the committee will review the changes to process.

TB1 8/4/2.7 Integrated Performance Report

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

- February was a challenging month and performance in all areas was challenged. The next part of the recovery phase will be discussed in the private Board.
- There is an improving picture on pressure ulcers with reduction in level 3 and 4 pressure ulcers compared to the same period last year. JDy is working with the Tissue Viability Team and has also included an external review.
- HSMR is as expected up to Nov 2020 and there is a breakdown of Covid-19 associated deaths.
- Since February there has been an increase in referrals which is positive as patients are seeking medical support as required.
- ED attendances are back to pre-Covid levels. However the Trust is still experiencing a number of patients declining or changing appointments due to patient choice. AH took the opportunity to encourage patients to attend their appointments.

Discussion:

- PM referred to increased referrals and asked how the Trust would ensure there was no external pressure on the waiting lists. AH and SH explained that national intervention has meant that system working is better for the organisation and patients. SH noted that referrals from GP colleagues are of a level the Trust would expect to see.
- EJ welcomed benchmarking across the Acute Alliance and also noted the positive development in relation to children's dental work. EJ asked if there has there been any impact from ambulance handover delays. AH explained that ambulance delays always have an impact and should be kept to a minimum as a priority. There is now a clear

escalation process and delays over 30 mins require a root cause analysis (RCA). The challenge going forward will be those who present as Covid-19 positive but this is monitored very closely.

- TB referred to the data quality rating on the Cancer Week Wait Performance slide and asked how the Board should interpret that. AH explained that the data quality rating was in relation to the referrals coming in. AH noted that he would ensure there is an explanation going forward. **ACTION: AH** **AH**
- RA referred to ED attendance and asked what the system is doing about public education relating to ED attendances, the impact on ambulances and additionally how this triangulates to the middle grade rota gaps identified in People and Culture Committee. AH explained that the conversion rate from ED was currently high. However, the Trust is mirroring the national messages to only attend when necessary. The "Think 111" programme has been rolled out and there have been some positive effects. Ambulance conveyances are reviewed. Additionally, the walk-in centre in town is monitored to look at busy periods and review their activity. The middle grade rota will continue to be a challenge but Covid-19 has presented opportunity to look at boundaries which will help to manage demand across the region.
- SH explained that the ICS have not yet developed their emergency care strategy. SH noted that she was leading the urgent and emergency care Board for the ICS which will determine the strategy.
- MvB referred to the stranded and super stranded patient numbers and asked what was being done at system level to mitigate this and ensure these patients are where they should be for optimal care. AH explained that the Trust is working with colleagues internally and externally to improve this and actions to improve discharge processes have had positive results.

TB1 8/4/3 QUALITY AND RISK

TB1 8/4/3.1 Board Assurance Framework and Corporate Risk Register

FMc presented the Board Assurance Framework and Corporate Risk Register which had been reviewed at the Board Committees. FMc noted the following key points:

- A paragraph had been added relating to the outcome of discussions at Committees and risks that will be considered going forward. The key themes were mental health provision, particularly in relation to CAMHS, delays in recruitment to the Surgical Division Director of Operations role and Covid-19 Recovery and waiting list management.
- The Trust adopted the use of a risk radar tool provided by Internal Audit to inform the review of strategic risks and any potential gaps as part of the executive meeting discussion. The exercise was useful and identified a gap in risks

associated with stakeholder engagement, reputation and political and regulatory change. It is also acknowledged that the tool did not reflect population health and demographics

Discussion:

- EJ noted the excellent report and it's responsive. EJ referred to the NICU risk (6836) and explained that it could also reflect an opportunity to be able to deliver care within the Trust's remit.
- EJ referred to the risks relating to people and workforce and the need to triangulate the People Plan, Best Place to Work and the Staff Survey to address the feedback already received from staff.
- FMc explained that the newly revised corporate priorities will be included in the next report.

TB1 8/4/3.2 Patient Experience Report Q3

JDy presented the Q3 Patient Experience Report which had been to CGC and highlighted the following key points:

- Compliance with agreed response times are not as good as reported previously which is largely due to the pressure on clinical services due to Covid-19.
- The PALS team are currently advising complainants that the Covid-19 pandemic is causing a strain on services and that this is likely to delay response times.

Discussion:

- NM noted that as part of his weekly discussion with JM an issue was raised relating to communication on the wards. PALS should be part of the access point in those circumstances where relatives are unable to contact the patient on the ward. NM asked if there should be a re-emphasis that people struggling to contact their relatives on a ward should contact PALS. SH asked JDy to reiterate access via PALS if people are unable to see their relative/friend. **ACTION: JDy** **JDy**
- SH further requested that JDy bring back the position on visiting guidance when this work has developed. **ACTION: JDy** **JDy**
- MVB asked if the Trust had enabled video visiting. It was explained that PALS have enabled this service but there is further work to ensure the resource to do this is consistent.

TB1 8/4/3.3 Learning from Deaths Report

PC presented the report and thanked Claire Gorzanski and Belinda Cornforth for providing the report: PC noted the following key points:

- The Q3 report preceded the peak in Covid-19 in January and February this year and therefore the next report will indicate higher figures.

- Mortality remains within expected levels and weekend. HSMR still sits within the expected levels although there is ongoing work to review weekend provision.
- There is an increasing trend in deaths from sepsis and this will be a focus going forward.
- Further to feedback relating to issues of lack of explanation of learning the report has been updated to address this.
- There has been a shift in focus to the Medical Examiner role which was introduced in April 2020 to support bereaved families and drive improvements in the investigation and reporting of deaths.

Discussion:

- DB thanked the team for the helpful report and acknowledged that hospital acquired infection will occur due to the high transmissibility which the report provides clarity on. DB referred to the first wave and asked how Duty of Candour has been addressed. PC explained that all deaths from Covid-19 either probable or definite were managed the same. The reports have been completed and shared with families which offer a telephone call and meeting if required. PC noted the Trust was mentioned in a national newspaper and the message from the family was balanced and transparency was welcomed.
- TB asked how we satisfy ourselves that these reviews are produced in a consistent way. PC explained that the right diversity of opinion is required and there is a viewpoint from medical staff, quality governance staff, nurses and AHPS and a quality assurance process which is robust. TB suggested that there could be an opportunity across system working for increased governance and quality assurance.
- TB further queried if still births go through a process of review if they are avoidable. PC explained that still births are reviewed separately but this is an omission and this will be incorporated going forward. **ACTION: PC** JDy explained that there is a process in place and still births are reported into a central reporting system. **PC**
- EJ acknowledged the improvements over the last year but suggested further work is required in understanding the learning from deaths of those patients with learning disabilities. EJ highlighted that there is a notable appreciation from relatives where the medical examiner had made direct contact.
- EJ flagged learning in relation to the hip fracture review and a focus on deaths and the changes to practice which will help improve levels of mortality.

TB1 8/4/4 FINANACIAL AND OPERATIONAL PERFORMANCE

TB1 8/4/4.1 Standing Financial Instructions (SFIs)

LT presented the report which asked the Board to accept the proposed amendments to the Trust's SFIs, including changes to delegated limits set out to update the text to accurately reflect the

current decision structure of the organisation. Additionally, it is recommended that full and final approval of the capital plan at Board is removed and individual capital programmes are subject to the same delegated limits as in year amendments to the capital plan.

Discussion:

- SY noted a typo in section 9 of the SFIs which would be amended.
- PK noted that the Audit Committee were content with the changes to the SFIs

Decision:
The Board approved the suggested changes to the SFIs.

PK separately suggested that the Trust Board revisit delegation of authority to the Finance and Performance (F&P) Committee. PK suggested that contract awards and renewals which go through robust process should fall within the remit of F&P with any issues escalated to Board as appropriate. PM agreed and LT noted she would review the scheme of delegation and come back with proposed limits. **ACTION: LT** **LT**

FMc noted the impact on the F&P terms of reference which will be aligned with the new delegated limits once they have been approved.

TB1 8/4/5 PEOPLE AND CULTURE

TB1 8/4/5.1 National Staff Survey Results

SY presented the report which had been prepared by L Lane. SY thanked the 2062 members of staff who completed the questionnaire and highlighted the following key points:

- The report provided a high level summary of how the Trust benchmarked against other Trusts. The Trust scored 52nd out of 129 Trusts.
- SY explained that it was important to note that the survey was completed prior to the heightened pressure on staff during January and February this year.
- The report details how the Trust performed within each theme and the team is working on the thematic responses and further work to delve into the detail is required.
- What is clear is that the health and well-being of staff is a focus.
- The business partners are working with divisions on actions in their areas.

Discussion:

- EJ suggested exploring why the Trust is below the national average in relation to staff believing there is a safety culture. PC explained that what is absent is the communication of the Quality and Safety work undertaken by the Trust. A

number of staff do not know the work achieved within the Quality directorate.

- SH referred to the scores and the disappointing outcome in relation to EDI and noted that there is an opportunity to discuss at a Board seminar later in the year. The Trust need to take action to do better for its staff.
- PM noted that the Trust aspires to be outstanding therefore staff need to believe they are providing outstanding care.
- NM reiterated the importance of the staff survey but also suggested it should be reviewed in relation to what would be the best for patients. NM asked how further review of the detail will come back. SY explained that the People and Culture Committee will review the detail and the changes that are made as a result.
- SH referred to the Quality Improvement (QI) work that had begun with KPMG and explained that it would be useful for the Board to think about how this work will be branded and communicated to staff.
- RA suggested there should be a balance of the best place to work for colleagues vs the best place for care. Staff surveys are a snapshot in time and should always be linked back to learning.

TB1 8/4/6 GOVERNANCE

TB1 8/4/6.1 Annual Review of Directors Interests/Annual Review Fit and Proper Persons Test

FMc presented the report and explained that as part of the Trust's licence agreement it is expected to publish the annual Register of Directors' interests to the Board.

- FMc noted that the Senior Independent Director (SID) had reviewed any positive declaration and no concerns had been raised.
- There is also a requirement for all executive and non-executive directors to complete an annual form of declaration confirming they continue to be fit and proper. This has been completed and no concerns have been raised.
- The Corporate Governance Department further collate and monitor a definitive list of all band 8d and above or equivalent staff required to complete an annual Conflict of Interest Declaration. These are monitored and recorded by the Corporate Governance team. The process of collating these declarations is currently under review due to the low return rate in 2020 and a new process will be in place by 2022 as agreed by the executive team.

Discussion:

- It was noted that PC and Peter Holloway were not on the published version in the meeting papers but would be included on the final version to be published on the Trust's website.

TB1 8/4/6.2 Integrated Governance Framework (IGF)

FMc presented the report which asked the Board to approve the revised IGF and the Board Committee's Terms of Reference. The following key changes were highlighted:

- Executive director titles have been updated in the document as this change comes into effect from 1st April 2021.
- The revised corporate priorities have been included for 2021/22.
- Section 8, has been updated to reflect the Trust's work as part of the Bath & North East Somerset, Swindon and Wiltshire (BSW) Integrated Care System (ICS) and Acute Hospital Alliance (AHA).
- The most recent version of Appendix 3 Trust Organisation Committee Assurance Map has been added.
- All Board Committee Terms of Reference have been to their respective Committee's and have been reviewed, updated and recommended for approval.

Discussion:

- FMc noted that further to a conversation with SY prior to the meeting appendix 2 had been updated as 'Chief Medical Officer' had been omitted in error.

Decision:

- The Board approved the revised Integrated Governance Framework, including the Board Committee Terms of Reference.

TB1 8/4/6.3 Accountability Framework

AH presented the report which asked the Board to approve the changes following the annual review of the Trust's Accountability Framework.

- There is now a consistent approach to divisions and divisional management which has transitioned from directorates over the last year.
- An additional section has been added on the Trust's recently agreed Programme Management Approach, which sets out how the Trust manages its change programmes.

Decision:

- The Board approved the changes to the Trust's Accountability Framework and it was noted the finalised version would be published on the Trust's intranet.

TB1 8/4/6.4 EPPR Compliance Statement

AH noted that the EPPR compliance statement was not required this year. He assured the Trust Board that there had been a local inspection from the BSW Executive and there were improvements on last year. The Trust is fully compliant.

The Board noted this update.

TB1 8/4/6.5 Register of Seals

NM presented the report which asked the Board to note the entries to the Trust's Register of Seals, which whilst not formally authorised by resolution of the Trust Board, have been authorised through powers delegated by the Trust Board.

The Board noted the report entries in the Trust's Register of Seals since the last report to the Board in November 2020.

TB1 8/4/6.6 External Well Led Review

FMc presented the report which asked the Board to approve the deferral of an external Well-led assessment to 2022.

FMc explained the rationale behind the proposed deferral as detailed in the report

Discussion:

- PK noted he was content to defer but felt that the last two external reviews could have been improved in relation to planning and asked for this to be considered for the next one. FMc explained that she would ask her peers about their experiences with different providers and will ensure the tender specification is explicit in what is expected.
- PM noted his support to defer and suggested that further thought was required as to what a well-led organisation looks like as part of the ICS.
- EJ asked if this is different from CQC Well-led review. FMc explained that as a Foundation Trust the hospital is expected to undertake an objective external review against the CQC well-led framework.

Decision:
The Board agreed to defer the external well-led review to 2022.

TB1 8/4/7 CLOSING BUSINESS

TB1 8/4/7.1 Agreement of Principle Actions and Items for Escalation

N Marsden noted that from the discussions during the meeting the Trust Board and leadership teams were focussed on planning ahead and refocusing concerns on non-Covid-19 related issues.

TB1 8/4/7.2 Any Other Business

There was no other business.

TB1 8/4/7.3 Public Questions

JM explained a situation, which had been discussed as part of the Patient Experience Report, relating to a patient's relative who had great difficulty getting in contact with them whilst they were an

inpatient. JM highlighted the importance of PALS in this situation and asked if the recorded message on ward phones could be changed to direct people to PALS. SH explained that with limited staff in PALS this would pass on the issue. SH explained that now the prevalence of Covid-19 on the wards has lessened there should be more staff available to answer ward phones but noted that different options could be considered.

JM noted his disappointment in the staff uptake of vaccine. JM asked what will be done to protect patients as the mortality of hospital acquired Covid-19 is high. SH noted that the Trust can only encourage and support staff to have a vaccination. Additionally, there are robust IPC measures in place which the Trust expects to remain in place for some time. JDy also noted that all staff are required to take a bi-weekly lateral flow test.

JM referred to the mortality report and noted that whilst it has improved he still felt this was open to misinterpretation. PC assured JM that he is looking into this.

There was a further query relating to the configuration of the Emergency Department (ED) and Outpatients. AH explained that the work to increase the size of ED is complete. There is further building work behind the Spinal Unit to provide more outpatient space.

TB1 8/4/7.4 Date of Next Public Meeting

Thursday 6th May 2021, Board Room, Salisbury NHS Foundation Trust

TB1 8/4/6 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).

Public Trust Board Action log

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

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
TB1 14/1/4.5/ TB1 4/3/1.6 TB1 4/3/2.1	**Maternity Ockenden Review -** TB and SH asked for future maternity reports to include more specific actions in relation to the Trust's response to the Ockenden Review.	**JDy**	No date confirmed	The team is awaiting feedback from the regional/ national consideration of all Trust submissions. Further updates will come back to CGC and Trust Board in due course.	N	4
TB1 8/4/3.2	**Patient Experience Report / Visiting Guidance -** 1) SH asked JDy to reiterate access via PALS if people are unable to see their relative/friend. 2) SH further requested that JDy bring back the position on visiting guidance when this work has developed.	**JDy**	01/07/2021		N	4
TB1 8/4/3.3	**Learning from Deaths Report** - Information relating to the learning from still births to be incorporated into the Learning from Deaths report.	**JDy**	01/07/2021		N	4
TB1 8/4/4.1	**Standing Financial Instructions (SFIs) -** LT to review the delegation of authority for F&P Committee and come back with proposed limits (Note -the F&P Terms of Reference will then be updated to reflect this once approved).	**LT**	06/05/2021	Discussed at F&P - LT working on this.	N	2
TB1 8/4/2.7	**Integrated Performance Report/ Data Quality -** AH to provide further narrative when data quality in the IPR is rated Amber/Red	**AH**	06/05/2021		N	2

Report to:	Trust Board (Public)	Agenda item:	1.8
Date of Meeting:	May 6 2021		

Report Title:	Chief Executive's Report			
Status:	Information	Discussion	Assurance	Approval
	X	**X**		
Prepared by:	Stacey Hunter and Gavin Thomas, Executive Services Manager			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive			
Appendices (list if applicable):	N/A			

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

Executive Summary:
The purpose of the Chief Executive's report is to highlight developments that are of strategic relevance to the Trust and which the Board of Directors needs to be aware of. This report covers the period since the board meeting on the 8th April 2021.

1. National and ICS Updates

As Board members will be aware the focus for the NHS nationally and the South West region is mirroring our local priorities and is centred on:

a) Continuation of the national vaccination programme which is progressing well with circa 40 million adults having received a vaccination of which 13.2 million adults have received both doses. The Department of Health and Social Care is currently inviting people aged 42 and over to get the jab. Our large vaccination centre at City Hall is supporting the national response and receiving excellent feedback from people who attend for this site for their vaccination. Our Medical Director is the executive with responsibility for this programme of work and I know he will want to join me in thanking our local communities for taking up their vaccinations and our team at City Hall who is delivering this service.

b) Operational plans for 21/22. The first draft of our organisation and ICS plan is due to be submitted in early May as per the timetable set out and shared with the Board at our April meeting. I would like to thank and acknowledge the leadership that Kieran Humphries is providing in coordinating this for the Trust but also for stepping up and doing this across the ICS. I attend a meeting with other BSW CEOs and the regional team to discuss our progress on the 23rd April 2021. This highlighted to opportunities to share innovation across the ICS's in the South- West as well as our specific areas of concern which need further work and focus. From a Trust perspective Board colleagues will be aware we need to address our gaps in theatre staffing as a priority to enable more Priority 3 and 4 activities to be delivered.

c) Our local place based work with Wiltshire Integrated Care Alliance (ICA) is being supported by Executive colleagues and other senior leaders from the Trust. The activities are focused in a development programme which will cover the following areas with partners over the coming months :

   a. Purpose: core functions of our ICA and the value proposition
   b. Agreed membership of the ICA including organisational sign-up and alignment as a place-based partner
   c. ICA operating model: processes, decision making and governance, structure, culture and values, engagement
   d. Leadership of place-based partnership (type, roles, styles, behaviours)
   e. Resource requirements and infrastructure
   f. Relationship between our ICA and a) ICS structures, b) existing partnerships, and c) organisational governance structures
   g. Formation of provider collaborative
   h. Changing role and function of the CCG

As discussed at our recent Board strategy session this work is a priority for us in respect of how the ICA can support the integration and transformation of services that require different providers of health and care to deliver collectively. The outputs of the above work will be overseen by the BSW ICS Partnership Board which myself and the Chair are members of.

2. COVID Update and resetting of services

As a result of a continued reduction in cases and in line with national guidance, the hospital was pleased to be able partially lifted its visitor restrictions in April. Patients are now able to have a daily visitor for one hour, but must book to visit at least a day in advance. There are some exceptions to the one visitor only rule, for example the Children's Ward and Neonatal Intensive Care Unit, vulnerable adults and patients nearing the end of life.

The Trust, along with system partners, is focused on restarting services and tackling the backlog faced as a result of COVID-19.

Our Divisional Management teams have restarted elective services aligned with the initial plans shared with the Board in April. These plans continue to prioritise those patients who need their treatment more urgently aligned with the national classification of Priority 1 and 2 appointments and procedures, as well as restarting some of the less clinically urgent activities classified as Priority 3 and 4. This is a challenge given we must still observe social distancing and Infection Prevention and Control measures, which impacts capacity in outpatient and inpatient pathways. I recognise that some of our patients are experiencing prolonged waiting times as a direct consequence of the pandemic and I would like to reassure them and our local communities that we are working really hard and following all of the relevant national guidance to be able to respond to this as quickly as we are able too.

The Board will be aware that the national 21/22 operational plan has set elective recovery thresholds for the first 6 months of the year which organisations and systems will be measured against. At the time of writing this report the validated position for our performance during April against these thresholds isn't available. I will be able to provide a verbal update at our Board meeting which will include our position relative to the other Acute Providers in our ICS.

We are cognisant that we must take every opportunity to be innovative and transformative in responding to the challenges patients are facing in respect of long waiting times rather than relying on the way we have always done things. Throughout the pandemic our clinical and operational teams have made impressive and rapid changes to the way care is offered and we need to build on this success where we can safely change the way we plan and deliver care to patients. Now really is the time for thinking differently and testing new ways of working and we're encouraging teams to do this.

We are in the process of making changes to our Integrated Performance Reports so we can ensure that the Board has visibility of our progress against our recovery of our elective activity and our performance against the elective recovery milestones as set out in the Operational Plan on an on-going basis.

Alongside our activity and performance reset , I noted in my April Board report that it was important we also redoubled our efforts on the improvements we want to deliver across our quality , safety and experience key performance indicators . The detail of this is shared via our IPR and discussed in detail at our Clinical Governance Board sub-committee. There are some early signs of improvement with a reduction in the numbers of patients acquiring Grade 2 pressure ulcers in hospital during March 2021 and no incidences of Grade 3 or 4 pressure ulcers. The Chief Nurse has set out further work and ambition for pressure area prevention and care to ensure we prioritise the actions needed to sustain the improvements.

The hospital hub COVID-19 vaccination site closed mid-April after successfully delivering over 13,000 vaccinations to staff, health and social care workers and extremely vulnerable patients. A big thank you to the team of staff and volunteers who did a truly amazing job mobilising and running this centre so efficiently and at such pace.

3. Unannounced CQC Inspections

On 31st March the Care Quality Commission (CQC) carried out an unannounced focused inspection of our Spinal Injuries Unit and our Maternity Services.

The CQC spent the day with colleagues observing how these teams are working and undertook 1-1 discussions with key personnel and spoke with staff and patients. They also examined patient-related records and have requested further governance-related documents since their visit.

Whilst we haven't yet had formal feedback, some initial feedback was provided. They inspectors acknowledged how welcome they were made to feel and commented on the conduct, engagement and can-do approach of everyone they had contact with, which they described as 'exemplary'.

There were some areas for immediate attention within Maternity services highlighted to the team, some areas of concern in both services whereby the CQC have indicated they may seek further information and or want to see improvement. In lieu of having received their report and evidence appendices from this inspection at the time of writing this paper I attach a letter I received from them on the 9th April 2021 which summarises their initial feedback (Appendix 1 CQC letter)

The full report will be shared once received.

4. Workforce

In month, there continues to be a reduction in sickness to 3.18%. All 3 clinical divisions have reported anxiety/stress, gastro, infectious diseases and MSK in their top 4 reasons for sickness absence. While within the corporate division, the main reasons are nervous system disorders, injury/fracture, dental and oral and other MSK.

Staff turnover in month was below target at 9.73%, this compare to last month's position of 9.40%. In month there were 42 leavers and 45 starters. There has been a considerable increase in leavers compared to the previous month of 24.

Although we have had some really good successful outcomes with recruitment - i.e. Radiographers, Consultant Radiologists, Aseptic Manager and Lead Technician for Training posts, work continues across all Divisions on the difficult to recruit roles, with a continued focus on Consultant Dermatologists, Consultant Gastroenterologists and Theatre ODPs.

Paul Wood has commenced as the interim Director of Transformation as temporary replacement for Esther Provins for a period of 6 months.

The Chief People Officer recruitment process closes week commencing 26th April with the shortlisting panel and interview date confirmed. There has been a positive response at this stage of the process.

Mandatory and Statutory training remains slightly above target. Medicine remains just under target (89.37%) in month and has been proactively discussed at all Divisional meetings.

All Divisions are focusing on hand hygiene as it remains to be the only topic below target.
A MLE report has been shared with all departments in the Divisions with targeted emails being sent to individuals who are 6 months out of date on their MLE.

Two out of the three Clinical Divisions have made a slight improvement on the previous month for non-medical appraisals. This has been discussed at all Divisional meetings.

Medical appraisals remain under target, but with a slight increase on month for Surgery. Plans continue to be in place for continued improvement.
Surgery is tasking service managers to set SMART goals for a trajectory to get their compliance back on track.

There are 5 outstanding actions in relation to the People Plan, with plans in place for these to be completed over the coming weeks. Proposals are in place to review the People Plan in line with the National Planning Guidance, with a focus on a refresh and reflection on progress made. A draft People Plan on a page has been developed and will be discussed at the People & Culture Committee on the 29th April, with a revised action plan taking into account the NHS Operational Planning Guidance at the June committee.

5. Finance

The Trust has now reached the end of the 2020/21 financial year, reporting a financial balanced position (subject to the annual audit). It has been a year like no other in which significant additional funding for both day to day operations and capital investment has been received in order the aid us in our response to the Covid-19 pandemic. Despite the pandemic, the Trust has made significant headway on a number of capital projects including: a physical redesign of the emergency care pathway; critical infrastructure improvements; a new cardiac catheter lab; and investment in clinical systems such as electronic prescribing and pathology lab systems. A number of these projects will be continuing into 2021/22.

2021/22 will see the continuation of the vaccination programme, operated by the Trust out of Salisbury City Hall, as well as a significant focus on the recovery of planned care pathways where the Trust is seeking to maximise the use of the announced 'Elective Recovery Fund' for the benefit of our population.

6. KMPG Operational Excellence Programme

As part of our joint working with BSW system hospital partners, we have commenced an Operational Excellence development programme in partnership with KPMG.

This exciting development programme aims are to help us;

- Develop Future Trust Strategy and new ways of working building on the work we have undertaken to date ;
- Develop our culture of continuous improvement for all our staff teams to engage in and take forward
- Develop our internal capability and capacity to sustain a continuous improvement and operational excellence approach working together with our BSW hospital and other partner organisations

I have agreed to be the SRO and will be supported by KPMG and The Trust transformation and OD team working together. The Board will have an opportunity later today to discuss the first stage of the work which is an operational readiness assessment with our colleagues from KMPG.

Regular updates will be provided on this programme journey and resultant changes that we will embark upon as an organisation in improving the effectiveness of how we work and our services for local population

7. News

Lloyd's pharmacy opening

I was delighted to officially open the new Lloyds pharmacy on the hospital site.

Lloyds is now dispensing outpatient prescriptions for the Trust, with a new outpatient prescription service provided to clinics. The new pharmacy is also available to visitors and staff for a range of pharmacy retail items and over the counter medicines.

All other medicines used within the hospital, including for inpatients and any other pharmacy related service will continue to be available from the Trust hospital pharmacy.
The partnership with Lloyds allows us to provide a convenient service to those being treated in outpatient clinics, as well as visitors and staff, while the Trust's pharmacy focuses on inpatients and vital services.

COVID-19 and Gum Disease

Dr Graham Lloyd-Jones, Consultant Radiologist (pictured below), working with international researchers, has developed a theory that gum disease could be the main risk factor for developing severe COVID-19.

The scientific hypothesis highlights the importance of good oral hygiene during illness with COVID-19. It explains that the virus is found in saliva and that the first step the virus takes on its way to the lungs could be through damaged gums. It would then enter the bloodstream and pass into the blood vessels of the nec and chest, through the heart, and to the lung blood vessels. Dr Lloyd- Jones explained, "The risk factors fo severe COVID-19 and gum disease are the same. It could be that gun disease is converging and principal risk factor for severe COVID-19. You can read the Salisbury Journal article about the research report here

Stacey Hunter
Chief Executive
April 2021

CQC HSCA Compliance
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Stacey Hunter
Chief Executive Officer
Salisbury NHS Foundation Trust
Odstock Road
Salisbury
Wiltshire
SP2 8BJ

Sent via email to stacey.hunter7@nhs.net

9th April 2021

CQC Reference Number: INS2-10392358831.

Dear Stacey

Re: Focussed inspection of the maternity and spinal departments – Salisbury District Hospital - 31st March 2021

Following the inspection of the maternity and spinal departments, undertaken on 31st March 2021, I wanted to take this opportunity to confirm in writing, the verbal feedback given at the end of the inspection.

Before I do so, I would like to make clear how welcome we were made to feel and by all the people involved in make the inspections happen at Salisbury hospital. In the current climate, we do not underestimate the impact our presence has on staff. The conduct, engagement and "can-do" approach of everyone we came into contact with was exemplary. Please pass on our thanks once again to all involved.

This letter does not replace the report we will send to you, but simply confirms what we fed-back on 31 March 2021 and during our conversations on 1st and 9th April and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence appendix, this correspondence should be used to inform discussions with the board.

We decided to inspect the departments for two main reasons. Firstly, we felt that there were issues relating to both services that we could not gain assurance from by remote means. Coupled with that was information that caused us to be concerned with regards the domains of safety and leadership. For these reasons those domains formed the basis of this inspection, hence it's focussed nature.

Maternity Core Service

During the inspection we noted the following good practice:

- Multidisciplinary PROMPT training was being delivered virtually and there was a strong focus on ensuring staff completed this training after in-person training sessions had been paused due to the pandemic.
- The assessment forms in the day assessment unit were clear and well-structured.
- Junior doctors we spoke with were positive about risk management and escalation processes.

Following the on-site inspection activities, we escalated the following safety concerns to the maternity leadership team:

- Staff were not aware of guidelines on cleaning of the birthing pool and told us they used disinfecting wipes and a household cleaning product to clean the pool.
- Staff could not access a policy for the evacuation of the birthing pool and the instructions for evacuation of the birthing pool was not displayed.
- Checks on emergency resuscitation equipment were not always completed on labour ward.

We escalated our concerns with the leadership and governance structure within maternity services in terms of the triumvirate and organisation of the clinical division. The medical director acknowledged these were known issues. The interim head of midwifery and consultant lead were capable individuals who were well thought of but more support was needed from the executive team and trust board to improve the service.

Maternity Data requested on 31/03/2021

- Current maternity dashboard
- Current maternity risk register
- Maternity governance meeting minutes (last three)
- Results of recent maternity staff surveys and actions
- Minutes from HSIB round table (last three)

Further information needed to request to support our judgements:

- Maternity Workforce Review February 2021 (paper copy received on site) – digital copy and confirmation of approval of business case and which option is being taken forward needed
- Last three MOEWS audits and action plans
- WHO audits for obstetric theatres including action plans (last three)
- Guideline for evacuation of the birth pool
- Guideline for cleaning of the birth pool
- Data on delays to induction of labour (percentage of delays compared to all inductions of labour) (last three months)
- Appraisal rates for midwifery and obstetrics staff (current)

- Percentage of midwives who have had a yearly meeting with a Professional Midwifery Advocate (current)
- Maternity vision and strategy including mental health strategy (current)
- Copies of perinatal mortality meetings (last three)
- Minutes of Maternity improvement board meetings (last three)
- Most up to date version of maternity improvement action plan
- Copy of last three ward to board reports for maternity
- Team meeting minutes (last three for maternity unit and community)
- Maternity and Neonatal newsletter (last three)
- Lone-worker policy for community staff (current)

Spinal Core Service

During the inspection we also found the following good practice:

- Staff demonstrated pride in their work. They felt part of a team and were passionate about working with people who had experienced spinal cord injury.
- Staff we spoke with told us they felt comfortable raising concerns and there had been an improvement in the safety culture of the unit.

Following the on-site inspection activities, we escalated the following safety concerns to the leadership team:

- We found a fire door which was not alarmed and could provide access both from and into the unit which prevented a safety risk.
- We found an out of date enteral feeding tube connector which had an expiry date of December 2019 and an out of date blood specimen sample kit.
- We reviewed 12 patient records and found around 70% of them were incomplete or inconsistent. We were informed risk assessments were completed but kept elsewhere. This was not clear from the records we viewed.
- The environment was cluttered and there were access issues in the dining room due to this.
- Staff told us they had escalated staffing issues but were not clear on what action had been taken in response to this by the division.
- Recent changes to the divisional structure were still being embedded.

Further information needed to request to support our judgements:

- VTE audit and action plan
- Falls audit and action plan
- Pressure ulcer audit and action plan
- Call bell data – audit and action plan
- Acuity tool used for establishing levels of staffing required for nursing and therapy
- Staffing numbers for nursing staff and therapy staff compared to staff required.
- Staffing numbers for training grade Dr and numbers required.
- Ward to board report from spinal service.
- Spinal risk register

- Divisional risk register
- Outcome measures data for therapy services.
- ASIA and SCIM audits and plans for action.
- Action plan in response to Quality Surveillance Programme.
- Documentation audit results and action plans
- Department strategy and vision for service.

In respect of our requests for additional information we would like these documents to be returned to us by midday on Wednesday 14th April. Please send this information to HSCAfurtherinformation@cqc.org.uk quoting CQC Reference Number: INS2-10392358831.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to NHS Improvement.

As per our discussion today it would be helpful to have a call with Suzzane Cunningham and we await her availability in order to arrange this.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

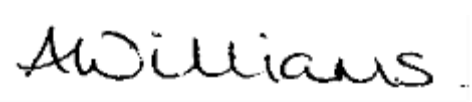
If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours Sincerely



Amanda Williams
Head of Hospital Inspection

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	6th May 2021		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	27th April 2021
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Miss Eiri Jones, Chair CGC			
Board Sponsor (presenting):	Miss Eiri Jones, Chair CGC			

Recommendation

Trust Board members are asked to note the items escalated from the Clinical Governance Committee (CGC) meeting held on the 27th April 2021. The report both provides assurance and identifies areas where further assurance was sought and is required.

Key Items for Escalation

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - The meeting focus was firmly on returning to gaining assurance from business as usual, noting the small numbers of Covid-19 patients in the Trust.
  - The Covid-19 update focussed on one outbreak where the route of transmission could not be identified. It was also noted positively that the vaccine programme continued to deliver well.
  - The transformation update focussed on building on what is already in place and realigning the programme in the coming months to provide support to the operational services on their restart priorities. From a QI perspective, the team plan to work with the KPMG team. Further work will be undertaken to review and confirm any quality impact risks in relation to the transformation programme.
  - A detailed presentation was given by the Stroke services team. The presentation commenced by outlining the impact that Covid-19 had on the service, in particular the impact on performance by the necessary relocation of the service. Assurance was provided in relation to reset of the service. Further discussion related to the small size of the service and how it works with its current partners. A key challenge is the need to improve access to the thrombectomy service to achieve 24/7 and 7/7 services and a timeline is required for this. Technology improvements are needed and work has restarted to enable remote input. The team were asked about partnership working across the Acute Alliance and they confirmed that discussions were happening. Tertiary care is provided from Southampton with weekend support from Bournemouth and Poole. It was noted that whilst the SNNAP rating had been at B pre Covid-19, the team felt they were close to achieving an A rating and were focussed on achieving this for patients. Patient feedback is generally good in relation to the service.

- As had occurred at the F&P committee in relation to performance metrics, a detailed discussion around the quality metrics in the IPR was held. Recognising the changes over the past 12 months, future reports over time will include a focus on outcomes and having upward assurance from the Divisions and other services. It was noted that 3 key areas, stroke, pressure ulcers and falls all had a detailed discussion on this month's CGC agenda.
- A falls update was provided to the committee, building on the previous plan presented last year. It is positive to note that there has been a 46% reduction in high harm falls with fractures over the past 5 years. However, the population demographic indicates that falls will continue to occur in the community. Therefore, a more strategic approach is being implemented using national evidence and tools and in discussion across the acute alliance and BSW. The approach will also be embedded in a change programme linked to the quality priorities.
- A dementia service update was also presented as a follow up to last year's presentation. It was noted that some increase in resource has been identified and that improvements have been made despite the challenge of Covid-19. These include a weekly dementia meeting. Additional nursing and medical posts have been identified to ensure that there is wider coverage of the service and support to front line staff.
- A pressure ulcer update was provided to the committee. In addition to a focus on improving the quality of care in this area, the team have sought external expert advice to ensure that all that can be done is being implemented in a timely way. As with falls, it is positive to note that there has been a 52% reduction in the last 5 years for grade 3 and 4 pressure ulcers. There has been a 39.5% increase in grade 2 pressure ulcers (a national picture) with some of the ones occurring in the last year being due to Covid-19. These were associated with medical devices and patient acuity alongside the necessity to deliver care in different ways. Again, the improvement plan is linked to the Trust quality priorities.
- The upward report from CMB was noted as providing good information and assurance to the committee. The CMO outlined the importance of triangulating this information with other available data, something the committee has a focus on. The plan to invite services to present to the committee will continue through this coming year and will focus on current quality priorities.
- Whilst there was no specific agenda item in relation to maternity this month, the recent CQC visit was discussed. The final report is still awaited. The ongoing focus on maternity improvement was noted and the safety champion roles will be discussed at the Board meeting. The next Maternity Improvement update is on the May CGC agenda.

In summary, there was a strong focus on assurance in relation to resetting and restarting in this month's CGC.

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.2
Date of Meeting:			

Committee Name:	Finance and Performance		**Committee Meeting Date:**	27th April 2021
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Paul Miller, Non Executive Director			
Board Sponsor (presenting):	Paul Miller, Non Executive Director			

Recommendation
To note key aspects of the Finance and Performance (F&P) Committee meeting of the 27th April 2021

Items for Escalation to Board
(1) Shared Electronic Patient Record (EPR) Outline Business Case (OBC) – The Committee received and reviewed a very long outline business case (104 pages) which followed the 5 case business case methodology. Whilst the Committee are ultimately recommending this OBC for approval at the Trust Board meeting on the 6th May 2021, the following issues were highlighted and I have structured these comments around the 5 cases for ease of reference; ***Strategic case*** – no issues and the Committee fully accept the need to change systems ***Economic case*** – the Committee accepted option 2 (a single shared EPR platform across all three providers. However it should be noted that 6 of the 8 critical success factors (CSF) on page 59 are arguably directly dependent on some level of "standardization" within the final EPR solution. Particularly CSF 1 – support horizontal integration of services/care, CSF 5 – support multi-site service and CSF 8 – support the workforce (greater flexibility for the workforce to be deployed between the 3 acute trust sites. ***Commercial case*** – The OBC does not recommend a clear procurement route (page 20) instead it says "*a decision about the proposed best route for procurement will be taken by the acute trusts, post OBC-approval and a Procurement Strategy developed to support this activity"*. Whilst the OBC does not recommend a particular procurement route it does say that a successful one can be chosen. As an update since the April F&P Committee, I have

been informed an EPR procurement strategy has now been produced and will go to the EPR Project Board on the 17th May 2021 for approval, which is good to know, but ideally this procurement recommendation could have been contained within this OBC given closeness of the respective meetings and the fact that the procurement will run parallel with the production of the Full Business Case (FBC) i.e. the Trust Board will not have a say on the decision of the chosen procurement route.

However the commercial case raises three concerns (a) on page 69 it is recommended that the final EPR solution needs to have the ability to operate a **multi-tenant architecture** across all 3 separate trusts. This issue was discussed at the Committee and whilst it was accepted that this way forward was technically possible it could be very expensive to implement and run if not tightly controlled (b) if the end result of a divergent implementation resulted in 3 significantly different EPR solutions, then it could compromise the decision to have a single EPR in the first place (note the comment about CSF's being dependent on standardization above) and (c) on page 71 the OBC states that BSW is in a unique situation "*whilst the successful procurement of a new EPR system for more than one acute trust has been achieved in the past, the situation in BSW is the first instance of three separate acute trusts entering into a joint procurement for a shared EPR system. This means that there are likely to be governance and commercial issues to be overcome in setting up contracts……"*

Financial case – This case contained three financial elements (a) System costs - The OBC states that EPR system costs have been taken from pre-procurement market engagement conversations with potential vendors (pages 75 to 77) this seems reasonable and there appeared to be some high level consistency around these supplier costs, (b) Other costs – on page 76 there is a list of costs not quantified or included in the OBC e.g. data migration, system interfacing and back fill of clinical posts to support implementation etc. These costs are material and whilst they maybe difficult to quantify, an attempt should have been made to quantify these within this OBC as they will directly impact on affordability and (c) on pages 73 to 75 the OBC states that "*benefits have been quantified using an industry standard approach to potential benefit identification*", however the Committee could not find any background to provide assurance on the two 10 year vendor benefits presented (£91,400,254 and £167,474,007) even though they were presented to the nearest pound. Further the rationale of why there is a £76,073,753 difference in benefits between two acceptable EPR solutions (bottom of page 70) could not be explained either. In conclusion the Committee accepts that at OBC stage there can be a level of financial uncertainty and this is clearly the case in this OBC, therefore this financial uncertainty needs to be clearly and fully addressed when the Full Business Case (FBC) is presented to the Trust Board and no assurance can be taken at this stage about affordability.

Management case – The management case looks at how the preferred option will be delivered and the recommended project and change management arrangements appear to be reasonable on paper, though the real challenge is in actually delivering, particularly in a unique procurement where "*three separate acute trusts entering into a joint procurement for a shared EPR system"* (see above). That said one issue that did appear to be missing was the business as usual (BAU) arrangements to manage the EPR solution on a day to day basis once implemented. This is important because the benefits are stated over 10 years and therefore the arrangements for managing the BAU should be considered in the management case i.e. a single EPR IT support team, 2 or 3?

(2) Approval of contracts – one contract was presented to the Committee for support, prior to going to the Trust Board meeting on the 6th May 2021;

(a) Commercial software partner agreement

The recommendation to award a 3 year contract, covering the 3 Trusts in the Acute Hospital Alliance (AHA) was supported by the Committee.

(3) Maternity Workforce Business Case – A business case was presented to the Committee that sort support for an investment of circa £400k in the Trusts maternity leadership structure, to meet the recommendations cited in the external review of the maternity unit culture, workforce and safety and to ensure the delivery of the immediate and urgent actions cited within the Ockenden Report 2020. This investment is on top of an additional 5.2wte clinical maternity roles already agreed, to address the Trusts staffing requirements identified by the latest Birthrate Plus staffing review. The Committee noted that this business case had already been supported by the Trust Management Committee (TMC), with the exception of appointing a Consultant Midwife (though this Midwife Consultant decision will be revisited at a later date) and the Committee supported the outcome of the TMC business case discussion.

(4) Integrated Performance Report (including Covid-19 update) – There was a wide-ranging discussion about the rate of progress around recovering the operational performance of the Trust. The performance information highlights small improvements in certain areas, but not the change in performance hoped for. The Committee recognise that we are early in our journey of recovery, but we need to ensure that all things that can assist recovery are considered e.g. clinical leadership, management support, quality improvement and transformation support and training, as well as action plans, extra resources and performance management.

(5) Finance report as at 31st March 2021 – 2020/21 has been an extremely challenging and complicated year financially, despite this the Trust has reported a year end underspend of £78,000 (before audit), which is a significant improvement on the Trusts original 2020/21 operational plan deficit of £15.2m.

Going forward the NHS financial regime is uncertain, therefore the identification of the Trusts underlying deficit for 2021/22 and beyond is a challenge. That said for 2021/22 the Trust needs to financially operate as efficiently and as effectively as possible, within its existing cost base and ensure that as a minimum our performance meets the national NHS Operational Plan expectations.

(6) Transformation programme update – The Committee received a comprehensive update of where our current programme is, as staff return to their substantive roles post-covid. The next step, being undertaken by the Executive Team, is to review the various projects that make up the Trusts transformation programme and align these over the next 6 months to meet the operational and quality/safety needs of the Trust.

(7) Corporate Governance Statement (Provider license self-certification) – This was received and approved, with a minor change.

(8) Annual Review of Committee Effectiveness – This was received and approved.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	28 April 2021		

Report Title:	Trust Management Committee (TMC)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		X	
Prepared by:	Stacey Hunter & Gavin Thomas, Executive Services Manager			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive Officer			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the report outlining items raised at the Trust Management Committee meeting held on 28th April 2021.

Executive Summary:
The meeting of the Trust Management Committee was held on the 28th April 2021 This month's meeting reviewed some of the priorities we have asked the teams to focus on as we transition from managing the pandemic to restoring our business as usual activities. It is important to note that key performance indicators against the month 1 plan were not yet available for TMC to oversee. There we no business cases to be reviewed this month. TMC noted that the Executive Team have undertaken a process to review all expenditure that Divisions and or corporate services have identified as still being required to respond to COVID. The outputs of this review will agree where ongoing spend can continue to be supported otherwise the expectation is that it stops at the end of April 2021. This process is aligned to the requirements on us all to deliver a balanced position from a financial perspective within the allocations we have received for the first 6 months of this year. The performance against the 4 hour Emergency Care Standard has been challenged over the last 3-4 weeks with a number of days when it has been below 75%. The Medicine Divisional team recognise that it is a priority to improve this to ensure we are providing a better experience for those patients who are currently facing longer waiting times for their care in our ED. The Divisional team reported that our ED department has seen an increase in demand similar to that of pre COVID levels with a high conversion rate of admissions into hospital, which is consistent with the pattern the majority of EDs in the South West and across England are reporting. The clinical teams report that the combination of the increased number of attendances with a higher proportion of individuals who are more

acutely unwell is challenging them. The high conversation rate of people who need hospital admission has required escalation beds to opened putting pressure on bed occupancy and flow. The DMT were asked to provide a detailed plan of the internal improvement actions needed as well as the urgent and emergency care improvements that Wiltshire Integrated Care Alliance partners need to support.

The Medicine Division noted that the second new Cardiac Catheter Lab has been delivered which is excellent news for colleagues and patients and also that they have established a triumvirate within the Division to lead their work on strengthening speciality to divisional level governance .

The committee received an update from the corporate governance team who has established a comprehensive system of oversight in relation to the management of our Trust policies. The policy owners are responsible to ensure that the policies are fit for purpose in respect of up to date content and reviewed and ratified before their expiry date.

It is a positive step to have visibility of this from an assurance perspective and whilst TMC noted that there has some progress there are still a significant number of policies that have been beyond their review date for a long time. It is recognised that some of this may be due to COVID however it is important that we re-establish prioritising this work .TMC asked for the following :

1) Reminder to all policy owners of what they need to do to get a policy extended (where appropriate) and the expectation that significant progress is made over the next 2 months on the current position of out of date policies.
2) Noted there needs to further training to policy owners of how to upload renewed policies onto Microguide.
3) An update paper to TMC in June 2021

The committee noted the extraordinary efforts of the procurement department who were able to deliver a capital programme more than double the size of the original 19/20 plan. The efforts of our capital planning, estates and clinical staff have all been excellent in respect of delivering this level of improvement for patients in the last 12 months capital work.

The Executive Performance Review escalation report to TMC highlighted the progress that the CSFS Division and diagnostic teams have made in returning the activity levels and increasing the performance standards for patients across the majority of our diagnostic services. The progress in the reduction of patients acquiring pressure ulcers in hospital was also noted.

TMC received the Clinical Management Board escalation report and drew attention to the overall standard of this report which is excellent and encouraged other report authors to see this as something to aim for when writing their escalation reports. Peter Collins thanked Clare Gorzanski for the standard of the CMB paper

End of Report

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

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Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	6 May 2021		

Report from: (Committee Name)	People and Culture		**Committee Meeting Date:**	29 April[th] 2021
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Michael von Bertele			
Board Sponsor (presenting):				

Recommendation

The Trust Board are asked to note the items escalated from the People and Culture Committee on 29th April.

The Committee was informed of a backlog of policies that required updating. Work is in hand to prioritise the necessary actions.

An update on the Health and Safety Committee raised some concerns about how risks in a number of areas are being identified and then managed. This is a potentially serious problem and the imminent appointment of a new H&S manager is an important step towards mitigation, but we shall expect an update on progress at the next P&C meeting in June.

We received the annual update on Voluntary Services, which highlighted the outstanding efforts made to maintain a volunteer service that makes such an important contribution to the quality of care we deliver. The volume of volunteer activity was severely curtailed at the height of the pandemic but is now recovering, and is being tracked in detail by ProVisit - an application that records exactly what is being done. It was noted that although somewhat separate from volunteer activity, the recording of Patient Experience has also taken a hit and steps are needed to improve access for those who collect it, including our Governors.

In a similar vein, the retirement of Pearl James as the Volunteer Governor has left a significant gap and efforts are underway to recruit to this important role. A Volunteers' Steering Group is being established in order to align volunteer activity more closely with the Trust's priorities in recognition of the crucial role they play.

After many false starts it was a relief to see that progress has been made in the recording of leaver experience, and that leaver surveys will be a central component in the ESR, enabling us to capture feedback before an individual actually leaves the Trust. This is an important element of staff feedback, both critical and complimentary, and will feed into our Best Place to Work agenda and has the potential to inform workforce planning more broadly.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	06 May 2021		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Louise Drayton, Performance and Capacity Manager			
Executive Sponsor (presenting):	Lisa Thomas, Chief Finance Officer			
Appendices (list if applicable):	N/A			

Recommendation:
The Board is requested to note the report and highlight any areas of performance where further information or assurance is required.

Executive Summary:
The level of impact from Covid-19 on hospital pressures continued to reduce through March, with the number of inpatients reducing from 34 on 1st March to 3 by 31st March. Bed occupancy remained at a comfortable level of 87% supporting good flow throughout the organization. Staff sickness levels reduced to 3.18% from 3.62% in M11 with Covid-19 related sickness or isolation falling in line with community prevalence reducing. The level of flow in the organization was reflected in performance against the Four Hour access standard at 90.9% (87.9% in M11), the highest level achieved since the first Covid-19 wave, when bed occupancy was also low. Attendances were higher in M11 (4730 vs 3644 in M10) mirroring the trend that has been seen following previous eases in lockdown restrictions. Time to ward within 4 hours of a stroke improved at 50% (35.7% in M11), but only 73% of patients spent 90% of their time on the stroke unit. The acute stroke unit moved to its original location on level 2 with 20 beds, whilst 13 rehabilitation beds remain on Breamore ward and the consultant workforce increased from 2 to 3 people. Elective activity continues to be a challenge to increase due to restricted numbers in some services. The ICU bay on Laverstock ward was completed during the month and became operational, ceasing escalation into theatres. Elective and Daycase activity levels were improved from M11, but did not reach the levels set in the Phase 3 plan. As a result the

number of patients waiting over 52 weeks for elective treatment increased from 995 in M11 to 1142 in M12.

Performance against the 6 week diagnostic standard reduced slightly to 92.8% (93.5% in M11). The national position at M10 was 71.5% so SFT are significantly ahead of many Trusts in recovering this standard. The main area yet to recover is Cardiology Echocardiograms; however improvement actions have been identified with performance expected to start improving from M1. The main risk to ongoing improvement and achievement of this standard remains increasing referral levels.

The number of patients seen within 2 weeks with an urgent suspected cancer referral improved from 76.59 in M11 to 816% (provisional) in M12. The Breast pathway has been challenging, but improvement is beginning to be seen. 62 Day performance has improved by just short of the 85% standard at 83% (provisional) in M12.

HSMR is statistically significantly higher than expected and is due to the denominator super spells being lower than usual from March 20 onwards due to the impact of the Covid-19 pandemic. If Covid-19 activity is removed the HSMR reduces to within the expected range. The weekday and weekend HSMR remain within the expected range

The Trust recorded a bottom line surplus of £78k at the year-end (after adjusting for Donated Assets). The financial plan had assumed a control total deficit of £0.1m for the month, and a £15.2m deficit for the year, no central MRET or FRF was therefore assumed. The Trust's improved performance against this target is due to the increase in funding made available to NHS providers in 2020/21.

The costs directly driven by the Covid-19 response have now reached £5.7m, 62% of which relates to hours worked by the Trust's existing workforce, though a combination of redeployment from BAU duties and additional hours. The high costs seen in month 11 have begun to level off as the level of Covid-19 activity in the Trust has fallen; bank nursing, junior doctor additional shifts and ancillary staff remain the areas mainly affected.

Board Assurance Framework – Strategic Priorities	Select as applicable
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Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

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Integrated Performance Report

May 2021

(data for March 2021)

An outstanding experience for every patient

Summary

Salisbury NHS Foundation Trust

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Elective activity continues to be a challenge to increase due to restricted numbers in some services. The ICU bay on Laverstock ward was completed during the month and became operational, ceasing escalation into theatres. Elective and Daycase activity levels were improved from M11, but did not reach the levels set in the Phase 3 plan. As a result the number of patients waiting over 52 weeks for elective treatment increased from 995 in M11 to 1142 in M12.

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Structure of Report

Performance against our Strategic and Enabling Objectives

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

Summary Performance
March 2021

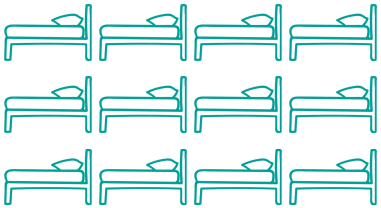
NHS Salisbury NHS Foundation Trust

There were **2,477** Non-Elective Admissions to the Trust

We delivered **35,027** outpatient attendances, **29%** through video or telephone appointments

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

We carried out **212** elective procedures & **1,716** day cases



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

RTT 18 Week Performance: **65%** ↓

Total Waiting List: **19,583** ↑

92.8% ↓ of patients received a diagnostic test within **6 weeks**

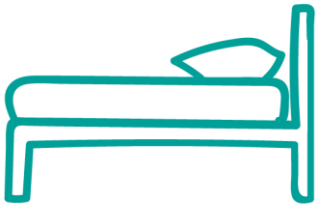
Our income was **£36,740k** (£14,766k over plan)

18.6% ↑ of discharges were completed before 12:00

Emergency (4hr) Performance **90.9%** ↑

(Target trajectory: 95%)

63 patients stayed in hospital for longer than 21 days



Our overall vacancy rate was **-0.08%** ↓

Reading a Statistical Process Control (SPC) Chart

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

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

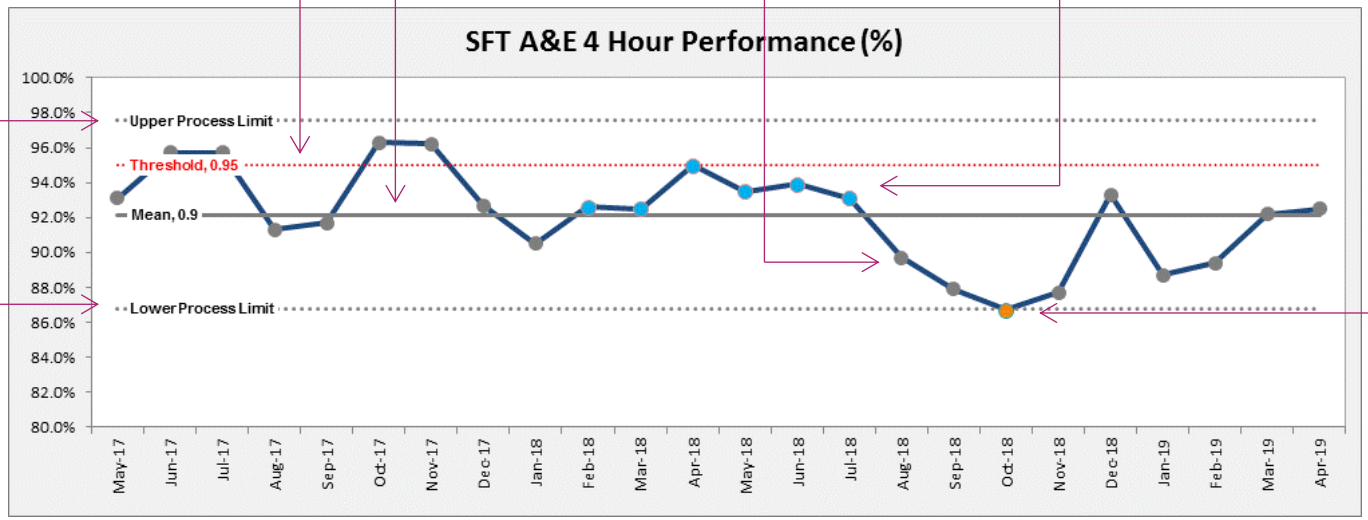
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

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

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



Statistical Process Control Chart Key:

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

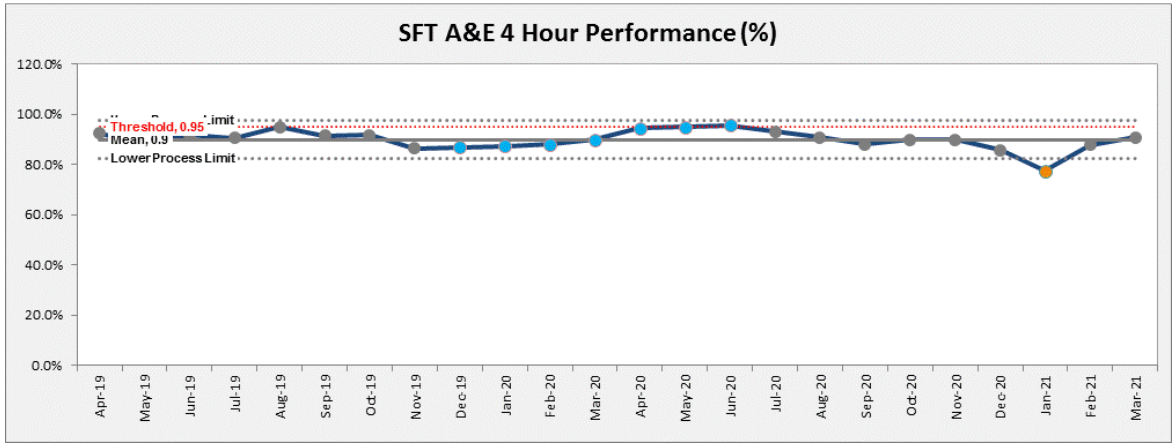
Salisbury NHS Foundation Trust

Part 1: Operational Performance

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

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

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	90.9%
Attendances:	4730
12 Hour Breaches:	0
ED Conversion Rate:	30.3%

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

M12 saw an increase in performance for the 4 hour standard as compared to M11 (increase from 87.9%). There was an increase in attendance numbers of 1095 in M12 as compared to M11.

Conversion rate has decreased in M12 (from 36.4% in M11) which shows a decrease in acuity of patients requiring admission, supporting the increase in performance this month.

At the end of M12 the pathway for patients presenting with C19 was amended and the RCU de-escalated from 30 beds to 10 beds. Category A C19 patients still attend ED but with the remainder now triaging through AMU, the pathway between ED and RCU has less demand from other areas, resulting in more efficient pathways for patients.

Flow is still of concern out of ED, particularly during the twilight part of the day where most breaches are incurred.

Medical staffing cover had very few concerns in M12. Junior doctor rotation in M1 of 21/22 is likely to cause some concerns to doctor skill mix.

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

Front door strategy group in place and meeting regularly to discuss improvements for SDEC and OPAL related activity.

Medicine DMT regularly working with ED leadership team on improvement actions that the Department can support to improve performance.

Consultant interviews due to take place to appoint two Consultants to vacant posts (this will achieve full Consultant establishment for the first time in 3 years).

Consultant rota and demand and capacity work has been completed by Clinical Lead. Identified where workforce and infrastructure meets demand and where it does not. DMT to review and agree next actions.

Risks to delivery and mitigations

Junior doctor rotation in M1 is of concern due to skill mix of incoming doctors (mitigated by educational supervision from within the Department).

Lockdown release phase 1 and 2 have seen increase in daily attendance rates (back to near pre Covid-19 demand).

Space issues in minors (ortho OPD) and safety concerns in waiting rooms causing additional pressure to the department. DMT to discuss options. Space/estates work for minors expected Autumn 2021.

Nursing establishment needs for ongoing use of majors 11-15 to be submitted as part of Covid-19 21/22 funding requests.

Statistical Process Control Chart Key:

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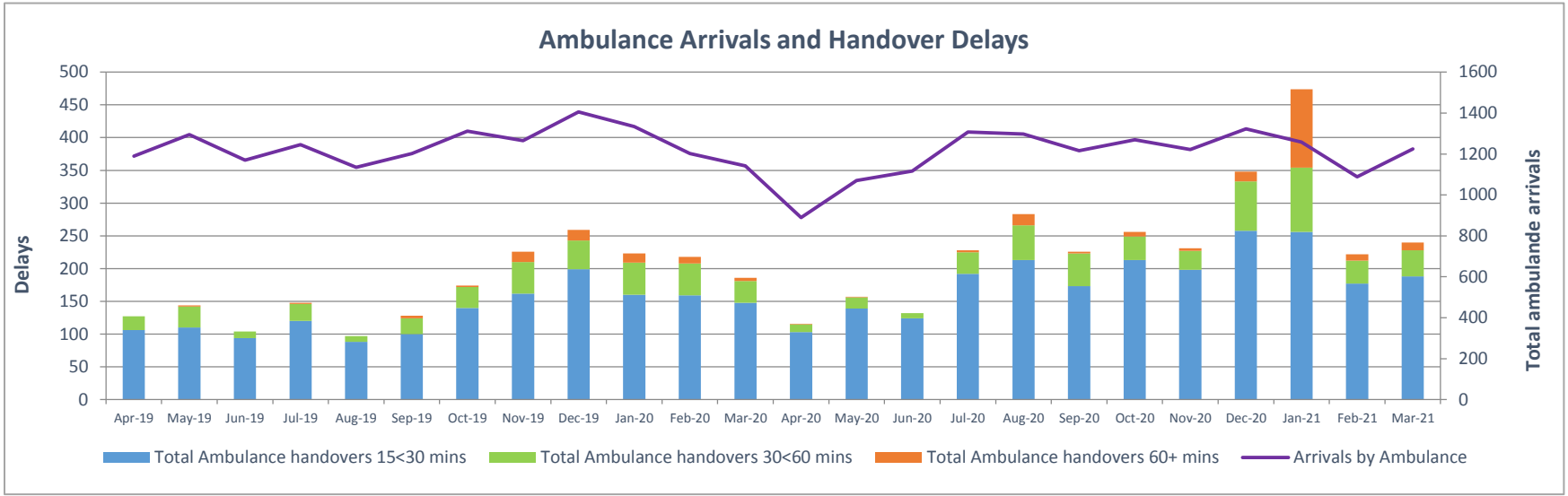
Ambulance Handover Delays

National Key Performance Indicators



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

- Ambulance handover delays have fluctuated with an upward trend since July 2020, peaking in January 2021 (Covid-19 peak)
- Peak of handovers of over 1 hour in January 2021 (Covid-19 Peak)
- Decreasing handovers in last 2 months.

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

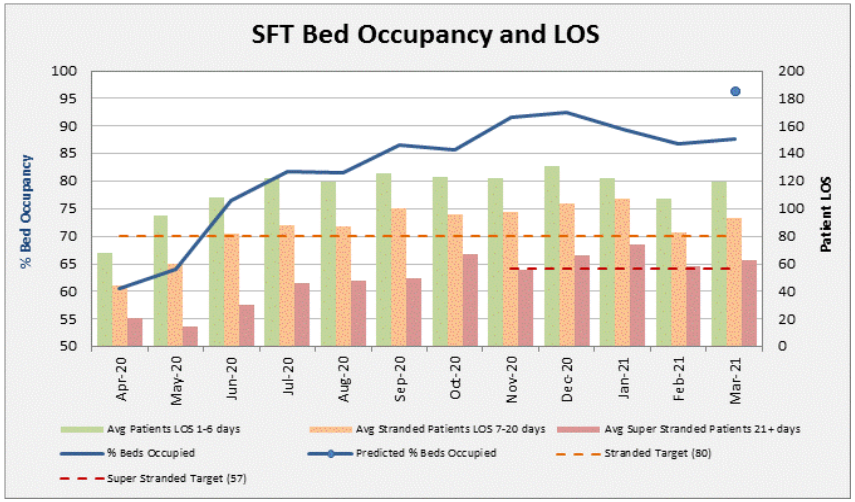
- BSW wide improvement plan.
- Prompt escalation process when patients exceeding 30 min wait. Process in place.
- Work with SWAST to improve pathways for category 3 & 4 patients.
- Promotion to general public regarding alternative health pathways e.g. 111. central fund nationally of £2M to promote 111.
- Improve straight to specialty pathways and Same Day Emergency Care (SDEC).

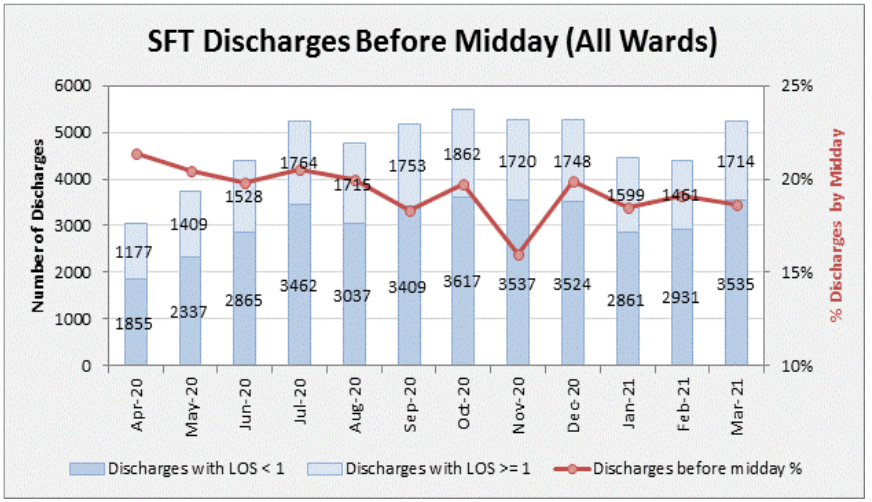
Risks to delivery and mitigations

- Increasing attendees including ambulance conveyance.
- SWAST SFT catchment area tend to have junior crews.
- Lack of timely access to general practice by patients.
- Increasing call stack for 111 will encourage patients to come to ED rather than wait for 111.

Patient Flow and Discharge

Are We Effective?





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

Occupancy began to rise in March although significantly below the peak in December. The LOS data demonstrates a steady hold in the 7 day+ LOS group, with a rise in the numbers of 1-6 days from February indicating churn in this group. The challenge will be preventing this group becoming 7-20 days in April.

Discharges also rose to levels seen in November 2020 but with an improved picture of discharges before 12.00 midday. Going into recovery will require an approach not to lose momentum in this area, facilitating morning discharges to support ED and assessment areas flow through to inpatient areas.

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

The Trust has employed a Head of Patient Flow with a remit to support and lead areas of work aimed at ensuring capacity and journeys culminating in discharge that meet the needs of patients.

Additionally, areas of focus identified across the Trust include:

- Making best use of electronic patient tracking systems
- Criteria led discharge across adult inpatients
- Criteria to reside – continue education and roll out of responsibility to record and report. SFT reports both regionally and nationally, and needs to develop it's use of the data to focus on areas of internal development also.

Risks to delivery and mitigations

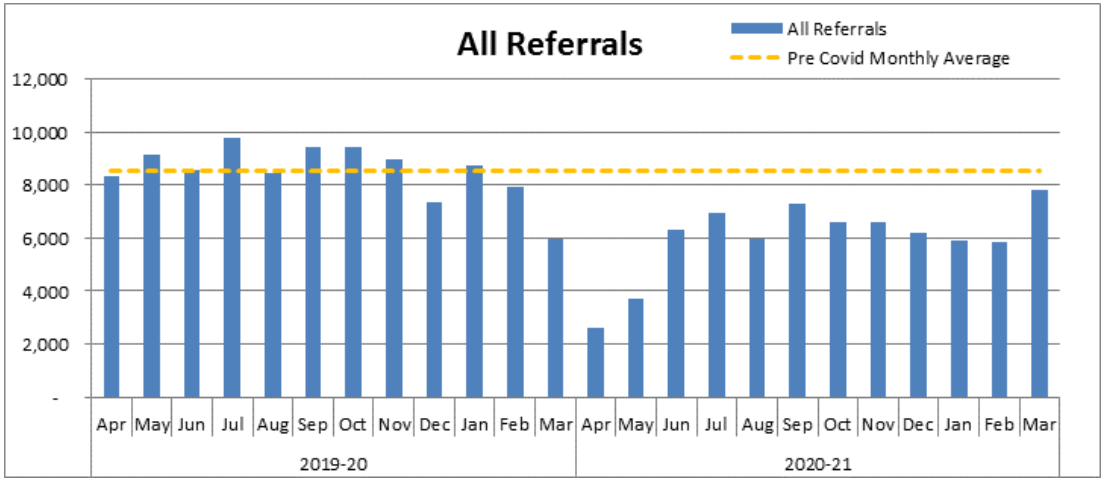
Relaxing Covid-19 restrictions or challenges in the vaccination program that could lead to a surge in Covid-19 infections will restrict Trust capacity and ability to undertake work identified as long term project work in the area of LOS and patient flow

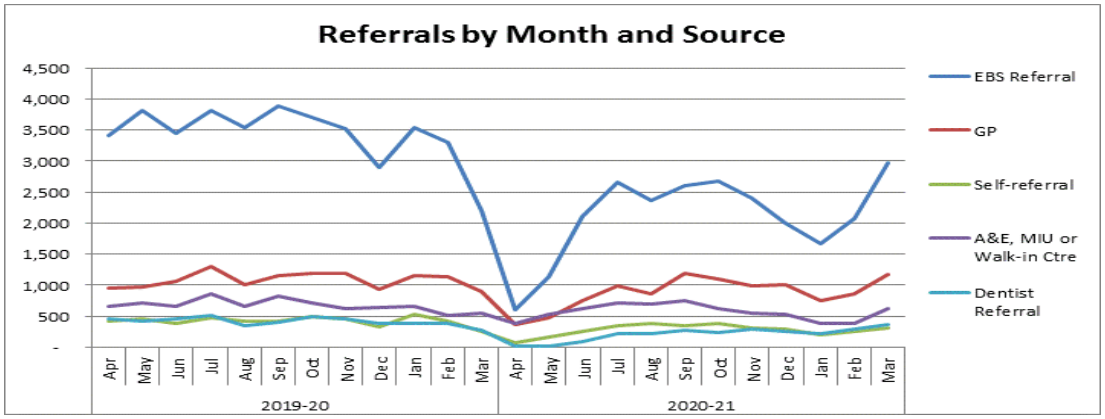
Effective engagement, if not achieved with clinicians and broader services – e.g. pharmacy, diagnostics etc. will affect the Trust ability to deliver improvements in these areas.

Resource available to support development of these programs may not be immediately available or may detract from areas of work elsewhere.

Referrals

Additional Supporting Information





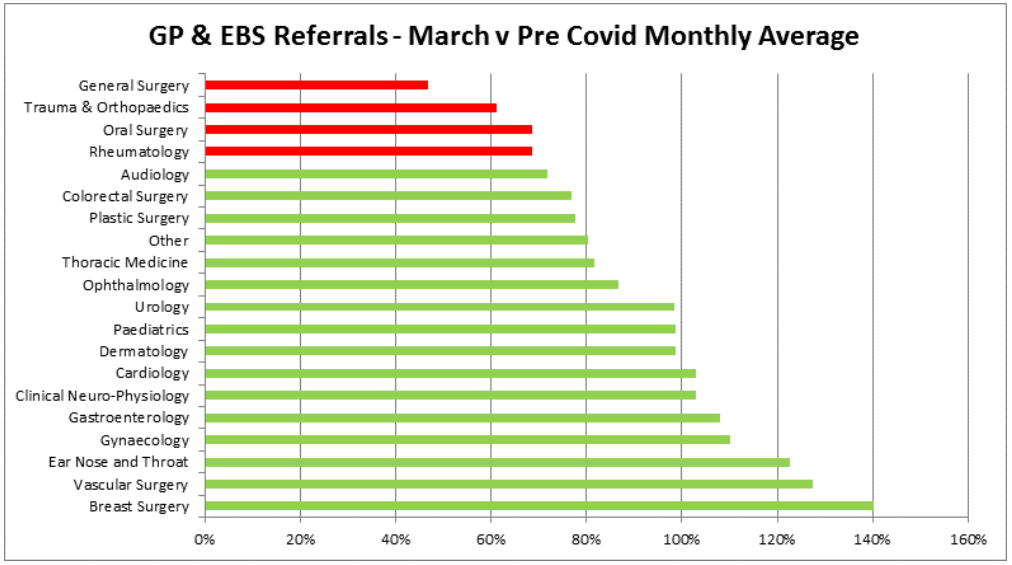
Comments

Referral levels remain below pre Covid-19 levels despite regular communication around services being open. However, M12 referrals were the highest they have been since the start of the pandemic, suggesting that activity is returning. To pre pandemic levels.

Referrals

Additional Supporting Information

Specialty	March '21	Pre Covid Monthly Average	% of Pre Covid Monthly Average
Breast Surgery	315	225	140%
Vascular Surgery	73	57	127%
Ear Nose and Throat	371	303	123%
Gynaecology	335	304	110%
Gastroenterology	177	164	108%
Clinical Neuro-Physiology	134	130	103%
Cardiology	260	253	103%
Dermatology	183	186	99%
Paediatrics	168	170	99%
Urology	237	241	98%
Ophthalmology	357	412	87%
Thoracic Medicine	84	103	82%
Other	475	591	80%
Plastic Surgery	228	294	78%
Colorectal Surgery	220	287	77%
Audiology	222	309	72%
Rheumatology	116	169	69%
Oral Surgery	36	52	69%
Trauma & Orthopaedics	111	182	61%
General Surgery	40	86	47%

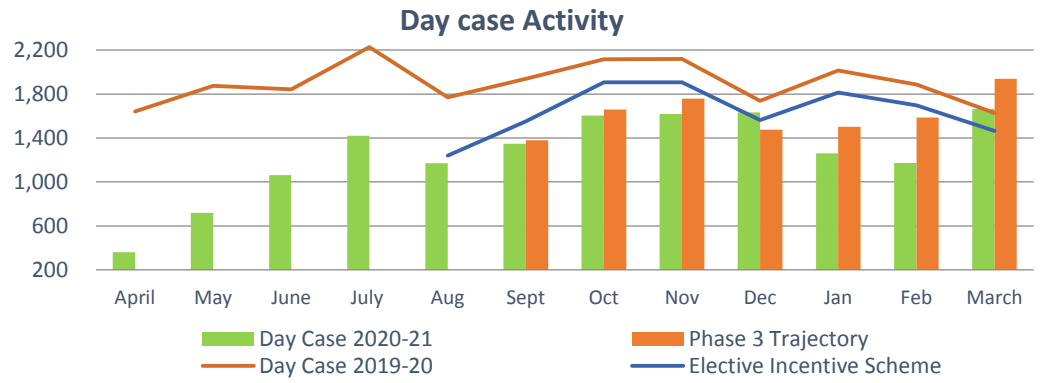


Comments

With referral levels in M12 the highest they have been since the start of the pandemic in M12 of 2019/2020, referrals by specialty were much closer to pre Covid-19 levels. Referrals for Breast surgery in particular remain high.

Activity recovery – Day case (target 80%)

Are We Effective?



Specialty	March	Pre Covid Monthly Average	% of Pre Covid Monthly Average
Urology	177	116	153%
Plastic Surgery	311	219	142%
General Surgery	204	203	101%
Breast Surgery	13	13	100%
Gastroenterology	375	380	99%
Neurology	21	21	98%
Rheumatology	99	109	91%
Spinal Surgery Service	13	15	88%
Gynaecology	46	60	77%
Respiratory Medicine	11	14	76%
Cardiology	78	108	72%
Oral Surgery	62	89	70%
Dermatology	5	8	65%
Vascular Surgery	7	11	64%
Colorectal Surgery	66	109	61%
ENT	25	45	56%
General Medicine	49	89	55%
Ophthalmology	71	158	45%
Interventional Radiology	4	14	29%
Trauma & Orthopaedics	2	67	3%

Daycase activity in M12 increased from M11 (1674 in M12 compared to 1162 in M11) but despite the increase this was unfortunately still 265 below the Phase 3 trajectory submitted to NHSE/I.

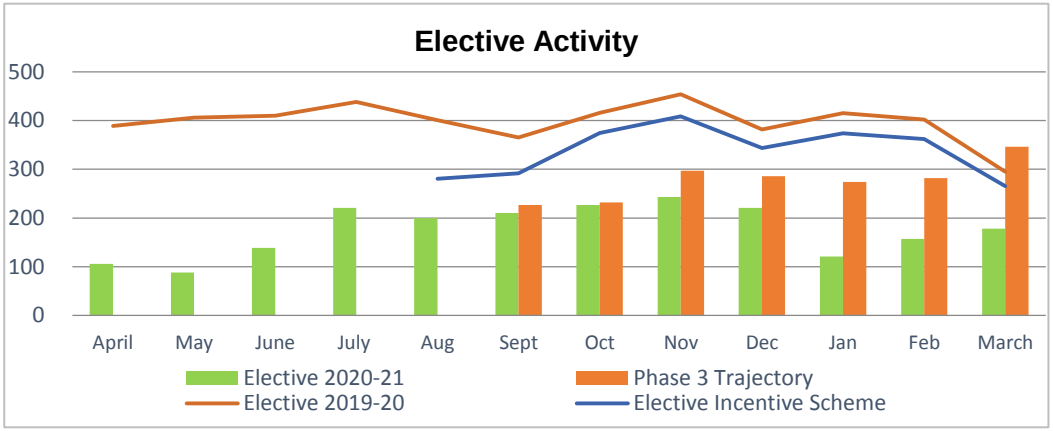
The partial closure of the Day Surgery Unit due to continues to impact capacity with some theatres remaining closed.

Theatre space continues to be allocated by clinical priority and need resulting in theatre access varying by specialty month to month and the impact of this can be especially seen on specialities with a high proportion of clinically routine, low priority patients such as ENT and Ophthalmology.

ENT and Oral Surgery remain challenging to increase with proportionally higher numbers of aerosol generating procedures.

Activity recovery – Electives (target 80%)

Are We Effective?



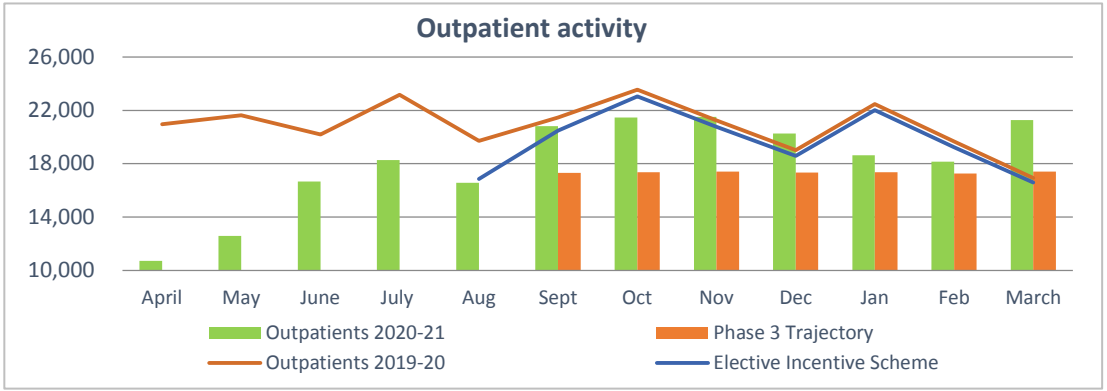
Specialty	March	Pre Covid Monthly Average	% of Pre Covid Monthly Average
Clinical Haematology	6	4	135%
General Medicine	7	6	110%
General Surgery	21	25	82%
Colorectal Surgery	17	22	79%
Gynaecology	17	23	75%
Gastroenterology	3	4	71%
Cardiology	7	10	67%
Urology	32	61	52%
Breast Surgery	5	12	42%
ENT	10	28	36%
Plastic Surgery	28	85	33%
Oral Surgery	4	12	33%
Trauma & Orthopaedics	4	89	4%
Spinal Surgery Service	0	16	0%

Elective activity continued to be significantly impacted by the Covid-19 challenges although it was slightly increased from M11. 174 electives were performed against a trajectory of 346 resulting in a shortfall of 172 against the Phase 3 trajectory submitted to NHSE/I.

The specialties with the highest variance from plan were Trauma & Orthopaedics, Plastic Surgery, ENT and Gynaecology where, as with the daycases, having high proportions of clinically routine, low priority patients is impacting the access to theatre capacity as specialties with clinically urgent patients are being prioritised meaning that specialities with lower levels of urgent patients continue to recover activity levels more slowly.

Activity recovery – Outpatients (target 100%)

Are We Effective?



Specialty	March	Pre Covid Monthly Average	% of Pre Covid Monthly Average
Respiratory Medicine	1944	579	335%
Gastroenterology	452	282	160%
Endocrinology	366	261	140%
Clinical Haematology	478	360	133%
Medical Oncology	475	361	132%
Colorectal Surgery	565	461	123%
Rheumatology	898	871	103%
Genito-Urinary Medicine	559	550	102%
Urology	819	810	101%
Gynaecology	667	660	101%
Breast Surgery	447	444	101%
Plastic Surgery	1853	1934	96%
Cardiology	572	603	95%
ENT	700	738	95%
Orthotics	526	558	94%
Oral Surgery	696	745	93%
Ophthalmology	2223	2444	91%
Diabetic Medicine	239	273	87%
Paediatrics	743	864	86%
General Surgery	255	325	78%
Orthodontics	233	299	78%
Audiology	696	910	77%
Dermatology	637	842	76%
Trauma & Orthopaedics	1240	1772	70%
Spinal Surgery Service	108	240	45%
Physiotherapy	0	395	0%

Outpatient activity levels for M12, increased significantly from M11 (21,167, in M12 compared to 18,400 in M11), and exceeded the forecast Phase 3 trajectory submitted to NHSE/I with outpatient activity in March 2021 being 3765 ahead of plan with a range of specialties achieving 90% or above. Specialties with fewer Covid-19 related constraints can be seen to have fully recovered with activity for some being well over 100%.

With increased numbers of appointments being undertaken virtually, the level of outpatient procedures has reduced.

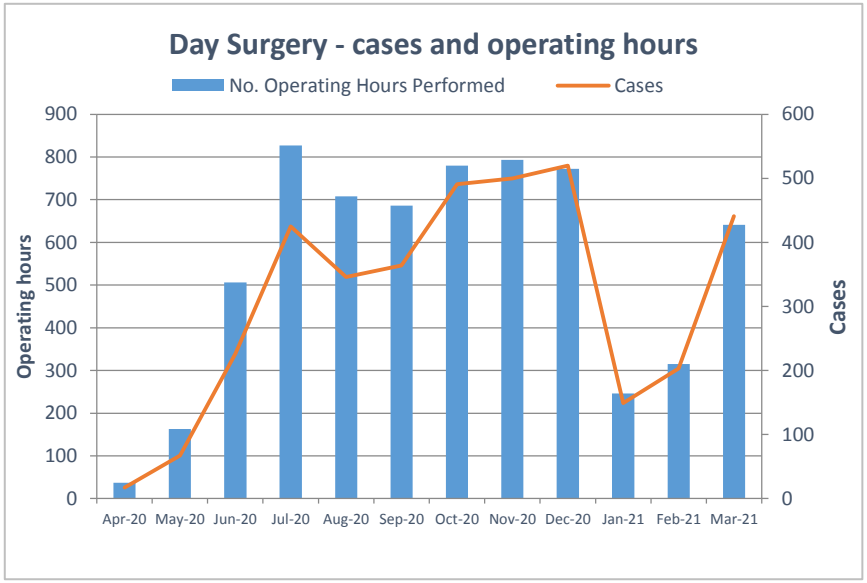
An air change solution for both the ENT & Oral Surgery outpatient departments has been identified, and work has been completed in the Oral Surgery area, and is current being undertaken in ENT, with activity for these specialties expected to rise following this although there has been a reduction in activity while the work has been undertaken.

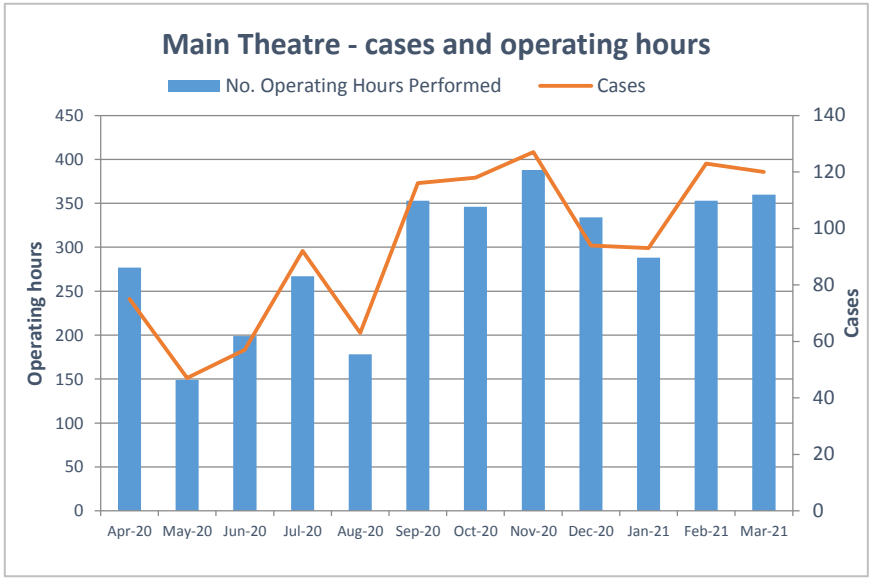
Space constraints across outpatient departments continue to be a challenge, particularly in specialties with low levels of patients suitable for virtual appointments such as Trauma & Orthopaedics. The modular build, which has a revised opening date of the 4th May, will increase the number of patients that can be safely seen and the move of T&O into their new footprint on Level 3 later this year will also increase capacity.

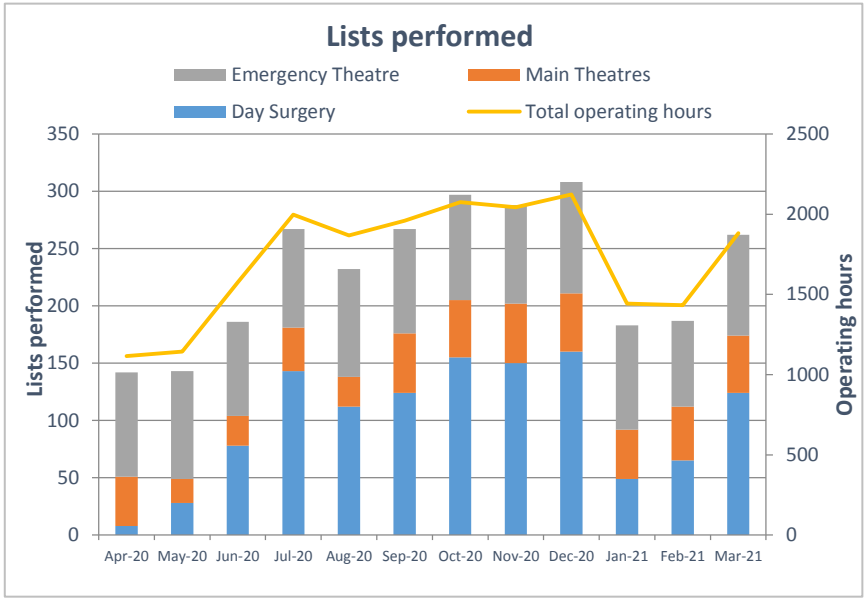
Virtual appointments are working well in some specialties with Gastroenterology seeing the majority of their outpatients virtually. Urology, Gynaecology and Cardiology are also seeing good use of virtual appointments.

Activity recovery - Theatres

Additional Supporting Information







Theatre activity continued to be limited in M12 although both daycase and main theatres activity increased from M11.

Theatre activity was expected to increase more significantly in Q4 with the further re-opening of Main Theatre capacity, but this has only been partially achieved, and was further impacted by the continued escalation of ITU into the Main Theatre footprint. The continued partial closure of the Day Surgery Unit continues to impact capacity with some theatres remaining closed.

Significant challenges remain around staffing, sickness levels, agency fill and recruitment and Covid-19 related absence remains a difficult issue to mitigate.

Theatre staff payment incentive continues.

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

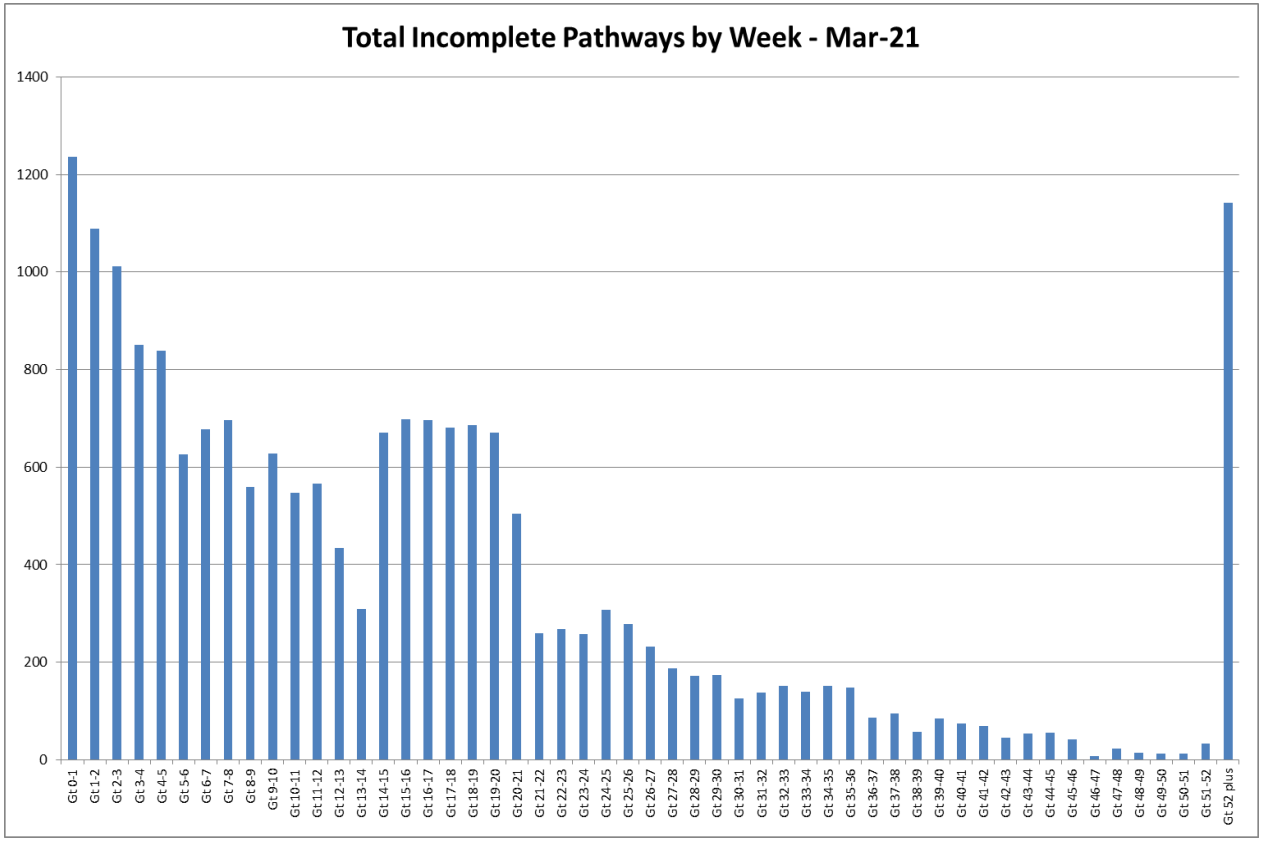
National Key Performance Indicators

Top 5 lowest 18 week performance

Specialty	WL Total	Total <18 weeks	% <18 weeks
Ophthalmology	2515	1226	48.7%
Plastic Surgery	1259	715	56.8%
Ear, Nose & Throat (ENT)	1651	946	57.3%
Oral Surgery	1456	857	58.9%
Trauma & Orthopaedics	1373	853	62.1%

Top 5 largest 18 week breach backlog

Specialty	WL Total	Total 18 wk breaches	% <18 weeks
Ophthalmology	2515	1289	48.7%
Ear, Nose & Throat (ENT)	1651	705	57.3%
Other	3093	648	79.0%
Oral Surgery	1456	599	58.9%
Plastic Surgery	1259	544	56.8%



RTT performance declined slightly in March at 65.45% (67.6% in M11). This is due to reduced theatre activity and continued challenges in outpatient capacity.

As part of the support work for areas with the poorest compliance, and largest volumes, the Surgical DMT continue to focus on Ophthalmology reviewing options to increase their outpatient capacity options and the transfer of patients to two outsourcing solutions continues with 400 patients transferred so far.

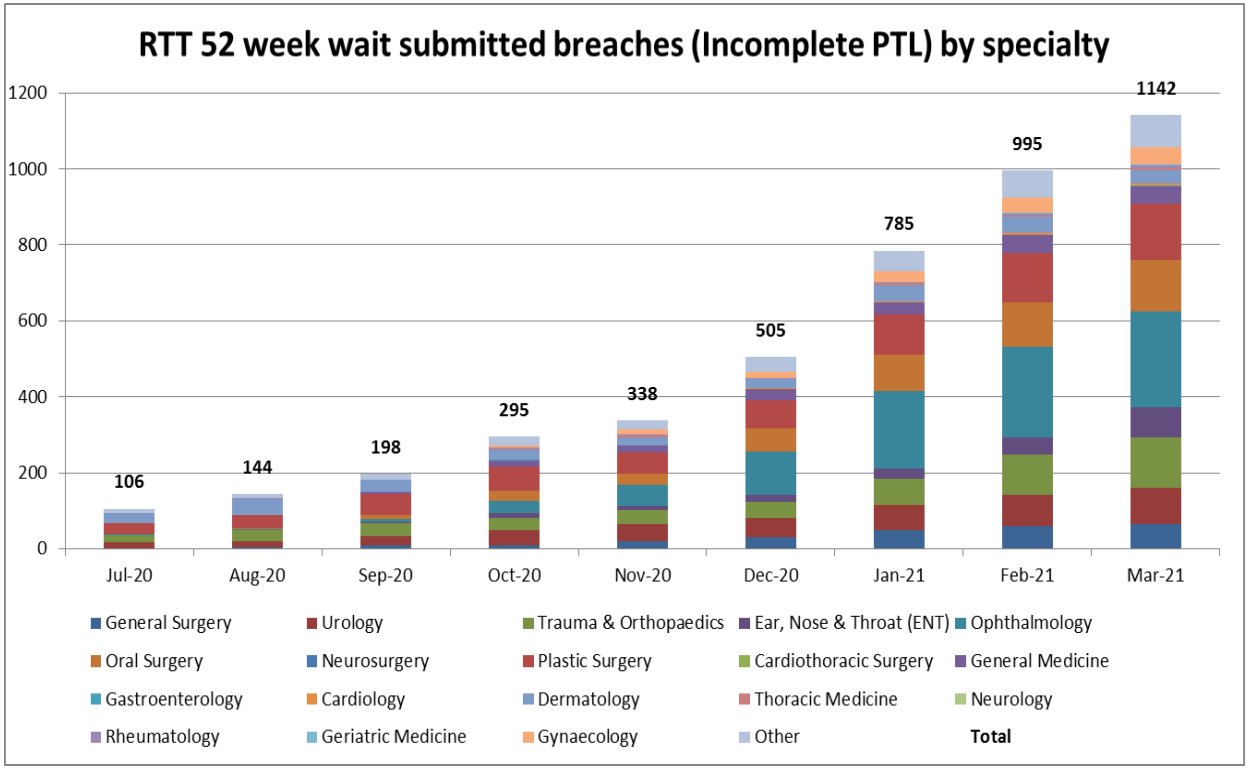
Additionally the air change solutions identified for ENT and Oral Surgery will improve their capacity but improvement will be limited until these are in place. The opening of the modular build in May will also provide additional capacity for ENT.

Work on Dermatology and Plastic Surgery productivity continues and additional minor operation capacity continues to be organised including Saturday outpatient and surgical lists.

Theatre allocation continues on the basis of clinical priority, and specialties with a lower proportion of higher priority patients have reduced operating space for routine procedures.

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

National Key Performance Indicators



Top 5 with highest 52 week wait submitted

Treatment function	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	% change from previous month
Ophthalmology	2	3	7	32	55	115	202	238	253	6%
Plastic Surgery	28	33	54	64	54	74	107	132	148	12%
Oral Surgery	1	3	12	27	30	61	97	117	135	15%
Trauma & Orthopaedics	20	27	34	34	37	44	71	104	134	29%
Urology	15	18	25	38	44	49	65	84	96	14%

The number of patients waiting longer than 52 weeks has grown by 147 patients to a total of 1142 of which 105 patients have requested to pause their pathway due to Covid-19 concerns.

As part of the phase 3 activity assumptions the Trust forecast that the number of over 52 week patients would grow every month until the end of 2020-21. The forecast position for M12 was 346 patients over 52 weeks. The forecast was completed when the Trust had zero Covid-19 inpatients and assumed that this level would continue.

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

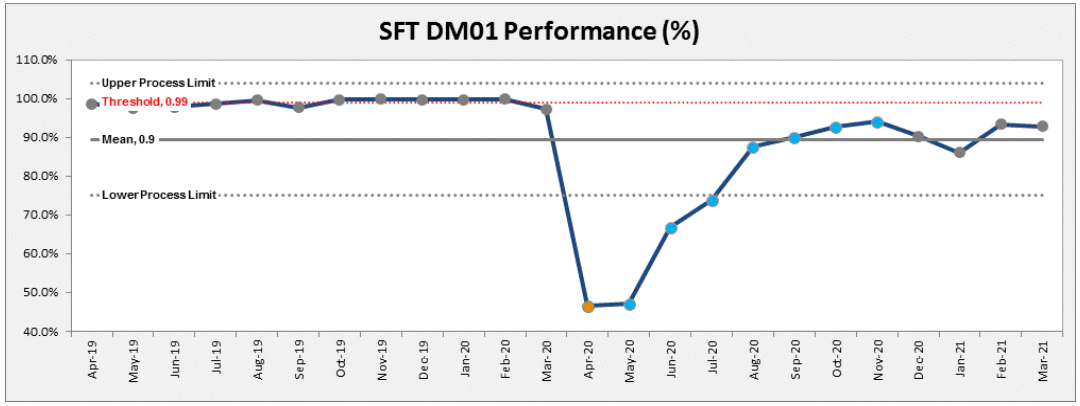
Of the 254 patients waiting on an outpatient pathway, 141 are in Ophthalmology and 44 in ENT. There have been specific challenges to increasing activity in both these areas, in Ophthalmology this is in relation to the ability to socially distance, outpatient capacity and the proportion of vulnerable patients in this group, and this is why outsourcing to the two additional providers continues. In ENT the challenges have been linked to their air flow and space constraints in the outpatient area but the additional capacity that comes online in M2, in both the modular build and following the completion of the air flow work in ENT, will work to reduce these.

Of the patients waiting on an admitted pathway, there were 27 patients have been recently expedited to priority level 2 (should be treated within 4 weeks of prioritisation), 162 patients are priority level 3 (should be treated within 3 months), and the rest are levels 4, 5 and 6 (more than 3 months). The specialty split is broader, with the highest being in Plastic Surgery (134), Oral Surgery (122), Orthopaedics (103) and Urology (91). The most re-start of transferring Orthopaedic patients to Newhall from M1 will work to reduce these.

Regular review of the prioritisation is undertaken to ensure that circumstances have not changed and the allocated priority is appropriate. Guidance issued from the Federation of Surgical Specialty Associations forms the basis for prioritisation.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	92.8%
Waiting List Volume:	3734
6 Week Breaches:	266
Diagnostics Performed:	7033

Background, actions being taken and risks and mitigations

Performance standard in month has not been achieved as a direct result of Covid-19. April projections confirm that the target is not achievable for M1 21/22 owing to sustained increased in the referral rate in Cardiology and MRI, and capacity relating to skill mix for MRI. Activity in M12 significantly improved compared to M11 in all Diagnostic areas.

Endoscopy

14 confirmed in month breaches, attributable to Covid-19.

Radiology (Inc. DEXA)

13 in month breaches. All 12 MRI breaches attributable to unexpected downtime of Mobile MRI at end of M12.

Audiology

16 in month breaches, all attributable to Covid-19. Activity continues to increase in-month with recovery of DM01 planned for end of M1 21/22.

Cardiology

223 in month breaches, all attributable to capacity restraints associated with Covid-19. Activity in month has increased, and plans are in place to recover the DM01 position within the first 6 months of 21/22.

Neurophysiology

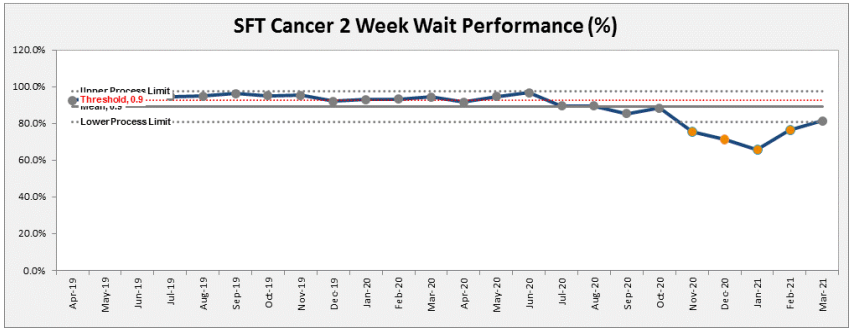
0 in month breaches – services has both recovered and sustained their waiting list position.

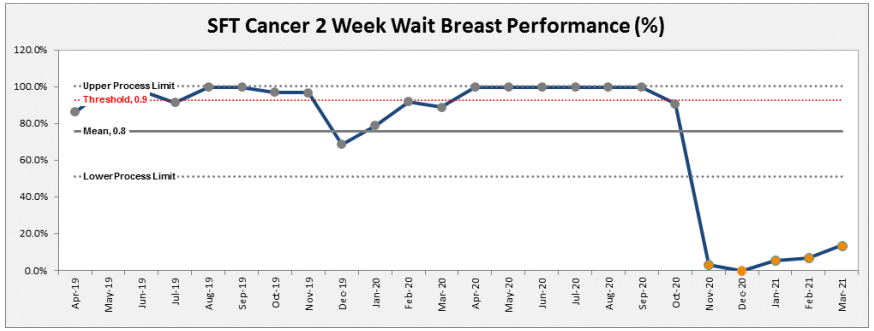
Cancer 2 Week Wait Performance Target 93%

National Key Performance Indicators

Performance Latest Month	Performance	Num/Den	Breaches
Two Week Wait Standard:	81.6%	877/1075	198 (23 patient choice)
Two Week Wait Breast Symptomatic Standard:	13.7%	751	344

Data Quality Rating:





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

Two week wait standard not achieved for M12 (1075 patients seen in total; 877 seen within target; 198 breaches). This is due to a variety of reasons including:

- Face to face outpatient capacity: 155 breaches
- Patient choice: 23 breaches
- Incomplete GP referrals (including qFIT result): 10
- Endoscopy capacity (as a result of patient requiring a Covid-19 swab pre-diagnostic): 7 breaches
- Clinical delays: 2 breaches

Breast symptomatic two week wait standard not achieved for M12 (51 patients seen in total; 44 breaches). Delays associated with patient choice and one stop clinic capacity.

2ww performance not achieved for quarter 4 2020/21, with validated performance of 75.6% (2549 patients seen in total; 1927 in target; 622 breaches)

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

Booking teams continue to prioritise cancer patients, though ongoing challenges remain in relation to patient choice and DNAs. This is likely to impact on service delivery for some time; revised GP comms in place to remind primary care of the importance of ensuring patients are willing and able to attend hospital.

Implementation of Faecal Immunochemical Testing (qFIT) within primary care continues to become embedded. Revised colorectal 2ww referral form in circulation and has resulted in improved quality of referrals and increase uptake in the use of qFIT. Uptake is audited on an ongoing basis by the Rapid Referral Office, with findings shared with BSW CCG for them to engage directly with relevant practices requiring improvement.

Challenges within breast service due to increase in referrals, social distancing restrictions and outpatient capacity. Fifth one stop clinic in place and demand and capacity modelling completed, suggesting (based on assumptions) that improvement should be seen from April 2021 onwards. There has been ongoing improvement in delivery against this standard across Quarter 4.

Weekly PTL, cancer ops and cancer action group in place to look to prevent avoidable breaches. This then enables cancer services to work with the relevant team to expedite where possible. Use of cancer escalation process now business as usual.

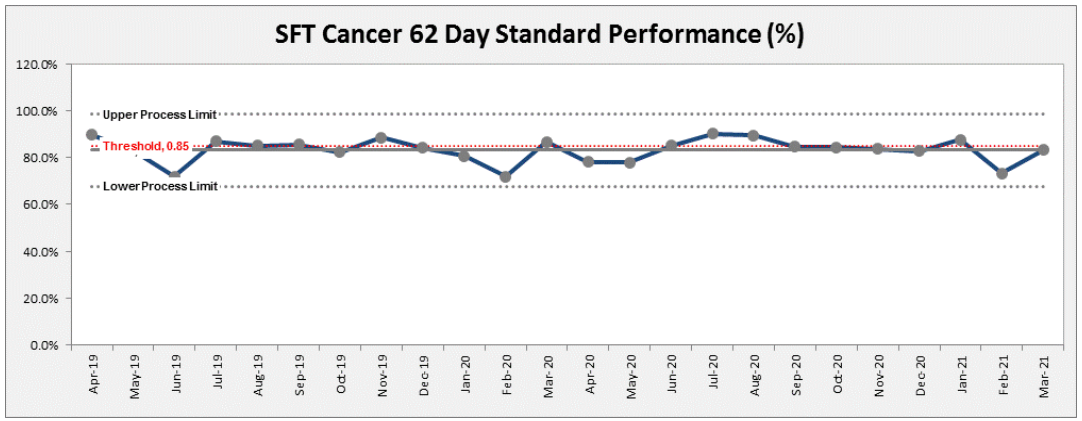
Risks to delivery and mitigations

Risk associated with potential increase in referrals as a result of the 'Covid-19 backlog' (patients who chose not to present to their GP during their pandemic, who may present at a later date).

Ongoing review of referrals figures underway; demand and capacity modelling will be undertaken for tumour sites at risk of not achieving standard as referrals increase.

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

March 21	Performance	Num/Den
62 Day Standard:	83.0%	71/85.5
62 Day Screening:	N/A	N/A

Risks to delivery and mitigations

Month 12 62 day performance standard not achieved, with validated month end performance of 83% (85.5 patients treated in total; 71 in target; 14.5 breaches). Breach reasons predominantly associated with complex diagnostic pathways, patient choice and capacity. 62 day performance standard for Quarter 4 2020/21 not achieved, with validated performance of 82.3% (192.5 patients treated in total; 158.5 in target; 34 breaches).

Two 104 day breaches reported in March following treatment:

- 1 x Lung; patient choice delay
- 2 x Colorectal; complex diagnostic pathway and multiple patient choice delays throughout pathway

No screening patients treated in month, though performance standard not achieved for Quarter 4 2020/21 (3 patients treated in total; 2 breaches).

Future performance continues to remain fragile, though cancer treatments continue to be prioritized. Risk associated with delivery of cancer services alongside routine activity. Cancer services and DMT continue to focus on longest waiters and PTL backlog (patients on the PTL over 62 days); this continues to show improvement. Weekly cancer action group established to maintain DMT focus on cancer care delivery. Current focus on Head & Neck cancer pathway improvement.

Month 12 31 day performance standard achieved, with validated month end performance of 96.2%. Performance standard achieved for Quarter 4 2020/21, with validated performance of 96.6%.

Month 12 28 day Faster Diagnosis Standard achieved, with month end performance of 83.9%. Gap analysis to be undertaken prior to external reporting in June 2021; further work required in relation to data quality. Performance standard achieved for Quarter 4, with performance of 79.1%

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

Stroke & TIA Pathways

Are We Effective?

SFT SSNAP Case Ascertainment Audit Score:

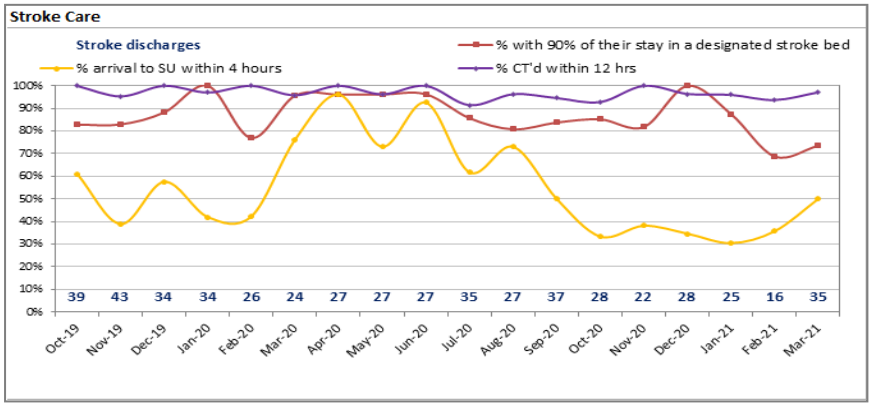
Year	Q1	Q2	Q3	Q4
2019-20	B	B	B	Not Reported
2020-21	Not Reported	Not Reported	Not Reported	Not Reported

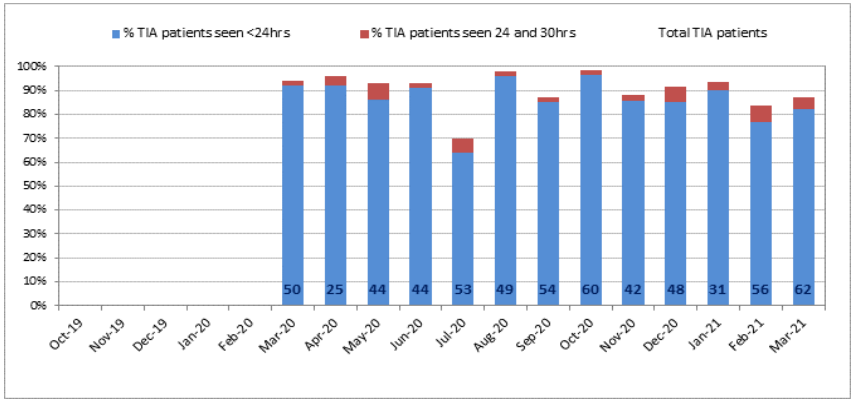
Data Quality Rating:

% Arrival on SU <4 hours: 50.0%

% CT'd < 12 hours: 97.1%

% TIA Seen < 24 hours: 82.3%





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

51% of stroke patients had a CT within 1 hour exceeding the 50% national target. Patients reaching the stroke unit within 4 hours improved to 50%. Delays occurred for 17 patients due to waiting for specialty doctor (4), transferred to AMU (4), waiting for a bed (4), inpatient stroke (2), in ED at 4 hours (2) and late referral (1). 2 (6%) stroke deaths within 7 days and 3 (9%) stroke deaths within 30 days both lower than expected. Only 73% of stroke patients spent 90% of their time on the stroke unit below the national target (80%), as 3 patients were admitted to AMU and 6 patients moved wards to make way for new stroke patients

As expected, TIA performance improved but 11 patients were affected by full clinics. The consultant workforce increased from 2 to 3 from mid-March which improved the capacity to see outpatients.

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

In mid-March 21, the acute Stroke Unit moved from Level 4 back to Level 2 with 20 beds enabling improved therapy provision and the stroke rehabilitation beds (13) remained on Breamore ward, giving a total of 33 stroke beds.

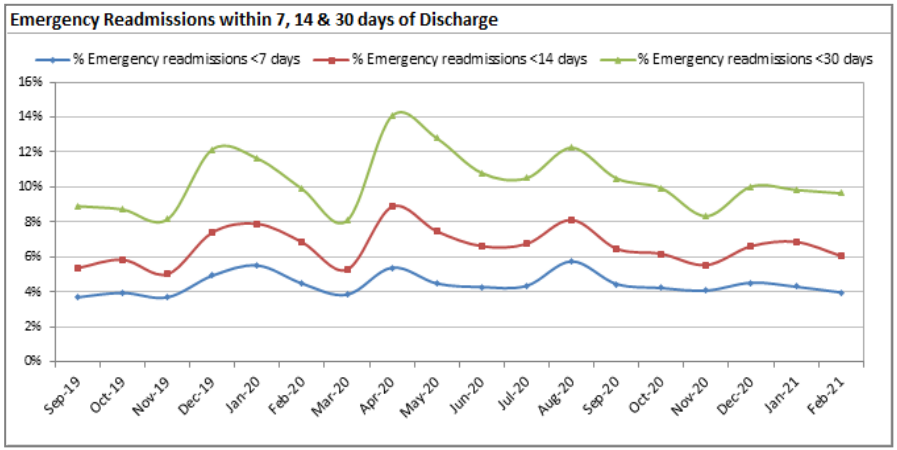
Risks to delivery and mitigations

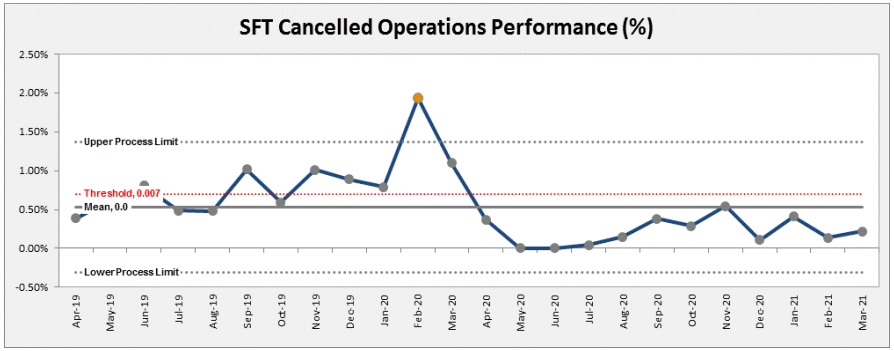
Ward staffing improved in March following a high level of Covid-19 related illness on Laverstock ward.

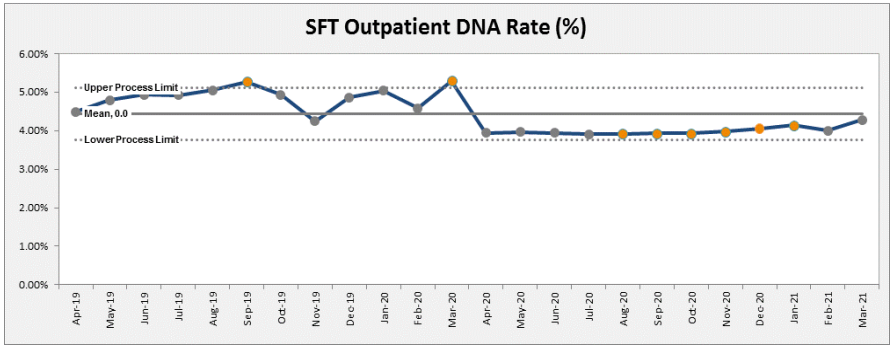
SSNAP data is not likely to be published for Q4 20/21.

Other Measures

Are We Effective?







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

Salisbury NHS Foundation Trust

Part 2: Our Care

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

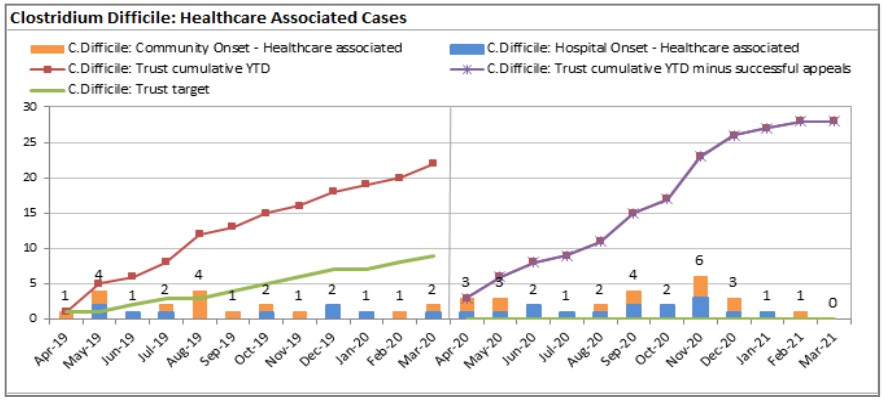
Infection Control

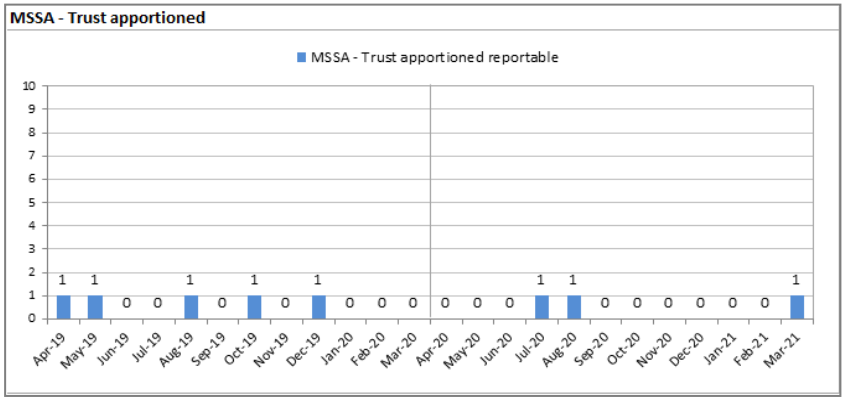
Data Quality Rating:

Are We Safe?

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

MRSA	2019-20	2020-21
Trust Apportioned	0	3





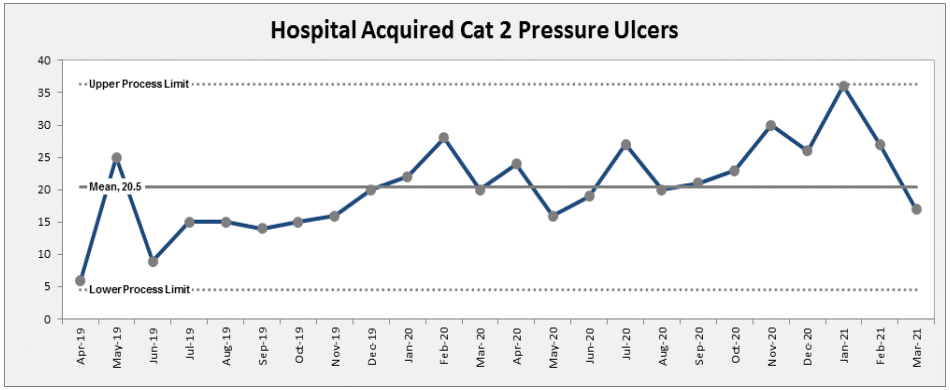
Summary and Action

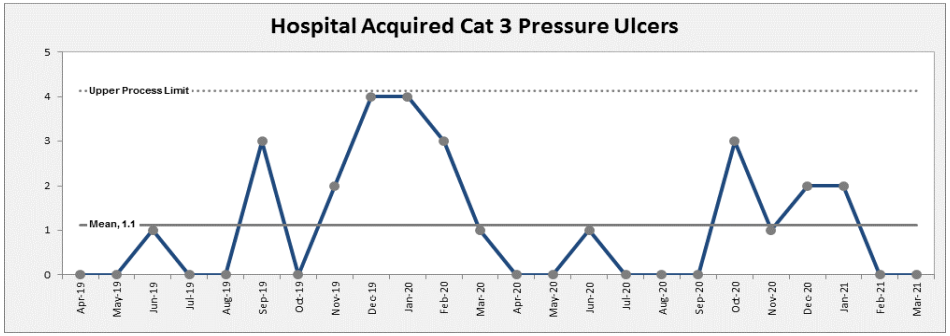
- 1 hospital onset MRSA bacteraemia. The patient was known to be previously MRSA positive in June 20 but had no clearance screening in the community. The Microbiologist concluded it was a community acquired deep seated infection. The post infection review showed that admission screening was carried out, there was timely commencement of topical decolonisation therapy and the patient was isolated in a side room. The patient was treated for a urinary tract infection with oral Vancomycin (not correct indication) and infection prevention and control audits on RCU were not completed as they should have been. The patient later died of 1a) MRSA septicaemia.
- No hospital or community onset C.difficile healthcare associated cases in March.
- 1 hospital onset MSSA bacteraemia in a patient on Tisbury/CCU. The source of the infection is unclear and sadly the patient died. No practice concerns were found but there was learning in relation to completion of the Isolation Risk assessment tools for patients in isolation, and documentation in relation to the insertion dates for cannulae.
- 2 hospital onset E Coli bacteraemias. 1 patient on Pitton ward with a lower respiratory tract infection and a patient on Amesbury ward with a lower urinary tract infection as likely sources of infection.

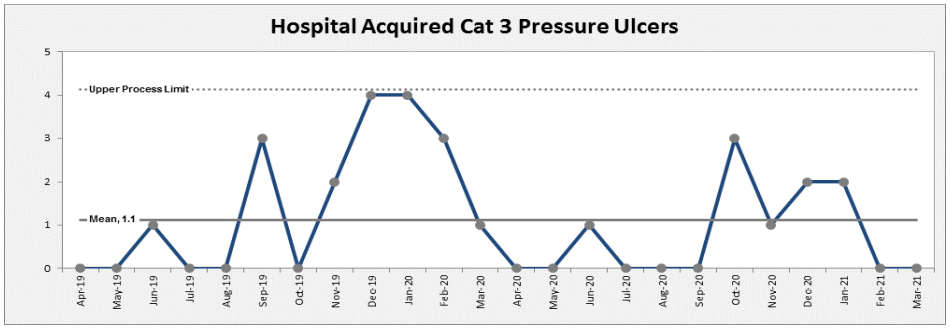
Pressure Ulcers

Are We Safe?

Data Quality Rating:







Per 1000 Bed Days	2019-20 Q4	2020-21 Q1	2020-21 Q2	2020-21 Q3	2020-21 Q4
Pressure Ulcers	1.73	2.27	1.92	2.10	2.21

Summary and Action

The number of category 2 pressure ulcers decreased from 27 in February to 17 in March. The biggest decrease was seen in the Medicine Division from 20 category 2 pressure ulcers in February to 11 in March. No category 3 or 4 pressure ulcers. No device related pressure injuries or specific themes.

A significant increase in category 2 pressure ulcers in 20/21 of 2.12 per 1000 bed days (286 ulcers) compared to 1.28 per 1000 bed days in 19/20 (199 ulcers). A significant reduction in category 3 and 4 pressure ulcers from 0.13 per 1000 bed days in 19/20 (18 category 3; and 3 category 4 pressure ulcers) to 0.07 per 1000 bed days in 20/21 (9 category 3; and 1 category 4 ulcer).

Improvements implemented in March – Band 5 education programme re-started with a good uptake, focusing on differentiating between a pressure ulcer, moisture associated damage and deep tissue injury.

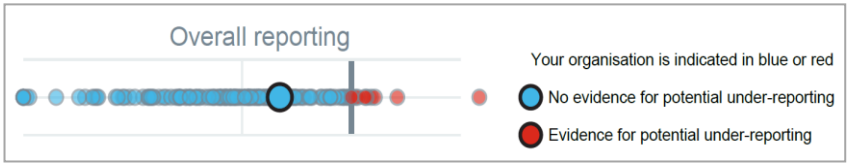
The plan remains to re-establish the PDSA cycle for skin inspection in AMU. A monthly 'Stop the Pressure' campaign and theme of the month starts in May 21 with Tissue Viability Nurses visiting wards and providing on the spot education. Pressure ulcer link nurse meetings re-start in May 21.

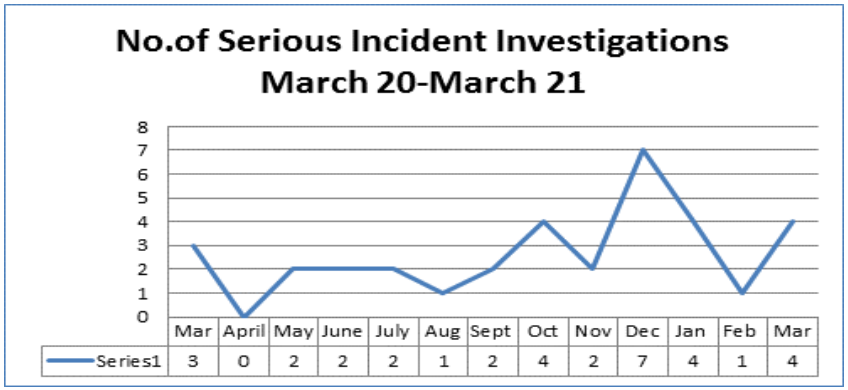
Incidents

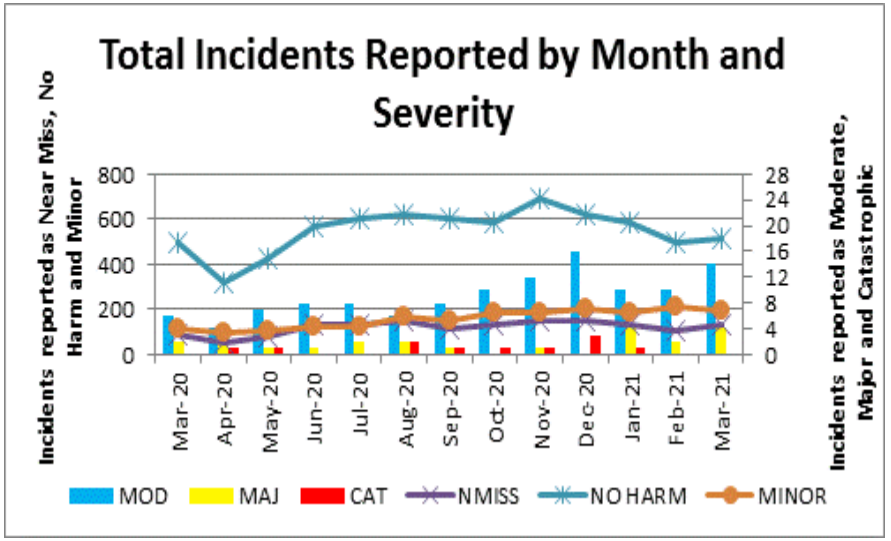
Are We Safe?

Year	2019-20	2020-21
Never Events	2	0

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







Summary and Action

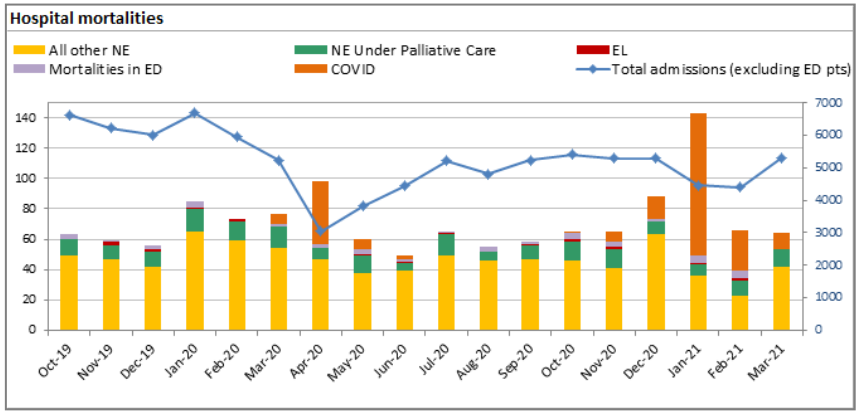
4 serious incident investigations commissioned in March:

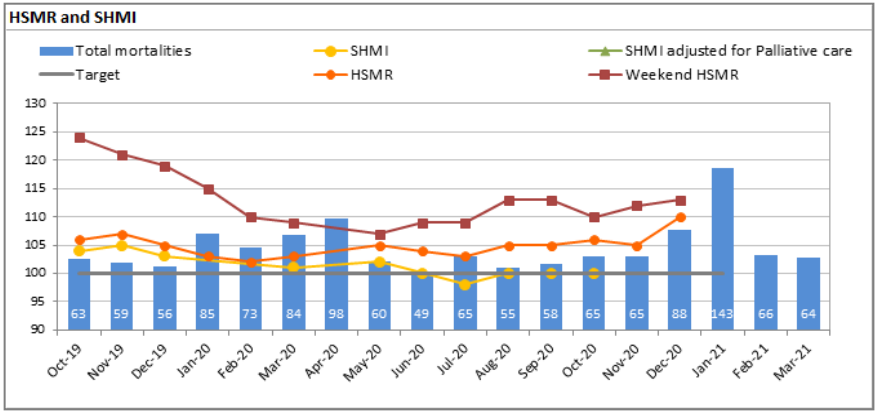
- Medicine Division – Category 4 pressure ulcer.
- CSFS Division – Genetics specimen
- CSFS Division – Missed basal cell carcinoma diagnosis
- Surgical Division – Delay to breast cancer treatment

Mortality Indicators

Are We Safe?

Data Quality Rating:





Summary and Action

HSMR rose to 110.3 and is statistically significantly higher than expected. This is due to the denominator super spells being lower than usual from March 20 onwards due to the impact of the Covid-19 pandemic. If Covid-19 activity is removed from the HSMR basket then the HSMR reduces to 107.9 for the latest 12 month period and within the expected range and December 20 is no longer statistically significantly higher than expected. The weekday and weekend HSMR remain within the expected range.

Of the 64 deaths in March, 11 were associated with Covid-19 disease and of these:

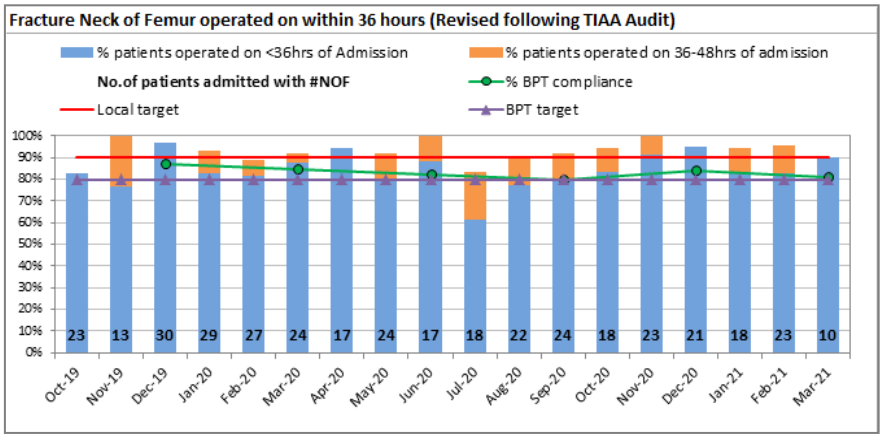
- 9 cases were community onset
- 1 were hospital onset indeterminate healthcare associated
- 0 were hospital onset **probable** healthcare associated
- 1 were hospital onset **definite** healthcare associated

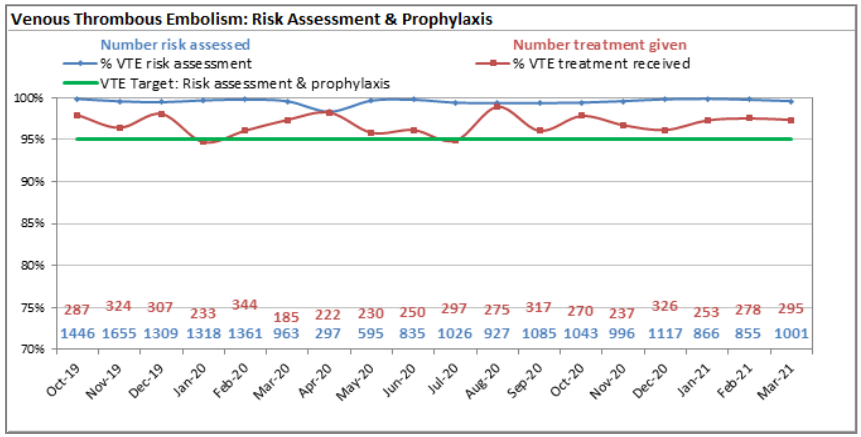
A duty of candour letter will be sent to the bereaved families of the probable and definite healthcare associated cases once contact tracing has been completed. In March, there were no new outbreaks of Covid-19 declared on the wards.

Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?

Data Quality Rating:





Summary and Action

Please note: due to the time it takes to complete clinical coding, the current months fracture neck of femur data will be subject to change the following month):

In March, 4 patients did not receive hip surgery for a hip fracture/distal shaft fracture within 36 hours:

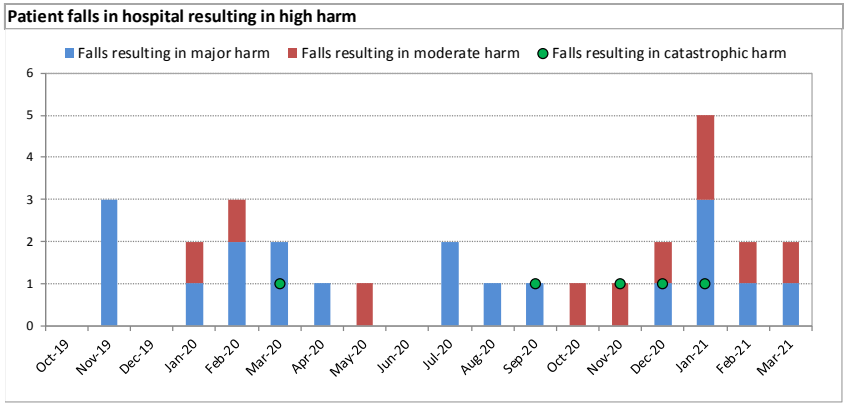
- A patient had a fractured hip as a result of an inpatient fall and had surgery at 38 hours waiting for theatre space. The patient required a 1 unit post-operative blood transfusion and had a prolonged length of stay of 22 days (national average length of stay 15 days).
- A 60 year old patient admitted with a fractured hip had uncomplicated surgery at 48 hours waiting for theatre space and was discharged on day 6.
- A patient admitted following a fall and a fractured hip had surgery at 74 hours waiting for theatre space. The post-operative period was complicated by delirium which resolved following treatment of diarrhoea and vomiting but had a prolonged length of stay of 22 days.
- A 77 year old patient admitted with a distal shaft fracture had surgery at 119 hours. The patient was under the care of the orthopaedic team at Oxford for a bone lesion which required an MDT plan, had 2 units of blood pre-operatively for anaemia and developed a large post-operative haematoma requiring a further unit of blood and was discharged on day 11.

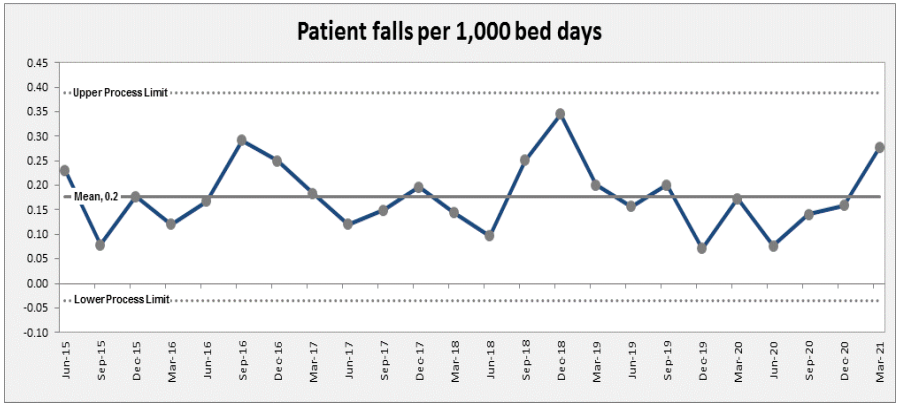
The Trust continued to report good performance in VTE risk assessment and prophylaxis. An increase in March in the number of inpatients with a new VTE as measured by the Safety Thermometer. The majority (12) were new admissions cancer related, 6 occurred in Covid-19 positive patients and 3 patients developed a VTE/PE within 28 days of the Astra Zeneca Covid-19 vaccine (not the rare carotid sinus thrombus). Root cause analysis of all hospital acquired VTEs continued to be undertaken and showed appropriate prophylaxis and treatment. A root cause analysis report is presented to the Thrombosis Committee quarterly.

Patient Falls

Are We Safe?

Data Quality Rating:





Summary and Action

In March, 2 high harm falls:

- A patient suffered major harm from a fractured hip on Pitton ward which required surgical treatment. No lapses in care were found. It was an unfortunate accident when the patient sat down and slid off the bed.
- A patient suffered moderate harm on AMU from a head injury which resulted in an extension of a subdural haemorrhage which was managed conservatively.

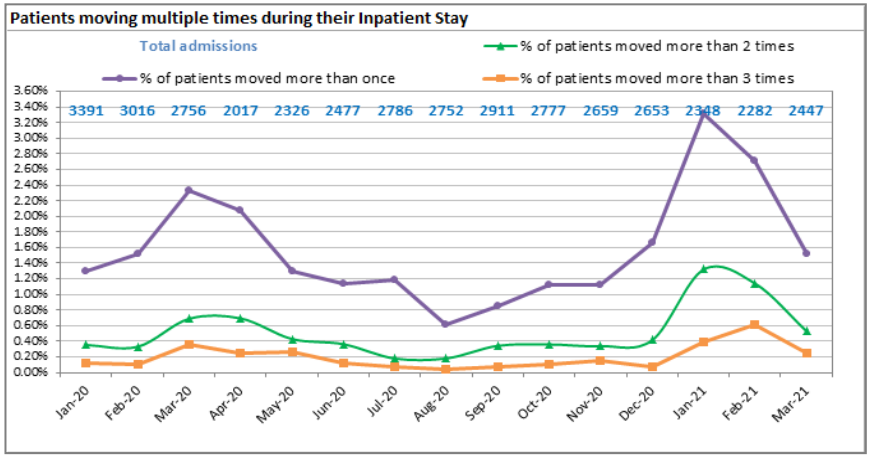
A Trust wide falls improvement plan with aggregated learning from SWARMs and serious incident inquiries is in place. There are plans to introduce a falls prevention facilitator to lead improvement work.

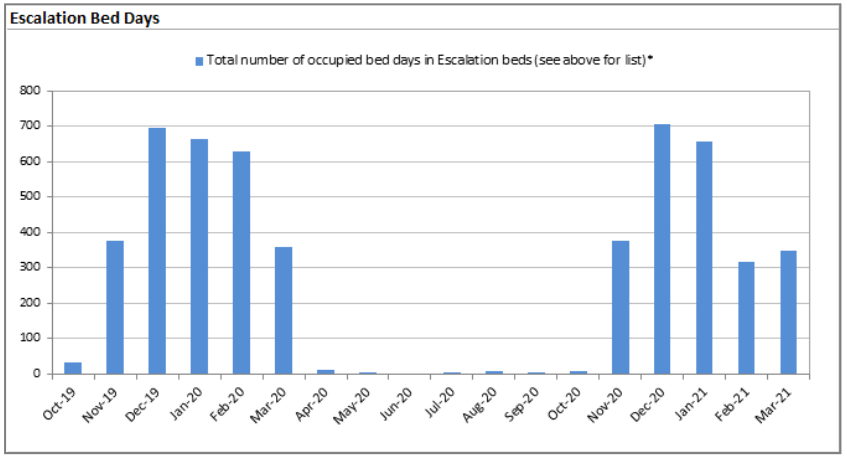
Patient Experience

Are We Safe?

Last 12 months	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Bed Occupancy %	60.5	64.0	76.4	81.7	81.5	86.6	85.7	91.5	92.4	89.4	86.7	87.5

Data Quality Rating:





Summary and Action

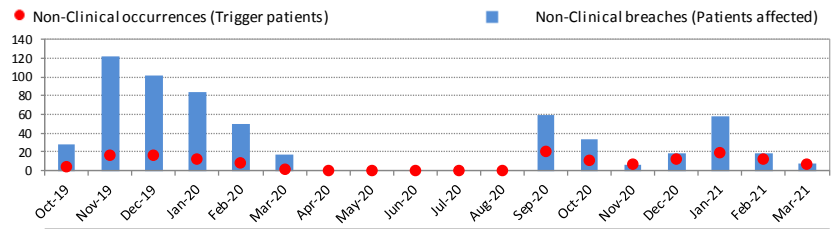
Although the overall number of admissions started to increase, the number of patients with Covid-19 decreased in March and as a result the number of multiple ward moves significantly decreased. Escalation beds open remained at a relatively low level. The bed occupancy rate increased slightly to 87.5%.

Patient Experience

Are We Safe?

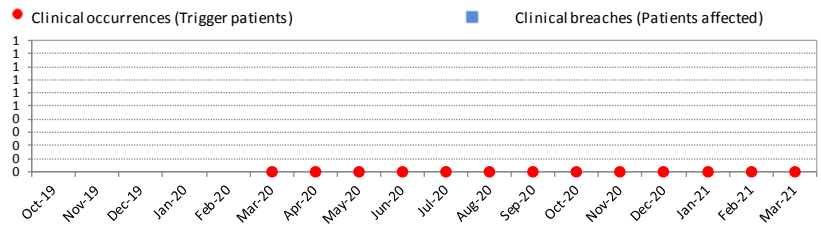
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
■	28	122	102	84	50	17	0	0	0	0	0	59	33	7	18	58	18	8
●	4	17	16	13	8	2	0	0	0	0	0	20	11	7	12	19	13	7

Delivering Same Sex Accommodation - Clinical



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
■						0	0	0	0	0	0	0	0	0	0	0	0	0
●						0	0	0	0	0	0	0	0	0	0	0	0	0

Summary and Action

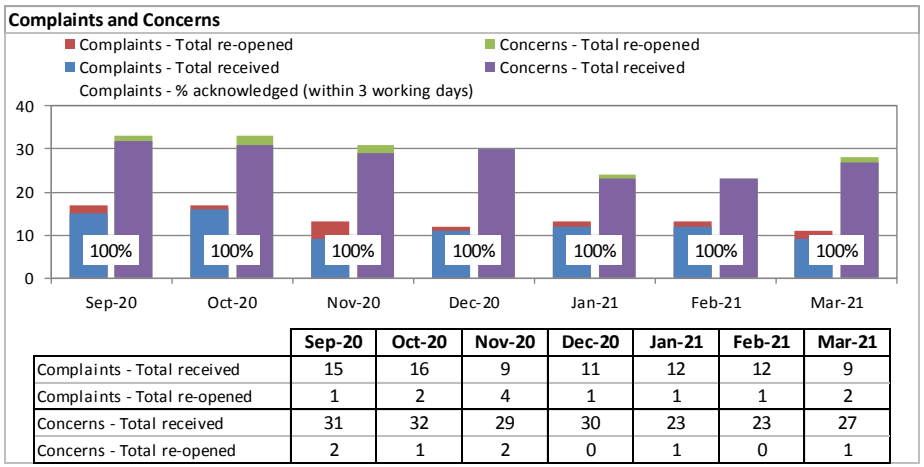
7 occurrences of non-clinical mixed sex accommodation breaches in March affecting 8 patients in the following areas:

- 5 breaches affecting 5 patients in Radnor ward. Privacy and dignity was maintained in the individual bed space. These were patients unable to be transferred to a general ward within 4 hours of the decision the patient was fit to move. The majority were resolved within 24 hours.
- 1 breach affecting 3 patients on Farley. The majority were resolved within 24 hours.

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

Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?



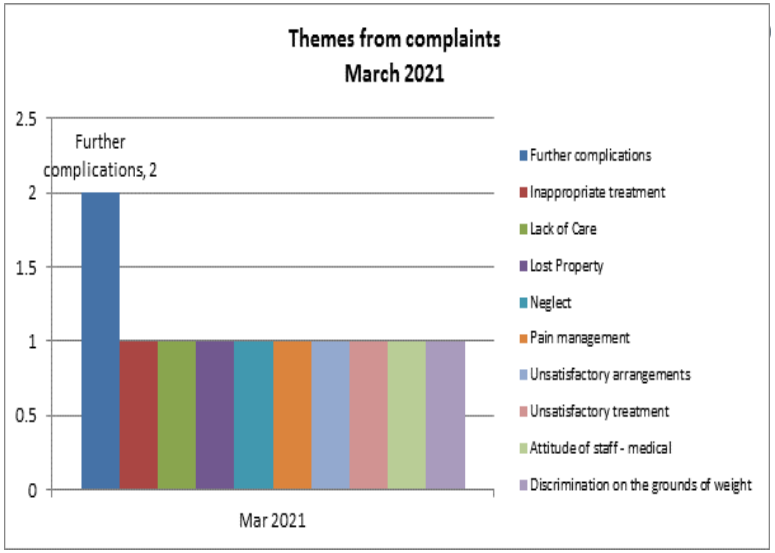
	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Complaints - Total received	15	16	9	11	12	12	9
Complaints - Total re-opened	1	2	4	1	1	1	2
Concerns - Total received	31	32	29	30	23	23	27
Concerns - Total re-opened	2	1	2	0	1	0	1

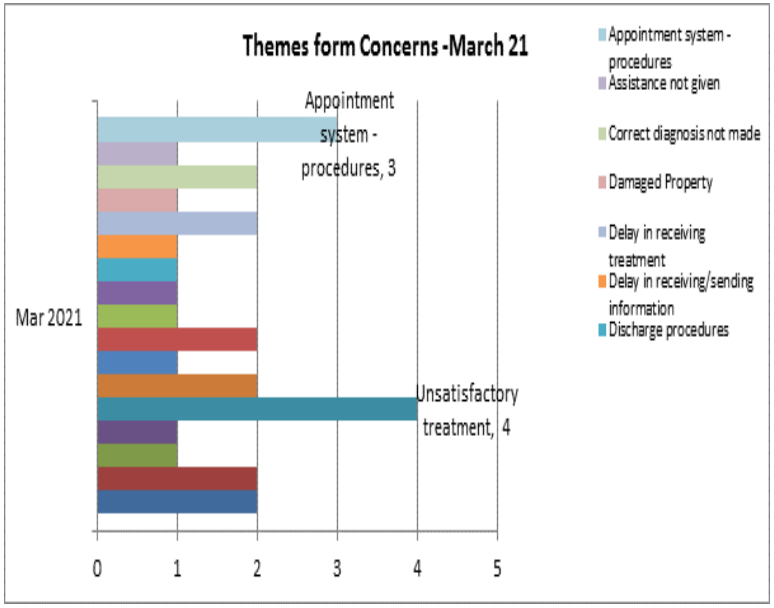
Summary and Actions:

17 complaints were responded to in March 21, of which 8 were not upheld and 9 were partially upheld.

Examples of actions from closed complaints:

- The plastic trauma team are to introduce a DNA letter for patients which will include details on how to rebook the trauma clinic appointment.
- The staff member sited in the complaint has reflected on the concerns raised and has shown good insight into the importance of ensuring that women's preferences are taken into consideration when discussing lifestyle choices.





Part 3: Our People

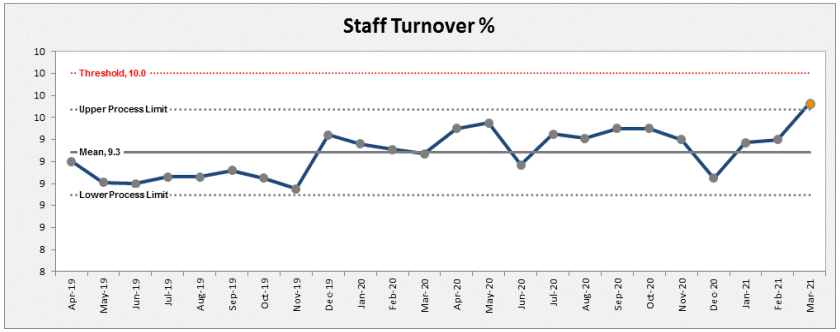
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

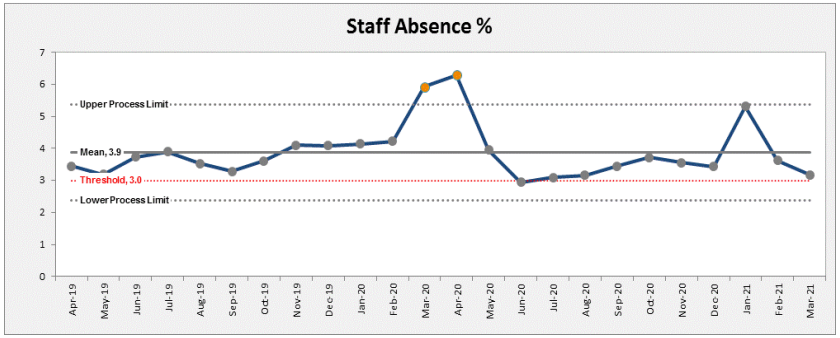
Workforce - Total

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	Mar '21		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	425.1	444.66	(19.5)
Nursing	967.1	1,059.89	(92.8)
HCAs	425.2	513.33	(88.2)
Other Clinical Staff	623.8	654.83	(31.0)
Infrastructure staff	1,227.9	1,316.41	(88.5)
TOTAL	**3,669.1**	**3,989.12**	**(320.0)**





Summary and Action

Staff Turnover in month was below target at 9.73%, this compares to last month's position of 9.40%. In month 11 there were 42 leavers and 45 starters. There has been a considerable increase in starters in comparison to last month.

Although we have had some really good successful outcomes with recruitment - i.e. Radiographers, Consultant Radiologists, Aseptic Manager and Lead Technician for Training posts, work continues across all Divisions on the difficult to recruit roles, with a continued focus on Consultant Dermatologists, Consultant Gastroenterologists and Theatre ODPs.

The Divisional hotspots for vacancies in month being Facilities (11.88%), Surgery (4.25%) and Corporate.

There continues to be a decrease in the sickness rate in month at 3.18% compared to last month's position 3.62%.

All three Clinical Divisions have reported Anxiety/Stress, Gastro, Infectious diseases and MSK in their top 4 reasons for sickness absence. Within the other Division, the main reasons for sickness absence falls within Nervous System Disorders, Injury/fracture, Dental and Oral and other MSK.

Currently, there are 58 cases in stage 2 - 4 and 31 long term sickness cases currently being managed, 2 of which are Covid-19 related.

Workforce – Staff Training and Appraisals

Use of Resources

Summary and Action

Mandatory and Statutory training remains slightly above target. Medicine remains just under target (89.37%) in month and has been proactively discussed at DMT.

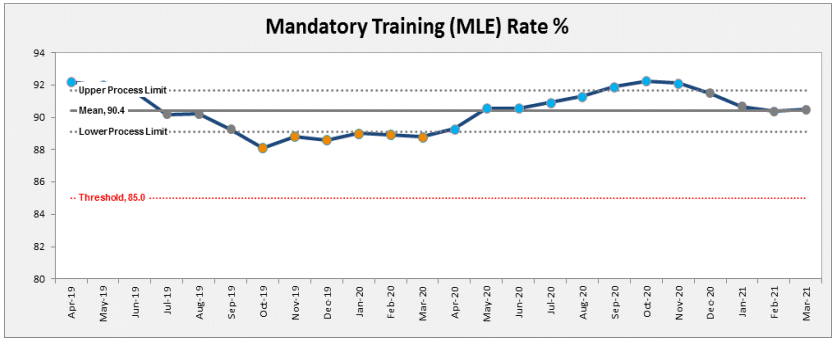
All Divisions are focusing on hand hygiene as it remains to be the only topic below target.

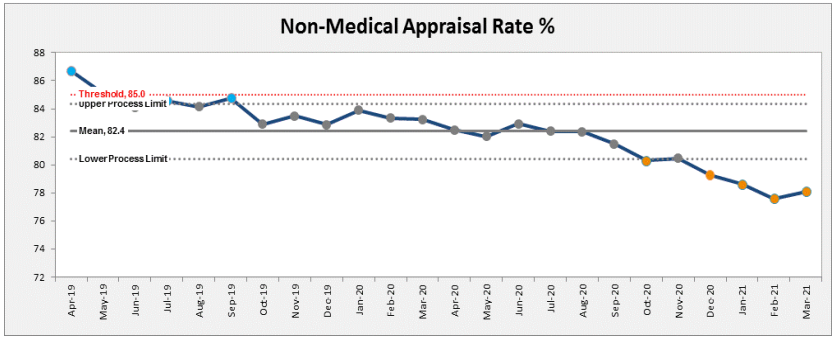
A MLE report has been shared with all departments in the Divisions with targeted emails being sent to individuals who are 6 months out of date on their MLE.

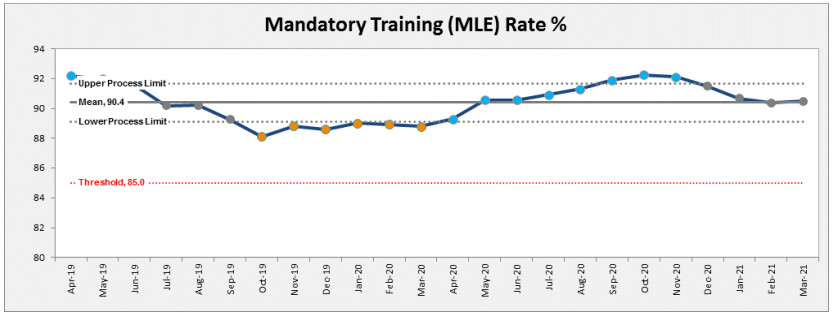
Two out of the three Clinical Divisions have made a slight improvement on the previous month for non medical appraisals. This has been discussed at all DMTs. Concerns have been raised with the Windows 10 upgrades impact and the secondment of senior managers to City Hall Vaccination Centre.

Surgery are tasking service managers to set SMART goals for a trajectory to get their compliance back on track.

Medical appraisals - this remains under target, but with a slight increase on month for Surgery. Plans continue to be in place for continued improvement.







Feedback from Friends and Family test

What was good about your experience?

March 2021

"All the staff are so caring and they do everything you asked them to do. The care and cleanliness is top".
Britford

"All the staff were very kind and welcoming and explained everything clearly."
Cardiac Suite

"The breast feeding team has been extremely helpful so far in supporting me to have the confidence to breastfeed. It has also helped me emotionally and mentally."
Maternity Postnatal

"The unit was clean, staff lovely and surgeon very good at explaining my choices, what would happen and undertaking the operation. Thank you.."
Surgical Assessment Unit

"Excellent, could not have received more care and attention. Made me feel cared for and relaxed"
Emergency Department

"Someone is always around when needed. Friendly and made you feel comfortable."
Downton

"No waiting. Greeted by a helpful member of staff. Doctor was clear, precise and more than happy to answer questions and make sure I was comfortable."
Moire Fringe Clinic

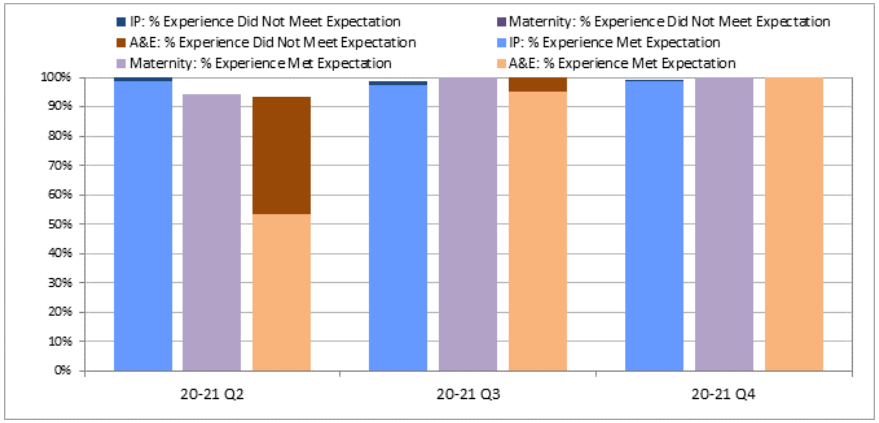
"Very friendly staff. Lovely food. I loved my stay. Thank you all and stay safe xx"
Odstock

"Efficient, polite and friendly. Felt well cared for, supported and informed at every stage. Staff were amazing and reassured me throughout. An excellent experience."
Endoscopy

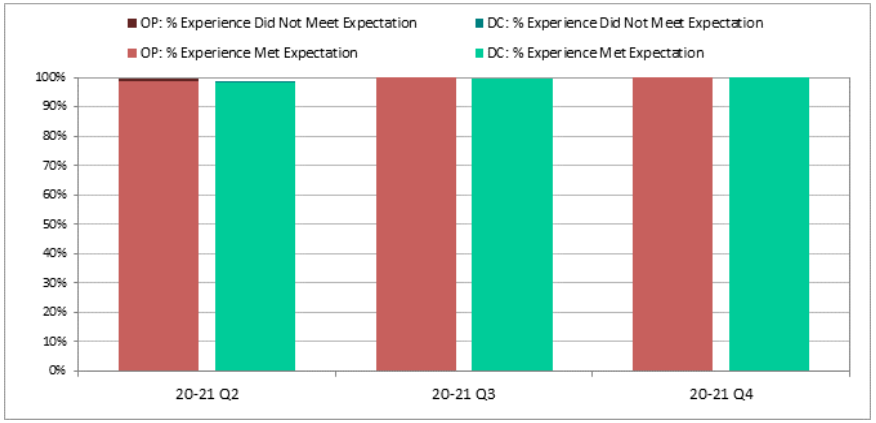
Friends and Family Test – Patients and Staff

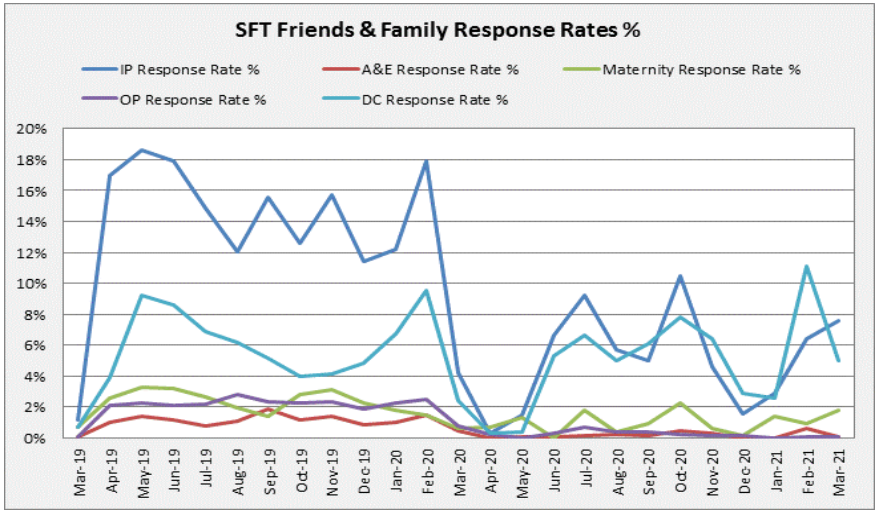
Use of Resources

Patient Responses: Inpatient, Maternity and A&E



Patient Responses: Outpatient and Daycase





The figures in Q4 20/21 are reported as the proportion of patients whose experience met their expectation or had not met their expectation. No patients reported a very poor or poor experience in March.

The previous slide provides some quotes from patients about what was good about their experience across a range of wards and departments.

In September, the Best Place to Work discovery phase report was published which describes the experience of our workforce. The aim was to understand the culture and the 'way we do things around here' as these shape the behaviour of everyone in the organisation and directly affects the quality of care they provide.

The discovery work acknowledged the Trust as a caring, friendly organisation with professional staff who strive to provide the best possible care for patients. Staff are proud of the hospital and proud of the care and treatment we give to our local community. A Board seminar was held on 11 February to discuss the top 3 themes and work towards a commitment to inform the Trust strategy.

Part 4: Use of Resources

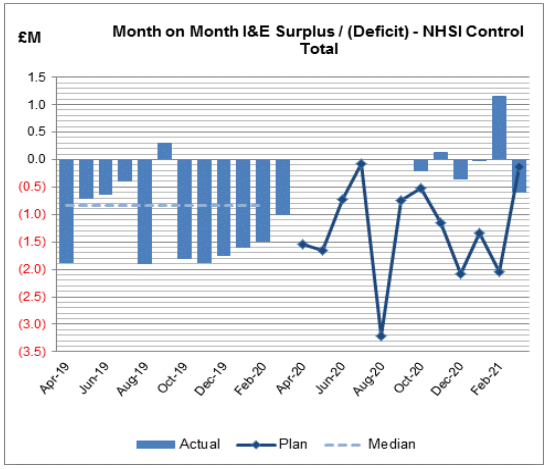
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

Position	Mar '21 In Mth			Mar '21 YTD			2020/21
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Income							
NHS Clinical Income	18,640	22,922	4,282	210,545	228,666	18,121	210,545
Other Clinical Income	888	9,256	8,368	10,407	15,026	4,619	10,407
Other Income (excl Donations)	2,416	4,532	2,116	28,992	45,903	16,911	28,992
Total income	**21,944**	**36,710**	**14,766**	**249,944**	**289,595**	**39,651**	**249,944**
Operating Expenditure							
Pay	(13,636)	(24,099)	(10,463)	(163,634)	(183,051)	(19,417)	(163,634)
Non Pay	(6,977)	(11,106)	(4,129)	(84,050)	(89,286)	(5,236)	(84,050)
Total Expenditure	**(20,613)**	**(35,205)**	**(14,592)**	**(247,684)**	**(272,337)**	**(24,653)**	**(247,684)**
EBITDA	**1,331**	**1,505**	**174**	**2,260**	**17,258**	**14,998**	**2,260**
Financing Costs (incl Depreciation)	(1,463)	(2,114)	(651)	(17,474)	(17,180)	294	(17,474)
NHSI Control Total	**(132)**	**(609)**	**(477)**	**(15,214)**	**78**	**15,292**	**(15,214)**
Add: impact of donated assets	*52*	*1,357*	*1,305*	*1,626*	*803*	*(823)*	*1,626*
Add: Impairments	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: Central MRET	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: FRF	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Surplus/(Deficit)	***(80)***	***748***	***828***	***(13,588)***	***882***	***14,470***	***(13,588)***



Variation and Action

The Trust recorded a bottom line surplus of £78k at the year end (after adjusting for Donated Assets).

The plan had assumed a control total deficit of £0.1m for the month, and a £15.2m deficit for the year, no central MRET or FRF was therefore assumed. Performance against the original plan is summarised in the table above. The Trust's improved performance against this target is due to the increase in funding made available to NHS providers in 2020/21.

Notable is the increase in Pay costs versus those planned, with the temporary cessation of cost releasing efficiency schemes (although productivity schemes remain core to the phase 3 recovery). Pay costs directly related to Covid-19 now stand at £5.7m YTD.

It should be noted that both income and pay costs have increased by £7.1m respectively in April 2021 to reflect the additional pension contribution for permanent staff paid for by the Department of Health and Social Care (DoHSC).

Loans due to DoH have been converted to PDC in 20-21 and as a consequence there is a favourable variance on loan interest payable. This is driving the under-spend on financing costs, although this has been offset by a number of impairments following a review of the fixed asset register.

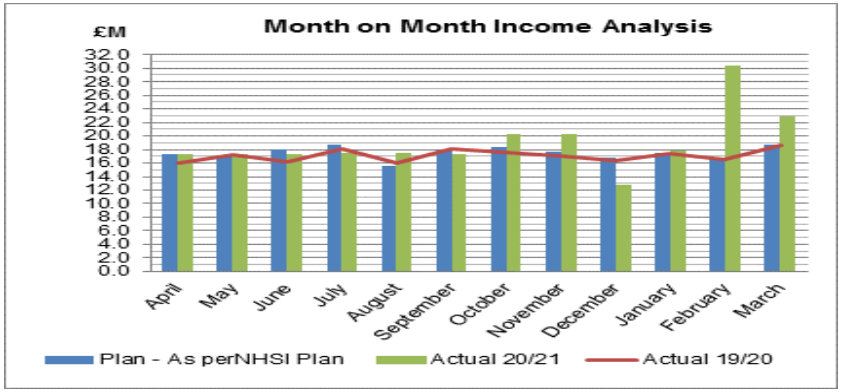
The Elective Incentive Scheme (EIS) has been suspended.

Income & Activity Delivered by Point of Delivery

Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Mar '21 YTD Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	9,231	7,760	(1,471)
Day Case	17,350	11,063	(6,287)
Elective inpatients	18,375	6,120	(12,255)
Excluded Drugs & Devices (Inc. Lucentis)	19,268	18,126	(1,142)
Non Elective inpatients	62,462	55,910	(6,552)
Other	50,838	106,196	55,358
Outpatients	33,021	23,491	(9,530)
TOTAL	**210,545**	**228,666**	**18,121**



SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s	Phase 3 Forecast (YTD) £000s	Phase 3 FC Var (YTD) £000s
BSW CCG	117,168	136,052	18,884	133,552	2,500
Dorset CCG	23,955	24,844	889	24,844	-
West Hampshire CCG	17,210	17,226	16	17,226	-
Specialist Services	32,739	32,766	27	32,431	335
Other	19,473	17,778	(1,695)	16,563	1,215
TOTAL	**210,545**	**228,666**	**18,121**	**224,616**	**4,050**

Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
A&E	72,139	47,130	(25,009)	67,369	(20,239)
Day case	22,948	15,030	(7,918)	21,587	(6,557)
Elective	4,868	2,111	(2,757)	5,114	(3,003)
Non Elective	27,875	25,228	(2,647)	25,991	(763)
Outpatients	256,625	216,937	(39,688)	251,732	(34,795)

Variation and Action

Activity in March has improved compared with February across all of the main points of delivery. The most notable areas of additional Day case activity by specialty are Plastic Surgery, Urology, Ophthalmology, Gastroenterology, Rheumatology, and Gynaecology. Non Elective spells have increased in General Surgery, Plastic Surgery, General Medicine, Cardiology and Gastroenterology. Outpatients have increased in Urology, Breast Surgery, Ophthalmology, Oral Surgery, Paediatrics, Respiratory Medicine and Gastroenterology. The only significant improvement in any one particular specialty in elective inpatient spells was in Gynaecology with an additional 12 spells being recorded.

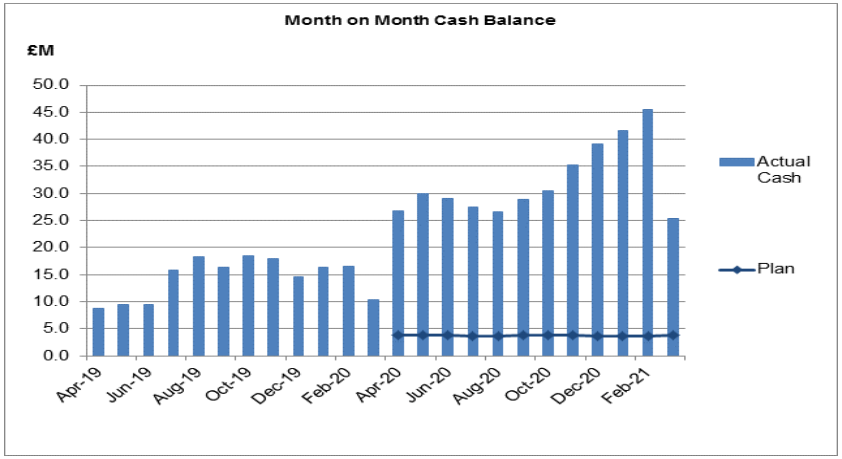
Covid-19 response contractual payment values with main commissioners were based on the Month 9 agreement of Balances (from a provider perspective), adjusted by 2.8% for inflationary pressures. From October onwards, Top up and Covid-19 funding is being received from BSW CCG c£2.5m per month and has been reclassified in month as Clinical income.

The underlying activity has been valued at less than the agreed block by £60,354k (26%) for the year to date due to the temporary cessation of non-urgent planned work and phased recovery response. The variance to the Phase 3 forecast is due to Specialist services High cost drugs and devices and Cancer drugs that sit outside of the block arrangements. Additional income of £2.5m was received from BSW CCG in March. The Elective Incentive scheme was suspended from November onward and no impact has been included within the position.

Cash Position & Capital Programme

Capital Spend:  **Cash & Working:** 

Use of Resources



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

Payments on account in advance up until 31st March 2021 have been received, each a month in advance meaning March 2021 saw no contractual payment. Block contract payments for the first six months of 2021-22 will commence again in April 2021.

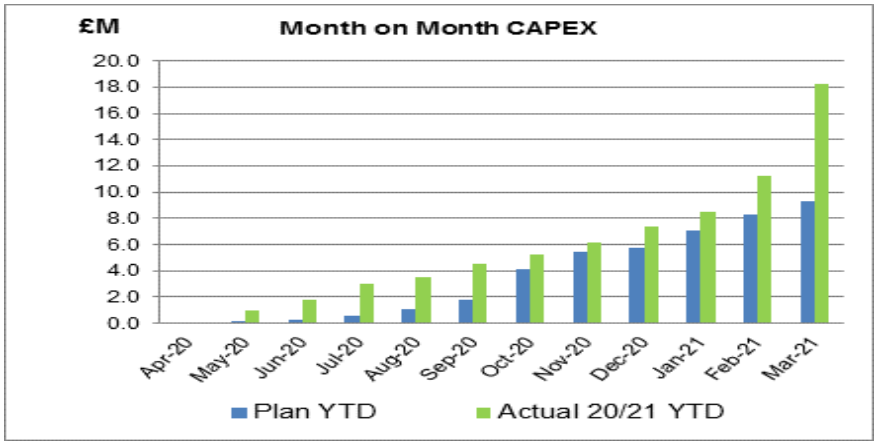
The Trust continues to hold considerable cash balances to cover the outstanding capital spend for the year. During February 2021 the Trust's cash position increased following the receipt of £3.185m estimated compensation for deemed lost income due to Covid-19 in 2020-21. It is considered £0.894m of the latter funds will need to be returned.

The cash flow position will continue to be closely monitored to ensure any potential shortfalls are identified moving into 2020-21.

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

Capital Expenditure Position

	Annual	Mar '21 YTD		
	Plan	Plan	Actual	Variance
Schemes	**£000s**	**£000s**	**£000s**	£000s
Building schemes	850	850	529	321
Building projects	2,600	2,600	1,961	639
IM&T	2,600	2,600	3,496	(896)
Medical Equipment	2,578	2,578	1,934	644
Other	449	449	492	(43)
Addition: Critical Infrastructure Fund	*3,455*	*3,455*	2,490	965
Addition: Covid 19	*1,446*	*1,446*	1,446	0
Addition: Other National projects	*6,466*	*6,466*	5,951	515
TOTAL	**20,444**	**20,444**	**18,299**	**2,145**



Summary and Action

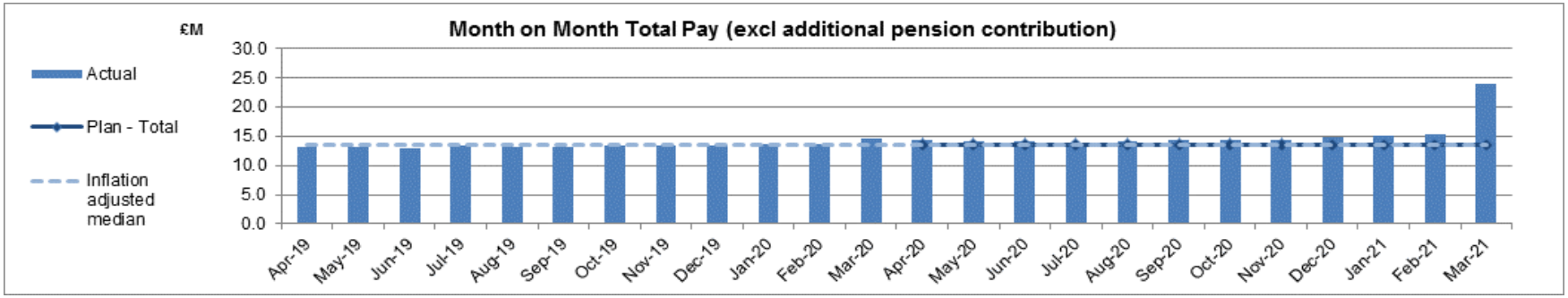
In addition to the Critical Infrastructure Fund of £3.455m, the Trust has received notification of various national funding streams, including Covid-19 approved schemes totalling £7.912m in the year. These schemes are all funded through additional Public Dividend Capital. The Trust has received all cash associated with these projects. Schemes where the announcement of funding was made during the 2020/21 financial year are highlighted blue in the table.

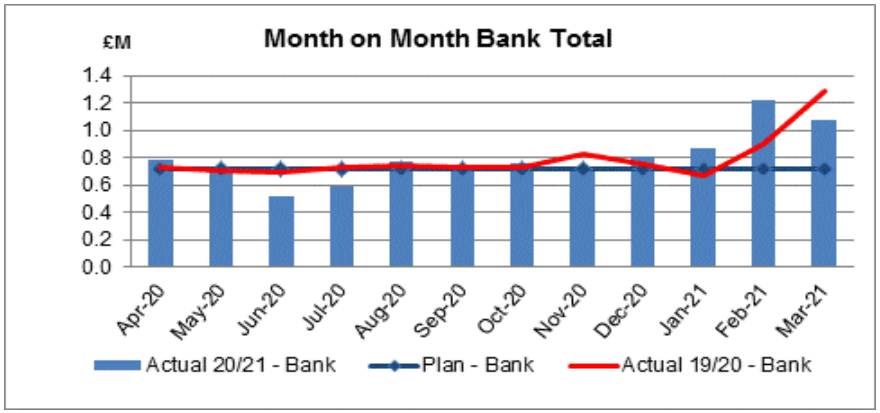
As a result of the considerable additional funding allocated to the Trust in the year, some funds have not been spent in the 2020/21 financial year. This slippage was notified to the regional NHSEI regional teams as soon as the risk became apparent. Allowance has been made in the 2021/22 capital plans for those schemes not completed in 2020/21.

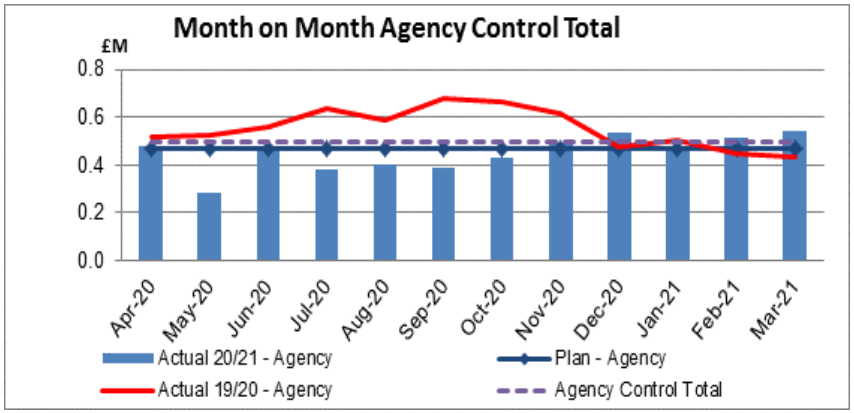
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

Pay expenditure increased by £8.76m, or 57%. The main driver of this was a technical adjustment of £7.07m to reflect the cost of DoHSC pension contributions. Other technical adjustments include an increase of £894k in the annual leave provision, as this is driven largely by the workforce's efforts in responding to Covid-19 NHSEI have provided Trusts with financial support to offset this increase.

The costs directly driven by the Covid-19 response have now reached £5.7m, 62% of which relates to hours worked by the Trust's existing workforce, though a combination of redeployment from BAU duties and additional hours. The high costs seen in month 11 have begun to level off as the level of Covid-19 activity in the Trust has fallen; bank nursing, junior doctor additional shifts and ancillary staff remain the areas mainly affected.

In addition to these directly reported costs, analysis has been undertaken on the reduced availability of rostered staff (caused by a variety of reasons including sickness, self-isolation, shielding etc.), this now stands at c30%, Trust 2020/21 budgeted assumptions had been 19%. The Trust's strong recruitment position means that despite this reduction in availability, there have been sufficient temporary staffing availability to limit the increase in unfilled shifts (thought this does however lead to increased costs).

The Trust's WTE increased by 10.24 wtes month on month, and this reflects an increase in substantive staff of 40.3 wte, and a reduction in the temporary workforce of 29.8 wte. The increase in substantive staff were in Support to Nursing (22.63 wtes) and Infrastructure staff (17.10 wtes). The increase in substantive support to Nursing were spread evenly across Medicine, and the increase in substantive Infrastructure staff occurred mainly in Salisbury Trading and Transformation & Informatics.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.1
Date of Meeting:	06 May 2021		

Report Title:	Review and Agreement of Corporate Objectives 2020-21 and 2021-22			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓			✓
Prepared by:	Louise Drayton, Performance and Capacity Manager Kieran Humphrey, Associate Director of Strategy			
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance			
Appendices (list if applicable):				

Recommendation:

The Board is requested to:

a) **Note** the review of progress and lessons learnt against the Corporate Objectives which were revised during the first wave of the COVID-19 Pandemic
b) As part of Operational Planning for 2021-22, **approve** the proposed Corporate Objectives for 2021-22 (set out in section 4 of the report), **noting** the next steps in programme and performance management.

Executive Summary:

As part of the operational planning process for 2021-22, this report reviews the progress made against the Corporate Objectives which were revised for delivery as part of the ongoing management of and recovery from the COVID-19 pandemic. The report reflects the evolving nature of the Trust's approach to establishing, delivering and measuring its annual corporate priorities, with the aim of achieving a better reflection of the Trust's strategic priorities in the delivery of key projects.

The report summarises the proposed corporate objectives for 2021-22, demonstrating alignment with the planning processes in the NHS nationally, our Integrated Care System and Alliance and the resource allocations planned in our transformation programmes. It sets out the next steps in improving the oversight and delivery of the initiatives included in our Corporate Priorities.

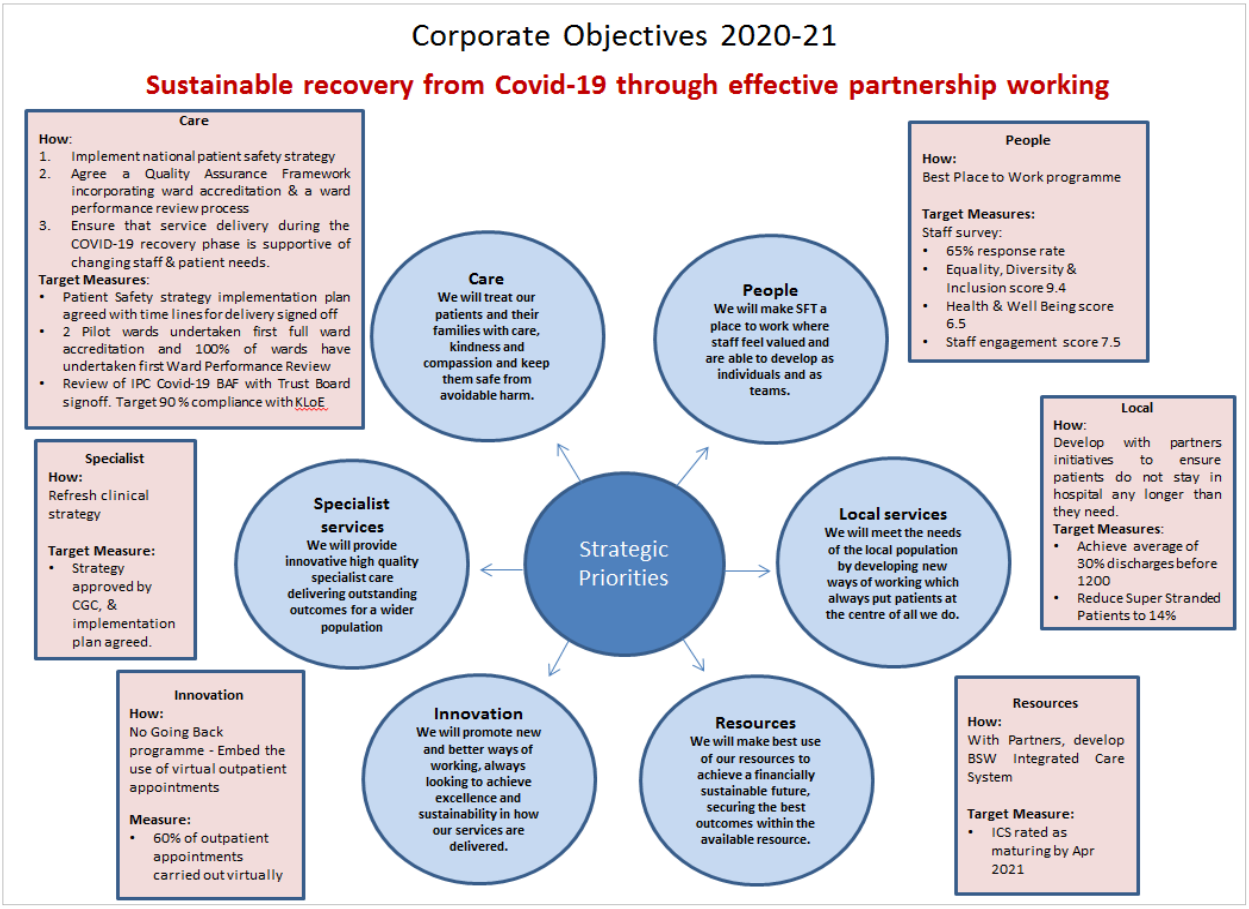
Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
Specialist Services - We will provide innovative, high quality specialist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

Corporate Objectives – End of Year Review & Objectives for 2021-22

1. Introduction

On 17 March 2020, NHSE/I published revised guidance on next steps on the NHS Response to COVID-19 which included suspension of normal planning processes. The Board reviewed the draft Trust Operating Plan at its April meeting, accepting that many of the initiatives required suspension. Further guidance on the second phase of the NHS response to COVID-19 was published on 29 April 2020, which included guidance on the restart and recovery of services. In line with this guidance, the Trust commenced recovery activity and this included setting priority actions for the remainder of 2020-21.

We identified a small number of priorities that both contributed to the Trust's strategy and assisted in recovering from COVID-19.



2. Review of objectives

Local	
Aim	We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all we
How	Develop with partners initiatives to ensure patients do not stay in hospital any longer than they need.
Measure	• Reduce super stranded patient to 14% • Achieve average of 30% of discharges before 12:00
Exec Sponsor	Andy Hyett

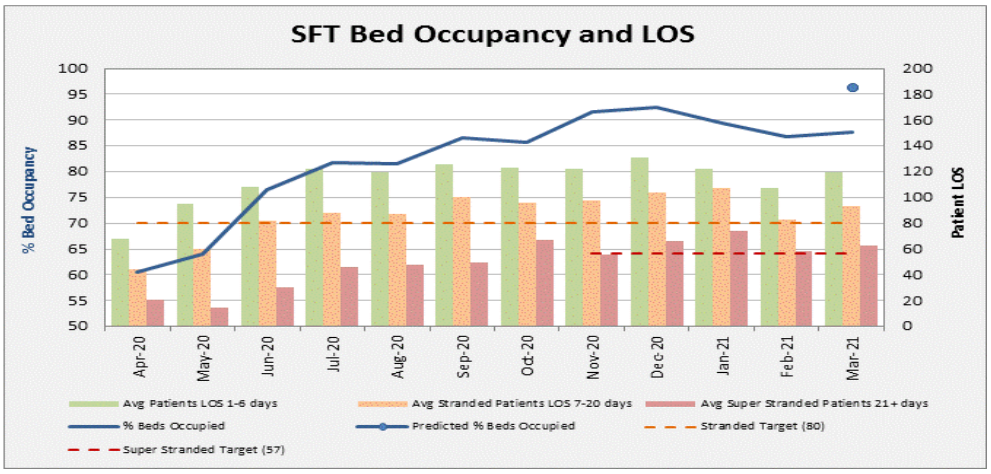
Progress

Super stranded patients

During the first wave of Covid-19 guidance was issued by NHSE/I for hospital discharge through the pandemic. This outlined a significant change to the way acute hospitals planned and referred patients for discharge services, with funding in place to support a rapid discharge to assess model. An improvement was seen almost immediately in the number of stranded and superstranded patients. With the refresh of the corporate priorities in June 2020 in the context of recovery from covid-19, the plan for super stranded patients was reset to a level of 14% of occupied beds rather than an absolute number. The reason for this being the low occupancy levels in the Trust could artificially show or hide progress

2020/21	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Super stranded Patients (21+ days)	21	24	29	44	48	50	68	55	63	73	54	56
Average Occupied beds	191	189	227	325	256	280	352	302	359	291	269	262
% of occupied beds super stranded	11.0 %	12.7 %	12.8 %	13.5 %	18.8 %	17.9 %	19.3 %	18.2 %	17.5 %	25.1 %	20.1 %	21.4 %

Data source: patient flow dashboard

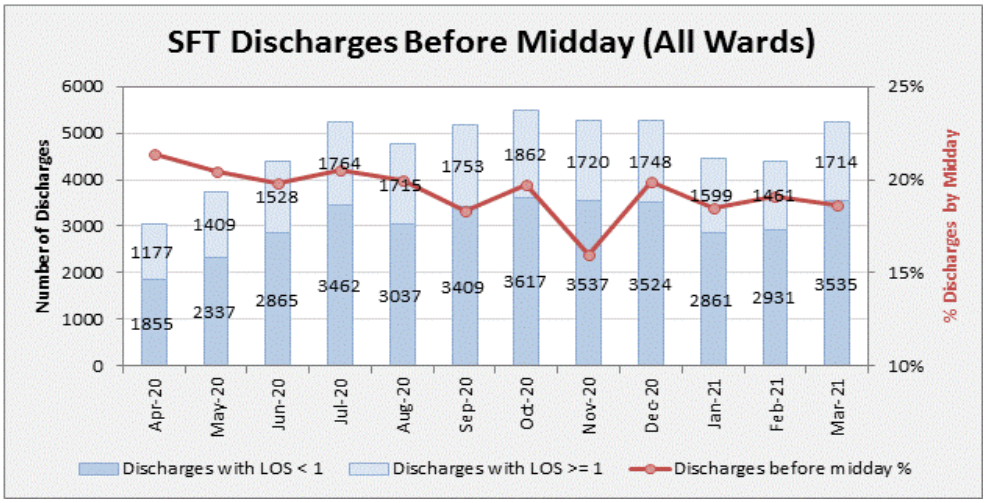


Data source: Integrated Performance Report May 21

As the impact from the first wave reduced, non-urgent elective work was restarted in the hospital, and non-elective & emergency levels all began to rise with the impact of bed occupancy once again rising. With this the proportion of super stranded patients began to rise. A second, more intense, wave of Covid-19 in Q4 caused further increases, with many Covid-19 patients requiring long hospital stays.

Discharges before 1200

Similarly to stranded patients there was an immediate improvement in discharges before midday, but as activity in the hospital increased there has been a fluctuation in the levels, and further Covid-19 waves have slowed the pace of the improvement work. A criteria led discharge pilot has been undertaken, and work is underway to roll this our across wards.



Data source: Integrated Performance report May 2021

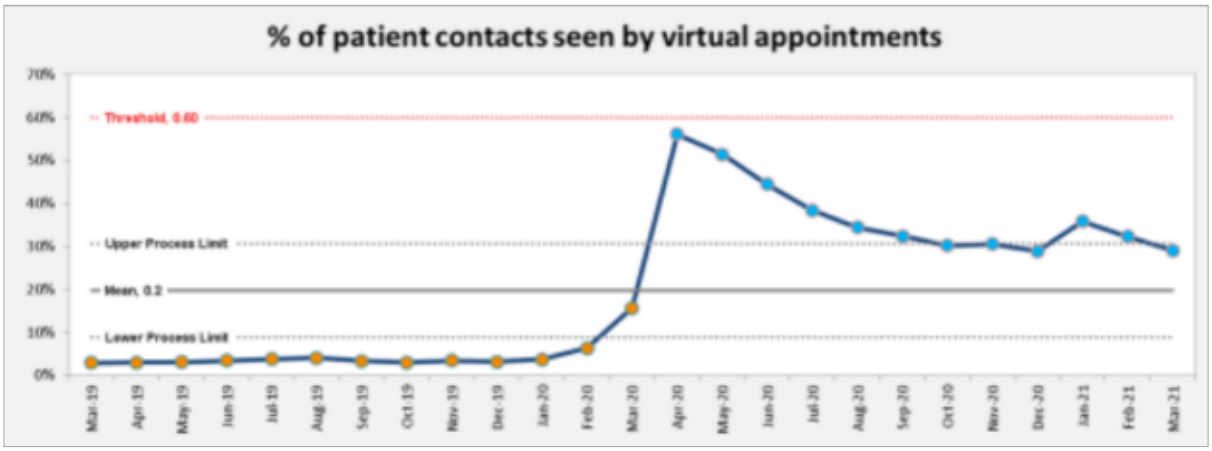
Innovation	
Aim	We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered.
How	No Going Back programme - Embed the use of virtual outpatient appointments
Measure	60% of outpatient appointments carried out virtually
Exec sponsor	Esther Provins

Progress

29.08% of all outpatient appointments in March were virtual (compared to 32.51% in February). Face to Face appointments were heavily restricted in the first wave, with virtual appointments being the default. As face to face services have restarted and outpatient attendances increased the proportion of appointments that were virtual has decreased, and it has been challenging to increase. However the actual number of virtual appointments has doubled over the year from 4290 in March 20 to 10,077 in March 21. Patient feedback has been promising; with 86% of patients saying their video appointment was better than face to face, and 95% being happy to be seen to by video.

A 'virtual by default' review was started in March, to assess which outpatient services could also move to delivery through virtual means. This is expected to be completed by the end of May and will form part of the 21/22 project work.

In addition to this, a new Advice and Guidance platform has been procured and will roll out across the Trust from mid-April further supporting virtual activity.



Data source: Integrated Performance report May 2021

Care	
Aim	We will treat our patients and their families with care, kindness and compassion and keep them safe from avoidable harm.
How	1. Implement national patient safety strategy 2. Agree a Quality Assurance Framework incorporating ward accreditation on & ward performance review process 3. Ensure that service delivery during the COVID-19 recovery phase is supportive of changing staff & patient needs.
Measure	• Patient Safety strategy implementation plan agreed with time lines for delivery signed off • 2 Pilot wards undertaken first full ward accreditation and 100% of wards have undertaken first Ward Performance Review • Review of IPC Covid-19 BAF with Trust Board signoff. Target 90 % compliance with KLoE
Exec sponsor	Judy Dyos

Progress:

Patient Safety Strategy

National guidance was expected for the patient safety strategy but has been delayed. The Trust has good overview systems in place and has implemented weekly safety summits reviewing all moderate and above risks. The sign off process for serious incident investigations is being reviewed. These systems provide confidence in the management of patient safety in lieu of the strategy update, which will follow when the national guidance is released.

Ward accreditation

A ward accreditation process has been established and 100% of wards have had reviews. A clinical summary dashboard is being developed to support the process; however this has been delayed due to Covid-19. A ward accreditation data pack is in place as an interim solution.

IPC Covid-19 BAF

The IPC BAF has been regularly reviewed throughout the year reflecting frequent guidance change. We are over 90% compliant with KLoE, the key areas outstanding are around ventilation in relation to limitation with our physical estate. This also forms part of the DipC report which is regularly reviewed at Board.

People	
Aim	**We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams**
How	Best Place to Work programme
Measure	Staff Survey: • 65% response rate • Equality, Diversity & Inclusion score 9.4 • Health & Well Being score 6.5 • Staff engagement score 7.5
Exec sponsor	Lynn Lane/Susan Young

Progress:

A total of staff (54.2%) took part in the 2020 staff survey. This compares to a response rate for last year's survey of 54.0% (1,954 responses). The median response rate was 45.4% and was slightly lower than the 2019 median of 46.9%. SFT is significantly above the median and increased on 2019 response rate.

Equality, Diversity & Inclusion score of 9.1 (average 9.1). A deterioration on last year's score which was above average.

Health & Well Being score 6.2 (average 6.1). Improved 0.1 from last year

Staff engagement score 7.2 (average 7.0) 0.2 points higher than average, same score as last year.

The Best Place to Work project continues with further detailed plans.

Specialist	
Aim	**We will provide innovative high quality specialist care delivering outstanding outcomes for a wider population**
How	Refresh clinical strategy
Measure	Strategy approved by CGC, & implementation plan agreed
Exec sponsor	Peter Collins

Progress:

Development of the Clinical Strategy has taken place alongside the wider strategic review being undertaken by the Trust, as we seek to align and simplify our strategic priorities and direction. Chief Medical Officer Peter Collins and Associate Director of Strategy, Kieran Humphrey have been working closely to take this work forward under the umbrella of our proposed strategic priorities of **population**, **partnerships** and **people**.

While ‘publication’ of the new clinical and corporate strategy is only one component of the work, completing this important step will take longer than anticipated due to the pressures of COVID-19 management, Phase 3 planning (in Q2 2020-21) and the wider system development work that the Trust is taking a leading role in. However, the strategic direction is increasingly driving our corporate priorities, relationships with partners and investment in our staff.

The Trust is keen that our future strategic direction is the driver for our work and prioritisation across all areas of the Trust, and we are progressing well through a wide engagement and communication programme, with a view to ensuring that our new strategies are in place as part of our new Corporate Priorities for 2021-22. These priorities link to the specific areas of focus in our clinical strategy – particularly elective recovery, integrated urgent care and frailty services, maternity and mental health service reviews and advancing our digital approaches to care.

Resources	
Aim	**We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resource.**
How	With Partners, develop BSW Integrated Care System
Measure	ICS rated as maturing by Apr 2021
Exec sponsor	Lisa Thomas

Progress:

Bath and North East Somerset,
Swindon and Wiltshire Partnership
Working together for your health and care

BSW achieved designation as an Integrated Care System in Q3 2020-21 and is embracing fully the next steps on Integrated Care set out in the Government White Paper published in February 2021. The system’s planning, prioritisation, performance management and transformation is increasingly moving toward the integrated approach defined by national policy. Our own strategic direction and priorities reflect this ambition. Moving forward into 2021-22, our commitment to work with our partners and deliver services to our communities in an integrated way is further driving our corporate priorities, and we will input further to the development of our ICS, Board to Ward, at all levels of the organisation.

3. Lessons learnt

The Trust continues to develop and refine its approach to delivery and performance of its objectives. The monitoring of measures related to each objective was incorporated in the Integrated Performance Report (IPR) which supported the overview and importance of the identified work streams. The objectives at times required more detailed plans and operational support, however progress was made during 2 waves of a pandemic when operational focus was managing immediate patient safety, ensuring staff were supported and maintaining all urgent services.

Objectives were agreed initially with the Executive Team, and sometimes this didn't fully reflect the priorities of the divisions. Our approach for 2021/22 will be to engage the divisions and the Executive Team in agreeing priorities to ensure we have covered the top down and bottom up development and planning, improving the engagement and communication of the process, and therefore ownership of the objectives.

Quarterly updates were taken through the relevant Board Committee with oversight responsibility; we can develop this further and establish reporting structures for project plans, with an operational lead identified for each objective.

The priorities were aligned with the Board Assurance Framework, which gave the Board more visibility of progress against objectives.

4. Looking forward – Corporate Priorities 2021-22

Included in the Trust's wider operational plans for 2021-22 are a proposed set of corporate priorities – the areas of work that the Trust will commit to prioritise work and progression, alongside system partners. To build on the alignment of strategic priorities and operational delivery, the table below demonstrates where priorities are underpinned by national policy, the priorities of BSW ICS and have identified programme/project management support. There are areas where this may not yet be the case and we will need to confirm the arrangements to ensure progress is made in these areas.

The next steps in this process are proposed as:

- Agreement of the Corporate Priorities as part of approval of the Trust's operational plans in 2021-22
- Agreement of performance measurements for each priority
- Assessment and management of any gaps in strategic alignment and programme/project resource
- Evolution of performance management structures including use of an Integrated Performance Framework (building on our developing IPR) for use across teams, Divisional Performance Management, the Board and its Committees.
- Adjusting our Board Assurance Frameworks and prioritisation exercises to reflect our revised Clinical and Corporate Strategy development.

Corporate Objectives 2021-22: Alignment to system priorities, operational guidance and transformation programme

Division	Priority	Link to NHSE Operational Planning Guidance 2021-22 (see key below)	Link to BSW ICS / Wiltshire Alliance Operational Plans	Link to emerging SFT strategic priorities	Identified in SFT Transformation Programme / Project Support
Medicine	**a) Frailty – Integrated Pathway**	✓ (E)	✓ (Wilts Alliance)	Population	✓
	b) Embed discharge improvements including therapies/rehab model	✓ (E)	✓ (Wilts Alliance)	Partnerships	✓
	c) Integration of urgent care services	✓ (E)	✓ (BSW Urgent Care Board)	Partnerships	
Surgery	**d) Elective Programme recovery (including system planning**	✓ (C)	✓ (BSW Planned Care Board, Acute Hospital Alliance)	Population Partnerships	✓
CSFS	**e) Maternity Review**		✓ (Maternity Programme Board)	Population	✓
	f) Review of Mental Health Services	✓ (C)	✓ (Wilts Alliance, Mental Health Thrive Board)	Population Partnerships	
Quality	**g) Sustain Recovery from COVID**	✓ (B)	✓ (Wilts Alliance)	Population	
	h) Staff Health and Well Being	**✓ (A)**	**✓ (Wilts Alliance)**	**People**	✓
	i) Improve Safety vs Known Risks			Population	

Division	Priority	Link to NHSE Operational Planning Guidance 2021-22 (see key below)	Link to BSW ICS / Wiltshire Alliance Operational Plans	Link to emerging SFT strategic priorities	Identified in SFT Transformation Programme / Project Support
	j) Ward to Board Assurance on Safety			Population	
	k) Strengthen Partnerships to Improve Population Health	✓ (F)	✓ (Population Health Board, Wilts Alliance)	Partnerships Population	
	l) Strategy for specialised commissioned services including rehab and reablement			Population	
Corporate	**m) IT – ePMA, Pathology LIMS, shared EPR, SBS (ledger)**		✓ (Acute Hospital Alliance, Wilts Alliance)	Partnerships	✓
	n) Strategy Review and Implementation		✓ (Wilts Alliance)	Population Partnerships People	✓
	o) OD and Improvement Programme	✓ (A)	✓ (Wilts Alliance)	People	✓
	p) Best Place to Work	✓ (A)	✓ (Wilts Alliance)	People	✓

Key: NHS England Operational Planning Priorities 2021-22

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention

B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19

C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services

D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities

E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay

F. Working collaboratively across systems to deliver on these priorities.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.2.1
Date of Meeting:	06 May 2021		

Report Title:	Corporate Governance Statement Self-Certifications FT4, G6, CoS7 (Continuation of Services) and Training for Governors			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance			
Appendices (list if applicable):	Appendix 1 – Evidence to support the response Appendix 2 – Provider Licence Conditions			

Recommendation:

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

- Recommendation that the Board approve the Trust's Provider Licence self-certifications.

Executive Summary:

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

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

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

The Director of Corporate Governance and Director of Finance have reviewed the statements and evidence sets and is proposing that the Board of Directors responds with confirmed for all elements. This was supported by the Finance and Performance Committee. The evidence to support the response is outlined in Appendix 1 of the paper.

There is currently no new guidance issued by NHSI and therefore, templates and deadlines mirror those for 2020/21.

Self-certification Timeline

Condition G6(3)	The provider has taken all precautions to comply with the licence, NHS acts and NHS Constitution	By 31 May
Condition G6 (4)	Publication of condition G6(3) self-certification	By 30 June
Condition FT4 (8)	The provider has complied with required governance arrangements	By 30 June
Condition CoS7(3)	The provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement.	By 31 May

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

1 Purpose

1.1 To provide evidence of compliance against the Provider Licence to support a decision by the Finance and Performance Committee.

2 Background

2.1 NHS Foundation Trusts are required to self-certify annually whether or not they have:

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

3 Self-certification requirements

3.1 Providers need to self-certify the following after the financial year-end:

NHS Provider Licence conditions
The provider has taken all precautions to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))
The provider has complied with required governance arrangements (condition FT4 (8))
If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (condition CoS7(3))
Governors have received the necessary training to ensure they are equipped with the skills and knowledge they need to undertake their role

3.2 Providers must publish their G6 self-certification by 30 June 2021.

3.3 It is up to providers how they undertake their self-certification process; however, a number of templates have been provided which the Trust has used as the basis of the document in Appendix 1.

3.4 Trusts are required to state either “confirmed” or “not-confirmed” against each element of the licence condition. Any “not-confirmed” must provide an explanation why.

3.5 Boards must sign off the self-certification no later than:

- G6/CoS7: 31 May 2021
- FT4: 30 June 2021

3.6 Self-certifications do not need to be submitted to NHS Improvement (NHSI) however, NHSI can audit Trusts and ask for evidence that they have self-certified, either by providing the completed or relevant Board minutes and papers recording sign-off.

3.7 In the absence of 2019/20 guidance, templates and deadlines are based on guidance from last year.

4 Summary

4.1 The Director of Corporate Governance and the Director of Finance have reviewed the statements and evidence sets and is proposing that the Committee responds with “confirmed” for all elements. The evidence to support the response is outlined in Appendix 1.

4.2 For condition FT4, the Board is also required to consider any risks and mitigating actions for each element of the Provider Licence condition. These are described in Appendix 1.

4.3 The Provider Licence conditions are outlined in Appendix 2 in reference to Condition G6.

4.4 The responses will be transcribed into the NHSI templates once agreed.

5 Recommendations

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

Fiona McNeight, Director of Corporate Governance

		Proposed Response	Evidence	Risks	Mitigating Actions
	FT4 – Corporate Governance Statement				
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	• Well-led Framework CQC inspection rated Trust as 'Good' • Annual Governance Statement • Head of Internal Audit Opinion • Board Assurance Framework • Board Committee annual effectiveness evaluation • Annual review of corporate objectives • Annual Director declaration of interests and Fit and Proper Persons • Compliance with the Code of Governance • External audit of the annual report and accounts • Quality Account • Internal and External Audit Reports • Constitution review and updated December 2020. • Board development programme • Policy management process • Incident management structure during pandemic to ensure continued effectiveness of governance systems and processes during the National level 4 incident.	• Nil identified	
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	• Central management of incoming National and Local correspondence to ensure effective oversight of required action and deliverables.	• Nil identified	

		Proposed Response	Evidence	Risks	Mitigating Actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	• Integrated Governance Framework • Accountability Framework • Executive performance reviews • Directorate Governance Committees • Board and Committee annual effectiveness reviews • Scheme of Delegation and Standing Financial Instructions • Committee terms of reference annual review • Escalation reports from Board Committee Chairs to the Board • Annual review of Board and Committee work plans • Governor observers at all Board and Board Committees • Bi-weekly meetings with the Lead Governor and Chairman • Governance structure review completed March 2020. Gaps in the structure identified and OD &P Management Board implemented • Internal Audit reports	• Nil identified	
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the	Confirmed	• Monthly Integrated Performance Report to Board • Annual Operating Plan and budget • Standing Financial Instructions • Head of Internal Audit Opinion • Annual Governance Statement • Internal Audit Programme and reports	• The Trust's internal control systems are not sufficiently robust to ensure compliance	• The systems and processes are regularly tested through the internal and external audit programmes, and the robust approach to risk management

		Proposed Response	Evidence	Risks	Mitigating Actions
	Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		• Revised committee structure March 2020 and associated terms of reference • External audit of the annual report and accounts • Risk Management Strategy • Corporate and Divisional risk registers • Deep dive of Divisional Risk Registers with the Chief Nursing and Medical Officers • Board Assurance Framework • Risk based Board and Committee work plans • Subsidiary Governance Committee • Subsidiary Governance Framework • Annual planning process • Electronic Board administration solution • Board Committee escalation reports		• Targeted improvement in corporate processes and procedures.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:	Confirmed	• Well-led Framework CQC inspection rated Trust as 'Good' • Board development programme • Board effectiveness evaluation	• As above	• As above

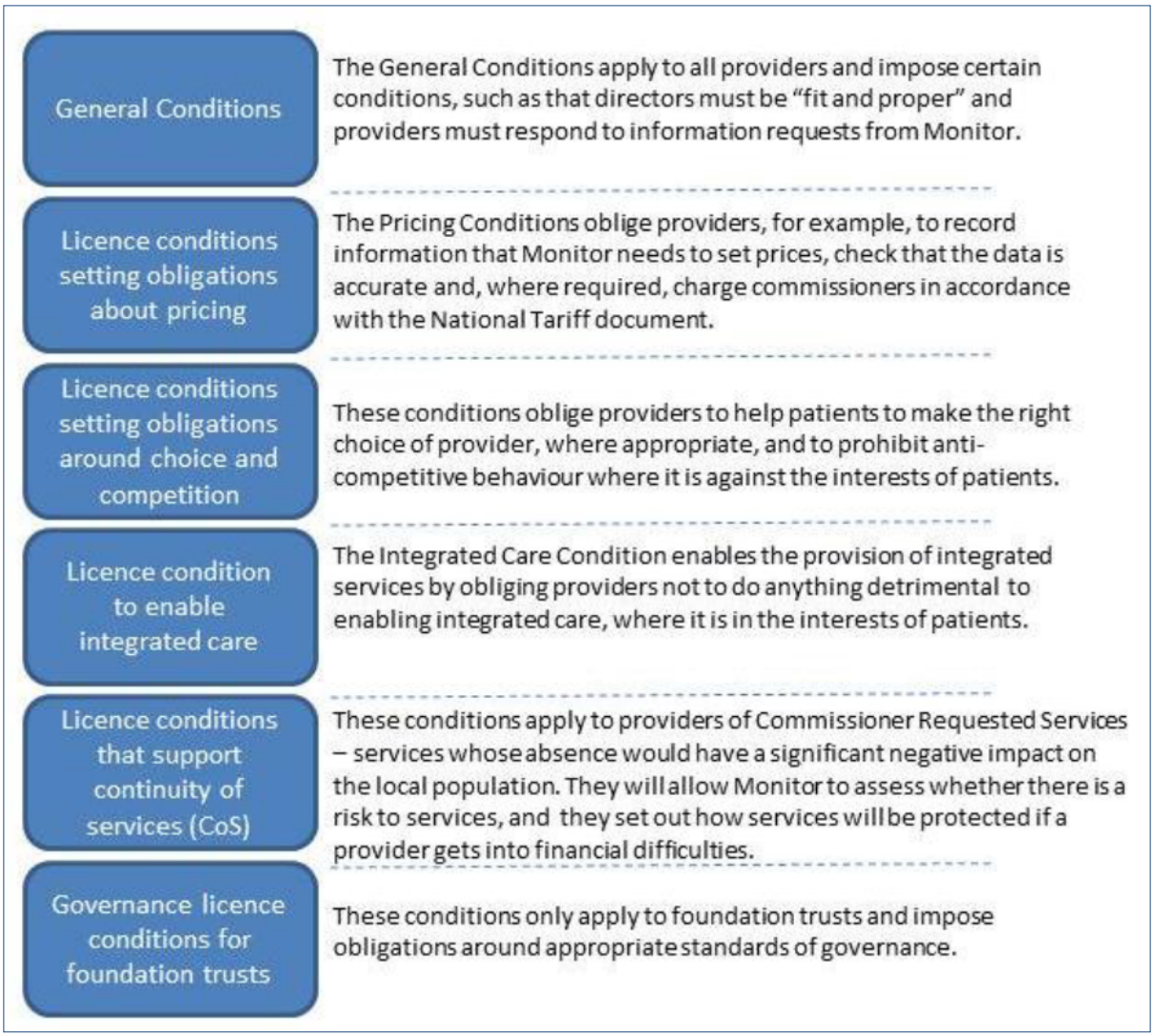
		Proposed Response	Evidence	Risks	Mitigating Actions
	(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		report • Monthly quality and performance reports • Executive annual appraisals • Integrated Governance Framework • Customer care reports to Board • Clinical Governance Committee (CGC) • Freedom to Speak Up Guardian and Guardian of Safe Working reports to CGC. • Board safety walks • Active engagement with Commissioners, local Health Scrutiny, Health and Well-being Boards and Healthwatch • Patient and staff stories to each Board meeting.		
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the	Confirmed	• Workforce report • Nurse skill mix review bi-annually • Revalidation and appraisal processes • Executive Performance Reviews • Board development programme	• There is a risk of unforeseen workforce changes at Board and sub-Board level	• Deputies in post for all Executive Directors • Recent substantive Executive appointments

		Proposed Response	Evidence	Risks	Mitigating Actions
	conditions of its NHS provider licence.		with external facilitation • Externally facilitated Executive coaching • Annual Fit and Proper Person declaration process		• The Board has appointed to all Non-Executive Director roles and has Governor observors for Board and Board Committees
General condition 6 – Systems for compliance with licence conditions					
1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed- although the Trust is still subject to enforcement action where NHSI has found the Trust in breach of license conditions.	• Internal Audit and clinical audit work programmes • Data Security and Protection Toolkit compliance • Fit and Proper Person requirements included in all Director appointments and annual declaration • Board Assurance Framework • Integrated Governance Framework • Accountability Framework • CQC Registration • Risk Management Strategy • Annual submission of reference costs • Annual reference cost assurance report • Signed contracts with Commissioners based on national tariffs	N/A	N/A
Continuity of Services condition 7 – Availability of Resources					
1	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it		N/A	N/A	N/A

		Proposed Response	Evidence	Risks	Mitigating Actions
	after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.				
or	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed	The Trust has reported a significant deficit for the last few years and historically had to take on cash loans which have subsequently been converted to Public Dividend Capital. This position improved to breakeven in 2020/21 due to the Covid funding regime. The funding regime is still uncertain for 2021/22 however the allocation for the first six months shows the Trust at a breakeven position with sufficient cash. Allocations are yet to be confirmed for the second half of the financial year. The Trust is working on the basis further efficiencies will be required.	N/A	N/A
Training of Governors					
	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	• Induction and mandatory training Programme • Governor development days • Governor observers on all Board and Board Committees • Informal Governor and NED meetings • Bi-weekly meetings with the Lead Governor and Chairman • Attendance at external training events	N/A	N/A

Appendix 1 – Provider Licence Self-Certification

Appendix 2: Provider Licence Conditions



Appendix 2: Provider Licence Conditions

General Conditions

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

General Condition 1: Provision of information

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

General Condition 2: Publication of information

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

General Condition 3: Payment of fees to Monitor

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

General Condition 4: Fit and proper persons

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

General Condition 5: Monitor guidance

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

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

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

General Condition 7: Registration with the Care Quality Commission

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

General Condition 8: Patient eligibility and selection criteria

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

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

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

Pricing Conditions

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

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

Pricing Condition 1: Recording of information

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

Pricing Condition 2: Provision of information

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

Pricing Condition 3: Assurance report on submissions to Monitor

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

Pricing Condition 4: Compliance with the National Tariff

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

Pricing Condition 5: Constructive engagement concerning local tariff modifications

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

Choice and Competition Conditions

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

These conditions apply to all licence holders.

Choice and Competition Condition 1: Patient choice

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

Choice and Competition Condition 2: Competition oversight

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

Integrated Care Condition

The Integrated Care Condition applies to all licence holders.

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

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

Continuity of Services Condition

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

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

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

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

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

Continuity of Services Condition 2: Restriction on the disposal of assets

This licence condition ensures that licensees keep an up-to-date register of *relevant* assets used in the provision of Commissioner Requested Services. It also creates a requirement for licensees to obtain Monitor's consent before disposing of these assets when Monitor is concerned about the ability of the licensee to carry on as a going concern.

Continuity of Services Condition 3: Monitor risk rating

This condition requires licensees to have due regard to adequate standards of corporate governance and financial management.

Continuity of Services Condition 4: Undertaking from the ultimate controller

This condition requires licensees to put in place a legally enforceable agreement with their 'ultimate controller' to stop ultimate controllers from taking any action that would cause licensees to breach the licence conditions. This condition specifies who is considered to be an ultimate controller.

Continuity of Services Condition 5: Risk pool levy

This licence condition obliges licensees to contribute, if required, towards the funding of the "risk pool" - this is like an insurance mechanism to pay for vital services if a provider fails.

Continuity of Services Condition 6: Cooperation in the event of financial stress

This licence condition applies when a licensee fails a test of sound finances, and obliges the licensee to cooperate with Monitor in these circumstances.

Continuity of Services Condition 7: Availability of resources

This condition requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services.