Bundle Trust Board Public 8 July 2021

1	OPENING BUSINESS
1.1	10:00 - Presentation of SOX certificates
	Sister Zara Sanderson, Living our Values Professional SOX *June SOX of the month - The Emergency Department, The Acute Medical Unit and Cardiology*
1.2	Declaration of Interests
1.2	10:10 - Patient Story
1.3	Welcome and Apologies
	Apologies received from Paul Wood, Tania Baker
1.4	Declaration of Interests
1.5.a	10:30 - Draft Minutes of the Trust Board Meeting held on 6 May 2021
	Minutes attached from meeting held on 6th May 2021 *For approval*
	1.5a Draft Public Board mins 6 May 2021.docx
1.5.b	Draft Minutes of the Electronic Trust Board Meeting held on 14 June 2021
	Minutes attached from electronic meeting held on 14th June *For approval*
	1.5b Draft-Electronic Board Minutes 14th June 2021.docx
1.6	10:35 - Matters Arising and Action Log
	1.6 Public Trust Board action log.pdf
1.7	Register of Attendance
	Register of Attendance - Public Board 2021-22.docx
1.8	10:40 - Chairman's Business
	Presented by Nick Marsden *For information*
1.9	10:45 - Chief Executive Report
	Presented by Stacey Hunter *For information*
	1.9a CEO Board Report June for July Board.docx
	1.9b B0642_ICS design framework_16june.pdf
	1.9c Salisbury OE_Current State Workshop update.pptx
2	PEOLPE AND CULTURE COMMITTEE
2.1	10:55 - Freedom to Speak Up Guardian Annual Report
	Presented by Susan Young *For assurance*
	2.1 FTSU Annual Report 2020-21 (Final June 2021).docx
2.2	Nursing Skill Mix (deferred to September)
2.3	11:05 - Improving our People Practices
	Presented by Susan Young
	2.3a Trust Board Coversheet Improving our People Practices 2021.docx
	2.3b Item 1.6.2b Dido Harding Letter to Chairs CEOs 24 May 2019 (2).pdf
	2.3c Item 1.6.2c Prerena Issar Letter to CEOs HRDs (2).pdf
	2.3d Item 1.6.2a SFT Recommendations relating to Disciplinary Procedures (YOUNG Susan (SALISBURY NHS FOUNDATION TRUST)).docx
	2.3e Disciplinary_2021_Just_Culture.docx
3	ASSURANCE AND REPORTS OF COMMITTEES
3.1	11:15 - Charitable Funds Committee - 17 June
	Presented by Nick Marsden *For assurance*
	3.1 Escalation report - from CFC Committee 17 June 2021 19.docx
3.2	11:20 - Finance and Performance Committee - 5 July

** Presented by Paul Miller*
** For assurance*

3.3 11:25 - Clinical Governance Committee - 29 June

Presented by Eiri Jones
For assurance

3.4 11:30 - Trust Management Committee - 30 June

Presented by Stacey Hunter
For assurance

3.4 TMC Escalation report.docx

3.5 11:35 - People and Culture Committee - 24 June

Presented by Michael von Bertele
For assurance

3.5 P&C Escalation report - June 2021.docx

3.6 11:40 - Integrated Performance Report (M2) to include exception reports

Presented by Susan Young
For assurance

3.6a 080721 IPR cover Board.docx

3.6b IPR July 2021 final v2.pptx

3.7 11:55 - Extraordinary Audit Committee - 18 June

Presented by Paul Kemp
For assurance

3.7 Escalation Report from Committee to Board - Extraordinary Audit Committee 18th June 2021.docx

4 GOVERNANCE

4.1 12:00 - Register of Seals

Presented by Fiona McNeight
For information

4.1 Register of Seals.docx

4.2 12:05 - BREAK

5 QUALITY AND RISK

5.1 12:20 - Patient Experience Report Q4/Annual Report

Presented by Judy Dyos
For assurance

5.1 Patient Experience Report Q4 May 2021 final.docx

5.2 12:30 - Learning from Deaths Report Q4/Annual Report

Presented by Peter Collins
For assurance

5.2 Learning from deaths report Q4 20 21 May 21 PC approved 26 05 21.docx

5.3 12:40 - Director of Infection Prevention Control Report

Presented by Judy Dyos
For assurance

5.3a Trust Board Summary sheet Annual DIPC Report (2020-21).docx

5.3b DIPC Report Annual Update 2020-21 (v.2).doc

5.3c IPC BAF National V1.2 (archive from March 2021) SFT Q4 20-21 POST IPCC.....pdf

5.3d IPC BAF National V.16 12.02.2021 SFT V3.0 (April 2021 Q4 2021 reveiw....pdf

5.4 12:50 - Maternity - Clinical Negligence Scheme for Trust (CNST)

Presented by Judy Dyos
For approval

5.4a Front sheet for Trust Board Meeting July 2021 Maternity CNST paper June 2021.docx

5.4b CNST MIS Board self certification report 2021 for Trust Board July 2021.docx

5.4c Gap Analysis action 1-3.pdf

5.4d Gap Analysis action 4-6.pdf

5.4e Gap analysis action 7-10.pdf

5.4f Changed MIS requirements 2019 Vs 2021.docx

5.4g Board declaration 2021 MIS Year 3.pdf

6 FINANCIAL AND OPERATIONAL PERFORMANCE

6.1 13:00 - Data Security and Protection Toolkit Self-Assessment

Presented by Lisa Thomas
For assurance

6.1 DSPT Audit Committee 2021.docx

6.2 13:10 - Data Protection Officer Annual Report and Compliance with GDPR

Presented by Lisa Thomas
For assurance

6.2 SIRO report for FP July 21 finalv2.docx

7.1 13:20 - Agreement of Principle Actions and Items for Escalation

7.2 13:25 - Any Other Business

7.3 13:30 - Public Questions

7.4 Date next meeting

9 September 2021

8 Resolution

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

Salisbury NHS Foundation Trust

DRAFT
Minutes of the Public Trust Board meeting held at 10:00am on Thursday 6 May 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
Andy Hyett (AH)	Chief Operating Officer
Stacey Hunter (SH)	Chief Executive

In Attendance:

Kieran Humphrey (KH)	Associate Director of Strategy (for item TB1 6/5/3.1)
Kylie Nye (KN)	Corporate Governance Manager (minutes)
Fiona McNeight (FMc)	Director of Corporate Governance
Paul Wood (PW)	Interim Director of Transformation
Kat Glaister (KG)	Head of Patient Experience (for item TB1 8/4/1.2)
Nicola Jones (NJ)	Oral Surgeon (for item TB1 6/5/1.2)
John Mangan (JM)	Lead Governor (lead observer)
Kevin Arnold (KA)	Governor (observer)
Jennifer Lisle (JL)	Governor (observer)

ACTION

TB1 6/5/1 OPENING BUSINESS

TB1 6/5/1.1 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.

- Emily East – Staff Nurse, Sarum Ward
- Chelsea Butchers – Midwife, Maternity

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

SH noted it was international day for Midwifes this week and International day for nurses next week and both stories illustrated the unique contribution that nurses and midwifes make and the impact they have at the best and worst time of people's lives. This reflects that people are going the extra mile to support individuals

and communities and this should not be taken for granted.

TB1 6/5/1.2 Staff Story

This month's Staff Story was from Nicola Jones, who attended the Board to provide a summary of her experiences during the height of Covid-19 in January 2021, when she was redeployed onto Pitton Ward. NJ explained that as oral surgeon who had worked in the Trust for 17 years she had never been on call and had very little contact the with ward structure.

When her day surgery list got cancelled one morning she saw that people were being asked to help out on wards if they were unable to do their normal roles. NJ ended up on Pitton Ward, a busy ward with every patient having tested positive for Covid-19. NJ did whatever she was asked to do and helped to shower patients, helped with bed pans, collected specimens, made tea and coffee and served lunch. NJ noted what a brilliant team it was and how positive it had been to be able to lend a hand and feel like she was able to help in a situation where everyone was run off their feet. NJ explained that there were some amazing student nurses, health care assistants and staff nurses and the team atmosphere was great with everyone going the extra mile.

It was noted that Carlos Lopez, charge nurse from Pitton Ward had been asked to attend and share his story but he unfortunately had other commitments.

Discussion:

- NM thanked NJ for her story and noted how humbling it was to hear one of many stories of staff going the extra mile to help out. NM noted that whilst the prevalence of Covid has decreased it is helpful to be reminded of what staff achieved as part of their role or in a redeployment role and NM extended his thanks to all staff who helped during a difficult period.
- SH thanked NJ and noted that what Carlos would have said is that during this time described two thirds of Pitton's permanent team were off sick with Covid-19 or were isolating and as described and it shared more than it's burden of patients who were sick with Covid-19. This was a really tough situation for those staff left, including Carlos and they were doing the bare necessities to be able to get through work and therefore hugely befitted from the help of others.
- PM asked NJ what she had taken from this experience and NJ explained that Salisbury has some great team work and colleagues and as awful as Covid has been, a positive to take from this is that she could introduce herself to other colleagues and be welcomed into a foreign environment where she was able to utilise basic skills to help.
- JDy thanked NJ and all those who helped the nursing teams. JDy also noted that Carlos should be recognised as going over and above what was expected and expressed

thanks to him too.

- EJ queried what support had been offered to these staff who had worked exceptionally hard during Covid. It was explained that there are a lot of people who need support and the Trust is looking as people individually as everyone has reacted in a different way. There is psychologist support and health and well-being initiatives that are widely communicated throughout the Trust. It is recognised that the response to Covid-19 in relation to health and wellbeing was quite reactive and therefore there is a focus on how the Trust want to approach health and wellbeing in the mid to long term. There has been analysis of the Staff Survey and there are lessons that can be learnt. This will be reviewed by the executive team in the coming weeks and will report back to Board.

TB1 6/5/1.3 Welcome and Apologies

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

- Peter Collins, Chief Medical Officer

TB1 6/5/1.4 Declarations of Conflicts of Interest

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

TB1 6/5/1.5 Minutes of the part 1 (public) Trust Board meeting held on 8th April 2021

NM presented the minutes which were agreed as an accurate record of the meeting held on 8th April 2021.

TB1 6/5/1.6 Matters Arising and Action Log

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

- **TB1 14/1/4.5, TB1 4/3/1.6, TB1 4/3/2.1 Maternity Ockenden Review:** It was noted that the team is still awaiting feedback from the regional and national consideration of Trust submissions. However, NM noted that there would be a verbal update on the Care Quality Commission CQC focused inspection of maternity and spinal departments.
- **TB1 8/4/4.1 Standing Financial Instructions**: LT noted this would come to a future meeting. **LT**
- **TB1 8/4/2.7 – IPR/ Data Quality:** AH explained that narrative on data quality will be included in the IPR going forward. Item closed.

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

TB1 6/5/1.7 Chairman's Business

NM highlighted the following key points:

- There is a lot of work underway focussing on the next six

months to ensure non-Covid related work recovers and this will be picked up in conversations throughout the meeting.
- Simon Stevens will be retiring from the NHS in July and will be missed in a lot of aspects. He has set the direction of travel in how the NHS moves forward and his leadership during the Covid pandemic and vaccination programme was exemplary.

TB1 6/5/1.8 Chief Executive's Report

SH presented the report and highlighted the following key points:

- The Trust, along with system partners, is focused on restarting services and tackling the backlog faced as a result of Covid. Our Divisional Management teams have restarted elective services aligned with the initial plans shared with the Board in April.
- April's performance has not yet been validated but the target has been hit and SH thanked the executives and operational colleagues for their hard work. There is also a good level of confidence that the Trust will achieve May's target too. That being said there is significant backlogs and there is further work to do to get patient waiting times at an acceptable level
- On 31st March the Care Quality Commission (CQC) carried out an unannounced focused inspection of our Spinal Injuries Unit and Maternity. The initial feedback (letter included in papers) highlighted some areas for immediate action in Maternity and there was correspondence as of yesterday in terms of their intention to submit a warning notice in Maternity. The full written report has not yet been received but there will be a factual accuracy process for a 10 day period which will be a focus for the team. This will be picked up in Private Board.
- Dr Graham Lloyd-Jones, Consultant Radiologist, has been working alongside international researchers has developed a theory that gum disease could be the main risk factor for developing severe Covid-19. This research has received national attention and there has been an article in the local paper.

Discussion:

- PM referred to Electronic Patient Record (EPR) patient business case and asked further to conversations at the Finance and Performance Committee when this would be coming to Board. It was noted that the outline business case (OBC) had been discussed at the Acute Hospital Alliance and there was an agreement to defer the final OBC going to Board until June.

TB1 6/5/1.9 Care Quality Commission focused inspection of the maternity and spinal departments

SH noted that as mentioned above the letter from the CQC was included in the papers.

EJ referred to Ockenden requirements and there was a detailed discussion. The following key points were noted:

- JDy and EJ have been working closely to address the Maternity Safety Champion activity that is required. The data will be reported each month to ensure the Board is clearly sighted on safety metrics across maternity services. There are now monthly safety meetings and there are more walk-arounds so staff can escalate issues and management can review how the team is progressing.
- EJ explained that a new requirement following the Ockenden report is for a Maternity Safety Champion. EJ noted that the annex describing the role should be circulated to provide the Board with the expectations of this new position. **ACTION: JDy** **JDy**
- In December and January it was not possible to do the walk-arounds due to Covid-19. However, theses have since been picked up again. There are specific requirements for Board updates in relation to Maternity. NM explained that given the experience of EJ, she has been asked to support this role. However, NM noted that there are many requirements coming from the centre and care is being taken to ensure the lines are not blurred between executive director and non-executive director responsibilities.
- SH asked EJ and JDy to consider the expectations in relation to continuity of care and the impact this could have from a staff retention perspective. SH suggested this should be reviewed in detail with a further Board discussion once this has been reviewed in the maternity team. **ACTION: JDy** **JDy**
- EJ reminded the Board that one of the Kirkup recommendations in relation to Morecambe Bay was very explicit about the Department of Health being mindful when there was new policy approach recommendation that consideration was given to resource in totality. EJ noted that she would value constructive challenge from Non-Executive colleagues.
- JDy clarified that the Trust had the Better Births team to review staffing in November 2019 which is the data used for the current reports. However, we have not yet had a review of staffing by Continuity of Carer which is currently being organised. .
- The Board discussed how often an update on Maternity should be coming to the meeting. SH suggested this be considered outside of the meeting.
- PM reflected that in relation to performance the focus is normally on outcomes and how a service is doing based on that. It is clear that the work required in Maternity involves a focus on inputs, e.g. policies, procedures and job roles.

TB1 6/5/2 ASSURANCE AND REPORTS OF COMMITTEES

TB1 6/5/2.1 Clinical Governance Committee (CGC) – 27 April

EJ presented the report, providing a summary of escalation points from the meeting held on 27th April:

- The Committee discussed the current Covid-19 status but the main focus was receiving assurance that non-Covid work was on the path to recovery.
- There was a conversation in relation to the quality metrics in the IPR and how future reports over time will include focus on outcomes and having upward assurance from Divisions.
- The transformation update focused on 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 KPMG team.
- The Committee received assurance reports from several services, with a detailed presentation in relation to Stroke services. Whilst there are challenges it is hoped that the SSNAP rating will go from a B to an A rating.
- There was an update on falls and pressure ulcers of which improvement has been seen in both areas.
- The recent CQC visit was discussed and a maternity improvement plan is expected to come to May's CGC.

TB1 6/5/2.2 Finance and Performance Committee – 27 April

PM provided a summary of escalation points from the Finance and Performance Committee held on 27th April:

- There was further consideration in relation to the EPR business case and PM noted that it was a positive that the Acute Hospital Alliance were looking into the issues in detail.
- The Commercial Software Partner agreement was recommended for approval to the Board.
- The Committee discussed the Maternity Workforce Business case to strengthen leadership in the department and this was supported.
- The Committee discussed the IPR and the comments in the escalation report relate to activity in March. It is positive to see further progress in April.
- There was a discussion in relation to performance and how it is dependent a wide variety of measures. There needs to be a focus on how the organisation can be self-supporting and self-sustaining from the bottom up.

Discussion:

- The Board noted that in the mid to long term, the work with KPMG and 'Best Place to Work' (BPTW) programme is leading the cultural work and expectations needs to be managed in respect of timeframes. Alongside this is the work to address gaps in divisional teams to ensure there is the bandwidth to continue to deliver on plan and deliver elective recovery. It should be recognised that the Trust's cultural plans will take some time.
- AH explained that this is not just about capability it is also to

address succession planning and develop staff for the future.

TB1 6/5/2.3 Trust Management Committee – 28 April

SH provided a summary of escalation points from the Trust Management Committee (TMC) held on 28th April:

- There were no business cases presented to TMC this month. The executive team have been involved in a lengthy exercise to review ongoing Covid-19 expenditure to agree funding past April 2021.
- There was a conversation relating to the volatility of the 4 hour emergency standard. The Emergency Department (ED) has seen high acuity and stark changes in time of presentation. The department are working to realign resource to ensure consistency in the department. The Board apologised to any patients who have had a long wait in ED as it is not the standard we aspire to provide.
- The Committee received an update on the status of Trust policies. Whilst it is acknowledged there is now heightened visibility if these policies, there are a number that are out of date. The corporate governance team and divisions have been given actions which will hopefully result in rapid improvements. An update will come to TMC in June.

Discussion

- FMc explained work was ongoing with policy authors to get the policies ratified and to streamline the process. This piece of work is high on the agenda and the aim is to reduce the number of out of date policies significantly over the next few months.
- PM suggested reviewing the policies in relation to risk based prioritisation.
- MVB discussed centralised templates and it was noted that whilst there are no central templates there could be shared learning between providers and the Trust could reflect from good examples from other Trusts.
- SY noted that some policies required prioritisation as a result of national guidance, particularly in relation to the disciplinary policy. This policy will come back to a future Board meeting to be discussed.
- AH noted that the process has been really helpful and this has identified those policies which can be removed from Microguide and have been replaced.

TB1 6/5/2.4 People and Culture Committee – 29 April

MvB provided a summary of escalation points from the People and Culture Committee held on 29th April:

- MvB thanked SY and CW who had recently joined the Trust and were working hard on several priority areas of

improvement within OD and People.

- The Health and Safety Committee raised so0me 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 meeting in June.
- The Committee received an 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.
- 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.

Discussion:

- The Committee discussed the gap in the volunteer governor role once the current governor leaves at the end of May. The Board were assured that someone had put themselves forward and there would be a bi-election process later this year to ensure the identified vacancies in the Council of Governors are filled.
- PM referred to the Health and Safety vacancies and asked as a Committee if it is clear which key posts in the organisation have not been recruited to and how the Trust intends to fill these. SY explained that a paper will be going to a future Committee meeting in relation to this. There has been work to include succession planning for individual and critical roles in the workforce planning process. There is more that can be done internally in relation to talent management which also links in with the ongoing Best Place to Work programme.
- EJ noted the positive work in relation to capturing leaver comments. EJ asked if there were any critical issues that had been picked up in relation to Health and Safety. SY observed that issues that have arisen are historic and it is felt that Health and Safety as a topic needs a higher profile across the Trust.

TB1 6/5/2.7 Integrated Performance Report (M12)

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

- Covid-19 cases remain low and staff sickness has decreased in comparison to previous months.
- Hospital Standardised Mortality Ratios (HSMR) has increased which is expected.
- There have been improvements in the Breast pathway and two week wait performance.
- Referrals have increased, which is positive. However, the number of patients who are presenting later has also increased and it is expected this will continue.

- ED activity has increased and as discussed earlier there has been higher acuity and peaks in attendance at unusual times of the day. Plans are in place to help manage this.
- Positively, the work on Laverstock ward to expand ITU escalation has increased and Stroke services have moved based to their original footprint.
- The central focus is theatres and elective recovery and the Trust is working with the system to ensure patients are seen and treated as quickly as possible.

Discussion:

- PK noted that whilst two week wait breast performance has improved, it has not been as significant as hoped. PK asked when the Board could expect to see a trajectory for two week cancer pathways to where it should be.
- AH explained that there has been an increase in two week wait referrals. The current average is 16 days against a 14 day target. The cancer team are currently working to scale up capacity but this is an ever changing situation. This will come back to F&P next month.
- SH explained that in the services where there is volatility in performance further support is required to allow for more sophisticated trajectory planning. PK asked for the IPR to include some data on the heightened demand that had been described. **ACTION: AH** **AH**
- TB noted her concerns in relation to HSMR which did increase and is a retrospective figure. TB noted that Covid-19 death rate is higher comparatively to the national death rate. TB further noted that December was prior to the second wave of Covid so this is a concern as a 12 month average. SH agreed that this required further assurance and suggested a further explanation go back to the next CGC/ Board meeting. **ACTION: PC** **PC**
- TB added that the report should be revised to consider the language used in the narrative and the Trust continue to report unadjusted statistics which TB suggested could be misleading. DB agreed with TB's comments and asked if the Trust was being ambitious enough to maintain or improve mortality. NM asked for this to be passed to PC.
- PM noted the work that had gone into developing the IPR. However, the IPR does not currently reflect the recovery journey and suggested that further work is required to improve reporting. NM recognised that information requirements will change as we move forward but is also conscious of the pressure on the organisation to provide this data.
- LT noted that the report will change but explained that this is unlikely to be from 1st April as expected.
- EJ referred to structure of IPR and as discussed at F&P and CGC the report should be proportionate to the issues.
- AH is working with Communications in relation to expectations of the public. Additionally, there is ongoing work with GPs to communicate that writing in to expedite patient's treatment creates more work whilst not necessarily

changing the outcome for the patient. There are also a number of people who are still choosing not to come in for treatment and conversations with these patients are ongoing.

- SH explained that there is an emerging set of data with the ICS which will supplement the report as it is an aggregate plan.
- RA referred to those people not wanting to attend hospital and asked how the Trust could work with the system to enable a clear message to those vulnerable people who are concerned about the hospital environment. AH explained that there had been regional publicity and national messages. Additionally, all patients who choose not to come in have a conversation with their clinician. AH and KH are looking at taking a couple of specialities and looking at an alternative solution.

TB1 6/5/3 FINANCIAL AND OPERATIONAL PERFORMANCE

TB1 6/5/3.1 Corporate Priorities 2021/22

KH presented the report which asked the Board to note the review of progress and lessons learnt against the Corporate Objectives which were revised during the first wave of the Covid-19 pandemic. The report further asked the Board, as part of 2021/22 Operational Planning, to approve the proposed corporate objectives, noting the next steps in programme and performance management.

Discussion:

- PK noted that he was concerned that there were 16 broadly described priorities. PK felt that they needed more clarification. KH noted that the challenge is to be more specific in some areas and there is more work to do in relation to tangible delivery and how change is demonstrated.
- PM referred to project support and resource and if there is no resource in a particular area it cannot be a priority. KH explained this is being aligned with the transformation team to ensure sufficient resource is allocated. It is recognised there are challenges in resourcing some priorities. PM therefore reflected that these priorities are a work in progress. KH explained that the Board could approve the list of priorities, acknowledging further development is needed and if there is not the resource the priorities are refined.
- SH explained that the paper does not convey the detail. For example, when looking at super stranded patients, not all disproportionate increase was driven by people with Covid-19. This is largely due to the inconsistencies in working with community and social care colleagues and not having a clear capacity plan from partners outside of the organisation. This is therefore a priority for this year as this will severely affect the elective recovery going forward.
- EJ reflected that the list is long list but on a national basis

these are important. She reflected that a number of quality priorities do not have project support identified. Additionally, the priorities do not include the new patient safety strategy as that will change how the Trust reviews and learns from harms.

- SH reflected on the financial constraints and how that impacts on which priorities receive the required project support. Some of this will be about using the people we already have differently. EJ agreed that and noted that some of this is part of people's day jobs and agreed it is more about approach and looking at people's roles.
- PM suggested that there needs to be realistic change programme that addresses national priorities which also provides further assurance on when these are likely to be delivered.
- JDy referred to quality priorities and explained that the ward to board assurance on safety will encompass a range of different aspects. In relation to the Patient Safety Framework this will not be available until spring 2022 so this was taken off the corporate priority list for this year. The expectation is that project support will be undertaken by risk safety team.
- NM suggested the Board approve the priorities but there needs to be detailed plans in relation to timescales. PK suggested that if the Board approve these priorities knowing we do not have the resources this does not helping the organisation. NM explained that these priorities will apply to this organisation over a number of years. The Board will then need to see a further update of deliverable objectives over the next 6-12 months.
- LT did not disagree that there were too many objectives but noted that this list reflects national priorities so it cannot be reduced.
- SH suggested the Board approve this as a list of areas to work on, which will stretch beyond this year and then bring a delivery plan back which will clarify what will be achieved in 2021/22. NM agreed. **ACTION: KH** **KH**

Decision:

- The Board approved the list of corporate objectives but on the understanding that a delivery plan would come back to the Board to clarify the Trust's objectives for 2021/22.

TB1 6/5/4 CLOSING BUSINESS

TB1 6/5/4.1 Agreement of Principle Actions and Items for Escalation

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

- Further clarification is required to ensure the Board is aware of the corporate priorities and timescales for 2021/22.
- The work on Trust Policies is important and should be a focus.
- In relation to the IPR there is further work to align to the Trust's corporate priorities whilst also not adding additional unnecessary work to business support teams.

TB1 6/5/4.2 Any Other Business

NHSI Self-Certification (FT4, G6, CoS7)

FMc presented the paper which had been presented to F&P. It was noted that appendix 1 listed the evidence. Once approved by the Trust Board this will be published on the Trust's website.

Discussion:

- There was a discussion in relation to adding the recent CQC warning notice in relation to Maternity. It was agreed that this would be reflected upon outside of the meeting and updated as appropriate. **ACTION: FMc** **FMc**
- PK noted his concerns in relation to appendix 1 and the columns which state there are no risks identified against principle systems and standards.
- There was a discussion relating to cross referencing and triangulating to the Annual Governance Statement. (*Post meeting note: this was discussed at private board the risk relating to internal control weaknesses has been addressed in the self-certification).*

TB1 6/5/4.3 Public Questions

JM referred to the volunteer governor and the need to enhance the significance of staff governors and the Staff Committee which needs some focus. NM noted that the Trust is working to ensure staff governor engagement is improved.

JM thanked TB for her comments on HSMR and noted that a report would be coming back to the Board from PC which will address previous concerns raised in relation to palliative care coding.

TB1 6/5/4.4 Date of Next Public Meeting

Thursday 8th July 2021, Board Room, Salisbury NHS Foundation Trust

TB1 6/5/5 RESOLUTION

TB1 6/5/5.1 Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

Salisbury NHS Foundation Trust

DRAFT

Electronic Minutes of the Trust Board meeting held via email Monday 14th June.

Meeting Participants:

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

Copied in for Awareness:

Fiona McNeight (FMc)	Director of Corporate Governance

Minutes:

Kylie Nye (KN)	Corporate Governance Manager

ACTION

TB2 14/6/1 Delegation of Accounts Sign-Off to Audit Committee

KN emailed all Board members on 9th June 2021 explaining that the Extraordinary Audit Committee would have to be deferred to 18th June 2021. Due to this change in the timetable it was necessary to ask the Board to delegate Audit Committee to sign off the annual accounts.

The email asked for all Board members to respond by close of play Monday 14th June.

Responses were received by email with the exception of one who did not respond.

Decision:

The Board delegated authority to the Audit Committee to sign off the annual accounts.

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. **June - monthly report on maternity to come to CGC. This has been added to the business cycle.**	Y	3
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**	08/07/2021	On July's agenda	N	2
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**	08/07/2021	On July's agenda	N	2
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**	22/07/2021	Discussed at F&P - LT working on this - update to July Audit Committee.	N	4

Reference Number	Action	Owner	Deadline	Current progress made	Completed Status (Y/N)	RAG Rating
TB1 6/5/1.9	**Maternity -** **1)** EJ explained that a new requirement following the Ockenden report is for a Maternity Safety Champion. EJ noted that the annex describing the role should be circulated to provide the Board with the expectations of this new position. **2)** SH asked EJ and JDy to consider the expectations in relation to continuity of care and the impact this could have from a staff retention perspective. SH suggested this should be reviewed in detail with a further Board discussion once this has been reviewed in the maternity team.	**JDy**	08/07/2021		N	**2**
TB1 6/5/2.7	**Integrated Performance Report (M12) -** **1) Breast cancer data** - PK asked for the IPR to include some data on the heightened demand that had been described. 2) **HSMR** - TB noted her concerns in relation to HSMR which did increase and is a retrospective figure. TB noted that Covid-19 death rate is higher comparatively to the national death rate. TB further noted that December was prior to the second wave of Covid so this is a concern as a 12 month average. SH agreed that this required further assurance and suggested a further explanation go back to the next CGC/ Board meeting.	**AH** **PC**	08/07/2021		N	**2**
TB1 6/5/3.1	**Corporate Priorities 2021/22 -** SH suggested the Board approve this as a list of areas to work on, which will stretch beyond this year and then bring a delivery plan back which will clarify what will be achieved in 2021/22.	**KH**	08/07/2021		N	**2**
TB1 6/5/4.2	**NHSI Self-Certification (FT4, G6, CoS7) -** There was a discussion in relation to adding the recent CQC warning notice in relation to Maternity. It was agreed that this would be reflected upon outside of the meeting and updated as appropriate.	**FMc**	31/05/2021	Self certification updated.	Y	**3**

Register of Attendance – Public Board 2021/22

	8 April	6 May	8 July	9 September	4 November	January 2022	March 2022	attendance rate
Nick Marsden	✓	✓						2/2
Tania Baker	✓	✓						2/2
Michael von Bertele	✓	✓						2/2
Paul Kemp	✓	✓						2/2
Paul Miller	✓	✓						2/2
Stacey Hunter	✓	✓						2/2
Lisa Thomas	✓	✓						2/2
Andy Hyett	✓	✓						2/2
Judy Dyos	✓	✓						2/2
Susan Young	✓	✓						2/2
Eiri Jones	✓	✓						2/2
Rakhee Aggarwal	✓	✓						2/2
David Buckle	✓	✓						2/2
Peter Collins	✓	x						1/2

Governor Observer							
John Mangan	✓	✓					
Lucinda Herklotts							

Attended - ✓

Apologies – X

Report to:	Trust Board (Public)	Agenda item:	1.9
Date of Meeting:	8 July 2021		

Report Title:	Chief Executive's Report			
Status:	Information	Discussion	Assurance	Approval
	X	X		
Prepared by:	Stacey Hunter			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive			
Appendices (list if applicable):	Appendix 1 :NHSE/I ICS Design Framework June 2021 Appendix 2: Presentation Operational Excellence – Current State Workshop			

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 May 6th 2021 and Board colleagues are asked to note :

- We are resetting and recovering our services back to address the waiting times and increased number of referrals.
- Our emergency department and pathways have been extremely busy over this last 6 weeks with activity reaching pre-pandemic levels. For emergency admissions this has been higher than pre pandemic levels requiring escalation beds to open in May and June.
- The health and wellbeing of our people remains a priority as we reset and we are conscious of the increase in both planned and unplanned work and the impact this may have on our colleagues.
- We continue to play an active role in the development of partnership arrangements at a local place, ICS and regional level in advance of the new legislation expected later this summer.
- Our vaccination team continue to manage the COVID vaccination programme from the large vaccination site at City Hall and have responded to the request to accelerate the schedule aligned to the next review of national local down easing measures mid-July.
- We remain vigilant about the new variants of COVID and are refreshing surge plans with a particular focus on the impact of respiratory viruses in children and our preparations for winter
- The recent CCQ focused inspections in Maternity and Spinal services are due to published in or around the time of this Board meeting. A verbal update will be provided at the Board.
- The readiness assessment that KMPG are undertaking as part of the operational excellence programme has been shared with Executives in June. The next stage of this

work to agree the roadmap takes place on the 15th July 2021

- Maternity Leadership and governance arrangements have now changed with the emphasis on recruiting to the additional midwifery and clinical leadership roles to enable the improvements to be delivered.

1. National and ICS Updates

NHSE/I published the Integrated Care Systems (ICS) design framework in June 2021 which is due to go before parliament during the summer (appendix 1). If the legislation is passed our Integrated Care System will become a statutory organisation from April 2022 and is expected to operate in shadow form from October 2022.
The guidance for ICS sets out plans for two Integrated Care System Boards. The ICS Health and Care Partnership will set the broad strategy for the partnership, whilst the ICS NHS Body will have a critical role to play in executing the strategy. The current ICS Partnership Board is in discussions with key stakeholders re the details of how the accountability, governance, decision making and delegations will work within the proposed new arrangements. It will be important for the Trust to continue to contribute to the proposals and the Board will want to take some time to consider the detail as it emerges.

The local place based arrangements need to be determined as part of these considerations with a focus on developing the behaviours and relationships needed to allow more joined up, efficient ways of working together to provide the best possible prevention, care and treatment for our population.

Our Acute Hospital Alliance (AHA) collaboration continues to make good progress with the elective care strategy for BSW, the EPR project and the continued review of back office support services. There is a proposal going to the AHA Board at the end of June to strengthen the governance and leadership arrangements which I will update the Board about in due course. There is further guidance due from NHSE/I for provider collaborations which it will be important to reflect going forward.

Our partnership work extends beyond our ICS and executive colleagues are engaged actively in our arrangements with other providers in Wessex to ensure that our population can continue to access the care they need that relies on these partnerships. From a specialist commissioning perspective the South West will delegate a significant amount of this function to 3 sub-regional groups. We are included in a group with the Dorset system rather than the 2 other BSW acute hospitals linking back into Southampton as our main tertiary provider. A new DSW (Dorset, Salisbury & Wessex) partnership board has been recently established to oversee these arrangements. I and the Medical Director are members of this group which has only had one meeting thus far.

2. COVID Update and resetting of services

The Trust continues to focus on the significant challenge of reducing waiting times for our local population and has established a COVID recovery group to oversee this. This includes a continuation of the clinical prioritisation of patients (P1-6) as set out nationally and weekly monitoring of our performance against the plan. The Board will be aware that the finance and performance subcommittee have recently endorsed a proposal brought forward by the Executive Team to insource additional theatre staff to increase the number of elective theatre sessions available each week. The COVID recovery group will need to monitor overall theatre activity

closely to ensure that the additional investment to insource is delivering over and above the original recovery plan we committed too.

We are taking stock to ensure that we are leveraging the different ways of working we have learnt during the pandemic and adopting best practice in respect of efficient and effective services – for example delivering on the 'Getting It Right First Time (GIRFT) recommendations in all of our specialities.

Progress against our recovery plan will be shared via the IPR and continue to be fed into the Board via the Finance and Performance Sub-committee escalation report.
The numbers of patients requiring hospital care for COVID has remained very low over this period. There are some increases in the number of community cases which the Chief Operating Officer and our tactical response continue to keep in view.

Fiona Hyett remains on secondment in our Vaccination Director role and along with the team at City Hall is delivering on the requirements of the COVID vaccination programme as part of the BSW plan. The national team have asked for specific aspects of the programme to be accelerated (all second jabs to be offered to those eligible aged 40 and over before the 18th July) at the same time as opening up appointments for people aged 18 and over. The team are confident that they can deliver on the additional requirements aligned with vaccine supply. I am immensely proud of the work our vaccination teams are doing, not only saving lives but also changing how all of us are able to take steps back to a more usual way of life as lockdown measures ease.

Our teams working in acute services have experienced an exceptionally busy period with ED attendances back at pre COVID levels (many days exceeding pre COVID levels) and emergency admissions at peak levels. This is replicated across our ICS, regionally and nationally and I appreciate that these levels of demand alongside the elective recovery programme are creating significant challenges for our colleagues. I know the Board will want to join me in acknowledging this level of pressure and thanking our teams for everything they continue to do.

The ICS Urgent Care Board which I chair on behalf of the system has 6 priority areas of work for the coming year and has agreed that the work relating to minor injury/illness and discharge to assess needs to be accelerated to mitigate some of the overall pressures in the system.

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3. Finance

The Trust has reported a modest surplus of £60k in May, with the reduced costs associated with planned care being offset by premium cost in the Trust's emergency pathways. Without mitigation this has the potential to drive the Trust into deficit as we move toward the Autumn with expectations of reduced funding for the second half of the financial year. The Trust will continue to work with BSW partners on identifying opportunities to reduce our costs whilst recognizing the pressure and demand on our services particularly within the emergency pathway.

4. KMPG Operational Excellence Programme

The Executive team met with our colleagues from the Operational Excellence programme to receive the outputs from the readiness assessment which Board members have contributed to. The purpose of the *current state review* provides us with a baseline measurement of the Trust's current level of maturity against the key organisational attributes of an organisation with a strong improvement culture.
Please see appendix 2 for the detail that was shared in the session.
This information will be used to support the next stage of the work which is to build and agree an improvement roadmap tailored to our needs. This is scheduled for the 15th July and is a key step on our improvement journey.

5. Maternity

The new Divisional management and leadership arrangements for Women's and New-born services are now in place which are designed to focus support for the improvements that we want to make within our Maternity services.
Board members will be aware that one of the constraints to delivering on the improvement plan has been having sufficient capacity and capabilities in the Maternity team which the Board agreed to support with significant additional resource.
The recruitment process for the additional roles is underway and I can report that we have successfully appointed a new community midwifery lead and a new Divisional Director of Operations has started work as part of the Divisional triumvirate with the Clinical Director and Director of Midwifery.
The response to the Director of Midwifery recruitment is positive at this stage and the Chief Nurse will be able to update the Board on this key appointment in due course.
The team have strengthened the maternity champions' safety process and are using a variety of channels to raise awareness about the roles and process including undertaking 3 walkabouts in Maternity over the last month.
There is more for us to do to deliver on the overall improvements we want to support the team to make, the detail of this will be shared via the Clinical Governance Board sub-committee and any material issues shared back with the Board.

6. CQC report

At the time of writing this report the CQC have advised the Trust that they expect to be in a position to publish our final report following their recent inspections to our Spinal and Maternity services in and around the 7th July . I will provide a verbal update to the Board when we meet on the 8th July.
I know the Board will want to join me in welcoming the report which aligns with and builds on the work the Board have been leading in respect of making improvements to strengthen our maternity leadership and some of the day to day systems and processes in these services.
We are pleased that the inspectors found several areas of good practice in our Spinal and Maternity units and recognised that our teams work incredibly hard every day to offer safe and compassionate care to individuals and their families.
Once the final report is published the action plan to address the specific recommendations will be shared with the Board.

7. Workforce

The turnover for month 2 has moved above the Trust target (10.57%). There were 38 leavers and 38 starters by headcount. Women and Newborn had the highest turnover of the Clinical Divisions (11.7%). The main reason for leaving was relocation and lifestyle choices. Across all Divisions the main reason for leaving was relocation to enable staff to be closer to family.
The vacancy rate in month was 5.53%, compared to 4.99% in May. The Division with the highest vacancy rate was Surgery at 7.73%. The staff group with the highest number of vacancies Trust wide was Registered Nurses at 81 FTE (7.98%). In month 131 vacancies (126 WTE) were advertised and a total of 142 offers were made. This compared to 87 vacancies and 127 offers made in month 1. Recruit to hire time for month 2 remained at 61 days (from the point post is authorised to actual start date) or 35 days (from the point post is authorised to offer accepted).
The sickness rates for the month are 3.22%; sickness for the rolling year is 3.52%. Medicine, Surgery and Women and Newborn sickness rates are all higher than the Trust target. Anxiety, stress and depression remain the top cause of sickness across all Divisions. The HR business partners are supporting the managers to ensure that our long term and short term sickness is managed effectively within our policies

There was an increase in agency spend in month 2 to £356,278, in the same period the previous year spend was £280,589. This is as a result of variance against plan across the Divisions that teams are aware of with details of how this can be mitigated being agreed as part of the Executive Performance reviews. The majority of the variance is driven by covering substantive gaps via agency/locum routes and the costs of opening additional escalation beds.
There is a need to provide additional support to some of our Divisions who have difficult to recruit roles that our usual recruitment and retention measures are not sufficient for e.g. Theatres, Acute Medicine. It is recognised that we have some significant work to do to develop a more comprehensive workforce plan for these areas. This will require some dedicated expertise to reduce the continued volatility and reliance in agency /locum support.
The Chief People Officer post has now been successfully offered to Melanie Whitfield, with a commencement date of 6th September 2021.

8. News

Celebrating Pride

To celebrate Pride Month in June, and to demonstrate our commitment to supporting our LGBT+ community, we proudly raised our Rainbow flag on The Green and all staff were invited to attend this socially-distanced ceremony. And as the sun was shining, staff were treated to an ice cream, specially adorned with rainbow sprinkles, from an ice cream van.

League of Friends shop reopening

The much-missed League of Friends shop reopens on 21st June. The shop has been closed during COVID-19 when most volunteers were not allowed to work on site. It's great to be able to welcome them back as they are a cheering addition to the site.

Classification: Official

Publications approval reference: PAR642

Integrated Care Systems: design framework

Version 1, June 2021

Contents

Introduction and summary

Everyone across the health and care system in England, in the NHS, local authorities and voluntary organisations, has made extraordinary efforts to manage the COVID-19 pandemic and deliver the vaccination programme while continuing to provide essential services.

We still face major operational challenges: tackling backlogs; meeting deferred demand, new care needs, changing public expectations; tackling longstanding health inequalities; enabling respite and recovery for those who have been at the frontline of our response; and re-adjusting to a post-pandemic financial regime. The intensity of the incident may have abated, but we are still managing exceptional pressure and uncertainty, with differential impacts across the country.

As we respond, Integrated Care Systems (ICSs) will play a critical role in aligning action between partners to achieve their shared purpose: to improve outcomes and tackle inequalities, to enhance productivity and make best use of resources and to strengthen local communities.

Throughout the pandemic our people told us time and time again that collaboration allowed faster decisions and better outcomes. Co-operation created resilience. Teamwork across organisations, sectors and professions enabled us to manage the pressures facing the NHS and our partners.

As we re-focus on the ambitions set out in the NHS Long Term Plan, it is imperative we maintain our commitment to collaborative action, along with the agility and pace in decision-making that has characterised our response to the pandemic.

We want to do everything we can to support this nationally and give you the best chance of making effective and enduring change for the people you serve.

This means seizing the opportunities presented by legislative reform to remove barriers to integrated care and create the conditions for local partnerships to thrive. And it means asking NHS leaders, working with partners in local government and beyond, to continue developing Integrated Care Systems during 2021/22, and preparing for new statutory arrangements from next year.

We know this is a significant ask. This document sets out the next steps. It builds on previous publications[1] to capture the headline ambitions for how we will expect NHS leaders and organisations to operate with their partners in ICSs from April 2022. It aims to support you as you continue to deliver against the core purpose of ICSs and put in place the practical steps to prepare for their new arrangements that we expect to be enabled by legislation in this Parliamentary session.

The ambition for ICSs is significant and the challenge for all leaders within systems is an exciting one. Successful systems will align action and maintain momentum during transition, with systems continuing to make progress in improving outcomes and supporting recovery while embedding new arrangements for strategic planning and collective accountability across partners. The collective leadership of ICSs and the organisations they include will bring teams with them on that journey and will command the confidence of NHS and other public sector leaders across their system as they deliver for their communities. The level of ambition and expectation is shared across all ICSs – and there will be consistent expectations set through the oversight framework, financial framework national standards and LTP commitment – with ICSs adjusting their arrangements to be most effective in their local context.

It is important that this next year of developing ICSs and implementing statutory changes, if approved by Parliament and once finalised, builds on progress to date and the great work that has already taken place across the country. Effective transition will see high performing systems taking their existing ways of working and creatively adapting these to the new statutory arrangements. It is an acceleration, in the current direction.

This document begins to describe future ambitions for:

- the **functions of the ICS Partnership** to align the ambitions, purpose and strategies of partners across each system[2]
- the **functions of the ICS NHS body**, including planning to meet population health needs, allocating resources, ensuring that services

[1] Integrating care: next steps to building strong and effective integrated care systems and Integration and innovation: working together to improve health and social care for all NHS Operational Planning and Contracting Guidance

[2] Guidance on the Partnership will be developed by DHSC with local government, NHS and other stakeholders. Expectations described here are based on the proposals set out in the Government's White Paper and initial discussions with local government partners.

are in place to deliver against ambitions, facilitating the transformation of services, co-ordinating and improving people and culture development, and overseeing delivery of improved outcomes for their population

- the **governance and management arrangements** that each ICS NHS body will need to establish to carry out those functions including the flexibility to operate in a way that reflects the local context through place-based partnerships and provider collaboratives
- the opportunity for **partner organisations** to work together as part of ICSs to agree and jointly deliver shared ambitions
- **key elements of good practice** that will be essential to the success of ICSs, including strong clinical and professional leadership, deep and embedded engagement with people and communities, and streamlined arrangements for maintaining accountability and oversight
- the key features of the **financial framework** that will underpin the future ambitions of systems, including the freedom and mechanisms to use resource flexibly to better meet identified needs and to manage financial resources at system level
- the roadmap to **implement new arrangements** for ICS NHS bodies by April 2022 to establish new organisations, appoint leadership teams to new statutory organisations and to ensure that people affected by change are offered a smooth transition that allows them to maintain focus on their critical role in supporting recovery from the pandemic.

Further information or guidance, developed through engagement with systems and stakeholders, will be made available to support detailed planning. Where relevant, this will follow the presentation of proposed legislation to Parliament.

We have heard a clear message from systems that they are looking for specificity about the consistent elements of how we will ask them to operate, alongside a high degree of flexibility to design their ways of working to best reflect local circumstances. This document aims to achieve both: to be clear and specific on the consistent requirements for systems and to define the parameters for the tailoring to local circumstances which is key to success. It goes beyond likely minimum statutory requirements and sets out the ambition from NHS England and NHS

Improvement[3] on what will be necessary for systems to be successful as they lead our recovery from the pandemic and the wider delivery of the Long Term Plan.

The Framework does not attempt to describe the full breadth of future ICS arrangements or role of all constituent partners but focuses on how we expect the NHS to contribute. For non-NHS organisations, we hope this document will provide helpful framing on how the NHS will be approaching the proposed establishment of ICS NHS bodies, and inform broader discussions on the creation of system-wide and place-based partnership arrangements.

From the outset, our ambition for ICSs has been co-developed with system leaders, people who use services and many other stakeholders. We will continue this approach as we develop guidance and implementation support, based on feedback and ongoing learning from what works best.

The Framework is based on the objectives articulated in Integrating Care: next steps, which were reflected in the Government's White Paper.[4] But content referring to new statutory arrangements and duties, and/or which is dependent on the implementation of such arrangements and duties, is subject to legislation and its parliamentary process. Systems may make reasonable preparatory steps in advance of legislation but should not act as though the legislation is in place or inevitable.

[3] In this document we use 'NHS England and NHS Improvement' when referring to the functions and activities of both NHS England and NHS Improvement prior to April 2022, and NHS England only from April 2022 (subject to legislation).

[4] This document uses the terminology of the White Paper (ICS Partnership and ICS NHS Body). The final legal terms to be adopted for the new statutory components of each ICS will be determined by the legislation.

Context

In November 2020 NHS England and NHS Improvement published *Integrating care: Next steps to building strong and effective integrated care systems across England*. It described the core purpose of an ICS being to:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- **enhance productivity** and value for money
- help the NHS support broader **social and economic development**.

It emphasised that the next phase of ICS development should be rooted in underlying principles of subsidiarity and collaboration. It described common features that every system is expected to have and develop, as the foundations for integrating care, with local flexibility in how best to design these to achieve consistent national standards and reduce inequalities, as:

- decisions taken closer to, and in consultation with, the communities they affect are likely to lead to better outcomes
- collaboration between partners, both within a place and at scale, is essential to address health inequalities, sustain joined-up, efficient and effective services and enhance productivity
- local flexibility, enabled by common digital capabilities and coordinated flows of data, will allow systems to identify the best way to improve the health and wellbeing of their populations.

Reflecting insight drawn from local systems, the document outlined the key components to enable ICSs to deliver their core purpose, including:

- **strong place-based partnerships** between the NHS, local councils and voluntary organisations, local residents, people who access service their carers and families, leading the detailed design and delivery of integrated services within specific localities (in many places, long-established local authority boundaries), incorporating a number of neighbourhoods
- **provider collaboratives**, bringing NHS providers together across one or more ICSs, working with clinical networks and alliances and other partners, to secure the benefits of working at scale.

In February 2021 NHS England and NHS Improvement made recommendations to Government to establish ICSs on a statutory basis, with strengthened provisions to ensure that local government could play a full part in ICS decision-making. These proposals were adopted in the Government's White Paper *Integration and Innovation: working together to improve health and social care for all*, and we expect legislation to be presented to Parliament shortly. This document is based on our expectations as to the content of that legislation, describing how new arrangements would look if the proposals were implemented, while recognising that the legislation is subject to Parliament's amendment and approval.

Subject to the passage of legislation, the statutory[5] ICS arrangements will comprise:

- an ICS Partnership, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS
- an ICS NHS body, bringing the NHS together locally to improve population health and care.

This ICS Design Framework sets out in more detail how we expect NHS organisations to respond in the next phase of system development, including the anticipated establishment of statutory ICS NHS bodies from April 2022. It describes the 'core' arrangements we will expect to see in each system and those we expect local partners to determine in their local context; depending on their variation in scale, geography, population health need and maturity of system arrangements.

Its purpose is to provide some 'guide rails' for NHS organisations as they develop their plans - reflecting the best ways of serving communities and patients in their specific local context - to give them the best chance of delivering on the four core purposes, in the urgent context of COVID recovery.

[5] ICSs will comprise a much wider set of partnership arrangements supported by this statutory framework.

The ICS Partnership

Each ICS will have a Partnership at system level established by the NHS and local government as equal partners. The Partnership will operate as a forum[6] to bring partners – local government, NHS and others – together across the ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for their population.

The Partnership will facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. This joined-up, inclusive working is central to ensuring that ICS partners are targeting their collective action and resources at the areas which will have the greatest impact on outcomes and inequalities as we recover from the pandemic.

We expect the ICS Partnership will have a specific responsibility to develop an 'integrated care strategy' for its whole population using best available evidence and data, covering health and social care (both children's and adult's social care), and addressing the wider determinants of health and wellbeing. This should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments. We expect these plans to be focused on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities. We expect each Partnership to champion inclusion and transparency and to challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It should support place- and neighbourhood-level engagement, ensuring the system is connected to the needs of every community it includes.

The Government has indicated that it does not intend to bring forward detailed or prescriptive legislation on how these Partnerships should operate. Rather the intention is to set a high-level legislative framework within which systems can develop the partnership arrangements that work best for them, based on the core principles of equal partnership across health and Local Government, subsidiarity, collaboration and flexibility.

[6] The ICS Partnership will be a committee, rather than a corporate body.

To support this process, formal guidance on ICS Partnerships will be developed jointly by the Department of Health and Social Care (DHSC), NHS England and NHS Improvement, and the Local Government Association (LGA), and consulted on ahead of implementation, including on the role and accountabilities of the chair of the Integrated Care Partnership. This document gives an overview of the type of information that we expect to be included in that guidance.

Establishment and membership

The Partnership will be established locally and jointly by the relevant local authorities and the ICS NHS body, evolving from existing arrangements and with mutual agreement on its terms of reference, membership, ways of operating and administration. Appropriate arrangements will vary considerably, depending on the size and scale of each system.

Members must include local authorities that are responsible for social care services in the ICS area, as well as the local NHS (represented at least by the ICS NHS body). Beyond this, members may be from health and wellbeing boards, other statutory organisations, voluntary, community and social enterprise (VCSE) sector partners, social care providers and organisations with a relevant wider interest, such as employers, housing and education providers and the criminal justice system. They should draw on experience and expertise from across the wide range of partners working to improve health and care in their communities, including ensuring that the views and needs of patients, carers and the social care sector are built into their ways of working. The membership may change as the priorities of the partnership evolve.

To facilitate broad membership and stakeholder participation, Partnerships may use a range of sub-groups, networks and other methods to convene parties to agree and deliver the priorities set out in the shared strategy.

Leadership and accountability

The ICS NHS body and local authorities will need to jointly select a Partnership chair and define their role, term of office and accountabilities.

Some systems will prefer the Partnership and ICS NHS body to have separate chairs. This may, for instance, provide greater scope for democratic representation. Others may select the appointed NHS ICS body chair as the chair for both the NHS

Board and the Partnership to help ensure co-ordination. This will be a matter for local determination.

We expect public health experts to play a significant role in these partnerships, specifically including local authority directors of public health and their teams who can support, inform and guide approaches to population health management and improvement.

Partnerships will need clear and transparent mechanisms for ensuring strategies are developed with people with lived experience of health and care services and communities, for example including patients, service users, unpaid carers and traditionally under-represented groups. These mechanisms should draw on best engagement practice; for example, by using citizens' panels and co-production approaches, including insights from place and neighbourhood engagement. Partnerships should build on the expertise, relationships and engagement forums that already exist across local areas, building priorities from the bottom up, to ensure the priorities in the strategy resonate with people across the ICS.

As a key forum for convening and influencing and engaging the public, the Partnership will need to be transparent with formal sessions held in public. Its work must be communicated to stakeholders in clear and inclusive language.

Partnership principles

The ICS Partnership will play a key role in nurturing the culture and behaviours of a system. We invite systems to consider these 10 principles:

1. Come together under a distributed leadership model and commit to working together equally.
2. Use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.
3. Operate a collective model of accountability, where partners hold each other mutually accountable for their shared and individual organisational contributions to shared objectives.
4. Agree arrangements for transparency and local accountability, including meeting in public with minutes and papers available online.

5. Focus on improving outcomes for people, including improved health and wellbeing, supporting people to live more independent lives, and reduced health inequalities.
6. Champion co-production and inclusiveness throughout the ICS.
7. Support the triple aim (better health for everyone, better care for all and efficient use of NHS resources), the legal duties on statutory bodies to co-operate and the principle of subsidiarity (that decision-making should happen at the most local appropriate level).
8. Ensure place-based partnership arrangements are respected and supported, and have appropriate resource, capacity and autonomy to address community priorities, in line with the principle of subsidiarity.
9. Draw on the experience and expertise of professional, clinical, political and community leaders and promote strong clinical and professional system leadership.
10. Create a learning system, sharing evidence and insight across and beyond the ICS, crossing organisational and professional boundaries.

The ICS NHS body

ICS NHS bodies will be established as new organisations that bind partner organisations together in a new way with common purpose. They will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of their population. They will ensure that dynamic joint working arrangements, as demonstrated through the response to COVID-19, become the norm. They will establish shared strategic priorities within the NHS and provide seamless connections to wider partnership arrangements at a system level to tackle population health challenges and enhance services at the interface of health and social care.

Functions of the ICS NHS body

The ICS NHS body will be a statutory organisation responsible for specific functions that enable it to deliver against the four core purposes:

- **Developing a plan** to meet the health needs of the population within their area, having regard to the Partnership's strategy. This will include ensuring NHS services and performance are restored following the pandemic, in line with national operational planning requirements, and Long Term Plan commitments are met.
- **Allocating resources** to deliver the plan across the system, including determining what resources should be available to meet the needs of the population in each place and setting principles for how they should be allocated across services and providers (both revenue and capital). This will require striking the right balance between enabling local decision-making to meet specific needs and securing the benefits of standardisation and scale across larger footprints, especially for more specialist or acute services.
- **Establishing joint working arrangements** with partners that embed collaboration as the basis for delivery of joint priorities within the plan. The ICS NHS body may choose to commission jointly with local authorities, including the use of powers to make partnership arrangements under section 75 of the 2006 Act and supported through the integrated care strategy, across the whole system; this may happen at place where that is the relevant local authority footprint.

- **Establishing governance arrangements** to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a system financial envelope set by NHS England and NHS Improvement.
- **Arranging for the provision of health services** in line with the allocated resources across the ICS through a range of activities including:

– Putting contracts and agreements in place to secure delivery of its plan by providers. These may be contracts and agreements with individual providers or lead providers within a place-based partnership or provider collaborative. They will reflect the resource allocations, priorities and specifications developed across the whole system and at place level. We expect contracts and agreements to be strategic, long-term and based on outcomes, with providers responsible for designing services and interventions to meet agreed system objectives.

– Convening and supporting providers (working both at scale and at place) to lead[7] major service transformation programmes to achieve agreed outcomes, including through joining-up health, care and wider support. In addition to ensuring that plans and contracts are designed to enable this, the ICS NHS body will facilitate partners in the health and care system to work together, combining their expertise and resources to deliver improvements, fostering and deploying research and innovations.

– Working with local authority and VCSE partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care. This may be delegated to individual place partnerships and delivered through integrated teams working in neighbourhoods or across local places, further supporting the integration of planning and provision with adult social care and VCSE organisations.

- **Leading system implementation of the People Plan** by aligning partners across each ICS to develop and support the ‘one workforce’, including through closer collaboration across the health and care

[7] It is expected that the ICS NHS body will be able to delegate functions to statutory providers to enable this.

sector, and with local government, the voluntary and community sector and volunteers (See ‘People and culture’ section below).

- **Leading system-wide action on data and digital**: ICS NHS bodies will work with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services and ultimately transform care to put the citizen at the centre of their care (see ‘Data and digital’ section below);
- Using joined-up data and digital capabilities to **understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvemen**t in performance and outcomes.
- Working alongside councils to **invest in local community organisations and infrastructure** and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, **ensuring that the NHS plays a full part in social and economic development and environmental sustainability**.
- **Driving joint work on estates, procurement, supply chain and commercial strategies** to maximise value for money across the system and support these wider goals of development and sustainability
- **Planning for, responding to and leading recovery from incidents** (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.
- **Functions NHS England and NHS Improvement will be delegating** including commissioning of primary care and appropriate specialised services.

We expect that all clinical commissioning group (CCG) functions and duties will transfer to an ICS NHS body when they are established, along with all CCG assets and liabilities including their commissioning responsibilities and contracts.

Relevant statutory duties of CCGs regarding safeguarding, children in care and special educational needs and disabilities (SEND) will apply to ICS NHS bodies. We will clarify in guidance how these statutory duties will transition to ICS NHS bodies. ICSs should support joint working around responsibilities such as safeguarding through new and existing partnership arrangements; and health and

care strategies and governance should account for the needs of children and young people.

The board of the ICS NHS body will be responsible for ensuring that the body meets its statutory duties. We expect these duties will include supporting achievement of the triple aim, improving quality of services, reducing inequalities, ensuring public involvement, obtaining clinical and public health advice, promoting innovation and research, and other duties that may be defined in law.

We are reviewing our own operating model - including how our functions and activities will be carried out in future and how associated resources will be deployed -in the context of the expected creation of statutory ICS NHS bodies. We are committed to ensuring that the principle of subsidiarity is applied in considering our own functions, that resources are devolved accordingly, and that the creation of ICS NHS bodies does not lead to duplication or create additional bureaucracy within the NHS. We will co-design our new arrangements with the sector and our partners.

People and culture

Better care and outcomes will be achieved by people – local residents, service users, carers, professionals and leaders – working together in different ways. Successful ICSs will develop a culture that attracts people to work in and for their community and supports them to achieve their full potential.

The NHS People Plan sets out the ambition of having 'more people, working differently, in a compassionate and inclusive culture'. Although individual employers remain the building blocks for delivering the People Plan, ICSs have an important role in leading and overseeing progress on this agenda – including strengthening collaboration among health and care partners – and have already developed their own local People Plans setting out how they will achieve this ambition in their area. These plans should be aligned with the ICS Partnership's Strategy as it is developed and be refreshed annually, taking account of national priorities.

From April 2022, ICS NHS bodies are expected to have specific responsibilities for delivering against the themes and actions set out in the NHS People Plan and the people priorities in operational planning guidance. ICS NHS bodies will play a critical role in shaping the approach to growing, developing, retaining and supporting the entire local health and care workforce. While the People Plan sets out specific objectives and responsibilities for NHS organisations, we expect ICS NHS bodies to adopt a 'one workforce' approach and develop shared principles and ambitions for people and culture with local authorities, the VCSE sector and other partners.

Those planning and delivering health and care services are employed by a range of different organisations (including the ICS NHS body in future). Each will have strategies for attracting, retaining and developing the people they need to deliver the services and functions they are responsible for. To deliver against the ICS's four core purposes and to make the local area a great place to work and live, the ICS NHS body – working with the ICS Partnership – will help bring these partners together to develop and support the 'one workforce' which contributes to providing care across the system. This includes supporting the expansion of primary care and integrated teams in the community and closer collaboration on workforce development across the health and care sector, and with local government, the third sector and volunteers.

The ICS NHS body will be expected to establish the appropriate people and workforce capability to discharge their responsibilities, including strong local leadership. In particular, the ICS NHS body will need to:

- have clear leadership and accountability for the organisation's role in delivering agreed local and national people priorities, with a named SRO with the appropriate expertise (registered people professional (CIPD accredited) or with equivalent experience)
- demonstrate how it is driving equality, diversity and inclusion. It should foster a culture of civility and respect, and develop a workforce and leadership that are representative of the population they serve.

To support local and national people priorities for the one workforce in the system, the ICS NHS body should work with organisations across the ICS to:

- Establish clear and effective governance arrangements for agreeing and delivering local strategic and operational people priorities. This will include ensuring there are clear lines of accountability and streamlined ways of working between individual organisations within the system, with other ICSs and with regional workforce teams
- Support the delivery of standardised, high-quality transactional HR services (eg payroll) across the ICS, supported by digital technology. These services should be delivered at the most effective level within the ICS footprint, based on the principle of subsidiarity, but proactively taking opportunities for collaboration and securing the benefits of delivering at scale. Local arrangements for delivering these services should be agreed by relevant employers across the system, facilitated by the NHS ICS Body, to support standardisation and remove duplication to allow for the reallocation resources to deliver on the strategic people agenda across the ICS
- Ensure action is taken to protect the health and wellbeing of people working within the ICS footprint, delivering the priorities set out in the 2021/22 planning guidance and in the People Promise, to improve the experience of working in the health and care system for all
- Establish leadership structures and processes (including leadership development, talent management and succession planning approaches) to drive the culture, behaviours and outcomes needed for

people working in the system and the local population, in line with the Leadership Compact[8]

- Undertake integrated and dynamic workforce, activity and finance planning based on population need, transformation of care models and changes in skills and ways of working – reflected in the system people plan and in the ICS Partnership's Strategy
- Plan the development – and where required, growth – of the one workforce to meet future need. This should include agreeing collaborative recruitment and retention approaches where relevant, planning local educational capacity and opportunities, and attracting local people into health and care employment and careers (including creating long-term volunteering opportunities)
- Develop new ways of working and delivering care that optimise staff skills, technology and wider innovation to meet population health needs and to create flexible and rewarding career pathways for those working in the system. This should be enabled by inclusive employment models, workforce sharing arrangements and passporting or accreditation systems
- Contribute to wider local social and economic growth and a vibrant local labour market, through collaboration with partner organisations, including the care home sector and education and skills providers.

To support ICS NHS bodies to discharge these responsibilities and deliver national and local people and workforce priorities, we will work with Health Education England to publish supplementary guidance and implementation support resources for ICSs on developing their strategic People capabilities, including a People operating model.

[8] The NHS Leadership Compact will set out the compassionate and inclusive behaviour we want all our leaders to show towards people. It will require every leader, at every level, to recognise, reflect and bring to life every day six core principles focused on: equality and diversity; continuous improvement; kindness, compassion and respect; trust; supporting people and celebrating success; and collaboration and partnership. The Compact will be published in due course.

Governance and management arrangements

Strong and effective governance and management arrangements are essential to enable ICSs to deliver their functions effectively. The pandemic has shown the success of partnership approaches that allow joined-up, agile and timely decision-making underpinned by common objectives. ICSs will build from this to establish robust governance and management arrangements that are flexibly designed to fit local circumstances and that bind partners together in collective endeavour.

This guidance provides an overview of our expectations for ICS governance and management arrangements. We will provide further resources throughout the year that share learning on the different approaches ICSs are developing.

The ICS NHS board

The statutory governance requirements for the NHS ICS body will be set out in legislation and NHS England and NHS Improvement will provide further guidance on the constitution of the board and process for this being agreed prior to establishment. This section provides an overview of our current expectations which will be developed, through engagement. As a new type of organisation, the governance arrangements for ICS NHS bodies will be different to those of existing commissioner and provider organisations in the NHS. They will need to reflect the different ways of working that will be required for ICS NHS bodies to effectively deliver their functions - as independent statutory NHS bodies, that bring together parties from across the NHS. The minimum requirements we set out are designed to provide a common framework for effective leadership and governance in this context.

The ICS NHS body will have a unitary board. The board will be responsible for ensuring the body plays its role in achieving the four purposes of the wider ICS and should be constituted in a way that ensures this focus on improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and contributing to broader social and economic development.

All members of the ICS NHS board (referred to below as “the board”) will have shared corporate accountability for delivery of the functions and duties of the ICS

and the performance of the organisation. This includes ensuring that the interests of the public and people who use health and care services remain central to what the organisation does. The board will be the senior decision-making structure for the ICS NHS body.

The statutory minimum membership of the board of each ICS NHS body will be confirmed in legislation. To carry out its functions effectively we will expect every ICS NHS body to establish board roles above this minimum level, so in most cases they will include the following roles:

- Independent non-executives: chair plus a minimum of two other independent non-executive directors (as a minimum required to chair the audit and remuneration committees). These individuals will normally not hold positions or offices in other health and care organisations within the ICS footprint.
- Executive roles (employed by the body): chief executive (who will be the accountable officer for the funding allocated to the ICS NHS body), director of finance, director of nursing and medical director.
- Partner members: a minimum of three additional board members, including at least:
  - one member drawn from NHS trusts and foundation trusts who provide services within the ICS's area
  - one member drawn from the primary medical services (general practice) providers within the area of the ICS NHS body
  - one member drawn from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the area of the ICS NHS body.

We expect all three partner members will be full members of the unitary board, bringing knowledge and a perspective from their sectors, but not acting as delegates of those sectors.

We expect the partner members from NHS trusts/foundation trusts and local authorities will often be the chief executive of their organisation or in a relevant executive-level local authority role.

The process of appointing the partner members, and the rules for qualification to be a member, will be set out in the constitution of the body.

The final composition of the board and the process of appointment of partner members will need to be consistent with any requirements set out in primary legislation and is therefore subject to Parliamentary process.

ICS NHS bodies will be able to supplement these minimum board positions as they develop their own ICS NHS body constitution, which will be subject to agreement with NHS England and NHS Improvement.

We expect all members of the board will be required to comply with the Nolan Principles of Public Life and meet the Fit & Proper Persons test, and boards must have clear governance and board level accountability for discharging the associated regulations.

Boards of ICS NHS bodies will need to be of an appropriate size to allow effective decision making to take place. Through a combination of their membership, and the ways in which members engage partners, the board and its committees should ensure they take into account the perspectives and expertise of all relevant partners. These should include all parts of the local health and care system across physical and mental health, primary care, community and acute services, patient and carer representatives, social care and public health, with directors of public health having an official role in the ICS NHS bodies and the Partnership.

It will be important that boards have strong leadership on issues that impact upon organisations and staff across the ICS, including the people agenda and digital transformation.

The ICS NHS body will be expected to promote open and transparent decision-making processes that facilitate finding consensus, drawing on agreed decision-making processes to manage areas of disagreement to ensure that the statutory duties of the ICS NHS body continue to be met. The board and its committees will have to make decisions transparently, holding meetings in public and publishing the papers.

NHS England and NHS Improvement will publish further guidance on the composition and operation of the board, including a draft model constitution. We will also provide guidance on the management of conflicting roles and interests,

ensuring partners can work together effectively and that the public can have confidence decisions are being made in their best interests as taxpayers and service users (see below for new provider selection regime).

Committees and decision-making

All ICS NHS bodies will need to put arrangements in place to ensure they can effectively discharge their full range of duties and functions. This is likely to include arrangements for committees and groups to advise and feed into the board, and to exercise functions delegated by the board. Boards may be supported by an executive group including, for example, other professional and functional leads, to manage the day-to-day running of the organisation.

These arrangements should address the cross-cutting functional responsibilities of the body including finance and resources, people, quality, digital and data performance and oversight. They should enable full involvement of clinical and professional leaders, leaders of place-based partnerships and providers, including relevant provider collaboratives. We expect the ICS NHS body will have arrangements that bring all relevant partners together to participate in decision-making.

We expect that each board will be required to establish an audit committee and a remuneration committee. The board may establish other decision-making committees, in accordance with its scheme of delegation. The board may also establish advisory committees to advise it on discharging certain duties, such as public and patient engagement.

The legislation is expected to give ICS NHS bodies flexibility in how they establish and deploy such committees. In particular, they will have the power to:

- appoint individuals who are not board members or staff of the ICS NHS body to be members of any committee it has established
- establish joint committees with NHS Trusts/FTs to which they may delegate responsibilities (decision making) in accordance with those bodies' schemes of delegation.

As ICSs will have significant flexibility in how and where decisions and functions are undertaken, every ICS NHS body should maintain a 'functions and decision map' showing its arrangements with ICS partners to support good governance and

dialogue with internal and external stakeholders. This should include arrangements for any commissioning functions delegated or transferred by NHS England and NHS Improvement.

The boards of ICS NHS bodies, and their committees, should conduct their business in a way that builds consensus, and should seek to achieve consensus on decisions. They should foster constructive challenge, debate and the expression of different views, reflecting the scope of their remit and their constituencies. They should have agreed processes for resolving differences in the first instance, if consensus cannot be reached; for example, through referencing the principles and behaviours set out in the ICS NHS body's constitution and by assessing the decision for consistency with overarching objectives (including the triple aim) and plans already agreed. The chair may make decisions on behalf of the board where there is disagreement. Where necessary boards may draw on third party support such as peer review or mediation by NHS England and NHS Improvement.

The ICS NHS body's constitution may provide for a vote to be taken where consensus cannot be reached and to set out how the vote will be conducted (for example, the chair having the casting vote). However, voting should be considered a last resort rather than a routine mechanism for board decision-making.

Place-based partnerships

Partnerships between organisations to collectively plan, deliver and monitor services within a locally defined 'place' have a long history. These place-based partnerships have typically been established by local agreement according to their context and this bottom-up approach has been an important enabler to meaningful collaboration. However, as part of the development of ICSs, we now expect that place-based partnerships are consistently recognised as key to the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health.

We have asked each system to define its place-based partnership arrangements, covering all parts of its geography, agreed collaboratively between the NHS, local government and other system partners working together in a particular locality or community.

There is no single way of defining place or determining a fixed set of responsibilities that a place-based partnership should hold. All systems should establish and

support place-based partnerships with configuration and catchment areas reflecting meaningful communities and geographies that local people recognise. In the smallest ICSs, the whole system may operate as a single place-based partnership. The arrangements for joint working at place should enable joined-up decision-making and delivery across the range of services meeting immediate care and support needs in those local places but should be designed flexibly to reflect what works in that area.

The ICS NHS body will want to agree with local partners the membership and form of governance that place-based partnerships adopt, building on or complementing existing local configurations and arrangements such as Health and Wellbeing Boards. At a minimum, these partnerships should involve primary care provider leadership, local authorities, including directors of public health, providers of acute, community and mental health services and representatives of people who access care and support.

The ICS NHS body will remain accountable for NHS resources deployed at place-level. Governance and leadership arrangements for place-based partnerships should support safe and effective delivery of the body's functions and responsibilities alongside wider functions of the partnership. Each ICS NHS body should clearly set out the role of place-based leaders within the governance arrangements for the body.

An NHS ICS body could establish any of the following place-based governance arrangements with local authorities and other partners, to jointly drive and oversee local integration:

- consultative forum, **informing** decisions by the ICS NHS body, local authorities and other partners
- committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources[9]
- joint committee of the ICS NHS body and one or more statutory provider(s), where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee in accordance with their schemes of delegation

[9] Contracts would be awarded and held, and payments made, by the ICS NHS body as the legal entity.

- individual directors of the ICS NHS body having delegated authority, which they may choose to exercise through a committee. This individual director could be a joint appointment with the local authority or with an NHS statutory provider and could also have delegated authority from those bodies
- lead provider managing resources and delivery at place-level under a contract with the ICS NHS body, having lead responsibility for delivering the agreed outcomes for the place.

Effective leadership at place level is critical to effective system working, but the specific approach is to be determined locally. The roles of place-based leaders will include convening the place-based partnership, representing the partnership in the wider structures and governance of the ICS and (potentially) taking on executive responsibility for functions delegated by the ICS NHS body CEO or relevant local authority.

Supra-ICS arrangements

There are some functions where ICS NHS bodies will need to work together; for example, commissioning more specialised services, emergency ambulance services and other services where relatively small numbers of providers serve large populations, and when working with providers that span multiple ICSs or operate through clinical networks. In many areas, multiple providers and ICS NHS bodies will need to work together to develop a shared plan for cancer services, with existing Cancer Alliances[10] continuing to use their expertise to lead whole-system planning and delivery of cancer care on behalf of their constituent ICSs, as well as providing clinical leadership and advice on commissioning. Similarly, provider collaboratives, including those providing specialised mental health, learning disability and autism services, will span multiple ICS footprints where this is right for the clinical pathway for patients.

The governance arrangements to support this will need to be co-designed between the relevant providers, NHS ICS bodies clinical networks or alliances and, where relevant, NHS England and NHS Improvement regional teams. In smaller ICSs it will be particularly important to establish joint working arrangements at the appropriate scale for the task, joining up planning for services across a wider

[10] Service Development Funding for cancer will continue to be provided to Cancer Alliances to enable them to continue to deliver their existing functions on behalf of their constituent ICS(s).

footprint where that makes sense to establish provider collaboratives at the appropriate scale to support service transformation across wider clinical networks.

ICSs and ambulance providers, which typically provide services to a population across multiple ICSs, should agree their working relationships carefully to ensure that, where appropriate, there is a joined-up dialogue between ICSs and their relevant ambulance provider, avoiding unnecessary variation in practice or duplication of communication. Alongside this, ambulance providers should consider how they can play their role effectively as part of individual systems, provider collaboratives and place partnerships, for example supporting the implementation of an effective integrated urgent care offer.

Quality governance

Quality is at the heart of all that we do. Each NHS organisation has individual responsibilities to ensure the delivery of high quality care. ICS NHS bodies will also have statutory duties to act with a view to securing continuous improvement in quality. We expect them to have arrangements for ensuring the fundamental standards of quality are delivered including to manage quality and safety risks and to address inequalities and variation; and to promote continual improvement in the quality of services, in a way that makes a real difference to the people using them.

ICSs are expected to build on existing quality oversight arrangements, with collaborative working across system partners, to maintain and improve the quality of care. ICS NHS bodies will need to resource quality governance arrangements appropriately, including leading System Quality Groups (previously Quality Surveillance Groups) and ensuring that clinical and care professional leads have capacity to participate in quality oversight and improvement. Operational support will also be provided through NHS England and NHS Improvement regional and national teams in line with National Quality Board's guidance, namely the refreshed *Shared Commitment to Quality* and the *Position Statement*. These key documents set out the core principles and consistent operational requirements for quality oversight that ICS NHS bodies are expected to embed during the transition period (2021/22) and beyond.

The role of providers

Organisations providing health and care services are the frontline of each ICS. They will continue to lead the delivery and transformation of care and support, working alongside those who access their services and the wider communities they serve. As ICSs have developed, providers have increasingly embraced wider system leadership roles, working with partners to join up care pathways, embed population health management, reduce unwarranted variation and tackle heath inequalities.

The arrangements put in place by each ICS Partnership and ICS NHS body must harness the expertise, energy and ambition of the organisations directly responsible for delivering integrated care.

As constituent members of the ICS Partnership, the ICS NHS body and place-based partnerships, providers of NHS services will play a central role in establishing the priorities for change and improvement across their healthcare systems and delivering the solutions to achieving better outcomes.

We expect the contracts health service providers hold (NHS Standard, or national primary care[11] supplemented locally) to evolve to support longer term, outcomes-based agreements, with less transactional monitoring and greater dialogue on how shared objectives are achieved.

Primary care in Integrated Care Systems

All primary care professionals have a fundamental role to play in ensuring that ICSs achieve their objectives. The success of efforts to integrate care will depend on primary care and other local leaders working together to deliver change across health and care systems.

Primary care should be represented and involved in decision-making at all levels of the ICS, including strategic decision-making forums at place and system level. It should be recognised that there is no single voice for primary care in the health and care system, and so ICSs should explore different and flexible ways for seeking primary care professional involvement in decision-making. In particular, primary care should have an important role in the development of shared plans at place and

[11] Primary care contracts will continue to be negotiated nationally

system, ensuring they represent the needs of their local populations at the neighbourhood level of the ICS, including with regards to health inequalities and inequality in access to services.

ICSs should explore approaches that enable plans to be built up from population needs at neighbourhood and place level, ensuring primary care professionals are involved throughout this process.

The role of primary care networks

Primary care networks (PCNs), serving the patients of the constituent general practices, play a fundamental role improving health outcomes and joining up services. They have a close link to local communities, enabling them to identify priorities and address health inequalities. PCNs will develop integrated multi-disciplinary teams that include staff from community services and other NHS providers, local authorities and the voluntary, community and social enterprise (VCSE) sector to support effective care delivery. Joint working between PCNs and secondary care will be crucial to ensure effective patient care in and out of hospital.

PCNs in a place will want to consider how they could work together to drive improvement through peer support, lead on one another's behalf on place-based service transformation programmes and represent primary care in the place-based partnership. This work is in addition to their core function and will need to be resourced by the place-based partnership.

ICSs and place-based partnerships should also consider the support PCN clinical directors, as well as the wider primary care profession, may need to develop primary care and play their role in transforming community-based services. Place-based partnerships may also wish to consider how to leverage targeted operational support to their PCNs, for example with regard to data and analytics for population health management approaches, HR support or project management.

Voluntary, community and social enterprise partners

The VCSE sector is a vital cornerstone of a progressive health and care system. ICSs should ensure their governance and decision-making arrangements support close working with the sector as a strategic partner in shaping, improving and delivering services and developing and delivering plans to tackle the wider determinants of health. VCSE partnership should be embedded as an essential part

of how the system operates at all levels. This will include involving the sector in governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans.

We expect that by April 2022 Integrated Care Partnerships and the ICS NHS body will develop a formal agreement for engaging and embedding the VCSE sector in system level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector. These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level. A national development programme is in place to facilitate this in all areas.

Independent sector providers

All providers, including independent providers to the NHS and local authorities, will need to be engaged with other relevant partners in the ICS, through existing or newly formed arrangements, to ensure care meets the needs of the population and is well co-ordinated.

NHS trusts and foundation trusts

NHS trusts and foundation trusts will play a critical role in the transformation of services and outcomes within places and across and beyond systems.

As now, they will work alongside primary care, social care, public health and other colleagues in each of the places or localities they serve, to tailor their services to local needs and ensure they are integrated in local care pathways. They will also be more involved in collectively agreeing with partners how services and outcomes can be improved for that community, how resources should be used to achieve this and how they can best contribute to population health improvement as both service providers and as local ‘anchor institutions’. The most efficient and appropriate ways of doing this will vary for different types of providers and in different local contexts. ICS NHS bodies will need to work with providers that span multiple ICSs and cross ICS boundaries, including ambulance and community trusts, to agree arrangements that ensure they are fully engaged.

In future, we expect the ICS NHS body could ask NHS trusts and foundation trusts to take on what have been ‘commissioning’ functions for a certain population,

building on the model that NHS-led provider collaboratives for specialised mental health, learning disability and autism services have been developing.

The success of individual trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver safe and effective care. This will include delivering their agreed contribution to system financial balance, improving quality and outcomes and reducing unwarranted variation and inequalities across the system as a whole, in the context of the new 'triple aim' duty to promote better health for everyone, better care for all and efficient use of NHS resources.

The new provider selection regime

NHS England and NHS Improvement has recommended that Parliament legislates to remove the current rules governing NHS procurement of healthcare services; and these are replaced by a new regime specifically created for the NHS.

This regime would give decision-makers greater discretion in how they decide to arrange services, with competition and tendering a tool to use where appropriate, rather than the default expectation. We want to make it straightforward for local organisations to continue with existing service provision where the arrangements are working well and there is no value in seeking an alternative provider. Where the system wants or needs to consider making changes to service provision, we want there to be a flexible, sensible, transparent and proportionate process for decision-making that allows shared responsibility to flow through it, rather than forcing the NHS into pointless tendering and competition.

The central requirement of the proposed new regime is that decisions about who provides NHS services must be made in a transparent way, in the best interests of patients, taxpayers and the population. The regime would need to be applied by NHS bodies (NHS England and NHS Improvement, ICS NHS bodies, NHS trusts and foundation trusts) and local authorities when making decisions about who provides healthcare services (the new regime will not apply to other local authority services).

The regime sets out the steps that decision-making bodies should take when seeking to justify continuing existing arrangements with an existing provider; how to select the most suitable provider when a service is new or changing substantially, but a competitive procurement is not appropriate; and how to run a competitive

procurement where this is considered appropriate. The regime sets out some key criteria decision-makers need to consider when arranging services, as well as requirements around transparency and scrutiny of decisions. Further details can be found at www.england.nhs.uk/publication/nhs-provider-selection-regime-consultation-on-proposals/

Provider collaboratives

Provider collaboratives are partnership arrangements involving two or more trusts (foundation trusts or NHS trusts) working across multiple places to realise the benefits of mutual aid and working at scale. The response to COVID-19 has demonstrated both the need for and potential of this type of provider collaboration. During 2021/22 the dynamic management of capacity and resources, greater transparency and collective accountability seen during the pandemic must be continued and developed. Specifically, providers are expected to work together to agree and deliver plans to achieve inclusive service recovery, restoration and transformation across systems, and to ensure services are arranged in a way that is sustainable and in the best interests of the population.

From April 2022 trusts providing acute and/or mental health services are expected to be part of one or more provider collaboratives. Community trusts, ambulance trusts and non-NHS providers (eg community interest companies) should participate in provider collaboratives where this is beneficial for patients and makes sense for the providers and systems involved.[12]

The purpose of provider collaboratives is to better enable their members to work together to continuously improve quality, efficiency and outcomes, including proactively addressing unwarranted variation and inequalities in access and experience across different providers. They are expected to be important vehicles for trusts to collaboratively lead the transformation of services and the recovery from the pandemic, ensuring shared ownership of objectives and plans across all parties.

[12] Community trusts, ambulance trusts and other providers may need to maintain relationships with multiple provider collaboratives, and/or focus on relationships within place-based partnerships, in ways they should determine with partners.

Provider collaboratives will agree specific objectives with one or more ICS, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved.

Provider collaboratives will help facilitate the work of alliances and clinical networks, enabling specialty-level plans and decisions to be made and implemented in a more coordinated and systematic way in the context of whole system objectives. For example, Cancer Alliances already work with the providers in their local systems to lead a whole system approach to operational delivery and transformation, and in future Alliances will work with their relevant Provider Collaboratives.

It will be up to providers, working with partners, to decide on the specific model and best governance arrangements for their collaboratives.

ICS NHS bodies will contract with NHS trusts and foundation trusts for the delivery of services, using the NHS Standard Contract. For services delivered through collaborative arrangements, ICS NHS bodies could:

- contract with and pay providers within a collaborative individually. The providers would then agree as a provider collaborative how to use their respective resources to achieve their agreed shared objectives
- contract with and pay a lead provider acting on behalf of a provider collaborative (whole budget for in-scope services). The lead provider would agree sub-contracting and payment arrangements across the collaborative. The existing mental health provider collaboratives have been successfully based on lead provider arrangements.

The ICS NHS body and provider collaboratives should define their working relationship, including participation in committees via partner members and any supporting local arrangements, to facilitate the contribution of the provider collaborative to agreed ICS objectives.

Further guidance on provider collaboratives will be published in due course.

Clinical and professional leadership

All ICSs should develop a model of distributed clinical and care professional leadership, and a culture which actively encourages and supports such leadership to thrive. This includes ensuring professional and clinical leaders have protected time and resource to carry out system roles, and are fully involved as key decision-makers, with a central role in setting and implementing ICS strategy.

These arrangements should support and enhance those of the organisations within the ICS footprint, which are responsible for the professional and clinical leadership of their people and services.

They should reflect the learning and experience gained from CCG clinical leadership, building out from this to reflect the rich diversity of clinical and care professions across the wider ICS partnership, including health, social care and the VCSE sectors, embedding an inclusive model of leadership at every level of the system.

Specific models for clinical and care professional leadership will be for ICSs to determine locally and we recognise that ICSs are at different stages of development in this regard. We will provide further resources describing the features of an effective model, informed by more than 2,000 clinical and care professionals and illustrating case studies from systems with more advanced approaches. These features include:

- effective structures and communication mechanisms to connect clinical and care professional leaders at each level of the system
- a culture which systematically embraces shared learning, supporting its clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities
- protected time, support and infrastructure for clinical and care professional leaders to carry out their system leadership roles
- clearly defined and visible support for clinical and care profession leaders, including support to develop the leadership skills required to work effectively across organisational and professional boundaries
- transparent approaches to identifying and recruiting leaders, which promote equity of opportunity and a professionally and demographically diverse talent pipeline which reflects that community it serves.

We will expect ICSs to use the resources to support self-assessment of their clinical and professional leadership model and implement mechanisms to measure their progress and performance. We encourage systems to consider how they could use a peer review approach to support their development in this area, buddying with other systems to undertake their assessment and develop subsequent plans.

For the NHS ICS body, the clinical roles on the Board, described in the 'Governance and management arrangements' section, are a minimum expectation, ensuring executive-level professional leadership of the organisation. Individuals in these roles are expected to ensure leaders from across clinical and care professions are involved and invested in the purpose and work of the ICS.

The ICS NHS board will be expected to sign off a model and improvement plan for clinical and care professional leadership that demonstrates how this will be achieved, and to ensure that the five guiding principles described above are reflected in its governance and leadership arrangements.

Working with people and communities

The parties in an ICS, including those of the ICS Partnership, the NHS ICS body and place-based partnerships will be expected to agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

As part of the ICS-wide arrangements, we expect each ICS NHS body to build a range of engagement approaches into their activities at every level and to prioritise engaging with groups affected by inequalities. The solutions to reducing inequalities will often be found by engaging with communities through relational and strengths-based approaches drawing on the experience of local authority, VCSE and other partners with experience and expertise in this regard.

We expect that this will be supported by a legal duty for ICS NHS bodies to make arrangements to involve patients, unpaid carers and the public in planning and commissioning arrangements, and by the continuation of the existing NHS trust and foundation trust duties in relation to patient and public involvement, including the role of foundation trusts governors.

Working with a range of partners such as Healthwatch, the VCSE sector and experts by experience, the ICS NHS body should assess and where necessary strengthen public, patient and carers' voice at place and system levels. Places are an important component, as they typically cover the area and services with which most residents identify. We are working with ICSs, Healthwatch England and others to identify and disseminate some of the most effective place-based approaches, for example through place-level citizens' panel work.

Arrangements in a system or place should not just provide a mechanism for commentary on services but should be a source of genuine co-production and a key tool for supporting accountability and transparency of the system. Where decision-making affects communities, groups or specific services, these arrangements (including any formal consultation) should fully engage those affected, including populations, patients and carers across health and social care.

We have previously set out seven principles for how ICSs should work with people and communities. These are:

1. Use public engagement and insight to inform decision-making
2. Redesign models of care and tackle system priorities in partnership with staff, people who use care and support and unpaid carers
3. Work with Healthwatch and the voluntary, community and social enterprise sector as key transformation partners
4. Understand your community's experience and aspirations for health and care
5. Reach out to excluded groups, especially those affected by inequalities
6. Provide clear and accessible public information about vision, plans and progress to build understanding and trust
7. Use community development approaches that empower people and communities, making connections to social action.

Each ICS NHS body should use these principles as a basis for developing a system-wide strategy for engaging with people and communities, building on the existing relationships, good practice and networks across system partners.

As part of this strategy, the body should work with its partners across the ICS to develop arrangements for:

- ensuring the ICS Partnership and place-based partnerships have representation from local people and communities in priority setting and decision-making forums
- gathering intelligence about the experience and aspirations of people who use care and support, together with clear approaches to using these insights to inform decision making and quality governance.

More detailed information will be made available to systems in guidance on membership and governance of ICS NHS bodies and in the implementation support for how ICSs work with people and communities.

Accountability and oversight

The ICS NHS body will be a statutory organisation. The members of its unitary board will have collective and corporate accountability for the performance of this organisation and will be responsible for ensuring its functions are discharged. NHS England and NHS Improvement through its regional teams, will agree the constitutions and plans of ICS NHS bodies and hold them to account for delivery through the chair and chief executive.

ICSs more broadly bring together NHS, local government and other partners, who each retain formal accountability for the statutory functions they are responsible for. Building on the relationships and ways of working they have developed to date, these partners will need to maintain a working principle of mutual accountability, where, irrespective of their formal accountability relationships, all partners consider themselves collectively accountable to the population and communities they serve, and to each other for their contribution the ICS's objectives.

Providers of NHS services will continue to be accountable:

- for quality, safety, use of resources and compliance with standards through the provider licence (or equivalent conditions in the case of NHS trusts) and CQC registration requirements
- for delivery of any services or functions commissioned from or delegated to them, including by an NHS ICS body, under the terms of an agreed contract and/or scheme of delegation.

Executives of provider organisations will remain accountable to their boards for the performance of functions for which their organisation is responsible. Where an executive of an NHS provider organisation sits on the board of an NHS ICS body, they will in their capacity as a member of that board also be accountable – collectively with other board members – for the performance of the ICS body and ensuring its functions are discharged. And when acting as an ICS body board member, they must act in the interests of the ICS body and the wider system, not those of their employing provider. NHS England and NHS Improvement will provide guidance to support ICS NHS bodies to manage conflicting roles and interests of board members.

Approach to NHS oversight within ICSs

The oversight arrangements for 2022/23 will build on the final 2021/22 System Oversight Framework (SOF) reflecting the statutory status of ICS NHS bodies from April 2022. We expect these arrangements to confirm ICSs' formal role in oversight including:

- bringing system partners together to identify risks, issues and support needs and facilitate collective action to tackle performance challenges
- leading oversight and support of individual organisations and partnership arrangements within their system.

While ICS NHS bodies will, by default, lead local oversight and assurance, NHS England and NHS Improvement's future statutory regulatory responsibilities will be similar to its existing ones. This means that any formal regulatory action with providers will, when required, be taken by NHS England and NHS Improvement.

We will work with each ICS NHS body to ensure effective and proportionate oversight of organisations within the ICS area, with arrangements that reflect local delivery and governance arrangements and avoid duplication. In particular, where additional assurance or intervention is required, NHS England and NHS Improvement will work with the ICS partners to ensure such action is informed by the perspective of system stakeholders, and that any recovery plans agreed align with system objectives and plans.

NHS England and NHS Improvement and ICS NHS bodies may, over time, decide to take the role of provider collaboratives and place-based partnerships into account when determining how to address issues identified through system oversight. This may, for instance, include looking to these arrangements (and the partners involved) for support where poor performance is identified; or considering the effectiveness of collaborative working arrangements when considering whether systems/providers have an effective plan for improvement/recovery.

Systems will also benefit from existing local authority health overview and scrutiny committees reviewing and scrutinising their work. Scrutiny provides a mechanism for local democratic accountability through local government elected members. It enables valuable connections to be made between the experience and aspirations of residents and ICS governance, via the relationships that local councillors have with their constituents.

Accountability and transparency in ICSs will also be supported via:

- clearly agreed and articulated arrangements for how the system works with people and communities
- public meetings, published minutes, and regular and accessible updates on the ICSs' vision, plans and progress against priorities.

We are working with colleagues from the Care Quality Commission (CQC) and DHSC to agree the process and roles for reviewing and assessing systems. The aim is that this would complement the role of NHS England and NHS Improvement, avoiding duplication and overlap, and support the delivery of integrated care across system partners.

The proposed principles for NHS system oversight are:

- working with and through ICSs, wherever possible, to provide support and tackle problems
- a greater emphasis on local priorities and on system performance and quality of care outcomes alongside the contributions of individual organisations to system goals
- matching accountability for results with improvement support, as appropriate
- greater autonomy for ICSs and organisations with evidence of collective working and a track record of successful delivery of NHS priorities, including tackling inequality, health outcomes and access
- compassionate leadership behaviours that underpin all oversight interactions.

Financial allocations and funding flows

Systems are currently funded under the COVID financial regime through a system funding envelope for each ICS, which includes system top-up and COVID fixed allocation arrangements. In due course, system funding allocations will move back towards the population-based distribution and funding quantum allocated as part of the Long Term Plan funding settlement, taking account of subsequent funding allocations and the outcome of the Spending Review.

ICS allocations

NHS England and NHS Improvement will make financial allocations to each ICS NHS body for the performance of its functions. Decisions about spending will be devolved to ICS NHS bodies.

This will include the budgets for:

acute, community and mental health[13] services (currently CCG commissioned)

primary medical care (general practice) services (currently delegated to CCGs)

running cost allowances for the ICS NHS body.

This may also include the allocations for a range of functions currently held by NHS England and NHS Improvement, including:

- other primary care budgets
- relevant specialised commissioning services suitable for commissioning at ICS level (for example, excluding highly specialised services)
- the allocations for certain other directly commissioned services
- a significant proportion of nationally held transformation funding and service development funding
- the Financial Recovery Fund
- funding for digital and data services.

[13] Every ICS will be required to continue to meet the mental health investment standard and as such a minimum level of mental health funding remains ringfenced (ICSs are free to invest above this level).

Funding will continue to be linked to population need. Allocations will be based on longstanding principles of supporting equal opportunity of access for equal needs and contributing to the reduction of health inequalities. NHS England and NHS Improvement's approach will continue to be informed by the independent Advisory Committee on Resource Allocation (ACRA).[14] Allocations will be set in a way that avoids large swings in funding that would risk destabilising local health economies.

NHS England and NHS Improvement will allocate funding to ICSs, continuing to take into account both the need of their population ('the target allocation') and how quickly ICSs move towards their target allocations (known as pace-of-change). We would not make a centrally set allocation to 'place' within the ICS. Existing allocations tools can be adapted to support ICS NHS bodies in making decisions about how to deploy resource to places.

An open book relationship between providers of NHS services, supported by improved cost data (PLICS), will give further transparency for stakeholders that the NHS is meeting its commitment to deploy resource according to need and tackle inequalities.

Full capital allocations will be made to the ICS NHS body, based on:

- the outcome of the 2022/23 capital settlement for operational capital, building on the arrangements initially implemented in 2020/21
- capital budgets being a combination of system-level allocations (operational capital), nationally allocated funds (for large strategic projects) and other national programmes
- the methodology being kept under review to ensure available capital is best allocated against need. We hope future allocations can be set over a multi-year, subject to the outcome of the next Spending Review.

Distribution of funds by the ICS NHS body

The ICS NHS body will agree how the allocation will be used to perform its functions, in line with health and care priorities set at a local level.

[14] An independent committee of academics, public health experts, GPs and NHS managers that makes recommendations on the preferred, relative, geographical distribution of resources for health services.

Money will flow from the ICS NHS body to providers largely through contracts[15] for services/outcomes, which may be managed by place-based partnerships or provider collaboratives.

The existing provider collaboratives for specialised mental health, learning disability and autism services have paved the way in taking on budgets through lead provider arrangements. In conjunction with ICS leaders, we will consider supporting provider collaboratives to take on further responsibility for use of resources to deliver population health outcomes.

The ICS NHS body will be able to commission jointly with local authorities under a section 75 joint commissioning arrangement, as CCGs can.

Spending will be part of a plan to deliver financial balance within a system's financial envelope, which would also be set by NHS England and NHS Improvement. This envelope covers expenditure across the whole system, including spending by NHS trusts/foundation trusts for services delivered for commissioners from outside the system.

Each ICS will have an agreed framework for collectively managing and distributing financial resources to address the greatest need and tackle inequalities in line with the NHS system plan, having regard to the strategies of the Partnership and the Health and Wellbeing Board/s. This is in line with the duty we expect to remain for the system to have regard for reducing health inequalities.

Financial rules will apply to ensure delivery of key national commitments, such as the Mental Health Investment Standard and the primary medical and community health services funding guarantee.

Based on these local priorities and national rules (including the National Tariff Payment System), the ICS NHS body will agree:

- priorities and outcomes to be achieved in plan against NHS budget (with clinical advice and with regard to ICS Partnership plan)
- the distribution of the NHS revenue allocation (both total financial value and service lines) to:

[15] The ICS NHS body will also be able to make grants to VCSE organisations and to NHS Trusts/FTs. In future, the ICS NHS body may wish to use its expected power to delegate its functions to statutory providers.

  - each place-based partnership as appropriate
  - each NHS provider (individually contracted or via a lead provider contract, including where operating as part of a provider collaborative)
  - contracts with other service providers
  - other collaboratives partnerships.
- A capital plan including how capital spend should be prioritised locally (developed through collective decision making across NHS providers, and with ability to co-ordinate with the estates and assets managed by local authorities).

The ICS NHS board and chief executive (AO) will be ultimately responsible for services under delegation arrangements with place-based partnerships or through lead provider contracts. They will need to put in place proportionate mechanisms to provide assurance on the spending of public money.

Setting budgets for places

The ICS NHS body will have the freedom to set a delegated budget for place-based partnerships to support local financial decisions to spend ICS NHS resources. However, it must adopt the principle of equal access for equal need and the requirements to reduce health inequalities. The ICS NHS body should engage local authority partners on the ICS NHS resources for the NHS services to be commissioned at place and support transparency on the spending made at place level. It should explain any variation from previous CCG budgets and enable the shared planning or pooling of NHS and local authority budgets, including stated minimum NHS contributions to Better Care Fund arrangements.

Budget allocated to and managed within a place (under the agreed schemes of delegation) might include:

- primary medical care
- other primary care as delegated/transferred from NHS England and NHS Improvement – dental, pharmaceutical, ophthalmology services
- community services
- community mental health including IAPT
- community diagnostics
- intermediate care

- any services subject to Section 75 agreement with local authority
- any acute or secondary care services that is has been agreed should be commissioned at place-level.

Financial and regulatory mechanisms to support collaboration

ICS NHS bodies will have a duty to co-operate with other NHS bodies, including NHS trusts and foundation trusts, and local authorities. They also have a duty to promote integration. These duties, combined with the new triple aim duty, should be a key driver for ensuring NHS ICS partners work together to meet the four purposes of the ICS with the resources available.

Collaboration in the NHS has accelerated in recent years and this is already supported by a wide range of enablers to ensure a shared investment in system objectives and plans.

Enablers already established, or expected to be established, through NHS England and NHS Improvement's system-by-default approach include:

- Setting system financial envelopes, which describe the funding available to spend in an ICS, including CCG allocations and national sustainability funding. These budgets will be based on population need and will support systems to work together to free up resources, which can be spent elsewhere in the system
- Proposals to establish an aligned payment and incentive (API) approach, in which fixed payments are set for an agreed level of planned activity; variable payments would also be agreed for activity above or below these plans. This should give the ICS NSH body, NHS trusts and foundation trusts greater certainty over payments and the agreed level of activity these payments will cover
- Inclusion of a System Collaboration and Financial Management Agreement in the NHS standard contract, which is a collaborative document aimed to ensuring NHS system partners work together to deliver shared financial objectives. The ICB, NHS trusts and foundation trusts will agree in advance ways of working and the risk management approach to dealing with unplanned pressures

- Change in oversight focus in the System Oversight Framework (SOF) which works with and through the system to tackle problems with an emphasis on system performance and greater autonomy for organisations with evidence of effective joint working.
- Guidance to be issued on provider governance to support providers to work collaboratively as part of ICSs to deliver system objectives. This will include an updated Code of Governance for NHS provider trusts, updated guidance on the duties of foundation trust governors, and updated memorandums for accounting officers of foundation trusts and NHS trusts. New guidance will be issued under the NHS Provider Licence that good governance for NHS providers includes a requirement to collaborate.

In addition to these policy developments, further enablers to support system collaboration are expected from the proposed legislation and policy, including:

- A common duty for ICS NHS bodies, NHS trusts and foundation trusts in relation to the triple aim, which requires them to have regard to the wider effect of their decisions in each of the three strands of the triple aim improving population health, quality of care and the use of resources
- Imposition of duties on the ICS NHS body to act with a view to ensuring system financial balance and to meet other financial requirement and objectives set by NHS England and NHS Improvement. This would also apply to NHS trusts and foundation trusts. This should mean that ICS NHS bodies, NHS trusts and foundation trusts have shared investment in the delivery of system financial balance and strong reason to collaborate to agree a system plan for meeting this; supported by a review of the NHS provider licence
- Powers to ensure organisational capital spending is in line with system capital plans. A review of the NHS provider licence in light of the new legislation and policy developments and specifically to support providers to work effectively as part of ICSs to deliver system objectives.

Services currently commissioned by NHS England and NHS Improvement

The legislation will enable the direct commissioning functions of NHS England and NHS Improvement to be jointly commissioned, delegated or transferred at an appropriate time to ICS NHS bodies.

NHS England and NHS Improvement is considering how it might shift some of its direct commissioning functions to ICS NHS bodies. Subject to discussions with systems and our Regions and further work on HR, our intention is to enable ICS NHS bodies to take on responsibility as soon as they are ready to do so after the enactment of legislation.

Commissioning of primary medical services is currently delegated to CCGs and will transition immediately into ICS NHS bodies when they are established. ICS NHS bodies might also take on primary dental services, general ophthalmic and pharmaceutical services commissioning.

Further work is taking place at national and regional levels to explore how the commissioning model for specialised services could evolve , in line with the safeguards and four principles set out in *Integrating Care: Next steps to building strong and effective integrated care systems across England*.

NHS England and NHS Improvement has a range of other direct commissioning functions including health and justice, armed forces and aspects of public health. Engagement with ICSs will continue to establish how they could take on greater responsibility for these services in future.

Data and digital standards and requirements

The standards and requirements for digital and data will be centred around the What Good Looks Like framework, which will set out a common vision to support ICS leaders to accelerate digital and data transformation in their systems with partner organisations. Based on consultation with a wide range of NHS and care stakeholders, the framework identifies seven success measures and will be published in the first quarter of 21/22.

We expect digital and data experts to have a pivotal role in ICSs, supporting transformation and ensuring health and care partners provide a modern operating environment to support their workforce, citizens and populations.

From April 2022, systems will need to have smart digital and data foundations in place. The way that these capabilities are developed and delivered will vary from system to system. Systems will locally determine the right way to develop these capabilities and to ensure they are available at system and place level, and across provider collaboratives.

Specifically, ICS NHS bodies are expected to:

- Have a renewed digital and data transformation plan that is embedded within the ICS NHS body plan and details the roadmap to achieve 'What Good Looks Like'; and enables a cross system approach to transformation, so that changes to models of care and service redesign involve digital and data experts working with partners from all relevant sectors.
- Have clear accountability for digital and data, with a named SRO with the appropriate expertise, (registered professional or with equivalent experience), underpinned by governance arrangements that have clear oversight and responsibility for digital and data standards and requirements for the ICS and enabling partner organisation programmes and services.
- Invest in levelling-up and consolidation of infrastructure, linked to the future ICS reference target architecture and data model, adopting a simplified cloud-first infrastructure that provides agility and frictionless cross-site working experience for the workforce.

- Implement a shared care record, that allows information to follow the patient and flow across the ICS to ensure that clinical and care decisions are made with the fullest of information.
- Ensure adherence by constituent partners to standards and processes that allow for interoperability across the ICS, and alignment to forthcoming national guidance.
- Enable a single co-ordinated offer of digital channels for citizens across the system and roll out remote monitoring technologies to help citizens manage their care at home.
- Cultivate a cross-system intelligence function to support operational and strategic conversations, as well as building platforms to enable better clinical decisions. This will require ICSs to have linked data, accessible by a shared analytical resource that can work on cross-system priorities.
- Agree a plan for embedding population health management capabilities and ensuring these are supported by the necessary data and digital infrastructure, such as linked data and digital interventions. Online PHM support can also be found at https://future.nhs.uk/populationhealth/grouphome and here Population Health Management - e-Learning for Healthcare (e-lfh.org.uk).

Arrangements should be co-ordinated across the NHS and local government, as well as between NHS organisations.

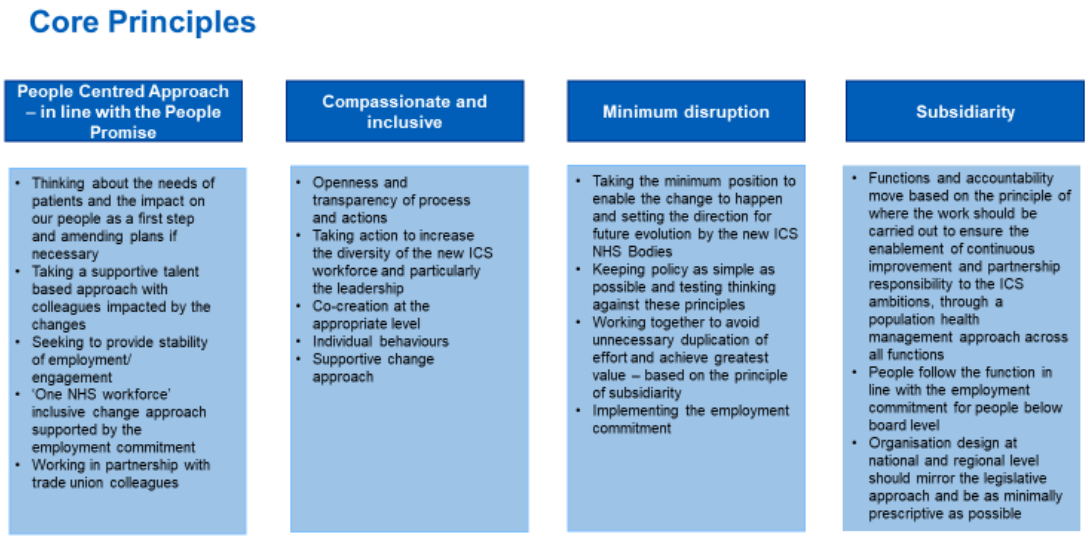
Managing the transition to statutory ICSs

We will work in partnership with systems, individual organisations affected, trade unions, voluntary organisations and central and local government to ensure the opportunities for improved outcomes for populations and improvements for our people are realised. We aim to create an environment that enables this change to take place with minimum uncertainty and employment stability for all colleagues who are involved.

The change and transition approach is guided by our Employment Commitment and a set of core principles designed to inform the thinking and actions of all colleagues throughout the process, acknowledging the wide variation in circumstances across systems.

> **The Employment Commitment**
>
> *"NHS people within the wider health and care system (below board level) affected directly by these legislative changes, including CCGs, NHS England and NHS Improvement and NHS providers, will receive an employment commitment to continuity of terms and conditions (even if not required by law) to enable all affected colleagues to be treated in a similar way despite a variety of contractual relationships. This commitment is designed to provide stability and remove uncertainty during this transition."*

The Employment Commitment is designed to minimise uncertainty and provide employment stability for people who will transfer directly from their employment or engagement directly into the statutory ICS NHS body. During the transition period the Employment Commitment asks affected organisations not to carry out significant internal organisational change and not to displace people. The commitment does not apply to those people in senior/board level roles who are likely to be affected by the new ICS Board structure and will have to go through organisational change as part of the abolition and establishment process.



Accountability for managing the change process will be with the current ICS and CCG leadership, with increasing involvement of the new leaders (eg chair, chief executive and others at board level) who may be appointed on a shadow or designate basis, pending the legislation.

Each ICS should make initial arrangements to manage the transition and ensure that there is capacity in place ready for implementation of the new ICS body. Plans should be agreed with regional NHS England and NHS Improvement teams.

Each ICS should ensure that planning adequately addresses the implications of organisational development implications as operations evolve from the current into the future configuration. This should be explicitly based in the local context.

It is important to note that any plans are subject to the passage of the legislation. Systems cannot pre-empt the decision of Parliament on whether to approve a bill or how it is to be amended. While plans can be made, systems should not take decisions or enter into arrangements which presume any legislation is already in place or that it is inevitable it will become law, before the Parliamentary process has been completed.

The overarching aim is to ensure and enable:

- the safe transfer of functions into the ICS NHS body (ie existing statutory functions that are to be exercised by the ICS NHS body) and prepare for the ICS body to take on new functions as appropriate
- the smooth transition of our people (ie legally compliant, with minimum disruption).

The indicative outputs expected in every ICS over the course of the transition period in 2021/22 are set out below. This is subject to legislation and other factors (including pending decisions on ICS boundaries in some areas).

By end Q1 Preparation	• Update System Development Plans (SDPs) against the key implementation requirements (functions, leadership, capabilities and governance) and identify key support requirements. • Develop plans in preparation for managing organisational and people transition, taking into account the anticipated process and timetable, and any potential changes to ICS boundaries and the need to transform functions to support recovery and delivery across the ICS.
By end Q2 Implementation	• Ensure people currently in ICS Chair, ICS lead or AO roles are well supported and consulted with appropriately. • Carry out the agreed national recruitment and selection processes for the ICS NHS body chair and chief executive, in accordance with guidance on competencies and job descriptions issued by NHS England and NHS Improvement. This will reflect the expected new accountabilities and responsibilities of ICS NHS bodies. • Confirm appointments to ICS Chair and chief executive. Subject to the progress of the Bill and after the second reading these roles will be confirmed as designate roles. • Draft proposed **new** ICS NHS body MoU arrangements for **2022/23**, including ICS operating model and governance arrangements, in line with the NHS England and NHS Improvement model constitution and guidance. • Plan for CCG teams to only operate at sub-ICS level where the SDP confirms that the ICS plans to establish a significant place-based function at that footprint. • Begin due diligence planning.
By end Q3 Implementation	• Ensure people in impacted roles are well supported and consulted with appropriately.

	• Carry out the recruitment and selection processes for designate finance director, medical director, director of nursing and other board level role in the NHS ICS body, using local filling of posts processes. • Confirm designate appointments to ICS NHS body finance director, medical director and director of nursing roles and other board and senior level roles. • ICS NHS bodies and ICS Partnerships to be ready to operate in shadow form. • Engagement on local ICS Constitution and governance arrangements for ICS NHS body and ICS Partnership.
By end Q4 Transition	• Ensure people in affected roles are consulted and supported. • Continue the recruitment and selection processes for all other designate ICS NHS body senior roles, including place-level leaders and non-executive roles, using local filling of posts processes. • Confirm designate appointments to any remaining senior ICS roles (in line with our relevant guidance) so that as much of the ICS NHS executive board and other senior leadership is ready (subject to formal decisions on appointments after the legislation is in place/in force). • Complete due diligence and preparations for staff and property (assets and liabilities, including contracts) transfers from CCGs and other NHS staff transfers to new ICS NHS body in line with our guidance. • Commence engagement and consultation on the transfer with trade unions. • Complete preparations to shift our direct commissioning functions to ICS NHS body, where this is agreed from 1 April 2022. • Ensure that revised digital, data and financial systems are in place ready for ‘go live’. • Submit the ICS NHS body constitution for approval and agree the 2022/23 ICS MoU with NHS England and NHS Improvement, setting out key elements of how the new ICS NHS body and ICS Partnership will operate in the future, in accordance with guidance to be issued by NHS England and NHS Improvement.

NHS England and NHS Improvement is working with a range of stakeholder groups, including a newly formed ICS Transition Partnership Group, which is a sub-group of the national Social Partnership Forum, to make available a range of resources and guidance to support the transition. The following document will be published in support of this:

- Employment Commitment Guidance – which builds on the commitment made in the FAQs published on 11 February 2021 and sets out what 'board level' means in this context. This also sets out the national support and senior level support that is available for colleagues affected by these changes.

After the legislation is introduced, we will publish further resources and guidance to support people transition planning and implementation.

Conclusion

As we move into the next phase of system development, we must capture and build on the spirit and practice of partnership now embedded across the NHS local councils, the VCSE sector and beyond. We continue to face an unprecedented challenge as a health and care system, but ICSs offer a clear way forward.

Strengthening local partnerships through ICSs is one of the most important and exciting missions in the public sector today. We would like to thank colleagues in every part of every system for your continued efforts to pursue it. This is an opportunity to deliver better care and population health; to ensure services treat us all as individuals and respond to our increasingly complex health and care needs. It is also an opportunity to work in partnership with local residents in new ways, removing even more of the traditional barriers to joined-up, personalised care and support.

Building on the achievements of system leaders over several years, the further ‘transformation by necessity’ prompted by the pandemic provides a platform for ongoing improvement of relationships, services and outcomes. Working together through ICSs will allow us to seize these opportunities, ensure our health and care systems are fit for the future and that we achieve world class health outcomes for our whole population.

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This publication can be made available in a number of other formats on request.

Publication approval reference: PAR642

NHS
Salisbury
NHS Foundation Trust

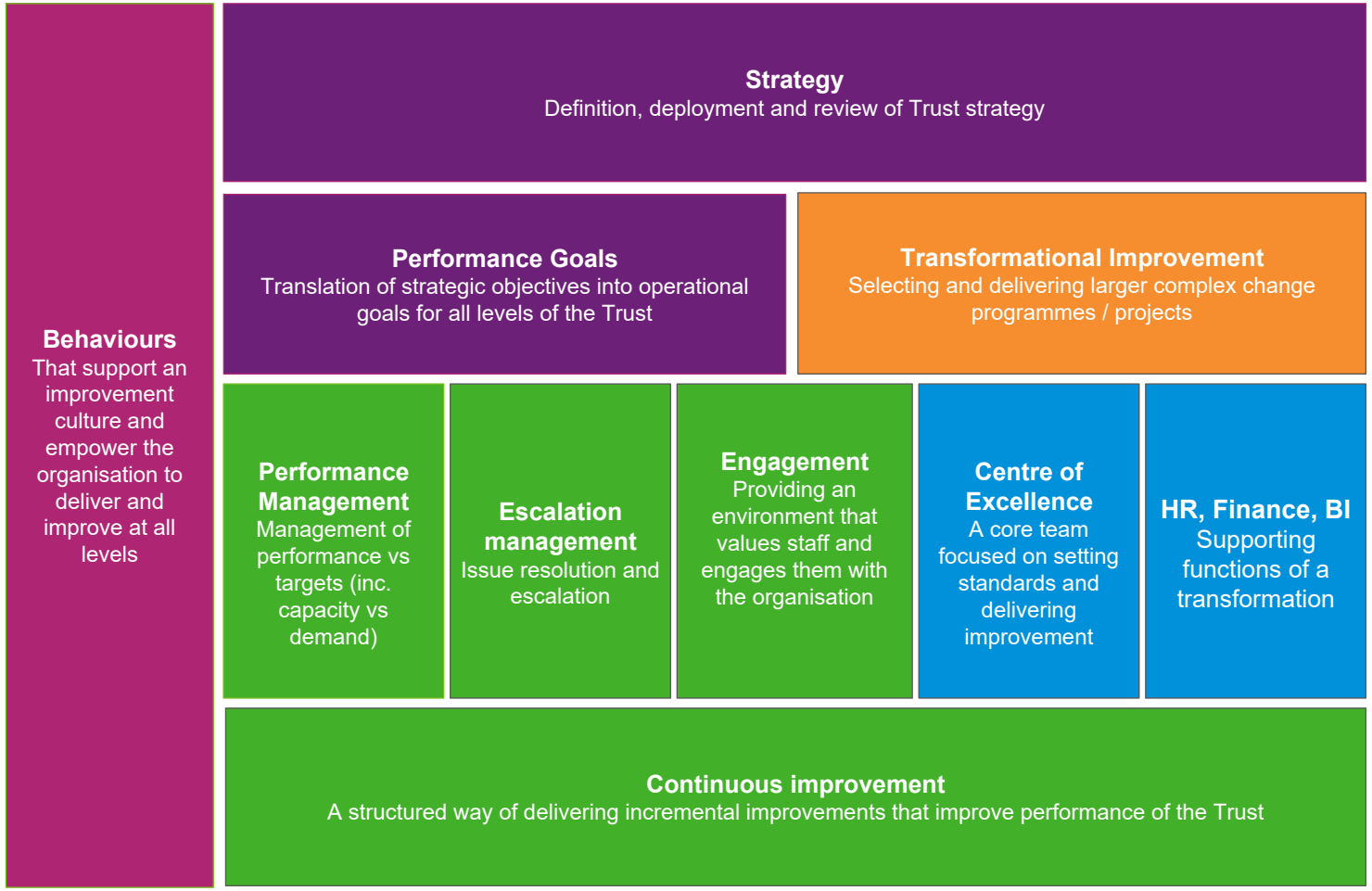
Operational Excellence – Current State Workshop

June 2021

An outstanding experience for every patient

What organisational attributes do we want to understand?

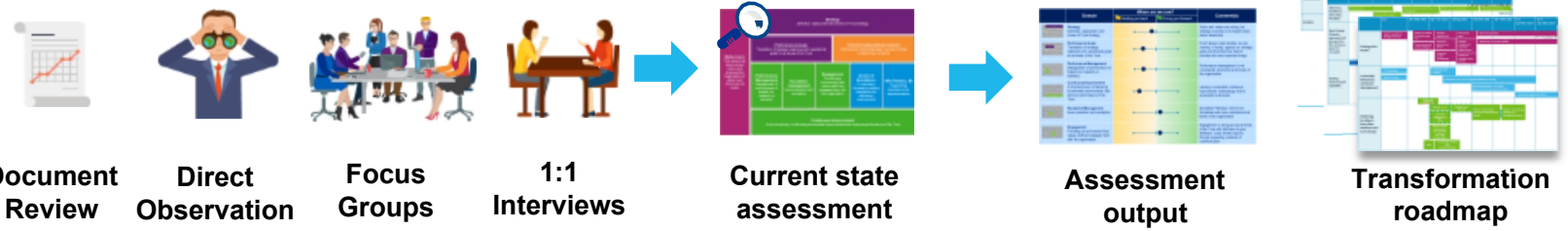
There are 12 domains that we are assessing to help form the building blocks of Improving Together



Approach for Current State Review and Roadmap

The purpose of the current state review is to provide a baseline regarding the organisation's **current level of maturity** against the key **organisational attributes** of an organisation with a strong improvement culture. This will support the production of an **improvement roadmap tailored to the organisation**.

Our Approach



Approach for information gathering

The 10 - 12 domains were assessed by collating data through four forms of input:

1:1 Interviews

- ✓ Chief Executive Officer
- ✓ Chief Operating Officer
- ✓ Finance Director
- ✓ Medical Director
- ✓ Director of Nursing
- ✓ Director of Corporate Governance
- ✓ Interim Director of Transformation
- ✓ Director of OD and People
- ✓ Head of QI
- ✓ Associate Director of Education, Inclusion, Comm's & Engagement
- ✓ Associate Director of Strategy
- ✓ Deputy COO (2)
- ✓ Transformation Director
- ✓ Head of Clinical Effectiveness
- ✓ Chief Information Officer
- ✓ Matron of Quality Improvement

Document Review

- ✓ Best Place to Work Programme overview
- ✓ BP2W Boards reports
- ✓ Transformation programme Reports
- ✓ Transformation Update for Finance and Performance Committee
- ✓ Culture Diagnostic Plans
- ✓ IPR Update – Progress Summary
- ✓ Board Strategy Review
- ✓ Board ICS Strategy
- ✓ BSW Academy Background
- ✓ Culture and Leadership Programme Launch
- ✓ NHS People Plan on a change
- ✓ Operational Planning
- ✓ PHM Board Review
- ✓ Staff Survey responses
- ✓ Couple of other documents and reports

Direct Observation

- ✓ Operational Management Board
- ✓ Clinical Management Board
- ✓ Medicine Exec Performance Review
- ✓ Transformation Innovation and Digital Board
- ✓ Ward Performance Review
- ✓ Surgery DMT
- ✓ Finance Performance Committee
- ✓ Clinical Governance Committee
- ✓ Trust Management Committee
- ✓ CS & FS Exec Performance Review
- ✓ Surgery Exec Performance Review
- ✓ Clinical Risk Group
- ✓ Trust Board Committee

Focus Groups

- ✓ CSFS (Core)
- ✓ Medicine
- ✓ Surgery
- ✓ Transformation and Innovation
- ✓ Nursing Midwifery Allied Health
- ✓ Senior Leadership Forum

The following slides present the findings, supported by insights; quantitative and qualitative data from the inputs mentioned above.

Current State Review: Summary (1/2)

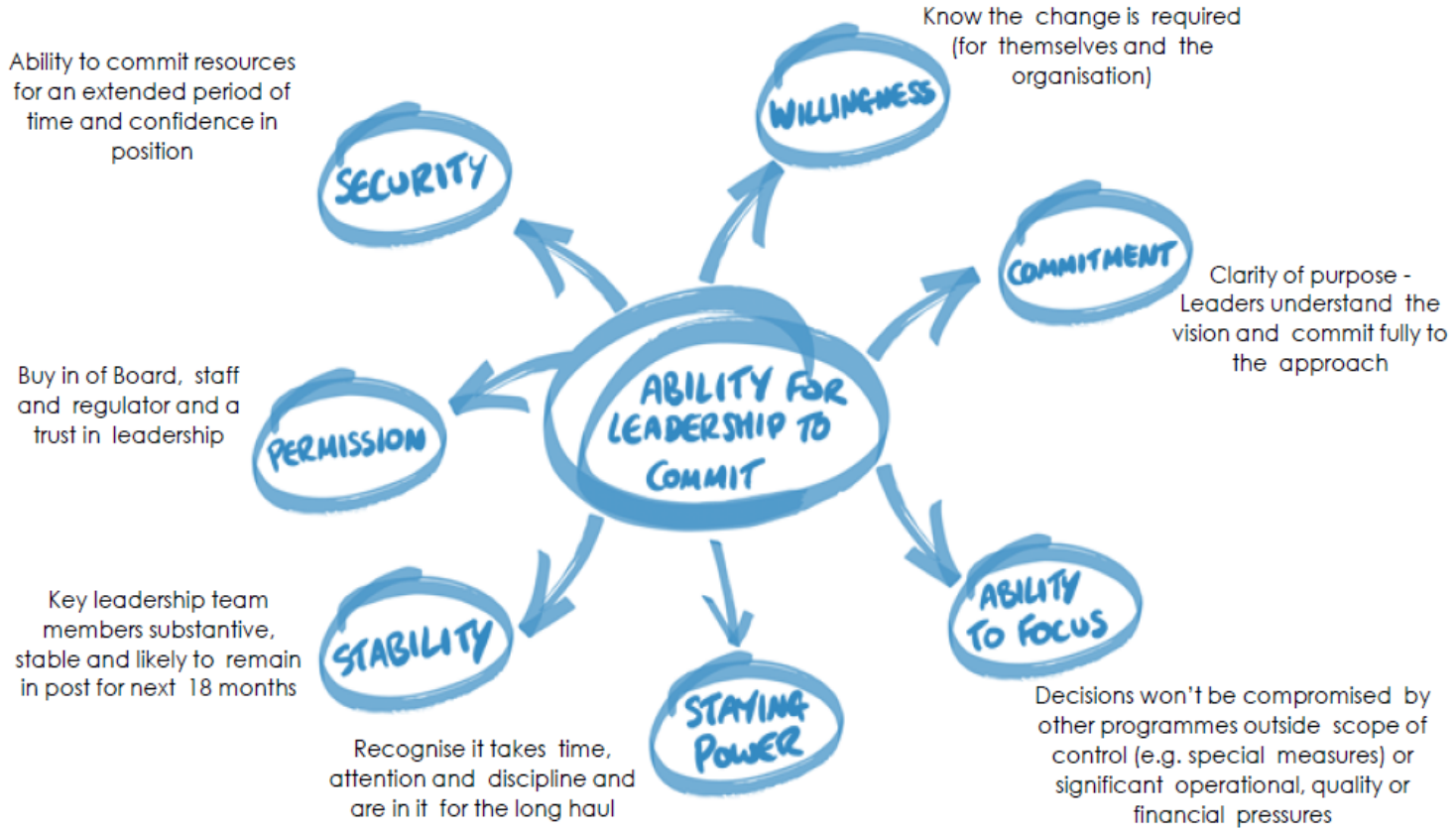
	Domain	Where are we now?		Comment(s)
		Holding you back	*Driving you forward*	
	**Strategy** Definition, deployment and review of Trust strategy			Vision and values are strong, but strategy is lacking in its impact below senior leadership
	**Performance Goals** Translation of strategic objectives into operational goals for all levels of the Trust			It isn't always clear whether we are 'winning or losing' against our strategic goals and therefore how best to prioritise the most important things
	**Performance Management** Management of performance vs targets (inc.capacity vs demand)			Performance management is not consistently structured at all levels of the organisation
	**Continuous Improvement** A structured way of delivering incremental improvements that improve performance of the Trust			Lacking a consistent continuous improvement methodology that is accessible to all levels
	**Escalation Management** Issue resolution and escalation			Escalation Pathways need to be formalised and more consistent at all levels of the organisation
	**Engagement** Providing an environment that values staff and engages them with the organisation			Engagement is strong across all levels of the Trust with staff keen to give feedback. Could further improve through expanding methods of communication

Current State Review: Summary (2/2)

	Domain	Where are we now?	Comment(s)
		Holding you back / *Driving you forward*	
	**Behaviours** That support an improvement culture and empower the organisation to deliver and improve at all levels		Leader behaviours are considered generally positive, recent changes to executive team are seen as an opportunity. There is a noteworthy appetite for change and improvement
	**Transformational Improvement** Selecting and delivering larger complex change programmes / projects		Too many projects and initiatives implemented at the same time with limited clarity on where we are heading and how they link to the strategic objectives
	**Centre of Excellence** A core team focused on setting standards and delivering improvement		Absence of a cohesive core team focusing on the organisation-wide continuous improvement that is empowered enough to bring about sustained improvement
	**Business Intelligence** Supporting functions of a transformation		BI and analytics are used in a limited capacity with varying accessibility and little standardisation
	**Finance** Supporting functions of a transformation		Good structures in place for coordinating between finance, HR, and performance
	**HR/People Management** Supporting functions of a transformation		There is a focus on supporting HR needs at all levels of the Trust, but some groups of staff need to be given equal opportunities as others. Historic leadership challenges had impacted on process

The critical success factors

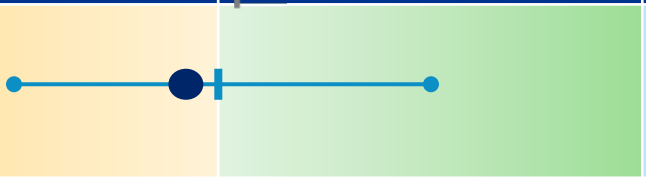
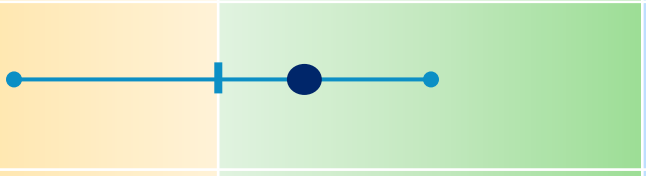
Our transformational experience working across healthcare systems in North America and the UK has allowed us to distil a set of critical success factors that need to be in place within the leadership team to undergo a successful long term sustainable improvement journey.



Overall critical success factors assessment – SFT (1/2)

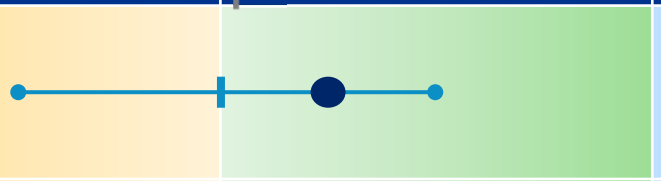
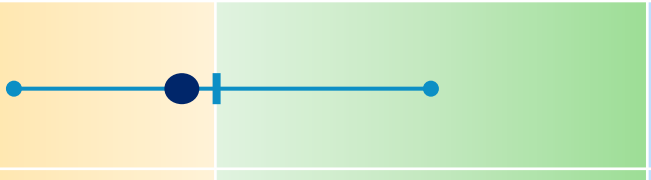
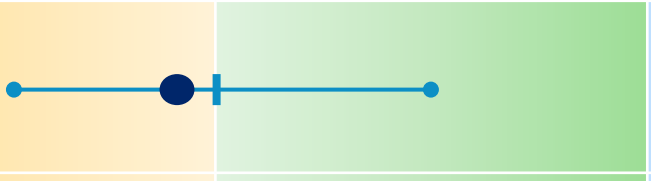
Salisbury NHS Foundation Trust

This is an overall assessment of the status of the critical success factors being in place for SFT. This is subject to a discussion with the aim to gain a consensus on the status of the CSFs and the actions / commitments the leadership will need to take to ensure they develop further / remain in place where applicable.

Domain	Where are we now?		Comment(s)
	Holding you back	*Driving you forward*	
Willingness Know the change is required for themselves and the organisation			Varied opinions of willingness to change personal behaviour
Commitment Clarity of Purpose-Leaders understand the vision and commit fully to the approach			Evident commitment to the approach
Ability to focus Decisions won't be compromised by other programmes outside the scope of control			NHSi may play a role in deviating focus for key priorities

Overall critical success factors assessment – SFT (2/2)

This is an overall assessment of the status of the critical success factors being in place for SFT. This is subject to a discussion with the aim to gain a consensus on the status of the CSFs and the actions / commitments the leadership will need to take to ensure they develop further / remain in place where applicable.

Domain	Where are we now?		Comment(s)
	Holding you back	*Driving you forward*	
Staying Power Recognise it takes time, attention and discipline and are in it for a long haul			Considerable recognition that this improvement is a multiyear journey
Stability Key Leadership team members substantive, stable and likely to remain in post for next 18 months			Mixed responses on the ability to have healthy conflict among leadership team and gap in joint accountability in some areas
Permission Buy in of Board, Staff and Regulator and a trust in leadership			Fragility in trust as the team is considerably new
Security Ability to commit resources for an extended period of time and confidence in position			Plan in place but high risk

NHS Salisbury NHS Foundation Trust

Report to:	Rust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	24 June 2021		

Report Title:	Freedom to Speak Up Guardian Annual Report 2020-21			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Elizabeth Swift, Freedom to Speak Up Guardian Jean Scrase , Associate Director EICE			
Executive Sponsor (presenting):	Susan Young, Interim Chief People Officer			
Appendices (list if applicable):	FTSU Survey Gap Analysis Update – Appendix A			

Recommendation:
The Board is asked to **note** the contents of the report which is provided for information and assurance.

Executive Summary:
For information: • FTSU Annual Report 2020-21 • Summary and gap analysis of Freedom to Speak Up National Survey

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 present an overview of the work of the Freedom to Speak Up (FTSU) Guardian over the year including high level details of the number of cases raised, a thematic analysis and any learning from these cases.

2 Background

2.1 It has been 5 years since the publication of the Francis Freedom to Speak Up Review in 2015. The speaking up culture of the health sector in England has changed with a network of over 600 FTSU Guardians in over 400 organisations. The 20 Key Principles for NHS organisations to implement, which included an emphasis on creating a culture of safety, raising concerns, culture free from bullying, visible leadership and valuing staff. These principles are not being followed by all organisations and regulators are mobilising and taking this more seriously.

2.2 In addition, while the mission of the National Guardian's Office is to make speaking up business as usual in the NHS, the broader strategy is to effect cultural change.

2.3 Salisbury NHS Foundation Trust is committed to implementing the recommendations of the Francis Report 2015 and embedding a strong culture throughout the Trust.

3 National Guardian's Office

Freedom to Speak Up Annual Report 2020 - presented to parliament by the Rt.Hon. Matt Hancock, Secretary of State for Health. Highlights include:

- Working in partnership with others to improve speaking up across patient pathways
- The use of data and intelligence to improve understanding of the speaking up landscape and to support improvements in the way speaking up takes place across the whole of healthcare
- Improving the system to effect cultural change, including working with the CQC on rating so that speaking up gets proper consideration and training for hospital inspectors
- Making speaking up business as usual, with learning from a growing Pan Sector Network of over 50 organisations including the police, aviation, the arts, the charity sector, financial services, defence and many more.

Full details of the report can be found here:

https://www.nationalguardian.org.uk/wp-content/uploads/2021/03/ngo_ar_2020_digital.pdf

4 Freedom to Speak Up Annual Survey 2020

The annual survey was carried out resulting in a gap analysis which identifies key areas for future focus. **Appendix A** contains the detail.

https://www.nationalguardian.org.uk/wp-content/uploads/2021/03/ftsug_survey_report_2020.pdf

5 Freedom to Speak Up Guardian Activity

5.1 **National Work** – The FTSUG has continued to actively engage with the National Guardian's Office, including responding to surveys, timely submission of quarterly data returns and putting forwards ideas for future development of the Guardian role.

At the start of the first lockdown, the National Guardian's Office launched the first of three pulse surveys to guage the impact of the pandemic on speaking up. There has been a mixed response, those who had an established culture of speaking up said it made things easier. Others had a less positive response reporting there simply was not enough time to listen to everything workers were raising. The CQC Chief Inspectors and the National Guardian wrote to all Trust CEO's and Chairs to remind them about how important it was to maintain safe speaking up channels for their workers.

WRES work- The National Guardian's Office are working with colleagues in NHS England/Improvement to develop a programme of activity to help deliver the commitment in the People Plan about joint training for Freedom to Speak Up Guardians and Workforce Race Equality Standard (WRES) Experts. The National Guardians Office have approached the Trusts FTSUG to benefit from our experience of a joined up approach to EDI and FTSUG and will be visiting the Trust later in the year to gather evidence when visiting restrictions are eased.

5.2 **Regional Work -** The FTSUG attends Regional Network meetings and actively participates in driving the FTSU agenda forward. As the health landscape continues to evolve with the development of integrated care systems (ICS), Regional Integration Plans have been produced to describe actions going forwards and how to measure progress and uptake. The National Guardian's Office is working with primary care organisations to show how this can work at system level. SFT is currently drawing up a contract to enable the Trust's Guardian to act on a consultancy basis to support Sarum North PCN in setting up a Freedom to Speak Up service. By working in partnership with others we will improve speaking up across patient pathways.

The FTSUG is in regular contact with the Guardians at Royal United Hospitals Bath and also Great Western Hospitals. This relationship is key for peer support, benchmarking and working together to push the Speaking Up agenda forwards as part of the BSW partnership.

5.3 **Local work –**

- **Care Quality Commission (CQC) –** CQC inspections understand the link between quality of leadership and management and the quality of service delivery. Listening and responding to people who speak up, tackling the barriers to speaking up are a significant element to the CQC rating process under the key line of enquiry (KLOE) 3 as part of the well led question. Although the last formal inspection was in 2018 the FTSUG continues to engage with the local CQC team providing information and assurance when needed.
- **Training** - The National Guardian's Office has launched, with Health Education England, training for all workers, and plan training for managers and leaders – with the view that everyone needs to take personal responsibility for their actions. In response to this, the Trust has agreed that

this basic training 'Speak Up' became mandatory from 1st April 2020, giving current staff 12 months to complete the on line package. 'Listen Up' is the next training package to be delivered as part of the Leadership and Management offer which targets staff with line management responsibilities. This module should be available during the summer 2021. An introduction video has been produced for Induction Training while social distancing guidance is still in force, with the intention that face to face training and workshops will resume when restrictions ease.

- **Promoting FTSU** – Contact details for Freedom to Speak Up support was put in the daily Covid-19 trust wide bulletins, and new posters have been produced and are placed in prominent places across the entire estate.
- **Key relationships** – the FTSUG continues to collaborate with many teams in order to support speaking up despite the challenges that COVID restrictions have brought. Although less frequent that in the previous 12 months, remote meetings are held with People Business Partners, Risk, PALS, Litigation, Clinical Psychology, Staff Side, Chaplaincy, Guardian of Safe Working, Chief Registrar, Executives and Non-Executives and protected groups such as the BAME forum and the Disability Network. FTSU is also a member of the Leadership Forum and has been involved with the NHSI Culture and Leadership Programme and actively contributed to the Best Place to Work programme by facilitating focus groups. The FTSUG has access to the CEO, Chairman and Executive Lead as and when required, as well as having monthly 1:1's. All these relationships help to develop an open culture where speaking up is fostered and welcomed.
- **FTSU Ambassadors** – Agreement was given for 5 Ambassadors to be recruited in September 2020 as it has been recognised that FTSUG's cannot be effective in isolation. The Ambassadors were appointed in a fair and open way and barriers to appointment were identified and addressed. The National Guardians Office has recently published guidance on developing Ambassador networks with recommendations for FTSUG's and organisations. SFT is fully compliant with the recommendations made in this document, including ring fenced time for Ambassadors to support speaking up.
- **Cases** – concerns raised to the FTSUG has increased from 85 cases during 2019-20 to 105 cases, which is an increase of 23.5% during 2020-21. Of these, 17 concerns were Covid-19 related which may have contributed to this significant increase. Where issues are complex external investigations commissioned by the Executive Team have taken place.

6 Summary of cases raised during 2020/21

6.1 Annual data - summary of issues raised 1st April 2020 – 31st March 2021

During this period 105 cases were raised with the FTSUG and the charts below show the breakdown by professional group and National Guardian Office identified themes:

Profession

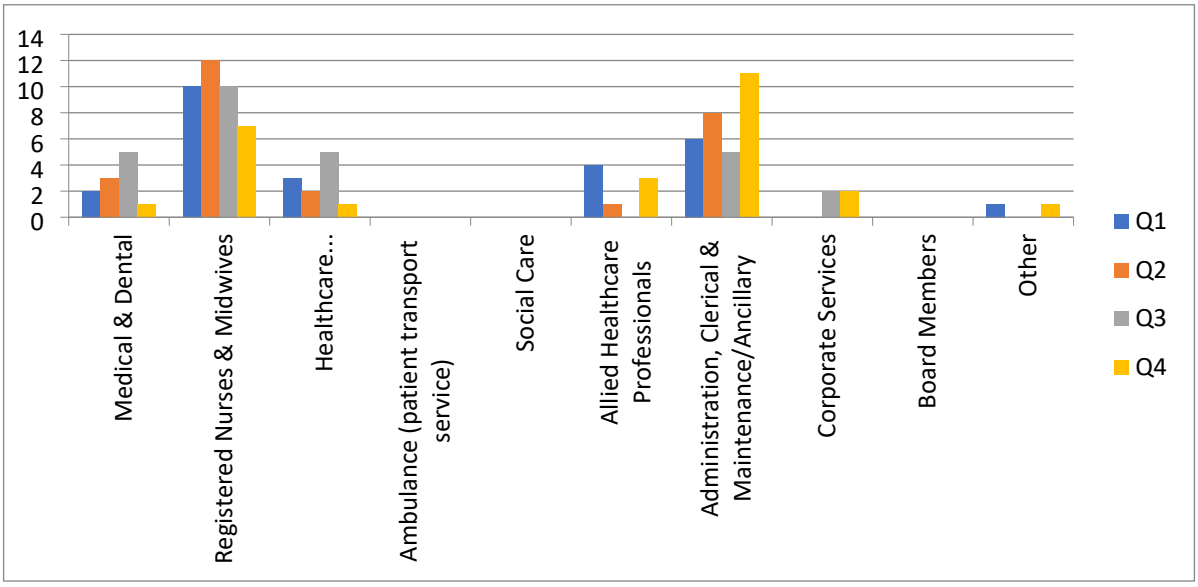
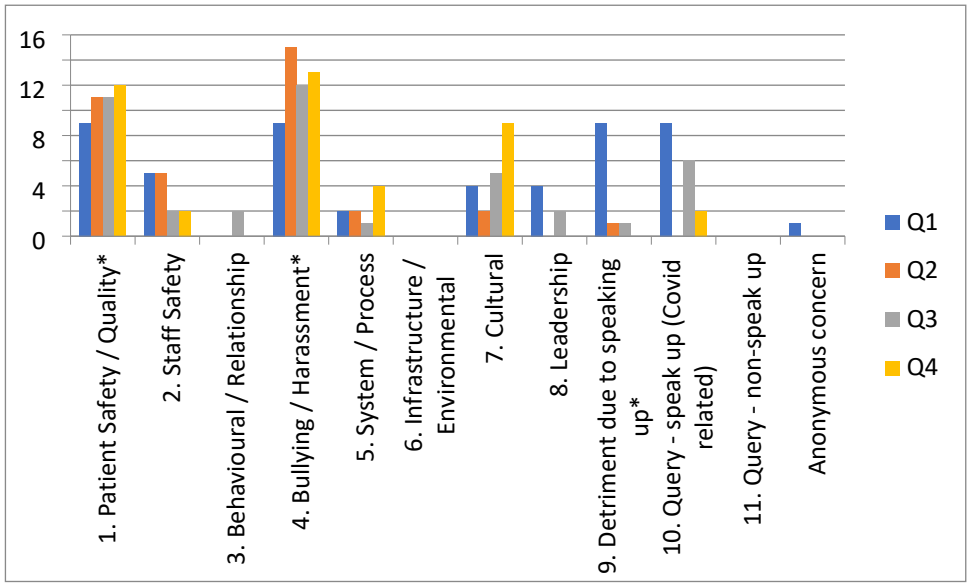
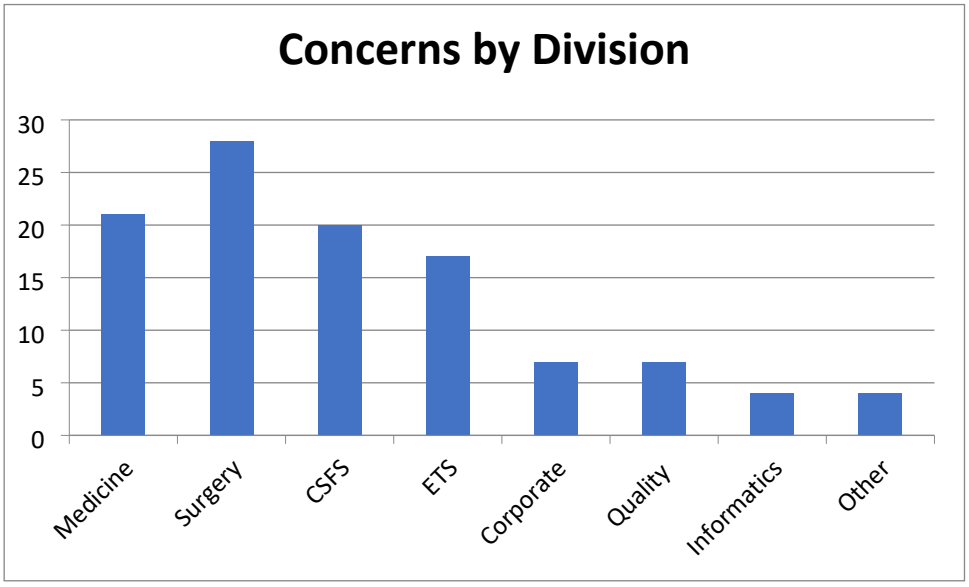


Table of Themes

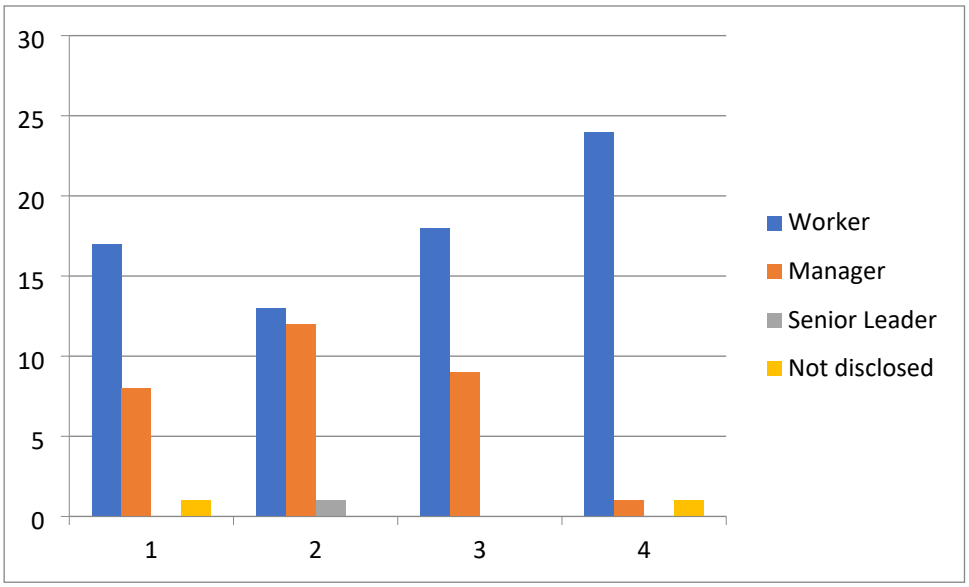


*Themes required to be reported to the National Guardians Office. The other themes are for local use. Some cases will contain more than one theme.



As we can see from the data, there are similar amounts of concerns being raised in the clinical divisions, with the Surgery Division being the highest.

Concerns by Professional Background



Cases that have an element of patient safety or quality have been reported to the Clinical Governance Committee and assurance provided that appropriate steps have been taken.

WRES data – At SFT approximately 17% of the 3952 staff are from a Black, Asian or Minority Ethnic background. Of the 105 concerns raised, 17% were raised by staff from a Black, Asian or Minority Ethnic background which is representative of the workforce. The FTSUG works closely with the BAME Network to ensure that Speaking Up is promoted and barriers that this particular staff group may face are discussed and addressed.

7 Benchmarking

7.1 The national data is summarised below for 2017/18, 2018/19 and 2019/2020. There has been a delay due to the pandemic for the reconciliation and publication of the data for 2020/21 from the National Guardian's Office.

	2017/18	2018/19	2019/20	2020/21
Total cases	7,087	12,244	16,199	No data
Element of Patient Safety	2,267	3,523	3,726	No data
Element of Bullying & Harassment	3,189	4,969	5,831	No data
Suffered Detriment	354	564	486	No data
Anonymous	No data	1,491	2,105	No data

SFT data for the same period:

	2017/18	2018/19	2019/20	2020/21
Total cases	28	21	85	105
Element of Patient Safety	16	11	44	43
Element of Bullying & Harassment	9	12	60	49
Suffered Detriment	No data	No data	16	11
Anonymous	1	0	1	1

The following should be noted from a comparison of the Trust data with the national data:

- The trends described, particularly the increase in the number concerns, reflects the picture seen nationally
- Nurses and midwives continue to be the staff group who raise the most concerns both nationally and locally.
- The Guardian has only received one anonymous concern
- Bullying and harassment is similar as is patient safety
- SFT reported 11 cases where there was a perception of negative treatment for speaking up

The below table shows the concerns raised in the BSW network during 2020/21.

Organisation	Q1	Q2	Q3	Q4	Total
Salisbury Hospital NHS Foundation Trust	**26**	**26**	**27**	**26**	**105**
Royal United Hospitals Bath NHS Foundation Trust	**12**	**11**	**42**	**38**	**103**
Great Western Hospitals NHS Foundation Trust	**12**	**11**	**8**	**6**	**37**

7.2 **Feedback -** A feedback form is sent to all staff who raise a concern, which asks if they would speak up again, how they found the experience and if they have suffered detriment due to speaking up. Approximately 18% of staff returned the form and the FTSUG also seeks verbal feedback when appropriate. There has been positive and negative experiences from staff who have raised concerns, below are a few examples:-

"I would speak up again as it was a safe haven and I was listened to. It's a shame nothing was resolved. I have signposted colleagues but they have seen the bad result that happens when you speak up so they probably won't come forwards."

"Thank you for your help and support in this matter. There was no feedback from line management and was told off for raising it to the Freedom to Speak Up Guardian. I suffered detriment for speaking up"

"After initial uncertainty, I am pleased I spoke up and I have the confidence in this service to speak up again. I was thanked for speaking up".

"Would definitely speak up again and has been singing FTSU praises. I think this is a fantastic service for staff and I no longer feel alone".

"Would speak up again and recommend to colleagues. Fast response, listened too and provided good verbal support and listening ear with good signposting to help".

All concerns have been followed up and feedback provided to the individual staff members. Of the concerns raised in 2020/21, 12 remain open with investigations in progress, and appropriate action has been taken whenever possible.

Other feedback would suggest that an area for improvement would be looking at the timeliness of responding to concerns and does the Trust have enough trained investigators.

7.3 **NHS Staff Survey questions and the FTSU Index 2020-21**

Working with NHS England, the National Guardian's Office (NGO) has brought together four questions from the NHS Staff Survey into a 'Freedom to Speak Up (FTSU) Index. These questions ask whether staff feel knowledgeable, secure and encouraged to speak up, and whether they would be treated fairly after an incident. The FTSU Index seeks to allow trusts to see how an aspect of their FTSU culture compares with other organisations so learning can be shared, and improvements made. This is the third year in a row that the FTSU Index has been published. This year's index is based on the results from the 2020 NHS Staff Survey. Currently, the FTSU Index only includes data for NHS Trusts. This year's results show the national average for the FTSU Index has continued to rise. The FTSU Index once again showed a positive correlation between higher index scores and ratings received by the Care Quality Commission (CQC). Trusts with higher index scores were more likely to be rated 'good' or 'outstanding' by the CQC.

The FTSU index was calculated as the mean average of responses to the following four questions from the 2020 NHS Staff Survey:

- % of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 16a)
- % of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 16b)
- % of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know who to report it (question 17a

- % of staff "agreeing" or "strongly agreeing" that they would feel secure raising unsafe clinical practice (question 17b)

	2018-19	2019-20	2020-21
Salisbury NHS Foundation Trust	80%	80.5%	79.8%
Great Western Hospitals NHS FT	79%	82.1%	79.6%
Royal United Hospitals Bath NHS FT	75%	77.2%	78.9%

The national average for this year's index was 79.2%, with 79% being the average for Acute Trusts.

There was an additional question included in the 2020 NHS Staff Survey which focused on workers feeling safe to speak up more generally:

- % of staff "agreeing" or "strongly agreeing" that they would feel safe to speak up about anything that concerns them in their organisation (question 18f)

Question 18f was not included in this year's FTSU Index to allow for comparability to previous years, but has been analysed alongside the index score for this report.

Q18f – would you feel safe to speak up about anything that concerns you in your organisation?	
Salisbury NHS Foundation Trust	68.2%
Great Western Hospitals NHS FT	65.1%
Royal United Hospitals Bath NHS FT	67.7%

The highest performing Trust had a result of 78.3%, and the lowest performing Trust had a result of 43.7%.

8 Summary of Learning from Speaking Up

The majority of the concerns raised have resulted in learning for the Trust. A summary of this learning is described below:

- Learners in Practice policies and procedures have been revised to support staff and managers.
- Focus groups arranged for staff to have a safe place to talk openly with feedback themed and anonymised for line managers to reflect on and action plans put in place.
- Identified support needed for redeployed individuals returning to their previous role and integrating back into the team.
- Challenged poor behaviours to include openness and visibility of managers, disciplinary action taken where appropriate.
- Independent review into the employee experience and wellbeing within a department where many concerns were raised, resulting in a report with recommendations including support for staff wellbeing, including examining shift patterns, flexible working, additional training and development. This work is ongoing.
- Discriminatory behaviour has been addressed by appropriate training given to the individuals concerned with support put in place for those who spoke up.

- Managers should hold regular meetings with their teams to ensure that staff are aware of local changes and issues, as well as wider Trust changes that may affect them.
- FTSUG works with the Divisions looking at themes and trends of concerns raised. Action plans to be developed in response.

All these improvements will help our staff deliver an outstanding experience every time for our patients.

Speaking up is about anything that gets in the way of delivering high quality care.

9 Summary

9.1 All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the Freedom to Speak Up (FTSU) report and recent guidance from NHSI/E and the CQC: This paper provides the Committee with assurance that best employment practice for FTSUG has been adopted at Salisbury NHS Foundation Trust.

10 Recommendations

10.1 The Board is asked to note the Freedom to Speak Up Annual Report 2020/21 and consider appropriate actions for improvement going forwards.

Elizabeth Swift
Freedom to Speak Up Guardian

Appendix A

Freedom to Speak Up Guardian Survey 2020
Findings and Recommendations Gap Analysis

	Area	Recommendation	How SFT Meet the Recommendation
1.	Appointment	Leaders should appoint FTSU Guardians through fair and open competition Leaders should assure themselves that there are no barriers to anyone who may want to apply for the FTSUG role Leaders should take steps to assure themselves that existing arrangements have the confidence of the workforce	Full time FTSUG appointed through the formal process, in a fair and open way.
2.	Ring-fenced time	Leaders should provide FTSU Guardians with ring-fenced time for the role, taking account of the time needed to carry out the role and meet the needs of workers in their organisation. Leaders should be able to demonstrate the rationale for their decisions about how much time is allocated to the role. CQC consider the commitment to the FTSUG role, including the provision of ring-fenced time, as an important element in their assessment of well-led	FTSU Guardian is full time with adequate time to fulfil the role. FTSU Guardian has regular update meetings with the CQC to provide assurance that the Trust is fully committed to supporting FTSU
3.	Feedback on performance	Freedom to Speak Up Guardians must, with the necessary support of their leaders, including provision of sufficient ring-fenced time, gather feedback on their performance	Feedback is sought by FTSUG when cases are closed. The response rate is variable, those who suffer detriment or leave the Trust tend not to respond.
4.	Speaking up training for workers, managers and senior leaders	Leaders should provide effective speaking up training for all workers, ensuring this meets the expectations set out in the national guidelines published by the National Guardians Office.	The Trust has agreed to make the on-line Speak Up training mandatory for all staff from 01/04./2021. FTSUG also provides face to face training in workshops (not during pandemic).
5.	Groups facing barriers to speaking up	Leaders should work with their Freedom to Speak Up Guardian to identify potential groups that face barriers to speaking up, and work towards addressing those barriers.	FTSUG works closely with EDI lead and staff networks to identify barriers and work towards addressing those barriers.
6.	Characteristics of FTSU Guardians	Leaders should seek assurance that their speaking up arrangements are effective for workers	NGO has commissioned research to shed light on whether the ethnicity of a guardian acts as a barrier to workers of other ethnicities speaking up. This work is scheduled to conclude in the first quarter of 21/22.

			17% of SFT staff who raised concerns during this period were from a Black or Ethnic Minority background which suggests there does not appear to be a barrier with regards to the ethnicity of the FTSUG. FTSU Ambassadors are representative of the workforce.
7.	Detriment	Leaders must communicate that detriment will not be tolerated, act to prevent detriment occurring and look into cases of detriment when it is reported.	This element is being integrated into the Leadership Development programme for leaders in the organization. More work needs to be done with regards to following up on reported detriment.

CLASSIFICATION: please select

Report to:	Trust Board	**Agenda item:**	2.3
Date of Meeting:	08 July 2021		

Report Title:	Improving our People Practices			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Claire Wilkinson & Susan Young			
Executive Sponsor (presenting):	Susan Young, Interim Chief People Officer			
Appendices (list if applicable):	Appendix 1 - Dido Harding Letter to Chairs & CEO's 24 May 2019 Appendix 2 - Prerena Issar Letter to CEO's & HRS's Dec 2020 Appendix 3 - Trust response to NHSI/E recommendations Appendix 4 - Disciplinary Policy			

Recommendation:

The Trust Board is asked to note, for assurance, the work being undertaken by the Trust to improve our people practices following recommendations from NHSE/I in 2019.

Executive Summary:

In May 2019 all NHS Trusts were issued with guidance in relation to 'learning lessons to improve our people practices' this formed advice to Trusts around investigations and disciplinary procedures. It incorporated recommendations from an Advisory group convened following the tragic death of Amin Abdullah.

In December 2020 the NHSE/I Chief People Officer wrote to all Trusts following up on the initial recommendations and advising that all Trusts updated their Disciplinary policies incorporating these recommendations. Furthermore the output of this work must be formally documented at a Trust Board Public meeting. This is the reason for this paper and appendices being presented.

We would specifically like to draw the Board's attention to Appendix 3 of this report, this seeks to provide assurance of the Trust's actions since 2019 and the work set to continue in the near future.

The ratified updated Disciplinary policy is included as Appendix 4 of this report in order to publish it on the Trust public website to meet the requirements of NHSE/I. The policy has been developed in line with the recommendations of Dido Harding's letter of May 2019 and has been consulted widely across the Trust prior to the formal ratification process.

The policy also references ACAS Code of Practice, and the Trust Freedom to Speak Up: Raising concerns policy.

CLASSIFICATION: please select

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	☐

Chief Executive and Chair's Office
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

To:
NHS trust and NHS foundation trust chairs and chief executives

24 May 2019

Dear colleagues

Learning lessons to improve our people practices

I am writing to share with you the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust three years ago.

In late 2015, Amin Abdullah was the subject of an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. Verita's recommendations were accepted by the Trust, in full, and have largely been implemented.

Subsequently, NHS Improvement established a 'task and finish' Advisory Group to consider to what extent the failings identified in Amin's case are either unique to this Trust or more widespread across the NHS, and what learning can be applied. Comprising of multi-professional stakeholders and subject matter experts representing both the NHS and external bodies, together with an advocate for Amin's partner, the Group conducted an independent analysis of both the Verita findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. HR directors of provider organisations were advised of the Group's activity and invited to share details of any local experiences and/or examples of measures being taken to improve the management of employment issues.

The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective

application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

The NHS England and NHS Improvement People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances. This view certainly echoed many of the comments we have received from across the NHS during our recent People Plan engagement.

Some of the proposed recommendations will require further discussion with key stakeholders, including regulatory and professional bodies (in particular, I am keen that consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues, is given more prominence in the 'well-led' assessment domain). The majority, though, can be immediately received and applied.

Enclosed with this letter is additional guidance relating to the management and oversight of local investigation and disciplinary procedures which has been prepared based on the Advisory Group's re-commendations. You will recognise the guidance as representing actions characteristic of responsible and caring employers and which reflect our NHS values. I would ask that you, your HR team and your Board review them and assess your current procedures and processes in comparison and, importantly, make adjustments where required to bring your organisation in line with this best practice. I would draw your attention to item 7 of the guidance and ask you to consider how your Board oversees investigations and disciplinary procedures. Further, with respect to any cases currently being considered and all future cases, I would ask you to review the following questions (and, where necessary, take corrective action in response):

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?

- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?

- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.

- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

In highlighting these issues, which I know will be important to you and your teams, I would like to thank all those colleagues who directly contributed to and informed the work completed by the Advisory Group. I would particularly like to acknowledge the endeavours of Amin's partner Terry Skitmore and his advocate Narinder Kapur, without whose dedication and sacrifices the Amin Abdullah inquiry and subsequent development work by NHS Improvement would not have taken place.

I know that we are all keen to ensure we treat our people fairly and protect their wellbeing. Implementing the attached guidance consistently well across the NHS will contribute to that goal. It is tragic that we are learning these lessons after Amin's death, but we owe it to him and the others who have suffered in similar circumstances to act now.

Thank you for your attention to these vital issues.

Best wishes

Baroness Dido Harding
Chair, NHS Improvement

Enclosure:

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

Copies:

Chair, Care Quality Commission
Chair, NHS Providers
Chair, Nursing and Midwifery Council
Chief Executive, NHS Employers

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

1. Adhering to best practice

a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).

b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

2. Applying a rigorous decision-making methodology

a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

3. Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

4. Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

5. Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

6. Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.

b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.

c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

Classification: Official

Publication approval reference: PAR293

Prerana Issar

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

01 December 2020

To:

- NHS trust CEOs, HR directors, workforce directors
- NHS foundation trust CEOs, HR directors, workforce directors

Dear Colleagues,

Re: Sharing good practice to improve our people practices

I hope you are doing well in these challenging times.

In May 2019 we shared with you an important piece of work in response to a tragic event that occurred at Imperial College Healthcare NHS Trust (ICHT) four years ago. Sadly, Amin Abdullah, a nurse who at the time was the subject of an investigation and disciplinary procedure, tragically took his own life. Details of the investigation, conducted by an appointed advisory group, together with the reasons for its commission, are provided in the enclosed letter (enclosure 1).

The advisory group made a series of recommendations, many of which were used as the basis for the provision of additional guidance to provider organisations (also at the enclosure). In addition, in November 2019, I wrote to healthcare professionals and regulatory bodies, encouraging review and examination of any guidance and standards provided to members and registrants to address the issues highlighted to support compassionate leadership and improvement across the healthcare system (enclosure 2).

Since Amin's passing, ICHT has worked collaboratively with Amin's partner Terry Skitmore and his advocate Narinder Kapur, alongside other stakeholders, to create a revised policy for handling staff related concerns or complaints. I am writing to share this with you as an example of good people practice, albeit arising from such tragic circumstances (enclosure 3).

The shared learning from Amin's experience has demonstrated the need for us to work continuously and collaboratively, to ensure that our people practices are inclusive, compassionate and person-centred, with an overriding objective as to the safety and wellbeing of our people. These values are central to our recently published People Plan and People Promise.

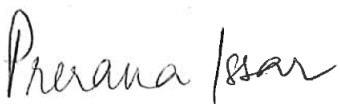
Our collective goal is to ensure we enable a fair and compassionate culture in our NHS. I urge you to honestly reflect on your organisation's disciplinary procedures, review the recommendations we issued in May 2019 and the attached example of good practice, and consider what has worked well and what could be further improved.

Where action is required, I urge NHS organisations to commit to tangible and timely action to review on a yearly basis and by the end of this financial year, all disciplinary procedures against the recommendations and that these are formally discussed/minuted at a **Public** Board or equivalent. We will continue work with the CQC to embed the learning from these reviews to form part of the formal oversight framework. I would also like to suggest your policy is made available on your organisation's public website by the end of the financial year.

As we prepare for the second wave of COVID-19, our staff should feel supported in every sense, including demonstrating a sensitive and compassionate approach to colleagues throughout the disciplinary procedure and process.

Many thanks for everything you are doing to provide services during this challenging time.

Best wishes,



Prerana Issar
NHS Chief People Officer

Enclosure

1. Learning lessons to improve our people practices – Letter to all NHS trust and NHS foundation trust chairs and chief executives, 24 May 2019.

2. Guidance and standards for registrants in relation to local investigations and disciplinary procedures - Letter from Prerana Issar to healthcare professional and regulatory bodies, 04 November 2019.

3. Imperial College Healthcare NHS Trust - Disciplinary Policy and Procedure, July 2020.

Salisbury response to the NHSE/I Guidance and recommendations relating to the management and oversight of local investigation and disciplinary procedures

NHS/I Guidance & Recommendation relating to the management & oversight of local investigation & disciplinary procedures	SFT Response
Adhering to best practice	The Disciplinary policy review is now complete and has been ratified and approved as required. Engagement and consultation with staff side and staff and managers across the Trust formed part of this process. 6 of the 7 recommendations already exist within the current policy. Areas of focus are our approach to the Just Learning & Culture piece, to reference ACAS guidelines, and signposts for additional wellbeing support. The Trust ensures that in all disciplinary matters there remains independence and objectivity in decision making. This includes the appointment of an Investigating Officer and Disciplinary panel members. To ensure all these roles can be undertaken in an independent way there is never any conflict of interest between panel members or investigating officers with the employee under investigation/disciplinary. Any conflicts are dealt with usually at appointment stage when an alternative person is found. The investigating officer is always from outside of the person's area of work and not had any connection to the individual as part of their role.

Applying a rigorous decision-making methodology	We are currently developing a written checklist to support the decision making process. We are focussed on developing a Just & Learning Culture as part of our People Plan. We appreciate that to embed this new way of working will take years, so it is important that we include this as part of our MLE / Induction process. Our current process requires more than one person making decisions on any sanctions to be applied. Although we have 3 people on our panel, one is a HR representative and takes the role of adviser to the panel rather than decision maker. The HR representative advising the panel will also ensure checks and balances within decision making, being mindful of best practice and case law and advise the panel of this. As part of the policy there is also a decision making checklist when the panel is considering an outcome of dismissal and the decision is always made by more than one person, with HR advice.
Ensuring people are fully trained and competent to carry out their role	We have recently developed and implemented Investigating Officer training. The first session delivered was with a group of Matrons, and now funding has been agreed there will be at least another 2 sessions in the next couple of months which will aim to train another 16 members of staff. The next line of training for development is around the Case Manager. Discussions are being had right now in relation to securing support from either our Solicitors or ACAS.

	The Interim Chief People Officer recently ran a knowledge sharing session with the People Operations team. We are also starting a programme and work and training around Just & Learning Culture with the team to focus on the learning from Merseycare. The People Operations team also participate in case learning reviews after all complex cases have included and have involved Case Managers as part of these processes.
Assigning sufficient resources	We are very thorough on assigning the correct resources, for example, 2 x Investigating Officers for a Dignity at Work case. Support from a People Advisor is always secured. Concerns have been raised regarding workloads which can sometimes lead to delays. There is more to do with this in discussion with managers regarding releasing their staff to undertake this time critical piece of work. As part of the appointment process of the Investigating Officer their availability is consider (e.g. no planned annual leave etc.) to ensure there are no unnecessary delays to the process. This is also covered within the Investigation training so that Investigating Officers think about their capacity when agreeing to undertake the investigation.
Decisions relating to the implementation of suspensions/exclusions	All suspensions are made with consideration given to the impact on the individual, the impact on any other individuals involved (e.g. person raising a complaint) and the impact of on the investigation taking place whilst the person is in the workplace. Decisions for suspension of clinical staff (not medical staff)

	are always discussed and agreed between the Deputy Director of Nursing and Head of People Operations. In addition, where further advice is required, this is sought from Deputy Chief People Officer and the Chief Nurse. Non-clinical staff suspension decisions are discussed with the Chief Operating Officer. Decisions for suspensions of medical staff are made by the Chief Medical Officer in consultation with NHS Resolution. Extensions on suspensions are discussed every two weeks including confirmation of whether suspension is still required.
Safeguarding people's health & wellbeing	All formal documentation that is sent to staff includes contact details for support at that time, for example, a Wellbeing Officer, the Freedom to Speak Up Guardian, Occupational Health and Counsellor. We will be adding details relating to the Mental Health First Aiders. Case conferences with Occupational Health are being introduced. All process outcome letters are reviewed by all panel members as a check and balance and signposting for support is included in the letters. Areas of development include a communication plan, which describes the period of engagement etc.
Board-level oversight	The People Operations Team review lessons learnt on a regular basis, and highlight case work at the Executive Performance Reviews. There is still further work to do to

	develop the reporting arrangements including data, assurance and oversight.

Disciplinary Policy

1. Quick Reference Guide

This policy provides an overview of the roles, responsibilities and monitoring practices linked to the management of disciplinary proceedings across Salisbury NHS Foundation Trust.

This Policy should be read and used in conjunction with the Disciplinary Procedure so as to ensure that the consistency of practice is promoted at all times.

2. Introduction

2.1 Salisbury NHS Foundation Trust (the 'Trust') believes that disciplinary rules and procedures are essential in the workplace if acceptable levels of conduct are to be achieved. This procedure has therefore been developed to define such standards and to emphasise the Trusts desire to support employees' at all times. This includes the development of a culture where employees' are encouraged to learn from mistakes as they occur.

2.2 This approach supports the NHS's desire to embed a culture of fairness, openness and learning and helps promote the notion that employees should feel confident to speak up when things go wrong, rather than fear blame. Therefore in all cases of concern linked to misconduct, an objective and prompt examination of the issues should be carried out to establish whether a formal investigation is warranted. Instead could training and development of the employee, coupled with further support, guidance or informal management be more suited to the situation.

2.3 This policy has been developed in consultation with the Trust's recognised trade unions and is in accordance with the ACAS Code of Practice on disciplinary and grievance procedures.

2.4 Where an employee's ability to do their job is affected by a lack of skill or knowledge, the Trust's Performance Management policy should be used.

2.5 Where an employee's ability to do their job is affected by ill health, the Trusts Attendance Management policy should be used.

Version Details

Version No.	Updated by	Updated on	Description of changes
8	Head of People Operations	May 2021	Full policy re-write

3. Purpose & Scope

3.1 This Disciplinary Policy and its associated procedure provides a framework through which concerns about an employee's behaviour (or actions) can be reviewed in a fair and timely manner.

3.2 Through clear definitions of unacceptable standards, the policy also highlights Trust expectations linked to behaviour and provides clarity as to the processes that an employee may face should unacceptable behaviours be displayed.

3.3 This policy and its associated procedure apply to all staff directly employed by the Trust. For Medical Staff and Dentists see 3.4.

This includes trainees, secondees and staff on honorary contracts or joint contracts with the Trust and another employer.

3.4. Disciplinary matters relating to Medical staff and Dentists should be addressed using the Trust's 'Handling Concerns and Disciplinary Procedures for Doctors and Dentists Policy', which in certain circumstances refers matters back to this Disciplinary policy.

3.5. Cases of alleged staff misconduct committed outside of the work environment may also be managed through this policy.

In such cases careful consideration will be given as to whether the alleged misconduct has damaged either Trust reputation or the reputation of the staff member's role.

4. Definitions

4.1. Conduct is defined as an individual's behaviour; therefore, misconduct can be defined as the demonstration of inappropriate or unacceptable behaviours.

Appendix A provides examples of activities that the Trust would interpret as misconduct.

4.2. For the purposes of this policy and its associated procedure, misconduct is broken down into two distinct categories - misconduct and gross misconduct. These categories are defined below:

- Misconduct constitutes behaviours that transgress acceptable boundaries but which could be managed incrementally to address shortfalls. Examples of such misconduct are included in appendix A.

- Usually conduct would relate to the actions of the employee within the workplace. However in certain circumstances it may be appropriate to apply this policy to incidents outside the workplace (to include arrests or criminal proceedings) which bring the Trust into disrepute.

- Gross misconduct constitutes behaviours that exceed acceptable boundaries and which, given their nature cannot be managed incrementally. Cases can be so serious that they destroy the trust, confidence and employment relationship between employer and employee. In such instances disciplinary action up to and including summary dismissal may be required. Examples of such gross misconduct are included in Appendix A.

4.3 **Reasonable belief:** Any disciplinary action taken will be based on a reasonable belief that misconduct has occurred. This is significantly different to a criminal investigation whereby the onus is to prove an occurrence 'beyond reasonable doubt'.

5. Roles and Responsibilities

5.1. Trust

5.1.1. Through regular communications, appraisal and training opportunities the Trust is committed to develop a skilled and knowledgeable workforce who fully understands the behaviours expected of them.

5.1.2 The Trust is also committed, through the development of policies and procedures, to ensure all employees are treated fairly and in a consistent manner.

5.2 Line Managers

Line Managers will be expected to:

5.2.1. Promote awareness of Trust policies and procedures and cascade how such documents will be used to manage situations as they arise.

5.2.2. Use the Trust's policies and procedures to ensure fairness and consistency across their service and hence the wider Trust.

5.2.3 Ensure staff have current job descriptions which accurately reflect their roles and responsibilities.

5.2.4. Ensure that annual appraisals are completed within their areas of responsibility and that these appraisals, through objective setting, reinforce the Trust's values and behaviours.

5.2.5. Where conduct issues start to emerge the Line Manager must discuss these with the individual at the earliest possible opportunity so as to promote corrective action.

5.2.6. Ensure that conduct issues are managed effectively so as to minimise impact on patient safety, service delivery and staff morale.

5.2.7 Maintaining confidentiality during and after the application of this policy.

5.2.8 Notify the Trust of any investigations undertaken by an external authority such as the General Medical Council, the Nursing and Midwifery Council or the Information Commissioners Office.

5.3 Employees

Employees will be expected to:

5.3.1 Familiarise themselves with the Trust policies and procedures to ensure they understand Trust expectation associated with appropriate behaviour.

5.3.2. Ensure they have current job descriptions, which accurately reflect their role and responsibilities. Where this is not the case, they should discuss with their Line Manager at the earliest opportunity.

5.3.3. Ensure they have an annual appraisal with their Line Manager which, through objective setting reinforces responsibilities for the upcoming year.

5.3.4. Raise concerns with the Line Manager if they feel they are struggling in their role or within their team.

5.3.5. Raise concerns with the Line Manager if they believe the behaviour of others is inappropriate or unacceptable.

5.3.6. Where issues are raised engage with the Line Manager to bring about a resolution as quickly as possible.

5.4. OD and People

5.4.1 The Chief People Officer has delegated responsibility from the Trust Board to ensure this policy and its associated procedure are properly implemented and monitored.

5.4.2. The People Operations Team have a responsibility to ensure that the policy and its associated procedure are used in a fair and consistent manner. This will involve:

- Providing advice and guidance to Managers linked to the interpretation and application of this policy.
- Providing expert advice at formal disciplinary hearings and appeals.
- Providing access to training and coaching for managers in the handling of disciplinary matters
- Monitoring and reporting disciplinary outcomes and actions to ensure both consistency and the highlighting of emerging trends.
- Reviewing and amending this policy as necessary.

5.5. Trade Unions

5.5.1 The Trust recognises the important role Trade Unions play in the resolution of disciplinary matters and members are encouraged to approach their representatives to discuss any concerns.

5.52 The Trust will work collaboratively with Trade Unions to address unacceptable and inappropriate behaviours.

6. Policy Principles

6.1. The Trust encourages Managers and staff, wherever possible, to resolve conduct concerns as quickly and informally as possible.

6.2. It is acknowledged that conduct is related to behaviour and as such staff may feel that a Manager is criticising them personally when a conduct matter is raised.

Therefore and wherever possible, Managers and staff are encouraged to use established guidelines which detail the Trusts expectations for appropriate behaviour/s. These include

- This and other Trust policies
- The Trust's values and beliefs
- Professional competency frameworks where applicable

6.3. Should Managers pursue formal disciplinary action they must ensure that the staff member/s are fully informed of the allegations made against them, the processes that will be followed and the ongoing progress of the investigation.

6.4. Dependant on the nature of the disciplinary issue the Trust may be obliged to inform the staff member's professional body.

6.5 If an individual chooses to resign from the Trust and refuses to engage during the disciplinary process there may be occasions e.g. safeguarding concerns, where the case will continue and be heard in their absence. If the case is found against the former member of staff the Trust may be obliged to refer the case to the relevant professional body. We therefore encourage staff to maintain engagement with the disciplinary process at all times.

6.6. Wherever possible the Trust will attempt to preserve the staff member's employment and alternative solutions such as redeployment may be considered

6.7 All managers who chair or sit on hearing panels must have completed appropriate Trust training or have equivalent experience in such matters.

6.8 Disciplinary cases will be treated sensitively and confidentially. Information will only be shared with those who have a legitimate right to be informed in accordance with Trust procedures and the Data Protection Act 2018. Breaches of confidentiality by any party may result in disciplinary action.

7. Handling Allegations of Misconduct and Investigating the Facts

7.1 Allegations of misconduct will be carefully assessed by the relevant manager, with support from the People Operations team, to decide the next course of action i.e. whether the situation can be managed informally or whether formal investigation appears warranted.

7.2 Such consideration should involve discussion with the employee to establish their version of events and may also involve discussion with other individuals associated with the alleged misconduct.

7.3 Where an alleged safeguarding incident is reported a 'HR huddle' will be convened to determine whether the incident falls within this policy or whether processes outlined in the Trust's Allegations against Staff policy should be followed. The 'HR huddle' must include a Deputy Director of Nursing, the Head of People Operations or their nominated deputy and a Safeguarding Lead.

7.4 Where it is decided that further investigation and/or formal action is appropriate, this must be approved by the case manager and/or senior manager in the department following consultation with a member of the People Operations team.

7.5 Investigations will be carried out without unreasonable delay in accordance with the Trusts Workforce Investigation policy and procedure. The case manager will be responsible for both commissioning and determining the scope of the investigation and for monitoring the timely progress of the investigation to reduce undue delays.

7.6 Throughout the formal stages of the disciplinary procedure the employee has the right to be accompanied by their Trade Union representative or a work colleague who has had no involvement in the matter of concern. The Trust reserves the right to refuse the employee from being accompanied by a work colleague whose presence it is perceived might undermine the disciplinary process.

In exceptional circumstances it may be appropriate for the employee to be represented by a family member i.e. when acting as an advocate for an employee with a disability. Any such decision would need to be agreed by the case manager.

7.7 Once the investigation is complete, the manager will consider the findings and with support from the People Operations Team decide if further action is required i.e. whether there is a case to answer, whether the matter can be dealt with informally or whether formal disciplinary action may be appropriate. The decision to move to a formal disciplinary hearing must be approved in consultation with a member of the People Operations team.

7.8 If the case manager believes there is a case to answer at a formal hearing, they must prepare a report setting out the case and the investigation findings.

8. Referrals to Professional Bodies and Other Agencies

8.1 Depending on the allegations, where an employee is registered with a professional body, such as a registered nurse, midwife or nursing associate, it may be appropriate to notify the regulatory body. This decision will be taken by the most senior professional lead from the division, in conjunction with the relevant professional lead for the Trust such as the Director of Deputy Director of Nursing.

8.2 Where allegations concern the safeguarding of children or vulnerable adults, the Trust's Safeguarding Team must be notified without delay.

8.3 In line with the legislative requirements of the UK GDPR, incidents relating or potentially relating to a personal data breach must be reported to the Trusts Data Protection Officer (DPO) and dependent upon severity, reported to the Information Commissioners Office.

8.4 Where appropriate, investigations by the counter fraud team and other agencies such as the police or social services may be carried out separately from investigations completed under this procedure. In such instances the Trust will fully co-operate with these external investigations but will not delay its internal investigations unless absolutely necessary.

9. Informal Management of Allegations **(Please refer to Procedure Document for Specific Process Details)**

9.1 The Trust recognises that cases of minor misconduct can often be resolved informally through open dialogue which details both shortcomings and possible remedial action.

9.2 In many cases additional training, coaching and advice may be recommended to help resolve a situation.

9.3 When a matter arises and the Line Manager chooses to initiate an informal discussion with the employee, they must still make it clear that the meeting forms part of the disciplinary process. As such and in advance of the meeting the employee should be provided with a copy of the Disciplinary Policy and Procedure and a description of the matters that are to be discussed. This is to ensure that all parties are aware of the context of the meeting.

9.4 During such meetings the Manager must ensure that the employee fully understands the need for behavioural improvement and that failure to achieve this, following appropriate support, may lead to instigation of the formal procedure.

9.5 The informal stage of this policy is not time-bound and whilst some instances of misconduct can be managed through conversation or via the establishment of an action plan, others will need to be progressed more quickly. Any such decision on how the case might be progressed should be discussed in conjunction with the People Operations Team

9.6 Where appropriate, managers may summarise concerns and expectations in writing, a copy of which will be placed on the employee's personal file. If informal action does not bring about the required improvement, or the misconduct is too serious to be classed as minor, formal disciplinary action may be considered.

9.7 The Manager must recognise that the staff member may find this process stressful and as such put in place mechanisms to monitor their wellbeing e.g. referral to Occupational Health, conduct a stress risk assessment, signpost to other Trust support services, hold regular meetings etc.

10. Formal Procedure (Please refer to Procedure Document for Specific Process Details)

10.1 The decision to enter straight into or progress to the formal stage of this policy should be made by the Line Manager in conjunction with a member of the People Operations team

10.2 Once such a decision is made, it is usual for the Line Manager to become the Case Manager with responsibility to appoint an Investigating Officer. These activities should be undertaken in line with the Trust's Workforce Investigation policy and procedure.

10.3 In some instances it may not be appropriate for the Line Manager to become the Case Manager. In such cases and following advice from People Operations team, a peer or more Senior Manager should be appointed.

10.4 The Case Manager on review of the investigation report and following discussion with the People Operations team will decide on the next course of action i.e. no case to answer or advancement to a disciplinary hearing.

10.5 The disciplinary hearing should be held as soon as possible following conclusion of the investigation. As such Managers, employees and their representatives must make every effort to attend scheduled meetings.

11. Disciplinary Hearing (Please refer to Procedure Document for Specific Process Details)

11.1 A disciplinary hearing should be chaired by a Manager of appropriate seniority and authority to make necessary decisions i.e. up to and including dismissal. Such authority to dismiss is explained further in appendix B. The Chair should have no previous connection with the case.

An OD and People representative of appropriate seniority and/or experience should also be appointed

For Registrants (eg NMC/ HCPC) a Divisional Head of Nursing or Deputy Director of Nursing/ AHP must be invited to join the panel as a Professional Advisor. In certain circumstances a specialist/ technical expert may also sit on the panel to support the Chair.

11.2 Throughout the formal stages of the disciplinary procedure the employee has the right to be accompanied by their Trade Union representative, a work colleague who has not been involved in the matter of concern or where agreed by the case manager, a family member.

11.3 The Trust reserves the right to refuse the staff member from being accompanied by a work colleague whose presence it is perceived might undermine the disciplinary process.

11.4 Formal hearings should be considered as meetings between the Trust and the individual employee and as such discussions should primarily be undertaken between the Trust and the individual; however we recognise the important function of a Trade Union representative, or work colleague, and in such hearings they can support the individual by making representations, offer relevant supplementary information that adds value to the hearing, raise points of order and, if requested by the staff member, sum up the case. Any questions put directly to the individual should initially be answered by the individual

11.5 The employee and the Case Manager will be provided with the opportunity to present their cases to the Disciplinary Panel prior to any decision or sanction being made. Further details associated with this process can be found in appendix C

11.6 Where an employee or their representative are unable to attend the first set date for the disciplinary hearing, the Trust must postpone to a time proposed by the employee, providing that the alternative time is both reasonable and not more than 5 working days after the date originally proposed.

If that second date proves problematic the Trust would offer one further date that is again not more than 5 working days after the date proposed by the employee.

If necessary the hearing would take place in the employee's absence on the second alternative date.

11.7 It is the Trust's policy to audio record all formal hearings. Audio recordings can be made available on request to employees who are subject to formal disciplinary/capability proceedings and, with their consent, to their representative. Audio recordings will be destroyed after one year.

12. Preparation for the Hearing

12.1 All parties will be given **at least** 5 working days' notice of the hearing in order to have time to prepare. Every effort must be made to give as much notice as possible and 5 working days should be seen as the absolute minimum.

12.2 The employee will be provided with two copies of the management report (investigation report) and any related documents including witness statements to be presented at the hearing. Any personal patient information will be redacted.

12.2 Prior to the hearing, the employee will be advised that they may be subject to disciplinary action up to and including dismissal.

13 Appeal **(Please refer to Procedure Document for Specific Process Details)**

13.1 The employee has the right to appeal against any decision made during the formal stage of this process.

14. Counter Claims

14.1 This disciplinary process will not be stopped should the employee submit grievance or dignity at work (bullying and harassment) claims against the Line Manager during the informal or formal stages of the process.

Instead the allegations would be subject to a parallel workforce investigation in accordance with the relevant Trust policy. If appropriate either party could then use the outcome of the parallel investigation as evidence during the disciplinary and/or appeal hearing.

15. Suspension (Exclusion)

15.1 In most cases, suspension from work will not be necessary and the employee will be able to continue in their normal role while matters are investigated.

15.2 When considering suspension, managers must assess the risks of the employee remaining at work. In all cases advice should be sought from a member of the People Operations team.

15.3 Where a manager wishes to suspend an employee, they must seek approval from a senior manager within their Division and the Head of People Operations. A Deputy Director of Nursing must be consulted for a suspension involving a nurse.

15.4 Suspension is not a disciplinary sanction and therefore is not an assumption of guilt.

15.5 Further detailing information lined to the exclusion process can be found in the Trusts Exclusion and Restriction of Practice Policy

16. Criminal Offences and Offences Committed Outside Work

16.1 Employees are obliged to inform their manager if they are subject to a police investigation so as to allow the Trust to take any necessary steps i.e. protect the safety of others, prepare for media enquiries.

All alleged criminal offences will be dealt with in line with the Trust's Allegations against Staff policy

16.2 If an employee is charged with, or convicted of a criminal offence committed outside of the regular work environment, consideration will be given as to whether the offence renders the employee unsuitable for continued Trust employment. In such instances the Trust reserves the right to take action independently of any legal proceedings.

16.3 Where an alleged offence or police investigation relate to mistreatment of a child or an "at risk" adult, the manager should inform the trust safeguarding team as a matter of urgency.

16.4 Where allegations that occur outside of the Trust are brought to the Trust's attention by other agencies or professional bodies, and those allegations have the potential to bring the reputation of the Trust into disrepute, the Trust will investigate the matter as fully as possible. If this investigation concludes that reputational damage is a possibility, action up to and including dismissal may be considered.

17. Supporting Employees

17.1 Being subject to allegations of misconduct can be very upsetting and stressful for the employee and any other affected colleagues.

17.2 Managers are therefore responsible for maintaining communications and must ensure that the employee and any other affected colleagues receive clear, timely, and comprehensive updates under the matter in concluded. Such communications are imperative if the employee is to be informed of progress, if they are to be provided with the opportunity to raise questions and if assurances as to their general health and wellbeing are to be gathered.

17.3 Where there are concerns about an employee's health or wellbeing, Occupational Health advice will be obtained.

17.4 Employees, including those who are involved as witnesses, will be supported throughout the process by an appropriate manager and where necessary directed to the Trusts Occupational Health/counselling services.

17.5 All employees being subject to allegations will be given the contact details of the Trust Freedom to Speak Up Guardian.

18. Monitoring Compliance with, and the Effectiveness of, this Policy

18.1. The People Operations team will gather and analyse data on a quarterly basis and use this data to ensure policy compliance and the consistent management of cases. Trend data will also be identified and used to address problem areas

18.2. Subsequently, this data will be used to inform and improve policies and provide recommendations for improving working practices. The People Operations team will provide relevant reports, based on this data, to committees when requested.

18.3 Further analysis associated with the use of this policy will be available from publication of the Trust's annual Workforce Race Equality Standard (WRES) report and the Workforce Disability Equality Standard (WDES) report.

19. Policy Review

19.1. Following approval this policy will remain valid for three years. An earlier review may be necessary should exceptional circumstances resulting from this policy arise or should legislative changes mean that the policy become unfit for purpose.

20. Equality Impact Assessment for Policies

Salisbury NHS Foundation Trust aims to design and implement services and policies that meet the diverse needs of its services, population and workforce, ensuring that none are placed at a disadvantage over others

This document has been assessed against the Trust's Equality Impact Assessment Tool which was presented to the ratifying committee.

21. Associated Documents

- Workforce Investigation Policy and Procedure
- Exclusion Policy and Procedure
- Performance Management Policy and Procedure
- Attendance Management Policy and Procedure
- Grievance Policy and Procedure
- Dignity at Work (Bullying and Harassment) Policy and Procedure
- Freedom to Speak Up: Raising concerns policy
- Allegations against Staff Policy
- Disclosure and Barring Service Policy
- Maintaining High Professional Standards in the Modern NHS
- ACAC Code of Practice 1 - Disciplinary and Grievance
- Safeguarding Vulnerable Groups Act 2006

22. Supporting Websites

ACAS - https://www.acas.org.uk/

DBS - https://www.gov.uk/government/organisations/disclosure-and-barring-service

Post Holder /Author Responsible for Policy:	Head of People Operations
Date Written:	May 2021
Approved By:	OMB
Ratified by:	TMC
Next Due for Review:	June 2024

APPENDIX A

EXAMPLES OF MISCONDUCT

This list outlines activities that the Trust may define as **MISCONDUCT** if they occur regularly or continue following reasonable guidance and advice

Continued breaches may lead to disciplinary action

Cumulative breaches may lead to dismissal

This list in not exhaustive

- Attendance & hours - failure to fulfil contractual hours; deliberate misuse of timesheets, abuse of breaks, absent without leave.
- Timekeeping - failure to attend punctually and regularly. The distance of an individual's home from his place of work or any difficulty of access cannot be accepted as a reason for irregularity or warranting preferential hours.
- Notification of sickness and other absences - failure to follow appropriate reporting instructions for sickness, emergency leave, contact with infectious illnesses etc.
- Breaches of standing financial instructions and standing orders.
- Failure to maintain professional registration, failure to conform to professional codes of conduct and other legal requirements.
- Failure to disclose a criminal conviction or charge; failure to disclose significant health issues which may have an impact on working duties.
- Refusal/failure to obey reasonable management requests and instructions quickly and efficiently, omitting or neglecting to carry out reasonable orders or failing to observe operational requirements, policies or procedures.
- Confidential and commercial information - breach of confidence relating to staff and/or patients.
- Abuse of status or position when dealing with other staff or members of the public.
- Wilful, careless, inappropriate or unethical behaviour likely to compromise patient safety, or create serious dysfunction to the effective running of a service.
- Disrespectful behaviour such as sarcasm, mockery or mimicry, which cause personal offence.
- Conflict of interest including failure to disclose relationships to candidates for appointment.
- Breach of IG security and governance standards and Data Protection Guidelines, including misuse, inappropriate use or abuse of access to information systems including smartcards or access cards and passwords.
- Inappropriate use of social media, e.g. incidents of bullying of colleagues or bringing the Trust reputation in to disrepute.
- Health and safety breaches including failing to maintain a roadworthy motor vehicle if used for Trust business.
- Failure to hold a valid driving licence or adequate insurance if vehicle used for Trust business.
- Failure to adhere to the Trust's smoking policy.

EXAMPLES OF GROSS MISCONDUCT

This list outlines activities that the Trust may define as **GROSS MISCONDUCT** and which may lead to summary dismissal without the requirement of previous warnings.

This list is not exhaustive and other offences may constitute gross misconduct

- Theft, unauthorised removal of possessions or property.
- Fraud – e.g. any fraud or attempt to defraud the Trust or a member of the public in the course of official duties including falsification of timesheets and financial claims, not notifying the Trust of known overpayment, working elsewhere whilst reporting sick or undertaking private work when scheduled to be on duty/on call.
- Failure to comply with Standing Financial Instructions and Standing Orders.
- Deliberate falsification, unauthorised alteration or destruction of records.
- Corruption, improper practice and conflict of interest including; receipt of money, goods, favours or excessive hospitality in respect of services rendered and improper use of position in the Trust.
- Confidentiality Breaches – wilful breaches of confidentiality in connection with employment relating to patients, clients, staff and business.
- Assault and Fighting – e.g. assault upon an employee which takes place on Trust premises or upon a patient in the care of the Trust.
- Malicious Damage – to the Organisation's staff or patients property.
- Court, Criminal or Police Proceedings – of a type where the nature of the conviction and the individual's conduct warrants dismissal because of its employment implications.
- Negligence/Professional Misconduct.
- Misuse or misappropriation of drugs including failure to report incorrect administration of treatment or medication.
- Ill-treatment, neglect or abuse (verbal or physical) of staff, patients or clients.
- Inappropriate conduct and behaviour which may bring the Trust into serious disrepute including inappropriate use of social networking.
- Drink and Drug Abuse – e.g. a serious case of an employee being unfit for duty through alcohol or being under the influence of illegal drugs.
- Discrimination or Harassment – in breach of the Trust's Equality, Diversity and Inclusion Policy or Dignity at Work (Bullying and Harassment Policy).

  This includes discrimination or harassment to members of staff, patients or clients on the grounds of race, sex, nationality, ethnic origin, disability, trade union activity, sexual orientation or chosen gender expression or identity.

- Serious acts of insubordination.
- Breach of Copyright and Patent Rules – It is illegal to use unlicensed software, breach copyright or abuse intellectual property rights.
- Abuse of the Trust's policies on computer use.
- Any action/omission, which can reasonably be judged to have resulted in a complete lack of confidence/trust in the individual by the Trust.
- Serious negligence or wilfully disobeying a reasonable instruction or Health & Safety rule where the result may result in injury/danger to patients, staff or the public.
- Misuse of Trust property.

The Trust may pursue internal disciplinary action if any of the above offences are alleged to have taken place, regardless of parallel Court Prosecution. The Trust has a right to dismiss an employee without awaiting the outcome of legal proceedings at the point they are satisfied that the allegation was committed.

APPENDIX B

AUTHORITY TO DISMISS GUIDELINES

Salisbury NHS Foundation Trust has an obligation to provide clear guidance as to Trust roles which have been assigned authority to sanction employee dismissals.

This document provides such guidance and should be used by Commissioning Managers and the People Operations team when establishing disciplinary hearing panels.

AUTHORITY TO DISMISS

The Chair of a formal hearing that may culminate in a dismissal must have authority to dismiss awarded by the Trust; their role then potentially becomes the 'Dismissing Officer'.

The following role categories have been designated as having authority to dismiss:

Band 8b role with leadership and managerial responsibility and accountability e.g. Divisional Manager, Head of Nursing.

Band 8c and 8d with leadership and managerial responsibility and accountability e.g. Deputy Directors, Divisional Director of Operations.

Band 9 and Executive Directors

The selection of the appropriate role of the Dismissing Officer will be considered on a case-by-case basis. Consideration will be given to the following:

- The role of the person subject to the process
- Impartiality
- The nature of the case e.g. highly clinical, of a sensitive nature
- The complexity of the case
- The experience and training to the Dismissing Officer

When a potential dismissal is identified following investigation a band 8a or above senior OD & People professional must be involved in the Disciplinary hearing.

Training will be made available for those staff undertaking the role of Dismissing Officer to ensure a consistent and fair process is maintained.

In the case of dismissal of the Chief Executive, the panel would comprise half of the Non-Executive Directors of the Trust Board plus the Chairman. There is no right of internal appeal against the decision of the panel.

APPEALS AGAINST DISMISSAL

The Chair of a formal appeal hearing against dismissal must already be designated as having the authority to dismiss by the Trust.

The following role categories have been designated as having authority to consider appeals against dismissal:

Band 8b role with leadership and managerial responsibility and accountability

Band 8d with leadership and managerial responsibility and accountability

Band 9 and Executive Directors

AUTHORITY TO DISMISS MEDICAL STAFF

Dismissal of medical staff may only be effected with the involvement of the Chief Medical Officer (CMO) and must adhere to the Maintaining High Professional Standards in the Modern NHS.

For doctors in Training Grades, this must involve the Chief Medical Officer (CMO) with the knowledge of the Post Graduate Dean or their nominee.

APPENDIX C

Procedure to be followed at Disciplinary Hearings

The procedural guidelines outlined below are recognised for being a standard format for the conduct of disciplinary hearings and should be followed, unless agreed otherwise, by all parties .

NB: During any stage of the meeting either side may request an adjournment.

1.0 Management Case

- The case manager presents their findings from the investigation process, using written statements and witnesses (as appropriate).
- Following questions from the case manager, the employee or their representative is able to question each witness as they appear.
- Following questions from the employee or their representative, the disciplinary panel hearing the case are able to question each witness as they appear
- The case manager completes the presentation of their case.
- The employee or representative is able to question the case manager.
- The disciplinary panel are able to question the case manager.

2.0 Employee Case

- The employee or representative presents their case, using written statements and witnesses (as appropriate).
- Following questions from the employee or their representative, the Case Manager is able to question each witness as they appear
- Following questions from the case manager, the disciplinary panel hearing the case are able to question each witness as they appear
- The employee or representative completes their presentation.
- The case manager is able to question the employee or their representative.
- The disciplinary panel are able to question the employee or their representative.

3.0 Management sum up their Case

- No new information may be referred to at this point.

4.0 Employee or Representative sums up their Case

- No new information may be referred to at this point.

5.0 Adjournment / Panel deliberate

- Once both sides have put forward their cases, the disciplinary panel should adjourn the hearing to consider their decision in private.
- If the disciplinary panel is able to make a decision after a short adjournment, the meeting should be re-convened and the decision communicated.
- The disciplinary panel considering the case may require access to additional information in order to clarify points or need further time to reach a decision. In such circumstances a further meeting will be set up as soon as practicable so as to allow a decision to be reached.

5.1 In cases where the outcome could potentially result in Dismissal

- In order to establish fairness in a possible dismissal case, the panel must establish the following at the time of dismissal:

- Has the Trust's Disciplinary policy and procedure been applied and followed fairly and consistently?
- Have all the facts been recorded and documented accurately? Was the investigation process fair and reasonable?
- Based on the evidence is there a genuine belief that misconduct has occurred?
- What performance record does the employee have?
- Did the employee fully understand the job requirements and behaviour standards?
- Has the employee received a warning of possible dismissal if conduct standards are not improved?
- Has the employee been allowed a reasonable period of time to correct their performance/behaviour to meet set standards?
- Has the employee had an opportunity to present their point of view?
- Are there any mitigating factors that may excuse or explain the employees misconduct
- Has consideration been given to redeploying or downgrading the employee?
- Is the dismissal decision based on fact? Not emotion or inference.
- Would dismissal be consistent with past practice? Is it a reasonable response in the circumstances?
- Would the Trust be able to justify dismissal if the employee claimed discrimination and/or unfair dismissal?
- Consider whether dismissal is appropriate under all of the circumstances

6.0 Communicating the Outcome

The disciplinary panel will confirm the outcome of the hearing to the employee in writing, normally within 5 working days of the date of the hearing.

The letter must contain the following information:

- A summary of the allegations made
- The agreed disciplinary outcome with relevant timescales
- Reason(s) for the decision
- Consequences of continued breaches of the same/similar nature
- Where an improvement in conduct is required, details of the required improvement including timescales
- The employees right of appeal.

APPENDIX D

Out of Hours Procedure to Follow in the Event of an Allegation of Improper Behaviour

This procedure should be followed in the event of an incident occurring or where a complaint is made **outside of normal working hours**.

1. An incident occurs or a complaint is made (including an allegation from a patient)

2. Person raising concern notifies Clinical Site Co-Ordinator

3. Person raising concern completes Incident Form or makes a statement

4. Clinical Site Co-Ordinator contacts on-call Duty Manager and outlines the allegation/incident that has been raised. Decision made as to the seriousness of the incident and whether the Duty Manager needs to come into the Trust. In the event that the incident is in a non-clinical area, the Facilities On-Call Manager should be contacted in the first instance. The Duty Manager would then be informed for information.

5. The Clinical Site Co-Ordinator should gather available information from the patient, employees or the person raising the concern. Wherever possible statements should be gathered. Where this is not possible the Clinical Site Co-ordinator should make their own record of events/conversations.

6. Clinical Site Co-Ordinator/Duty Manager speaks to the member of staff involved and asks for statement

7. Clinical Site Co-Ordinator and Duty Manager take into consideration the nature of the incident and discuss possible courses of action for the remainder of the shift:

    a) Suspension from duty – where suspension is applicable the on-call Executive Manager **must** be informed before suspending
    b) Ending the employee's shift early
    c) Restricting the employees access to certain work areas or certain types of work (supervised practice)
    d) Moving the employee to a different work area

8. In the event of a serious incident, the Clinical Site Co-Ordinator and Duty Manager should decide whether the police need to be informed

9. The Clinical Site Co-Ordinator will ensure that, where necessary, appropriate cover is arranged

10. The Clinical Site Co-Ordinator/Duty Manager should advise the employees Line Manager of the incident the following day.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.1
Date of Meeting:	8 July 2021		

Report from: (Committee Name)	Charitable Funds Committee		**Committee Meeting Date:**	17 June 2021
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			
Prepared by:	Nick Marsden, Chair			
Board Sponsor (presenting):	Nick Marsden, Chair			

Recommendation

The Trust Board are asked to note the items below for information from the Charitable Funds Committee meeting held on 17th June 2021

The committee received an up-to-date position with regard to fundraising for the charity. During the Covid pandemic all of the major fundraising activities have been postponed and therefore there was a significant shortfall in the annual traditional revenue raised by the charity. However the funds that were raised managed to cover the ongoing annual support that the charity provides to the various groups such as ArtCare and Elevate within the organisation.

Major fundraising activity is slowly returning to normal with reopening of the bookshop in the main entrance and bucket collections have restarted in a controlled fashion.

The Committee received the management accounts for the charity and despite the reduced funding raising we are in a strong financial position.

The committee was hoping to have participated in a strategy session to determine the financial strategy going forward but given the activity in the rest of the organisation this has been postponed but will hopefully be completed prior to the next committee meeting.

Key Items for Escalation

None

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.4
Date of Meeting:	08 July 2021		

Report Title:	Trust Management Committee (TMC) – 30 June 2021			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		X	
Prepared by:	Lisa Thomas, Chief Finance Officer			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the report outlining items raised at the Trust Management Committee meeting held on 30th June 2021.

Executive Summary:

This month's Trust Management Committee Meeting had a full agenda which centred around performance challenges, policy and strategy updates and considered three businesses cases.

The committee discussed the revised Health and Wellbeing strategy and it was noted that this had been an ongoing discussion since November 2020 and was of central importance to the Trust. It was noted that the top four areas of sickness across the Trust currently are Psychological, Gastrological, COVID and Musculoskeletal problems. The revised strategy aims to work with our staff to promote good physical, mental and psychological health and wellbeing, and to support those who need help, with an overall goal to reduce ill health in our staff, take a holistic approach, to be inclusive and have Health and Wellbeing Champions throughout the Trust from the Top Down.

TMC had discussion in relation to the revised Terms of Reference for the Health and Safety Committee following previous reviews as mentioned in last month's escalation report. These terms of reference, it was noted need to be reviewed again following substantial changes following recent significant work and therefore they need to go back though the Health and safety Committee for approval before coming to TMC for ratification.

TMC noted the escalation reports from the Executive Performance Reviews, Integrated Performance reports , Clinical Management Board and Operational Management Board. There were immediate issues to escalate to the Trust Board. Most of these have been discussed at the relevant board sub-committees in May and as such the Board will receive

the escalations where needed via the Board sub-committee reports. The consistent theme across all reports were the need to balance challenges in operational performance at the front door, with staffing pressures alongside elective recovery.

TMC received three Business cases, one of which was approved out right namely Arrhythmia Specialist Nurse, as this will enable increased clinic capacity leading to significantly reduced waiting times; by 35% (currently waiting time stands at 16 weeks). This ensures that patients are seen in a timely manner, ensuring evidence-based treatment protocols can be initiated improving patient outcomes.

The committee received two other Business Cases, namely Attend Anywhere and Maternity Ultrasound Service Improvement, both of which were approved in principle, but further discussions are required outside of the committee, with a view to taking Chair's actions

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	☒

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.5
Date of Meeting:	8 July 2021		

Report from: (Committee Name)	People and Culture		**Committee Meeting Date:**	24th June 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 24th June..
The Committee received the FTSUG annual report and noted the good progress that has been made in encouraging people to raise concerns. It was clear however that there is still an undercurrent of concern that speaking out can have detrimental effects on the individual and this is a cultural challenge for all organisations, not just Salisbury. We assessed that we are still in the foothills of cultural change but are making progress with the building of a Base Camp from which to ascend. Staff feedback and attitudes are key to making Salisbury the "best place to work" and the committee noted that there is still a lot of work to be done in gaining a better understanding of our culture and what is required to change it. Linked to this we reviewed the Workforce Race Equality and Disability data (WRES and WDES) that must be submitted and noted that the bald statistics paint a picture that probably oversimplifies the true position in Salisbury. We agreed that more work is needed to disaggregate the data to enable us to gain a better understanding of what it can tell us, and where there are true obstacles to progression by individuals who are properly qualified, and where the very real opportunities lie in making full use of the extraordinary talent of the people we have recruited.
We reviewed the risks related to P&C presented in the BAF and concluded that they do not adequately reflect the range of challenges – in particular in the recruitment of people for a host of hard to fill posts. More work is required to present the risks and mitigation in a bit more detail.

Key Items for Escalation
As above

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.6
Date of Meeting:	08 July 2021		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Louise Drayton, Performance and Capacity Manager			
Executive Sponsor (presenting):	Susan Young, Chief People Officer			
Appendices (list if applicable):				

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

Executive Summary:
Attendance numbers through the Emergency Department continue to increase, with the highest monthly levels since December 19 seen in M2 (6010 attendances compared to 5386 in M1). Significant challenges in filling rota gaps are further adding pressure to the service with performance against the 4 hour standard decreasing slightly from 85% in M1, to 84.1% in M2. Ambulance arrivals remain high, with handover delays occurring for almost 1 in 4 ambulance arrivals, and bed occupancy levels sustained at over 90%. Stroke and TIA performance continues to remain challenging, with flow issues a factor in the number of patients reaching the Stroke unit within 4 hours (falling from 48% in M1 to 28% in M2). Likewise TIA performance reduced from 92% in M1 to 60% in M2, with the loss of a Stroke locum compounding issues. A review at departmental/divisional level has been requested by CMO with the expectation of a recovery action plan to return to SSNAP A or B performance. Increasing elective activity remains a priority and encouragingly a reduction in the number of patients waiting over 52 weeks was achieved for the second month (937 in M2 versus 1059 in M1). Referral to Treatment performance increased from 65.5% in M1 to 71.6% in M2. The Elective Recovery Fund (ERF) threshold was met; although at POD level elective activity remain under plan despite the progress made. Over performance in Daycases, Outpatient Attendances and Outpatient Procedures have mitigated the shortfall to ensure overall achievement of the threshold. Early calculations imply SFT will have contributed c£0.9m to the system total of c£8.6m YTD. The activity threshold level for ERF was 75% in

M2, this rises again to 80% in M3.

The Trust continues to operate within its allocated H1 2021/22 contractual envelopes up to the end of May 2021, with a YTD reported surplus of £145k (excluding the impact of donated assets).

Recovery of the 6 week Diagnostic standard remains positive with 95.02% of patients requiring a diagnostic test receiving it within 6 weeks. The main area yet to recover is Cardiology with a recovery trajectory in place. Increasing referral levels for all modalities present a risk to recovery.

Mortality indices have begun to normalise following the peak of deaths seen in January attributed to the second wave of the COVID-19 pandemic. SHMI (which excludes Covid-19 deaths but includes all palliative care coded deaths) remains just below the national medical in the last reported period.

An increase in high harm falls has been noted in May from 1 in April to 7 in May. 3 majors requiring surgery and 4 moderates. The Falls Lead post, which will sit within Medicine Division, is out to advert and there is a matron focus on falls reduction. A cluster review has been requested by the CNO to identify more detail on themes.

A dashboard for Maternity and detail on the Saving Babies Lives Care Bundle version 2 is included in the report for the first time. In May there were 0 stillbirths, maternal deaths or neonatal deaths within 28 days of birth.

Further development of this report is planned, with a working group identified to review the current content and ensure the report is providing oversight on the right elements. A development schedule will be identified, and updates provided each month on progress.

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

NHS
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NHS Foundation Trust

Integrated Performance Report

July 2021

(data for May 2021)

An outstanding experience for every patient

Summary

Attendance numbers through the Emergency Department continue to increase, with the highest monthly levels since December 19 seen in M2 (6010 attendances compared to 5386 in M1). Significant challenges in filling rota gaps are further adding pressure to the service with performance against the 4 hour standard decreasing slightly from 85% in M1, to 84.1% in M2. Ambulance arrivals remain high, with handover delays occurring for almost 1 in 4 ambulance arrivals, and bed occupancy levels sustained at over 90%.

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Increasing elective activity remains a priority and encouragingly a reduction in the number of patients waiting over 52 weeks was achieved for the second month (937 in M2 versus 1059 in M1). Referral to Treatment performance increased from 65.5% in M1 to 71.6% in M2. The Elective Recovery Fund (ERF) threshold was met; although at POD level elective activity remain under plan despite the progress made. Over performance in Daycases, Outpatient Attendances and Outpatient Procedures have mitigated the shortfall to ensure overall achievement of the threshold. Early calculations imply SFT will have contributed c£0.9m to the system total of c£8.6m YTD. The activity threshold level for ERF was 75% in M2, this rises again to 80% in M3.

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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
May 2021

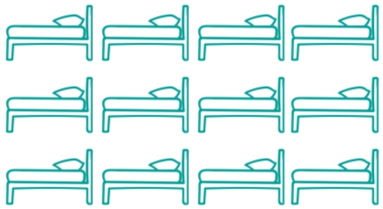
NHS Salisbury NHS Foundation Trust

There were **2,388** Non-Elective Admissions to the Trust

We delivered **34,641** outpatient attendances, **26%** through video or telephone appointments

We met **4 out of 7** Cancer treatment standards

We carried out **210** elective procedures & **1,668** day cases



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

RTT 18 Week Performance:
71.6% ↑
Total Waiting List: **18,196** ↓

95.0% ↑ of patients received a diagnostic test within **6 weeks**

Our income was **£23,724k** (£55k under plan)

18.7% ↑ of discharges were completed before 12:00

Emergency (4hr) Performance
84.1% ↓
(Target trajectory: 95%)

52 patients stayed in hospital for longer than 21 days

Our overall vacancy rate was **5.53%** ↑

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

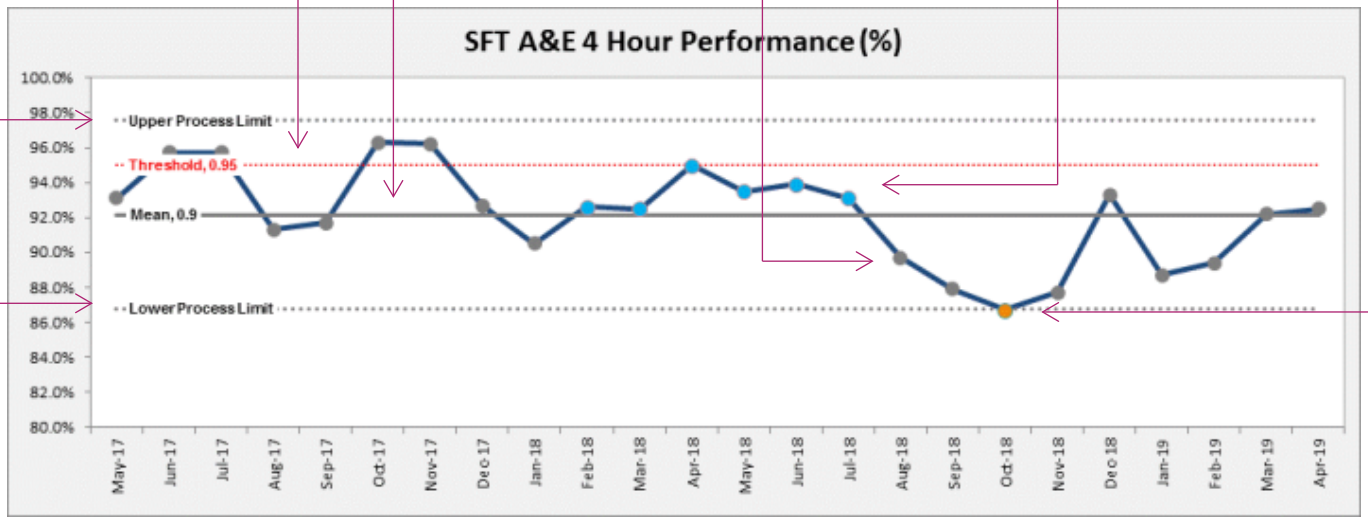
The red line shows the target for the KPI, if there is one

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

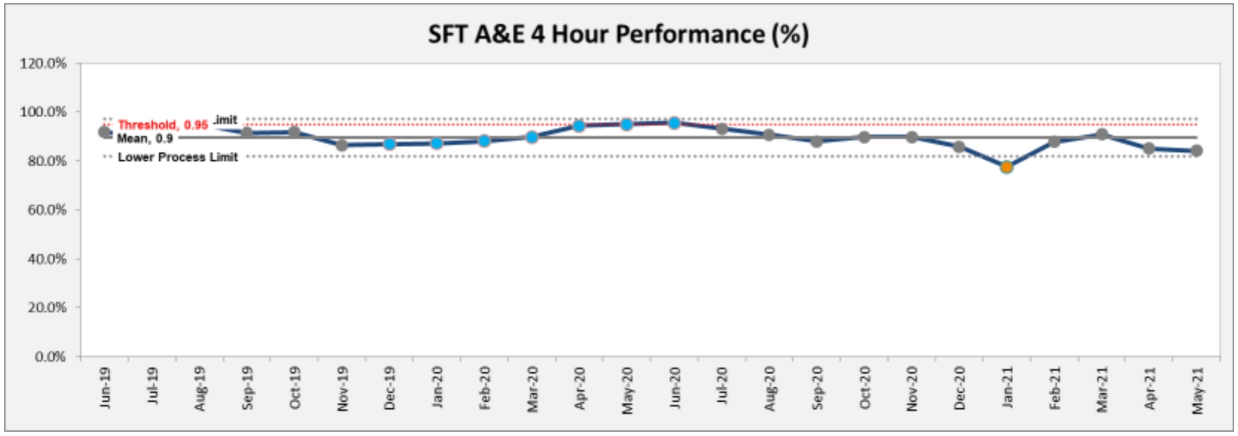
Salisbury NHS Foundation Trust

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:	84.1%
Attendances:	6010
12 Hour Breaches:	0
ED Conversion Rate:	28.8%

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

Month 2 saw a further decrease in performance for the 4 hour standard as compared to M1 (decrease from 85%). There was a an increase in attendance numbers of 324 in M2 compared to M1, and overall the highest monthly attendance numbers seen since December 2019.

Increases in minors and paediatric attendances, with the majority of patients self presenting (60%) with less than 4% using 111. 33% attendances age 70-90 years. 17% attendances age 0-20 years

Conversion rate has decreased slightly in M2 (from 30.7%)) which is still showing acuity of patients requiring admission, contributing to the decrease in performance this month. We have also seen a large rise in attendances form the Military, M2 in 2019/20 showed 121 attendances, compared to M2 in 2021 to 271 attendances.

Flow out of the department still remains a concern, and again twilight hours is still contributing to most of the breaches.

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

Re-enforcing triage escalation tools for majors and minors. This is to ensure safety of patients awaiting triage., with the continued increase in attendances into the department. We are working on a plan with ED and paeds to increase floor space for paeds co-located to ED

Detailed analysis on attendances, to explore patterns and establish if workforce matches demand. Daily monitoring of performance, system working and support. System work to promote alternative pathways for self help

UEC improvement groups set up focusing on flow and CTR, SDEC and compliance of new ED standards.

Recent appointment of junior and middle grade overseas doctors (arrival TBC), to fill workforce gaps. Working with WH&C staffing collaboration to improve front door frailty service to admission avoid. Also exploring having social services at front door to admission avoid.

Risks to delivery and mitigations

Challenging staffing, however recruit is in place and agency will support gaps. Covid-19 nursing uplift numbers have been made substantive, recruitment underway for B7, B5 and B2 vacancies.

Risk that demand will not drop and may increase especially in relation to paediatric respiratory conditions. Further increases in Covid-19 prevalence may have a negative impact in delivery, Covid-19 escalation plan is in place. Working with partners to promote the use of 111 and alternative pathways.

Continuous review of staffing levels to ensure appropriate given the increased demand.

Statistical Process Control Chart Key:

- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
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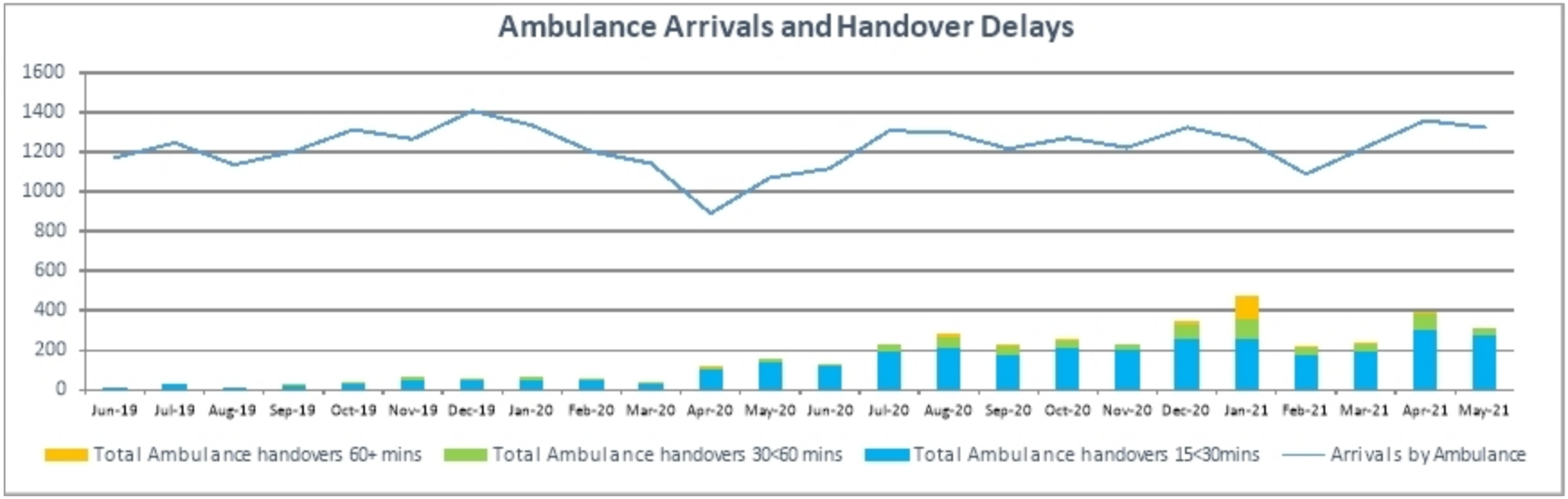
Ambulance Handover Delays

National Key Performance Indicators



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

There has been a small decrease of ambulances attending in M2 of 1323 compared to M1 of 1357, but numbers arriving still remain high.

We have seen a reduction in handover delays in M2, >1 hour breaches have reduced from 11 in M1 to 4 in M2. Handover delays from 30 – 60 minutes have also reduced from 67 in M1 to 28 in M2.

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

Bi-monthly meetings occur between SWAST and clinical leads to discuss any issues.

SWAST requested to complete a full set of observations on patients which triggers News2 score, which will help stream line handovers.

SWAST have been asked to pre alert any patient with a News2 of 8 or above, which gives time to plan to off load ahead of arrival in the department.

Active monitoring of handover delays with rapid escalation of capacity concerns impacting the process.

Analysis of cat 3 &4 conveyances which should not be brought to ED.

There is 24 hour access to SWAST Bronze Operating Officer

Risks to delivery and mitigations

Capacity within the department remains an issue, we are still waiting to increase waiting room capacity to assist in planning space to off load ambulances.

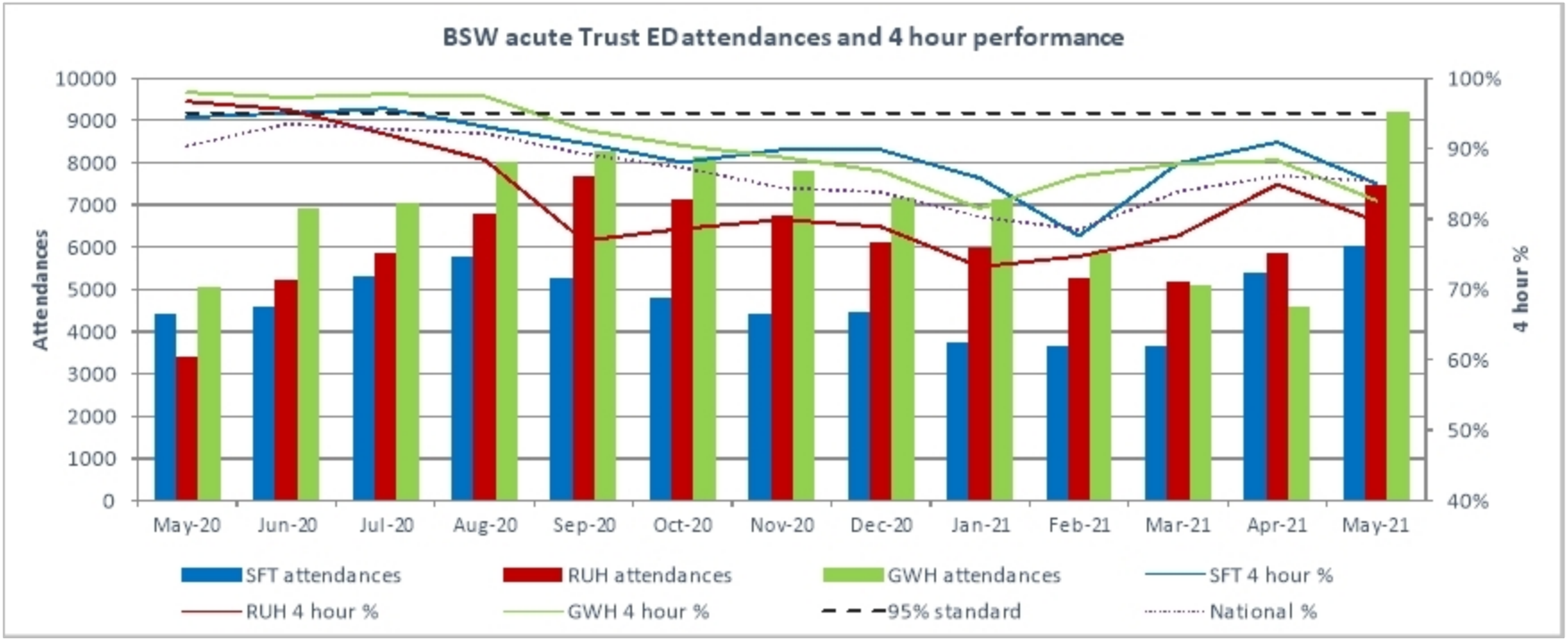
This is managed on a daily basis until the work is completed.

Nursing and medical staffing gaps will continue to impact in ambulance handovers if no senior staff available to take hand over.

Recruitment in progress for nursing and medical staff.

BSW Context – Emergency Access (4hr) standard

Are We Effective?

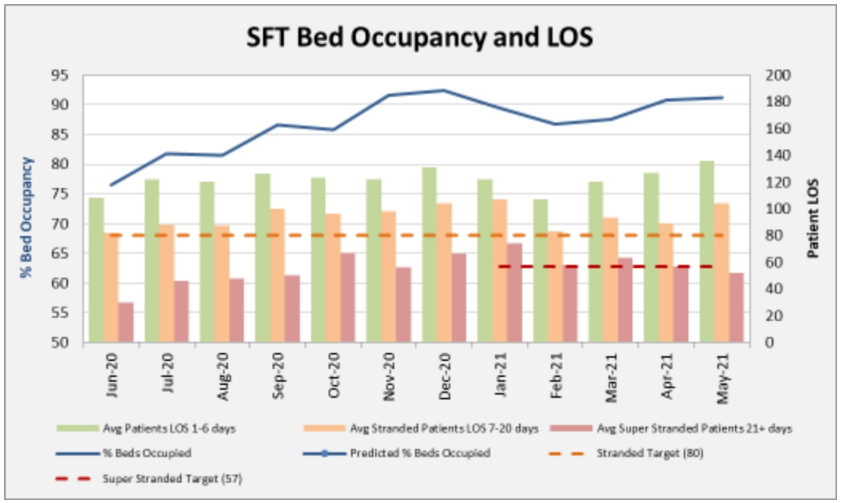


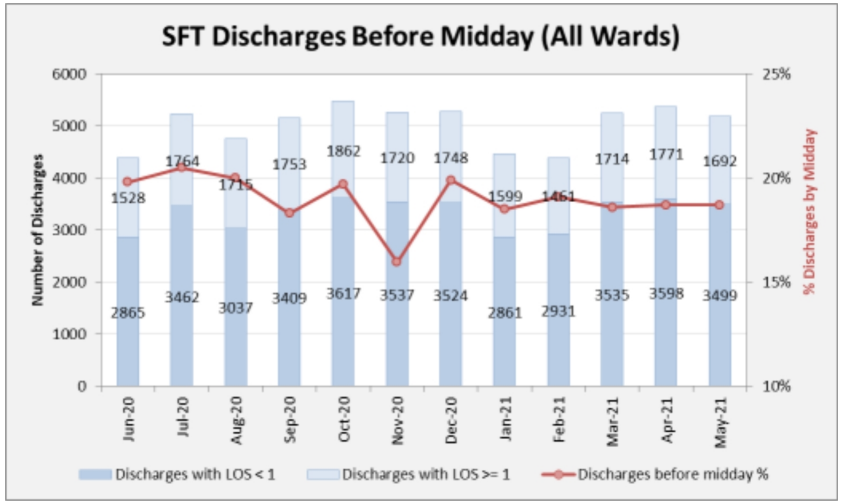
Attendances in the Emergency Department rose significantly in M2 with levels at all three BSW acute Trusts equal or to or the highest since the start of the pandemic. This increase in activity was also mirrored at a National level. Performance against the Four Hour standard deteriorated at all BSW acute Trusts. The National performance against the standard was 83.7%, both GWH and RUH were below the National position with both at 80%, SFT achieved performance slightly above the National average at 84.1%.

Nationally the Four Hour standard has not been met since 2015, and in May only 4 out of 112 reporting Trusts achieved the 95% standard.

Patient Flow and Discharge

Are We Effective?





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

Bed occupancy has continued an upward trend and whilst the 21 day + length of stay group has continued to remain stable there has been a rise in the 7-20 and 1-6 groups. This is overall positive, indicating turnover in capacity however the challenge is to prevent those with stays of 7-20 days move into the longest LOS group.

Focus in the Trust has remained on pre noon discharges and this can be seen in the consistent performance in 2021 in increasing occupancy and turnover. Comparisons with this time last year are difficult given the changes to the circumstances in the health of the nation related to the Covid-19 pandemic. Efforts continue to improve this percentage that will benefit capacity and flow, ensuring access to care in the right place at the right time

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

Concentration continues in the expert panel – examining patient journeys of more than 14 days exploring escalation of actions required to support timely treatment and discharge planning. Wards are engaged in this work and are keen to provide assurance they are striving for the highest standards of care and treatment for their patients.

There is a newly established patient flow program with the key objectives of establishing 'criteria to reside' decision making as business as usual on wards, and criteria led discharge. Both these elements will support a reduction in long length of stay and pre noon discharges and impact is anticipated to be seen in September 2021. Wards will design local improvements relating to flow and it is anticipated these will include discharge summary, medication and transport issues.

Patient flow reporting metrics are currently being revised and will move from reporting of stranded/superstranded to reporting on No Criteria To Reside on this slide in line with operational program of work.

Risks to delivery and mitigations

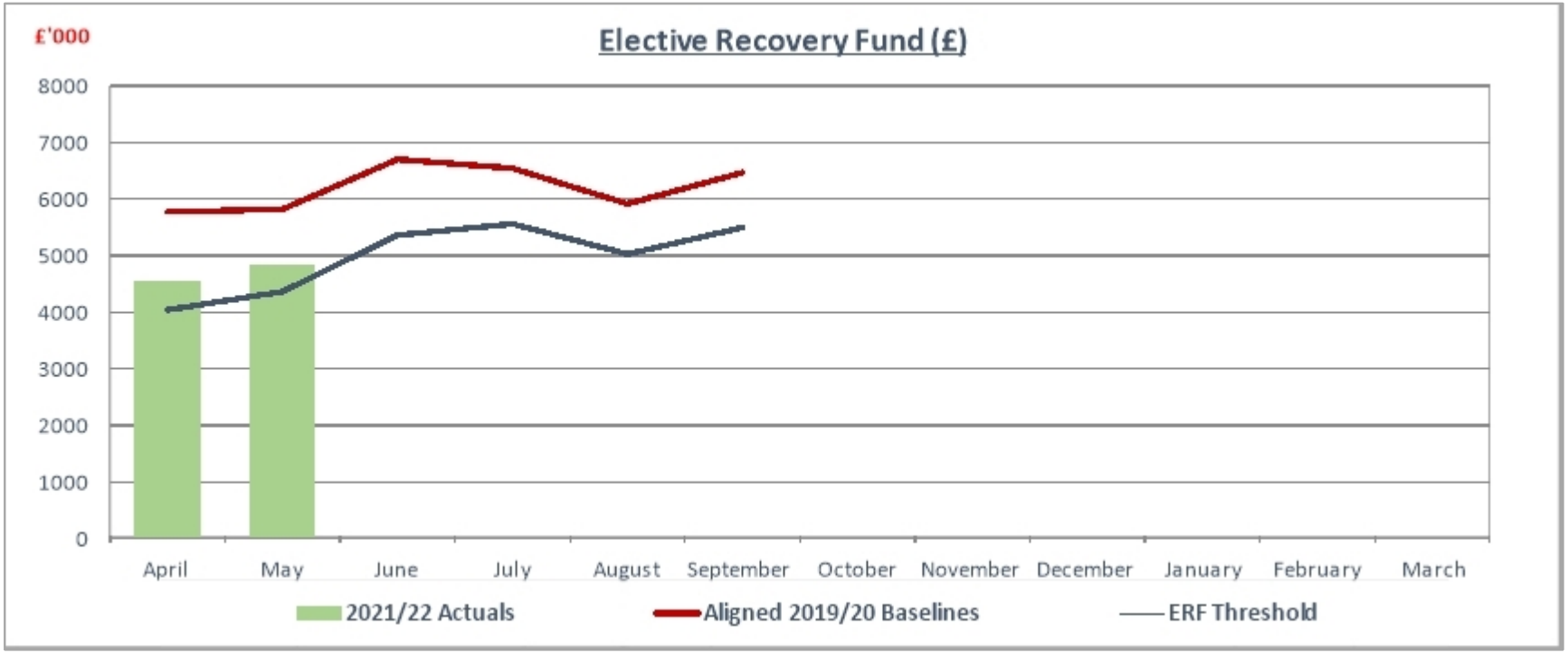
An increase in prevalence of Covid-19 as restrictions are lifted increasing pressure on capacity and flow, and the ability of staff to engage in improvement work

Limited capacity in community health and social care services will result in an increase in LOS and numbers of people not meeting the criteria to reside

Staffing constraints – any shortages will impact on the ability to deliver smooth flow, planning and discharge

Context – Elective Recovery Fund

Are We Effective?

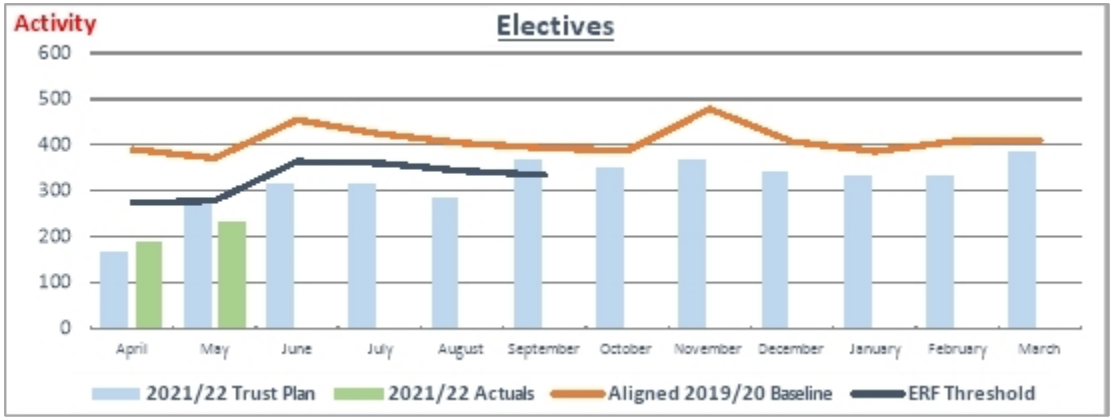


The above graph details the value of the combined ERF eligible activity from Elective, Daycase, Outpatient Attendances and Outpatient procedure PODs – the actual volume of activity associated with this value is split by POD in the following pages.
The Trust exceeded the threshold for ERF for month 2. Elective activity increased in M2 when compared to month 1, however it was not enough to exceed the ERF threshold at elective POD level. Over-performance in Daycases, Outpatient Attendances and Outpatient Procedures have mitigated the elective shortfall for this month and the ERF value threshold has been achieved.
The ERF threshold for month 2 is 75% of 19/20 levels, this rises again to 80% in Month 3, and 85% for Months 4-12.

Activity reported in this graph is only activity that is eligible to be included in the ERF calculations. Excluded from this is Cross Border and Overseas Patients, Maternity & Midwifery and Patient Covid-19 Testing Clinic. Local contracting rules-do not apply for ERF purposes. Activity that does not attract any national or contractual tariffs is included (e.g. pre-admission clinics and ward attendances).

Activity recovery – Electives (target 75%)

Are We Effective?



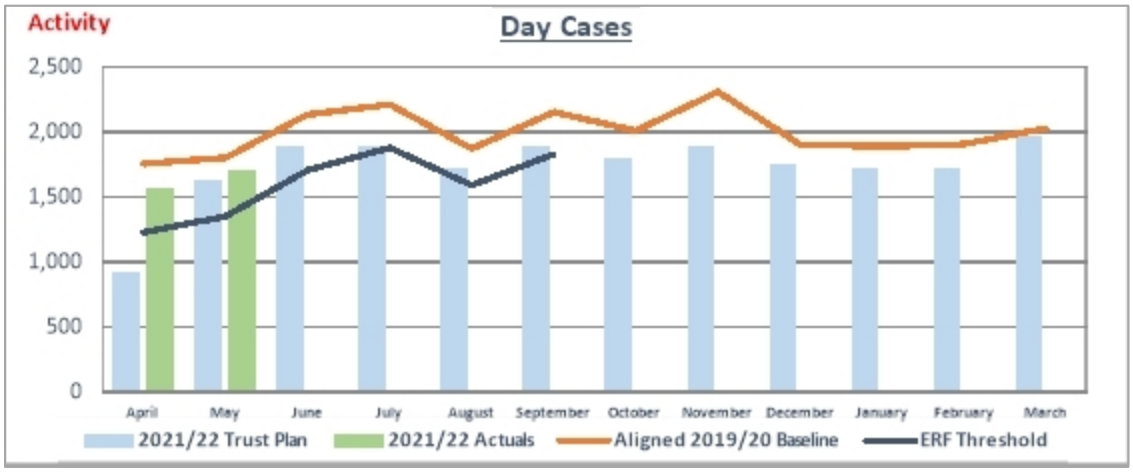
Electives			
Specialty	2019-20	2021-22	Delivery
Clinical Haematology	5	8	177%
Breast Surgery	6	9	142%
General Medicine	5	7	129%
Cardiology	8	9	111%
Interventional Radiology	1	1	111%
Paediatrics	4	4	111%
Spinal Injuries	7	6	83%
Oral Surgery	6	5	79%
Urology	52	40	76%
Gynaecology	17	13	76%
Gastroenterology	3	2	74%
Colorectal Surgery	25	16	63%
General Surgery	25	16	63%
Maxillo-Facial Surgery	2	1	55%
Plastic Surgery	79	39	50%
Trauma & Orthopaedics	69	34	49%
ENT	28	9	32%
Spinal Surgery Service	20	6	30%
Vascular Surgery	3	0	0%
Paediatric Plastic Surgery	1	0	0%
Paediatric Trauma And Orthopaedics	1	0	0%

The target levels for Elective activity to meet the Elective Recovery Fund (ERF) threshold in month 2 was 75%. The Trust achieved performance of 55% therefore falling short of the ERF threshold, this was also a slightly lower level of electives than expected in the plan as 228 electives were performed against a plan of 265 resulting in a shortfall of 37 against plan. This was an increase from M1 when 184 were performed.

Main areas of underperformance were the surgical specialties of Plastic Surgery, ENT, Oral Surgery and Trauma & Orthopaedics having high proportions of clinically routine, low priority patients impacting their 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 – Day case (target 75%)

Are We Effective?



Day Cases			
Specialty	**2019-20**	**2021-22**	**Delivery**
Interventional Radiology	5	18	398%
Geriatric Medicine	2	5	276%
Respiratory Medicine	6	16	253%
Urology	81	187	232%
Oral Surgery	103	124	120%
Breast Surgery	14	16	111%
Dermatology	4	4	111%
Cardiology	90	98	109%
Plastic Surgery	219	230	105%
Spinal Surgery Service	29	28	97%
Gynaecology	36	34	94%
Gastroenterology	370	334	90%
General Surgery	168	149	89%
Ophthalmology	152	117	77%
ENT	42	30	72%
Rheumatology	101	73	72%
Colorectal Surgery	189	134	71%
Neurology	26	16	61%
General Medicine	73	41	56%
Trauma & Orthopaedics	72	15	21%
Vascular Surgery	23	1	4%

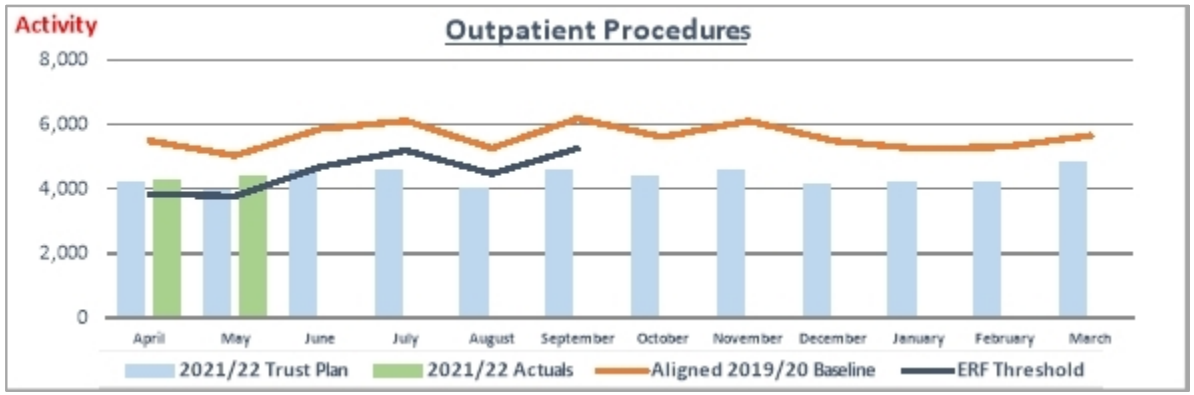
The target levels for daycase activity to meet the Elective Recovery Fund (ERF) threshold in month 2 was 75%. The Trust achieved performance of 91% exceeding the ERF threshold and helping to mitigate the shortfall of elective activity. This was also a slightly higher level of daycases than expected in the plan as 1695 were performed against a plan of 1573. This was an increase from M1 where 1545 daycases were performed.

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

Performance driven forward by running of high throughput lists: Plastic Surgery increased weekend activity with two high throughput Saturdays and the running of another BSW WLI Weekend for Paediatric Oral Surgery and ENT.

Activity recovery – Outpatient Procedures (target 75%)

Are We Effective?



Outpatient Procedures			
Specialty	**2019-20**	**2021-22**	**Delivery**
Gynaecology	212	659	311%
Paediatrics	20	52	261%
Breast Surgery	41	87	214%
Clinical Cardiac Physiology	110	230	208%
Gynaecological Oncology	24	38	162%
Urology	196	257	131%
Clinical Neurophysiology	169	166	98%
Respiratory Physiology	74	68	92%
Trauma & Orthopaedics	48	41	86%
Audiology	514	429	83%
Oral Surgery	158	125	79%
Dermatology	380	270	71%
Ophthalmology	1,177	834	71%
Plastic Surgery	696	481	69%
Rheumatology	28	19	68%
Orthodontics	256	170	66%
Respiratory Medicine	244	155	63%
Vascular Surgery	32	19	60%
ENT	415	209	50%
Colorectal Surgery	24	10	41%
Paediatric Ear Nose And Throat	41	14	34%
Interventional Radiology	18	5	28%
Optometry	16	3	18%
Neonatal care	20	3	15%

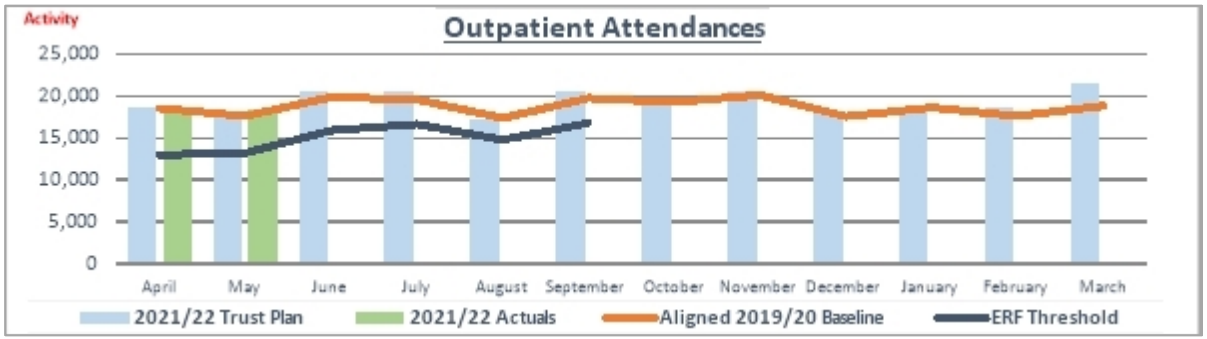
The target levels for Outpatient Procedure activity to meet the Elective Recovery Fund (ERF) threshold in month 1 was 75% and the Trust exceeded this threshold helping to mitigate the shortfall of elective activity. However, with the increased numbers of appointments being undertaken virtually, and the space constraints in many outpatient areas, the level of outpatient procedures has reduced compared to 19/20 baseline.

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

The installation of the air change solution for both the ENT & Oral Surgery outpatient departments will mean outpatient procedure activity for these specialties, both with high levels of AGP procedures, will now rise.

Activity recovery – Outpatient Attendances (target 75%)

Are We Effective?



Outpatient Attendances			
Specialty	2019-20	2021-22	Delivery
Geriatric Medicine	91	171	187%
Burns Care	88	164	187%
Urology	398	671	169%
Clinical Cardiac Physiology	649	1,077	166%
Plastic Surgery	958	1,494	156%
ENT	334	494	148%
Occupational Therapy	76	111	146%
Gastroenterology	242	338	140%
Clinical Haematology	386	534	138%
Ophthalmology	1,033	1,391	135%
Endocrinology	252	330	131%
Dermatology	308	392	127%
Speech And Language Therapy	358	451	126%
Medical Oncology	422	491	116%
Gynaecology	348	403	116%
Spinal Injuries	155	173	112%
Colorectal Surgery	524	553	106%
Respiratory Medicine	366	386	105%
Orthoptics	178	185	104%

Specialty	2019-20	2021-22	Delivery
General Surgery	342	341	100%
Cardiology	560	539	96%
Anticoagulant Service	118	113	96%
Orthotics	617	592	96%
Oral Surgery	480	455	95%
Breast Surgery	433	389	90%
Rheumatology	984	860	87%
Rehabilitation	428	368	86%
Clinical Physiology	406	344	85%
Trauma & Orthopaedics	1,785	1,486	83%
Paediatrics	843	685	81%
Diabetic Medicine	246	198	80%
Vascular Surgery	216	155	72%
Audiology	514	336	65%
Spinal Surgery Service	208	135	65%
Cardiac Rehabilitation	373	231	62%
Clinical Psychology	204	114	56%
Hepatology	85	38	45%
Physiotherapy	785	218	28%
Stroke Medicine	98	1	1%

The target levels for Outpatient activity to meet the Elective Recovery Fund (ERF) threshold in month 1 was 75%. The Trust achieved performance of 103% exceeding the ERF threshold and helping to mitigate the shortfall of elective activity. This was also a significantly higher level of outpatients than expected in the plan as 21,661 (21,423 in M1) were performed against a plan of 17,857.

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

Space constraints across outpatient departments continue to be a significant challenge, particularly in specialties with low levels of patients suitable for virtual appointments such as Trauma & Orthopaedics, Oral Surgery and Orthodontics, and recovery for some specialties is being limited by a lack of access to clinical space. The move of T&O into their new footprint on Level 3 later this year will increase capacity.

Focussed work is being undertaken to improve medium-long virtual models as there is some creep in specific specialties back to onsite preferences. However virtual appointments are working well in a number of specialties with Gastroenterology seeing the majority of their outpatients virtually. Urology, Gynaecology and Cardiology are also seeing good use of virtual appointments.

Theatre Performance

Theatre KPI's

	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 21	Feb 21	Mar 21
19/20	497	532	501	531	453	522	524	555	476	548	481	364
20/21	239	294	327	317	346	362	379	401	328	248	263	383
21/22 Actual	301	378										
21/22 Plan	252	411	452	456	441	463	451	463	451	435	423	482
21/22 Plan+	252	411	551	560	540	563	554	568	547	541	517	588

Measure - Theatre Performance & Efficiency	Area	Target	May
% Utilisation	Day Surgery Theatres	90%	68.09%
	Main Theatres	85%	92.12%
Turnaround	Day Surgery Theatres	8 mins	14 mins
	Main Theatres	12 mins	25 mins
% Late Starts (over 15 minutes beyond start of list)	Day Surgery & Main Theatres	2%	70.88%
% short notice Hospital Cancellations (0-3 days)	Total	2%	0.49%
% Short notice Patient Cancellations (0-3 days)	Total	2%	5.08%

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

Underperformance of elective activity accounts for the theatre activity being lower than plan in M2. This was mainly due to workforce issues in theatres which did not allow the running of as many theatres as anticipated in the plan.

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

Due to current IPC requirements all patients, except emergency, trauma and clinically urgent patients, are required to be booked with enough notice to undertake 14 days enhanced social distancing and hand hygiene before their surgery. This means that no capacity that becomes available due to cancellations can be utilised in Day Surgery, due to it being a green pathway environment, and can only be utilised in Main Theatres if there is demand for clinically urgent patients. This impacted activity, and utilisation, in May when there was a significant number of patient cancellations with less than 14 days notice leaving opportunity on lists unable to be realised.

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

Approaches to tackle these issues are high volume, low complexity lists both in the week for a number of specialties, and as WLI weekend lists for Plastic Surgery.

The FourEyes productivity and efficiency work focusing on list utilisation will drive forward the realisation of opportunity on lists especially in the Day Surgery Unit. The limitation to this is the current IPC guidance for 14 days enhanced social distancing and hand hygiene before surgery though.

Also as part of the Surgery Division's Elective Recovery Plan an insourcing theatre model has been procured. This commences from the 21st June for weekday lists, and the 26th June for weekends, and will provide significant increases in theatre capacity – see Plan Plus. This will provide opportunity to date increased numbers of long waiting, clinically routine, patients on additional day surgery unit lists and will also allow local teams to be utilised in main theatres to increase the number we are able to run therefore increasing elective capacity.

Risks to delivery and mitigations

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

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

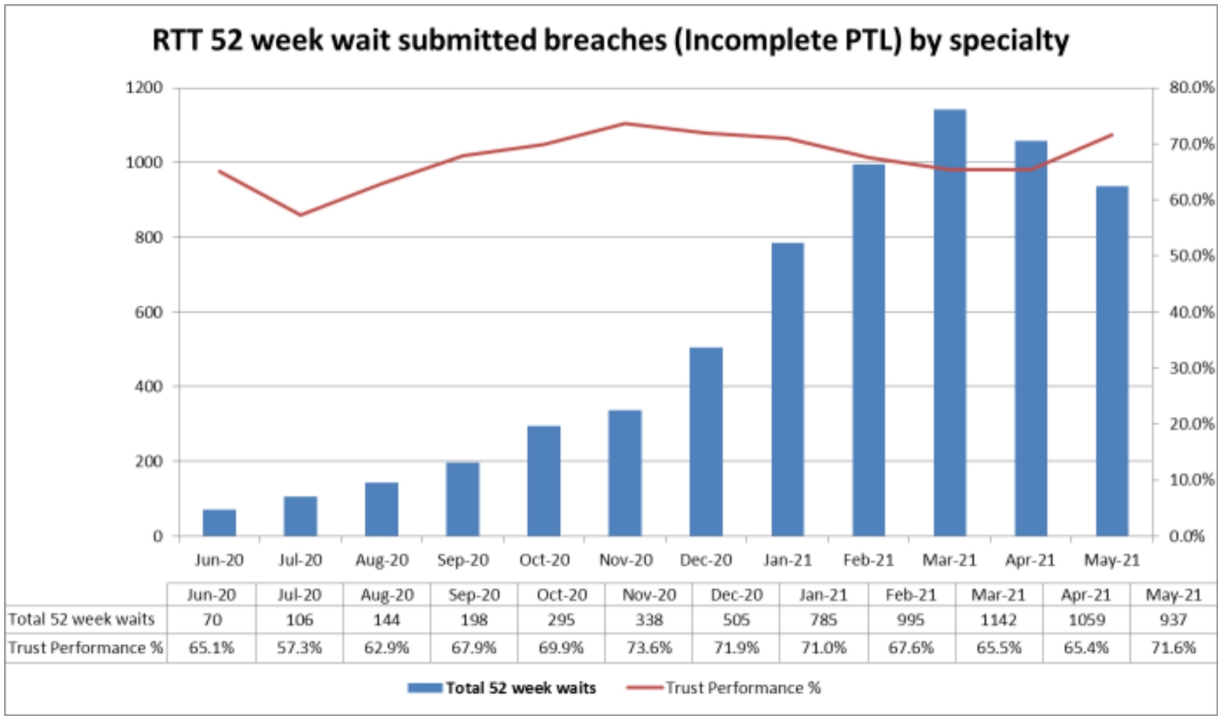
Continued high rate of less than 14 day cancellations impacting ability to improve utilisation. Escalated to Clinical Director and Medical Director to discuss the option to risk assess low risk pathways

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

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

Referral To Treatment (RTT) (52 week + waits)Target 92%

National Key Performance Indicators



	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Total 52 week waits	70	106	144	198	295	338	505	785	995	1142	1059	937
Trust Performance %	65.1%	57.3%	62.9%	67.9%	69.9%	73.6%	71.9%	71.0%	67.6%	65.5%	65.4%	71.6%

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

Treatment function	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	% change from previous month
Ophthalmology	7	32	55	115	202	238	253	203	158	-22%
Plastic Surgery	54	64	54	74	107	132	148	139	145	4%
Trauma and Orthopaedic	34	34	37	44	71	104	134	130	114	-12%
Oral Surgery	12	27	30	61	97	117	135	146	102	-30%
Urology	25	38	44	49	65	84	96	89	94	6%

The number of patients waiting longer than 52 weeks has decreased by 122 patients to a total of 937 of which 107 patients have requested to pause their pathway due to Covid-19 concerns.

Approximately 25% of patients waiting longer than 52 weeks are waiting at the non-admitted stage of their pathway and 75% are waiting on an admitted pathway.

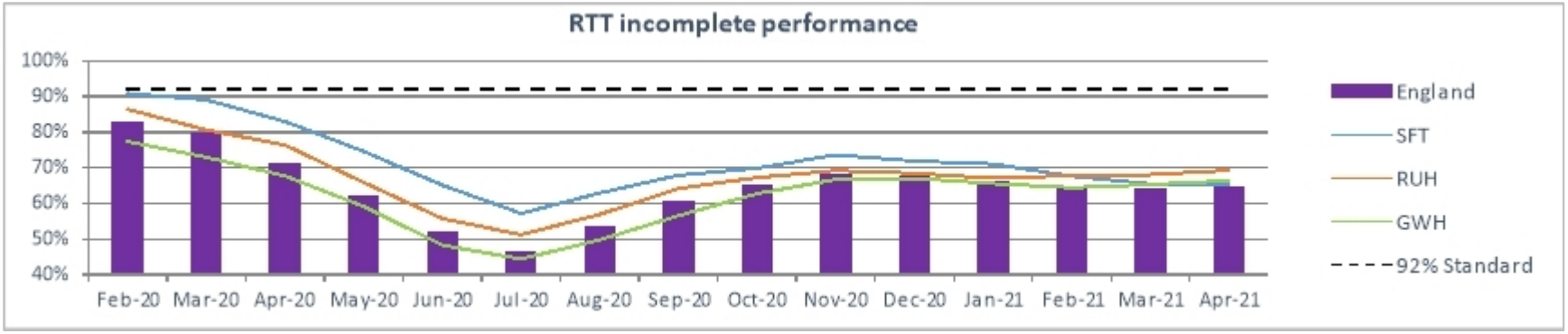
Of the patients waiting on an outpatient pathway, 102 are in Ophthalmology and 32 in ENT. There have been specific challenges to increasing activity in both these areas in Ophthalmology this is in relation to the ability to socially distance, outpatient capacity and the proportion of vulnerable patients 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 created from M2, in both the modular build and following the completion of the air flow work in ENT, will work to reduce these.

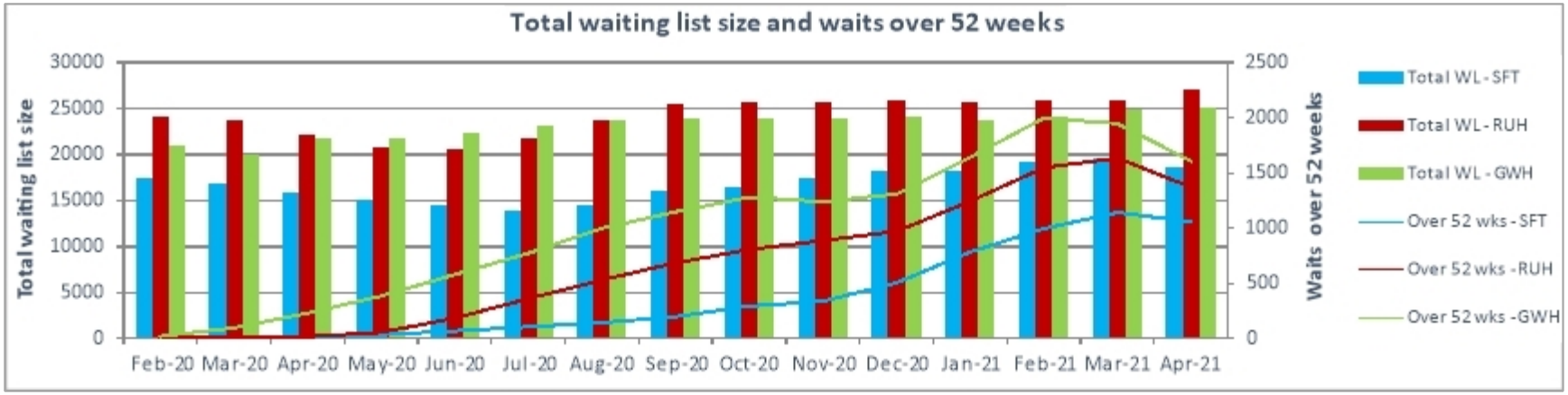
Of the patients waiting on an admitted pathway, 15 patients have been recently expedited to priority level 2 (should be treated within 4 weeks of prioritisation), 133 patients are priority level 3 (should be treated within 3 months), and 437 are levels 4, 5 and 6 (more than 3 months). The specialty split is broader, with the highest being in Plastic Surgery (78), Urology (66), Orthopaedics (53), General Surgery (43) and Ophthalmology (40). The continued transfer of Orthopaedic patients to Newhall will work to reduce these further as will the increase of routine elective orthopaedic lists at SFT from M4. Additional Saturday high volume lists for Plastic Surgery continue to run to further address this cohort. Additionally the insourcing theatre model which commences from the 21st June for weekday lists and the 26th June for weekends will provide significant increases in capacity to tackle this cohort of long waiting patients.

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. We will provide the Board with an updated 52 week reduction trajectory in future reports.

Context – Referral To Treatment (RTT)

Are We Effective?





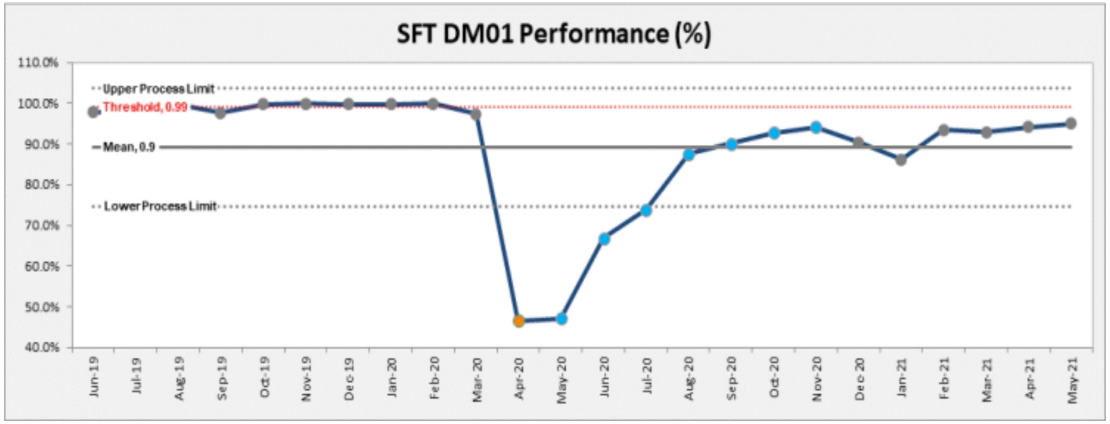
Referral to Treatment performance improved slightly nationally at 64.4% (64.4% in M1). Across BSW all three acute Trusts remained higher than the national position with SFT at 65.4%, RUH at 69.33% and GWH at 66.39%. Total waiting lists at a national level topped 5 million (growth of 1.18 million since April 2020) for the first time, and locally increases were also seen at GWH (25198 vs 24919 in M12) and RUH (27007 vs 25921 in M12). SFT reduced the total waiting list to 18649 (19561 in M12).

The number of patients waiting over 52 weeks for treatment was reduced at all three trusts with SFT at 1057 (1142 in M12), RUH at 1372 (1672 in M12), and GWH at 1608 (1949 in M12). Collectively the over 52 week backlog was 4037 at the end of M1 (4725 in M12).

A collaborative approach to paediatric dental lists was achieved in M1 with a number of paediatric dental lists undertaken at SFT, but jointly staffed by the three trusts. The longest waiting patients from across the system were treated improving equity of access across the wider system. Further opportunities to apply the model to other services/specialties are being explored.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	95.02%
Waiting List Volume:	3852
6 Week Breaches:	192
Diagnostics Performed:	6957

Background, actions being taken and risks and mitigations
Performance standard in month has not been achieved owing a combination of Covid-19 and increased referral rates in some diagnostic specialties. June projections confirm that the target is not achievable for M3 owing to continued capacity constraints in Cardiology, increased referrals in Ultrasound exceeding in month capacity and increased referrals in Audiology combined with reduced capacity owing to staff changes. Improvements continue to be made by Cardiology in line with the recovery trajectory, with the service predicting the ability to book within DM01 tolerances in M4. Activity in M2 declined in comparison to M1 this was a combined impact of a reduced referral rate for some tests and the double bank holiday.

Endoscopy
1 confirmed in month breach

Radiology (Inc. DEXA)
29 confirmed in month breaches. 21 of which were MRI, whereby capacity outstripped demand, despite additional clinical sessions taking place.

Audiology
33 confirmed in month breaches. DM01 recovery not achieved as planned owing to an increase in the referral rate. Staffing levels in month also reduced, but activity remained static owing to additional clinical sessions being provided. Audiology to rebase their recovery trajectory.

Cardiology
129 confirmed in month breaches, all attributable to Covid-19. Cardiology remain on target against their recovery trajectory.

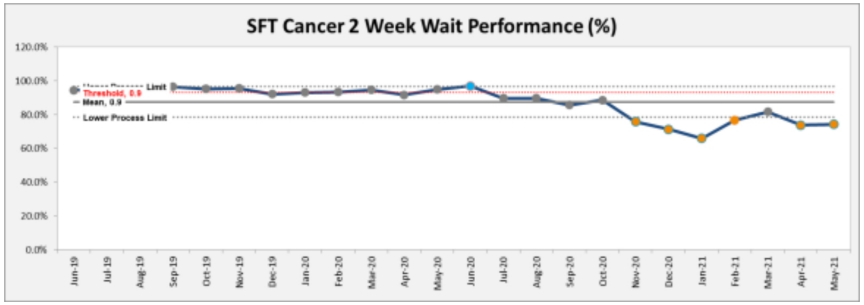
Neurophysiology
0 in month breaches – service has recovered and continues to sustain their waiting list position.

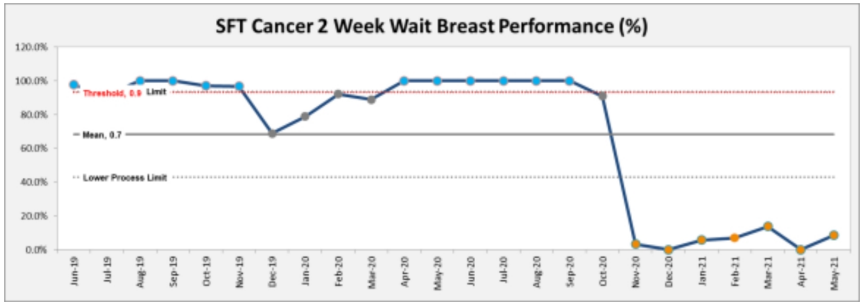
Cancer 2 Week Wait Performance Target 93%

National Key Performance Indicators

Performance Latest Month	Performance	Num/Den	Breaches
Two Week Wait Standard:	74.2%	722/973	251 (37 patient choice)
Two Week Wait Breast Symptomatic Standard:	9.62%	5/51	46

Data Quality Rating:





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

Two week wait standard not achieved for Month 2 (973 patients seen in total; 722 seen within target; 251 breaches). This is due to a variety of reasons including:

- Face to face outpatient capacity (predominantly breast one stop clinic capacity): 202 breaches
- Patient choice delays: 37 breaches
- Incomplete GP referrals: 7 breaches
- Administrative delays: 7 breaches
- Endoscopy capacity: 1 breach

Breast symptomatic two week wait standard not achieved for Month 2 (51 patients seen in total; 5 seen within target; 46 breaches). Delays associated with patient choice and one stop clinic capacity.

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

Challenges within breast service due to increase in referrals, social distancing restrictions and outpatient capacity. Existing one stop clinic capacity has been increased to pre Covid-19 levels (slots previously lost due to cleaning between patients/social distancing) to manage referrals on an ongoing basis. Additional clinics established over May and June to manage backlog. Demand and capacity modelling undertaken with NHS Improvement/IST which suggests that improvement should be seen from the end of June 2021 onwards if assumptions remain consistent.

Booking teams continue to prioritise cancer patients, though ongoing challenges remain in relation to patient choice delays. This is likely to impact on service delivery going forward; 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 has significantly improved. Two week wait standard achieved within Colorectal service for Month 2.

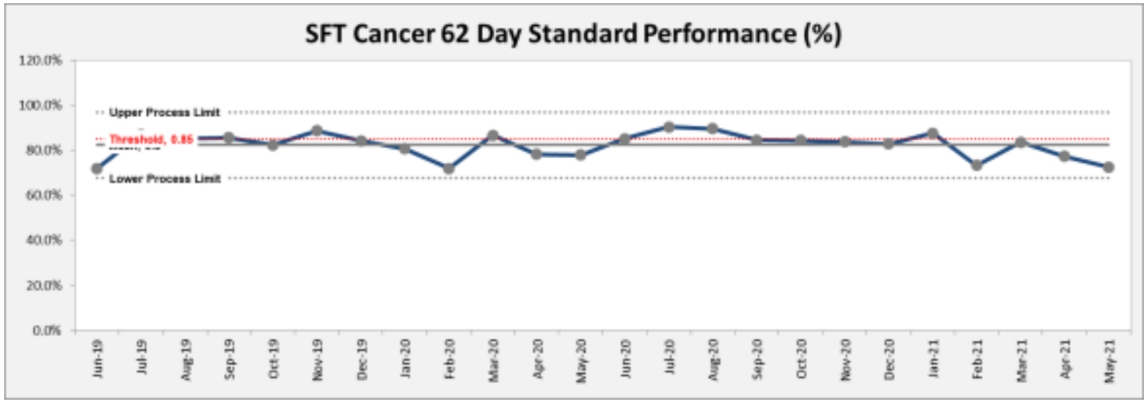
Risks to delivery and mitigations

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 the pandemic, who may present at a later date). Referral rates have remained consistently high across all tumour sites since March 2021.

Capacity restraints within Gynaecology service. Issue relates to clinician capacity and not felt to be a long term issue. CSFS DMT are currently reviewing job planning and have completed demand and capacity modelling to understand gap. Service currently scoping need for a locum consultant to support additional capacity.

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

March 21	Performance	Num/Den
62 Day Standard:	83.48%	48/57.5
62 Day Screening:	100%	1/1

Risks to delivery and mitigations

Month 2 62 day performance standard not achieved, with validated month end performance of 83.48% (57.5 patients treated in total; 48 treated in target; 9.5 breaches). Breach reasons predominantly associated with complex diagnostic pathways, patient choice, clinical delays and capacity. Focus on following improvement actions:

- Regular communication to primary care regarding importance of patients attending appointments with reassurance on Covid-19 safety.
- Review of patients feedback to establish concerns and address.
- Extensive work on inequality taking place to address local issues e.g. diverting the chemo bus to 'hard to reach areas'.

Two 104 day breaches reported in May following treatment:

- 2 x Urology breaches:
    - Diagnostic delay as a result of patient choice, though subsequent delay as patient unfit for treatment and wanted time to consider options before proceeding;
    - Complex diagnostic pathway and patient choice delays

62 day screening performance standard achieved for Month 2. Significant capacity constraints flagged within Bowel Cancer Screening service due to recover and backlog from Covid-19 pandemic; the service is anticipating that performance will be affected over 2021/22. Breast cancer screening referrals have restarted.

Month 2 31 day performance standard achieved, with validated month end performance of 98.85% (1 breach).

Month 2 28 day faster diagnosis standard achieved, with month end performance of 81.80%. It is important to note that performance against this standard is subject to change as some data is input retrospectively. Additional tracker to be recruited to imminently to help with data quality and completeness.

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:

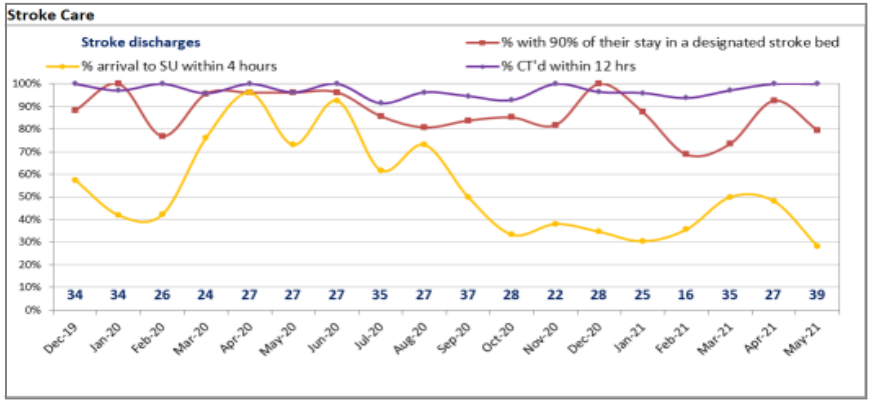
Year	Q1	Q2	Q3	Q4
2020-21	Not Reported	Not Reported	Not Reported	Not Reported
2021-22				

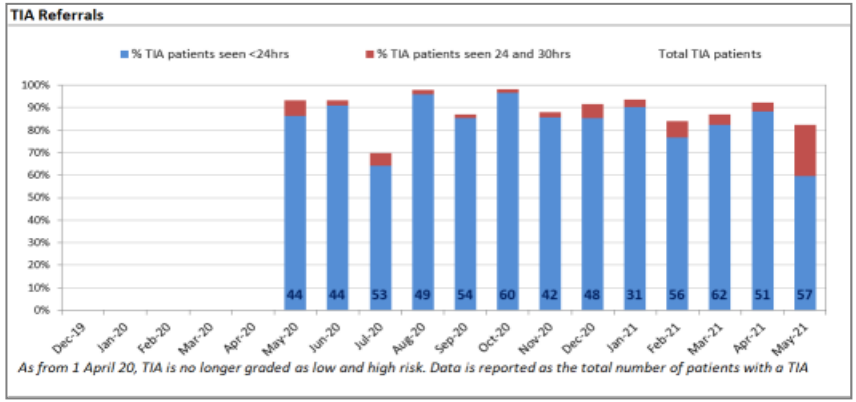
Data Quality Rating:

% Arrival on SU <4 hours: 28.2%

% CT'd < 12 hours: 100%

% TIA Seen < 24 hours: 59.6%





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

44% of stroke patients had a CT within 1 hour, a decrease from 56% in April and below the 50% national target. Patients reaching the stroke unit within 4 hours decreased from 48% in April to 28% in May. Delays occurred for 26 patients due to waiting for a bed (8), admitted to AMU (6), waiting for specialty doctor (4), in ED at 4 hours (3), waiting 1st doctor (2), inpatient stroke (1), waiting diagnosis (1) and waiting for Porters (1). There were 4 stroke deaths in May, with 7 and 30 day mortality below the national targets. A decrease from 92% in April to 79% in May (just below national target of 80%) in stroke patients spending 90% of their time on the stroke unit. 42% of patients were referred to the Early Supported Discharge team, exceeding the 40% national target. Thrombolysis target also achieved at 17%.

60% TIA performance, a significant decrease from 92% in April. This was attributable to an unexpected loss of the locum stroke consultant coinciding with annual leave.

SSNAP data for Q1 21/22 based on May data suggest our service would score C. As yet there is no indication of when SSNAP plan to start publishing official scores.

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

A decline in stroke data and TIA performance is the subject of a review at departmental/divisional level with the expectation of a recovery plan to return to SSNAP A or B performance

A business case is being written for an Advanced Nurse Practitioner in Stroke Care, which will include extended hours for specialist cover. A previous trial of this role demonstrated significant benefits in service delivery.

Risks to delivery and mitigations

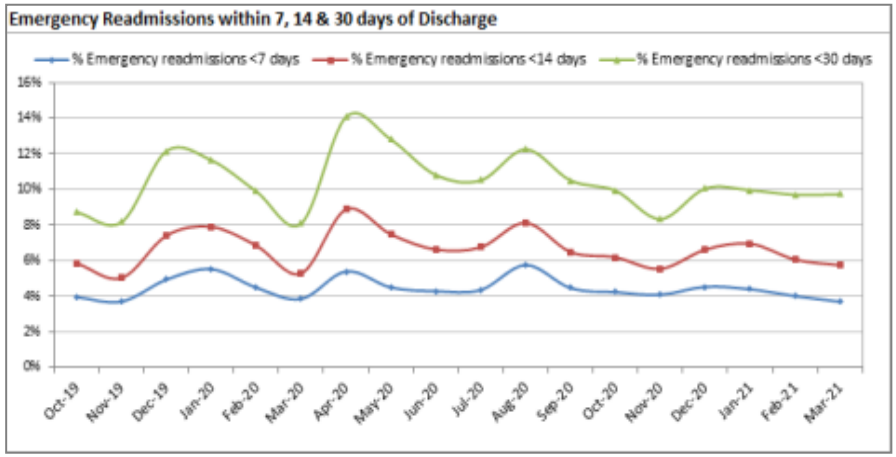
Ward staffing is stretched due to the requirement to cover the acute stroke unit and the Respiratory Care Unit.

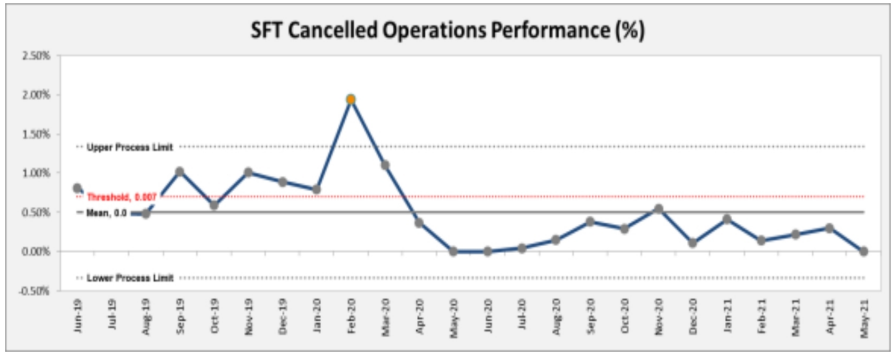
Clinical staffing stretched due to intermittent locum consultant cover and loss of junior doctors. Partially mitigated by reviewing work and prioritising e.g. 1 daily TIA clinic instead of 2.

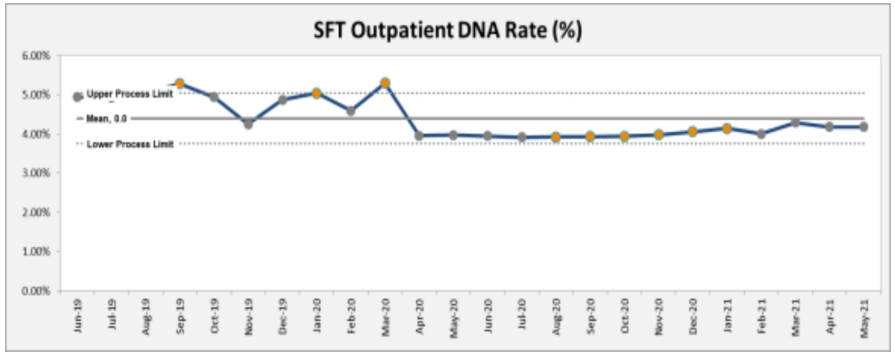
The Stroke Strategy Group is to start meeting again in June 21 by MS teams.

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		

Maternity Dashboard

Data Quality Rating:

Are We Safe?

Metric	Measure	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Q1 21/22
Still Birth	Number	1	0	0	1	0	0	4	0	0	0	0	0	0
	% of all babies delivered	0.60%	0.00%	0.00%	0.50%	0.00%	0.00%	2.20%	0.00%	0.00%	0.00%	0.00%	0.0%	0.00%
Babies requiring cooling	Number	0	0	0	1	0	1	0	0	0	0	1	0	3
Maternal Mortality	Number	0	0	0	0	0	0	0	0	0	0	0	0	0
Neonatal deaths within 28 days Born at Trust	Number	0	0	0	0	0	1	0	0	0	2	0	0	0
Neonatal Mortality	%	0.00%	0.00%	0.00%	0.00%	0.00%	0.50%	0.00%	0.00%	0.00%	1.20%	0.00%	0.00%	0.00%
Pre Term Birth Rates (24+0 - 36+6)	Number	14	8	7	10	11	11	15	9	10	3	18	15	33
	%	8.20%	4.30%	4.20%	5.50%	5.30%	5.60%	8.30%	5.30%	6.30%	1.70%	9.90%	9.6%	9.70%
Continuity of Carer	Number of women	20	31	28	16	24	19	21	19	17	34	5	11	16
	% of women with continuity	11.80%	16.80%	16.90%	8.70%	11.50%	9.70%	11.70%	11.10%	10.80%	19.30%	2.70%	7.0%	4.70%

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

In May there were 0 stillbirths, maternal deaths or neonatal deaths within 28 days of birth

No babies required transfer for cooling in May

15 babies were born between 24+0 - 36+6 weeks gestation accounting for 9.6% of births in May. Babies born under 27 weeks gestation (NICU admission gestation) are reviewed and an exception report completed and reviewed by the ODN

11 women were booked on a continuity of carer pathway

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

The service is producing an action plan detailing how we will work to achieve Continuity of Carer across the service and meet the national target of 35% - with a focus on Black, Asian, Minority ethnic groups and women from area of high deprivation. Action plan to be completed by August 2021.

Data is being gathered from across the region to identify a benchmark level to compare against, this will be included in this report.

Risks to delivery and mitigations:

Twice weekly case review meetings of all cases triggering a Datix

If SII commissioned external reviewer will be on panel in 100% of cases

Continue to monitor and track progress through our dashboard

Risk of not achieving 35% continuity of carer within service

Saving Babies' Lives Care Bundle v2

Are We Safe?

Data Quality Rating:

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

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

SBLCBv.2 is a care bundle that brings together 5 elements of care to reduce perinatal mortality

Completion of quarterly surveys detailing compliance and change in practice at trust level

Within each element above there is criteria that determines compliance

Compliance of SVBLCBv.2 reported through NHSR Maternity Incentive Scheme annually.

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

Element 1 – fully compliant, SOP in draft for reintroduction for CO monitoring in pregnancy (change due to Covid-19 guidance)

Element 2 – non compliant with 1 aspect – UAD scans for High risk women by 24/40. Need to increase workforce skill and capacity – compliant with current trust and regional guidance

Element 5 – Non compliant with recording of antenatal corticosteroids on Maternity Information system – Digital Midwife (when appointed) to action by Q4 21/22

Risks to delivery and mitigations:

Non compliance to all elements of care bundle therefore unable to demonstrate compliance with CNST maternity incentive scheme

Element 2 mitigation in place compliant with trust guidance, review of all cases of FGR by Fetal surveillance Lead Midwife and Lead Obstetrician

Recruitment of digital midwife to improve compliance of Element 5

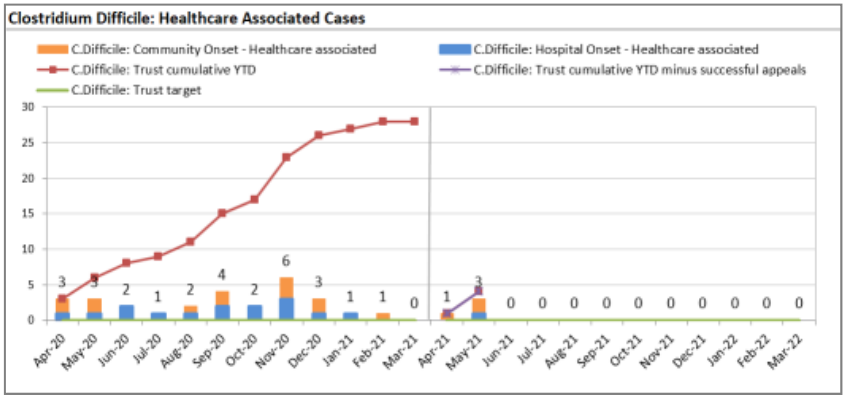
Infection Control

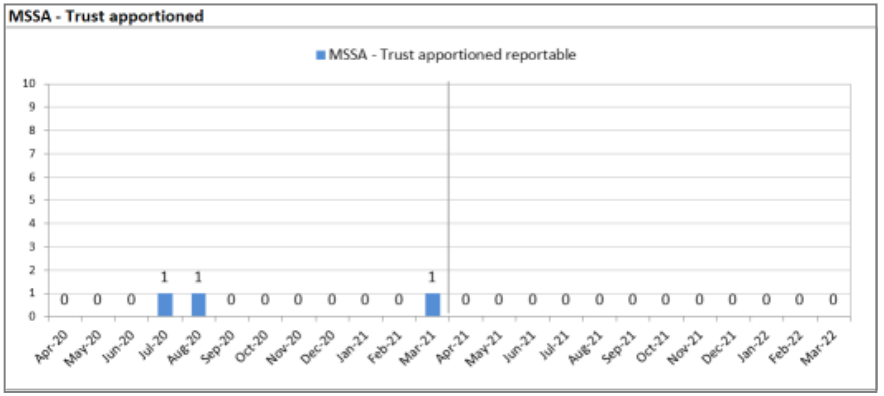
Data Quality Rating:

Are We Safe?

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

MRSA	2020-21	2021-22
Trust Apportioned	3	0





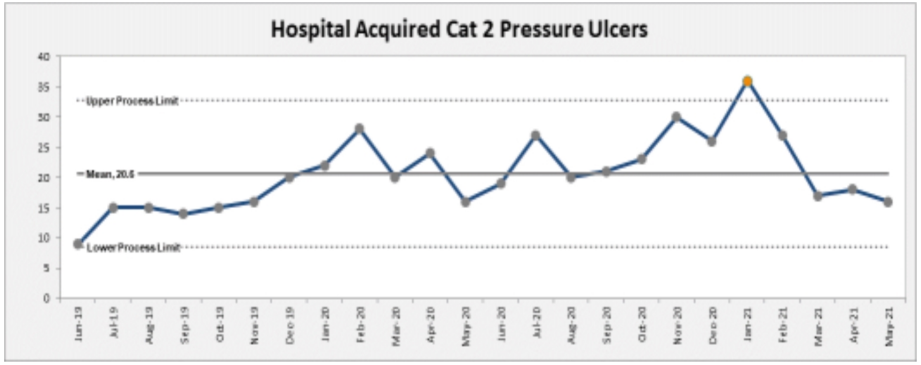
Summary and Action

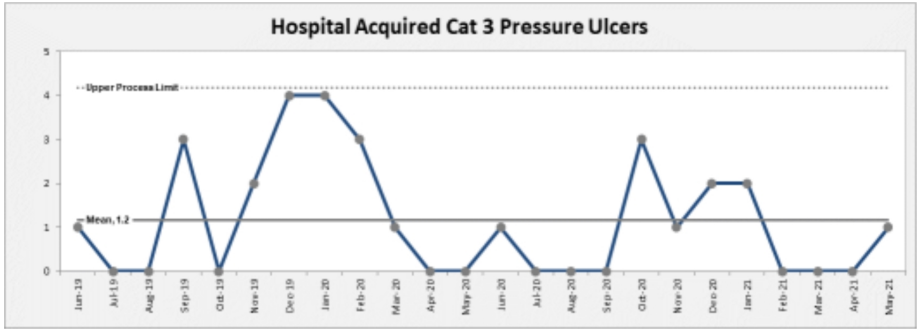
- 1 hospital onset C.difficile healthcare associated case in May for a patient on Redlynch Ward. 2 stool samples tested C.difficile not detected. The patient remained isolated, and a subsequent stool sample was sent and tested C.difficile positive. Learning from this case identified that this last sample was sent independently by a staff member with no prior review or discussion. The staff member was not based on the ward, and the Ward Sister has provided feedback to the relevant line manager to ensure follow up support.
- 2 community onset C.difficile healthcare associated cases in May:
  - A patient had a 6 day inpatient stay in the prior 4 weeks. From a retrospective review of the patient's healthcare records, 1 episode of Type 5 to 6 stools was recorded when an inpatient, however this would not have triggered the criteria for the Diarrhoea Pathway/clinician review requirements.
  - Sample sent for a patient admitted on 27.05.21 via ED to Pitton Ward, where the patient had an inpatient stay in the preceding 4 weeks. The patient was known to be previously C.difficile positive in March 2021 (reportable case), and again in April 2021 (not a reportable case) and had first been identified as C.difficile positive in 2017. On this current readmission to hospital, a Microbiologist had requested that a stool sample was sent to test for C.difficile.
- No MRSA or MSSA bacteraemias in May.
- 2 hospital onset E Coli bacteraemias:
  - AMU – Unknown source, the blood cultures were taken at day 4 of admission. The Microbiologist recorded that the patient was commenced on Ciprofloxacin, was found to have AFB in bone marrow, and was discharged home on triple therapy.
  - Pembroke Ward – Unknown source, blood cultures taken on day 14 of admission. The Microbiologist recorded that the patient had myelodysplastic syndrome with neutropenia, with a PICC line in situ for regular transfusion. The patient was receiving antibiotic therapy, however sadly died, with the cause of death recorded as 1a. Sepsis, 1b. Neutropenia, 1c. Myelodysplastic syndrome with excess blasts, and 2. Rheumatoid arthritis.

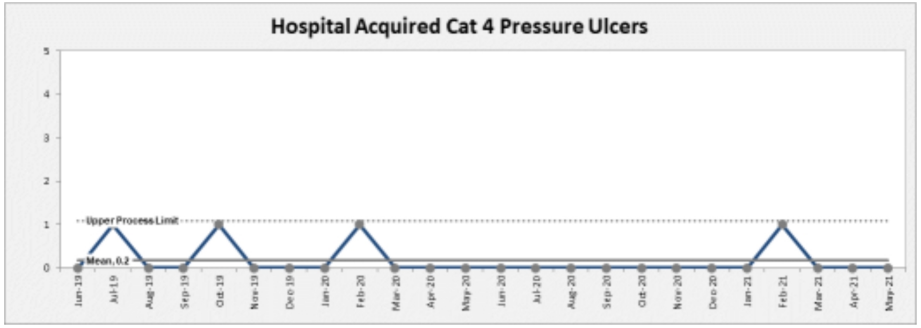
Pressure Ulcers

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

Category 2 pressure ulcers decreased to 16 in May from 18 in April.

There was 1 hospital acquired category 3 pressure ulcer on Longford Ward which was device related (not a failure of device). A SWARM identified that there were omissions in the identification of the pressure ulcer (thought to be folliculitis) and therefore no referral to Tissue Viability (TV) team for review, regular skin checks and documentation. An SII has been commissioned.

There has been an increase in Deep Tissue Injury from 0 in April to 6 in May. These were all obtained on Whiteparish Ward, where there was also a significant increase in the number of category 2 pressure ulcers in May (8 in May compared to 0 in April). Action taken includes the TV team working closely with the Whiteparish team to identify themes and causes, the TV Lead Nurse undertaking regular ward rounds with the Whiteparish staff to support and provide education and identify gaps in care, TV team raising with the Matrons within their weekly Matron meeting and Matrons supporting where needed. The Orthotics Department have provided some teaching and provided a stock of pressure relieving boots to the ward, as a theme of heel pressure ulcers was identified within the numbers given.

There were 3 unstageable pressure ulcers. These will continue to be monitored and treated by TV team and be graded once depth of wound is ascertainable.

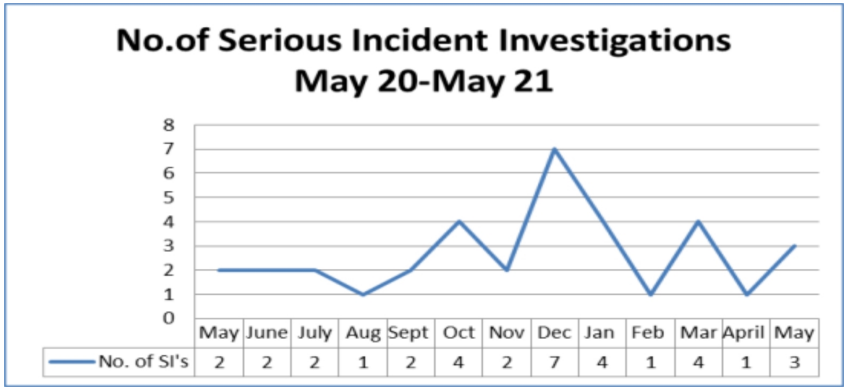
The Band 5 education programme continues, though uptake has slowed and the Link Nurse meeting was restarted at the end of May, with approximately half of the Link Nurses attending.

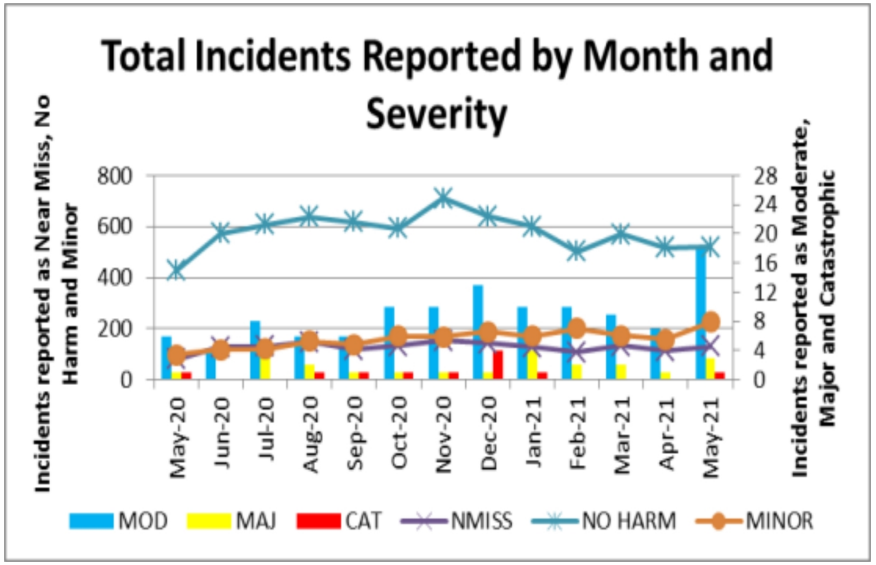
Incidents

Are We Safe?

Year	2020-21	2021-22
Never Events	0	0

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





Summary and Action

3 serious incident investigations commissioned in May:

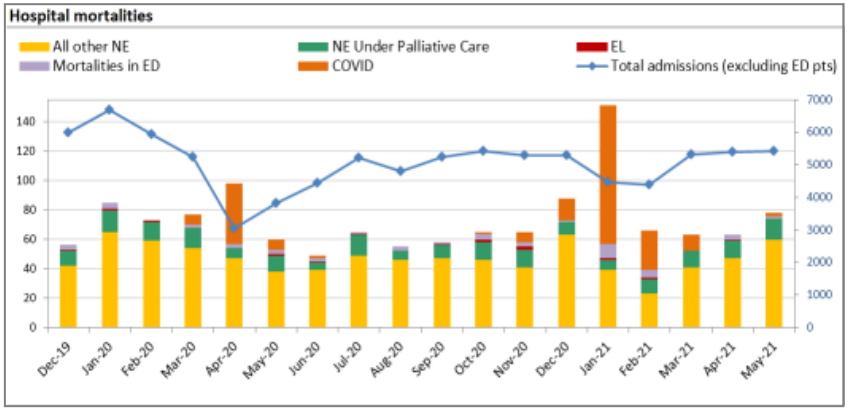
- **Surgical Division**
  - a missed BCC, received treatment for a skin ulcer over a 6 year timeframe.
  - unintended knee surgery outcome and requirement for further surgery at a future date.

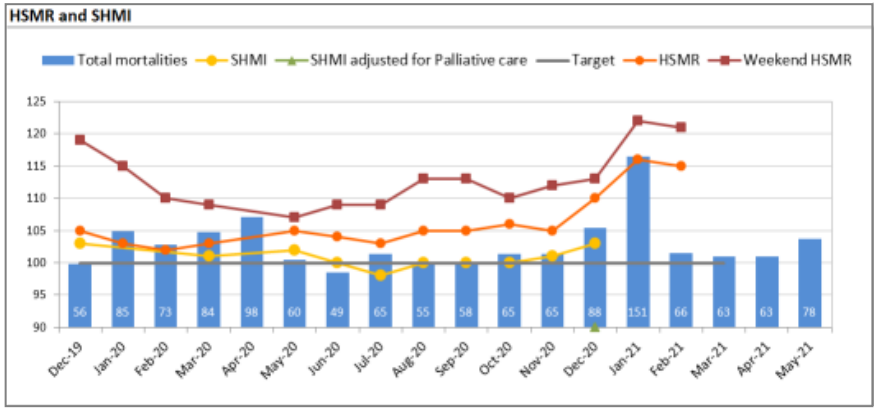
- **Medicine Division** – Category 3 pressure ulcer to right breast from a spinal brace.

Mortality Indicators

Are We Safe?

Data Quality Rating:





Summary and Action

There were 2 deaths in May from COVID-19 disease. The review of all deaths attributable to COVID-19 continues. The outbreak of COVID-19 declared in April was closed in May, with no new outbreaks declared. The CMO has asked the mortality surveillance group to conclude the review of all deaths from COVID-19 in the second wave by the end of Q3. A random selection of non COVID-19 deaths from January 2021 will also be reviewed to provide assurance that the extraordinary demand on services seen at the peak of the COVID-19 second wave did not adversely affect the care given to non COVID-19 patients.

Crude mortality has reduced back to expected levels after the spike in January associated with deaths from COVID-19.

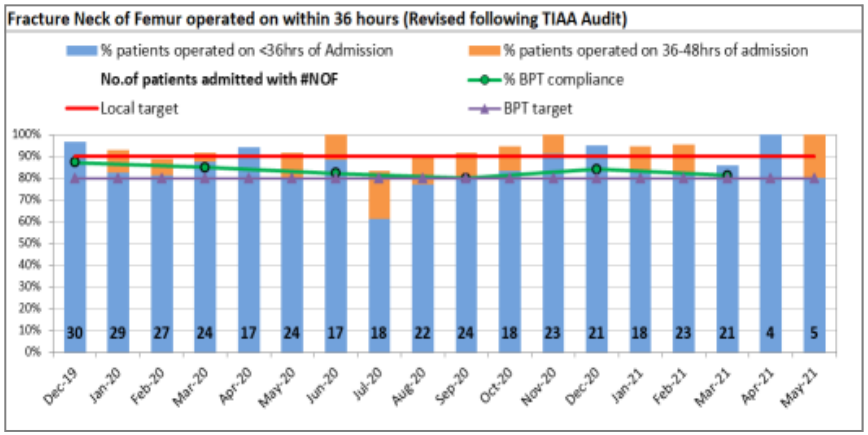
The latest SHMI for the Trust (Feb 2020 – Jan 21) excluding the hospice site remains with expected values at 0.98. This nationally reported statistic excludes deaths from COVID but includes all deaths with palliative care coding.

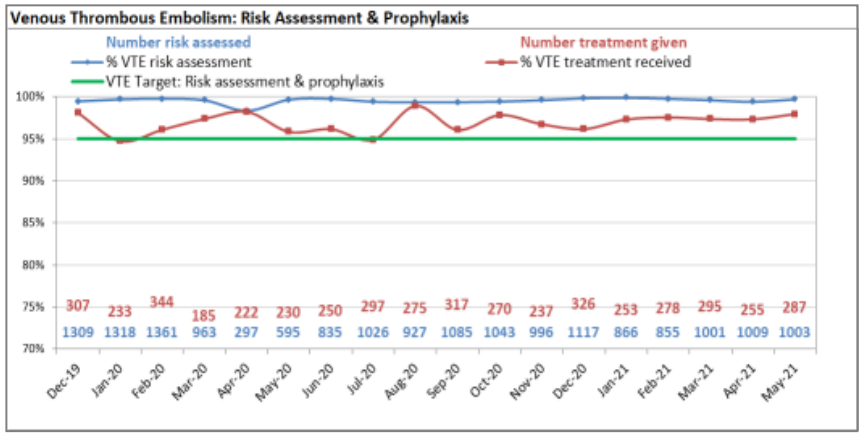
HSMR remains higher that national and peer average in February at 113.8 but has fallen from the January peak and there remains a consistent differential between weekday and weekend (as is the case for national and peer figures). The Chief Medical Officer and the mortality surveillance group continue to monitor and review excess deaths in specific disease groups to look for themes for learning and improvement.

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):

Best practice tariff compliance in May 21 was 78.57%.

5 patients operated on and discharged in May 21 did not receive hip surgery for a hip fracture/peri-prosthetic fracture within 36 hours for the following reasons:

Awaiting theatre space:

A 90 year old admitted with a fall following a hip fracture. Uncomplicated surgery and recovery and discharged on day 8.

An 88 year old patient admitted following a fall with a hip fracture had uncomplicated surgery at 38 hours. The patient developed post-operative AKI and received intravenous fluids. Discharged to bed based care on day 24.

An 86 year old admitted following a fall with peri-prosthetic fracture. Surgery was uneventful but the patient developed post-operative urinary retention requiring catheterisation with development of subsequent AKI. The patient was treated for UTI and AKI resolved. Was reviewed by Urology for several failed trials without catheter, was commenced on treatment and for further follow-up post discharge which occurred on day 30 to bed based care.

Awaiting medical review/investigation or stabilisation – An 84 year old patient admitted following a fall with a hip fracture. Uncomplicated surgery and recovery. The patient experienced some medical problems which prolonged the admission and was discharged on day 39.

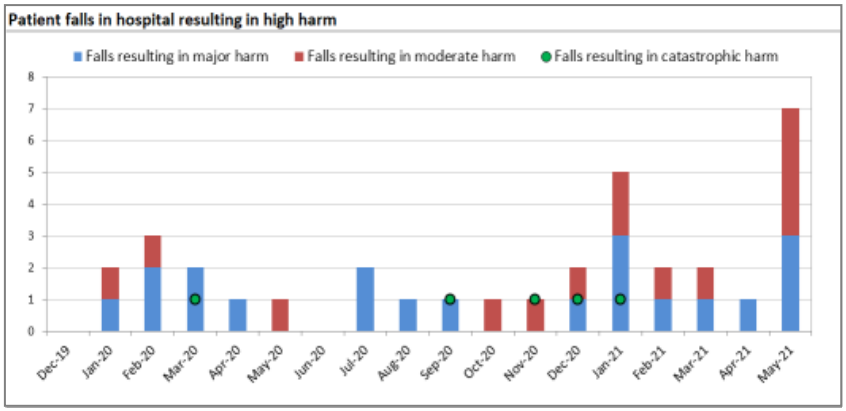
Awaiting revision surgeon – A 75 year old admitted following a fall with a peri-prosthetic fracture had uncomplicated surgery at 139 hours. Recovered well and discharged on day 10.

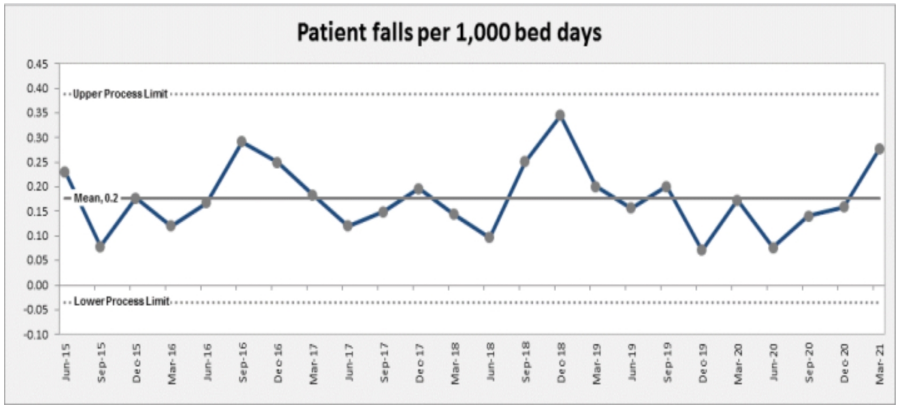
The Trust continued to report good performance in VTE risk assessment and prophylaxis

Patient Falls

Are We Safe?

Data Quality Rating:





Summary and Action

3 high harm falls and 4 moderate falls in May:

- A repatriated patient on Odstock Ward awaiting ongoing surgical treatment of infected metal work in left knee, suffered major harm from a fractured neck of femur
- A patient on Durrington Ward suffered major harm following an unwitnessed fall resulting in fractured neck of femur
- A patient on Amesbury Ward rehabilitating well post-surgery for a left fractured neck of femur, unfortunately suffered major harm from a right fractured neck of femur requiring further surgery **(SII 410)**
- Following cardiology intervention and medical treatment, a patient on Tisbury Ward had a fall and suffered moderate harm from a pubic rami fracture which was treated conservatively **(SII 410)**
- A patient on Durrington Ward suffered moderate harm from a fractured pubic rami which was treated conservatively
- A patient on Amesbury Ward suffered moderate harm from a fracture pubic rami which was treated conservatively **(SII 410)**
- A patient in the Hospice suffered moderate harm from a fractured L2 which was treated conservatively **(SII 410)**

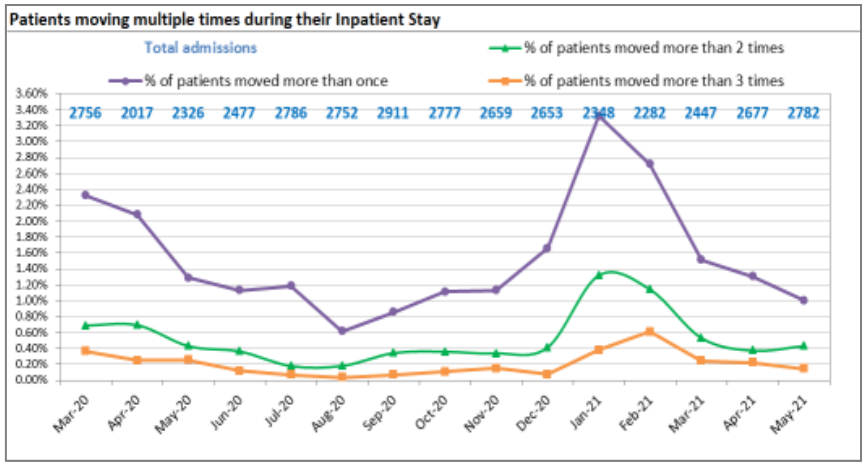
There advert for the Falls Lead is out to advert and matrons sessions are focusing on falls reduction.

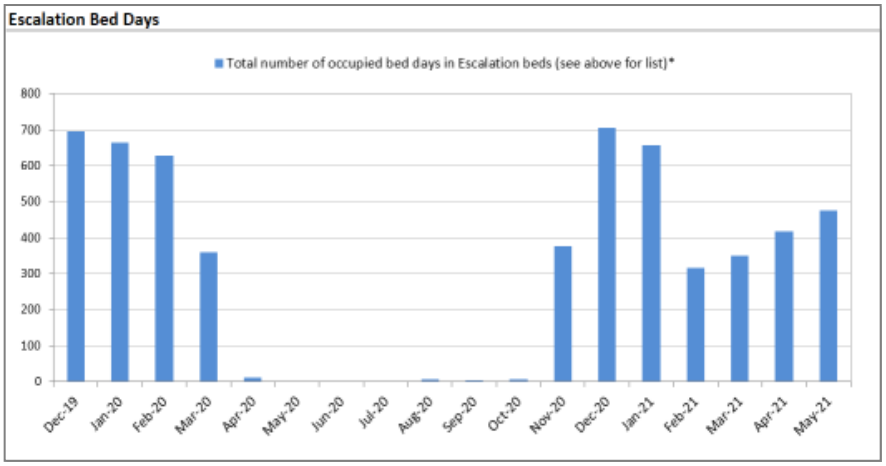
Patient Experience

Are We Safe?

Last 12 months	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
Bed Occupancy %	76.4	81.7	81.5	86.6	85.8	91.6	92.4	89.4	86.8	87.6	90.8	91.2

Data Quality Rating:





Summary and Action

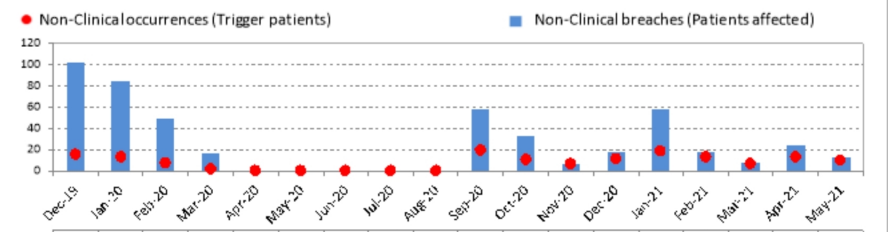
A gradual increase in the number of admissions has been seen over the last 3 months, associated with an increased number of open escalation beds and bed occupancy rates for the 3rd consecutive month. On a positive note, the number of patients moved more than once continued to decrease with the number of multiple moves being similar to April.

Patient Experience

Are We Safe?

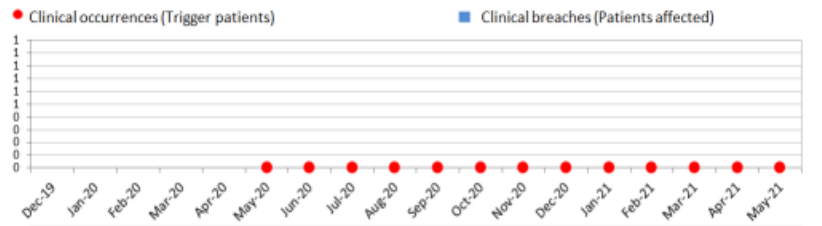
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	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	Apr-21	May-21
■	102	84	50	17	0	0	0	0	0	59	33	7	18	58	18	8	24	13
●	16	13	8	2	0	0	0	0	0	20	11	7	12	19	13	7	13	10

Delivering Same Sex Accommodation - Clinical



	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	Apr-21	May-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

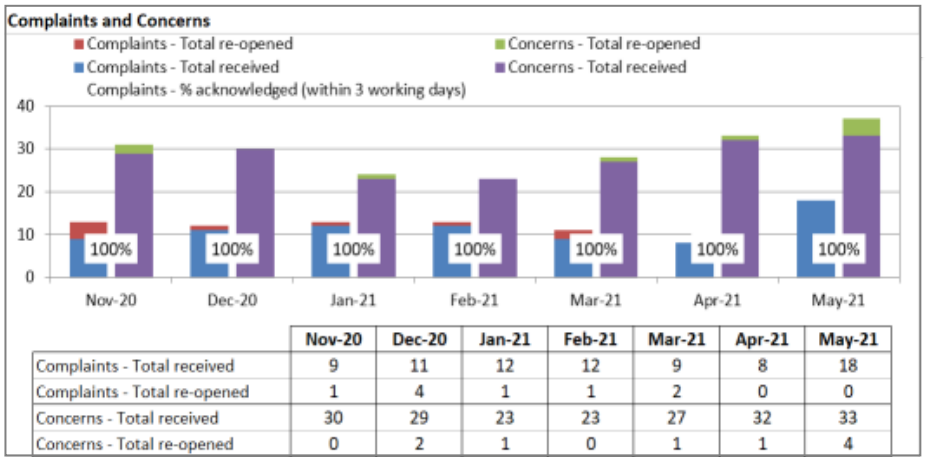
10 occurrences of non-clinical mixed sex accommodation breaches in May affecting 13 patients in the following areas:

- 9 breaches affecting 9 patients on the Intensive Care Unit. 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 24-48 hrs. Of the 9 patients, 1 patient had a breach time of over 2 days awaiting a speciality bed.
- 1 breach affecting 4 patients on AMU assessment bay. Privacy and dignity was maintained in the Assessment Bay by Quikscreens and the provisions of separate designated male and female bathrooms at each end of the bay.

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?



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Complaints - Total received	9	11	12	12	9	8	18
Complaints - Total re-opened	1	4	1	1	2	0	0
Concerns - Total received	30	29	23	23	27	32	33
Concerns - Total re-opened	0	2	1	0	1	1	4

Summary and Actions:

Top 4 themes of complaints include:

- Unsatisfactory treatment
- Attitudes of medical staff
- Further complications
- Nursing care

Top 3 themes of complaints include:

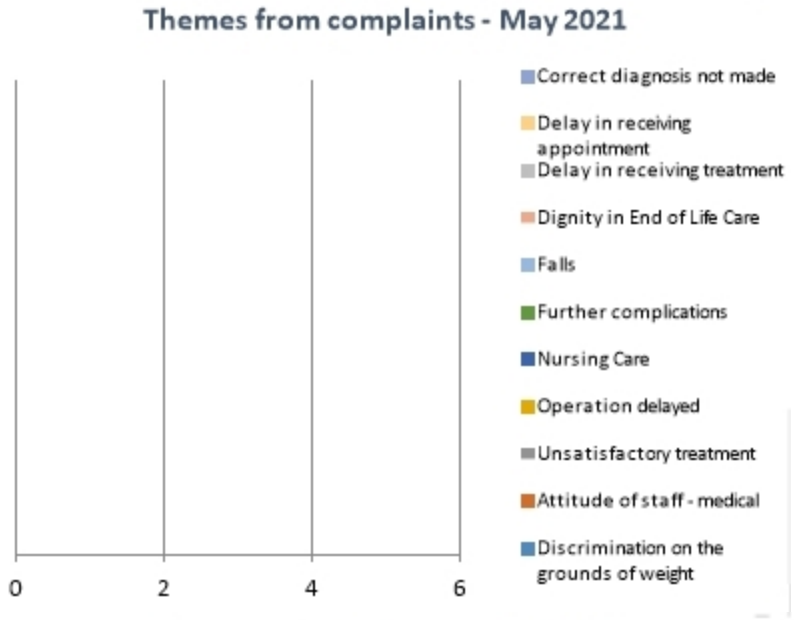
- Attitude of medical staff
- Insensitive communication
- Unsatisfactory treatment.

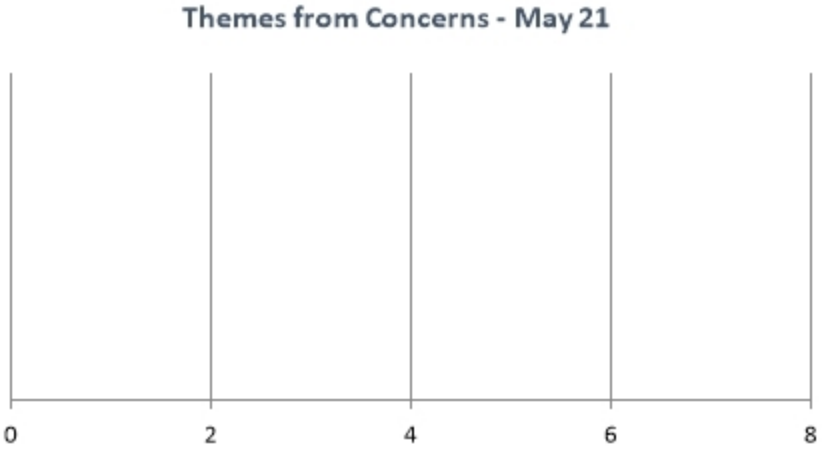
From complaints closed in May 21, 5 were partially upheld, 1 upheld and 7 Not upheld.

Examples of actions from closed complaints:

- Medical ward – the implementation of a 'Discharge Checklist' to ensure that patients are ready for discharge prior to their exit from hospital , which includes a thorough check for any intravenous lines and cannulas.
- Failed implant to be sent to the London Implant Retrieval Centre for analysis.

Data Quality Rating:





Part 3: Our People

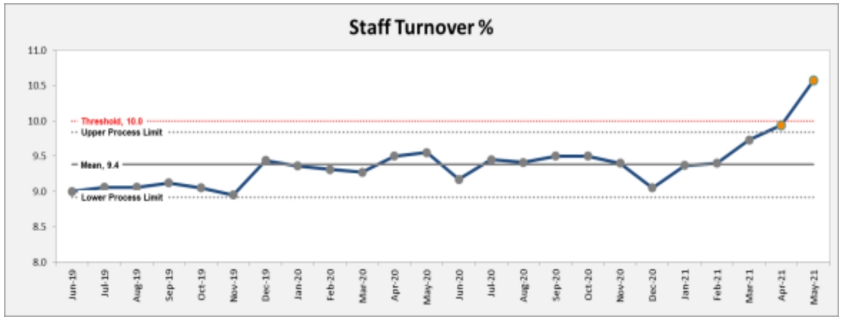
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

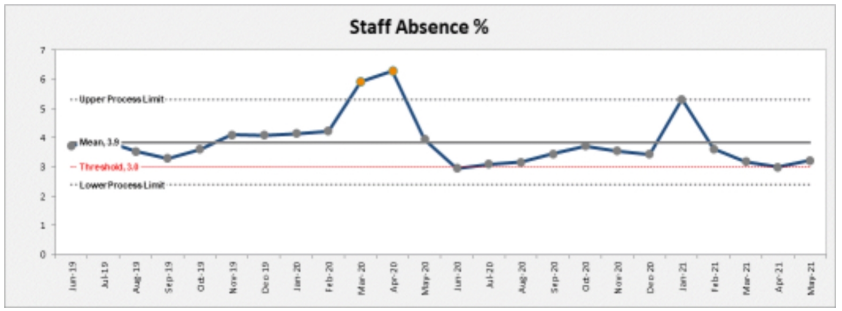
Workforce - Total

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	May '21		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	443.1	438.2	4.9
Nursing	1,028.8	1,003.1	25.7
HCAs	487.8	483.4	4.4
Other Clinical Staff	666.2	669.6	(3.4)
Infrastructure staff	1,364.4	1,371.6	(7.2)
TOTAL	3,990.3	3,965.99	24.3





Summary and Action

Turnover for month 2 has moved above the Trust target (10.57%). There were 38 leavers and 38 starters by headcount. Corporate had the highest turnover of the Clinical Divisions (13.69%). The main reason for leaving was relocation and lifestyle choices. Across all Divisions the main reason for leaving having been staff stating relocation to enable them to be closer to family.

Vacancy rate in month was 5.53%, compared to 4.99% in April. It is noted that in month 1 establishment and budgets were reset impacting vacancy rates.

In month 131 vacancies (126 WTE) were advertised and a total of 142 offers were made. Recruit to hire time for month 2 remained at 61 days (from the point post is authorised to actual start date) or 35 days (from the point post is authorised to offer accepted)

We are supporting the Medicine Division with a recruitment campaign to recruit 20.4wte Trust Grade doctors to cover existing gap. Interviews scheduled for 15, 16, 17 June.

Sickness for the month saw a slight increase to 3.22%, sickness for the rolling year was at 3.52%. Medicine, Surgery and Women and Newborn sickness are the Divisions higher than the Trust target. Facilities sickness increased within month and work is underway with the BP and Divisional Management team to ensure absence meetings are taking place and staff are being supported as required.

Across the Trust 36 staff are being supported under the long term sickness process and 51 staff under short term sickness processes. There are 12 hotspot areas that the People Operations team are proactively supporting managers in.

Workforce – Staff Training and Appraisals

Use of Resources

Summary and Action

Mandatory training was at 88.9% for month 2. This is slightly below the previous month and comparative to this time last year. 3 Divisions are below target – Corporate (84.7%), CSFS (89.9%), Medicine (88.8%) and W&N (80.4%).

Corporate – Areas within Corporate less than 90% are: Finance & Procurement (81%), Operations (78%) OD & People (82%).

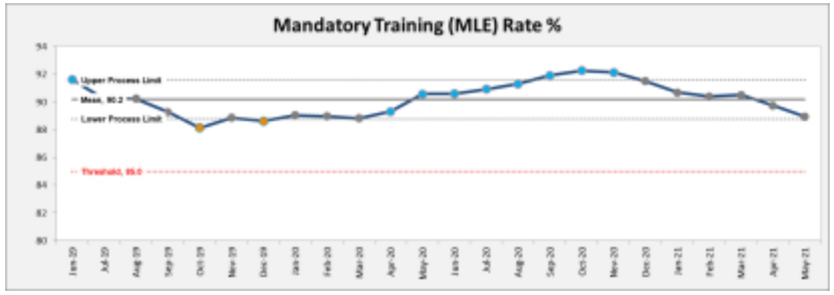
CSFS has three areas of focus within month – Hand Hygiene, Moving and Handing and Safeguarding Children. The People BP is working with the DMT and sending out targeted emails to individuals out of date and also working with Education on the quality of data. Medicine is adopting a similar approach and writing to all staff. Medicine's areas of focus are Hand Hygiene, GDPR and Moving and Handling.

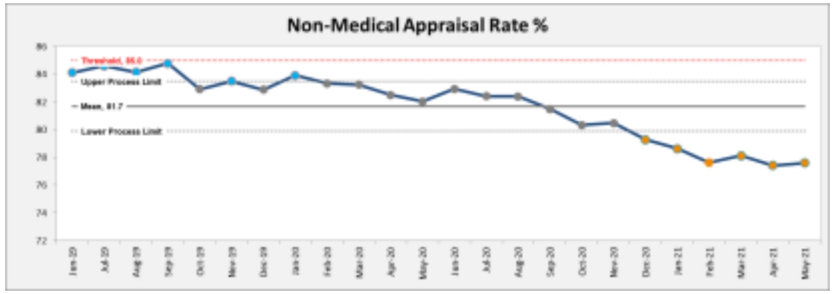
Appraisals remain under target at 77.6%, this is an improvement on the previous month position (77.4%). Hotspot areas are Corporate (54.6%), Medicine (75.8%) and Surgery (81.0)

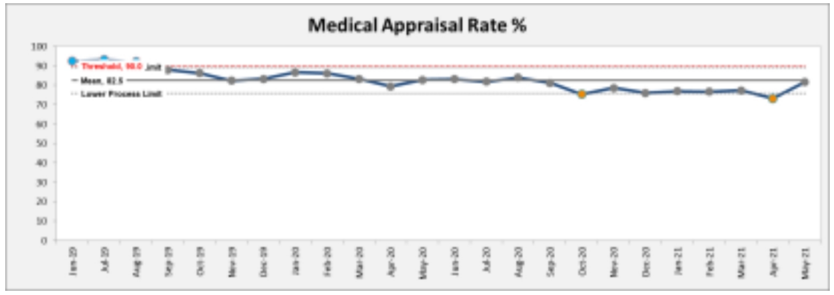
Within Corporate, those areas under target are: CEO 50%, Estates 0%, Finance and Procurement 31%, OD & People 47%. Transformation & Informatics 75% and Quality 78%

To recover these positions Surgery is tasking managers to complete overdue appraisals by end Q1, Medicine have tasked all wards with improving compliance and the DMT working on a more targeted approach.

As Corporate is under target for both Appraisals and Training the People Business Partner is working with each Directorate within it to ensure action plans are in place to increase compliance by end of Q1.







Feedback from Friends and Family test

What was good about your experience?

May 2021

"The company of the other patients having been together over Easter" Amesbury

"Apart from the broken bones it was a lovely 12 day stay! Good food, amazing staff and very comfortable. Will actually miss it, thank you" Downton

"Staff were very kind and caring. I liked how they introduced themselves at start of each shift" Britford

"All staff professional and efficient. Treated my mother with dignity and kindness. She has dementia so I accompanied her. Covid precautions adhered to. Admission to discharge was faultless. Thank you" DSU & Plastics

"Excellent - this was a helpful, informative and useful appointment with a professional who obviously had understanding of the issues and practical suggestions what would help. Very impressed. Also invited communication with education so support could be provided" Rheumatology

"Despite being very busy the team looked after me the best they could. The staff are very caring and I am thankful for all their time and efforts. The caring and kindness of this team are brilliant." SAU

"I can't fault anything. All the staff were wonderful and friendly" Farley RCU

"Excellent consultant, allayed my fears, wouldn't be afraid to have it again. Thank you. Endoscopy

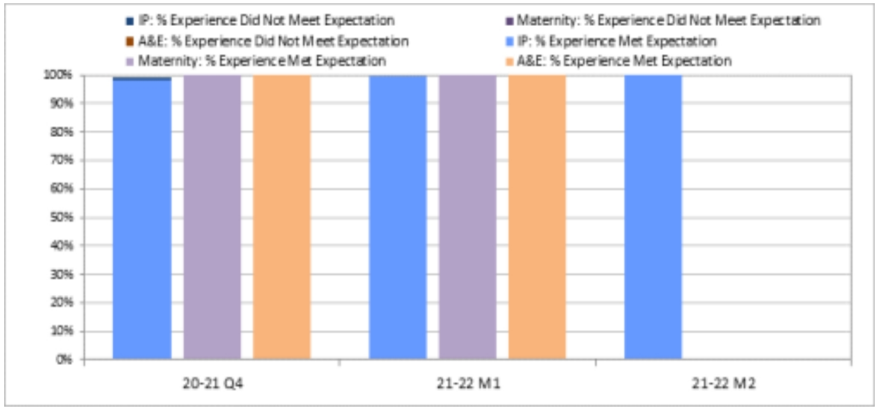
"The staff were very polite, courteous, efficient and cleanliness was great. Food was nice too." Redlynch

"The staff are excellent in all departments. The care I received was excellent. The nurses and care staff work above and beyond the standards required in the health service and I can't thank them enough. Thank you very very much" Whiteparish

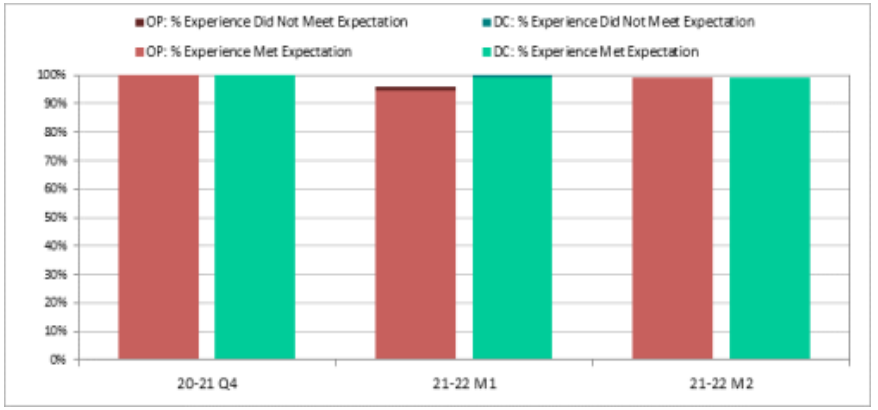
Friends and Family Test – Patients and Staff

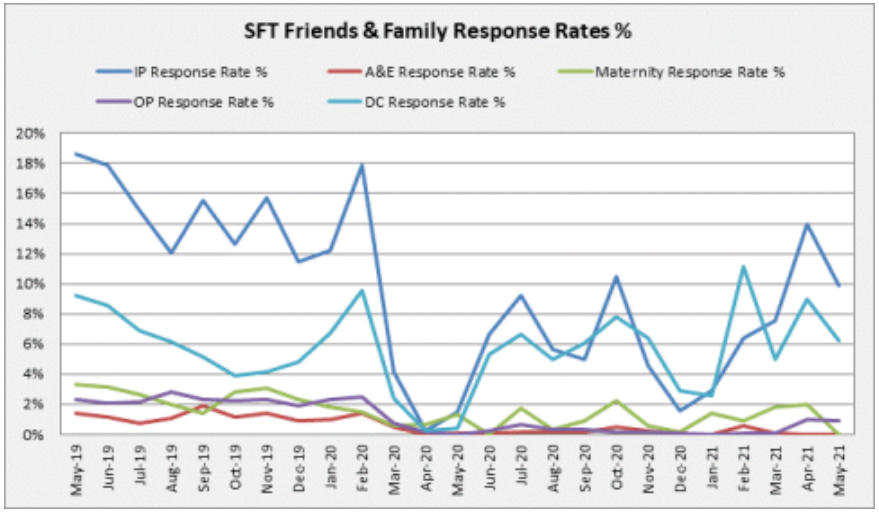
Use of Resources

Patient Responses: Inpatient, Maternity and A&E



Patient Responses: Outpatient and Daycase





Not all areas are currently actively giving out FFT cards but PALS are encouraging areas with nil return to recommence handing the cards out.

The new question (thinking about your recent experience … + what was good and what could be better) is generating some useful ideas for improvement as well as recognising excellence in care.

Themes are presented in the quarterly patient experience report.

Part 4: Use of Resources

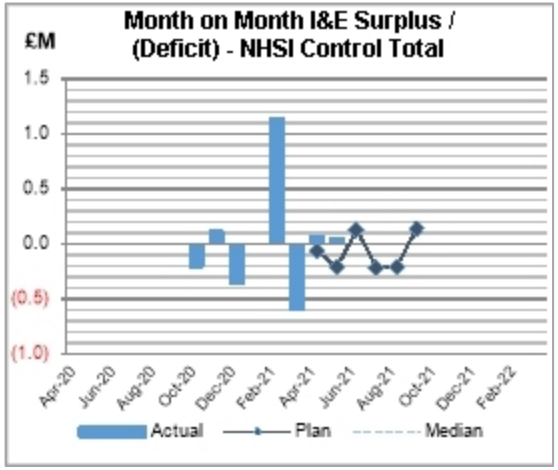
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

	May '21 In Mth			May '21 YTD			H1 2021/22
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical Income	20,690	20,793	103	41,381	41,456	75	0
Other Clinical Income	657	450	(207)	1,313	969	(344)	127,625
Other Income (excl Donations)	2,432	2,481	49	4,864	5,053	189	15,350
Total income	**23,779**	**23,724**	**(55)**	**47,558**	**47,478**	**(80)**	**142,975**
Operating Expenditure							
Pay	(14,804)	(14,673)	131	(29,655)	(29,581)	75	(88,784)
Non Pay	(7,398)	(7,442)	(44)	(14,773)	(14,681)	92	(44,930)
Total Expenditure	**(22,202)**	**(22,115)**	**87**	**(44,428)**	**(44,261)**	**167**	**(133,714)**
EBITDA	**1,578**	**1,610**	**32**	**3,130**	**3,217**	**87**	**9,261**
Financing Costs (incl Depreciation)	(1,544)	(1,549)	(6)	(3,087)	(3,072)	15	(9,261)
NHSI Control Total	**34**	**60**	**26**	**43**	**145**	**102**	**0**
Add: impact of donated assets	(59)	(68)	(9)	(117)	(79)	38	(351)
Surplus/(Deficit)	**(25)**	**(7)**	**17**	**(74)**	**65**	**139**	**(351)**



Variation and Action

The Trust continues to operate within its allocated H1 2021/22 contractual envelopes up to the end of May 2021, with a YTD reported surplus of £145k (excluding the impact of donated assets). Expenditure envelopes are derived from the system's winter 2019/20 run rate, meaning expenditure growth beyond baseline inflationary (excluding that specifically funded for Covid-19 measures) will drive a cost pressure for the Trust that needs to be mitigated.

The Trust continues to see a supressed cost associated with planned care, with activity reported up to the end of May assessed as being at 77% of a 2019/20 baseline. Expectation is that the Trust meets 85% in advance of September 2021 as a minimum, achieving this will attract additional marginal cost.

The reported position excludes any benefit from the Elective Recovery Fund, the process for final agreement of system allocation means a 10-12 week lead time on confirmation following the close of the period, but early calculations imply SFT will have contributed c£0.9m to the system total of c£8.6m YTD, with the system overall. It has been agreed in the first instance that marginal costs associated with activity incremental to the plan.

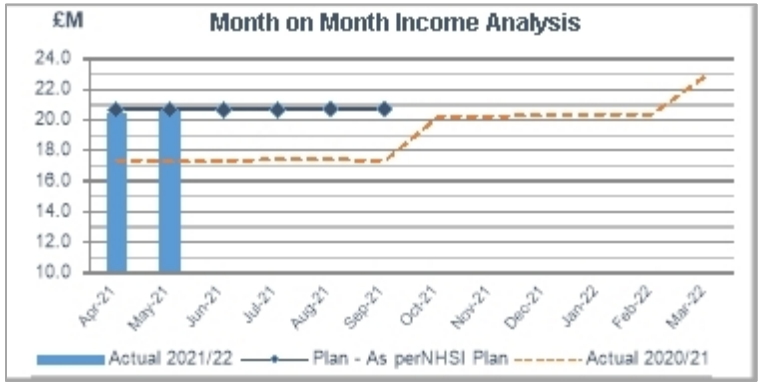
Income & Activity Delivered by Point of Delivery

Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	May '21 YTD		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	1,472	1,602	130
Day Case	1,882	2,378	496
Elective inpatients	1,514	1,227	(287)
Excluded Drugs & Devices (Inc. Lucentis)	3,464	3,112	(352)
Non Elective inpatients	10,505	10,598	93
Other	18,532	17,826	(706)
Outpatients	4,012	4,713	701
TOTAL	**41,381**	**41,456**	**75**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW CCG	25,379	25,379	-
Dorset CCG	4,161	4,161	-
Hampshire, Southampton & IOW CCG	3,132	3,132	-
Specialist Services	5,664	5,656	(8)
Other	3,045	3,128	83
TOTAL	**41,381**	**41,456**	**75**



Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
A&E	11,244	10,902	(342)	7,269	3,633
Day case	2,451	3,240	789	1,076	2,164
Elective	567	481	(86)	374	107
Non Elective	6,621	5,598	(1,023)	4,267	1,331
Outpatients	36,641	43,084	6,443	21,877	21,207

Variation and Action

Activity in May has been strong in day cases, however, due to a combination of factors, elective activity has not achieved the planned expectations. Day case activity has improved against plan in the surgical specialties of Urology, Colorectal, Ophthalmology, and Oral Surgery but has fallen below April's level in Plastic Surgery, and in Gastroenterology where additional lists this month have not taken place. Activity in elective inpatients showed improvements in Spinal Surgery and T&O although both of these specialties fall short of planned levels year to date. Additional weekend working is planned for June which should support the elective performance. Non-Elective spells are notably above plan year to date in General Medicine, Geriatric Medicine, Gynaecology and Stroke Medicine. Non-Elective activity in month was lower in General Surgery, T&O and ED. Outpatient performance has been good overall with improvements in month in T&O, Urology, Respiratory Medicine and Gynaecology.

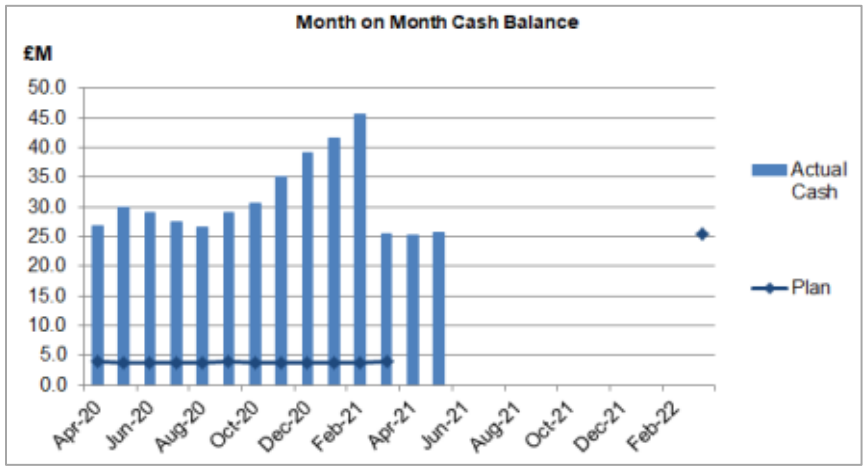
For the first 6 months of 2021/22 the Trust will continue to receive fixed payments from the main commissioners which have been based on Phase 3 payments (October 2020 to March 2021) uplifted by 0.5%. There is additional funding for growth and Covid-19. Some high cost drugs and devices are paid on a cost and volume basis by NHS E. An Elective Recovery Fund payment will be applicable in the first six months of 2021/22 to systems who achieve delivery above set thresholds. As this applies at a system level, this has not been included in the Month 2 position. However, delivery of day cases, electives, outpatient procedures and outpatients was at 83% against a threshold of 75%. This would result in additional funding of £479k in month and £975k year to date, to be deployed by BSW should other system partners deliver above the target. The target increases 80% in June and then 85% from July onwards. Therefore, whilst the May position is encouraging, further work will be required to achieve the level to trigger additional funding.

Cash Position & Capital Programme

Capital Spend: 

Cash & Working: 

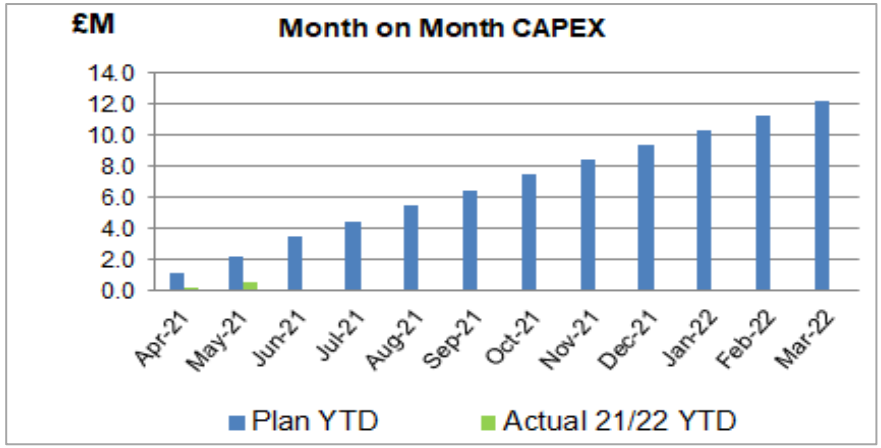
Use of Resources



The Trust has now returned to the pre Covid-19 mid-month contractual payment arrangements. Block contracts and a balanced revenue plan have been agreed up to 30th September 2021 and guidance is awaiting for the second half of the year.

The base assumption from a cash forecasting perspective is that the Trust will continue to report a balanced revenue position throughout 2020/21.

Capital Expenditure Position				
Schemes	Annual Plan £000s	May '21 YTD		
		Plan £000s	Actual £000s	Variance £000s
Building schemes	900	396	130	266
Building projects	5,254	830	32	798
IM&T	3,872	646	301	345
Medical Equipment	1,728	290	46	244
Other	450	74	74	0
TOTAL	**12,204**	**2,236**	**583**	**1,653**



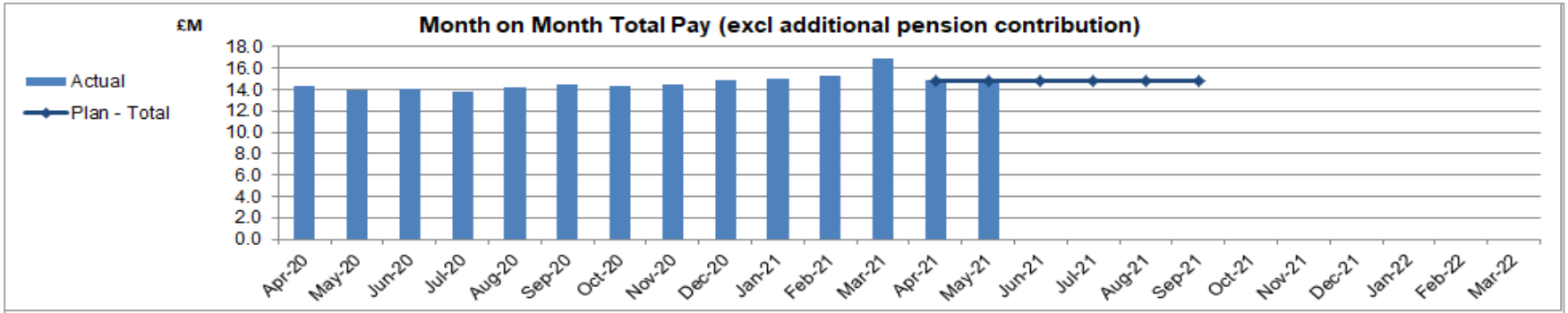
Summary and Action

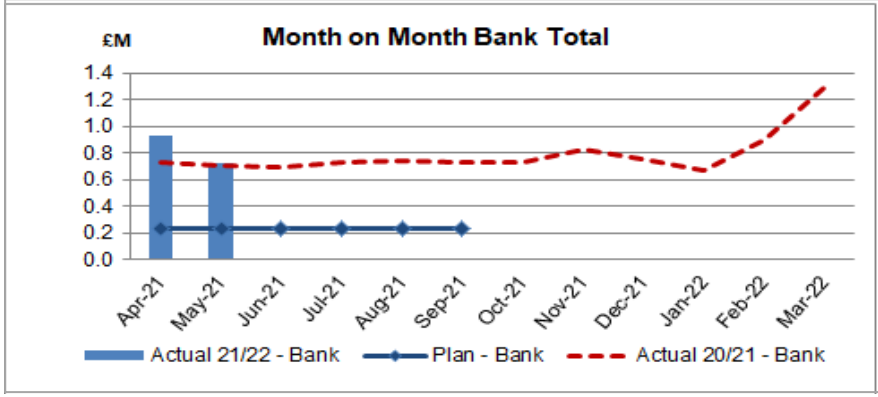
2021/22 capital allocations have been made at a system level, and although the Trust's baseline allocation of £12.2m exceeds the initial 2019/20 allocation by c£3m, the Trust remains capital constrained based on an initial assessment of over £20m. The internal funding of a £12.2m capital plan is contingent of the Trust delivering a balanced revenue position in 2020/21, and a further £0.5m from the opening cash balance.

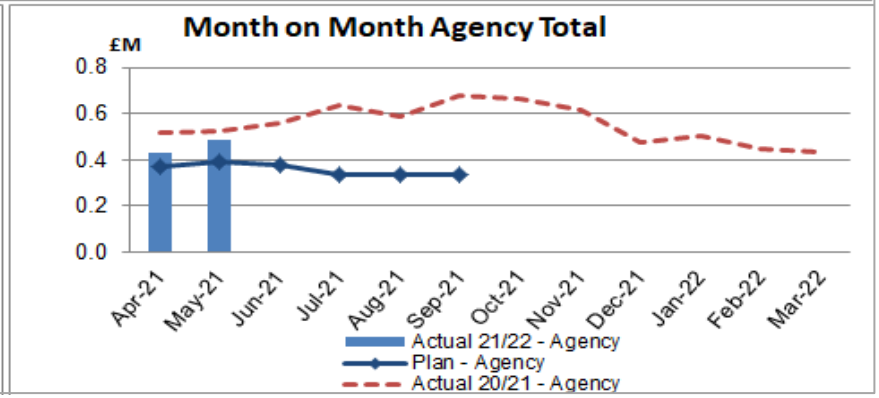
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

The Trust's pay costs have reduced to planned levels in May, with the Trust now showing a modest £75k (0.3%) underspend YTD with significant reductions in the costs of non-consultant medical grades and support to nursing staff on the wards.

Medical rotas in emergency pathways continue to be supplemented by high cost agency middle grades, with the Trust working to mitigate known substantive gaps in June and July. A forward projection shows that there are also gaps in the training rotation due in August 2021, it is likely a number of these will be resolved in the intervening period and recruitment plans to cover with Trust grade doctors are underway.

The Trust has reported 7 WTE infrastructure supports staff over and above planned, this relates to the vaccination centre at Salisbury City Hall, where the firma plan is for staffing to be provided by RUH, but any staffing provided by SFT is considered 'out of envelope' and directly reimbursed through NHSEI.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.7
Date of Meeting:	8th July 2021		

Report from: (Committee Name)	Extraordinary Audit Committee		**Committee Meeting Date:**	18th June 2021
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Paul Kemp (Audit Committee Chair)			
Board Sponsor (presenting):	Paul Kemp			

Recommendation

The Trust Board is asked to note that the Committee agreed to the adoption of the Annual Report and Accounts on behalf of the Board, as it was given delegated authority to do.

Key Items for Escalation

Due to a variety of process issues, a number of which were external to the Trust, it was not possible to complete the approval of the 2020/21 Annual Report and Accounts on the planned date of 20th May. An extraordinary meeting of the Committee was called for the 18th June to finalise this process.

Process Status Ahead of the Meeting

At the start of the meeting, the Committee took note that

- The Head of Internal Audit Report and LCFO report had been reviewed at the May meeting, agreed by the Committee and escalated to the June Board for formal adoption.
- The Board reviewed and agreed the content of the Annual Report and Annual Governance Statement in June, subject to minor alterations and updates.
- A Board minute had been issued, recording a decision by the Board to delegate authority to the Committee to approve the accounts on its behalf.

Draft Financial Statements

The draft financial statements for the period were presented by the finance team, highlighting any major items for the Committee's attention. There were no specific issues raised in the accounts and no challenges were raised by committee members.

External Auditors Report and Draft Opinion

The Audit lead from Grant Thornton presented his audit findings report. It was noted that, due to changes in auditing standards, larger audit samples were reviewed this year compared to previous years. The report confirmed that there were no unadjusted differences noted in their review of the financial statements and that work was complete, subject to final formalities, such as the Trust's provision of a Letter of Representation and Grant Thornton partner review.

The draft Audit Opinion was essentially unqualified in respect of the Annual Report and Accounts for 2020/21, the key section of the opinion stating;

> In our opinion, except for the possible effects of the matter described in the 'Basis for qualified opinion' section of our report, the financial statements:
>
> - give a true and fair view of the financial position of the Group and the Trust as at 31 March 2021 and of the Group's expenditure and income and the Trust's expenditure and income for the year then ended;
> - have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021;
>
> and
>
> - have been prepared in accordance with the requirements of the National Health Service Act 2006

There was a minor qualification noting that the auditors had not been able to attend the inventory count at the end of the previous year, due to the Covid pandemic.

There were a number of recommendations to management noted in the auditor's report that were discussed by the Committee. The majority of these related to the operation and function of the finance IT system, which is currently in the process of replacement, with a planned go live of the new system in July 2021. Management expressed their confidence that the new system had been designed and configured to address the shortcomings in the old system identified by the auditors and the Committee recommended a post implementation review be undertaken in good time to confirm this before the next annual report cycle begins in January 2022.

It should be noted that the auditors have not yet completed their Value for Money report linked to the year end cycle. This was committed for completion ahead of the scheduled July Audit Committee.

Letter of Representation

As part of the year end process, the Trust is required to provide a Letter of Representation to the Auditors, confirming that management have informed the auditors of all relevant matters and undertaken all processes associated with the report properly.

As is normal practice, the Committee asked the Chief Executive and Director of Finance to formally confirm that this was correct to the best of their knowledge, which they did.

Conclusion

Based on the papers provided and the discussion undertaken during the meeting, the Committee agreed that, on behalf of the Board, the Annual Report and Accounts were approved and that the Trust should sign the Letter of Representation.

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	08 July 2021		

Report Title:	Register of Seals			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x			
Prepared by:	Sasha Grandfield, PA and Board Support Officer			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the entries to the Trust's Register of Seals which, while not formally authorised by resolution of the Trust Board, have been authorised through powers delegated by the Trust Board.

Executive Summary:
To report entries in the Trust's Register of Seals since the last report to Board in April 2021. None of the signatories who witnessed the fixing of the seal of Salisbury NHS Foundation Trust had an interest in the transactions they witnessed.

Register of Seals entries

No.	Date signed in Register	Approval Details	Held on file with:	Signature one:	Signature Two:
363	21/4/2021	Pathology Managed Service Agreement	Laurence Arnold	Stacey Hunter	Lisa Thomas
364	12/5/2021	Pathology Managed Services Agreement Lot 4 Transfusion	Laurence Arnold	Lisa Thomas	Stacey Hunter
365	12/5/2021	Lease of part of Pharmacy Unit, Level 3, SDH, by Lloyds Pharmacy Limited	Laurence Arnold	Lisa Thomas	Nick Marsden

Report to:	Trust Board (Public)	**Agenda item:**	5.1
Date of Meeting:	08 July 2021		

Report Title:	Q4 Patient Experience Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Katrina Glaister, Head of Patient Experience			
Executive Sponsor (presenting):	Judy Dyos, Director of Nursing			
Appendices (list if applicable):	**1.** Complaint themes over the last financial year **2.** 2020/21 graphs of complaints and concerns **3.** FFT 2020/21 **4.** Demographics of patients making a complaint 2020-21 **5.** My Expectations – from the new NHS Complaint Standards			

Recommendation:
The Board is asked to note this report.

Executive Summary:

This report provides a report of activity for Q4 2020/21 in relation to complaints and the opportunities for learning and service change. Key data for the whole year is presented in the appendices. Some key changes are highlighted below:

- During the third lock down, under the Complaint Regulations we could extend the response time frame (for 6 months or more) as long as we explained this to complainants. At this stage we advised complainants that the strain on services due to the COVID-19 pandemic could cause a delay in their response. We were advised at middle of March 2021 that this should cease and the response letters to complainants have been altered in response. All teams are now expected to meet the agreed timeframe
- Whilst only 50% of green complaints (non-complex issues where a response is due witin 25 working days) met their target response time, all amber cases (complex issues where a response is due in 40 days) met the target response time.
- New National Complaint Standards have been published by the Ombudsman and will be rolled out across the NHS in 2022. We have applied to be a pilot site. The Standards aim to support organisations in providing a quicker, simpler and more streamlined complaint handling service, with a strong focus on early resolution by empowered and well-trained staff. They also place a strong emphasis on senior leaders regularly reviewing what learning can be taken from complaints, and how this learning should be used to improve services.
- Although not appearing as a strong theme within complaints PALS have seen a significant

increase in patients/families logging their lost property with them. PALS take a proactive approach with lost and found property and have managed to reunite a wheelchair, hand bag and makeup bag with their rightful owners. PALS plan to visit all wards/departments over Q1 2021/22 and remove all lost property, log it and endeavour to return it to the rightful owner.

- Attitude of Staff is a recurring theme but does not appear to be a trust wide issue and is related to specific staff in specific areas over specific time frames. A chart showing the trend of complaints/concerns surrounding staff attitude is presented in the appendices.
- The new contract for translation services is hoped to go live in Q1 2021/22
- In Q4 a total of 534 patients provided feedback through the Friends and Family Test (FFT). The numbers are increasing though as we are encouraging areas to start displaying the FFT feedback forms again. A total of 2,627 provided their feedback in 2020/21. The new FFT questions went live in Q1 2020/21 (a) what was good about your experience (b) how can we improve our service. Whilst the former continues to provide overwhelmingly positive comments the latter is providing some ideas for improvement. Wards, the Emergency Department and Maternity, have action plans in place to address the areas of concern in their location.

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

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

Purpose of paper

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

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

Background

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

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

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

1. Complaints responses during the 3rd wave of the pandemic

From March - July 2021 there was a national pause on complaints to allow clinical teams to manage their workload during the first wave of the pandemic. This has not been repeated as NHSE/I can only do this once. To allow them to do it a second time the Department of Health would have to take over and rewrite the Regulations and get these approved through the House Library again. Any changes would take time and would necessitate going out to consultation.

The Complaint Regulations allows individual organisations to explain to complainants that the COVID-19 pandemic was causing a strain on services and that responses could be delayed. Under the regulations we have at least up to 6 months to answer a complaint and then we can extend that as long as we explain to complainants the reasons and write to them with this information. All this is covered by Regulation 13(7) and 14(3) https://www.legislation.gov.uk/uksi/2009/309/contents/made

During Q4 all complainants were advised that their response could be delayed. NHSE/I have since advised that from April 2021 there should be no slowdown in responses and all complainants should receive their response at their agreed timescale.

2. Sharing Outstanding Excellence (SOX)

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

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

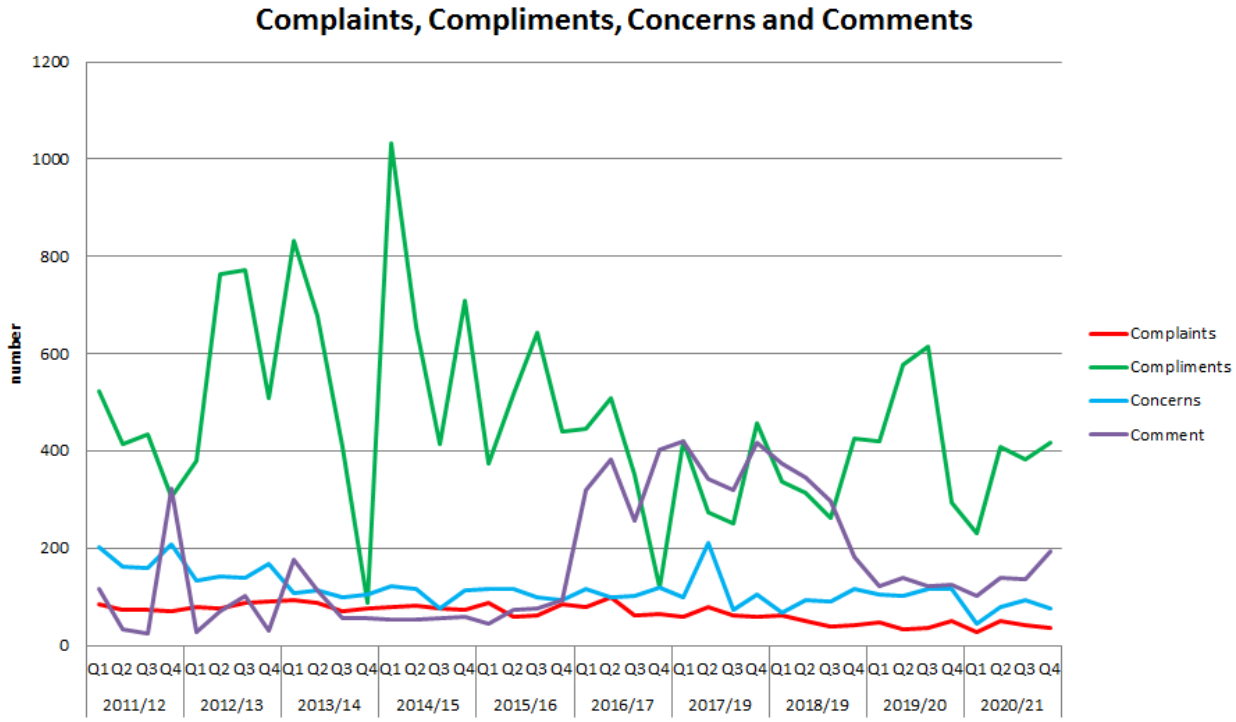
Increasingly we are seeing patients use the email address to give unsolicited feedback. For example:

- Dear SDH. I would like to send my thanks and express my gratitude to the ED department, the surgery team, X-Ray and to the staff on Britford ward. I was seen on Friday evening and admitted – everyone was kind, professional and courteous. Everything was checked and examined, nothing was too much trouble. I was well looked after and given the extraordinary times and pressures on the NHS it was reassuring. I completed a questionnaire on my departure but I also wanted to email personally. Thank you.
- Good evening, I just wanted to say a quick thank you to all the eye unit staff but especially the receptionist on the Eye Unit. I have had to attend a few times recently which I was nervous about because of the treatment I was receiving and I always found her to be happy, friendly and welcoming when I first arrived and for the duration of my time in the unit, she always seemed busy

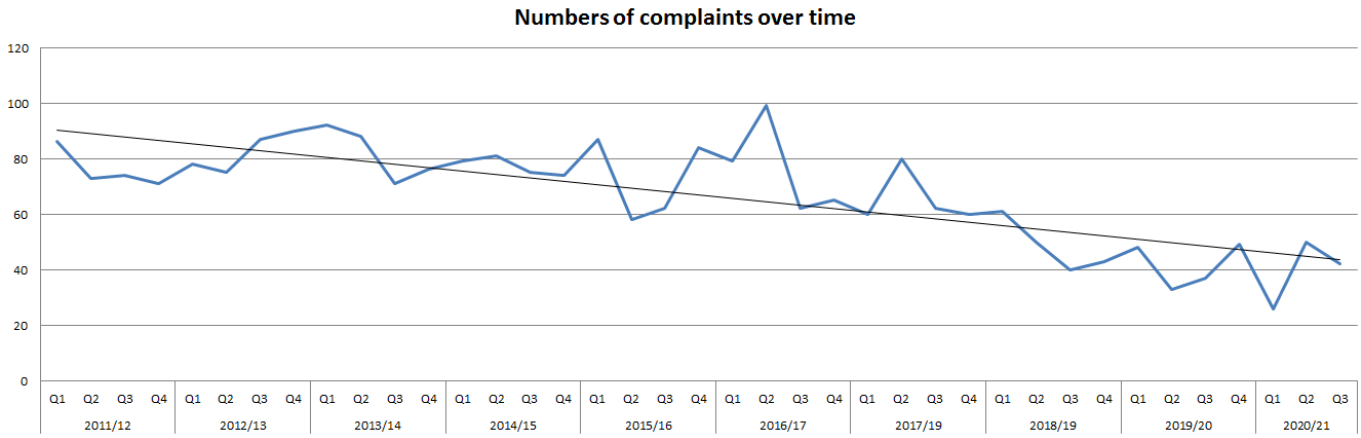
but nothing was ever a problem and she went out of her way just to check people were ok, including me. I also had to call about an appointment problem and she was so helpful and made sure the issue was sorted immediately. I hope this can be passed on.

3. Complaints

The graph below shows the numbers of complaints, compliments, concerns and comments over time.



Below you can see that complaints continue to show a slight downward trend.



Complaint themes

Throughout the NHS in Q4 the key theme across all organisations was communication (16%) followed by patient care (13%) This quarter ours are patient care (50%), values and behaviours (14%) and communication (11%).

	CSFS	Transformation & IM&T	Medicine	Surgery	totals
Clinical Treatment - O&G	1	0	0	0	1
Clinical Treatment - Paediatrics	1	0	0	0	1
Covid-19	0	0	1	0	1
Delay in receiving treatment	0	0	0	1	1
Dementia	0	0	1	0	1
Discharge procedures	0	0	1	0	1
Drug Error	1	0	0	0	1

Funding problems	0	0	0	1	1
Further complications	1	0	2	1	4
Inappropriate treatment	1	0	0	1	2
Information not given to patient	1	0	0	0	1
Insensitive communication	1	1	0	0	2
Lack of Care	0	0	1	0	1
Lack of communication	0	0	0	1	1
Lost Property	0	0	1	0	1
Neglect	0	0	2	1	3
Nursing Care	0	0	1	0	1
Pain management	0	0	0	1	1
Unsatisfactory arrangements	0	0	1	0	1
Unsatisfactory Outcome	0	0	0	1	1
Unsatisfactory treatment	2	0	3	0	5
Attitude of nursing staff	1	0	0	0	1
Attitude of staff - medical	0	0	1	1	2
Discrimination - disability	0	0	0	1	1
Discrimination - weight	0	0	0	1	1

Concern themes Q4 – clinical divisions

	CSFS	Medicine	Surgery	totals
Appointment system - procedures	1	0	3	4
Assistance not given	0	2	0	2
Clinical Treatment - O&G	1	0	0	1
Correct diagnosis not made	0	1	2	3
Covid-19	1	2	0	3
Damaged Property	1	0	0	1
Data protection	0	0	0	0
Delay in receiving appointment	0	1	1	2
Delay in receiving treatment	1	0	2	3
Delay in receiving information	0	0	1	1
Discharge procedures	0	2	0	2
Falls	0	0	1	1
Further complications	1	1	0	2
Infection risk	1	0	0	1
Information not given to family	0	3	0	3
Information not given to patient	0	1	0	1
Lack of communication	2	1	4	7
Lost Property	0	0	1	1
Neglect	1	0	0	1
Next of Kin/Power of Attorney	0	1	0	1
Nursing Care	0	0	1	1
Operation cancelled	0	0	1	1
Operation delayed	0	0	2	2
Poor facilities/environment	0	0	0	0
Unsatisfactory arrangements	0	2	0	2
Unsatisfactory treatment	1	8	0	9
Wrong information	1	2	1	4

Attitude of nursing staff	2	0	1	3
Attitude of staff - admin	3	0	0	3
Attitude of staff - medical	3	1	1	5
totals	20	28	22	

Concern themes Q4 – non clinical divisions

	Transformation & IM&T	Facilities	OD&P	Operations Directorate	Quality Directorate	totals
VID appointment system	0	0	0	0	1	1
Data protection	1	0	0	0	0	1
Poor facilities/environment	0	1	0	0	0	1
Unsatisfactory arrangements	0	0	0	1	0	1
Attitude of staff - admin	0	0	1	0	0	1
Attitude of staff - medical	0	0	1	0	0	1
totals	1	1	2	1	1	

In Q4 the Trust treated 14,144 people as inpatients, day cases and regular day attendees. Another 112,132 people were seen in the Emergency Department (includes the walk-in clinic) and 49,857 as outpatients (this excluded telephone calls). 37 complaints were received which is 0.049% of the number of patients treated.

417 compliments were received across the Trust in Q4. Those sent directly to the Chief Executive, PALS or via the SOX inbox are acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment/national patient survey/RTF/FFT the PALS team complete a SOX which is sent to the individual and their line manager.

Concerns, comments and enquiries closed within 10 working days of receipt.

A total of 386 comments, concerns and enquiries were logged by PALS this quarter. Of this number 86.8%% were closed within 0 -10 days.

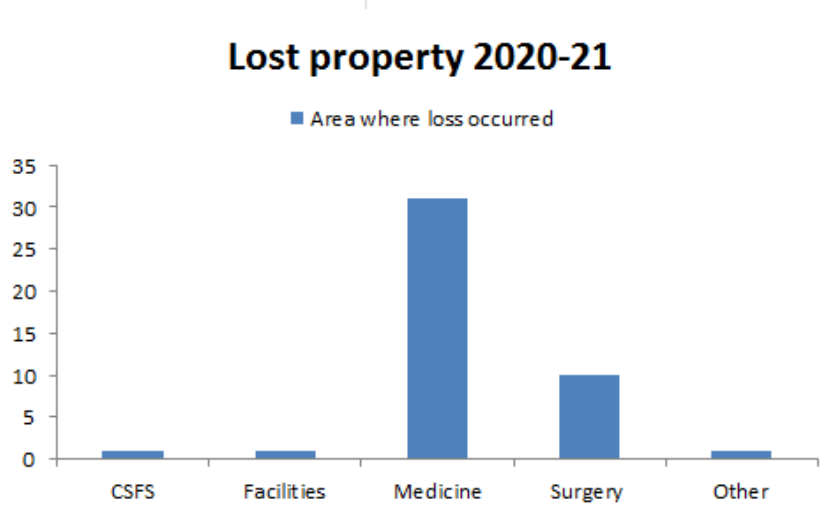
Concerns, enquiries and comments - closed within 10 working days	No.	%
Not yet closed	33	8.6
0-10 working days	335	86.8
11-24 working days	22	2.9
25+working days	25	1.8
Total	**348**	

Lost property

Although not appearing as a key theme within complaints, PALS have seen a significant increase in patients/families logging their lost property with them.

PALS take a proactive approach with lost and found property and have managed to reunite a wheelchair and a handbag with their rightful owners.

PALS plan to visit all wards/departments over Q1 2021/22 and remove all lost property, log it and endeavour to return it to the rightful owner.



Concern themes Q4

1. Clinical divisions

	CSFS	Medicine	Surgery	Total
Appointment system - procedures	0	0	1	1
Assistance not given	0	1	0	1
Correct diagnosis not made	0	1	0	1
Delay in making diagnosis	0	0	1	1
Delay in receiving appointment	0	0	2	2
Delay in receiving treatment	0	1	3	4
Dementia	0	0	1	1
Discharge procedures	0	2	0	2
Drug error	0	1	0	1
Early discharge	0	1	0	1
Further complications	2	0	2	4
Information not given to family	0	1	0	1
Information required	0	0	1	1
Insensitive communication	4	3	1	8
Lack of communication	4	4	2	10
Lack of equipment/aids/appliances	0	1	0	1
Missing patient	0	1	0	1
Nursing Care	0	1	1	2
Operation cancelled	0	0	1	1
Operation delayed	0	0	3	3
Operation delayed following admission	0	0	1	1
Pain management	0	0	1	1
Unsatisfactory arrangements	0	3	1	4
Unsatisfactory outcome	0	1	0	1
Unsatisfactory treatment	4	7	3	14
Attitude of nursing staff	0	5	0	5
Attitude of staff - admin	1	0	1	2
Attitude of staff - medical	2	2	8	12
Total	17	36	34	87

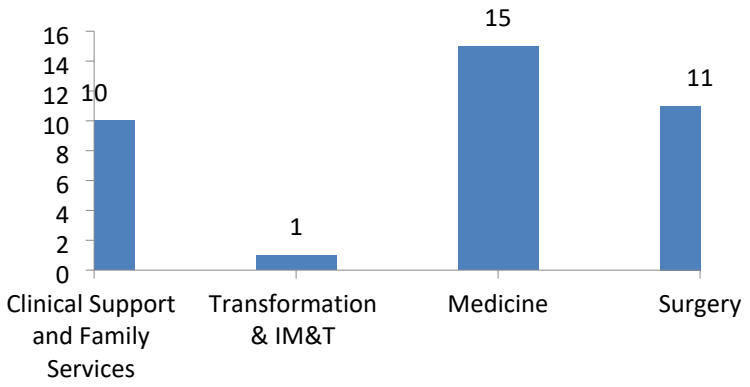
2. **Non-clinical divisions**

	IT	Facilities	Finance and Procurement	OD & P	Quality	Estates	Total
Discharge procedures	0	1	0	0	0	0	1
Funding problems	0	0	1	0	0	0	1
Insensitive communication	0	0	0	1	0	0	1
Lack of communication	0	0	0	0	1	0	1
Patient confidentiality	2	0	0	0	0	0	2
Poor facilities/environment	0	0	0	0	0	1	1
Total	2	1	1	1	1	1	7

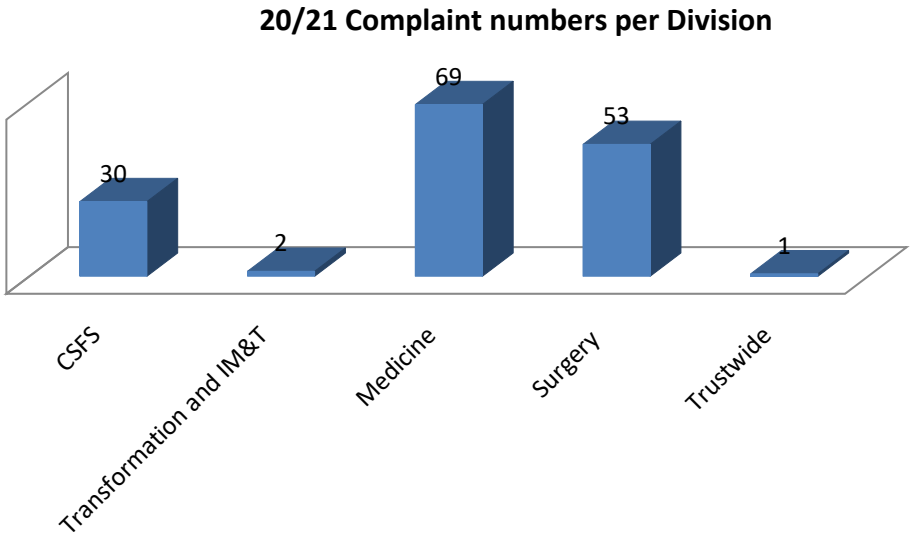
Examples of actions from Q4 closures:

- 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 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.
- Improved communications between the wards during transfers. The case to be discussed at the next clinical governance session.
- Amendments to be made to the community midwifery team's handover documentation, in order to clearly highlight those women with additional care needs.
- The Maternity Services are currently in the process of appointing a designated Bereavement Midwife. This appointment will provide the Maternity Department with the opportunity to expand the Service they offer to bereaved families, both in maternity and across the wider Trust.
- Learning from the case will be fed back to the workforce. Amendments have been made to the process of identifying ectopic pregnancies during ultrasound, thus ensuring that a second opinion is sought.
- Issues raised have been discussed in the MDT and the team have reflected on how the situation was managed. The patient can be referred back after surgery by private consultant and ongoing care can then be provided.
- Ward sister will reiterate to all her team regarding the importance of maintaining communications with patient's families.
- A new appointment was made for the complainant.
- Communication to be feedback to the relevant teams.

Q4 -Complaint numbers per Division



The chart above demonstrates the allocation of complaints across the Divisions. The Medicine Division received 40.5% of all complaints logged during this quarter, followed by Surgery who received 29.7% and CSFS who received 27% of all complaints.



The chart above shows the allocation of complaints for 20/21. The Medicine Division recieved the highest proportion of complaints in this financial year.

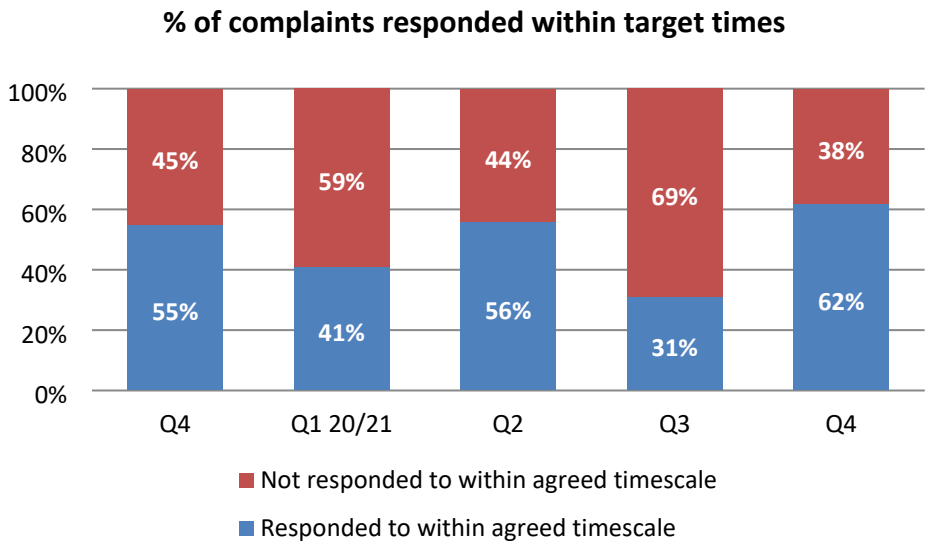
The chart below demonstrates a breakdown of complaints responded to in Q4 within the agreed target time.

CLOSED COMPLAINTS

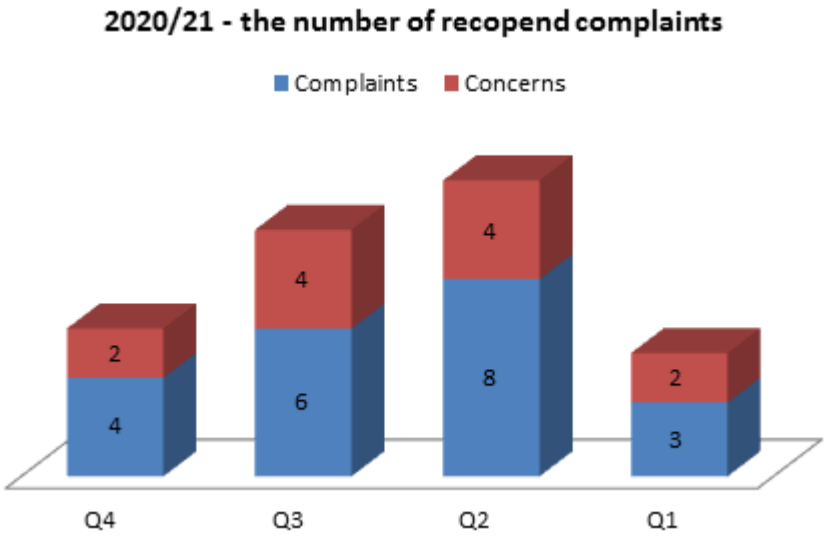
	On target	Overdue	Total	% compliance	
Green	*6*	*6*	*12*	*50%*	*(target: <=25 working days)*
Amber	*4*	*0*	*4*	*100%*	*(target: <=40 working days)*
Red	*0*	*0*	*0*	*---*	*(target: <=60 working days)*
Total complaints	**10**	**6**	**16**	**63%**	

(for the period 01 Jan 2021 to 31 Mar 2021)

Whilst only 50% of green complaints (non-complex issues where a response is due witin 25 working days) met their target response time, all amber cases (complex issues where a response is due in 40 days) met the target response time.



The graph reveals a significant increase in complaints being responded to within the agreed target times; demonstrating a 24% increase in compliance from the previous quarter.



In Q4 we have seen a reduction in reopened complaints. Reasons why the complaints were reopened include:

- Unhappy with the outcome.
- Contested an aspect of the response. Patient did not feel that they were informed of the risk associated with the surgery.
- Unhappy with the response surrounding scheduled appointments.

4. Complaints by directorate

Clinical Support and Family Services

	Q4 2019-20	Q3 2020-21	Q4 2020-21
Complaints	8	7	10
Concerns	10	17	20
Compliments	42	37	27
Re-opened complaints	0	0	1
% closed complaints responded to within agreed timescale	42%	442%	27%
Complaints closed in this quarter	7	9	11
% closed concerns responded to within 25 working days	56%	38%	68%

- There were 10 complaints raised in Q4, gynaecology received the most (n=4), the main theme being unsatisfactory treatment.
- 1 complaint was re-opened in Q4; the reason stated was that the complainant felt not all their concerns were answered.
- 11 complaints were closed in Q4; with 27% being responded to within the agreed timescale. The reason for delay on the others was due to awaiting statements from staff/clinicians however this was a particularly busy time for them and their clinical commitments on the wards.
- 20 concerns were raised in Q4. Radiology received the most (n=7), the main theme being attitude of staff.
- The PALS department received 41 comments and enquiries for CSFS in Q4 which were investigated, managed and responded to by the team.
- Total activity within the division was 30389 and of this number 0.03% raised a complaint.
- There is one action plan outstanding from the division.

Themes and actions from concerns and complaints closed in this quarter

Q4 themes		
Department	**Themes**	**Actions**
Gynaecology	Unsatisfactory treatment	Gynaecology complaints and concerns reviewed over the last 12 month period. An extraordinary Gynae meeting was held and a verbal update provided to the Execs on the 24th March.
Radiology	Attitude of staff	Radiology has had 15 complaints and concerns in the last 12 months, Christina Steele to liaise with Simon Clarke to do a review to recognise any themes.
Q3 themes		
Department	**Themes**	**Actions**
The Maternity Department	Unsatisfactory treatment and Insensitive/lack of communication	A learning opportunity has been identified for a newly appointed midwife to the community team. It was felt that in order to enhance her experience with low risk, uncomplicated pregnancies she will be supported by midwives who are experienced in this model of care. **Update** Maternity department has concluded the pilot for the continuity team and the midwives have been redeployed into the community teams. This now means that new band 5 midwives do not case load and can receive better support. Several concerns have been raised in relation to the restrictions surrounding accompanying partners, family and friends to the antenatal clinic. As from the 14th December 2020, partners are welcome to attend all clinic appointments. **Update:** On the 20th January 2021 SFT introduced lateral flow testing to enable partners to attend 12 and 20 week scans. At present, SFT do not have the capacity to lateral flow partners to attend all appointments however SFT continue to work on this. In regards to concerns raised surrounding staff behaviour and insensitive communications, in all cases supervised personal refection has been undertaken. **Update** The staff member sited in the complaint is aware of the escalation process should a woman request something which is outside routine practice and the organisational policy of the service. Themes from complaints will be shared with the workforce via the monthly Maternity and Neonatal newsletter. **Update** Themes of complaints have been shared with the work force in January's addition of the newsletter.

Q2 themes		
Department Gynaecology Unsatisfactory clinical treatment	**Actions** The lead clinician will review the previous 12 months of concerns and complaints relating to Gynaecology. Themes and learnings to be presented to CSFS DMT.	**Update** Due to current pressures on services/resources, this action has not yet been completed. The department are planning on suspending this action for 6 months and will then revisit.
Q1 - There were no themes identified in Q1		

Compliments

CSFS received 27 compliments in Q4; the breakdown is as follows;

Bowel Screening =5, Maternity =3, Radiology =1, and Sarum =18.

Medicine Division

	Q4 2019-20	Q3 2020-21	Q4 20-21
Complaints	16	19	15
Concerns	38	36	28
Compliments	169	250	148
Re-opened complaints	0	2	0
% closed complaints responded to within agreed timescale	56%	40%	33%
Complaints closed in this quarter	16	15	18
% concerns responded to within 25 working days	90%	68%	58%

- 15 complaints were received in Q4. Spire ward received the most with 4 (n=4); the main theme was unsatisfactory nursing care.
- 18 complaints were closed in Q4 and of these 33% were responded to within the agreed timescale. This was a particularly busy time for the clinical staff due to the pandemic so this caused delays in gaining statements.
- No complaints were re-opened in Q4.
- There were 28 concerns raised in Quarter 4. The Emergency Department received the most (n=9) with No particular theme is evident.
- The PALS department received 118 comments and enquiries for Medicine in Q4 which were investigated, managed and responded to by the team.
- Total activity within the directorate was 25616 and of this number 0.05% raised a complaint.
- The Complaints Co-ordinator is waiting for 4 outstanding action plans from the directorate.

Themes and actions from concerns and complaints closed in this quarter

Q42 0-21 themes Area	Topic	Action
Department/Ward Spire ward	**Topic** Unsatisfactory nursing care	**Action** 01/04/2021 Intensive Support commenced. Led by Director of Nursing and Matron. Matron undertaking supervision with the nursing team to gain understanding of issues and concerns. Weekly facilitated sessions with MDT.

Feedback on actions from the previous quarter's themes Q3		
Stroke Unit	Further complications	During Q3 the Stroke ward had an enlarged template to manage (i.e. Laverstock and Breamore) so 26 beds to 49. The team was therefore unable to give the level of care that they would have liked. Another factor is that the Locum Consultant (who had been with them for some time) became increasingly burnt out which would have had a negative impact on the patients and other staff. **Update**: A new stroke consultant has been appointed with no current concerns identified. The 10 bed side is managed by a different team of medics, therefore not impacting on Stroke services.

Q2 (2020/21)	Actions	Updates
Emergency Department Unsatisfactory discharge procedures. Incorrect diagnosis made. Insensitive communication Attitude of nursing and admin staff	Continued work to ensure the all patients have an ED discharge summary and that all junior doctors ask for a senior review prior to discharging patients. Each complaint is reviewed by a clinician to ascertain if a diagnosis has been missed or simply perceived to have been missed. If there is learning points the consultants have been reviewing the pathways and ensuring that all staff is aware of the learning from the complaint. During this difficult time we have several issues with communication – complex, new processes for patients, regular changes to staff workloads etc. It has undoubtedly raised the number of dissatisfied customers in ED and for a lot of staff has been the most challenging time of their career. We have dealt with these complaints on an individual basis with each member of staff taking time to reflect on attitudes and behaviours and how this could be improved upon whilst recognising the processes which have created patient unrest – Planned changes to waiting areas, navigation around department should help reduce confusion and support staff with irate patients	Junior Doctor induction explicit in covering discharges and escalation processes. Junior Doctors require an agreed Consultant peer group sign off to be allowed to formulate their own management and discharge plans. Complaints are reviewed by clinicians and any immediate learning disseminated via safety briefs, email, comms diary and complaints and learning also incorporated into quarterly M&Ms open to all from the Dept via Teams and face to face. Improved signage now in place understand crowding in waiting rooms at time can be an issue which hopefully will be resolved once new Outpatients build completed and specialities in shared areas move out. Feedback and constant reminders to staff around compassionate conversations, privacy in Dept as some cubicles are still curtains and close to areas where conversations occur. This has been a real challenge since COVID. We have tried to have prompt contact but in reality complaints have fallen quite out of date. We have displayed posters with House Rules and reminders to be kind etc. There are still ongoing challenges with regards to the lack of visitors due to the COVID restrictions. The Medical wards are trialling new handover sheets to better communication between staff and relatives.

Q1 themes	Actions	update
Emergency Department Unsatisfactory treatment	Prompt telephone contact with complainants. Work within the department with setting professional behaviours and encouraging civility, compassion etc. Focus on education and training of staff - increased SIM activity which includes communication of difficult news to patients and relatives. Development of a new junior doctor rota pattern to include dedicated time for learning and development.	This is ongoing with commitment to ongoing SIM training and the new rota has been launched and we are seeing protected SPA time for junior docs as well as our senior doctors happen regularly.
Farley RCU Unsatisfactory treatment and communication	Many of these concerns are around the problems highlighted because of Covid-19 and the lack of visiting by relatives. A white board has been set up in the office on RCU to record all conversations with families and should be completed at least once during the day. There has been a general theme around communication throughout medicine as a whole. Also Farley/RCU, Spire and Laverstock are setting up communication sessions for staff especially around end of life issues. 1 has taken place more to be announced	There are still ongoing challenges with regards to the lack of visitors due to the COVID restrictions. The Medical wards are trialling new handover sheets to improve communication between staff and relatives.

Compliments for Q4

AMU=9, Durrington=21, Emergency Department=11, Farley=7, Hospice=15,Redlynch = 1, Tisbury=30, Spire=42, Stroke unit=19 and Whiteparish =12.

Surgical Division

	Q4 2019-2020		Q3 2020-21	Q4 2020-21
	Surgery	MSK	Surgery	Surgery
Complaints	12	11	16	11
Concerns	27	22	32	22
Compliments	74	-	88	139
Re-opened Complaints & Concerns	1	2	6	4
% closed complaints responded to within agreed timescale	83%	64%	37%	50%
Complaints closed in this quarter	6	8	19	13
% closed concerns responded to within 25 working days	83%	52%	44%	65%

- There were 11 complaints received in Q4 quarter with Gastroenterology, Orthopaedics, Urology and Plastics Department having the same number each (2). There is no particular theme with the complaints but there were two ‘discrimination cases’, one with Gastroenterology and one with Ophthalmology.
- There were no complaint meetings held in this quarter although two are to be booked in as the complainants requested face-to-face meetings and due to Covid-19, these had to be put on hold.

- There were 22 concerns raised in Quarter 4. Gastroenterology had 3 concerns, Ophthalmology, Chilmark Suite, Downton Ward, ENT, Orthopaedics and Rheumatology all had 2 concerns each. Four concerns were in regard to Lack of Communication but there was no one area highlighted. Appointments system were raised in 3 concerns but were for across different areas.
- There were 3 complaints and 1 concern re-opened in Q4. Two are still open and two are closed.
- The main themes for the 17 complaints closed in Q4 were; Lack of communication (2), Delay in making diagnosis (2) and Attitude of staff, one nursing and one medical.
- The main themes for the 23 concerns closed in Q4 were; Lack of communication (4) across 4 specialties; Attitude of staff (4) across 3 specialties; and Operation delayed (4) across 4 specialties
- The PALS department received 72 comments and enquiries for Surgery in Quarter 4 which were investigated, managed and responded to by the team which was a slight increase of 12 on Q3.
- Total activity within the Division was 20,128 and of this number 0.05% raised a complaint.
- There are no action plans outstanding for the Surgery Division.

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

Q4 200/21		
Six different areas across the division	Lack of communication .	Learning shared with various members of staff through all 6 areas, with local resolution able to resolve 2 out of 6 cases. Direct action taken place in the following areas:- • Ward Clerk has had further training. • ENT secretaries have been asked to make holding/acknowledgement calls within 24hrs of an answerphone message.
Ophthalmology	Attitude of staff	Both issues raised by the two cases have been feed back to the Ophthalmology team members and have been resolved by the team. Covid-19 has meant that there are restrictions which are beyond the staff's control
Downton Ward	Attitude of Nursing Staff Lack of Communication Unsatisfactory Arrangements	Learning has been shared with various members of staff on Downton Ward, with local resolution able to resolve case. Direct action taken on Downton ward and Ward Clerk has received further training. All nurses have been reminded that patients should be given a mask on discharge as this is part of the discharge process.
Feedback on actions that remain open from previous quarters **Q3 2020-2021**		
Cleft	Appointment System	Glidescope missing resulting in operation order change and then cancellation when Theatres ran out of operating time **Update Q4 2021:** An investigation has taken place and the findings shared with all teams.
Endoscopy	General Service Provision and Creation of New GI Unit	A new GI Unit and a new GI Unit Manager and Clinical Lead was finalised in 2020 to pull the GI/Endoscopy/Colonoscopy services together. This will help reduce the complaints received, as the Clinical Lead and GI Manager have already started to work with the team to change the attitude and improve the service for patients. **Update Q4 2021:** There has been a reduction in complaint and concern cases this quarter with 7 GI Unit cases (complaint, concerns and re-opened) in Q4, compared to 9 cases in Q3 and 9 cases in Q2.

Division-wide	Delay in receiving treatment	Delays due to ongoing Covid-19 pandemic and impact on surgery and outpatient appointments. We are prioritising our patients using the NHS England national framework and criteria. Every patient has been triaged by the clinicians according to the national triage criteria. This means that some patents who may think they were urgent were not allocated as a high priory because of the pandemic and the need to only operate on clinically urgent patients such as cancer patients and those who are categorised as risk to life and limb. However, the Central Booking team have been given information and advice on how to explain this to patients when providing updates and cancelling appointments/surgery **Update Q4 2021:** Covid-19 recovery and the re-starting of services continues and as a result, the number of cases regarding a delay in receiving treatment has dropped from 6 cases in Q3 to 0 cases in Q4.
Division-wide	Attitude of Medical Staff	We have appointed 2 new Deputy (part time) Surgery Clinical Divisional Directors to support the Clinical Director. One of them has been very supportive in talking to staff who may need some guidance in their attitude and behaviour. **Update Q4 2021:** Seven cases closed this quarter were due to the attitude of staff, down from 8 in Q3.
Feedback on actions that remain open from previous quarters: **Q2 2020-2021 themes**		
Endoscopy	Communication & Care	Case will be discussed at the next Clinical Governance Session by the Band 6 Nursing Team on 19/11/2020. **Update Q4 2021:** Completed 17/12/2020.
There were no outstanding actions for Q1		
Q4 2019/20 themes and updates		
Laser Clinic	Lack of capacity; resulting in delayed and cancelled appointments	**Laser Clinic** has experienced some service delivery issues; which the team are working to resolve. There is a programme of training ongoing, and it is anticipated that in the near future they will have two fully trained members of the nursing staff, in the Dermatology/Plastics team. It is hope this will increase the capacity of the laser clinic; thus reducing the need for the service to reschedule patient's appointments. **Update Q1 2020:** The training plan is in progress. Activity in the laser clinic was put on hold as part of the Trust's response to the pandemic, and has not yet restarted. **Update Q2 2020:** Restarting of Laser activity has now been signed off. **Update Q4 2021:** The Laser Clinic was restarted in April 2021 and we hope to increase capacity in the coming months.
Orthopaedics	Lack of information or miscommunication	Misinformation received regarding preoperative testing; which was unfortunately due to human error. This has been addressed with both the booking and administration teams in Central Booking. A crib card to remind staff of the timings

		regarding the validity of pre-ops and bloods and swabs for various specialties has been produced and circulated to the teams. Plans are in place to amend the letter template for orthopaedic operations to include further information about the timeframes for pre-op bloods and swabs. **Update Q1 2020:** Changes to template letters currently on hold due to Covid-19 as we are not currently able to undertake any routine orthopaedic procedures and several main theatres have been repurposed for the Covid-19 escalation. **Update Q2 2020:** We are sending orthopaedic patients to New Hall hospital and are working through the highest priority patients first as per the guidelines given to us by NHS England, these patients are being booked and pre-opted by New Hall who will be sending their own letters to these patients, therefore our template letters have not yet been changed for orthopaedic patients. **Update Q4 2021:** This is an ongoing process and we are working with all our clinical teams to help support them with patient communication, however, the Covid-19 restrictions have meant that some patient processes have changed out of our control and patients' expectations have been difficult at times. The Surgery Division continues to work with our patients and staff to improve communication and once elective orthopaedic operations restart we will ensure the letter templates are updated accordingly.

Compliments

139 compliments were received in Quarter 4, the breakdown is as follows:

Radnor - 50, Britford – 22, Chilmark Suite – 14, Downton Ward – 14, Odstock Ward – 11, Amesbury Suite – 9, Urology – 5, Orthopaedics – 4, OMF – 2, Ophthalmology – 2, Breast Team – 1, Dermatology – 1, Med/Surg O/P – 1, Orthopaedics – 1, Plastic O/P – 1, Rheumatology - 1

5. Parliamentary and Health Service Ombudsman (PHSO)

There were no new Ombudsman's cases reported this quarter.

In 20/21 the Ombudsman notified the Trust of their decision not to uphold two complaints that had been referred to them in February 2020.

One case was partially upheld by the Ombudsman in Sept 2020. The PHSO found no failings in the overall care and treatment provided to the patient by the Trust. However, they found that the Trust did not appropriately consider the patient's needs during her capacity assessment; by taking all practical steps to reflect the patient's circumstances and meet her particular needs. The Trust is currently working on the implementation of the Ombudsman's recommendations.

PHSO update COVID-19

The COVID-19 pandemic continues has had a significant impact on their service; compounded by similar challenges in NHS organisations resulting in a queue of over 3,000 complaints waiting to be looked at.

What changes will we see?

The PHSO has decided they will focus on the more serious complaints about health services in which people may have faced a more significant impact and where they feel they can make the biggest difference. For other complaints where someone has faced less of an impact, they will consider whether there is anything they can do to help resolve things quickly, but if not, they will close the complaint. This will allow them to help complainants who have faced a significant impact more promptly than would otherwise be possible.

For the first time the PHSO has published data about their recommendations for upheld and partially upheld cases. They have also published a data table of complaints received, assessed and investigated

about NHS Organisations. This data will be published every quarter alongside their existing health complaints statistics report.

NHS Complaint Standards

New NHS Complaint Standards have been published by the Ombudsman and will be introduced across the NHS in 2022. Pilot sites have been asked to work with the Ombudsman to test the various aspects of the Standards and we have applied to be a pilot site.

The NHS Complaint Standards set out how organisations providing NHS services should approach complaint handling. They apply to NHS organisations in England and independent healthcare providers who deliver NHS-funded care.

The Standards aim to support organisations in providing a quicker, simpler and more streamlined complaint handling service, with a strong focus on early resolution by empowered and well-trained staff. They also place a strong emphasis on senior leaders regularly reviewing what learning can be taken from complaints, and how this learning should be used to improve services.

The Complaint Standards are based on My Expectations, which set out what patients expect to see when they make a complaint about health or social care services (see appendix 5). You can read a summary of the new Standards here.

6. Trust wide feedback

Patients surveyed

In Q4 a total of 534 patients provided feedback through the Friends and Family Test (FFT). This is down from 636 in the last quarter. The numbers are increasing though as we are encouraging areas to start displaying the FFT feedback forms again. A total of 2,627 provided their feedback in 2020/21.

Friends and Family Test

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

		Rating											
	Total Responses Received	Very good		Good		Neither Good nor poor		Poor		Very poor		Don't know	
Day Case	275	255	93%	20	7%	-	-	-	-	-	-	-	-
Emer Dept	13	11	85%	2	15%	-	-	-	-	-	-	-	-
Inpatients	200	173	86.5%	24	12%	2	1%	1	0.5%	-	-	-	-
Maternity	29	29	100%	-	-	-	-	-	-	-	-	-	-
Outpatients	17	17	100%	-	-	-	-	-	-	-	-	-	-

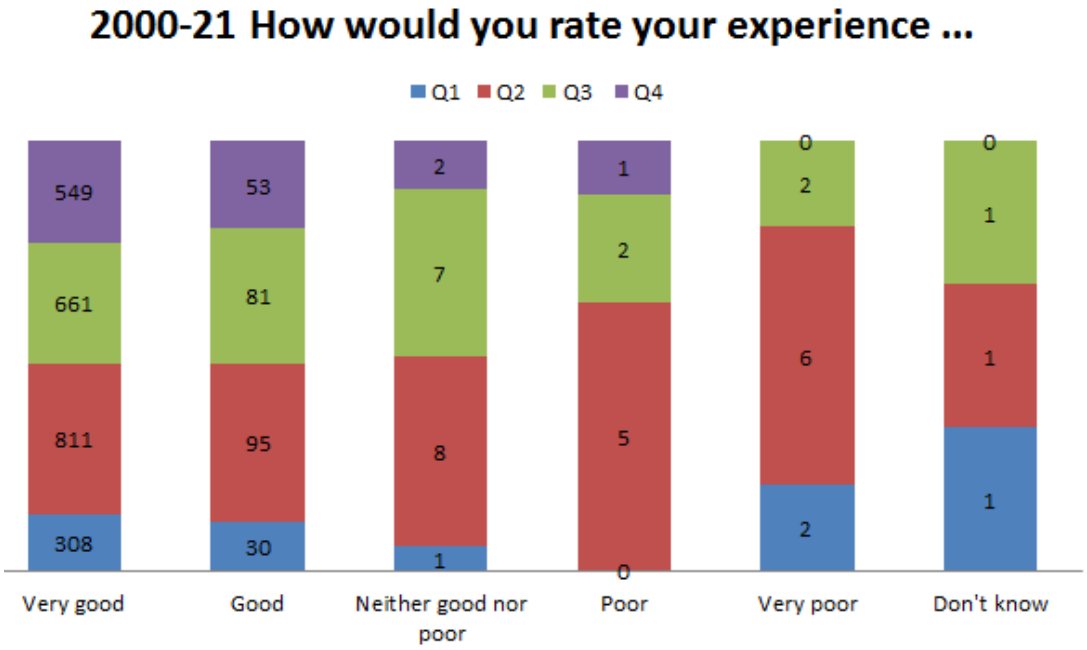
Some feedback received this quarter

What was good about your experience?

- You the NHS are angels sent from heaven. Attentive to every need of every patient even though at this time you are very stretched. Keep up your amazing work all of you and I applaud you all.
- Extremely supportive to my son and myself, and understanding of his needs. We are very grateful.
- Professionalism and care of staff. Very acceptable meals
- Excellent nursing, really cared for in every way. Good food, hot water in the shower, kindness from everyone. Best stay ever. Too many to be named to recommend.

What could we have done better?

- Small comment. Meals quite adequate but tended to arrive tepid/cool
- Please reduce noise from the nurses' station! It is so difficult to rest when there is a lot of loud chat and banter going on. And consultants on the ward should be aware too - patient confidentially an issue. Too much noise also from mobile phones and trolleys.
- It's a shame when all staff do not introduce themselves and some came across quite rude and abrupt. The weekend cleaners do a fantastic job but not so much in the weekdays - the floor wasn't cleaned and I had to ask for my room to be cleaned and toilet roll replaced. They took 2mins - room and bathroom couldn't have been cleaned in that short time!



PATIENT AND PUBLIC INVOLVEMENT – NATIONAL SURVEYS

No national survey results were published within the reporting period.

URGENT AND EMERGENCY CARE SURVEY 2020

Work commenced September 2020

ADULT INPATIENT SURVEY 2020

Work commenced November 2020

CHILDREN AND YOUNG PERSONS SURVEY 2020

Work commenced November 2020

MATERNITY SURVEY 2020

This survey will commence in February 2021

Action taken on areas of concern

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

7. Health Watch Wiltshire feedback

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

8. Translation and Interpretation

The Procurement team have been working with PALS on a new tender for the interpretation and translation managed service. The idea is that a 'one stop' service will be provided (BSL, video, telephone,

face-to-face and translation of written material). This piece of work has been done in conjunction with the other organisations in our STP. The new contact should commence in May 2021.

This quarter's most frequently used languages for face-to-face interpretation (used on 5 occasions):

- Polish 20% Arabic 20% Romanian 20% Portuguese 20% Mandarin 20%

Total spend for face-to-face interpreting this quarter is £880

The areas where interpretation was used most often are:

- Audiology = 20% Children's Outpatients = 40% Oral Surgery 20% DSU 20%

British Sign Language was used on 1occasion this quarter with a total spend of £140

Translation was used for 4 documents with a total spend of £750

The **total spend for 2020/21** is:

Face-to-face interpretation: £880
British Sign Language: £140
Translation (of documents): £750
Overall total: £1800

9. Patient Stories

Patient stories are taken to every public Board meeting. The Head of Patient Experience has now completed a Masters level course on digital patient stories.

10. NHS Digital

Nationally there were 26,293 complaints in Q4. The key theme across all organisations was communication (16.4%) followed by patient care (12.7%)

Q4 data (2019-20) is available here https://digital.nhs.uk/data-and-information/publications/statistical/data-on-written-complaints-in-the-nhs/2019-20-quarter-4-ns

11. Patient and public involvement (PPI)

Please see separate end of year report for updates and progress against our engagement strategy.

PPI Projects are shared on the following web page on the Intranet:
http://intranet/website/staff/quality/customercare/patientandpublicinvolvement/ppiprojects/index.asp

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

PPI Projects are shared on the following web page on the Intranet:
http://intranet/website/staff/quality/customercare/patientandpublicinvolvement/ppiprojects/index.asp

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

12. Social media

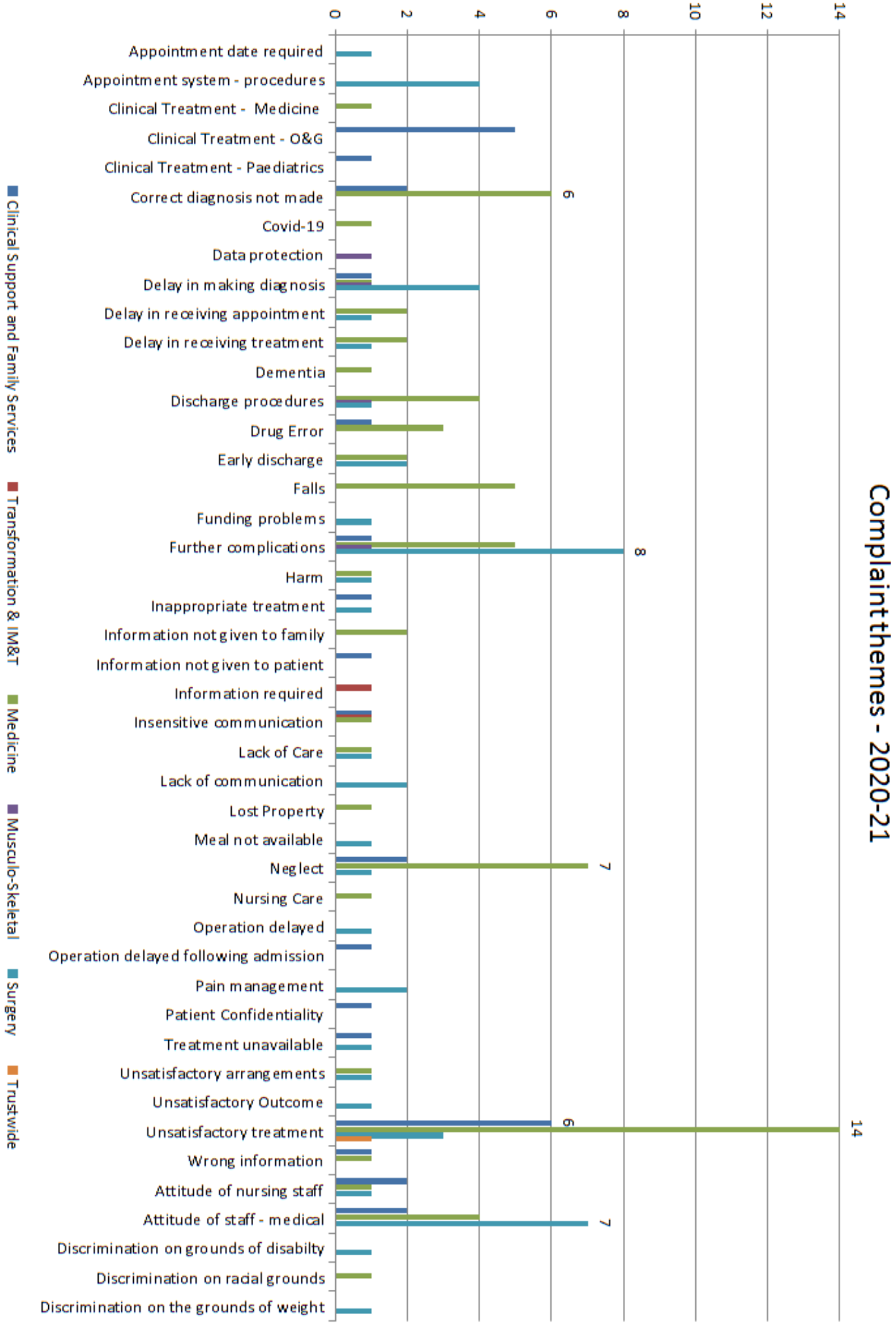
NHS Website feedback

There were no items of feedback posted on the NHS Website in Q4.

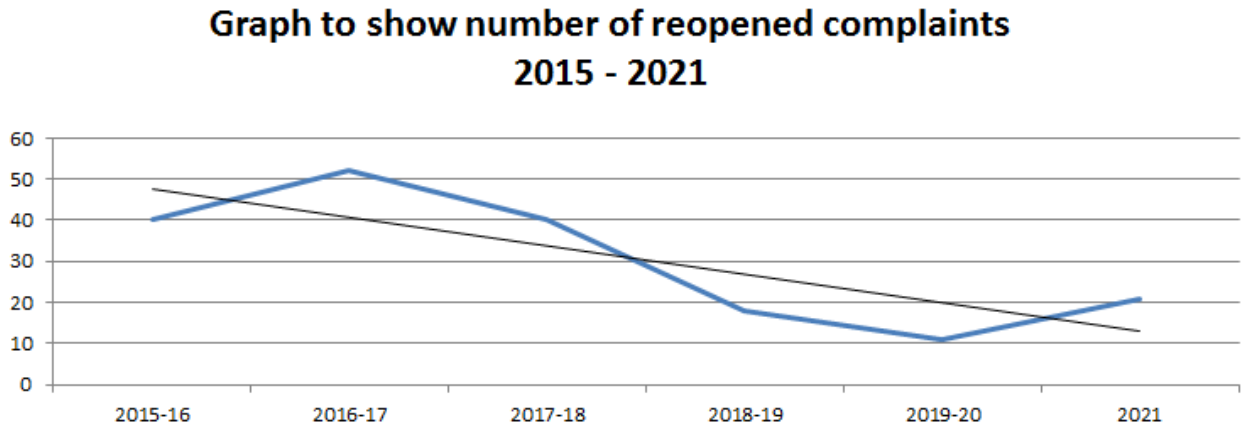
All feedback is available here: https://www.nhs.uk/services/hospital/salisbury-district-hospital/P1700/ratings-and-reviews

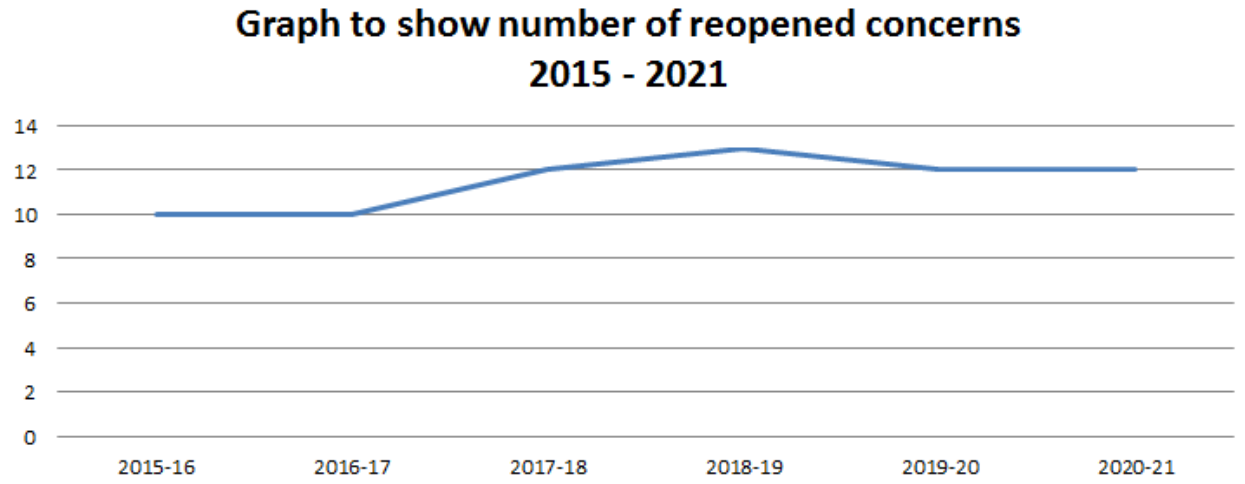
Appendix 1

Complaint themes over the last financial year

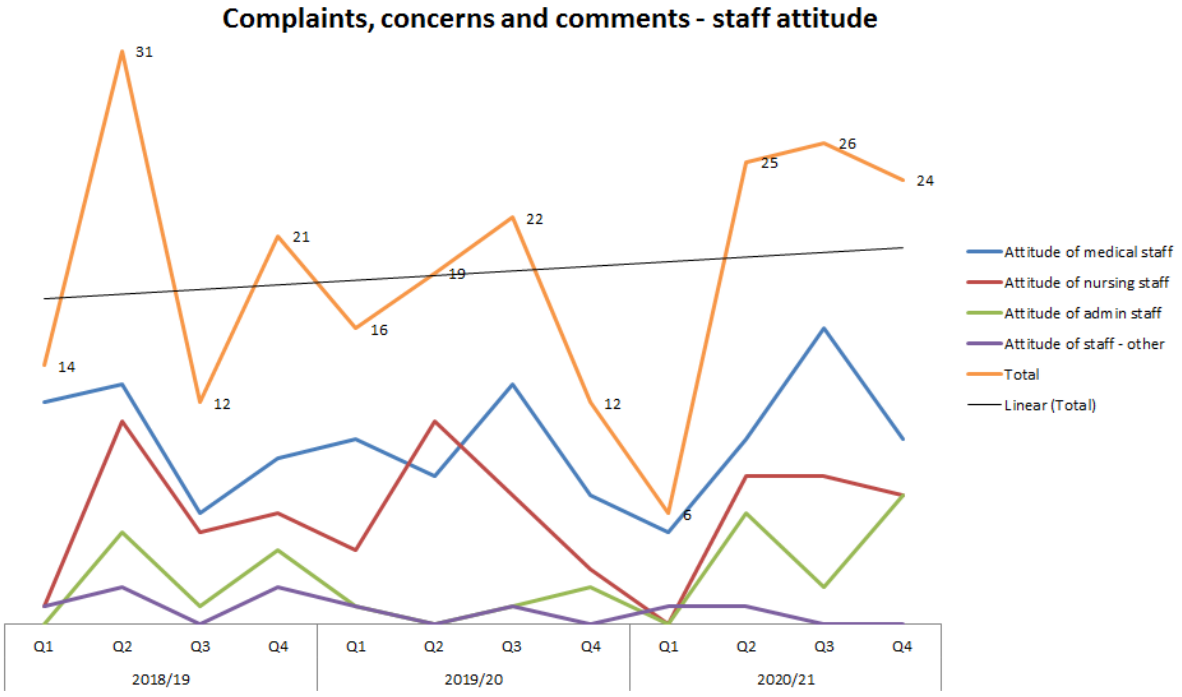


Appendix 2





Whilst the rate for complaints that are reopened has seen a continuing downward trend over time; the same cannot be said for concerns. Different staff groups are involved in writing response letters for concerns and the letters do not get the same level of scrutiny as complaint responses do. Additional training to help staff investigate and respond to concerns will be offered in 2021/22.



The numbers of concerns, complaints and comments surrounding staff attitude continue to show a slight upward trend. The data for Q1 20/2021 (start of the COVID-19 pandemic) skews the data somewhat as we received very few complaints and concerns at this time. Attitude of Staff is a recurring theme but does not appear to be a trust wide issue and is related to specific staff in specific areas at specific times..

Appendix 3

Friends and Family test

The new FFT questions went live in April 2020.

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

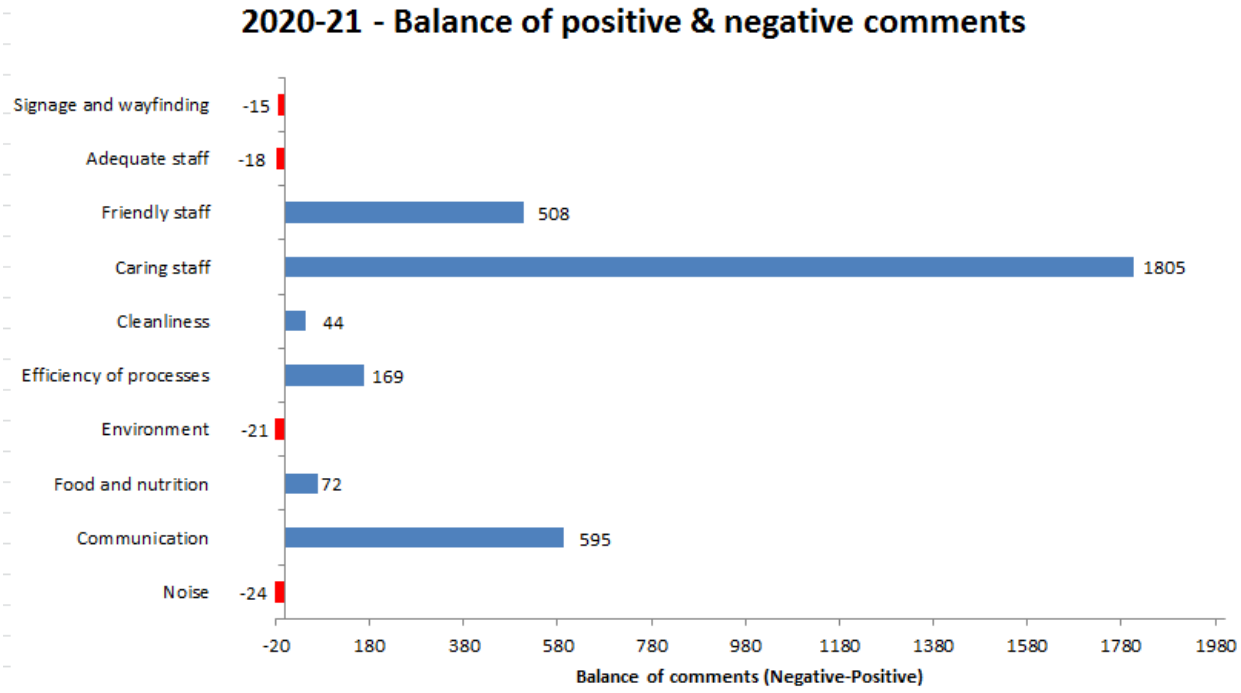
The new question has a new response scale:

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

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

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

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



The themes 'Signage and wayfinding' and 'adequate staffing' are only seen in Q2 onwards and perhaps reflect the numerous ward/outpatient moves that took place after this date and the impact of the pandemic on staffing levels across the Trust.

Examples of comments in each of the categories are given below

Signage and wayfinding

- 'The photocopy of the main hospital map was totally illegible'.
- 'Generally signage around the hospital grounds very poor and confusing'.
- 'Better instructions on how to find the department and where to park. Our form said to park in CP10 which is staff only'.

Adequate staffing levels

- ‘More nurses if possible. They are too busy to give best care’.
- ‘It is not right that you leave one member of staff on the ward during the day or night. The poor nurse was rushed off her feet and if I could have helped, I would!’
- ‘The care and treatment I received was outstanding. I was given important information and involved in decision making. The consultant and doctor were very professional. There were enough nurses on the floor at all times. I was made to feel comfortable and was checked on regularly. The catering staff were amazing. The cleaners do a good job as the ward was spotless. Thank you’

Friendly staff

- ‘All the staff were polite, friendly and efficient. Bringing a vast range of skills into a cohesive act that works turning the ward into a happy environment’.
- ‘Lovely ward with beautiful views and the most kind and caring staff. Such a friendly hospital. The nurses were so busy but still made time for me’.
- ‘The attitude, efficiency and friendliness of the staff. I didn't meet anyone who was grumpy or couldn't explain when I had a question. Your greatest aptitude is your staff’.
- ‘On both occasions I found the receptionists quite unfriendly with no compassion for poorly patients’.
- ‘My consultant was not friendly to start with and needed to realise I had no previous information as to what to expect’.

Caring staff

- ‘Everything very efficient, nurses caring and professional. My consultant and nurses explained fully on the process. I couldn't have wished for better care. 100% satisfied’.
- ‘Perfect care, attention, communications, and information from start to finish. Amazing patience and empathy with tricky patients too!’
- ‘I needed and would have welcomed a bit more reassurance and comforting during episodes when I was feeling really unwell’.

Cleanliness

- ‘Everybody was very friendly. The hospital was very clean even though I was in there 4.5hrs I wasn't waiting long to be seen. All extremely professional’.
- ‘Everyone was polite and helpful. Area was clean and welcoming’.
- ‘I was a bit worried about general surface cleanliness - mainly the floor.’
- ‘First class facilities. Clean and well managed. Lovely caring staff’.

Efficiency of processes and procedures

- ‘The care, concern and coordination shown by a large team was impressive. The reception information was calming. The post op information was well thought out and very helpful to take home. Thank you all very much’
- ‘You do all you can. Please ask the staff to check the name of patients before attempting bloods’
- ‘Ran very smoothly and on time. Excellent service’.
- ‘The patient self-service check in machine gives the impression that you have checked in once the ethnicity page is completed. This is not the case and I had not checked in. I was then late for my appt. Please simplify it’.

Environment

- I think the bathroom could benefit from a makeover and perhaps get the shower working’.
- ‘The chair for the procedure was very uncomfortable and the wrong height’.
- ‘Less light at night!

- ‘Rubbish pillows and bathroom. If you self-wash at least supply more hooks and shelves - you end up putting your belongings on the bins! Car park machine malfunctions which cause a lot of stress. Strip lights on patient’s eyes - please use as little as possible’

Food and nutrition

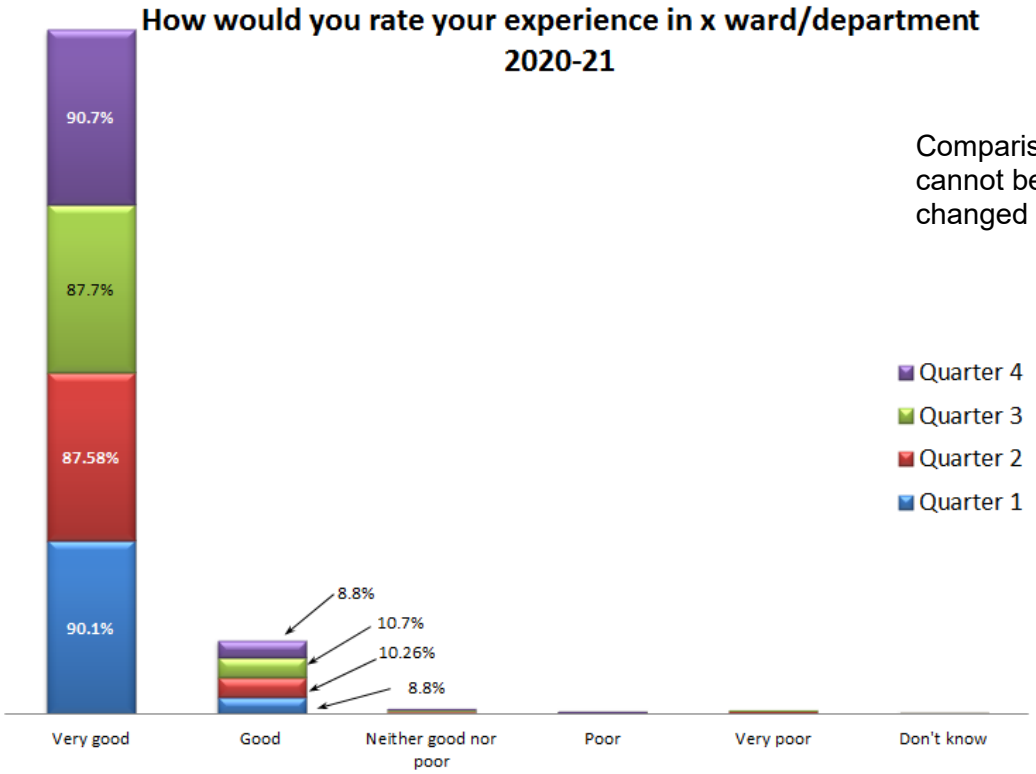
- ‘The staff were great as was the food selection’
- ‘Food was excellent and the staff were caring, attentive, professional and kind. A big thank you’.
- ‘Sorry but I didn't like the food or the bed’.
- ‘Please do something about the food. I found it hard to have a good meal. Food was tepid at best’. One night did not even get what I ordered. Bring back snack and mag trolley rounds’.
- ‘Food better than adequate, good choice and imaginative’.

Communication

- ‘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’.
- ‘Better communication about possible waiting times as despite being given a particular time to attend, the wait can be several hours to be seen. Not a problem but helpful to understand as I had been nil by mouth for 12hrs’.
- ‘Could have communicated with me better in the sense of what is happening, what is going to happen and the plan going forward. I felt like I was left in the dark’.
- ‘I liked that people talked to me while they were doing other things so I knew what was going on’.

Noise

- ‘My room lacked sunlight and had periods of excessive noise from rubbish disposal’.
- ‘Morning cleaner unnecessarily noisy - really was bang/crash!’
- ‘On occasion the alarms appear to go on for quite a long time which impacts on sleep and rest. Appreciate that this might be staff level problems’.
- ‘Very noisy at night! Do you really need all the bleeps! Staff could whisper first before being so loud!’

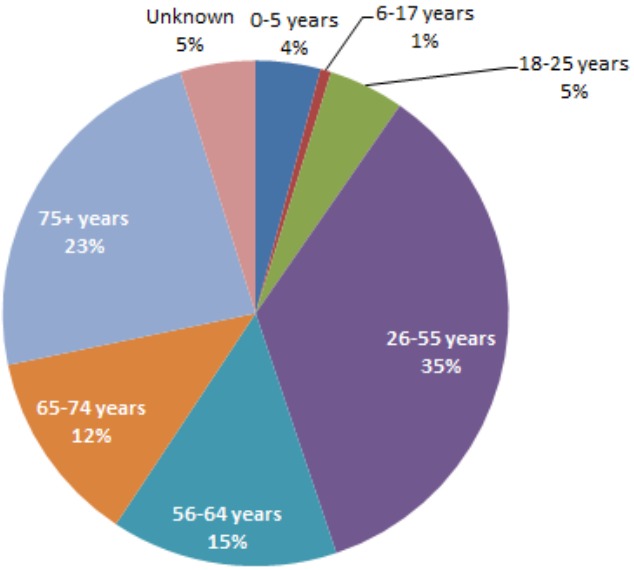


Comparison with previous years cannot be made as the FFT question changed in Q1 2020/21

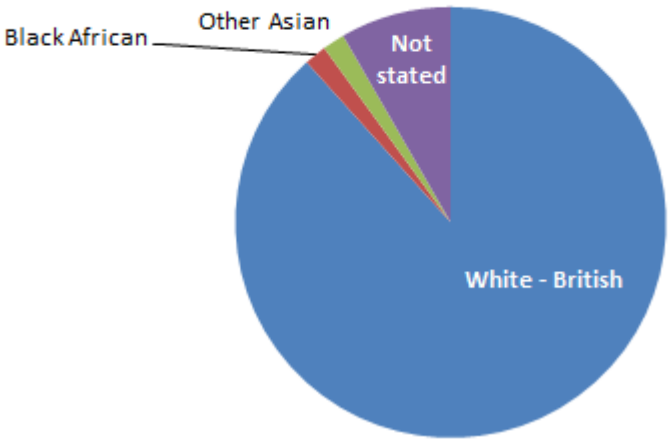
Appendix 4

Demographics of patients making a complaint 2020-21

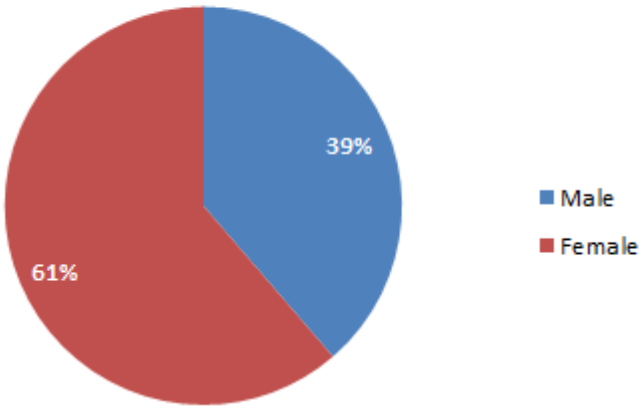
The age of patients making a complaint (2020/21)



The ethnicity of patients making a complaint (2020/21)

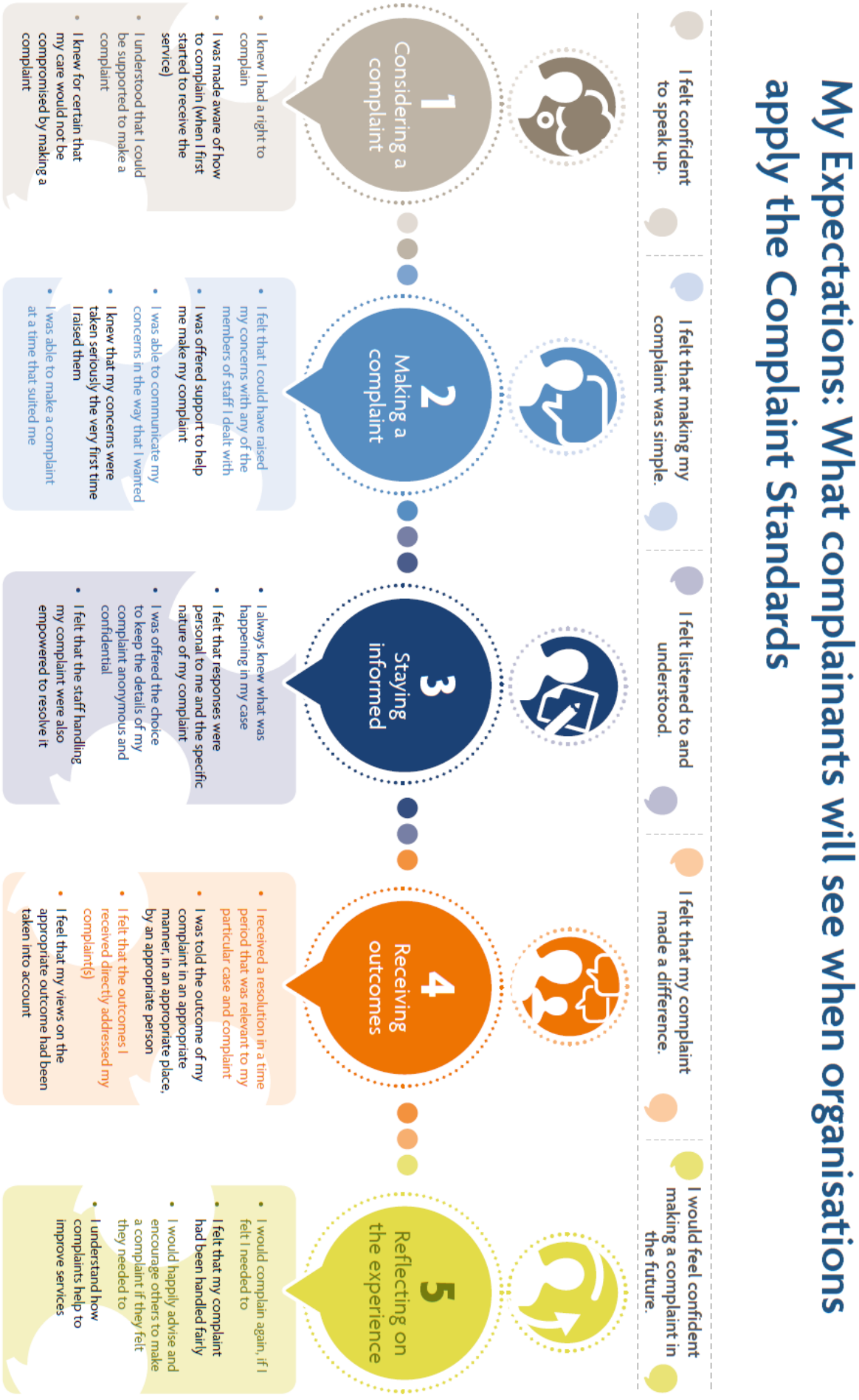


The gender of patients making a complaint (2020/21)



Appendix 5

My Expectations – from the new NHS Complaint Standards



Report to:	Trust Board (Public)	**Agenda item:**	**5.2**
Date of Meeting:	8 July 2021		

Report Title:	Q4 Learning from Deaths 2020 - 2021			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	
Prepared by:	Dr Belinda Cornforth, Consultant Anaesthetist, Chair of the Mortality Surveillance Group Claire Gorzanski, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Peter Collins, Chief Medical Officer			
Appendices (list if applicable):	Appendix 1 – Mortality dashboard Q1 - Q4 2020/21 Appendix 2 - Learning from deaths action plan. Appendix 3 – Mortality dashboard explanation of terms			

Recommendation:
Assurance that the Trust is learning from deaths and making improvements.

Executive Summary:
Learning from deaths in Q4 has again been dominated by patients who died from COVID-19 where there was an increase in the number of hospital acquired COVID cases mitigated by additional measures already put in place to reduce the risk of nosocomial transmission. Improvements made in response to learning from the Q3 bereavement survey showed that 50% of families were contacted by the EOLC or HPCT team, use of messagetoalovedone increased, changes were made to visiting practice so more relatives could be with their loved ones at end of life and communication training undertaken with key staff. Positive assurance of the management of patients with heart failure. Of concern, is the management of some patients who died of a gastrointestinal haemorrhage in respect of the absence of the use of the acute upper GI bleed care bundle and delay in OGD due to the inability to provide an out of hours endoscopy service on site. Both will be the focus of improvement actions. Improvements required in fluid balance monitoring and urinalysis on admission are now part of the patient safety programme. The Trust's HSMR has increased in Q4 likely due to the effect of COVID deaths, both in terms of direct mortality from COVID, as well as the secondary bias effects (the reduced bed base occupied by non-COVID patients, a likely increase in acuity for non-COVID activity, as well as a differential in the dates of COVID pressures nationally), making accurate benchmarking difficult. The Chief Medical Officer and the Mortality Surveillance Group are

monitoring Q1 2021/22 data with an expectation of normalisation of mortality indices. The Chief Medical Officer has also commissioned a review of non-COVID related deaths to ensure no omissions in care. The SHMI which retains all palliative care coded spells and has had COVID activity removed, shows the main hospital site remains within the expected range at 95.26.

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

Q4 2020/2021 Learning from Deaths report

1. Purpose

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

2. Background

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

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

3. Learning in Q4 20/21

Trust and departments:

- Q4 (particularly January 21) was dominated by deaths of patients who died from COVID where there was an increase in the number of hospital acquired COVID cases mitigated by additional measures put in place to reduce the risk of nosocomial transmission (see section 7). The review has shown that there were less patient moves from ward to ward, but still a significant number of moves within wards from bay to bay or sideroom.
- Improvements made in response to learning from the Q3 bereavement survey showed that 50% of families were contacted by the EOLC or HPCT team, use of messagetoalovedone increased, changes were made to visiting practice so more relatives could be with their loved ones at end of life and communication training was undertaken with key staff.
- A review of a sample of deaths of patients who died from heart failure was undertaken in response to a rising trend in relative risk of death. Good compliance with advanced care planning and early DNAR discussions. National audit showed that lower mortality rates are in patients seen by heart failure teams who should be involved in all patients as input improves patient outcomes overall. In this Trust, heart failure patients were either admitted to the Cardiology ward or to a general medical ward and are seen as part of a Cardiology outreach service within the Trust. 85% of patients were reviewed by the team.
- A review of 15 patients who died of a gastrointestinal haemorrhage. Initial findings found some excellent care especially in time to consultant review and management of medication. However, the absence of the use of the acute upper GI bleed care bundle led to subjective decision making. 5 patients had an OGD delayed or did not have one at all due to the Trust's inability to provide an out of hours endoscopy service on site. All the patients were frail and unlikely that this affected outcome. Areas for improvement are: 1) Implement the acute upper GI bleed care bundle. 2) Review the out of hours endoscopy provision to improve the timely access for patients who need an urgent endoscopy.
- Improvements required in fluid balance monitoring and urinalysis on admission are to be part of the patient safety programme and reported and a work plan overseen by the Patient Experience and Patient Safety Group

Individual level:

- Individual case discussion with doctors and nurses to enable assisted reflection has continued in Q4.

4. Medical Examiners (ME)

The new ME system was introduced in April 20 to ensure excellence in care for the bereaved and learning from deaths to drive improvement. The system was established in the Trust by August 2020 and the following progress made in Q4:

- In Q4 83% of acute hospital deaths were scrutinized by a ME and relatives were contacted to ensure they understood and agreed with the cause of death and to give them the opportunity to raise any concerns. This compared to 79% in Q3.

- The process for scrutinising Hospice and Emergency Department deaths is the next stage and will be progressed in Q1/2 2021/22.
- A summary of our data is submitted quarterly to the regional ME. It is anticipated that the Trust will be required to submit data to the national ME IT system if and when it is available.
- A local network of MEs exists to share learning and provide an independent review facility if needed.

5.0 Working with bereaved families

5.1 Telephone follow up

The ME/MEOs consistently contact all families whose loved ones have died in the acute Trust. In addition the Specialist Palliative Care Team (HPCT) and the End of Life Care (EOLC) team provide an additional one off bereavement call to the family of patients supported by their teams prior to their death. This accounts for about 50% of all patients that die. As well as offering condolences, it is an opportunity to listen, support the bereaved and allow families to ask questions or raise concerns about the care of their loved one and the support they received. It is a huge opportunity for learning, feedback to ward leaders and to identify QI projects.

Most queries are resolved during the initial call or a second call is arranged following a review of the health care record. The HPCT refers patients directly to Salisbury Hospice's family support team if formal bereavement support is indicated. The EOLC team signpost mainly to GP's and local bereavement support groups, but can access the family support team if significant needs are identified. Families greatly appreciate the bereavement follow up call, both for those who have had positive and negative experiences of care.

Notably, most who raise queries or suggestions for learning did not raise them with the Medical Examiner immediately following their loved one's death. Whether this is due to a time lapse or they feel more able to talk to an EOLC nurse already known to them is unclear, but the benefits of these telephone bereavement calls is evident. Not all families (45%) are able to access this support as the team is not resourced for it. Work is underway with Critical Care to explore how this service can be replicated and potentially expanded to support as many bereaved families as possible.

5.2 'Your Views Matter' bereavement survey

The 'Your Views Matter' bereavement survey is offered to every bereaved family who contacts the bereavement suite following the death of a loved one in the acute Trust. In Q4 20/21, there were 237 deaths in the acute trust, over half of families (n =134) consented to a survey being sent and 77 (57%) responded, a total of 1 in 3 families. The majority contained positive comments with 78% of respondents rating the overall care in the last days of life as good or very good. Relatives who were able to be with their loved ones at end of life, expressed their appreciation at being able to do so. However, over a third of relatives were unable to visit, either due to the risk COVID-19 presented to them or the visiting restrictions.

The impact of this is demonstrated by only 12% of families having any face to face discussions with a health care professional in the last days of care with almost 50% of families relying on communication with medical staff by telephone. 9 in 10 families were told that their loved one was going to die, many over the phone, over a third of whom were alone at the time of being told. The vast majority felt that it was done sensitively.

All of the 7 responses that had difficulty understanding what was said involved the telephone; with phone signal, accents and vocabulary being the main challenges. Some of the improvement actions taken in Q3 are already showing a benefit with 15 families using the *messagetoalovedone* service with very positive reviews. The chaplaincy team adjusted the way they communicated with families who were unable to visit. Almost 1 in 3 families said that their loved one had received chaplaincy support and feedback regarding both the chaplaincy service and the ME's role remained very good.

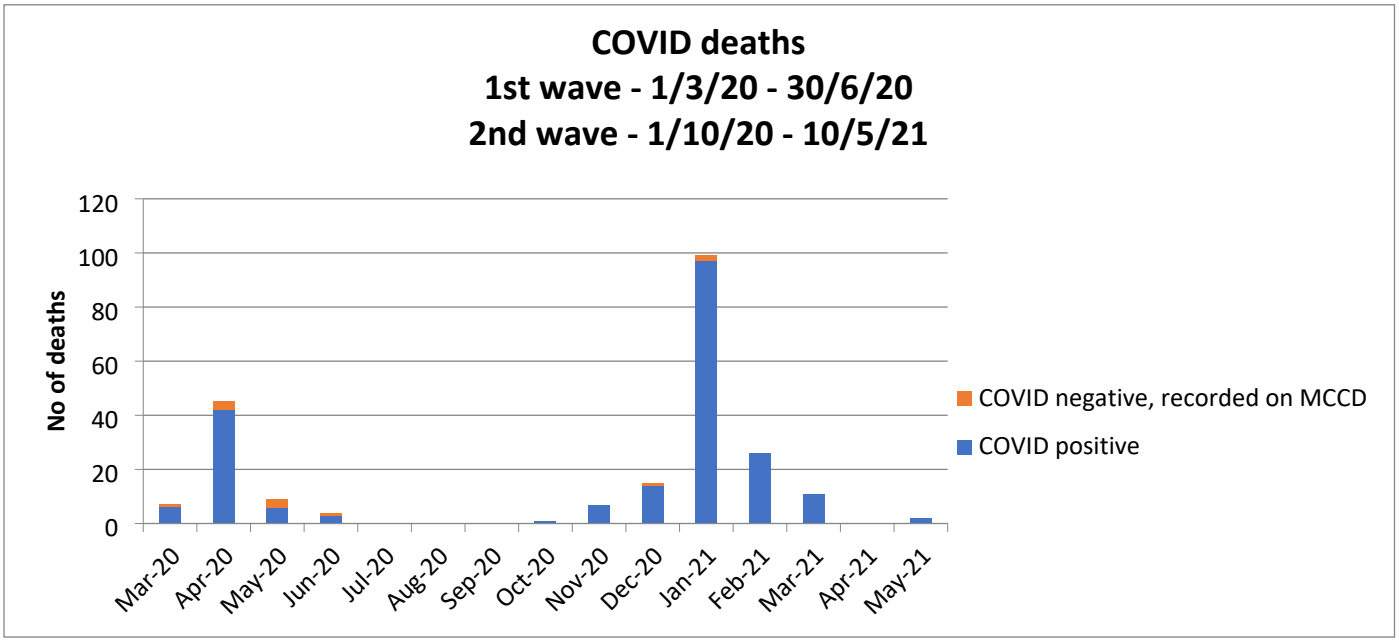
5 respondents rated the care as poor or very poor, with all rating communication and support to loved ones as very poor or poor. None of these respondents raised formal complaints but 3 gave consent to be contacted by the lead nurse for EOLC who was able to listen to their stories and use their experiences to influence the actions derived below to drive future improvements. All of the families found benefit and comfort knowing that by sharing their experience, action would be taken to help improve care for others. The table below sets out the main themes for improvement and actions taken in response.

Relative feedback	Trust action
Families struggling to get through to the wards via telephone. When they do get through, lacking meaningful updates. Being told "she's fine" is misleading and generic.	The second wave and restricted visiting highlighted the need for communication training using the telephone. 12 staff have completed a SimCommAcademy Advanced Communication, Train the Trainer course in April 21 with a view to training ward staff across the Trust. The EOLC team plan to collaborate with the Practice Education team to deliver a bespoke ½ day communication training package which will form part of EOLC training for nursing staff. It will address specific themes identified from bereavement surveys and calls.
Families commenting on how visiting restrictions varied between wards. Also how previous guidance stipulated that patients needed to be receiving EOLC to qualify for extended visiting. Several patients who died whilst receiving active treatment were denied visiting for this reason.	Updated guidance produced to reflect national easing of restrictions and a flow chart to aid decision making for clinical staff being introduced. Wording on guidance has been changed to patients identified as **nearing end of life** as opposed to **receiving end of life care**. This enables patients still receiving active treatment to receive extended visiting should they be identified at risk of dying.
Families not aware of message to a loved one / virtual visiting	Daily communication between EOLC CNS team and PALS to inform of any patients nearing end of life. PALS then make contact with families to offer support with communication with the wards. Introduced a patient A4 magnetic white board to display messages and family photos at the bedside.
A small number of families had been given inaccurate information / or did not hear the correct information on what to do next after their loved one had died. This led to them waiting for bereavement suite staff to contact them instead of them making contact with the bereavement team.	Current procedures now uploaded to a new link on the hospital website under "information for the recently bereaved" so that relatives can view correct procedures online.
Families commented on how busy telephone lines are to the bereavement suite and multiple attempts to try to get through. Answerphone is in place but families leave multiple messages and voice negative experience. Once through, very positive about the staff in the bereavement suite and their helpfulness and compassion.	Advice on hospital website to be altered so that families expect the answerphone and to leave their details. This is opposed to expecting a person to answer and the getting the answerphone. The message on the answerphone to be changed to reflect this.

6.0 Mortality dashboard, learning, themes and actions

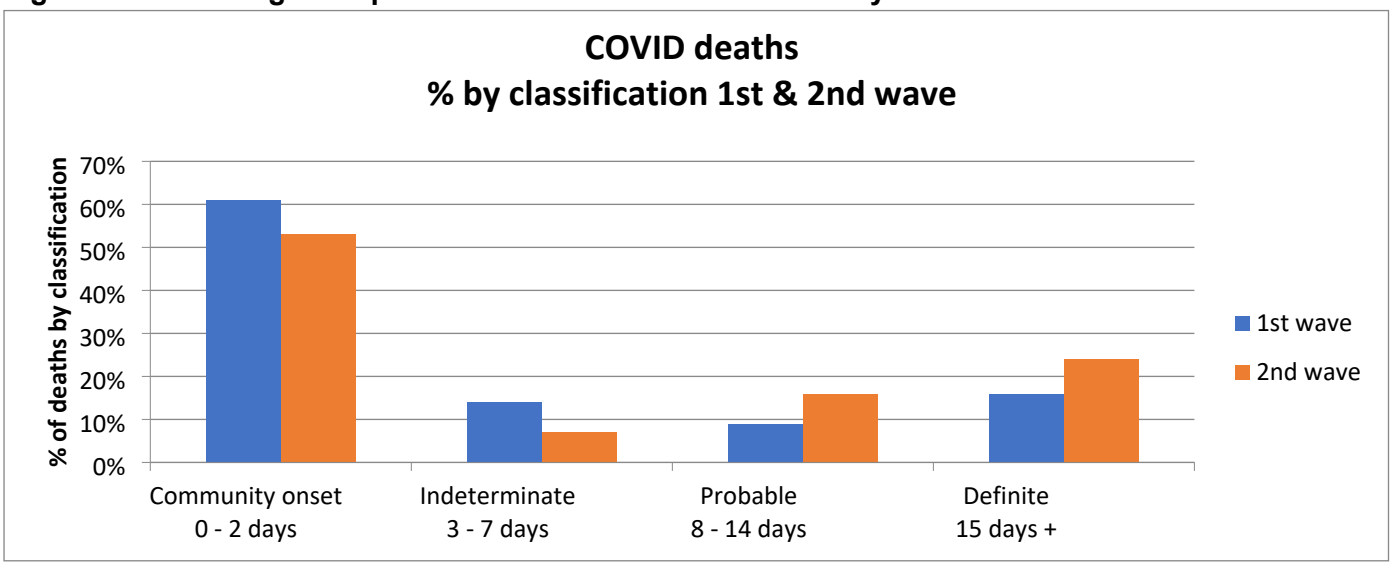
In Q4 20/21, 281 deaths occurred in the Trust. The total includes patients who died in the Emergency Department and the Hospice. Of these, 261 (93%) deaths were reviewed by a Qualified Attending Practitioner. The Medical Examiners scrutinised all acute hospital deaths (excluding deaths in the Emergency Department) and by the end of Q4, 234 (83%) of deaths had been scrutinised. 5 deaths were unexpected. The second wave of the COVID-19 pandemic started in October with 156 deaths of patients who tested positive for COVID by 31 March 21 (April 21 – 0, May 21 – 2 deaths, a total of 158 + 3 patients tested negative).

7.0 Review of deaths of patient with COVID-19 and learning



The emergence of a new more transmissible Kent variant of COVID-19 in the 2nd wave increased the number of patients affected by nosocomial transmission. In the 1st wave, 14 (25%) patients probably or definitely acquired COVID in hospital compared to 63 (40%) in the second wave. The majority of hospital acquired cases occurred in December 20 and January 21 when COVID was at its peak on the 11 wards where outbreaks were declared.

Figure 1: Percentage comparison of 1st and 2nd wave deaths by NHSE classification



Additional measures put in place to mitigate the risk of nosocomial transmission were:

- As the number of cases increased additional bed capacity was opened including the Day Surgery Unit for inpatient capacity.
- To enable beds to be socially distanced some beds were removed from wards.
- Enhanced existing Level 1 PPE for staff working in close contact with patients within the ward environment and wards that had COVID-19 positive patients cohorted in bays. The enhancement was a change from wearing the recommended Level 1 surgical face mask to a Level 3 FFP3 face mask for which each individual was successfully fit tested.
- A team was set up to support the wards in testing inpatients for COVID in accordance with our standard operating procedure.
- A maternity lateral flow hub was set up to enable partners to attend scans and clinic appointments as well as being with them during labour.
- Provided mutual aid to the Mental Health Trust (AWP) where an outbreak of COVID affecting 63 patients was declared at Fountain's Way Hospital. This Trust provided oxygen and oxygen saturation monitors and a respiratory consultant to review patients at the hospital, thus reducing admissions to this hospital.
- Invited NHS Improvement to review practice which took place in January. The main advice was to increase the level of audits so rapid changes could be made where needed.

A review of the second wave deaths is underway and 83 (51%) of 161 structured judgement reviews have been completed to 14/5/21. Duty of Candour will be applied in cases of hospital onset probable or definite cases.

8.0 CUSUM alerts

Three new CUSUM alerts raised in Q4 20/21:

- Other liver diseases 11 deaths compared to 4.5 expected, relative risk 246 arose in December 2020. These cases will be subject to a review and the outcome reported to the Mortality Surveillance Group in June or September 21.
- Pathological fracture 5 deaths compared to 1.5 expected, relative risk 352 arose in December 2020. This alert was last investigated in November 20 of 4 patients who presented with a fractured neck of femur with a background of multiple comorbidities and frailty each of whom had a high risk of mortality on admission. The Mortality Surveillance Group felt that due to the small number of deaths in this group, further statistical analysis is unlikely to provide any meaningful in-sight.
- Therapeutic endoscopy operations on urethra 1 death compared to 0 expected, relative risk 1383 arose in December 2020. This case will be reviewed and the outcome reported to the Mortality Surveillance Group in June 21.

CUSUM alerts raised in Q3 20/21:

- Cancer of brain and nervous system 6 cases compared to 2.5 expected, relative risk 42.9. All 6 patients died in the Hospice. The Mortality Surveillance Group agreed this alert should be investigated and presented to the meeting in June 2020.

9. Death following a planned admission to hospital

In Q4 20/21, 2 deaths of patients following a planned admission:

- A 77 year old man admitted from diabetic clinic with foot cellulitis and osteomyelitis with multiple comorbidities. Treated with IV antibiotics. Anaemia noted and plan for OGD/colonoscopy. Later developed acute kidney injury and gastroparesis but despite active treatment he continued to

deteriorate and died. Medical examiner scrutiny – death sudden but not unexpected. No learning points identified.

- A 51 year old woman admitted, investigated and treated for chest pain and found to have a metastatic lung malignancy and new atrial fibrillation and confusion. CT/MRI showed shower emboli led to a small ischaemic infarct. The patient self discharged on day 6. Returned for EBUS 2 days later and desaturated with stridor during the procedure. Repeat CT was unchanged but clinically the patient was diagnosed with a probable brain stem ischaemic stroke and a possible pulmonary embolism. Dalteparin had been given the day before. The patient continued to deteriorate and a palliative approach taken. She also tested positive for COVID-19 on day 3 of her admission. Coroner agreed the cause of death 1a) Ischaemic stroke of the brainstem 1b) Atrial fibrillation 2) Primary lung malignancy invading the left atrium with metastasis to the brain. Medical examiner scrutiny – death expected. Potential learning: case to be discussed at the Respiratory Team Mortality and Morbidity meeting.

10. Unexpected deaths

In Q4, there were 5 unexpected deaths:

1. A 90 year old man admitted with multiple comorbidities and treated for an ischaemic stroke, diagnosed with hospital onset COVID-19 infection and had an inpatient fall leading to an intracranial bleed from which he deteriorated and died. The case was referred to the coroner (SWARM F277). Learning: frequency of the falls risk assessment, staffing during COVID, known high risk patient.
2. A 79 year old man with known tetraplegia treated for sepsis secondary to a ureteric stone, transferred to RBH for a nephrostomy and transferred back to SFT for surgery. Developed aspiration pneumonia and COVID-19 and became fit for discharge. Further episode of aspiration pneumonia followed by a sudden cardiac arrest with return of spontaneous circulation but later died. Medical examiner – death unexpected and referred to the coroner. Family were concerned the patient was in a side room and would not be able to easily call for help.
3. A 90 year old frail man with dementia, falls had a sudden cardiac arrest (no signs of pulmonary embolism) with no obvious cause, not seen by a doctor over the weekend. DNAR should have been in place earlier in admission as the patient endured CPR. Medical examiner – death unexpected, referred to coroner. Learning: DNAR decision early in admission.
4. An 84 year old man admitted with known lung cancer receiving community palliative care and a traumatic subdural haematoma. Following treatment he became fit for discharge but had an inpatient fall and suffered a head injury (graded as no harm) whilst waiting for a package of care. No change in CT head. He received treatment for possible aspiration pneumonia but continued to deteriorate and died. Medical examiner – death unexpected, case referred to the coroner. Cause of death agreed 1a) aspiration pneumonia, 1b) carcinoma of the lung 2) Frailty of old age, chronic excess alcohol use.
5. A 48 year old man admitted with chest pain. CT angiogram showed an ascending aortic aneurysm. Whilst waiting for urgent transfer to UHS had cardiac arrest and died following a prolonged resuscitation. Delay in admission - GP had requested admission the day before but was asked to arrange an X-ray for the patient as an outpatient. Referred to coroner, post mortem revealed a dissecting thoracic aortic aneurysm. Case to be discussed at AMU Mortality and Morbidity meeting. Case discussed at the weekly Patient Safety Summit (currently graded as catastrophic harm)

11. Stillbirths, neonatal deaths and child deaths

In Q4 20/21:

- No stillbirths. Total stillbirths in 20/21 – 7.
- Three neonatal deaths of babies all born before 24 weeks with known fetal abnormalities and died of extreme prematurity. Total neonatal deaths in 20/21 – 7.
- One child death (SII 397) graded as catastrophic harm. Total child deaths in 20/21 – 1.

12. Patients with a learning disability

In Q4, 3 patients with learning disabilities died:

- A 68 year old man admitted from his care home with COVID-19 and treated in accordance with his expressed wish for full treatment. Despite active treatment, including CPAP, the patient deteriorated and died peacefully. Expected death. No potential learning identified.
- A 52 year old man with severe learning disabilities admitted with relapsed acute myeloid leukaemia and community acquired pneumonia. Treated with IV antibiotics and escalated to meropenem. CT head showed two indeterminate lesions. The next day he was found with a low GCS, hypertensive with a dilated pupil clinically considered a spontaneous intracerebral haemorrhage and died shortly afterwards. Medical Examiner considered death was sudden but not unexpected. No potential learning identified.
- A 67 year old man admitted from his nursing home where he was diagnosed with COVID-19 3 days before. Active treatment of COVID-19 pneumonia with antibiotics, dexamethasone, fluids and treatment dose of anticoagulation therapy but showed no signs of improvement after 3 days of treatment. Safeguarding concern raised poor oral intake and feeding support on the ward. The patient continued to deteriorate and died. Case referred to the coroner. Medical examiner scrutiny: death sudden not unexpected. Potential learning – case subject to a structured judgement review.

13. Patients with a serious mental illness

In Q4, 2 patients with a serious mental illness died:

- An 82 year old woman who was an inpatient at Fountain's Way Hospital under a Section 3 of the Mental Health Act for psychosis. Transferred to SDH as COVID positive and despite active treatment died within 24 hours of admission. Death to be reviewed by Consultant Psychiatrist.
- A 73 year old man who was an inpatient at Fountain's Way Hospital under a Section 3 of the Mental Health Act for a diagnosis and treatment of a first psychotic episode. Transferred to SDH following a GI bleed due to a duodenal ulcer investigated and treated with an OGD – adrenaline injected and clipped. The patient was also COVID positive following an outbreak at Fountain's Way hospital and treated for COVID pneumonia and later had a possible STEMI but was not able to have acute coronary syndrome treatment as high risk from recent GI bleed and died later the same night. The death was not considered avoidable. Death to be reviewed by Consultant Psychiatrist.

14. HSMR rolling 12 month trend to January 21

Figure 2: HSMR relative risk of all diagnoses Feb 20 – Jan 21

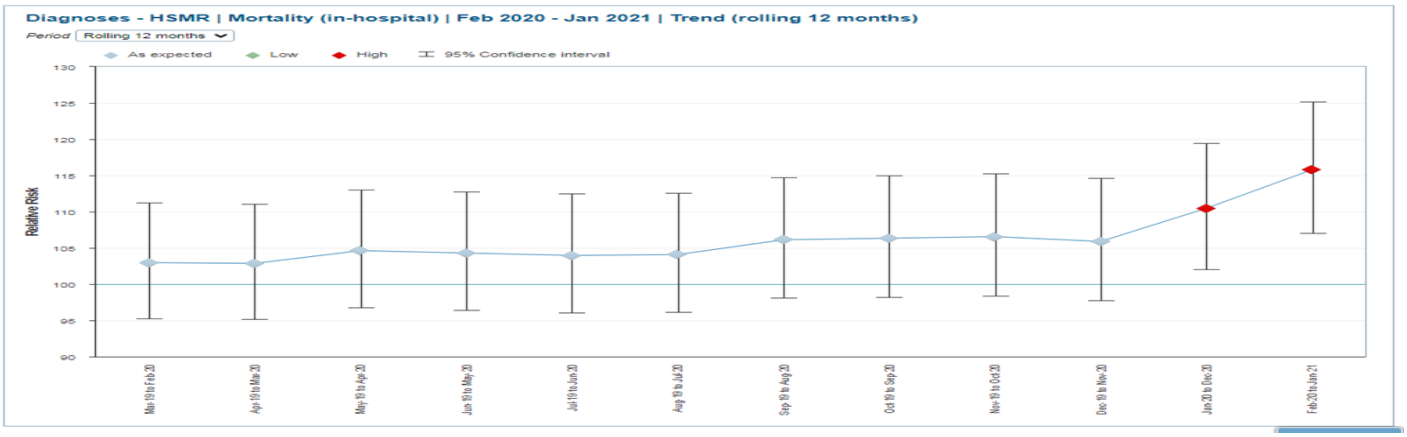
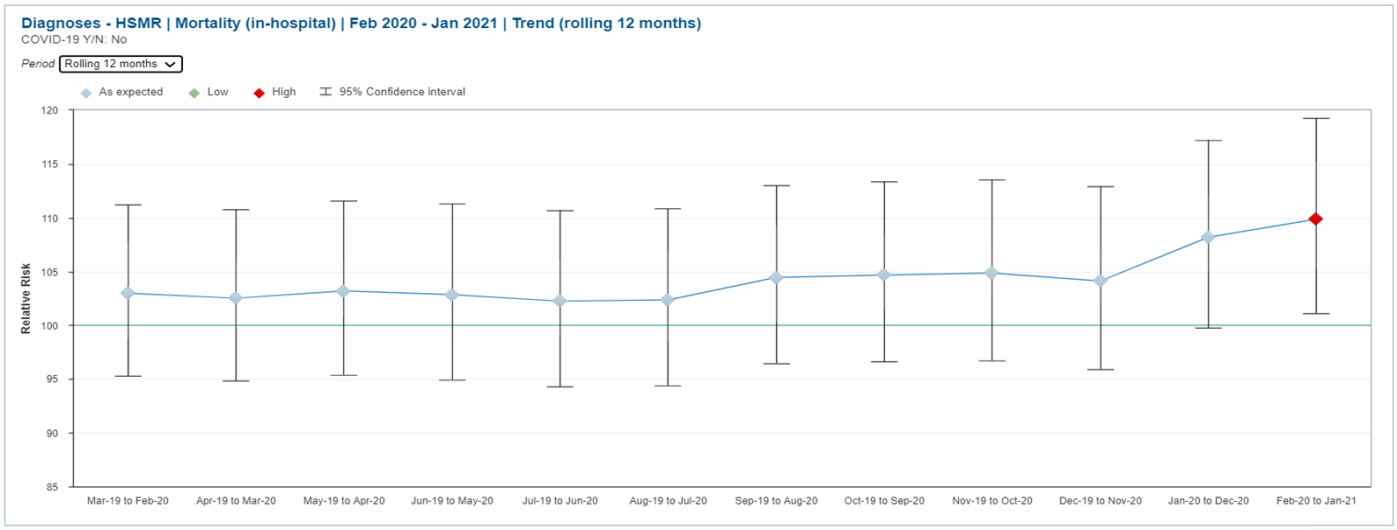


Figure 2 shows HSMR is 115.8 and is statistically significantly higher than expected from December 20 for all diagnoses. If COVID-19 is excluded, the HMSR is 109.9 and remains statistically significantly higher than expected – see Figure 3.

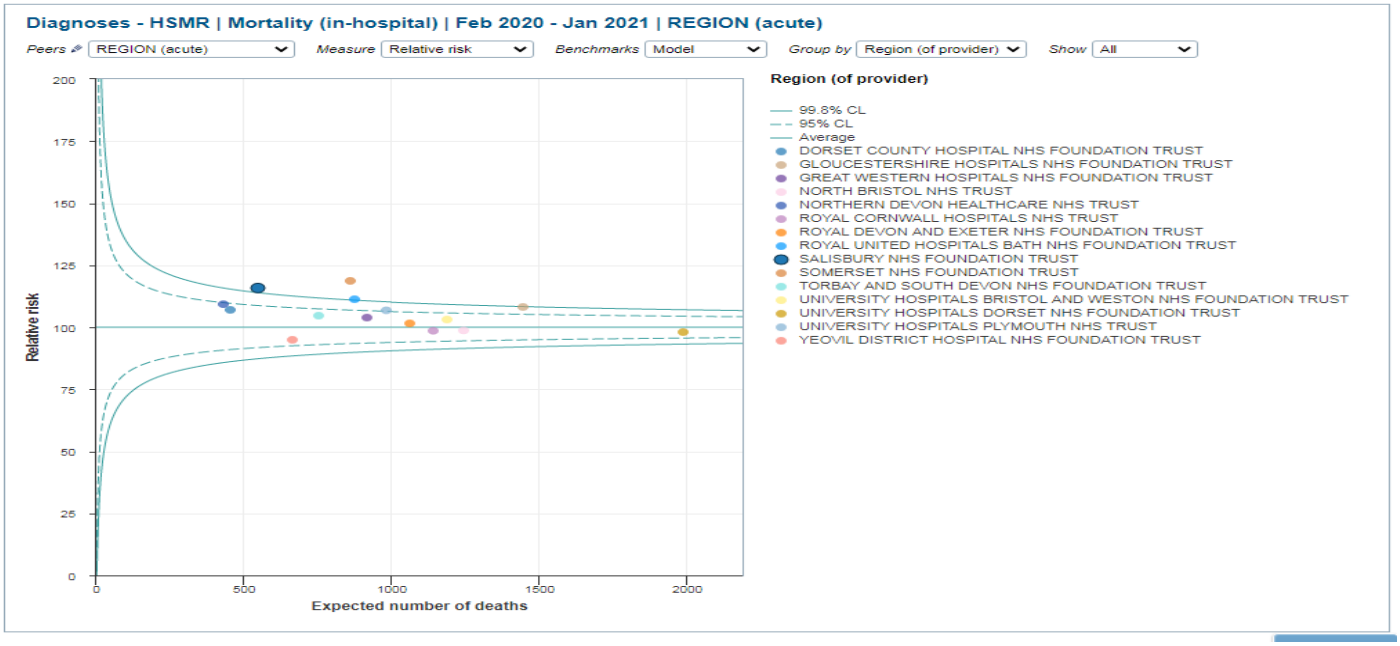
Figure 3: HSMR relative risk excluding COVID-19 Feb 20 – Jan 21



The Trust's HSMR has increased in Q4 likely due to the effect of COVID deaths, both in terms of direct mortality from COVID, as well as a secondary bias effect (the reduced bed base occupied by non-COVID patients and a likely increase in acuity for non-COVID activity as well as a differential in the dates of COVID pressures nationally), making accurate benchmarking difficult. The Chief Medical Officer and the Mortality Surveillance Group are monitoring Q1 2021/22 data with an expectation of normalisation of mortality indices. The Chief Medical Officer has also commissioned a review of non-COVID related deaths to ensure no omissions in care. The SHMI which retains all palliative care coded spells and has had COVID activity removed, shows the main hospital site remains within the expected range at 95.26.

15. Mortality (in-hospital) regional peer comparison Feb 20 – Jan 21

Figure 4: Mortality (in-hospital) regional peer comparison Feb 20 – Jan 21



A peer comparison of regional acute Trusts shows that this Trust is one of five with an HSMR that is statistically significantly higher than expected. 8 Trusts had an HSMR within the expected range and 2 have an HSMR statistically significantly lower than expected

Figure 5: Mortality (all diagnoses) comparison to COVID similar peers (Feb 20 – Jan 21)

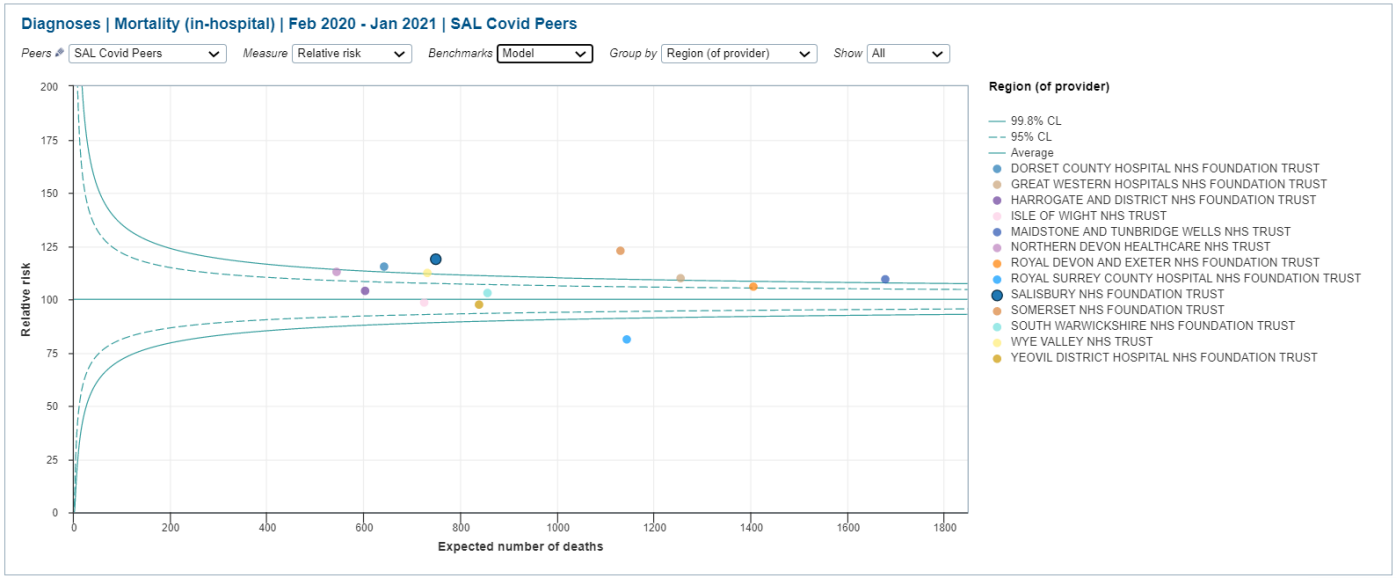


Figure 5 shows the Trust is sitting above the outer control limit along with a number of other Trusts in the peer group.

Figure 6: Mortality (all diagnoses) comparison to COVIDs similar peer group (Feb 20 – Jan 21)

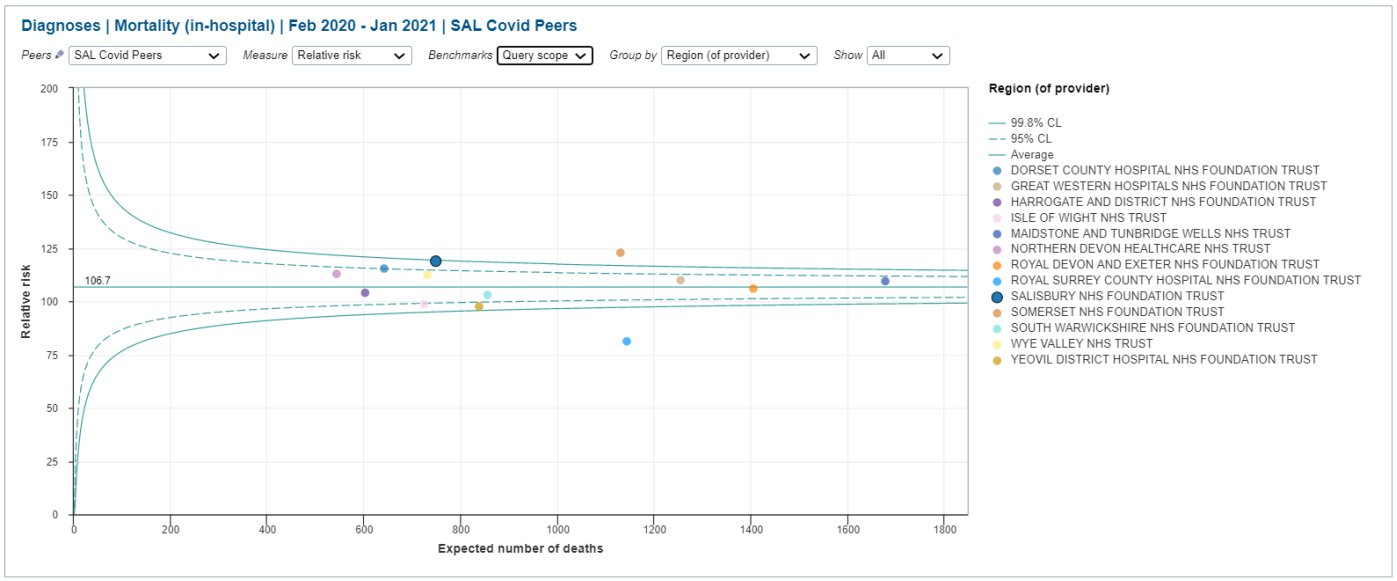
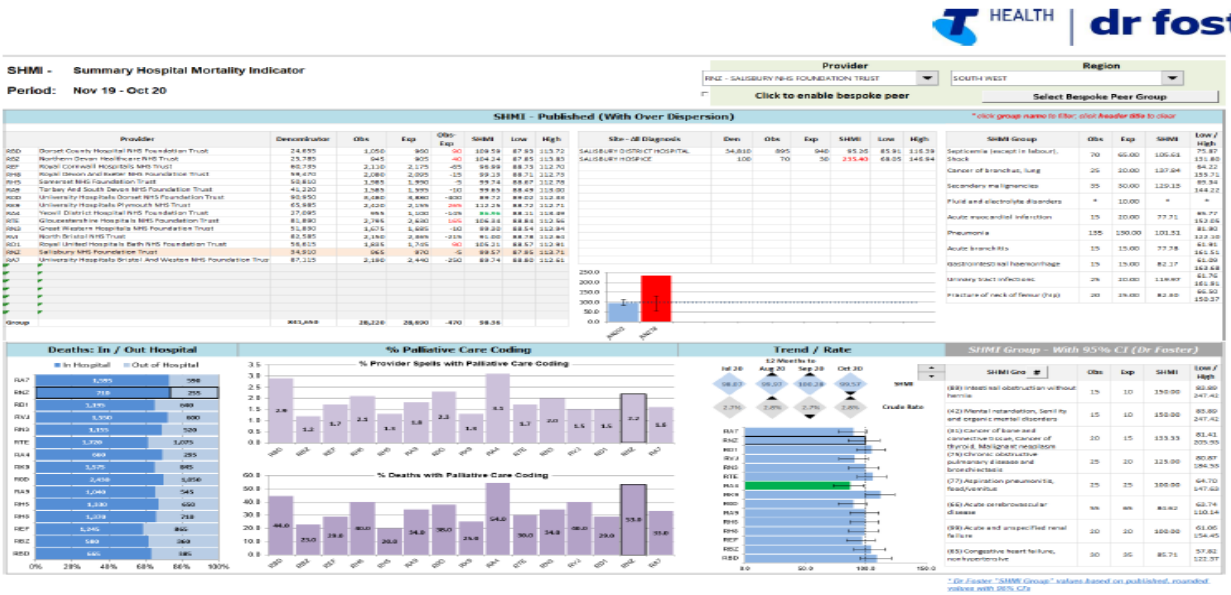


Figure 6 re-adjusts the benchmark to that of the COVID similar peer group (i.e the centre line of the funnel plot has moved to represent the average of the peer group) and this brings the Trust just within the outer control limits.

16. SHMI Nov 2019 – Oct 2020

SHMI is 99.57 within the expected range to October 2020 and when adjusted for palliative care is 88.5. When comparing SHMI by site Salisbury District Hospital is 95.26 and Salisbury Hospice is 235.40. When compared with regional peers the Trust has a SHMI within the expected range.

Figure 7: SHMI regional peer comparison Nov 2019 – Oct 2020



17. Comorbidity and palliative care profile 20/21

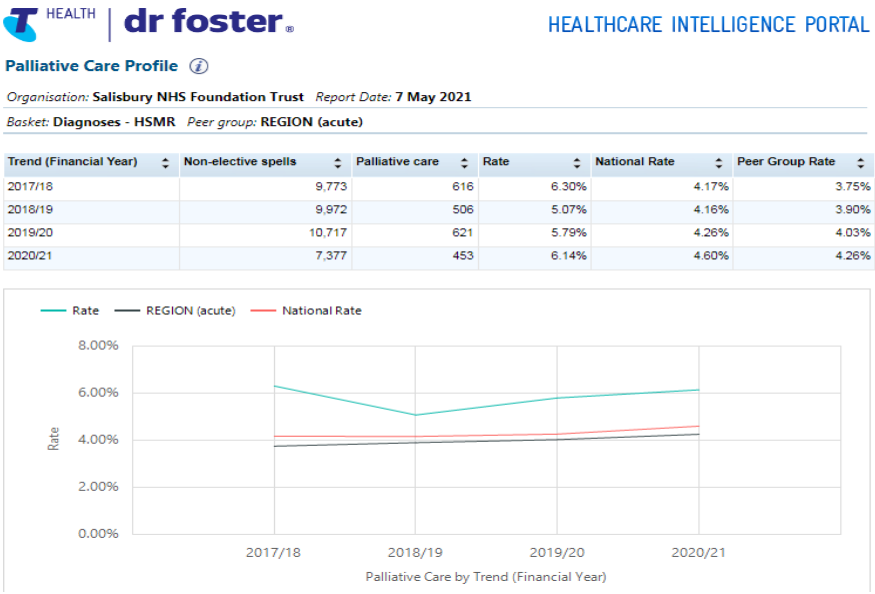
Trends in comorbidity coding have shown an improvement since the Q3 20/21 report in the Trust's Charlson comorbidity upper quartile rate for the HSMR basket from 22.3% in Q3 to 23.6% in Q4 and an improvement as an index of national from 89 in Q3 to 95 in Q4. This means the proportion of a Trust's HSMR spells are where the Charlson comorbidity score for the primary diagnosis episode is in the national upper quartile for that diagnosis and admission type (the observed value). The expected value is the equivalent proportion nationally (100).

It was noted in the Q1 report that SFT had a lower than average number of secondary diagnosis codes overall. In response, the Clinical Coding Department undertook an audit and made a number of improvements. A further audit took place in Q3 based on Dr Foster's diagnosis group, highest numbers under the P25 centile with no Charlson comorbidities and those recorded outside of the first 14 codes. So far, 14 diagnostic groups and 442 episodes have been subject to audit. The outcome showed that 5% of episodes were found to have missing Charlson comorbidities and 0.9% of episodes with Charlson comorbidities were recorded after the first 14 diagnostic codes. 4 diagnostic groups are still to be audited and a final report issued. The interim action, as 57% of the episodes related to endoscopy elective day cases, is to review the data sources from endoscopy coding by 30/9/21. The interim report will be presented to the Mortality Surveillance Group in June 2021.

Figure 8: Trend in comorbidity profile

	2017/18	2018/19	2019/20	2020/21
Upper-quartile comorbidity	24.5%	24.2%	23.3%	23.6%
as index of national (100)	98	97	93	95

Figure 9: Trend in palliative care profile



Trend (Financial Year)	Non-elective spells	Palliative care	Rate	National Rate	Peer Group Rate
2017/18	9,773	616	6.30%	4.17%	3.75%
2018/19	9,972	506	5.07%	4.16%	3.90%
2019/20	10,717	621	5.79%	4.26%	4.03%
2020/21	7,377	453	6.14%	4.60%	4.26%

The trend in the Trust's palliative care coding rate for non-elective spells in 20/21 is 6.14% and remains higher than the national rate of 4.60% and peer group rate of 4.26%.

18. Weekday/weekend HSMR

Figure 10 shows the non-elective weekday HSMR is 114.1 and weekend HSMR is 122.2 to January 21 showing a significant increase since October 2020. Emergency admissions overall have a statistically significantly higher than expected relative risk.

Figure 10: HSMR weekday/weekend admission Feb 20 – Jan 21

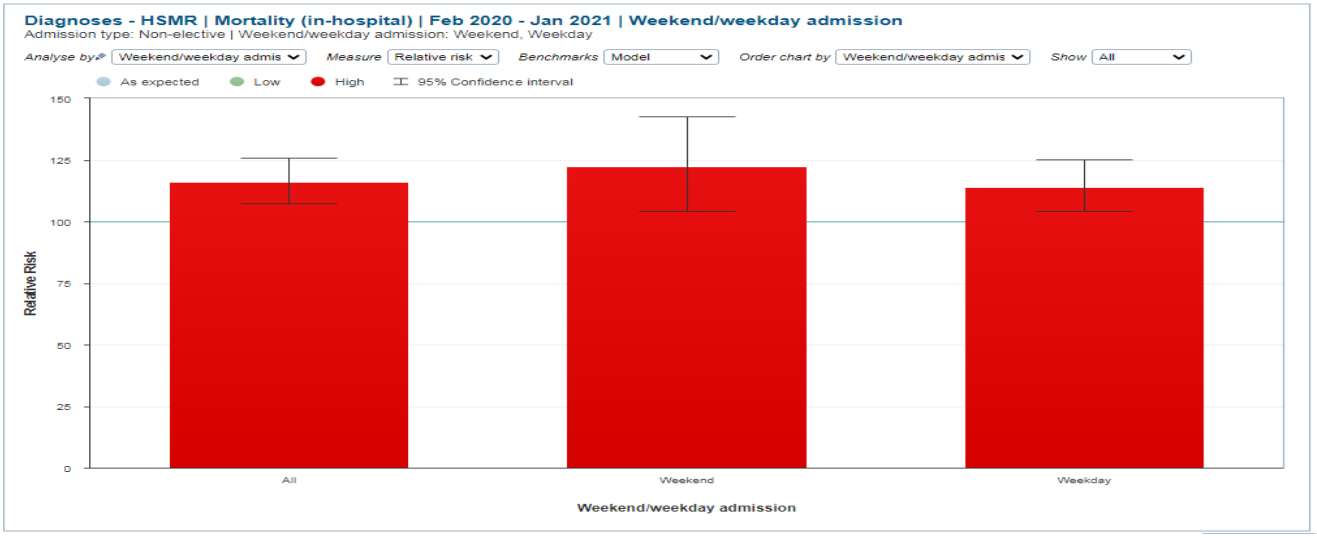
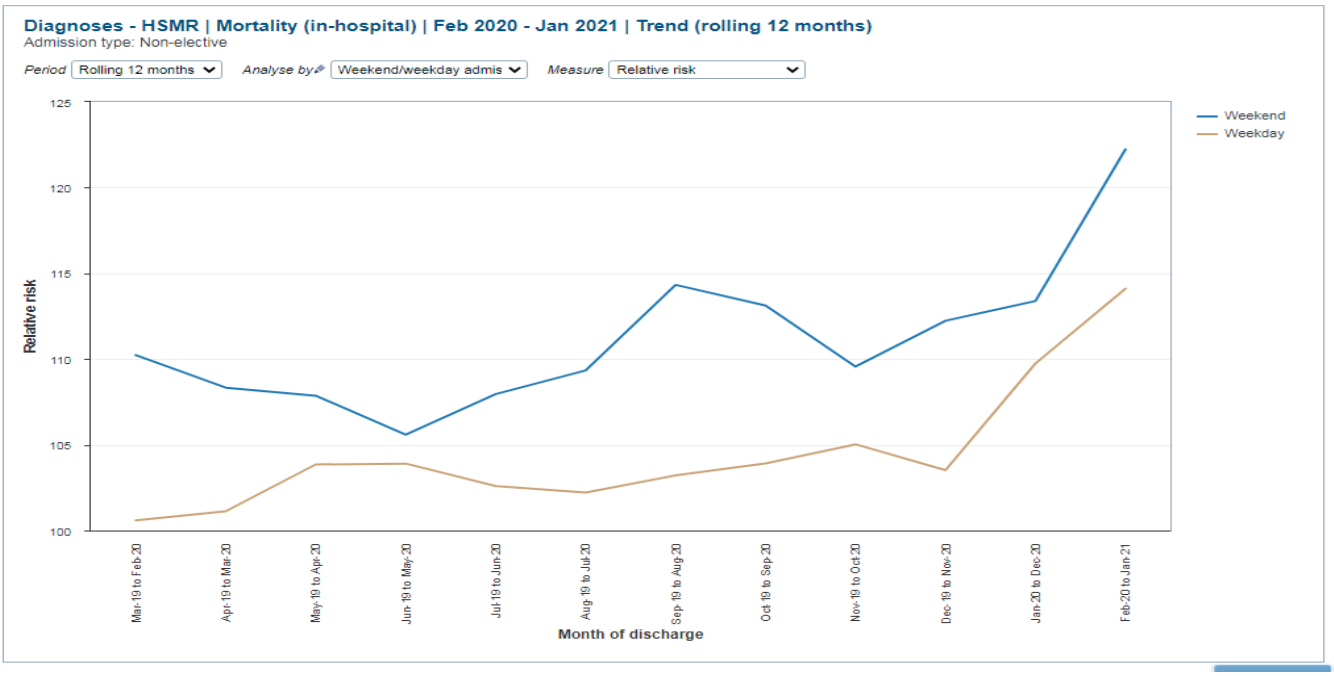


Figure 11: Rolling 12 month trend in emergency weekend and weekday Feb 20 – Jan 21



The rolling 12 month trend shows both weekday and weekend HSMR has shown an overall linear increase.

19. Deaths in high risk diagnosis groups (Feb 20 – Jan 21)

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

Figure 12: Trend in relative risk for septicaemia (except in labour)

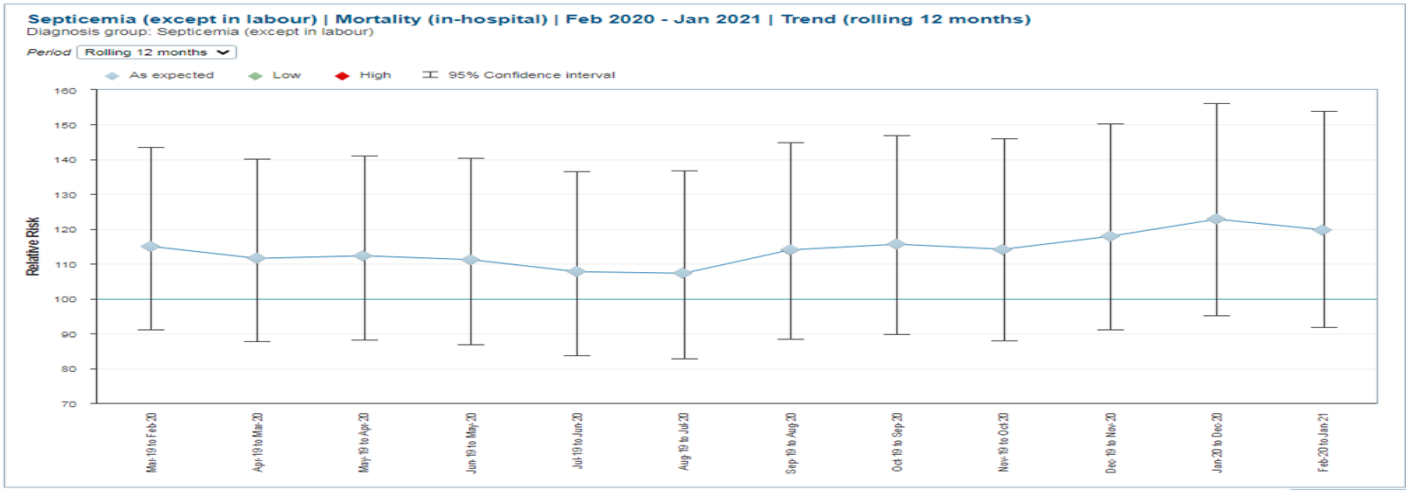


Figure 13: Trend in relative risk for pneumonia

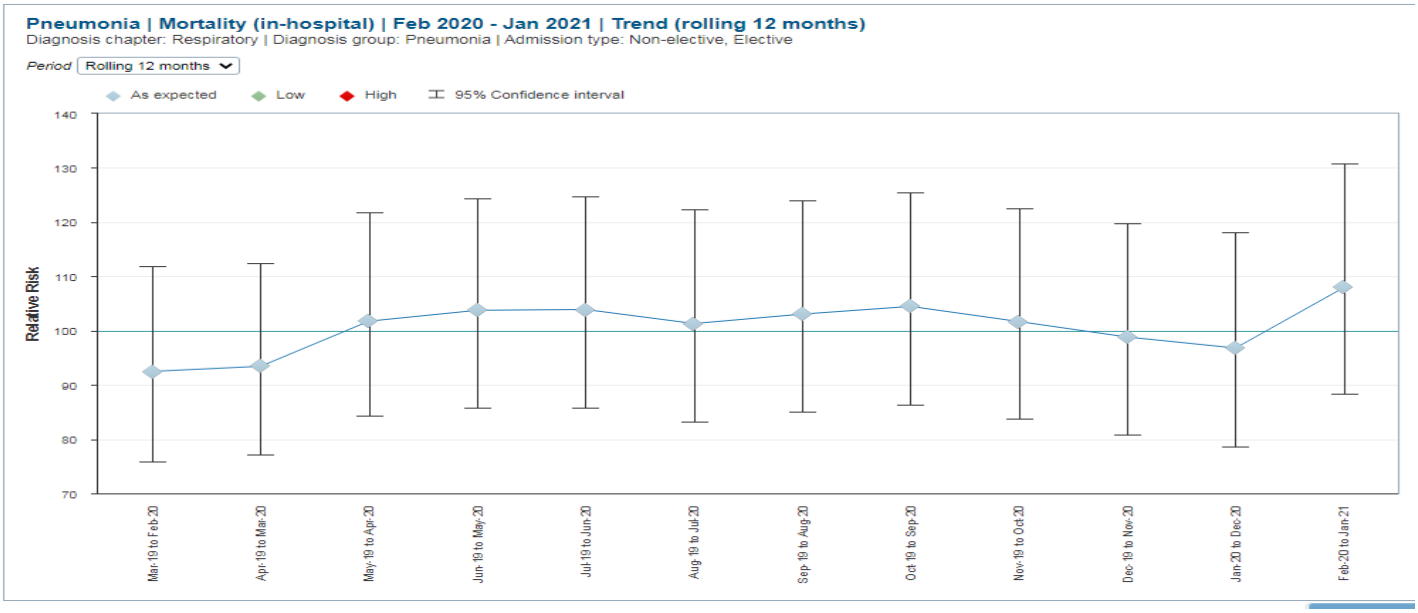


Figure 14: Trend in relative risk for acute cerebrovascular disease

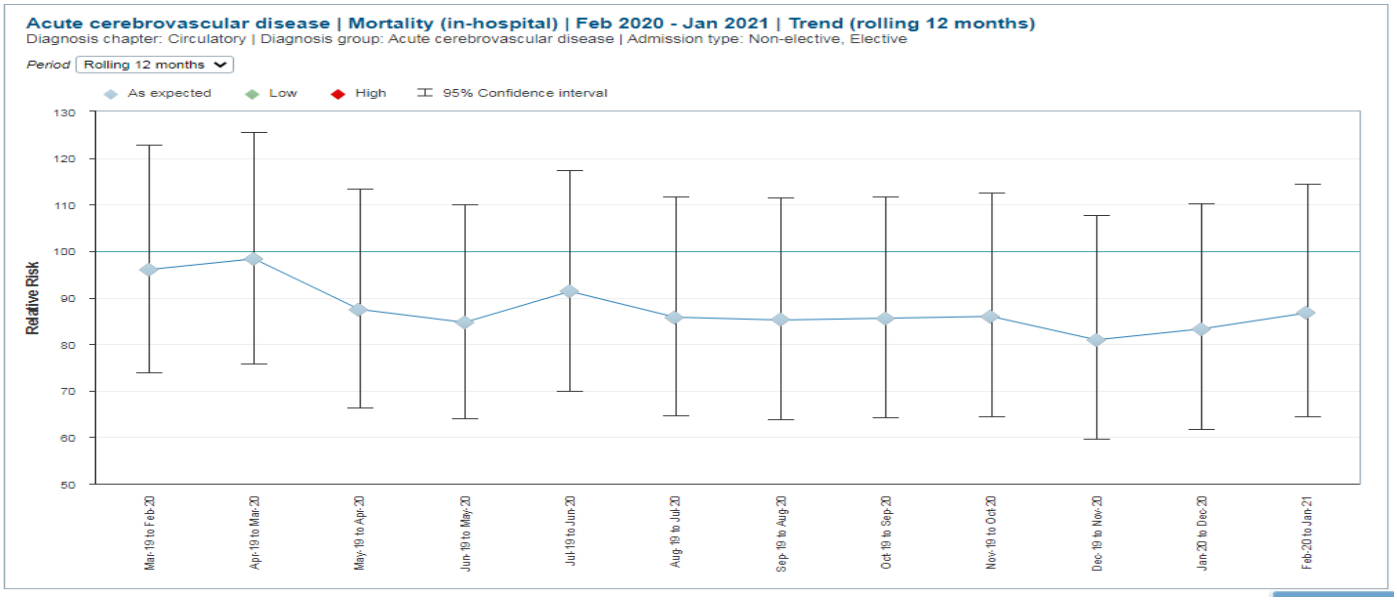


Figure 15: Trend in relative risk for acute myocardial infarction

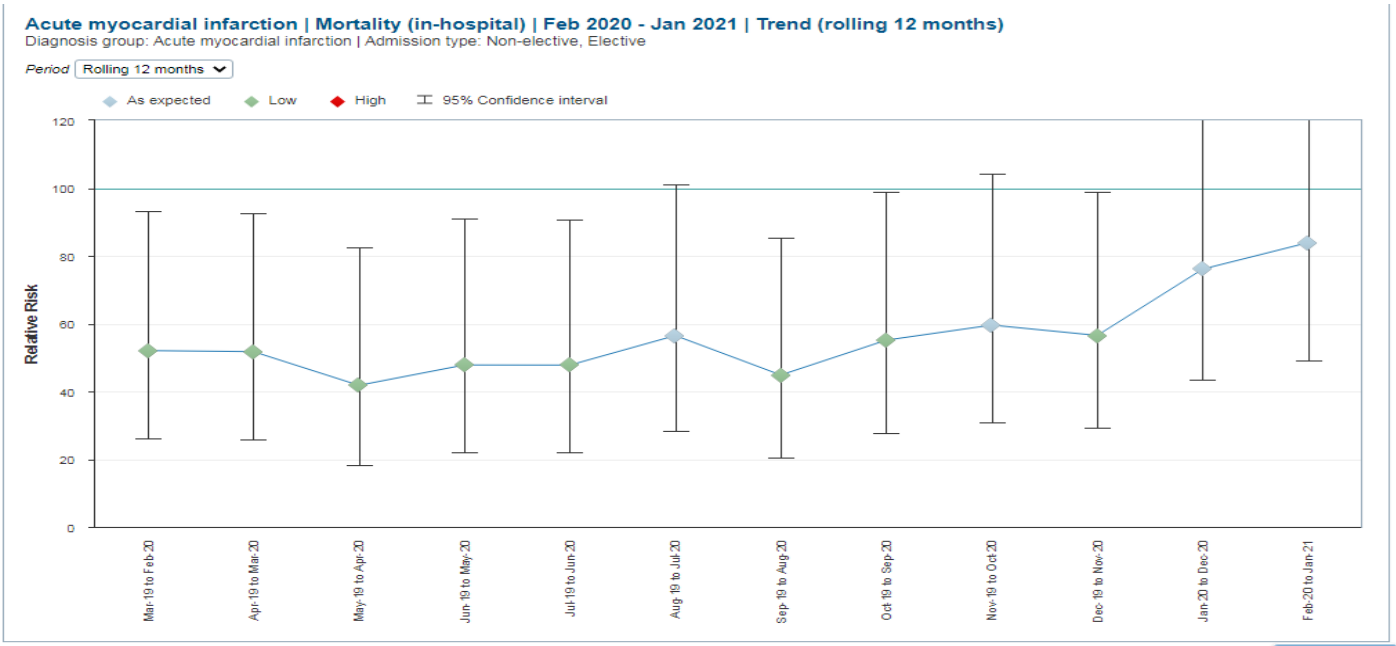
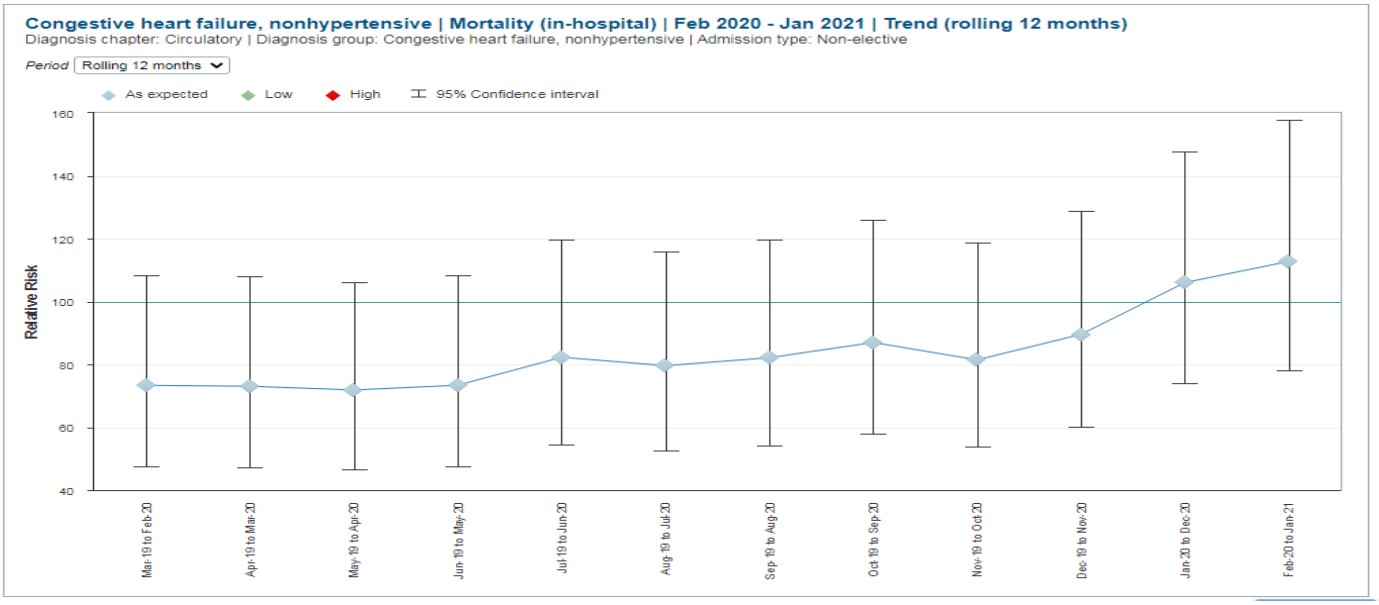


Figure 16: Trend in relative risk for congestive heart failure



In response to the upward trend in congestive heart failure, non hypertensive from January 20 – December 20, a local audit was undertaken of 13 cases randomly selected from 35 cases that were flagged as a relative risk in the data. Of the 13 cases:

- Patient age ranged from 67 – 94 years old, median age 88.4 years
- 85% had heart failure team involvement.
- 1 patient had COVID-19 disease.

The type of heart failure was:

- HFrEF – Heart failure with reduced ejection fraction
- HFpEF – Heart failure with preserved ejection fraction
- Valve disease; not for intervention – usually patients approaching end of life.

Advanced care planning:

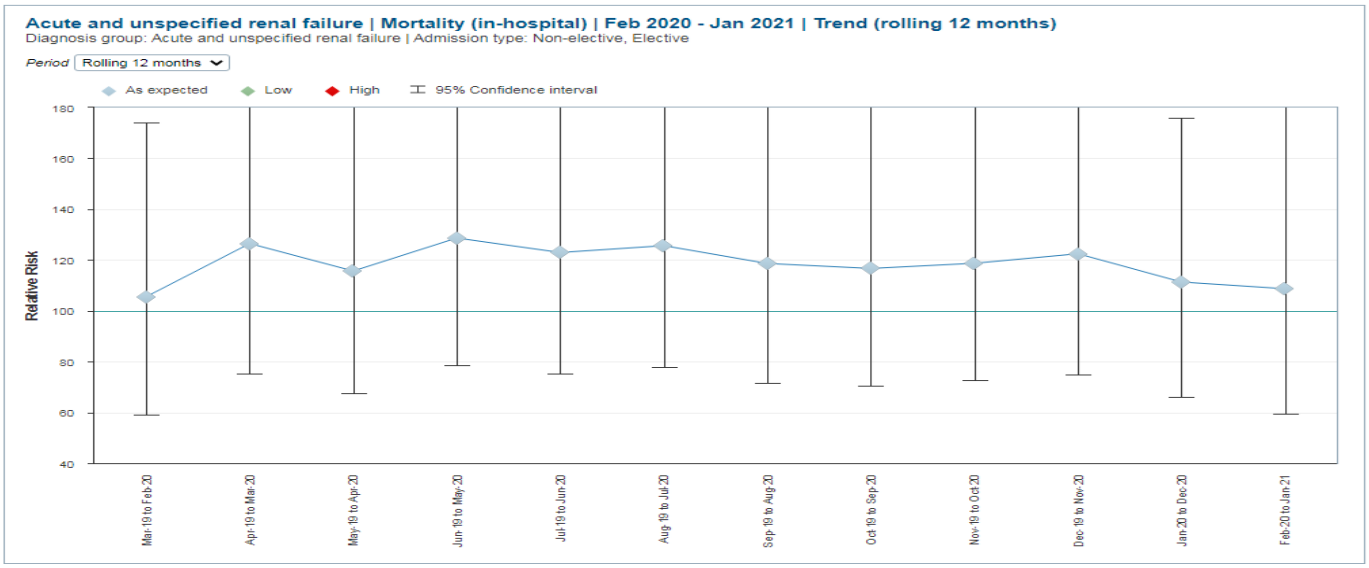
- 100% had a DNAR signed during admission
- 77% were referred to palliative care / end of life care team

- 100% had documented conversations with family regarding deterioration and involvement of chaplaincy. Good care.

Conclusions:

- Heart failure is a progressive disease in a group of older patients.
- HFrEF patients have disease modifying and mortality reducing interventions. Seen by Heart Failure team and medication prescriptions.
- HFpEF – there are no disease modifying treatment protocols – symptom control is the mainstay of treatment.
- National audit data suggests that the lower mortality rates are in patients seen by heart failure teams who should be involved in ALL patients as their input improves patient outcomes overall. In this Trust, heart failure patients are either admitted to the Cardiology ward or to a general medical ward and are seen as part of a Cardiology outreach service within the Trust.

Figure 17: Trend in relative risk for acute and unspecified renal failure



In June 2020 an assurance report was presented at the Mortality Surveillance Group following an increase in the number of expected deaths of patients with an acute kidney injury (AKI) admitted as an emergency to the Trust. A retrospective case notes review of 15 deaths of patients was completed of those admitted to hospital between November 2018 and October 2019. An update on the progress of the action plan was presented at the Mortality Surveillance Group in April 21.

Action plan:

1. Develop Trust guidelines for the management of metabolic acidosis ?Dr James Haslam
2. Obtain an update on the implementation of NHSI (2019) alert 'resources to support safe and timely management of hyperkalaemia' – Dr James Haslam – completed.
3. Improve the compliance with accurate fluid balance monitoring – (CR 353) - Kirsty Benfield and Emma Cox.
4. Improve compliance with urinalysis undertaken as part of the screening process on admission – TBC.
5. Follow up monitoring of in-patients who have received IV contrast – Maria Ford.

The Chief Medical Officer agreed that Dr Haslam is the right person to lead on the management of hyperkalaemia/metabolic acidosis and agreed to ask him to complete this work. In discussion with the Chief Nurse, it was agreed to prepare a work plan for the Patient Experience and Patient Safety Group (PEPS) and include fluid balance monitoring and urinalysis improvement work in the plan. Progress to be reported to the PEPS group.

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Figure 18: Trend in relative risk for fracture of neck of femur

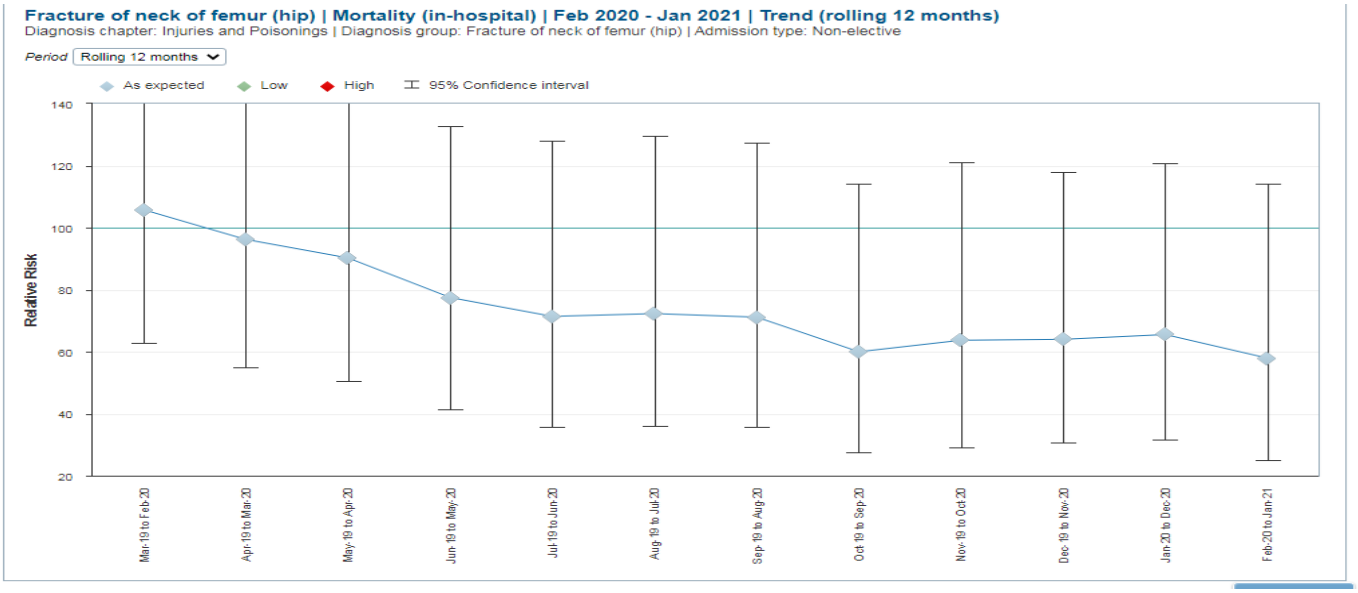
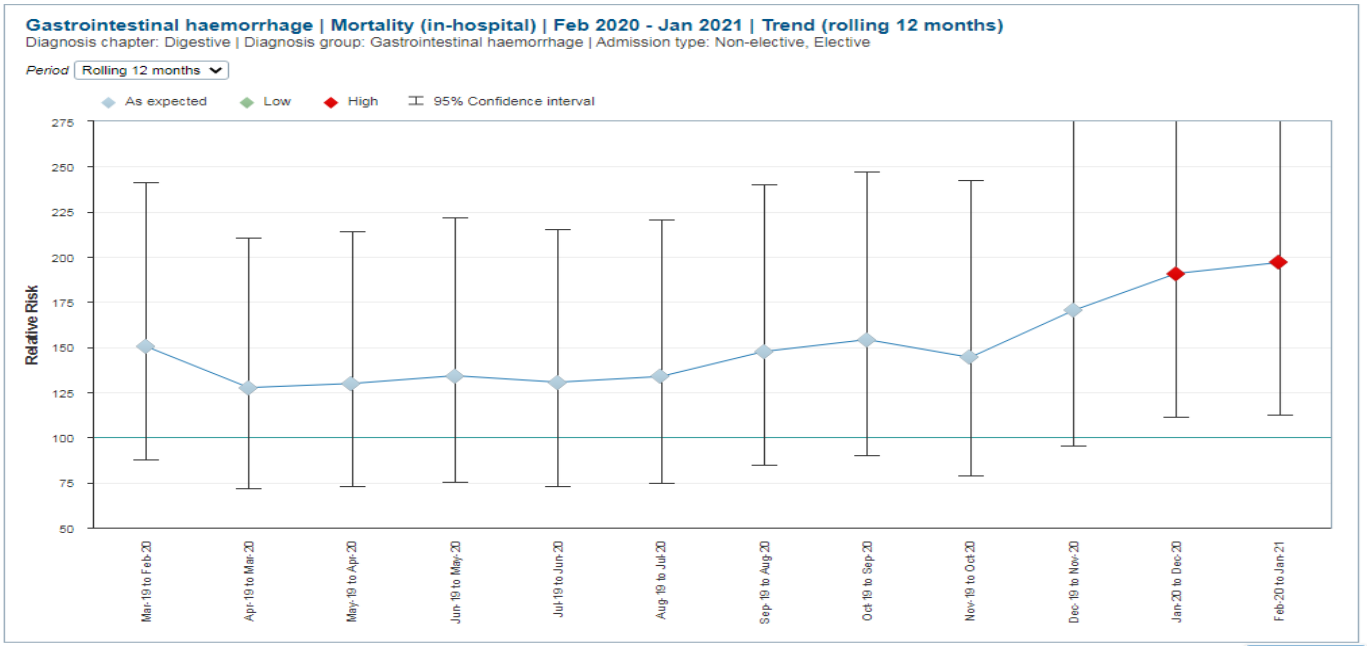


Figure 19: Trend in relative risk for gastrointestinal haemorrhage



A gastrointestinal haemorrhage CUSUM alert arose in August 2020 of 16 patients who died compared to 4.6 expected with a relative risk of 144. The 16 deaths occurred between October 2019 and October 2020 15 of the 16 cases had been reviewed but the analysis needs to be completed and a report prepared.

The initial findings:

- Some excellent care especially in time to consultant review and management of medication.
- The absence of the use of the acute upper GI bleed care bundle led to subjective decision making.
- Five patients had an OGD delayed or did not have one at all due to the Trust's inability to provide an out of hours endoscopy service on site. All the patients were frail and thus it is unlikely (but not impossible) that this affected outcome.

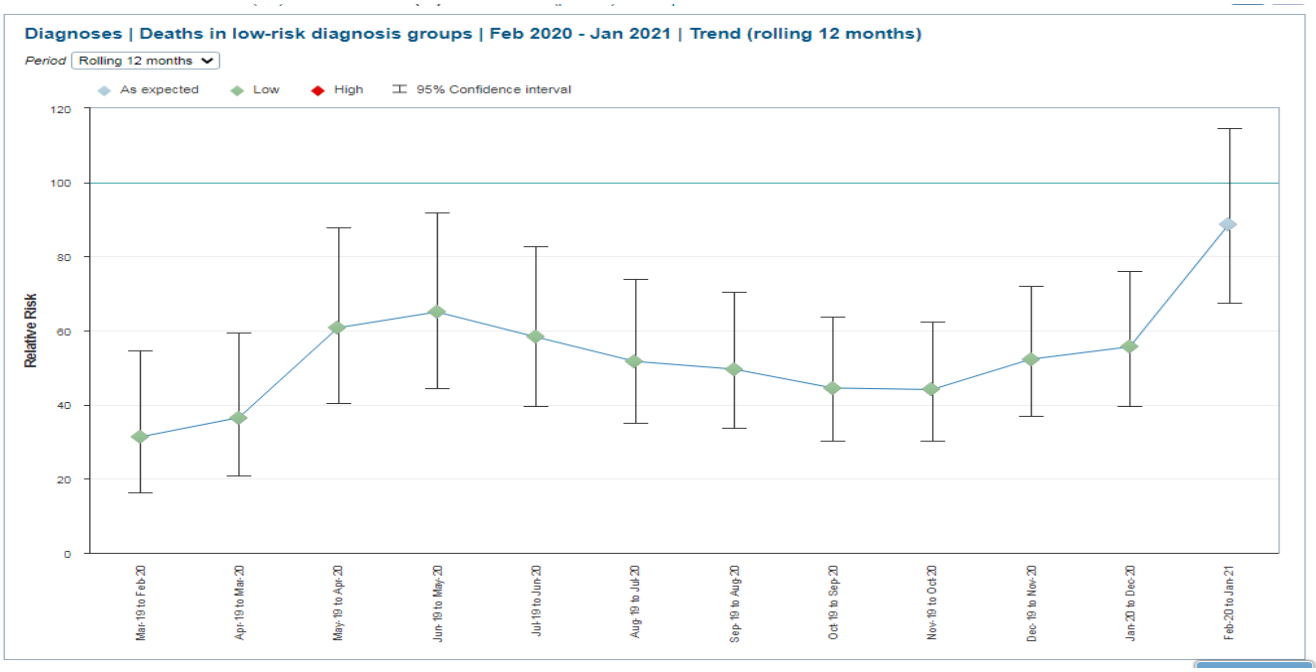
Areas for improvement are:

- ➢ Implement the acute upper GI bleed care bundle.
- ➢ Review the out of hours endoscopy provision to improve the timely access for patients who need an urgent endoscopy.

The finalised report will be presented at the Mortality Surveillance Group in June 2021.

20. Deaths in low risk diagnosis groups (Feb 20 – Jan 21)

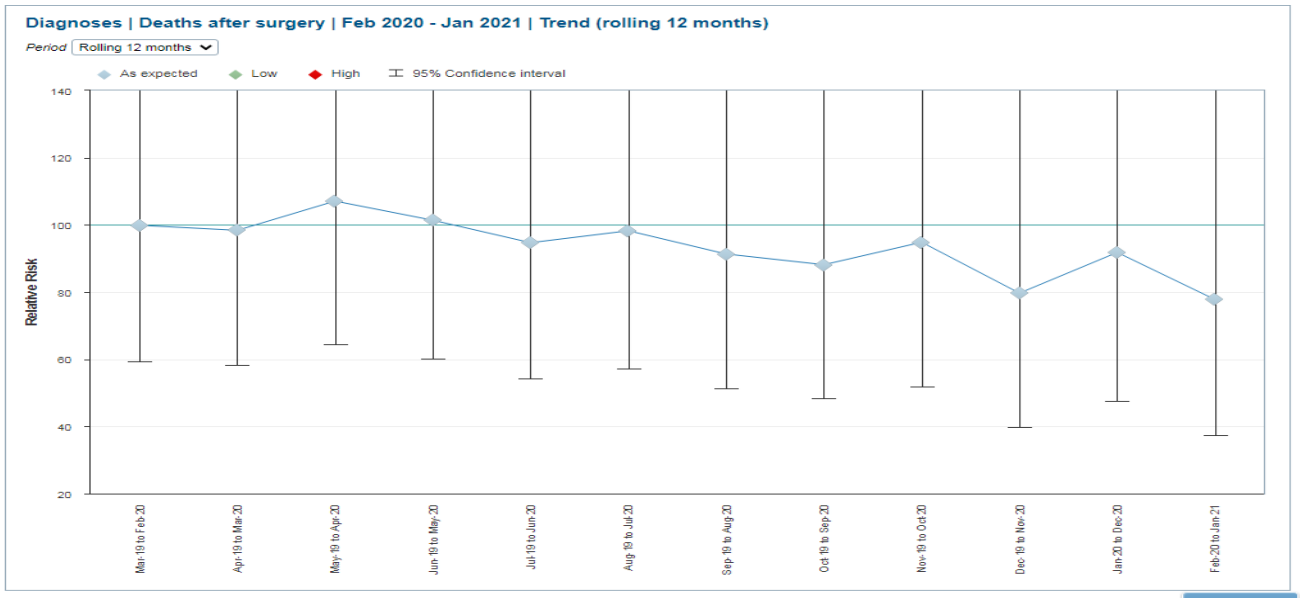
Figure 20: Trend in relative risk for deaths in low risk diagnosis groups



The relative risk of death in a low risk group is 88.7 and is lower than expected. The rise in January 2021 is attributed to deaths in the viral infection group (COVID-19) which is considered a low risk diagnosis group.

21. Deaths after surgery (Feb 20 – Jan 21)

Figure 21: Trend in relative risk for deaths after surgery



The relative risk of death after surgery is 77.8 and is as expected.

22. Summary

Learning from deaths in Q4 has again been dominated by patients who died from COVID-19 where there was an increase in the number of hospital acquired COVID cases mitigated by additional measures already put in place to reduce the risk of nosocomial transmission. Improvements made in response to learning from the Q3 bereavement survey showed that 50% of families were contacted by the EOLC or HPCT team, use of messagetoalovedone increased, changes were made to visiting practice so more relatives could be with their loved ones at the end of life and communication training undertaken with key staff.

Positive assurance of the management of patients with heart failure. Of concern, is the management of some patients who died of a gastrointestinal haemorrhage in respect of the absence of the use of the acute upper GI bleed care bundle and delay in OGD due to the inability to provide an out of hours endoscopy service on site. Both are the focus of improvement actions. Improvements required in fluid balance monitoring and urinalysis on admission are now part of the patient safety programme.

The Trust's HSMR has increased in Q4 likely due to the effect of COVID deaths, both in terms of direct mortality from COVID, as well as the secondary bias effects (the reduced bed base occupied by non-COVID patients, a likely increase in acuity for non-COVID activity, as well as a differential in the dates of COVID pressures nationally), making accurate benchmarking difficult. The Chief Medical Officer and the Mortality Surveillance Group are monitoring Q1 2021/22 data with an expectation of normalisation of mortality indices. The Chief Medical Officer has also commissioned a review of non-COVID related deaths to ensure no omissions in care. The SHMI which retains all palliative care coded spells and has had COVID activity removed, shows the main hospital site remains within the expected range at 95.26.

23. Recommendation

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

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

Claire Gorzanski,
Head of Clinical Effectiveness

14 May 2021
PC updated 26/5/2021

Appendix 1 **SALISBURY NHS FOUNDATION TRUST - MORTALITY DASHBOARD 2020/2021**

	Apr 20	May 20	Jun 20	Q1	Jul 20	Aug20	Sep 20	Q2	Oct 20	Nov 20	Dec 20	Q3	Jan 21	Feb 21	Mar 21	Q4	Total
Deaths	98	60	49	**207**	65	55	58	**178**	65	65	88	**218**	151	66	64	**281**	**884**
1st screen	94	56	48	**198**	63	47	54	**164**	60	61	86	**207**	140	60	61	**261**	**830**
% 1st screen (QAP)	96%	93%	98%	**96%**	97%	85%	93%	**92%**	92%	94%	98%	**95%**	93%	91%	95%	**93%**	**94%**
Medical Examiner (ME) scrutiny						22	43	**65**	47	49	77	**173**	133	51	50	**234**	**472**
% ME scrutiny						40%	74%	**57%**	78%	75%	87%	**79%**	88%	77%	78%	**83%**	**77%**
Case reviews (SJR)	54	16	10	**80**	11	0	0	**11**	3	11	21	**35**	98*	26*	14*	**138**	**264**
% case reviews	55%	27%	20%	**39%**	17%	0%	0%	**6%**	4%	17%	24%	**16%**	65%	39%	22%	**49%**	**30%**
COVID +ve deaths	42	6	3	**51**	0	0	0	**0**	1	7	14	**22**	97	26	11	**134**	**207**
Deaths with Hogan score 1	89	58	47	**194**	65	54	55	**174**	64	64	86	**214**	148	65	62	**275**	**857**
Deaths with Hogan score 2 - 3	7	2	2	**11**	0	1	3	**4**	1	1	2	**4**	3	1	2	**6**	**25**
Deaths with Hogan score 4 - 6	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**
Learning points	13	4	2	**19**	0	2	4	**6**	6	6	9	**21**	17	4	3	**24**	**70**
Family/carer concerns	1	6	5	**12**	0	2	3	**5**	3	2	5	**10**	6	2	2	**10**	**37**
CUSUM alerts	1	0	0	**1**	1	13	1	**15**	2	3	1	**6**	0	0	3	**3**	**25**
CUSUM investigated	0	0	0	**0**	1	12	0	**13**	0	3	0	**3**	0	0	0	**0**	**16**
Deaths investigated as a SII	1	1	0	**2**	0	0	1	**1**	1	1	4	**6**	2	0	0	**2**	**11**
SIIs graded as catastrophic	0	0	0	**0**	0	0	1	**1**	1	1	2	**4**	2	0	0	**2**	**7**
Death following an elective admission	0	1	1	**2**	1	0	1	**2**	1	2	0	**3**	1	1	0	**2**	**9**
Unexpected death	1	1	0	**2**	2	0	0	**2**	1	3	3	**7**	2	0	3	**5**	**16**

Stillbirth	1	1	0	**2**	0	0	1	1	0	0	4	**4**	0	0	0	**0**	**7**
Neonatal death	1	0	0	**1**	0	2	0	2	0	1	0	**1**	0	1	2	**3**	**7**
Child death	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	0	0	**1**	**1**
Learning disability deaths	1	0	0	**1**	0	0	1	**1***	0	1	1	**2**	1	1	1	**3**	**7**
Reported to LeDeR programme	1	0	0	**0**	0	0	0	**0**	0	1	1	**2**	0**	0**	0**	**0****	**3**
Serious mental illness	0	0	0	**0**	0	3	0	**3**	0	0	0	**0**	2	0	0	**2**	**5**
Maternal deaths	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**

Note explanatory notes in appendix 3 * SJR to be completed by Q1 21/22 ** 3 cases will be reported to the LeDeR programme when reviews completed.

MORTALITY DASHBOARD THEMES AND ACTIONS 2020/2021 **Appendix 2**

No	Learning points	Action point	By whom	By when	Update 10/5/21	Status
1	Plan the introduction of the ReSPECT form (Treatment Escalation Plan & DNAR form)	Work programme to be developed with planned implementation by 31/3/2021	BSW CCG and Resuscitation Committee	31/03/21 Extend to 30/9/21	The national version 3 was published in August 20. BSW CCG are leading the introduction of ReSPECT with support from SFT's Resuscitation Officer and Resuscitation Committee. A further planning meeting took place on 5/5/21 with a plan agreed to roll out ReSPECT system wide over the next 6 months	
2.	Learning arising from the COVID death (1st wave) review in Q1 & Q2 20/21	Evaluate the effectiveness of the actions already taken from the review of patients who die from COVID in the 2nd wave.	Divisional Management Teams	31/03/21	The review of deaths of patients with COVID-19 was presented to the Clinical Governance Committee in November 20.	
3	Learning arising from the COVID death (2nd wave) review	Raise learning themes as they arise so that changes can be made in real time.	Medical Examiners SPCT/EOLC teams	31/3/2021	Additional measures put in place to mitigate the risk of nosocomial transmission – see section 3 of Q4 20/21 report	

SALISBURY NHS FOUNDATION TRUST
MORTALITY DASHBOARD – EXPLANATION OF TERMS

1. Deaths – the number of adult, child and young people deaths in the hospital including the Emergency Department and the Hospice.

2. 1st screen - the Qualified Attending Practitioner (QAP) develops and records their own preliminary view of the cause of death before discussing the case with the Medical Examiner or Medical Examiner Officer and only completes the medical certificate of the cause of death (MCCD) after this discussion.

3. Medical Examiner scrutiny – the number and proportion of deaths scrutinised by a Medical Examiner. Medical Examiners are senior medical doctors who review deaths and are trained in the legal and clinical elements of the death certification processes. The purpose of the Medical Examiner system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths, provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased and to improve the quality of death certification.

4. Case review (SJR) - the number and proportion of deaths subject to a full case review using the structured judgement review (SJR) method. Case record reviews involve finely balanced judgements. Different reviewers may have different opinions about whether problems in care caused a death. This is why the data is not comparable.

5. COVID deaths – the number of patients who died in hospital who tested positive for COVID.

6. Deaths with a Hogan score* of 1 – 3. The scores are defined as: 1) Definitely not avoidable 2) Slight evidence of avoidability 3) Possibly avoidable but not very likely less than 50/50.

7. Deaths with a Hogan score* of 4 – 6. The scores are defined as 4) Probably avoidable more than 50/50. 5) Strong evidence of avoidability 6) Definitely avoidable. NHSI guidance ‘Any publication that seeks to compare organisations on the basis of the number of deaths thought likely to be due to problems in care is actively and recklessly misleading the reader’.

8. Learning points – the number of issues identified from reviews and investigation (including examples of good practice). The main purpose of this initiative is to promote learning and improve how Trusts support and engage with families and carers of those who die in our care.

9. Family/carer concerns – the number of concerns raised by families and carers that have been considered when determining whether or not to review or investigate a death. All families are offered support from our bereavement service and involved in investigations where relevant.

10. CUSUM (or cumulative sum) alerts - are statistical quality control measures which alert the Trust to when the number of deaths observed exceeds the number expected in a diagnostic or procedure group. Each death in a CUSUM alert is usually subject to a full case review to promote learning and improvement.

11. Deaths investigated as a SII (serious incident inquiry) - the number of deaths investigated as a serious incident inquiry and graded as catastrophic.

12. Deaths following a planned admission – are patients who died following a planned admission to hospital. Our reviews indicate that the majority of these patients had progressive disease and were admitted to hospital for symptom control or a procedure to relieve their symptoms.

13. Unexpected deaths – of patients who were not expected to die during their admission to hospital are subject to a full case review.

14. Stillbirth – is a baby that is born dead after 24 completed weeks of pregnancy.

15. Neonatal death – is the death of a live born baby during the first 28 days after birth.

16. Child death – the death of a child up to the age of 18. All unexpected child deaths are reviewed by the Wiltshire and Swindon Child Death Overview Panel.

17. Learning disability deaths – all patients with a learning disability aged 4 to 74 years who die in hospital. The Trust reports all these deaths to the LeDeR programme.

18. LeDeR programme – Learning Disabilities Mortality review programme hosted by the University of Bristol aims to guide improvements in the quality of health and social care services for people with learning disabilities across England. The programme reviews the deaths of people with learning disabilities.

19. Serious mental illness – all patients who die in hospital with a serious mental illness.

20. Maternal deaths – is the death of a woman while pregnant or within 42 days of the end of pregnancy from any cause related to or aggravated by the pregnancy or its management. Maternal deaths are rare events.

References

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

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.3
Date of Meeting:	08 July 2021		

Report Title:	Director of Infection Prevention & Control (DIPC) Annual Report for 2020/21			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Allison Hopkins, Infection, Prevention and Control Nurse, Infection Prevention & Control Team			
Executive Sponsor (presenting):	Judy Dyos, Director of Nursing and DIPC			
Appendices (list if applicable):	Included within the report			

Recommendation:

The Board is asked to:

1. Note the report, and the performance against Infection Prevention and Control requirements for the year.

2. Minute/document that the Board continues to acknowledge their collective responsibility as described within the DIPC report and confirm receipt of assurance on IPC actions and controls for the year.

3. Note the additional information submitted in the IPC Board Assurance Framework documents (covering the periods pre and post February 2021 up to Q4 2020/21).

Executive Summary:

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is delegated to the Director of Infection Prevention & Control (DIPC) who is the Director of Nursing.

The DIPC Reports together with the monthly Key Quality Performance Indicators Report are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of the annual DIPC Report is to inform the Trust Board of the progress made during 2020/21 against the plan and to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The action plan focuses on the Trust achieving the standards identified in 'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (2015), to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible.

This report takes the opportunity to celebrate the successes and highlights the increasing challenges moving forward:

1. For this reported period there has been unprecedented impact across the Trust from the COVID-19 pandemic. During quarter 3 (2020/21), the Trust declared COVID-19 outbreaks in 5 areas within the medical division. Dduring quarter 4 (2020/21), the Trust declared COVID-19 outbreaks in 5 areas within the medical division, in addition to declaring 1 COVID-19 outbreak in a non-clinical department. All outbreaks were managed in-line with the Trust Outbreak Management policy and included representation from PHE and BSW partners. A total of 202 patients with a positive result were identified within the outbreak areas. Application of the national COVID-19 case definitions to these 202 cases classifies 66 as hospital onset; probable healthcare associated, and 87 as hospital onset; definite healthcare associated.
2. Use of the Perfect Ward App continues to provide transparency of infection prevention and control practices through audit within each ward area and now includes a COVID-19 specific audit.
3. Significant work continues with our decontamination services and led by the Trust Decontamination Lead.
4. Water safety has been the subject of ongoing focus, with our ageing estate and environment posing challenges, to ensure we have effective controls in place.
5. During 2020/21, there have been 3 unrelated hospital onset MRSA bacteraemia cases (against a target = 0). On investigation 1 case subsequently deemed as community acquired infection. Key learning has been agreed for these incidents.
6. For 2020/21, the *C.difficile* case objective was not set for the Trust by NHSI/E. Tthe Trust has reported 28 healthcare associated *C.difficile* cases to PHE, of which 13 cases were community onset and 15 cases were hospital onset. Increasing numbers have been identified nationally and the IPC Team will be part of a BSW C-Difficile Collaborative during 2021-22.
7. Evidence to support compliance with the IPC national IPC COVID-19 standards is collated within the IPC Board Assurance Framework documents. The IPC BAF was revised in February 2021 with 2 standards currently flagging as non-compliant.
   A) Signage to denote high/medium and low risk areas is under development.
   B) Ventilation (wards) there is no national guidance to confirm ventilation requirements. Ventilation of all areas is now included within the scope of the Space Allocation Committee.

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

Salisbury
NHS Foundation Trust

INFECTION PREVENTION AND CONTROL

DIRECTOR OF INFECTION PREVENTION AND CONTROL

ANNUAL REPORT

April 2020 – March 2021

JUDY DYOS
Director of Infection Prevention and Control (DIPC)

May 2021 (v.2)

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APPENDICES

1. INTRODUCTION

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is delegated to the Director of Infection Prevention & Control (DIPC) who is the Director of Nursing.

The DIPC Reports together with the monthly Key Quality Performance Indicators (KQPI) Report are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of this annual update DIPC Report is to inform the Trust Board of the progress made against the 2020/21 Annual Action Plan (Appendix A), to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The action plan focuses on the Trust achieving the standards identified in 'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (2015), to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible.

For the reported period, the Trust has experienced an exceptionally challenging twelve months for infection prevention and control, with the major incident response to the ongoing COVID-19 pandemic.

2. GOVERNANCE ARRANGEMENTS

The work towards achieving the objectives of the Annual Action Plan 2020/21 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) and onto the Clinical Governance Committee (CGC), which completes the governance arrangements (Appendix B).

3. INFECTION PREVENTION & CONTROL ARRANGEMENTS

A comprehensive infection prevention and control service is provided Trust wide. The Infection Prevention and Control Team (IPCT) provides a liaison and telephone consultation service for all inpatient and outpatient services, with additional arrangements for seven day service cover by an Infection Control Nurse (ICN) during declared Norovirus outbreaks.

The IPCT currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 3.0 whole time equivalent (w.t.e) ICNs and secretary (0.6 w.t.e). In February 2021, a further ICN (1.0 w.t.e) commenced in post for a six month secondment period. In addition, there are 3 Consultant Microbiologists, one of whom is the Trust Antimicrobial Lead.

4. ASSURANCE ACTIVITIES

The IPCC monitors the action plan on behalf of the Trust Board, which is achieved through the following actions:

- Agree an annual infection control programme and monitor its implementation
- Oversee the implementation of infection control policies and procedures
- Monitor and review the incidence of HCAI
- Develop and review information regarding infection prevention and control
- Monitor the activities of the Infection Prevention and Control Team
- Benchmark the Trust's delivery of control of infection standards in various accreditation systems, and against Care Quality Commission (CQC) Regulations
- Monitor the implementation of infection prevention and control education
- Receive regular updates from the Antibiotic Reference Group (ARG)
- Receive regular updates from the IPCWG

- Monitor compliance and formal reporting on Legionellosis and Pseudomonas water management, via the Water Safety Group (WSG)
- Receive regular reports from the Decontamination Working Group (DWG)
- Receive regular reports from the Facilities directorate regarding cleaning programmes.

5. HEALTHCARE ASSOCIATED INFECTION (HCAI) STATISTICS AND SURVEILLANCE

The Trust is required to report any HCAI outbreaks externally as a serious incident (SI). An outbreak is defined as the occurrence of two or more related cases of the same infection over a defined period. When a HCAI outbreak is declared, the Trust initially reports the outbreak to the relevant Clinical Commissioning Group (CCG) and other regulatory bodies, e.g. NHS Improvement (NHSi), within 2 working days, and must undertake an investigation and submit a formal written report within 45 working days.

The Trust is also required to record these incidents on the strategic executive information system (STEIS) in line with the Serious Incident Framework: Supporting learning to prevent recurrence (NHS England, 2015), and the Health Protection Agency HCAI Operational Guidance & Standards (2012), Health Protection Agency now Public Health England (PHE) from 1st April 2013.

During 2020/21, the Trust has had **no** declared internal outbreaks of:

- Viral gastroenteritis (Norovirus)
- *Clostridioides difficile* (*C.difficile*)
- *Staphylococcus aureus*, including Methicillin Resistant *Staphylococcus aureus* (MRSA)
- Methicillin Sensitive *Staphylococcus aureus* (MSSA)
- Carbapenemase producing enterobacteriaceae (CPE)
- Invasive Group A Streptococcus (iGAS)
- Multi-drug resistant Acinetobacter baumannii (MDRAB)
- Chickenpox (Varicella zoster)
- Extended Spectrum Beta Lactamase (ESBL) producers, including *Klebsiella Pneumoniae*
- Pertussis
- Respiratory Syncytial Virus (RSV)
- Influenza ('flu)
- Vancomycin Resistant Enterococcus (VRE)
- Tuberculosis (TB).

Additional information regarding alert organisms can be accessed from the PHE website: https://www.gov.uk/government/organisations/public-health-england

The ICNs provide clinical teams with infection control advice, support and education on a daily basis to all inpatient and outpatient areas. The management of patients admitted with suspected and known alert organisms is discussed, and risk assessments undertaken. The Isolation Risk Assessment Tool (IRAT), Flowchart for the Management of Inpatients with Diarrhoea, and Diarrhoea Pathway have been developed and implemented to assist staff competency and confidence in the management of cases.

The availability of sideroom facilities across the Trust site to isolate infected patients can be limited at times when demands on bed capacity are high. In such instances, risk based decisions are necessary. Patients with alert organisms can be safely managed either within cohort bays, or isolation nursed in a bedspace. The ICNs continue to review patients nursed in siderooms on a daily basis to prioritise high risk patients. Information and guidance is communicated to the ward nursing and medical teams and the Clinical Site Coordinators (CSC), with additional written documentation provided to support staff in the ongoing management of these patients.

5.1 Coronavirus (Wuhan CoV)

On 31st December 2019, the World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province in China. On 12th

January 2020, it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak. The virus is referred to as SARS-CoV-2, and on 11th February, WHO named the syndrome caused by this novel coronavirus COVID-19. The source of the outbreak has not yet been determined. According to current evidence, it is primarily transmitted between people through respiratory droplets and contact routes. Airborne transmission is possible in specific settings in which procedures or support treatments that generate aerosols are performed. The first cases were confirmed in the United Kingdom (UK) at the end of January 2020 and WHO declared a pandemic on 11th March 2020.

From January 2020, the Trust initiated emergency planning and resilience response measures utilising significant PHE guidance and updates published as the situation continued to evolve. This included the identification of emergency assessment/triage areas, respiratory assessment zones and care areas, testing programme and personal protective equipment practice management. The Trust has followed established Emergency Preparedness, Resilience and Response (EPRR) protocols which include the instigation of strategy planning and Incident Management Team meetings, with key personnel to agree actions and develop iRespond cards across the directorates and disciplines. This work has remained ongoing throughout 2020/21.

The IPCT has continued to provide representation within the various identified workstreams, which has included Incident Management Team (IMT), Clinical Review Group (CRG), Workforce, Recovery, Personal Protective Equipment (PPE) and Virtual Board Round (VBR). (*Of note: in relation to PPE supplies, the Trust worked exceptionally hard to ensure adequate stock levels of the required standard were maintained).*

An Infection Prevention and Control (IPC) 'Task and Finish' Group was set up in June 2020 to provide a forum to review and action the continual changes to the IPC guidance published by PHE related to COVID-19. There was representation in the group from all clinical divisions as well as Corporate, Estates and Facilities. Key achievements of the group included providing evidence to populate the IPC Board Assurance Framework (BAF) document (version 1.3); Outbreak Management Framework/Policy and process agreement; reviewing and final agreement for use of portable fans in clinical environments Standard Operating Procedure (SOP) and risk assessment document; patient visiting protocol and related risk assessment documentation; review of risk assessments for COVID secure workplaces, with adaptations (where possible) of the environments and feedback of national learning.

The IPC Task and Finish Group was stood down during quarter 3 (2020/21), with ongoing work feeding into other existing meetings already attended by the IPC Task and Finish members. This included the Ventilation Task and Finish Group, PPE Group, VBR, and IPC update meetings with Matrons, with appropriate escalation to CRG and IMT. As the IPC BAF was updated nationally, the required changes and amendments were completed internally, with the document presented via the IPCWG to the IPCC, and to follow the established governance pathway to Trust Board.

5.2 COVID-19 outbreak prevention and management

During quarters 3 and 4 of 2020/21, updates to the outbreak management and reporting iRespond card were completed to reflect the changes to external reporting requirements. This included an amended definition of an outbreak for all communicable diseases in addition to COVID-19. The aim of the card continues to ensure that the Trust implements a rapid and well coordinated response to an outbreak of COVID-19 infection, in line with requirements set out in the South West Regional COVID-19 Healthcare Setting Outbreak Framework. The roles and responsibilities of all individuals and departments involved in outbreak management are clearly defined, making efficient use of available resources in order to limit the spread of infection and minimise the disruption of clinical services. It was necessary for the Trust to implement the planned outbreak response process during quarters 3 and 4 of 2020/21, with the declaration of 11 COVID-19 outbreaks.

During quarter 3 (2020/21), the Trust declared COVID-19 outbreaks in 5 areas within the medical division:

- Longford Ward (spinal) declared on 20th November 2020, with positive results for 4 patients and 1 staff member linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 29th December 2020.
- Tisbury Cardiac Care Unit (CCU) declared on 28th November 2020, with positive results for 4 patients and 1 staff member linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 24th December 2020.
- Respiratory Care Unit (RCU) declared on 17th December 2020, with positive results for 8 patients and 4 staff members linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 25th January 2021.
- Durrington Ward (acute frailty) declared on 24th December 2020, with positive results for 19 patients and 5 staff members linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 2nd February 2021.
- Pitton Ward (respiratory) declared on 30th December 2020, with positive results for 35 patients and 21 staff members linked to this outbreak cohort (included results for Downton Ward that could be linked to Pitton Ward). The outbreak was closed by the ICNs on the external reporting system on 25th February 2021.

During quarter 4 (2020/21), the Trust declared COVID-19 outbreaks in 5 areas within the medical division, in addition to declaring 1 COVID-19 outbreak in a non clinical department:

- Tisbury CCU declared on 6th January 2021, with positive results for 39 patients and 7 staff members linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 25th March 2021.
- Laverstock and Breamore Wards (stroke – acute and rehabilitation) declared on 13th January 2021, with positive results for 41 patients and 15 staff members linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 8th March 2021.
- Redlynch Ward (medical, gastroenterology) declared on 18th January 2021, with positive results for 24 patients and 6 staff members linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 8th March 2021.
- Whiteparish Ward (medical, endocrinology) declared on 18th January 2021, with positive results for 24 patients and 9 staff members linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 19th March 2021.
- Breamore Ward (stroke rehabilitation) declared on 22nd February 2021, with positive results for 4 patients and zero staff members linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 19th March 2021.
- Central Booking Department (non clinical) declared on 28th January 2021, with positive results for 8 staff members linked to this outbreak cohort (although 1 staff member had a clear community link). The outbreak was closed by Occupational Health Services on the external reporting system on 25th February 2021.

For all of these outbreaks, the Outbreak Management Group (OMG) was formed with review meetings held throughout. The meetings were well attended by all required individuals and departments within the Trust and by representatives from PHE and Bath and North East Somerset (BANES), Swindon and Wiltshire CCG. The OMG ensured that appropriate arrangements were in place to care for the affected patients and staff, instigating and monitoring the effectiveness of the control measures implemented in containing the spread of infection. The impact on service delivery was constantly reviewed, with communication to all relevant groups, including patients, relatives, carers and staff completed as appropriate. The production and distribution of meeting notes and actions was undertaken by the ICNs. The outbreaks were reported externally to the NHS Outbreak System on the Insights Platform (NHS England & NHS Improvement) within the expected reporting timeframes (within 24 hours of declaration). Updates were reported on the same system when

additional cases were identified and/or following an outbreak management review meeting. A further notification was made on the same system at the ending of an outbreak, defined as when there had been no confirmed cases with onset dates in the 28 days since the last positive result.

Across all of the COVID-19 outbreaks in quarters 3 and 4 of 2020/21, there were positive results for a total of 202 patients. Application of the national COVID-19 case definitions to these 202 cases classifies 66 as hospital onset; probable healthcare associated, and 87 as hospital onset; definite healthcare associated. The Trust recognises that where any infections are classified as hospital onset healthcare associated then there is clearly scope for learning, and that this is the same for COVID-19 infections. Therefore a Trust wide Serious Incident Inquiry (SII) will be undertaken to encompass all of the COVID-19 outbreaks. The process will aim to understand the Trust response and identify the positive outcomes and actions, in addition to key learning and any recommendations. This will be completed in quarter 1 of 2021/22, with the outcomes produced into a formal report and follow the standard Trust SII process.

6. MANDATORY SURVEILLANCE

Alert organism and alert condition surveillance data is collected and used by the Trust to detect outbreaks and monitor trends.

It is a mandatory requirement for NHS Acute Trusts to report Methicillin Resistant *Staphylococcus aureus* (MRSA) and Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias, and *Clostridioides difficile* infections to the Department of Health (DH) via the HCAI Data Capture Site (DCS) system, hosted by Public Health England (PHE).

6.1 Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias

During 2020/21, there have been 3 unrelated hospital onset MRSA bacteraemia cases identified for inpatients within the medical division (Pembroke Ward, Whiteparish Ward and Respiratory Care Unit (RCU)). The MRSA bacteraemia post infection review (PIR) toolkit was completed by the division for all the cases, with learning fedback to the IPCWG.

For the MRSA bacteraemia case reported during quarter 4 of 2020/21, a review meeting was also held to discuss the case. From all of the factors considered for this patient, both prior to and since admission to hospital, it was concluded that this was a community acquired deep seated infection. It was agreed that for the Trust, there were no actions directly related to the acquisition of this MRSA bacteraemia.

Key learning from the 3 hospital onset MRSA bacteraemia cases identified in 2020/21 includes:

- The development of a local competency booklet for peripherally inserted central catheters/lines (PICC) (Pembroke Ward)
- Continuing monitoring and assessment of all invasive devices by staff and maintaining the required care documentation e.g. at the time of insertion, and for continuing care with consistent recording of visual infusion phlebitis (VIP) scores (Pembroke and Whiteparish Wards)
- Clinician follow up of results from all samples sent to the Laboratories (Whiteparish Ward)
- Vancomycin prescribing concern (RCU) – *raised by the Consultant Microbiologist with the Medical Director*
- Completion of IPC practice audits, completion and sign of ward team Cleaning Task Lists, and enable Matron oversight of Managed Learning Environment (MLE) nursing staff training records for assigned workforce (RCU).

The Trust's MRSA hospital onset case target for 2020/21 was zero.

6.2 Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias

During 2020/21, there have been 3 unrelated hospital onset MSSA bacteraemia cases, where the sources of infection were identified as:

- Skin or soft tissue (1 case)
- Lower respiratory tract (1 case)
- Unclear source (1 case).

Post infection reviews were completed by the ward teams with key learning identified. This included adherence to the relevant Trust policies for the taking of blood cultures and the insertion and continuing care of invasive devices, and completing the documentation requirements for these aspects of care. The reviews also highlighted the requirement for ensuring completion of documentation and other practice audits as appropriate, in relation to urinary catheters, central lines or peripherally inserted central catheters (PICC).

Of note: Currently, there is no national guidance for data definition of MSSA bacteraemia cases for targets to be set. Therefore, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the MSSA bacteraemia cases recorded within the Trust. This allows the cases to be classified as either hospital onset or community onset.

6.3 Gram-negative organism bloodstream infections (GNBSIs)
The increase in gram negative organism bacteraemia infections is a national concern. Mandatory surveillance of *Escherichia coli* (E.coli), *Klebsiella species (spp.)* and *Pseudomonas aeruginosa* bacteraemias has been introduced by the Department of Health (DH). This reporting at the Trust now requires enhanced investigation and data entry onto the PHE DCS website. This work is undertaken by the ICNs. A national action plan 'Tackling antimicrobial resistance 2019 –2024' (January 2019) advises that work should continue to healthcare associated GNBSIs, adopting a systematic approach to preventing infections and delivering a 25% reduction by 2021/22 with a full 50% reduction by 2023/24.

6.3.1 *Escherichia coli (E.coli)*
Following the identification of a positive blood culture result for E.coli, a Consultant Microbiologist completes a PHE mandatory enhanced surveillance form. In consultation with the relevant clinician, key patient factors are considered in order to establish if the case is likely to be healthcare related. However, it may not be possible to determine.

Of the 17 hospital onset cases identified during 2020/21, an unknown or no underlying focus of infection was identified for 3 cases, and the remaining 14 cases had a source of infection identified. Of these unrelated 14 cases, the sources of infection were:

- Hepatobiliary (2 cases)
- Lower urinary tract (5 cases)
- Gastrointestinal or intra-abdominal collection (4 cases)
- Intravascular device (1 case)
- Lower respiratory tract (2 cases).

Of note: 3 of these E.coli bacteraemia cases were also identified to be Extended Spectrum Beta-Lactamase (ESBL) producing organisms and a further 1 bacteraemia case had a second organism identified (Klebsiella spp.).

The Trust will continue to work closely with local community and hospital partners to reduce the incidence of *E.coli* bloodstream infections (BSIs) for the whole health economy, with the initial focus on reducing those infections related to urinary tract infection (UTI). In addition, as usual activity levels resume, the ICNs will continue to work collaboratively with the relevant CCGs who are leading on achieving this Quality Premium guidance.

6.3.2 *Klebsiella sp.* and *Pseudomonas aeruginosa*
During 2020/21, there have been a total of 5 hospital onset *Klebsiella spp.* bacteraemia cases and 6 hospital onset *Pseudomonas aeruginosa* bacteraemia cases.

Of note: the Klebsiella spp. bacteraemia case sample also identified E.coli organism (as detailed in section 6.3.1).

Further information relating to official statistics and benchmarking of performance can be found at: https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis

6.4 *Clostridioides difficile (C.difficile) Infection*

The control of this infection is managed by the combination of adherence to the correct infection control practices, environmental cleaning, equipment decontamination and prudent antibiotic stewardship.

The Trust continues to apply DH guidance for *C.difficile* testing and all *C.difficile* positive stool samples that test toxin positive are reportable to PHE. For 2019/20, changes were made to the *C.difficile* reporting algorithm. This included the addition of a prior healthcare exposure element for community onset cases, and reducing the number of days to apportion hospital onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.

For 2019/20, the *C.difficile* case objective set for the Trust by NHSi and NHS England (NHSE) was no more than 9 healthcare associated reportable cases. This was a 50% reduction on the previous year's limit. These objectives have been set using the Trust data from 1st April 2018 to 31st December 2018. For 2020/21, no C.difficile case objectives were set for the Trust. Guidance for testing and reporting *C.difficile* cases remained unchanged and the safety and care of patients remains our concern and priority.

Unfortunately, during 2020/21 the Trust has reported 28 healthcare associated *C.difficile* cases to PHE, of which 13 cases were community onset and 15 cases were hospital onset. Incident investigations are carried out for all hospital onset cases using a 'SWARM' approach. This process is facilitated by the ICNs with the relevant Clinical Leader to assess whether there were any lapses in quality care provided to the patient and whether this contributed to the case. In addition, the ICNs undertake a case review for the community onset cases to establish whether any lapses in care occurred during their previous hospital admission (in the preceding 4 weeks).

Due to the COVID-19 pandemic workload, no healthcare associated *C.difficile* cases have been identified for submission to the relevant CCGs for the Appeals Process Panel.

From the completed incident investigations for the hospital onset cases, lapses in care were identified. Key learning included improvements required for the use of the Diarrhoea Pathway, completion of stool charts and related documentation, sampling of symptomatic patients, and the closure of a bay to facilitate additional environmental cleaning (one case only).

During 2020/21, the ICNs have completed additional investigations for the *C.difficile* cases identified within the community setting, where these patients have previously had a recent inpatient episode of care at the Trust. This has resulted in the implementation of enhanced environmental cleaning of identified clinical areas.

The Trust has been notified of a South West Regional HCAI C.difficile infection improvement collaborative event planned for quarter 2 of 2021/22. The aim is to reduce harm to the population of the South West Region from C.difficile infection and share wider learning. There will be representation from the Trust at this event, with outcomes fedback to the DIPC and IPCWG.

6.4.1 Periods of increased incidence of *C.difficile*

As previously reported for 2018/19 (February 2019), the PII for Pembroke Ward was extended to include the suite facility. The required incident investigations were completed with the involvement of relevant personnel. Further measures were also implemented across the areas, including additional environmental cleaning by Housekeeping and extra audits and monitoring of practices, overseen by the relevant senior staff including the Head of Nursing (HoN) and Matrons. At the request of the IPCWG, ribotyping and enhanced fingerprinting service results were reviewed by the

ICD with final reporting to the DIPC. No outbreak was declared retrospectively and a meeting was held during quarter 3 of 2020/21 with the Pembroke Unit team to formally feedback all the *C.difficile* ribotyping results, revisit shared learning and close the PII of *C.difficile.* The learning outcomes demonstrated improved use of the Diarrhoea Pathway, not routinely sending repeat stool samples and confirmed the actions undertaken in response to a medication delay for one patient. Work was ongoing for ensuring documentation of source and protective isolation dates in patient healthcare records, with monitoring and progress updates expected to the IPCWG in quarter 1 of 2021/22.

Please see Appendix C for the Infection Prevention & Control 'Dashboard' of 2020/21 for further detail of HCAI data.

6.4.2 Notification of intention to review financial sanctions and sampling rates from 2020/21
The faecal sampling and *C.difficile* infection testing rates for all NHS providers will be reviewed to determine how they compare, especially for similar institutions. PHE already collects Laboratory data on such sampling and testing rates on a quarterly basis. PHE are aware that workload variation between Laboratories will affect *C.difficile* infection testing rates, e.g. the proportion of all faecal samples received that originates from the community as opposed to from hospitalised patients.

Preliminary analyses of the data already submitted to the PHE DCS system shows marked workload variations between Laboratories, which need to be explained/addressed to minimise the risk of ascertainment bias on *C.difficile* infection rates. Failure to diagnose *C.difficile* infection raises the possibility of poor outcomes for patients and missed opportunities for control. There will be a particular focus on providers with high *C.difficile* infection rates but low sampling/testing rates relative to their peers. The option to review financial sanctions and the current lapses in care process will be undertaken ahead of objective setting.

There has been no further update received for the Trust regarding this.

6.5 Surgical Site Infection Surveillance (SSIS)
The ICNs coordinate data collections for the national SSIS programme of various surgical procedures, which are applicable to the Trust. Where orthopaedic surgical procedures are performed, Trusts are required to undertake mandatory SSIS every year. This must be for a minimum of a three months surveillance period or until a cohort of 50 cases has been achieved.

The Trust complies with this annual requirement to undertake SSIS. Surveillance was commenced at the beginning of quarter 2 of 2020/21 for total knee replacement (TKR) surgery. However, due to the current COVID-19 pandemic, all elective TKR surgery was being undertaken at a local private hospital. Therefore, following discussions and agreement with the divisional team, the surveillance category was changed to the repair of fractured neck of femur (NOF).

From the data collected during quarter 2 of 2020/21, a total of 51 cases were entered onto the national database and reconciled within the required time frame set by PHE, with 1 deep infection identified. The Trust received a letter from PHE for the quarter 2 surveillance category results, identifying the Trust as a high outlier with regard to the 2% infection rate (surgical site infection risk for this category above the 90th percentile). This was followed up with the Consultant for the patient, who reviewed the case identifying nothing unexpected and no clear trends, and fedback to the Mortality and Morbidity meeting for the orthopaedic specialty. This detail was included within a response provided to PHE.

From the data collected during quarter 3 of 2020/21, a total of 35 cases were entered onto the national database and reconciled within the required time frame, with no surgical site infections identified. Data collection continued in quarter 4 of 2020/21, with final records to be entered onto the national database and submitted for reconciliation by the end of quarter 1 (2021/22). Formal reports outlining progress with SSIS have been presented at the IPCC meetings and disseminated

to relevant Trust personnel. Active data collection for this category of surgery will continue into quarter 1 of 2021/22 to ensure that an extended cohort number of cases are attained.

6.6 MRSA screening

The Trust has continued to report MRSA screening rates for all elective and emergency admissions to ensure continued improvement in reducing infections. These screening compliance rates are monitored by the Divisional Management Teams (DMTs) and reported as a KQPI. The ICNs undertake a monthly emergency admission MRSA screening audit, and a quarterly elective admission MRSA screening audit.

Feedback is provided to DMTs about compliance rates and any identified missed screens for follow up actions. For 2020/21, the Trust compliance rates for MRSA emergency screening ranged from 84.33% - 97.89%. For MRSA elective screening, the Trust compliance rates ranged from 58.14% - 100%. However, it must be acknowledged that the number of elective patients within one of the elective screening cohorts was exceptionally small.

Outcomes of any follow up of actions undertaken by the clinical divisions are included within their current reporting processes and to include any shared learning. The current Trust screening policy exceeds the requirements outlined within the Department of Health guidance published in 2015, and continues following further review by the Trust.

6.7 Infection in Critical Care Quality Improvement Programme (ICCQIP)

From April 2017, the Trust has participated in the surveillance of bloodstream infections in patients attending the Intensive Care Unit (ICU) and Neonatal Unit (NNU). From the data submitted so far, report updates have been provided by PHE and cascaded to the area leads.

6.8 Private Healthcare Information Network (PHIN)

The Trust is now mandated to report externally regarding private patients via PHIN. In relation to infection prevention and control, this involves the ICNs undertaking monthly cross checking of a dedicated SharePoint database of private patients. If it is identified that a patient has a HCAI that is externally reportable (as per national mandatory reporting definitions), then this is added to the SharePoint database for the relevant patient, for submission to PHIN by the Trust.

From the data provided to the ICNs for review, there have been no externally reportable infection alert organisms identified for this patient group.

7. HAND HYGIENE

Fifty two areas (including wards and departments) across the three clinical divisions carry out a monthly audit of hand hygiene compliance in their area against the World Health Organisation's (WHO) '5 moments for Hand Hygiene'.

The Trust target for hand hygiene compliance rates is >85%, with formal reporting by the divisions of measures implemented to improve non-compliance. When compliance is poor, the ICNs support individual clinical areas and staff groups promoting patient safety and hand decontamination. The audit results continue to be disseminated according to staff groups for each area. This action has provided evidence to strengthen the feedback process for the divisions to take the necessary action.

Due to the COVID-19 pandemic, there have been no audits completed by the external auditor during quarters 2020/21. However, the clinical divisions have been undertaking cross auditing within their areas and specialities to further validate the audit process.

Detailed analysis was undertaken to identify the key areas of non-compliance, which were predominantly staff missing moment number 5, handwashing after contact with patient surroundings and also following removal of gloves. The results were reported via the DIPC and the IPCC and feedback was provided to the clinical leaders and DMTs to address the shortfall in

practice. Additional education and support has been provided by the ICNs to staff groups focusing on these audit findings.

For the internal hand hygiene audits completed by the inpatient clinical areas, the overall average compliance rate for 2020/21 ranges from 57.57% - 100%. It should be noted there has been a higher rate of non-completion/non-return of audits from areas during 2020/2021, and this has reduced the overall average compliance score for these areas.

The 'Red, Amber and Green' rating for the hand hygiene compliance audits continues and includes actions to be identified for areas that do not achieve the 'pass threshold' of 85% or show improvements. This RAG rating was further revised and the impact of these measures being monitored by the IPCWG, DMTs and Matrons Monitoring Group (MMG) now the Patient Led Assessment in the Clinical Environment (PLACE) Steering Group.

8. ANTIBIOTIC STEWARDSHIP

The COVID-19 pandemic has continued to present challenges during Quarters 3 and 4 of 2020/21 for the Antimicrobial Reference Group (ARG). We had to suspend our weekly antimicrobial stewardship ward rounds from mid-December till February due to the second wave of the COVID-19 pandemic as Salisbury was a hotspot.

8.1 Commissioning for Quality and Innovations (CQUINs) for 2020/21

All CQUINs continued to be held for the remainder of 2020/21. However, the antimicrobial/CQUIN Pharmacy Technician continued to collect data as per the 2019/20 "Improving the management of lower urinary tract infections in older people" CQUIN. This continues to set the Trust in a good place in terms of following national guidance on the treatment of urinary tract infections.

8.2 Total antibiotic consumption

Reducing total antimicrobial usage has now become part of the NHS contract. Our target is to reduce by 1% every year. Our in-house year-end figures show our total antibiotic usage increased by 1.85%. This can be attributed to the COVID-19 pandemic.

8.3 Action plan for 2021/22

The CQUINs for 2021/22 are currently on hold during Quarter 1 and Quarter 2 due to the COVID-19 pandemic. The lower urinary tract infections CQUIN may start in Quarter 3 and it will be extended to include all patients over 16 years with a diagnosis of UTI, including upper, lower and catheter-associated UTI. We are already making plans as to how to tackle this CQUIN.

We will continue our weekly antimicrobial stewardship ward rounds as these have had a significant impact in ensuring compliance with the Trust's anti-infectives guidelines and helped reduce inappropriate use of antibiotics. We will extend our AMS activities to include regular audits, the findings of which will be forwarded to the IPCC.

9. AUDIT

The ICNs have not undertaken any formal policy audit during 2020/21, but have been actively involved in supporting identified clinical areas to complete the *'Perfect Ward' Application'* (PWA) infection prevention and control inspections. This process ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust. *(Of note: these inspections include policy practice standards as part of audit criteria).*

Any observations/findings are fedback verbally to the clinical leader/nurse in charge at the time with instruction to access the results report to identify any required actions. The results are also available for the HoN and Matrons to access (via the application), with formal reports fedback via MMG meetings (now the PLACE Steering Group). (Completion of these audits has been in addition to the 'spot checks' and observational practice audits undertaken by the ICNs during daily clinical visits to ward areas).

The HoN, Matrons and Clinical Leaders also complete the additional PWA quick COVID-19 assessment inspections within identified clinical areas. These focus on monitoring and assurance around a number of measures, including signage, provision of hand hygiene opportunities, provision of PPE and observations of PPE practices, and adherence with the relevant COVID-19 pathway in the area. It also includes the questioning of staff around COVID-19 symptoms for patients and staff and the resulting actions indicated, isolation and decontamination practices, and demonstrating awareness of visiting guidance and how to escalate any staffing concerns. When required, the ICNs have continued to support the areas and staff with addressing any concerns arising from these inspections.

Please see Appendix D and Appendix E for further details, the results continue to provide transparency across a number of IPC indicators at practice level.

10. EDUCATION AND TRAINING ACTIVITIES

Education and training continues to be an important part of the work of the IPCT. Mean compliance scores for 2020/21 were 76.75% for staff completion of hand hygiene assessments and 92% for staff completion for IPC computer based learning (CBL) package.

The drop in hand hygiene assessment compliance may be attributed to the access opportunities during 2020/21 due to the COVID-19 pandemic. In response, the ICNs have continued to focus on the promotion of different working opportunities for staff to complete their hand hygiene assessment. This has included arranging extra sessions within specific work areas and enabling identified staff to be trained to undertake hand hygiene assessments. Furthermore, the clinical divisions facilitated the completion of hand hygiene assessments for staff by utilising a ultra-violet (UV) light box for rotation through their divisional areas and departments.

The ICNs have contributed to formal and informal teaching sessions within clinical areas and other Trust departments. Several of the core infection prevention and control sessions have been delivered for different staff groups, in addition to specific topic requests. The ICNs have also met with small groups and teams or on a one-to-one basis, to provide guidance and aid improved understanding of policies and practices. There has been a continued focus on promoting learning through the daily clinical visits undertaken by the ICNs. Formal meetings with the Infection Control Link Professionals (ICLPs) group were not held during 2020/21. Instead, there has been communication via email and through discussions with various ICLPs as part of both routine and additional visits undertaken by the ICNs to clinical and non clinical areas. Details of education opportunities provided are available from the ICNs.

11. DECONTAMINATION

11.1 Progress on actions from 2020/21

Progress on actions from some of the bigger projects was affected during quarter 1 due to the COVID-19 pandemic and re-prioritisation of work but some progress was made in quarter 2. The Trust's Authorised Engineer for Decontamination (AE (D)) had early visits cancelled due to the pandemic, but during recent visits the AE (D) spent some time in the Laboratories supporting the teams with their autoclaves to follow up on actions identified in response to a previous Health & Safety Executive (HSE) visit, undertaking an Assurance Audit in Sterile Services Limited (SSL) and undertaking the IHEEM audit for Endoscopy Joint Advisory Group (JAG) accreditation.

The Managed Service Contract for our Trophon devices, which provide high level decontamination of invasive ultrasound probes has progressed, resulting in five new devices arriving on site at the end of quarter 4. Four of the devices replace existing devices, offering improvement on our existing models and will be introduced following refresher training of staff within Radiology. The fifth device will be a new installation in Obstetric and Gynaecology outpatients and will be introduced following full training of staff. The work to find an automated solution for Fertility is ongoing.

There is still no confirmed start date for the refurbishment work in SSL. A recent presentation on the plans by the Steris Project Lead identified there will be times when closure of the facility is required, but this will be planned in advance. Contingency plans for both instrumentation and endoscope re-processing may be required to be activated.

11.2 Key Success stories in 2020/21
A bid to introduce single use 'buttons' on the fleet of Endoscopy scopes was recently agreed despite a significant cost pressure. The business case highlighted the challenges with cleaning and traceability of these small items and recognised the need to improve practice. Single use buttons will provide more robust assurance and improve patient safety.

In response to queries and requests for reassurance, updated posters were designed to support staff with decontamination of re-usable devices during the pandemic. In addition, an increase in options for single use items were made available to order within the Trust, such as blood pressure (BP) cuffs and saturation probes. This gave an alternative approach which was preferred by some clinical areas, especially those dealing with a high number of positive cases.

Review of Trust processes occurred following publication of NICE IPG666, reducing the risk of transmission of CJD via surgical instruments. As well as existing practice, the review was extended to include additional specialities such as spinal surgery where it was agreed that whilst the likelihood was low, there were opportunities for instruments to come into contact with high risk tissues during unplanned complications to procedures. Additional steps have been added to provide additional assurance and reduce potential risks.

All six Dry Storage Cabinets (DSCs) have now been installed; three are already in use and the final three are awaiting their validation results. Those in use already offer an increase in storage capacity, longer validated storage times and safe storage of the full range of endoscopes used within the Endoscopy unit.

11.3 Key challenges for quarters 1 and 2 of 2021/22
The Trust continues to have a vacant Authorised Person Decontamination (AP (D)) position which is being covered in part by additional support from our AE (D). The clarification of a process where all servicing and testing arrangements, and associated results, can be efficiently captured is required as these are usually overseen and co-ordinated by the AP (D).

Re-establish regular visits to clinical areas. Due to the cessation of some services, relocation of departments and redeployment of some staff during COVID pressures, the programme of routine audits in clinical areas was interrupted. Audits and reviews of practice were undertaken instead on an as-required basis in response to introduction of new processes, procedures or ways of working. The Decontamination Lead will be re-introducing the routine audits of clinical areas as clinical services resume; focussing on working with the teams to ensure any changes in practice introduced as a result of COVID have been captured within departmental SOPs and comply with Essential Quality Requirements and plans are in place to work towards Best Practice where possible.

12. CLEANING SERVICES

This section summarises the key components of the Trust's cleaning programme, to ensure the provision of a safe and clean environment for patients and their relatives, visitors and staff. The following areas of work are managed by the Housekeeping Department and Facilities directorate.

12.1 Patient led assessment of the care environment (PLACE) internal audits
The Trust developed (with ward leaders) and implemented a programme of PLACE audits for 2019/20 and planned to undertake 60 internal PLACE assessments between June 2019 and March 2020, using the new NHSi PLACE criteria.

The result of each PLACE assessment is submitted to the Health and Social Care Information Centre using the PLACE Lite tool and discussed with ward leaders at the monthly Matrons Monitoring Group (replaced by the PLACE Steering Group, as from October 2020).

Due to the pandemic, in March (2020) the Director of Nursing approved the internal PLACE assessments and Housekeeping audits be temporarily suspended. Approval to recommence these has been given and a plan was in place to commence in October 2020. However, due to the second wave of COVID these continued to be suspended for review in June 2021.

To support social distancing and to minimise footfall within clinical areas the number of participants in PLACE inspections will be limited, with no Governors or Volunteers present.

12.2 National PLACE
We have been informed by NHSi that this year's National PLACE inspection has been cancelled due to the COVID pandemic; we await further information regarding the National PLACE for 2021.

12.3 Deep clean programme/rapid response team
The deep clean and decorating programme commenced in April 2020 and was completed in May 2021 on schedule. All areas and every bedspace was completed and signed off. 2021/2022's plan was circulated at May's PLACE Steering Group and commenced on the 1st May 2021 (a copy of the Deep Clean programme is available from the Housekeeping Department).

12.4 Improvement Work Over the past 6 months
To support the Trust's COVID-19 response the Housekeeping Team is providing a 24 hour service with a small cleaning team on site out of hours. We are awaiting feedback for the Execs on whether this service is still required and whether there is funding available. A recent recruitment drive was undertaken in February 2021 to fill all vacancies and ensure staff are trained during the second wave.

Below are tables from the past 2 years indicating the increased activity during the pandemic.

2020/21 MONTH	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**TOTALS**
POST INFECTIONS	1564	1726	1558	1408	1121	1180	1200	1304	1575	2589	1694	1341	**18260**
ENHANCED HRS	38.5	48.25	47.5	72.25	95	56	53.75	96.5	105.5	102.25	65.25	57	**837.75**
DOUBLE CLEANS HRS	4.5	0	40.25	82.25	60.25	77.5	105	149.5	140.25	0	26.25	27	**712.75**
BIOQUELL	30	29	37	62	36	42	39	30	50	10	58	50	**473**

(Table 1)

2019/20 MONTH	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**TOTALS**
POST INFECTIONS	521	720	519	670	589	528	612	650	937	647	604	1189	**8186**
ENHANCED HRS	55	90.75	68.5	91.75	74.25	79.75	87.75	94	122	92.75	95	70	**1021.50**
DOUBLE CLEANS HRS	75	50.25	73	61.75	69	85.5	76.50	39.25	47	60.75	54.75	28.75	**721.50**
BIOQUELL	37	58	53	43	46	42	58	35	66	35	23	30	**526**

(Table 2)

12.5 Challenges for the coming 6 months
Housekeeping will be reviewing the new National Cleaning Standards including key elements, task lists, risk categories, audit requirements and any cost pressures associated to any changes.

13. WATER SAFETY MANAGEMENT

This section summarises the water safety management precautions that the Trust has taken during quarters 3 and 4 of 2020/21. The Trust manages the safety of water systems in line with the Health Technical Memorandum (HTM) 04-01 (Pt B) Safe Water in Healthcare Premises and HTM 04-01 (Pt C) Pseudomonas (guidance for augmented care units), together with the technical guidance document HSG274 part 2.

To assist the management process in respect of the water systems across the site, regular meetings of teams (Responsible Person (RP) and Deputy Responsible Person (dRP) water) from ETS and FES Ltd (Private Finance Initiative (PFI) maintenance contractor) are held on a monthly basis, to review progress with planned preventive maintenances' (PPMs) and actions in respect of water safety.

The Trust continues to keep the domestic hot water temperature elevated above 65°C as a precaution in the challenge of Legionella control. The water systems within hospitals are complex; therefore the testing and controls we have in place are designed to mitigate the risks to our patients and staff.

13.1 Legionella

Emergency review meetings (See Tables 3 and 4 for Legionella, listing counts reported >1000 cfu/l) and Table 5 for high counts for Pseudomonas) have taken place in the Trust as a result of the sample results. The actions and results of the ongoing checks have been circulated to senior members of the Trust in a series of e-mail communications as events occur, and as regular reports to the Water Safety Group (WSG) and IPCC. Actions taken have included the cleaning and disinfection of outlets, with temperature checks and increased flushing where necessary.

Legionella						
	Ward / Department	LG Ref	Location	Action plan	Test result as of 18th May 2021	
					Pre	Post
1	Sarum	7	4.05.02 (WHB)	Disinfect outlet, flush and re-sample	1100	40
2	Sarum	253	Room 9 (Shower)	Disinfect outlet, flush and re-sample	2600	40
3	ENT	13	3.4.14 (WHB)	Remedial works on-going on system by ETS.	2600	5400

(Table 3)

Table 1 Legionella						
	Ward / Department	LG Ref	Location	Action plan	Test result as of 18th May 2021	
					Pre	Post
4	ENT	15	3.4.24	Disinfect outlet, flush and re-sample	2000	600
5	Level 3 Disabled WC	69	Level 3 street	Outlet replaced and works completed on the hot and cold supply, flush and resample.	2200	800
6	Labs (L3)	91	3.15.01	Remedial works on-going on system by ETS.	840	160
7	Labs (L3)	92	3.15.03	Remedial works on-going on system by ETS.	>20	340
8	Labs (L4)	96	4.16.22	Remedial works on-going on system by ETS.	>20	460
9	Respiratory	94	3.16.19	Continue to flush and resample.	1600	1000
10	Amesbury	PFI	4.10.245	Two clear results, 3rd sample required.	>20	>20

(Table 4)

13.2 Pseudomonas Sampling

Live counts are being managed on Sarum and Odstock Wards, with the latest actions and results from resampling listed on Table 5 below.

Pseudomonas						
	Ward / Department	PS Ref	Location	Action plan	Test result as of 18th May 2021	
					Pre	Post
1	NICU	01	WHB 77.01	1st clear, resample	ND	ND
2	NICU	20	Shower 77.17	1st clear, resample	ND	ND
3	NICU	28	WHB 77.08	Remedial works required, PAL filter fitted	21	62
4	Sarum	218	4.06.32	1st clear, resample	ND	ND
5	Odstock	116	4.11.32	PAL filter fitted, remedial works required prior to resample.	>100	>100
6	Odstock	123	4.11.33	PAL filter fitted, remedial works required prior to resample	>100	>100
7	Odstock	179	4.11.48	PAL filter fitted, remedial works required prior to resample	>100	>100

(Table 5)

13.3 Achievements for quarters 3 and 4 of 2020/21

- The Estates team have completed remedial works on the water systems (hot & cold), that have been identified as issues from the investigation of positive sample results. The focus of the works has been on SDH North, Sectors 14 – 16 (laboratory areas) on Level 3 Sectors 3 – 5 (outpatient areas).
- The level of flushing compliance for clinical areas has been maintained and the figures for Q3 + Q4 are 63.6% for Priority 1 areas and 96.1% for Priority 2.
- Maintaining the temperature of the main hot and cold water systems.
- Completion of PPM's (Temp checks, flushing, sampling etc.) in the area of Water Safety in exceptional circumstances due to the Covid-19 pandemic, and it's direct and in-direct impact on the Estates team.

13.4 Key Focus for quarters 1 and 2 of 2021/22

- Maintaining the temperature of the hot and cold water systems across the Trust.
- Completion of routine sampling for Pseudomonas on augmented wards – Radnor Ward (Intensive Care Unit), Neonatal Unit (NNU), Pembroke and Longford Wards.
- Ensuring sufficient resource (labour & financial) to complete all PPM's directly associated with water safety.
- Engagement of key members (DIPC, Consultant Microbiologist, ICNs) of the Water Safety Group (WSG) in supporting action plans and quarterly meetings of the WSG.
- Training and appointment of a new dRP for Water Safety in the absence of an Operational Manager.
- Award and complete a site water risk assessment, this is a survey of the water systems (hot and cold) that identifies areas that require investment due to the condition of the systems and/or risks such as 'dead legs' etc.

14. CONCLUSION

This annual DIPC Report has provided the Trust Board with evidence of the measures in place that have made a significant contribution to improving infection prevention and control practices across the Trust. The report has detailed the progress against the Action Plan for 2020/21 in reducing HCAI rates for the Trust.

For 2021/22, the key ambitions for the Trust will include:

- Continued response to the impact of the COVID-19 pandemic
- Ongoing focus on the reduction of all reportable HCAIs and ensure preventable infections are avoided
- Continued reinforcement to improve compliance with hand hygiene practices and behaviours
- Maintaining achievements with antimicrobial stewardship
- Sustain progress with contingency planning and improvement plans for decontamination services
- Maintaining progress with education, training and audit relating to infection control practices and policies
- Monitor and manage water safety
- Maintaining a clean and safe environment for patients and staff through the Trust Housekeeping service.

15. ACKNOWLEDGEMENTS

The author would like to acknowledge the assistance of the following people in the compilation of this report:

- Fiona McCarthy, Senior Nurse, and Allison Hopkins, ICN, Infection Prevention and Control Team (Sections 1, 2, 3, 4, 5, 6, 7, 9, 10, 14 and 15)
- Sithembile Ncube, Lead Pharmacist for Antimicrobials and Risk Management and Medicines Safety Officer (Section 8)

- Clare Goodyear, Trust Decontamination Lead and Medical Device Safety Officer (Section 11)
- Michelle Sadler, General Manager, Facilities and Amanda Urch, Head of Housekeeping and Portering (Section 12)
- Terry Cropp, Responsible Person for Water and Senior Estates Officer (Section 13).

APPENDIX A

Infection Prevention & Control – Annual Action Plan 2020/21

Please note: The numbering **does not** depict the order of priority for the Trust, but reflects the numbered duties within the Hygiene Code.

Domain and Key Actions	Who By	Status
1 Management, Organisation and the Environment **1.1 General duty to protect patients, staff and others from HCAIs** **1.2 Duty to have in place appropriate management systems for Infection Prevention and Control**		
Continue to promote the role of the DIPC in the prevention & control of HCAI	Chief Executive	Continuous
DIPC as Chair of the Infection Prevention & Control Committee (IPCC)	Chief Executive	In place
Lead infection prevention & control in the Trust and provide a six monthly public report to the Trust Board	DIPC	In place
Monitor and report uptake of mandatory training programme	IPCT	In place
Continue contribution to implementation of the Capacity Management policy	DIPC	In place
Ensure a programme of audit (incorporating Saving Lives High Impact Interventions) is in place to systematically monitor & review policies, guidelines and practice relating to infection prevention & control	IPCWG/IPCC	Monthly
Continue to review staffing levels via Workforce Planning	DDIPC	Continuous
Complete bedpan washer replacement and dirty utility room upgrade programme within the Trust (for inpatient clinical areas), including the Spinal Unit.	DIPC	Complete
1.3 Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks		
Maintain the role of DIPC as an integral member of the Trust's Clinical Governance & risk structures (including Assurance Framework)	Chief Executive	Continuous
Ensure active maintenance of principle risks relating to infection prevention and control, and that the system of Root Cause Analysis (RCA) is used to review risks relating to these	DIPC/JH/ICNs	In place
Active Surveillance & Investigation:		
Continue implementation of mandatory Surveillance Plan for HCAI & produce quarterly reports for IPCC	IPCT	In place
Review implementation of 'alert organism' & 'alert condition' system	JH/PR/LA/PF	Continuous
Use comparative data on HCAI & microbial resistance to reduce incidence & prevalence	JH/PR/LA/PF	In place
Promote liaison with Public Health England (PHE) for effective management & control of HCAI	DIPC/JH/ICNs	Continuous

Domain and Key Actions	Who By	Status
1.4 Duty to provide and maintain a clean and appropriate environment for health care		
Ensure maintenance and monitoring of high standards of cleanliness via policy management and audit, and environmental audits	DIPC/IR/MS	Monthly
Review schedule of cleaning frequency and standards of cleanliness, making them publicly available	DIPC/IR/MS/ Matrons	Monthly
Ensure adequate provision of suitable hand washing facilities, hand products/alcohol gel and continued implementation of 'WHO - Five Moments' and use of 'CleanYourHands' resources	ICNs	Continuous
Continue IP&C involvement in overseeing all plans for construction & renovation	TC	Continuous
Ensure effective arrangements are in place for appropriate decontamination of instruments and other medical devices/equipment	DIPC/CG	Continuous
Ensure the supply and provision of linen and laundry adheres to health service guidance	IR	Continuous
Ensure adherence to the uniform and Bare below the elbow (BBE) policies and workwear guidance through audit and formal reporting via the monthly Matrons Monitoring Group meetings (renamed PLACE Steering Group from quarter 2 of 2020/21)	DIPC/HoNs/Matrons	Continuous
1.5 Duty to provide information on HCAIs to patients and the public **1.6 Duty to provide information when a patient moves from one health care body to another** **1.7 Duty to ensure co-operation**		
Ensure publication of DIPC report via the Trust website	DIPC	6 monthly
Review Capacity Management policy & documentation to ensure communication regarding an individual's risk, nature and treatment of HCAI is explicit	DIPC	Completed
Include obligations under the Code to appropriate policy documents	DIPC	Ongoing
1.8. Duty to provide adequate isolation facilities		
Continue implementation and monitoring of the Isolation policy and monitoring of practice via audit	HoNs/Matrons/ IPCT	Ongoing
1.9. Duty to ensure adequate laboratory support		
Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation	JH/PR/LA/PF	Continuous

Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control		
Core policies are:		
Standard infection control precautions	ICNs	In place
Aseptic technique	ICNs	In place
Major outbreaks of communicable infection (Outbreak policy)	ICNs	In place
Isolation of patients	JH	In place
Safe handling and disposal of sharps	PK/DC	In place
Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries	ICNs	In place
Management of occupational exposure to BBVs and post exposure prophylaxis.	PK/LM/DC	In place
Closure of wards, departments and premises to new admissions (Outbreak & Capacity Management)		In place
Disinfection policy	MS	In place
Antimicrobial prescribing	JH/SN	In place
Mandatory reporting HCAIs to Public health England (PHE)	JH	In place
Control of infections with specific alert organisms; MRSA and *C.difficile*	IPCT	In place
Additional policies:		
Transmissible Spongiform Encephalitis (TSE)	JH	In place
Glycopeptide Resistant Enterococcus (GRE)	JH	Included in
Acinetobacter species	JH	Isolation
Viral Haemorrhagic fever (VHF)	JH	Policy
Prevention of spread of Carbapenem resistant organisms	JH	In place
Diarrhoeal infections	JH	In place
Surveillance	ICNs	In place
Respiratory viruses (RSV)	GD	In place
Infection control measures for ventilated patients	MF	In place
Tuberculosis	JH	In place
Legionellosis risk management policy and procedures, including pseudomonas	TC	In place
Strategic Cleaning Plan & Operational Policy	MS	In place
Building & Renovation – Inclusion of Infection Control within Building Change, Development & Maintenance	TC	In place
Waste Management Policy	TC	In place
Linen Management Policy	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	CG	In place

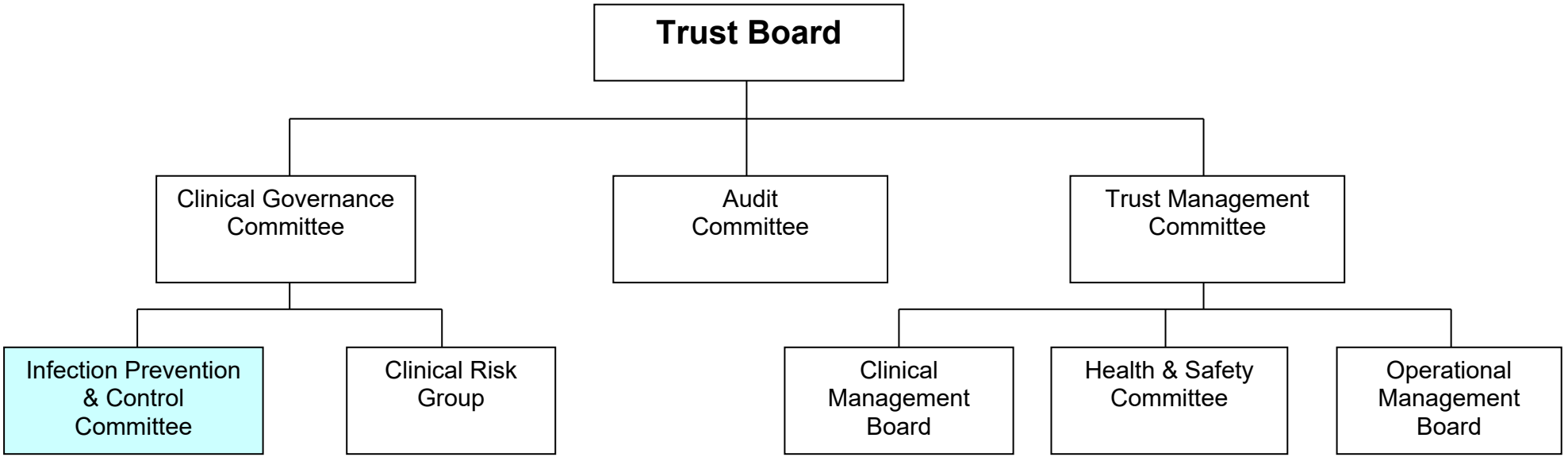
Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonable practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs		
Ensure all staff can access relevant Occupational Health & safety services (OHSS)	LL/SY/LM	Continuous
Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place	LM	Continuous
Continue the provision of infection prevention and control education at induction	IPCT	Continuous
Continue the provision of ongoing infection prevention and control education for existing staff	IPCT	Continuous
Continue recording and maintaining training records for all staff via the MLE	Education Dept.	Continuous
Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and objectives of all staff	DIPC/DMTs	In place
Enhance and monitor the role of the Infection Control Link Professionals	HoN/Matrons/ICNs	Continuous

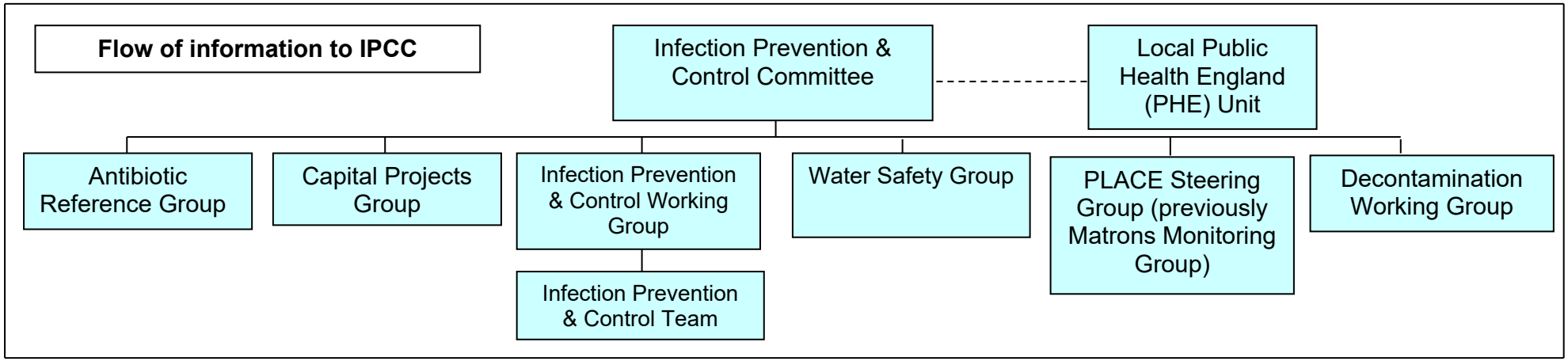
KEY INITIALS

DIPC Lorna Wilkinson, Director of Infection Prevention & Control (DIPC) *(until June 2020)*
DIPC Judy Dyos, Director of Infection Prevention & Control *(from June 2020)*
DDIPC Denise Major & Fiona Hyett, Deputy DIPCs
CG Clare Goodyear, Trust Decontamination Lead and Medical Devices Safety Officer
JH Julian Hemming, Consultant Microbiologist & Infection Control Doctor (ICD)
PR Paul Russell, Consultant Microbiologist
PF Paul Flanagan, Consultant Microbiologist & Antimicrobial Lead *(from July 2020)*
LA Layth Alsaffar, Consultant Microbiologist *(initially Locum then substantive post from September 2020)*
IR Ian Robinson, Operations Director, Estates & Facilities
TC Terry Cropp, Responsible Person for Water & Senior Estates Officer
HoN Heads of Nursing *(previously Directorate Senior Nurses)*
PK Paul Knight, Health & Safety Manager, Occupational Health (OH) Department *(until March 2021)*
DC David Cotterill, Health & Safety Advisor, Occupational Health (OH) & Safety Deputy Manager *(from January 2021)*
SN Sithembile Ncube, Lead Pharmacist for Antimicrobials and Risk Management and Medicines Safety Officer
GD Geoffrey Dunning, Neonatal Unit Charge Nurse
MF Maria Ford, Quality Improvement Matron *(previously Nurse Consultant in Critical Care)*
LL Lynn Lane, Interim Director of Organisational Development & People *(until April 2021)*
SY Susan Young, Interim Director of Human Resources *(from March 2021)*
MS Michelle Sadler, Facilities Manager
LM Lisa McLuckie, Head of Occupational Health and Well-being Lead *(new appointment April 2020)*

APPENDIX B

Formal Trust Reporting Structure





APPENDIX C (End of year 2020/21)

Clinical Directorates	Inpatient areas/wards	*Clostridium difficile* - all cases (reportable and not reportable)			Bacteraemias - all cases are reportable to Public Health England (PHE)										Outbreak declared	PII declared	Hand Hygiene (mean %)	IPC PWA % (mean score)
		Sample taken			*MRSA*		*MSSA*		*E.coli*		*Pseudomonas aeruginosa*		*Klebsiella sp.*					
		Hospital onset; healthcare associated	Community onset; healthcare associated	No lapses in care	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	See main repot for details			
Clinical Support & Family Services	Labour Ward																↑ 90%	N/A
	Neonatal Unit																↑ 99.17%	N/A
	Post-natal Ward																→100%	N/A
	Sarum Ward (inc. Children DAU)		2					1	1	2				1			↓ 82.6%	→ 99.45%
	CS&FS Totals:		2					1	1	2				1				
Medicine	AMU		2					3		4		1		1			↑ 68.06%	↓ 94.34%
	Breamore Ward (opened Q3 in Medicine)									1					22.02.21		75.30%*	97.13%*
	Durrington Ward	1													24.12.20		↑ 84.62%	↑ 95.06%
	ED (inc. SSEU)					1		13		53		6		14			↓ 79.33%	↑ 95.24%
	Respiratory Care Unit (RCU) Level 2 template)	1			1					2		1			17.12.20		↓ 57.57%	↓ 93.64%
	Hospice Unit																↓ 99.58%	96.65%*
	Laverstock Ward (Stroke Unit)	1 + 1							1						13.01.21 (included Breamore)		↑ 72.96%	↓ 96.84%
	Longford Ward (moved from Surgery)														20.11.20		↓ 90.43%	↓ 91.26%
	Pembroke Ward	3			1						1						↓ 93.75%	↑ 94.5%
	Pembroke Suite									1							↓ 96.97%	N/A
	Pitton Ward	1							1						30.12.20		↓ 89.95%	↓ 93.18%
	Redlynch Ward	1 + 1							3		1				18.01.20		↓ 72.61%	↓ 94.03%
	Spire Ward	2 + 2	1							1							↓ 95.78%	↓ 94.54%
	Tisbury CCU	1 + 1					2								28.11.20 & 06.01.21		↓ 94.51%	↓ 95.09%
	Whiteparish Ward	1			1				1						18.01.20		↓ 86.70%	↓ 92.11%
	Medicine Totals:	10 + 7	2 + 1		3	1	2	16	6	62	2	8		15				
Surgery	Amesbury Suite		1					1	2								↓ 79.77%	↑ 89.11%
	Britford Ward		1						1		1			1			↑ 76.48%	↓ 95.92%
	Chilmark Suite	1															↓ 80.69%	↓ 95.25%
	Day Surgery Unit																↑ 85.75%	↓ 96.78%
	Downton Ward	3 + 1						1	2	4	1						↓ 96.13%	↓ 95.55%
	Odstock Ward	1					1										↑ 97.18%	↑ 95.27%
	Radnor Ward								5		2		5				↓ 79.29%	↑ 97.41%
	Surgery Totals:	5 + 1	2				1	2	10	4	4		5	1				
Additional info: Other samples e.g. GP, Emergency Assessment, SAU, OPD, Mortuary, Private Hospital			9 + 2					2		4		1		1				

All SFT samples including inpatient and outpatient areas, GP and other e.g. Emergency Assessment ***(does not include 1 additional blood cultures sample processed at SFT taken in the external Dialysis Unit and identified E.coli)***

C.difficile reportable cases = red

C.difficile not reportable cases = blue

Perfect Ward scoring:

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed

Hand hygiene scoring:

	Score above 85%
	Score 61% - 84%
	Score below 60%

* = no previous audits available to enable comparison

APPENDIX D

Perfect Ward Application (PWA) Infection Prevention & Control (IPC) Inspection Compliance scores for Quarters 1 & 2 of 2020/21

Ward/ Dept	Division	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Sarum	Clinical Support & Family Services			26.06.20 (100%)	31.07.20 (97.6%)	26.08.20 (100%)	29.09.20 (100%)
Acute Medical Unit	Medicine	06.04.20 (86.3%)	13.05.20 (96.2%)		07.07.20 (100%)	05.08.20 (100%)	08.09.20 (94.3%)
Durrington Ward	Medicine	09.04.20 (92.3%)	12.05.20 (93.8%)	16.06.20 (96.1%)	07.07.20 (94.2%)	23.08.20 (96.2%)	06.09.20 (96.2%) 25.09.20 (86.2%)
Farley RCU Ward	Medicine	28.04.20 (92.2%)	20.05.20 (89.6%)	17.06.20 (96.1%)	01.07.20 (96.2%)	01.08.20 (96.2%) 04.08.20 (98.1%) 13.08.20 (92.2%) 31.08.20 (98.1%)	
Hospice Unit	Medicine						
Laverstock Ward (Stroke Unit)	Medicine	25.04.20 (96.2%)	20.05.20 (98.1%)	06.06.20 (97.9%)	12.07.20 (96%)	20.08.20 (95.6%)	20.09.20 (98.1%)
Pembroke Ward	Medicine			28.06.20 (93.9%)	11.07.20 (92.3%)		
Pitton Ward	Medicine	05.04.20 (96.1%)	08.05.20 (88.2%)	09.06.20 (96.2%)	09.07.20 (92.3%)	04.08.20 (90.2%)	20.09.20 (96.2%)
Redlynch Ward	Medicine	20.04.20 (94.1%)	20.05.20 (92.3%)		01.07.20 (96.1%)	05.08.20 (96%)	27.09.20 (98%)
Tisbury CCU	Medicine	15.04.20 (94.2%)	08.05.20 (92.3%)	04.06.20 (94.3%)	05.07.20 (96.1%)	30.08.20 (96.2%)	27.09.20 (97.9%)
Whiteparish Ward	Medicine		10.05.20 (88.5%)	21.06.20 (96.2%)	24.07.20 (96.1%)	13.08.20 (90.4%)	06.09.20 (92.3%)
Spire Ward	Medicine	29.04.20 (98%)	25.05.20 (94.3%)	03.06.20 (86.5%)	20.07.20 (94.3%)	28.08.20 (100%)	06.09.20 (96.2%)
Amesbury Suite	Surgery	01.04.20 (86.5%) 17.04.20 (94.2%)	06.05.20 (80%)	17.06.20 (94.2%)	16.07.20 (82.7%)	27.08.20 (88.2%)	20.09.20 (90.4%)
Chilmark Suite	Surgery	01.04.20 (100%)		22.06.20 (100%)	18.07.20 (97.8%)	26.08.20 (92.5%)	20.09.20 (96%)
Odstock Ward	Surgery	18.04.20 (88.2%)	27.05.20 (95.7%)	30.06.20 (98.1%)	28.07.20 (98%)	27.08.20 (98%)	12.09.20 (92.3%)
Longford Ward	Surgery	21.04.20 (86%)	28.05.20 (96.2%)	21.06.20 (91.8%)	23.07.20 (84%)	20.08.20 (88.2%)	13.09.20 (96.2%)
Britford Ward	Surgery		27.05.20 (97.7%)	23.06.20 (98%)	27.07.20 (95.7%)	27.8.20 (98%)	14.09.20 (98%)
Downton Ward	Surgery	15.04.20 (100%)	06.05.20 (94.3%)	09.06.20 (87.8%)	07.07.20 (98.1%)	31.08.20 (94.2%)	10.09.20 (98.1%) 15.09.20 (98.1%) 28.09.20 (98%)
Radnor Ward	Surgery	27.04.20 (94%)	15.05.20 (96.2%)	28.06.20 (94.1%)	18.07.20 (100%)	21.08.20 (98%)	25.09.20 (98%)
Day Surgery Unit	Surgery	08.04.20 (97.6%)	05.05.20 (97.7%)	22.06.20 (97.7%)	24.07.20 (93.2%)	13.08.20 (97.9%)	11.09.20 (100%)

APPENDIX D

Perfect Ward Application (PWA) Infection Prevention & Control (IPC) Inspection Compliance scores for Quarters 3 & 4 of 2020/21

Ward/ Dept	Division	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Sarum	Clinical Support & Family Services		26.11.20 (100%) 30.11.20 (98%)		12.01.21 (100%)		21.03.210 (100%)
Acute Medical Unit	Medicine	05.10.20 (100%)	06.11.20 (94.2%)	02.12.20 (90.2%)	10.01.21 (92.2%)	06.02.21 (90.2%)	02.03.21 (94.1%)
Durrington Ward	Medicine	07.10.20 (96.2%)	13.11.20 (98.1%)	16.12.20 (98.1%)	14.01.21 (100%)	11.02.21 (94.2%)	06.09.20 (94.2%) 5
Farley RCU Ward	Medicine	17.10.20 (86%) 26.10.20 (98.1%)		03.12.20 (92.3%)		04.02.21 (90.2%)	09.03.21 (92%)
Hospice Unit	Medicine					15.02.21 (93.3%)	18.03.21 (100%)
Laverstock Ward (Stroke Unit)	Medicine	10.10.20 (98.1%) 25.10.20 (94.3%)	13.11.20 (96.2%)	14.12.20 (100%)	27.01.21 (100%)	16.02.21 (94.3%)	22.03.21 (94.1%)
Pembroke Ward	Medicine			07.12.20 (94.2%) 27.12.20 (94.3%)		15.02.21 (94.2%)	27.03.21 (98.1%)
Pitton Ward	Medicine	14.10.20 (98.1%)	25.11.20 (96.2%)	30.12.20 (98.1%)	20.01.21 (96.2%)	10.02.21 (94.3%)	16.03.21 (76%)
Redlynch Ward	Medicine	13.10.20 (96%)	20.11.20 (94.1%)	28.12.20 (96.1%)		17.02.21 (100%) 25.02.21 (76.9%)	14.03.21 (92.5%) 21.03.21 (96.2%)
Tisbury CCU	Medicine	24.10.20 (94.2%)	07.11.20 (94.2%)	07.12.20 (92.5%)	25.01.21 (94.2%) 30.01.21 (100%)	13.02.21 (94%)	08.03.21 (96.1%)
Whiteparish Ward	Medicine	30.10.21 (90.4%)	02.11.20 (88.5%)	03.12.20 (92.5%)	18.01.21 (96.2%)	07.02.21 (94%) 11.02.21 (84%)	22.03.21 (96.2%)
Spire Ward	Medicine	21.10.20 (88.5%) 26.10.20 (96.2%)	27.11.20 (96.1%)	05.12.20 (86.8%)	19.01.21 (94.3%) 23.01.21 (98.1%)	05.02.21 (98.1%)	08.03.21 (96.2%)
Longford Ward	Medicine (moved from Surgery)	18.10.20 (94.1%)	15.11.20 (98%)	13.12.20 (94%)	10.01.21 (92.3%)	09.02.21 (96.1%)	06.03.21 (96.2%)
Breamore Ward (Stroke Rehab)	Medicine (when reopened)			07.12.20 (94.2%)	31.01.21 (98.1%)	20.02.21 (98.1%)	21.03.21 (98.1%)
Emergency Department	Medicine	13.10.20 (95.9%)		03.12.20 (100%)	05.01.21 (98.1%)		30.03.21 (95.8%)
Amesbury Suite	Surgery	19.10.20 (90%)	24.11.20 (94.2%)	08.12.20 (88.2%)	20.01.21 (88.2%)	10.02.21 (92.2%)	04.03.21 (92.2%) 12.03.21 (86.3%)
Chilmark Suite	Surgery	03.10.20 (89.1%)	08.11.20 (95.7%)	13.12.20 (86.3%)	22.01.21 (94.1%)	09.02.21 (98.1%)	05.03.21 (98.1%)

Odstock Ward	Surgery	16.10.20 (98.1%)	07.11.20 (96.2%)	27.12.20 (96.2%)	27.01.21 (86.3%)	11.02.21 (98.1%)	04.03.21 (98%)
Britford Ward	Surgery	27.10.20 (98%)	11.11.20 (96.2%)	03.12.20 (93.8%)	11.01.21 (87.5%)	11.02.21 (94.1%)	04.03.21. (98.1%)
Downton Ward	Surgery	16.10.20 (100%)	13.11.20 (94.2%)	22.12.20 (93.8%)	21.01.21 (95.9%)	04.02.21 (98.1%)	03.03.21 (98.1%) 12.03.21 (84.6%)
Radnor Ward	Surgery	13.10.20 (100%)	30.11.20 (98%)			17.02.21 (100%) 24.02.21 (93.2%)	06.03.21 (100%)
Day Surgery Unit	Surgery	09.10.20 (100%)	23.11.20 (95%)	21.12.20 (92.3%)	25.01.21 (97.9%)	25.02.21 (94.7%)	11.03.21 (97.4%)

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed

(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

APPENDIX E

Perfect Ward Application (PWA) Quick COVID-19 Assessment Compliance scores for Quarters 1 & 2 of 2020/21

Ward/ Dept	Division	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Sarum	Clinical Support & Family Services				16.07.20 (100%)	26.08.20 (100%)	
Acute Medical Unit	Medicine	27.04.20 (100%)			10.07.20 (96%)		10.09.20 (96%)
Durrington Ward	Medicine	22.04.20 (97.7%)		16.06.20 (97.7%)	28.07.20 (96%)		10.09.20 (100%)
Farley RCU Ward	Medicine		29.05.20(100%)		24.07.20 (100%)		
Hospice Unit	Medicine						
Laverstock Ward (Stroke Unit)	Medicine		27.05.20 (100%)	17.06.20 (100%)	28.07.20 (100%)		
Pembroke Ward	Medicine	27.04.20 (96.6%)		09.06.20 (98.9%)	17.07.20 (100%)		
Pitton Ward	Medicine	22.04.20 (100%)	30.05.20 (100%)		28.07.20 (100%)		
Redlynch Ward	Medicine	27.04.20 (100%)	30.05.20 (96.3%)		28.07.20 (100%)		10.09.20 (100%)
Tisbury CCU	Medicine	27.04.20 (100%)	30.05.20 (100%)	16.06.20 (98.6%)	27.07.20 (96%)		
Whiteparish Ward	Medicine	27.04.20 (100%)	30.05.20 (100%)		24.07.20 (96%)		
Spire Ward	Medicine	24.04.20 (96.8%)	29.05.20 (100%)	17.06.20 (100%)	24.07.20 (92%)		
Amesbury Suite	Surgery	01.04.20 (85.7%) 02.04.20 (100%) 16.04.20 (100%)		09.06.20 (100%)	17.07.20 (100%)		
Chilmark Suite	Surgery	01.04.20 (85.7%)		24.06.20 (100%)	17.07.20 (100%)		
Odstock Ward	Surgery	02.04.20 (86.4%) 17.04.20 (100%)		23.06.20 (96%)			
Longford Ward	Surgery	01.04.20 (100%) 16.04.20 (100%)			08.07.20 (98.9%)		
Britford Ward	Surgery			24.06.20 (91.7%)			
Downton Ward	Surgery	23.04.20 (88.9%) 29.04.20 (84.9%)		24.06.20 (92.9%)			
Radnor Ward	Surgery	22.04.20 (100%) 29.04.20 (100%)			09.07.20 (100%)	24.08.20 (100%)	21.09.20 (100%)
Day Surgery Unit	Surgery	22.04.20 (95%)		25.06.20 (93.1%)			

APPENDIX E

Perfect Ward Application (PWA) Quick COVID-19 Assessment Compliance scores for Quarters 3 & 4 of 2020/21

Ward/ Dept	Division	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Sarum	Clinical Support & Family Services	22.10.20 (100%)			22.01.21 (100%) 26.01.21 (100%) 27.01.21 (96.6%) 28.01.21 (96.6%)	08.02.21 (100%)	01.03.21 (100%)
Acute Medical Unit	Medicine	13.10.20 (100%)		09.12.20 (100%)	13.01.21 (96.7%)	07.02.21 (93.3%) 12.02.21 (95.6%)	29.03.21 (96.7%)
Durrington Ward	Medicine			09.12.20 (98.3%)	13.01.21 (100%) 27.01.21 (98.9%)	01.02.21 (96.7%) 09.02.21 (96.8%) 10.02.21 (100%) 11.02.21 (100%)	20.03.21 (100%)
Farley RCU Ward	Medicine	13.10.20 (96.8%)		09.12.20 (93.5%)	13.01.21 (96.9%) 27.01.21 (96.8%)		08.03.21 (97.9%) 09.03.21 (98.9%) 11.03.21 (100%) 26.03.21 (100%)
Hospice Unit	Medicine				26.01.21 (89.7%)	12.02.21 (96.6%) 19.02.21 (96.6%) 26.02.21 (100%)	10.03.21 (96.7%) 18.03.21 (96.4%) 29.03.21 (96.3%)
Laverstock Ward (Stroke Unit)	Medicine			07.12.20 (89.3%)	7 audits completed 7 audits (all 100%)	17 audits completed 1 audit (96.6%) 1 audit (96.8%) 1 audit (96.9%) 14 audits (all 100%)	06.03.21 (100%) 14.03.21 (100%) 22.03.21 (96.4%)
Pembroke Ward	Medicine	20.10.20 (97.6%)		07.12.20 (93.1%) 15.12.20 (97.7%)	27.01.21 (93.1%)	01.02.21 (100%) 15.02.21 (100%) 26.02.21 (100%)	01.03.21 (98.9%) 08.03.21 (100%) 22.03.21 (100%)
Pitton Ward	Medicine			11.12.20 (100%)	7 audits completed 1 audit (93.5%) 1 audit (95.7%) 2 audits (both 96.7%) 3 audits (all 100%)	7 audits completed 1 audit (92.9%) 1 audit (95.1%) 2 audits (both 96.4%) 1 audit (96.8%) 2 audits (both 100%)	03.03.21 (96.6%) 07.03.21 (100%)
Redlynch Ward	Medicine			11.12.20 (100%)	13.01.21 (100%) 27.01.21 (100%) 30.01.21 (100%) 31.01.21 (98.45%)	03.02.21 (100%) 09.02.21 (98.9%) 21.02.21 (100%)	04.03.21 (100%) 21.03.21 (100%)

Tisbury CCU	Medicine		17.11.20 (100%) 30.11.20 (98.9%)	18.12.20 (100%)	6 audits completed 1 audit (93.5%) 1 audit (96.8%) 4 audits (all 100%)	26 audits completed 1 audit (97.8%) 25 audits (all 100%)	21 audits completed 1 audit (93.1%) 1 audit (96.9%) 19 audits (all 100%)
Whiteparish Ward	Medicine		19.11.20 (95.6%)	11.12.20 (100%) 18.12.20 (100%)	6 audits completed 6 audits (all 100%)	27 audits completed 2 audits (92.9%) 1 audit (96.3%) 1 audit (96.6%) 2 audits (96.9%) 1 audit (98.9%) 20 audits (all 100%)	17 audits completed 17 audits (all 100%)
Spire Ward	Medicine			10.12.20 (90%)	24.01.21 (100%)	05.02.21 (95.7%) 13.02.21 (94.6%)	01.03.21 (89.2%) 08.03.21 (96.8%)
Longford Ward	Medicine (moved from Surgery)		30.11.20 (96.9%)			01.02.21 (100%) 11.02.21 (96%)	30.03.21 (100%)
Breamore Ward (Stroke Rehab)	Medicine (when reopened)			07.12.20 (100%)	27.01.21 (100%) 31.01.21 (100%)	9 audits completed 9 audits (all 100%)	15 audits completed 15 audits (all 100%)
Emergency Department	Medicine			22.12.20 (93.1%)	05.01.21 (95.1%)	03.02.21 (98.9%)	24.03.21 (98.9%)
Amesbury Suite	Surgery			15.12.20 (92.7%)	23.01.21 (100%)	04.02.21 (96.7%) 12.02.21 (100%) 23.02.21 (96.7%)	06.03.21 (95.6%) 14.03.21 (96.8%)
Chilmark Suite	Surgery			02.12.20 (96.6%)	23.01.21 (100%)	04.02.21 (100%) 12.02.21 (100%) 23.02.21 (100%)	06.03.21 (96.7%) 14.03.21 (96.4%)
Odstock Ward	Surgery		23.11.20 (100%)		20.01.21 (96.8%) 27.01.21 (96.8%)	02.02.21 (96.8%) 11.02.21 (96.8%) 18.02.21 (96.8%) 23.02.21 (95.7%)	04.03.21 (100%) 13.03.21 (96.2%) 20.03.21 (96.6%) 28.03.21 (96.6%)
Britford Ward	Surgery	13.10.20 (93.5%)			27.01.21 (96.6%)	10.02.21 (92.9%)	13.03.21 (83.3%)
Downton Ward	Surgery	12.10.20 (93.3%)			04.01.21 (100%) 26.01.21 (100%) 28.01.21 (100%) 29.01.21 (100%)	19 audits completed 1 audit (93.8%) 1 audit (96.9%) 17 audits (all 100%)	03.03.21 (100%) 13.03.21 (100%)
Radnor Ward	Surgery	14.10.20 (93.1%)		01.12.20 (96.9%)	28.01.21 (100%)	05.02.21 (100%) 17.02.21 (100%)	07.03.21 (93.5%)
Day Surgery Unit	Surgery		23.11.20 (96.4%)		25.01.21 (94.6%)	24.02.21 (100%)	10.03.21 (96.6%)

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed

(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

Publications approval reference 001559

Infection prevention and control board assurance framework, version 1.2

22nd May 2020

Updates since version 1, published on 4 May 2020, are highlighted in yellow

SFT DOCUMENT 1.0 DRAFT 16TH JUNE 2020

Link to national IPC guidance;
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886668/COVID-19_Infection_prevention_and_control_guidance_complete.pdf

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance	Dec-20	Mar-21
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)
1.1 Infection risk is assessed at the front door and this is documented in the patient notes.	DIVISIONS	Non-elective in- patients tested on admission. Categories applied to patients according to perceived risk. Elective patients tested as part of the elective pathway. Outpatients screened for symptoms on arrival. LFT testing in ED , if negative then cepheid rapid test undertaken to identify what pathway the patient follows	1. Non-elective patients may be categorized as low risk and be transferred into open bay before test result. 2. Patients may become positive after admission either due to being incubation stage on admission or due to hospital acquired covid. 3. No current auditing of documentation for front door assessment.	1. Fast tests used for low risk patients as higher risk are not cohorted on test result alone. 2. All patients with negative test are retested in accordance with the testing action card.			
1.2 Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission.	DIVISIONS	1. Patients cared for in 'red' cubicles in Sarum, NNU and Maternity as reflected in action cards (03.116, 03.136 & 03.146). 2. Reference to action card 03.148 and 03.151, non elective surgical and medical admissions pathway and flow for testing. Acute admission and A, B, C categories, reference to de - isolation action card 03.149. 3. Virtual Board identifies new and potential pathway changes/complexities that require review and cascade	1. Inappropriate patient move. 2. Risk of missing routime swabbing	1. Virtual Board Round meeting monitors positive patients and timeline of positive patients with contact tracing. 2. Fast covid swab used on admission and attempt made to isolate until result available. 3. Fast tests used for low risk patients as higher risk are not cohorted on test result alone. 4. All patients with negative test are retested in accordance with the testing action card. 5. Implementation of swabbing team			
1.3 Compliance with the national guidance around discharge or transfer of COVID- 19 positive patients.	DIVISIONS	1. Not been required in Paediatrics and Maternity. 2. All patients who are contacts or confirmed positive are told to continue quarantine until 14 days. Patients transferred to residential homes are all tested negative prior to transfer. Reference to action card 3.110, management of suspected coronavirus cases and transportation home.	1. Unknown compliance of documentation of isolation post-discharge instructions.	1. Care facilities informed of positive result and confirmed at Virtual Board Round.			
1.4 Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice.	DIVISIONS	1) PWA audit for Covid by matrons 2) Daily review in all wards by IPC team 3) Oversight by Head of Nursing on a regular basis	Audits not done daily on Outbreak Wards	1. Increased to daily in outbreak areas 2. Increased to weekly on non-outbreak wards (COVID inspection) 3. Monthly IPC inspections via PWA 4. Outbreak meetings undertaken in-line with Trust action card and national reproting requirements.			
1.5 Monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice.	DIVISIONS	1) Weekly PPE meeting to ensure adequate supply and distribution 2)IPC daily oversight of PPE across clinical areas 3) PWA covid audit to assess compliance 4) Action cards reviewed by DDON to ensure they are current	Staff fatigue leading to reduced compliance Shortage of PPE on wards	1. Additional store of PPE in central store and available via the Site Team 2. Trust has not suffered PPE shortages and FIT Testing on all masks in place.			
1.6 Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase.	DoN	1) Staff undertaking twice weekly LFT 2)PCR available for any positives and staff isolate until they get the outcome form PCR 3) All staff are guided through a review of actions and interactions by OH 4)Actions card to detail process approved vis IMT 5) Positive staff reviewed at daily Virtual Board which has micro , IPC and DDoN on the review panel 6) All staff positives track and traced and any compliance breeches managed	Breaks in compliance continue to be an issue despite multiple comms, signage and messages	OH track and trace processes .			
1.7 Training in IPC standard infection control and transmission-based precautions are provided to all staff.	DIVISIONS	1)PPE champion sessions 2)Targeted training for high risk areas 3)IPC inductions sessions 4) On line skills for health session	Face to face training reduced due to classroom restrictions	1. IPC standard training available on MLE and education and information available via the Trust microsite and the action cards. 2. IPC Team undertake ad-hoc and on demand sessions (as has always existed)			
1.8 IPC measures in relation to COVID-19 should be included in all staff induction and mandatory training.	IPC	1) IPC training is mandatory in all induction sessions	COVID specific training is not part of induction on-line training.	National resources for IPC Training becoming available in March 2021 and will be used to enhance the exisitign training.			
1.9 All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work.	Corporate	1) Poster and signage hand face space in all areas 2) Communications reminding staff on daily messaging 3)Hygiene stations at entrance to hospitals with signage	1. Lack of compliance in some areas (coffee rooms) and ward spaces due to high volume of staff attending areas.	1. Revisitng of ward spaces for those areas experiencing ongoing outbreak - review of staff flow and shared spaces. 2. Social Distancing Group have been in place since beginning of pandemic. 3. Screens Task and Finish Group			

1.10 All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance.	IPC	1. Action cards for all PPE requirements in-line with PHE guidance and accessible via Trust intranet portal. PPE compliance monitored through PWA COVID specific and PWA IPC inspections (in-patient areas). Hand hygiene audits monthly (all clinical departments). 2. PPE group commenced at the beginning of the outbreak with a coordinated response between Procurement, OH&SS, Divisional Management Teams, DDoN, IPC and Executive incidence response leads. 3.Individual and department reviews by IPC as required. 4. Specific discussions with high risk areas (Radnor, RCU, ED/RAZ) when making changes to PPE agreed via the PPE group and documented practices within local SOPs. 5. Training records by IPC.	1. PWA available within in-patient areas. No specific PPE auditing in outpatient departments. 2. Continue to have departments with < 85% compliance with hand hygiene audits and non-submission of audits. 3. Risk in staff knowledge and keeping updated with continued changes to PPE requirements. 5. Ongoing FIT testing requirements due to national supply changes and the removal of 3M. 6. IPC hold records for staff trining they have undertaken but not all staff.	1. Use of Matron's rounds to reiterate PPE compliance. 2.IPC team continual rounds and ongoing 'on the spot' education and support. 3. Weekly PPE meeting as part of coordinated Trust COVID tactical response. 4. Less changes to national guidance has resulted in more embedded use of PPE. 5. FIT Testing Team have more robust process and have increased capacity.			
1.11 National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way.	IPC	1. Additional IPC meetings to focus on COVID specific changes commenced on 10/06/20 (runs 3/4 weeks with 1/4 weeks on IPC 'business as usual'). All changes are updated on the action cards and cascaded in the Comms and available on the Trust intranet site. 2. Most recent guidance released 21.01.2021	1. COVID -19 PWA inspections monthly on in-patient wards. 2. Matrons rounds provide oversight. 3. Action tracker from the IPC meeting records dates of changes. Representatives from clinical divisions.	1. Limited monitoring in out-patient settings. 2. Action cards updated and approved at IMT 03.03.2021			
1.12 Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	IPC/DIPC	1. Departmental risk assessments on DATIX and escalated via the Trust process to Board. 2. Key risks identified at the IMT incident meeting. 3. Risk assessments for COVID secure areas reviewed at IPC meeting. Additional risks identified via the clinical divisions. 4. IPC BAF recorded at Trust Board August 2020.	IPC BAF to be presented at CMB, TMC, CGC and TB July - August 2020. 2. Revised BAF national document 12.02.2021	1. Key risks escalated as required via Covid meetings and not delayed until existing Trust assurance meetings. 2. IPC BAF to be presented to Board April 2021 (Q4).			
1.13 Risks are reflected in risk registers and the board assurance framework where appropriate.	ALL	1. As above. 2. Internal audit of the Trust risk process. 3. Discussion of divisional risk assessment via Governance Meetings.	There are variations in the Divisional Governance and performance meetings agenda. (CSFS definitely have COVID as a standing agenda item).	As above Risk assessment in place regarding the potential outbreak risk amongst patients and/or staff - Risk No 6570 Risk assessments in place for Ventilation, Outbreak, BAF Compliance; Social Distancing beds			
1.14 Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens.	IPC	1. RCA documents of all reportable HCAIs with robust appeal process in place with the CCGs. 2. National data submission on HCAI's. 3. IPCWG/ICC meetings documented with minutes and action tracker. 4.Trust KQI reporting monthly for reportable HCAIs at CMB 5. Bi-annual DIPC report through Trust governance pathway to TB. 6. Policies and procedures for managing infection and prevention e.g. Outbreak policy. Policy compliance monitored via IPC Team and incorporated into RCA documentation and PWA inspections. 7. PWA inspections. 8. Risk assessments in place for example risk of flu outbreak; risk of increasing C.difficile cases against trajectory in the contract. 9. Monthly review of reportable HCAI cases at 'Share and Learn'.	1. Increase in reported C-Diff in comparison with 2019-20 (recognised nationally).	1. New Matrons Round inspection currently being formatted on PWA as an assurance inspection undertaken by Matrons and senior nursing management.			
1.15 That Trust CEOs or the executive responsible for IPC approve and personally signs off all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	DoN	1) triple approval by CEO, Coo and DoN in place 7 days per week					
1.16 Ensure Trust Board has oversight of ongoing outbreaks and action plans.	DoN	1) Outbreak data presented to private trust board and Clinical Governance committee DoN regularly updates the Executice Team regarding Outbreak position. SII report to be completed and full update will be within the DIPC report.		Presented Jan 2021			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance	Dec-20	Mar-21
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)
2.1 Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas.	DIVISIONS	1. Designated unit (RCU) for management of suspected and confirmed COVID-19 patients. 2. RCU management by designated Matron with cohort of senior nursing team who remained on the RCU (6x Band 6, 4 x B6 Staff). 3. Respiratory specialist nurses, education department and CCOT with support from quality directorate , worked through competencies and upskilling to ensure all reached a level of competence and confidence to work with this group of patients. 4.Staffing ratio was supported to allow high numbers of staff with additional support of day and night rota for CPAP and respiratory support. The team were supported by the respiratory consultants and doctors on the ward at all times. 5. ITU/RCU training and induction, use of runners, task teams, theatre SOP. 6. Reference to action card 3.101 standard infection control principles. Action card 3.102 & 3.102A regarding infection control PPE, and donning and doffing of PPE with support provided by IPC Team and use of PPE 'wardens'. 7. High risk areas supported by Chaplaincy, Clinical Psychology and Palliative Care Teams for staff and patients experiencing end of life care. 8. PWA Quick Covid 19 assessment to ensure staff understanding in these areas. 9. Standard judgement review commissioned for Covid 19 related deaths in hospital 10. Currently no high harm incidents related to this group of patients or staff	Unknown timeframe or impact of any 2nd wave C_pap training 2. 2nd wave has required retraining of staff and support from ITU with CPAP. 3. Significant impact of staff sickness in wave 2	Continued monitoring of national and regional intelligence. Review locally when any national learning identified (such as Trust outbreaks) 2. 'Red line' staffijg document produced for nursing to identify minimum staffing levels. 3. Staff redeployment to clinical areas from non-clinical areas (ward buddy scheme) 4. Redeployment of doctors to to medicine 5. Use of the miltary to support clinical areas.			
2.2 Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to COVID-19 isolation or cohort areas.	FACILITIES	1. Housekeeping staff have been Fit tested for level 3 mask, MLE PPE units in date and practical training given by supervisors and shadow training with other experienced housekeepers. No trends within incident reporting regarding practices by housekeeping staff. Designated cleaners to clinical areas.	Overnight cleaning team will have to cross all areas. On risk register (no 6571).	All staff aware of regimes and PPE.			
2.3 Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance.	FACILITIES	1. Training guides/practical training and shadow training given prior to undertaking an infection clean. Additional training given to under HPV decontamination for specific supervisors and senior housekeeping staff. All cleaning requests are validated, form completed and signed off by ward sister on completion. Discussions with Housekeeping and IPC to agree any additional cleaning including 'double cleans' and reviewed daily and as required.	1. Continued changes in IPC guidance. Not an issue in Q3 and Q4	1. Membership of IPC Group.			
2.4 Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance.	FACILITIES	1. RAZ areas increased cleaning hours and cleaning after every patient transfer, in addition to the "normal" ward cleaning. Implementation of double cleaning required for side rooms, Infection control will inform housekeeping daily Mon - Fri where they require double cleans. Sign off sheet and decontamination sheets are available for review.	1. High number of wards in outbreak status and/or have cohort bays for COVID-19 positive patients.	1. Increased cleaning requirements as required. 2. Monitored through the Outbreak Manageemnt meetings.			
2.6 Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.	FACILITIES	1. Our chlorine based products are in use across the site. These products meet the national guidance and have been signed off by Infection Control and Occupational Health. COSHH sheets are available.	A challenge remains that many non-clinical equipment providers are not familiar with providing data/information on this level of cleaning and therefore decisions were made where necessary on standard Trust practice, and any reports of device damage will be monitored.	Wipes are available for non-clinical equipment in clinical areas (e.g. keyboards, photocopiers, phones etc.) which have been agreed with IPCT, Decontamination Lead and IT. External providers have been asked to provide guidance where appropriate.			
2.7 Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products.	FACILITIES	1. Our chlorine based products are not washed off, so appropriate contact time is in place.					
2.8 As per national guidance: • 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily • rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily).	FACILITIES	1. Increased number of cleaners who undertake additional touch point cleaning every day. 2. Non-clinical areas have identified cleaning regimes to provide self cleaning of areas and equipment. 3. Individual users will decontaminate electrical equipment, mobiles and tablets etc. 4. Room cleaning will be undertaken by the departmental staff when PPE is removed. 5. Staff are to wipe all touch point twice daily and hourly in outbreak zones	1. No auditing in place of non clinical areas. 2. Potential challenges of changing supply of wipes. 3. No auditing of cleaning of electronic devices such as tablets, keyboards, phones (including personal phones).	COVID secure risk assessments require confirmation that staff are meeting the requirements. Continued discussion with Procurement re supplies and decision via IPC. Refreshed posters have been circulated to remind staff of correct methods of decontamination of re-usable equipment and incorporated IT equipment to recognise the increase use of electronic devices and technology within clinical areas (see 2.6)			
2.9 Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken.	FACILITIES	A process is in place for contaminated linen which is returned to the on-site laundry and decontaminated to the appropriate standard in line with BSEN14065 and HTM01-04. Process posters have been circulated to all linen areas.					
2.10 Single use items are used where possible and according to single use policy.	DECON LEAD	Disposable mops and cloths are used in RED zone areas including any side rooms. Single use equipment is used as per Trust policy where possible.	No monitoring of single use items.	For PPE would be monitored and managed via PPE Group.			
2.11 Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance.	DECON LEAD	Any items left in the room are cleaned. Ward staff undertake the decontamination of equipment and use Clinell "clean" tape to highlight this action has been completed. All reusable equipment to be decontaminated as per Trust Policy. In-patient areas monitored via PWA.	Limited audit evidence.	Refreshed posters have been circulated to remind staff of correct methods of decontamination of re-usable equipment and incorporated IT equipment to recognise the increase use of IT within clinical areas. In addition during the COVID pandemic, additional items have been added to stock availability such as single use blood pressure cuffs and pulse oximeter probes to provide an alternative to our normal re-usable items for areas to order if appropriate. Refreshing of some SOPs to include decontamination of COVID where relevant.			

2.12 Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	ALL DEPARTMENTS	1) PWA audit 2)Staff are to wipe all touch point twice daily and hourly in outbreak zones 3) Enhanced cleaning in outbark zones		COVID secure risk assessments require confirmation that staff are meeting the requirements. Continued discussion with Procurement re supplies and decision via IPC. Refreshed			
2.13 Ensure the dilution of air with good ventilation e.g. open windows in admission and waiting areas to assist the dilution of air.	ETS	Walk-round of all areas completed as part of recovery with capacity and flow reviewed. Space allocation committee reviewing appropriate spaces for specific services. National guidance on ventilation chased through NHSI sacral times Trust Ventilation Task and Finish Group introduced.	1. Unknown air exchanges and ventilator levels in many areas. 2. Additional ventilation system ordered for APG zones 3. National guidance as referenced in national IPC guidance has not been published.	Areas undertaking AGPs to be identified and assessment of air exchanges to be completed. 2. Ventilation risk assessment in place 3. Ventilation improvement works in progress (not wards) 4. All areas clinical amd non-clinical encouraged to have windows open and maintain ventilation where possible.			
2.14 There is evidence organisation have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants.	FACILITIES	Chlorine based cleaning solution everywhere anyway pre covid. (sochlor/actichlor etc) so we would continue as we have been.					

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	**Compliance**	Dec-20	Mar-21
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)
3.1 Arrangements around antimicrobial stewardship are maintained.	IPC CONSULTANT	New Microbiologist in post and Antimicrobial pharmacist remains in post	Only 1 x per week ward round	1. Micro staffing levels will now permit the establishment of an antibiotic ward round. This is to start w/b 13/07/20. Currently established for once a week with aspiration for possibly twice weekly dependent on findings/needs . 2. Increased resilience and continuity with pharmacists and fully established microbiology team.			
3.2 Mandatory reporting requirements are adhered to and boards continue to maintain oversight.	IPC	1. RCA documents of all reportable HCAIs with robust appeal process in place with the CCGs. 2.National data submission on HCAI's. 3.IPCWG/ICC meetings documented with minutes and action tracker. 4.Trust KQI reporting monthly for reportable HCAIs at CMB 5. Bi-annual DIPC report through Trust governance pathway to TB. 6. Policies and procedures for managing infection and prevention e.g. Outbreak policy. Policy compliance monitored via IPC Team and incorporated into RCA documentation and PWA inspections. 7. PWA inspections. 8. Risk assessments in place for example risk of flu outbreak; risk of increasing C.difficile cases against trajectory in the contract.	None 2. National increase in non-COVID HCAI's reflected within the Trust	1. Exisiting Trust IPC contol measures in place. No contract trajectories for this year. All external reproting continues.			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance	Dec-20	Mar-21
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)
4.1 Implementation of national guidance on visiting patients in a care setting.	DM/KG	1. Action card on patient visiting with restrictions and guide for staff. Specific areas detailed for individual approaches and agreed at IMT. No serious complaints raised regarding visiting restrictions. 2. High risk patients in Spinal Unit subject to separate action card to protect shielding patients. 3. Action card for delivering patient belongings coordinated by PALS. 4. Capacity for relatives/carers to communicate virtually expanded and detailed on Trust external website . 5. Specialties with separate guidance followed national and local requiremetns during suspension.	Evidence of staff undertaking risk assessment with visitors who require PPE. Variation in PWA inspections.	COVID-19 quick assessment completed on PWA. 2. Visitng Action card has been reviewed for both resticted visiting and susequent suspended visiting in wave 2. 3. Visitors logs in place.			
4.2 Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access.	DR/LA	1. Entry to clinical areas restricted with use of 'SALTO locks' . 2. RCU specific signage regarding designated status (now removed due to reduced numbers).	1. Sudden influx of numbers will require reinstating of signage.	1. Numbers discussed via IMT and actions agreed . Signage can be reinstated quickly. 2. Signage reinstated for these areas as required.			
4.3 Information and guidance on COVID-19 is available on all trust websites with easy read versions.	KG/DR	Easy read information available. Additional added and noted by Healthwatch Wiltshire. No complaints or concerns raised regarding information. Links with Mencap and local LD partners. Internal communications - via IMT for general communications to staff and the public. With traditional broadcast and print media being agreed by a combination of CEO, COO and Exec OD&P based on recommendations from Head of Communications (or Deputy).					
4.4 Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved.	DIVISIONS	1. In Surgical division use of SBAR handover process and sticker in patient medical notes on any transfer. Taking in to consideration action card 3.130 & 03.138 management of identified contact patients. 2. In Medical division - wherever clinically appropriate patient with Covid 19 are nursed within the RCU template and not transferred out unless proven negative following the de-escalation policy. Discharges to residential placements are only allowed after negative screens. Any contact are advised as such on discharge.	1. No audited evidence of SBAR or other patient transfer. 2. Key challenges in wave 2 with patient moves to reduce risk of infection spread. 3. Timely swabbing of patients.	1. Currently nil identified serious incidents due to harm from lack of infection status . 2. Nil poor outcomes discussed in Virtual Board Round. 3. Descalation action card. 4. No reported incidents on DATIX due to harm from lack of infection status . 5. Introduction of LFT for patients when required. 6. Swabbing team to support continuity of patient testing			
4.5 There is clearly displayed and written information available to prompt patients, visitors and staff to comply with hands, face and space advice.	Estates	1) Signage around the estate detailing hand face space 2) hygiene stations at all entrances with masks and gels 3) Visiting limited to essential only (End of Life Carers etc.) 4) Social media campaign about what to do when on site 1. 5. Patients asked to replace face coverings with masks at height of second wave.		1. Patient discharge leaflet outlining contact status and guidance. Included reminders regarding hands, face, space.			

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance	Dec-20	Mar-21
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)
5.1 Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID -19 cases.	IPC	Non-elective in- patients tested on admission. Categories applied to patients according to perceived risk. Elective patients tested as part of the elective pathway. Outpatients screened for symptoms on arrival. LFT testing in ED , if negative then cepheid rapid test undertaken to identify what pathway they patient follows	During very busy period some swabs were missed at the intervals required (1,3, 5-7 days and then weekly)	Swabbing team in place to ensure all patients are tested at intervals as per action cards			
5.2 Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimize the risk of cross-infection, as per national guidance.	DIVISIONS	1. Medical division - RAZ and standard Majors process in place as per action card. Any resp symptoms or common complications are directed through RAZ (Reference to action card 3.098A & B ED and clinical response management of Covid 19 patients. ED configuration and service delivery action card). 2. Surgical division - No 3.129. SAU action card and outpatient action cards. 3. CS&FS - Action cards (03.116, 03.136, 03.146), risk register, SOPs.	Designated 'red and green' areas to be approved and signed off by DIPC by September 2020. false negative tests or patients being positive at day 3	1.All patients swabbed and all staff are wearing PPE appropriate to activity. 2. Screening undertaken in outpatient settings. 3. High, medium and low risk (red, amber green) pathways approved via IMT as per national guidance. 4. LFT introduced into ED on 26.12.20 as per national guidance. Also used in SAU and AMU.			
5.3 Staff are aware of agreed template for triage questions to ask.	DIVISIONS	clinicians establish if there is previuos knowlegde of a positive diagnosis or are there any features to suggest COVID but this is down to clinical judgment..	No agreed template for questions.	1. Triage key questions are asked and documented			
5.4 Triage undertaken by clinical staff trained and competent in the clinical case definition, and patient is allocated to the appropriate pathway as soon as possible.	DIVISIONS	Clear pathways for patients to be triaged into categories A-D etc and ation cards to support this. This with the LFT and ?or Ceheid result leads to alloaction of a bed in a suitable are for that category of patient	1. Occassional risk of patient testing positve despite lack of symptoms and negative LFT.	1. action cards for planned pathway detailing requirement of patients in cat A-D. 2. LFT at front door to support risk of non symptomatic positive cases.			
5.5 Face coverings are used by all outpatients and visitors.		1) Signage around the estate detailing hand face space 2) hygiene stations at all entrances with masks and gels 3) Visiting limited to essential only (End of Life Carers etc) 4) Social media campaign about what to do when on site 5) Leaflet for inpatients detailing mask wearing , hand face and space		1. In wave 2 peak visitors asked to wear a surgical mask rather than a covering.			
5.6 Face masks are available for patients with respiratory symptoms.		Hygiene stations at all entrances with masks and gels	1. Patient may refuse to wear a mask	1. Staff to request not enforce for patients.			
5.7 Provide clear advice to patients on the use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high risk pathways, if this can be tolerated and does not compromise their clinical care.		As per point 8					
Not included in version 1.4 - Mask usage is emphasized for suspected individuals.	DIVISIONS	1. Mask usage for staff as per action cards and monitored via PWA Quick Covid 19 assessment to ensure staff understanding of management of suspected individuals. 2. Reference to action card 3.102 re PPE and infection control and for patients action card 03.154. 3. Identification of PPE requirements via PPE Group including the procurement of hoods for where masks are not suitable. 4. Leaflet for inpatients detailing mask wearing , hand face and space	1. Ongoing informal observation and reports of poor compliance with wearing of masks.	1. All management teams responsible for being up-to-date with mask requirements and provide ongoing feedback to staff. Messages via daily briefing regarding PPE requirements and external communications to patients.			
5.8 Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	DIVISIONS	1. Screens provided in outpatient areas and/or social distancing floor tape. Waiting areas marked out for maximum usage.	1. Lack of consistency and difficulty for areas to recover with service requirements.	1. Walk rounds of all non-in patient areas undertaken and reported via Recovery Cell. Review of service delivery via Space Allocation Committee. 2. Screens task and finish group in place and reports to IMT. 3. Areas asked to risk assess where staff may be returning from work			
5.9 Note new wording: For patients with new-onset symptoms, isolation, testing and instigation of contract tracing is achieved until proven negative.	DIVISIONS	1. Wards and medical staff review all patients with new resp symptoms and all patients are screened on admission and rescreened every 7 days. Reference to action card 03.148 & 03.151 non elective medical and surgical admission pathway and flow of testing. Also reference action card 3.098A regarding clinical response to suspected coronaviruses. 2. Designated person to undertake contract tracing which commences on notification and undertaken by B7 Sister at the weekend. 3. Positive patients reviewed at the Virtual Board Round and correct contact tracing verified.	1. Risk to number of available of side rooms for isolation. 2. If 2nd wave occurs and high volumes of patients, additional resources will be required to provide timely contact tracing. Unknown pressure on capacity for testing.	1. Twice daily review of side rooms by IPC. 2.Regular review of covid result and senior decisions made as to appropriateness of cohorting patients to allow isolation capacity. Use of ward area with high number of siderooms. 3. Daily VBR and including weekends to provide 7 day tracing of positive patients.			
Not included in version 1.4 - Patients with suspected COVID-19 are tested promptly.	DIVISIONS	1. All patients are tested on admission and retested in accordance with action card . Any patients with new symptoms are also isolated and tested. Reference to action card 03.148 & 03.151 non elective medical and surgical admission pathway and flow of testing. Also reference action card 3.098A regarding clinical response to suspected coronaviruses.					
5.10 Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced.	DIVISIONS	1. Process and SOP in place for cohorting and de-isolating negative patients which includes senior clinical review and is not reliant on test results. Use of whiteboard to trace patients. 2.Virtual Board Round meetings to highlight and discuss. 3.PWA quick covid 19 assessment feedback to remind staff are procedures.	During peak of wave 2 lack of ability to segregate into side rooms.	Cohorting of contacts introduced and cohorted by contact (not mixing of contacts).			
5.11 Patients that attend for routine appointments and who display symptoms of COVID-19 are managed appropriately.	DIVISIONS	1. Patients are contacted regarding symptoms prior to testing and asked again on arrival. Wherever possible patients are seen using "Attend Anywhere". 2. STOP Station SOP for consistency of practice across departments.	1. Lack of audited evidence regarding management.	1. Nil serious incidents raised regarding possible transmission in out patient areas.			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance	Dec-20	Mar-21
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)
6.1 Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas.	DIVISIONS COMMS	RAZ and standard Majors process in place as per action card. Keep left signs throughout the estate One way system in place in restaurants, OPDs and all areas this is possible Limited access to coffee rooms (1 in 1 out) Maximum numbers on all doors and masks worn in offices unless alone or under numbers with 2 metres distance Visit limited to essential only Restricted access to the site has been in place since Q1	Not possible in all areas but all are have been reviewed and	1. Areas continue to be reviewed - some layout and geography of areas does not allow one way entrances and exits. Areas provide additonal touch point cleaning.			
6.2 All staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe.	IPC DIVISIONS	1. Monthly hand hygiene submission in all clinical areas. 2. PPE training provided by IPC Team and records kept. 3. IPC Training on MLE and monitored via IPCWG. 4. Following the introduction on 15/06/20 of masks in non-clinical areas a risk assessment to validate COVID -Secure areas introduced and signed off via the IPC Group and then via IMT. 5. Requirements regarding social distancing within working environments identified with maximum occupancy room signage and link to number 4. 6. Staff shielding, redeployment, working from home guidance and associated safety overseen by Trust Workforce Group. 7. Staff well being and direction to OH support identified via daily bulletin and encouraged discussion with line managers.	1. Continued changes to guidance could result in out-of date practices.	1. Immediate updating of action cards on receipt of new guidance which has been reviewed at IPC Group. 2. Updated guidance to staff via Trust daily comms and intranet. 3. National update to the quick COVID 19 PWA assessment by the PWA organisation. 4. Improvement in FIT testing provision to speed up process of fitting on multiple masks			
6.3 All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it.	IPC	Refer to section 1.6		1. Enhanced level 1 PPE introduced locally in January due to cohorting of COVID positive cases and high staff absence.			
6.4 A record of staff training is maintained.	IPC DIVISIONS	1. IPC record of training delivered by the IPC Team. 2. FIT Testing register.	1. Continued challenges with the supply of PPE and repetitive FIT testing required. 2. See section 1.10	1. Co-ordinated via the PPE Group. 2. Improvement in FIT testing provision to speed up process of fitting on multiple masks			
6.5 Appropriate arrangements are in place so that any reuse of PPE in line with the MHRA CAS alert is properly monitored and managed.	DIPC/PPE	1. All reuse of PPE is agreed via the PPE group.	Degradation of reuse items.	1. Monitored with Trust H & S Manager and regulated via PPE Group. Any significant risks would be added to the risk register.			
6.6 Any incidents relating to the re-use of PPE are monitored and appropriate action taken.	IPC/DIVISIONS	1. All incidents would be reported via DATIX and identified by Trust H &S Manager/Procurement with discussion at PPE Group.					
6.7 Adherence to PHE national guidance on the use of PPE is regularly audited.	DIVISIONS	1. Surgical division - Covid secure risk assessments-red, green and blue areas. PPE champions and PPE meetings. Reference to action card 5.037, PHE guidance for healthcare workers. 2. PPE champions in CS &FS from 26/06/20. 3. PWA quick COVID-19 inspection and existing PWA inspections. 4. Incidents related to COVID picked up by Decontamination Lead and discussed at Trust H and S Committee.	1. Currently no standardised inspection/audit within non in-patient areas.	1. PPE usage within in-patient areas audited via PWA IPC and COVID audits.			
6.8 Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: *hand hygiene facilities including instructional posters *good respiratory hygiene measures *maintaining physical distancing of 2meters wherever possible, unless wearing PPE as part of direct care *frequent decontamination of equipment and environment in both clinical and non-clinical areas *clear advice on use of face coverings and face masks by patients/individuals, visitors and by staff in non-patient facing areas.	IPC	1) Signage around the estate detailing hand face space 2) hygiene stations at all entrances with masks and gels 3) Visiting limited to essential only (End of Life Carers etc) 4) Social media campaign about what to do when on site 5) leaflet for impatient detailing mask wearing if possible , hands, face, space					
6.9 Staff regularly undertake hand hygiene and observe standard infection control precautions.	DIVISIONS	1. Monthly hand hygiene submission in all clinical areas. 2. PWA IPC Inspection.	1. Standard precautions are not routinely audited within non in-patient areas.	1. Daily COVID 19 inspection within in-patient areas in outbreak during February and weekly in non-outbreak areas.			
6.10 The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance. Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas.	ETS/IPC	1. Hand driers removed from use on the 13th of July from the following areas:- SDH North public toilets, Spinal Unit, Hedgerows, Block 29 and the Staff Club. Note:- a decision was made to also remove from use the hair driers that are installed in the Staff Club changing areas. 2. Procurement have been informed of the increase in paper towels and they do not believe stock will be a problem. 3. Extra bins are also in place within the facilities.	1. Increased risk of sewage leaks via blockages caused by wipes in the waste system.	Link to RA 6545 - actions completed			
6.11 Staff understand the requirements for uniform laundering where this is not provided for on site.	DIVISIONS/FACILITIES	1. Laundering of uniforms to be completed within existing washing guidelines provided with uniforms. Addition of reinforcement of the requirement to change on-site and courier uniform within a laundry bag or similar. 2. Clinical staff not usually in uniform provided with scrubs in high risk areas and/or required to wear work specific clothing changed into and out of at work.	1. Not formally monitored.	1. Staff made aware of this requirement within own scope of personal responsibility.			
6.12 All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance, if they or a member of their household displays any of the symptoms.	ALL	1. Reference to action card 5.037 PHE guidance for healthcare workers. Staff seeking appropriate and prompt testing for themselves or household. 2. Trust Comms directed to OH services with 7 day cover to provide guidance on testing and isolation requirements.					
6.13 A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	DoN	1) Daily Virtual board review of all positive patients and staff 2) Contact tracing undertaken daily to ensure all positives cases managed effectively and in correct pathways 3) BSW local surveillance data reviewed via IMT and Gold command		Regular Outbreak Meetings held during Q3 and Q4 attended by PHE, BSW and NHSI&E. Review of Site by DoN with NHSI&E IPC Lead. Daily VBR (7 days per week) to monitor for any HCAI and trace contacts where required.			
6.14 Positive cases identified after admission who fit the criteria for investigation, should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	DoN	1) Daily Virtual board review of all positive patients and staff 2) Contact tracing undertaken daily to ensure all positives cases managed effectively and in correct pathways 3) Daily outbreak meeting , all outbreaks traced with gant charts 4) Outbreaks reported Via immarch portal 5) PHE attend outbreak meeting three day per week		See section 6.13			
6.15 Robust policies and procedures are in place for the identification of, and management of outbreaks of infection.This includes the documented outcome of outbreak meetings.	DoN	Action card detailing management of outbreak, personnel required and reporting responsibilities in place Outbreak status from 24.03.21 - nil COVID Outbreaks within the Trust.		1. Walkround completed with NHSI/E in January 2021 2. Outbreak management card updated in-line with national guidance January 2021. 3. All Outbreak meetings recorded and sgared with PHE/CCG.			

7. Provide or secure adequate isolation facilities

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance	Dec-20	Mar-21
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)
7.1 Restricted access between pathways if possible (depending on size of facility, prevalence, incidence rate high/low) by other patients/individuals, visitors or staff.	DIVISIONS	RAZ and standard Majors process in place as per action card. Keep left signs throughout the estate One way system in place in restaurants, OPDs and all areas this is possible Limited access to coffee rooms (1 in 1 out) Maximum numbers on all doors and masks worn in offices unless alone or under numbers with 2 metres distance Visiting limited to essential only Signage of ward status	1. Movement of staff required during peak 2. Asymptomatic positive cases arising in amber areas.				
7.2 Areas/wards are clearly signposted, using physical barriers as appropriate to patients/ individuals, and staff understand the different risk areas.	IPC COMMS DIVISIONS	Signage of ward status Hand face space sign at ward entrances	1. Red zones have specific signage but no agreed signage for other areas.				
7.3 Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate.	DIVISIONS	1. Patients isolated within the RCU/Radnor template unless specialty requirements denote higher risk and then isolated within a sideroom facility. Use of siderooms,cohorting, signage, red/amber areas etc. Liaison of site management team and IPC team with ward staff to ensure appropriate patient placement within the Trust. Reference to action card 3.130 and 3.101, standard infection control principles and ongoing management of identified contact patients. Discussed with IPC Team and monitored via Virtual Board Round meeting.	1. Unpredicted positive patients.	1.Moved on positive screening and contact tracing undertaken as required. Actions reviewed at Virtual Board Round. 2. During peak of wave 2 wards redesignated for positive COVID-19 cohort areas to provide a separate space for any green pathways and reduce risk of spread. Full cleaning of areas before returning to specialty provision.			
7.4 Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance.	DIVISIONS/ETS	No positive or negative pressure rooms in use within the Trust. Patients are all in designated ward/clinical specific environments. No non-clinical environments utilised for clinical capacity.	See 2.12 re ventilation				
7.5 Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	DIVISIONS/IPC	1. Management between clinical teams and Microbiology/IPC Team. All standard policies and processes in place. Trust wise reporting regarding HCAI. Ongoing regular monitoring via PWA.	Policy audits not undertaken over 2019/20. Previous internal audit not identified concerns. Good feedback from CQC framework review July 2020.	Daily monitoring with ward visits by IPC and links with Site and clinical teams regarding practice. Audit plan to be identified.			

8. Secure adequate access to laboratory support as appropriate

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance		
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)
8.1 Ensure screens taken on admission given priority and reported within 24 hours.	Divisions Labs	Non-elective in- patients tested on admission. Categories applied to patients according to perceived risk. Elective patients tested as part of the elective pathway. Outpatients screened for symptoms on arrival. LFT testing in ED , if negative then cepheid rapid test undertaken to identify what pathway they patient follows All new positive reported each morning and review at daily Virtual board with IPCC DDoN and Micro Average reporting time 20 hours. Patients priority categorised by A,B and C.					
8.2 Regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to the time the result is available.	Labs	All new positive reported each morning and review at daily Virtual board with IPCC DDoN and Micro	Reporting and monitoring reports not generated.	Any issues as a result of delay followed uo on case by case basis.			
8.3 Testing is undertaken by competent and trained individuals.	DIVISIONS	Testing revisited with areas with high false negatives and assessment undertaken of all staff	No specific training logged	1. National video available and PR to create in-house info to be circulated by Divisions to staff with check in that staff have watched training info. 2. Swabbing team intrduced			
8.4 Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance.	DIVISIONS OH	Symptomatic staff (days 1-5) are referred for swabbing on the day they report their symptoms to us and are placed on the swabbing list for the next day. Antibody testing in progress. Staff LFT introduced in December 2020					
8.5 Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	DIVISIONS	All new positive reported each morning and review at daily Virtual board with IPCC DDoN and Micro Additional LFT for patients as contacts introduced to support reduction in outbreak risk	Non-compliance with action card resulting in missed screens	Introduction of swabbing team. Monitoring continues as VBR.			
8.6 Screening for other potential infections takes place.	DIVISONS	As per existing pathways for e.g. MRSA screening and C.difficile. Sepsis pathway in place.					

9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance		
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21	Q4 (20/21)
9.1 Staff are supported in adhering to all IPC policies, including those for other alert organisms.	IPC/DIVISIONS	Refer to section 1.8					
9.2 Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff.	IPC/DIVISIONS	Refer to section 1.4; 1.6; 1.6					
9.3 All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance.	FACILITIES	All potential COVID 19 waste is placed in orange bags and picked up as per Trust Policy via the waste teams. Waste stream for masks in non-clinical areas is managed at increased level than national guidance (which only requires a black bag) to ensure consistency and risk of incorrect disposal.					
9.4 PPE stock is appropriately stored and accessible to staff who require it.	PROCUREMENT	1. PPE stock and usage closely monitored and discussed at PPE Group. Access processes robust as evidenced by no incidents of PPE unviability for staff. 2. CS &FS Comms directly to heads of service and leads. PPE update given at weekly DMC and disseminated by HoS to teams. Monthly Divisional PPE Champions group.					

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance	Dec-20	Mar-21
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)
10.1 Staff in 'at-risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported.	DIVISIONS OD and P	1. Undertaking of individual staff risk assessment, use of occupational health, welfare check of redeployed staff, debriefing in all areas of impact. Reference to action card 03.134, 03.153 & 03.144, guidance for Trust employees defined as vulnerable/extremely vulnerable. This would be covered and met within the COVID risk assessment which ensures the correct work task is being offered according to the nature of the risk e.g. pregnancy, BAME, age, health and the risk assessment also has a psychological wellbeing section on that should be completed between manager and employee. Also, when the pandemic first affected the UK, any staff member could ring our COVID OH line for guidance and support. Three telephone lines in our call centre room was attended 12hrs/day, seven days/wk. This support line continues but is 8-6pm Mon-Fri now. On these calls, we would aim to answer any questions or signpost people if we cant and we also would write a letter to the manager to reflect the clinical advice we gave to ensure the advice is communicated thoroughly. Physical and Psychological wellbeing is also supported via the signposting details on the microsite available to all staff. Consistency panel set up to review the Vulnerable staff risk assessments - selection reviewed each week and managers invited to attend meetings to discuss any concerns with scores or actions taken. Staff risk assessment has been initially focused on vulnerable staff including BAME, but have been expanded to all staff. COO and HRD meeting monthly with BAME staff.	1. Staff choice to remain at work where advised not.	1. PPE worn at all times and staff offered alternative areas to work. 2. Risk assessment document template reviewed as required and in-line with national guidance.			
10.2 That risk assessment(s) is(are) undertaken and documented for any staff member in an at risk or shielding group, including Black, Asian and Minority Ethnic (BAME) and pregnant staff.	ALL	100% of staff have been risk assessed					
10.3 Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained.	MEDICAL DEVICES	Written information (in line with manufacturer and PHE guidance) is issued with each system to provide step by step instructions on their use and management. It additionally acts as a resource out of hours and is available as part of the COVID response action pack. Decontamination Lead provides briefing on collection and signature sheet in place for tracking systems. Hoods being used for staff who fail fit testing. Fit testing programme in place. Task and finish group established to review and implement 'Southampton hoods'. (This product was not introduced and Versafloo hoods are used). Decontamination process in line with manufacturers guidance and Trust IPC policy. ESR utilised to capture of trained staff.	No previous record of briefing and staff collecting the hoods are not always the end users. Risk of requiring more hoods than current supply but not currently an issue.	1-Decontamination Lead has commenced list to evidence information signposted to staff collecting, also capturing where staff collecting are not end users. 2. Task and Finish Group in place for procurement of new hoods. Additional hoods on order to increase current availability and managed via PPE group. 3. Stabilised FIT Testing Team to support staff education and monitoring of kit.			
10.4 Staff who carry out fit test training are trained and competent to do so	OD and P	External provider brought into for training all fit testers Retraining undertakes and Train the Trainer approach used.					
10.5 All staff required to wear an FFP respirator have been fit tested for the model being used, and this should be repeated each time a different model is used.	OD and P	Respirators not issued unless testing has been undertaken Those that fail all masks and a Trust Respirator require a permission email to be sent by the line manager requesting hood. Those that have no taste or smell will be issued a hood if deemed necessary by line manager	1. Increasing instability of types of mask available and subsequent impact on FIT Testing resource 2. Increasing number of FIT Test fails requiring highwe number of respirators. 3. Withdrawal of valved masks for use when undertaking steril procedures.	Process for respirator hoods in place. Weekly PPE Group to identify any issues of concern/risk FFP3 maintained on ESR and FTT visit clinical areas routinely and challenge where masks are not being worn effectivelty and further trssting is required. Testing is being undertaken on a range of masks so staff have more than 1 option.			
10.6 A record of the fit test and result is given to, and kept by the trainee, and centrally within the organisation.	OD and P	All results are kept on ESR so staff can be viewed some wards have adopted a colour coding system which is now being rolled across other wards Staff provided with a record of testing (paper).					
10.7 For those who fail a fit test, there is a record given to, and kept by the trainee, and centrally within the organisation of repeated testing on alternative respirators and hoods.	OD and P	Those that fail with Respirator are issued a hood , record via testing teams					
10.8 For members of staff who fail to be adequately fit tested, a discussion should be had regarding redeployment opportunities and options commensurate with the staff member's skills and experience, and in line with nationally agreed algorithm. A documented record of this discussion should be available for the staff member, and held centrally within the organisation as part of employment record, including Occupational Health.	OD and P	Staff that have failed fit testing and do not have a hood have been redeployed to a suitable are , records Via ESR and testing team There have not been any issues with the supply of hoods. Staff are supplied with a respirtator or hood as required. Copy of their personal testing is given to the staff member.					
10.9 Following consideration of reasonable adjustments e.g. respirator hoods, personal reusable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm, and a record kept in the staff member's personal record and Occupational Health service record.	OD and P	as above	Record not held by staff member	Review with testing team to ensure staff hold the record Staff now have paper copy of the record and it is added to ESR. Staff not substantive are kept on a spreadsheet sa not on the ESR.			
10.10 Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.		all results held on ESR	Record not held by staff member and unable to access ESR record currently. Records are not reviewed by the Board - ESR reports not yet run.	Review with testing team to ensure staff hold the record			
10.11 Consistency in staff allocation should be maintained, reducing movement of staff and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance.	DIVISIONS	Housekeeping staff are allocated to specific wards and remain in that area until the end of their shift. Those staff that undertake post infection cleans do attend different areas, however strict PPE and decontamination processes are followed. Divisional teams have not embraced reducing movement between staff areas. Daily staffing meeting in place, red and green zones not clearly defined. Mitigation - antigen testing on Pembroke and Spinal where patient group vulnerable has not shown any positive results. Virtual Board Round looking at any hotspots of staff absence.		Link to Risk assessment 6568 for Surgical Division			
10.12 All staff should adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	ALL	1. COVID secure risk assessments in place with approval process. Trust wide signage for floors and for maximum occupancy with wearing of masks if this is breached. 2. Security teams and allocated staff to provide guidance and reminders to staff regarding social distancing. Social distancing Task and Finish group established, floor signs, posters, rooms labelled. Public areas not deemed as COVID safe.		Risk register of high-risk areas (labs, pharmacy) have had walk rounds with Sue Biddle			
Removed from version 1.4 Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas.	ALL	1. Surgical division - Creation of spinal bubble staff testing. Retraining of delayed staff. Dedicated Chilmark elective surgery team. Staffing meetings. Liaison between IMT and DMT teams. 2. Medical division - On opening of the RCU staff were identified to work in the area and moved over on the roster. Wherever possible staff were working in the same location. 3. CS&FS - maximum numbers in rooms for doctors . 4. Estates and Facilities staff have a variety of shifts running all days each staff areas has room loading, decontamination stations and appropriate masks with good promotion of social distancing.	Lack of assurance across all clinical areas	Raised with ward leaders via NMAHP Forum - examples of taped handover, use of different spaces for handover were given. Ward offices/rest rooms labelled with room numbers, chairs taken out etc. Training rooms limited and use of virtual training. Staff canteens been converted to staff only, tables distanced etc.			
10.13 Health and care settings are COVID-19 secure workplaces as far as practical, that is that any workplace risk(s) are mitigated maximally for everyone.	ALL	Daily comms used for all staff update Signage in place for what is required and room numbers on all doors Risk assessment and OJA in place for enhamced PPE COVID secure risk assessments completed					
10.14 Staff are aware of the need to wear facemasks when moving through COVID-19 secure areas.	ALL	As above					
10.15 Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing.	OD and P	All staff isolating whether its for 7 days or 14 days are logged on a spreadsheet in OH and on our OH diary system called cohort. Antigen testing on Pembroke and Spinal and roll out of Antibody testing. Virtual Board Rounds on hotspots. COO and OD&P Executive Director meeting with BAME group monthly to seek their views on the Health and wellbeing agenda	Unknown within the Divisions how the supporting of staff who are at home and self-isolating - feedback from shielding group has been poor re contacts from line managers (and redeployed staff too).				
10.16 Staff who test positive have adequate information and support to aid their recovery and return to work.	OD and P	When staff test positive, OH use a comprehensive assessment process to ensure guidance is being followed accordingly, the staff member and manager is advised accordingly and a system in place that if someone isn't well enough to RTW after the 7 days, that they seek further OH input so we can update our records and advise them and their manager again. There are also some cases where staff are particularly unwell and OH will do a welfare call with them too to provide additional support.	As 10.15				

Publications approval reference: 001559
Infection prevention and control board assurance framework
February 12th, 2021. V1.6 Updates from V1.5 highlighted

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance			
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)
1.1 Infection risk is assessed at the front door and this is documented in the patient notes.	DIVISIONS	Non-elective in- patients tested on admission. Categories applied to patients according to perceived risk. Elective patients tested as part of the elective pathway. Outpatients screened for symptoms on arrival. LFT testing in ED , if negative then cepheid rapid test undertaken to identify what pathway the patient follows	1. Non-elective patients may be categorized as low risk and be transferred into open bay before test result. 2. Patients may become positive after admission either due to being incubation stage on admission or due to hospital acquired covid. 3. No current auditing of documentation for front door assessment.	1. Fast tests used for low risk patients as higher risk are not cohorted on test result alone. 2. All patients with negative test are retested in accordance with the testing action card.				
1.2 There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative	DIVISIONS	Testing and transfer action card including LFT for contact patients. Wards redesignated .	Challenges for capacity vs specialty requirements can result in patient moves.	Continued review of contacts via daily VBR and Outbreak Management Meetings.				
1.3 That on occasions when it is necessary to cohort COVID or nonCOVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	IPC FACILITIES	COVID-19 positive patients cohorted during outbreak and when COVID-19 patients exceeded non-COVID. Contacts of COVID 19 positive also cohorted to reduce risk of transmission. PWA rapid COVID 19 inspection completed daily in areas of outbreak (from January 2021) and weekly for all other in-patient areas. Cleaning agreed between Housekeeping and IPC including additional enhanced cleaning - monitored at Outbreak Management meetings. All areas undergo deep cleaning and HPV disinfection of the environment.	National and local prevalence high and experiencing expected 2nd wave whilst in lockdown measures. Compliance with daily and weekly auditing compliance. Number of Outbreaks in January maximised at 9 in-patient and 1 staffing (non-clinical department)	Review walk round with NHSI/E and attendance at Outbreak Management Meetings of PHE and CCG IPC Lead. Daily Outbreak Management Meetings during January 2021 and monitoring of patients via VBR.				
1.4 Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice a) staff adherence to hand hygiene? b) IPC board assurance framework c) staff social distancing across the workplace d) staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: • a) clinical • b) non-clinical setting	ALL	Hand hygiene and IPC practice inspection and audits in lace and monitored at Outbreak Management Meetings, IPCWG. Concerns raised at IMT and PPE Groups if needs. All new guidance monitored via IPCWG and additional forums if required. Quarterly submission of BAF to IPCC and Board. Staff social distancing in place including COVID secure risk assessments, Screens Group and room numbers and all staff wearing of FRSM unless exempt (process in place through Occ Health). Staff individual heals risk assessments.	Non-compliance identified in hand hygiene inspections Restrictions in office space to facilitate staff at work	Discussed at IPCWG , Matron's Meeting , Ward Performance Reports. Screens in wards and encouraging natural ventilation in all areas. Ventilation T and F Group in place.				
1.5 Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	IPC DIVISIONS	PPE compliance monitored as per section 1.4 PPE Champions introduced Q1 and Q2 of 2020-21. IPC Link Nurses established for several years.	Role of Champions requires review of trained individuals from wave 1. Some IPC Link Nurses redeployed or no longer active	Review role of link nurse in IPC in line with RCN Guidance (Jan 2021) and include appropriateness of non-clinical areas				
1.6 Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include preparisational systems in place to monitor results and staff test and trace	COO	In place since December 2020.						
1.7 Additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	DoN IPC	All staff LFT as per 1.6 during increased nosocomial period - additional testing not advised within Outbreak Management Meetings with the exception of first declared outbreak on 20.11.20 when LFT not available routinely.						
1.7 Training in IPC standard infection control and transmission-based precautions are provided to all staff.	DIVISIONS	1)PPE champion sessions 2)Targeted training for high risk areas 3)IPC inductions sessions 4) On line skills for health session	Face to face training reduced due to classroom restrictions	1. IPC standard training available on MLE and education and information available via the Trust microsite and the action cards. 2. IPC Team undertake ad-hoc and on demand sessions (as has always existed)				
1.8 IPC measures in relation to COVID-19 should be included in all staff induction and mandatory training.	IPC	1) IPC training is mandatory in all induction sessions	COVID specific training is not part of induction on-line training.	National resources for IPC Training becoming available in March 2021 and will be used to enhance the existing training.				
1.10 All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance.	IPC	1. Action cards for all PPE requirements in-line with PHE guidance and accessible via Trust intranet portal. PPE compliance monitored through PWA COVID specific and PWA IPC inspections (in-patient areas). Hand hygiene audits monthly (all clinical departments). 2. PPE group commenced at the beginning of the outbreak with a coordinated response between Procurement, CH&SS, Divisional Management Teams, DDoN, IPC and Executive incidence response leads. 3.Individual and department reviews by IPC as required. 4. Specific discussions with high risk areas (Radnor, RCLI, ED/RAZ) when making changes to PPE agreed via the PPE group and documented practices within local SOPs. 5. Training records by IPC.	1. PWA available within in-patient areas. No specific PPE auditing in outpatient departments. 2. Continue to have departments with < 85% compliance with hand hygiene audits and non-submission of audits. 3. Risk in staff knowledge and keeping updated with continued changes to PPE requirements. 5. Ongoing FIT testing requirements due to national supply changes and the removal of 3M. 6. IPC hold records for staff training they have undertaken but not all staff.	1. Use of Matron's rounds to reiterate PPE compliance. 2.IPC team continual rounds and ongoing 'on the spot' education and support. 3. Weekly PPE meeting as part of coordinated Trust COVID tactical response. 4. Less changes to national guidance has resulted in more embedded use of PPE. 5. FIT Testing Team have more robust process and have increased capacity.				
1.11 **There are visual reminders** displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	IPC	Posters and signage across SFT site and in clinical and non-clinical areas. Included on the intranet. Floor markings for social distancing.						
1.12 National IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	IPC	Monitored by Lead ICN Nurse, DIPC and Deputy DIPC and alerts coordinated by EPRR Lead. Reviewed via IPCWG and additional discussions as required to ensure dissemination is agreed and introduced.						
1.13 Changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	IPC/DIPC	1. Departmental risk assessments on DATIX and escalated via the Trust process to Board. 2. Key risks identified at the IMT incident meeting. 3. Risk assessments for COVID secure areas reviewed at IPC meeting. Additional risks identified via the clinical divisions. 4. IPC BAF recorded at Trust Board August 2020.	IPC BAF to be presented at CMB, TMC, CGC and TB July - August 2020. 2. Revised BAF national document 12.02.2021	1. Key risks escalated as required via Covid meetings and not delayed until existing Trust assurance meetings. 2. IPC BAF to be presented to Board April 2021 (Q4).				
1.14 Risks are reflected in risk registers and the board assurance framework where appropriate	ALL	1. As above. 2. Internal audit of the Trust risk process. 3. Discussion of divisional risk assessment via Governance Meetings.	There are variations in the Divisional Governance and performance meetings agenda. (CSFS definitely have COVID as a standing agenda item).	As above Risk assessment in place regarding the potential outbreak risk amongst patients and/or staff - Risk No 6570 Risk assessments in place for Ventilation, Outbreak, BAF Compliance; Social Distancing beds				
1.13 Risks are reflected in risk registers and the board assurance framework where appropriate.	ALL	1. As above. 2. Internal audit of the Trust risk process. 3. Discussion of divisional risk assessment via Governance Meetings.	There are variations in the Divisional Governance and performance meetings agenda. (CSFS definitely have COVID as a standing agenda item).	As above Risk assessment in place regarding the potential outbreak risk amongst patients and/or staff - Risk No 6570 Risk assessments in place for Ventilation, Outbreak, BAF Compliance; Social Distancing beds				
1.16 That Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	DoN	Triple review process in place and CEO sign off daily . All positive patients reviewed at virtual board rounds that are daily in higher period of covid positive cases and three ties weekly in lowered level of prevalence	Annual leave may mean one of the group may not sign this off	COO is also part of the sign off aiming for a triple sign off but one of 4 executives				
1.17 This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	DoN	IPC BAF escalated to Board meetings to provide assurance . Board minutes capture this . DoN regularly updates the Executive Team regarding Outbreak position. SII report to be completed and full update will be within the DIPC report.						
1.16 Ensure Trust Board has oversight of ongoing outbreaks and action plans.	DoN	1) Outbreak data presented to private trust board and Clinical Governance committee DoN regularly updates the Executive Team regarding Outbreak position. SII report to be completed and full update will be within the DIPC report.		Presented Jan 2021				
1.19 There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	DoN	Executive teams walk about timetables 7 days per week at periods of higher prevalence . Non clinical areas reviewed by service leads . Perfect ward covid audit used daily in ward s with covid position patient and weekly elsewhere by Band 7 and senior nurses review data	Executive and manager do not use a structured template for this but Matrons dn Hons review review ward convid data and Peer review					

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)
Systems and processes are in place to ensure:								
2.1 Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas.	DIVISIONS	1. Designated unit (RCU) for management of suspected and confirmed COVID-19 patients. 2. RCU management by designated Matron with cohort of senior nursing team who remained on the RCU (6x Band 6, 4 x B6 Staff). 3. Respiratory specialist nurses, education department and CCOT with support from quality directorate , worked through competencies and upskilling to ensure all reached a level of competence and confidence to work with this group of patients. 4.Staffing ratio was supported to allow high numbers of staff with additional support of day and night rota for CPAP and respiratory support. The team were supported by the respiratory consultants and doctors on the ward at all times. 5. ITU/RCU training and induction, use of runners, task teams, theatre SOP. 6. Reference to action card 3.101 standard infection control principles. Action card 3.102 & 3.102A regarding infection control PPE, and donning and doffing of PPE with support provided by IPC Team and use of PPE 'wardens'. 7. High risk areas supported by Chaplaincy, Clinical Psychology and Palliative Care Teams for staff and patients experiencing end of life care. 8. PWA Quick Covid 19 assessment to ensure staff understanding in these areas. 9. Standard judgement review commissioned for Covid 19 related deaths in hospital 10. Currently no high harm incidents related to this group of patients or staff.	Unknown timeframe or impact of any 2nd wave C_pap training 2. 2nd wave has required retraining of staff and support from ITU with CPAP. 3. Significant impact of staff sickness in wave 2	Continued monitoring of national and regional intelligence. Review locally when any national learning identified (such as Trust outbreaks) 2. 'Red line' staffiig document produced for nursing to identify minimum staffing levels. 3. Staff redeployment to clinical areas from non-clinical areas (ward buddy scheme) 4. Redeployment of doctors to to medicine 5. Use of the miltary to support clinical areas.				
2.2 Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to COVID-19 isolation or cohort areas.	FACILITIES	1. Housekeeping staff have been Fit tested for level 3 mask, MLE PPE units in date and practical training given by supervisors and shadow training with other experienced housekeepers. No trends within incident reporting regarding practices by housekeeping staff. Designated cleaners to clinical areas.	Overnight cleaning team will have to cross all areas. On risk register (no 6571).	All staff aware of regimes and PPE.				
2.3 Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance.	FACILITIES	1. Training guides/practical training and shadow training given prior to undertaking an infection clean. Additional training given to under HPV decontamination for specific supervisors and senior housekeeping staff. All cleaning requests are validated, form completed and signed off by ward sister on completion. Discussions with Housekeeping and IPC to agree any additional cleaning including 'double cleans' and reviewed daily and as required.	1. Continued changes in IPC guidance. Not an issue in Q3 and Q4	1. Membership of IPC Group.				
2.4 Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	FACILITIES	1. Process in place for signing off terminal cleans.	1. Confidentce in the signing off process between ward lead and housekeeping	1. Minimum daily discussion with IPC and Housekeeping confirming cleaning requirements. 2. PWA inspections discussed at Outbreak Management Meetings.				
2.4 Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance.	FACILITIES	1. RAZ areas increased cleaning hours and cleaning after every patient transfer, in addition to the "normal" ward cleaning. Implementation of double cleaning required for side rooms, Infection control will inform housekeeping daily Mon - Fri where they require double cleans. Sign off sheet and decontamination sheets are available for review.	1. High number of wards in outbreak status and/or have cohort bays for COVID-19 positive patients.	1. Increased cleaning requirements as required. 2. Monitored through the Outbreak Manageemnt meetings.				
2.6 Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.	FACILITIES	1. Our chlorine based products are in use across the site. These products meet the national guidance and have been signed off by Infection Control and Occupational Health. COSHH sheets are available.	A challenge remains that many non-clinical equipment providers are not familiar with providing data/information on this level of cleaning and therefore decisions were made where necessary on standard Trust practice, and any reports of device damage will be monitored.	Wipes are available for non-clinical equipment in clinical areas (e.g. keyboards, photocopiers, phones etc.) which have been agreed with IPCT, Decontamination Lead and IT. External providers have been asked to provide guidance where appropriate.				
2.7 Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products.	FACILITIES	1. Our chlorine based products are not washed off, so appropriate contact time is in place.						
2.8 As per national guidance: • 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily • rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily).	FACILITIES	1. Increased number of cleaners who undertake additional touch point cleaning every day. 2. Non-clinical areas have identified cleaning regimes to provide self cleaning of areas and equipment. 3. Individual users will decontaminate electrical equipment, mobiles and tablets etc. 4. Room cleaning will be undertaken by the departmental staff when PPE is removed. 5. Staff are to wipe all touch point twice daily and hourly in outbreak zones	1. No auditing in place of non clinical areas. 2. Potential challenges of changing supply of wipes. 3. No auditing of cleaning of electronic devices such as tablets, keyboards, phones (including personal phones).	COVID secure risk assessments require confirmation that staff are meeting the requirements. Continued discussion with Procurement re supplies and decision via IPC. Refreshed posters have been circulated to remind staff of correct methods of decontamination of re-usable equipment and incorporated IT equipment to recognise the increase use of electronic devices and technology within clinical areas (see 2.6)				
2.9 Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken.	FACILITIES	A process is in place for contaminated linen which is returned to the on-site laundry and decontaminated to the appropriate standard in line with BSEN14065 and HTM01-04. Process posters have been circulated to all linen areas.						
2.10 Single use items are used where possible and according to single use policy.	DECON LEAD	Disposable mops and cloths are used in RED zone areas including any side rooms. Single use equipment is used as per Trust policy where possible.	No monitoring of single use items.	For PPE would be monitored and managed via PPE Group.				
2.11 Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance.	DECON LEAD	Any items left in the room are cleaned. Ward staff undertake the decontamination of equipment and use Clinell "clean" tape to highlight this action has been completed. All reusable equipment to be decontaminated as per Trust Policy. In-patient areas monitored via PWA.	Limited audit evidence.	Refreshed posters have been circulated to remind staff of correct methods of decontamination of re-usable equipment and incorporated IT equipment to recognise the increase use of IT within clinical areas. In addition during the COVID pandemic, additional items have been added to stock availability such as single use blood pressure cuffs and pulse oximeter probes to provide an alternative to our normal re-usable items for areas to order if appropriate. Refreshing of some SOPs to include decontamination of COVID where relevant				
2.12 Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	ALL DEPARTMENTS	1) PWA audit 2)Staff are to wipe all touch point twice daily and hourly in outbreak zones 3) Enhanced cleaning in outbark zones		COVID secure risk assessments require confirmation that staff are meeting the requirements. Continued discussion with Procurement re supplies and decision via IPC. Refreshed				
2.13 Ensure the dilution of air with good ventilation e.g. open windows in admission and waiting areas to assist the dilution of air.	ETS	Walk-round of all areas completed as part of recovery with capacity and flow reviewed. Space allocation committee reviewing appropriate spaces for specific services. National guidance on ventilation chased through NHSI sacral times Trust Ventilation Task and Finish Group introduced.	1. Unknown air exchanges and ventilator levels in many areas. 2. Additional ventilation system ordered for APG zones 3. National guidance as referenced in national IPC guidance has not been published.	Areas undertaking AGPs to be identified and assessment of air exchanges to be completed. 2. Ventilation risk assessment in place 3. Ventilation improvement works in progress (not wards) 4. All areas clinical amd non-clinical encouraged to have windows open and maintain ventilation where possible.				
2.14 Monitor adherence environmental decontamination with actions in place to mitigate any identified risk	ALL DEPARTMENTS							
2.15 Monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	ALL DEPARTMENTS							

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance			
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)
3.1 Arrangements around antimicrobial stewardship are maintained.	IPC CONSULTANT	New Microbiologist in post and Antimicrobial pharmacist remains in post	Only 1 x per week ward round	1. Micro staffing levels will now permit the establishment of an antibiotic ward round. This is to start w/b 13/07/20. Currently established for once a week with aspiration for possibly twice weekly dependent on findings/needs . 2. Increased resilience and continuity with pharmacists and fully established microbiology team.				
3.2 Mandatory reporting requirements are adhered to and boards continue to maintain oversight.	IPC	1. RCA documents of all reportable HCAIs with robust appeal process in place with the CCGs. 2.National data submission on HCAI's. 3.IPCWG/ICC meetings documented with minutes and action tracker. 4.Trust KQI reporting monthly for reportable HCAIs at CMB 5. Bi-annual DIPC report through Trust governance pathway to TB. 6. Policies and procedures for managing infection and prevention e.g. Outbreak policy. Policy compliance monitored via IPC Team and incorporated into RCA documentation and PWA inspections. 7. PWA inspections. 8. Risk assessments in place for example risk of flu outbreak; risk of increasing C.difficile cases against trajectory in the contract.	None 2. National increase in non-COVID HCAI's reflected within the Trust	1. Exisiting Trust IPC contol measures in place. No contract trajectories for this year. All external reproting continues.				

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with

KLoE	Completed b	Evidence	Gaps in assurance	Mitigating actions	Compliance			
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)
4.1 Implementation of national guidance on visiting patients in a care setting.	DM/KG	1. Action card on patient visiting with restrictions and guide for staff. Specific areas detailed for individual approaches and agreed at IMT. No serious complaints raised regarding visiting restrictions. 2. High risk patients in Spinal Unit subject to separate action card to protect shielding patients. 3. Action card for delivering patient belongings coordinated by PALS. 4. Capacity for relatives/carers to communicate virtually expanded and detailed on Trust external website . 5. Specialties with separate guidance followed national and local requiremetns during suspension.	Evidence of staff undertaking risk assessment with visitors who require PPE. Variation in PWA inspections.	COVID-19 quick assessment completed on PWA. 2. Visitng Action card has been reviewed for both resticted visiting and susequent suspended visiting in wave 2. 3. Visitors logs in place.				
4.2 Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access.	DR/LA	1. Entry to clinical areas restricted with use of 'SALTO locks' . 2. RCU specific signage regarding designated status (now removed due to reduced numbers).	1. Sudden influx of numbers will require reinstating of signage.	1. Numbers discussed via IMT and actions agreed . Signage can be reinstated quickly. 2. Signage reinstated for these areas as required.				
4.3 Information and guidance on COVID-19 is available on all trust websites with easy read versions.	KG/DR	Easy read information available. Additional added and noted by Healthwatch Wiltshire. No complaints or concerns raised regarding information. Links with Mencap and local LD partners. Internal communications - via IMT for general communications to staff and the public. With traditional broadcast and print media being agreed by a combination of CEO, COO and Exec OD&P based on recommendations from Head of Communications (or Deputy).						
4.4 Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved.	DIVISIONS	1. In Surgical division use of SBAR handover process and sticker in patient medical notes on any transfer. Taking in to consideration action card 3.130 & 03.138 management of identified contact patients. 2. In Medical division - wherever clinically appropriate patient with Covid 19 are nursed within the RCU template and not transferred out unless proven negative following the de-escalation policy. Discharges to residential placements are only allowed after negative screens. Any contact are advised as such on discharge.	1. No audited evidence of SBAR or other patient transfer. 2. Key challenges in wave 2 with patient moves to reduce risk of infection spread. 3. Timely swabbing of patients.	1. Currently nil identified serious incidents due to harm from lack of infection status . 2. Nil poor outcomes discussed in Virtual Board Round. 3. Descalation action card. 4. No reported incidents on DATIX due to harm from lack of infection status . 5. Introduction of LFT for patients when required. 6. Swabbing team to support continuity of patient testing				
4.5 There is clearly displayed and written information available to prompt patients, visitors and staff to comply with hands, face and space advice.	Estates	1) Signage around the estate detailing hand face space 2) hygiene stations at all entrances with masks and gels 3) Visiting limited to essential only (End of Life Carers etc.) 4) Social media campaign about what to do when on site 1. 5. Patients asked to replace face coverings with masks at height of second wave.		1. Patient discharge leaflet outlining contact status and guidance. Included reminders regarding hands, face, space.				

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance			
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)
5.1 Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID -19 cases.	IPC	Non-elective in- patients tested on admission. Categories applied to patients according to perceived risk. Elective patients tested as part of the elective pathway. Outpatients screened for symptoms on arrival. LFT testing in ED , if negative then cepheid rapid test undertaken to identify what pathway they patient follows	During very busy period some swabs were missed at the intervals required (1,3, 5-7 days and then weekly)	Swabbing team in place to ensure all patients are tested at intervals as per action cards				
5.2 Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimize the risk of cross-infection, as per national guidance.	DIVISIONS	1. Medical division - RAZ and standard Majors process in place as per action card. Any resp symptoms or common complications are directed through RAZ (Reference to action card 3.098A & B ED and clinical response management of Covid 19 patients. ED configuration and service delivery action card). 2. Surgical division - No 3.129. SAU action card and outpatient action cards. 3. CS&FS - Action cards (03.116, 03.136, 03.146), risk register, SOPs.	Designated 'red and green' areas to be approved and signed off by DIPC by September 2020. false negative tests or patients being positive at day 3	1.All patients swabbed and all staff are wearing PPE appropriate to activity. 2. Screening undertaken in outpatient settings. 3. High, medium and low risk (red, amber green) pathways approved via IMT as per national guidance. 4. LFT introduced into ED on 26.12.20 as per national guidance. Also used in SAU and AMU.				
5.3 Staff are aware of agreed template for triage questions to ask.	DIVISIONS	clinicians establish if there is previuos knowlegde of a positive diagnosis or are there any features to suggest COVID but this is down to clinical judgment..	No agreed template for questions.	1. Triage key questions are asked and documented				
5.4 Triage undertaken by clinical staff trained and competent in the clinical case definition, and patient is allocated to the appropriate pathway as soon as possible.	DIVISIONS	Clear pathways for patients to be triaged into categories A-D etc and ation cards to support this. This with the LFT and ?or Ceheid result leads to alloaction of a bed in a suitable are for that category of patient	1. Occassional risk of patient testing posiitve despite lack of symptoms and negative LFT.	1. action cards for planned pathway detailing requirement of patients in cat A-D. 2. LFT at front door to support risk of non symptomatic positive cases.				
5.5 Face coverings are used by all outpatients and visitors.		1) Signage around the estate detailing hand face space 2) hygiene stations at all entrances with masks and gels 3) Visiting limited to essential only (End of Life Carers etc) 4) Social media campaign about what to do when on site 5) Leaflet for inpatients detailing mask wearing , hand face and space		1. In wave 2 peak visitors asked to wear a surgical mask rather than a covering.				
5.6 Face masks are available for all patients and they are always advised to wear them	DIVISIONS	1. Masks available at entrances to the Hopsital and in wards and departments 2. PWA COVID 19 inspection data (in-patient areas)						
5.7 Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care	IPC	1. Masks available at entrances to the Hopsital and in wards and departments 2. PWA COVID 19 inspection data (in-patient areas)						
5.8 Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	DIVISIONS	All in-patients advised as per standard.	No current specific audit data for in-patients (but captured for other groups).					
5.9Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	DIVISIONS	1. Screens provided in outpatient areas and/or social distancing floor tape. Waiting areas marked out for maximum usage.	1. Lack of consistency and difficulty for areas to recover with service requirements.	1. Walk rounds of all non-in patient areas undertaken and reported via Recovery Cell. Review of service delivery via Space Allocation Committee. 2. Screens task and finish group in place and reports to IMT. 3. Areas asked to risk assess where staff may be returning from work				
5.10 To ensure 2 metre social & physical distancing in all patient care areas	ALL	1. All areas have posters regarding space. 2. Floor markings in corridors 3. Outpatient areas reviewed in Q1 and seating removed/reviewied. Screens in reception areas installed. 4. Bed spaces reviewed. 5. PWA COVID inspection data for compliance	1. Ward areas have limited space which resticts movement and ability to distance at all times.	1				
5.11 For patients with new-onset symptoms, isolation, testing and instigation of contract tracing is achieved until proven negative.	DIVISIONS	1. Wards and medical staff review all patients with new resp symptoms and all patients are screened on admission and rescreened every 7 days. Reference to action card 03.148 & 03.151 non elective medical and surgical admission pathway and flow of testing. Also reference action card 3.098A regarding clinical response to suspected coronaviruses. 2. Designated person to undertake contract tracing which commences on notification and undertaken by B7 Sister at the weekend. 3. Positive patients reviewed at the Virtual Board Round and correct contact tracing verified.	1. Risk to number of available of side rooms for isolation. 2. If 2nd wave occurs and high volumes of patients, additional resources will be required to provide timely contact tracing. Unknown pressure on capacity for testing.	1. Twice daily review of side rooms by IPC. 2.Regular review of covid result and senior decisions made as to appropriateness of cohorting patients to allow isolation capacity. Use of ward area with high number of siderooms. 3. Daily VBR and including weekends to provide 7 day tracing of positive patients.				
5.12 Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced.	DIVISIONS	1. Process and SOP in place for cohorting and de-isolating negative patients which includes senior clinical review and is not reliant on test results. Use of whiteboard to trace patients. 2.Virtual Board Round meetings to highlight and discuss. 3.PWA quick covid 19 assessment feedback to remind staff are procedures.	During peak of wave 2 lack of ability to segregate into side rooms.	Cohorting of contacts introduced and cohorted by contact (not mixing of contacts).				
5.13 There is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document	IPC DIVISIONS	1. Testing action card and patient movement and testingrequiremetns in place. 2.Testing results clarified in VBR review	1. Gaps in testing and risk of outbreak	1. VBR review 2. Swabbing team				
5.14 Patients that attend for routine appointments and who display symptoms of COVID-19 are managed appropriately.	DIVISIONS	1. Patients are contacted regarding symptoms prior to testing and asked again on arrival. Wherever possible patients are seen using "Attend Anywhere". 2. STOP Station SOP for consistency of practice across departments.	1. Lack of audited evidence regarding management.	1. Nil serious incidents raised regarding possible transmission in out patient areas.				

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance			
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)
6.1 Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas.	DIVISIONS COMMS	RAZ and standard Majors process in place as per action card. Keep left signs throughout the estate One way system in place in restaurants, OPDs and all areas this is possible Limited access to coffee rooms (1 in 1 out) Maximum numbers on all doors and masks worn in offices unless alone or under numbers with 2 metres distance Visit limited to essential only Restricted access to the site has been in place	Not possible in all areas but all are have been reviewed and	1. Areas continue to be reviewed - some layout and geography of areas does not allow one way entrances and exits. Areas provide additonal touch point cleaning.				
6.2 All staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe.	IPC DIVISIONS	1. Monthly hand hygiene submission in all clinical areas. 2. PPE training provided by IPC Team and records kept. 3. IPC Training on MLE and monitored via IPCWG. 4. Following the introduction on 15/06/20 of masks in non-clinical areas a risk assessment to validate COVID -Secure areas introduced and signed off via the IPC Group and then via IMT. 5. Requirements regarding social distancing within working environments identified with maximum occupancy room signage and link to number 4. 6. Staff shielding, redeployment, working from home guidance and associated safety overseen by Trust Workforce Group. 7. Staff well being and direction to OH support identified via daily bulletin and encouraged	1. Continued changes to guidance could result in out-of-date practices.	1. Immediate updating of action cards on receipt of new guidance which has been reviewed at IPC Group. 2. Updated guidance to staff via Trust daily comms and intranet. 3. National update to the quick COVID 19 PWA assessment by the PWA organisation. 4. Improvement in FIT testing provision to speed up process of fitting on multiple masks				
6.3 All staff providing patient care within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it.	IPC	Refer to section 1.6 Level 1 PPE (standard precautions on induction and within existing training package) Areas such as maternity, RCU, ITU (requiring Level 3 PPE) training provided. Regular Comms advising staff, PPE action cards and national training resources available on staff COVID-19 intranet site.	National training package - supporting behaviours to be incorporated in future training. Need to revisit that staff have ongoing undertanding of change and training provision.	1. Enhanced level 1 PPE introduced locally in January due to cohorting of COVID positive cases and high staff absence.				
6.4 A record of staff training is maintained.	IPC/DIVISIONS	1. IPC record of training delivered by the IPC Team. 2. FIT Testing register.	1. Continued challenges with the supply of PPE and repetitive FIT testing required. 2. See section 1.10	1. Co-ordinated via the PPE Group. 2. Improvement in FIT testing provision to speed up process of fitting on multiple masks				
6.7 Adherence to PHE national guidance on the use of PPE is regularly audited. with actions in place to mitigate any identified risk	DIVISIONS	1. Surgical division - Covid secure risk assessments-red, green and blue areas. PPE champions and PPE meetings. Reference to action card 5.037, PHE guidance for healthcare workers. 2. PPE champions in CS &FS from 26/06/20. 3. PWA quick COVID-19 inspection and existing PWA inspections.	1. Currently no standardised inspection/audit within non in-patient areas. 2. PLACE Steering group not active	1. PPE usage within in-patient areas audited via PWA IPC and COVID audits.2. IPCWG monitor compliance.				
6.8 Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: *hand hygiene facilities including instructional posters *good respiratory hygiene measures *maintaining physical distancing of 2meters wherever possible, unless wearing PPE as part of direct care *frequent decontamination of equipment and environment in both clinical and non-clinical areas *clear visually displayed advice on use of face coverings and face masks by patients/individuals, visitors and by staff in non-patient facing areas. *staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace.	IPC	1) Signage around the estate detailing hand face space 2) hygiene stations at all entrances with masks and gels 3) Visiting limited to essential only (End of Life Carers etc) 4) Social media campaign about what to do when on site 5) leaflet for impatient detailing mask wearing if possible , hands, face, space 6. How to wear and how to remove a face mask posters across the Trust. 7. All regular Comms include 'hands, space, face' message. Daily COVID 19 bulletins remind staff that we are required to follow national restrictions and actions. 8. Monitored via IMT reporting if lack of compliance observed.						
6.9 Staff regularly undertake hand hygiene and observe standard infection control precautions.	DIVISIONS	1. Monthly hand hygiene submission in all clinical areas. 2. PWA IPC Inspection.	1. Standard precautions are not routinely audited within non in-patient areas.	1. Daily COVID 19 inspection within in-patient areas in outbreak during February and weekly in non-outbreak areas.				
6.10 The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance. Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas.	ETS/IPC	1. Hand driers removed from use on the 13th of July from the following areas:- SDH North public toilets, Spinal Unit, Hedgerows, Block 29 and the Staff Club. Note:- a decision was made to also remove from use the hair driers that are installed in the Staff Club changing areas. 2. Procurement have been informed of the increase in paper towels and they do not believe stock will be a problem. 3. Extra bins are also in place within the facilities.	1. Increased risk of sewage leaks via blockages caused by wipes in the waste system.	Link to RA 6545 - actions completed				
6.11 Staff understand the requirements for uniform laundering where this is not provided for on site.	DIVISIONS/FACILITIES	1. Laundering of uniforms to be completed within existing washing guidelines provided with uniforms. Addition of reinforcement of the requirement to change on-site and courier uniform within a laundry bag or similar. 2. Clinical staff not usually in uniform provided with scrubs in high risk areas and/or required to wear work specific clothing changed into and out of at work.	1. Not formally monitored.	1. Staff made aware of this requirement within own scope of personal responsibility.				
6.12 All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance, if they or a member of their household displays any of the symptoms.	ALL	1. Reference to action card 5.037 PHE guidance for healthcare workers. Staff seeking appropriate and prompt testing for themselves or household. 2. Trust Comms directed to OH services with 7 day cover to provide guidance on testing and isolation requirements.						
6.13 A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	DoN	1) Daily Virtual board review of all positive patients and staff 2) Contact tracing undertaken daily to ensure all positives cases managed effectively and in correct pathways 3) BSW local surveillance data reviewed via IMT and Gold command		Regular Outbreak Meetings held during Q3 and Q4 attended by PHE, BSW and NHSI&E. Review of Site by DoN with NHSI&E IPC Lead. Daily VBR (7 days per week) to monitor for any HCAI and trace contacts where required.				
6.14 Positive cases identified after admission who fit the criteria for investigation, should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	DoN	1) Daily Virtual board review of all positive patients and staff 2) Contact tracing undertaken daily to ensure all positives cases managed effectively and in correct pathways 3) Daily outbreak meeting , all outbreaks traced with gant charts 4) Outbreaks reported Via immarch portal 5) PHE attend outbreak meeting three day per week		See section 6.13				
6.15 Robust policies and procedures are in place for the identification of, and management of outbreaks of infection.This includes the documented outcome of outbreak meetings.	DoN	Action card detailing management of outbreak, personnel required and reporting responsibilities in place Outbreak status from 24.03.21 - nil COVID Outbreaks within the Trust.		1. Walkround completed with NHSI/E in January 2021 2. Outbreak management card updated in-line with national guidance January 2021. 3. All Outbreak meetings recorded and spared with PHE/CCG.				

7. Provide or secure adequate isolation facilities

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance			
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)
7.1 Restricted access between pathways if possible (depending on size of facility, prevalence, incidence rate high/low) by other patients/individuals, visitors or staff.	DIVISIONS	RAZ and standard Majors process in place as per action card. Keep left signs throughout the estate One way system in place in restaurants, OPDs and all areas this is possible Limited access to coffee rooms (1 in 1 out) Maximum numbers on all doors and masks worn in offices unless alone or under numbers with 2 metres distance Visiting limited to essential only Signage of ward status	1. Movement of staff required during peak 2. Asymptomatic positive cases arising in amber areas.					
7.2 Areas/wards are clearly signposted, using physical barriers as appropriate to patients/ individuals, and staff understand the different risk areas.	DIVISIONS IPC	Signage of ward status Hand face space sign at ward entrances	1. Red zones have specific signage but no agreed signage for other areas.					
7.3 Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate.	DIVISIONS	1. Patients isolated within the RCU/Radnor template unless specialty requirements denote higher risk and then isolated within a sideroom facility. Use of siderooms,cohorting, signage, red/amber areas etc. Liaison of site management team and IPC team with ward staff to ensure appropriate patient placement within the Trust. Reference to action card 3.130 and 3.101, standard infection control principles and ongoing management of identified contact patients.	1. Unpredicted positive patients.	1.Moved on positive screening and contact tracing undertaken as required. Actions reviewed at Virtual Board Round. 2. During peak of wave 2 wards redesignated for positive COVID-19 cohort areas to provide a separate space for any green pathways and reduce risk of spread. Full cleaning of areas before returning to specialty provision.				
7.4 Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance.	DIVISIONS ETS	No positive or negative pressure rooms in use within the Trust. Patients are all in designated ward/clinical specific environments. No non-clinical environments utilised for clinical capacity.	See 2.12 re ventilation					
7.5 Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	DIVISIONS IPC	1. Management between clinical teams and Microbiology/IPC Team. All standard policies and processes in place. Trust wise reporting regarding HCAI. Ongoing regular monitoring via PWA.	Policy audits not undertaken over 2019/20. Previous internal audit not identified concerns. Good feedback from CQC framework review July 2020.	Daily monitoring with ward visits by IPC and links with Site and clinical teams regarding practice. Audit plan to be identified.				

8. Secure adequate access to laboratory support as appropriate

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance			
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)
8.1Testing is undertaken by competent and trained individuals.	DIVISIONS	Testing revisited with areas with high false negatives and assessment undertaken of all staff	No specific training logged	1. National video available and PR to create in-house info to be circulated by Divisions to staff with check in that staff have watched training info. 2. Swabbing team intrduced				
8.2 Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance.	DIVISIONS OH	Symptomatic staff (days 1-5) are referred for swabbing on the day they report their symptoms to us and are placed on the swabbing list for the next day. Antibody testing in progress. Staff LFT introduced in December 2020						
8.3Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	DIVISIONS AND LABS	Symptomatic staff (days 1-5) are referred for swabbing on the day they report their symptoms to us and are placed on the swabbing list for the next day. Antibody testing in progress. Staff LFT introduced in December 2020 Positive cases traced through VBR and testing dates discussed	No routine reproting of all swabbing. Missed swabbing could result in inintended HCAI.	Introduction of swabbing team. Monitoring continues as VBR.				
8.4 Screening for other potential infections takes place.	DIVISONS	As per existing pathways for e.g. MRSA screening and C.difficile. Sepsis pathway in place.						
8.5That all emergency patients are tested for COVID-19 on admission.	DIVISONS	Established screening practice in all admission areas in-line with Trust action card which also outlines screening required prior to patient transfer (in-hospital) LFT indtroduced into ED 26.12.20 and AMU/SAU January 2021						
8.6 That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise.	DIVISONS	Patients all tested routinely on admission then day 3, day 5 and then weekly. Tested on any new symptoms.						
8.7 That those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission.	DIVISONS	See 8.6						
8.8That sites with high nosocomial rates should consider testing COVID negative patients daily.	DIVISONS	Wards that are subject to outbreak tested negative patients daily. All patient contacts also tested daily.						
8.9That those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	DIVISONS	Action card in place for discharge testing.						
8.10 That those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.	DIVISONS	As 8.9						
8.11 That all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	DIVISONS	As directed by the action cards for elective care.						

9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance			
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)
9.1 Staff are supported in adhering to all IPC policies, including those for other alert organisms.	IPC/DIVISIONS	Refer to section 1.8						
9.2 Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff.	IPC/DIVISIONS	Refer to section 1.4; 1.6; 1.6						
9.3 All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance.	FACILITIES	All potential COVID 19 waste is placed in orange bags and picked up as per Trust Policy via the waste teams. Waste stream for masks in non-clinical areas is managed at increased level than national guidance (which only requires a black bag) to ensure consistency and risk of incorrect disposal.						
9.4 PPE stock is appropriately stored and accessible to staff who require it.	PROCUREMENT	1. PPE stock and usage closely monitored and discussed at PPE Group. Access processes robust as evidenced by no incidents of PPE unviability for staff. 2. CS &FS Comms directly to heads of service and leads. PPE update given at weekly DMC and disseminated by HoS to teams. Monthly Divisional PPE Champions group.						

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance			
Systems and processes are in place to ensure:					Q2 (20/21)	Q3 (20/21)	Q4 (20/21)	Q1 (21/22)
10.1 Staff in 'at-risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported.	DIVISIONS OD and P	1. Undertaking of individual staff risk assessment, use of occupational health, welfare check of redeployed staff, debriefing in all areas of impact. Reference to action card 03.134, 03.153 & 03.144, guidance for Trust employees defined as vulnerable/extremely vulnerable. This would be covered and met within the COVID risk assessment which ensures the correct work task is being offered according to the nature of the risk e.g. pregnancy, BAME, age, health and the risk assessment also has a psychological wellbeing section on that should be completed between manager and employee. Also, when the pandemic first affected the UK, any staff member could ring our COVID OH line for guidance and support. Three telephone lines in our call centre room was attended 12hrs/day, seven days/wk. This support line continues but is 8-6pm Mon-Fri now. On these calls, we would aim to answer any questions or signpost people if we cant and we also would write a letter to the manager to reflect the clinical advice we gave to ensure the advice is communicated thoroughly. Physical and Psychological wellbeing is also supported via the signposting details on the microsite available to all staff. Consistency panel set up to review the Vulnerable staff risk assessments - selection reviewed each week and managers invited to attend meetings to discuss any concerns with scores or actions taken. Staff risk assessment has been initially focused on vulnerable staff including BAME, but have been expanded to all staff. COO and HRD meeting monthly with BAME staff.	1. Staff choice to remain at work where advised not.	1. PPE worn at all times and staff offered alternative areas to work. 2. Risk assessment document template reviewed as required and in-line with national guidance.				
10.2 That risk assessment(s) is(are) undertaken and documented for any staff member in an at risk or shielding group, including Black, Asian and Minority Ethnic (BAME) and pregnant staff.	ALL	100% of staff have been risk assessed						
10.3 Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained.	MEDICAL DEVICES	Written information (in line with manufacturer and PHE guidance) is issued with each system to provide step by step instructions on their use and management. It additionally acts as a resource out of hours and is available as part of the COVID response action pack. Decontamination Lead provides briefing on collection and signature sheet in place for tracking systems. Hoods being used for staff who fail fit testing. Fit testing programme in place. Task and finish group established to review and implement 'Southampton hoods'. (This product was not introduced and Versafloo hoods are used). Decontamination process in line with manufacturers guidance and Trust IPC policy. ESR utilised to capture of trained staff.	No previous record of briefing and staff collecting the hoods are not always the end users. Risk of requiring more hoods than current supply but not currently an issue.	1. Decontamination Lead has commenced list to evidence information signposted to staff collecting, also capturing where staff collecting are not end users. 2. Task and Finish Group in place for procurement of new hoods. Additional hoods on order to increase current availability and managed via PPE group. 3. Stabilised FIT Testing Team to support staff education and monitoring of kit.				
10.4 Staff who carry out fit test training are trained and competent to do so	OD and P	External provider brought into for training all fit testers Retraining undertaken and Train the Trainer approach used.						
10.5 All staff required to wear an FFP respirator have been fit tested for the model being used, and this should be repeated each time a different model is used.	OD and P	Respirators not issued unless testing has been undertaken Those that fail all masks and a Trust Respirator require a permission email to be sent by the line manager requesting hood. Those that have no taste or smell will be issued a hood if deemed necessary by line manager	1. Increasing instability of types of mask available and subsequent impact on FIT Testing resource 2. Increasing number of FIT Test fails requiring highwe number of respirators. 3.	Process for respirator hoods in place. Weekly PPE Group to identify any issues of concern/risk FFP3 maintained on ESR and FTT visit clinical areas routinely and challenge where masks are not being worn effectivelty and further trssting is required. Testing is being undertaken on a range of masks so staff have more than 1 option.				
10.6 A record of the fit test and result is given to, and kept by the trainee, and centrally within the organisation.	OD and P	All results are kept on ESR so staff can be viewed some wards have adopted a colour coding system which is now being rolled across other wards Staff provided with a record of testing (paper).						
10.7 For those who fail a fit test, there is a record given to, and kept by the trainee, and centrally within the organisation of repeated testing on alternative respirators and hoods.	OD and P	Those that fail with Respirator are issued a hood , record via testing teams						
10.8 For members of staff who fail to be adequately fit tested, a discussion should be had regarding redeployment opportunities and options commensurate with the staff member's skills and experience, and in line with nationally agreed algorithm. A documented record of this discussion should be available for the staff member, and held centrally within the organisation as part of employment record, including Occupational Health.	OD and P	Staff that have failed fit testing and do not have a hood have been redeployed to a suitable are , records Via ESR and testing team There have not been any issues with the supply of hoods. Staff are supplied with a respirtator or hood as required. Copy of their personal testing is given to the staff member.						
10.9 Following consideration of reasonable adjustments e.g. respirator hoods, personal reusable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm, and a record kept in the staff member's personal record and Occupational Health service record.	OD and P	as above	Record not held by staff member	Review with testing team to ensure staff hold the record Staff now have paper copy of the record and it is added to ESR. Staff not substantive are kept on a spreadsheet sa not on the ESR.				
10.10 Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	OD and P	all results held on ESR	Record not held by staff member and unable to access ESR record currently. Records are not reviewed by the Board - ESR reports not yet run.	Review with testing team to ensure staff hold the record				
10.11 Consistency in staff allocation should be maintained, reducing movement of staff and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance.	DIVISIONS	Housekeeping staff are allocated to specific wards and remain in that area until the end of their shift. Those staff that undertake post infection cleans do attend different areas, however strict PPE and decontamination processes are followed. Divisional teams have not embraced reducing movement between staff areas. Daily staffing meeting in place, red and green zones not clearly defined. Mitigation - antigen testing on Pembroke and Spinal where patient group vulnerable has not shown any positive results. Virtual Board Round looking at any hotspots of staff absence.		Link to Risk assessment 6568 for Surgical Division				
10.12 All staff should adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	ALL	1. COVID secure risk assessments in place with approval process. Trust wide signage for floors and for maximum occupancy with wearing of masks if this is breached. 2. Security teams and allocated staff to provide guidance and reminders to staff regarding social distancing. Social distancing Task and Finish group established, floor signs, posters, rooms labelled. Public areas not deemed as COVID safe.		Risk register of high-risk areas (labs, pharmacy) have had walk rounds with Sue Biddle				
10.13 Health and care settings are COVID-19 secure workplaces as far as practical, that is that any workplace risk(s) are mitigated maximally for everyone.	ALL	Daily comms used for all staff update Signage in place for what is required and room numbers on all doors Risk assessment and QIA in place for enhamced PPE COVID secure risk assessments completed						
10.14 Staff are aware of the need to wear facemasks when moving through COVID-19 secure areas.	ALL	As above						
10.15 Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing.	OD and P	All staff isolating whether its for 7 days or 14 days are logged on a spreadsheet in OH and on our OH diary system called cohort. Antigen testing on Pembroke and Spinal and roll out of Antibody testing. Virtual Board Rounds on hotspots. COO and OD&P Executive Director meeting with BAME group monthly to seek their views on the Health and wellbeing agenda	Unknown within the Divisions how the supporting of staff who are at home and self-isolating - feedback from shielding group has been poor re contacts from line managers (and redeployed staff too).					
10.16 Staff who test positive have adequate information and support to aid their recovery and return to work.	OD and P	When staff test positive, OH use a comprehensive assessment process to ensure guidance is being followed accordingly, the staff member and manager is advised accordingly and a system in place that if someone isn't well enough to RTW after the 7 days, that they seek further OH input so we can update our records and advise them and their manager again. There are also some cases where staff are particularly unwell and OH will do a welfare call with them too to provide additional support.	As 10.15					

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	TB – 5.4
Date of Meeting:	Thursday 8th July 2021		

Report Title:	Maternity - Clinical Negligence Scheme for Trusts (CNST)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Prepared by:	Hannah Boyd Interim Head of Maternity and Neonatal services and Louise Jones, Head of Risk Management			
Executive Sponsor (presenting):	Judy Dyos, Director of Nursing			
Appendices (list if applicable):	CNST Gap Analysis Comparison of MIS Standards 2019 and 2021 NHSR Board Declaration Form			

Recommendation:

Maternity services are asking the Board members to consider the information and the evidence provided, to demonstrate achievement of 4 of the 10 maternity safety actions and to understand why the maternity service is non-compliant with 6 out of the 10 maternity safety actions. For those achieved the maternity service requests that the Board review the evidence provided to demonstrate compliance and for those standards not met, there is recognition of why the service is non-compliant. Assurance that detailed action plans are available to demonstrate how compliance will be achieved going forward.

To note there are still 3 outstanding action plans awaiting receipt in relation to:

Safety action 6' in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation'.

Safety action 8 'evidence that the paediatric and neonatal staff groups involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended in-house neonatal resuscitation training or Newborn Life Support (NLS)'

Safety Action 9 'Board Safety Champions'

Board members are asked to review and approve the CNST report and accompanying GAP analysis in order for the CEO to sign the Board Declaration form by 15th July 2021. (30th June - an extension was granted by NHSR to all Trusts for submission on 22nd July 2021 due to a technical fault with the Board Declaration Form. As this does not have any impact on the evidence requirements and will not change the overall compliance SFT continue to work towards the 15th July 2021).

Executive Summary:

The purpose of this report is to notify the Board that NHS Resolution (NHSR) is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. As in year two, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

There are 10 safety actions to demonstrate compliance. The table below describes the current position within the service, grouped accordingly describing compliance and non-compliance

Safety Actions Maternity services are compliant with:

Safety Action	Criteria	RAG Scoring
2	Are you submitting data to the Maternity Services Data Set to the required standard?	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
7	Can you demonstrate that you have a mechanism for gathering service user feedback and that you work with service users through you maternity voices partnership (MVP) to co-produce local maternity services	
10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?	

Safety Actions Maternity Services are non-compliant with:

Safety Action	Criteria	RAG Scoring
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths?	
3	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions Into Neonatal units Programme?	
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version 2?	
8	Can you evidence that the maternity unit staff groups have attended an 'in- house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019 training year?	
9	Can you demonstrate that the trust safety champions (Obstetrician, Midwifery and Neonatal) are meeting bimonthly with Board level champions to escalate locally identified issues?	

Board members should note the following:

1. Detailed information contained in Section 1 (Introduction) highlighting the Trust Board requirements

2. Table of Safety Actions for the Year 3 MIS (section 2)
3. Analysis and discussion in section 3 with supporting evidence
4. Conclusion

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

NHS
Salisbury
NHS Foundation Trust

Salisbury NHS Foundation Trust Maternity Self Certification
Maternity Incentive Scheme NHS Resolution,
Board Assurance Report
June 2021

1. Introduction

NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in year two, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. In order to mitigate the financial impact of Covid-19, CNST MIS contributions were not taken in April 2020 as would otherwise have occurred. Effectively this means that trusts have had a 'year off' paying their contributions and additional time to implement the year three scheme, albeit with some revisions to the requirements when relaunched on 1 October 2020 and then updated in March 2021.

With the delay in the funding element of the maternity incentive scheme in 2020/21, contributions into the incentive fund and distributions from it will be carried out in 2021/22 as per the usual timeframes.

In its third year, the scheme has further incentivised the ten maternity safety actions from the previous year with some further refinement. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

In 2019 the Maternity service at Salisbury NHS Foundation Trust (SFT) was successful in achieving compliance of the 10 criteria for NHS Resolution (NHSR), Clinical Negligence Scheme for Trusts (CNST). NHSR is operating a third year of maternity CNST as of the clinical negligence claims notified to NHSR Nationally in 2020/21, obstetric claims represented 15% of the volume but 43% of the value.

1.1 Maternity incentive scheme year Three: Conditions

To achieve eligibility for payment under the scheme, maternity services must submit a completed 'Board Declaration Form' to NHSR by 12 noon on Thursday 15 July 2021 and must comply with the following conditions:

a) Trusts must achieve all ten maternity safety criterions (Table 1 above).

b) The 'Board Declaration Form' must be signed three times and dated by the Trust Chief Executive to confirm the following:

- The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions sub requirements as set out in the safety actions and technical guidance document.

- The content of the 'Board Declaration Form' has been discussed with the commissioner(s) of the Trust's maternity services.

- There are no reports covering either this year (2020/2021) or the previous financial year (2019/20) that relate to the provision of Maternity services that may subsequently provide conflicting information to your declaration. E.g. CQC inspection report, healthcare safety investigation branch (HSIB) etc. All such reports should be brought to the MIS attention before 15th July 2021.

• The Board must give their permission to the Chief Executive to sign the 'Board Declaration Form' prior to submission to NHSR. Trust Board declaration form must be signed by the Trusts Chief Executive. If the form is signed by another Trust member this will not be considered.

1.2 Year Three Assessment Process

Maternity services are expected to provide a report to their Trust Board Committees demonstrating achievement (with evidence) for each criterion and Board members must consider the evidence and complete the 'Board Declaration Form'. Actions not met must have an action plan stating how compliance will be achieved. As in year two NHS Resolution will use external data sources to validate some of the maternity services responses.

1.3 NHSR Feedback Timescale

Timescale	Date
Completed Board reports with Board sign-off submitted to NHS Resolution	**By 12 noon on Thursday 15th July 2021**

1.4 Year Three Implications

Trusts that have not achieved all ten actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on Thursday 15 July 2021 to NHS Resolution (MIS@resolution.nhs.uk). The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the template. Action plans should not be submitted for achieved safety actions.

1.5 Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the trust Board only, and will not be reviewed by NHS Resolution.
- Trust submissions will be subject to a range of external verification points, these include cross checking with: MBRRACE-UK data (Safety action 1), NHS Digital regarding submission to the Maternity Services Data Set (Safety action 2), and against the National Neonatal Research Database (NNRD) for number of qualifying incidents reportable to the Early Notification scheme (Safety action 10)
- Trust submissions will also be sense checked with the Care Quality Commission (CQC).
- Trusts will need to use the active declaration form to report compliance with MIS by Thursday 15 July 2021. The active reporting declaration form will be published on the NHS Resolution's website in the forthcoming months.
- Only for a set amount of safety actions requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.

1.6 Timescales and appeals

Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution (MIS@resolution.nhs.uk) prior to the submission date.

The active Board declaration form must be sent to NHS Resolution (MIS@resolution.nhs.uk) from Monday 12 July 2021 to Thursday 15 July 2021. An electronic acknowledgement of Trust submissions will be provided within ten working days from submission date.

Submissions and any comments/corrections received after 12noon on Thursday 15 July 2021 will not be considered.

Further detail on the results publication, appeals and payments process will be communicated at a later date.

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2. MIS Year 3 Criteria Safety Actions

Table 1 below describes the ten safety actions and provides overall current compliance.

Table 1.

Criteria for Maternity CNST		RAG SCORING SFT position MIS Year 3
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths	
2	Are you submitting data to the Maternity Services Data Set to the required standard?	
3	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions Into Neonatal units Programme?	
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version 2?	
7	Can you demonstrate that you have a mechanism for gathering service user feedback and that you work with service users through you maternity voices partnership (NVP) to co-produce local maternity services.	
8	Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019	
9	Can you demonstrate that the trust safety champions (Obstetrician, Midwifery and Neonatal) are meeting bimonthly with Board level champions to escalate locally identified issues?	
10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?	

3. Analysis

3.1 Safety action 1:

Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Mothers and Babies Reducing Risk through Audits and Confidential Enquires (MBRRACE) has developed and establish a National standardised Perinatal Mortality Review Tool (PMRT). The PMRT has been designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'. The aim of the PMRT programme is to introduce the PMRT to support standardised perinatal mortality reviews across maternity and neonatal units.

The PMRT has been designed to support the review of the care of the following babies:

- All late fetal losses 22+0 to 23+6
- All antepartum and intrapartum stillbirths
- All neonatal deaths from birth at 22+0 to 28 days after birth
- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

Required standard	a) i). All perinatal deaths eligible to be notified to MBRRACE-UK from Monday 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death. ii). A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, **from Friday 20 December 2019 to 15 March 2021 will have been started before 15 July 2021.**
	b) **At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15 March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team**. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool **before 15 July 2021.**
	c) **For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought**. This includes any home births where care was provided by your Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trust should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and these actions.
	d) i. Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.
Minimum evidential requirement for trust Board	Notifications must be made and surveillance forms completed using the MBRRACE-UK reporting website. The perinatal mortality review tool must be used to review the care and draft reports should be generated via the PMRT. **A report has been received by the Trust Board each quarter from Thursday 1 October 2020 onwards that includes details of the deaths reviewed and the consequent action plans**. **The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met.**

The maternity service can confirm that the PMRT is used in review processes.

a) It should be noted that from the 11th January 2021 there has been 6 eligible cases requiring notification to MBRRACE. 5 of these were reported within 7 working days and the surveillance information completed. 1 case was reported within 8 days

Between Friday 20th December 2019 to March 15th 2021, 100% of all deaths, suitable for review using the PMRT (17 eligible cases), were commenced; this is against the 95% required standard.

b) 100% of cases of all deaths of babies suitable for review using PMRT, who were born and died in the Trust from Friday 20th December 2019 to Monday 30th June 2021, have been reviewed using the PMRT.

c) Within the same time frame, of the required 95% standard, 11 cases were informed, 3 have not yet been informed and 1 did not have the mental capacity to be informed.

d) Quarter 1, 2 and 3 Learning from deaths report went to Trust Board on November 5th 2020, 14th January 2021 and 8th April 2021 respectively. Although SFT can evidence submission these reports do not contain evidence regarding the use of PMRT and subsequent action plans. However, there are numerous reports that are submitted to the Board and Board sub committees that provide additional assurance that learning from deaths is reviewed within the maternity service and recommendations required are acted upon.

Table 2.
All cases reportable to MBRRACE from 20th Dec 2019 - 30th June 2021 are entered below. (Any reported as N/A do not meet the PMRT requirement). Non eligible case for CNST standards have been greyed out below.

Date of Incident	PMRT Case number	Date of Death	Date case reported to MBRACE/PMRT	Date review commenced on PMRT	Draft report available	Outcome
4/2/2020	67373	4/2/2020	10/02/2020	N/A	N/A	NND 21+5
3/3/20	67983	3/03/20	18/3/2020	27/4/2020	26/10/20	IUD 38+
25/3/20	68548	25/3/20	22/4/2020	4/5/2020	26/10/20	24+6 IUD
26/04/20	68938	26/04/20	15/05/2020	29/07/2020	17/08/2020	40+5 SB
1/6/2020	69291	1/6/2020	8/6/2020	6/7/2020	2/9/2020	29+5 IUD
6/7/2020	70071	6/7/2020	29/7/2020	29/7/2020	25/9/2020	23+6 IUD
29/08/2020	70560	29/08/2020	2/9/2020	2/9/2020	18/3/2021	30/40 NND
22/8/20	71120	22/08/2020	14/9/2020	9/10/2020	18/12/2020	22+1 NND
7/9/2020	71800	7/9/2020	26/10/2020	26/10/2020	21/4/2021	Term IUD
25/10/2020	72181	25/10/2020	17/11/2020	N/A	N/A	22/40 IUD
17/11/2020	72182	5/11/20	17/11/2020	N/A	N/A	TOP 23+5 A
21/11/2020	72269	21/11/2020	21/11/2020	N/A	N/A	TOP 23+2 A
18/11/2020	72270	20/11/2020	21/11/2020	8/1/2020	No draft report available yet	37 week NND
4/12/2020	72454	4/12/2020	4/12/2020	22/12/2020	16/3/2021	39/40 IUD

12/12/2020	72575	12/12/2020	13/12/2020	8/1/2021	No draft report available yet	26+5 A
17/12/2020	72678	17/12/2020	18/12/2020	8/1/2021	16/3/2021	37+ IUD
26/12/2020	72781	26/12/2020	28/12/2020	8/1/2021	28/4/2021	39/40 IUD
31/01/2021	73410	31/1/2021	1/2/2021	N/A	N/A	23+4 A
6/04/2021	74802	09/04/20221	15/04/2021	N/A	Not applicable as did not die in our Trust	34+6 NND
25/04/2021	74948	23/04/2021	25/04/2021	N/A	N/A	30+1 A
14/5/2021	75299	14/05/2021	18/5/2021	21/5 2021	Draft not available	25+
24/06/2021	75880	14/06/2021	22/06/2021	28/06/2021	Not applicable as died at home.	19 day NND
24/06/2021	75956	24/06/2021	28/06/2021	Not yet started	Draft not available	34 IUD

A =Abnormalities known
SB=Stillbirth
NND=Neonatal Death
IUD=Intrauterine Death
TOP=Termination of pregnancy

SFT are not fully compliant with safety action 1. An action plan will be submitted at the point of declaration to address deficiencies in order to be agreed at Board level.

3.2 Safety action 2:

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required standard	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.
Minimum evidential requirement for trust Board	NHS Digital will issue a monthly scorecard to data submitters (Trusts) that can be presented to the Board. It will help Trusts understand the improvements needed in advance of the assessment. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met All 13 criteria are mandatory. Items 1, 2, 4-13 will be assessed by NHS Digital and included in the scorecard. Item 3 will be reported to NHS Resolution.

SFT submits monthly data to NHS Digital demonstrating compliance with the maternity services data set. MSDS submission in January 2021 was fully compliant and all criteria met. (Evidence to support compliance can be found in gap analysis).

3.3 Safety action 3:

Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme (ATAIN)?

Required standard	D) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.
	E) A review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) is undertaken to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • Changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.
	F) An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19 period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion
	G) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.
Minimum evidential requirement for trust Board	Revised in light of COVID D) Commissioner returns on request – as per ODN request but there should be no expectation that Trusts are returning data on admissions between Sunday March 1 2020 and Monday August 31 2020. This should be taken from existing BadgerNet data directly for the intervening period. E) Review of term admissions should be an ongoing process. The review of admissions during Covid-19 should be completed by Friday 26 February 2021. Progress on Covid-19 related requirements are monitored monthly by the neonatal and board safety champions from January 2021. Evidence that the review specifically considered the impact of changes to parental access; staff redeployment, closure or reduced TC capacity and changes to postnatal visits on admission rates including those for jaundice, weight loss and poor feeding F) An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from ATAIN reviews. • Evidence of an action plan to address identified and modifiable factors for admission to transitional care. • Evidence that the action plan has been revised in the light of learning from term admissions during Covid-19. Where no changes have been made, the rationale should be clearly stated. • Evidence that the action plan has been shared and agreed with the neonatal, maternity safety champion and Board level champion. G) Evidence that progress with the revised ATAIN action plan has been shared with the neonatal, maternity safety champion and Board level champion.

When requested by the Operational Delivery Network (ODN) and commissioner, the Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are shared, this supports a future regional approach to developing Transitional care. The LMNS and the CCG have access to this information via badger net (electronic reporting system) and have not requested this information directly from the Trust.

All ATAIN cases were reviewed through the SWARM and ATAIN review process during the MIS reporting timeframe. The service recognised the potential risks that covid-19 could have on the Neonatal service and the

risk register was updated accordingly through this time. The Neonatal Unit developed an Action Card as part of the wider Trust Covid-19 response to reflect any changes that the pandemic had on the service.
The Neonatal service did not close at any point during the MIS reporting timeframe and there was no reduction in the transitional care capacity. The main carer of the baby was permitted access to the Neonatal Unit to be with their baby at all times and NICU staff were retained within the maternity and neonatal service, there was no redeployment. The neonatal service did not see an increase in admissions including those for jaundice, weight loss and poor feeding. Since March 2021 there is now formal documentation of an audit trail for all cases reviewed meeting the ATAIN criteria and action plans relating to cases in place including the assurance that covid-19 is not impacting on the babies within the service. This report is now shared monthly with the maternity and neonatal safety champions and Board level safety champions.

We cannot demonstrate full evidence of compliance against this safety action during the time period required. An action plan will be submitted at the point of declaration to address deficiencies in order to be agreed at Board level.

3.4 Safety action 4:

Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required standard	**Anaesthetic medical workforce** An action plan is in place and agreed at Trust Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 **Neonatal medical workforce** The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level **Neonatal nursing workforce** The neonatal unit meets the service specification for neonatal nursing standards. If these are not met, an action plan is in place and agreed at board level to meet these recommendations
Minimum evidential requirement for trust Board	**Anaesthetic medical workforce** Trust Board minutes formally recording the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met. Where Trusts did not meet these standards, they must produce an action plan (ratified by the Trust Board) stating how they are working to meet the standards. **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce training action. If the requirements are not met, an action plan should be developed to meet the recommendations and should be signed off by the Trust Board. **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, an action plan should be developed to meet the standards and should be signed off by the Trust board and a copy submitted to the Royal College of Nursing (doreen@crawfordmckenzie.co.uk) and Neonatal Operational Delivery Network (ODN).
What is the relevant time period?	Any six month period between December 2019 and Thursday 15 July 2021. If a nursing workforce review has been undertaken from September 2019 onwards, this will be accepted

Anaesthetic Medical workforce

The anaesthetic medical workforce meets the Anaesthesia clinical services Accreditation (ACSA) standards 1.7.2.5, 1.7.2.1 and 1.7.2.6. A letter of compliance can be found in the Gap analysis

Neonatal Medical Workforce

The neonatal unit does not meet the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. To meet the standard they required a middle grade to be available, which the paediatric service does not have due to only having a total of 3 middle grades available to work clinically.

Descriptions of paediatric medical roles in SFT

Tier 1 - GPVTS ST1/2 or F2 or trust grade SHO

Tier 2 - paediatric ST3-8 or consultant out of hours (shared with general paediatric service)

Monday – Fri 09.00- 17.00
Tier 1 - 1 doctor on rota for NICU / PNW / Deliveries
Tier 2 - joint cover for NICU / maternity and general paediatrics (minimum 1 doctor)

Monday - Friday 17.00-21.00

Tier 1 - 1 doctor joint NICU and general paediatrics
Tier 2 - 1 doctor joint cover NICU and general paediatrics (usually ST3-8)

Monday - Friday 21.00-09.00 and weekends 24 /7

Tier 1 - 1 doctor covering NICU and general paediatrics (some weekday nights this doctor also covers maternity / gynae when resident consultant for O&G)
Tier 2 - 1 doctor covering NICU and general paediatrics. At night this is most likely to be covered by a consultant but there are some registrar night shifts and some consultant long day shifts at the weekend

To date the mitigating factors have been:

1. Overnight it is usually a resident consultant on site with a second consultant available from home in case of twins etc., though this is the majority of nights it does not apply every night.
2. We are a relatively small DGH in terms of both NICU cots and paediatric unit.
3. General Paediatric /NICU / maternity areas are in close proximity.
4. NICU nurses undertake some extended roles including attending preterm or difficult deliveries with the medical team, bloods and IV cannulas

At this present time there is an ongoing dialogue within the ODN regarding the re- designation of SFT's neonatal unit. This would mean SFT would move from being a NICU to a local neonatal unit. The gestation of babies admitted to an LMU would change from 27 weeks to potentially 32 weeks. Dependant on the outcome of the re-designation the neonatal medical workforce will need reviewing.

Neonatal nursing workforce

The neonatal nursing workforce does meet the service specification for neonatal nursing standard. The service has undertaken a nursing work force calculation using the national CRG staffing tool to demonstrate compliance. (Evidence of compliance can be found in gap analysis)

We cannot demonstrate evidence of compliance against this safety action due to the non-compliance for the Neonatal Medical workforce standard. An action plan will be submitted at the point of declaration to address deficiencies in order to be agreed at Board level.

3.5 Safety action 5:

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment has been done.
	b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
	c) All women in active labour receive one-to-one midwifery care
	d) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board at least once a year, during the maternity incentive scheme year three reporting period (December 2019 – July 2021).
Minimum evidential requirement for trust Board	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified. Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls. The midwife to birth ratio The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls. Did Covid-19 cause impact on staffing levels? - Was the staffing level affected by the changes to the organisation to deal with Covid-19? - How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves
What is the relevant time period?	Any consecutive twelve month period between Wednesday 1st July 2020 and Thursday 15 July 2021.

a) Birthrate+(BR+) review was completed at SFT in December 2019. BR+ is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units for a significant number of years. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings, and have been endorsed by the RCM and RCOG.

The review that took place in December 2019 recognized a variance in midwifery staffing of **5.2wte midwives**. A statement of commitment from the Trust has been issued to finance the shortfall of midwifery staffing numbers within the service. A further review of the Birthrate+ model (May 2021) has identified the need to further increase clinical staffing establishment and includes modelling to ensure achievement of Continuity of Carer within the service.

Table 3. Birthrate+ (BR+) review December 2019

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

b) The midwifery coordinator in charge of labour ward should have supernumerary status 100% of the time; (defined as having no caseload of their own during their shift), this is to ensure there is an oversight of all birth activity within the service. The BR+ Acuity Tool is used to collect detailed information on activity within birthing environments on a 4 hourly bases and captures information on acuity at that time and safe staffing levels required to manage the acuity and what action(s) were taken to resolve the situation. The data collected will highlight if there are certain periods in the day/night and days of the week when the acuity is often above

the available number of midwives. From this information the service can also record and respond to 'Red Flag' situations i.e. delays in care or detection of deteriorating clinical situation or delay in pain relief.

Once the initial data had been reviewed and clarified the intrapartum acuity tool showed that there is a 99.05% compliance with supernumerary labour ward shift lead status. On those 20 occasions during the time period, there were clear mitigations, in line with the escalation policy, that were put in place that enabled the coordinator to resume supernumerary status as soon as possible.

Table 4. – Compliance of Coordinator remaining supernumerary between 1st July 2020 and 15th June 2021

Assessment Periods - Maximum number of scheduled assessments in selected data period	Supernumerary status of labour ward coordinator not achieved (number of episodes recorded on acuity tool)	Compliance of 100% supernumerary status
2094	20	99.05%

c) All women in active labour receive one-to-one midwifery care (Audit to support compliance can be found in the Gap analysis).

d) During the maternity incentive scheme year three reporting period (December 2019 – July 2021) a Midwifery staffing report was completed in October 2020 but was paused due to COVID-19 and a subsequent review has commenced in June 2021and a draft report is available. This details the mitigation in place to address and manage the shortfall in staffing. Mitigations included:

- Bank backfill as and when required to ensure safe staffing levels are maintained, particularly in response to short term sickness. The maternity unit currently using agency staff to support workforce.
- Relaunch a recruitment campaign to ensure that we are advertising broadly on social media and in Midwifery Journals/RCM advertisement
- Escalation process supported by escalation policy
- On call managers overnight.
- Daily staffing/safety huddle involving clinical leaders across maternity services to ensure staff are assigned according to fluctuating activity levels.
- Use of acuity tool within labour ward setting 4 hourly.
- Datix reporting for missed breaks and if the lead midwife is unable to be supernumerary, with evidence of involvement of duty manager and escalation policy.
- Red flag reporting is discussed monthly at the maternity risk meeting; any themes are then fed into the Trust Clinical risk group

The Birth rate plus report identified that SFT had 5.4wte specialist midwives (Named Midwife for Safeguarding Children, Specialist perinatal mental health midwife, antenatal screening, infant feeding team etc.) leaving a deficit of 2.33wte. A business case approved in March 2021 has incorporated this variance and will see a change in non-clinical structure within the service.

We can demonstrate evidence of compliance against this safety action during the time period required.

3.6 Safety action 6:

Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Required standard	1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2019/20 standard contract. 2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network 3. The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBv2 including the data submission requirements. The corroborating evidence is the SBLCBv2 survey and MSDS data, availability of this depends on the COVID-19 status. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net.
Minimum evidential requirement for trust Board	**Element one**: A. Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital. B. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. C. Percentage of women where CO measurement at 36 weeks is recorded. Trust board should receive data from the organisation's MIS evidencing 80% compliance. If CO monitoring remains paused due to Covid-19, the audit described above needs to be based on the percentage of women asked whether they smoke at booking and at 36 weeks. The Very Brief Advice and referral to smoking cessation services remain part of the pathway. The timing of the audit is at the Trust's discretion but should include the dates when women booked, and reference to the national CO testing policy at that time. A threshold score of 80% compliance should be used to confirm successful implementation. If the process metric scores are less than 95% Trusts must also have an action plan for achieving >95%. **Element two:** A. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking. In addition the Trust board should specifically confirm that within their organisation: 1) women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onward

	2) s 2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation. **Element three:** A. Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy. Revised safety actions - updated March 2021 41 B. Percentage of women who attend with RFM who have a computerised CTG. **Element four**: A. Percentage of staff who have received training on intrapartum fetal monitoring in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness. B. Percentage of staff who have successfully completed mandatory annual competency assessment. Obstetric consultants All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres. In the current year we have removed the threshold of 90%. This applies to fetal monitoring requirement of safety action 6. We recommend that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible. Trust Board should minute in their meeting records a written commitment to facilitate local, in-person, fetal monitoring training when this is permitted. **Element 5:** A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. B. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. C. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).

The bundle is designed to tackle stillbirth and early neonatal death. It brings together five Elements of care:

1. Smoking
2. Fetal Growth Restriction
3. Reduced Fetal Movements
4. Fetal Monitoring
5. Preterm Birth

The trust completes quarterly care bundle surveys submitted to NHSE Maternity Transformation (Q1/Q2 Paused due to covid-19, resumed Q3 – please see Gap analysis for Survey 4 and 5).

Table 5.

Element one	RAG scoring
A. Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital.	
B. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded	
C. Percentage of women where CO measurement at 36 weeks is recorded	Pause due to covid
Element two:	
A. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking. In addition the Trust board should specifically confirm that within their organisation: 1) Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards. 2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation. 3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.	SFT provide a service that adheres to the GAP pathway phase 2 which supports scans from 28
Element three:	
A. Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy	
B. Percentage of women who attend with RFM who have a computerised CTG.	
Element 4	
A. Percentage of staff who have received training on intrapartum fetal monitoring in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness. annual competency assessment	
B. Percentage of staff who have successfully completed mandatory annual competency assessment	
Element 5	

A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.	
B. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.	
C. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).	

The recommendations have been considered by the service, each of the elements is supported in practice or there is an alternative intervention. All of the recommendations of the bundle are in place except for women that are identified as high risk at booking for fetal growth restriction, that a uterine artery Doppler flow velocimetry should be performed by 24 completed weeks of pregnancy. SFT guidance supports scans from 28 weeks not 24.SFT provide a service that adheres to the GAP pathway phase 2, which ensures that we are maintaining appropriate surveillance of pregnancies, deemed high risk for early growth restriction, by starting surveillance scans from 28 weeks and at least every 3 weeks thereafter.

We therefore cannot demonstrate evidence of compliance against this safety action.

3.7 Safety action 7:

Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

Required standard	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?
Minimum evidential requirement for trust Board	Terms of Reference for your MVP A minimum of one set of minutes of MVP meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback Evidence of service developments resulting from coproduction with service users Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of UKOSS 2020 coronavirus data.
What is the relevant time period?	Friday 20 December 2019 until Thursday 15 July 2021

A Maternity Voices Partnership plus (MVPP) group is a multidisciplinary NHS working group for review and coproduction of local maternity services. This may include changes and quality improvement initiatives made during the Covid-19 pandemic. The maternity unit uses a variety of methods in order to encourage user involvement and the subsequent action planning on issues raised. The MVP is a conduit between service users and maternity and neonatal services and works collaboratively within the LMNS.

The MVPP meets quarterly with services within the LMNS. It reflects the experiences of the local community but remains as independent and accessible to all sections of the community. Within the maternity incentive scheme time period the MVPP have worked collaboratively with SFT to co-produce the local maternity service. Examples of this work are:

- Increasing women's choice of place of birth- development of the alongside midwifery unit.
- Increasing information for women during COVID -19
- Helping to shape maternity care in 2021
- Development of resources to improve knowledge and information regarding diversity and the inclusion of maternity staff and service users.
- The MVPP is prioritising hearing the voices of women from black, Asian and minority ethnic backgrounds and women living in areas of high levels of deprivation. The use of social media reinforces the MVPP key messages.

We can demonstrate evidence of compliance against this safety action during the time period required.

3.8 Safety action 8:

Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Required standard and Minimum evidential requirement	a) Covid-19 specific e-learning training has been made available to the multi-professional team members? b) team required to be involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since the launch of MIS year three in December 2019? c) there is a commitment by the trust board to facilitate multi-professional training sessions, including fetal monitoring training once when this is permitted.

MDT training was paused during COVID but the service commenced an eLearning package of training from March 2021. 105 out of 229 staff members completed the eLearning training. Currently June 2021 overall compliance sits at 50.7%. SFT continue to roll out and increase the amount of multidisciplinary training.

Table 6.

ELearning PROMPT TRAINNG

Staff group	Compliance (completed MDT training since Dec 2019
Midwives	73%
MCS's	43%
Obstetricians (all grades)	43%
Anaesthetists	64%
ODP	21%

Neonatal resuscitation Support training was on hold during COVID-19. We now have in house training which is available for all staff groups. Compliance for midwives is currently 44%. We have email confirmation that Paediatric Consultants and SHO's have been trained but this is not recorded or monitored for expiry within any database. We do not have any evidence for Neonatal Nurses or Registrars to date and this will therefore be part of the action plan provided to NHSR.

We therefore cannot demonstrate evidence of compliance against this safety action.

3.9 Safety action 9:

Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?

Required standard	a) A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. b) Board level safety champions are undertaking feedback sessions every other month, for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to Covid-19 service changes and service user feedback and can demonstrate that progress with actioning named concerns are visible to staff. c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. Taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas, a revised action plan describes how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve. d) Together with their frontline safety champions, the Board safety champion has reviewed local outcomes in relation to: I. Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of Covid-19, drawing on resources and guidance to understand and address factors which led to these outcomes. II. The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK. III. The MBRRACE-UK SARS-Covid-19 https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK_Maternal_Report_2020_v10_FINAL.pdf IV. The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups And considered the recommendations and requirements of II, III and IV on I. e)The Board Level Safety Champion is actively supporting capacity (and capability) building for all staff to be actively involved in the following areas: Maternity and neonatal quality and safety improvement activity within the Trust, including that determined in response to Covid-19 safety concerns.

	Specific national improvement work and testing lead by MatNeoSIP that the Trust is directly involved with.
Minimum evidential requirement for trust Board	a) Evidence of a written pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) the LMS and d) Patient Safety Networks. b) Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff. c) Evidence that discussions regarding safety intelligence, concerns raised by staff and service users in relation to, but not exclusively, the impact of Covid-19 on maternity and neonatal services; progress and actions relating to the local improvement plan(s) and QI activity are reflected in the minutes of Board, LMS and Patient Safety Network meetings. Minutes should also include discussions on where efforts should be positively recognised. d) Evidence of a safety dashboard or equivalent, visible to both maternity and neonatal staff which reflects action and progress made on identified concerns raised by staff and service users. This should include concerns relating to the Covid-19 pandemic. e) Evidence that Board level safety champions have reviewed their continuity of carer action plan in light of Covid-19. Plans should reflect how the Trust will continue or resume continuity of carer models so that at least 35% of women booking for maternity care are being placed onto continuity of carer pathways. In light of the increased risk facing, women from Black, Asian and minority ethnic backgrounds and women from the most deprived areas, local systems should consider bringing forward enhanced continuity of carer models primarily targeting these groups. f) Evidence of Board level oversight and discussion of progress in meeting the revised continuity of carer action plan. g) Evidence that the frontline and Board safety champions have reviewed local outcomes as set out in standard d) above and are addressing relevant learning, drawing on insights and recommendations from the two named reports and undertaking the requirements within the letter targeting perinatal support for Black, Asian and Minority Ethnic groups. h) Evidence of how the Board has supported staff involved in the four key areas outlined in part e) of the required standard and specifically to: work with Patient Safety Networks, local maternity systems, clinical networks, commissioners and others on Covid-19 and non Covid-19 related challenges and safety concerns, ensuring learning and intelligence is actively shared across systems utilise SCORE safety culture survey results to inform the Trust quality improvement plan. Undertaking of improvement work aligned to the MatNeoSIP national driver diagram and key enablers.
What is the relevant time period?	A written pathway, visible to staff and meeting the requirements detailed in part a) and b) of the action is in place by Friday 28 February 2020. Monthly feedback sessions continue to be undertaken in January 2020 and February 2020 and again every other month from no later than 30 November 2020. Progress with actioning named concerns from staff workarounds are visible from no later than 26 February 2021. An action plan relating to a minimum of 35% of women being placed onto a continuity of carer pathway, which prioritises women from Black, Asian, Minority Ethnic and the most vulnerable groups served by the Trust, should be agreed by the Board maternity safety champion by 26 February 2021. Progress in meeting the revised CoC action plan is overseen by the board on a minimum of a quarterly basis commencing January 2021. A review of mortality and morbidity cases has been undertaken and an action plan, drawing on insights from the two named reports and the letter has been agreed by Monday 30 November

	2020. Board level safety champion attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event held in March 2020 by 30 June 2021

Maternity safety champions work at every level in the trust and at regional and national level. They develop strong partnerships, can promote the professional cultures needed to deliver better care and play a central role in ensuring the safest care possible.

At SFT we have a safety champion's pathway that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from ward to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks.

Board safety champions undertake a walk round of the department bi monthly to hear any concerns raised by staff relating to safety issues, COVID 19 service changes and service user feedback. Evidence is provided within the (Gap analysis from our Executive Director)

Within the department the names of safety champions are visible to all maternity and neonatal staff. Front line and board safety champions meet monthly to discuss safety agenda and feedback from safety champions walk rounds.

SFT concluded a pilot continuity of carer project in January 2021. This was not carried forward due to safety concerns regarding skill mix and vacancy within the workforce. At present in the service we do not have a continuity of carer action plan. The restructure within the Maternity service should enable this work stream to be developed further to facilitate progression and we have requested support from the national team regarding this work stream.

During the timeframe stipulated for this safety action, compliance cannot be evidenced.

3.10 Safety action 10:

Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme?

Required standard	a) Reporting of all outstanding qualifying cases for the year 2019/20 to NHS Resolution's EN scheme. b) Reporting of all qualifying cases to the Healthcare Safety Investigation Branch (HSIB) for 2020/21. c) For qualifying cases which have occurred during the period 1 October 2020 to 31 March 2021 the Trust Board are assured that: 1. the family have received information on the role of HSIB and the EN scheme; and 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum evidential requirement for trust Board	Trust Board sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to HSIB and the NHS Resolution Early Notification team. Trust Board sight of evidence that the families have received information on the role of HSIB and EN scheme. Trust Board sight of evidence of compliance with the statutory duty of candour.
What is the relevant time period?	Reporting to NHS Resolution Monday 1 April 2019 to Tuesday 31 March 2020. Reporting to HSIB Wednesday 1 April 2020 to Wednesday 31 March 2021.

The 19/20 all outstanding qualifying cases were reported to NHS resolution early Notification scheme.

All qualifying cases for 2021 have been reported to the health care safety investigation branch (HSIB).

All cases that occurred between the 1st Oct and 1st March 2021 the family have received information on the role of HSIB and the EN scheme. There has been compliance will all 3 stages of duty of candour.

4. Conclusion

The maternity service can demonstrate compliance with 4 out of the 10 safety standards for the year 3 reporting period (December 2019 – July 2021). For the 6 safety actions where compliance cannot be demonstrated, there is a gap in evidence available. The standards request minimum evidence specific to timeframes within the Year 3 Maternity Incentive Scheme period and the maternity service is unable to provide this for all ten safety actions.

It has become apparent over recent weeks, when requesting the evidence to submit for CNST, that there was a lack of understanding within the work streams of what was actually required. Although the standards have changed since 2019, especially with the consideration of evidence around Covid-19 challenges to the workforce, ongoing work should have since been embedded in practice since the last CNST submission in 2019. Due to constraints within the maternity service in relation to the leadership structure and current gaps in senior positions within the workforce, there appears to have been no overall coordination or lead since the last submission to ensure the work that was evidenced at the time continued which would have made the transition to meet the requirement with the updated standards less onerous. This has had a significant impact on being able to provide evidence against the safety actions. The Board should be aware that in 2019 the maternity and neonatal services provided evidence against all 10 standards and questions may be raised by NHS Resolution as to why there is such disparity between the 2 submissions.

Moving forward, action plans are being completed and work has already started to be embedded, this will demonstrate that the service is working at pace towards full compliance of the 10 safety actions. The Board declaration form will be accompanied by the action plans detailing work required to demonstrate full compliance when the Trust submit this to NHSR by noon on 15th July 2021.

Maternity Incentive Scheme Gap Analysis - Year three 2021

Safety Action		Initials	Name	Role
1	National Perinatal Mortality Review Tool	KM	Kim Melbourne	Quality and Safety Lead Midwife
		CS	Clare Smith	Bereavment Lead Midwife
		AJK	Abi Kingston	Consultant lead for Risk
2	Maternity Services Data Set	Informatics	Carmel Payne	Senior Information Analyst & Reporting Lead
3	ATAIN	MP	Mary Pedley	Neonatal Consultant
		CAS	Charlotte Ashman Scott	Postnatal lead Midwife
		HR	Hannah Rickard	Consultant
		GD	Geoff Dunning	NNU manager
	Medical Workforce Planning	AJK	Abi Kingston	Consultant
		JB	Julia Bowditch	Consultant Anaesthetist
		RS	Rowena Staples	Neonatal Consultant
		GD	Geoff Dunning	NNU manager
5	Midwifery Workforce Planning	HB	Hannah Boyd	Interim Head of Midwifery
		VM	Vicki Marston	Deputy Head of Midwifery
6	Saving Babies Lives	VH	Tori Harper	Fetal Surveillance Lead Midwife
		SMV	Stuart Verdin	Consultant
7	Patient Feedback	LO	Lexi Oatley	Transformation Project Lead Midwife
8	Maternity Training	SS	Sally Smith	Practice education lead
9	Safety Champions	HB	Hannah Boyd	Interim Head of Midwifery
		AJK	Abi Kingston	Consultant
		GD	Geoff Dunning	NNU manager
		KM	Kim Melbourne	Quality and Safety Lead Midwife
		JD	Jusy Dyos	Chief Nurse
		EJ	Eiri Jones	NED
10	Early Notification Scheme	KM	Kim Melbourne	Quality and Safety Lead Midwife
		JL	Judith Leach	Trust Legal Team

CNST Maternity Incentive Scheme Year 3 Guidance

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Actions	RAG	Evidence
a)	**i.** All perinatal deaths eligible to be notified to MBRRACE-UK from Monday 11th January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death .	Notifications must be made and surveillance forms completed using the MBRRACE-UK reporting website.	CS	Compliant		
	ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to 15 March 2021 will have been started before 15 July 2021. This includes deaths after home births where care was provided by your Trust staff and the baby died	The perinatal mortality review tool must be used to review the care and draft reports should be generated via the PMRT.	KM/AJK	Compliant		PMRT report 20-12-19 to 15-3-21
b)	**i.** At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15 March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021.	All reviews need to be MDT review	KM/AJK	Compliant		
c)	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trust should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and these actions.		KM/AJK		To be discussed at CGC	
d)	Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.	Q1, Q2, Q3 Trust Board Learning from Deaths Board report	KM/AJK	Evidence provided however no action plan in the report Evidence needed for action plan is that actions documented in the Learning from Deaths report		Q1 Learning from deaths report Q1 20 21 August Q2 Learning from deaths report 20 21 October 20.docx Q3 Learning from deaths report 20 21 Jan 21.docx

All maternity Stillbirths, neonatal deaths and intra uterine deaths are presented quarterly at the Trust Mortality Surveillance group. PMRTS, investigation reports and perinatal minutes are submitted as evidence for these meeti

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Actions	Evidence	RAG
a)	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.	NHS Digital will issue a monthly scorecard to data submitters (Trusts) that can be presented to the Board. It will help Trusts understand the improvements needed in advance of the assessment. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met All 13 criteria are mandatory. Items 1, 2, 4-13 will be assessed by NHS Digital and included in the scorecard. Item 3 will be reported to NHS Resolution. Item 14 related to the Maternity Record Standard has been removed from the MIS safety action two.	Informatics	Compliant		

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Safety action 3: Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Actions	Evidence	RAG
d)	Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.	As and when requested, commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are shared with the Local Maternity System (LMS), ODN or commissioner.	GD	N/A	None as no request from Commissioner	
e)	A review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) is undertaken to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.	An audit trail which provides evidence that a review of term admissions during the period Sunday 1 March 2020 – Monday 31 August 2020 has been undertaken	GD	Multidisciplinary meetings occur monthly to review unexpected admissions into the Neonatal Unit. Due to the impact of Covid and staff required to work operationally these meeting were held less frequently but notes reviews continued.There were no closure of beds or any staff redeployment away from the clinical area. The Unit adopted a one parent only policy which was for a limited period of time (4 weeks) and at no point were mothers prevented from seeing their babies. Readmissions for weight loss and jaundice have not been impacted or increased over the months in question resulting in no tangiable impact from COVID19 on this service.	Action Plan required	
		Evidence that the review specifically considered the impact of changes to parental access; staff redeployment, closure or reduced TC capacity and changes to postnatal visits on admission rates including those for jaundice, weight loss and poor feeding .	GD		Action Plan required	
f)	An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion.	An audit trail which provides evidence and rationale for developing the agreed action plan to address local findings from ATAIN reviews.		Action tracker covering national ATAIN areas including hypoglycemia, respiratory support, observations etc. is ongoing and updated to reflect the progress the trust has made and influence further workstreams. We have also included an action tracker regarding implimentation and ongoing embedding of transitional care provision. COVID19 has not had a long or negative impact on these services which can be evidanced from our data collected on admissions to these services. All of this information is fed back to the board via the monthly safety champions meeting.	Action Plan required	
		Evidence of an action plan to address identified and modifiable factors for admission to transitional care.			Action Plan required	
		Evidence that the action plan has been revised in the light of learning from term admissions during Covid-19. Where no changes have been made, the rationale should be clearly stated.			Action Plan required	
		Evidence that the action plan has been shared and agreed with the neonatal safety champion and Board level champion.			Action Plan required	
g)	Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.	Evidence that progress with the revised ATAIN action plan has been shared with the neonatal safety champion and Board level champion.		Current audit trail now in situ from March 2021. Action plan to be developed to ensure that any Covid-19 restrictions and impact are captured and shared with the Safety Champions	Audit trail commenced to monitor ongoing review of cases with impact of Covid-19	

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Safety action 4: Can you demonstrate an effective system of clinical* workforce planning to the required standard?

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Related Risks	Actions	Evidence	RAG
b)	Anaesthetic medical workforce • An action plan is in place and agreed at Trust Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.7.2.5, 1.7.2.1 and 1.7.2.6	Trust Board minutes formally recording the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met.					
c)	Neonatal medical workforce • The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level	The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce			Action plan needed as non- compliant		
d)	Neonatal nursing workforce • The neonatal unit meets the service specification for neonatal nursing standards. If these are not met, an action plan is in place and agreed at board level to meet these recommendations	The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator.					

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Actions	Evidence	RAG
a)	A systematic, evidence-based process to calculate midwifery staffing establishment is completed.✓	Birthrate+ report Dec 2019		Completed December 2019		
b)	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service✓	Band 7 Co-ordinator Supernumerary every shift		99% compliant however mitigation in place - embedded in board report		
c)	All women in active labour receive one-to-one midwifery care✓	1:1 care in labour audit		none required 100% compliant		
d)	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board at least once a year, during the maternity incentive scheme year three reporting period (December 2019-July 2021).				Insert June 2021 report	

Action fully completed

Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)

Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Item number	Recommendation	Evidence required	Lead	Related Risks	Actions	Complete	Evidence	RAG
a)	Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2019/20 standard contract.	Completion of the SBLs Bundle		Safety Action 2	Compliant			
b)	Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.	Completion of the SBLs Bundle						
c)	The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBv2 including the data submission requirements. The corroborating evidence is the SBLCBv2 survey and MSDS data, availability of this depends on the COVID-19 status. The survey will be distributed by the Clinical Networks and should be returned to the Clinical Network or directly to england..atemitytransformation@nhs.net.							
Saving Babies Lives Requirements Evidence of the completed quarterly care bundle surveys for 2020/21 should be submitted to the Trust board.								
Element 1	Evidence of the completed quarterly care bundle surveys for 2020/21 should be submitted to the Trust board • Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital. • Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. • Percentage of women where CO measurement at 36 weeks is recorded.	The relevant data items for these indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. If CO monitoring remains pausedwithin the Trust due to Covid-19 the audit described above need to be based on the percentage of women asked whether they smoke at bookin gand at 36 weeks. The very brief advice and referral to smoking cessation servies remain part of the pathway. The timing of the audit is at the Trust's discretion bus should include the dates when women booked, and reference to the national CO testing policy at that time. A Threshold score of 80% compliance should be used to confirm successful implementation. If the process metric scores are less than 95% Trusts must also ahve an action plan for achieving >95%.		Safety Action 2				
	• Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking.	The relevant data items for these indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. If there is a delay in the provider trust MIS's ability to record these data at teh time of submission an in house audit of 40 consecutive cases using locally available data or case records should ahve been undertaken to assess comliance with this indicator. A threshold score of 8-% compliance should be used to confirm successful implementation.						
Element 2	**In addition the Trust board** should specifically confirm that within their organisation: 1) women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards 2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation. 3) there is a qurterly audit of the percentage of abbies born <3rd centile >37+6 weeks' gestation. If Trusts have elected to follow Appendix G due to staff shortages related to the Covid-19 pandemic trust boards should evidence they ahve followed the escalation guidance for the short ter management of staff https://www.england.nhs.uk/publications/saving-babies-lives-care-bundle-version-2-covid-19-information/). they shoudl also specificaly confirm that theya r fllowing the modiwfied pathway for women with a BMI >35 kg/m2. If this is not the case the trust board should described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network haas agreed that it is is acceptable clinical practice.	How should Trust board specifically confirm that within their organisation standard 1-2 above have been implemented? This should be confirmed as a minimum bvia inclusion in the Trust's standard operating procedure/guideliens.			Non compliant with 2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation Currently meet Trust guideline and GAP Perinatal INstuture pathway however the scans are not completed at 24 weeks but 28 weeks gestation			
Element 3	a) Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy. b) Percentage of women who attend with RFM who have a computerised CTG.	an in-house audit of two weeks' worth of cases or 20 cases whichever is the smaller to assess compliance with the element three indicators. A threshold score of 80% compliance should be used to confirm successful implementation. If the process indicator scores are less than 95% trusts must also ahvea n action plan for achieving >95%.						
Element 4	• Percentage of staff who have received training on intrapartum fetal monitoring in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness. • Percentage of staff who have successfully completed mandatory annual competency assessment.	An in-house audit should have been undertaken to assess compliance with these indicators. • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres. In the current year we ahve removed the threshold of 90%. this applies to fetal monitoring requirement of safety action 6. We recommend that trusts identify any shortfall in reaching the 90% threshold and commit to aaddressing this as soon as possible. trust Board should minute in their meeting records a written commitment to fcilitate local, in-person, fetal monitoring training when this is permitted.						
Element 5	• Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. • Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. • Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).	The relevant data items for these indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format. The Trust board should receive data from the organisation's MIS evidencing 85% compliance.						
	If there is a delay in te provider trust MIS's ability to record these data at the time of submission an i-house audit fo a minimum of four weeks' worth of consecutive cases up to a maximum of 20 cases to assess compliance with the element five indicators. **In addition,** the Trust board should specifically confirm that within their organisation: • women at high risk of pre-term birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • an audit has been completed to measure the percentage of singleton live births (less than 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids.						

Action fully completed
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Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Related Risks	Actions	Complete	Evidence	RAG
a)	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	• Terms of Reference for your MVP • Minimum of one set of minutes of MVP meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback • Evidence of service developments resulting from coproduction with service users • Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses • Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of UKOSS 2020 coronavirus data. A template pack hjas been developed by the safety action leads in ordeer to support trusts with evidencing compliance with the requirements of safety action seven. the pack can be found here https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme		No			   	

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Safety action 8: Can you evidence that the maternity unit staff groups of each maternity unit staff group have attended an 'in-house' multi-

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Related Risks	Actions	Complete	Evidence	RAG
a)	Can you confirm that Covid-19 specific e-lerning training has been made available to the multi-professional team members?	Evidence should be provided to the trust board that training resources have been provided to the multidisciplinary team members digitally or in person.	Practice Education Team		Compliant			
b)	Can you confirm that team required to be involved in immediate resuscitation of the newborn and management of the deteriorating new bon infant have attended your in-house neonatal rescitation training or Newborn Life Suport since the launch of MIS year three in December 2019.				Action Plan needed			
c)	You can confirm thtat there is a a commitment by the trust board to facilitate multi-professional training sessions, including fetal monitoring training once when this is permitted.				Compliant			

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Related Risks	Actions	Complete	Evidence	RAG
a)	A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks.	Evidence of a written pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) the LMS and d) Patient Safety Networks.			Compliant			
b)	Board level safety champions are undertaking feedback sessions **every other month** for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to Covid-19 service changes and service user feedback and can demonstrate that progress with actioning named concerns are visible to staff.	Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff.			Compliant			
c)	Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. Taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas, a revised action plan describes how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve.	Evidence that discussions regarding safety intelligence, concerns raised by staff and service users in relation to, but not exclusively, the impact of Covid-19 on maternity and neonatal services; progress and actions relating to the local improvement plan(s) and QI activity are reflected in the minutes of Board, LMS and Patient Safety Network meetings. Minutes should also include discussions on where efforts should be positively recognised.			Action plan needed as no CoC Action plan in place			
d)	Together with their frontline safety champions, the Board safety champion and MatNeoSIP Patient Safety Networks has reviewed local outcomes in relation to: **I**. Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of Covid-19, drawing on resources and guidance to understand and address factors which led to these outcomes. **II**. The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK. **III**. The MBRRACE-UK SARS-Covid-19 https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK_Maternal_Report_2020_v10_FINAL.pdf **IV**. The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups **And considered the recommendations and requirements of II, III and IV on I.**	Evidence of a safety dashboard or equivalent, visible to both maternity and neonatal staff which reflects action and progress made on identified concerns raised by staff and service users. This should include concerns relating to the Covid-19 pandemic.			Action plan needed as no CoC Action plan in place			
e)	The Board Level Safety Champion is actively supporting capacity (and capability) building for all staff to be actively involved in the following areas: • Maternity and neonatal quality and safety improvement activity within the Trust, including that determined in response to Covid-19 safety concerns • Specific national improvement work and testing lead by MatNeoSIP that the Trust is directly involved with	Evidence that Board level safety champions have reviewed their continuity of carer action plan in light of Covid-19. Plans should reflect how the Trust will continue or resume continuity of carer models so that at least 35% of women booking for maternity care are being placed onto continuity of carer pathways. In light of the increased risk facing, women from Black, Asian and minority ethnic backgrounds and women from the most deprived areas, local systems should consider bringing forward enhanced continuity of carer models primarily targeting these groups.			Action Plan needed			
		Evidence of Board level oversight and discussion of progress in meeting the revised continuity of carer action plan.			Action Plan needed		Evidence required	
		Evidence that the frontline and Board safety champions have reviewed local outcomes as set out in d) above and are addressing relevant learning, drawing on insights and recommendations from the two named reports and undertaking the requirements within the letter targeting perinatal support for Black, Asian and Minority Ethnic groups.			Action Plan needed		Evidence required	
		Evidence of how the Board has supported staff involved in the four key areas outlined in part e) of the required standard and specifically to: • work with Patient Safety Networks, local maternity systems, clinical networks, commissioners and others on Covid-19 and non Covid-19 related challenges and safety concerns • utilise SCORE culture survey results to inform local quality improvement plans • engage in relevant improvement/capability building initiatives nationally, regionally or via Patient Safety Networks • maintain oversight of improvement outcomes, learning and ensure intelligence is actively shared with key system stakeholders.					Evidence required	

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Safety action 10: Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Related Risks	Actions	Complete	Evidence	RAG
a)	Reporting of all outstanding qualifying cases for the year 2019/20 to NHS Resolution's EN scheme.	Trust Board sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to HSIB and the NHS Resolution Early Notification team. Trust Board sight of evidence that the families have received information on the role of HSIB and EN scheme. Trust Board sight of evidence of compliance with the statutory duty of candour.	KW / LBS	No	Awaiting report for Trust Board		Evidence required	
b)	Reporting of all qualifying cases to the Healthcare Safety Investigation Branch (HSIB) for 2020/21.✓						Evidence required	
c)	For qualifying cases which have occurred during the period 1 October 2020 to 31 March 2021 the Trust Board are assured that: **1. 1.** the family have received information on the role of HSIB and the EN scheme; and **2. 2.** there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour. ✓						Evidence required	

CNST changed requirements from 2019-2021submission

2019	2021
Safety action 1 a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death. b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death. c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought. d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.	 a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death. b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death. c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought. d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.
Safety action 2 The assessment will include data from the MSDS from January 2019. This data needs to be submitted to MSDS for the deadline of 31 March 2019. One MSDS criterion relates to data for six months, from October 2018 to March 2019, which needs to be submitted to MSDS for deadlines between 31 December 2018 and 31 May 2019. One criterion relates to the submission of data for the first month of MSDSv2. This data relates to April 2019 and needs to be submitted to the deadline of 30 June 2019.	 NHS Digital will issue a monthly scorecard to data submitters (Trusts) that can be presented to the Board. It will help Trusts understand the improvements needed in advance of the assessment. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met All 13 criteria are mandatory. Items 1, 2, 4-13 will be assessed by NHS Digital and included in the scorecard. Item 3 will be reported to NHS Resolution. Item 14 related to the Maternity Record Standard has been removed from the MIS safety action two.
Safety action 3 a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care. b) A data recording process for transitional care is established, in order to produce commissioner returns	 ~~A) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care.~~ ~~B) The pathway of care into transitional care has been fully implemented and is audited every other month. Audit findings are shared with the neonatal safety champion.~~ ~~C) A data recording process for capturing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded.~~ D) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care

for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2. c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews. d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN	Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC. In addition to include As and when requested, commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are shared with the Local Maternity System (LMS), ODN or commissioner. E) A review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) is undertaken to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding. **In addition evidence for standard e) to include:** An audit trail is available which provides evidence that a review of term admissions during the period Sunday 1 March 2020 – Monday 31 August 2020 has been undertaken Evidence that the review specifically considered the impact of changes to parental access; staff redeployment, closure or reduced TC capacity and changes to postnatal visits on admission rates including those for jaundice, weight loss and poor feeding . F) An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19 period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion. **In addition, evidence for standard f) to include:** An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from ATAIN reviews. Evidence of an action plan to address identified and modifiable factors for admission to transitional care. Evidence that the action plan has been revised in the light of learning from term admissions during Covid-19. Where no changes have been made, the rationale should be clearly stated. Evidence that the action plan has been shared and agreed with the neonatal, maternity safety champion and Board level champion. G) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions. **In addition evidence for standard g) to include:** Evidence that progress with the revised ATAIN action plan

	has been shared with the neonatal, maternity safety champion and Board level champion
Safety action 4 a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: *'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'* In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps. b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6	~~**Obstetric medical workforce**~~ ~~Proportion of trainees formally recorded in Board minutes and an action plan to address lost educational opportunities should be signed off by the Trust Board.~~ ~~The plan must also include an agreed strategy with dates, to address their rota gaps.~~ ~~A copy of the tool must be submitted to the RCOG at workforce@rcog.org.uk~~ **Anaesthetic medical workforce** Trust Board minutes formally recording the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met. Where Trusts did not meet these standards, they must produce an action plan (ratified by the Trust Board) stating how they are working to meet the standards. **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce training action. If the requirements are not met, an action plan should be developed to meet the recommendations and should be signed off by the Trust Board. **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, an action plan should be developed to meet the standards and should be signed off by the Trust board and a copy submitted to the Royal College of Nursing (doreen@crawfordmckenzie.co.uk) and Neonatal Operational Delivery Network (ODN).
Safety action 5 a) A systematic, evidence-based process to calculate midwifery staffing establishment has been done. b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on) d) A bi-annual report that covers staffing/safety issues is submitted to the Board	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service c) All women in active labour receive one-to-one midwifery care d) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board at least once a year, during the maternity incentive scheme year three reporting period (December 2019 – July 2021).
Safety action 6 Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity	1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019.

services. Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).	Note: Full implementation of the SBLCBv2 is included in the 2019/20 standard contract. 2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network . **Element four:** A. Percentage of staff who have received training on intrapartum fetal monitoring in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness. B. Percentage of staff who have successfully completed mandatory annual competency assessment. **In the current year we have removed the threshold of 90%. This applies to fetal monitoring requirement of safety action 6. We recommend that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible.** **Trust Board should minute in their meeting records a written commitment to facilitate local, in-person, fetal monitoring training when this is permitted.** 3. The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBv2 including the data submission requirements. The corroborating evidence is the SBLCBv2 survey and MSDS data, availability of this depends on the COVID-19 status. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net.
Safety action 7 Acting on feedback from, for example a Maternity Voices Partnership. User involvement in investigations, local and or Care Quality Commission (CQC) survey results. Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.	Terms of Reference for your MVP A minimum of one set of minutes of MVP meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback Evidence of service developments resulting from coproduction with service users Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of UKOSS 2020 coronavirus data. A template pack has been developed by the safety action leads in order to support trusts with evidencing compliance with the requirements of safety action seven. The pack can be found here https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/
Safety action 8	

Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year through Board sight of a staff training database or similar.	Can you confirm that: a) Covid-19 specific e-learning training has been made available to the multi-professional team members? b) team required to be involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since the launch of MIS year three in December 2019? c) there is a commitment by the trust board to facilitate multi-professional training sessions, including fetal monitoring training once when this is permitted.
Safety action 9 a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the trust ii. the Local Learning System (LLS) b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues c) The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff	a) A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. b) Board level safety champions are undertaking feedback sessions every other month, for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to Covid-19 service changes and service user feedback and can demonstrate that progress with actioning named concerns are visible to staff. c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. Taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas, a revised action plan describes how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve. d) Together with their frontline safety champions, the Board safety champion has reviewed local outcomes in relation to: I. Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of Covid-19, drawing on resources and guidance to understand and address factors which led to these outcomes. II. The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK. III. The MBRRACE-UK SARS-Covid-19 https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK_Maternal_Report_2020_v10_FINAL.pdf IV. The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups And considered the recommendations and requirements of II, III and IV on I. e) The Board Level Safety Champion is actively supporting

	capacity (and capability) building for all staff to be actively involved in the following areas: -Maternity and neonatal quality and safety improvement activity within the Trust, including that determined in response to Covid-19 safety concerns ~~The Patient Safety Networks of which each Trust will be a member –~~ - Specific national improvement work and testing lead by MatNeoSIP that the Trust is directly involved with - ~~The Patient Safety Network clinical leaders group where Trust staff are members~~
Safety action 10 Trust Board sight of trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team.	a) Reporting of all outstanding qualifying cases for the year 2019/20 to NHS Resolution's EN scheme. b) Reporting of all qualifying cases to the Healthcare Safety Investigation Branch (HSIB) for 2020/21. c) For qualifying cases which have occurred during the period 1 October 2020 to 31 March 2021 the Trust Board are assured that: 1. the family have received information on the role of HSIB and the EN scheme; and 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

Maternity incentive scheme - Guidance

Trust Name	
Trust Code	

This document must be used to complete your trust self-certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. **Your trust name will populate each tab. If the trust name box is coloured pink please update**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.**

The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested.

There are multiple additional tabs within this document:

Tab A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed within the condition of the scheme with each maternity incentive scheme safety action. Note, 'N/A' (not applicable) is available only for set questions. The information which has been populated in this tab, will automatically populate onto tab D which is the board declaration form.

Tab B - action plan summary sheet - This will provide you information on your Trust's progress in completing the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet - This sheet will enable your Trust to insert action plan details for any safety actions not achieved.

Tab D - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution.

Upon completion of the following processes please add an electronic signature into the three allocated spaces within this document: one signature to declare compliance stated in the board declaration form with the safety actions and their sub-requirements, one signature to confirm that the maternity incentive scheme evidence have been discussed with commissioners and a third signature to declare that there are no external or internal reports covering either 2020/21 financial year or the previous financial year (2019/20) that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 15 July 2021.
Any queries regarding the maternity incentive scheme and or action plans should be directed to **MIS@resolution.nhs.uk**
Technical guidance and frequently asked questions can be accessed here:
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

Submissions for the maternity incentive scheme must be received no later than 12 noon on **Thursday 15 July 2021** to MIS@resolution.nhs.uk
You are required to submit this document signed and dated. Please do not send evidence to NHS Resolution.

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Were all perinatal deaths eligible notified to MBRRACE-UK from the 11 January 2021 onwards to MBRRACE-UK within 7 working days and the surveillance information where required completed within four months of each death?	Yes
2	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 20 December 2019 to 15 March 2021 been started before 15 July 2021?	Yes
3	Were at least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 20 December 2019 to 15 March 2021 reviewed using the PMRT, by a multidisciplinary review team? Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021.	Yes
4	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents told that a review of their baby's death will take place? This includes any home births where care was provided by your Trust staff and the baby died.	No
5	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents' perspectives, questions and any concerns they have about their care and that of their baby sought? This includes any home births where care was provided by your Trust staff and the baby died.	No
6	If delays in completing reviews were anticipated, were parents advised of this and were they given a timetable for likely completion?	Yes
7	Have you submitted quarterly reports to the Trust Board from 1 October 2020 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
8	Were the quarterly reports discussed with the Trust maternity safety champion from 1 October 2020 onwards?	Yes

Safety action No. 2
Are you submitting data to the Maternity Services Data Set to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Were your Trust compliant with all 13 criteria in either the December 2020 or the January 2021's submission?	Yes
2	Has the Trust Board confirmed that they have fully conformed with the MSDSv2 Information Standards Notice, DCB1513 And 10/2018, which was expected for April 2019 data, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-CT.	Yes

Safety action No. 3
Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Please note standard a), b) and c) of safety action 3 have now been removed.		
Standard D) Commissioner returns on request for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.		
1	Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC. Is this in place?	N/A
Standard E) A review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) is undertaken to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.		
2	Has a review of term admissions to the neonatal unit and to TC during the COVID period (Sunday 1 March 2020 – Monday 31 August 2020) been undertaken and completed by 26 February 2021 to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding	Yes
An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion.		
3	Do you have evidence of the following • An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from ATAIN reviews. • Evidence of an action plan to address identified and modifiable factors for admission to transitional care. • Evidence that the action plan has been revised in the light of learning from term admissions during Covid-19. Where no changes have been made, the rationale should be clearly stated. • Evidence that the action plan has been shared and agreed with the neonatal, maternity safety champion and Board level champion.	Yes
Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.		
4	Has the ATAIN action plan been revised in the light of learning from term admissions during Covid-19 and has it been shared and agreed with the neonatal, maternity and Board level champions, with progress on Covid-19 related requirements monitored monthly by the neonatal and board safety champions from January 2021?	Yes
5	Has the progress with the Covid-19 related requirements been shared and monitored monthly with the neonatal and maternity safety champion ?	No
6	Has the progress on Covid-19 related requirements been monitored monthly by the board safety champions from January 2021?	No

Safety action No. 4
Can you demonstrate an effective system of clinical workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Please note that the standards related to the obstetric workforce have been removed.		
1	**Anaesthetic medical workforce** Have your Trust Board minuted formally the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met?	Yes
2	If your Trust did not meet these standards, has an action plan been produced (ratified by the Board) stating how the Trust is working to meet the standards?	N/A
3	**Neonatal medical workforce** Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing?	No
4	If your Trust did not meet the standards outlined in requirement no.3, has an action plan been produced (signed off by the Board) stating how the Trust is working to meet the standards?	No
5	**Neonatal nursing workforce** Does the neonatal unit meet the service specification for neonatal nursing standards?	Yes
6	If your Trust did not meet the standards outlined in requirement no.5, has an action plan been produced (signed off by the Board) and shared with the RCN, stating how the Trust is working to meet the standards?	N/A

Safety action No. 5
Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed?	Yes
2	Has your review included the percentage of specialist midwives employed and mitigation to cover any inconsistencies?	Yes
3	Has an action plan been completed to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent been completed, where deficits in staffing levels have been identified?	Yes
4	Do you have evidence that the Maternity Services detailed progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls?	Yes
5	Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with **supernumerary labour ward co-ordinator** status in the scheme reporting period? This must include mitigations to cover shortfalls.	Yes
6	If trust did not meet this standard, has an action plan been produced detailing how the maternity service intends to achieve 100% supernumerary status for the **labour ward coordinator** which has been signed off by the Trust Board, and includes a timeline for when this will be achieved?"	Yes
7	Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with **1:1 care in labour** in the scheme reporting period? This must include mitigations to cover shortfalls.	Yes
8	If trust did not meet this standard, has an action plan been produced detailing how the maternity service intends to achieve 100% compliance with **1:1 care in labour** has been signed off by the Trust Board, and includes a timeline for when this will be achieved?"	N/A
9	Do you have evidence that a review has been undertaken regarding COVID-19 and possible impact on staffing levels to include: - Was the staffing level affected by the changes to the organisation to deal with COVID? - How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves?	Yes
10	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board at least once every 12 months within the scheme reporting period?	Yes

Safety action No. 6
Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of Trust Board level consideration of how the Trust is complying with the Saving Babies' Lives Care Bundle Version 2 (SBLCBv2), published in April 2019?	Yes
2	Has each element of the SBLCBv2 been implemented? Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by the Clinical Network.	Yes
3	The quarterly care bundle survey must be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net. Have you completed and submitted this?	Yes
ELEMENT 1 - Reducing smoking in pregnancy		
Standard a) Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital. If CO monitoring remains paused due to Covid-19, the audit described above needs to be based on the percentage of women asked whether they smoke at booking and at 36 weeks.		
4	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
5	If the process metric scores are less than 95% for Element 1 **standard A**, has an action plan for achieving >95% been completed?	Yes
Standard b) Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.		
6	Has **standard b)** been successfully implemented (80% compliance or more)?	Yes
7	If the process metric scores are less than 95% for element 1 **standard b)**, has an action plan for achieving >95% been completed?	N/A
Standard c) Percentage of women where CO measurement at 36 weeks is recorded.		
8	Has **standard c)** been successfully implemented (80% compliance or more)?	Yes
9	If the process metric scores are less than 95% for element 1 **standard c)**, has an action plan for achieving >95% been completed?	Yes
ELEMENT 2 - Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction		
Standard a) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking.		
10	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
11	If the process metric scores are less than 95% for element 2 **standard a)**, has an action plan for achieving >95% been completed?	Yes
Do you have evidence that the Trust Board has specifically confirm that all the following 3 standards are in place within their organisation:		
12	1) women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards	Yes
13	2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation	No
14	3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation	Yes
15	If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board evidenced that they have followed the escalation guidance for the short term management of staff?	N/A
16	If the above is not the case, has your Trust Board described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice?	Yes
17	If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board confirmed that the Maternity Services are following the modified pathway for women with a BMI>35 kg/m2?	N/A
18	If Trusts have elected to follow Appendix G due to staff shortages related to the Covid-19 pandemic Trust Boards should evidence they have followed the escalation guidance for the short term management of staff (https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-Covid-19-information/). They should also specifically confirm that they are following the modified pathway for women with a BMI>35 kg/m2. If this is not the case, has your Trust Board described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice?	N/A
ELEMENT 3 Raising awareness of reduced fetal movement		
Standard a) Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy.		
19	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
20	If the process metric scores are less than 95% for element 3 **standard a)**, has an action plan for achieving >95% been completed?	N/A
Standard b) Percentage of women who attend with RFM who have a computerised CTG		
21	has **standard b)** been successfully implemented (80% compliance or more)?	Yes
22	If the process metric scores are less than 95% for element 3 **standard b)**, has an action plan for achieving >95% been completed?	N/A
ELEMENT 4 Effective fetal monitoring during labour		
Standard a) Percentage of staff who have received training on fetal monitoring in labour in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness.		
23	Has the Trust Board minuted in their meeting records a written commitment to facilitate local, in-person, fetal monitoring training when this is permitted?	Yes
24	If the process metric scores are less than 90% for Element 4 standard a), has the trust identify shorfall in reaching the 90% and commit to addressing those?	Yes
Standard b) Percentage of staff who have successfully completed mandatory annual competency assessment.		
25	Have training resources been made available to the multi-professional team members?	Yes
26	If the process metric scores are less than 90% for **Element 4 standard b)**, has the trust board identify shorfall in reaching the 90% and commit to addressing those when this is permitted?	Yes
ELEMENT 5 Reducing preterm births		
Standard a) Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth		
27	Has **standard a)** been audited? Completion of the audit for element 5 standards A should be used to confirm successful implementation.	Yes
28	If the process metric scores are less than 85% for Element 5 **standard a)**, has an action plan for achieving >85% been completed?	N/A
Standard b) Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.		
29	Has **standard b)** been audited? Completion of the audits for element 5 standards B should be used to confirm successful implementation.	Yes
30	If the process metric scores are less than 85% for Element 5 **standard b)**, has an action plan for achieving >85% been completed?	Yes
Standard c) Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).		
31	Has **standard c)** been audited? Completion of the audits for element 5 standards C should be used to confirm successful implementation.	Yes
32	If the process metric scores are less than 85% for Element 5 **standard c)**, has an action plan for achieving >85% been completed?	N/A
33	Do you have evidence that the Trust Board has specifically confirmed that: • women at high risk of pre-term birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • an audit has been completed to measure the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.	Yes

Safety action No. 7

Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have Terms of Reference for your Maternity Voices Partnership group meeting?	Yes
2	Are minutes of Maternity Voices Partnership meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback?	Yes
3	Do you have evidence of service developments resulting from coproduction with service users?	Yes
4	Do you have a written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses?	Yes
5	Do you have evidence that the MVP is prioritising the voice of woman from Black Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation as a result of UKOSS 2020 coronavirus data?	Yes

Safety action No. 8

Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
MULTI-PROFESSIONAL MATERNITY EMERGENCY TRAINING, including Covid-19 specific training, including maternal critical care training and mental health & safeguarding concerns training In the current year we have removed the threshold of 90% for this year. This applies to all safety action 8 requirements. We recommend that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible.		
Can you confirm that: Covid-19 specific e-learning training has been made available to the multi-professional team members listed below:		
1	Obstetric consultants	Yes
2	All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota	Yes
3	Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes
4	Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)	Yes
5	Obstetric anaesthetic consultants	Yes
6	All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota	Yes
7	Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)	Yes
8	Can you evidence that 90% of all staff groups in line 1-7 above have attended the the multi-professional training outlined in the technical guidance?	No
9	If the trust has identify any shortfall in reaching the 90% threshold described above in requirement no.8, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions when this is permitted?	Yes
NEONATAL RESUSCITATION TRAINING Can you evidence that the following staff groups involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since launch of MIS year three in December 2019:		
10	Neonatal Consultants or Paediatric consultants covering neonatal units	Yes
11	Neonatal junior doctors (who attend any deliveries)	No
12	Neonatal nurses (Band 5 and above)	No
13	Advanced Neonatal Nurse Practitioner (ANNP)	Yes
14	Midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) Maternity theatre midwives who also work outside of theatres	Yes
15	Can you evidence that 90% of all staff groups in line 10-14 above have attended the the neonatal resuscitation training as outlined in the technical guidance?	No
16	If the trust has identify any shortfall in reaching the 90% threshold described above in requirement no.15, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions once when this is permitted?	Yes

Safety action No. 9

Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a pathway been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions, share safety intelligence between each other, the Trust Board, the LMS and MatNeoSIP Patient Safety Networks?	Yes
2	Do you have evidence that the written pathway is in place, visible to staff and meeting the requirements detailed in part a) and b) of the action is in place by Friday 28 February 2020?	No
3	Do you have evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff?	Yes
4	Are Board level safety champions undertaking monthly feedback sessions for maternity and neonatal staff to raise concerns relating to safety issues, including those relating to COVID-19 service changes and service user feedback?	Yes
5	Was a monthly feedback sessions for staff undertaken by the Board Level safety champions in January 2020 and February 2020?	No
6	Were feedback sessions for staff undertaken by the Board Level safety champions every other month from 30 November 2020 going forward?	
7	Do you have a safety dashboard or equivalent, visible to both maternity and neonatal staff which reflects action and progress made on identified concerns raised by staff and service users? This must include concerns relating to the Covid-19 pandemic.	Yes
8	Is the progress with actioning named concerns from staff workarounds visible from no later than 26 February 2021?	No
9	Has the CoC action plan been agreed by 26/02/2021 and progress in meeting the revised CoC action plan is overseen by the Trust Board on a minimum of a quarterly basis commencing January 2021?	No
10	Has the Board level safety champion reviewed the continuity of carer action plan in the light of Covid-19, taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas? The revised action plan must describe how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve.	No
11	Do you have evidence of Board level oversight and discussion of progress in meeting the revised continuity of carer action plan?	No
Together with their frontline safety champions, has the Board safety champion has reviewed local mortality and morbidity cases has been undertaken and an action plan, drawing on insights from the two named reports and the letter has been agreed		
12	I) Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of COVID-19, drawing on resources and guidance to understand and address factors which led to these outcomes by Monday 30 November 2020?	No
13	II) The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK.	No
14	III) The MBRRACE-UK SARS-COVID19 report	No
15	IV) The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups	No
16	Together with their frontline safety champions, has the Board safety champion considered the recommendations and requirements of II, III and IV on I by Monday 30 November 2020?	No
Do you have evidence that the Board Level Safety Champions actively supporting capacity (and capability), building for all staff to be actively involved in the following areas:		
17	• work with Patient Safety Networks, local maternity systems, clinical networks, commissioners and others on Covid-19 and non Covid-19 related challenges and safety concerns, ensuring learning and intelligence is actively shared across systems	
18	• utilise SCORE safety culture survey results to inform the Trust quality improvement plan	Yes
19	Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event held in March 2020 by 30 June 2021	Yes

Safety action No. 10

Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all outstanding qualifying cases for 2019/2020 been reported to NHS Resolution EN scheme?	Yes
2	Have all qualifying cases for 2020/21 been reported to Healthcare Safety Investigation Branch (HSIB)?	Yes
3	For cases which have occurred from 1 October 2020 to 31 March 2021 the Trust Board are assured that: 1. the family have received information on the role of HSIB and EN scheme: and 2. there has been compliance with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	Yes
4	Have the Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team?	Yes

NHS Resolution

Section A : Please choose your trust in the Guidance tab

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	No
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	No
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	No
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?	No
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes
8	Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?	No
9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	No
10	Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme? a) Reporting of all outstanding qualifying cases to NHS Resolution EN scheme for 2019/2020 b) Reporting of all qualifying cases to Healthcare Safety Investigation Branch (HSIB) for 2020/21	Yes

NHS Resolution

Section B : Please choose your trust in the Guidance tab

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action	Q1 NPMRT	**To be met by**	Q1 2021/22

Work to meet action	*All cases, to ensure parental involvement, are invited to contribute questions through the review process, to be documented within maternity records and on PMRT. For all deaths to continue to be reported via the IPR to Trust board quarterly and to include action plans and learning.*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*Maternity Risk facilitator and Bereavement Lead Midwife*
Lead executive director	*Judy Dyos*
Amount requested from the incentive fund, if required	*2,000*
Reason for not meeting action	*Systems and processes not in place or embedded in practice. Poor implementation of the PMRT.*
Rationale	*New processes in place to ensure ward to board visibility regarding all deaths and learning outcomes within maternity and neonatal services*
Benefits	*Better understanding and cascading of learning throughout department. To provide assurance to the board reagrding activity and learning within the maternity and neonatal department. Parents involvment in the review process to demonstarte openess and transparency. Embedding clear reporting processes to support the governance within the department*
Risk assessment	*Unable to demonstrate a safe and robust service to service users and within the organisation.*

How?	**Who?**	**When?**

Monitoring	PMRT report produced monthly and progress monitored through the materntiy risk meeting. PMRT repors included in Quarterly Quality report for CGC Parental involvement SOP to be finalised	Maternity Risk facilitator	Monthly SOP by 31st August 2021

Action plan 2

Safety action	Q3 Transitional care	**To be met by**	Q1 2021/22

Work to meet action	*From June 2021 monitoring has been undertaken for all term admission to the neontal unit and TC. Monitoring of cases includes specific identification of the impact of: □ closures or reduced capacity of TC □ changes to parental access □ staff redeployment □ changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.Action plan in place to address local findings from ATAIN reviews, action plan shared at monthly safety champion meetings. 1x PA for designated medical neonatal lead to sit on DMT and board safety champions.*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*Geoff Dunning*
Lead executive director	*Judy Dyos*
Amount requested from the incentive fund, if required	*5,000*

Reason for not meeting action	*Review of term admissions to NNU continued via trust SWARM & neonatal Datix process. ATAIN meetings continued through this time but were reduced from the normal 6 per year to only 4 in 2020. No impact from covid-19 was noted at this time only the temporary stop to partners attending for the first month of lockdown in April 2020 so no impacted noted on standards included. However lack of documentation to evidence an audit trail of this does not exist during specific timeframe therefore unable to demonstrate full compliance. However we have monitored redadmission rates for conditions outlined and Salibury NHSFT did not see a rise in these issues compared with 2019.*
Rationale	*The findings & learning points from the ATAIN process where always commuicated and disseminated within maternity as these findings were fed into the perinatal monthly meeting. The head of nursing for the trust has always been included on ATAIN minutes criculation but at the time in question the trust did not have a robust maternity/neonatal safety champions meeting to feed this information into the trust board therefore ensuring that they had oversight of this process.*
Benefits	*During the time in question the trust was reviewing infants in line with national requirments but we did not have a formalised process about feeding into the board which we now have. The clear benefit of this standadised process is that the trust board will now have a more indepth understanding and be able to monitor progress and benefits of this process*
Risk assessment	*Non compliance with ATAIN, CNST. Potential of missed opportunties for learning and identifiying omissions of care*

How?	**Who?**	**When?**

Monitoring	Weekley senior medical staff notes reviews happening for term admissions to NICU by both maternity & neonatal teams	Geoff Dunning, Jim Baird, Charlotte Ashman-Scott & Hannah Rickard ATAIN group	Weekly
	Regular ATAIN meeting with ATAIN group to review admissions pull out & disseminate learning and update	Geoffrey Dunning & Charlotte Ashman-Scott	Monthly
	ATAIN action tracker Real time spreadsheet including term admission info, themes, learning outcomes etc.	Geoffrey Dunning & Charlotte Ashman-Scott	daily & after ATAIN meeting
	Aviodable term admissions to NICU will have Datix filled out and completed	Mary Pedley & Geoffrey Dunning	Weekly Monthly
	Action plan and audit trail to be presented to safety champion meeting	Mary Pedley & Hannah Rickard	Monthly
	Dissemination of learning within maternity service via perinatal meeting		

Action plan 3

Safety action	Q4 Clinical workforce planning	**To be met by**	Q4 2021/22

Work to meet action	*Neonatal Medical workforce non compliant with BAPM standard. To escalate to Trust Board how SFT do not meet the standards required for the Neonatal medical workforce and review according to Redesignation outcome.*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*Rowena Staples*
Lead executive director	*Peter Collins*
Amount requested from the incentive fund, if required	-
Reason for not meeting action	*Non compliant with Neontaal medical workforce standard* *BAPM: Tier 1 Resident out of hours care should include a designated tier one clinician - SFT Tier 1 - 1 doctor covering NICU and general paediatrics (some weekday nights this doctor also covers maternity / gynae when resident consultant for O&G)* *BAPM: Tier 2 A designated experienced junior doctor ST 4-8 or appropriately trained specialty doctor or ANNP SFT: Tier 2 - 1 doctor covering NICU and general paediatrics. At night this is most likely to be covered by a consultant but there are some registrar night shifts and some consultant long day shifts at the weekend*
Rationale	*The purpose of the action plan is to inform the board of why we are not currently meeting the BAPM standard and constraints that surround this.*
Benefits	*nil*
Risk assessment	*Continued non - compliance. Mitigtaion in place to address the risk*

	How?	**Who?**	**When?**
Monitoring	Redesignation process	Rowena Staples	Q3 21/22

Action plan 4

Safety action		**To be met by**	
Work to meet action			
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner			
Lead executive director			
Amount requested from the incentive fund, if required			
Reason for not meeting action			
Rationale			
Benefits			
Risk assessment			

	How?	Who?	When?
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action			
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner			
Lead executive director			
Amount requested from the incentive fund, if required			
Reason for not meeting action			
Rationale			
Benefits			
Risk assessment			

	How?	Who?	When?
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

NHS Resolution

Maternity incentive scheme - Board declaration Form

Trust name Please choose your trust in the Guidance tab
Trust code

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	No	Yes	2,000	
Q2 MSDS	Yes		-	
Q3 Transitional care	No	Yes	5,000	
Q4 Clinical workforce planning	No	Yes	-	You have missing data in your action plan for this unmet safety action, please check
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	No		-	You have not entered an action plan for this unmet safety action, please check
Q7 Patient feedback	Yes		-	
Q8 In-house training	No		-	You have not entered an action plan for this unmet safety action, please check
Q9 Safety Champions	No		-	You have not entered an action plan for this unmet safety action, please check
Q10 EN scheme	Yes		-	
Total safety actions	**4**	**3**		**You have validations on 4 safety actions. Please recheck the tab B (Safety Actions Summary Sheet) and/or tab C (Action plan entry) before discussing with your board and commissioners before submitting this form to NHS Resolution.**
Total sum requested			**7,000**	

Sign-off process:

Electronic signature

For and on behalf of the board of Please choose your trust in the Guidance tab

Confirming that:
The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

Electronic signature

For and on behalf of the board of Please choose your trust in the Guidance tab

Confirming that:
The content of this form has been discussed with the commissioner(s) of the trust's maternity services

Electronic signature

For and on behalf of the board of Please choose your trust in the Guidance tab

Confirming that:
There are no reports covering either **this year (2020/21) or the previous financial year (2019/20)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.

Electronic signature

For and on behalf of the board of Please choose your trust in the Guidance tab

Confirming that:
If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the

Name:
Position:
Date:

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda items:**	6.1
Date of Meeting:	08 July 2021		

Report Title:	Data Security and Protection Toolkit 2020-21 Final Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	Heidi Doubtfire-Lynn Data Protection Officer			
Executive Sponsor (presenting):	Lisa Thomas Director of Finance & Senior Information Risk Owner (SIRO)			
Appendices (list if applicable):	Appendix A			

Recommendations:

The Committee notes this report, and in particular:

- That the Trust has reported one data protection incident to the Information Commissioners Office (ICO) and no action is being taken against the Trust.
- The Trust has submitted a Standards Not Met data security and protection toolkit return on 28th June 2021 which is supported by an improvement plan covering the completion of three assertions in an agreed improvement plan. The national cyber security team approved the plan and amended the Trusts submission status to Standards Not Fully Met (Plan agreed). Work to complete the three outstanding assertions will be finished by December 2021.
- All actions resulting from the PwC audit have been implemented.

Executive Summary:

On the 28th June 2021, Trust has successfully completed 107 of the 110 mandatory and 28 of the mon-mandatory assertions. Therefore, the Trusts Senior Information Risk Owner authorised the submission of a Standards Not Met Toolkit, and a supporting improvement plan attached as Appendix A, which was subsequently approved by the NHS Digital Cyber Security Team with the caveat that its contents is completed in fully by the end of December 2021. The Trusts DSPT publication now states, Standards Not Fully Met (Plan Agreed). This enables the Trust to tender for new services without being penalised.

Board Assurance Framework – Strategic Priorities	Select
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. Introduction and Purpose

1.1 This report has been compiled on behalf of the Senior Information Risk Owner and is the final Data Security and Protection Toolkit (DSPT) report covering the period 1st October 2020 to the 30th June 2021.

1.2 The purpose of this report is to inform the Committee members of the final submission of the DSPT on the 28th June 2021.

1.3 The report provides an update on progress made by the Trust since the release of the V3 DSPT in November 2020, highlights areas of improvement, and any concerns in the Trust's risk management framework.

2. Background

2.1 The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations providing NHS services to measure their performance and compliance against the National Data Guardian's 10 data security standards listed below:

1. Personal confidential data
2. Staff Responsibilities
3. Training
4. Managing Data Access
5. Process Review
6. Responding to Incidents
7. Continuity Planning
8. Unsupported Systems
9. IT Protection
10. Account Suppliers

2.2 The above 10 standards are then segregated into 149 assertions of which 110 are mandatory, and 40 are non-mandatory. All organisations are expected to be compliant with the mandatory requirements by the last working day prior to the 30th June 2021.

2.3 The v3 DSPT contained eighteen (18) new assertion items which became mandatory this year, which primarily focus on providing documentary evidence confirming, audit logs are retained for sufficient periods, unnecessary user accounts are removed, system back up procedures are in place, password configuration has been deployed and enforced, and penetration test completed within the DSPT year and firewalls have been configured appropriately.

2.4 The Trust is not required to conduct a Cyber Essential Plus assessment within this Toolkit year. However, the NHS introduced an Independent Assessment Framework and Scope for Auditors in 2020-21. It is designed to be used with reference to the 'NHS Digital DSP Toolkit Independent Assessment Guide' and the 'NHS Digital DSP Toolkit Independent Assessment Summary'.

2.5 The Independent Assessment Tool provides the Trust and auditors with details of the evidential documentation they would expect to see in support of each Assertion point.

2.6 This year NHS Digital has mandated that the audit scope for 2020-21 reduced, due to the shortened timescale for completing the Toolkit. However, the independent assessments and audits must include the following thirteen (13) Mandatory Assertion points 1.6,1.8, 2.2,3.1,4.2,5.1,6.2,7.2,7.3,8.3,8.4,9.2 and 10.2.

2.7 This report confirms the Trusts Audit schedule for the v3 DSPT has been amended to reflect the national guidance and commenced on the 8th February 2021. The audit findings established that key governance document was not in place for the Information Governance Working Group (IGWG) and meetings and minutes were not retained. This report confirms the IGWG terms of reference and minutes of meets have been approved. Actions, risks and concerns raised at the

IGWG meetings are escalated to the, SIRO and Caldicott Guardian via regular monthly meetings between the CIO and DPO in addition to the DSPT standing performance report to the IGSG.

3. Status

3.1 On the 28th June 2021, Trust has successfully completed 107 of the 110 mandatory and 28 of the mon-mandatory assertions. Therefore, the Trusts Senior Information Risk Owner authorised the submission of a Standards Not Met Toolkit, and a supporting improvement plan attached as Appendix A, which was subsequently approved by the NHS Digital Cyber Security Team with the caveat that its contents is completed in fully by the end of December 2021. The Trusts DSPT publication now states, Standards Not Fully Met (Plan Agreed). This enables the Trust to tender for new services without being penalised.

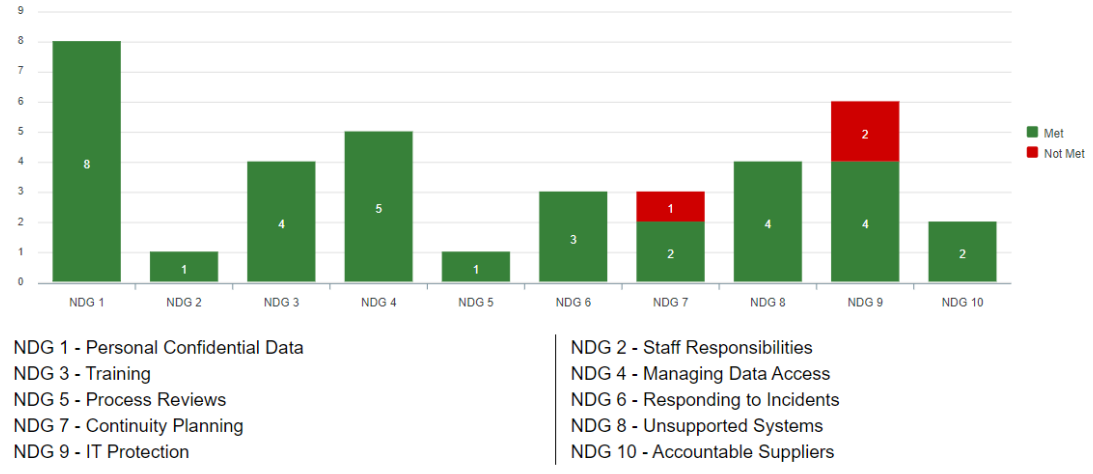
3.2 The detailed actions underpinning the improvement plan will be monitored by the Chief Information Officer to ensure completion and assured through Information Governance Steering Group to the SIRO.

3.3 The outstanding three assertions are:

- 9.2.2 and 9.3.2 – these relate to undertaking a penetration test and having an associated action plan. The Trust understood they were compliant with this assertion. Advice since January 2021 from NHS Digital that the penetration test would be delayed until confirmation of onsite testing was available due to Covid. However differing guidance from NHS Digital was provided in mid May 2021 which has seen the Trust urgently find other arrangements for a penetration test. This is now booked for August 2021.

- 7.3.6 – this requires the Trust to have backups of data stored offline. The Trust is non-compliant as whilst there are backups stored at opposite ends of the site, they remain on the same network. Discussions with our existing 3rd party supplier, has progressed to ensure a solution can be put in place by the deadline. Capital funding was identified to support this indicatively as part of 2021/22 planning however is subject to confirmation of the detailed proposal under development.

3.1 Chart 2 below provides a pictorial view of the Trusts DSPT status, Standard Not Fully Met (Plan Agreed).



NDG 1 - Personal Confidential Data
NDG 2 - Staff Responsibilities
NDG 3 - Training
NDG 4 - Managing Data Access
NDG 5 - Process Reviews
NDG 6 - Responding to Incidents
NDG 7 - Continuity Planning
NDG 8 - Unsupported Systems
NDG 9 - IT Protection
NDG 10 - Accountable Suppliers

Source: https://www.dsptoolkit.nhs.uk/

4. Data Security Incidents External Referred to the Information Commissioner

4.1 This report confirms that during the reporting period, the Trust reported one data protection incident to the Information Commissioners Office (ICO), the Department of Health, NHS England, NHS Digital and NHSX which resulted in no action being taken against the Trust.

4.2 The reported incident related to video footage being taken by an employee.

5. Summary

5.1 The report acknowledges This report also recognises and appreciates

6. Recommendations

6.1 The Committee notes this report, and in particular:

- That the Trust has reported one data protection incident to the Information Commissioners Office (ICO) and no action is being taken against the Trust.

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

- All actions resulting from the PwC audit have been implemented.

Appendix A

19/20 DSP Toolkit Evidence item reference	19/20 DSP Toolkit Evidence item text	Current status of the evidence item (Met/Work on-going/No further work planned)	Has the organisations COVID 19 response prevented completion of this evidence item?	Outstanding actions	Action owner	Completion date for evidence items
7.3.6	Are your backups kept separate from your network ('offline'), or in a cloud service designed for this purpose	Work on-going. Our existing contracted back up solution does not include off-line backups. Backups are separated across computer centres which are the opposite ends of the site however they are still on the same network.	Yes, due to competing priorities within IT operations, discussions around options for offline backups have been delayed.	The Trust is working with our third party supplier ANS to look at instigating a routine tape backup solution with off-site storage of these. An action plan has been developed with ANS to support the implementation of this.	Richard Gibson, IT Operations Manager	30/12/2021
9.2.2	The date the penetration test and vulnerability scan was undertaken.	Work On-going. The Trust was given incorrect guidance by NHS Digital since January as to the requirement of this assertion given Covid restrictions. Differing advice was given mid May so the Trust has urgently commenced arranging a penetration test.	No	The penetration test has been booked for the 9th-11th August, with feedback and an action plan to be produced after this	Richard Gibson, IT Operations Manager	30/09/2021
9.3.2	As per 9.2.2	As per 9.2.2	As per 9.2.2	As per 9.2.2	As per 9.2.2	As per 9.2.2

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda items:**	6.2
Date of Meeting:	08 July 2021		

Report Title:	Senior Information Risk Owner Quarterly Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		x	
Prepared by:	Heidi Doubtfire-Lynn, Data Protection Officer (DPO) Jon Burwell, Chief Information Officer (CIO)			
Executive Sponsor (presenting):	Lisa Thomas, Director of Finance			
Appendices (list if applicable):	n/a			

Recommendations:

The Committee notes this report, and in particular:

- That the Trust's SIRO is satisfied that additional risks introduced by the Trust's COVID response are proportionate and managed appropriately.
- The Trust's Freedom of Information compliance has risen by 2% between November 2020 and the end of January 2021 and now stands at 76% against the 90% target. The aim is to get back to compliance by December 2021.
- That the Trust has reported one data protection incident to the Information Commissioners Office (ICO) and no action is being taken against the Trust.
- The Trust has submitted a compliant data security and protection toolkit return on 30th June 2021 subject to the completion of three assertions in an agreed improvement plan. The DSPT has been approved by the SIRO (Director of Finance) with the DPO and CIO (as deputy SIRO) undertaking the necessary due diligence. The detailed actions underpinning the improvement plan will be monitored by the Chief Information Officer to ensure completion and assured through Information Governance Steering Group

Executive Summary:

This report is the quarterly SIRO update, providing an update on progress made by the organisation from February 2021 to 1st June 2021. It highlights areas of improvement, and any concerns in the Trust's compliance with statutory regulations that are overseen by the Information Commissioner's Office (ICO) and the mandatory cyber security programme that is overseen by NHS Digital via the Data Security and Protection Toolkit.

The SIRO is satisfied that additional risks introduced by the Trust's COVID response are proportionate and managed appropriately. A number of risks have been also accepted as going into business as usual rather than specifically associated with COVID given the positive impact they have had.

The Trust's Freedom of Information compliance has risen by 2% between November 2020 and the end of January 2021 and now stands at 76% against the 90% target. The IG team continues to remind departments of deadlines and supports where possible to complete FOI by the deadline. The aim is to get back to compliance by December 2021.

This report confirms that during the reporting period, the Trust reported one data protection incident to the Information Commissioners Office (ICO), the Department of Health, NHS England, NHS Digital and NHSX which resulted in no action being taken against the Trust.

The report confirms the Trust will be submitting a compliant DSPT submission, however it does include an improvement plan for three assertions (one for offline backup storage and two associated with the annual penetration test). The improvement plan submitted can be seen in Appendix A and aims to be in place within the required six months.

Windows 10 remains a priority project as it will mitigate a range of cyber risks. Extended support has been procured from Microsoft to ensure there is sufficient risk mitigation until the roll out has been completed. 14 other projects are underway as part of cyber essentials to upgrade systems and remove the reliance on unsupported operating systems. Governance and oversight of key performance indicators relating to IT operational performance and security has been refreshed over the last two months.

Board Assurance Framework – Strategic Priorities	Select
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. Introduction and Purpose

1.1. This report is the quarterly SIRO report, providing an update on progress made by the organisation since the last report in February 2021. It highlights areas of improved compliance, and areas of concern within the Trust's compliance with statutory and regulatory standards overseen by the Information Commissioner's Office (ICO).

1.2. In addition, the report provides an update on progress made in respect of our mandatory cyber security programme and the 2020-2021 Data Security and Protection Toolkit which is overseen by NHS Digital.

2. Current risk level

2.1. The number of open risks requiring oversight by the SIRO has reduced slightly since February 2021. 5 of the risks opened as a direct result of Covid have been accepted

and closed. These risks related to potential IG risks associated with new activities to support patient care and patient experience such as “send a message to a loved one”. With these activities expected to continue longer term it has been agreed with the SIRO that the risks should be accepted and closed. The allocation of risks being monitored by the SIRO is being reviewed with Divisions to ensure they understand the need for highlighting information governance/security risks accurately.

2.2. This report confirms the Informatics department has one critical risk scoring above twelve. Confirmation of actions taken will appear in the next IGSG Risk Report if not reviewed before the 30th June 2021.

2.3. This report confirms 12 of the IGSG risks relate to cyber security. These are being overseen by the Cyber Security Team. Progress has been made regarding Care CERT compliance with the initial risk rating of 15 in March 2020 has now reduced to 10 following a concerted effort by the Team, who continue to improve working practices and the management assets. The weekly “Tech Group” (operational oversight group chaired by the IT Operations Manager) has been reviewed with refreshed terms of reference to ensure the correct focus and monitoring is provided to drive down cyber security risks. The IT Health Assurance Dashboard forms a key part of the oversight and will be used also for upward assurance. The Trust is working with the supplier to streamline the production of appropriate dashboards.

2.4. The risk of a cyber or ransomware attack logged on the Trust’s Board Assurance Framework currently scored 10 against a target of 6.

2.5. In November 2021, the Transformation, Innovation and Digital Board approved the pausing of technical elements of the cyber essentials programme until January 2021. This was recognising the focus on Covid activities and other priority digital programmes. Work has now recommenced on the project with a capital funding in 2021/22 allocated to support the removal of around 70% of unsupported servers.

2.6. The Windows 10 project is c.70% complete with a projected completion timeframe of mid-August 2021. The project has been delayed over the last month with Covid isolations and sickness however increased resources are in place to reduce the risk of further delay wherever possible. Monthly calls are in place with NHS Digital to monitor progress with the Chief Information Officer, who also oversees progress daily given the importance of no further delays. The Trust has procured an additional year’s worth of Windows 7 extended support to mitigate the cyber risks whilst the roll out is complete.

2.7. Alongside Windows 10, the Trust is also commencing the Office 365 roll out which must be complete by October 2021. The project will be run in phases with phase 1 being core programmes (Work, Outlook, Excel, PowerPoint). An ICS working group is in place to align rollout principles, training and uses wherever possible. An addendum to the original N365 business case is being presented in July 2021 with a recommendation to extend the desktop licence numbers to cover all staff. The expected need has been established due to having a clearer understanding of how the cloud tenant licencing will work with technologies such as virtual desktop infrastructure.

2.8. COVID associated risks continue to be routinely monitored reviewed and where appropriate closed. Since the last report four (4) additional COVID related risks have been added to the risk register. This now brings the number up to 14. These are broken down as (risk scores of 16(x1) 12 (x1) 9 (x1), 8 (x1) 6 (x8), 4(x1), 3 (x1) and 2(x1)).

3. COVID-19 Risks

4. Freedom of Information Compliance

4.1. The ICO has mandated that authorities must respond to 90% of requests within 20 working days. The Trust is currently operating compliance level has risen by 2% between November 2020 and the end of January 2021 stands at 76%. The Trust's Freedom of Information compliance has risen by 2% between November 2020 and the end of January 2021 and now stands at 76%. The IG team continues to remind departments of deadlines and supports where possible to complete FOI by the deadline. The aim is to get back to compliance by December 2021.

4.2. 88 requests have been responded to between 1st February and 7th June 2021. A total of 20 refusal notices have been issued sighting, Section 43 (commercial Interests) for three, a Section (40) absolute exemption (personal data), a further 15 had a Section 38 (health and safety exemption) applied, whilst the remaining one was refused under Section 31 (law enforcement).

5. Mandatory GDPR, Information Governance and Cyber Security Training

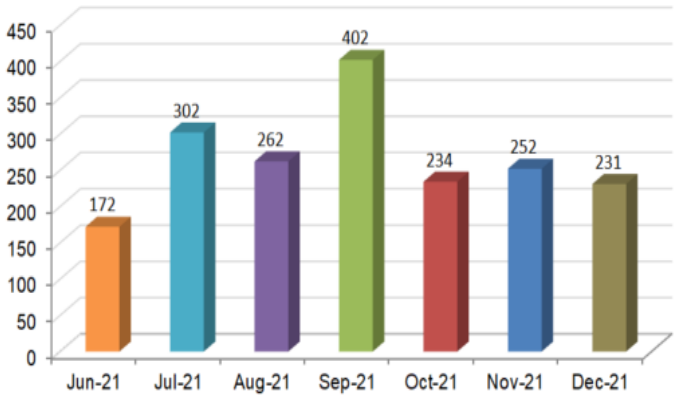
5.1. This report confirms that the Trust has already achieved the 2020/21, 95% standard on the 1st October 2020, which meets the terms and conditions of the DSPT.

5.2. The current mandatory training compliance levels, as of the June 2021 shows the overall level of compliance for permanent full and part time staff defined in Standard 3[1] of the 2020-21 Data Security and Protection Toolkit currently stands at 84% a fall of 11% since 1st October 2020 against a threshold of 95%.

5.3. Additional training continues to been prioritised and performance is overseen by the Operational Management Board (OMB) on a monthly basis with daily chasing by the IG department and weekly compliance reports to all management teams in the Trust.

5.4. This report confirms that between June and December 2021, 1,855 employees training will expire. Chart 1 right illustrates the expiry of training by month until the end of the year. The peak in September 2021 reflects the efforts made last year to achieve the 95% prior to the 2019-20 DSPT submission at the end September 2021.

Chart 1: GDPR, IG and Cyber Security Training Expiry



5.5. This report confirms that the Trust Board Members[2] compliance remains at 100%.

6. Specialist Information Asset Owner (IAO) and Information Asset Administrator (IAA) Identification and Training

6.1. Each of our information 'assets' (systems, record stores regardless of whether electronic or paper) require a named IAO. Some IAOs have an IAA to assist them discharge their responsibilities.

6.2. The Trust currently has 15 designated Information Asset Owners/Directorate and Service Managers (IAOs) and 125 Information Asset Administrators (IAAs) supporting them.

[1] https://www.dsptoolkit.nhs.uk/

[2] DSPT 2019-20 3.4.2 What percentage of the Board Members have completed appropriate data security and protection training

6.3. The number of assets recorded on the resister has decreased by three, which is still 22 higher than reported in December 2019. 68 of the assets have been graded as operationally critical to the Trust.

6.4. All assets logged on the Trust's information asset register have Information Asset Owners assigned, which is a mandatory requirement. All operational systems now have assigned owners and administrators.

6.5. The disruption from Covid-19 has impacted on the Trusts ability to refresh information asset documentation and tasks carried out by clinical operational staff. However, the deferral of the DSPT 2020/21 reporting to the 30th June 2021 provides additional time to complete the tasks.

6.6. As of the 15th February 2021, the IG department has received 30% of the documentary evidence for the 70 critical assets, whilst 72% of the remaining one hundred and ninety nine assets remain outstanding. Work continues to support and gather this evidence prior to the 30th June 2021.

6.7. In recent months 82% of the 269 information asset contents have been reviewed, analysed and categories to assess the sensitivity of the data held within them. The analysis thus far, unsurprisingly indicates that 107 assets hold highly sensitive personal data, 36% contain personal data categorised as medium to low risk, and the remaining 20% (49) include no personal data, and present minimal risk to the Trust from a data protection and confidentiality perspective. Work continues to complete the remaining 18% in the coming months and will form part of the overall risk profile for each asset and further details will incorporated into this report.

7. Subject Access Requests (SARs)

7.1. The Trust's organisational oversight of the number of SARs being processed has improved since the advent of GDPR in 2018. All departments releasing and handling SAR requests maintain statistical compliance information which is incorporated into an overarching disclosure compliance report to IGSG measuring the trends, number of complaints received, in addition to lessons learnt and action taken.

7.2. The Trust has received four SAR related complaints during the preceding seven months. Three related to additional information being included in the information released and are being internally managed. The most recent complaint arose when an email delivered to a member of staffs email account in November 2020, failed to be actioned until a complaint was received by the individual's solicitor in late January 2021.

8. Data Protection Impact Assessments (DPIAs)

8.1. A Data Protection Impact Assessment (DPIA) is a process mandated under the GDPR Articles 35 and 36 to help the Trust identify and minimise data protection risks.

8.2. At the time of writing, 31 DPIAs have been signed off since February 2021. The number of DPIAs 'in progress' has fallen to 9 from 21 in the same period. There has been an increase in the number of DPIAs being completed – 29 in 2018, 38 in 2019, and 92 in 2020 and so far 31 in 2021 (including No DPIA required and No longer required). Presently the Trust has 50 DPIAs on the DPIA Register which includes 8 from 2020.

8.3. This report confirms the Data Protection Officer sought advice and guidance from the Information Commissioners Office (ICO) once since October 2020 to date.

9. Security and Confidentiality Incidents Reported to the ICO

9.1. This report confirms the Trust voluntarily referred itself to the ICO for investigation following a patient safeguarding and privacy incident. The ICO considered the supporting information provided by the Trust, and concluded no further action would be necessary on this occasion. This incident is being investigated by the Police, Organisational Development & People, and externally reported in compliance with the NHS Serious Incident Framework which is designed to support learning and prevent recurrence of harm[3].

10. Systems providing patient care

10.1. Under the Security of Network & Information Systems Regulations (NIS)[4], the Trust is required to report system outages which significantly affect patient care to the ICO within the same 72 hour statutory timeframe as GDPR. Organisations failing to report a significant event could potentially result in a monetary penalty or enforcement notice being issued in line with GDPR.

10.2. A 'significant event' is defined under the NIS Regulations as an unplanned event which prevents and disrupts service users/the public and employees from accessing, using a service or system. The severity of the incident is calculated from the number of users affected; the duration of the disruption; and the size of the geographical area affected.

10.3. There have been no unplanned NIS reportable outages within the Trust from January 2020 to date.

11. Consent and fair processing – electronic communications

11.1. In Quarter 2 2019/20 the IG team conducted an audit to assess our compliance with regulations under the Privacy and Electronic Communications Regulations (PECR). The audit confirmed that the Trust's external website and subordinate sites did not comply with the ICO Code of Practice: Use of Cookies and Similar Technologies guidance or GDPR consent requirement. The risk of non-compliance is overseen by the Chief Information Officer, and has a score rating of nine (9), logged as a risk on the Trust's risk management system.

11.2. Achieving PECR compliance ran alongside two other goals of achieving accessibility and security compliance. Therefore, the CIO had input from web development, cyber security and the IG team. Progress against compliance is overseen by the Web Development Group on behalf of the Trust.

11.3. The Trust has taken a policy of where appropriate, to work with services to redevelop microsites in house recognising this provides the greatest assurance on compliance, with the in-house development team utilising the same modern technology used for the Trust's website. Three websites have already been migrated or are in the process of being so. The My Trusty website has been migrated out of the ownership of the Trust directly as part of this compliance process.

11.4. The project to review the options for the Trust's intranet is underway led by the Communications department. As part of this one option is the development of the intranet using SharePoint 2019 which is part of the N365 contract. If agreed as the option to progress with as for the underlying programme, then this would provide the potential of having a secure intranet available to all staff on any device via their NHS mail login. Agreement on the appropriate technology and kick off of the project is expected to be in July 2021.

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[3] NHS England Serious Incident Framework: https://www.england.nhs.uk/patient-safety/serious-incident-framework/

[4] https://www.legislation.gov.uk

12. Salisbury NHS Foundation Trust's Data Security and Protection Toolkit (DSPT) 2020-21 v3 Compliance 15.02.2021

12.1. The v3 DSPT contained eighteen (18) new assertion items which became mandatory this year, which primarily focus on providing documentary evidence confirming, audit logs are retained for sufficient periods, unnecessary user accounts are removed, system back up procedures are in place, password configuration has been deployed and enforced, and penetration test completed within the DSPT year and firewalls have been configured appropriately.

12.2. The Trust is not required to conduct a Cyber Essential Plus assessment within this Toolkit year. However, the NHS introduced an Independent Assessment Framework and Scope for Auditors in 2020-21. It is designed to be used with reference to the 'NHS Digital DSP Toolkit Independent Assessment Guide' and the 'NHS Digital DSP Toolkit Independent Assessment Summary'.

12.3. The Independent Assessment Tool provides the Trust and auditors with details of the evidential documentation they would expect to see in support of each Assertion point.

12.4. This year NHS Digital has mandated that the audit scope for 2020-21 reduced, due to the shortened timescale for completing the Toolkit. However, the independent assessments and audits must include the following thirteen (13) Mandatory Assertion points 1.6,1.8, 2.2,3.1,4.2,5.1,6.2,7.2,7.3,8.3,8.4,9.2 and 10.2.

12.5. This report confirms the Trusts Audit schedule for the v3 DSPT has been amended to reflect the national guidance and commenced on the 8th February 2021. The audit findings established that key governance document was not in place for the Information Governance Working Group (IGWG) and meetings and minutes were not retained. This report confirms the IGWG terms of reference and minutes of meets have been approved. Actions, risks and concerns raised at the IGWG meetings are escalated to the SIRO and Caldicott Guardian via regular monthly meetings between the CIO and DPO in addition to the DSPT standing performance report to the IGSG.

- The Trust has sufficient evidence in place to meet all bar three mandatory assertions within the DSPT's 10 standards, these being covered as part of an improvement plan. The improvement plan is acceptable as part of a DSPT submission if the Trust can look to be compliant within 6 months of submission. The improvement plan submitted can be seen in Appendix A. The detailed actions underpinning the improvement plan will be monitored by the Chief Information Officer to ensure completion and assured through Information Governance Steering Group

12.6. The three assertions are:

- 9.2.2 and 9.3.2 – these relate to undertaking a penetration test and having an associated action plan. The Trust understood they were compliant with this assertion. Advice since January 2021 from NHS Digital that the penetration test would be delayed until confirmation of onsite testing was available due to Covid. However differing guidance from NHS Digital was provided in mid May 2021 which has seen the Trust urgently find other arrangements for a penetration test. This is now booked for August 2021.

- 7.3.6 – this requires the Trust to have backups of data stored offline. The Trust is non-compliant as whilst there are backups stored at opposite ends of the site, they remain on the same network. Discussions with our existing 3rd party supplier has progressed to ensure a solution can be put in place by the deadline. Capital funding was identified to support this indicatively as part of 2021/22 planning however is subject to confirmation of the detailed proposal under development.

13. Cyber security audits and reviews

13.1. The Trust has worked with Templar Executives to review its policies which were previously under a single IG Framework. This has resulted in the creation of 18 smaller policies covering the key aspects of cyber security and information governance, aligned with national best practice. 8 of these policies have been reviewed internally and approved (ratification in July 2021 at OMB) with the remainder being completed in the next two months.

13.2. The Trust's password policy now complies with the NHS Mail and N365 defines within the central contract. The Trust internal procedures, automatically identifies compromised passwords, users are then required to rest them. The Windows 10 roll out continues to improve oversight of software versions, security patch identification and deployment. The Cyber Essential programme will replace and decommission unsupported servers. The DSPT assertion associated with unsupported operating systems requires the Trust to ensure appropriate oversight and assurance up to the SIRO of progress and continued risk mitigation in place. This is achieved through the Transformation, Innovation and Digital Board (projects) and Information Governance Steering Group.

13.3. As part of the annual cyber security awareness programme, on-line Cyber Security training has been issued to Informatics staff, IAO and IAA. The due date for completion is 30th November 2021. Further online awareness training has also been sent to staff who entered details into the annual phishing exercise ran in conjunction with NHS Digital.

14. CareCERT/ATP compliance

14.1. The CareCert notification previously commissioned by NHS Digital to offer advice and guidance to health and social care organisations to respond effectively and safely to cyber security threats, has now been superseded by the introduction of Microsoft Defender Advanced Threat Protection (ATP). ATP monitors the Microsoft Windows operating system on a PC, laptop or server to identify any indicators of cyber security comprise or attack, it can then take immediate action to address the problem before it spreads. It also alerts local system managers and the DSC.

14.2. Threat intelligence bulletins are issued by NHS Digital weekly via email when assessed as medium or low severity. High severity threats, are immediately sent to organisations, rather than waiting for the weekly bulletin. Specific, local threats to individual organisations are also provided when identified. There is an expectation that all Microsoft vulnerabilities will be actioned and completed within the specified 14 day time frame.

14.3. Timescales for resolving high, medium and low CareCERT advisories are rarely set by NHS Digital, however when they are, the Trust reports on progress through the NHS Digital portal. Where organisations are not able to meet set timescales, mitigations are reported through the portal and approved by the SIRO and CEO.

14.4. The recently installed IT Health Assurance Dashboard shows that the Trust has 227 outstanding risks, up from 205 in the last report. The dashboard now forms a key component of the refreshed Tech Group meetings reviewed fortnightly to ensure progress is made to reduce overall cyber risk to the Trust. The supplier is actively working the Trust to improve the usefulness of the dashboard and provide improve analytics to support highlighting any anomalies and themes.

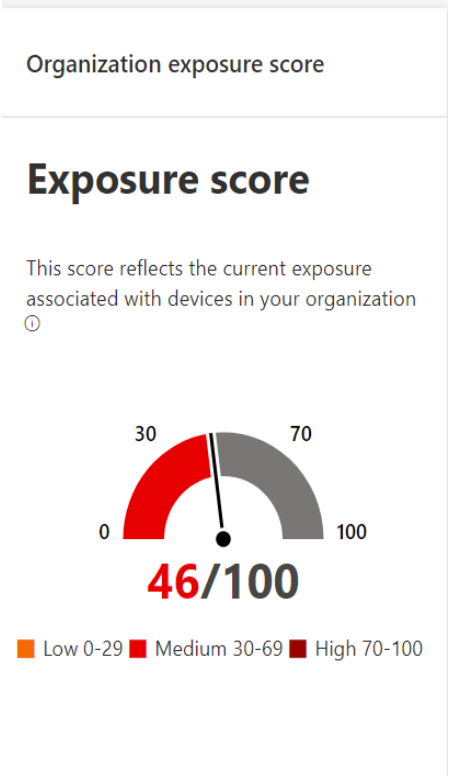
14.5. As Windows 10 is rolled out, a number of CareCERTs will also be closed given this cleanses the existing environment and versions of software we use. The members of the cyber security team who have been supporting the Windows 10 team are expected to be released back to focus on purely cyber security from September 2021. They will

continue to own the processes for ensuring then Trust maintains the improved position on CareCERT compliance, patch deployment and provide onward assurance.

15. Advanced Threat Protection

15.1. Microsoft Advanced Threat Protection (ATP) provides the Trust with better cyber security protection. It is linked to the NHS Digital Data Security Centre (DSC).

15.2. ATP remotely monitors the Microsoft Windows operating system on a PC or laptop to identify any issues, and alerts local system managers and the DSC. These alerts give a NHS wide view of system status, to device level, in real time. The DSC can more quickly and effectively coordinate the overall NHS response to cyber threats as they happen.



15.3. Local organisations continue to be responsible for managing their own devices and will lead on any intervention necessary. The DSC responds to any threat identified in a local system, alerting and making recommendations to the organisation to reduce, or remove, any actual or potential risks.

15.4. The previous quarter's report confirmed that the Trust had successfully deployed ATP to all laptops, workstations and servers and is monitoring this on a monthly basis comparing it to active directory. A key component of the exposure score relates to Windows 10 migration hence the importance this. Where new risks are identified by ATP (or other source such as Sophos prior to this), these are reviewed by local teams and where appropriate, third party suppliers, tested and applied as soon as practically possible. This will be prioritised dependant on expected risk level.

15.5. Image 3 right denotes the current position within the ATP. Source: https://securitycenter.windows.com/dashboard

16 Cyber Essentials Plus

16.1 Cyber Essentials Plus is a standard that all health and care organisations are expected to achieve with the DSPT providing assurance on this (rather than direct accreditation required). The main requirements relate to firewalls, secure configuration, user access controls, malware protection and patch management.

16.2 As highlighted earlier in the report, the programme has been delayed however the project has recommenced with 14 separate upgrades planned for this financial year alongside larger projects such as Windows 10.

16.3 Resource has commenced to improve IT General controls with particular focus on standard operating procedures compliance and monitoring.

16.4 An options paper will be presented on the future of iPM and Symphony (the Trust's old patient administration system and ED system respectively). A review of paper records will be undertaken prior to this to consider whether sufficient information is held in this format to remove the need to maintain these two systems. Through Windows 10, the devices with

these programmes on are now under 10 devices (mainly in medical records for subject access requests and destruction activities).

17 Recommendations

17.1 The Committee notes this report, and in particular:

- That the Trust's SIRO is satisfied that additional risks introduced by the Trust's COVID response are proportionate and managed appropriately.

- The Trust's Freedom of Information compliance has risen by 2% between November 2020 and the end of January 2021 and now stands at 76% against the 90% target. The aim is to get back to compliance by December 2021.

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7.3.6	Are your backups kept separate from your network ('offline'), or in a cloud service designed for this purpose	Work on-going. Our existing contracted back up solution does not include off-line backups. Backups are separated across computer centres which are the opposite ends of the site however they are still on the same network.	Yes, due to competing priorities within IT operations, discussions around options for offline backups have been delayed.	The Trust is working with our third party supplier ANS to look at instigating a routine tape backup solution with off-site storage of these. An action plan has been developed with ANS to support the implementation of this.	Richard Gibson, IT Operations Manager	30/12/2021
9.2.2	The date the penetration test and vulnerability scan was undertaken.	Work On-going. The Trust was given incorrect guidance by NHS Digital since January as to the requirement of this assertion given Covid restrictions. Differing advice was given mid May so the Trust has urgently commenced arranging a penetration test.	No	The penetration test has been booked for the 9th-11th August, with feedback and an action plan to be produced after this	Richard Gibson, IT Operations Manager	30/09/2021
9.3.2	As per 9.2.2	As per 9.2.2	As per 9.2.2	As per 9.2.2	As per 9.2.2	As per 9.2.2