NHS

Salisbury

NHS Foundation Trust

Quality Account 2021-2022

Contents

Glossary of Terms

ACP	**Advanced Clinical Practitioner** *An experienced healthcare professional with a Masters level award or equivalent qualification*
BAF	**Board Assurance Framework** *A document used to report strategic objectives, risks, controls, and assurances to the Board*
BAME	**Black, Asian, and Minority Ethnic**
BAUS	**British Association of Urological Surgeons**
BSOTS	**Birmingham Symptom Specific Obstetric Triage System** *A maternity triage system which involves an assessment of patients to determine how urgently they need to be seen*
BSW/ BSW Partnership	**Bath and North East Somerset, Swindon, and Wiltshire Partnership** *An integrated care system made up of NHS and local authority care organisations*
CCG	**Clinical Commissioning Group** *These groups commission most hospital and community services for the area that they serve*
C.diff	**Clostridium Difficile** *A type of bacteria that commonly causes diarrhoea*
CESG	**Clinical Effectiveness Steering Group**
CIG	**Clinical Implementation Group**
CMB	**Clinical Management Board** *This is a senior operational committee responsible for monitoring the quality-of-care provision including oversight of patient safety, patient experience and clinical effectiveness*
CMO	**Chief Medical Officer** *An individual responsible for overseeing the medical operation of a hospital, formally known as the Medical Director*
CNO	**Chief Nursing Officer** *An individual responsible for overseeing the nursing operation of a hospital, formally known as the Director of Nursing*
COVID-19	**Coronavirus Disease** *An infectious disease caused by the SARS-CoV-2 virus*
CNS	**Clinical Nurse Specialist** *An advanced practice nurse*
CQC	**Care Quality Commission** *The independent regulator of health and adult social care in England*
CQUIN	**Commissioning for Quality and Innovation** *A framework for supporting improvements in the quality of services and the creation of new, improved patterns of care*

DoLS	**Deprivation of Liberty Safeguards** *A set of checks under the Mental Capacity Act 2005 which provide a means of lawfully depriving someone of their liberty in either a hospital or care home, if it is in their best interests and is the least restrictive way of keeping the person safe from harm*
DPWG	**Deteriorating Patient Working Group**
DSP	**Data Security and Protection**
EOLC	**End of Life Care**
EPMA	**Electronic Prescribing and Medicines Administration** *An electric system which helps to facilitate and enhance the communication of a prescription or medicine order*
ERS	**Employer Recognition Scheme** *Encourages employers to support defence and inspire other organisations to do the same*
FFT	**Friends and Family Test** *A feedback tool that anyone can use to give quick, anonymous feedback to providers of NHS services*
GIRFT	**Getting It Right First Time** *A national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change*
H@NT	**Hospital at Night**
HEE	**Health Education England** *A body of the Department of Health and Social Care that supports the delivery of excellent healthcare and health improvement to the patients and public of England*
ICB	**Integrated Care Board** *Each Integrated Care System (ICS) will have an Integrated Care Board (ICB). This is a statutory organisation that will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS*
ICS	**Integrated Care System** *A partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area*
IG	**Information Governance**
IPC	**Infection, Prevention, and Control**
IS	**Independent Sector**
MCA	**Mental Capacity Act** *A law which is designed to help people who cannot make decisions for themselves because they lack the mental capacity to do so*

MCCD	**Medical Certificate of Cause of Death**
ME	**Medical Examiner** *A senior medical doctor who is trained in the legal and clinical components of the death certification process*
MEOWS	**Modified Early Obstetric Warning Score** *A scoring system which helps to determine the severity of illness in patients which has been adapted for the normal physiological changes seen in pregnancy*
NC2R	**No Criteria to Reside** *Patients who are medically fit for discharge*
NEWS	**National Early Warning Score** *A scoring system which helps to determine the severity of illness in patients*
NHSE/I	**National Health Service (NHS) England/Improvement**
NICE	**National Institute for Health and Care Excellence** *A body of the Department of Health and Social Care that produces guidelines*
OMG	**Outbreak Management Group**
OP	**Outpatient**
OPAL	**Older People's Assessment and Liaison service** *Provides early comprehensive geriatric assessment to prevent avoidable admissions and remove the barriers which can lead to longer stays in older patients*
OPTB	**Outpatient Transformation Board**
PALS	**Patient Advice and Liaison Service** *Offers confidential advice, support and information on health-related matters and provides a point of contact for patients, their families, and their carers'*
PCN	**Primary Care Network** *A network of GP Practices working together with community, mental health, social care, pharmacy, hospital, and voluntary services in their local area*
PPE	**Personal Protective Equipment**
PROMs	**Patient Reported Outcome Measures** *Assess the quality of care delivered to NHS patients from the patient perspective*
PSIRF	**Patient Safety Incident Response Framework** *Outlines how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted*

RCEM	**Royal College of Emergency Medicine**
SDEC	**Same Day Emergency Care**
SDH	**Salisbury District Hospital**
7DS	**Seven Day Services**
SFT	**Salisbury NHS Foundation Trust**
SHMI	**Summary Hospital-level Mortality Indicator** *The ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die based on average England figures, given the characteristics of the patients being treated*
SJR	**Structured Judgement Review** *A process for undertaking a review of the care received by patients who have died*
SOX	**Sharing Outstanding Excellence** *A method of paying a compliment to a team or a member of staff and a way of learning from when things go well*
VTE	**Venous Thromboembolism** *A blood clot that starts in a vein*
WHC	**Wiltshire Health and Care** *An NHS Partnership focused on community services in Wiltshire*

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 resulting from consultation with patients and the public, our staff, and Governors.

Part 1 - Statement on Quality from the Chief Executive

I am pleased to present our quality account for 2021/22 for Salisbury NHS Foundation Trust, which shows how we have performed against our priorities this year and sets out the main areas of focus for 2022/23.

Sadly, the pandemic has continued to have a significant impact on our organisation and services over the last year, and our hearts continue to go out to all of those who have been impacted by COVID-19, and above all to those who have lost loved ones during this most tragic of times. This year has been another challenging year due to COVID-19 and the continued pressure on our services as a result.

The impact of COVID-19 has been far greater than anyone could ever have imagined, but despite the challenges that we have all faced there is still so much that we have achieved and can be proud of. I know that so many of you have worked tirelessly throughout this time and I am truly grateful for all that our staff have done and continue to do to help. Everyone across our organisation can be immensely proud of their contribution and efforts. I wish to also express my personal gratitude to the staff and volunteers across our community who have continued to support our organisation over the past year, and to our system partners in Bath, Swindon, and Wiltshire (BSW) for their continued support whilst we have looked to further align our plans and priorities.

When I first joined Salisbury NHS Foundation Trust in September 2020, I reported that my focus would be on resetting services following the impact of COVID-19, and, although COVID-19 has continued to disrupt our services I am pleased to report the significant progress which we have continued to make over the past year to improve the quality of care.

This year has seen the launch of our new strategy across the organisation, which is to be driven by a programme of work called ‘Improving Together.’ Our new strategy is enabling us to prioritise workstreams as we identify key priorities for each of our People, Population, and Partnerships (widely known as the ‘three P’s’). This strategy will help to ensure that we have a renewed focus on delivering on our COVID-19 recovery plans. We will also be investing in our people by ensuring that we continue to look after our staff, improve inclusion and belonging, seek new ways of working and delivering care, and develop a model which is fit for the future.

The COVID-19 pandemic has reminded us of the health inequalities that currently exist within our population and we recognise that there is more that we can and must do to deliver services that prioritise these issues. We also acknowledge that not everyone will have experienced the care they had hoped to receive over the past year, and many of you will have been waiting longer than ever to receive care in our organisation. Reducing our hospital waiting times will therefore be a key objective over the next year, which will be supported by the development of and investment in our workforce and people across all professions. Other key priorities will include reducing the number of patient falls, improving the discharge of patients, and working with partners to care for more people at home. We will also be seeking to find digital solutions which are able to support these wider recovery plans.

I would like to offer specific thanks to our teams in Maternity and Spinal services who have supported and responded to a Care Quality Commission inspection. Inspectors commented positively on the engagement from everyone involved which is a great demonstration of living our values.

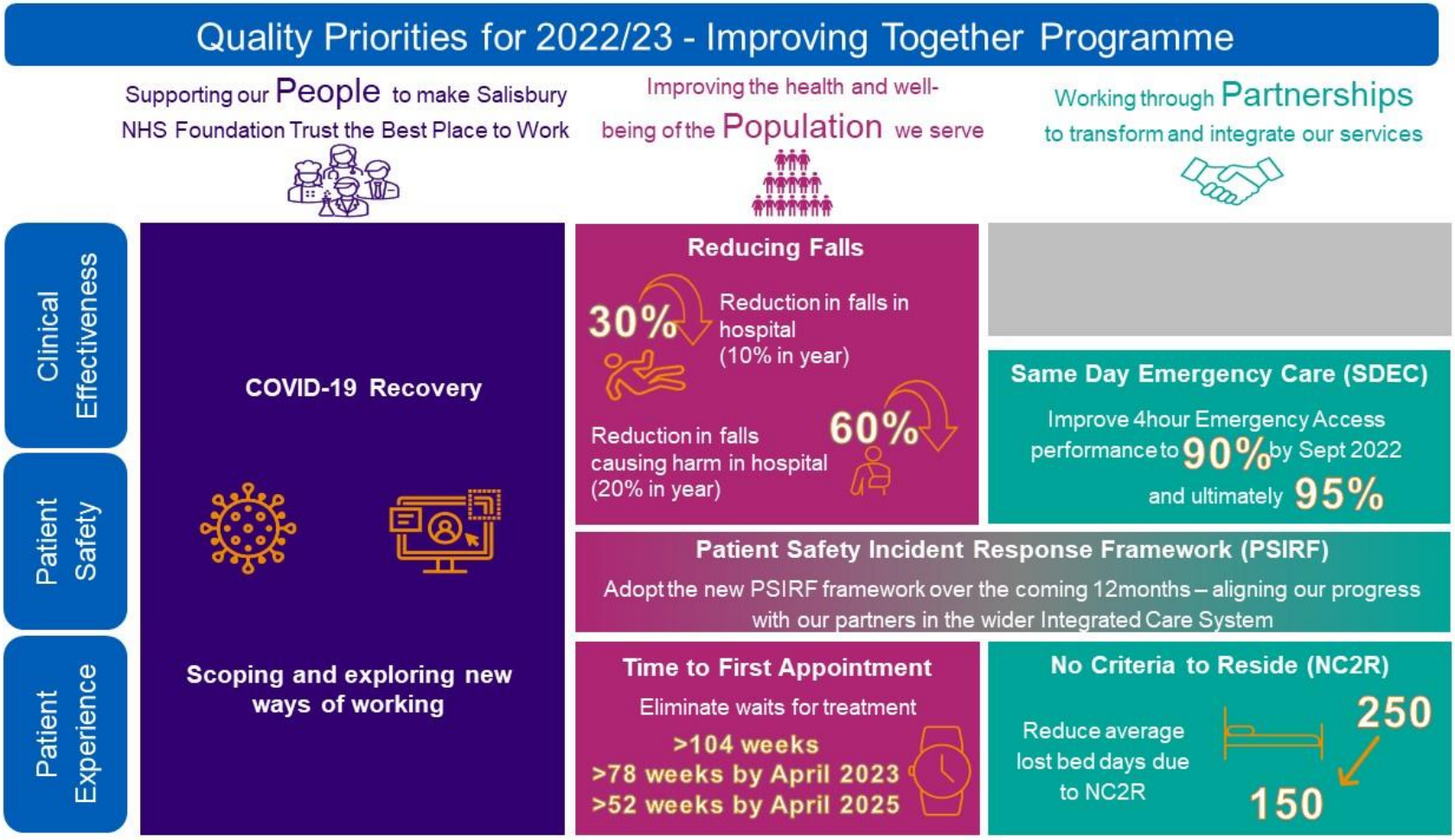
I would like to close by expressing a heartfelt thank you and appreciation on behalf of the Board to each and every member of our staff for everything you have done and are doing each day in service of the communities we provide care for. We couldn’t do this without the contribution from all of you.

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

Stacey Hunter
Chief Executive

Part 2A - Quality Priorities

Our Priorities for 2022/23



Vision and Goals

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

To deliver the NHS Long Term Plan and the Trust Vision, we need to develop the way in which we all work together and learn. Therefore, in 2020 the Trust undertook a significant conversation with staff. This conversation enabled staff to express in their own words what it felt like to work at the Trust.

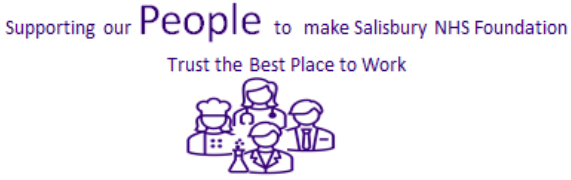
In response to this consultation and other available information, such as the annual national NHS Staff Survey and exit interviews, the Trust Board and colleagues considered how best to build on what was discovered and what was already being done, and how to act to improve our culture, behaviours, and management processes in order to deliver our vision, strategic priorities and goals.

Whilst over the last two years the NHS continued to face an unprecedented level of pressure related to COVID-19, this resulted in the need to reprioritise work-streams and enable a renewed focus on COVID-19 recovery. The Trust is therefore intending to deliver on this re-prioritisation work through its new strategy in 2022/23, which will be driven by a programme of work called *Improving Together*. Our priorities will be identified under the three strategic themes of **Population, Partnerships and People.**

Improving Together

Improving Together is an approach that colleagues in other Trusts locally and across the country have already been engaged in to deliver sustainable long-term improvement. At Salisbury NHS Foundation Trust, this is now the programme by which the whole Trust will develop and improve skills, processes, and behaviours and ultimately the mechanism by which we will deliver our new strategy. With the simple goal of delivering an excellent experience for patients, their families, and staff, and being in a position where everyone can proudly say that Salisbury NHS Foundation Trust is the best place to work.

Bringing together many improvement initiatives already underway, this programme will be the vehicle which will enable our people to improve their skills, help remove things that staff feel block them from delivering outstanding patient experiences every time and will enable us all to provide the care we aspire to. At its heart, the programme makes sure that our ongoing priorities and the things we focus our time and energy on will help deliver our vision of an outstanding patient experience, while bringing our Values to life and offering new development and training opportunities to staff across the organisation.



Key Aims of Improving Together:

- ✓ Over the next 2-3 years all staff will be invited to take part in the programme.
- ✓ Through the introduction of a new “Coach House” team, which will be our learning and training hub, Improving Together will provide all staff from all departments with the opportunity to improve their ways of working, develop new skills and deliver better services and care across the hospital, embedding a culture of continuous improvement in all our teams and services.
- ✓ In time, the tools and techniques developed as part of Improving Together will become the natural way in which the Trust works.

Improving Together

- ✓ The Trust launched its new Strategy 2022-26 and has identified priorities under the strategic themes of **Population, Partnerships and People**.
- ✓ The Improving Together processes and methodology drives a renewed focus on prioritisation. The strategic plan reflects the 10 key priorities in national guidance and includes **Breakthrough Objectives** and **Strategic Initiatives** identified through Improving Together and BSW shared system priorities.
- ✓ **Recovery of elective care activity and reducing waiting times will be our key operational focus, supported by investment and development in our workforce across all professions.**

Strategic Planning

A strategic framework underpins the Trust's approach to deployment of the objectives outlined above. See Appendix A.

Having established ten areas (vision metrics) by which the Trust will measure its progress against our Strategy, teams across the Trust have analysed the top contributing themes and actions which will help the Trust make a 'breakthrough' on the themes it has identified. Focus on these areas is intended to drive a step change in improvement (circa 30%), and four areas have been selected for focus over the next 12-18 months. The specialties and frontline teams who can make the most significant contribution to improvement will be engaged and focus in these areas will drive improvement in quality across the whole organisation. These four areas will be prioritised at the highest level.

Through the Improving Together programme, four Breakthrough objectives have been identified, which are Trust priorities to be delivered in the next 12-18 months. These will be delivered by frontline teams through operational management structures

Breakthrough Objective	Areas of Focus	Project Support and Resource	Expected Improvement
1. Same Day Emergency Care	Emergency pathways Acute Medical Unit Specialty Focus (e.g., Paediatrics)	✓ Identification of countermeasures, actions, and expected benefits completed. ✓ Improving Together training and methodology being rolled out to these front-line teams ✓ Strategic filtering process is aligning programme and project support to Breakthrough Objectives	Improve 4hr Emergency Access performance to 90% by Sept 2022 and ultimately to 95%.
2. No Criteria to Reside (NC2R)	Breamore, Spire, Redlynch, Downton Wards		Reduce average lost bed days due to NC2R from 250 to 150.
3. Time to First Appointment	Ophthalmology Skin Services (Plastics and Dermatology), Gynaecology ENT, Oral Surgery		Eliminate waits for treatment >104 weeks Eliminate waits for treatment >78 weeks by April 23 Eliminate waits for treatment >52 weeks by April 25
4. Reducing Falls	Durrington, Pitton, Redlynch, Spire, Amesbury Wards		30% reduction in falls in hospital (10% in year) 60% reduction in falls causing harm in hospital (20% in year)

COVID-19 Recovery and Developing New Ways of Working

Nationally, NHS organisations and Integrated Care Boards (ICBs) are being asked to plan for a return to pre-pandemic operations and activity levels. As our operational picture has significantly changed in the last two years, recovering to pre-pandemic levels of activity will require fundamental improvements in system operational resilience, workforce development and a further return to 'normal' working conditions.

Therefore, 2022/23 will be a transition year in our approach both to planning and delivery as we deploy our new strategy, adjust to an environment increasingly focused on post-pandemic recovery, and manage the inequalities to both "access to healthcare" and "health outcomes" which have been further exposed across our communities.

Increasingly, our ability to deliver a plan for the Trust is reliant on interdependencies across our health and care system, and achieving a consistent and coherent picture across Bath, Swindon, and Wiltshire (BSW) will be a priority to ensure we can align our own plans and ambitions with the support of the wider partnership.

Workforce development will also be an important element to enabling the whole NHS to deliver the increases in activity outlined in the guidance. The greatest risk posed to delivery is a general shortage of clinically qualified staff, which existed before, and has now been exacerbated by the pandemic. Layered on top is the sustained pressure and high infection rates which impact retention and absence from work. Without due attention to stabilising and rebuilding the workforce as we emerge out of the pandemic, the national priorities, and our local plans, will simply not be achievable.

Ultimately, our plan is based on a series of balances – a commitment to move forward with the Trust strategy and make progress against our priorities of People, Population and Partnerships, renewed drive for improvement through Improving Together, a clear and ambitious national expectation for elective recovery and a recognition that the pandemic has increased our challenges in managing non-elective activity and the inter-relationships between acute hospital care and community and social care services. Data and digital technology will also provide an important role in delivering our objectives over the next few years, considering the impact that COVID-19 has already had on core services and how the Trust has already adapted to engage both patients and staff through its use.

Developing our People Promise

Salisbury NHS Foundation Trust is a *People Promise* exemplar site, and one of only 21 in the country. The NHS People Promise is all about our promise to work together to improve the experience of working in the NHS for everyone (NHS England » Our NHS People Promise). The Trust's immediate priority will be to address the increase in staff turnover (12.24%), vacancy (3.65%), and sickness absence (5.21%) rates across our workforce, which has contributed to the operational challenges we have experienced during 2021/22. Our actions and priorities for 2022/23 will be set around four key priorities (see **Figure 1**).

Figure 1 – How will we deliver our People Promise?

1. **Looking after our people**

   - ✓ Improving retention by delivering the NHS People promise to improve the experience of our staff, through a focus on flexible working, early to/mid/late career conversations and enabling staff to understand their pensions.
   - ✓ Continue to support the health and wellbeing of our staff, including through effective health and wellbeing conversations and the mental health hubs.
   - ✓ Improve attendance by addressing the root cause of non-COVID-19 related sickness absence and where appropriate supporting staff to return to work.

2. **Improving belonging in the NHS**

   - ✓ Improve the Black, Asian and minority ethnic disparity ratio, delivering the six high impact actions to overhaul recruitment and promotion practices.
   - ✓ Implement plan to promote equality across all protected characteristics.

3. **New ways of working and delivering care**

   - ✓ Accelerate the introduction of new roles, such as anaesthetic associates and first contact practitioners, and expanding advanced clinical practitioners
   - ✓ Develop the workforce required to deliver multidisciplinary care closer to home, including supporting the rollout of virtual wards and discharge to assess models.
   - ✓ Ensure the highest level of attainment set out by the 'meaningful use standards' for e-job planning and e-rostering is met, to optimise the capacity of the current workforce.
   - ✓ Maximise volunteer services such as the NHS cadets and NHS reservists (achieving the Employer Recognition Scheme (ERS) Gold Award).

4. **Growing for the future**

   - ✓ Expand international recruitment through ongoing ethical recruitment of high-quality nurses and midwifes.
   - ✓ Leverage the role of NHS organisations as anchor institutions/networks to widen participation and create training and employment opportunities, including through expanding apprenticeships as a route into working in health and care.
   - ✓ Make the most effective use of temporary staffing, including by expanding collaborative system banks and reducing reliance on high-cost agency staff.
   - ✓ Ensure training of postgraduate doctors continues, with adequate time in the job plans of supervisors to maintain education and training pipelines.

Adopting the Patient Safety Incident Response Framework (PSIRF)

The PSIRF is a key part of the NHS Patient Safety Strategy published in July 2019, which will help to improve our understanding of safety by drawing insight from patient safety incidents. Early adopter sites are feeding back on their experience in May/June 2022. Based on these outcomes, this will start to shape the process nationally that all Trusts will be expected to follow. A national implementation group will provide the NHS with guidance on how to respond to patient safety incidents, and investigations should feed continuous improvement. These will be used proactively as well as reactively.

There is an expectation that Trusts will adopt the new PSIRF over the following 12 months after roll-out in May/June 2022. The plan is for us to work with our local partners though our Integrated Care System (ICS) so that progress is aligned (further information about the PSIRF can be found in Part 3 of this report).

Consultation and Monitoring of our Priorities

Each year the Trust is required to identify and outline its quality priorities. We consulted on our organisational strategy and approach to quality with several stakeholders, and shared our priorities with Commissioners, Governors, Healthwatch, and our Trust Executives. The final priorities were approved at Trust Board.

The priorities that we chose represent the three indicators of quality (patient safety, clinical effectiveness, and patient experience) and have been embedded across our business plans for 2022/23. As last year saw the establishment of three new steering groups for each of these areas at Salisbury NHS Foundation Trust, our quality priorities were initially discussed at each of these committees before being reported upwards to our Clinical Management Board for further scrutiny.

Progress in the achievement of these priorities will be monitored through quarterly reporting to the Trust Clinical Management Board in 2022/23.

Looking Back at 2021/22 - What did we say we would do?

1. Sustain the recovery from COVID-19 through effective partnership working and improve the quality and experience of care for patients and staff

The year 2020/21 was dominated by the need for the whole health and care system to respond to the COVID-19 pandemic and subsequently to recover our services and take action to address some of the wider health inequalities exposed by COVID-19. Therefore, on 7 August 2020, NHS England issued guidance about the third phase of the NHS response to COVID-19 on urgent actions Trusts must take to address inequalities in NHS provision and outcomes. NHS England asked Trusts to work collaboratively with local communities and partners to take the following eight urgent actions:

1. Protect the most vulnerable from COVID-19, **2. Restore** NHS services inclusively, **3. Develop** digitally enabled care pathways in ways which increase inclusion, **4. Accelerate** preventative programmes which proactively engage those at greatest risk of poor health outcomes, **5. Support** those who suffer mental ill health, **6. Strengthen** leadership and accountability, **7. Ensure** datasets are complete and timely, and **8. Collaborate** locally in planning and delivering action.

2. Improve the health and wellbeing of our staff in the recovery of COVID-19

The impact of the COVID-19 pandemic has taken its toll on the physical and mental wellbeing of our staff and we want to do all we can to continue to support our staff to recover their wellbeing to improve their quality of life. This will also improve our patients' experience of hospital care.

3. Continue to improve patient safety and reduce avoidable harm based on our known risks

Patient safety is about maximising the things that go right and minimising the things that go wrong for people experiencing healthcare, such as acquiring an infection in hospital, a fall resulting in a fracture, a pressure ulcer, a missed or delayed cancer diagnosis, an error or missed dose of medication. Safety is integral to the NHS definition of quality in healthcare, alongside effectiveness and patient experience.

The vision for patient safety in the NHS is to continuously improve patient safety. To do this the NHS is building on two foundations; a patient safety culture and a patient safety system. The NHS patient safety strategy published in July 2019 described three strategic aims to support the development of a patient safety culture and a patient safety system. The national patient safety strategy was to be implemented by 2022 and in preparation, we nominated a Patient Safety Specialist, whose role is to lead safety improvements across the Trust to ensure that systems thinking, human factors and just culture principles are part of all patient safety activity. The strategic aims are:

- Improving understanding of safety by drawing on intelligence from multiple sources of patient safety information (insight)
- Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (involvement)
- Designing and supporting programmes that deliver effective and sustainable change in the most Important areas (improvement)

4. Provide ward to Board assurance on fundamental standards of patient care at ward and department level

Ward accreditation schemes have been shown to promote safer patient care in hospitals by motivating staff and sharing best practice between ward areas. They aim to promote better health outcomes, better patient experience and ensures the ward is a better place to work, train and learn. The overall aim is to, a) Improve the basic standards and quality of care at ward level and reduce variation in standards between wards, and b) Increase staff pride within their ward area.

The scheme involves regularly completing audits and assessments to provide information on how well a ward is doing in meeting standards of patient care. Accreditation brings together key measures of nursing and clinical care into one overarching framework to enable a comprehensive assessment of

the quality of care at ward or team level. When used effectively, if can drive continuous improvement in patient outcomes and satisfaction and improve staff experience. It creates a collective sense of purpose necessary to help staff who have been trained in quality improvement to work with their teams to learn and improve and make positive changes for patients and their families as well as make the hospital the best place to work for staff.

The programme is aligned to our strategic priorities and corporate objectives and is supported by the Chief Nurse who meets with the ward teams regularly, to hear about their progress and undertakes a walk-round on the ward to meet staff and patients to gain a real sense of the ward and what it feels like to be a patient and a member of the team.

5. Strengthen our partnerships with other healthcare organisations to improve the health of our local population

Integrated care is about giving people the support they need, joined up across local councils, the NHS and other partners, such as the voluntary, community and social enterprise sectors. It removes traditional divisions between hospitals and family doctors, between physical and mental health and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care.

Integrated Care Systems (ICS) are new partnerships between organisations that meet health and care needs across an area, to co-ordinate services and plan in a way that improves population health and reduces inequalities between different groups and thereby improves the quality and experience of care. An important part of an ICS is that decisions about how services are arranged should be made as closely as possible to the people who use them. For most people, their day-to-day health and care needs are met locally where they live or work. Partnerships in these places are an important building block of integration and one of the strengths of the system is that arrangements can be adapted to reflect local needs.

Our objective in 2021/22 was to place renewed importance on understanding the population we serve and invest in our partnerships and service integration.

How have we achieved this?

This year has been another challenging year due to continued operational pressures experienced at the Trust and the direct impact of COVID-19. In retrospect, and with our understanding of COVID-19, we acknowledge that we were ambitious with the priorities which we set for 2021/22. However, we have managed to make significant progress across a number of these workstreams despite the significant pressures which were experienced across the organisation. Whilst some of our targets have not been fully achieved, we acknowledge that our priorities have sometimes needed to shift in response to the demands of the pandemic. In other instances, the national benchmarks and timelines have changed in response to these challenges too.

1. Sustain the recovery from COVID-19 through effective partnership working and improve the quality and experience of care for patients & staff

1.1 **To protect the most vulnerable from COVID-19, we will continue to review our infection prevention and control COVID-19 Board Assurance Framework (BAF) to achieve 90% compliance with the standards. Partially Achieved**

We made some excellent progress this year against this priority and almost fully achieved our target of 90% compliance.

How will we fully achieve this?

- In Quarter 1, 2022/23, there will be revised national standards, as the prevalence of COVID-19 decreases and there will be publication of an updated IPC BAF. We will continue to aim for 90% compliance.

Trust compliance with the Infection Prevention and Control (IPC) national standards for COVID-19 is measured by using the IPC Board Assurance Framework (BAF). The BAF provides documented evidence as to how confident we are that the standard is in place as well as helping to identify areas of risk and any associated actions. The standards change throughout the year, for instance in responding to changes in the national guidance for managing COVID-19 within the hospital setting. Protecting patients from hospital acquired infection is central to the 'care' element of the Trust strategy.

- Overall, we have 91 standards fully compliant **(86%)** and 14 partially compliant (13%). All partially compliant standards have been implemented in practice and we are working on the evidence associated with these.
- At Quarter 4 we had one non-compliant standard (from 106 standards in total). This reflected our ability to report a specific data set to Trust Board regarding the number of staff with completed FIT* Testing. This information is reported within the organisation and work is in progress to fully meet the standard. This is a low-level risk as the actual compliance with FIT Testing is good.
  FIT testing is a term used to denote the safe fitting of FFP3 respirator masks

1.2	**To restore our services inclusively, we will continue to work with our Acute Hospital Alliance partners to share planned elective care, work towards a shared approach to waiting list management, and system wide pathway reform. Achieved** • Salisbury NHS Foundation Trust long waits continue to consistently decrease at all monitoring points of 104 weeks, 78 weeks, and 52 weeks, with all three measures being ahead of required targets. • System Chief Operating Officers, along with Deputies and Recovery Leads, continue to meet within a framework of monthly Elective Care Board and fortnightly Elective Care Group meetings. Frameworks for mutual aid continue to be developed to support equity of access to care/treatment for patients across the BSW geography, including use of Sulis Hospital Bath and the Independent Sector (IS) providers to support NHS delivery requirements for 2021/22. • A BSW System Elective Care Programme Manager has been appointed to support pan-system working, including the development of joint/shared waiting lists. • System support is being provided by Price Waterhouse Coopers in terms of ensuring an aligned planning process across all three system acute providers, and FourEyes Insight for improving theatre utilisation, with close links to the SW Region Theatre Improvement Manager. • Winter pressures including delayed discharges and the prevalence of the Omicron variant of COVID-19 had significant negative impact on progress, impacting capacity across the Intensive Care Unit, base wards and most specifically escalation into the Day Case Unit. There have been clinical staffing challenges (nursing, medical and allied healthcare professional) in multiple modalities/specialties across the system. • There has been ongoing use and inclusion of IS capacity to support activity for 2022/23 across the system, and a consideration for the development of protected elective capacity and cold site operating. • A bid to provide additional ward capacity on the Trust site is to be operational from Quarter 2 in 2023/24. There are options for outsourcing and insourcing of services and staffing, to manage demand and mitigate system-wide staffing challenges.

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Achieve 60% of patient contacts seen by virtual appointments and work with our system partners to procure a virtual solution so that all Trusts can use the same system regardless of geographical location and improve the patient experience. Not Yet Achieved

The Trust is currently achieving 24.9% of all outpatient (OP) activity delivered via virtual methods, as of February 2022 (25.3% monthly average over the last 6 months).
This priority continues to be monitored internally at the Outpatient Transformation Board (OPTB) and at the BSW OP Transformation Board. Agreement was made in July 2021 to align internal targets with the national request to achieve 25% of outpatient appointments virtually by March 2023 (rather than the original target of 60%).

How will we fully achieve this?

The Trust has a new non-face-to-face working clinical lead in post who continues to work with specialties to assess opportunity for further virtual working. There is also a BSW-wide project group that meets monthly to discuss and agree next steps/opportunities regarding increasing virtual mediums across OP departments.
Having secured external funding, a BSW-wide procurement process has been completed, and a new provider of video consultations has been approved. Transition to the new supplier will begin in April 2022, and once complete all acute providers in BSW will be utilising the same platform for virtual consultations. It is hoped that having a long term, embedded solution will help us to be able to increase our virtual consultation provision within the Trust.
The Trust has been successful in securing a 12-month extension to its current contract, to mitigate against the short timescales of transition, and to ensure that there is no gap in service provision. A Trust project group will be established to ensure that the transition to our new video consultation platform is successful.

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To reduce health inequalities, pilot a scheme to track ‘linked’ pairs of patients on the same cancer pathway to provide assurance that patients from vulnerable groups are prioritised for treatment in a fair and equitable way. Achieved

The Trust has set up a healthcare inequalities group chaired by the Chief Medical Officer to ensure that:
<ol type="a">
The Trust works with partners to identify and reduce inequalities in health outcomes in our local population using the CORE20PLUS5* approach outlined in the BSW health inequalities strategy.
The Trust ensures that it systematically looks for and reduces health inequalities in its own internal processes (e.g. waiting lists for investigation and treatment) focusing on key groups including BAME, socially or economically disadvantaged, those with learning disabilities, rural populations, and military personnel.

* The Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level.
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1.5	**Evaluate the impact on practice of our clinical leadership programme. This supports clinical leaders from all professional backgrounds to develop high quality, safe and compassionate care and to work with local leaders to re-design care pathways and systems. Partially Achieved** • After pausing this during late 2021, we now have five senior consultants that are attending a BSW system-wide leadership course. The first module of six was delivered in mid-March. Full evaluation and impact will be reported on in due course. Our doctors, hailing from a mix across Plastics, Cardiology, Obstetrics and Gynaecology, and Plastic Reconstructive, have been mixed in with Royal United Hospital, Bath and Great Western Hospital to build on partnership, relationships, and systems learning / leadership. **How will we fully achieve this?** • The course will be completed by August 2022. • There were limited numbers and take up on the first advertised run. • The plan is to use the first cohort as ambassadors to champion our next system-wide course.
1.6	**Use population health management data to identify areas of health inequalities and work with our partners and system leaders to plan improvement programmes. Achieved** • The Trust is working at both a system level and at pace (through the Wiltshire Alliance) to provide the infrastructure and networks to allow population segmentation and identification of inequalities in outcome and access to services. • Phase 1 of the roll-out of the BSW Population Health programme is focussed on Primary Care Networks (PCNs) in the north of Wiltshire, which has limited the ability of Salisbury NHS Foundation Trust to provide secondary care partnership. • The Trust is now part of the BSW system inequalities group and is collaborating on several projects to identify and address inequalities. The Trust has linked with a Salisbury PCN to support it becoming a “fast follower” of the BSW phase 1 roll-out. • Through participation in this pilot and the launch of the new Trust strategy, we have an increased strategic prioritisation of population health management. We have identified our role in preventing ill health as one of our Vision metrics in delivering our strategy and aim to provide more consistent assessments of risk factors leading to ill health for our patients, staff, and their families. This is currently being developed through a further analysis of what actions would make the most significant impact in improving health in the communities who use or deliver our services.

1.7	**Working with our partners, start reporting access and outcomes, by protected characteristics and deprivation, for our population and take improvement actions where needed. Achieved** • Both the Trust and BSW now have data available which allows us to assess our waiting lists by protected characteristics and deprivation and make judgements about the impact these demographics have on relative waiting times. • Through the Health Inequalities Group, we will be able to decide whether revisions to clinical policy will have a positive impact on reducing inequalities in accessing care for people who live in our most deprived communities or have a protected characteristic. • We are contributing to a Health Inequalities Impact Assessment, particularly for elective care recovery as part of our planning for the delivery of elective care in 2022/23.

2. Improve the health and wellbeing of our staff in the recovery from COVID-19

2.1	**Ensure our staff, including Black, Asian and Minority Ethnic (BAME) staff and anyone who is vulnerable or who needs additional support has a COVID-19 risk assessment and action taken where needed. Partially Achieved** • 91% of the workforce have a COVID-19 risk assessment in place. • All new starters have their risk assessment completed as part of recruitment checks. • Completion of a COVID-19 risk assessment remains mandatory. **How will we fully achieve this?** • Whilst 91% of the workforce had a risk assessment completed, we are aiming for 100% compliance. This has been challenging due to the continuous changes in national guidance. The Trust is currently in the process of redesigning the risk assessment and will be providing additional support by contacting individuals who still need to complete them.

2.2	**Ensure every member of staff has a health and wellbeing conversation as part of their annual appraisal and regular meetings with their line manager. Partially Achieved** • Wellbeing conversations are being trialled in a pilot process, thus far launched in the Acute Medical Unit and by the Transformation team. The intention is to fully understand what support, training, and awareness (communications) need to be in place to launch this across the Trust. • Key roles are currently being recruited to support this work and to bridge gaps in Occupational Health. **How will we fully achieve this?** • This has not yet been fully launched across the Trust. The plan is to launch, pending full review of the trial, in early May 2022. • A working party, with external support, is in place to ensure that the trial is concluded, and the launch of health and wellbeing conversations is achieved.
2.3	**Introduce a re-designed induction programme for staff new to the Trust that includes information and a discussion about health and wellbeing. Achieved** Induction experience and training may be contributing factors for staff leaving the Trust, and there is a valuable opportunity to celebrate with new starters their choice to join Salisbury NHS Foundation Trust. • A redesigned induction programme has now been introduced although further development is proposed, based on feedback. • The focus of the induction programme has been on the first few days at the Trust, for instance providing a tour of the hospital and including a paid lunch. • The format, content, and style of the first morning have been restructured so that it is upbeat and informative, and there are further plans to remove some non-essential presentations. • The correspondence process is being reviewed to see how we can engage with new starters before they enter the Trust. • The next stage of development is looking at the 30 and 90-day review formats so feedback can be received on how staff are being inducted into their departments; what is good and what needs to change. • The managers' induction sheet is being updated to help managers understand what is expected of them.

2.4 **Achieve 90% of our frontline staff having the seasonal flu vaccination and the COVID-19 vaccination. Partially Achieved**

- The Trust achieved 96% of staff having both their 1st and 2nd COVID-19 vaccinations.
- The Trust achieved **79%** uptake of flu vaccination amongst staff, which is a 4% increase on last year when measured by national data (although below our 90% target).

1st and 2nd dose COVID-19 vaccinations	**96%**
Flu vaccination	**79%**

How will we fully achieve this?

- Achieving 90% uptake of flu vaccinations by frontline staff with patient contact will remain a high priority for the Trust and will form part of the Commissioning for Quality and Innovation (CQUIN) framework for 2022/23.
- We have increased the number of staff who can vaccinate and plan to provide dedicated teams to this priority. This will include having roving teams, offering appointments at all hours, utilising our communications team for support, and targeted invitations.

- The plan to run a 7-day service for 4-weeks was very successful and this was followed up by roving vaccinators who offered slots in the staff cafeteria and visited departments.
- A system called *VaccinationTrack* has increased uptake and ensured that the Trust had a robust record of all staff vaccinated, with dashboard data enabling targeted communications and campaign materials.
- Targeted work was undertaken with hard-to-reach staff groups to support them being enabled to book appointments and be vaccinated.
- All vaccination events were recorded directly onto a point of care system at the time of vaccination, ensuring accurate health records and supporting the notification of GP records and national databases.

2.5	**Progress actions identified by the Board and the staff Cultural Change Team in the Best Place to Work diagnostic assessment, so that staff networks are able to contribute to and inform decision making and create a culture of civility, support and compassion.** **Partially Achieved** • Due to several key changes in the Trust, this action is being reviewed and reconsidered in light of a new 'People' and subsequent organisational development and leadership strategy.  **How will we fully achieve this?** • The Trust is now focusing on the actions required to support it being a People Promise Exemplar Site and a significant re-alignment of approach needs to be considered to ensure that this can be delivered. Ongoing engagement with staff networks will continue and activity will be seen across the seven tenets of the NHS People Promise.
2.6	**Commence an intensive quality improvement programme to increase the spread of an improvement culture to ensure sustainable change.** **Achieved** • 'Vision' metrics, 'breakthrough' objectives and strategic initiatives have been developed to provide focus and alignment to the Trust Strategy. • Our 'Coach House' team are now fully in place, delivering training and coaching sessions to divisional and front-line teams. • Two intense boot camp sessions were held in the winter of 2021/2022 for Coach House colleagues, executive deputies, and other Trust colleagues. • Improving Together identity has been developed and is being used on presentations. • The programme was officially launched in the Trust in March 2021. • Divisional and Front-line training has commenced and is due for completion in the Summer of 2022. • A communications and engagement plan is in place, managed by a dedicated communications and engagement manager. • Recruitment of colleagues within the Organisation, Development and Leadership team has been successful with staff now in post. • A dedicated microsite on the Trust Intranet is up and running for staff.

3. Continue to improve patient safety and reduce avoidable harm based on our known risks

3.1	**Prepare for the implementation of the national patient safety strategy in 2022. Achieved** • We have been preparing for the implementation of the Patient Safety Incident Response Framework (PSIRF), which is replacing the 2015 Serious Incident Framework. This framework will guide the NHS on how to develop cultures, systems and behaviours which are needed to respond to patient safety incidents in a way which will ensure that we learn from them and will improve. • Early adopter sites are feeding back on their experience in May or June 2022, and these outcomes will start to shape the process nationally that all Trusts will be expected to follow. • The National PSIRF implementation group will provide the NHS with guidance on how to respond to patient safety incidents. • Investigations should feed continuous improvement and will be used proactively as well as reactively. • There will be a shift of focus from harm to risk. Initially there will be a dual process running whilst Serious Incident Investigations continue to be commissioned and investigated and the new PSIRF review methods are implemented and rolled out. • There is an expectation that Trusts adopt the new PSIRF over the next year. The plan is that we work within our Integrated Care System so that progress is aligned.
3.2	**Introduce electronic prescribing and medicines administration (EPMA) which is known to improve patient safety. Partially Achieved** • Electronic prescribing and medicines administration (EPMA) has not yet been introduced but work is progressing, and the foundations are being developed. **How will we fully achieve this?** • The Programme Delivery Team are now in place and work has begun on building the components of the EPMA Solution. • Deployment of the digital mobile workstations and digital medicine administration carts is underway. • The programme communication plan has been approved and is being actioned along with training plans being established. • A clinical decision-making group (the Clinical Implementation Group - CIG) has been established to support the development of EPMA and associated developments.

3.3

Reduce the number of patients who acquire a Category 2 pressure ulcer by 20% during a hospital admission from 286 in 2020/21 to 229 in 2021/22 and reduce Category 3 and 4 pressure ulcers to zero. **Not Yet Achieved**

Although we did not fully achieve this target significant progress was made over the last year to reduce the number of patients acquiring pressure ulcers. Pressure ulcer training and skin care reviews have been available virtually which this has freed up caseload time for delivering prevention advice for complex patient needs. There are also further plans to train additional staff and increase education events across the organisation.

- The total number of Category 2 pressure ulcers was 264 in 2021/22 compared to 286 in 2020/21**. We achieved a reduction of 8% compared to our intended target of 20%.**
- **There was also a 20% reduction in the total number of Category 3 and 4 pressure ulcers in 2021/22.**

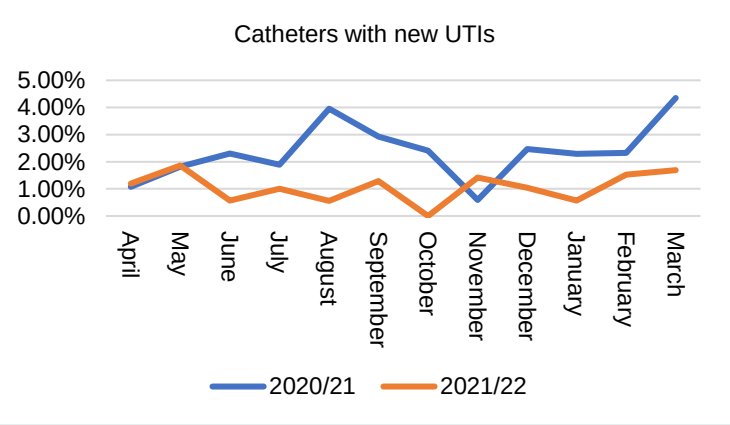
Category 2 Pressure Ulcers (2021/22 Total)	**264**
Category 3 Pressure Ulcers (2021/22 Total)	**7**
Category 4 Pressure Ulcers (2021/22 Total)	**1**

How will we fully achieve this?

- Escalation of skin damage and earlier detection of clinical areas of concern has been established through monitoring hospital acquired pressure ulcers on a weekly basis, in a Tissue Viability and Matron Huddle.
- Tissue viability link nurses have increased with a minimum of two per ward area.
- The Tissue Viability team continue to offer Pressure Ulcer Prevention education sessions twice a month and encourage attendance from all staff.
- All categories of pressure ulcer will continue to be discussed at the weekly Matron Huddle meeting (as operational pressures allow) and key learning will be identified at our monthly Share and Learn meetings.

3.4	**Reduce the number of patients who have a preventable fall in hospital by 20% from 10.96 per 1,000 occupied bed days in 2020/21 to 7.68 per 1,000 bed days in 2021/22. Not Yet Achieved** • Falls reduced slightly to 9.69 per 1,000 bed days when compared to last year, but we did not achieve our intended target of a 20% reduction. Our progress on this priority has been impacted by capacity issues, including COVID-19 outbreaks and staffing levels. **How will we fully achieve this?** • There is a Trust-wide falls reduction strategy. • Progress on actions and monitoring of outcomes are discussed and reported into a multi-disciplinary falls working group, monthly audits undertaken from all inpatient areas and high harm falls monitored via a weekly patient safety summit. • A dedicated Falls Reduction Specialist was appointed at the end of October 2021 to help drive the work and will be a visible resource for staff across the Trust. • A real time post-falls review by the Falls Reduction Specialist is providing staff and patients with advice and guidance. • Falls reduction has been identified as a top priority for the Trust and has been selected as a 'breakthrough' objective as part of the Improving Together programme and will continue to be a quality priority for 2022/23.
3.5	**Fully implement risk assessment throughout pregnancy and record it at every contact with the patient including a review of the intended place of birth as recommended in the Ockenden national report for all Maternity Services. Partially Achieved** • Risk assessments are routinely recorded for patients at key times throughout their pregnancy. **How will we fully achieve this?** • Some improvements are required in the documentation of asking or revisiting the intended place of birth. This was evidenced in a recent audit. • The format of our notes does not currently lend themselves to this documentation. We are therefore looking at alternative digital solutions.

3.6	**Ensure women attending the Maternity Day Assessment Unit are triaged appropriately in accordance with the clinical guideline for their presenting condition and in line with Birmingham Symptom Specific Obstetric Triage System (BSOTS) and time frames. This will inform assessment by a senior doctor in a timely manner. Partially Achieved** • The monthly audit continues to evidence good compliance with the BSOTs framework with 80% - 90% of women being reviewed within the given timeframe over the past 6 months. **How will we fully achieve this?** • To fully achieve this target, we will implement new paperwork to capture the discussion for all clinicians at each face-to-face appointment. We will continue to audit monthly against this standard.
3.7	**Fully implement consultant-led labour ward rounds twice a day, 7 days a week as recommended in the Ockenden national report for all Maternity Services. Achieved** • The January 2022 local audit demonstrated 100% compliance.
3.8	**Reduce the number of missed or delayed cancer diagnoses from 5 in 2020/21 to zero in 2021/22, by ensuring robust processes are in place across the patient pathway. Achieved** • There have been no Datix* incidents reported in relation to patients being lost to follow up since August 2021. • A Skin Cancer Follow-up Navigator has been in post from December 2021, who is establishing robust processes for the use of follow-up coding in the identification of patients. An audit of all patients with a malignant melanoma was undertaken (patients diagnosed since April 2015), with feedback provided to the clinical team as required for outstanding queries. • An audit of all patients diagnosed with lung and head and neck cancer was undertaken, again with feedback to the clinical team for action as required. There are plans to undertake an audit across all remaining tumour sites in conjunction with Cancer Pathway Navigators. • There has been successful recruitment of Cancer Pathway Navigators for Breast, Urology and Haematology. The outstanding post within Gynaecology is due to be advertised imminently; this will ensure there is equity across all tumour sites. ***Datix is a reporting system used to report clinical incidents across the organisation.***

3.9	**Improve compliance of antibiotic prescriptions for lower urinary tract infection in patients over 65* to meet the National Institute for Health and Care Excellence guidance for diagnosis and treatment from 59% in 2020/21 to 90% in 2021/22. Partially Achieved** • Compliance of antibiotic prescriptions for lower urinary tract infection for patients over 65 is now 76%, which is an increase up from 59% last year. • Retrospective and real-time auditing has continued this year. • The real-time auditing has been used as an opportunity to engage with the prescribing teams. • Some engagement with foundation doctors has meant that discussions can be had around the NICE guidance on signs and symptoms, choice of antibiotics and antibiotics course length. • There has been no specialist antibiotic pharmacist since July 2021. The antimicrobial technician continues to work on improving compliance, but this is dependent on antimicrobial technician capacity. **How will we fully achieve this?** • Moving forward into the new year, a new specialist antibiotic pharmacist has been recruited to start in May 2022. • The plan is to run lunchtime education sessions for the foundation doctors, and further education will be needed for the new intake of junior pharmacists. ***This priority relates to patients over 65 and not over-16 (as originally stated in error)***
3.10	**Reduce the number of new catheter associated urinary tract infections (UTIs) to show improvement as measured by the Safety Thermometer. Achieved** • For the 2021/22 year, the number of new catheter associated urinary tract infections have shown a significant reduction on 2020/21. 

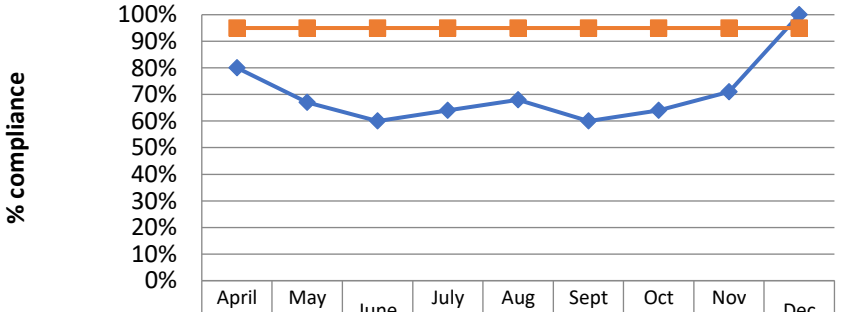
3.11 **Improve the escalation response when a patient triggers a NEWS2 (national early warning scoring system) score of five or more.** **Achieved**

- We have improved the escalation response when a patient triggers a NEWS2 score of 5 or more, as shown in the graph, but we acknowledge that further work is needed to embed these improvements and ensure that they are sustained.

Challenges:

- Previously, COVID-19 and current capacity problems have precluded improvement work from being established and sustained.
- Access to senior medical review during evening period and gaps in the response to escalation calls across the day have provided challenges.
- Documentation of escalation and the reliance on verbal communication has also been an issue.

Appropriate documented escalation in line with Trust protocols for patients who trigger 5 and above



	April 2021 (n=17)	May 2021 (n=15)	June 2021 (n=5)	July 2021 (n=11)	Aug 2021 (n=22)	Sept 2021 (n=15)	Oct 2021 (n=25)	Nov 2021 (n=14)	Dec 2021 (n=3)
% compliance	80%	67%	60%	64%	68%	60%	64%	71%	100%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%

Further Actions:

- A deterioration and sepsis steering group has been re-established.
- The NEWS2 audit criteria were agreed at the Nursing, Midwifery and Allied Healthcare Professionals Forum.
- Cardiac arrest rates remain low when compared to other Trusts of a similar size.
- Larger screens showing NEWS2 scores across the wards have been trialled.
- A Hospital at Night (H@NT) bleep coordinator model is working as designed.

3.12	**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. Achieved** • Antibiotic administration within one hour of being diagnosed with sepsis is now at 72%. Significant progress has been made (up from 43% and with a larger sample size). There is also a trend for increased compliance out of hours when escalated via the Hospital at Night Team coordinator (84%). • Audit results from early 2022 suggest that the sepsis screening tool has improved compliance within the emergency department and has enhanced capture of sepsis. • A Deteriorating Patient Working Group (DPWG) has been established and is meeting regularly. • A sepsis screening tool has been reviewed and agreed. Use has been variable across wards and this has been a focus of the work stream led by the Critical Care Outreach Team. • Use of the Modified Early Obstetric Warning Score (MEOWS) and recognition of obstetric patients (or post-partum) has improved significantly.

4. Provide ward to Board assurance on fundamental standards of patient care at ward and department level

4.1	**Pilot the first full ward accreditation on two wards and share the learning to enable other wards to adopt the programme.** **Not Yet Achieved** • The pilot for ward accreditation has been delayed due to operational pressures in the Trust. • The dataset required for this continues to be developed, however some of this information is already being used as part of ward performance reviews. **How will we fully achieve this?** • In view of the continuing operational pressures a proposed date to start the pilot is June 2022.
4.2	**Ensure all wards take part in a ward performance review process with the Chief Nursing Officer and report progress via a ward accreditation dashboard.** **Achieved** • Ward performance reviews were completed with good engagement from all ward leaders. • There has been a temporary postponement in the last quarter due to operational and staffing pressures in the Trust. • All ward leaders have access to the ward performance data via a data dashboard (Power-BI) which enables them to look up their own data trends. • This dashboard has been discussed at the Nursing Midwifery Allied Health Professionals meeting. • Ward Performance reviews are again planned for 2022/23.

4.3

Ensure all patients aged 65 years and over* are screened for dementia and delirium within 72 hours of admission and, if positive, have a diagnostic assessment and where needed are referred to their GP, memory clinic or mental health team. Not Yet Achieved

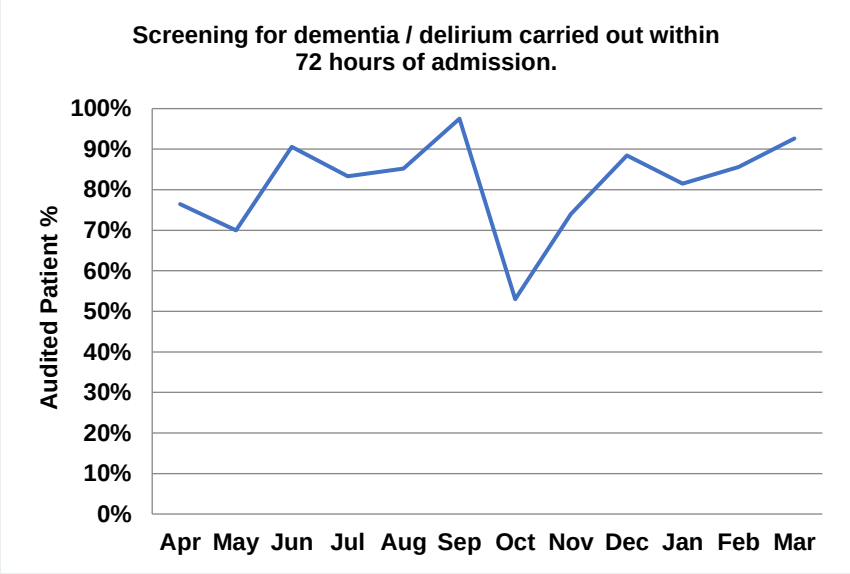
The results for 2021/22:

Screening within 72hrs	**82%**
Diagnostic Assessment	**69%**
Referral to GP, Memory Clinic, or Mental Health Team	**47%**

- The dementia and delirium screening assessment remains a key priority for the Trust. As well as being highly prevalent in hospitalised patients, it strongly predicts poor outcomes such as falls and other medical complications.

How will we fully achieve this?

- The plan is to provide training to the dementia and delirium link nurses to undertake audits, helping to ensure that we can achieve 100% compliance in this area.
- We are planning to add this metric to the ward performance dashboard to increase visibility of our performance and actions required



Adult inpatients were included in the data collection from September 2021.

4.4	**Ensure patients are discharged within 48 hours of being fit to go home and roll out criteria-led discharge to all wards so patients are discharged from hospital without unnecessary delays. Partially Achieved**

- This priority remains connected to the workstreams within the Urgent and Emergency Care Recovery and Improvement Programme.

How will we fully achieve this?

- The recording of Criteria to Reside data is being rolled out to ward staff in key areas and a poster has been created for distribution as a visual reminder to aid decision making in recording.
- The Criteria to Reside audit is to be established as a regular event to support the understanding and improvement of data quality in this area. Criteria Led Discharge continues to be an area of ambition, currently paused in recognition of the challenges facing the Trust currently. Through data validation, we can demonstrate the reduction in the numbers of patients remaining in hospital overnight who are fit to go home without support.
- We are conducting a piece of work to establish what the in-hospital delays are to patients going home which will form part of a plan to reduce this further where possible, such as process inefficiencies and therapy shortages.

5. Strengthen our partnerships with other healthcare organisations to improve the health of our local population

5.1	**The Trust will play a full role in achieving an effective newly formed BSW Integrated Care System. Achieved** The Trust has active membership at senior level at the Integrated Care System (ICS) architecture group and all the current governance meetings. The Trust has demonstrated a system approach in its revised strategy and has demonstrated system leadership in key areas (e.g., system paediatric surgery initiative, providing capacity for long waiters). The Trust has appointed a clinical lead for system working to ensure a senior clinical voice within the ICS.
5.2	**Develop a programme of work with our local Primary Care Networks tailored to the needs of our local population. Achieved** • Several meetings have been held between the Deputy Chief Medical Officer and Primary Care representatives to develop a platform for further engagement. • A specific working group of Trust representatives, led by the Deputy Chief Medical Officer, have agreed with Primary Care representatives several actions to avoid inappropriate transfer of work from Secondary Care to Primary Care. A jointly written document outlining expectations of Secondary Care clinicians is in the final stages of drafting and will be circulated amongst Trust consultants in May 2022. • Regular meetings with Primary Care Network Clinical Directors and senior representatives are to be established to continue further engagement and collaborative work.

5.3	**Work with our partners to develop and deliver an integrated frailty model. Partially Achieved** • The model continues to be developed but significant progress has been made over the last year. **How will we fully achieve this?** • The Older People's Assessment and Liaison service (OPAL) continues to provide the core same day discharge service for older patients at SFT, working in the emergency department and the acute medical unit. A pilot project providing a twilight OPAL service showed clear benefits and a proposal has been submitted to fund this substantively. • We have two trainee Advanced Clinical Practitioners (ACP) in older persons care who will qualify next Spring. A business case is in progress to fund their ACP roles which will include developing our frailty Same-Day Emergency Care (SDEC) offer at SFT, as well as offering further integration with and development of a system-wide frailty pathway. • Wiltshire Health and Care (WHC) ACPs continue to explore an in-reach (into SFT) role supported by OPAL and the emergency department. • Virtual wards supported by Geriatricians and OPAL clinicians have expanded across our Primary Care Networks (PCNs) and include more General Practitioner Multi-disciplinary team meetings. • Virtual wards for care homes have been implemented in a joint project with WHC. • OPAL is developing pathways, including for emergency department falls attenders, which will integrate with WHC and their community rapid response. • We are in discussions to engage a clinical communications supplier to also provide additional resources to support Primary Care.

Part 2B - Statements of Assurance from the Board

Review of Services

During 2021/22 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 2020/21 represents 100% of the total income generated from the provision of relevant health services by Salisbury NHS Foundation Trust for 2021/22.

The Integrated Governance Framework is reviewed on an annual basis and sets out how 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 our patients, their families and the people who work for and with us', by an organisation that is well managed, cost-effective and has a skilled and motivated workforce. At the same time the Accountability Framework 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. Service deep dives provide assurance to the Committee on the quality-of-service provision and are aligned to corporate risk identified within the Corporate Risk Register and Board Assurance Framework.

The Trust Board undertakes 'Safety Walkabouts' on a weekly rolling programme. This direct engagement with clinical and non-clinical teams ensures that Board members are sighted on the safety concerns of staff and brings the Board discussions to life. In addition, the Executive Team have implemented 'Back to the Floor' sessions. All Executives go out for three hours every month and work with clinical and non-clinical teams with the aim of enhancing 'ward to Board' communication. This provides the opportunity for the Executives to speak to staff in all departments, patients, and their families, giving them first-hand knowledge of improvements being made and where further improvements are needed.

The Trust has also embarked on its Improving Together programme which is our approach to building a culture of continuous improvement. The programme is designed to enable staff to understand the Trust Vision and strategy and how they can contribute to delivery of the strategy whilst being empowered to make improvements in their area of work.

The Trust has strengthened the quality governance arrangements over the last year with the introduction of three key steering groups: patient safety, patient experience and clinical effectiveness. These three groups report to the Clinical Management Board and together, provide oversight of all aspects of quality.

Participation in Clinical Audits

During 2021/22, 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 that Salisbury NHS Foundation Trust participated in, and for which data collection was completed during 2021/22, are listed in **Table 1** 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.

Table 1. Eligible national audits and clinical outcome review programmes and those the Trust participated in during 2021/22

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
British Association of Urological Surgeons (BAUS)	Cytoreductive Radical Nephrectomy Audit	✓	100%
	Management of the Lower Ureter in Nephroureterectomy Audit	✓	100%
Case Mix Programme (CMP)	Audit	✓	100%
Chronic Kidney Disease Registry	Audit	Not Applicable	Not Applicable
Cleft Registry and Audit Network (CRANE)	Audit	✓	100%
Elective Surgery (National PROMs Programme)	Audit	✓	Reporting was suspended due to COVID-19

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
Falls and Fragility Fractures Audit Programme (FFFAP)	Fracture Liaison Service Database	Not Applicable	Not Applicable
	National Audit Inpatient falls	✓	100%
	National Hip Fracture Database	✓	100%
Inflammatory Bowel Disease (IBD) Registry,	Biological Therapies Audit	✗	Not Applicable
LeDeR – Learning from lives and deaths of people with a learning disability & autistic people (previously known as Learning Disability Mortality Review Programme)	Audit	✓	100%
Major Trauma Audit: The Trauma Audit & Research Network (TARN)	Audit	✓	100%
National Asthma and COPD Audit Programme (NACAP)	Paediatric Asthma: Secondary Care	✓	100%
	Adult Asthma: Secondary Care	✓	100%
	Chronic Obstructive Pulmonary Disease (COPD)	✓	100%
	Pulmonary Rehabilitation – Organisational and Clinical Audit	✓	100%
National Audit of Breast Cancer in Older People	Audit	✓	100%
National Audit of Cardiac Rehabilitation	Audit	✓	100%
National Audit of Cardiovascular Disease Prevention	Audit	Not Applicable	Not Applicable

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
National Audit of Care at the End of Life (NACEL)	Audit	✓	100%
National Audit of Dementia (Care in General Hospitals)	Audit	✓	100%
National Audit of Pulmonary Hypertension	Audit	Not Applicable	Not Applicable
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Audit	✓	80%
National Cardiac Arrest Audit (NCAA)	Audit	✓	100%
National Cardiac Audit Programme (NCAP)	National Audit of Cardiac Rhythm Management (CRM)	✓	100%
	Myocardial Ischaemia National Audit Project (MINAP)	✓	100%
	National Adult Cardiac Surgery Audit	Not Applicable	Not Applicable
	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	✓	100%
	National Heart Failure Audit	✓	100%
	National Heart Failure Audit National Congenital Heart Disease (CHD)	Not Applicable	Not Applicable
National Child Mortality Database	Audit	✓	100%
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Audit	✓	100%

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
National Clinical Audit of Psychosis	Audit	Not Applicable	Not Applicable
National Comparative Audit of Patient Blood Management & NICE Guidelines	Audit	✓	90%
National Diabetes Audit – Adults	National Diabetes Foot Care Audit	✓	100%
	National Diabetes Inpatient Audit - Harms Reporting in England	✓	100%
	National Core Diabetes Audit	✓	100%
	National Pregnancy in Diabetes Audit	✓	100%
National Emergency Laparotomy Audit (NELA)	Audit	✓	89%
National Gastro-intestinal Cancer Programme	National Oesophago-Gastric Cancer (NOGCA)	✓	100%
	National Bowel Cancer Audit (NBOCA)	✓	100%
National Joint Registry (NJR)	Audit	✓	100%
National Lung Cancer Audit (NLCA)	Audit	✓	100%
National Maternity and Perinatal Audit (NMPA)	Audit	✓	100%
National Neonatal Audit Programme (NNAP)	Audit	✓	100%

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
National Outpatient Management of Pulmonary Embolism	Audit	Not Applicable	Not Applicable
National Paediatric Diabetes Audit (NPDA)	Audit	✓	100%
National Prostate Cancer Audit	Audit	✓	100%
National Vascular Registry	Audit	Not Applicable	Not Applicable
Neurosurgical National Audit Programme	Audit	Not Applicable	Not Applicable
Out-of-Hospital Cardiac Arrest Outcomes Registry	Audit	Not Applicable	Not Applicable
Paediatric Intensive Care (PICANet)	Audit	Not Applicable	Not Applicable
Prescribing Observatory for Mental Health (POMH-UK)	Audit	Not Applicable	Not Applicable
Royal College of Emergency Medicine Quality Improvement Programme	Pain in Children	✓	These audits are in progress, but it is anticipated that we will contribute 100%
	Infection control	✓	
Sentinel Stroke National Audit programme (SSNAP)	Audit	✓	100%
Serious Hazards of Transfusion (SHOT): UK National Haemo-vigilance	Audit	✓	100%

National Clinical Audit			
Audit title	**Details**	**Participation**	**% of cases submitted**
Society for Acute Medicine Benchmarking Audit (SAMBA)	Audit	✓	100%
Transurethral Resection and Single Instillation Mitomycin C Evaluation in Bladder Cancer Treatment	Audit	✓	100%
UK Cystic Fibrosis Registry (Paediatrics)	Audit	✓	100%

National Confidential Enquiries			
Audit title	**Details**	**Participation**	**% of cases submitted**
Child Health Clinical Outcome Review	Transition from Child to Adult Services Study	✓	This audit is in progress, but it is anticipated that we will contribute 100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Perinatal Mortality Surveillance	✓	100%
	Perinatal Mortality and Morbidity Confidential Enquiries	✓	100%
	Maternal Mortality Surveillance and Mortality Confidential Enquiries	✓	100%
Medical and Surgical Clinical Outcome Review Programme	Crohn's Disease Study	✓	These audits are in progress, but it is anticipated that we will contribute 100%
	Epilepsy Study	✓	
Mental Health Clinical Outcome Review Programme	Audit	Not Applicable	Not Applicable

The participation in these audits is in line with the Trust's annual clinical audit programme which aims to ensure 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 its performance against other similar Trusts and to decide on further improvement actions. The annual programme also includes several audits agreed as part of the contract with our Clinical Commissioning Groups.

The reports of 40 national clinical audits and clinical outcome review programmes that were published in 2021 were reviewed by Salisbury NHS Foundation Trust in 2021/22. Of these, 17 (42.5%) were formally reported to the Clinical Management Board or to the Clinical Effectiveness Steering Group by the clinical lead responsible for implementing the changes in practice. Further examples of national clinical audits and the actions Salisbury NHS Foundation Trust intends to take to improve the quality of healthcare provided can be found in Appendix B.

Local clinical audits

The reports of 121 (100%) local clinical audits were reviewed by the Trust in 2021/22. Examples of local clinical audits and the actions Salisbury NHS Foundation Trust intends to take to improve the quality of healthcare provided can also be found in Appendix B.

Research

The number of patients receiving relevant health services provided or subcontracted by Salisbury NHS Foundation Trust in 2021/22, that were recruited during that period to participate in research approved by the National Institute for Health Research were 1,669 patients into 49 studies. There were 938 participants who were recruited into eight COVID-19 studies. This compares with 2,222 patients recruited into 33 studies in 2020/21.

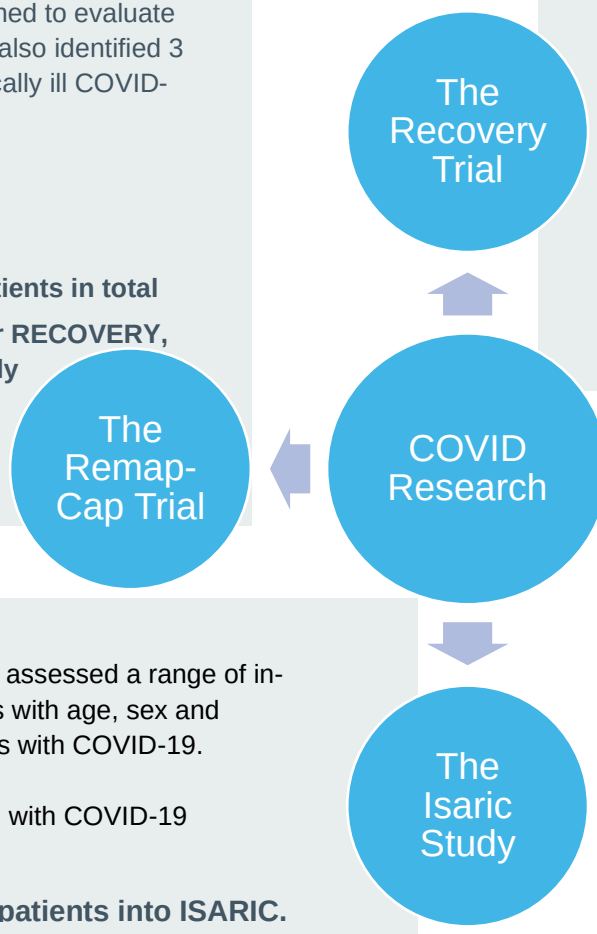
Since March 2020, the Trust has supported urgent public health studies to investigate potential treatments, vaccines, and diagnostic tests for COVID-19. The results are now informing practice worldwide. During 2021/22, the Trust has also increased non-COVID-19 research.

The Trust has re-opened over 95% of studies which had paused during the pandemic, continued to support the COVID-19 studies, and opened 20 new studies giving the Trust a portfolio of 100 studies that are open to recruitment and/or have patients in follow up. The Trust has secured national funding in collaboration with other partner organisations and opened and started recruiting into four studies that are Trust-led:

- **ELABS – Early Laser for Burns Scars**
- **BOWMAN – Abdominal FES for bowel management in spinal cord injury**
- **TETRAGRIP – Usability trial of an FES orthosis for people with tetraplegia**
- **HIIT – Impact of upper body HIIT on postprandial metabolic control in persons with chronic paraplegia**

Further information is available in the Trust Research Annual Reports which are available at www.salisbury.nhs.uk/about-us/trust-reports-and-reviews/

How did we participate in COVID-19 Research in 2021/22?



The Remap-Cap trial (www.remapcap.org), which is based in intensive care units and designed to evaluate treatments for the sickest patients, has also identified 3 drugs that are effective for treating critically ill COVID-19 patients in intensive care units:

- The corticosteroid hydrocortisone
- Tocilizumab and Sarilumab

✓ **The Trust has recruited 45 patients in total into the REMAP-CAP trial. As for RECOVERY, the drugs were made immediately available in the NHS and have saved lives around the globe.**

The Recovery Trial (www.recoverytrial.net) is a University of Oxford-led trial which been testing a range of potential treatments for patients admitted to hospital for COVID-19 since March 2020. The trial has, so far, identified 3 drugs which reduce patient deaths:

- Dexamthasone
- Tocilizumab
- Baricitinib

✓ **The Trust has recruited 186 patients in total into the RECOVERY trial.**

The ISARIC study (isaric.org) systematically assessed a range of in-hospital complications and their associations with age, sex and ethnicity - and their outcomes for the patients with COVID-19.

It has shown that 1 in 2 patients hospitalised with COVID-19 developed a complication.

✓ **The Trust has recruited 1291 patients into ISARIC.**

The SIREN trial (snapsurvey.phe.org.uk/siren) characterises COVID-19 infections, reinfections and estimates the protective effect of SARS-CoV-2 antibodies and vaccines.

SIREN showed that vaccination gives increased protection against SARSCoV-2 infection, regardless of prior infection status, and has informed government policy on vaccinations in the UK.

✓ **The Trust has recruited 128 members of staff, who have been screened for both C19 and antibodies on a regular basis.**

Goals agreed with Commissioners

Our Commissioning for Quality and Innovation (CQUIN) performance

Due to the COVID-19 pandemic all CQUINs were suspended in 2021/22. Trusts were therefore not required to submit or gather performance data related to this.

These schemes are being recommenced from April 2022 and therefore our performance against them will be reported in next year's Quality Account.

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. The Trust has not participated in any special reviews or investigations by the CQC in 2021/22. The CQC monitors the Trust under a Single Oversight Framework and is segmented as a Level 3 provider where we are offered mandated support.

The Trust was last subject to a full CQC inspection, including Use of Resources, in November and December 2018, receiving an improved rating of 'Good'.

Care Quality Commission unannounced inspection of core services

On 31 March 2021, the Trust had an unannounced inspection of the Spinal Services and Maternity Services, with the report published in May 2021. The overall rating for the Spinal Services was unchanged from 'Requires Improvement'.

The Maternity Services rating changed from 'Good' to 'Requires Improvement' and a Section 29A Notice was served, focused on:

- **leadership and culture**
- **governance and risk management**

The Trust worked with CQC during 2021 to provide evidence of its compliance against the notice. The CQC carried out a short notice, announced inspection in October 2021, focused on the parts of the service that did not meet legal requirements at the last Maternity Services inspection. In the report published December 2021, the CQC judged the requirements of the warning notice had been met, although identified further work was needed to embed the changes and ensure improvements were sustained. The rating of 'Requires Improvement' remained the same.

The teams in both Spinal Services and Maternity Services have been committed to making improvements as identified in their respective 'must do' and 'should do' actions following the May 2021 report. In addition, the Maternity Services team have engaged in the NHSE/I Maternity Safety Support Programme. Progress of all work has been overseen by the Divisional Management Teams and reported to the Clinical Governance Committee.

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 confidence that decisions that are made using the information are appropriate and ultimately will help to deliver more responsive, high quality and cost-effective services.

Over 2021/22, the Trust continued work on its Business Intelligence Transformation project which included work to replace its data warehouse and delivering modern tools to support the improvement of data quality and the use of information more widely. We expanded our Data Quality Maturity Assessment to cover all reporting outputs and recruited a full time Data Quality Manager to lead the Data Quality elements of this project.

Our Data Quality Policy was recently updated to reflect the progress made in the last year and the scheduled improvements planned for the next twelve months. During the past year we have implemented the Data Quality Notification (DQN) app which allows staff in the Trust to see which areas of Data Quality need improving and give assurance to the Data Quality Team that these are being actioned. We have created a Data Quality Improvement Plan for 2022/23 which outlines actions we want to take to achieve improved Data Quality performance and time scales in which we hope to complete these. We have also developed the Data Quality Champion role which has enabled more staff to understand their Data Quality responsibilities and produced a training module that will be completed by all new starters so that Data Quality is recognised right from the beginning of staff's employment with the Trust.

Salisbury NHS Foundation Trust submitted records during 2021/22 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 **Table 2.** 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.

Table 2 - Patient records with a valid NHS number and General Medical Practice Code

Data item	Salisbury NHS Foundation Trust 2020/21	National benchmark 2020/21	Salisbury NHS Foundation Trust 2021/22 (M1-10 only)	National benchmark 2021/22
Valid NHS number				
% for admitted patient care	99.8%	99.5%	99.9%	99.6%
% for outpatient care	99.9%	99.7%	99.9%	99.7%
% for Emergency Department care	99.4%	98.9%	99.6%	98.9%
Valid General Medical Practice Code				
% for admitted patient care	99.6%	99.8%	99.9%	99.7%
% for outpatient care	99.9%	99.8%	99.9%	99.6%
% for Emergency Department care	99.6%	99.6%	99.9%	99.5%

Data Security and Protection Toolkit Attainment Levels

Information governance (IG) is a term used to describe how information is used. It covers system and process management, records management, data quality, data protection and the controls needed to ensure information sharing is secure, confidential, and responsive to Salisbury NHS Foundation Trust and the people it serves.

Good information governance means ensuring the information we hold about our patients and staff is accurate, keeping it safe, and available at the point of care. The Data Security and Protection Toolkit (DSPT) is the way we demonstrate our compliance with national data protection standards. All NHS organisations are required to make an annual submission at the end of June, to assure compliance with data protection and security requirements.

The Trust self-assessment against the 2020/21 Data Security and Protection Toolkit confirmed compliance in all areas, with a status of 'Standards Met'. The self-assessment for 2021/22 is due for submission at the end of June 2022.

Clinical Coding Error Rate

Salisbury NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2021/22 by the Audit Commission.

Salisbury NHS Foundation Trust commissioned an external clinical coding audit from *D&A Consultancy* (specialist clinical coding auditors) to provide evidence for the Data Security and Protection (DSP) Toolkit during the reporting period. The error rates reported in the audit for that period for diagnoses and treatment coding (clinical coding) were:

- **Primary Diagnoses Incorrect 4.0%**
- **Secondary Diagnoses Incorrect 4.9%**
- **Primary Procedures Incorrect 4.1%**
- **Secondary Procedures Incorrect 6.4%**

DSP toolkit Standard 1 attainment level was:

- **Exceeds standards**

Clinical Coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records. Clinical Coding audit methodology is available from NHS Digital.

The clinical coding results should not be extrapolated further than the actual sample of 200 Finished Consultant Episodes (100 Trauma and Orthopaedics, 50 Urology and 50 Obstetrics).

Seven Day Hospital Services – implementing the priority clinical standards

The seven-day hospital services (7DS) programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed in 2013, and since 2016 Salisbury NHS Foundation Trust has completed a bi-annual 7DS audit focusing on four priority standards:

- **Clinical standard 2:** Consultant-directed assessment.
- **Clinical standard 5:** Diagnostics.
- **Clinical standard 6:** Interventions.
- **Clinical standard 8:** Ongoing review.

Due to the COVID-19 pandemic in March 2020, acute Trusts were not mandated to submit self-assessment reports for 2021/22. However, Salisbury NHS Foundation Trust felt it was essential that we continue to provide assurance on our seven-day services, and as such, a 7DS audit for year 2021/22 is currently underway and an internal report is likely to be published in the Summer of 2022.

Freedom to Speak Up (whistleblowing and raising concerns)

The Freedom to Speak Up Service is provided by the Trust to empower staff to raise a concern outside of an individual's management process should they require it. The service is led by a Freedom to Speak Up Guardian, supported by a team of Ambassadors.

The remit of the service is to support the development of a culture that is open and transparent so that raising concerns becomes business as usual for all staff. The Trust's Freedom to Speak Up Guardian is responsible for providing confidential advice and support to staff in relation to any concerns about patient safety or any concern that has a detrimental effect on their working conditions. They can also offer advice and support to ensure concerns raised are handled appropriately and result in a clear outcome. The Trust's Freedom to Speak Up Guardian has direct access to all senior leaders including the Chief Executive and all Board members.

This year the Trust has shown commitment to Freedom to Speak Up by making online Freedom to Speak Up training – 'Speak Up', mandatory for all staff therefore ensuring every staff member knows how to raise concerns safely. There is also an online training package available for staff with line management responsibility called 'Listen Up' to enable consistency and quality for when concerns are raised.

Themes and trends are reported quarterly to Board for assurance and to highlight lessons learned from concerns that have been raised. In the year 2021/22, 89 concerns were raised to the Freedom to Speak Up Guardian. Of these 36 had an element of patient safety and quality, and these concerns were escalated immediately to senior leaders for appropriate action.

	Themes	Cases Q1 2021/22	Cases Q2 2021/22	Cases Q3 2021/22	Cases Q4 2021/22
1	Element of Patient Safety and Quality*	8	8	9	11
2	Bullying/Harassment*	7	10	11	10
3	Disadvantageous and/or demeaning treatment*(detriment)	0	2	1	5
4	COVID -19 related concerns	0	1	5	0

Please note that some cases record more than one theme

Information on how to access the Freedom to Speak Up service is readily available via daily communication on the Staff Bulletin email, posters are displayed in prominent areas, and business cards are handed to every new member of staff.

Consolidated annual report 2021/22 on doctors and dentists in training rota gaps and improvement plan

Details of rota gaps are presented quarterly to the People and Culture Committee as part of the Guardian of Safe Working Report. The annual report presents a consolidated view of the rota gaps. Below is a summary of approximate rota gaps across all grades and specialties for the financial year 2021/22. There are approximately 150 junior doctors that are expected to be supplied by the deanery. Where there is a shortfall the Trust aims to mitigate this by covering the gap with locally employed doctors (LED).

	Apr 2021	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan 2022	Feb	Mar
Whole Time Equivalent (WTE) deanery gap	20.5	14.5	23.1	23.1	17.7	20.3	20.9	20.3	22.6	23	24.25	24.25
LED cover	5	6	6	6	3	2.2	3.2	2.6	5	5	9	9
Net WTE gap	15.5	8.5	17.1	17.1	14.7	18.1	17.7	17.7	17.6	18	15.25	15.25

The overall rate ranges from circa 88% to 95% of expected posts filled. This is comparable to national figures.

It is noted at committee that there is a significant disparity between junior (F1- ST2) and senior (ST3+) levels, with a poorer fill rate at ST3+ level. This has been raised at deanery level.

Plans for Improvement:

- The Trust has invested in 12 new Foundation Posts to improve resilience in key areas such as the Emergency Department Rota.
- The Trust will implement a new electronic rostering system for doctors in 2022/23, which will provide a greater opportunity for oversight of potential gaps in rotas due to leave and sickness and make it easier for staff wishing to work extra hours to offer to fill shifts.
- In 2022/23 the Trust plans to complete a medical workforce review of key services to ensure that there is the correct skill mix to provide sustainable quality care and to maximise the opportunities provided by Advanced Care Practitioners and Physicians Associates.
- The Trust continues to work with Health Education England (HEE)

National Core Set of Quality Indicators

All Trusts are required to report their performance against a statutory core set of quality indicators as part of their quality accounts. The indicators are based on recommendations by the National Quality Board. They are split into five domains. In this section we report:

1. **Our performance against these indicators; presented in a table format, for at least the last two reporting periods**
2. **The national average (where available)**
3. **A supporting commentary, which explains the variation from the national average and the steps taken or planned to improve quality**

Domain 1 – Preventing people from dying prematurely

Summary Hospital-level Mortality Indicator (SHMI)

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. Therefore, a ratio of 1.0 would represent an equal number of deaths when compared to the number expected. It covers in-hospital deaths and deaths that occur up to 30 days post discharge for all diagnoses excluding still births. The SHMI is an indicator which reports on mortality at Trust level across the NHS in England and it is produced and published as an official statistic by NHS Digital.

National Quality Priorities						
a. Trust SHMI:	**Dec 2018 – Nov 2019**		**Dec 2019 – Nov 2020**		**Dec 2020 – Nov 2021**	
	Salisbury	**National Average**	**Salisbury**	**National Average**	**Salisbury**	**National Average**
The value of the SHMI for the Trust	1.0465	1.0	1.0035	1.0	1.0667	1.0
The banding of the SHMI for the Trust	As Expected	As Expected	As Expected	As Expected	Above Expected	As Expected
SHMI broken down by Site:						
The value of the SHMI for Salisbury District Hospital (excluding hospice site)	0.9948	1.0	0.9596	1.0	1.0281	1.0
The banding of the SHMI for Salisbury District Hospital (excluding hospice site)	As Expected	As Expected	As Expected	As Expected	As Expected	As Expected
The value of the SHMI for Salisbury Hospice	2.2947	1.0	2.3652	1.0	2.3025	1.0
The banding of the SHMI for Salisbury Hospice	Above Expected	Above Expected	Above Expected	Above Expected	Above Expected	Above Expected
b. Palliative Care Coding:						
b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust (all sites). The palliative care indicator is a contextual indicator.	50.0%	36%	52.8%	36%	51.8%	39%

Trust statement

Salisbury NHS Foundation Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust. Salisbury NHS Foundation Trust recognises the importance of providing good quality care to people with life-limiting conditions and to those who are dying. We are proud to include our local Hospice on site. As mortality statistical models compare across all acute hospital trusts (the majority of which will not contain hospice services) the number of expected deaths at Salisbury NHS Foundation Trust will always sit above expected levels. When the main hospital site is separated from the hospice, expected deaths fall well within the expected range. The proportion of deaths with a palliative care coding has no specific target but is felt to be a measure of how Trusts recognise those in the last phase of their life and provide services to support them and their loved ones during that time (i.e., a higher figure is better).

Salisbury NHS Foundation Trust intends to, or has taken the following actions to improve mortality and harm, and so the quality of its services:

- Completing a review of all 170 COVID-19 deaths related to the second wave of the pandemic.
- Undertaking a focused review of patients who had a non-COVID-19 cause of death to ensure that care was not compromised due to our pandemic response.
- Screening 100% of acute hospital inpatient deaths through our medical examiner system. *

Please refer to Part 3 of this report for further information about how we are learning from deaths.

Domain 2 - Enhancing quality of life for people with long-term conditions

This section is related to mental health services and admission to acute wards where the Crisis Resolution Home Treatment Team were gate keepers. As these are not commissioned at Salisbury NHS Foundation Trust, there are no indicators to report within Domain 2.

Domain 3 – Helping people to recover from episodes of ill health or following injury

Patient Reported Outcome Measures (PROMs)

National Quality Priorities												
Patient reported outcome measures (EQ5D Index)	**Apr 19 – Mar 20**				**Apr 20 – Mar 21**				**Apr 21- Mar 22**			
	SFT	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**
i) hip replacement surgery	0.462	0.453	0.579	0.372	*	0.467	0.579	0.378	*	Not yet published	Not yet published	Not yet published
ii) knee replacement surgery	0.323	0.334	0.409	0.221	*	0.317	0.434	0.215	*	Not yet published	Not yet published	Not yet published

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust.

PROMs have been collected by all providers of NHS-funded care since April 2009. They assess the quality of care delivered to NHS patients from the patient perspective. They currently cover two clinical procedures (hip and knee replacements) and calculate the health gains after surgical treatment using pre-operative and post-operative surveys.

**** Data not published due to small number of procedures or submission being suspended due to COVID-19***

PROMs data for Salisbury NHS Foundation Trust has not been published for the last two financial years due to the reasons already specified above.

Patients readmitted to hospital within 30 days of being discharged

The updated Quality Account guidance states that the regulations refer to a 28-day readmissions period rather than the 30-day period specified.

National Quality Priorities												
Percentage of patients readmitted within 28 days of discharge from hospital by patient age group	Apr 2019 – Mar 2020				Apr 2020 – Mar 2021				Apr 2021- Mar 2022			
	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest
Age 0 to 15	5.82%	12.5%	56.8%	2.1%	15.98%	11.9%	64.4%	2.8%	12.32%	Not yet published	Not yet published	Not yet published
Age 16 or over	6.56%	14.7%	37.5%	1.9%	7.25%	15.9%	112.9%	1.1%	6.38%	Not yet published	Not yet published	Not yet published

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to reduce re-admissions, and so the quality of its services:

- Advanced Nurse Practitioners are working in the Acute Medical Unit to manage patients who can 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. This also enables clinicians to bring patients directly into an outpatient facility to receive treatment but avoid admission.
- We are working with our BSW ICS partners to embed 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.
- We are developing a model of care with system partners to have Acute Care Practitioners at the 'front door' of the hospital to manage community attendances with a treat at home philosophy.
- We are working with the walk-in centre, to enable patients who present to the Emergency Department with conditions that could be treated at the walk-in centre to access virtual walk-in-centre consultations whilst still in the Emergency Department at Salisbury NHS Foundation Trust.
- We will continue to ensure that emergency re-admission rates within 7, 14 and 30 days of discharge are reported to the Board at every meeting.

**** A person's ReSPECT form includes recommendations about emergency treatments that could be helpful and should be considered, as well as those not wanted by or that would not work for the patient [Resuscitation Council UK]***

Domain 4 – Ensuring people have a positive experience of care

Responsiveness to the personal needs of patients

National Quality Priorities												
Responsiveness to the personal needs of its patients	**Apr 19 – Mar 20**				**Apr 20 – Mar 21**				**Apr 21- Mar 22**			
Based on the average score of five questions from the National Inpatient Survey	**SFT**	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**	**SFT**	**National Average**	**Highest**	**Lowest**
	68.6%	67.1%	84.2%	59.5%	75.2%	74.5%	85.4%	67.3%	Not yet published	Not yet published	Not yet published	Not yet published

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust. Each year the Trust participates in the national adult inpatient survey. A nationally agreed questionnaire was sent to a random sample of 1,250 patients and the results analysed independently by the Patient Survey Co-ordination Centre. The national inpatient survey will be published in October 2022 when the number of patients who responded to the survey in 2021 will be known and reported in the Quality Account 2022/23. Themes from the national adult inpatient survey, the Friends and Family Test, complaints and concerns are identified by each ward and an improvement plan prepared.

This year we are also due to take part in the following national surveys which will be reported in the Quality Account 2022/23:

- The Urgent and Emergency Care Survey will take place again in September 2022
- The Children and Young Persons survey will take place again in November & December 2022
- The National adult inpatient survey will take place again in November 2022
- The Maternity Survey took place in February 2022

Salisbury NHS Foundation Trust intends to, or has taken the following actions to, improve responsiveness to in-patient personal needs, and so the quality of its services:

- We have been working with the Oncology Department to gather patients' views on the current facilities in Oncology outpatients. An online focus group was held and covered topics such as space, signposting and the current patient journey in the facilities available now. Artcare has now joined us to look at décor and themes and another online focus group is being arranged.
- We will continue planning for our paediatric patient and family forum. In the meantime, we are focusing on improving engagement around Friends and Family Testing (FFT) in this area and working with the play specialists to promote and highlight national days of celebration. This includes suggesting crafting from patients to decorate displays and we are asking them to judge our staff photography competition - using this to select images for our 'message to a loved one' card service.
- The Patient Advice and Liaison Service (PALS) has now delivered over 3,000 messages since our 'Message to a loved one' service began in April 2020. As well as delivering messages, we continue to facilitate video calls carried out by staff volunteers and encourage personal photos to be sent in. These are displayed on a small tabletop white board alongside the cards, close to the patient's bedside. All of this allows us to offer a more connected and personal service which has been appreciated by families and patients alike. We continue to identify areas that will benefit from the use of iPads, which were received through a communications grant and we hope this will continue to improve our ability to keep patients connected with their loved ones during their stay in hospital.
- PALS have worked with the Stars Appeal Charity and are currently awaiting a delivery of clothes that can be given to patients if needed, if for example, they have come in as an emergency. We also have toiletries and underwear for patient use.
- We will invest in our Friends and Family Test (FFT) to ensure greater accessibility and increase participation in this, appreciating its value in providing "real-time" feedback.
- We will continue to develop robust methods of drawing insights from the FFT, using these as early-indicators for areas of improvement and a focus for development plans.
- PALS are working with Sarum ward to offer a selection of wellbeing apps on iPads we will provide to them. We are working with staff to find out what would be beneficial for them to have access too. Apps around Diabetes, Anxiety and Self-harm have been suggested to allow staff to introduce and showcase them before discharge and to encourage and educate parents and children.
- Following patient and staff feedback, PALS have put together some bedside information for patients. It highlights the ways they can keep in touch with loved ones during their stay and offers some useful contacts and information. Each poster is displayed by the bedside.

Patients who would recommend the Trust to their family or friends

National Quality Priorities						
	April 2019 – March 2020*		April 2020 – March 2021*		April 2021 – March 2022	
	SFT	England Average	SFT	England Average	SFT	England Average
Response rate of patients who would recommend the ward or Emergency Department to friends or family needing care						
Emergency Department	1.2%	12.1%	0.2%	10.8%	0.2%	10.8%
Inpatients	9.3%	24.7%	5.1%	16.3%	9.1%	18.9%
Score of patients who would recommend the ward or Emergency Department to friends or family needing care						
Emergency Department	92.8%	85.1%	100%†	87.5%	87.2%†	77.9%
Inpatients	97.3%	95.9%	99.4%	94.8%	98.4%	94.4%

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust. The pandemic has affected the Friends & Family Test (FFT) response rates as feedback cards were removed as a national requirement. Ward areas have re-started FFT, but responses are not received from every service. The result is not having a representative and diverse view of all patients' experiences.

Our short-term plans to increase response rates include redesigning feedback forms on the website, creating QR codes on posters for individual wards or outpatient areas, and ensuring that those seen virtually have equal opportunity to give feedback on their care experience. We also plan to explore options to receive FFT feedback via text message and to pilot this in the Emergency Department.

The Trust consistently receives above average positive feedback, and our aim is to consistently achieve 95% and above of people who rate their experience as 'Very Good' or 'Good', Trust-wide.

**** Data submission was paused from February 2020 to November 2020 as part of the response to COVID-19***

† Data supressed for some months due to the low number of responses.

Staff who would recommend the Trust to their family or friends

National Quality Priorities												
National Staff Survey Results	Apr 19 – Mar 20				Apr 20 – Mar 21				Apr 21- Mar 22			
	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest
The percentage of staff employed by or under contract to the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	78.1%	70.6%	90.5%	39.8%	78.7%	74.3%	91.7%	49.7%	67.7%	66.9%	89.5%	43.6%

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust. Each year the Trust participates in the National NHS Staff Survey. Staff are sent a nationally agreed questionnaire and the results are analysed by the Staff Survey Co-ordination Centre. This year the results have been aligned with the NHS People Promise so Trusts can compare against the seven elements in the Promise, and in comparison, with other acute Trusts around the country. The response rate of our most recent staff survey was 49% (1,881 people) compared to an average rate of 46% across other Trusts. Across our clinical divisions around 90% of staff felt that their role made a difference to patients or service users.

The past two years have been difficult and exhausting for all staff. The COVID-19 pandemic has disrupted our work and home lives in ways never imagined, so it is important to understand the impact that has had on our experiences at work. It is good to see the positive results in some areas as this gives us the opportunity to learn and improve across the Trust. However, there are other areas where the results are not as positive as we would like, and it is important that we understand more about that, and what would make the Trust a better place to work for everyone.

We know that many staff said they are experiencing 'burnout' and the Trust very much wants to support staff to stay safe and well at work. Staffing levels have been, and continue to be, a real challenge and we recognise that at times this can leave staff feeling overwhelmed, exhausted, and frustrated. To help address this, the head count has been increased by circa 400 additional staff and we have taken other steps to manage staffing levels. Research has shown that an engaged workforce is also a productive and high-performing workforce which, for the NHS, means better patient experience and outcomes. That is why over the past year the Trust has taken steps to support the wellbeing of our people and to improve our sense of a hospital community. An additional 'birthday' holiday has been granted and continues to be in place, and several staff thank you events including the Food for Fuel week, September Thank You week and the comedy night were held. The cafeteria has been reconfigured to enable its use outside normal hours. The survey results show that there is much more for the Trust to do to make Salisbury District Hospital a better place to work. There will be opportunities to join 'listening' events across the Trust, and the output from these events will be used to inform action planning, developing some actions which have an early impact for staff and some longer-term solutions, based on staff input and ideas.

Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

Patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)*

National Quality Priorities												
VTE Risk Assessment	Apr 19 – Mar 20				Apr 20 – Mar 21				Apr 21- Mar 22			
	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest
Percentage of patients receiving a VTE risk assessment	99.6% (internal audit)	Reporting suspended due to COVID-19			96.8% (internal audit)	Reporting suspended due to COVID-19			99.1% (internal audit)	Reporting suspended due to COVID-19		

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as patient level data regarding this is collected monthly by the ward pharmacist from patients' prescription charts. The data is captured electronically and analysed by a senior nurse before it is then overseen by the Trust's Thrombosis Committee.

Salisbury NHS Foundation Trust continues to be an exemplar for the prevention and treatment of VTE (blood clots) and we achieved **99.1%** of patients being assessed for the risk of developing blood clots and **98%** receiving appropriate preventative treatment in 2021/22. We continue to monitor our progress and feedback the results to senior doctors and nurses. The VTE service has seen a total of 651 blood clot events in 2021/22, of which 97 (14.9%) were attributed to hospital care. This compares to a national average of 25%. All blood clot events were reviewed, and 93.8% of patients sadly developed their blood clot despite being provided with appropriate treatment (known as thromboprophylaxis).

*** A venous thromboembolism (VTE) is a blood clot which starts in a vein and usually occurs deep inside the body, for instance, in the lower leg.**

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

- Conduct detailed enquiries of patients who developed blood clots in hospital to ensure we learn and improve.
- Review our VTE clinical COVID-19 protocols in line with the most recent National Institute for Health and Care Excellence (NICE) guidance on VTE prevention, prophylaxis, and treatment.
- Increase education on VTE prevention across the Trust introducing VTE champions on all in-patient wards to assist in the cascade of information.
- Provide VTE prevention written information to all patients on discharge.
- Work alongside Thrombosis UK to produce VTE prevention information. Details will be added to the discharge summary to signpost patients to find further information. Patients will also receive a SMS message following discharge with a link to access directly to obtain further VTE prevention information.
- Introduce an electronic VTE risk assessment which will be completed on admission. This will replace the paper version on the prescription chart and completion will be mandatory. Audit will continue to be performed monthly, but the data will be pulled directly from the system.

Rate of Clostridium difficile (C.diff) infection

C.diff is a type of bacteria that commonly causes diarrhoea

National Quality Priorities												
Rate per 100,00 bed days of C.diff infection	Apr 19 – Mar 20				Apr 20 – Mar 21				Apr 21- Mar 22			
	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest
Rate per 100,000 bed days of C.diff infection amongst patients aged 2 or over	11.7	26.3	115.6	0	24.8	33.1	161.3	0	Not yet published	Not yet published	Not yet published	Not yet published

Trust statement

Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust. The data is reported for Hospital Onset C.diff cases only.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to, reduce the number of C.diff cases, and so the quality of its services:

- Reduce the numbers further by reviewing all reportable cases to identify any learning that can be shared within the Hospital. This work will continue over the next 12 months.
- Continue to identify learning through our internal incident investigation process.
- Continue to participate in and contribute to regional improvement projects for the reduction and prevention of C.diff.

The number of C.diff cases has been increasing nationally during the last 12 months and this is also the experience at Salisbury NHS Foundation Trust. Although numbers have increased, we continue to perform well and rank 47 out of 137 Trusts reporting data nationally.

Patient safety incidents and the percentage that resulted in severe harm or death

National Quality Priorities												
	Apr 19 – Mar 20				Apr 20 – Mar 21				Apr 21- Mar 22			
	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest
Number of patient safety incidents	6,766	N/A	22,340	1,392	6,655	N/A	37,572	3,169	6,947	N/A	47,623	22
Rate of patient safety incidents (per 1,000 bed days)	43.79	N/A	110.2	26.3	51.6	N/A	118.7	27.2	43.5	N/A	Not yet published	Not yet published
Number of patient safety incidents that resulted in severe harm or death	33	N/A	95	0	37	N/A	261	4	34	N/A	400 (severe) 440 (death)	0 (severe) 0 (death)
% of patient safety incidents that resulted in severe harm or death	0.52%	N/A	1.6%	0.0%	0.6%	N/A	2.8%	0%	0.49 %	N/A	Not yet published	Not yet published

Trust statement
Salisbury NHS Foundation Trust (SFT) considers that this data is as described as it is taken from the national dataset using data provided by the Trust. We have good collaborative working across the organisation, in the divisions, and at our weekly patient safety summit which promotes a culture of reporting and transparency.

Salisbury NHS Foundation Trust intends to, or has taken the following actions to, reduce the number of patient safety incidents and the percentage that resulted in severe harm or death, and so the quality of its services:

- Continue to support and encourage areas of high reporting but plan to increase focus on departments with a lower reporting rate. It cannot be assumed that lower reporting is due to fewer patient incidents rather than a lack of reporting.
- Work with colleagues from across the Divisions to change the Trust approach to the management of incidents to maximise learning opportunities (work supported by the Trust Chief Medical Officer (CMO) and Chief Nursing Officer (CNO)). It is essential that staff can recognise when patient harm has occurred, and that they feel safe and supported to raise their concerns and understand the importance of reporting these incidents.

Ensuring that our patients receive safe, high quality care is at the centre of all that we do. The Trust has implemented a weekly multi-disciplinary Patient Safety Summit where all patient safety incidents graded moderate or above and significant near misses are reported and discussed by the appropriate divisional team. The summit has representation across all divisional teams, Risk management, CMO, CNO, Director of integrated Governance and the CCG. This collaborative process ensures that early actions can be taken to minimise further harm occurring, serious incidents are recognised promptly, and duty of candour is initiated with patient and families from the outset of the investigation to ensure inclusion with the process.

Part 3: Other/Provider Information

Learning from COVID-19

Responding to Outbreaks

Salisbury NHS Foundation Trust first declared an outbreak of COVID-19 in November 2020. During the following 6 months, a further 10 outbreaks were declared affecting the in-patient wards and one outbreak in a non-clinical area (12 in total). Overall, 206 patients and 69 staff were associated with the in-patient outbreaks and eight staff within the non-clinical setting. The Outbreak Management Group (OMG) met regularly in line with the Trust action card with representatives from external partners and all internal and external reporting was completed as required. All actions identified within the OMG to mitigate risks and resolve the outbreaks were completed by the end of May 2021.

In June 2021, a representation of staff groups met for a facilitated discussion and reflection on the experience of the outbreaks and to identify and agree any learning. Teams involved were also given the opportunity to provide written feedback if unable to attend. The group identified the following contributory factors:

- Timeliness in the testing of in-patients for COVID-19
- Patient moves
- Staff movement and social distancing

An incident enquiry which investigated the hospital outbreaks concluded that there were no specific identified failures of Trust policies and procedures or failures in care, and that the outbreaks occurred because of the pandemic. However, there were several contributory factors with the pattern and frequency of the outbreaks, consistent with a rapidly rising prevalence of COVID-19 within the community and a subsequent demand for hospital admission.

Several positive factors included:

- Having Virtual Board Round (VBR) and OMG meetings. The aims of the VBR being to ensure that all positive cases of COVID-19 within Salisbury NHS Foundation Trust were identified and considered within the scope of the required response to infection, prevention, and control (IPC) measures and to support the clinical teams
- Staff responsiveness
- The introduction of enhanced Level 1 personal protective equipment (PPE)
- Use of the *Tendable App* COVID-19 data for assurance. This allows a set of inspections to be undertaken routinely every month including patient and staff experiences, IPC standards (including hand hygiene), documentation, the environment, and several quality standards. The data is live and immediate and provides a history of compliance with standards over time.

Learning from Deaths

The Trust has been continuing to learn from COVID-19 deaths in 2021/22, and, as such, we completed a review of 170 patients who died from coronavirus (COVID-19) in hospital between June 2020 and August 2021. The aim of the review was to ascertain whether patients who died from coronavirus were managed appropriately and in accordance with both national and local guidance, and to identify any problems in care where lessons could be learned and shared. The reviews were undertaken based on the structured judgement review (SJR) method recommended by the Royal College of Physicians. This is a standardised and validated method for reviewing case records of adult patients who have died in acute general hospitals in England and Scotland.

We identified a total of 1,162 inpatients who tested positive for COVID-19 during the second wave, of which 14% died from COVID-19. This compares to 30% of patients who tested positive and died of COVID-19 in the first wave.

Most problems related to issues of infection control which were picked up as part of the Trust's investigation into COVID-19 outbreaks.

Positive feedback from families and carers included:

- Good evidence of the cause of death being discussed and agreed with the family
- Good examples of communication, e.g., with family, the ward, and the End of Life (EOL) team
- Specific praise to hospital staff and individual wards where care was received
- Offering bereavement surveys to families when concerns about care had been raised

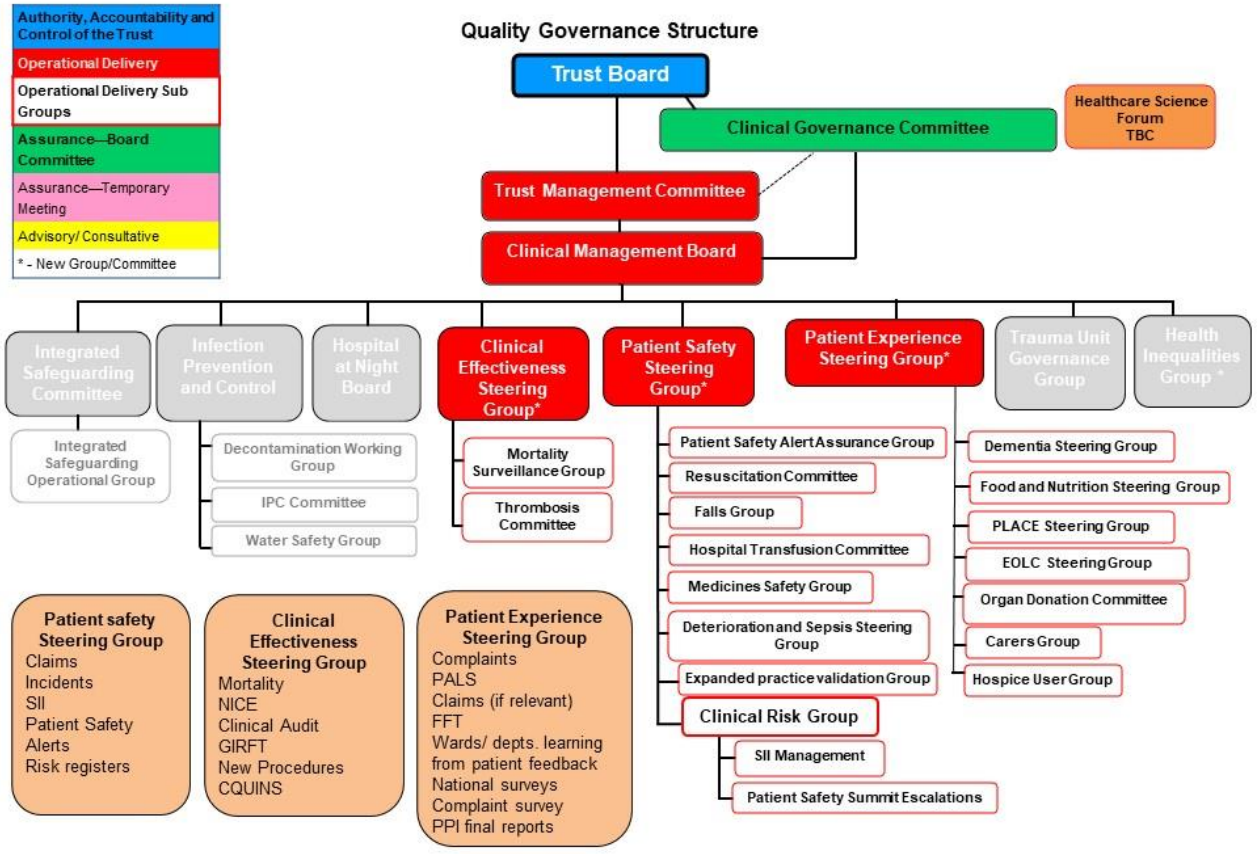
Some families reported difficulties with communicating with wards and staff, and there were sometimes delays in communicating the COVID-19 status with the family. The findings of this review have been shared with divisions and clinical teams with a clear emphasis on the importance of good communication around clinical status, including COVID-19 status and its implications. Full duty of candour will be completed for the families of all patients who died with/of hospital acquired COVID-19 Infection according to the NHS definitions.

An alert has been introduced to identify patients to the End of Life Care (EOLC) clinical nurse specialist (CNS) team electronically, who are no longer receiving physiological observations. The EOLC CNS is then able to communicate with and support the family if appropriate. Strict visiting restrictions during the second peak stated exceptional visiting allowances for "patients receiving EOLC". This was expanded in May 21 to include patients at risk of dying within the next 48 hours so that patients still receiving curative treatment but at risk of dying could be included.

A separate review was also undertaken of patients who died of non-COVID-19 causes during the peak of the COVID-19 outbreak, the aim being to determine whether patient care was impacted by the COVID-19 pandemic and to consider any actions and learning that may need to be implemented. The overall care of patients was not deemed to have been impacted by the pandemic, although there were several lessons identified. This included improving note documentation, reducing movement of patients, and improving communication. There was prompt recognition of the deteriorating patient and evidence of timely decision making on the ceiling of care (which describes the level of treatment a patient should receive) and treatment to be given. The input of the palliative care team for these patients was deemed to have been excellent.

What is Quality?

As per the Health and Social Care Act of 2012, the NHS has a duty to continually improve the quality of care being delivered across a range of health services. Quality is defined as having three dimensions: patient safety, clinical effectiveness, and patient experience. At Salisbury NHS Foundation Trust we recognise the importance of each of these elements of quality and care, and, as such, in 2021/22 our governance restructuring has resulted in the formation of three new sub-groups to represent each of the three arms of quality. The steering groups each report upwards to the Clinical Management Board (CMB), where all aspects of quality are scrutinised and discussed. The governance structure is shown below.



Patient Experience

Patient Stories

Patient Stories continue to be heard at our Trust Board meetings and, increasing, are becoming a feature within our divisional meetings (most recently at our Maternity Clinical Governance Meeting). This continues to be a successful approach to ensuring our people hear the first-hand experiences of our service users and take learning from these. We will continue to test the additional values that can be taken from the patient stories including exploring how a patient's experience can contribute to internal business cases or assist with driving clinical priorities.

We are also keen to explore the benefits of promoting these stories in the public arena where appropriate.

Virtual Visiting

PALS have facilitated virtual visiting via *Attend Anywhere* for patients and their relatives with the use of iPads. Staff have volunteered to carry out the calls with patients in their own time and to date we have enabled 264 calls to take place. This has been fundamental in facilitating a range of interactions for patients with their loved ones, overcoming local, national and international barriers.

PALS have run and promoted the service working with the End of Life team and chaplains to identify patients who would initially benefit from the offering. This is also evolving into an extension of the *'message to a loved one'* offering. We are now working with the Volunteers team to recruit volunteers specifically for this project so this can become a more reliable and cohesive offering to all of our patients.

Send a Letter to a Loved One

Since April 2020 almost 3,000 messages from families to their loved ones being cared for within the hospital have been received into the dedicated Patient Advice and Liaison Service (PALS) inbox. These messages are printed into cards and delivered to patient bedsides.

This initiative has been really well received and continues to grow in popularity.

We would like to thank our colleagues in the League of Friends for supporting this project and to all the staff who have contributed to the card designs to date.

Bedside Posters

This idea was developed by a member of staff who during their loved ones stay in the hospital observed that there appeared to be a lack of key information conveniently available.

PALS worked with the staff member to put together some bedside information to inform future patient stays. It summarises the ways they can keep in touch with family and friends during their stay and also contains other useful contacts and information. Posters are laminated and displayed by patient bedsides.

Clinical Effectiveness

Learning from Deaths

During 2021/22 there were 898 inpatient and emergency department deaths at Salisbury NHS Foundation Trust. This figure represents the largest number of deaths per financial year on record and represents a 20% increase on a pre-COVID-19 year. This comprised the following number of deaths occurring in each Quarter (Q) of that reporting period:

- **204 patients died in Q1**
- **202 patients died in Q2**
- **237 patients died in Q3**
- **255 patients died in Q4**

Overall, 83 % of these deaths were scrutinised by a Medical Examiner, representing 100% of all acute in-hospital deaths and a significant number of the deaths occurring in the hospice (considered community deaths). This is notable given the circumstances of the last 12 months.

Of the deaths scrutinised:

- 75% were issued a with a Medical Certificate of Cause of Death (MCCD).
- 25% were notified to the coroner. Before the medical examiner system, the national figure was reported as ~45%. Of those notified to the coroner, the vast majority (~70%) resulted in a MCCD being issued.
- 86% of the deceased's next-of-kin were able to register the death within 3 days. This is notable, given that deaths cannot be scrutinised or recorded at weekends/bank-holidays.
- Only 1.5% of MCCDs issued are 'declined' by the registrar office and then automatically notified to the coroner. The community rate is nearer 10%.
- The deaths scrutinised resulting in a request for a further review (structured judgement review or 'SJR') was 11%.

Notable areas for Improvement:

- Some falls occurred in patients already documented as at 'high risk' of falling. Falls will be a top priority for the Trust for 2022/23 and has been selected as one of our breakthrough objectives as part of the Improving Together programme (outlined in Part 2 of this report). This is also one of our quality priorities for 2022/23.
- Some next-of-kin found it difficult to obtain regular updates from ward teams and were frustrated at the COVID-19 restrictions for visiting (see section titled, *Learning from COVID-19* for further information about how we have been learning from COVID-19).

Future developments

The requirement for non-coronial deaths to be scrutinised by a Medical Examiner (ME) will be statutory from Summer 2022. This will be for all deaths – in the hospital and the community. It will require a substantial expansion of the ME service that currently exist in all hospitals. This will be challenging but work is already underway to meet this requirement

Introducing a Clinical Effectiveness and Patient Safety Newsletter

This year we have worked on the development of a new clinical effectiveness and patient safety newsletter, which has been published and distributed to staff via the online bulletin. Content has included a summary of serious incidents and key learning, case studies, and information from our quality and care integrated performance report (IPR).

Healthcare Improvement Projects

In November 2021 our Foundation Year 2 doctors were invited to present quality improvement projects which they had been involved in. Improvement projects included improving the recognition and management of inpatient constipation, time to cannulation, wellbeing, and pain management. Specific actions included:

- Developing/improving guidelines for management of constipation
- Developing a Trust-wide stool chart - combining elements of different charts across the Trust
- Reducing the time needed to gather cannulation equipment, and therefore reducing the total time to carry out the procedure
- Reducing the number of surfaces touched during cannulation, therefore reducing the infection risk through contact with multiple surfaces
- Improving Junior Doctor wellbeing through a wellbeing project
- Improving and updating guidance about pain management of patients

SMILE Oral Project

The SMILE Oral Care Pathway is a quality improvement project that is being piloted at Salisbury NHS Foundation Trust. The project was initially launched on 1st November 2021, and we are hoping it will go live Trust-wide later this year (2022). SMILE refers to providing gold standard mouth care and oral hygiene to patients whilst an inpatient, ensuring inpatients are assessed on admission and reviewed during their stay, have access to oral hygiene products and that staff receive training and education to be able to support the patient. Staff from across oral surgery, education, radiology, and the wards are involved in this pilot supported by the Head of Quality Improvement and Transformation department.

Getting It Right First Time (GIRFT)

Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients. The programme undertakes clinically led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved. The GIRFT visits continued to take place virtually since they were restarted in October 2020, following a suspension due to COVID-19.
In the year 2021/22, GIRFT visits occurred in three hospital services. These were for the lung cancer, plastic surgery, and paediatric trauma and orthopaedic specialties.

In addition to undertaking visits, the GIRFT team are also working with systems and regions to help the NHS with post-COVID-19 elective recovery, aiming to reduce the backlog of patients waiting for operations and to improve outcomes and access to care. The GIRFT High Volume/ Low Complexity (HVLC) speciality programme engages system partners to work at pace to agree standardised pathways and adopt best practice, as well as pooling capacity and resources, to achieve top decile performance in clinical outcomes and equity of access to care for their population. An HVLC system meeting was held in February 2022, and the actions and recommendations from this continue to be progressed.

Key Highlights:

Lung Cancer	**This visit highlighted an excellent service with good time to diagnostics and recorded patient experience.** • 93% of patients were seen within two weeks and 100% of patients received treatment within 31 days of diagnosis (1st out of 130 Trusts) • It was identified that Salisbury District Hospital does not perform or document as much EBUS (endobronchial ultrasound) in comparison to some other Trusts, which aids the diagnosis of lung cancer. • Recruitment was cited as the main barrier, and therefore the service is actively looking to recruit more chest physicians
Plastic Surgery	**This visit highlighted some excellent areas of practice, particularly regarding hand trauma surgery where an additional operating theatre was opened after a successful pilot.** • High praise was given to the amputations and rehab provide to veterans and the pressure ulcer service provided to the spinal patients with specialist nurses. • Some coding issues were highlighted in the skin cancer service to improve case capture. • The team were encouraged to participate in a national study for pressure ulcers recognising the significant unmet need. • The service was asked to provide a Standard Operating Procedure (SOP) for civilian care of amputations that could be shared with other Trusts as an exemplar.
Paediatric Trauma and Orthopaedics	**This visit highlighted several areas of notable good practice. This included having a good network setup with University Hospital Southampton NHS Foundation Trust, running a good outpatient clinic set-up, and the successful development of a virtual fracture clinic.** • The waiting time for an outpatient appointment was identified as being particularly long and averaging 34 weeks. More paediatric orthopaedic clinics need to be provided to address this, and we are considering how this can be supported by the visiting consultants from University Southampton NHS Trust. • Following this visit the service are now also looking to expand their elective service activity, and in particular foot and ankle day case surgery.

Patient Safety

Number of Moderate, Severe, and Catastrophic Incidents

Table 3

	2019/2020		2020/2021		2021/2022		% change from 20/21
Severity	**Number**	**% of total**	**Number**	**%of total**	**Number**	**%of total**	**to 21/22**
no harm	7188	82.76	6899.00	79.33	6469.00	67.86	-6.23
minor incident	1368	15.75	1684.00	19.36	2817.00	29.55	67.28
moderate incident	91	1.05	85.00	0.98	206.00	2.16	142.35
major incident	30	0.35	18.00	0.21	30.00	0.31	66.67
catastrophic incident	8	0.09	11.00	0.13	11.00	0.12	0.00
Total	**8685**	**100.00**	**8697.00**	**100.00**	**9533.00**	**100.00**	9.61

Table 4

	2019/2020		2020/2021		2021/2022		% change from 20/21
Result	**Number**	**% of total**	**Number**	**%of total**	**Number**	**%of total**	**to 21/22**
No adverse result from incident	6108	70.33	5848.00	67.24	6336.00	66.46	8.34
Near Miss - No harm, prevented incident	1390	16.00	1437.00	16.52	1551.00	16.27	7.93
Harm occurred as a result of incident	1187	13.67	1412.00	16.24	1646.00	17.27	16.57
Total	**8685**	**100.00**	**8697.00**	**100.00**	**9533.00**	**100.00**	9.61

Tables 3 and 4 (above) reflect the 9.6% increase in the number of incidents reported in 2021/22 and the level of harm attributed to the incident. As you can see there has been an increase of 16% in the number of incidents resulting in harm overall. An increase of 66% in the number of major harms (18 in 2020/21 compared to 30 in 2021/22). The number of catastrophic incidents has remained the same as the previous year (11).

The number of commissioned serious incident investigations and clinical reviews has increased over the last 12 months from 45 in 2020/21 to 67 in 2021/22. This has resulted in further work being carried out in relation to managing deterioration, medication errors and the booking of appointments for outpatients.

- A new deterioration and sepsis steering group was established to manage the deteriorating patient.
- We have also been implementing a standard approach to respond to medication errors that occur. This project includes the development of an audit tool, introducing staff reflection and the development of an e-learning package to provide staff with additional training, and has been developed by staff in clinical wards and departments, supported by the Head of Quality Improvement.

A note about the Patient Safety Incident Response Framework (PSIRF)

- As previously outlined in our priorities for 2022/23, adopting the Patient Safety Incident Response Framework will be a key priority over the next 12 months.

- There will be a shift of focus from harm to risk. Initially there will be a dual process running whilst serious incidents continue to be commissioned and investigated and the new PSIRF review methods are implemented and rolled out. Trusts are being encouraged to wait before making any significant investments/changes based on the introductory version of the Framework. While the principles will ultimately remain the same, all documents are being revised including learning response tools and templates as well as other guides (e.g., patient, family, and staff engagement) and standards. The national team will also be producing a preparation guide to help guide organisations through several phases (e.g., orientation, diagnostic, measuring success, planning, policy development, etc) over a 12-month period to enable transition to PSIRF in 2023.

- All the revisions will be based on feedback from the early adopters and recommendations from the evaluation of the programme.

How Are We Safeguarding Adults? (Mental Capacity Act & DoLS, Domestic Abuse and Learning Disabilities)

Safeguarding adults is about **protecting a person's right to live in safety, free from abuse and neglect.** According to the Care Act 2014 the aims of safeguarding adults are to:

- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
- Safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives "Making Safeguarding Personal".
- Promote an outcomes approach to safeguarding that works for people resulting in the best experience possible.
- Raise public awareness so that professionals, other staff, and communities as a whole play their part in preventing, identifying and responding to abuse and neglect.

What have we done to improve adult safeguarding in 2021/22?

- ✓ Introduced Level 3 Adult Safeguarding Training for identified staff groups.
- ✓ In collaboration with MENCAP we made an educational video to support our Learning Disability community access their COVID-19 vaccinations.
- ✓ We have completed a *Changing Places* toilet (www.changing-places.org)
- ✓ We have reviewed and re-written our Learning Disability Hospital Passport.
- ✓ We have introduced attaching Lasting Powers of Attorney and Advanced Decisions to Refuse Treatment onto a patient record on the *Lorenzo* patient administration system and added an alert to those records.
- ✓ We now share information with the North and West Wiltshire Multi Agency Risk Assessment Conference.
- ✓ Liberty Protection Safeguard introduction has been delayed beyond April 2022, but we have continued to meet within the local health and social care arena.
- ✓ We have continued to provide Adult Safeguarding, MCA & DoLS and Domestic Abuse training via Teams and the classroom throughout the pandemic.
- ✓ We have received funding for, and appointed into, the Band 7 Adult Specialist Safeguarding Professional post.
- ✓ We have published a new Restrictive Practice Policy.

✓ We continue to work towards full compliance with the NHSE/I Learning Disability Standards for Acute Trusts

Safeguarding Children

The following two case studies are based on real patients (anonymised) and help to demonstrate the steps that we have been making to improve the safeguarding of children in 2021/22

Case study 1: Effective Multi-agency Working

A young person (YP) was admitted to Sarum Ward with concerns over their mental health; they were in for a while whilst receiving care and treatment. It was deemed that their home was not a safe place to be discharged into and therefore, they were discharged into foster care. The placement broke down due to their behaviour and they were readmitted to Salisbury NHS Foundation Trust (SFT). A second foster placement was found; however unfortunately that placement broke down as well and they were again readmitted to SFT. Children's Social Care was unable to find a suitable foster placement and the YP remained an inpatient on the Ward for approximately three months. The named nurse used the Case Resolution Policy to escalate SFT concerns about the YP being an inpatient and that it was not the best place for them. Through working together with the Local Authority, a positive outcome was achieved and the YP was found a suitable placement that would meet their needs and give them support and encouragement.

Impact on the Child:

Practitioners and organisations need to be ready to stand up in the best interests of children even if this brings them into disagreement with other practitioners, with other organisations, or with their own managers and employing bodies. Children should always remain central, and an escalation procedure essentially seeks out an approach to resolving conflict in the child's best interests. (WSCB Case Resolution Protocol – Wiltshire Safeguarding Vulnerable People Partnership (wiltshirescb.org.uk)

CASE STUDY 2: We Can Talk Training (due to the increased numbers of children and young people being seen due to their Mental Health)

Two practitioners had been identified to be project leads for *We Can Talk*. *We Can Talk* has been produced by *Healthy Teen Minds* in conjunction with hospital staff, young people and mental health experts to provide an education framework and one-day online training package. It has been designed to support sustainable changes in practice, hospital culture and improve the experience of children and young people attending our service who are in mental health crisis.

Healthy Teen Minds produced and first piloted the *We Can Talk* project to address the reported lack of acute hospital staff confidence and competency in caring for children with mental health needs and the research which showed that children and young people had an overwhelmingly negative experience when presenting in crisis.

As part of the *We Can Talk* project the Project Leads were asked to complete a small quality improvement (QI) project. Here at Salisbury that QI project was to develop distraction packs for young people to access while waiting to be reviewed or during their admission. The distraction packs have been implemented and the early results are positive.

Impact on the Child

Once staff have completed the training it will have a positive impact on young people as the aim is to improve staff confidence and competency in caring for children and young people with mental health needs or in crisis and therefore making their experience more positive.

What further actions have been taken?

- ✓ Three Safeguarding Children Audits have been completed in 2021/22: A Maternity Domestic Abuse Audit, a Multi-Agency Safeguarding Hub Referral Audit, and a Staff awareness of safeguarding children audit. All audits were disseminated, and action plans put into place where improvements were needed.

- ✓ A consultant in Emergency Medicine was involved with the RCEM National Quality Improvement Project – Care of Children in ED 2019/20. The aim of the project was to measure and improve safeguarding practice in the care of young people. In summary, Salisbury NHS Foundation Trust was better than the national average at providing a senior review of infants at high risk of safeguarding concerns or a review of the notes when an infant, child or adolescent leaves the department without being seen. The notes are also reviewed by the Named Nurse for Safeguarding Children. The required policies and systems are in place.

- ✓ A Children's Safeguarding Learning event was held in February 2022. There were several guest speakers whose topics included County Lines, Contextual Safeguarding, Myths of Invisible Men and more. Positive feedback was received as it was the first learning event held for a while and the focus was on safeguarding children who were vulnerable, and raising awareness

- ✓ The New Children's and Adults' Safeguarding Training Policy was produced to reflect the changes in the Intercollegiate Documents. This was to ensure that all practitioners were aware of the training they needed to fulfil their role and be able to recognise children who are at risk of harm.

- ✓ Eight Registered Practitioners successfully completed the Safeguarding Supervision Training which will have an impact on the supervision figures. Safeguarding supervision is important for staff working with children so they remain child focused to improve outcomes for children.

- ✓ Multi-Departmental Safeguarding Supervision was implemented and had a positive result with staff feeding back that it was supportive, informative, working together, keeping child focused, to improve outcomes for children.

- ✓ The 'Think Family' approach is becoming embedded across Salisbury NHS Foundation Trust with more practitioners from adult areas recognising when a child could be at risk

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Other Notable Achievements

SOX Awards

Sharing Outstanding Excellence (SOX) nominations can be made by patients to recognise the excellence of staff and members of staff to recognise their colleagues who go the extra mile.

All staff who receive nominations receive a nomination certificate and their nomination is displayed on the SOX notice board.

Every month ten nominations are shortlisted. These ten nominations are then presented at an Executive Director Meeting where two are chosen to be SOX of the month, one nominated by a patient and one nominated by a colleague. The two SOX of the month winners are presented with a certificate by members of the Executive Team and featured in the Staff Bulletin.

The two SOX of the month winners are noted at the Public Trust Board meeting and then they are considered for the SOX of the Year Award which is presented at the Staff Awards in September. Our recent winners were:

Award	Department
January Staff SOX of the Month	Catering Team
January Patient SOX of the Month	Wessex Rehabilitation Team
February Staff SOX of the Month	Two Members of the Central Booking Team
February Patient SOX of the Month	Staff on Day Surgery & Sarum Ward
March Staff SOX of the Month	A Member of Staff on the Maternity Unit
March Patient SOX of the Month	Staff on Pitton Ward

Improving Together

Improving Together is our new strategic initiative that involves all Trust staff members. It is a programme and a new way of working focused on continuous improvement, supported by the development of a coaching culture.

The first four frontline teams started their Improving Together training in March. Teams got creative with ‘sharpies’ and shared their past experiences of change at the Trust before delving deeper. The day included an overview of the programme and the various tools and methods that will enable the teams to implement focused and sustainable local changes.

Remote Monitoring Heart Failure Patients

The heart failure team were involved in the first Dragon's Den initiative, where it was proposed that some patients with a diagnosis of heart failure would benefit from being provided with an automatic blood pressure machine. The medications given to this patient group have a significant impact on prognosis and reducing mortality, therefore, having prompt and effective “up titration” is of real benefit for the population and contributes to hospital avoidance.

To change doses, we need to monitor both blood results and the patient's blood pressure, and by providing this machine we can change medications more quickly, saving clinic visits, which for some patients can involve lengthy journeys.

These machines are easy to use, and the feedback from patients has been positive.

Patients get peace of mind knowing that they can contact the heart failure nurse team, and then by providing readings from these machines, decisions regarding changes to care can be made quickly if needed, with communication to Primary Care.

Administrative & Clerical Governance Group

Administrative staff account for around 1,000 employees across the Trust, with no solid representation.

It was felt that this lack of solid representation needed to change and mirroring the already established Clinical Governance sessions would be accepted well.

This aligns with the NHS People Plan:

- ✓ Promoting inclusion
- ✓ Looking at opportunities to share best practice
- ✓ Enabling collaboration to help make sustainable continuous improvement Trust-wide. There has been many a good idea shared.

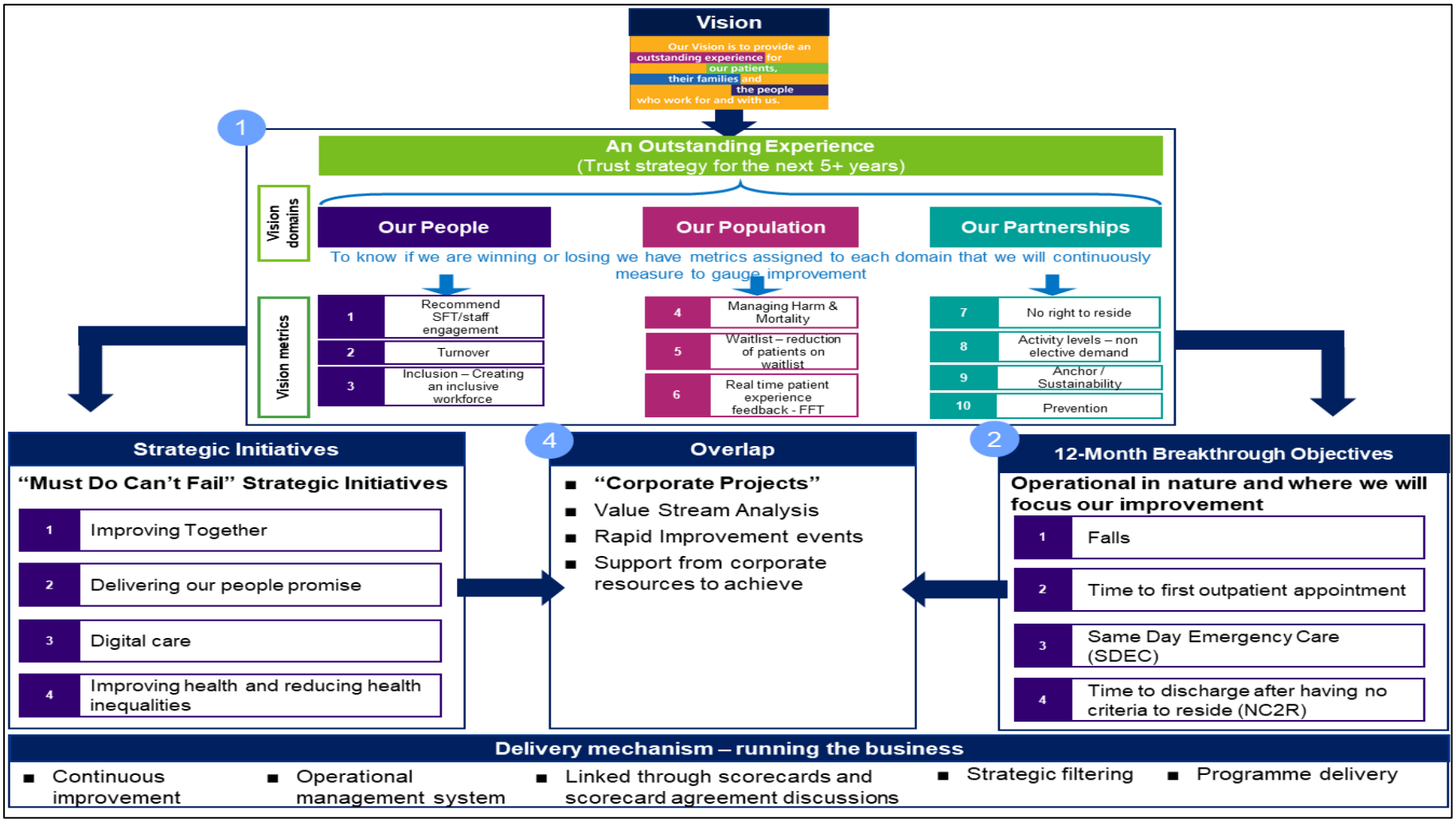
The plan is to implement champions across the Trust, looking for small wins and providing a forum of support for this staff group.

The Chief Registrar Role

The Chief Registrar role is a senior leadership role endorsed by HEE England, which aims to support trainee doctors in leadership initiatives, and in developing hospital services. This role has been undertaken by a training registrar every year, and individuals within this post have spent about 60% of their time clinically, and the remainder engaging in initiatives to provide a bridge between senior leadership teams and the medical workforce, engaging in quality improvement which aims to improve hospital services, as well as to help increase morale and productivity amongst Junior Doctors.

Over the past few years, our Trust has been allocated individuals who have had the privilege of being mentored by our Chief Medical Officer, who himself has a passion for promoting leadership within the organisation. Some of their successes include Junior Doctor rota redesign, embedding the Junior Doctor perspective within Trust Management meetings, engaging their Junior Doctor colleagues in quality improvement projects, participation in Junior Doctor forum which is also led by our Guardian of Safe Working, establishing a Junior Doctor of the month award, and establishing a Quality Newsletter that promotes clinical effectiveness by spotlighting up to date audits, guidelines, serious incident reports, and patient experience stories.

Appendix A – Our Strategic Planning Framework



Appendix B – Audit Examples and Actions

Examples of National Clinical Audits that were presented to the Clinical Management Board (CMB) or Clinical Effectiveness Steering Group (CESG) in 2021/22	
Audit Title	**Outcome / Actions to improve quality of healthcare**
Case Mix Programme (CMP) Published in June 2021 Presented to CMB in August 2021	The CMP is an audit of patient outcomes from adult general Critical Care Units. Due to the pandemic, data from 2020/21 is not comparable to usual activity. Key successes include that no non-clinical transfers occurred. Mortality compares well to similar units, and there was very low acquired infection in the unit. Timely discharge can sometime be difficult. **Actions to improve the quality of healthcare** 1. Early identification of patients suitable for ward transfer (morning multidisciplinary ward round). 2. Ensuring patients are ready to be discharged as soon as possible (discharge ready checklist). 3. Ensuring that the hospital prioritises Intensive Care Unit discharges.
National Cardiac Audit Programme (NCAP) **National Audit for Adult Percutaneous Coronary Interventions** Published in October 2021 Presented to CESG in February 2022	The aim of this audit is to look at Percutaneous Coronary Intervention (PCI) data for Salisbury NHS Foundation Trust compared to the U.K. average, and against a certain set of standards. The Trust continues to be performing better than the national average in most instances, although door-to-balloon times and the percentage of patients receiving angiography in less than 72 hours is slightly below the U.K. average. The Trust reports excellent outcomes with a procedural success rate of 98%. **Actions to improve the quality of healthcare** 1. Undertake a visit to Dorset County Hospital to review pathways (where they are performing above the U.K. average). 2. Write and submit a business case for provision of acute coronary syndrome nursing support. 3. Initiate a discussion with the ICS to increase collaboration with our partners.
National Maternity and Perinatal Audit - NHS Maternity Care for Women with a Body Mass Index of 30kg/m2 or Above (data 2015 to 2017) Published in May 2021 Presented to CMB in October 2021	The aim of the audit is to compare maternal and neonatal outcomes for women with a BMI ≥30kg/m² versus women with a BMI of 18.5-24.9kg/m². The Trust has already implemented most of the recommendations from the report. **Actions to improve the quality of healthcare** 1. To undertake a local audit on BMI (to review outcomes) and put an action plan in place as required. 2. Update the BMI advice on the hospital guidelines system to reflect the national guidelines.

Examples of National Clinical Audits that were presented to the Clinical Management Board (CMB) or Clinical Effectiveness Steering Group (CESG) in 2021/22	
Audit Title	**Outcome / Actions to improve quality of healthcare**
National Neonatal Audit Programme (data 2019) Published November 2020 Presented to the Clinical Management Board on 16th June April 2021)	This audit aims to assess the care given to babies admitted to neonatal units and identify areas for quality improvement. The data demonstrated that the use of maternal steroids is fully embedded in practice and the breastfeeding team achieved 100% against the breastfeeding standards. An area of further development relates to cord clamping, where some new guidance was released during the audit period. **Actions to improve the quality of healthcare** 1. To review cord clamping at the Neonatal and Maternity Governance Meeting. 2. Obstetrics and Paediatrics Lead to raise introduction of deferred cord clamping at the Divisional Management Team Meeting. 3. Investigate if cord clamp timing can be added to the IT system (called 'E3'). 4. Provide training about cord clamping to the Obstetric and Maternity Team.
National Paediatric Diabetes Audit (NPDA) Published in June 2021 Presented to CMB in June 2021	The aim of this audit is to identify information that improves the quality of care for children and young people affected by diabetes. 79.4% of the unit's young people aged >12 years received all seven key health checks within the audit year compared to 54.4% across England and Wales. The result is significantly higher than the national mean. The number of children using insulin pumps at Salisbury NHS Foundation Trust has reduced since last year's audit (Salisbury NHS Foundation Trust is at 39.3% compared to 38.0% nationally). There has been a significant increase in continuous glucose monitoring over the last two years. Some improvements are needed in the recording of patient information (e.g., smoking /vaccination status), the uptake of dietetic appointments, and the governance of continuous glucose monitoring. **Actions to improve the quality of healthcare** 1. Improve the use of our annual review clinic questionnaire to address recording of smoking status and flu vaccination. 2. Review the need for a new dietetic system at a team 'away' day. 3. Participate in the continuous glucose monitoring audit. 4. Develop an online structured education package for diabetes.

Examples of National Clinical Audits that were presented to the Clinical Management Board (CMB) or Clinical Effectiveness Steering Group (CESG) in 2021/22	
Audit Title	**Outcome / Actions to improve quality of healthcare**
RCEM – Assessing Cognitive Impairment in Older People / Care in Emergency Department (data: 2019/20) Published in February 2021 Presented to CMB in May 2021	The purpose of this quality improvement project is to track the performance of emergency departments in assessing cognitive impairment in older people (≥65), documenting assessment using established delirium pathways, and communicating findings back to Primary Care upon discharge. Some improvements need be made in the recording of cognitive assessments and the communication to Primary Care. A key success was submitting our findings from 145 patients to the national project team. **Actions to improve the quality of healthcare** 1. Increase assessment of cognitive impairment using the AMT10 assessment tool (a tool used to assess mental impairment in elderly patients) in a new clerking proforma. 2. Participate in the RCEM re-audit 'assessing for cognitive impairment in older people report' in 2022/23.
RCEM – Care of Children in Emergency Departments (data: 2019/20) Published in February 2021 Presented to CMB in May 2021	The aim of this project is to help emergency departments measure and improve safeguarding practice in the care of young people. Salisbury NHS Foundation Trust performs better than the national average at providing a senior review of infants at high risk of safeguarding concerns, or reviewing the notes when an infant, child or adolescent leaves the department without being assessed. The notes are also reviewed by the Named Nurse for Safeguarding Children. The required policies and systems are in place. We are looking to increase compliance with the use of an adolescent psychosocial risk assessment, such as the HEEADSSS tool (to understand adolescent behaviour and assess risk taking behaviours to provide appropriate interventions in partnership with a young person), with a focus on children aged 12 – 17 years old. **Actions to improve the quality of healthcare** 1. Roll out the use of the HEEADSSS tool (or similar) to assess psychosocial risk in children and young people. 2. Review options for having a dedicated adolescent space in the emergency department with QR codes and an 'adolescent box' which contains accessible information for the child.

Examples of Local Clinical Audits	
Audit Title	**Comments and actions to improve quality of healthcare**
Audit of recommendation 1.1.11 of NICE Guideline 185: Acute Coronary Syndromes	This audit was completed to check compliance with NICE Guideline 185: Acute Coronary Syndromes, recommendation 1.1.11. The audit provided evidence that the Trust is fully compliant with the recommendation and that no further action is required.
Audit to determine compliance with the 1cm rule in Breast Mammography Technique	The purpose of the audit is to give the mammographers a tool to analyse their technique and target improvement in the amount of breast tissue imaged. If more of the breast tissue is imaged, it is more likely that subtle abnormalities may be found that may need further investigation and could lead to a better outcome for our patients. Some variation in results was identified. The team have introduced a technique outcome file in the department, which can be used for self-evaluation post-clinic and used for continuous professional development. This will be re-audited in 12 months' time.
Evaluating communication with primary care regarding long stay burns patients	The 2018 British Burns Association recommends "communication with GPs and community teams related to long stay patients (at least monthly) during their inpatient stay". The results of the first round of the audit showed that some improvements were required, and after discussion with other centres in the South West Burns Network a new communication system was developed. Following the introduction of the communication system the re-audit demonstrated that there had been significant improvements, but it was still felt that further refinements could be made to the system. Once the changes are embedded a second re-audit will be completed.
Fascia Iliaca Block (FIB or FICB) for fractured neck of femur patients in the Emergency Department	The Royal College of Emergency Medicine recommends that "Fascia Iliaca Block (FIB or FICB) should be available in Emergency Departments as part of the pain management strategy for patients with fractured neck of femur (NOF)". This is a form of pain relief which provides a local anaesthetic to the nerves in the hip. The audit objective was to determine the rate of fascia iliaca blocks for fractured NOF patients in the Emergency Department. The results of the audit demonstrated that some further work was required and following completion of this work a re-audit was carried out. The re-audit evidenced an increase in the percentage of fractured NOF patients receiving pre-operative FIB from 36.7% to 69.6%.
The use of the Warrington stroke categories to predict discharge date from the stroke unit	The length of stay in the stroke unit can be of considerable duration due to the difficulties in determining rehabilitation potential in a timely manner on admission. This can be an issue for therapy staff who are new or rotational. This audit aimed to demonstrate whether using the Warrington stroke categories (which is used to guide the therapy team in the patient's rehabilitation potential) can reduce the length of stay for the patient. The results of the audit showed that 80% of discharges occur within the predicted discharge of the Warrington score. Further actions include using the Warrington categories to guide discharge plans for all appropriate patients and for the predicted date of discharge from the Warrington categories to be clearly placed on the therapy section of the consultant worklist.

A Local Clinical Audit Case Study

Nurse Led Nipple and Areola Tattooing Micro-Pigmentation Service

Background

Nipple and Areola Tattooing Micro-Pigmentation is a procedure which is performed using needles to place pigments under the skin. The aim is to improve the cosmetic appearance of the breast by matching the colour and size to the opposite nipple areola. All patients who attended the Nurse Led nipple areola tattoo service for tattooing were asked to complete a patient questionnaire to audit patient satisfaction. The questionnaire was granted approval by the Patient and Public Involvement Group at Salisbury NHS Foundation Trust. Data was collected between June and December 2021.

Results

- 65 people completed the survey.
- The audit identified that 100% of patients felt that they were given adequate information in clinic regarding tattooing and felt well prepared for their procedure.
- In total, 100% reported an improvement with body image, with many respondents commenting on how they felt complete or whole again and that they no longer focused on their surgical scars.
- Following tattoo treatment, patients are provided with verbal information and a written leaflet regarding their aftercare. All patients reported being provided with this information.
- Patients were provided with a card with the teams' names, contact details and emergency out of hours telephone numbers (should they experience a problem during out-of-hours, weekends or a bank holiday). Again, 100% of patients reported having received the contact details.
- All patients reported receiving a follow up appointment.
- The service covers the Wessex Region, and some patients expressed a preference for a telephone call or a virtual appointment. Patients were given the option to choose their method of follow up.

Conclusion

The nurse led tattoo treatment provides a service that has a positive impact on how patients feel following breast reconstruction. Many patients commented on how they felt whole and complete again afterwards. Also, that their self-confidence had greatly improved since the tattooing. Patients reported being well prepared for their treatment, having been provided with information on their aftercare and the contact details of whom to call should they have a concern. All patients were followed up in a nurse led clinic. The level of satisfaction expressed by patients was greatly rewarding for the team providing the service.

Appendix C – Letters of Assurance

The following were all invited to comment and provide assurances on the content of the Salisbury NHS Foundation Trust Quality Account 2021/22:

- **Wiltshire Council Health Select Committee**
- **Salisbury NHS Foundation Trust Governors**
- **Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group**
- **Healthwatch Wiltshire**

Copies of the responses received have been attached in this Appendix, along with a Directors' Responsibilities Statement which has been signed by the Chairman of the Trust Board and the Chief Executive.

Salisbury NHS Foundation Trust (SFT)

Statement from Wiltshire Council Health Select Committee, dated 17 June 2022

The Wiltshire Health Select Committee welcomes the opportunity to comment on the quality account.

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 tremendous challenges in responding to the COVID-19 pandemic whilst simultaneously maintaining service delivery was noted, as were the achievements and opportunities documented within the account.

The following high-level comments were raised when reviewing the account:

- Considering the priorities for 2022/23, we welcome the commitment to reduce the time to the first appointment and eliminating waits for treatment. We would look to see clear evidence in next year's account towards delivery of these priorities.

- We hope the 16.57% increase in incidents where harm occurred because of the event will be addressed during 2022-23.

- The continued prioritisation of falls reduction is key, and we support the efforts of the Trust to achieve the 20% reduction in the number of patients who have preventable falls in the hospital.

- In response to the pandemic, we commend the Trust for supporting staff to recover their physical and mental wellbeing, and the impact this will have towards improving patients' experience of hospital care.

- Congratulations to the Trust on its work with the Acute Hospital Alliance partners to share planned elective care, work towards a shared approach to waiting list management, and system wide pathway reform.

- The Health Select Committee is interested in addressing health inequalities and we would congratulate the Trust on achieving reduction in health inequalities for cancer patients

- We very much welcome the Trust's aim to achieve 100% compliance for staff receiving a Covid risk assessment and note that 91% have already been assessed.

- Finally, we note the reduction in reducing the number of category 2 pressure ulcers from 286 in 2020/21 to 264 2021/22, an 8% reduction. We welcome the commitment to improve this to a 20% reduction and look forward to seeing the results in next year's account.

Wiltshire's Health Select Committee welcomes the opportunity to continue to work closely with the Trust and we look forward to receiving an update on your proposed campus programme at our July committee meeting.

Cllr Johnny Kidney,
Chairman of the Health Select Committee, Wiltshire Council

Statement from the Governors – 6 June 2022

The Quality Account shows how the Trust has performed against our priorities this year and sets out the main areas of focus for 2022/2023. As the account sets out, there are many areas where the Trust has achieved improvements, and of course some, where further work is required.

Governors welcome the changes on the way the report has been produced in previous years by aligning the report to the three tiers of quality, i.e. patient experience, patient safety and clinical effectiveness and to the key priorities of the new strategy that focus on delivering on COVID recovery plans, reducing waiting times, investing in our people, seeking new ways of working and delivering care, and developing a model which is fit for the future.

The governors acknowledge the progress made over the last year to improve the quality of care despite the significant impact of Covid19 that continued to disrupt the Trust's ability to maintain high levels of achievement against waiting times and patient pathways designed to deliver best outcomes.

The governors note the impact on staff; high workload, high absences because of Covid and changes to their usual job or place of work. All these are reflected in the responses to the staff attitude survey, and we support the Board initiatives that have been arranged to listen more to staff, to attempt to make their working lives better and to express thanks.

The governors have been given an opportunity to provide feedback on the Quality Account in draft. We endorse the priorities provided for 2022/23.

The governors would like to thank all our staff for the tireless work they have done and are doing each day in service of the communities the Trust provides care for.

Lucinda Herklots, Lead Governor 7 June 2022

Bath and North East Somerset,
Swindon and Wiltshire
Clinical Commissioning Group

Statement from Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group on Salisbury NHS Foundation Trust (SFT) Limited 2021-22 Quality Account

NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group (BSW CCG) welcome the opportunity to review and comment on the Salisbury NHS Foundation Trust (SFT) Quality Account for 2021/2022. 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 NHSE/I presentation guidance.

The CCG recognises that 2021/2022 has continued to be a difficult year due to the COVID-19 Pandemic and that this has impacted on services provided by SFT. The CCG would like to thank SFT for their continued contribution to supporting the wider health and social care system during the COVID-19 recovery phase.

It is the view of the CCG that the Quality Account reflects SFT's on-going commitment to quality improvement and addressing key issues in a focused and innovative way. Although achievement of some priorities during 2020/21 have continued to be affected by COVID-19, SFT has still been able to make achievements against most of their priorities for 2021/22 including:

1. Of 106 standards set out in the Infection Prevention and Control (IPC) Board Assurance Framework (BAF), SFT have achieved full compliance with 86% (91) providing assurance that they are able to evidence and identify risks associated with IPC practices in line with national guidance.
2. Consistent reduction of long waits; appointment of a BSW System Elective Care Programme Manager to support a system response to planned elective care and the development of joint/shared waiting lists; and implementation of systems support to develop an aligned planning process across the three BSW acute providers.
3. Implementation of a healthcare inequalities group, participation in the BSW system inequalities group, and using data to identify areas for improvement with the aim of reducing health inequalities both in the local population and also within SFT's own internal processes.
4. Providing support to staff including on-going work to improve the number of staff who have completed a COVID risk assessment; continued roll out of the wellbeing conversations pilot; a redesigned induction programme to improve engagement and orientation with new starters; and development of an improvement culture within SFT.
5. Routine recording of risk assessments for patients at key points throughout their pregnancy; 80-90% of women receiving a review within expected time frames; and 100% audit compliance showing that consultant-led labour ward rounds took place twice a day, 7 days a week.
6. Reducing the number of missed or delayed cancer diagnoses to 0 with no recorded incidents of patients being lost to follow up since August 2021, this is supported by audit programmes and recruitment of Skin Cancer Follow up and Cancer pathway Navigators who are focused on improving processes.

7. There has been a significant improvement in the administration of antibiotics following diagnosis of sepsis, with 72% of patients receiving antibiotics within an hour of being diagnosed compared to 43%, including increased compliance out of hours.
8. Strengthening of partnerships including appointing a clinical lead to provide senior representation within the Integrated Care System.

The CCG notes that due to the ongoing impact of COVID 19, some of the priorities have not reached the expected outcome at this stage, such as achieving 60% of patient contacts to be seen by virtual appointments and standardising virtual solutions across BSW, reducing the number of category 2 pressure ulcers by 20% and category 3 and 4 pressure ulcers to 0, reducing the number of patients who have a preventable fall by 20%: and piloting ward accreditation. The CCG also recognises the impact of COVID-19 on staff which is reflected in the annual staff survey and welcomes the additional staff recruitment as well as the health and wellbeing initiatives introduced to support existing staff members.

The CCG supports SFT's identified Quality Priorities for 2022/2023. It is recognised that several of the priorities described in this Quality Account align to the NHS priorities set out in the NHS Long Term Plan and Operational Planning Guidance with a crucial focus on reducing inequalities. The CCG welcomes continued engagement in the agreed service improvement plan and focus on developments as part of their Improving Together programme, including:

People: Covid recovery including scoping and exploring new ways of working.
Population: Reducing the number of patient falls and the number of patient falls resulting in harm, eliminate waiting times for treatment and implementation of the Patient Safety Incident Response Framework.
Partnerships: As part of the Same Day Emergency Care programme, SFT aims to improve performance against 4-hour emergency access. SFT also aims to reduce the number of patients in their hospital with No Criteria to Reside.

Of the above initiatives, Same Day Emergency Care, No Criteria to Reside, Time to First Appointment and Reducing Falls have been identified as breakthrough objectives as they were identified as the top contributing themes within the Trust.

It is encouraging to read that SFT is a People Promise exemplar site with work ongoing to improve staff experience of working in the NHS, with four key priorities identified for 2022/23:

- **Looking after our people:** Improving retention, supporting staff health and wellbeing and improving attendance.
- **Improving belonging in the NHS:** improving the ratio of Black, Asian and minority ethnic disparity and promoting equality across all protected characteristics.
- **New ways of working and delivering care:** accelerating the introduction of new roles, workforce development and maximising volunteer services.
- **Growing for the future:** expanding international recruitment, creating training and employment opportunities, using temporary staff effectively and ensuring sufficient placement capacity to support student's achieve timely qualification and registration.

The CCG would also like to highlight SFT's participation in several COVID-19 research programmes, which has resulted in a better understanding of the virus and what medicines can treat the infection, reducing the severity of symptoms and reducing both patient deaths and also the need for hospitalisation.

It is recognised that following an unannounced inspection by the CQC to SFT's spinal and maternity services, we recognise that SFT are focusing on the identified areas for improvement, engaging with the CQC and CCG and continuing to make progress against related actions.

NHS Bath and North East Somerset, Swindon and Wiltshire CCG, together with associated co-commissioners, are committed to sustaining strong working relationships with SFT and together with wider stakeholders, will continue to work collaboratively to achieve our shared priorities as the Integrated Care Alliance develops in 2022/23.

Yours sincerely

Gill May
Director of Nursing and Quality
BSW CCG

Salisbury
NHS Foundation Trust

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 2021/22.*
- *The content of the quality report is not inconsistent with internal and external sources of information*
- *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.*
- *There is no national requirement for NHS trusts or NHS foundation trusts to obtain external auditor assurance on the quality account for 2021/22. Therefore, no limited assurance report is available on the quality account report in 2021/22.*

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
Date 9 June 2022

Stacey Hunter
Chief Executive
Date 9 June 2022

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