QUALITY ACCOUNT

2019 – 2020

Patient-centred & Safe
Professional
Responsive
Friendly

Outstanding **every** time

Quality account 2019 – 2020 contents

Priority 1 – Work with our partners to prevent avoidable ill health & reduce health inequalities

Smoking screening

83% (19/20)

82% (18/19)

(Target 80%)

Smoking brief advice and NRT offered

91% (19/20)

92% (18/19)

(Target 90%)

Alcohol screening

80% (19/20)

77% (18/19)

(Target 80%)

Alcohol brief advice

92% (19/20)

89% (18/19)

(Target 90%)

mencap – The voice of learning disability

Treat me well

'Treat me well' campaign launched with **Mencap** in June 19 at **'Here we are'** event

- Patients were able to familiarise themselves with the hospital layout and
- Learn about reasonable adjustments they are entitled to

Antibiotic prescriptions

Best practice for lower urinary tract infection in older people

51% (19/20)

(Target 90%)

Antibiotic prescriptions

Prevention for patients having elective colorectal surgery

76% (19/20)

(Target 90%)

Priority 2 – Reduce avoidable patient harm by 50% over 3 years (2019 – 2021)

Patients over 65 receiving 3 key falls prevention measures

34% (19/20)

Target 80%

High harm falls in hospital

24 (19/20) **36** (18/19)

Inpatient sepsis screening

100% (19/20) **84%** (18/19)

Inpatient sepsis treatment

55% (19/20) **67%** (18/19)

Target 90%

100%

of patients had their vital signs scored and recorded

MRSA blood stream infections

0 cases (19/20) **3 cases** (18/19)

Escalated to doctor (recorded)

83% (19/20) **73%** (18/19)

Target 95%

Lowest gram negative blood stream infections in the region

Priority 3 – Work with our partners to improve patient flow through the hospital

This year we updated our patient flow improvement programme & relaunched it as **'Ready, Steady, Go'** & measure key elements of the SAFER care bundle

Consultant review within 14 hours of admission

90% (19/20)

Target 90%

Early discharge before midday

16% (19/20)

Target 33%

Home as the preferred place of care at end of life

109 (69%) patients (19/20)

36 (62%) patients (18/19)

Emergency laparotomy best practice (new 2019)

71%

(Q1-Q3 19/20)

Target 80%

Chronic obstructive pulmonary disease best practice

70% (Q1- Q3 19/20) **57%** (18/19)

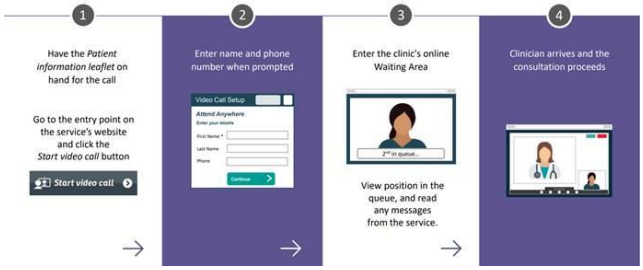
Target 60%

Priority 4 - Design new models of care to provide patients with more convenient access to services & make the most of digital care

Older Person's Assessment and Liaison team
OPAL

Discharged
910 (43%) (19/20)
588 (42%) (18/19)
patients on the same day

Attend anywhere – we have introduced 'Attend Anywhere' outpatient clinics so that patients can speak to a doctor or nurse in the comfort of their own home



- More 'one stop' clinics – tests & consultation at the same clinic
- Digital apps – a tool for patients to self-manage their condition
- 'Consultant Connect' - instant telephone advice while the patient is with the GP

Target 75%

Same Day Emergency Care (19/20)

95%
for patients with a pulmonary embolus

94%
for patients with atrial fibrillation

90%
for patients with community acquired pneumonia

Priority 5 – Improve the health & wellbeing of our staff

Quality Improvement Launched

37 coaches trained

Staff vacancy rate

1.21% (19/20)
6.93% (18/19)
Target 5%

Access to learning & development

Apprenticeship Training

90 people (19/20)
10 people (18/19)

I've had my **Flu Jab**

80%
of our staff had the flu vaccine
Target 80%

Quality Account

Introduction

Quality accounts, which are also known as quality reports, are annual reports for the public that detail information on the quality of services the Trust provides for patients. They are designed to assure patients, families, carers, the public and commissioners that the Trust regularly scrutinises the services it provides and concentrates on those areas that require improvement.

Quality accounts look back on the previous year's performance explaining where the Trust is doing well and where improvement is needed. They also look forward, explaining the areas that have been identified as priorities for improvement as a result of consultation with patients and the public such as the Warminster Health, Wellbeing and Social Care Forum, our staff and governors in 2019/2020.

Part 1

Our commitment to quality - the Chief Executive's view

I am proud to introduce the 2019/2020 quality account for Salisbury NHS Foundation Trust, in what has been an exciting and busy time in my third year here in Salisbury.

This year has again been a challenging year, with unrelenting pressure on our services along with the national emergency caused by coronavirus (COVID-19), but despite the challenges we have faced, when we take the time to reflect on the year there is a lot that that we can be extremely proud of.

We have achieved a great deal this year. In March 2019, the CQC gave us a rating of 'good' overall following their inspection in December 2018, as a result of our continued dedication, compassion and professionalism. This was a fantastic achievement and an important milestone in our improvement journey to deliver our vision of providing an outstanding experience for our patients. We will continue to strive to make improvements where the CQC said we could and should.

Our ambition now, is to be rated as an outstanding Trust, and we will do this by listening to our patients and stakeholders and act on their feedback to continually improve the care we provide and support transformation and innovation. I was delighted that some of our patients have told their story at the Board this year, so that we heard first-hand, their experiences to help us continue our improvement journey.

Throughout the year, the work of our staff has also continued to be recognised in local, regional and national awards – raising the profile of our hospital and highlighting the quality of care we provide for our patients. Our patients have also shown their appreciation through surveys, letters and compliments.

We have made significant progress with our ambitious transformation plans and worked to build a culture of continuous improvement and, above all, we have continued to strive for high quality and safe care for our patients, 24 hours a day.

This year, we performed well on national quality and operational standards by making improvements in the emergency care pathway. We were able to do this with greater involvement of our community and social care partners in the redesign of patient pathways to provide patients with the best possible care in the most appropriate setting.

Next year, promises to be challenging, but with exciting opportunities to develop even further our partnerships with B&NES, Swindon and Wiltshire Sustainability and Transformation Partnership (BSW STP) and Primary Care Networks to ensure our patients benefit from integrated pathways through whole

system working. Since this quality account was produced and priorities consulted on with key stakeholders the world has changed drastically due to the COVID 19 pandemic. The reset of services from this will play a key part of our work next year and may have an impact on the priorities in 2020/21, particularly if we experience more waves of the disease. We look forward to continuing to build on the successes of this year, strengthening our partnership working and working towards our ambition to provide an outstanding experience for every patient.

To the best of my knowledge the information in this document is accurate.

Cara Charles-Barks
Chief Executive
4 June 2020

On behalf of the Trust Board,
4 June 2020

Part 2A: Priorities for improvement and statements of assurance from the Board

This section of the quality account describes the progress made against the priority areas for improvements identified in the 2019/2020 quality account and our priorities for 2020/2021. It includes why the new priorities have been chosen, how the Trust intends to make the improvements and how it plans to measure them. It also sets out a series of statements of assurance from the Board on key quality activities and provides details of the Trust's performance against core indicators.

2.1 Progress against the priorities in 2019/2020

These priorities were identified by speaking to patients, families and carers, the public, our staff and governors, Warminster Health, Wellbeing and Social Care Forum, our partners, local GPs and our commissioners through face to face meetings and surveys.

The Trust's priorities in 2019/2020 were:

Priority 1 Work with our partners to prevent avoidable ill health and reduce health inequalities.

Priority 2 Reduce avoidable patient harm by 50% over 3 years (2019 – 2021).

Priority 3 Work with our partners to improve patient flow through the hospital.

Priority 4 Design new models of care to provide patients with more convenient access to services and make the most of digital care.

Priority 5 Improve the health and wellbeing of our staff.

2.2 Quality priorities in 2020/2021

A similar process has been used to identify the quality priorities for 2020/2021. These priorities fit with our strategic objectives and were considered by the Clinical Governance Committee and recommended to and agreed by the Trust Board. We have also taken into consideration the NHS Long Term Plan, the B&NES, Swindon and Wiltshire Sustainability and Transformation Partnership (STP) and our clinical strategy, our corporate risk register and quality concerns in deciding our quality priorities to ensure we continue to provide an outstanding experience for every patient.

The Trust's quality priorities for 2020/2021 are:

Our Trust quality priorities link to our strategic objectives:

Priority 1 Work with our partners to prevent avoidable ill health
(Strategic objective: innovation and local services)

Priority 2 Introduce the new national patient safety strategy to reduce avoidable harm
(Strategic objective: care)

Priority 3 Work towards the implementation of the national learning disability improvement standards
(Strategic objective: care and local services)

Priority 4 Work with our partners to value patient's time by ensuring that they are only in hospital when necessary
(Strategic objective: innovation, local services, specialist services)

What we did in 2019/2020:

The numbered points below indicate the quality priorities set for 2019/2020; the paragraph that follows is the progress made towards their achievement.

Priority 1 Work with our partners to prevent avoidable ill health and reduce health inequalities

Description of the issue and reason for prioritising it:

The NHS Long Term Plan sets out new commitments for action that the NHS must take to improve prevention of avoidable illness and its exacerbations. It does so whilst recognising that a comprehensive approach to preventing ill health also depends on action that only individuals and communities can take to tackle the wider threats to health. The Global Burden of Disease study https://doi.org/10.1016/S0140-6736(18)32207-4 quantifies and ranks the contribution of various risk factors that cause premature death in England. The top five are 1) smoking 2) poor diet 3) high blood pressure 4) obesity and 5) alcohol and drug use. Lack of exercise is also significant.

The role of the NHS includes secondary prevention by detecting disease early, preventing deterioration of health and reducing symptoms to improve quality of life. The NHS Long Term Plan sets out practical action to do more to use the thousands of contacts we have with patients as positive opportunities to help people improve their health.

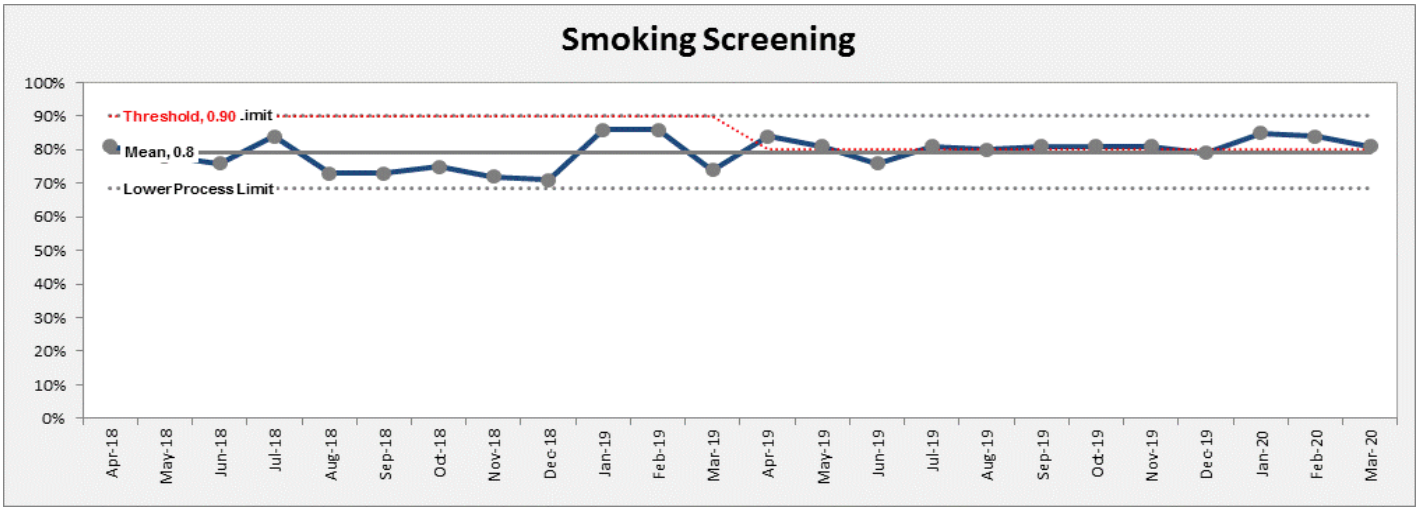
What we did in 2019/2020:

1.1 Increase the number of adult patients admitted to hospital who are screened for smoking and alcohol use and are given very brief advice to 80% by March 2020

Smoking is England's biggest preventable cause of death, causing nearly 80,000 premature deaths a year and a heavy toll of illness. People who stop smoking reduce the risk of heart disease, stroke and cancer. It can also help to reduce wound infections and improves wound and bone healing.

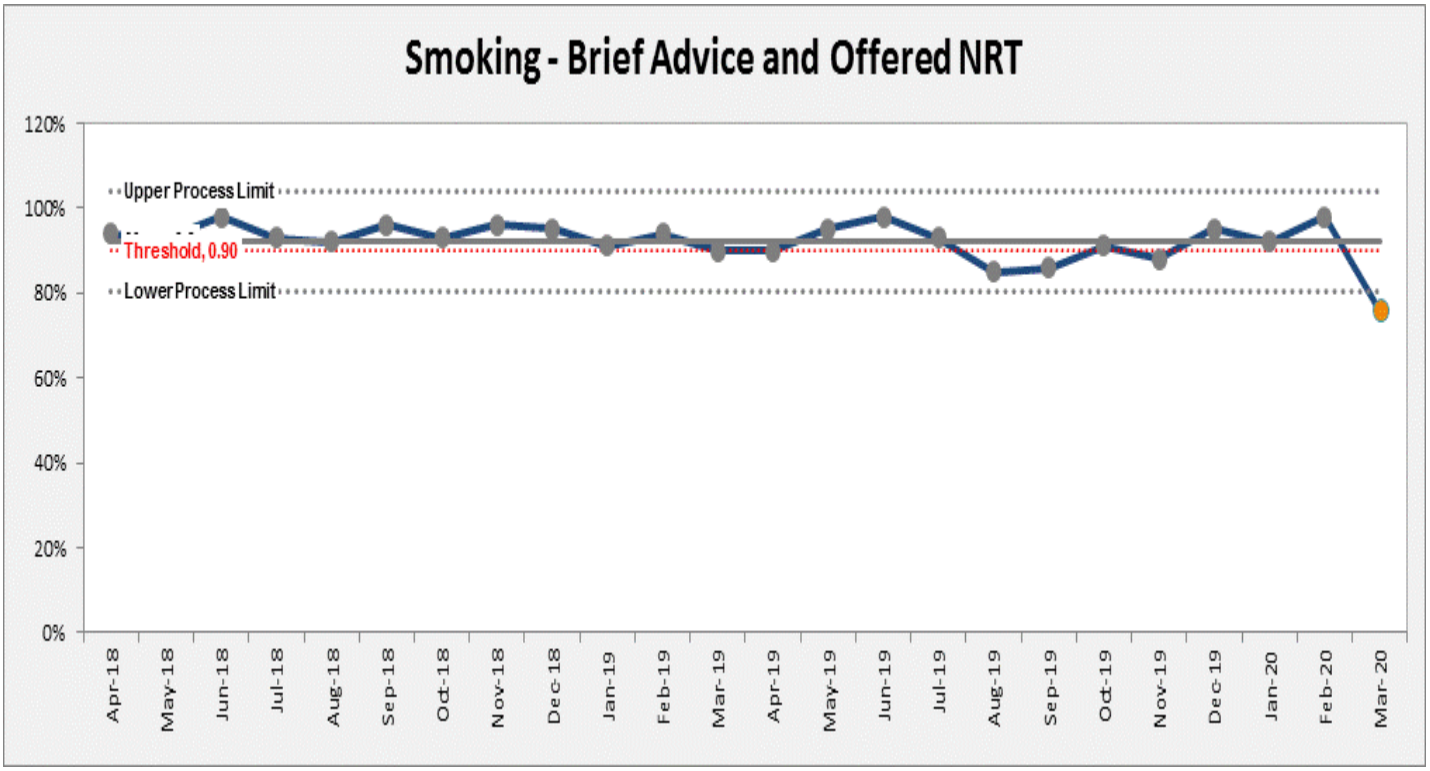
Last year, our pharmacy team took on the responsibility, as part of their discussions with the patient about their medicines, to ask patients whether they smoked and if so gave brief advice on how to stop smoking and offered nicotine replacement therapy. Our data shows (figure 1) that this year, the pharmacy team and specialist nurse improved and sustained performance reaching the NHS England national target of 80% of patients screened during a stay in hospital. We also sustained giving brief advice and offering nicotine replacement therapy to our patients who smoked (figure 2). Wiltshire Council health trainers have also worked with our patients to help them stop smoking and drink alcohol at below the lower risk level.

Figure 1: Patients screened for smoking status



See appendix 1 page 87 – Reading a statistical process chart.

Figure 2: Patients given brief advice and offered nicotine replacement therapy (NRT)

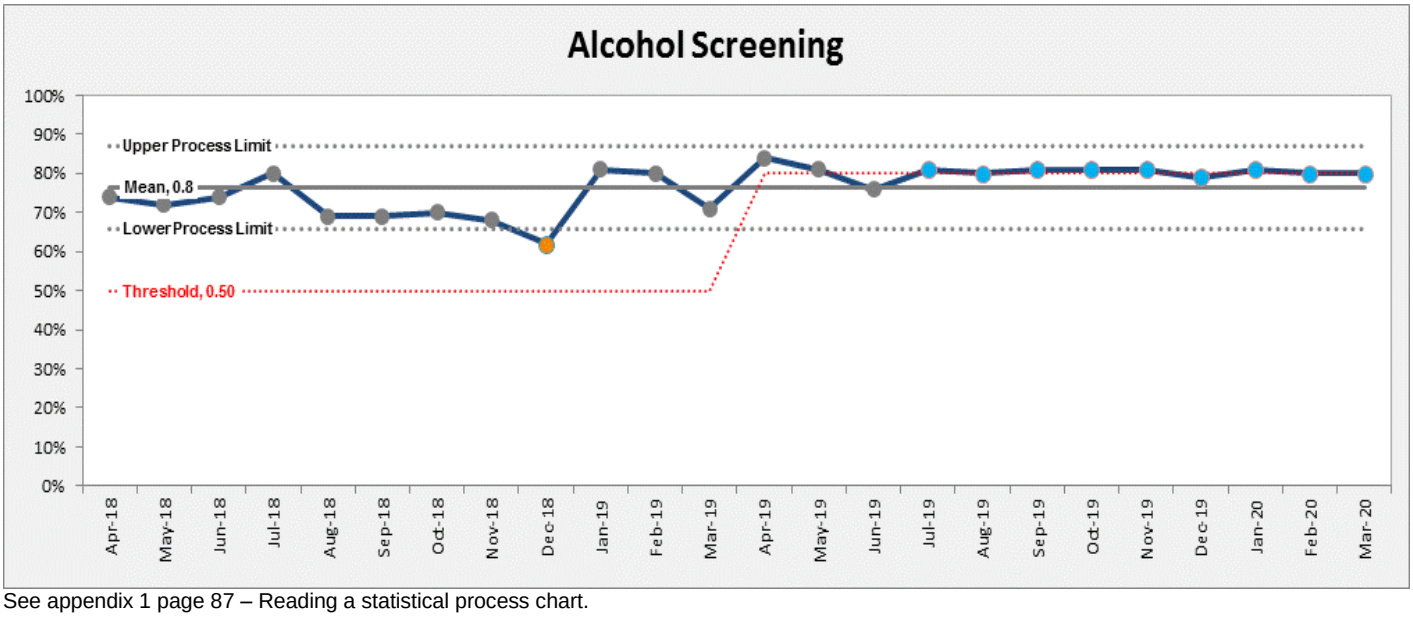


See appendix 1 page 87 – Reading a statistical process chart.

Alcohol misuse is when people drink in a way that is harmful or when people are dependent on alcohol. To keep health risks from alcohol to a low level, both men and women are advised not to regularly drink more than 14 units of alcohol a week.

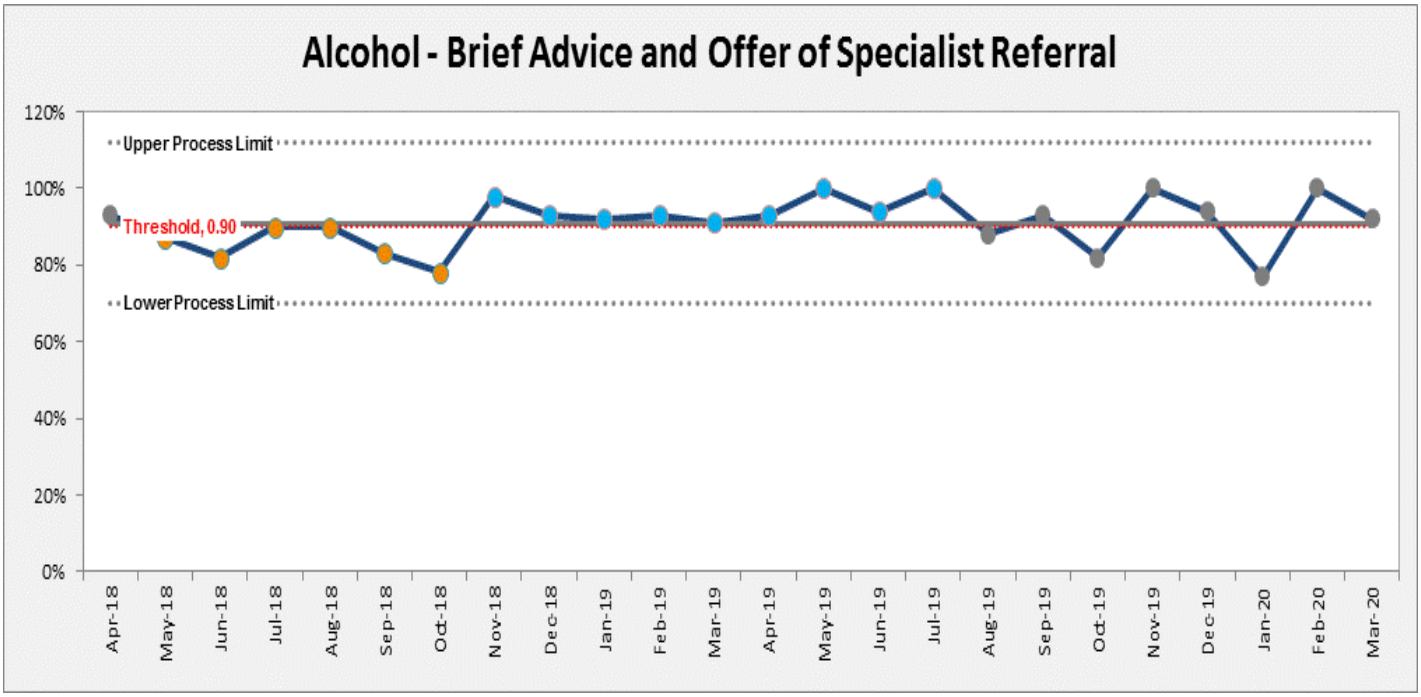
Our data shows (figure 3) that our pharmacy team and specialist nurse have improved practice and reached and sustained the NHS England 80% national target this year for screening patients for alcohol use. The team have also met the target of 90% being given brief advice on how to reduce alcohol to lower levels and offered a specialist referral (figure 4).

Figure 3: Patients screened for alcohol status



See appendix 1 page 87 – Reading a statistical process chart.

Figure 4: Patients given brief advice and offered a specialist referral

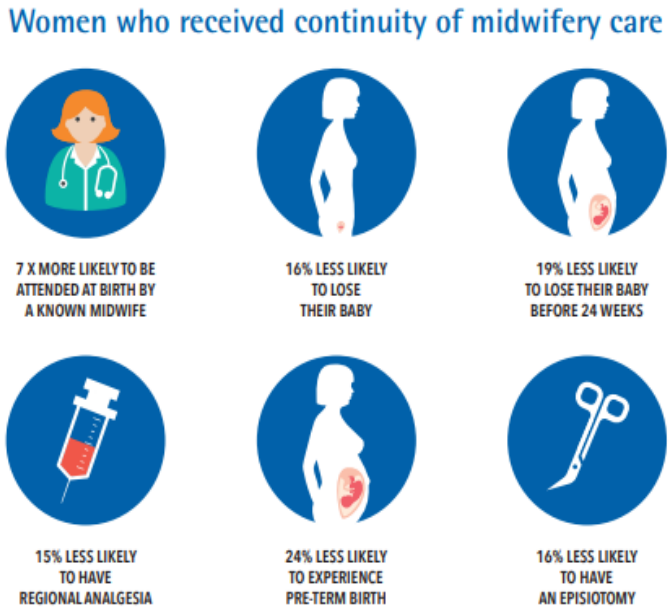


See appendix 1 page 87 – Reading a statistical process chart.

1.2 Implement a continuity of carer model to help improve outcomes for the most vulnerable mothers and babies. By March 2020, 20% of vulnerable mothers will benefit from continuity of carer throughout their pregnancy, labour and the postnatal period. (In 2019/2020, NHS England increased the target to 35% of women receiving continuity of carer)

Continuity of midwifery care includes an emphasis on the natural ability of women to experience birth with minimum intervention, monitoring needed to ensure a safe pregnancy and birth, and the wellbeing of the woman and her family. Continuity of midwifery care contributes to improving quality and safety of maternity care based on a relationship of mutual trust and respect in line with the woman's decision.

Figure 5: Evidence shows continuity of carer is safer than conventional care (Cochrane Database of Systematic Reviews 2016) – midwife-led continuity models versus other models of care for childbearing women https://doi.org/10.1002/14651858.CD004667.pub5



In addition, the evidence indicates that continuity of carer is more personal and that women attended at birth by a known midwife reported high ratings of satisfaction with:

- Information
- Advice and explanation
- Place of birth
- Preparation for labour and birth
- Choice for pain relief
- Feeling in control.

In Salisbury's maternity services, a pilot of continuity of midwifery care was provided by a team of 5 midwives (Ivy Team) who offered individualised care to 100 women who had had a previous difficult pregnancy or birth between October 18 to November 19. The team cared for the women during pregnancy, by a known midwife during labour, birth and the postnatal period. The feedback from the women was overwhelmingly positive. The scheme continues to be provided as part of daily practice and next year the service will work towards 51% of women being able to benefit from continuity of midwifery care.

Figure 6: Salisbury maternity services continuity of midwifery carer

Continuity of carer	Number (1 April 19 – 31 March 20)
Women who gave birth	2236
Women who received continuity of carer	257 (11.5%)

1.3 Work with local acute Trusts to develop a carers policy and staff training to gain a better understanding of the needs of people with learning disabilities and autism

This year, our Trust has worked with other local Trusts to plan the introduction of a standardised carers policy for people with learning disabilities and autism across the region. However, this has not been possible to achieve within the year as every Trust had a different policy and training requirements. We see this as an excellent opportunity to work with Bath & North East Somerset, Swindon and Wiltshire sustainability and transformation partnership (STP) to reduce variation and design a standardised carer's policy in 2020/21. The Trust does not have a carers policy but is committed to the vital work done by carers and, in working together with them, as expert partners in care. We are a signatory to the Carers Charter and Memorandum of Understanding which includes similar information expected in a carers policy and is shown at the following link: https://www.salisbury.nhs.uk/InformationForPatients/Pages/Carers.aspx

We work in partnership with Carer Support Wiltshire who provide regular staff training in classroom and ward based sessions on how to support carers.

The Trust is fortunate to have a new role of a volunteer co-ordinator which covers both the hospital and community. The co-ordinator runs a weekly Carers café in Springs restaurant with Carers Support Wiltshire and Carers Support at Salisbury Medical Practice. This role helps to raise awareness of carer's issues amongst local organisations. The co-ordinator also provides support and helps carers by identifying issues that may be affecting them and raising them with the Salisbury Community Engagement Service, Salisbury Area Board and other local Health and Wellbeing forums.

1.4 Launch the 'Treat me well' campaign in April 2019

People with a learning disability face sharp healthcare inequalities, often poor lifelong health, delayed presentation and lower uptake of screening. We need to do more to improve this by providing patient centred, individualised care by making reasonable adjustments for people with a learning disability in hospital.

We have worked in partnership with Mencap to launch the 'Treat me well' campaign. This campaign is dedicated to improving how people with a learning disability are treated in hospital by making simple adjustments that make a big difference to the person. More time, staff education and awareness, better communication and clearer information can all help to make sure someone with a learning disability is treated well in hospital.

During the national learning disability week in June 2019 the South Wiltshire branch of Mencap held an event at the hospital called 'Here We Are'. The event was attended by staff, people with learning disabilities and carers to familiarise themselves with the hospital layout and learn about reasonable adjustments they are entitled to.

Further work next year, is to create a changing facility, launch a learning disability ambassador role to increase awareness about reasonable adjustments and support patients with a learning disability when they come into hospital.

1.5 Achieve 90% of antibiotic prescriptions for lower urinary tract infection in older people meeting the National Institute of Health and Care Excellence (NICE) guidance for lower urinary tract infection

Resistance to antibiotics arises when the organisms that cause infection evolve ways to survive treatments. Resistance is a natural biological phenomenon but is increased by various factors such as misuse of medicines, poor infection control practices and global trade and travel. Many of the medical advances in recent years such as organ transplants and cancer chemotherapy treatment need antibiotics to prevent and treat infections in patients made more susceptible by the treatment. Without effective antibiotics, even

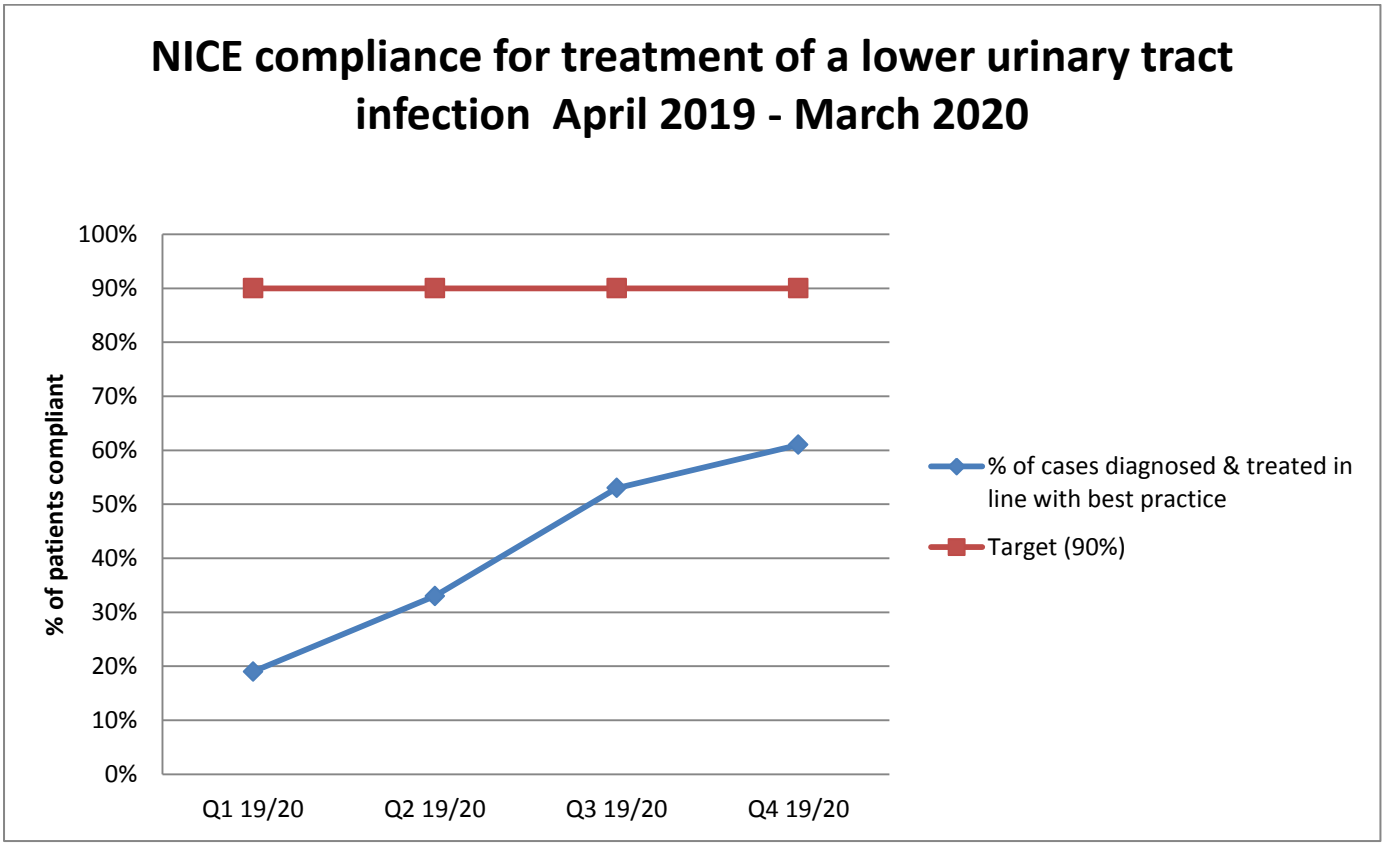
minor surgery and routine operations could become high risk procedures if serious infections cannot be effectively treated.

In January 2019, the Government published the UK's 20 year vision for antimicrobial resistance which focuses on the UK continuing to play its part in delivering best practice using surveillance, research, awareness and education. Of particular importance, is strong antibiotic stewardship, ensuring antibiotics are only used to treat infections based on a diagnostic test and the right antibiotic given promptly to reduce harm from sepsis.

Up to half of older people have bacteria present in their bladder and urine which does not cause any symptoms and is not harmful. It does not need to be treated with antibiotics as it may cause harm by inducing resistance to antibiotic therapy. The NICE guidance on antimicrobial prescribing recommends that diagnosis of an infection should be made on the basis of new signs and symptoms of a urine infection, such as pain on passing urine, a high temperature, blood in the urine or the need to pass urine frequently. When an infection is suspected a urine sample should be sent to the laboratory for testing and antibiotic treatment started only in line with the guidance. The guidance makes it clear that a urine dipstick, which detects protein and blood in the urine, should not be used as it is unreliable in patients over 65 years old.

This year, our pharmacy team have led an improvement programme which involved raising awareness of antibiotic resistance, education and information. This improvement can be seen in figure 7 but there is clearly more work to be done to improve and this will continue as a priority next year.

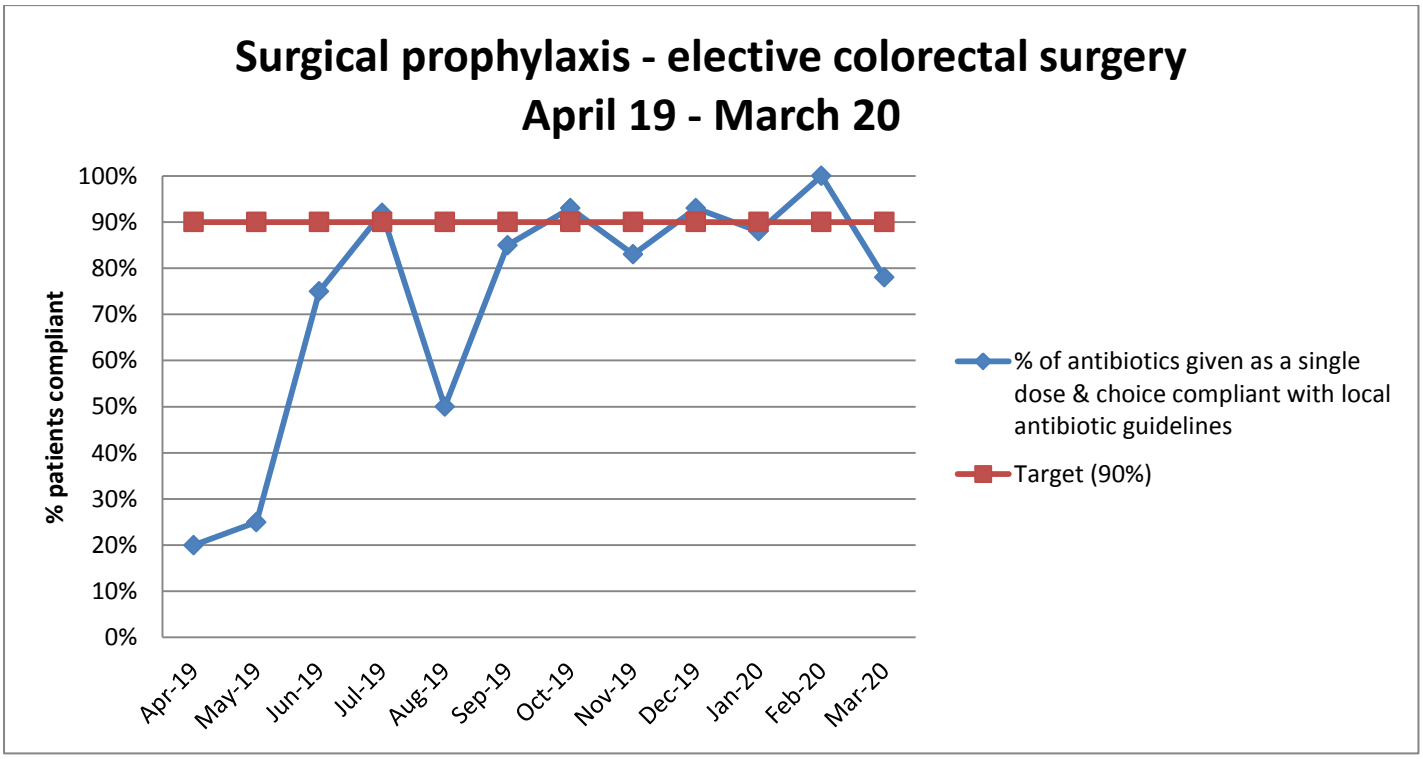
Figure 7: Overall compliance with NICE guidance for treatment of a lower urinary tract infection



1.6 Achieve 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose in accordance with local antibiotic guidelines

This was another improvement project we started to reduce antibiotic consumption in line with best practice based on National Institute of Health and Care Excellence (NICE) guidance. This was to ensure patients who had planned bowel surgery were only given a single dose of antibiotics at the start of the anaesthetic and not given routine antibiotic treatment after the operation unless it was needed for an infection. Figure 8 shows our surgical team significantly improved by sharing best practice in education sessions and measuring their practice. Of 131 patients who had planned bowel surgery, 99 (76%) patients had antibiotics given as a single dose which complied with national antibiotic guidelines.

Figure 8: Compliance with NICE guidance for surgical infection prevention 2019 – 2020



How we reported progress throughout the year:

Tobacco and alcohol screening was reported to the Clinical Management Board. Progress with maternity continuity of carer pilot was reported to the Maternity Governance Group and progress in the care of patients with learning disabilities reported to the Clinical Management Board. Antibiotic prescribing was reported to the Antibiotic Reference Group and Infection Prevention and Control Committee.

What our patients and staff have told us:

- 'A patient said: 'I have been a pipe smoker for 20 years and previously smoked 60 cigarettes a day. With the input of the hospital stop smoking advisor, I am delighted to say that since hospital discharge I have purchased a Vape Pipe and not had one puff of tobacco in the old pipe since'.
- Alcohol liaison service – 'the dedication and assistance has been above and beyond anything I could have expected. The care has been exceptional. Thank you from the bottom of my heart'.

Priority 2 Reduce avoidable patient harm by 50% over 3 years (2019 – 2021)

Description of the issue and reason for prioritising it:

Patient safety is a priority for the NHS, which aims to be the best and safest healthcare system in the world. Patient safety is the avoidance, during the provision of health care, of unintended or unexpected harm to people, such as medication errors, never events, harm from sepsis, pressure ulcers, harm from bloodstream infections, such as e-coli, and falls resulting in fractures or serious harm. Improving maternity and neonatal safety is also a priority.

We have renewed our patient safety programme from 2019 – 2021 and aligned our priorities with the Wessex Patient Safety Collaborative to focus our improvement work in four key areas of work. We have worked hard to raise awareness of the impact culture has on safety, and developed a culture where frontline staff are supported to speak up when errors occur. We know that we perform relatively well on this from our staff survey questions on safety but as per the national picture we want to do more. We continue to be candid with patients and their families when things go wrong so we can continually learn and improve. Although much has been achieved, we aim to do more to reduce avoidable harm of patients, who deteriorate, through improved recognition, response and use of early warning systems. We shall continue to contribute to the national ambition set out in Better Births https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf of reducing the rates of maternal and neonatal deaths, stillbirth and brain injuries that occur during or soon after birth by 20% by 2020.

What we did in 2019/2020:

2.1 Demonstrate a responsive safety culture by training our staff in human factors, learning and sharing lessons when things go wrong and from when things go right

Human factors training focuses on optimising staff performance through a better understanding of the behaviour of other staff, their interactions with one another and with the team. By understanding human limitations the training offers ways to minimise human frailties with the aim of reducing never events (events that should never happen such as wrong site surgery), errors and its consequences for the patient.

A total of 201 of senior doctors, nurses and other clinical staff attended a human factors training half day on 21 November 2019 given by an external Consultant Orthopaedic Surgeon and Patient Safety expert. This year, we have had two never events associated with an air flow meter and retained swab but neither patient suffered harm. This is a reduction from three never events last year. We have continued to provide clinical simulation training for our staff of scenarios which focus both on the technical and human factors elements of clinical care that are often challenging for doctors or nurses, such as difficult conversations, clinical emergencies and technical skills.

2.2 Achieve 80% of older inpatients receiving three key falls prevention actions

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65, and 50% of people older than 80, falling at least once a year.

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and in some cases death. Falling also affects family members and carers of people who fall and has an impact on the quality of life, health and healthcare costs.

The National Institute for Health and Care Excellence guidance provides recommendations for the assessment of risk and prevention of falls in older people during a hospital stay. The guidance recommends all patients of 65 and over should be considered for a multifactorial assessment and intervention.

A multifactorial assessment identifies the patient's individual risk factors for falling such as cognitive impairment, continence problems, falls history, footwear, health problems and medication that may increase the risk of falling, mobility and balance problems and visual impairment.

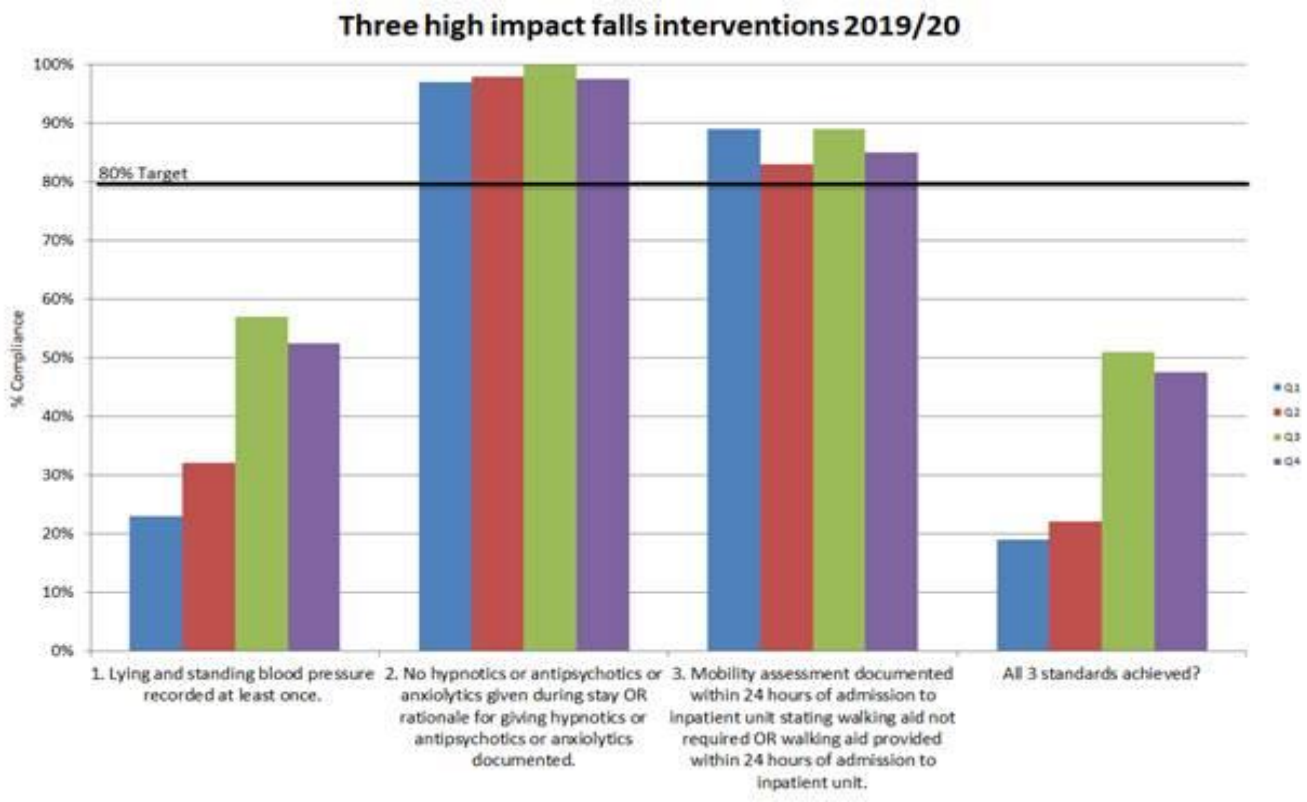
All older people who fall frequently or who are assessed as being at increased risk of falling should have an individual intervention plan. Specific elements of successful interventions include strength and balance training, home hazard assessment and intervention, vision assessment and referral to an optician and a medication review with a change or stopping all or some medicines.

Three high impact falls prevention actions are felt to be most effective. These are:

1. Lying and standing blood pressure recorded at least once
2. No sleeping tablets or antipsychotic or sedative medicines given during a patient's stay
3. Mobility assessment recorded within 24 hours of admission and if a walking aid is needed, provided within 24 hours of admission to hospital.

Of 380 patients, 130 (34%) had all 3 interventions during their inpatient stay compared to an 80% national target. Figure 9 shows we have made a big improvement in the recording of lying and standing blood pressure and this will continue to be a priority for next year.

Figure 9: Three high impact falls prevention interventions



Improvement actions we have taken this year include:

- The lying and standing blood pressure became a compulsory field on the hand held electronic device used by nurses and therapists to record clinical observations. The field pops up 12 hours after the patient is admitted and every 12 hours there-after until the lying and standing blood pressure has been successfully recorded. We have seen an improvement in this measure across the year.
- Ward based teaching sessions on falls assessment and interventions completed.
- We contributed to the National Falls Awareness week – this involved a daily trolley dash with information and a quiz to all the wards with a particular focus on lying and standing blood pressure.
- A development day was held with the Britford ward team focusing on reducing falls.
- The introduction of a Nursing Assistant Falls Forum in November 2019.

Overall, we have achieved a reduction in high harm falls from 36 in 2018/19 to 24 in 2019/20.

2.3 Reduce hospital acquired MRSA bloodstream infections to zero

Last year (2018/19), 3 patients had an MRSA bloodstream infection. All of these cases were investigated to establish what more could be done to reduce this to zero. We continued to monitor hand hygiene practice and compliance with our MRSA screening policy. We also undertook a deep cleaning programme of all our wards and made repairs where needed. Since April 2019, no patient has had an MRSA bloodstream infection. Public Health England data shows the Trust rate of MRSA blood stream infections was zero per 100,000 occupied bed days for 2019/20 compared to a rate of 0.64 in the South West and 0.76 in England. This shows the Trust continues to benchmark positively when compared to all acute trusts in the South West and England.

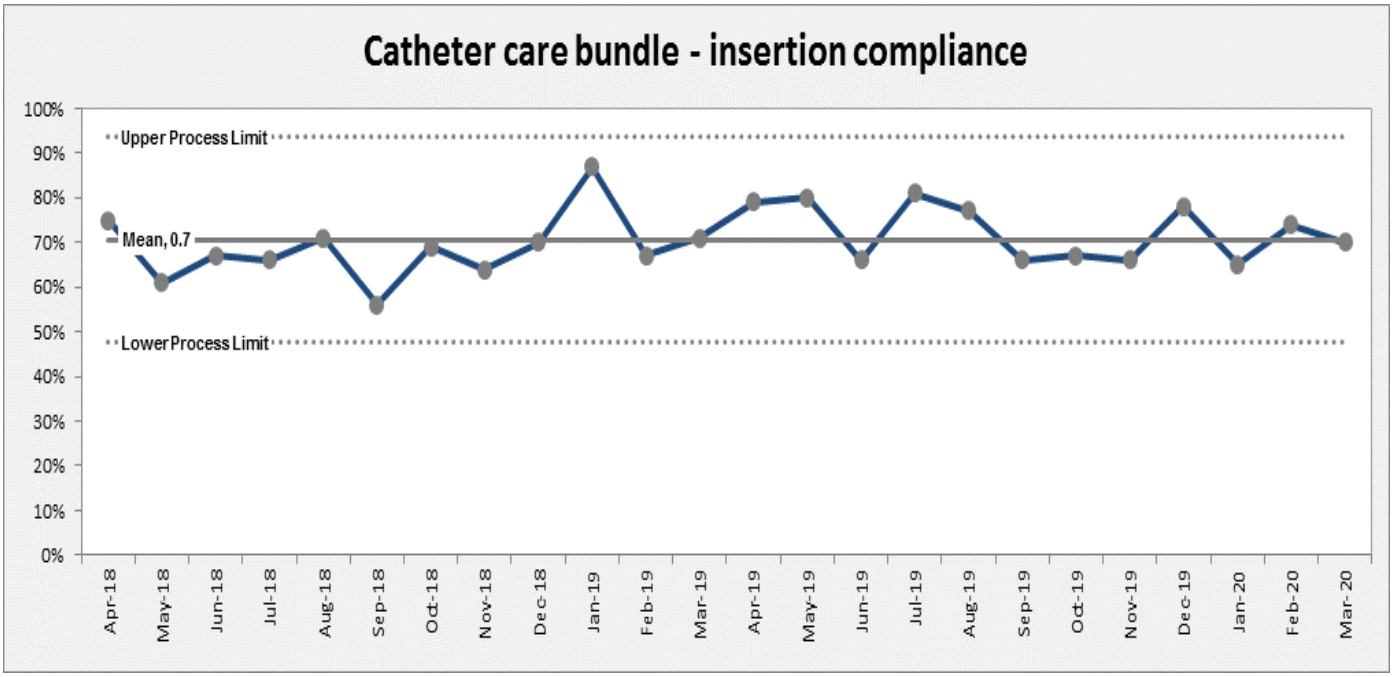
2.4 Work collaboratively with the Clinical Commissioning Group in reducing the overall number of gram negative blood stream infections across the health system

In 19/20, the Trust had the lowest gram negative blood stream infection rate across the region for hospital onset gram negative blood stream infections. Public Health England data shows the Trust rate of E.Coli blood stream infections was 10.32 per 100,000 occupied bed days compared to a rate of 21.6 in the South West and a rate of 22.5 in England. We continue to work closely with the Clinical Commissioning Groups sharing best practice, information and intelligence around all identified positive cases and take improvement actions where needed. We continue to submit surveillance data to Public Health England and benchmark positively compared to all acute trusts in the South West.

2.5 Continue to reduce the number of patients who develop a new catheter associated urinary tract infection in hospital as measured by the Safety Thermometer

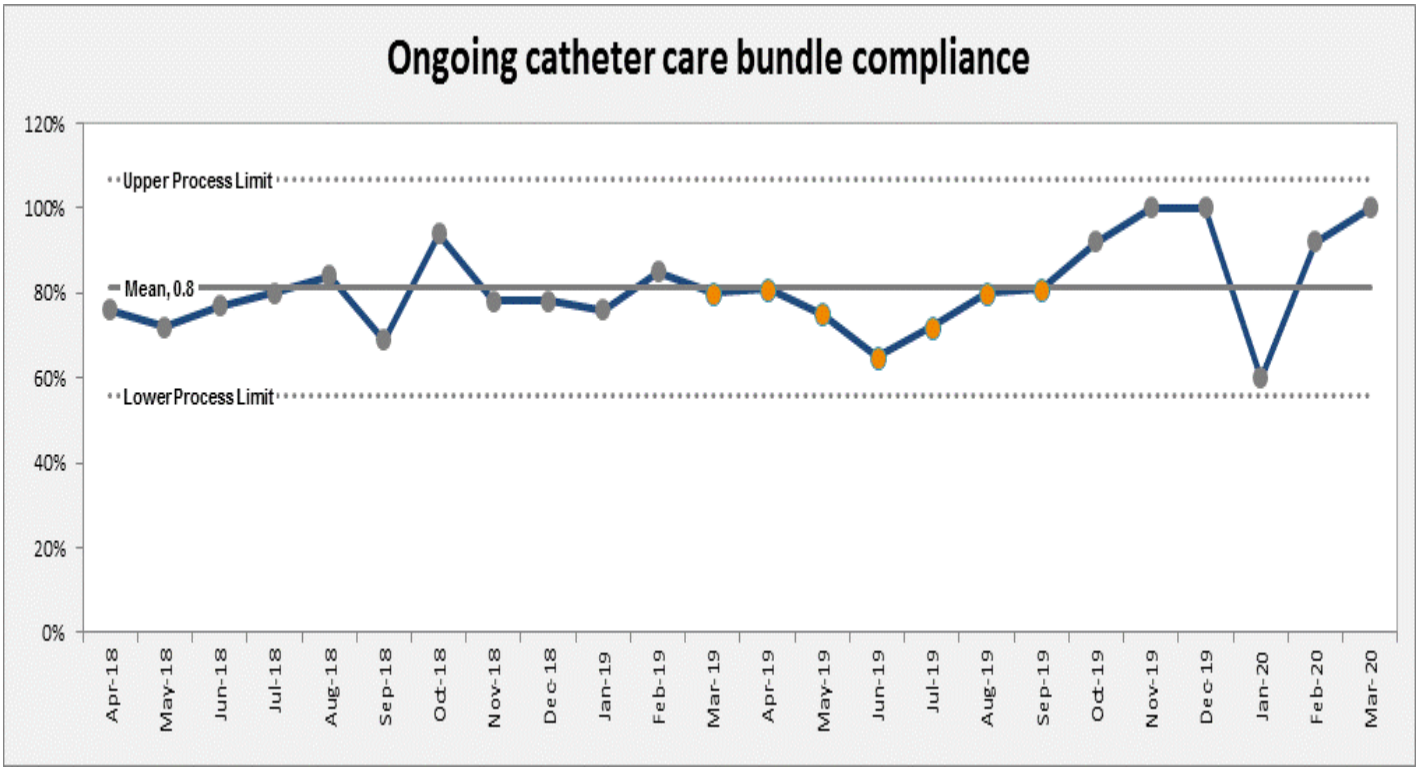
If a patient has a urinary catheter in place, bacteria can travel up the catheter and cause an infection in the bladder or kidney. However, infections can be prevented by taking some simple steps using an insertion and on-going catheter care bundle. This is a set of practices, which when used together, helps reduce urine infections when a catheter is first put in and remains in place and ensures it is promptly removed when no longer needed. We have continued to audit compliance with the insertion and ongoing catheter care bundle. Figure 10 shows we have sustained practice over the last two years but we need to do more to reach full compliance. Figure 11 shows we have not significantly improved practice this year and we need to do more to reach full compliance.

Figure 10: Catheter care bundle - insertion compliance



See appendix 1 page 87 – Reading a statistical process chart

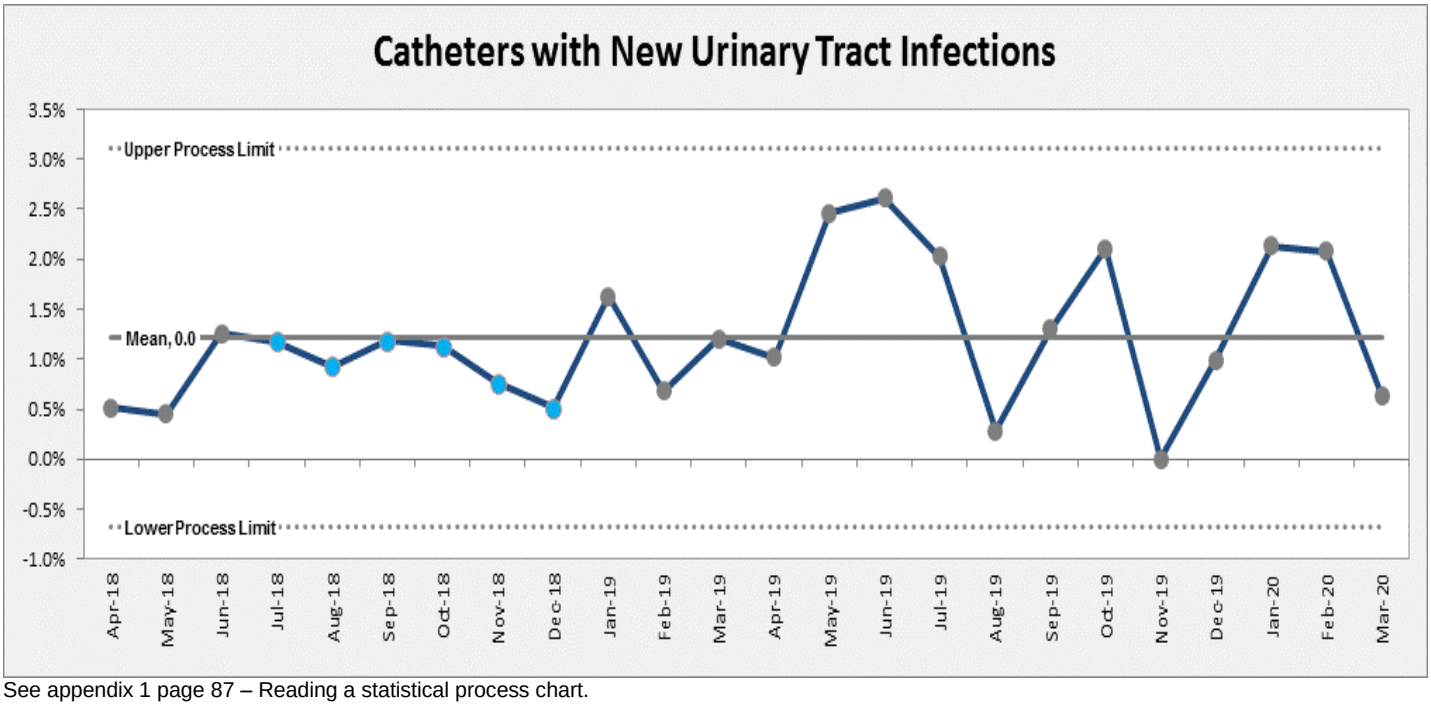
Figure 11: Ongoing catheter care bundle compliance



See appendix 1 page 87 – Reading a statistical process chart.

The combination of education sessions, catheter bundles and the use of new catheter packs reduced the number of new catheter associated urinary tract infections in 2018 but this was not sustained in 2019. However, our Safety Thermometer data is collected on one day a month and is a snap shot in time – whilst this gives us a good indication about our practice, it is not absolute numbers. We need to work out a better way of recording this next year (figure 12). This is a key area for improvement as part of our work to reduce antimicrobial resistance.

Figure 12: Safety Thermometer data of the number of inpatients with a catheter with a new urinary tract infection April 2018 – March 2020



See appendix 1 page 87 – Reading a statistical process chart.

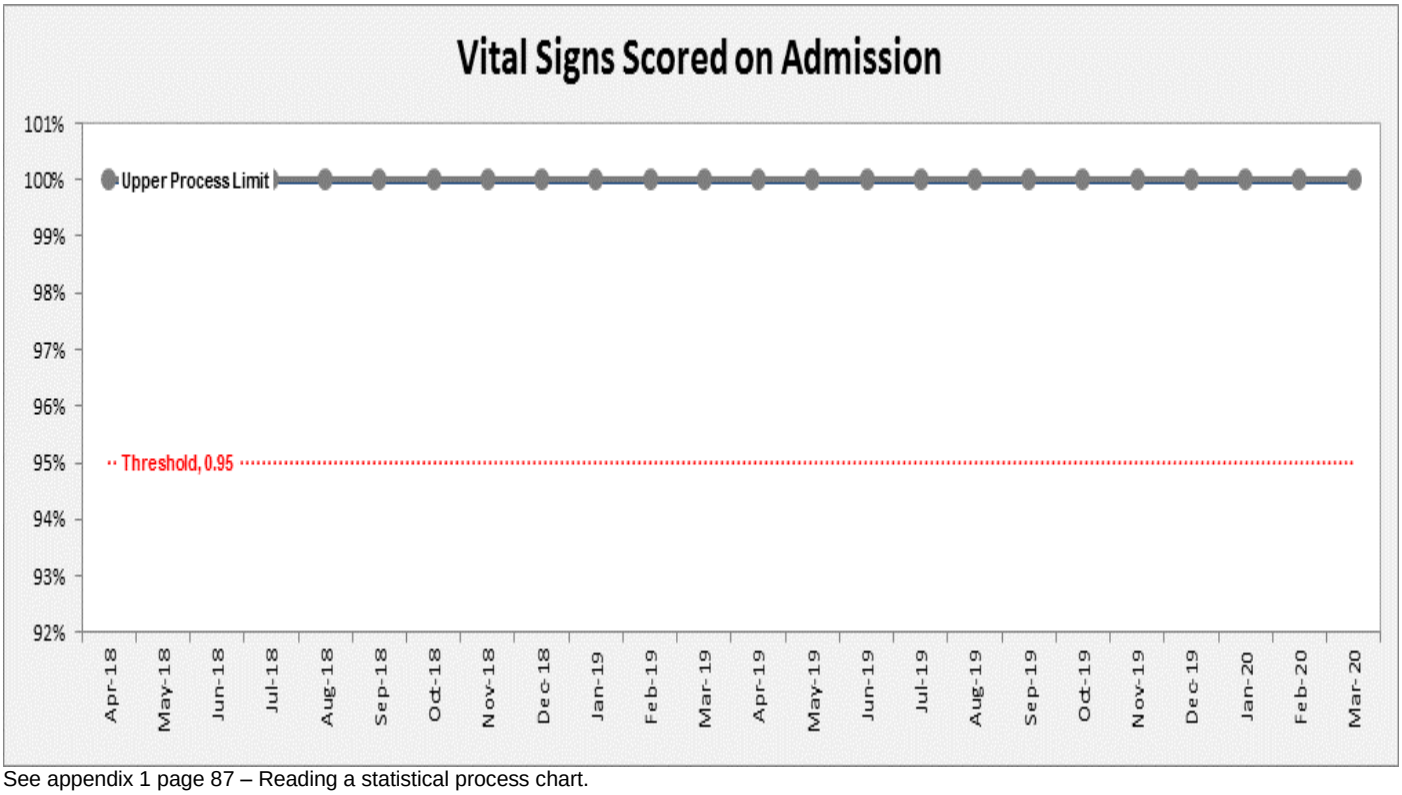
2.6 Improve the recognition of the deteriorating patient through the embedding of NEWS2 (national early warning scoring system)

Recognising and responding to clinical deterioration is a key patient safety challenge in improving patient outcomes. Nationally, the commonest problem identified in learning from deaths or clinical incidents is failure to recognise or act on deterioration.

In February 2019, we fully implemented the National Early Warning Score (NEWS2) to standardise the assessment of acutely ill and deteriorating patients. Patient's vital signs (temperature, pulse, blood pressure, respiration rate, oxygen levels, and level of consciousness or new confusion) are recorded and each vital sign is given a score. The higher the score the more unwell the patient is and this triggers an escalation response to a member of the medical or surgical team.

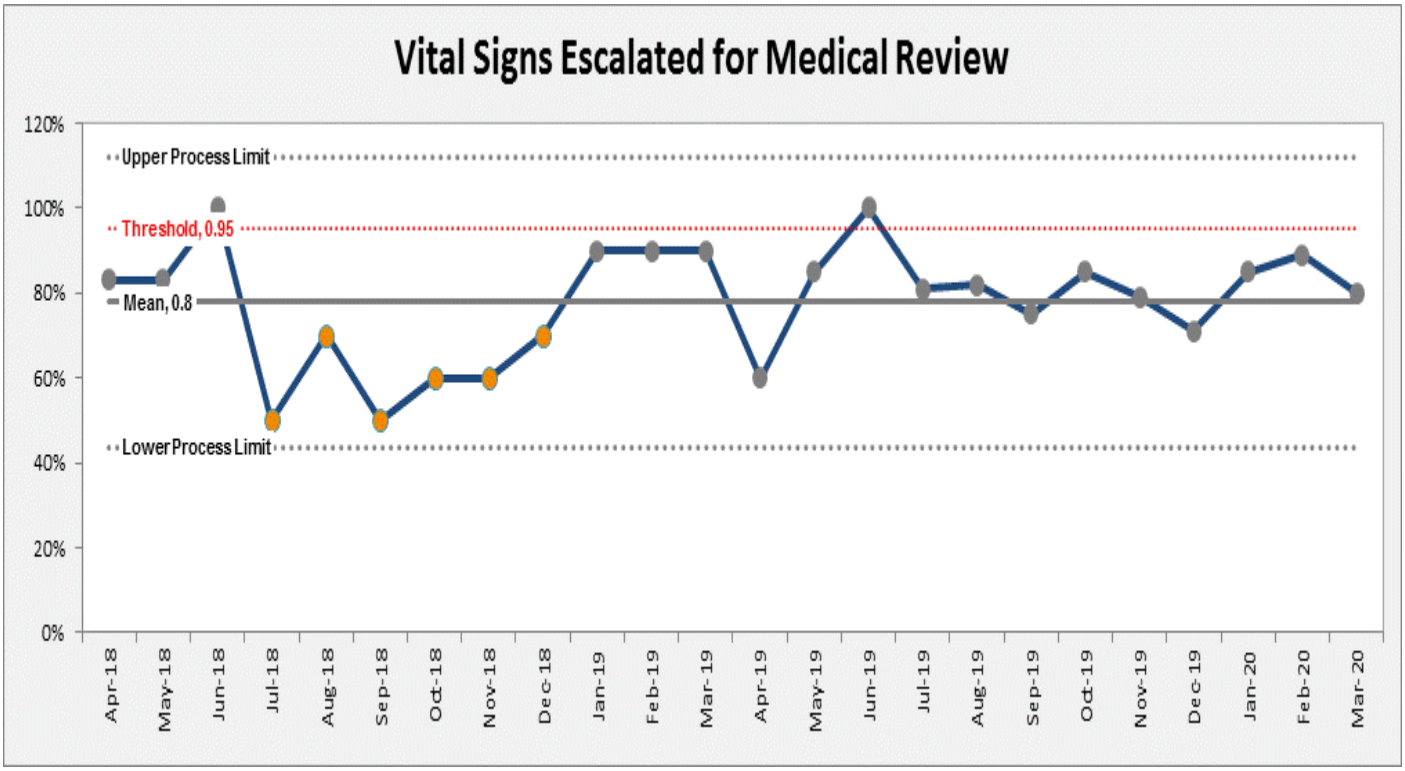
Our audit results show (figure 13) that all patients (100%) had their vital signs recorded on admission to hospital in line with our protocol. Compliance with escalation improved following the introduction of electronic hand held devices in February 2019 to record the patient's clinical observations and prompt staff to escalate to a senior decision maker depending on the score and this will continue to be a focus of improvement in 2020/21 (figure 14).

Figure 13: Vital signs scored on admission



See appendix 1 page 87 – Reading a statistical process chart.

Figure 14: Vital signs escalated for a medical review



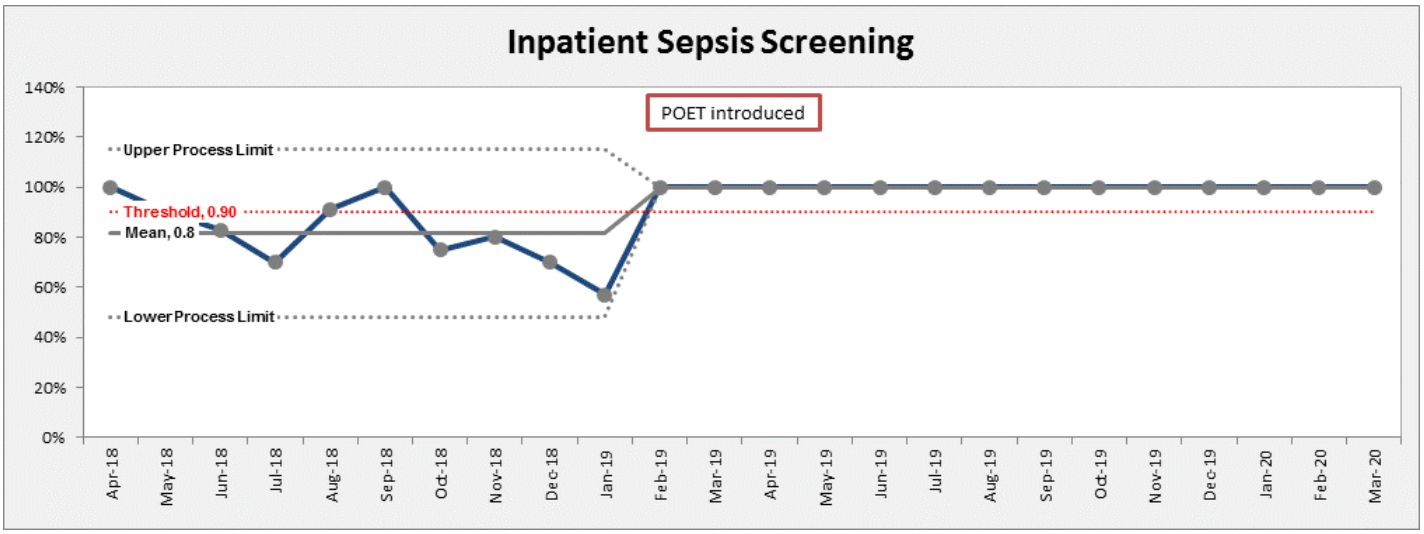
See appendix 1 page 87 – Reading a statistical process chart.

2.7 Reduce harm from sepsis by improving the number of inpatients screened for sepsis and treated with intravenous antibiotics within an hour of diagnosis of sepsis.

Sepsis is a time critical condition that can lead to organ damage, multi-organ failure, septic shock and death. Rapid diagnosis and treatment are crucial to survival. During 2018/2019 we improved screening and treatment using the Sepsis Six practices of patients admitted through our Emergency Department, Acute Medical Unit and Surgical Assessment Unit but we needed to do more to improve screening and treatment of in-patients through an ongoing education and audit programme.

We have sustained the same percentage of adults screened for sepsis as inpatients through an ongoing education and audit programme and improved to 100% from February 2019 onwards with the full implementation of NEWS2 recorded on a hand held electronic device called POET (figure 15).

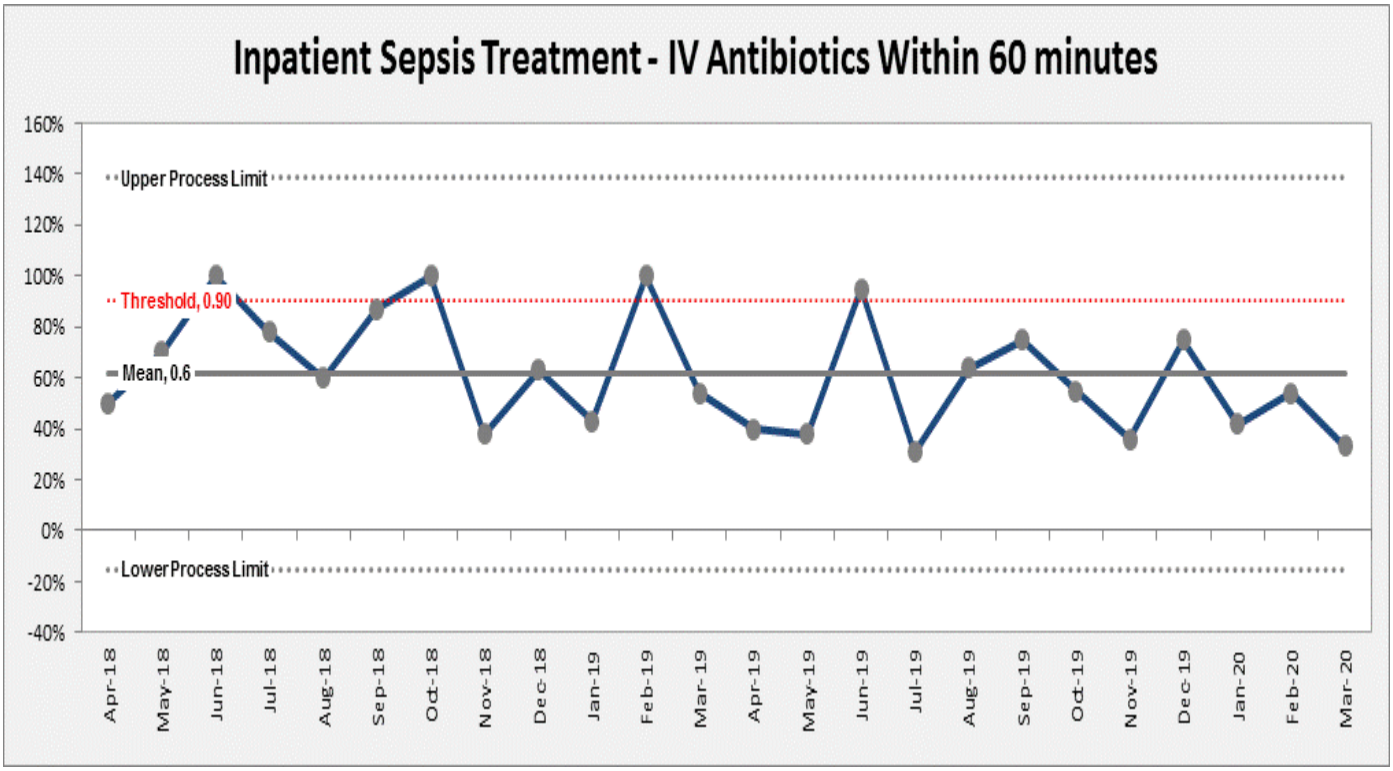
Figure 15: Sepsis <u>screening</u> of inpatients



See appendix 1 page 87 – Reading a statistical process chart.

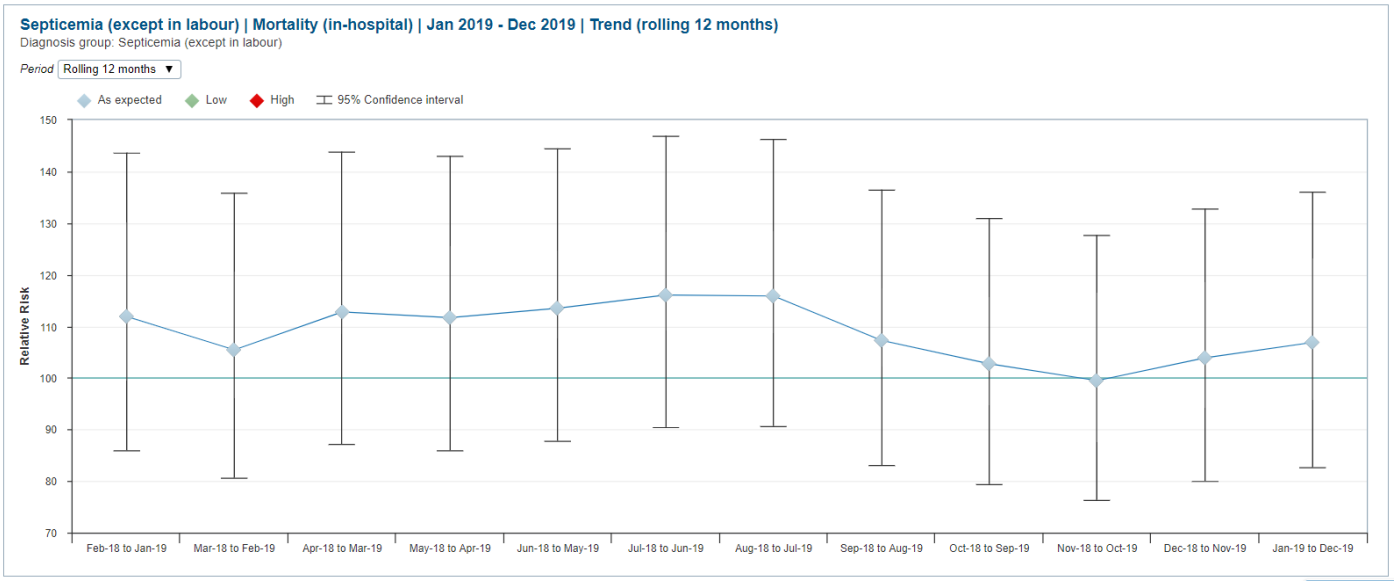
The data in figure 16 shows variation across two years with no sustained improvement over time to treatment in the administration of intravenous antibiotics within 60 minutes of diagnosis. This may be due to the small numbers of adults being treated with antibiotics for sepsis (average 11 patients per month, range 3 – 21 patients) and this will continue to be a focus for our improvement work next year. However, the positive outcome of the improvement work has been a decrease in the relative risk of death from sepsis over the last 2 years (figure 17).

Figure 16: Sepsis <u>treatment</u> of inpatients



See appendix 1 page 87 – Reading a statistical process chart.

Figure 17: Relative risk of death from sepsis



2.8 Introduce the new Saving Babies Lives care bundle to reduce the number of stillbirths and neonatal deaths.

We have continued to use the 'Saving Babies' Lives' care bundle which is designed to reduce stillbirths and early neonatal deaths. The care bundle has four elements:

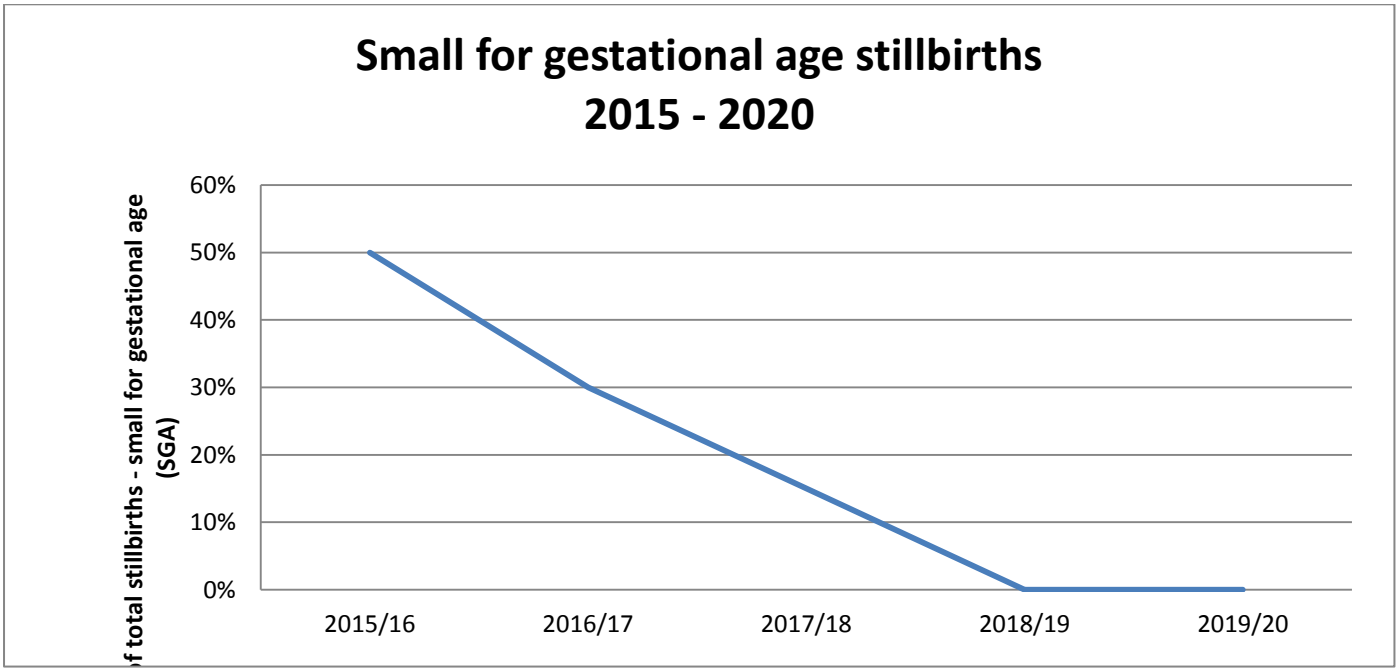
1) To support women to stop or reduce smoking in pregnancy
2) Women are given information to ensure they act the same day if their baby is not moving as much as usual.
3) Each woman is given a customised growth chart to measure the growth of her baby during pregnancy. If the baby is not growing as it should, additional scans, blood tests or delivery are arranged.
4) During labour, for those women who have their baby's heart beat monitored continuously, a second midwife or doctor should review the heart beat trace every hour to confirm it is normal or needs urgent action. This element also includes ensuring midwives and doctors are up to date with their training in interpreting the baby's heart beat trace in labour.

Our community midwives have continued to sustain excellent progress in supporting women to stop smoking in pregnancy by asking them to give a carbon monoxide reading when a woman books for her maternity care. Women who smoke are given brief advice on how to stop smoking and referred to the specialist maternity stop smoking service. In addition, this year community midwives have focused efforts on taking a carbon monoxide reading at every antenatal contact.

We have sustained a high percentage of women who received written information about reduced fetal movements and discussed it at every antenatal appointment to ensure every woman understands the importance of acting on reduced fetal movements the same day.

All doctors and midwives must undertake annual training in the interpretation of the baby's heart beat trace and a competency assessment to ensure effective monitoring of the baby in labour. In addition, a system of 'fresh eyes' is in place. This includes a review of the heartbeat trace by a second midwife or doctor every hour. Figure 18 shows that since 2015, the Salisbury maternity team have improved the detection of small for gestational age babies in pregnancy. As an outcome, there were no stillborn babies that were small for gestational age by March 2020.

Figure 18: Reduction in small for gestational age (SGA) stillbirths 2015 – 2020



The new (version 2) of the Saving Babies Lives care bundle includes:

- Identifying a fetal monitoring lead for a minimum of 2 days a week per unit to improve the standards of risk assessment in labour and the baby's heart beat trace.

- Reducing pre-term birth by predicting and preventing it and ensuring the best care when pre-term birth cannot be avoided. This includes better antenatal risk assessment, a clear pathway for specialist care for women at risk of pre-term birth, referral pathways to specialist pre-term birth prevention clinics and increasing appropriate use of steroids, aspirin and Magnesium Sulphate.

Our maternity team are planning to introduce a pathway for assessment and management of women at risk of preterm labour in 2020 and identifying a fetal monitoring lead. As maternity care is a high risk area, it continues to be a priority both locally and nationally.

How we have reported progress throughout the year?
Bloodstream infections have been reported to the Infection Prevention and Control Committee. Human factors, falls prevention, deteriorating patients and sepsis have all been reported progress to the Patient Safety Steering Group. Saving Babies Lives care bundle work has been reported to Maternity Governance meetings.

What our patients have told us:

- 'My only concern was not being admitted initially when my GP contacted the Acute Medical Unit. If I had been admitted I could have had blood cultures before commencing antibiotics which would have helped greatly in my care and perhaps have prevented many GP contacts. Earlier intervention may have been more cost effective'.
- 'The staff on the Coronary Care Unit are truly professional and when I was transferred there from the assessment ward, I felt safe'.

Priority 3 Work with our partners to improve patient flow through the hospital

Description of the issue and reason we prioritised it:

How our patients move through the hospital is crucial to ensuring that patients are cared for in the right place at the right time by the right people. Having the right patient in the right place at the right time improves outcomes and enhances patient experience. Although, we have undertaken a significant amount of work with support from NHS Improvement, Emergency Care Improvement Support Team (ECIST) and our partners to improve, we, like many other hospitals, continue to be challenged by the number of patients requiring care at home or experiencing delays and therefore, this is a top priority for us in 2020/2021.

Our hospital 'Ready, Steady, Go' patient flow programme uses four of the SAFER care bundle measures. The programme focuses on:

- **Ready** - the admission part of the patient's journey from arrival in the Emergency Department, Acute Medical Unit or Surgical Assessment Unit through to the first assessment by a consultant within 14 hours of admission (90% of patients) or discharge the same day.
- **Steady** – is the patient's journey from admission to a ward to the day of discharge. The key measure is all patients should have an expected date of discharge decided within 14 or 48 hours.
- **Go** – is preparation for discharge and the day of discharge and a review of patients who have been in hospital over 7 days by a senior team. The key measure is 33% of patients should be home before lunch (discharged by 12 noon) and a reduction in the number of patients in hospital over 7 days or over 21 days to below our target.

What we did in 2019/2020:

3.1 Improve compliance with the SAFER care bundle to ensure the right patient is in the right place at the right time

The **SAFER** care bundle has 5 elements of best practice and we have measured items 1, 2, 4 and 5 below:

1) **S**enior review – 90% of patients should have a review by a consultant within 14 hours of admission.

2) **A**ll patients should have an expected discharge date (EDD) and criteria set for discharge within 14 hours of admission.

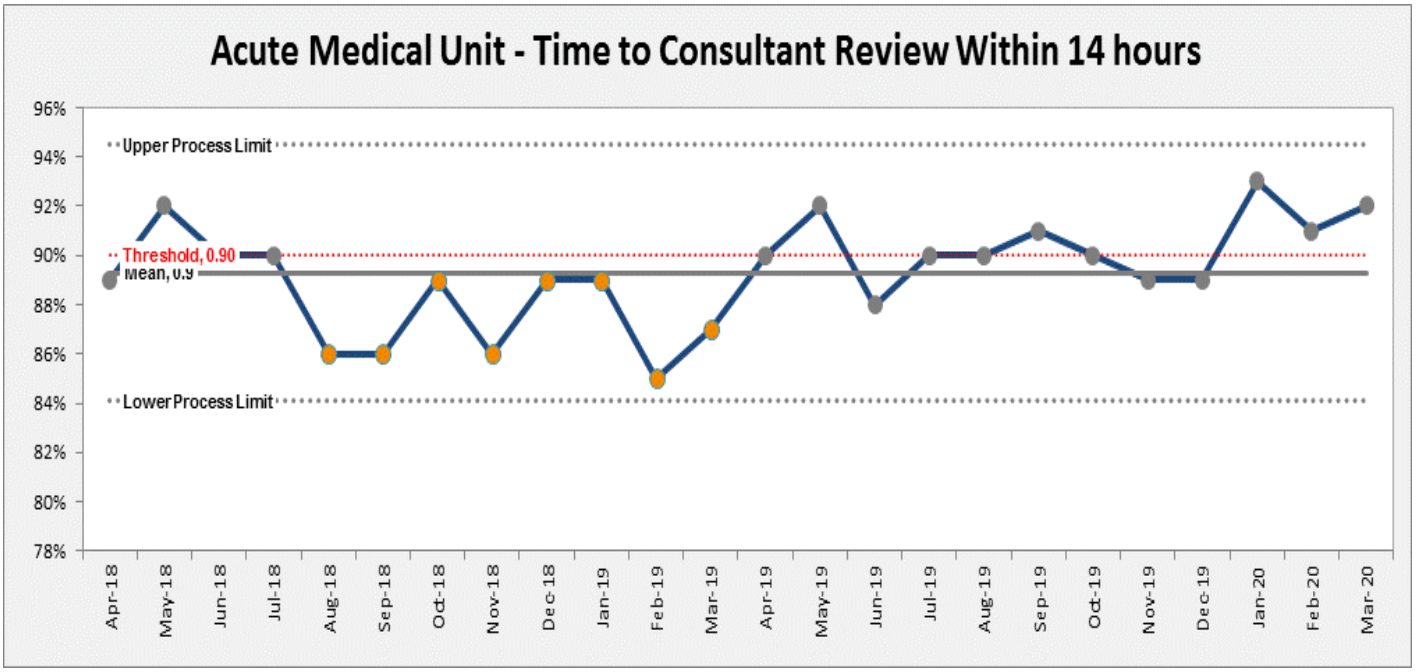
3) **F**low of patients from assessment units to inpatient wards should start as early as possible each day.

4) **E**arly discharge – a third of patients should be discharged from the ward before midday.

5) **R**eview – a review of patients with a length of stay over 7 days by a senior team with a clear 'home first' mind set.

Senior review - figure 19 shows that 90% standard of the admission part of the patient's journey from arrival in the Emergency Department and Acute Medical Unit through to the first assessment by a consultant within 14 hours of admission was consistently achieved in 2019/20.

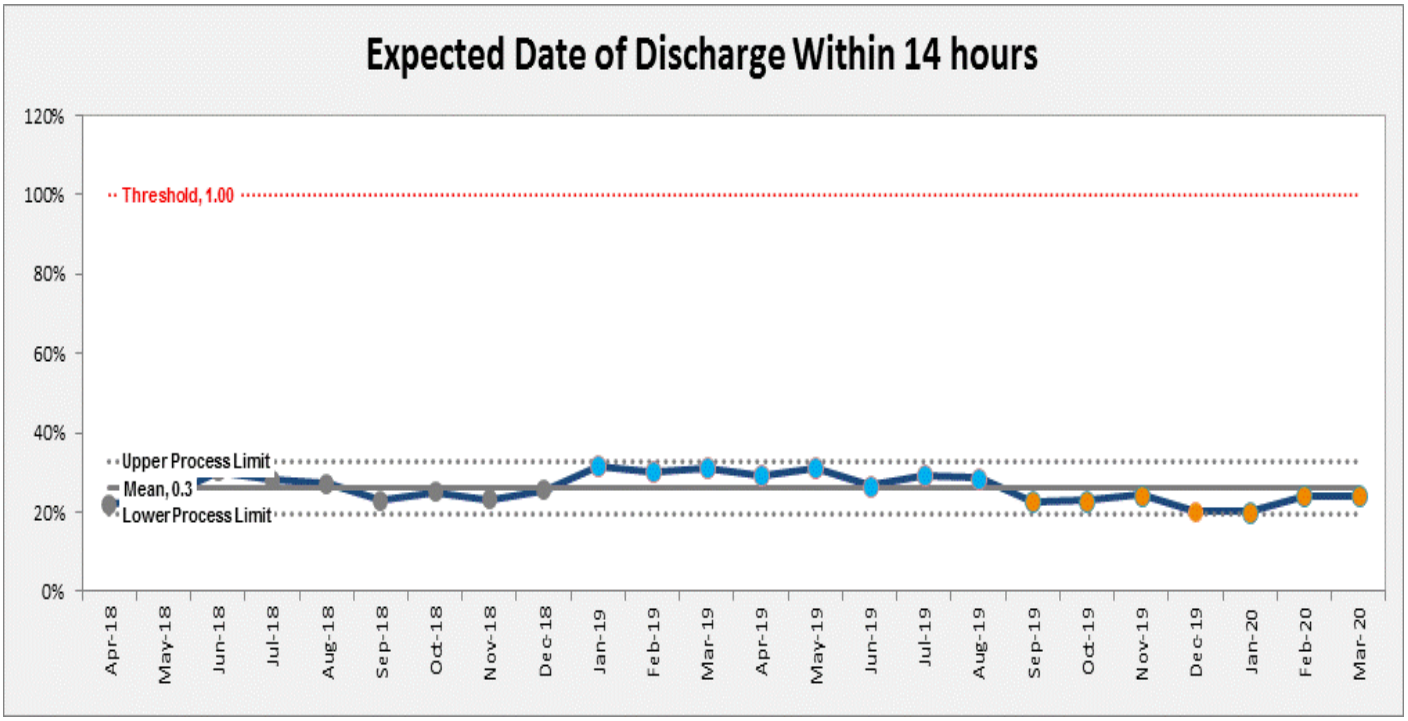
Figure 19: Time to consultant review within 14 hours of admission



See appendix 1 page 87 – Reading a statistical process chart.

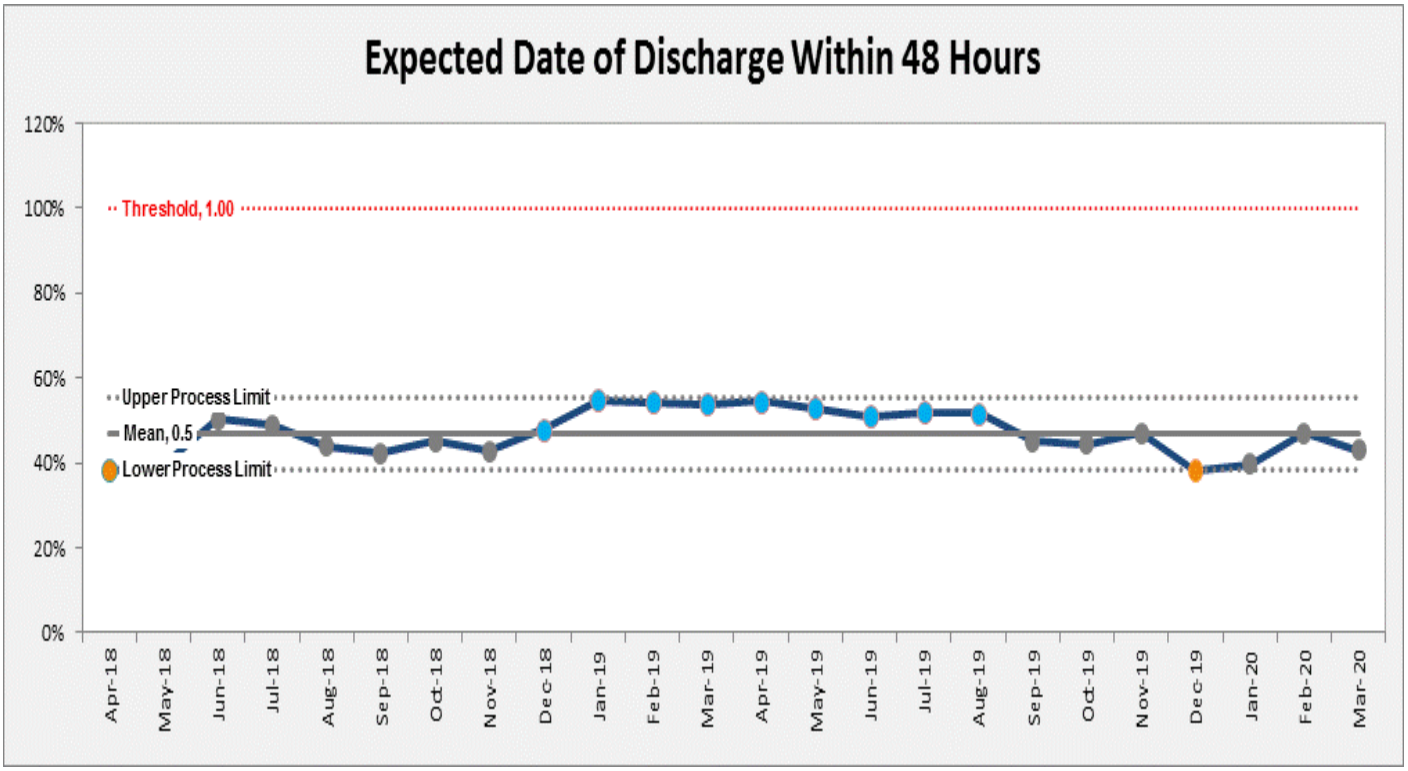
All patients should have an expected date of discharge set within 14 hours and 48 hours of admission (figures 20 and 21). Clinical teams often find it difficult to set an expected date of discharge with the patient at 14 hours when the patient is acutely ill. This is because a patient's response to treatment cannot always be predicted at that point. However, as the patient begins to improve it is easier to predict a date, as can be seen from figure 21 this improved to a mean of 50% within 48 hours of admission. We recognise this is an area that needs to improve and this will be a focus of work next year.

Figure 20: Expected date of discharge set within 14 hours



See appendix 1 page 87 – Reading a statistical process chart

Figure 21: Expected date of discharge set within 48 hours



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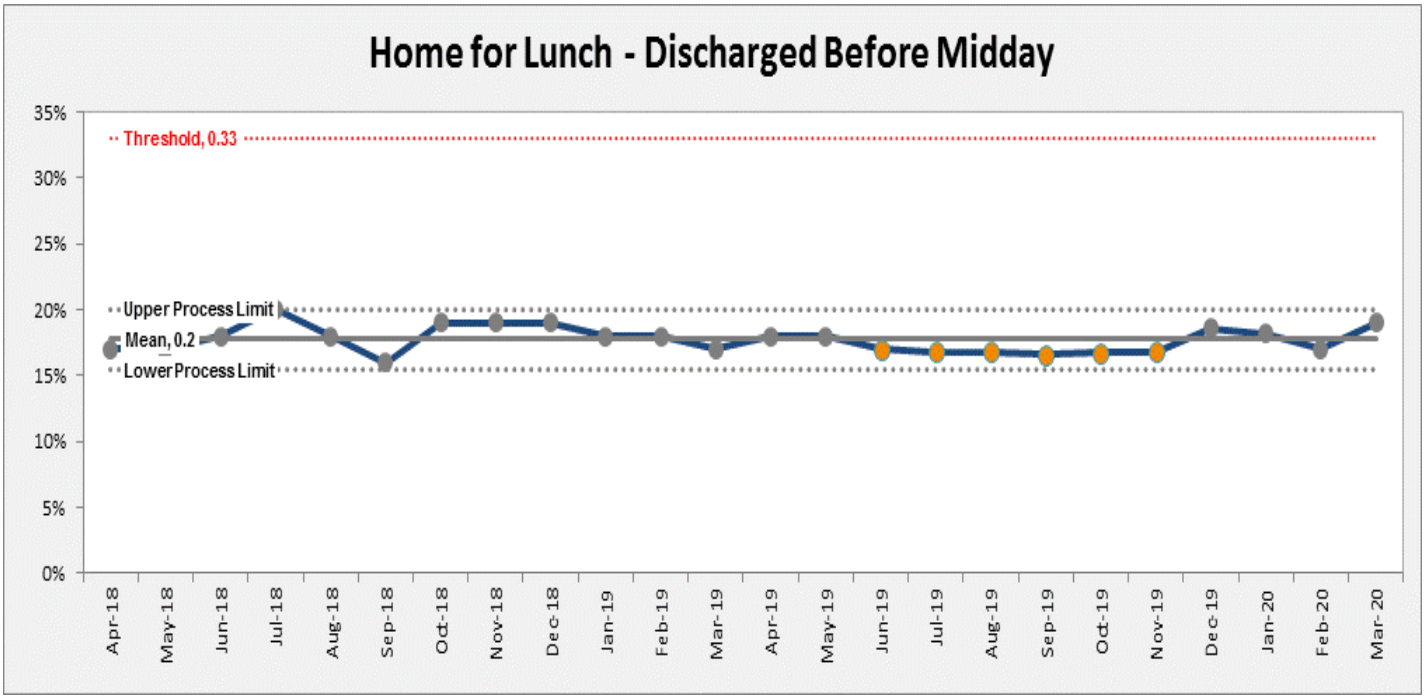
Early discharge – a third of patients should be discharged from the ward before midday. Figure 22 shows that on average only 16 - 21% of patients are discharged before midday compared to our 33% target. Our team are working hard to ensure the expected discharge date is discussed at the daily ward whiteboard round and discussed with the patient and family, as well as, ensuring take home medication, the discharge summary and transport home are arranged the day before the patient goes home.

Figure 22 shows that we need to improve the number of patients discharged before lunch.

Figure 22: Early discharge before midday (target 33%)



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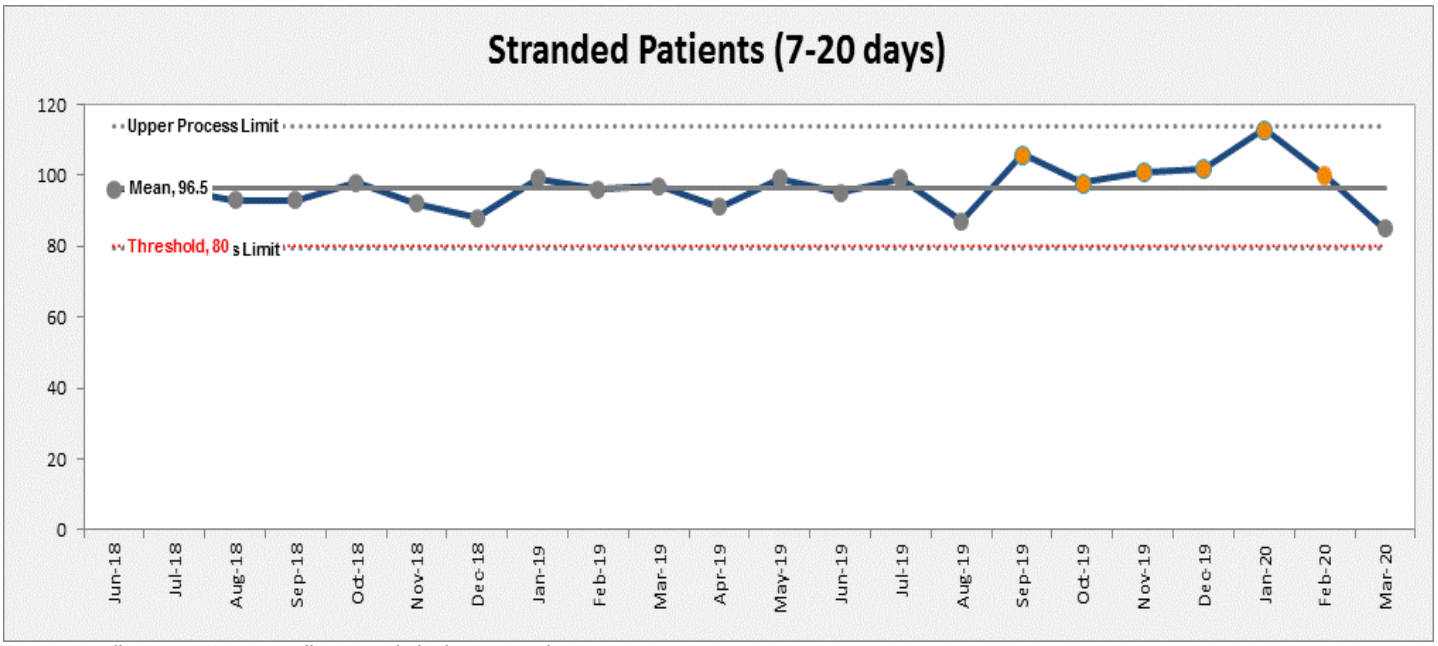
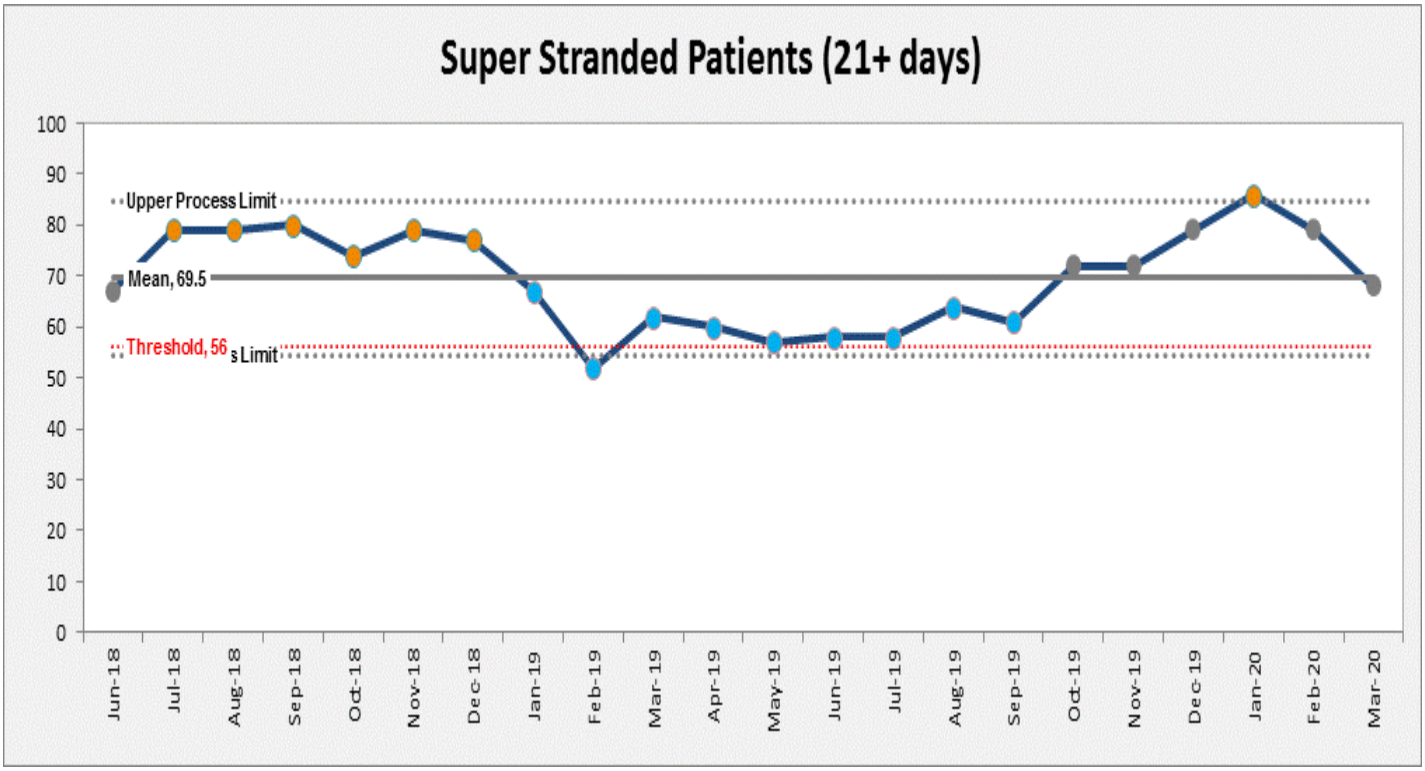
Review – a review of patients with a length of stay over 7 days by a senior team with a clear 'home first' mind set. Every week an Expert Panel of senior staff from the hospital meet with our community partners to review patients who are medically fit for discharge who have been in hospital for more than 7 days. The meeting decides on what further actions need to be taken by the hospital or community teams to progress a patient's discharge. This involves our community partners visiting specific wards to discuss patient discharge plans with the staff and assist with arrangements if needed. Despite this, figures 23 and 24 shows that the number of stranded (patients with a length of stay of 7 days or more) and super stranded patients (patients who have spent 21 days or more in hospital) increased in the last 6 months and remains a continued focus for improvement.

Figure 23: Stranded patients (target no greater than 80 patients)



See appendix 1 page 87 – Reading a statistical process chart.

Figure 24: Super-stranded patients (target no greater than 56 patients)



See appendix 1 page 87 – Reading a statistical process chart.

NHS Improvement, Emergency Care Improvement Support Team (ECIST) undertook a review of the implementation of the SAFER care bundle at this hospital and concluded their work in October 2019. They recommended the Trust continues to work across the whole system and embed the SAFER care bundle. This remains a priority in 2020/21.

In addition to measuring the SAFER care bundle our 'Ready, Steady Go' programme has made a number of improvements this year.

A '**Ready'** working group, led by a senior doctor, was set up to look at options for improving efficiency and effectiveness of the admission part of the patient's journey. This has included:

- Working with GPs and the ambulance service, a multidisciplinary team reviewed patients who attended the Emergency Department frequently (10 or more attendances a year) to help plan and support personalised care with each patient. This has been shown to help reduce frequent attendances.

- Introduction of a single assessment document so that the patient is only assessed once by a doctor in the Emergency Department, rather than the same examination being repeated a second time, when the patient is admitted to the Acute Medical Unit or Surgical Assessment Unit.

- Appointment of two new Advanced Nurse Practitioners to the Acute Medical Unit team to manage patients who are able to go home the same day following assessment, diagnosis and treatment. This service is being tested Monday to Friday and 44% of the patients seen by the Practitioners have been able go home the same day.

  We are planning to expand the service by providing a clinic room adjacent to the Acute Medical Unit where Emergency Department patients who attend with conditions such as a pulmonary embolism, cellulitis, headache, chest pain or an unexplained temperature can be seen and treated by the Advanced Nurse Practitioners and if appropriate discharged home.

- We have developed a 'Care in a Chair' pathway for when patients arrive in the Emergency Department or other assessment areas who are clinically stable but require treatment and observation. These

patients are able to have blood tests, medication and intravenous fluids whilst sitting in a chair and are more likely to go home than if on a trolley or bed.

- The Stroke Unit tested a nurse practitioner role for 12 days between 9 to 5 in December 19. The nurse met potential stroke patients on admission to the Emergency Department and the Stroke Unit. The nurse arranged the initial scan, assessments and transfer to the Stroke Unit. This increased the percentage of patients admitted to the stroke unit within 4 hours from 38.9% to 57.6% and patients receiving a CT within 1 hour increased from 39.5% to 73.5%. This will be considered as an addition to the service in 2020/21.

A '**Steady'** working group, led by a senior doctor, was set up to look at options for improving efficiency and effectiveness of our internal processes. This has included:

- Improving and using a structured handover of a patient from one department to another. This means a nurse or doctor explains to the receiving nurse or doctor, the patient's situation, background, assessment and recommendation for their care and treatment (SBAR).

- Better use of electronic whiteboards to record the patient's expected date of discharge. An electronic alert is sent to a specialist nurse or team if, for example, a patient with heart failure is admitted, to prompt the specialist nurse to see the patient the same or next day.

- Our stroke team have tested a ward round sheet to improve the effectiveness of ward rounds. This ensured that the team are clear about the patient's diagnosis and plan and everything the patient needs, such as a test, is arranged promptly to progress their care and treatment. The plan is to use the ward round sheet on every medical ward.

- Making all referrals within the hospital electronic rather than paper. We have introduced an electronic referral system for all patients who need an endoscopy to examine their gullet and stomach.

- Doctors in training have developed 'how to guides' for new doctors starting at the hospital to help them become familiar with processes as quickly as possible.

- Over the winter period, the Acute Medical Unit have had a ward based pharmacist and technician 7 days a week to ensure patients have their medicines reviewed promptly and their take home medicines are issued promptly on discharge. This will continue into 2020/21.

- We are planning to examine the co-ordination of the workload of medical teams during the day time at weekends to ensure it runs as smoothly as during the week and at night.

- In November 19, Wiltshire Council introduced a CHAT programme (Conversations Helping All Thrive) to change the way adult social care operates in Wiltshire. It was tested on Durrington ward with the aim that the social care team work more closely with people at risk of losing their independence and continue with them until their situation is stabilised to help the person retain control of their life.

Go – is on the day of discharge. A 'Go' working group, led by the Head of the Integrated Discharge Bureau (a team of specialist nurses, therapists and social workers) was set up to streamline discharge processes. This has included:

- Specialist discharge co-ordinators who support patients with complex discharge needs changed from being ward based to case based. This means each co-ordinator manages the same patient from admission to discharge which improves continuity and reduces delays.

- Patients are allocated to discharge co-ordinators with the most appropriate skills for their personalised care. For example, a patient who needs a home assessment and equipment is best assessed by an Occupational Therapist.

- We are planning that the discharge co-ordinators are able to receive referrals from the electronic whiteboards so the team can respond on the same day.

- The Older People's Assessment Liaison Team (OPAL) assess patients in the Emergency Department and for patients with social care needs, the team now include a social worker for a social care assessment within 4 hours. The team work closely with Medvivo (GP out of hours service) who are able to access community social care support so patients can go home within 4 hours. If needed, an appointment can be arranged for the patient to be reviewed in the Rapid Access Care of the Elderly clinic (RACE) within 48 hours.

- Introduction of a Trusted Assessor in February 2020 funded by Wiltshire Care Partnership. Care regulations require that patients admitted from a nursing or care home must be assessed by the matron or manager of the home before the patient is able to return, once fit to leave hospital. This often leads to delays. The Trusted Assessor is able to undertake an assessment on behalf of the care home, maintains contact with the home and assists on the day of discharge to ensure the patient has their medication, travel arrangements are in place and a discharge summary. It is too early to say whether this role will have an impact on reducing delays and will continue to be reported next year.

- We are working with GPs to be able to access the patient's primary care record. This enables discharge co-ordinators to view community staff reports and write reports themselves and upload them to the system. This helps to reduce patients being asked the same questions several times and reduces duplication and delays

3.2 Increase the number of patients who are able to be discharged to their preferred place of care at the end of their life

This year, applications for fast track funding increased significantly in comparison with the previous two years as did the number of patients successfully discharged to their preferred place of care at the end of their life (figure 25). This is important because personalised care at the end of life will result in a better experience tailored around what really matters to the person.

This was achieved by a multi-agency best practice group who took the following improvement actions:

1. End of life care specialist nurses facilitated earlier identification of patients eligible for fast track funding at the daily ward whiteboard meetings.
2. The fast track discharge paperwork was streamlined and made accessible 24/7.
3. A ward based information pack was introduced on all wards.
4. Ongoing 'lunch and learn' ward meetings were held every day in October for doctors, nurses and therapists to improve understanding of the fast track process and how to achieve a successful discharge

Figure 25: Fast track applications granted and patients discharged to the preferred place of care

Measure	2017/18	2018/19	2019/20	2019/20 overall performance
Number of fast track applications made	76	58	157	⇧
Number of successful discharges to preferred place of care	52 (68%)	36 (62%)	109 (69%)	⇧
Number of patients who died in hospital	24	22	48	
	⇧ Better ⇔ As expected ⇩ Worse			

3.3 Work towards achieving 60% best practice (a set of practices when used together improve patient outcomes) compliance for patients with chronic obstructive pulmonary disease.

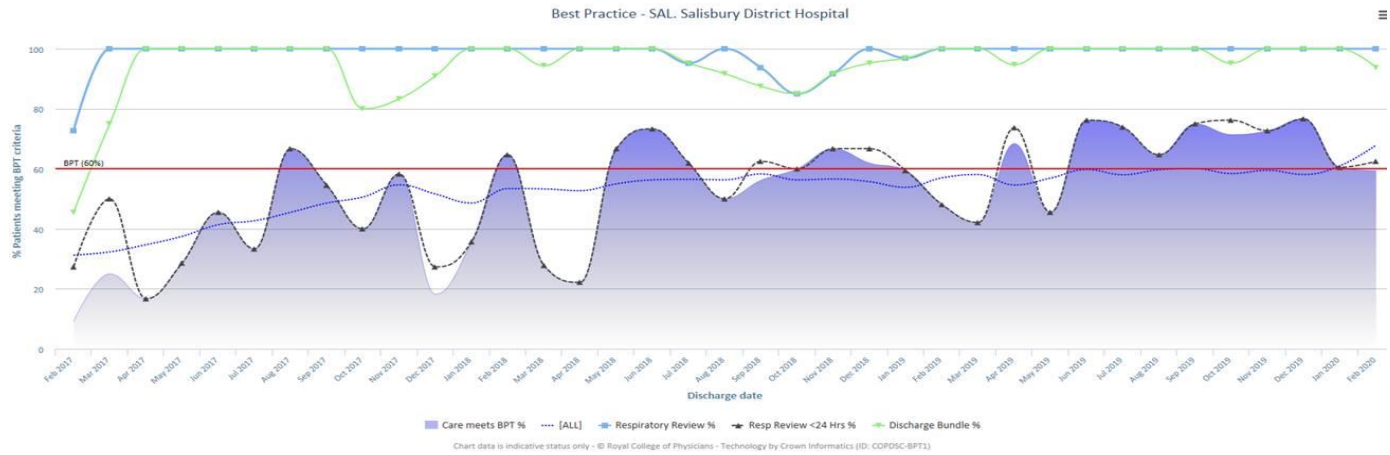
Chronic obstructive pulmonary disease (COPD) is a condition where a patient experiences airflow obstruction. Exacerbations and infections often occur, where there is a rapid and sustained worsening of symptoms beyond normal day to day variations. In 2017, NHS England introduced COPD best practice guidelines. These include:

- Patients receiving a specialist review by a member of the respiratory team within 24 hours of an emergency admission for worsening of their COPD and

- A discharge care bundle is completed before leaving hospital. These are a set of 5 high impact actions (review of the patient's medications and inhaler technique, a self-management plan and emergency drug pack, referral for stop smoking and a pulmonary rehabilitation course and follow up within 72 hours of discharge).

Specialist input has been shown to improve outcomes. Figure 26 shows the improvements the team have made over 3 years and since June 2019 have achieved the target of 60% for best practice by completion of the discharge care bundle and specialist team review at weekends. The discharge care bundle has also been shown to reduce re-admission rates of patients with COPD. In 2018, in the national COPD clinical audit of 58 patients who received care at this hospital, 47 (81%) were not re-admitted to hospital within 30 days of discharge compared to 75% nationally.

Figure 26: National COPD audit programme of Salisbury District Hospital compliance with best practice (target 60%)



3.3 Work towards achieving 80% best practice compliance for patients having an emergency laparotomy.

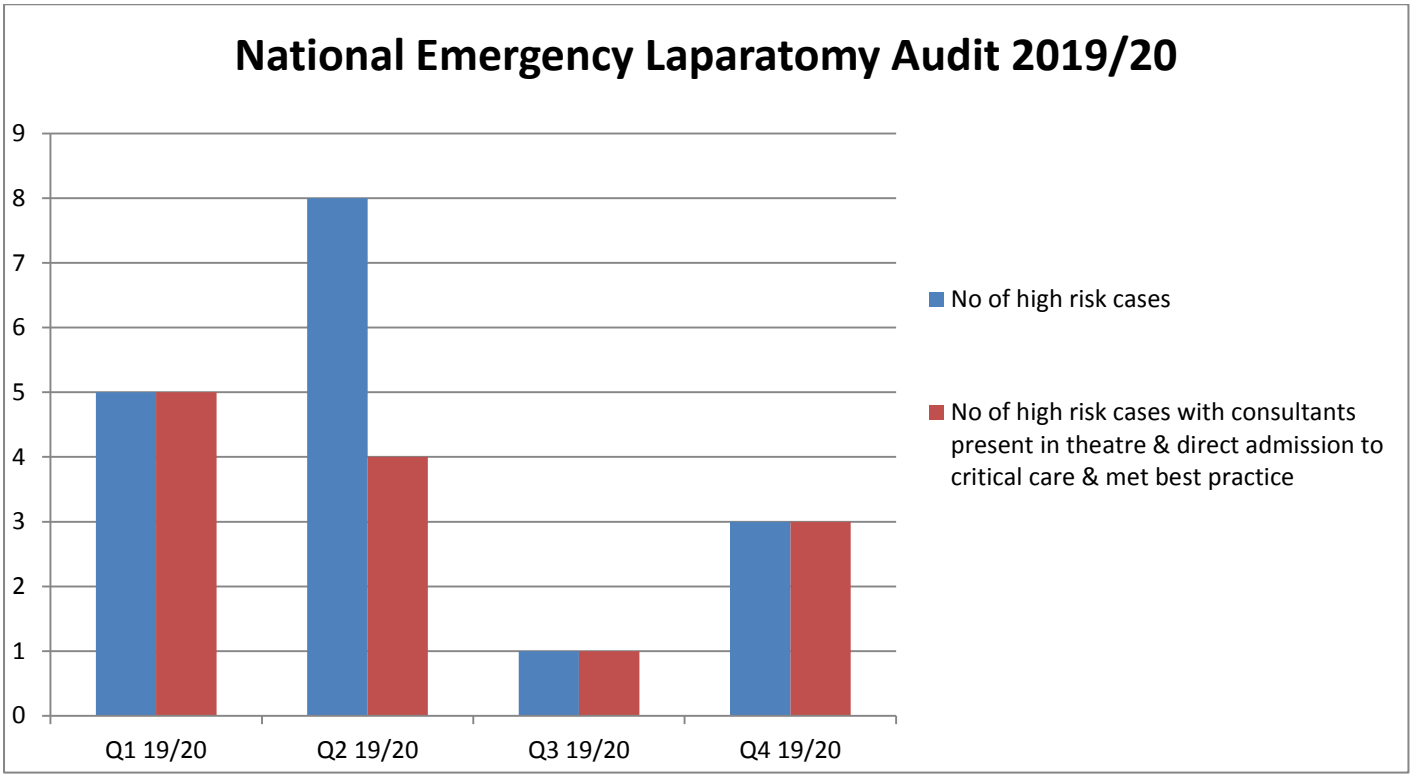
High risk patients who need an emergency laparotomy (abdominal surgery) are those who have a predicted risk of death of 5% or higher. A score is calculated taking into account the patient's age, vital signs, blood results and history of heart and lung disease. The best practice key factors are that:

- A consultant surgeon and consultant anaesthetist is present during surgery AND

- The patient is admitted directly to a critical care unit after surgery.

Figure 27, shows 13 (76.4%) of 17 high risk patients received best practice. In Q2, 4 patients had surgery performed by senior trainees who were eligible to apply for a consultant post but were not yet in a consultant post. In Q2, post-operative length of stay of all patients receiving an emergency laparotomy was 11 days compared to a national mean of 14 days.

Figure 27: National Emergency Laparotomy Audit programme of Salisbury District Hospital compliance with best practice (target 80%)



How we reported progress throughout the year:

Compliance with best practice for patients with chronic obstructive pulmonary disease and an emergency abdominal laparotomy were reported to the Clinical Management Board. Patient flow was reported to the Transformation Board. Patients able to be discharged to their preferred place of care were reported to the End of Life Strategy Steering Group.

What our patients have told us and what we plan to do to improve:

- 'More verbal and written information on do's and don't would have been very helpful when discharged '. We have tested a 'table talker' on Spire ward and Farley ward family room. The 'table talker' is designed to promote conversations about the patient's plan of care and highlights the importance of staying active in hospital. We will be gathering patient and relative feedback on the initiative and if it is successful we will make it available on every ward in the hospital.
- 'Time it took to be discharged'.
- 'I received excellent care during my 10 days in hospital and am very impressed and grateful by the level of social care given to me since my discharge'

Priority 4 Design new models of care to provide patients with more convenient access to services and make the most of digital care

Description of the issue and reason we prioritised it:
The NHS is undertaking a journey of transformation, whilst experiencing rising demand for its services, and reduction in social care provision, as the population ages and more people live with long term conditions. We need to do more to design new models of care to provide patients with more convenient access to services and health information. The increase in same day emergency care is one of the commitments in the NHS Long Term Plan and will reduce pressure on hospital beds, improve length of stay and patient experience. By moving care out of hospitals and closer to the patient we will improve the health of the population and the quality of care.
We need to make the most of digital care and get the most out of our IT systems to drive efficiency and deliver improved patient outcomes. We also need to use the data from our systems to benefit patients in the acute care setting and continued care once they leave hospital as part of a whole health economy.

What we did in 2019/2020:

4.1 Work with our partners to reduce admissions and extend our Rapid Access Care of the Elderly clinics (RACE) to other parts of Wiltshire to provide care closer to patient's homes

The Older People's Assessment Liaison Team is a team of specialist therapists, nurses and a senior doctor which operates 7 days a week. The team assess patients with moderate or severe frailty and those with complex needs in the Emergency Department, Short Stay Emergency Unit and the Acute Medical Unit aiming for a safe and timely discharge The majority of these patients are discharged back home supported by the community team or to a community hospital. Some patients require support and follow up from their GP, specialist nurse or senior doctor either in the community or at one of the RACE clinics where they can be seen by a consultant in older people's medicine within 24 – 48 hours of referral.

The OPAL team have extended care closer to patient's home through a weekly virtual ward round. This means community teams, GPs and the OPAL team hold a teleconference to discuss patients and make plans for their care. This may involve making recommendations to a GP or arranging for community teams to follow up actions or a senior doctor (consultant in the care of the elderly) from the hospital visiting the patient at home. The OPAL team have sustained a high percentage of patients discharged the same day or within 24 hours as last year (figure 28).

Figure 28: Patients seen by the OPAL team and discharged the same day or within 24 hours of assessment

Measure	Target	2017/18	2018/19	2019/20	2019/20 overall performance
Number of patients seen by the OPAL team		962	1398	2115	⇧
Number of patients discharged the same day		466 (48%)	588 (42%)	910 (43%)	⇧
Number of patients discharged within 24 hours of OPAL team assessment	50%	Not recorded	1281 (92%)	1895 (90%)	

4.2 Achieve 75% of patients with a confirmed pulmonary embolus being managed in a same day setting where clinically appropriate.

Same day emergency care enables patients requiring emergency care to be appropriately managed on the same day, either without admission to hospital at all or admission for only a few hours. The key to success of same day emergency care is rapid assessment, diagnosis and treatment by a senior doctor in the Emergency Department, Acute Medical Unit and the Surgical Assessment Unit.

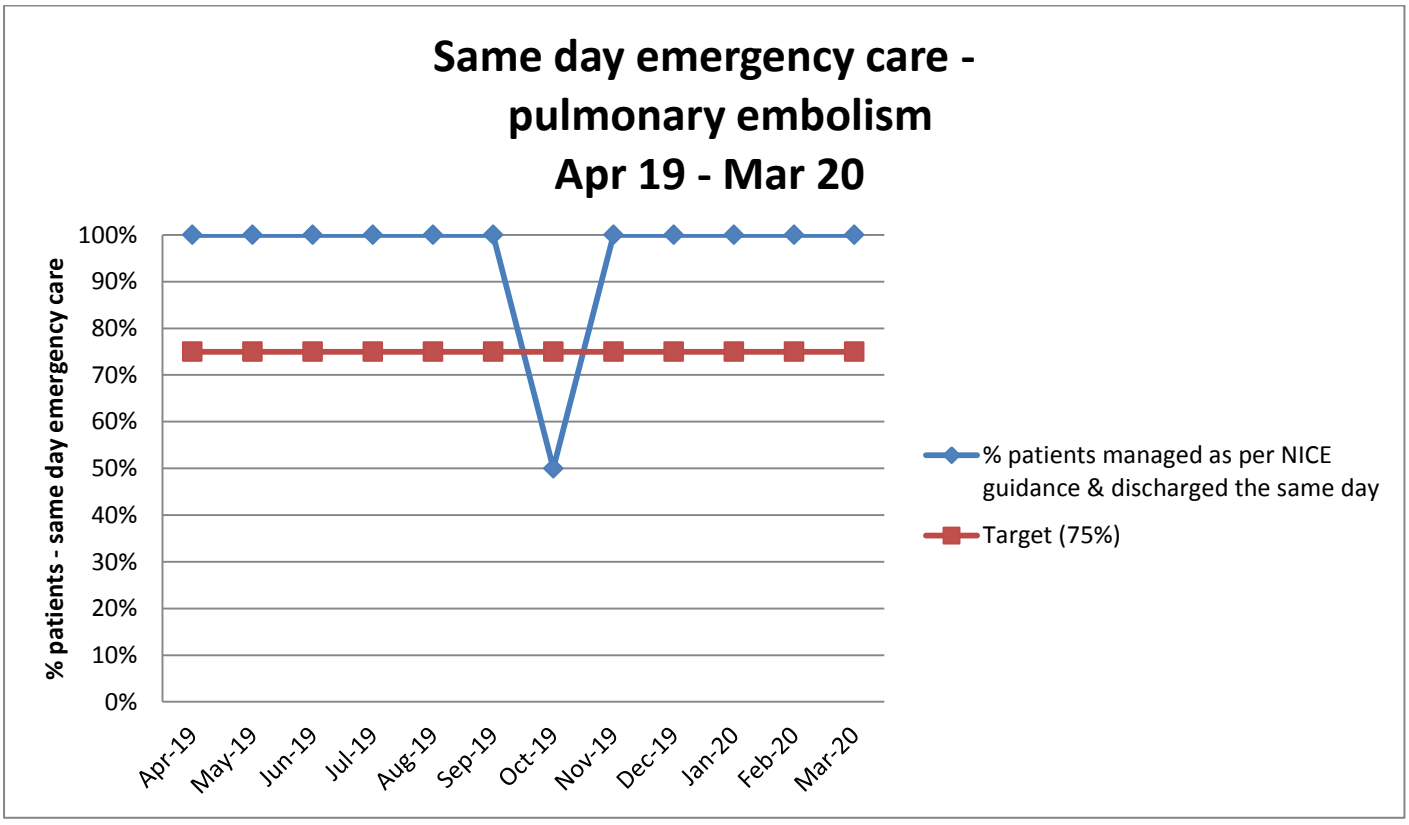
One condition that can be safely managed as same day emergency care is a pulmonary embolism. This is a blood clot that dislodges from the deep veins and travels round the circulation to the pulmonary arteries and may cause breathing difficulties. Pulmonary embolism is likely to occur if the patient has a history of blood clots, recent surgery, is acutely unwell, has cancer or is pregnant.

Diagnosis of a pulmonary embolism is made by an assessment of the patient's general medical history, a physical examination, chest X-ray and blood test. If the blood test is positive, an immediate CT or VQ scan and anticoagulant treatment (blood thinning) is started.

Figure 29 shows that of 39 patients who were clinically suitable for same day emergency care, all received a CT or VQ scan and started blood thinning treatment, and 37 (95%) went home the same day with an appointment to be seen by one of our specialist nurses in clinic.

The Trust continues to be an exemplar site for the prevention and treatment of blood clots and has led the way in developing same day emergency care for patients with deep vein thrombosis and pulmonary embolism.

Figure 29: Patients with a pulmonary embolism managed and discharged the same day (target 75%)



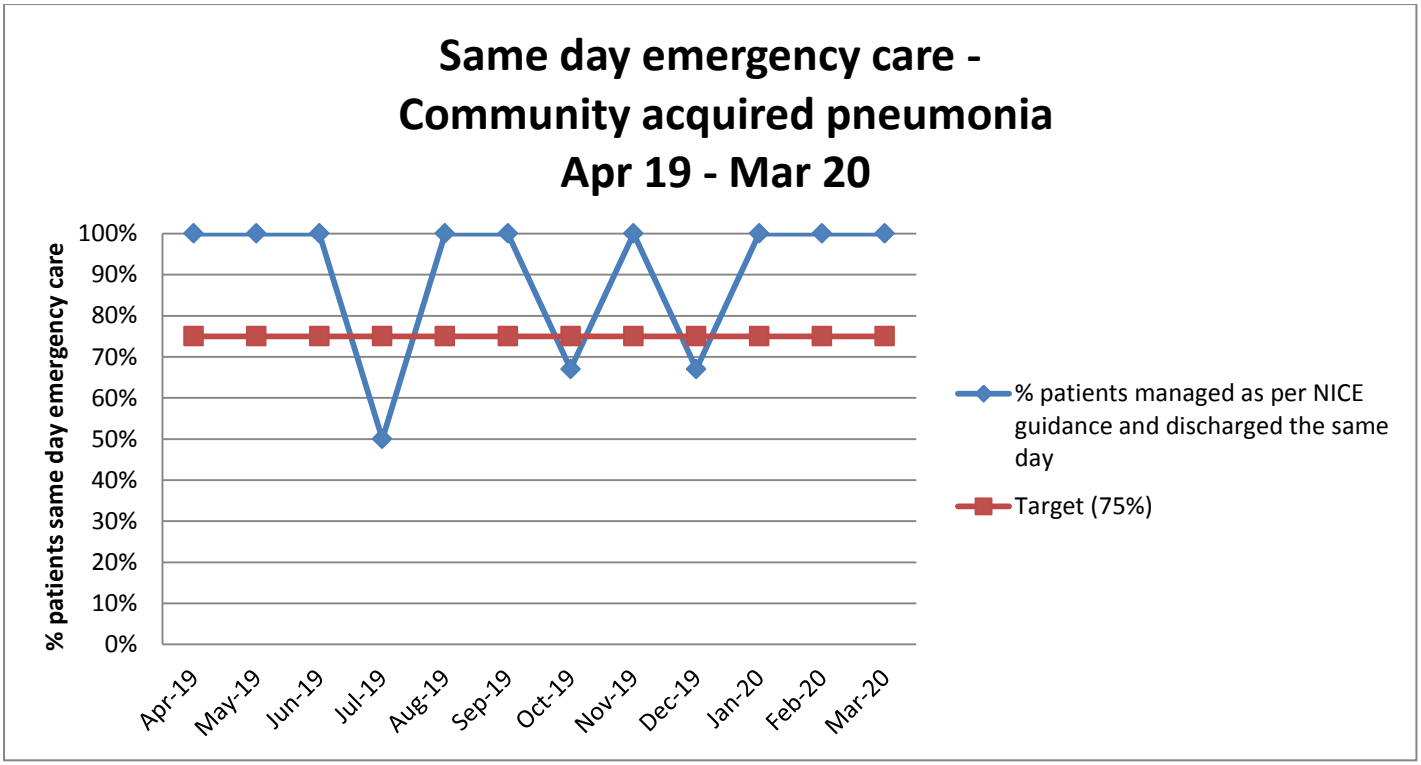
4.3 Achieve 75% of patients with confirmed community acquired pneumonia being managed in a same day setting where clinically appropriate

Another condition that can be safely managed in a same day setting is pneumonia which is an infection of the lung tissue which can cause breathing difficulties. Diagnosis of pneumonia is based on signs and symptoms and is confirmed by a chest X-ray. Pneumonia is a significant cause of patients being admitted to hospital.

Diagnosis of pneumonia is made by a clinical assessment and chest X-ray within 4 hours of arriving in hospital. In addition, a CURB65 score for pneumonia severity is recorded to help decide whether the patient needs to be treated in hospital or in a same day emergency setting. A patient with a CURB65 score of 0 – 1 can be safely managed in a same day emergency setting, but if the score is 2 or more hospital admission is needed. Treatment is a five day course of antibiotics started within 4 hours of admission to hospital.

Figure 30 shows that for the 31 patients who were clinically suitable for same day emergency care, they all received a chest X-ray, had a CURB score of 0-1 and started antibiotic treatment, but only 28 (90%) went home the same day with an appointment to be see their GP.

Figure 30: Patients with community acquired pneumonia managed and discharged the same day (target 75%)



4.4 Achieve 75% of patients with confirmed atrial fibrillation being managed in a same day setting where clinically appropriate

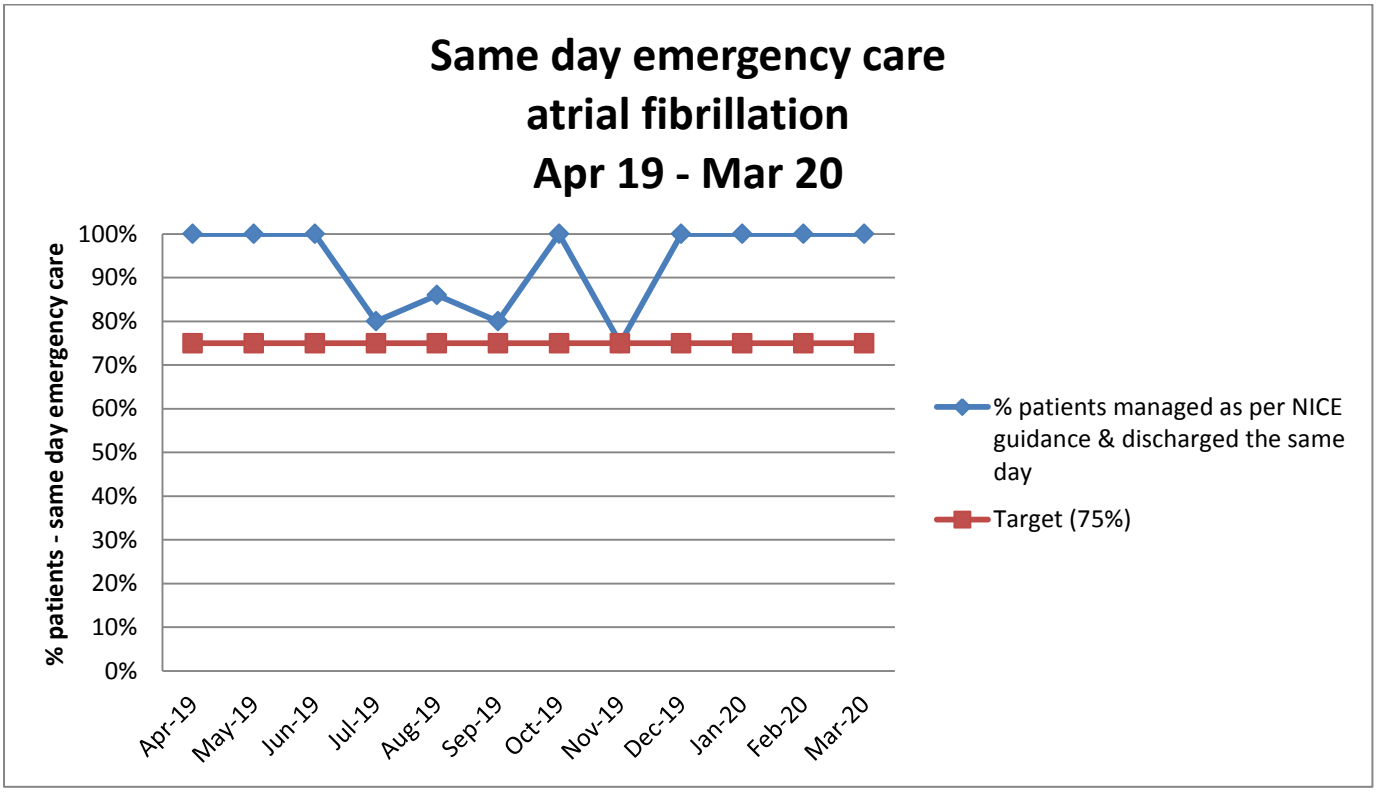
Another condition that can be safely managed in a same day setting is atrial fibrillation. This is an abnormal heart rhythm and, if left untreated, is a significant risk factor for stroke and other conditions. Men are more commonly affected than women and the prevalence increases with age. The aim of treatment is to prevent complications, particularly stroke, and alleviate symptoms.

Diagnosis of atrial fibrillation is made by taking the pulse to detect an irregular pulse of people who present with shortness of breath, palpitations, fainting, chest discomfort, stroke or a Transient Ischaemic Attack (TIA). An assessment includes an electrocardiogram (ECG), stroke and bleeding risks. Drug treatments

include blood thinning medication to reduce the risk of stroke, and treatment to restore or maintain the normal heart rhythm or to slow the heart rate in people who remain in atrial fibrillation. Non drug treatment includes cardioversion to return the heart to a normal rhythm or ablation treatment to create scar tissue to stop the abnormal electrical impulses that cause atrial fibrillation.

Figure 31 shows that 63 patients were clinically suitable for same day emergency care. All patients had an ECG and a risk score calculated, were started on rate or rhythm controlling drugs and blood thinning treatment if they were not already taking these drugs. 59 (94%) patients went home the same day.

Figure 31: Patients with atrial fibrillation managed and discharged the same day (target 75%)

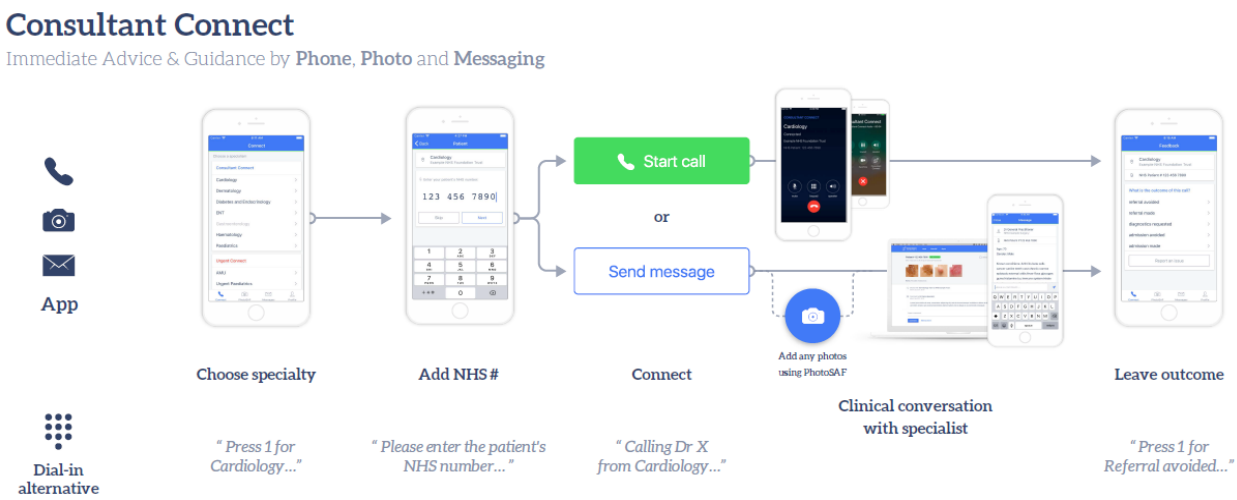


4.5 Work with our partners to transform the way we provide outpatient services, including digital solutions, by achieving our action plan year 1 milestones

Our patients and GPs have told us that we need to make our services accessible and responsive with clear points of contact via telephone or digital media and that appointments and letters should be sent out electronically where possible. The Trust is committed to transforming outpatient services as outlined in the NHS Long Term Plan to manage the rising demand and promote digitally enabled care.

In February 2020, in partnership with GPs, we introduced 'Consultant Connect' in four specialities. This is a means of enabling GPs to have immediate telephone access to a consultant for advice and guidance. This benefits patients by immediate advice from a specialist whilst sat with their GP. If any tests are required the GP can arrange them in the usual way. This system helps to reduce unnecessary referrals or admissions to hospital. Figure 32 shows how it works.

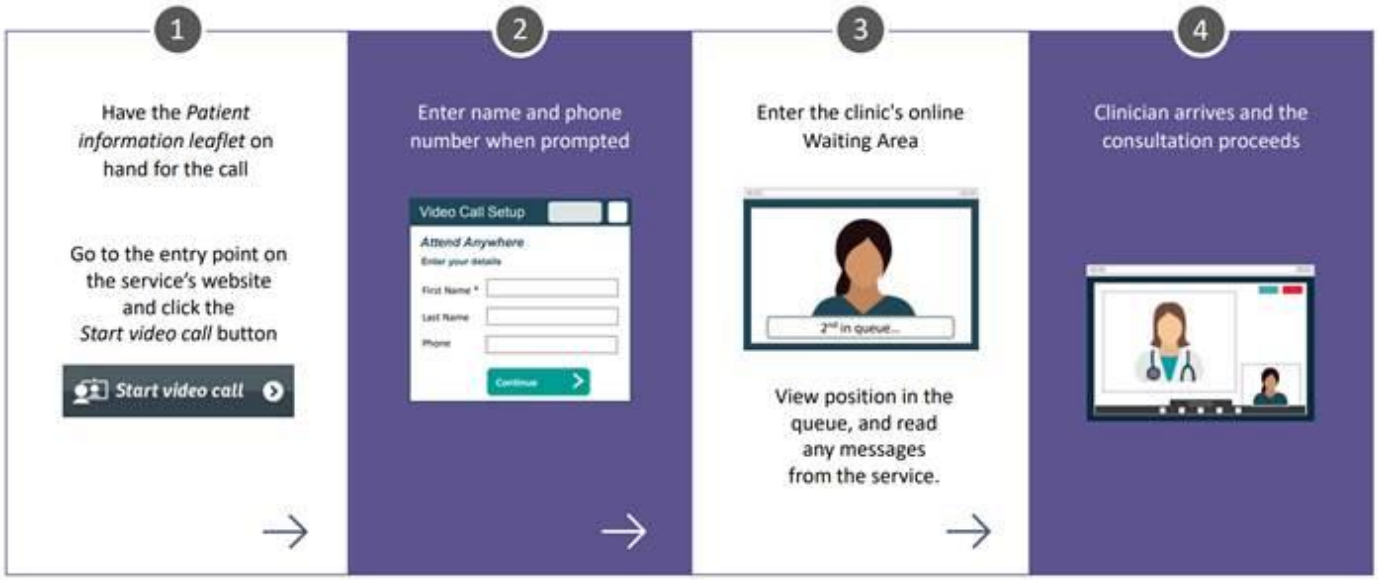
Figure 32: Consultant Connect – how it works



The NHS Long Term plan estimates that patients will be able to avoid up to a third of face-to-face outpatient visits by the use of 'virtual' or 'digitally-enabled' clinics, removing the need for up to 30 million outpatient visits a year. We have embraced digital technology to ensure that patients do not have to travel to the hospital except when a face to face consultation, physical examination or treatment is necessary.

We have increased the use of 'virtual' or digital-enabled clinics, including telephone clinics, virtual review clinics and video call clinics using 'Attend Anywhere'. The patient is able to have a consultation in the comfort and privacy of their own home, workplace or school using a computer, laptop, tablet or smartphone in the same way as a face to face appointment at the hospital. It avoids the need for patients to travel to the hospital unnecessarily and ultimately is more accessible and convenient for our patients. Figure 33 shows to use 'Attend Anywhere'.

Figure 33: How to use 'Attend Anywhere'



In January 2020, Dr Chris Anderson, Consultant Paediatrician held the first video call clinic using 'Attend Anywhere' allowing 4 patients to attend their follow-up appointment from the convenience of their own home using a computer. All four of the patients who attended were very positive about the experience and would like to attend their next appointment by video call.

What our staff said:

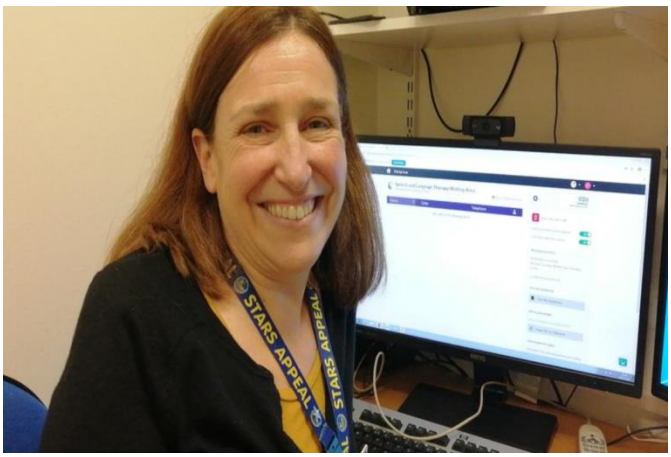
'The quality of the interaction between parents and their children is completely different when they are relaxed and in their own home - and this really helps me foster a 'team' approach to decision making'- Dr Anderson, Paediatric Consultant.

What our patients said:

'It is easier as I do not have to travel to the hospital, but the clinical advice was as good as before, knowing the paediatrician beforehand helped to make it an easier experience.'

In February, the Speech and Language Therapy team held their first video consultation appointments with a total of 5 appointments completed to date. Some appointments were completed in school with participation from parents.

Sandra Treslove, Speech and Language Therapist holding the first video consultation appointment



"I was able to meet with school staff who are supporting the child in school. So much easier to demonstrate speech activities than to write them in a programme for carry-over in the school setting. Able to observe how the child is being supported in school without offering an outreach appointment (hour drive away). Encourages liaison between school and home setting''

Benefits patients identified:

- Did not have to take time off work/school
- More convenient
- Did not have to arrange childcare/care for a relative
- Shorter time spent in the waiting room (than if attended in person)
- More comfortable waiting experience
- Less stressful
- I did not have to allow extra time before and after my appointment for parking, traffic, leaving work or school.

Since February, 16 specialities have introduced 'Attend Anywhere' and 953 consultations have been held by 101 doctors and nurses up to 29 April 2020.

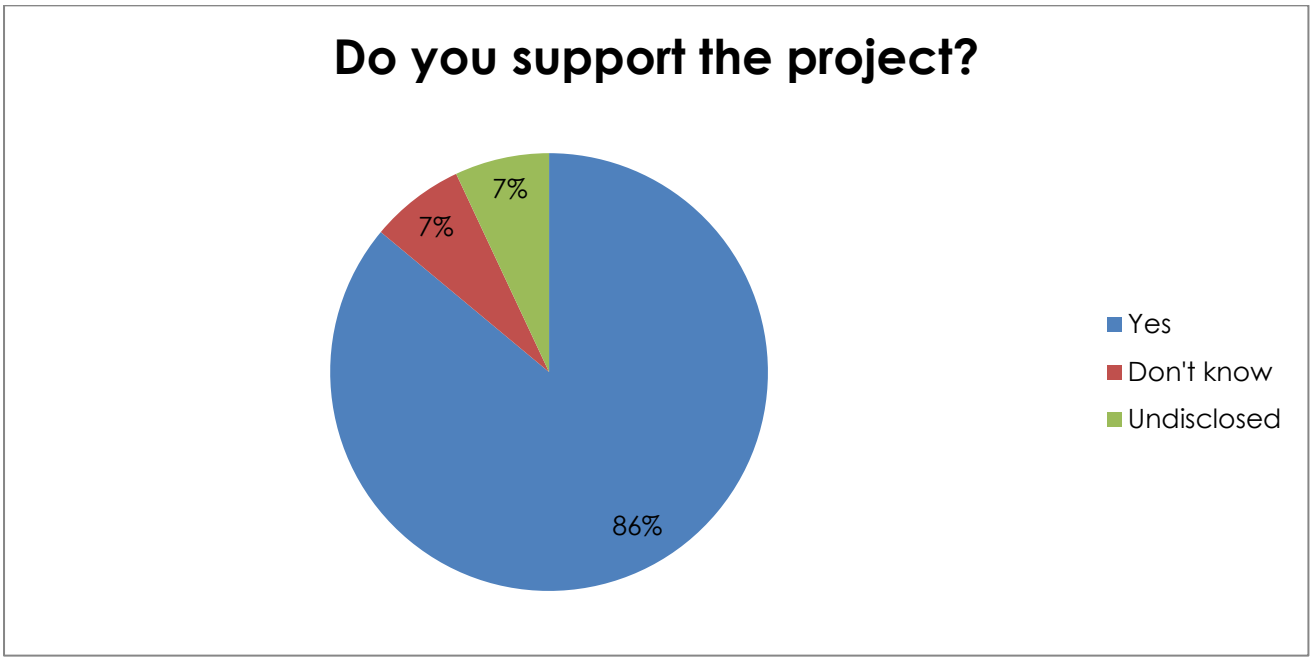
4.6 Work with our partners to develop the hospital site as a health and wellbeing campus over the next 5 years

We started the first phase of consultation events about our Salisbury Health and Wellbeing Campus project in March 2019 which included two public exhibition events, a stakeholder preview and a media briefing event. The aim was to launch the project and gather initial feedback from the public.

- 132 people attended in total:
    - 11 stakeholders
    - 3 media (Salisbury Journal, Spire FM, BBC Radio Wiltshire)
    - 32 general public on day 1 (Britford Community Hall)
    - 86 general public on day 2 (Red Lion Hotel, Salisbury)

- 43 gave written feedback on the day (37 were in support of the project)

Figure 34: Percentage of people who support the Salisbury Health and Wellbeing Campus project



- Of the 43 feedback forms received at the consultation events, 86% of respondents stated they supported the project
- 3 forms were undisclosed and a further 3 respondents stated they were not sure
- No forms stated they did not support the proposal
- Of those who were not sure, 2 felt that it was too early in the process for them to decide
- The most popular reasons for supporting the project were:
    - education opportunities
    - modernising the hospital,
    - community and city benefits
    - sustainability and future proofing

Questions and comments were addressed by the project team representatives during the exhibition. The team received overwhelmingly positive feedback with the majority of attendees agreeing that the project needs to happen.

Since April 2019, a business case has been developed and agreed by the Board in principle. Currently, work is ongoing to raise the profile and lobby the Government about the project. Positive discussions about the development of the site continue locally with the planning authorities. Further engagement with the public is planned in the summer of 2020.

How we reported progress throughout the year

Frailty pathway work, same day emergency care and outpatient transformation were reported to the Transformation Board. The development of the hospital site is reported to the Board.

Priority 5: Improve the health and wellbeing of our staff

Description of the issue and reason we prioritised it:

Health and wellbeing is now recognised as more than a matter for individual attention – successful organisations have recognised that good health is a key enabler to good business. Our staff have a direct impact on clinical outcomes and the experience of our patients. We are clear that when our staff are well and happy, the experience of our patients improve. Our Health and Wellbeing strategy acknowledges that the work and health and wellbeing of our staff are interlinked, and commits to promoting a culture where wellbeing is embraced by all of our employees.

Our national staff survey results 2018 showed that we needed to do more to take positive action on staff health and wellbeing. We needed to do more to support our staff with long term conditions, in particular, mental and emotional wellbeing and reconnect with our staff as carers, in caring for themselves, their families and patients. Equally, there is clear evidence to show that staff who feel engaged and can contribute to improvements at work and feel well supported by their managers provide better patient care.

What we did in 2019/2020:

5.1 Improve the health and wellbeing of our staff by achieving the Health and Wellbeing strategy action plan year 1 milestones.

The year 1 milestones were:

1) Improve our Occupational Health Service to ensure best practice is offered in a timely manner - this year, the service has reviewed all its practices to make them as responsive as possible to the needs of staff and make best use of appointments. Next year, a new software package will be introduced to enable the electronic capture of referral to appointment times. The software will also be able to send texts appointment reminders to staff to help to reduce the 'did not attend' rate.
2) We introduced a monthly clinic provided by Wiltshire Council health trainers to support staff make positive lifestyle changes – this has been in place for over a year and provides support mainly for staff who want to stop smoking, drinking alcohol above higher risk levels, weight management, emotional health and wellbeing, getting active and healthy nutrition.
3) Consider the introduction of an employee assistant programme to support staff with emotional health needs to contact a 24 hour telephone helpline. A business case has been prepared and will be presented to the Board later this year.
4) Train our staff to be able to provide mental health first aid to prevent staff developing poor health – our lead nurse for dementia care has undertaken a training course to train our staff. In March 2020, 10 members of staff have been trained in providing mental health first aid.
5) Re-instate the health and wellbeing working group to lead improvements and measure the effectiveness of our service. A health and wellbeing strategy group has continued to meet throughout the year and report activity and initiatives to the Board. A 'well-being at Salisbury' working group was also set up to generate ideas to improve wellbeing. Ideas centred on improving the use of open spaces for staff to enjoy, cycle to work scheme and hydration have been developed this year.
6) Expression of interest to test the new NHS healthy weight declaration – this has not been progressed this year.

Our national staff survey 2019 results showed that when respondents were asked 'Does your organisation take positive action on health and wellbeing 27.2% of staff said 'yes, definitely' compared to 28.2% in other acute Trusts. This shows there is more work needed to achieve the best result of 45.4% in other acute Trusts. We plan to do this through a programme of work to ensure the hospital is the 'Best Place to Work'. The programme will launch a diagnostic and listening phase to truly understand the culture of our hospital which will help the Board develop plans for the future.

5.2 Train more staff and teams in quality improvement methods and provide support to enable them to lead and implement sustainable change.

The Trust is committed to improvement, to ensure that we are meeting the needs of our local population in all that we do. It is recognised that adopting a continuous quality improvement approach delivers better patient outcomes. To ensure we can meet our full potential, we need to 'make change' as part of everyone's job, every day, in every part of the hospital. This requires a change in three areas; our culture, our capability and our capacity. We want staff to be open to try new things, for managers and leaders to offer support and work jointly with our staff and to take ownership for improving things within their control.

We have developed a range of quality improvement tools available to all staff to help them bring about change. https://viewer.microguide.global/guide/1000000334#content,ee9d87aa-dff5-4a36-8b3b-9e7319126454.

We have also trained Quality Improvement coaches to help and support teams and services to ensure successful improvement work is completed and ideas are shared to help people learn. To date we have trained 37 coaches.

Patient and public involvement is a key part of quality improvement and to support staff to do this our engagement toolkit has been updated and published https://viewer.microguide.global/guide/1000000334#content,1df17a5a-25ee-4524-ab5e-96031930d247 Patients, users, carers, community representatives and the general public continue to help us develop and co-design our local health services. For example, they have helped us with the redesign of our website and the development, design and content of our patient information app. We have also received help with the content and design of a 'table talker' (designed to promote conversations surrounding the plan of care and highlight the importance of staying active in hospital) and have helped shape the roll-out of our 'Attend Anywhere' service (see priority 4.5 and figure 31).

5.3 Continue with our recruitment and retention campaign to reduce our staff vacancy rate to less than 5%

Our vacancy rate for all staff in 2018/19 was 6.93% compared to our target of 5%. By March 2020, the rate for 2019/20 had reduced to 1.21%**.** Our turnover rate of staff remains at 9.27%, better than our target of 10%. The main focus of recruitment activity has been overseas recruitment of registered nurses and in August we saw the arrival of 91 nurses reducing our vacancy rate by March 2020 to 0.66%. To ensure we retain newly recruited and existing registered nurses, we are working with NHS Improvement to ensure all possible actions are taken and have been praised for the initiatives in place. A recent example was the introduction of a manager's breakfast club which enables managers at all levels to share improvements and learn.

At the same time we continue to work on recruiting 'hard to fill' vacancies in some medical specialities. This is often due to a national shortage where it has not been possible to fill these vacancies. This has led teams to look at new ways of working, with some work being undertaken by advanced nurse practitioners or working in partnership with other Trusts to form out of hours rotas.

5.4 Improve provision and access to learning and development to support our staff.

This year, we have worked with our staff to ensure a consistent message about the opportunities available for training and development and made them easier to access.

We have promoted Apprenticeship training in a range of jobs and increased the uptake of them from 10 in 2018/2019 to over 90 people undertaking an Apprenticeship this year.

We continue to work with the South West Leadership Academy. This is open to all staff who are able to attend a number of training days and workshops. New this year is a four workshop programme for clinical leaders. This covers 1) understanding the organisation and the role of Executive Directors 2) Leadership styles and managing teams 3) Principles of coaching and productive conversations 4) Quality improvement and finance. This year, 20 clinical leaders have attended these workshops.

We continue to run a Leadership Forum for leaders to come together to share experiences, learn from one another and hear from experts. In November, we were privileged to welcome Professor Michael West, from the Kings Fund who gave an inspirational workshop on Compassionate Leadership.

This year, we have improved the opportunity to undertake simulation training by taking it out to clinical staff in wards and departments as well as providing classroom sessions. This gives clinical staff the opportunity to practice skills, such as resuscitation and safeguarding and increases their knowledge and confidence when dealing with clinical situations.

5.5 Achieve 80% uptake of the flu vaccination of our frontline staff

On 30 September 2019, our seasonal flu campaign was launched by our Occupational Health and Wellbeing Service with a presentation given by a Public Health England expert. It is essential that our frontline staff have the vaccination to reduce the risk of the flu virus spreading across the hospital and our community. At the end of our flu campaign in February 2020, 80% of our frontline staff had received the vaccination.

How we reported progress throughout the year

Staff health and wellbeing was reported by the Health and Wellbeing Strategy Group to the Workforce Committee. Training our staff in quality improvement was reported to a newly established Quality Improvement Steering Group and the Transformation Board.

Part 2B: This section sets out our quality priorities for 2020/2021

2.1 Our priorities for quality improvement in 2020/2021 and why we have chosen them

Our quality priorities in 2019/2020 showed a very positive picture of improvement with an increase in the number of patients screened for smoking and alcohol use, given brief advice, treatment or referral to a specialist service. We held a successful launch with Mencap of the national 'Treat me Well' campaign. Our midwives undertook a successful pilot of midwifery continuity of carer with very positive feedback from women. Our teams achieved positive benchmarks on a range of infection prevention and control measures with some of the lowest rates of gram negative bloodstream infections in the region. Good outcomes in the management of sepsis and best practice management of patients with chronic obstructive pulmonary disease. We saw a significant increase in the number of patients who were able to go to their preferred place of care at the end of their life, and continued improvement in the number of older people cared for by the OPAL team frailty pathway. Same day emergency care targets were met for patients with a pulmonary embolus, atrial fibrillation and pneumonia. We have started to progress new models of outpatient care with 'Attend Anywhere' and 'Consultant Connect'. Positive work was undertaken to improve staff health and wellbeing and train our staff in quality improvement.

More work is required to improve the diagnosis and treatment of urinary tract infection and to consistently implement the one key falls prevention measure of lying and standing blood pressure in patients over 65 to reduce the number of inpatient falls. Improvement work is required to reduce the number of patients who acquire a category 3 or 4 pressure ulcer in hospital. We need to implement the Medical Examiner system to scrutinize all hospital deaths and improve the safety and effectiveness of the hospital at the weekend so that patients who need a medical review receive it. We also need to reduce the number of missed and delayed cancer diagnosis by improving cancer pathways. We will also review antenatal pathways and use of the Maternity Day Assessment Unit to ensure women are assessed by a senior doctor in a timely manner

Further work is required to improve patient flow through the Ready, Steady Go programme to ensure patients are in the right place at the right time and cared for by the right people. We have combined the learning from last year with information gathered by a broad range of methods to generate our priorities for improvement in 2020/2021.

These priorities were identified by listening to patient stories at the Board, meeting with patients, families and carers, the public, our staff and governors, Warminster Health, Wellbeing and Social Care Forum, our community partners, local GPs and our commissioners. Some of their comments are included in this report. Our priorities are also influenced by the NHS Long Term plan, the B&NES, Swindon and Wiltshire Sustainability and Transformation Partnership (STP), our strategic priorities, corporate risk register and existing quality concerns and our aspiration to achieve an outstanding rating by the Care Quality Commission at our next inspection.

We have also used information from three national patient surveys published in 2019 (Inpatients (2019), Urgent and Emergency Care (2018) and Children and Young People (2018) and our staff survey 2019 and identified themes from mortality case reviews, complaints and concerns, adverse incidents where we have caused harm and clinical audit, to help us decide on our quality priorities.

In 2019/2020, we had five very broad priorities with different work streams. Some of these work streams will continue to be reported in this quality account in section 2.2.

NHS England and NHS Improvement require the Trust to report progress of:

- Care Quality Commission inspection progress of improvement actions
- Learning from deaths and improvement actions
- Seven day hospital services – implementing the priority clinical standards
- Learning from national investigations – Freedom to Speak Up
- Annual report of doctors and dentists in training rota gaps – improvement plan

Our priorities for 2020/2021* are:

Priority 1 Work with our partners to prevent avoidable ill health

Priority 2 Introduce the new national patient safety strategy to reduce avoidable harm

Priority 3 Work towards the implementation of the national learning disability improvement standards

Priority 4 Work with our partners to value patient's time by ensuring that they are only in hospital when necessary.

*These priorities are **not** ranked in order of priority. The Trust Board agreed the 2020/2021 priorities on 4 June 2020.

Progress in our priority areas will be measured and monitored through the Trust's quality governance structure. To enable the Trust Board to do this, the Clinical Governance Committee and Clinical Management Board will receive monthly reports and ask for further work where assurance is needed. The Trust Board minutes and reports can be viewed on the Trust website at the link below: http://www.salisbury.nhs.uk/Pages/home.aspx

***Our priorities for 2020/21 may need to change in the light of risks emerging from the global coronavirus (COVID-19) pandemic and once our recovery plan is underway.**

The following section describes the issue, the reason for prioritising it and what we are planning to do:

***Priority 1 – Work with our partners to prevent avoidable ill health**

Description of the issue and reason for prioritising it:

The NHS Long Term Plan sets out commitments for action that the NHS must take to improve prevention of avoidable illness and its exacerbations. It does so whilst recognising that a comprehensive approach to preventing ill health also depends on action that only individuals and communities can take to tackle the wider threats to health. The NHS Long Term Plan is our opportunity to not only treat people, but also prevent them from getting ill in the first place and improve their quality of life. In particular, better antibiotic prescribing will reduce treatment failure and antimicrobial resistance and improve outcomes. Our staff flu vaccinations are crucial for reducing the spread of flu during winter months with a significant impact on the health of patients, staff and their families. Evidence shows us that continuity of midwifery care is safer than conventional care and our ambition is to increase the number of women who are able to benefit from this model of care in 2020/21.

What we will do in 2020/2021:

1.1 To reduce antimicrobial resistance, achieve 90% of all antibiotic prescriptions for urinary tract infection in patients over 16 that meet the National Institute for Health and Care Excellence guidance for diagnosis and treatment.

1.2 Achieve 90% of our frontline staff having the flu vaccination.

1.3 Work towards offering 51% of vulnerable women continuity of carer throughout their pregnancy, labour and postnatal period by March 2021.

How we will report progress throughout the year:

We will report antimicrobial stewardship to the Infection Prevention and Control Working Group, flu vaccination rates to the Workforce Committee and continuity of midwifery care to Maternity Governance Group.

*Priority 2 – Introduce the new national patient safety strategy to reduce avoidable harm

Description of the issue and reason for prioritising it:
Patient safety is a priority for the NHS which aims to be the best and safest healthcare system in the world. Patient safety is the avoidance of unintended or unexpected harm to people during the provision of health care such as medication errors, never events, harm from sepsis, pressure ulcers, infections and falls resulting in fractures or serious harm. Improving maternity and neonatal safety is also a priority.
A new NHS Patient Safety Strategy was launched in July 2019. The Strategy enables the NHS to continuously improve patient safety. To do this the NHS will build on two foundations: a patient safety culture and a patient safety system. The aim will support the development of both foundations by:

- Improving the understanding of safety by drawing intelligence from multiple sources of patient safety information.
- Equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system.
- Design and support programmes that deliver effective and sustainable change in the most important areas.

The impact will be continuous improvement in the safety culture, better incident reporting to inform patient safety workstreams, reducing death and complication rates, improving patient experience and reducing the cost of litigation.

What we will do in 2020/2021:

2.1 Implement the Medical Examiner system in scrutinising all non-coronal deaths in the hospital by March 2021.

2.2 Increase the percentage of patients who need a consultant review at the weekend receiving it from 77% in 2019 to 90% in 2020 thereby improving the safety and effectiveness of the hospital at the weekend.

2.3 Reduce the number of patients who fall in hospital resulting in a fracture or major harm by 10% in 2020/21.

2.4 Reduce the number of patients who acquire a category 3 or 4 pressure ulcer during a hospital admission by 20% in 2020/21.

2.5 Reduce harm from sepsis by increasing the number of patients admitted as an emergency and as an inpatient, treated with intravenous antibiotics within an hour of diagnosis of sepsis.

2.6 Review antenatal pathways and use of the Maternity Day Assessment Unit to ensure women with high risk pregnancies are identified and receive an assessment by a senior doctor in a timely manner.

2.7 Reduce the number of missed or delayed cancer diagnoses by improving cancer pathways.

How we will report progress throughout the year:
We will report progress with the implementation of the Medical Examiner system to the Mortality Surveillance Group, report falls resulting in harm and pressure ulcers to the Patient Safety Steering Group, antenatal pathways to Maternity Governance meetings and cancer pathways to the Cancer Board and daily consultant review at a weekend to the Clinical Management Board.

Priority 3: Work towards the implementation of the national learning disability improvement standards

Description of the issue and reason for prioritising it:

People with learning disabilities, autism or both and their families and carers should be able to expect high quality care across all services provided by the NHS. They should receive treatment, care and support that is safe and personalised and have the same access to services and outcomes as non-disabled people.

It is known that some people with learning disabilities, autism or both encounter difficulties when accessing NHS services and they can have a much poorer experience than the general population. Several national investigations and inquiries have found that some hospitals are failing to adequately respect and protect people's rights leading to preventable death and poor quality of life.

NHS Improvement has developed four standards that hospitals must meet:

1) Respecting and protecting rights
2) Inclusion and engagement
3) Workforce
4) Specialist learning disabilities services

These standards are supplemented by improvement measures or actions that Trusts are expected to take to deliver the outcomes that people with learning disabilities, autism or both and their families expect and deserve.

What we will do in 2020/2021:

3.1 To help identify patients with a learning disability and autism we will improve the use of our alerts system.

3.2 With the help of matched national funding we will build a changing facility for patients on the hospital site.

3.3 Continue the 'Treat Me Well' campaign and introduce learning disability ambassadors.

3.4 Introduce minimum reasonable adjustments in outpatient departments.

How we will report progress throughout the year:
We will report progress of this work to the Integrated Safeguarding Committee and Clinical Governance Committee.

*Priority 4: Work with our partners to value patient's time by ensuring that they are only in hospital when necessary

Description of the issue and reason we prioritised it:

Patients being in the right place at the right time with reduced delays is crucial to ensuring patients receive optimal care and experience. Although, we have undertaken a significant amount of work with our partners in 2019/2020 to improve timeliness of patients through the wards, measurements show that we have not improved as much as we expected and this remains a top priority for 2020/2021.

Our hospital 'Ready, Steady, Go' patient flow programme focuses on:

- **Ready** - the admission part of the patient's journey from arrival in the Emergency Department, Acute Medical Unit or Surgical Assessment Unit through to the first assessment by a consultant within 14 hours of admission (90% of patients) or discharge the same day.
- **Steady** – is the patient's journey from admission to a ward and preparation for discharge. The key measure is that the expected date of discharge is agreed with the patient within 14 hours and 48 hours of admission.
- **Go** – is on the day of discharge. The key measure is 33% of patients should be home before lunch (discharged by 12 noon) and a reduction in patients in hospital over 7 and 21 days.

What we will do in 2020/2021:

4.1 Achieve 60% of patients admitted to the Emergency Department with a suspected heart attack being tested with two highly sensitive troponin blood tests within 3.5 hours or less. A normal result rules out a heart attack and enables the patient to go home the same day.

4.2 Continue working with our partners in the Ready, Steady Go programme so that 33% of patients go home before lunch on the day of discharge.

How we will report progress throughout the year:

We will report progress of same day emergency care and the 'Ready Steady Go' programme to the Transformation Board.

2.2 Statements of assurance from the Board

Review of Services

During 2019/2020 Salisbury NHS Foundation Trust provided and/or subcontracted 55 relevant health services. Salisbury NHS Foundation Trust has reviewed all the data available to us on the quality of care in all 55 of these relevant health services. The income generated by the relevant health services reviewed in 2019/2020 represents 100% of the total income generated from the provision of relevant health services by Salisbury NHS Foundation Trust for 2019/2020.

In April 2019, the Integrated Governance Framework was updated and sets out the means by which the Trust Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the organisation's objectives. The framework is designed to ensure the strategic aim of delivering 'an outstanding experience for every patient', by an organisation that is well managed, cost effective and has a skilled and motivated workforce. At the same time the Accountability Framework was updated which specifies how the performance management systems are structured and tracked, to ensure delivery of the corporate objectives at every level of the organisation focusing across the breadth of quality, operational, finance and workforce performance.

The Clinical Governance Committee is the quality assurance committee of the Trust Board. It is responsible for overseeing the continuous improvement of the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care flourishes. The committee hears directly from clinical teams where risks to quality are identified to seek assurance that action is being taken to improve. Any recurrent themes are included as key objectives for improvement in the Trust service plan or in the Quality Account priorities. Our four quality priorities in 2020/2021 reflect these themes.

Each year the Trust has a number of external agency and peer review inspections. The reports, recommendations and action plans are discussed at one of the assuring committees. For example, the Human Tissue Authority (HTA) inspected our stem cell licence this year in July 2019. They found the Trust had met the majority of the HTA standards with 11 minor shortfalls in relation to governance and quality systems and premises, facilities and equipment standards. The shortfalls were related to document control, agreements, documentation of training, data retention, audit of records for completeness, systems for handling of serology testing samples, the Single European Code (SEC), incident reporting, risk assessments, the validation of transport containers, and the servicing and monitoring of equipment. All 11 of the minor shortfalls have been rectified and the HTA confirmed they were satisfied that all the shortfalls have been addressed by the end of March 2020. The outcome of the inspection was reported to the Clinical Governance Committee.

Participation in Clinical Audits

During 2019/2020, 55 national clinical audits and 13 clinical outcome review programmes covered relevant health services that Salisbury NHS Foundation Trust provides. During this period, Salisbury NHS Foundation Trust participated in 54 (98%) national clinical audits, and 13 (100%) clinical outcome review programmes of the national clinical audits and clinical outcome review programmes which it was eligible to participate in.

The national clinical audits and clinical outcome review programmes in which Salisbury NHS Foundation Trust was eligible to participate in during 2019/2020 are listed in figure 35.

The national clinical audits and clinical outcome review programmes that Salisbury NHS Foundation Trust participated in, and for which data collection was completed during 2019/2020, are listed in Figure 35 alongside the number of cases submitted to each audit or programme as a percentage of the number of registered cases required by the terms of that audit or programme.

Figure 35: Eligible national audits and clinical outcome review programmes and those the Trust participated in during 2019/2020

National Clinical Audit/ Clinical Outcome Review Programme	Eligible	Participation	% of cases submitted	Purpose of the audit
Assessing Cognitive Impairment in Older People - Care in Emergency Departments	Yes	Yes	100%	To identify where standards are not being reached in order to improve care for patients with delirium.
BAUS Urology Audits: Cystectomy	No	N/A	N/A	N/A
BAUS Urology Audits: Female stress urinary incontinence	Yes	Yes	100%	To publish surgeon patient outcomes data to improve standards of surgery and help patients make informed decision about their care
BAUS Urology Audits: Nephrectomy	Yes	Yes	100%	As above
BAUS Urology Audits: Percutaneous nephrolithotomy	Yes	Yes	100%	As above
BAUS Urology Audits: Radical Prostatectomy	No	N/A	N/A	N/A
Care of Children in Emergency Departments	Yes	Yes	100%	To help EDs measure and improve their safeguarding of young people.
Case Mix Programme (CMP)	Yes	Yes	100%	The CMP is an audit of patient outcomes from adult general critical care units.
Child Health Clinical Outcome Review Programme: Mental Health Conditions in Young People	Yes	Yes	100%	Examines the quality of healthcare to stimulate improvement in safety and effectiveness by learning from adverse events and other relevant data.
Child Health Clinical Outcome Review Programme: Long-term ventilation	Yes	Yes	100%	To identify remediable factors in the care of patients before their 25th birthday who are receiving, or have received, long-term ventilation.
Elective surgery (National PROMs Programme)	Yes	Yes	2018/19 Pre-op 76.3% vs 83.6% nationally Post-op 68.5% vs 68% nationally	Patient reported outcome measures (PROMs) survey patients before and after surgery for the following planned procedures; - Hip replacement - Knee replacement

Endocrine and Thyroid National Audit	Yes	Yes	100%	The audit provides information on outcomes of endocrine surgery, principally on the thyroid, parathyroid and adrenal glands in the UK.
Falls and Fragility Fractures Audit Programme (FFFAP)				
1) Fracture Liaison Service Database	No	N/A	N/A	N/A
2) National Audit Inpatient falls	Yes	Yes	100%	Evaluates compliance against best practice standards in reducing the risk of falls within hospitals.
3) National Hip Fracture Database	Yes	Yes	100%	Provides data on the care of patients with fragility fractures and inpatient falls received in hospital to facilitate improvements.
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes	Yes	50%*	To improve the care of patients and understanding of the treatments they receive, to enable research, and to increase knowledge about IBD in the UK. *IT external issues & team vacancy – only 50% data collection.
Major Trauma Audit: The Trauma Audit & Research Network (TARN)	Yes	Yes	82.3%	Examines trauma care data to improve emergency care management and systems. National case ascertainment target = 80%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	Yes	100%	All acute Trusts report on each case of C difficile to Public Health England.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)				
1) Perinatal mortality surveillance	Yes	Yes	100%	Analyses and reports national surveillance data in order to stimulate and evaluate improvements in health care for mothers and babies.
2) Perinatal mortality & morbidity confidential enquiries	Yes	Yes	100%	Identifies potentially preventable failures of care along the whole care pathway for improvement in care in the future.
3) Maternal mortality surveillance and mortality confidential enquiries	Yes	Yes	100%	As above
Medical and Surgical Clinical Outcome Review Programme				Explores the overall quality of care of patients admitted to hospital and have died.
1) Acute Heart Failure	Yes	Yes	100%	As above
2) Cancer in children, teenagers and young adults	Yes	Yes	100%	As above
3) Perioperative diabetes care	Yes	Yes	100%	As above
4) Pulmonary embolism	Yes	Yes	100%	As above
5) Acute bowel obstruction	Yes	Yes	100%	As above
6) Out of hospital cardiac arrests	Yes	Yes	100%	As above

7) Dysphagia in Parkinson's Disease	Yes	Yes	100%	As above
8) Physical Health in Mental Health Hospitals	Yes	Yes	100%	As above
Mental Health Care Pathway - CYP Urgent & Emergency Mental Health Care and Intensive	No	N/A	N/A	N/A
Mental Health Clinical Outcome Review Programme	No	N/A	N/A	N/A
Mental Health - Care in Emergency Departments	Yes	Yes	100%	To identify where standards are not being reached in order to improve care for mental health patients.
National Asthma and COPD Audit Programme (NACAP)				To drive improvements in the quality of care and services provided for asthma & COPD patients.
1) Paediatric asthma: secondary care	Yes	Yes	100%	As above
2) Asthma (Adult & paediatric) & COPD: primary care	No	N/A	N/A	N/A
3) Adult asthma: secondary care	Yes	Yes	100%	As above
4) Chronic obstructive pulmonary disease (COPD)	Yes	Yes	81%*	*81% vs 57% median case ascertainment England
5) Pulmonary rehabilitation	Yes	Yes	100%	As above
National Audit of Anxiety and Depression	No	N/A	N/A	N/A
National Audit of Breast Cancer in Older People	Yes	Yes	100%	Improves the quality of hospital care for older patients with breast cancer by looking at the care received and outcomes.
National Audit of Cardiac Rehabilitation	Yes	Yes	100%	To monitor and support cardiovascular rehabilitation teams and commissioners in delivering high-quality and effective services.
National Audit of Care at the End of Life (NACEL)	Yes	Yes	98%	Focuses on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals in England and Wales.
National Audit of Dementia (Care in general hospitals)	Yes	Yes	100%	Measures criteria relating to care delivery which are known to impact on people with dementia admitted to hospital.
National Audit of Pulmonary Hypertension	No	N/A	N/A	N/A
National Audit of Seizure Management in Hospitals (NASH3)	Yes	Yes	100%	Examines the facilities and care available to patients in order that it will identify how best to change services to reduce the numbers of seizures presenting at hospital.
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	Yes	100%	To improve the quality of care for children and young people with seizures and epilepsies.
National Bariatric Surgery Registry (NBSR)	No	N/A	N/A	N/A

National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%	Audit of in-hospital cardiac arrests in the UK and Ireland.
National Cardiac Audit Programme (NCAP)				
1) National Audit of Cardiac Rhythm Management (CRM)	Yes	Yes	100%	Examines the implant rates and outcomes of all patients who have a pacemaker, defibrillators or cardiac resynchronisation therapy implanted in the UK.
2) Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	100%	To examine the quality of the management of heart attacks in hospital
3) National Adult Cardiac Surgery Audit	No	N/A	N/A	N/A
4) National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Yes	100%	Examines the quality and process of care and compares patient outcomes.
5) National Heart Failure Audit	Yes	Yes	100%	Examines clinical practice and patient outcomes of patients discharged following an emergency admission with a primary diagnosis of heart failure.
6) National Heart Failure Audit National Congenital Heart Disease (CHD)	No	N/A	N/A	N/A
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	Yes	100%	Examines the quality of care for people living with inflammatory arthritis in England and Wales.
National Clinical Audit of Psychosis	No	N/A	N/A	N/A
National Diabetes Audit – Adults				Measures the effectiveness of diabetes care compared to NICE guidance.
1) National Diabetes Foot Care Audit	Yes	Yes	100%	As above
2) National Diabetes Inpatient Audit - data on services in England and Wales	Yes	Yes	100%	As above
3) National Diabetes Inpatient Audit - harms reporting in England	Yes	Yes	100%	As above
4) National Core Diabetes Audit	Yes	Yes	100%	As above
5) National Diabetes Transition	Yes	Yes	100%	As above
6) National Pregnancy in Diabetes Audit	Yes	Yes	100%	As above
National Emergency Laparotomy Audit (NELA)	Yes	Yes	100%	Compares inpatient care and patient outcomes undergoing emergency abdominal surgery in England and Wales.

National Gastro-intestinal Cancer Programme				
1) National Oesophago-gastric Cancer (NOGCA)	Yes	Yes	100%	Investigates whether the care received by patients with oesophago-gastric cancer is consistent with national standards.
2) National Bowel Cancer Audit (NBOCA)	Yes	Yes	100%	Measures the quality of care and survival rates of patients with bowel cancer in England and Wales.
National Joint Registry (NJR)	Yes	Yes	100%	Data analysis of joint replacement surgery in order to provide an early warning of issues relating to patient safety.
National Lung Cancer Audit (NLCA)	Yes	Yes	100%	Examines lung cancer care and outcomes to bring the standard of all lung cancer multidisciplinary teams up to that of the best.
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	100%	Evaluates processes and outcomes to identify good practice and areas for improvement in the care of women and babies in NHS maternity services.
National Neonatal Audit Programme (NNAP)	Yes	Yes	100%	Examines whether babies admitted to neonatal intensive and special care units received consistent care.
National Ophthalmology Audit	Yes	Yes	100%	Examines key indicators of cataract surgical quality.
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100%	Examines the quality of paediatric diabetes care by comparing outcomes to NICE quality and clinical standards.
National Prostate Cancer Audit	Yes	Yes	100%	Data analysis on the diagnosis, management and treatment of every patient newly diagnosed with prostate cancer and outcomes.
National Smoking Cessation Audit	Yes	Yes	100%	To help hospitals to recognise service deficiencies and provide both impetus and justification for healthcare providers to create an environment that is more conducive to helping smokers quit.
National Vascular Registry	No	N/A	N/A	N/A
Neurosurgical National Audit Programme	No	N/A	N/A	N/A
Paediatric Intensive Care (PICANet)	No	N/A	N/A	N/A
Perioperative Quality Improvement Programme (PQIP)	Yes	No	N/A	To improve patient outcomes from major non-cardiac surgery.
Prescribing Observatory for Mental Health (POMH-UK)	No	N/A	N/A	N/A
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)				
1) Antibiotic Consumption	Yes	Yes	100%	To reduce antibiotic consumption per 1,000 admissions

2) Antimicrobial Stewardship	Yes	Yes	100%	To reduce antibiotic consumption per 1,000 admissions and increase the proportion of antibiotic usage with the Access group of the AWaRe category
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	100%	Continuous patient level data analysis of in hospital care of patients with a stroke and TIA compared to national stroke standards.
Serious Hazards of Transfusion (SHOT): UK National Haemo-vigilance	Yes	Yes	100%	Examines adverse events and reactions in blood transfusion with recommendations to improve patient safety.
Surgical Site Infection Surveillance Service	Yes	Yes	100%	Hospitals record incidents of infection after surgery, track patient results and review or change practice to avoid further infections.
UK Cystic Fibrosis Registry (Paediatrics)	Yes	Yes	100%	Registry data to improve the health of children with cystic fibrosis through research, to guide quality improvement & to monitor the safety of new drugs.
UK Parkinson's Audit	Yes	Yes	100%	Measurement of practice against evidence-based standards and patient feedback in a continuous cycle of improvement.

The participation in the audits in figure 35 is in line with the Trust's annual clinical audit programme which aims to make sure that clinicians are actively engaged in all relevant national audits and confidential enquiries as well as undertaking baseline assessments against all NICE guidelines and quality standards. This enables the Trust to compare our performance against other similar Trusts and to decide on further improvement actions. The annual programme also includes a number of audits agreed as part of the contract with our Clinical Commissioning Groups.

The reports of 48 national clinical audits and clinical outcome review programmes that were published in 2019 were reviewed by Salisbury NHS Foundation Trust in 2019/2020. Of these, 34 (71%) were formally reported to the Clinical Management Board by the clinical lead responsible for implementing the changes in practice, and Salisbury NHS Foundation Trust has taken or intends to take the following actions to improve the quality of healthcare provided set out in figure 36.

Figure 36: Examples of national clinical audit reports reviewed during 2019/2020 with actions taken or planned by Salisbury NHS Foundation Trust (SFT)

National Ophthalmology Database: Cataract Audit 2019 (data Sept 17 – Sept 18)

Outcome marker	Trust - 17/18	National - 17/18
Posterior capsular rupture rate	**0.9%**	1.1%
Visual acuity loss rate	**0.3%**	0.9%

The Trust submitted 1204 cases undertaken by 13 surgeons. Outcomes were better than the national average and were achieved by efficient and consistent pre-operative assessment, using technology to create clear communication, 30% higher volumes consistently, navigated transition to a safer operating

platform and lens implant, excellent data quality and discussion of complications at the department mortality and morbidity meetings. New surgeons including trainees have a very thorough induction.

Salisbury NHS Foundation Trust will take the following improvement actions:

- Introduce patient reported outcome measures

NICOR National Heart Failure Audit 2019 (data 17/18)

Key performance indicators	National 17/18	SFT 17/18	SFT vs national
70% case ascertainment (221 cases)		93%	↑
Over 85% of patients have specialised team input during admission	82%	95.8%	↑
Place of care over 60% patients admitted to a cardiology ward	45%	72.8%	↑
Over 85% of heart failure rEF are discharged on all 3 disease modifying medicines: • ACEi/ARB • Beta blocker • MRA	82% 88% 54%	100% 96.6% 70.7%	↑
Over 50% are discharged with a 2 week follow-up appointment to see the specialist MDT		90.9%	↑

The Trust heart failure team had significantly better performance than the national average. Over the same time period 90% of heart failure patients had an inpatient echocardiogram. In addition, 549 patients were seen by the heart failure specialist nurses in 17/18. These were patients with a secondary diagnosis of heart failure or patients with a potential diagnosis who required specialist input during admission.

National Audit of Care at the End of Life 2019 (Data 2018)

All acute hospital adult deaths in April 2018. The Trust submitted 53 cases.

	Domain	National average 2018	SFT 2018
1	Recognising the possibility of death	9.1	**9.3**
2	Communication with the dying person	6.9	**6.5**
3	Communication with families	6.6	**7.0**
4	Involvement in decision making	8.4	**8.9**
5	Needs of families	6.1	**6.9**
6	Individual plan of care	7.4	**7.7**
7	Governance	9.5	**10.0**
8	Workforce	7.6	**9.2**

The Trust's results showed a significant improvement in end of life care since 2014. Clinical teams recognised the possibility of imminent death far earlier than the national average (135 hours compared to 74 hours nationally) and more patients received specialist support by the end of life care team or hospital palliative care team (52% compared to 38% nationally). The Trust received top marks for governance. 30% of patients compared to 20% nationally had the opportunity to be involved in discussions about their care. 82% of dying patients were regularly review compared to 64% nationally. Preferred place of care was recorded in 40% of cases compared to 28% nationally. Nutrition and hydration was discussed more often than nationally. Only 2% of patients were not able to eat or drink at the time of death compared to 10% nationally.

Salisbury NHS Foundation Trust will take the following improvement actions:

- Introduce the national ReSPECT form (Do not attempt resuscitation and Treatment Escalation Plan) with our community partners in 2020/21.

Local clinical audits

The reports of 163 (100%) local clinical audits were reviewed by the Trust in 2019/2020 and Salisbury NHS Foundation Trust intends to take, or has taken, the following actions to improve the quality of healthcare provided.

Chronic Obstructive Pulmonary Disease (COPD) admission care bundle audit 2016 – 2019 results

STANDARDS	2016	2018	2019	Change *2018 to 2019*
Was there a discharge sticker?	0%	18%	94%	↑
1. Ensure correct diagnosis - acute exacerbation of COPD	100%	100%	100%	<--->
1a. Chest Xray done (aim <4 hours of admission)	100%	100%	100%	<--->
1b. ECG done (aim <4 hours of admission)	91%	94%	100%	↑
1c. Record of spirometry in medical records	27%	53%	67%	↑
2a. Obs (BP, T, RR, SaO2), aim <1 hour of admission	100%	100%	100%	<--->
2bi. Has target range & O2 been prescribed?	90%	82%	94%	↑
2bii. Has target range & O2 been prescribed, AND signed for as administered?	30%	79%	92%	↑
3a. O2 sats ≤ 94% after 1 hour medical therapy/O2?	27%	44%	38%	↓
3b. ABG carried out, if SaO2 ≤94?	100%	100%	79%	↓
3c. Is pH<7.35 on ABG?	60%	20%	38%	↑
3d. If pH <7.35 has patient started on NIV?	100%	50%	33%	↓
3e. O2 alert card given to patient (on Microguide) if hypercapnic	0%	0%	33%	↑
4a. Nebulisers administered (aim <4hrs of admission)	100%	100%	100%	<--->

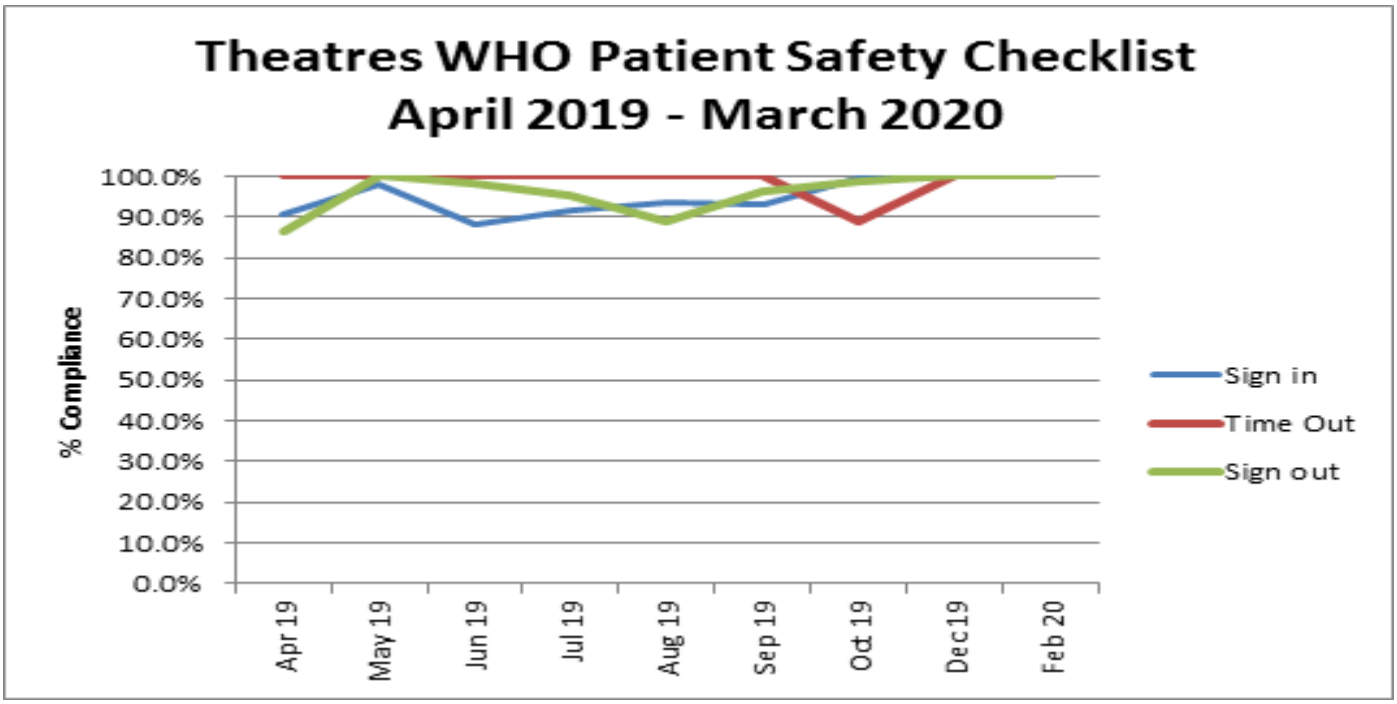
4b. Steroids administered (aim <4hrs of admission)	90%	100%	94%	<--->
4c. Antibiotics (if required) (aim to administer <4hrs of admission)	75%	88%	93%	↑
5a. Patient referred to Respiratory Team within 24 hrs of admission	25%	65%	89%	↑
5b. Respiratory Nurse Specialist or Respiratory Medical Team review (within 24hrs, includes ED/AMU time)	100%	53%	89%	↑

The Trust has sustained compliance with the admission care bundle and the two key elements of COPD best practice - patients who received a specialist review by a member of the respiratory team within 24 hours of an emergency admission and had the elements of the discharge care bundle before leaving hospital.

Salisbury NHS Foundation Trust will take the following improvement actions:

- Continue to submit patient level data to the National COPD Audit Programme secondary care audit.

Theatres World Health Organisation (WHO) Patient Safety checklist 2019 – 2020



The WHO surgical safety checklist was introduced to decrease errors and adverse events and increase teamwork and communication in surgery. The checklist has gone on to show a significant reduction in both deaths and complications and is used by the majority of surgical providers around the world.

In practice, a briefing is held 20 – 30 minutes before the start of the list. The surgeon, anaesthetist and the whole theatre team meet together to introduce themselves. The surgeon briefly explains the cases, any specific needs, including equipment, imaging and any implants required to ensure that everything is in place before the lists starts.

Next, is the ‘sign in’ phase which is done with the patient awake to ensure the patient is the correct patient having the correct operation, the surgical site is marked and consent confirmed. Once the patient is in

theatre and before the surgeon makes the incision the next phase is 'time out', which includes a check as to whether the patient has been given antibiotics, blood thinning medication and imaging displayed where needed. This also includes an additional patient check to ensure the correct patient is having the correct procedure.

Before the patient leaves theatre, the nurse completes an instrument and swab count check to ensure all items are present and correct. At the end of the case there is a 'sign out' phase. This ensures the operation is recorded appropriately and post-operative instructions are written, packs are removed and antibiotics and blood thinning medication administered if appropriate. Once the list is completed the whole team meet again to debrief as to how the list went and whether there were any problems, including human factors, and any areas for improvement next time if needed.

Salisbury NHS Foundation Trust will take the following improvement actions:

- Undertake an annual review to ensure staff are up to date with current WHO checklist patient safety standards.

Research

The number of patients receiving relevant health services provided or subcontracted by Salisbury NHS Foundation Trust in 2019/2020 that were recruited during that period to participate in research approved by the National Institute for Health Research were 1054 patients into 77 studies. This compares with 1581 patients recruited into 91 studies in 2018/2019.

The level of participation in clinical research demonstrates Salisbury NHS Foundation Trust's commitment to improving the quality of care we offer and to making a contribution to wider health improvement. Our clinical staff stay abreast of the latest treatment possibilities and active participation in research leads to improved patient outcomes. Summary information and contact details of study co-ordinators of all clinical research trials to which our patients are recruited are available at http://public.ukcrn.org.uk/search/.

Further information on research activity is in the annual report at:
http://www.salisbury.nhs.uk/AboutUs/TrustReportsAndReviews/Pages/landing.aspx

Goals agreed with Commissioners

A proportion of Salisbury NHS Foundation Trust's income in 2019/2020 was conditional on achieving quality improvement and innovation goals agreed between Salisbury NHS Foundation Trust and any person or body with whom the Trust entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2020/2021 are at the link below figure 37. The planned income through this route for 2019/2020 was £2,174,601 (in 2018/19 it was £3,837,253). The amount the Trust actually received in 2019/2020 was £2,062,601 (95%) following a year end agreement with all commissioners.

CQUIN contracts were signed with our commissioners during 2019/2020 as part of their overall contract. The Trust did not achieve all of the quality improvements as set out in Figures 37 and 38.

Figure 37: Trust performance for all local commissioners CQUIN targets 2019/2020

CQUIN quality improvement target	% performance achieved*	2019/20 income earned** NHSE guidance full Q4 payment due to COVID-19
CCG1: Antimicrobial resistance 1a) Lower urinary tract infections in older people (target 60 - 90%) 1b) Antibiotic prophylaxis in colorectal surgery (target 60 - 90%) *NHSE excluded Q1 results for payment purposes	51% *(Q2 – Q4 only) 76%	£48,000 £125,000
CCG2: Staff flu vaccinations 80% uptake of flu vaccinations by frontline clinical staff	80%	£386,000
CCG3: Alcohol and Tobacco *3a) Alcohol and Tobacco – screening (target 40 – 80%)* *3b) Alcohol and Tobacco – tobacco brief advice (target 50 – 90%)* *3c) Alcohol and Tobacco – alcohol brief advice (target 50 – 90%)*	82% 91% 92%	£386,000
CCG7: Three high impact actions to prevent hospital falls Achieve 80% of older inpatients receiving key falls preventions actions. *(target 25 – 80%)* *NHSE excluded Q1 results for payment purposes	*40% (Q2 – Q4 only)	£175,000
CCG11: Same day emergency care (target 50 – 75%) 11a) Pulmonary embolus 11b) Tachycardia with atrial fibrillation 11c) Community acquired pneumonia	95% 94% 90%	£386,000

Figure 38: Trust performance for NHS England Specialist commissioning CQUINS 2019/2020

CQUIN quality improvement target	% performance achieved	2019/20 income earned
PSS1 Medicines optimisation 1. Improving efficiency in the IV chemotherapy pathway from pharmacy to patient 2. Supporting national treatment criteria through accurate completion of prior approval proformas (Blueteq) 3. Faster adoption of prioritised best value medicines and treatment 4. Anti-fungal stewardship	100%	£93,412

Local CQUIN spinal cord injury treatment centre Spinal cord injured patients to have an up to date ASIA and SCIM III assessments	100%	£93,412
Armed Forces - Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community 1) Delivery of local implementation plan	100%	£56,985

Further details of the agreed CQUIN goals for Wiltshire, West Hampshire, Dorset, Bournemouth, Poole, Somerset, Southampton City, Isle of Wight and Portsmouth 2020/2021 are available electronically at the following link:
https://www.england.nhs.uk/wp-content/uploads/2020/01/cquin-20-21-indicator-specifications.pdf

Further details of the agreed CQUIN goals for Specialist Commissioning Prescribed Services 2020 – 2021 are available electronically at the following link:
https://www.england.nhs.uk/wp-content/uploads/2020/01/cquin-20-21-core-guidance.pdf

Care Quality Commission (CQC) registration

Salisbury NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is without conditions.

Salisbury NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission in 2019/2020.

The Care Quality Commission monitor the Trust under a Single Oversight Framework. The Trust is segmented as a Level 3 provider where we are offered mandated support.

Care Quality Commission inspection 2018

The Trust was inspected in November and December 2018. Four core services (Urgent and Emergency Care, Surgery, Critical Care and Spinal Services), Use of Resources and the Well-Led domain were inspected, leading to an overall rating of 'good' being published in a report in March 2019. The Care Quality Commission (CQC) identified areas of outstanding practice within the report and also found areas that the Trust 'should do' to improve.

Core services quality improvement plan

A quality improvement plan was written in March 2019 which identified 18 actions. Overall good progress has been made with 13 actions being completed and closed. 5 remain in progress. Progress against the improvement plan was monitored through the CQC core service task and finish group meetings until the end of September 2019. On-going monitoring of improvement is through service meetings, Directorate Management Teams or committees.

Well-led action plan

A well-led action plan was already in place and this was expanded following the CQC inspection. There were 47 actions within the plan and overall good progress has been made with 31 actions being completed and closed. 13 are still within their target date.

There has been significant work and improvement in many areas, in particular:
- Development and implementation of a Quality Improvement Strategy
- Complete revision of the Integrated Performance Report in terms of format and content
- Promoting Equality, Diversity and Inclusion
- Reviewing Freedom to Speak Up Guardian arrangements

Progress against the action plan was monitored through the CQC well-led task and finish group meetings until the end of September 2019. Outstanding actions are monitored through appropriate committees.

Development of a peer review programme

During autumn 2019, we have been proactive in developing a peer review programme to contribute towards our CQC preparedness. A great benefit of this type of programme is the opportunity to learn from each other and share good practice. Our programme consists of 3 elements:

- Peer review visits – a small team of clinical and non-clinical staff visit wards and departments with questions centred around safe, effective, caring and well-led.
- 15 Steps (first impressions and the environment) – a small team of clinical and non-clinical staff from our Patient Advice and Liaison Service visit wards and departments, the focus being on their first impressions i.e. what do patients and visitors see? What is important to them?
- Core service workshops – facilitated sessions that present an opportunity for some thinking time for the core services and to keep pace with the Trusts CQC agenda of achieving an outstanding rating.

The peer review programme is a work in progress. Elements that make up the programme are monitored and adjusted according to feedback received.

Data quality

Good quality information (data) underpins the effective delivery of patient care and is essential to drive improvements in the quality of care we deliver. Having high data quality standards gives us confidence that decisions we make using the information are appropriate and ultimately will help us to deliver more responsive, high quality and cost effective services.

Over 2019/20, the Trust has embarked on a business intelligence project which includes replacing our data warehouse and delivering modern tools to support the improvement in data quality and the use of information more widely. We have also introduced a data quality maturity assessment for our core reporting to ensure there is assurance on the quality of information. The assessments have been completed for key Trust committee reports and are being expanded to cover other key performance indicators during 2020/21. Underpinning all of this, is our data quality policy which has been refreshed in 2019/20. An implementation plan to support the journey of continuous improvement and ownership of data quality has been developed and approved at our Information Standards Group.

Salisbury NHS Foundation Trust submitted records during 2019/2020 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and valid General Medical Practice Code is set out in Figure 39. These are important because the NHS number is a key identifier for patient records and an accurate record of the General Medical Practice Code is essential to enable the transfer of clinical information about the patient.

Figure 39: Patient records with a valid NHS number and General Medical Practice code

Data item	Salisbury District Hospital *18/19	National benchmark *18/19	Salisbury District Hospital 19/20	National benchmark 19/20
Valid NHS number				
% for admitted patient care	99.7%	99.5%	99.7%	99.5%
% for outpatient care	99.8%	99.6%	99.8%	99.7%
% for Emergency Department care	98.9%	97.4%	98.8%	97.8%
Valid General Medical Practice code				
% for admitted patient care	99.9%	99.9%	99.8%	99.8%
% for outpatient care	99.9%	99.8%	99.9%	99.8%
% for Emergency Department care	99.9%	99.4%	99.8%	98.2%

*2018/19 month 11 data was reported in the quality account and is now reported for the full year

Data Security and Protection Toolkit Attainment levels

Salisbury NHS Foundation Trust's has not completed the 2019/2020 Data Security and Protection Toolkit self-assessment in line with the NHS Digital guidance associated with the national emergency caused by coronavirus (COVID-19). Salisbury NHS Foundation Trust confirms that it will be submitting a Data Security and Protection Toolkit assessment by 30 September 2020. This decision provides us with the opportunity to refocus our resources to combat COVID-19. Whilst, Salisbury NHS Foundation Trust recognises the submission deadline has being relaxed, we remain resolved in our commitment to maintaining and continually look for ways to proactively improve the security and confidentiality of personal information entrusted to us.

Clinical Coding Error Rate

Clinical coding translates the medical terminology written in a patient's health care record to describe a patient's diagnosis and treatment into a standard, recognised code. The accuracy of this coding underpins quality assurance, payments and financial flows within the NHS. Coding software is in place which ensures consistency of coding and provides an audit tool and a suite of data quality reports which enables local improvement actions to be taken. The coding software is embedded in the electronic patient health care record (Lorenzo) and the coded information is available for clinical teams to view.

Salisbury NHS Foundation Trust was not subject to a payment by results clinical coding audit during the year.

Salisbury NHS Foundation Trust was subject to an external Information Governance clinical coding audit by an independent company during 2019/2020 and the correct coding rate reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was:

Figure 40: Overall results of coding accuracy 2015 – 2020

	Annual external coding audit Correct % 2015/16	Annual external coding audit Correct % 2016/17	Annual external coding audit Correct % 2017/18	Annual external coding audit Correct % 2018/19	Annual external coding audit Correct % 2019/20
Primary Diagnosis	98%	98.5%	99.0%	98.5%	96.5%
Secondary Diagnosis	94.5%	95.1%	97.2%	98.1%	98.5%
Primary Procedure	97.8%	96.7%	98.8%	99.1%	97.8%
Secondary Procedure	97.9%	95.8%	97.8%	99.7%	95.6%

The speciality services reviewed within the sample in January 2020 were plastics, paediatrics, gynaecology and breast surgery. The results should not be extrapolated further than the actual sample audited.

The following improvement actions were progressed in 2019/2020:

1) Improved the consistency of co-morbidity coding by continuing to advise and support clinical teams. The coding team worked with the plastics team on an updated co-morbidity checklist printed on the back of the minor operations form. In this way, the surgeon was able to tick the relevant conditions immediately after the patient had had the procedure.
2) The coding team undertook refresher training about national coding standards of head injuries.
3) Senior coders examined the coding of patients admitted as an emergency at a weekend who died and worked with the Clinical Director of Medicine to improve the recording of comorbidities on the ward round.

Salisbury NHS Foundation Trust will be taking the following actions to improve data quality in 2020/2021:

1) Improve the identification and coding of secondary procedures and confirm improvements by undertaking monthly coding audits and feedback to the team.
2) Adjust in house training to improve the use of 'laterality' (the patient's right or left side subject to a procedure) and approach codes in line with the national coding standard.
3) Improve the coding of the primary diagnosis assigned to paediatric patients by using the information recorded in the patient's discharge letter.

Learning from deaths

During 2019/2020, 784 patients died in Salisbury NHS Foundation Trust. This comprised the following number of deaths which occurred in each quarter of 2019/2020 (figure 41).

Figure 41: Number of deaths, case record reviews and investigations

	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Total
Number of deaths	192	172	178	242	**784**
1st screen	185	164	169	229	**747**
Case record review	62	57	64	69	**252**
Deaths with a Hogan score 1*	183	163	174	227	**747**
Deaths with a Hogan score 2 – 3 **	8	9	4	12	**33**
Deaths with a Hogan score 4 - 6***	1	0	0	3	**4**
Serious incident inquiry	2	3	3	3	**11**
Serious incident inquiry - case rated as catastrophic	2	3	3	3	**11**
Unexpected deaths	4	2	3	3	**12**
Learning points identified	20	15	10	16	**61**

*Deaths with a Hogan score of: 1) Definitely not avoidable. ** Deaths with a Hogan score of: 2) Slight evidence for avoidability 3) Possibly avoidable, but not very likely, less than 50/50 *** Deaths with a Hogan score of: 4) Probably avoidable more than 50/50 5) Strong evidence of avoidability 6) Definitely avoidable.

By 31 March 2020, 747 (95%) of deaths had been screened to ascertain whether each case required a case record review. By 31 March 2020, 252 (32%) case record reviews and 11 investigations (serious incident inquiries) had been carried out in relation to 784 of the deaths included in figure 41. In 11 cases, a death was subjected to both a case record review and a serious incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 64 in the first quarter (April – June 2019)
- 60 in the second quarter (July – September 2019)
- 67 in the third quarter (October – December 2019)
- 70 in fourth quarter (January – March 2020)

11 cases representing 1.4% of the patient deaths during 2019/2020 were judged to be more likely than not to have been due to problems in the care provided to the patient based on a Hogan score of 4 – 6 or graded as catastrophic harm as an outcome of a serious incident inquiry.

In relation to each quarter this consisted of:

- 2 representing 1.0% for the first quarter (April – June 2019)
- 3 representing 1.7% for the second quarter (July – September 2019)
- 3 representing 1.7% for the third quarter (October – December 2019)
- 3 representing 1.2 % for the fourth quarter (January – March 2020)

These numbers have been estimated using the Hogan scoring system of 1 – 6 identified in the Hogan (2014): Preventable Incidents, Survival and Mortality Study 2 (PRISM) https://improvement.nhs.uk/uploads/documents/PRISM_2_Manual_V2_Jan_14.pdf.
The score of deaths are defined as: 1) Definitely not avoidable 2) Slight evidence of avoidability 3) Possibly avoidable but not very likely, less than 50/50 4) Probably avoidable more than 50/50 chance 5) Strong evidence of avoidability 6) Definitely avoidable.

The Trust has learnt the following from case record reviews and investigations conducted in relation to the deaths in 2019/2020:

- The importance of a timely review of acutely unwell patients who needed a medical review at a weekend but did not receive it.
- Escalation of deteriorating patients to a senior decision maker to ensure an appropriate plan is in place.
- Recognition of when a patient is dying and the importance of good communication with patients and families.
- Recognition of the dying patient and early discussions about ceilings of care to avoid unnecessary treatment.
- Patients admitted with a treatment escalation plan agreed in discussion with their GP who did not want admission to hospital and other patients receiving full investigations and treatment.
- Patients with a fractured hip receiving surgical treatment within 36 hours of admission to ensure the best outcome.
- Patients with a gastro-intestinal bleed receiving a care bundle approach to the management of their care to ensure the best outcome.

The Trust has taken the following actions as an outcome of the learning identified from case record reviews in 2019/2020:

- Reviewed the safety and effectiveness of services at a weekend and presented an analysis and action plan to the Board in November 2019 and an update in January 2020. http://www.salisbury.nhs.uk/AboutUs/TrustBoard/AgendaBoardPapersAndMinutesTrustBoard/Documents/SafetyandEffectivenessofservicesattheweekend_3_2.pdf
  http://www.salisbury.nhs.uk/AboutUs/TrustBoard/AgendaBoardPapersAndMinutesTrustBoard/Documents/PublicTrustBoard9January2020Agendabundle.pdf
- Undertook a quarterly audit of screening and escalation of deteriorating patients and fedback the results to clinical teams to drive further improvement.
- In July 19, a bereavement survey was re-started to ask relatives about the care of their loved one during their last admission. The majority of comments were very positive but the common theme for improvement was poor communication. These cases were discussed with ward leaders, medical staff and staff involved in the care of the patient. The information gained also helped to shape the ongoing teaching programme.
- Examined the causes of delays of patients who wished to be discharged to their preferred place of care and increased the number of patients discharged from 36 in 2018/19 to 109 in 2019/20.
- Sustained compliance with the admission care bundle and the two key elements of the chronic obstructive pulmonary disease best practice - patients who received a specialist review by a member of the respiratory team within 24 hours of an emergency admission and had the elements of the discharge care bundle before leaving hospital (figures 26).

The Trust is planning to take the following actions as an outcome of the learning identified from case record reviews in 2020/2021:

- In partnership with BSW STP, introduce the national ReSPECT form.
- Introduce the Medical Examiner system in April 2020 to scrutinise all deaths, except those subject to a coroner's inquest, and discuss the medical certificate of the cause of death with relatives to ascertain if they had any concerns about care and investigate them.

- Improve the hip fracture pathway to ensure surgery is carried out within 36 hours of admission.
- Improve the acute gastro-intestinal bleed pathway to ensure care is consistent with the British Society of Gastroenterology acute upper gastrointestinal bleed care bundle.
- Improve the safety and effectiveness of the hospital at the weekend to ensure 90% of patients who need a daily review at a weekend receive it.

The impact of the actions taken in 2019/2020:

- Embedded the recording of vital signs in accordance with NEWS2 criteria and improved the rate of screening and escalation to a senior decision maker. As an outcome, the relative risk of death from sepsis has declined over the last 2 years (see figure 17).
- Overall, sustained the 90% standard of patients being seen and assessed by a consultant within 14 hours of admission (see figure 43).
- Increased the number of patients who wished to return to their preferred place of care in accordance with their wishes (see figure 25).
- Improved the outcomes of patients with chronic obstructive pulmonary disease by applying the admission and discharge care bundle (figure 42) reducing the risk of death.
- Reduction in our weekend HSMR rate (figure 43).

Figure 42: Relative risk of death from chronic obstructive pulmonary disease

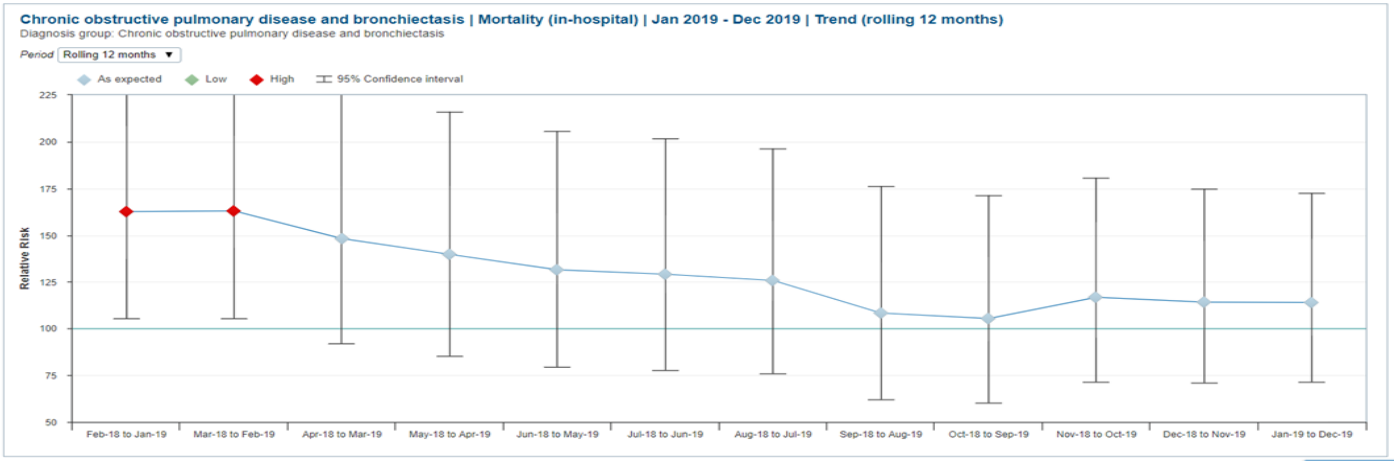
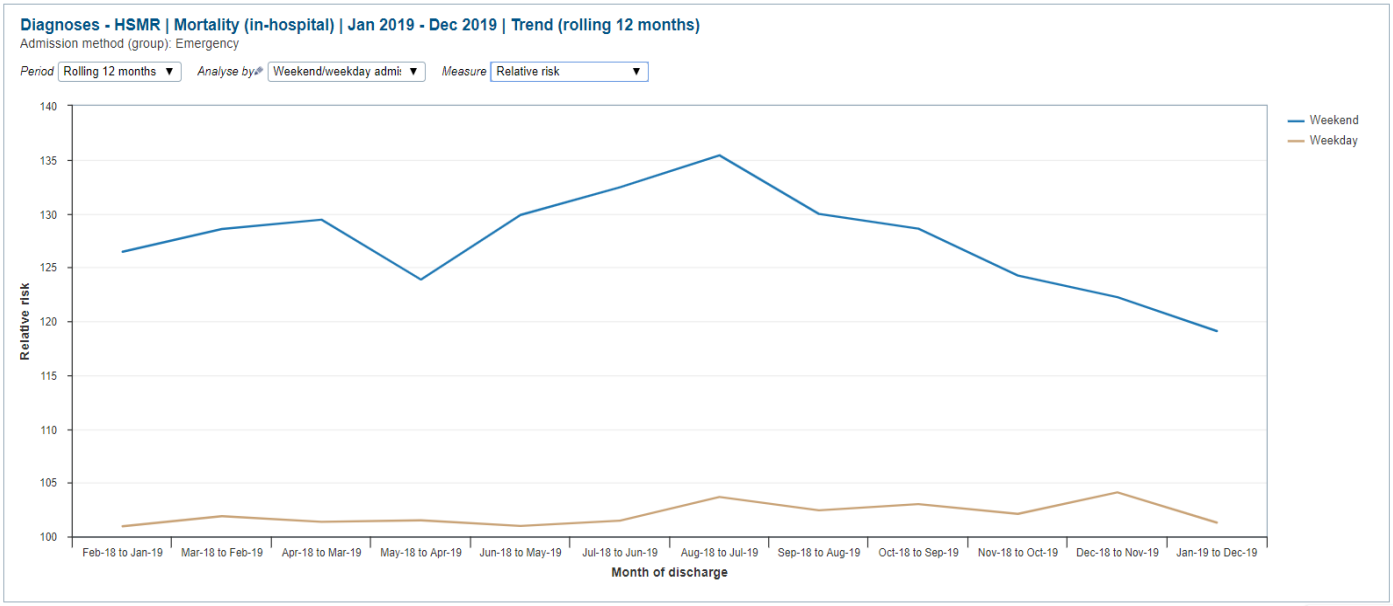


Figure 43: Rolling 12 month trend in weekend HSMR January 2019 – December 19



116 case record reviews and 10 serious incident inquiry of deaths which occurred in 2018/2019 were completed by 2019/2020. These deaths which took place in 2018/2019 are not included in the total number of deaths reported in figure 41. The full case reviews were undertaken as a result of CUSUM (or cumulative sum) alerts (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) or as a request by the Care Quality Commission to investigate, or as a serious incident inquiry into an adverse incident that caused serious harm or death.

None of the 116 deaths representing 0% of the patient deaths subject to a full case review as a result of CUSUM alerts in 2018/2019 were judged to be more likely than not to have been due to problems in the care provided to the patient.

Of the 10 deaths subject to a serious incident inquiry, 5 of the deaths, representing 0.62% of the patient deaths in 2018/19 investigated as a serious incident inquiry were judged to be more likely than not to have been due to problems in care provided to the patient. The number has been calculated using the Hogan method already described in this section and the grading of catastrophic harm as an outcome of the serious incident inquiry.

Therefore in total, 5 of the patient deaths, representing 0.62% of the 116 case record reviews and 10 serious incident inquiries undertaken in 2018/2019 were judged to be more likely than not to have been due to problems in the care. These deaths were not included in the total number of deaths in 2019/20 reported in figure 41.

Seven day hospital services – implementing the priority clinical standards

The seven day services standards are designed to ensure patients that are admitted as an emergency receive high quality care whatever day they enter hospital. In 2013 a Seven Day a Week Forum chaired by the National Medical Director, Sir Bruce Keogh was established to consider how services could be improved across 7 days particularly patients admitted at the weekend. In 2016, four of the ten clinical standards were prioritised for their potential to positively impact patient outcomes. These four standards are:

Standard 2 – Time to first consultant review - within 14 hours of admission to hospital
Standard 5 – Access to diagnostic tests – 7 days a week
Standard 6 – Access to consultant-delivered interventions – 7 days a week
Standard 8 – Ongoing review by a consultant twice daily of patients with high dependency needs and once daily for patients who need it.

In March and September 2019, we assessed ourselves against the four priority standards as part of a national survey run by NHS Improvement.

Figure 44: Standard 2: Consultant review within 14 hours of admission to hospital (standard 90%)

Standard	March 17	Sept 17	April 18	March 19	Sept 19
Proportion of patients reviewed by a consultant within 14 hours of admission to hospital	**92%**	**93%**	**93%**	**90%**	**90%**

Figure 45: Standard 5: Access to diagnostic tests

	Week March 19	Weekend March 19	Week Sept 19	Weekend Sept 19
CT	Yes	Yes	Yes	Yes
Echocardiogram	Yes	Yes	Yes	Yes
Microbiology	Yes	Yes	Yes	Yes
MRI	Yes	Yes	Yes	Yes
Ultrasound	Yes	Yes	Yes	Yes
Upper GI endoscopy	Yes	Yes	Yes	Yes

Figure 46: Standard 6: Access to interventions at this hospital or by formal arrangement with another hospital

Service	Weekday March 19	Weekday Sept 19	Weekend March 19	Weekend Sept 19
Critical care	Yes	Yes	Yes	Yes
PPCI	Yes	Yes	Yes	Yes
Cardiac pacing	Yes	Yes	Yes	Yes
Thrombolysis	Yes	Yes	Yes	Yes
Emergency general surgery	Yes	Yes	Yes	Yes
Interventional endoscopy	Yes	Yes	Yes	Yes
Interventional radiology	Yes	Yes	Yes	Yes
Renal replacement	Yes	Yes	Yes	Yes
Urgent radiotherapy	Yes	Yes	Yes	Yes

Figure 47: Standard 8: Ongoing review (standard 90%)

	Survey	
	March 19	Sept 19
% receiving required **twice** daily reviews	100%	100%
% receiving required **once** daily reviews	93%	92%

The Trust has taken the following actions to sustain good practice in 2019/2020:

- Introduced an independent provider in April 2019 to sustain the current gastroenterology service whilst establishing a long term arrangement with another NHS Trust.
- Established a full upper gastrointestinal endoscopy bleed rota with University Hospital Southampton. The service is provided 1 in 5 at this hospital and 4 in 5 via the University Hospital Southampton.
- Sustained the interventional radiology service with Royal Bournemouth Hospital.
- Developed a quality improvement strategy which included developing the workforce capacity and capability to undertake and sustain quality improvement.
- Introduced a quality improvement training programme.
- Reviewed the safety and effectiveness of the hospital at weekends and taken a range of improvement actions (see Learning from Deaths section links to Board papers)

The Trust is planning to take the following actions to sustain good practice in 2020/2021:

- Work with the Royal College of Physicians to review and improve the gastroenterology service.
- Improve compliance with home for lunch on the day of discharge to 33%.
- Explore options both network and local to increase provision of specialist care for stroke patients at a weekend.
- Continue improvement work to ensure the safety and effectiveness of the hospital at weekends.

Freedom to Speak Up (whistleblowing and raising concerns)

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is also an indicator of a well-led Trust. We encourage all our staff to speak up about any concern they have at work. Staff can raise a concern about risk, malpractice or wrongdoing that may cause harm to the service we deliver to patients. Staff can speak up in a number of ways:

- Formally or informally with their line manager or lead clinician or tutor.
- Our Freedom to Speak Up Guardian in person, by telephone or email.
- Our risk management team.
- Our executive director with responsibility for freedom to speak up – Director of Organisational Development and People in person, by telephone or email.
- Our Non-Executive Director in person, by telephone or email.

Alternatively, if staff feel unable to speak up to someone in the Trust they can raise a concern outside the organisation with:

- NHS England https://www.england.nhs.uk/ourwork/whistleblowing/raising-a-concern/

The types of concern a member of staff can raise if they are unable to speak to someone in the Trust:

- Concerns about unsafe patient care
- Poor clinical practice or other malpractice which may harm patients
- Failure to safeguard patients
- Maladministration of medications
- Untrained staff
- Unsafe working conditions
- Lack of policies
- A bullying culture
- Staff we are unwell or stressed and not seeking help

- NHS Improvement https://improvement.nhs.uk/resources/freedom-speak-guidance-nhs-trust-and-nhs-foundation-trust-boards/

The types of concern a member of staff can raise if they are unable to speak to someone in the Trust:

- How NHS Trusts and Foundation Trusts are being run
- Other providers with an NHS provider licence
- NHS procurement, choice and competition
- The national tariff

- Care Quality Commission for concerns about quality and safety. https://www.cqc.org.uk/ for quality and a safety concerns.

- Health Education England for concerns about education and training in the NHS. https://www.hee.nhs.uk/our-work/raising-responding-concerns

- NHS Counter Fraud Authority for concerns about fraud and corruption. https://cfa.nhs.uk/

- The NHS and Social Care Whistleblowing helpline for advice and support 08000 724 725 or a professional organisation such as the General Medical Council or Nursing and Midwifery Council or trade union representative.

We hope that when a member of staff raises a concern they feel comfortable to raise it openly, but we also appreciate that staff may want to do so confidentially. Staff are always thanked for speaking up and will always have access to the support they need.

If the concern is about quality of care or a patient safety incident, an investigation is carried out by someone independent of the case, to examine the concerns and wider circumstances. The person is advised how long it will take and is kept up to date with progress. The investigation report focuses on identifying the

cause and making recommendations to promote patient safety and learning. The person is told about the outcome of the investigation and change is monitored to ensure it is working effectively.

If the concern is about bullying and harassment, our Dignity at Work policy http://intranet/website/staff/policies/humanresources/personnelpolicies/dignity+at+work+(bullying+and+harrassment)+policy.asp encourages staff to seek resolution informally in the first instance, but if this is unsuccessful the person can raise a formal complaint. An investigation is carried out in the same way as a patient safety investigation.

We want to make sure our staff feel safe to raise a concern. Our policy makes it clear that if staff raise a genuine concern they will not be at risk of losing their job or suffering any form of reprisal as a result. As a Trust, we do not tolerate harassment or victimisation of anyone raising a concern. Nor do we tolerate any attempt to bully the person into not raising a concern. Any such behaviour is a breach of our values and, if upheld following investigation, could result in disciplinary action. Our policy is at the link below: https://viewer.microguide.global/SALIS/NONCLINICAL#content,2251b966-a148-4c50-a668-2a3b1d6b8079

Consolidated annual report 2019/20 on doctors and dentist in training rota gaps & improvement plan

Staff shortages and rota gaps result in an increased workload for doctors and dentists. Workload is a significant factor in the attractiveness of NHS roles. These rota gaps and vacancies for doctors and dentists in training are reported to the Workforce Committee along with the actions that have been taken or are planned to be taken to address them.

A number of rotas covering different medical and surgical specialities across the Trust have had intermittent gaps throughout the year. This has been due to variations in the number of doctors in training allocated to the Trust by Wessex Deanery, sickness absence and maternity leave. These gaps have largely been filled by Trust Grade doctors and these have been successful in most areas as they have contributed additional capacity to rotas.

The new junior doctor contract aims to reduce weekend working from the current pattern of 1 in 2 to 1 in 3 weekends. This has been successfully implemented in all areas except the Emergency Department and Paediatric Department. The Junior Doctor Forum were consulted about the changes and agreed to continue working the current pattern of 1 in 2 weekends in the Emergency Department and Paediatric Department until a solution is able to be put in place. The rotas are kept under review and regularly monitored in working towards 1 in 3 weekends in these two Departments.

The Trust is part of a collaborative with 8 other Trusts who use the Locums Nest booking system. This enables the Trust to access around 4,400 doctors who are registered to work in the system and increases our ability to fill shifts. The average fill rate from Locums Nest has been around 70% in 2019/20.

In 2019/20, sickness absence of doctors and dentists in training is low at 1.36%. The commonest reason for sickness was gastrointestinal problems followed by injury and fracture.

Improvement actions taken or planned to be taken are:

- Continue to secure specialist doctors recruited from agencies to fill rota gaps.
- Action plans are in place in each clinical division to fill hard to recruit posts and these include redesigning models of care, often provided by other health care professionals.

Reporting against core indicators

This section of the Quality Account provides comparisons of quality standards common to all hospitals.

The standards are set by the Department of Health and the information and data used is from NHS Digital. All data can be found at https://digital.nhs.uk. The standards that are benchmarked are:

- Summary hospital-level mortality indicator
- Patient reported outcome measures
- Emergency re-admissions within 28 days
- Responsiveness to the needs of patients
- Staff who would recommend the Trust to family and friends.
- Patients who would recommend the Trust to family and friends.
- Venous thrombo-embolism risk assessment
- C difficile
- Patient safety incidents.

Summary Hospital Level Mortality (SHMI)

Figure 48 presents the Trust's performance against the SHMI. Salisbury NHS Foundation Trust considers that the SHMI data is as described for the following reasons:

- SHMI is published by NHS Digital and compares the number of deaths in hospital and within 30 days of discharge with expected levels. It is not adjusted for patients admitted for end of life care, for example to Salisbury Hospice. Our SHMI for April 2019 to March 2020 was 101 and is within the expected range. If the number of deaths was exactly as expected the SHMI would be 100. However, some natural variation is to be expected and a number above or below 100 can still be within the expected range. Currently 47.4% of our deaths are patients admitted for palliative or end of life care compared to 41.7% in 2018/2019.

Salisbury NHS Foundation Trust has taken the following actions to improve by:

- Embedding and auditing compliance with the national early warning scoring system (NEWS2) to standardise recording of clinical observations and provided teams with education to ensure appropriate escalation of deteriorating patients.
- Continued with a ward based end of life care education and support programme.
- Examined the causes of delays of patients who wished to be discharged to their preferred place of care and increased the number of patients discharged from 36 in 2018/19 to 109 in 2019/20.
- Improved the use of the Chronic Obstructive Pulmonary Disease admission and discharge care bundle which is a set of practices when used together improves patient outcomes.
- Introduced a detailed examination of reasons for patients not receiving hip fracture surgery within 36 hours of admission and presented the analysis to the Orthopaedic and Anaesthetic clinical governance meeting.
- In July 19, a bereavement survey was re-started to ask relatives about the care of their loved one during their last admission. The majority of comments were very positive but the common theme for improvement was poor communication. These cases were discussed with ward leaders, medical staff and staff involved in the care of the patient. The information gained also helped to shape the ongoing teaching programme.
- Undertook a review of the safety and effectiveness of services at a weekend and presented an action plan to the Board in November and January 2020 which shows that good progress has been made.

Salisbury NHS Foundation Trust intends to take the following actions in 2020/21 to ensure the SHMI remains as expected by:

- In partnership with BSW STP, introduce the national ReSPECT form.
- Introduce the Medical Examiner system in April 2020 to scrutinise all deaths, except those subject to a coroner's inquest, and discuss the medical certificate of the cause of death with relatives to ascertain if they had any concerns about care and investigate them.
- Improve the hip fracture pathway to ensure surgery is carried out within 36 hours of admission.
- Improve the acute gastro-intestinal bleed pathway to ensure care is consistent with the British Society of Gastroenterology acute upper gastrointestinal bleed care bundle.

Figure 48: Summary Hospital-level mortality indicator (SHMI)

NHS Outcomes Framework Domain	Indicator	2016/17	2017/18	2018/19	2019/20	National average	Highest & lowest average other Trusts 2019/20
Domain 1: preventing people from dying prematurely	SHMI value	106	106	101*	101	100	114 higher than expected
	SHMI banding	As expected	As expected	As expected	As expected	As expected	88 lower than expected
Domain 2: Enhancing quality of life for people with long term conditions	Percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust.	28.7%	48.5%	41.7%	47.4%	Not available	

* In 2018/2019 SHMI was reported as 100 to December 2018. The full year SHMI was 101 to March 2019.

Patient Reported Outcomes Measures (PROMs)

Figure 49 presents the Trust's performance against PROMS. Salisbury NHS Foundation Trust considers that the PROMs are as described for the following reasons:

- PROMs measure health gain in patients undergoing hip and knee replacements in England, based on responses to questionnaires before and after surgery. The responses are analysed by an independent company and compared with other Trusts. The outcomes are published by NHS Digital.

- Salisbury NHS Foundation Trust PROMs provisional data from April 2018 to March 2019 of the 114 patients who had a total hip replacement, on both measures of health gain, patients reported a lower than average health gain than for England overall but neither were statistically significant. However, on the Oxford hip score for total hip replacement, patients reported slightly below average health gain compared with England overall (22 vs 22.2 in England).

- Salisbury NHS Foundation Trust PROMs provisional data from April 2018 to March 2019 of the 119 patients who had a total knee replacement, on one measure of health gain, patients reported higher average health gains than the England average and on the other health gain measure, slightly lower average health gains than the England average, but not statistically significant. The Oxford knee score for total knee replacement patients reported a slightly higher than average health gain than for England, an improvement on 2017/2018 (17.5 vs 17.2 in England).

Salisbury NHS Foundation Trust will be taking the following actions:

- Continue to increase the percentage of patients attending 'joint school' before surgery to learn about hip and knee exercises needed after the operation to ensure they get the best outcome from surgery. This year, we increased the percentage of patients attending 'joint school' from 62% in 2018/19 to 80% in 2019/20 who had planned surgery for a primary total hip or knee replacement. Next year, we aim to increase to 90%.

- Consider the introduction of a one to one session with a physiotherapist at the pre-operative assessment visit for patients with a complex case.

Figure 49: Patient Reported Outcome Measures (PROMs)

NHS Outcomes Framework Domain	Indicator	2017/18**	2018/2019***	National average 2018/2019	Highest average other Trusts 2018/2019	Lowest average other Trusts 2018/2019
Domain 3: helping people to recover from episodes of ill health or following injury	Patient reported outcome measures scores for:	Average health gain where full health = 1				
	i) groin hernia surgery	From 1 October 2017 NHSE no longer report this data				
	ii) varicose vein surgery	From 1 October 2017 NHSE no longer report this data				
	iii) hip replacement surgery	0.461	0.434	NHS Digital indicated there is insufficient data to present on hip and knee replacement surgery in 2019/20		
	iv) knee replacement surgery	0.311	0.311			

**In the 2018/2019 quality account provisional data for 2017/2018 was presented. The data is now finalised.
*** Data for 2018/2019 is indicative. Final data will be available in August 2020.

Emergency re-admissions within 28 days of discharge

Figure 50 presents the Trust's performance on emergency re-admissions within 28 days. Salisbury NHS Foundation Trust considers that the percentage of emergency re-admissions within 28 days of discharge from hospital is as described for the following reasons:

- Every time a patient is discharged and re-admitted to hospital staff code the episode of care.
- The re-admission data is given a score using the data quality assurance framework which is currently green.
- All patients who are re-admitted to hospital are validated by the Validation Officer, Central Booking Department to compare the patient's first admission primary diagnosis with the re-admission primary diagnosis to establish whether they were linked.
- Emergency re-admission rates within 7, 14 and 30 days of discharge are reported to the Board at every meeting.
- Between August 2018 and July 2019, our re-admission relative risk was 99.3 with 95% confidence limits ranging between 96.4 – 102.3 over the last 12 months. This was based on 4,392 patients who were re-admitted where the expected number would be 4,421. This represents 'as expected' relative risk when compared to other hospital Trusts nationally taking into account the Trust's case mix.

Salisbury NHS Foundation Trust has taken the following actions to reduce emergency re-admissions within 28 days of discharge to improve the quality of its services:

- Appointed two advanced nurse practitioners to the Acute Medical Unit to manage patients who are able to go home the same day following an assessment, diagnosis and treatment. The same day emergency care approach provides crucial support for GPs, nurses and therapists working in primary and community care to be able to help patients remain at home and avoid emergency re-admissions to hospital.

- With our partners, increased the provision of the Older People's Assessment and Liaison (OPAL) team in the hospital and community at weekends so that frail older patients who are able to go home with support are able to avoid admission or re-admission.

Salisbury NHS Foundation Trust intends to take the following actions to reduce re-admissions to improve the quality of its services:

- We are planning to expand the same day emergency care service by providing a clinic room adjacent to the Acute Medical Unit where Emergency Department patients who attend with conditions such as a pulmonary embolism, cellulitis, headache, chest pain or an unexplained temperature can be seen and treated by the Advanced Nurse Practitioners and if appropriate discharged home.

- Work with our BSW STP partners to introduce the ReSPECT form. Part of the form is a treatment escalation plan which describes the patient's wishes in the event of an emergency in agreement with their GP and avoids unnecessary admissions to hospital.

Figure 50: Emergency re-admissions within 28 days of discharge

NHS Outcomes Framework Domain	Measure:	2017/18	2018/19	2019/20	National average 2019/20	Highest average other Trusts 2019/20
Domain 3: helping people to recover from episodes of ill health or following injury	0 to 15	6.54%	5.82%	*9.56%	Not available	Not available
	16 or over	6.39%	6.56%	6.76%	Not available	Not available
Indicator: Percentage of patients readmitted within 28 days of discharge from hospital of patient by age group						

*Prior to December 2019, children who attended the paediatric day assessment unit were classed as outpatient attendances. From 1 December 2019, all children who attend the paediatric day assessment unit are classed as admissions (to ensure full coding). All children are offered temporary open access to the children's ward for those with an acute illness and are counted as a re-admission rather than an outpatient attendance if they re-attend for a review.

Responsiveness to the personal needs of patients

Figure 51 presents the Trust's performance on the responsiveness to the personal needs of patients. Salisbury NHS Foundation Trust considers that the mean score of responsiveness to in-patient personal needs is as described for the following reasons:

- Each year the Trust participates in the National In-patient Survey. A nationally agreed questionnaire was sent to a random sample of 1250 patients and the results were analysed independently by the Patient Survey Co-ordination Centre. 64% of patients responded to the survey in 2019 and improvement from 57% in 2018.
- Themes from the National In-patient Survey, real time feedback, the Friends and Family Test, complaints and concerns are identified by each ward and an improvement plan prepared.
- In 2019 we took part in the National Maternity Survey to collect feedback on women's experiences of the maternity service to learn from and improve the quality of care.

Salisbury NHS Foundation Trust has taken the following actions to improve responsiveness to in-patient personal needs and improved the quality of its services by:

- Our catering team successfully tested serving meals course by course on Britford Ward to keep food hot. Patient feedback was very positive and no concerns were raised about cold food.
- A national initiative called 'Eat, Drink, Move' was introduced on Spire Ward. The initiative promoted finger food for patients to encourage them to eat and mobility volunteers were introduced to encourage patients to get dressed and walk about.
- We introduced play volunteers to Sarum ward (children's ward) who offered regular play sessions. The team now have access to three volunteers.

Salisbury NHS Foundation Trust intends to take the following actions to improve responsiveness to inpatient personal needs and improve the quality of its services by:

- Art Care and the patient experience team are working with the maternity team to gather women's views including hard to reach groups on the new Birthing Centre.
- Work has started with the paediatric team to ensure children with complex needs who move to adult services when they are 18 years old have a smooth handover of care. Part of this work is to hold focus groups to understand what is important to young people when making the move to adult services. We will do this work in partnership with Mencap 'Treat me well' campaign volunteers.
- Radnor Ward was able to benefit from a large donation to make improvements to the unit. The improvements were planned as a result of feedback from patients who had been cared for in the Intensive Care Unit. The donation will pay for the addition of a shower room and toilet for patients when they are able to get out of bed.

Figure 51: Responsiveness to the personal needs of in-patients

NHS Outcomes Framework Domain	2016/17	2017/18	2018/19	2019/20	National average 2019/20	Highest average other Trusts 2019/20	Lowest average other Trusts 2019/20
Domain 4: ensuring that people have a positive experience of care	7.1	6.9	6.9*	6.8**	Not available	Not available	Not available
Indicator: Responsiveness to the personal needs of its patients (mean score)							

* In 2018/19 the provisional figure of 6.8 was reported. The final figure was 6.9.
** 6.8 is the provisional score of the 2019 national inpatient survey. The finalised score will be reported in the 2020/21 quality account.

The Friends and Family Test – Patients

Anyone using a service should be able to give feedback on that service. The NHS Friends and Family test is designed to be a quick and simple mechanism for patients and other people who use NHS services to give feedback, which can then be used to identify what is working well and to improve the quality of any aspect of patient experience.

Figure 52 and 53 shows the Trust's performance of patients who would recommend the Trust to family and friends. Salisbury NHS Foundation Trust considers the data collected from inpatients and patients discharged from the Emergency Department and wards who would recommend them if they needed similar care or treatment is as described for the following reasons:

- The Trust follows the Friends and Family Test national technical guidance published by NHS England to calculate the response rate and the percentage who would recommend the ward or the Emergency Department. The score measures the percentage of patients who were extremely likely or likely to recommend the hospital and the percentage of patients who were extremely unlikely or unlikely to recommend the hospital. 'Don't know' and 'neither likely nor unlikely' responses are excluded from the score.

The same Friends and Family Test question has been used since 2013 and in the light of feedback on the question itself, is changing in April 2020. A reworded mandatory question will be used as well as two free-text questions designed to elicit good quality feedback. There are a number of additional changes:

- The requirement for the feedback to be collected within 72 hours of a hospital visit is no longer required and from April 2020 patients can provide anonymous feedback whenever they want to.
- In maternity services, the requirement to collect feedback at set times has been removed and women will now be able to give feedback at any time in their pregnancy rather than waiting until the 36th week.
- Previous reported response rates will no longer be published (because there is no limit on how often a patient can give feedback). However, the Trust will continue to submit the same data and NHS England

will publish an indicator which will put the number of responses collected in the context of the size of the service provided. The aim of this is to give regulators a sense of how effectively the Friends and Family Test is being implemented in the Trust.

Salisbury NHS Foundation Trust has taken the following actions to improve the response rate and the percentage of patients who would recommend the hospital to friends and family needing care and improve the quality of its services by:

- Providing a range of different methods for patients to give their feedback, such as postcards, child-friendly postcards and the Trust website.
- Publishing the percentage who would recommend a ward or department every quarter and report it to the Board along with patient comments and any improvements we have made in response to feedback.
- Displaying the results on wards and departments with 'you said, we did' feedback.

Salisbury NHS Foundation Trust intends to improve the percentage of patients who would recommend the hospital to friends and family needing care and improve the quality of its services by:

- Exploring alternative means for patients to give their feedback.

Figure 52: Friends and Family test response rate of patients who would recommend the ward or Emergency Department

NHS Outcomes Framework Domain	Response rate:	2017/18	2018/19*	2019/20	National average 2019/20 M11	Highest other Trusts 2019/20 M11	Lowest other Trusts 2019/20 M11
Domain 4: ensuring that people have a positive experience of care	Wards:	21.0%	16.1%*	14.2%	24.4%	100.0%	1.1%
	Emergency Department	3.5%	0.9%*	1.2%	12.1%	44.4%	0.3%
	Trust Overall:	5.4%	4.4%*	2.1%	Not available as Trust overall average		
Indicator: Response rate of patients who would recommend the ward or Emergency Department to friends or family needing care							

In last year's Quality Account 2018/19* data was only available to February 2019. The full year is reported to March 2019.

Figure 53: Friends and Family test score of patients who would recommend the ward or Emergency Department

NHS Outcomes Framework Domain	Score:	2017/18	2018/19*	2019/20	National average 2019/20 M11	Highest other Trusts 2019/20 M11	Lowest other Trusts 2019/20 M11
Domain 4: ensuring that people have a positive experience of care	Wards:	97.1%	97.2%	96.6%	96.0%	100.0%	73.0%
	Emergency Department	98.3%	93.8%	93.0%	85.0%	99.0%	40.0%
	Trust Overall:	97.7%	97.3%	97.7%	Not available as Trust overall average		
Indicator: Score of patients who would recommend the ward or Emergency Department to friends or family needing care							

In last year's Quality Account 2018/19* data was only available to February 2019. The full year is reported to March 2019.

The Friends and Family Test – Staff

Figure 54 presents the Trust's performance on staff who would recommend the Trust to family and friends. Salisbury NHS Foundation Trust considers that the percentage of staff employed by, or under contract to the Trust during 2019/2020 who would recommend the hospital as a provider of care to their friends and family is as described for the following reason:

- Each year the Trust participates in the National Staff Survey. All staff are sent a nationally agreed questionnaire and the results are analysed by the Staff Survey Co-ordination Centre. The response rate of our staff survey was 54**%** in 2019 a significant increase from 39% in 2018.

- The Trust has an engaged workforce that is committed to delivering an outstanding experience for every patient.

Figure 54: National staff survey 2019 percentage of staff employed or under contract to the Trust who would be happy with the standard of care provided by the Trust and recommend it to a friend or relative needing treatment

NHS Outcomes Framework Domain	2016/17	2017/18	2018/19	2019/2020	Acute benchmark group in 2019/20
Domain 4: ensuring that people have a positive experience of care	82.6%	79.1%	77.4%	78.1%	Best result 87.4% Worst result 39.7%
Indicator: If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Question 21d)					

In previous quality accounts a composite score has been reported. However, in the 2018 national staff survey, only a percentage was given of staff who would recommend the Trust if a friend or relative needed treatment. To enable a direct comparison from 2015 onwards the score has been replaced with a percentage.

Salisbury NHS Foundation Trust plans to take the following actions to improve the percentage of staff who would recommend the hospital as a place to work to improve the quality of its services by:

- Undertake a programme of work to ensure that the hospital is the Best Place to Work. Undertake a diagnostic and listening exercise to truly understand the culture of our hospital to help the Board develop plans for the future.
- Continue to develop our staff health and wellbeing programme.
- Continue to train and support our staff in quality improvement to develop their capacity and capability to lead and sustain change

Venous thromboembolism (VTE)

Figure 55 shows the Trust's performance on VTE risk assessment. Salisbury NHS Foundation Trust considers that the percentage of patients admitted to hospital and who were assessed for the risk of VTE (blood clots) is as described for the following reasons:

- Patient level data is collected monthly by the ward pharmacist from the patients' prescription chart. The data is captured electronically and analysed by a senior nurse. The work is overseen by the Trust's Thrombosis Committee.

Salisbury NHS Foundation Trust has taken the following actions to improve the percentage of patients admitted to hospital who were risk assessed for VTE to improve the quality of its services:

- Salisbury NHS Foundation Trust continues to be an exemplar for the prevention and treatment of VTE (blood clots) and has continued to achieve 99.6% of patients being assessed for the risk of developing blood clots and 96.6% receiving appropriate preventative treatment. We will continue to monitor our progress and feedback the results to senior doctors and nurses.

- We continued to conduct detailed enquiries of patients who develop blood clots in hospital to ensure we learn and improve.
- Updated our VTE orthopaedic clinical protocols in line with the most recent National Institute for Health and Care Excellence (NICE) guidance on VTE prevention and prophylaxis.

In 2020/21 as an exemplar site, Salisbury NHS Foundation Trust intends to continue with the actions described above to sustain the percentage of patients admitted to hospital who are risk assessed for VTE and given preventative treatment. The VTE team intend to:

- Consider the introduction of risk assessment for VTE for children.

Figure 55: Patients admitted to hospital who were risk assessed for Venous Thromboembolism

NHS Outcomes Framework Domain	2017/18	*2018/19	2019/20	National average 2019/20	Highest other Trusts 2019/20	Lowest other Trusts 2019/20
Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm	99.4%	*99.5%	99.6%	Not available	Not available	Not available
Indicator: Percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism						

In last year's Quality Account *2018/19 data was only available to February 2019 was 99.5%. The full year is reported to March 2019 as 99.5%

Clostridium difficile infection

Figure 56 shows the Trust's C difficile performance. Salisbury NHS Foundation Trust considers that the rate per 100,000 bed days of cases of C.difficile infection are as described for the following reason:

- In February 2019, NHS Improvement published 'Clostridium difficile infection objectives for NHS organisations in 2019/20'. This document set out changes to the C.difficile reporting in 2019/20. The guidance added a prior healthcare exposure element for community onset cases when a patient had been an inpatient in the Trust in the previous four weeks, and reduced the number of days to apportion hospital onset healthcare associated cases from three or more days to two or more days following admission.
- From 1 April 2019, in line with the new guidance the Trust reported cases assigned as follows:
  - Hospital onset healthcare associated: cases that were detected in the hospital three or more days after admission.
  - Community onset healthcare associated: cases that occurred in the community (or within two days of admission) when the patient had been an inpatient in the Trust in the previous four weeks.

- For 2019/20, the C.difficile case objective set by NHS Improvement and NHS England for the Trust was no more than 9 cases. This was one of the lowest targets set across the region due to previous good performance (In 2018/19 the Trust had less than 18 cases).

- In 2019/2020, the impact of the changes in the definitions showed that 9 of the 22 cases were hospital onset with the remaining 13 cases classed as community onset healthcare associated (where patients were discharged within the previous 4 weeks).

- The Trust successfully appealed 8 hospital onset healthcare associated cases for no lapses in care to NHS Wiltshire Clinical Commissioning Group and West Hampshire Clinical Commissioning Group.

- The Trust continues to benchmark positively. Public Health England data shows the Trust rate of C.Difficile hospital onset cases was 5.8 per 100,000 occupied bed days in 19/20 compared to a rate of 13.42 in the South West and 15.42 in England.

- NHS Improvement and the Clinical Commissioning Groups are regularly briefed on this issue with no further action required to be taken. No financial fines have been levied by the Clinical Commissioning Groups.

Salisbury NHS Foundation Trust has taken the following actions in 2019/20 to reduce the rate per 100,000 bed days of cases of C. difficile infection to improve the quality of its services by:

- Maintaining and monitoring good infection control practices including hand hygiene, wearing of personal protective equipment, prompt isolation nursing and sampling of patients with suspected C. difficile.
- Maintaining and monitoring standards of environmental and patient care equipment cleanliness and taking actions to improve.
- Improved best practice in antibiotic prescribing.
- An in-depth analysis into the year to date cases was completed in October 2019 at a joint meeting with the Infection Prevention and Control Team, antimicrobial clinical lead and Pharmacist and the Heads of Nursing to review themes and learning. The main theme was patients being appropriately assessed and documentation.
- An action plan from a previous NHS West Hampshire Clinical Commissioning Group 'critical friend' review of C difficile cases in 2015 was revisited. The meeting was assured that the actions implemented in 2015 have been sustained in practice with the exception of the introduction of antibiotic champions.

Salisbury NHS Foundation Trust intends to take the following actions in 2020/2021 to reduce the rate per 100,000 bed days of cases of C. difficile infection to improve the quality of its services by:

- Continued vigilance through the above actions.
- Review of the established Trust 'Good practice guide for the management of inpatients with diarrhoea' following user feedback.
- Recommence monthly audits of antibiotic prescribing practice and focus on improvement actions.
- Continue collaborative working partnerships with the local Clinical Commissioning Groups to share learning and best practice.

Figure 56: Rate per 100,000 bed days of C difficile infection reported within the Trust amongst patients aged 2 or over

NHS Outcomes Framework Domain	2016/17	2017/18	2018/19	2019/20	National average 2019/20	Highest average other *SW Trusts 2019/20	Lowest average other *SW Trusts 2019/20
Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm	8.4	5.1	4.4	5.9	15.42	28.14	5.8
Indicator: The rate per 100,000 bed days of C difficile infection reported within the Trust amongst patients aged 2 or over							

*SW = South West

Patient safety incidents

Figure 57 shows the Trust's performance on patient safety incidents. Salisbury NHS Foundation Trust considers that the rate of patient safety incidents reported and the number and percentage of such incidents that resulted in severe harm or death are as described for the following reasons:

- The Trust actively promotes an open and fair culture that encourages the honest and timely reporting of adverse events and near misses to ensure learning and improvement actions are taken.
- The Trust submits patient safety incident data to the National Reporting Learning System.
- We work in partnership with our commissioners to share learning and improvement actions.
- The Trust reviews compliance with the Duty of Candour.

Salisbury NHS Foundation Trust has taken the following actions to reduce the rate of patient safety incidents and the number and percentage of such incidents that have resulted in severe harm or death to improve the quality of its services by:

- Investigating incidents and sharing the lessons learnt across the Trust and ensuring recommendations are implemented through the Executive Directorate Performance Review meetings.
- Continuing to monitor the completion of recommendations from reviews at the Clinical Management Board and Clinical Governance Committee.
- Ensuring timely identification of themes, trends and learning.
- A cancer risk summit was held in September 2019 following a cluster of serious incidents related to missed or delayed diagnosis of cancer to progress improvement actions. Three working groups were set up 1) To streamline the multidisciplinary team review of patients with cancer in line with national guidance 2) Improve appointment processes 3) Improve receipt and acknowledgement of abnormal results. Since June 2019, there have been no new cases of missed or delayed diagnosis of cancer. Progress has been made with all workstreams and a follow-up summit will be held in April 2020.
- A maternity safety improvement plan following a cluster of serious incidents.

Salisbury NHS Foundation Trust intends to take the following actions to reduce the rate of patient safety incidents and the number and percentage of such incidents that result in severe harm or death to improve the quality of its services by:

- Reviewing data from the National Reporting Learning System (NRLS) (figure 56) shows an increase in the number of incidents reported and the NRLS indicates there is no evidence for potential under reporting of incidents and the Trust remains within the expected range.
- The Trust will continue to improve its safety culture by actively promoting reporting, investigation of clinical incidents and serious incidents and share learning across the Trust and with our commissioners to ensure improvement.

Our national staff survey 2019 showed that when asked:

- My organisation treats staff who are involved in an error, near miss or incident fairly - this hospital is better than average compared to other acute Trusts (62.7% vs 59.6%).
- My organisation encourages us to report errors, near misses or incidents – this hospital is better than average compared to other acute Trusts (89.1% vs 88.2%).
- When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again – this hospital is better than average compared to other acute Trusts (71.4% vs 70.2%).

Figure 57: National Reporting Learning System rate of patient safety incidents reported and the percentage of incidents that resulted in severe harm or death

NHS Outcomes Framework Domain	Indicator	Oct 17 – Mar 18	*April 18 – Sept 18	*Oct 18 – Mar 19	April 19 – Sept 19
Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm	The number and rate of patient safety incidents reported within the Trust.	35.81 incidents per 1000 bed days	38.77 incidents per 1000 bed days	40.81 incidents per 1000 bed days	43.76 incidents per 1000 bed days
	The number and percentage of such incidents that resulted in severe harm or death	15 incidents 0.53%	11 incidents 0.36%	14 incidents 0.4%	18 incidents 0.6%

*2018/2019 data was not available by 1/5/19. The full year is now reported.

Duty of Candour

As part of our ongoing commitment to promoting a learning culture we have implemented the statutory Duty of Candour when patients suffer moderate or severe harm. Whilst our staff have always complied with their professional duty of candour, the statutory duty requires clear documentation of our explanation and an apology followed up by a letter. This year we have continued education sessions with many of our clinical teams and departments on how staff should comply with the Duty of Candour. We have provided learning resources for our staff and support from the quality team to enable our clinical teams to exercise their Duty of Candour. We have introduced a Duty of Candour compliance measure when patients suffer moderate harm and report it monthly to the Clinical Risk Group to drive and monitor further improvement.

Part 3: Other information

Review of Quality Performance

This section gives an overview of the quality of care offered by Salisbury NHS Foundation Trust based on performance in 2019/2020 against a range of selected indicators on patient safety, effectiveness and experience. These areas have been chosen to cover the priority areas highlighted for improvement in this Quality Account, as well as areas which our patients have told us are important to them, such as cleanliness and infection prevention and control. Our commissioners measure all these areas and our improvement schemes support these metrics.

These indicators are included in a monthly Integrated Performance Report – Quality and Care that is reported to the Board and Clinical Governance Committee.

Figure 58: Trust performance of patient safety, clinical effectiveness and patient experience indicators

Patient Safety Indicators							
Indicators	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**National average**	**What does this mean?**	**Data source**
1a.Mortality rate (HSMR)	117	101	*106	102.5	100	Lower than 100 is good	National definition of HSMR & SHMI
1b. SHMI	106	106	*101	101	100		
2. MRSA notifications**	0	0	3	0	0.76 per 100,000 bed days	0 is excellent	National definition
	(2)	0	(3)	(0)			
3. C. difficile infection per 1,000 bed days							
a. Trust and non-Trust associated	0.12	0.12	0.12	0.14	15.42 per 100,000 bed days	Lower than national average is good	National definition
b. Trust associated only	0.08	0.05	0.05	0.06			
4. 'Never events' that occurred in the Trust***	2	3	3	2	Not available	0 is good	National Patient Safety Agency
	1 related to surgery, 1 with an insulin device	These were associated with surgery	2 related to surgery, 1 with an air flow meter	1 related to a retained swab and 1 associated with an air flow meter			
5. Patient falls in hospital resulting in a fracture or major harm	35	29	36	24	Not available	Lower number is good	
Clinical Effectiveness indicators							
6. Patients having surgery within 36 hours of admission with a fractured hip	81.7%	78.6%	85.2%	81.9%	90%	Higher number is good	National definition with data taken from hospital system and national database.
7. % of patients who had a risk assessment for VTE (venous thromboembolism)	99.7%	99.5%	99.5%	99.6%	90%	Higher number is better	

8. % patients who had a CT scan within 12 hrs of admission with a stroke	within 12 hours						Local indicator
	98.7%	97.8%	99.2%	96.9%	Not available	Higher number is better	
9. Compliance with NICE Technology Appraisal Guidance published in year	80%	90%	89%	74%	Not measured	Higher number is better	Local indicator
Patient experience indicators							
10. Number of patients reported with ****category 3 & 4 pressure ulcers	3	3	3	21	Not available	Lower number is better	National definition (data taken from hospital reporting systems)
11. % of patients who felt they were treated with dignity and respect							
a. Yes always:	88%	85%	83%	84%	Not available	Higher number is better	National in-patient survey
b. Yes sometimes:	10%	12%	15%	14%			
12. Mean score of patients' rating of quality of care #	8.2	8.2	8.2#	8.3##	Not available	Higher number is better	National in-patient survey
13. % of patients in mixed sex accommodation	9%	6%	8.7%	8%	Not available	Lower number is better	
14. % of patients who stated they had enough help from staff to eat their meals	68%	67%	54%	63%	Not available	Higher number is better	
15. % of patients who thought the hospital was clean	71%	69%	67%	67%	Not available	Higher number is better	
16. % of patients who got enough to drink	NA	91%	90%	92%	Not available	Higher number is better	

* In 2018/2019 HSMR was reported as 103.2 to December 2018. The full year rate was 106 to March 19. In 2018/2019 SHMI was reported as 100 to December 2018. The full year rate was 101.
** In previous annual reports the Trust quoted Trust and non-Trust apportioned MRSA notifications as a total figure. This will have included community hospital and GP patients. The total figure is quoted in brackets in the table.
*** Never events are adverse events that should never happen to a patient in hospital. An example is an operation that takes place on the wrong part of the body. The national never events list was revised in April 2018 describing 15 categories of never events.
**** From 1 December 2018 pressure ulcers terminology changed from a 'grade' to a 'category'.
# The patient safety indicator name has been changed from '13. Mean score of patients stating the quality of care was very good or better' to 'Mean score of patients rating of quality of care' as it is no longer rated between excellent and poor but is on a sliding scale from 10 to zero. In 2018/19 report the mean score of patient's rating of quality of care was reported as 8.1. The finalised rating is 8.2.
8.3 is the provisional score from the 2019 national inpatient survey. The finalised score will be reported in the 2020/21 quality account.

NHS Improvement Single Oversight Framework 2019/20 Indicators

Figure 59: Trust performance indicators

Measure	2017/2018	2018/2019	2019/2020	Standard 2019/2020
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	91.3%	93.06%	91.9%	92%
Emergency Department maximum waiting time of 4 hours from arrival to admission/ transfer/ discharge*	93.5%	91.01%	90.06%	95%
All cancers: 62 day wait for first treatment from: • Urgent GP referral for suspected cancer • NHS Cancer Screening Service referral	86.0% 86.3%	84.6% 93.5%	83.3% 87.9%	85% 90%
C.difficile: variance from plan	8 Trust apportioned cases Variance -11	7 Trust apportioned cases Variance - 11	9 hospital onset healthcare associated cases 13 community onset health care associated cases **Total – 22 cases Variance + 13	Upper limit of 9 cases
Summary Hospital-level Mortality indicator	106 as expected	***101 as expected	101	100 or lower
Maximum 6 week wait for diagnostic procedures	98.7%	99.0%	98.8%	99%
Venous thromboembolism (VTE) risk assessment	99.5%	99.5%	99.6%	95%

*This includes Type 1, 2, & 3 Emergency Department attendances from 1 April 2017.
**In 2019/2020, 8 successful appeals for no lapses in care were made to NHS Wiltshire and NHS West Hampshire Clinical Commissioning Groups who agreed they could be removed from the Trust's figures as there were no lapses in care. The figure reported is the total number of hospital onset health care associated cases including the 8 cases successfully appealed.
***In 2018/2019 SHMI was reported as 100 to 30/9/2018. The full year rate was 101 to March 19.

Figure 60: Type 1, 2 and 3 attendance to the Emergency Department

Performance	2017/18	2018/19	2019/20
Type 1	91.79%	87.16%	86.03%
Type 1+2*	92.36%	87.97%	86.89%
Type 1+2+3	93.59%	91.01%	90.06%

Type 1 = Attendances to the Emergency Department at Salisbury District Hospital
Type 2 = Attendances to the Emergency Department (Ophthalmology) Outpatient Clinic at Salisbury District Hospital
Type 3 = Attendances to the Salisbury Walk-in Clinic (offsite). In 2018/19 Type 3 data was outside the scope of the Trust's external audit. In 2019/20 the Salisbury Walk-in Centre was managed by Salisbury NHS Foundation Trust from 1 April 2019.
*Type 1 & 2 & 3 are under the management of Salisbury NHS Foundation Trust and shows the performance of the Trust as 90.06% in 2019/20.

NHS
Salisbury
NHS Foundation Trust

Reading a Statistical Process Control (SPC) Chart

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

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

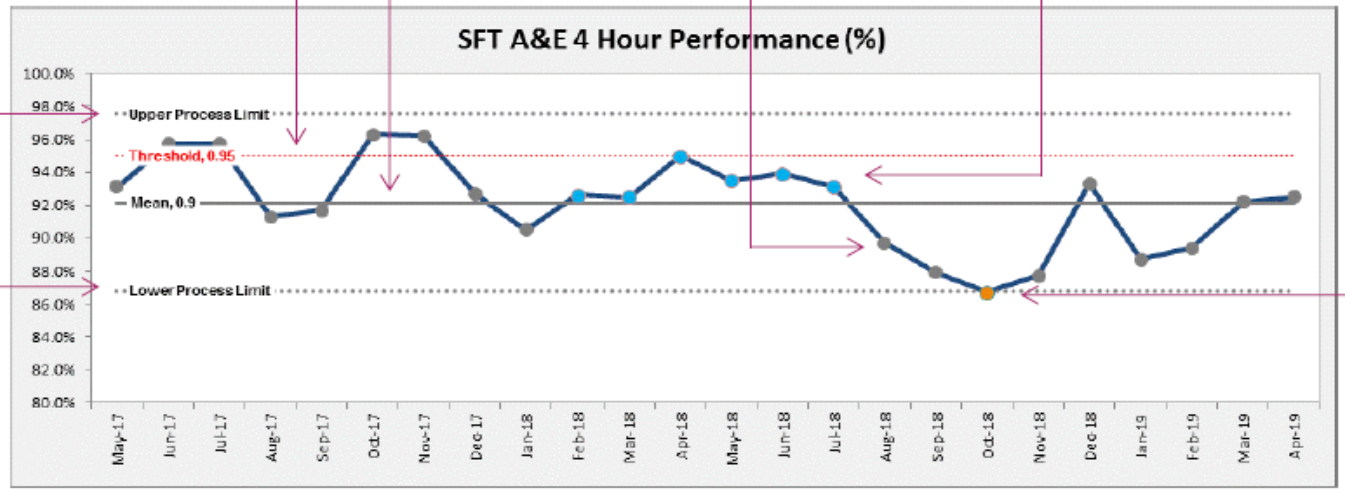
The red line shows the target for the KPI, if there is one

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 above the Mean or one point greater than the upper limit

Orange markers indicate that there has been a marked decline in performance, showing 6 or more points below the Mean or one point less than 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 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

Part 3: Annex 1

Bath and North East Somerset, Swindon and Wiltshire CCG

West Hampshire Clinical Commissioning Group

Statement from Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group on Salisbury NHS Foundation Trust 2019 - 2020 Quality Account – 13 May 2020

NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group (CCG) welcome the opportunity to review and comment on the Salisbury Hospital NHS Foundation Trusts' (SFT) Quality Account for 2019/2020. In so far as the CCG has been able to check the factual details, the view is that the Quality Account is materially accurate in line with information presented to the CCG via contractual monitoring and quality visits and is presented in the format required by NHS Improvement 2019/2020 presentation guidance. The CCG supports the Trusts' identified quality priorities for 2020-21.

It is the view of the CCG that the Quality Account reflects the Trusts' on-going commitment to quality improvement and addressing key issues in a focused and innovative way, as well as utilising the nationally set CQUIN schemes to support the achievement of many 2019-20 quality priorities. The Trust priorities for 2019-20 have outlined achievement in:

- Successes in reducing nursing vacancies and turnover.
- Lowest gram negative blood stream infections in the region
- Implementation of Saving Babies Lives care bundle and Continuity of Care in maternity services with the continued work in the Local Maternity System workstreams with the CCG and partners.
- Continued positive improvements in screening for those using alcohol and smoking, offering brief advice and referral to specialised services.
- Increase in the number of patients discharged to their preferred place of care at end of life.
- Good outcomes in utilising best practice management of patients with COPD.
- Supporting outpatient transformation through the use of 'Attend Anywhere' and 'Consultant Connect'. The CCG encourage a continued focus on improving the use of technology to support patient care.
- Same day emergency care for patients with Pulmonary Embolus, Atrial fibrillation and Community Acquired Pneumonia.

The CCG welcomes continued focus on:

- Safety and effectiveness of the hospital at the weekend
- Falls prevention and the promoting 3 high impact actions to prevent falls to reduce the number of patients who fall resulting in high harm.
- Reducing the number of patients who acquire a category 3 or 4 pressure ulcer in hospital.
- Review antenatal pathways and use of the Maternity Day Assessment Unit to ensure women are assessed by a senior doctor in a timely manner
- Use of Antibiotics for the treatment of Lower Urinary Tract Infections in older people, in line with NICE Guidance.
- Continuing from 19/20 the Treatment of Sepsis, building on the positive improvements in 19/20 to screen inpatients, and a decrease in the relative risk of death from sepsis over the last 2 to 3 year.

- Improving patient flow through the hospital through the 'Ready, Steady, Go' programme and continued use of the Safer Care bundles, including a particular focus on discharge planning and discharge before midday.
- Staff engagement and further improvements to the working environment, and leading healthy lives.

In addition, the CCG would like to highlight the continued work of the trust to understand patient and staff experiences of SFT to improve services. The CCG looks forward to working with the trust to explore innovative and new ways to gather information from patients and staff for continuous improvement based on feedback.

The Trust has continued the focus towards the elimination of mixed sex accommodation breaches. However when mixed sex breaches are unavoidable, during times of escalation and increased activity, the CCG has been provided with appropriate assurance by the Trust that all necessary mitigations have been put in place to preserve patients privacy, dignity and safety.

The CCG acknowledges the good work undertaken during 2019/20 to learn from deaths and that the Summary Hospital Level Mortality, as a key indicator in quality of care, is within the expected levels. The Trust has demonstrated that mortality reviews continue to be a priority area, with a particular focus on weekend mortality in 19/20. The Trust has identified continuing work through implementing the Medical Examiner system to scrutinize all hospital deaths and improve the safety and effectiveness of the hospital at the weekend so that patients who need a medical review receive it. The CCG also welcomes the Trusts' ongoing contribution to the national LeDeR programme.

The Trust has continued to take steps to learn from patient safety incidents and monitor this through the Clinical Management Board and Clinical Governance Committee. Of particular relevance are incidents relating to the Identification and management of falls and pressure ulcers, and the Trust is providing the CCG with assurance on how they are addressing these areas of improvements and embedding the learning to ensure that appropriate actions are taken to avoid reoccurrence. In addition, improvements in the number of incidents related to missed or delayed diagnosis of cancer are positive, with a continued focus of this into 20/21.

NHS Bath and North East Somerset, Swindon and Wiltshire CCG, together with associated co-commissioners, is committed to sustaining strong working relationships with SFT and together with wider stakeholders, aims to continue collaborative working that can support achievement of the identified priorities for 2020/21 across the whole health and social care system.

Gill May

Director of Nursing and Quality

Mike Fulford

Chief Operating Officer

West Hampshire CCG

Statement from Wiltshire Council Health Select Committee, dated 18 May 2020

The Wiltshire Health Select Committee welcomes the opportunity to comment on the quality account, especially when SFT could have chosen not to produce full Quality Accounts this year due to the Covid 19 pandemic.

As was also the case last year, the committee recognised the depth and detail of the Quality Accounts and appreciated the clarity of the information provided.

The committee also noted that information had been provided to explain why the trust had not achieved 100% of the number of registered cases required by the terms of national clinical audits and confidential enquiries, which is something the committee had highlighted last year. The Trust had engaged in a high number of audits.

The committee was pleased to note that priorities for which the targets had not been met in 2019-20 would still be areas of focus in 2020-21.

There were many positives to be noted, including the Trust having the lowest gram negative blood stream infection rate across the region for hospital onset gram negative blood stream infections, never events reducing from 3 to 2 and was recognised as an exemplar site for prevention and treatment of blood clots.

In terms of details included in the quality accounts, the committee would make the following comments:

1. ensure that targets are used in the infographics (page 5), otherwise it is difficult to assess any achievements;
2. some additional clarification may be required with regards to continuity of carers (page 13) as the committee understands the target of 51% would be for vulnerable women (not all pregnancies);
3. clarification may also be helpful with regards to the title of paragraph 1.3 as the paragraph then focused on carers (not people with learning disabilities and autism);
4. from page 59 onwards there seem to be a higher use of acronyms, it would be helpful to have a glossary.

The committee would also make the following suggestions:

1. to ensure that the reasonable adjustments available are clearly communicated to patients or user groups who may be requiring them (page 15 refers). This may of course already be planned;
2. To add an explanation, where possible, to explain the disparities in a graph when these may be hard to interpret, for example figure 8 and figure 14. It could be that the numbers concerned are very low, therefore any variation makes a big difference?

The committee would be very grateful if members of the SFT would be willing to attend a meeting of the Health Select Committee towards the end of 2020 (pending outcome of Covid 19) to provide the following information:

1. Home as the preferred place at end of life: target and achievement. Is there a monitoring of the quality of support offered and of how this was experienced by relatives or those close to the patients?

2. attend anywhere: as the number of services accessible through "attend anywhere" increase is there a monitoring of the patients who do access it (i.e. gender, age, etc. to help ensure all patients are able to access services that way);

3. antibiotics: progress on achieving 90% of antibiotic prescriptions for lower urinary tract infection in older people meeting the National Institute of Health and Care Excellence (NICE) guidance for lower urinary tract infection.

4. three high impact falls prevention actions: progress on:

- Lying and standing blood pressure recorded at least once (*lowest performing on Figure 9*)
- No sleeping tablets or antipsychotic or sedative medicines given during a patient's stay
- Mobility assessment recorded within 24 hours of admission and if a walking aid is needed, provided within 24 hours of admission to hospital.

(page 19 of the quality accounts refers – *"Of 380 patients, 130 (34%) had all 3 interventions during their inpatient stay compared to an 80% national target. There is clearly more work to be done to improve, particularly in the recording of lying and standing blood pressure, and this will continue to be a priority for next year."*)

5. carer policy and engaging with patients with learning difficulties and autism: progress on producing a carer policy and further information on engagement with patients with learning difficulties and autism.

6. Continue to reduce the number of patients who develop a new catheter associated urinary tract infection in hospital: to receive a progress update as this was identified as a key area for improvement, as the quality accounts stated not showing significant improvement for last year although sustained practice over last 2 years (pages 20 and 21).

7. sepsis treatment: It was positively noted that 100% sepsis screening of adults had been achieved (page 23) but sepsis treatment of inpatients was significantly below mean threshold (figure 16, page 23). To receive an update on progress regarding sepsis treatment.

8. predicting discharge date and discharge before midday: (pages 27 and 28 refer) progress update on systems in place to improve, as well as more information (if possible) on the reasons or issues known to prevent meeting target.

9. nurse practitioner role for Stroke unit: (page 30) to inform the committee whether a nurse practitioner role has been agreed.

10. preferred place of care at the end of their life: the improvement in enabling patients to be discharged to their preferred place of care at the end of their life was noted. However, the quality accounts did not give any indication of monitoring post-discharge to ensure that the experience was as expected for patients and those supporting them at the end of their life.

11. WHO checklist: Page 61 indicates that not all staff are up to date with the WHO checklist patient safety standards. Could some information be provided to explain the reasons and the measures in place to address this.

12. information: the committee would be grateful if some information could be provided on apprenticeships and RESPECT (including the RESPECT form).

The committee would also be grateful if members of the SFT would be willing to attend a briefing (informal meeting) of the Health Select Committee to provide information on the following:

- SAFER care bundle
- Ready / steady / go
- use of IT – consultant connect, virtual clinics, attend anywhere, etc.

Cllr Chuck Berry,
Chairman of the Health Select Committee, Wiltshire Council

Statement from Healthwatch, Wiltshire – 6 May 2020

Healthwatch Wiltshire thanks the trust for sharing its Quality account and welcomes the opportunity to comment. Healthwatch Wiltshire is an independent organisation that promotes the voice of patients and the wider public with respect to health and social care services.

Healthwatch Wiltshire is pleased to see the summary of priorities on the first pages alongside the use of infographics which displays the information is an easy to understand and accessible way.

We note there are some medical terms and jargon throughout the account and suggest a glossary of terms could be included in the future.

We are also pleased see quotes direct from patients about the care they received included throughout the account and that patients have been invited to share their stories with the board. We would encourage this to continue.

We note your work with people with a learning disability and are pleased to hear about plans to expand this going forwards, to create a changing places facility, launch a learning disability ambassador role to increase awareness about reasonable adjustments and support patients with a learning disability when they come into hospital. We have trained a number of adults with a learning disability who work with us as 'Quality checkers' and we'd be happy to discuss how we could support with this work going forwards.

Healthwatch Wiltshire are pleased to see a reduction in the number of high harm falls and that you have identified areas to improve this further in the year ahead.

Discharge and delayed discharges continue to be an issue, mainly linked with finding appropriate care. This reflects feedback that we have received over the course of the year. We are pleased this remains a priority area for the 2020/21. We have supported patient feedback in this area in the past and would be happy to discuss how we can support going forwards.

We were pleased to have been involved in testing 'Attend Anywhere' with our volunteers and they reported a positive experience. Given the current Covid pandemic, we know this is being rolled out more widely and we have been receiving positive feedback from people that have had video consultations. We are pleased to be involved in the Outpatient transformation programme going forwards.

Healthwatch Wiltshire has been involved from the early stages with the health and wellbeing campus project and have gathered some preliminary feedback from the public that we have shared with you. We are looking forward to supporting more public engagement in this area going forwards.

We are pleased that an updated Engagement toolkit has been shared with staff and that patients and public have been involved to develop and co-design services. We link in regularly with the Head of Patient Engagement and are glad to be involved in this process.

In terms of the number of deaths, we were concerned to see that the number of deaths that were deemed avoidable has risen for the last quarter and would like to know if this has been investigated. We are pleased to see that learning has been made and actions taken as a result of case record reviews.

We note that you identified patients who had undergone a total hip replacement has a slightly lower health gain rate compared to national data and wonder if you have considered why this could be. We are assured to see actions have been put in place to try and improve this.

Healthwatch Wiltshire recognises the work done to gather patient experiences and the actions taken to improve as a result of these such as serving meals course by course. We are happy to continue to support you to gather more feedback from patients.

Stacey Sims, Manager, Healthwatch Wiltshire

Statement from the Governors – 11 May 2020

In March 2020 the NHS declared the outbreak of Covid-19 a Level 4 Incident the highest category of national emergency. The Quality Account is for the year ending 31 March 2020. While there is overlap in these timescales this is marginal and is not considered material when commenting on the Quality Account for the whole year.

The Trust's aim to provide an outstanding experience for every patient is underpinned by an established commitment to patient safety and providing high quality care that respects patient choice.

The Quality Account sets out the Trust's priorities for quality improvement. It details the work programmes and projects that contribute to organisational learning and an enriched patient experience. The quality initiatives reach far and wide requiring the active participation by staff in all areas; staff with direct patient contact and those working in support of them. Together they uphold the Trust's reputation for providing responsive services and being a friendly and welcoming hospital.

The Trust is not immune or protected from the challenges faced by the NHS as a whole. Rising demand, shortages of skilled staff and financial constraints are issues that have stretched the aptitude of managers and staff. The toll is reflected in a small but continuing decline in the indicators of staff satisfaction. The Governors welcome the success of recent international recruitment initiatives and the priority being afforded to staff welfare.

The NHS Long Term Plan requires NHS organisations to work together to deliver integrated care. The Trust's commitment to its implementation locally is demonstrated through a dedication to partnership working, leadership within the wider health economy and its inclusion as a priority for 2020/21.

John Mangan - Lead Governor

11 May 2020

How to provide feedback

All feedback is welcomed, the Trust listens to these concerns and steps are taken to address individual issues at the time. Comments are also used to improve services and directly influence projects and initiatives being put in place by the Trust.

Part 3: Annex 2

Statements of Directors' Responsibilities for the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, Directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/2020 and supporting guidance on detailed requirements for quality reports 2019/20.

- The content of the quality report is not inconsistent with internal and external sources of information including:

    - Board minutes and papers for the period April 2019 to March 2020.

    - Papers relating to quality reported to the Board over the period April 2018 to March 2019.

    - Feedback from commissioners NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group dated 13 May 2020 and with West Hampshire Clinical Commissioning Group dated 16 June 2020.

    - Feedback from governors dated 11 May 2020.

    - Feedback from Healthwatch, Wiltshire dated 6 May 2020.

    - Feedback from Wiltshire Council Overview and Scrutiny Committee dated 18 May 2020.

    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 4 April 2019, 9 January 2020, 2 April 2020.

    - The 2019 national patient survey will be published in July 2020.

    - The 2019 national staff survey dated 18 February 2020.

    - The Head of Internal Audit's annual opinion of the Trust's control environment dated June 2020.

    - The Care Quality Commission inspection report for Salisbury NHS Foundation Trust dated 1 March 2019.

- The quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.

- The performance information reported in the quality report is reliable and accurate.

- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.

- The data underpinning the measures of performance reported in the quality report is robust and reliable and conforms to the specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.

  The quality report has been prepared in accordance with NHS England and NHS Improvement detailed requirements for quality reports 2019/20 and supporting guidance (which incorporates the Quality Accounts regulations) published at:
  https://improvement.nhs.uk/documents/6438/Detailed_requirements_for_quality_report_2019-20.pdf

  and NHS England and NHS Improvement letter to NHS Foundation Trusts dated 29 January 2020 on Quality accounts: reporting arrangements 2019/20 published at:
  https://improvement.nhs.uk/documents/6399/Quality_accounts_letter_2019-20.pdf

  as well as the standards to support data quality for the preparation of the quality report published by NHS England and NHS Improvement detailed requirements for external assurance for quality reports 2019/20 published at:
  https://improvement.nhs.uk/documents/6441/Detailed_requirements_for_assurance_for_quality_reports_2019-20.pdf

- In accordance with NHS England and NHS Improvement publication (approval reference 001559) sent to all NHS Trusts and Foundation Trusts on 28 March 2020 'Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic the work on assurance of the quality account and quality reports by external auditors was ceased. Therefore, no limited assurance report is available on the quality report for 2019/2020.

- NHS England and NHS Improvement published updated guidance 'NHS foundation trust annual reporting manual 2019/20' in April 2020 with additional changes since the publication of 001559 on 28 March 2020. The guidance indicated there is no requirement for a foundation trust to prepare a quality report and include it in its annual report for 2019/20. This is optional. The Trust decided to prepare the report in the usual way and publish it alongside the annual report.
  https://improvement.nhs.uk/documents/6599/FT_Annual_Reporting_Manual_2019-20_-_April_2020.pdf

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board.

Nick Marsden
Chairman
4 June 2020

Cara Charles-Barks
Chief Executive
4 June 2020

Independent Practitioner's Limited Assurance Report to the Council of Governors of Salisbury NHS Foundation Trust on the Quality Report

In accordance with NHS England and NHS Improvement publication (approval reference 001559) sent to all NHS Trusts and Foundation Trusts on 28 March 2020 'Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic, the work on assurance of the quality account and quality reports by external auditors was ceased. Therefore, no limited assurance report is available on the quality report for 2019/2020.