Bundle Trust Board Public 3 September 2020

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates

Rowena Staples
Respiratory Care Unit
Presented by Nick Marsden

1.2 10:05 - Staff Story

Spire Ward

1.3 Welcome and Apologies

1.4 Declarations of Interest, Fit and Proper/Good Character

1.5 10:25 - Minutes of the previous meeting

Minutes attached from meetings held on 2 July and 6 August
For approval

1.5 Draft Public Board mins 2 July 2020.docx

1.6 10:30 - Matters Arising and Action Log

Action Log Public Board Sept 2020.docx

1.7 Register of Attendance

Register of Attendance - Public Board 2020-21.docx

1.8 10:35 - Chairman's Business

Presented by Nick Marsden
For information

1.9 10:40 - Chief Executive Report

Presented by Stacey Hunter
For information

1.9 CEO Board Report September.docx

2 ASSURANCE AND COMMITTEE REPORTS

2.1 10:50 - Trust Management Committee - 24 August 2020

Presented by Andy Hyett
For assurance

2.1 TMC Escalation report September.docx

2.2 10:55 - Finance and Performance Committee - 25 August

Presented by Paul Miller
For assurance

2.2 Finance and Performance Committee escalation paper 25th August 2020.docx

2.3 11:00 - Clinical Governance Comittee - 28 July

Presented by Eiri Jones
For assurance

2.3 Escalation report - from CGCommittee to Board July 2020.docx

2.4 11:05 - Integrated Performance Report

Presented by Lisa Thomas
For assurance

2.4a IPR cover Board.docx

2.4b IPR September 2020 FINAL.pdf

3 GOVERNANCE

3.1 11:20 - Approve Board and Committee dates for 2021

Presented by Fiona McNeight
For approval

3.1a 12 Trust Board Dates cover sheet 2021.docx

3.1b Trust Board & Committee dates 2021.docx

3.2 11:25 - Annual Review of Board and Committee Effectiveness

Presented by Fiona McNeight
For assurance

3.2 Board and Committee Effectiveness Report August 2020.docx

3.3 11:30 - Corporate Governance Statement Self-Asessment

Verbal update by Fiona McNeight
For assurance

3.4 11:35 - Revised Board Assurance Framework

Presented by Fiona McNeight
For approval

3.4a BAF cover sheet September Board 2020.docx

3.4b BAF v1 New Corporate Objectives August 2020.docx

4 PEOPLE AND CULTURE

4.1 11:45 - Health and Safety Annual Report

Presented by Lynn Lane
For assurance

4.1 Revised H&S Annual Report Aug20.docx

4.2 11:55 - Guardian of Safe Working Annual Report

Presented by Juliet Barker
For assurance

4.2 Guardian of safe working annual report.docx

4.3 Medical Revalidation and Appraisal Annual Report (deferred to Novemner)

4.7 Communications Strategy (deferred to November meeting)

5 QUALITY AND RISK

5.1 12:05 - Director Infection Prevention Control

Presented by Judy Dyos
For assurance

5.1a Trust Board Summary sheet Annual DIPC Report (2019-20).docx

5.1b DIPC Report Annual Update 2019-20 (Final v.2).doc

5.2 12:15 - IPC Board Assuarance Framework

Presented by Judy Dyos
For assurance

5.2a IPC Board Assurance Framework Cover Sheet 22nd July 2020.docx

5.2b IPC BAF version 1.0 (our version 1.7draft) update 15.07.20.pdf

5.3 12:25 - Clinical Governance Annual Report

Presented by Sallie Davies
For assurance

5.3 Trust Board Annual Clinical Governance report 19 20.pdf

5.4 12:35 - Research Annual Report

Presented by Sallie Davies
For information

5.4 Trust board Research Annual report 201920 Sept 2020.pdf

6 CLOSING BUSINESS

6.1 12:45 - Agreement of Principle Actions and Items for Escalation

6.2 Any Other Business

6.3 12:50 - Public Questions

6.4 Date next meeting

Next Public meeting 5 November

7 Resolution

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

Salisbury NHS Foundation Trust

DRAFT

Minutes of the Public Trust Board meeting held at 11:00am on Thursday 2 July 2020 via Skype in The Board Room, Salisbury NHS Foundation Trust

Present:

Dr Nick Marsden	Chairman
Ms Tania Baker	Non-Executive Director
Mr Paul Kemp	Non-Executive Director
Mr Paul Miller	Non-Executive Director
Ms Eiri Jones	Non-Executive Director
Ms Rakhee Aggarwal	Non-Executive Director
Dr David Buckle	Non-Executive Director
Dr Michael von Bertele	Non-Executive Director
Mrs Cara Charles Barks	Chief Executive Officer
Mr Andy Hyett	Chief Operating Officer
Dr Christine Blanshard	Medical Director
Mrs Lisa Thomas	Director of Finance
Mrs Lynn Lane	Director of OD and People
Ms Judy Dyos	Director of Nursing

In Attendance:

Miss Kylie Nye	Corporate Governance Manager (minutes)
Mr John Mangan	Lead Governor (observer)
Mrs Fiona McNeight	Director of Corporate Governance
Ms Esther Provins	Director of Transformation
Mrs Kat Glaister	Head of Patient Experience

ACTION

TB1 02/07/01 **OPENING BUSINESS**

TB1 02/07/1.1 **Presentation of SOX (Sharing Outstanding Excellence) Certificates**

N Marsden noted the following members of staff who had been awarded a SOX Certificate:

- Toby Ferguson, Jackie Privett, Hayley Rowell and Tori Appleford – Administration Surgery
- Emma Hodgson - Maternity
- Claire Downs – Therapy ESD
- Scarlet Leahy – Maternity
- Tisbury Ward Team
- Claire Pettinger – AMU F1 Doctor
- Kieran Milton – Genomics LIMS and IT manager
- Emma Lambert – Trainee Nursing Associate RCU
- Claire Levi and Colin Keberka – Simulation Team
- Lee Boyes – Portering Service
- Denise Watson, ED Staff Nurse

N Marsden noted that a majority of the SOX awards this month were themed around the hard work of staff during the COVID-19 pandemic. The number of SOX awards reflects the recognition of a colleague's achievement and is indicative of the team work that has developed. N Marsden noted that the Board should be pleased and proud of how the Trust has performed and responded.

N Marsden noted that he has spent time in the last few weeks visiting different departments within the organisation and talking to people about how they are and how they have managed during this period. N Marsden noted that the key message from staff is the last few months have been challenging but teams have worked really well together. N Marsden and C Charles-Barks noted that they would present the SOX awards to staff personally.

TB1 02/07/1.2 **Staff Story**

N Marsden noted that there was not a staff story to present due to logistical issues but noted that the patient and staff stories would be reinstated once a practical solution had been found.

TB1 02/07/1.3 **Welcome and Apologies**

N Marsden welcomed everyone to the virtual meeting and noted there were no apologies.

N Marsden welcome Amie Dew, the Trust's CQC representative, to the meeting who had joined as an observer.

N Marsden welcomed Judy Dyos to her first Trust Board meeting as Director of Nursing.

TB1 02/07/1.4 **Declarations of Conflicts of Interest**

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

TB1 02/07/1.5 **Minutes of the part 1 (public) Trust Board meeting held on 4th June 2020**

N Marsden presented the minutes and the following points were noted:

- M von Bertele referred to p.13 which discussed the Board Governance Review. M von Bertele requested that the minute be slightly amended to suggest that the Workforce Committee required improvement, rather than not functioning.

- C Blanshard noted that clarification was required on p.8 relating to the discussion around stroke. C Blanshard noted that the time to event arrival can be extended because we have a dispersed rural population.

Subject to these amendments the minutes were agreed as an accurate record of the meeting held on 4 June 2020.

TB1 02/07/1.6 **Matters Arising and Action Log**

N Marsden presented the action log and the following items were noted:

- **TB1 4/6/1.7 - SFT COVID-19 Recovery Session** – C Charles-Barks noted that there were further updates regarding BSW (B&NES, Swindon and Wiltshire) and the Integrated Care System work and noted she would circulate papers from the meeting the following week. **ACTION:CCB**

- **TB1 4/6/2.2 Corporate Objectives –** C Charles-Barks noted that the corporate objectives were to be discussed in the private Trust Board. Item closed.

- **TB1 4/6/2.3 Workforce Committee –** It was agreed that the Workforce Committee would change I's name to People and Culture Committee. Item closed.

- **TB1 4/6/3.2 Board Governance Structure Review –** K Nye confirmed that the organisational meeting structure had been amended to reflect P Kemps' comments. Item closed.

There were no further matters arising.

TB1 02/07/1.7 **Chairman's Business**

N Marsden provided the following update:

- There has not been a great deal of discussion with region or centre as NHS Trust's anticipating the phase 3 announcement which should have been on 30th June.

Discussion:

- C Charles-Barks noted that the phase 3 guidance is expected as the current financial situation ends at the end of July. This will hopefully set out the roadmap for what the focus is financially and also plans for patient care going forward.

- N Marsden noted that he was to attend a Chairs Advisory Panel the following Monday and would report back from this at the next meeting.

TB1 02/07/1.8 **Chief Executive's Report**

C Charles-Barks presented the Chief Executive's report and highlighted the following key points:

- Performance will be picked up via the Integrated Performance Report but the main focus is switching services back on. The return of routine work is limited by the requirement to adhere to testing, distancing and cleaning regulations. Each department is preparing their own

standard operating procedures (SOPs) incorporating the guidance and key considerations to turning services back on.

- As discussed in the Chairman's report the block contract will be in place until end of July.
- The Trust has continued to recruit by conducting interviews virtually. The Trust is currently very conscious about supporting staff through this challenging time and beyond. Risk assessments are being conducted, which have initially been focussed on the more vulnerable staff, for example, those over 70, those from a BAME background or with an underlying medical condition.
- The Trust continues to experience very low numbers of COVID-19 patients. From Monday 15th June new measures were put in place regarding the use of face masks in line with national guidance. The dedication and professionalism shown by our staff in safely restoring services for patients shone through in the BBC 2 News night Programme's third feature on Salisbury Hospital, which focused on our hospital's road to recovery.
- The Best Place to Work programme, a cross organisational project to listen to our workforce in order to understand what it feels like to work for the Trust, relaunched in June. The collected information will support and inform the work of the Trust with an analysis of the current culture and leadership characteristics helping develop the corporate strategy. The annual BBQ will be held on 22nd July and will be used to test out feedback and current thinking from staff. This information will be culminated and will come back as reset proposal in September.
- At the beginning of June we celebrated Volunteers' Week and said thank you to our amazing hospital volunteers – all are members of our local community who give their time freely to help teams across the hospital
- The Trust celebrated Pride month in June, by decking out six of our tugs in the Pride Rainbow colours. The vehicles, which drivers use to deliver and collect and deliver items throughout the hospital, each have their base wrapped in individual colours of the Pride rainbow. The tugs are seen throughout the day by staff and patients across the hospital site and will be a highly visible reminder of Pride.

Discussion:

- P Miller noted that there are constraints and challenges in relation to starting services again and asked about the risk posed to patients who might be affected. C Charles-Barks explained that the Clinical Cell and Recovery Group oversee and provide a risk assess based service plan. The Trust is working on a granular basis in relation to risk assessing individual patients. The key challenges relate to the availability of space, staff, ICU capacity, equipment, PPE and drugs, which are all national issues.

- A Hyett explained that divisions are taking a conscious

decision about the consequences of non-treatment. C Blanshard noted that for those patients waiting for a procedure the Trust has been through the waiting lists and as more patients are added these are vetted clinically according to Royal College of Surgeon guidelines, and a similar process is underway with medical patients. A Hyett explained that there have been difficulties with some patients who require treatment, some urgently, but they are reluctant to come in. This is because they are anxious but also some patients do not want to undertake the 14 day isolation period before their planned procedure. Due to this the Trust is now reviewing procedures to balance the risk of a shorter isolation period against the risk of delaying procedures.

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- T Baker referred to the messages from the government which have been confusing and noted that whilst this is not directly a Trust issue it does have an impact on those attending their appointments. T Baker asked if the public health team are collating COVID-19 data and if the correct messages are being disseminated to the public. A Hyett explained that the Trust is working closely with the Department of Public Health. There is work underway on a communication on the south west's low prevalence T Baker referred to the recent publicity in the Salisbury Journal which had been really positive and encouraging for patients who might feel anxious.

- D Buckle supported the idea of relaxing the two week quarantine rule for those patients who require urgent procedures. D Buckle stated that due to the clinical consequences of some of these procedures potentially not going ahead the risk has to be assessed appropriately.

- E Jones referred to D Buckle's point regarding the two week isolation guidance and asked if the Trust is deviating from national guidance, are others doing this too and is there a clear justification. C Blanshard explained that there is flexibility within the national guidance and it suggests 14 days if possible and appropriate. This has been lessened for children to 7 days and services supplied by Endoscopy have also been reduced and approved by JAG (Joint Advisory Group). The Trust is also in communication with regional Medical Directors to ensure consistency.

- R Aggarwal referred to the support staff have received and asked if there is a regional and national appetite to provide staff with mental health support whilst business returns to normal. C Charles-Barks noted that all organisations were awaiting the release of People Plan which is currently being refreshed. The Trust is raising concerns nationally about the longitudinal effect on residual stress due to COVID-19 and the long term complications and implications. The Trust is currently exploring what can be learnt from military and how

a state of "decompression" can be explored and utilised by the NHS. L Lane explained that the HR Director's network is nationally discussing support for staff on an ongoing basis. The Trust is also encouraging all staff to take annual leave as they normally would over the summer to have a break and new wellbeing initiatives are being reviewed to ensure staff do feel well-supported at work. MVB stated that employee benefits provider has a service for mental health and well-being and support which all colleagues can access.

TB1 02/07/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 02/07/2.1 **Audit 17 June 2020**

P Kemp presented the report, providing a summary of escalation points from the meeting held on 17 June:

- The internal auditors reported an overall improvement compared to the previous year. Whilst this was noted by the Committee there was recognition of the progress required for the continuation of trajectory towards a good result.
- There is now a focus from the Executive to focus on clearing the overdue audit actions. The Committee will review progress at the next meeting.
- The Annual report and accounts were reviewed and approved.
- The external auditors provided a strongly qualified opinion as part of the Value for Money assessment. IAs with many NHS Trusts due to current circumstances the Trust is not able to be accounted for as a going concern.

Discussion:

- N Marsden noted that following the Audit Committee a Sub Board had taken place to review audit findings and were given delegated authority to approve the Annual Report and Accounts. The Annual Report is due to be laid to parliament on Monday 6th July.

- E Jones noted her concerns relating to the comments in the report regarding friction between finance and the external auditors. P Kemp noted that due to COVID the Trust and the auditors had to work in a way which was not aligned to the normal process. L Thomas noted that there had been healthy professional challenge throughout the process and it was recognised that it had been difficult for both parties to quickly adjust to a changing working environment. LT noted that ultimately the outcome had resulted in a better audit than the previous year.

- C Blanshard asked if the overdue actions were being transferred to the risk register. L Thomas explained that a majority of the actions were on the risk register under a broader issue. E Provins explained that from an IT

perspective there are still risks but work is underway to close the gaps in assurance and it is hoped that after the next meeting those actions will close.

TB1 02/07/2.2 **Trust Management Committee - 11 June 2020**

C Charles-Barks provided a summary of escalation points from the Trust Management Committee:

- The Committee received the update on Governance which had previously been approved by the Board. The Committee noted that the new OD & People Management Board terms of reference had been drafted and approved by L Lane with with meetings commencing from early September.
  It was agreed that from July all committees which report into TMC will have formal escalation reports produced for the Committee to receive.
- The Committee received a paper on FTSUG Ambassadors which upon review was noted to be lacking detail around costs to implement. The committee therefore agreed that the paper would need to return to the committee with costs included, for them to be able to ensure value for money.

The report was noted.

TB1 02/07/2.3 **Clinical Governance Committee – 23 June 2020**

E Jones provided a summary of escalation points from the Clinical Governance Committee:

- An annual self-assessment of the effectiveness of the CGC was presented and discussed.
- The Committee received a presentation of the management of pressure ulcers, reviewing the several contributing factors and the plans in place to address them. It was noted that whilst there has been a drop in pressure ulcers an update will be planned into the business cycle going forward.
- A detailed Serious Incident compliance report was presented. The Committee requested further assurance in relation to the timeliness of completion plans. Further assurance on learning and how CMB (Clinical Management Board) manage the oversight of SIIs was also requested.
- An update was provided in relation to progress of actions based on the risks identified in the Gastroenterology service. It was noted that the new structures under the leadership of surgery was positive and that this was expected to have a positive impact on the workforce risk
- Two key themes are the IT solutions and workforce solutions in certain areas as discussed in this committee. The second issue relates to decisions that were expected in the postponed workforce summit.

Discussion:

- L Thomas noted that workforce summit will be rescheduled but it should be recognised that what may have been a pressure point pre COVID, may have changed and this needs to be recognised. L Thomas explained that there is a risk of adding to the cost base and not getting a key return. There will be a workforce summit but the risks will have to be reviewed and escalated based on the Trust's priorities now.

- P Miller noted he had recently attended a patient safety walkabout and comments from staff were that bids for more staff had been submitted to finance and a response was expected. P Miller suggested that the message to departments in terms of more resource for staffing is that it is a collective decision where the funding is allocated, not just finance. C Charles-Barks explained that a wider piece of work will be underway as COVID will ultimately change the way we do business and requirements for workforce will look different. N Marsden supported this and recognised that workforce plans need to be in the context of the future.

TB1 02/07/2.4 **F& P Committee – 23 June 2020**

P Miller presented his report and summarised the key escalation points as follows:

- MRI recommendation report – The recommendation in this paper to award the tender was supported by the committee.
- Integrated performance and finance reports as at 31st May 2020 –The key issue is what happens to performance when activity increases as non-COVID NHS services resume and the current interim NHS financial regime ends, particularly going into the next financial year 2021/22.
- Transformation update – following the resetting of the Trusts transformation plan for 2020/21 the committee received the first update report. In addition this report highlighted that a proposal to award a new Microsoft Office contract (based on national NHS negotiations) would be going straight to the private Trust Board in July 2020, because of the timescale of negotiations.
- COVID-19 recovery update – The Trust continues to plan the detail and commence the recovery of non-COVID services within the hospital and the expectation is over time the hospital will see most services reinstated. A key element of this recovery is the production and approval of detailed standard operating procedures (SOP's) for all aspects of the Trusts services.
- Proposal for critical care surge in capacity – the Trust have developed three capital schemes to help us manage any future surge in critical care capacity. The intention is to submit these capital schemes for external central NHS funding. If these bids are not successful, then a separate set of business cases would need to be produced and

formally approved, if the intention was to reset the Trusts 2020/21 capital programme to accommodate them.
- Purchase of (PPE respiratory) hoods – The recommendation to purchase 150 units at a cost of £89,000 (excluding VAT) was supported by the committee.
- Campus development – the committee received a detailed report approved an extension to the existing partnership agreement with Salutem until the Trust Board meeting on the 3rd September 2020, on the condition that it did not commit the Trust to any additional costs, above and beyond the funding already approved by the Trust Board.

The report was noted.

TB1 02/07/2.5 **Workforce Committee – 25 June 2020**

M Von Bertele presented his report and summarised the key escalation points as follows:

- The Committee discussed the name and purpose of the committee following approval of the Terms of Reference agreed to change the name to "People and Culture Committee."
- The committee is expected to conduct a review of its own effectiveness annually, but in light of the critical observations made in the PwC audit of committees it was agreed that it would be appropriate to report on the changes and improvements made since that report was published.
- Work on "The Best Place to Work," that was paused at the start of the COVID-19 pandemic, has been kick started and rapid progress has been made on the first phase, consulting with staff and understanding their concerns and aspirations.
- The Committee noted the relatively poor compliance with mandatory training in some areas and agreed to revisit the target and how it might be achieved.

The report was noted.

TB1 02/07/2.6 **Charitable Funds Committee 18th June**

N Marsden presented his report and summarised the key escalation points as follows:

- The Committee welcomed the appointment of new the investment, planning and policy manager for the Charity and an outline of the work completed to date. It was agreed there would be a day planned in the next 6 weeks to have an in depth view of the initial findings since this role started.
- The Terms of reference were approved
- The head of fundraising report highlighted the increase in physical gifts to the charity in the peak of the Covid -19 pandemic and the committee noted the generosity of local

people and business was overwhelming. N Marsden thanked Dave Cates and the fundraising team for their support during the last few months.

The report was noted.

TB1 02/07/2.7 **Integrated Performance Report**

A Hyett presented the Integrated Performance Report to the Board and noted the following key points:

- Patients who have had a long wait for appointments and treatment remains the key concern and is being reviewed closely, including those delayed due to patient choice.
- HSMR has reduced but there is a risk of an increase in relation to COVID associated deaths.
- There has been an improvement in sickness absence levels and the OD and People team continue to drive this forward with performance reviews within divisions. There is recognition that COVID has affected staff and has also placed more pressure on those remaining employees who are not shielding and remain within the workplace.
- The number of care hours data has increased as the Trust has been running at low bed occupancy.
- In relation to finance the Trust remains on a block contract and awaits the phase three plans from the government. There are concerns that capital spend will be difficult.
- There has been an increase in referrals, especially in cancer and diagnostics. Work is ongoing to return to 90% capacity for diagnostics.

Discussion:

- M Von Bertele raised a concern regarding the data asking if they reflected those patients who would have come to the Trust had COVID-19 not been a concern. M Von Bertele asked if the Trust could quantify the number of patients who should have attended but did not. A Hyett explained that the comparison against those who would have come in is difficult but noted that he would look into the data. **ACTION: AH** A Hyett did note that there has recently been a higher rate of ambulance conveyance and higher rate of admission from ED indicating that those who need care and treatment are attending the hospital. **AH**

- P Miller referred to the reduction in the reduction in patient waiting list and asked if patients removed from the list by clinicians had the opportunity to challenge that removal. A Hyett confirmed that patients were able to challenge the decision.

- P Kemp referred to the SPC charts on p5 and noted that there are still issues with the data. EP noted that she would look into this. **ACTION: EP** **EP**

- E Jones requested further clarification that when people are removed from the list or do not want to come in the Trust captures the harms from that. A Hyett explained that when a patient is being removed there is a clinician/ patient conversation. The process is as active as it can be.

- T Baker queried how the activity at New Hall was being monitored and if it was our activity was it being included in the IPR. A Hyett explained that there is a weekly PTL meeting where it is decided what should take place at New Hall and this is aligned to the scoring of patients. There are operational challenges with New Hall and the Trust is working through these. T Baker queried who was responsible for managing the quality of care. A Hyett noted that as these are Inter-provider transfers the quality of care aspect sits with New Hall and the contract is nationally defined. C Blanshard explained that the Trust has reviewed on call cover arrangements, including where responsibility lies and there is a detailed understanding. This will change if we implement the prime provider model.

- C Charles-Barks referred to requirements to risk assessing those who are vulnerable, particularly those from a BAME background. L Lane noted that the total number of BAME staff is 763 and as of this morning there are 22 risk assessments which haven't been completed. This includes those stranded overseas, on maternity leave, and sickness absence. The next steps are to ensure the quality of the risk assessments is of an expected level. Line managers will continue to work with those who are most vulnerable and the Trust has offered risk assessments to all staff. R Aggarwal referred to the national picture and asked if the Trust knows of the proportion of BAME staff allocated to the COVID effort. L Lane noted that she can share those figures. **ACTION: LL** **LL**

- R Aggarwal further queried the low agency spend and asked if the Trust is expecting this to rise again if the temporary staffing office has the capacity to manage this. L Lane noted that the team are experienced and this is monitored on a continuous basis. There is a focus is to keep costs for agency and bank work low whilst also increasing activity which will be a challenge.

- J Dyos noted the skill mix review is due to come to the Board in the coming months and this will reflect changes to services and longer term solutions for maintaining staffing levels.

TB1 02/07/3 **GOVERNANCE**

TB1 02/07/3.1 **Accountability Framework**

A Hyett presented the Accountability Framework and highlighted the key points:

- The Accountability Framework has been reviewed in conjunction with the Integrated Governance Framework. Key changes have been aligned with the revised Divisional structure and changes to the monitoring of corporate service performance.

Discussion:

- P Miller asked if the revised report had embraced the revised Transformation Programme. A Hyett noted that this has not been fully reflected in the report and those new metrics will need to be added in. **ACTION: AH** **AH**

Decision:

- Subject to the above amendments the Board approved the revised Accountability Framework.

TB1 02/07/3.2 **Integrated Governance Framework**

F McNeight presented the report which provided a summary of the Integrated Governance Framework and the recent changes made.

- The Trust Board is asked to approve the revised Integrated Governance Framework and the Board Committee's Terms of Reference.
- Approve the CEO as a member of Finance and Performance, Clinical Governance and People and Culture Committees (as agreed at the June CGC meeting).
- Approve the Mental Health Strategy Committee reporting to TMC.

Discussion:

- M von Bertele referred to the organogram and noted that it was not clear where the information flows up to. This will be picked up outside the meeting. **ACTION: FMc** **FMc**

- E Provins noted that some of the duties listed under the executive team were historic and needed amending. E Provins noted that there is a lack of evidence of Quality Improvement. It was agreed to include a paragraph on QI. **ACTION: FMc** **FMc**

- C Charles- Barks referred to the Accountability Framework and noted the interchangeable use of directorate and divisions. A Hyett to check this and amend. **ACTION: AH** **AH**

- C Charles-Barks further queried how the framework is tested to ensure it is working. F McNeight noted that there is a follow up piece of work with A Hyett on the executive

performance reviews. There is a culture of continuous learning and sense checking. **ACTION: AH/FMc** **AH/FMc**

- E Jones noted that the Integrated Governance Framework was a great piece of work and a clear handbook on what the Trust should be doing.

Decision:

- N Marsden asked the Board if they were happy to approve subject to the amendments discussed. The Board approved the Integrated Governance Framework.

- The Board also approved the CEO as a member of Finance and Performance, Clinical Governance and People and Culture Committees. The CEO will be expected to attend 70% of meetings a year.

- The Board approved the Mental Health Strategy Committee to report to TMC.

TB1 02/07/3.3 **Fit and Proper Person Policy**

F McNeight presented the Fit and Proper Person Policy and noted that it had been to the Operational Management Board in June and was approved.

Decision:

- The Board approved the policy.

TB1 02/07/4 **QUALITY AND RISK**

TB1 02/07/4.1 **Patient Experience Report**

K Glaister presented the report and highlighted the following key points:

- Complaints continue to show a slight downward trend with 100% of complaints acknowledged within three working days.
- Actions from previous quarters have all been closed except one from Quarter 2 where work is ongoing.
- Complaint coordinators and PALS leads have completed QI coach training as this links to discussions with department leads and ensure the improvement conversation going throughout the process.
- In relation to timeliness of response there has been a reduction in responses being sent to complainants within 40 working days and 60 working days.

Discussion:

- D Buckle referred to timeliness of response and noted that it is vital that the Trust responds to the essence of the complaint and the target should be 100%. K Glaister explained that PALS have implemented a new process

which offers 25, 40 and 60 day pathways and this has worked well as a response time is agreed with the complainant. Additionally, further work has been done with departments to ensure complaints are managed appropriately.

- T Baker referred to social media and asked if the team responded in real time. K Glaister explained that the feedback from NHS websites is responded to straight away and for enquiries through social media timely responses are given.

- C Charles-Barks referred to engaging with harder to reach communities and the further work required on how they are reached. K Glaister noted that a survey has been approved at CRG (Clinical Reference Group) and health watch have agreed to publicise. The survey focuses on the community's experiences of COVID and the rapid changes as a result. J Dyos explained that recent discussions have included how those harder to reach groups are communicated with and social media might be a useful tool.

- R Aggarwal asked that in relation to communication with harder to reach groups is there available translators and is the Trust linking with community organisations or charities. K Glaister explained that several links have been made with organisations. The Trust does translate information leaflets and letters come with guidance. R Aggarwal suggested utilising staff skill-set and K Glaister advised that staff members have helped in the past and this is a piece of work going forward.

- M Von Bertele noted the positive change in the complaints department in the last 18 months and asked if the team were in touch with the defence medical welfare. KG noted that the Trust still has these links and there is good evidence of us being responsive to challenging times recently.

- NM thanked K Glaister and the team for their hard work.

TB 02/07/5 WORKFORCE

TB 02/07/5.1 2019 Staff Survey

L Lane presented the report and highlighted the following key points:

- 2019 saw the highest response rate the Trust has experienced which was a positive move forward.
- The Trust's results, which were presented in February 2020, showed that it achieved above average scores in eight of the eleven theme areas, average in two and below average in one

- The focus over recent months is quality of care, team working and quality of appraisals. The team have developed detailed action plans which the HR business partners are moving forward with their departments.
- There has also been further work to update the "you said, we did" campaign so staff are aware of the changes that have been made as a result of their feedback.

Discussion:

- C Charles-Barks asked when this year's survey is going to be released. L Lane reported that it would be in September. It is hoped the Trust can take the opportunity to integrate this into the "best place to work" conversations.
- M Von Bertele suggested that it was important to note that conversation is not a single point in time and it is important to give this message that comments are welcome and to feedback on their concerns at any time.

TB1 02/07/6 **CLOSING BUSINESS**

TB1 02/07/6.1 **Agreement of Principle Actions and Items for Escalation**

N Marsden noted the following highlights from the meeting:

- The organisation is at a point where the focus is on restarting services and the challenges involved. N Marsden suggested that this focus will continue at the Board over the next few months.
- The Trust is very conscious of the effects of COVID-19 on staff. The Trust is doing the utmost to provide support but there are new initiatives, for example, the military's idea of decompression and there needs to be a collective thought process on how best this can be achieved.
- Planning for future workforce is going to be a challenge but the context of the summit needs to be correct. Recognise that challenges have changed.

TB1 02/07/6.2 **Any Other Business**

No other business

TB1 02/07/6.3 **Public Questions**

- J Mangan referred to complaints and was reassured to see how the work has improved and noted that his neighbour had a good experience having recently suffered a stroke.
- J Mangan referred to flu immunisation and asked what steps the Board is taking to ensure the safety of vulnerable patients treated by a member of staff who has not been immunised. LL noted that the Trust's flu jab target is 90% but we are not able to enforce the vaccination upon staff. The Trust has started to develop a new communications approach to the Flu campaign and it is hoped that a majority of staff will have had their vaccine by the end of December.

- J Mangan asked if those who do not want to be immunised will be redeployed. C Charles-Barks noted this needed to be taken away for a separate risk based discussion and this will come back to CGC and People and Culture Committee.

TB1 02/07/ Date of Next Meeting

Thursday 6th August 2020, Board Room, Salisbury NHS Foundation Trust

TB1 02/07/ RESOLUTION

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

List of action items Trust Board Public 3 September 2020

Agenda item		Assigned to	Deadline	Status
1.6 Matters Arising and Action Log				
207.	TB1 02/07/1.6, • TB1 4/6/1.7 - SFT COVID-19 Recovery Session	Charles-Barks, Cara	03/09/2020	Completed
	Explanation action item C Charles-Barks noted that there were further updates regarding BSW (B&NES, Swindon and Wiltshire) and the Integrated Care System work and noted she would circulate papers from the meeting the following week.			
2.7 Integrated Performacne Report - M2				
208.	TB1 02/07/2.7 IPR / COVID data	Hyett, Andy	03/09/2020	Pending
	Explanation action item M Von Bertele asked if the Trust could quantify the number of patients who should have attended but did not. A Hyett explained that the comparison against those who would have come in is difficult but noted that he would look into the data.			
209.	TB1 02/07/2.7 - Integrated Performance Report	Provins, Esther	03/09/2020	Completed
	Explanation action item P Kemp referred to the SPC charts on p5 and noted that there are still issues with the data. EP noted that she would look into this. ***Update: This has now been resolved***			
210.	TB1 02/07/2.7 Integrated Performance Report/ BAME	Lane, Lynn	03/09/2020	Pending
	Explanation action item R Aggarwal referred to the national picture and asked if the Trust knows of the proportion of BAME staff allocated to the COVID effort. L Lane noted that she can share those figures outside of the meeting.			
3.1 Accountability Framework				
211.	TB1 02/07/3.1 Accountability Framework	Hyett, Andy	03/09/2020	Pending

	Explanation action item P Miller asked if the revised report had embraced the revised Transformation Programme. A Hyett noted that this has not been fully reflected in the report and those new metrics will need to be added in			
212.	TB1 02/07/3.1 Accountability Framework	Hyett, Andy	03/09/2020	Pending
	Explanation action item C Charles- Barks referred to the Accountability Framework and noted the interchangeable use of directorate and divisions. A Hyett to check this and amend.			
214.	TB1 02/07/3.2 Accountability Framework	Hyett, Andy McNeight, Fiona	03/09/2020	Pending
	Explanation action item Charles-Barks queried how the framework is tested to ensure it is working. F McNeight noted that there is a follow up piece of work with A Hyett on the executive performance reviews. There is a culture of continuous learning and sense checking.			
3.2 Integrated Governance Framework including Committee Terrms of Reference				
213.	TB1 02/07/3.2 Integrated Governance Framework	McNeight, Fiona	06/08/2020	Completed
	Explanation action item 1) M von Bertele referred to the organogram and noted that it was not clear where the information flows up to. This will be picked up outside the meeting. 2) E Provins noted that some of the duties listed under the executive team were historic and needed amending. E Provins noted that there is a lack of evidence of Quality Improvement. It was agreed to include a paragraph on QI.			

Register of Attendance – Public Board 2020/21

	2 April	21 May	4 June	2 July	3 September	5 November	January 2021	March 2021	attendance rate
Nick Marsden	✓	✓	✓	✓					4/4
Tania Baker	✓	✓	✓	✓					4/4
Michael von Bertele	✓	✓	✓	✓					4/4
Paul Kemp	✓	✓	✓	✓					4/4
Paul Miller	✓	✓	✓	✓					4/4
Cara Charles-Barks	✓	✓	✓	✓					4/4
Stacey Hunter									
Christine Blanshard	✓	✓	✓	✓					4/4
Lisa Thomas	✓	✓	✓	✓					4/4
Andy Hyett	✓	✓	✓	✓					4/4
Lorna Wilkinson	X	X	✓						1/3
Judy Dyos				✓					1/1
Lynn Lane	✓	✓	✓	✓					4/4
Eiri Jones	✓	✓	✓	✓					4/4
Rakhee Aggarwal	✓	✓	✓	✓					4/4
David Buckle	✓	✓	✓	✓					4/4

Governor Observer									
John Mangan	✓	✓	✓	✓					4/4
Lucinda Herklotts									

Attended - ✓

Apologies – X

Report to:	Trust Board (Public)	Agenda item:	1.9
Date of Meeting:	3 September 2020		

Report Title:	Chief Executive's Report			
Status:	Information	Discussion	Assurance	Approval
	✓			
Prepared by:	Gavin Thomas, Executive Services Manager			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive			
Appendices (list if applicable):	None			

Recommendation:
The Board is asked to note the report

Executive Summary:
This report provides an update for the Trust Board on some of the key issues and developments within this reporting period and covers: • **Introduction** • **Performance –** update on current performance • **Finance –** update on our financial recovery plan • **Workforce –** update on workforce situation • **COVID-19 response and winter planning** • **Maternity Review** • **Health, Education and Technology (HEAT) Project Salisbury update** • **Annual General Meeting** • **Best Place to Work**

Introduction

This is my first week at the Trust and I'm excited to have now joined the team. It is a real honour to be part of a team that is focussed on delivering compassionate and high quality care. I know that Cara Charles-Barks made an enormous difference over the last three years and saw the Trust through some difficult and unique times. I'm looking forward to building on what she achieved with staff at the Trust.

I am now starting an induction programme, which means I will be getting to learn more about the hospital and most importantly getting to know staff.

Performance

The Trust has had no new COVID-19 positive patients in this hospital since 2 July and cases in the South West remain low. The restart and recovery of services continues to be the Trust's main focus. Activity plans are being stepped up following further Phase 3 guidance issued on 31st July around expectations of accelerating the return of near normal levels of non COVID-19 activity.

Referral levels still remain a concern and are lower than pre COVID-19 levels. However, encouragingly attendances to our Emergency Department have returned to pre COVID-19 levels.

The Trust is continuing to try to reassure patients and the public that it is safe to attend, through communication channels such as media, leaflets and personalised letters.

Finance

We were notified in July that Covid-19 Phase 1 financial arrangements have now been extended to the end of September. In order to break even the Trust has lodged a claim for a £0.4m retrospective top up against an overall modelled cost base of £82m year to date, this puts us at the lower end of the scale for additional funding requirements when compared with our South West peers.

Guidance has now been issued setting out the NHS priorities for the remainder of 2020/21 and we are working with our system partners to accelerate our return to near-normal levels of non-Covid health services. July saw significant increases in the level of planned workload operating under revised operating procedures, meanwhile footfall through A&E and emergency admissions have both returned 2019/20 levels.

Workforce

Although there have been no events during July, we have continued to recruit now in slowly increasing numbers, by conducting interviews by Skype or Microsoft Teams. We have an HCA recruitment event planned for August which will take place using social distancing and other precautionary measures.

Induction is still continuing also with reduced numbers, only 26 new staff this month, and in compliance with social distancing guidelines. We will need to plan for a return to normal levels of recruiting as we move out of lockdown, as the number of vacancies has correspondingly increased.

In July, the Trust's overall sickness absence rose marginally to 3.09%, from June's 2.95%, with the top reason and increase in anxiety/stress, which managers have reported being related to the pandemic.

Mandatory training has again increased slightly at 90.92%, still above the 85% target, and non-medical appraisals have reduced slightly over June to 82.41%. Medical appraisal compliance will be reset following the national agreement for suspension of appraisals.

We are conscious of the need to continue to support all our staff and are seeking new ways of improving staff health and wellbeing through any available initiatives

COVID-19 response and winter planning

In light of COVID-19, it is more important than ever that effective plans are in place for this year's

flu season to protect those at risk, prevent ill-health and minimise further impact on the hospital and its wider community. Flu vaccination is one of the most effective interventions we have to reduce pressure on the health and social care system this winter. We will be highlighting the importance of staff vaccination through our annual flu campaign which starts this month. Our ambition is that 100% of healthcare workers with direct patient contact are vaccinated.

Maternity Review

In line with the Trust's commitment to openness and transparency Salisbury Foundation Trust has commissioned an external review of our maternity service that will focus on the culture within the department and any impact this may have on team working and service delivery.

The Trust has openly shared with the public and our regulators that we are undertaking this review and will communicate any key findings or service improvements that ensue.

Health, Education and Technology (HEAT) Project Salisbury update

On 18th August, the local community were invited to a webinar event to hear an update on the Health, Education and Technology (HEAT) Project Salisbury.

Launched in 2019, the HEAT Project Salisbury is exploring how to create a sensitive, phased and inclusive development around the Salisbury District Hospital site. The hospital-led project will integrate with the existing main hospital, offering a range of new facilities for health and wellbeing, education, skills, training, research and development.

Around sixty people attended the online event, where they could discuss the project's progress, hear about the next steps and take part in a Q&A session.

Annual General Meeting

The Trust's Annual General Meeting, on 28 September, will take a slightly different format this year. As a result of COVID-19 and the importance of adhering to social-distancing, we will no longer be holding a face-to-face event. Instead we will be sharing updates on our performance in 2019/20 by video and inviting our foundation trust members and local community to a virtual Q&A session on 28th September at 4.30pm, where they can ask the Board questions. This will provide the Board with a valuable opportunity to hear comments and I'm personally looking forward to introducing myself to and hearing from our local community.

Best Place to Work

The Best Place to Work programme, a cross organisational project to listen to our workforce in order to understand what it feels like to work for the Trust has now completed its 'discovery phase'.

The programme has engaged with hundreds of staff, through surveys, listening focus groups, virtual coffee breaks, stands in Springs and trolley dashes in departments and wards.

Further highlights from this Phase will be provided in today's meeting.

Stacey Hunter
Chief Executive

CLASSIFICATION: UNRESTRICTED

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	3 September 2020		

Report from: (Committee Name)	**Trust Management Committee (TMC)**		**Committee Meeting Date:**	19 August 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Gavin Thomas, Executive Services Manager			
Board Sponsor (presenting):	Andy Hyett, Chief Operating Officer			

Recommendation
The Board is asked to note the report outlining items raised at the Trust Management Committee meeting held on 19 August 2020.

Key Items for Escalation

The Trust Management committee took place on 19th August 2020; there were no items for formal escalation. The key points from the meeting are highlighted below.

Key Points:-

The committee received three business cases to consider at this month's meeting, namely Extension of LWBC service, the addition of a simulation technician and the implementation of direct award model and contract award to PlusUs.

Following review of all there cases, the committee approved all three business cases with the simulation technician business case subject to further discussions being held at charitable funds committee regarding funding.

It was noted by the committee that sickness for July was 3.09%.

The committee noted that a recent virtual peer review visit of the Paediatric Diabetes service had recently taken place and a subsequent letter outlining two concerns was received. The committee was assured that work is ongoing to address the concerns raised.

The committee further heard that staff within the trust have now set up an eco-council in order to look at ways of making the organisation more environmentally friendly and staff across the trust are being encouraged to join the council.

End of report

Salisbury NHS Foundation Trust

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

Committee Name:	Finance and Performance		**Committee Meeting Date:**	25th August 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Paul Miller, Non Executive Director			
Board Sponsor (presenting):	Paul Miller, Non Executive Director			

Recommendation
To note key aspects of the Finance and Performance Committee meeting of the 25th August 2020

Items for Escalation to Board
Emergency Department Modular Build Procurement – On the 6th August 2020 the Trust was awarded £2m to deliver improved waiting space, particularly for minor injuries and this additional space is to be operationally available by January 2021. Consequentially the Trust needs to award a contract ASAP to enable this timescale to be achieved. The procurement route recommended to the Committee was to commence a design and build tender, chosen through an existing procurement framework, with the outcome of that procurement process going straight to the Trust Board on the 3rd September 2020 for a decision. The Committee reviewed this recommendation in detail and ultimately supported the procurement approach, however noting that issues and concerns raised at the Committee would need to be addressed in the tender outcome paper, which goes to the Trust Board meeting on the 3rd September 2020. **e-PMA (Electronic Prescribing) Business Case –** Following discussions on a previous version of this business case, which went to the Committee in July 2020, the Committee received an updated business case for a new electronic prescribing system, the costs are approximately £2.2m over 5 years, with hopefully about £1.7m coming from a national IT funding bid to be submitted in mid-September 2020, with planned implementation early in 2021. This updated version of the business case aimed to address two key concerns from the July meeting (a) why was the Lorenzo e-PMA system recommended, as opposed to a wider procurement to obtain the best possible e-PMA system and (b) how would the system

implementation and associated change management be supported?

With regard to the second question the Committee were universally content that the updated business case had appropriately strengthened the implementation and change management arrangements for this very important clinical system. However the Committee were still not universally in support of the recommended Lorenzo e-PMA option. There was a majority view that whilst Lorenzo may not be the best e-PMA solution, it was "fit for purpose" and would seamlessly work as an existing module of the Trust existing Lorenzo Clinical Information System (CIS). Whilst the minority counter view was the Trust should still aim to obtain the best possible e-PMA solution and ensure an effective integration solution was found between that new e-PMA and the Trusts existing Lorenzo (CIS).

The outcome of the Committee was (a) an e-PMA system was a priority, therefore a clear decision one way or another was urgently required and (b) the updated business case (including the Lorenzo e-PMA solution) would be recommended to the Board meeting on the 3rd September 2020, however the Board would be free to make its own decision regarding the exact e-PMA solution approach to formally support.

Covid-19 – Recovery Planning Update – A series of papers where received and reviewed relating to the national expectations on covid-19 recovery, the associated operational constraints and the future NHS funding arrangements for the remainder of 2020/21. The key point to highlight is the national expectation that the Trust and our wider NHS system returns to near normal levels of pre-covid 19 activity as soon as possible i.e. 90% of the previous year's elective, outpatients and day case activity by October 2020.

The conclusions from the Committees discussions were (a) the planned increase in activity should not be viewed as simply a financial issue, as any "unearned income" was likely to remain in the NHS system i.e. CCG or Region. Instead the key imperative to increase clinical activity as soon as possible was to ensure patients on waiting lists got treated as soon as possible, thereby improving outcome and reducing clinical risk (b) there are likely to be real operational challenges and constraints, which may mean we will not meet the national aspirations and (c) what was missing from the Committees papers in August was a detailed operational analysis of how the Trust will increase our activity, with clear trajectories and information (at a sub specialty level etc) demonstrating how we are actually performing against these targets. This operational analysis and information is required as a matter of urgency, at both future F&P Committee meetings and future Clinical Governance Committee meetings (given the clinical risks associated with not treating patients in a timely manner).

Integrated performance and finance reports as at 30th July 2020 – both reports were received and noted the key issues were (a) elective activity and diagnostic performance were still concerns, however actions are still in hand to improve performance and address operational constraints (see above comments on covid-19 recovery) and (b) the Trust continues to financially break-even, as at month four as a consequence of the current interim NHS finance regime, which provides a nationally agreed financial "top up" to cover covid-19 excess costs and a locally agreed "true up" to bring the trust back to exact break-even.

Finally the Committee were informed that the Trust will be required to provide a 2020/21

year end financial outturn forecast in mid-September 2020 and Committee agreed to recommend to the Trust Board, at its meeting on the 3rd September 2020, that authority be delegated to the Director of Finance to submit this 2020/21 financial forecast (which is likely to be break-even).

Estates Critical Infrastructure Report – The Committee received and updated action plan which provided information on how the Trust is addressing the 13 potential health and safety breaches identified in the "Critical Plant Survey" published July 2020.

The summary of current performance as at the August F&P Committee meeting is;

4 x Red – HSE compliance or statutory breach risks remain, but actions and dates have been identified to address these risks

3 x Amber – after further clarification there is not likely to be a breach, but further work is required and again actions and dates have been identified to address these risks

6 x Green – no risk of breach remains or further work required, as the risks have been addressed

Finally there was discussion of remaining underlying risks e.g. professional estates staffing and key vacancies and it was agreed that whilst detail on these estates workforce issues was being overseen by the People and Culture Committee, future Trust Board meetings would provide an opportunity for wider triangulation and debate.

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Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	3rd September 2020		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	28th July 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Miss Eiri Jones			
Board Sponsor (presenting):	Miss Eiri Jones			

Recommendation

Trust Board members are asked to note the items escalated from the Clinical Governance Committee (CGC) meeting held on the 28th July 2020. The report provides assurance and identifies areas where further assurance was sought and is required. Due to the proximity of the meeting to the Trust Board, a verbal presentation was provided at the last Board meeting held on 1st August 2020.

Key Items for Escalation

- This meeting had another very full agenda with discussion given to key quality areas and also to the impact of Covid-19.
- It was positive to note that a new Governor has been nominated for the CGC who dialled in to the meeting. The Chair had previously made email contact with the new Governor to welcome her to the committee.
- The key issue to escalate to the Board is the limited assurance in relation to maternity services. At the previous meeting, concern had been raised by Non-Executives in relation to the length of time some incidents remained open. As this remained an issue, the Executives were asked for further assurance. The CGC was provided with information that in the duty of openness and candour an external review has been commissioned to explore the culture and performance of the service. The Executives confirmed that national indicators, audit results and user feedback continue to show good outcomes. The review will be reported through a future CGC.
- With reference to Covid-19 and the Safety and Experience elements of the Integrated Performance Report, a key area for focus remains the restarting of elective work. Assurance was requested for the next meeting in relation to any harms, with reviews requested for known delayed patients. 2 new cases of C.Difficile were reported and are under investigation. These were unrelated to each other. A positive note was the feedback in relation to the telephone bereavement support being provided to those who had lost someone to Covid-19.
- A 'by exception' verbal update was provided in relation to the Transformation programme. A full written report will be provided quarterly. Where relevant the transformation report will align with other reports such as the cancer reviews.

- A series of annual reports were received. These provided good assurance.
    - Clinical Audit Report and NICE Report 19/20. Good assurance was provided. Further assurance was sought in relation to where audit results were below the expected performance. The Executives provided assurance that these are reviewed through local governance arrangements and any re-audits reported through CMB to Executive Performance Review.
    - New Health Technologies Report. There was assurance that robust processes were in place before any new technology was implemented. During the Covid-19 period, an interim Executive approval process was in place for any urgently required decision. This would then proceed through to the next formal approval meeting.
    - Research Annual Report. Whilst the Trust does well in this area, this last year has been more challenging due to some interventional studies closing and the inability to find replacement studies as many have been suspended due to Covid-19 impact. The Trust is seen as a good performer in the region and is noted to be well engaged.
    - Director of Infection Prevention and Control (DIPC) Report. The report outlined good compliance with the Health and Social Care Act requirements and confirmed that the Trust is a low risk organisation, risks and issues are known and have good controls in place. A further paper in the meeting presented the IP&C BAF which identified areas for further consideration, namely antibiotic stewardship and estates ventilation. Both of these topics have previously been considered at the Board and CGC were advised that the estates issues are being considered through the People and Culture Committee.
    - Adult Safeguarding Report. This was deferred till September.
    - Dementia Report. This was deferred till September due to pressure on the service on the day of the meeting.
    - CQC National Benchmark Inpatient Survey. The Trust sits in the middle range of Trusts in England. The CGC requested assurance that a focus on the areas for improvement would take place in the coming year.
- Minutes from CMB and CRG were received. As previously noted, further assurance is being sought in relation to the timely management of serious incidents. It was also requested that escalation reports are provided to the CGC from these meetings. These will begin in September.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	03 September 2020		

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

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

Executive Summary:
Recovery from Covid-19 continues to be the main focus operationally for the Trust. Further Phase 3 guidance was issued on 31st July around expectations of accelerating the return of near normal levels of non-covid activity. July saw a shift away from the direct impact of Covid-19 as minimal activity was related to the management of the pandemic and related hospital admissions. The demand for unplanned care continues to increase with non-elective admissions at average levels in July for the preceding 12 months. This all contributes to a sharp increase in bed occupancy and increased patients staying 7 days+ across the Trust which will require continued focus as part of the patient flow corporate objective. Emergency Access performance remained above average levels over the past 12 months but fell marginally to 93.1% of patients being seen within 4 hours. Attendances have largely returned to pre-Covid levels. With activity recovering, stroke performance in some key metrics has fallen – but plans to restart supported discharge services and returning the Stroke Unit to Level 2 in the autumn are expected to address the challenge of increasing activity. Elective care continues to be affected, with the return of elective services heavily affected by the requirements of social distancing and isolation, and the reduced capacity in services in order to maintain this. Urgent and cancer services are being prioritised. The RTT performance dropped further to 57.3%, although the total waiting list size fell to 13,949 in July due to reduced referrals. As part of Phase 3 the Trust is planning for referrals to return

to previous levels through Q3, but the Trust will be challenged to achieve the expected productivity requirements set nationally.

Improvement continues against the Diagnostics standard, with performance at 73.9%. Patients choosing to wait for appointments and procedures continues to be a theme, and referral levels remain a concern. Increased referrals have meant Cancer 2 week performance fell, but the continued recovery of elective services will boost treatment numbers in Q3.

Category 2 pressure ulcers increased again to 27 (19 in June). They remain at a higher level than 2019 and a programme of education and observational visits focussed on identified hotspot areas will continue through August and September.

Sickness levels across the Trust increased marginally in July to just over the targeted 3% threshold – with a third of absences related to anxiety/stress/depression. The continued focus on 'Best Place to Work' and our well being offer are critical to addressing these absences.

The Trust continues to claim contract payments through the block and top up arrangements put in place through the Covid-19 response. We are, however, now moving towards a revised payment regime as outlined in the Phase 3 guidance published on 31 July. Phase 1 contractual arrangements have been extended to 30th September 2020, and guidance has been received that block contracts will be calculated through a similar methodology at system level.

As part of ongoing development of the integrated performance report, we are reviewing the metrics presented to ensure that they reflect the priorities set in Phase 3 of the NHS response to Covid-19 and the Trust's revised corporate objectives for 2020-21.

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

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Integrated Performance Report

September 2020

(data for July 2020)

An outstanding experience for every patient

Summary

Salisbury NHS Foundation Trust

Recovery from Covid-19 continues to be the main focus operationally for the Trust. Further Phase 3 guidance was issued on 31st July around expectations of accelerating the return of near normal levels of non-covid activity. July saw a shift away from the direct impact of Covid-19 as minimal activity was related to the management of the pandemic and related hospital admissions. The demand for unplanned care continues to increase with non-elective admissions at average levels in July for the preceding 12 months. This all contributes to a sharp increase in bed occupancy and increased patients staying 7 days+ across the Trust which will require continued focus as part of the patient flow corporate objective.

Emergency Access performance remained above average levels over the past 12 months but fell marginally to 93.1% of patients being seen within 4 hours. Attendances have largely returned to pre-Covid levels. With activity recovering, stroke performance in some key metrics has fallen – but plans to restart supported discharge services and returning the Stroke Unit to Level 2 in the autumn are expected to address the challenge of increasing activity.

Elective care continues to be affected, with the return of elective services heavily affected by the requirements of social distancing and isolation, and the reduced capacity in services in order to maintain this. Urgent and cancer services are being prioritised. The RTT performance dropped further to 57.3%, although the total waiting list size fell to 13,949 in July due to reduced referrals. As part of Phase 3 the Trust is planning for referrals to return to previous levels through Q3, but the Trust will be challenged to achieve the expected productivity requirements set nationally.

Improvement continues against the Diagnostics standard, with performance at 73.9%. Patients choosing to wait for appointments and procedures continues to be a theme, and referral levels remain a concern. Increased referrals have meant Cancer 2 week performance fell, but the continued recovery of elective services will boost treatment numbers in Q3.

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As part of ongoing development of the integrated performance report, we are reviewing the metrics presented to ensure that they reflect the priorities set in Phase 3 of the NHS response to Covid-19 and the Trust’s revised corporate objectives for 2020-21.

Structure of Report

Performance against our Strategic and Enabling Objectives

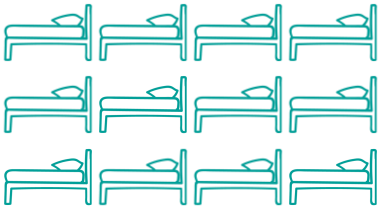
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Summary Performance
July 2020

NHS Salisbury NHS Foundation Trust

There were **2,773** Non-Elective Admissions to the Trust

We carried out **239** elective procedures & **1,475** day cases



73.9% ↑ of patients received a diagnostic test within **6 weeks**

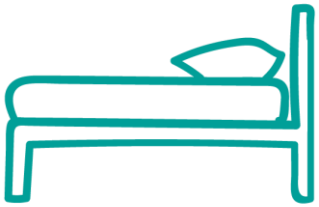
Emergency (4hr) Performance **93.1%** ↓
(Target trajectory: 95%)

We delivered **16,691** outpatient attendances; **40%** through video or telephone appointments

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

Our income was **£22,103k** (£88k over plan)

44 patients stayed in hospital for longer than 21 days



We met **5 out of 7** Cancer treatment standards

RTT 18 Week Performance:
57.3% ↓
Total Waiting List: **13,949** ↓

20.5% ↑ of discharges were completed before 12:00

Our overall vacancy rate was **1.19%** ↓

Reading a Statistical Process Control (SPC) Chart

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

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

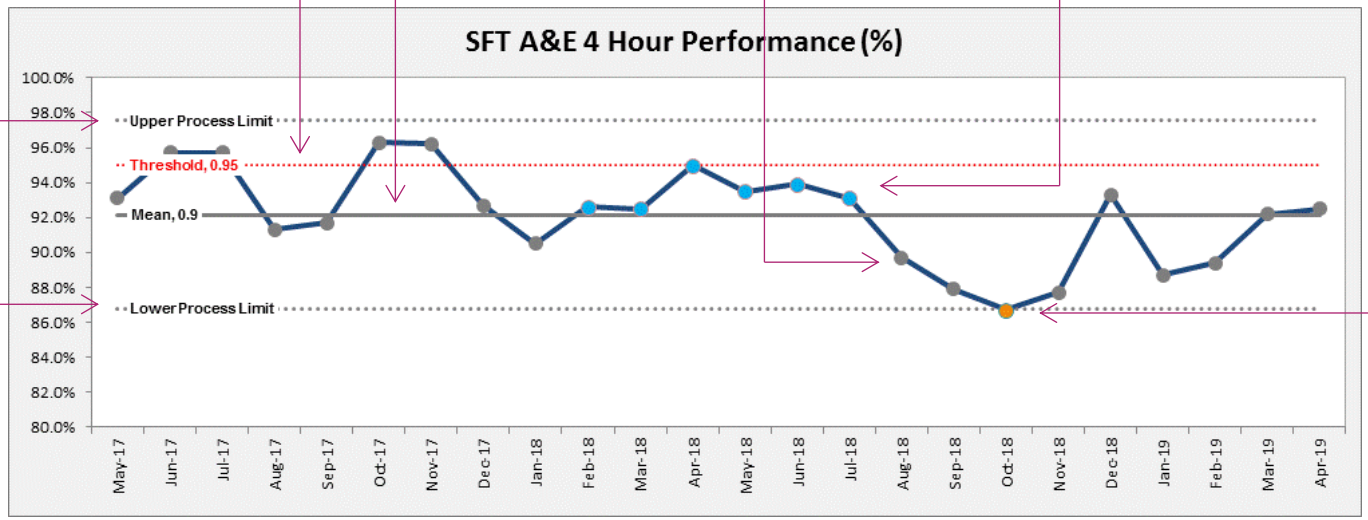
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

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

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



Statistical Process Control Chart Key:

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

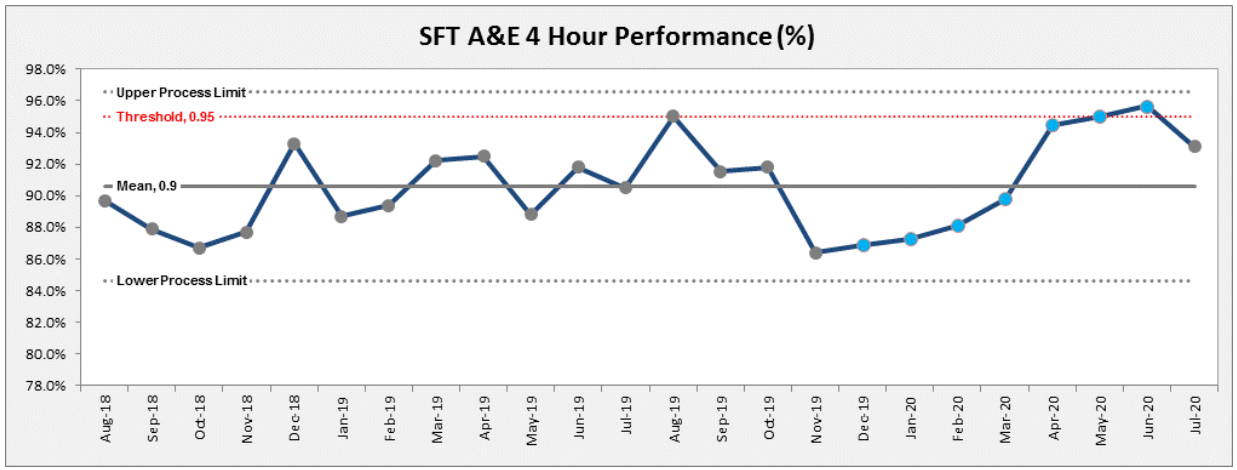
Salisbury NHS Foundation Trust

Part 1: Operational Performance

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

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

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	93.1%
Attendances:	5304
12 Hour Breaches:	0
ED Conversion Rate:	30.5%

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

M4 saw further closing of the gap between pre and post Covid-19 Type 1 ED activity with only 11% difference in attendances.

Paediatrics continue to be supporting outside of ED however the majority of activity is routed through ED.

RAZ activity has reduced to very low levels but unable to decommission RAZ until estates work completed to increase number of side rooms. Opening RAZ means that staffing is spread thinly across areas and performance is at risk.

Challenges with flow at times during July - frequent challenges coping with attendance surges in ED which is evidenced by an increase in time to treatment towards the end of July.

Increased numbers of attendance have put continued pressure on waiting room spaces and minors struggling to cope with shared facilities in Fracture clinic.

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

Agreement from Execs for work to progress in ED to create increased number of side rooms in ED. Awaiting start date for works. Once works complete RAZ can be decommissioned. Initial timescale for delivery was end of August 2020. This is likely to be mid September now. Once works completed paediatrics can return to be treated in ED.

Work on Single Assessment Document to try and target issues with flow to downstream wards – Simon Hunter leading. Aim to launch across Medicine initially and then progress to include Surgery.

Report on waiting room capacity to be submitted to space allocation committee by mid August and decisions on minors footprint to be confirmed by end of August.

Risks to delivery and mitigations

Risk of second wave of Covid-19 activity may halt plans to decommission RAZ – RAZ can continue to function as is and paediatric patients will need to remain with the paediatric service.

Junior doctor rotation and loss of 2 GPVTS posts at the last minute. Also loss of middle grade due to Covid-19 risk assessment and loss of Locum ED consultant - risk added to risk register due to number of staffing gaps. Active recruitment underway, use of agency staff to fill gaps. Risk to ED performance during this time. Workforce business case underway.

Service Manager has given notice – Review of role and reviewing opportunities relating to recruitment

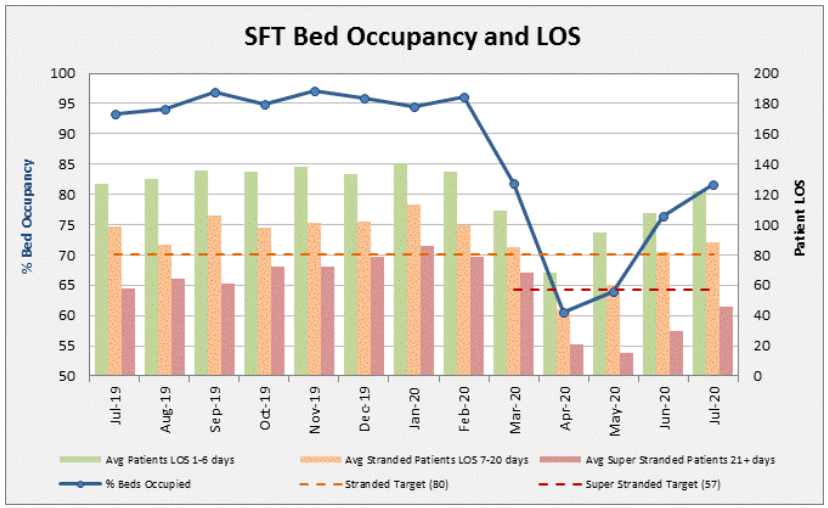
Space and social distancing in ED waiting room for majors and minors is a daily struggle – await decisions from space allocation and recovery group around potential solutions. News of government funding opening up options and planning beginning on solutions.

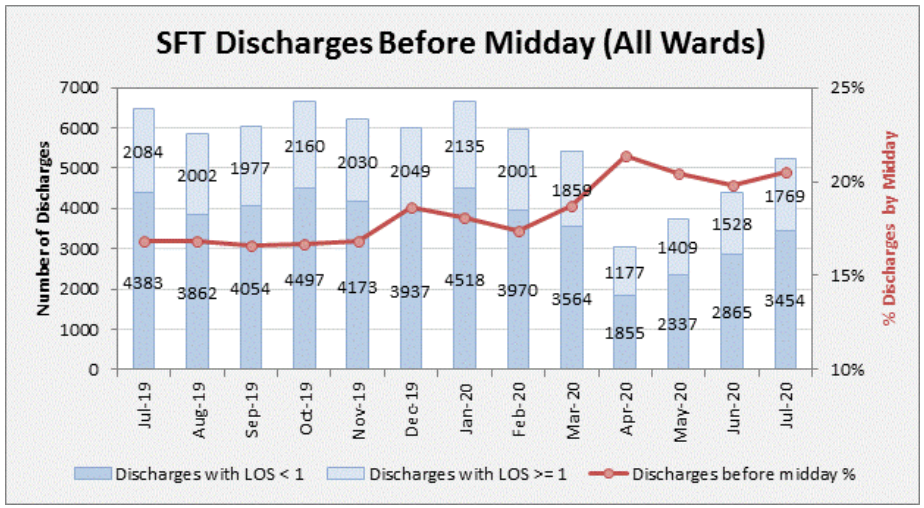
Statistical Process Control Chart Key:

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

Patient Flow and Discharge

Are We Effective?





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

Stranded patient data shows an increase from June in the numbers of inpatients with a length of stay beyond 21 days. This number still sits below the target set by NHSE/i but above that set locally for the Covid-19 period. It has been discussed with NHSI/E recently whether a revised target is appropriate given the new capacity. The data also reflects the increases in occupancy seen in the Trust since the intense exercise to release capacity in March/April and the declining Covid-19 emergency

Systems in Wiltshire, Dorset and Hampshire are developing recovery plans including new models and processes around discharge. This data reflects the complexities of moving to quite radical changes in community in that within this data the number of medically ready people is increasing.

Numbers of discharges before 12 are similar to pre Covid-19 statistics but represent a larger proportion of discharge numbers in the current occupancy. This drive and improvement needs to be built upon and the Trust must take the opportunity to do this work

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

Expert Panel to review all cases of inpatient stays of longer than 14 days has recommenced with support from the Medical Director who has offered both individual case and pathway development support

The Trust is involved in the system wide development of discharge pathways and referral processes that are planned to simplify and streamline the patient journey in Wiltshire. New discharge guidance will be issued by HM Government 1st September that will provide further direction regarding hospital discharge planning and reporting

There is internal work commencing around barriers to discharge before midday. Initial audits regarding recent discharges have been undertaken and results will be discussed by a project team the first week of September.

Work to develop criteria led discharge and NHSE/i are planning to support this work regionally in coming months

Risks to delivery and mitigations

Expert panel attendance can currently cover all wards every week. If occupancy continues to rise, this may return to a fortnightly review for each ward. This may affect the impact of the work done at ward level.

Contents of the guidance to be issued is being predicted, but it is unclear what the detail is and may affect current system planning. However local direction of travel is agreed and it is acknowledged that is will adapt as national requirements become evident

Work going forward to drive discharge before midday will be influenced by the results of the audits and currently not all issues are known. This work could become complex and therefore slower to achieve but there is considerable buy in from key areas of the Trust to improve performance in this area

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

National Key Performance Indicators

SFT RTT PTL Volume by CCG:

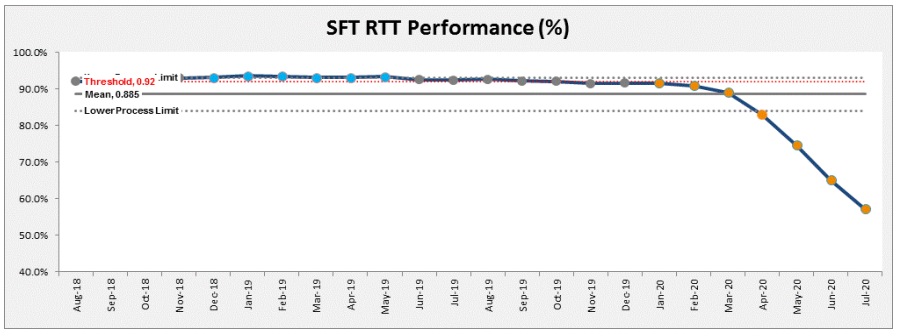
Total WL	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Dorset CCG (11J)	2,889	2,882	2,834	2,856	2,825	2,605	2,593	2,448	2,268	2,128	2,048	1,903
West Hampshire CCG (11A)	1,695	1,682	1,655	1,614	1,606	1,544	1,550	1,512	1,424	1,333	1,279	1,222
BSW (92G)	10,809	10,900	11,050	11,130	11,018	10,840	10,577	10,297	9,672	9,095	8,715	8,520
Other CCGs	2,800	2,822	2,729	2,718	2,747	2,643	2,722	2,667	2,594	2,499	2,401	2,304
Trust Total	**18,193**	**18,286**	**18,268**	**18,318**	**18,196**	**17,632**	**17,442**	**16,924**	**15,958**	**15,055**	**14,443**	**13,949**

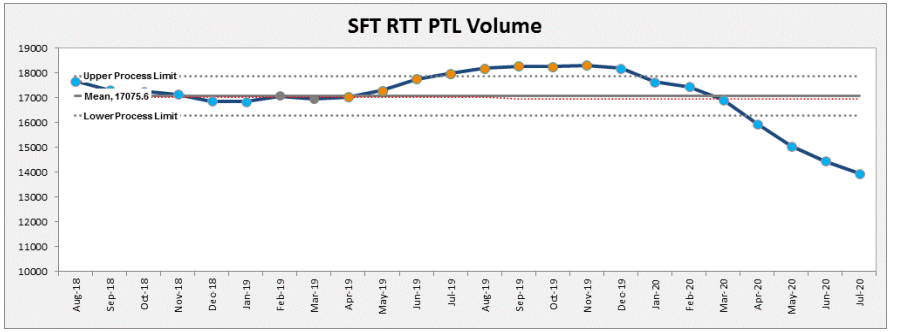
Data Quality Rating:

Performance Latest Month: 57.3%

PTL Volume: 13,949

52 Week Breaches: 106





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

Overall RTT performance fell further in July due to the continued impact of elective cancellations and restrictions during the height of Covid-19 and the limitations on recovery including social distancing, isolation requirements, impact of measures to ensure staff safety and reduced theatre list capacity. Poorest performance can be seen in those specialties that had significant capacity pressures prior to Covid-19, Dermatology, and also in those most significantly impacted by the above limitations and restraints, Oral Surgery, ENT and Ophthalmology.

This has been further impacted by the continuing slow increase of routine referral numbers which continue to be considerably below those in the pre Covid-19 period.

The total PTL size continues to be below the target of 16, 924 and was at the end of July -2975 under target at 13, 949 which was -494 from June's position. This is partly due to validation work, increased recovery activity, particularly day cases, and also the low referral rates.

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

Activity mapping has been undertaken to identify those specialties not yet back to pre- Covid-19 levels for daycases, electives and outpatients so that the limiting factors for this can be identified and work undertaken to resolve these. This supports the production of the Phase 3 Recovery trajectory based on current capacity and demand and aiming for the targets set out in the national letter.

For outpatient recovery all new demand held by each specialty and new patient wait times based on existing bookings are being reviewed monthly to monitor both backlog size and improvements in wait times to ensure these start to be seen. Follow up work has focused on converting patients to PIFU pathways; discharging patients back to the GP if the follow up would have no clinical value; assessing suitability for virtual appointment s and clinically prioritising for F2F appointments when appropriate.

Conversion to virtual appointments during the original COVID period was high. This is particularly appropriate for follow up. Increase in % of virtual appointments from around 4% pre-COVID to 58% in April, 53% in May, 46% in June and 40% in July and the approach remains to continue with as much elective outpatient activity as possible using virtual solutions, both video and telephone, recognising that there will be some specialties / conditions where this is not the best approach so we may see a fall in % from the height of the COVID period.

Urgent and cancer surgical activity continues to be undertaken and elective recovery theatre lists are now running in all theatres in the day surgery unit . Cases also continue to be transferred to Newhall and work is currently being undertaken to increase the usage of this capacity for T&O and cataract surgery.

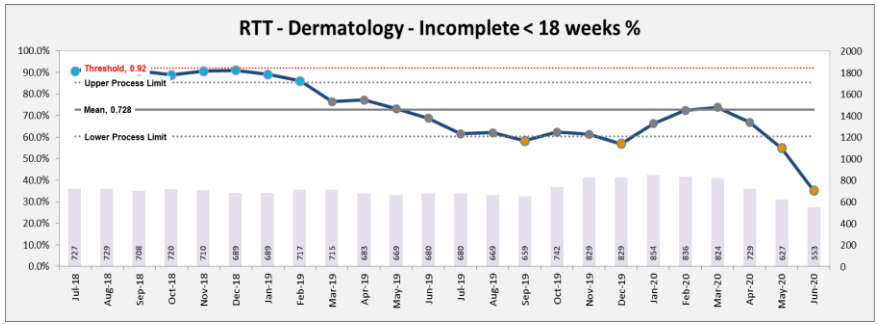
Risks to delivery and mitigations

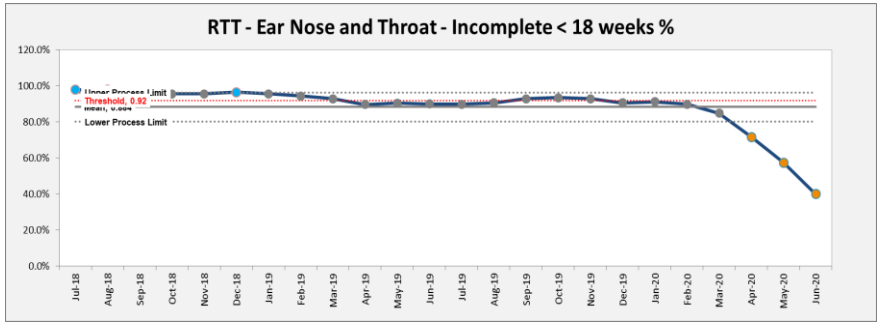
Continued risk of not achieving the performance standard in coming months de to the continued impact of the pandemic which has exacerbated the impact of previous capacity pressures..

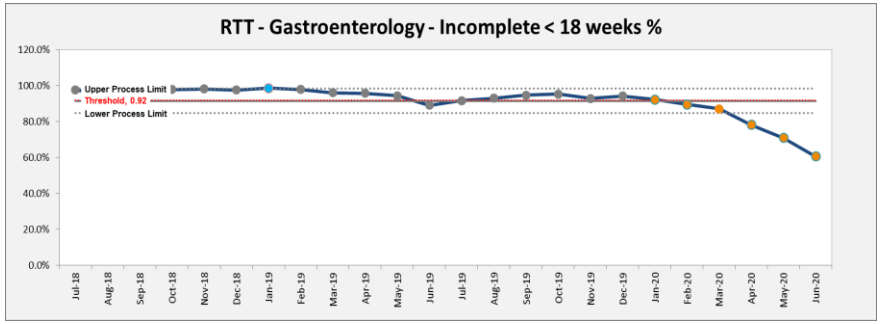
This is further affected by the continued low referral numbers, the impact of social distancing / IPC / PPE guidelines and the impact of patient choice as high volumes of patients are choosing to delay attendances and procedures at this time due to concerns about coming to the hospital at this time

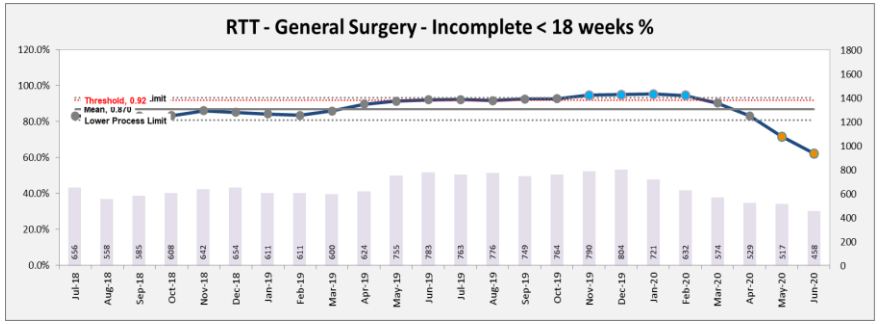
Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

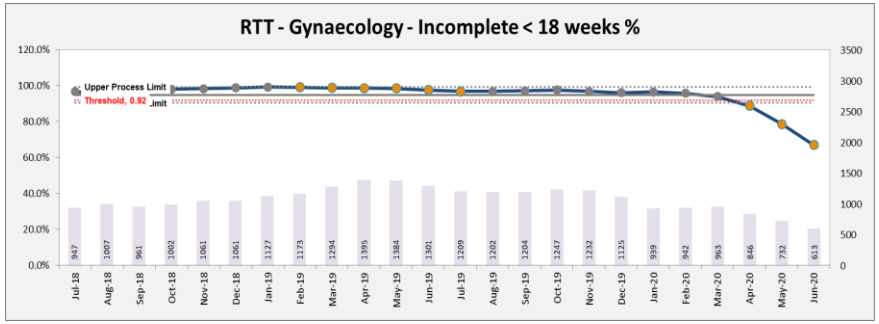
National Key Performance Indicators

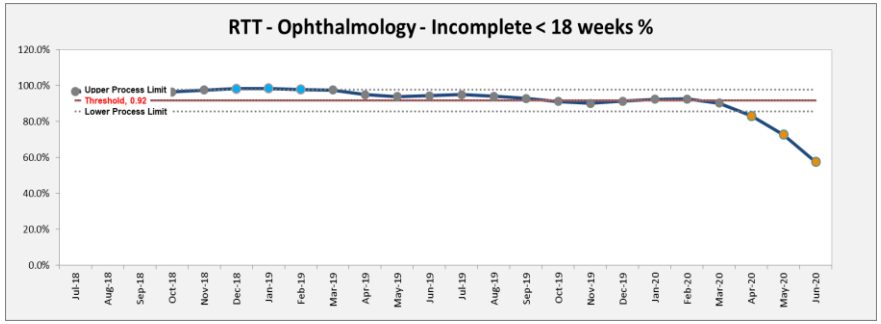






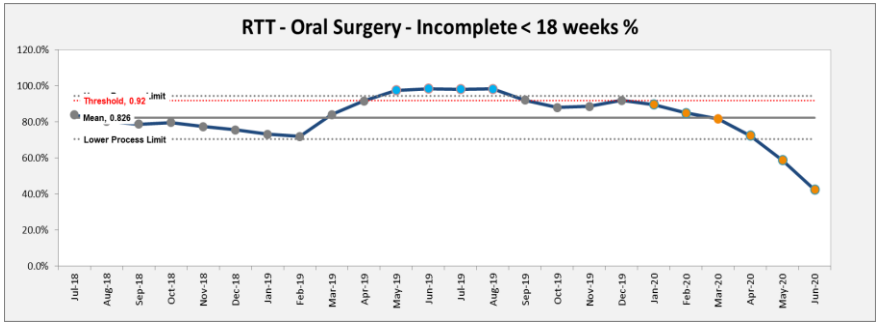


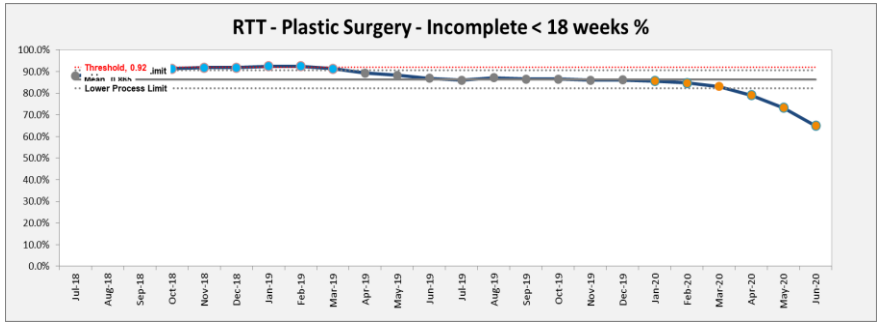


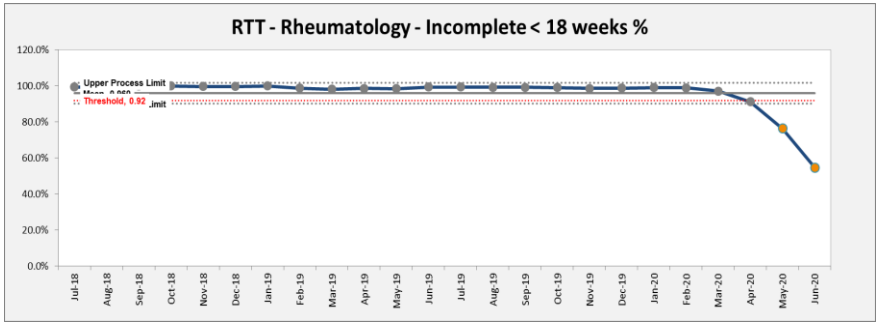


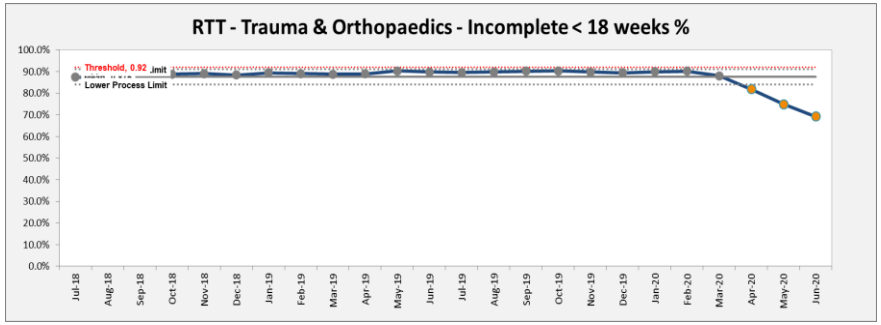
Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

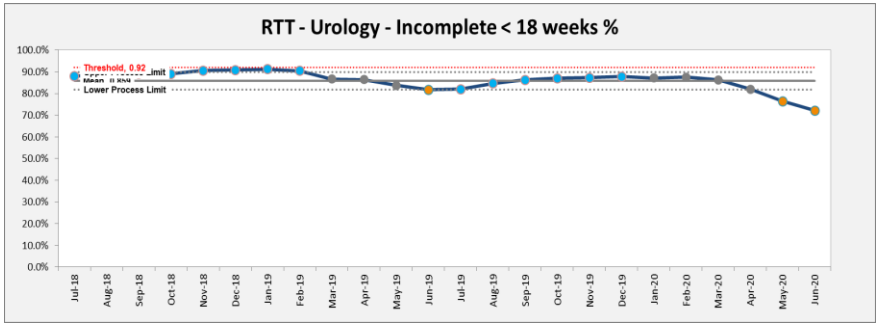
National Key Performance Indicators

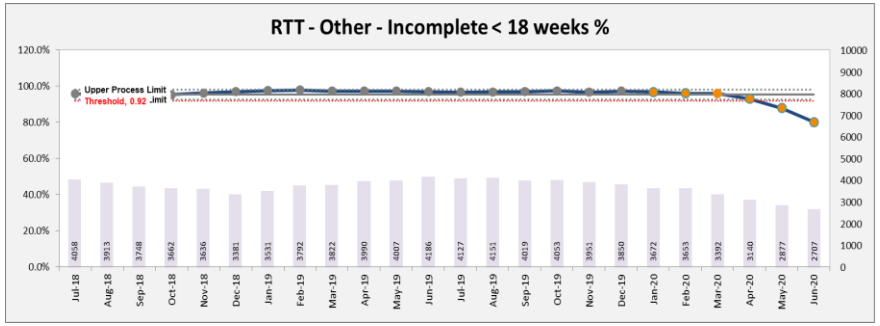






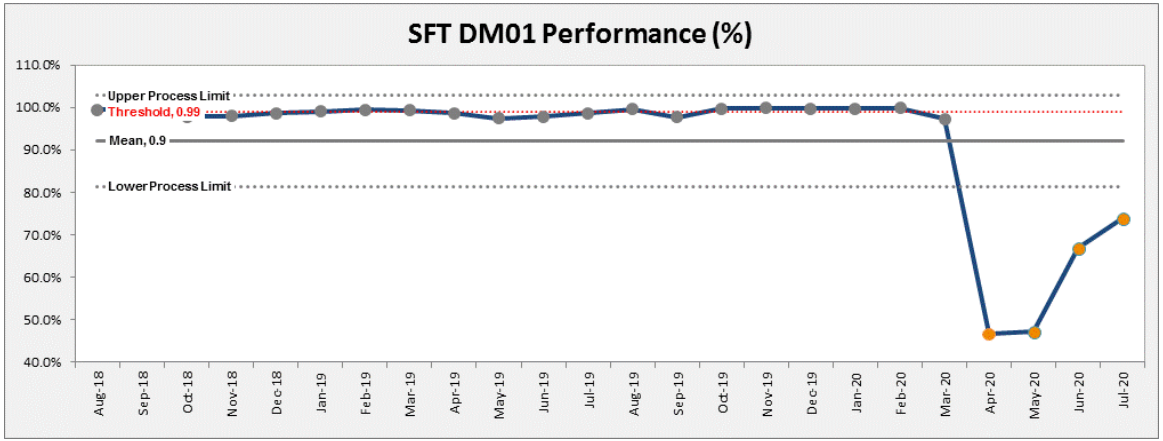






Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	73.9%
Waiting List Volume:	3,061
6 Week Breaches:	1,117
Diagnostics Performed:	6,112

Background, actions being taken and risks and mitigations
Performance standard in month has not been achieved as a direct impact of Covid-19. August projections confirm that the target is not achievable for M5, however there has been an improvement in the number of diagnostics performed (5179 in June) in M4 following the ongoing increase in capacity across multiple specialties and modalities. Specialties continue to feedback that some patients do not want to attend for their diagnostic test, until 'after Covid-19'. This is further impacting on the ability to improve performance against the Diagnostic standard as the majority of these patients have already breached 6weeks.

Endoscopy
9 confirmed in month breaches, all attributable to Covid-19

Radiology (Inc. DEXA)
413 confirmed in month breaches, all attributable to Covid-19

Radiology Reporting
Go live of the second provider for outsourcing remains on hold. Go/No Go decision to be made 1st week of September. Reduced activity has positively impacted on the number of outstanding scans for reporting so the risk of this service not being available at this time is mitigated against.

Audiology
1 confirmed in month breach

Cardiology
269 confirmed in month breaches, all attributable to Covid-19

Neurophysiology
107 in month breaches, all attributable to Covid-19

Cancer 2 Week Wait Performance Target 93%

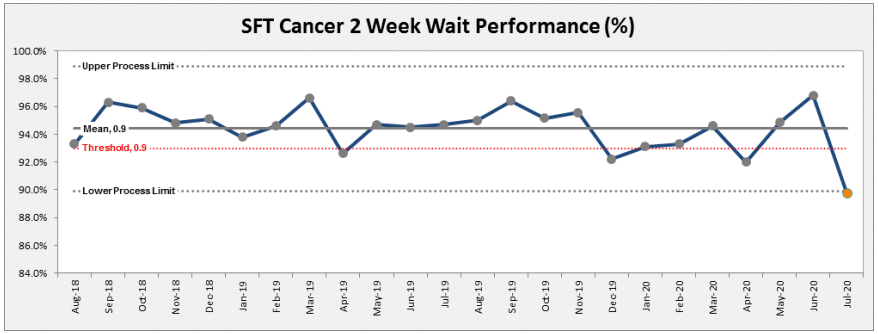
National Key Performance Indicators

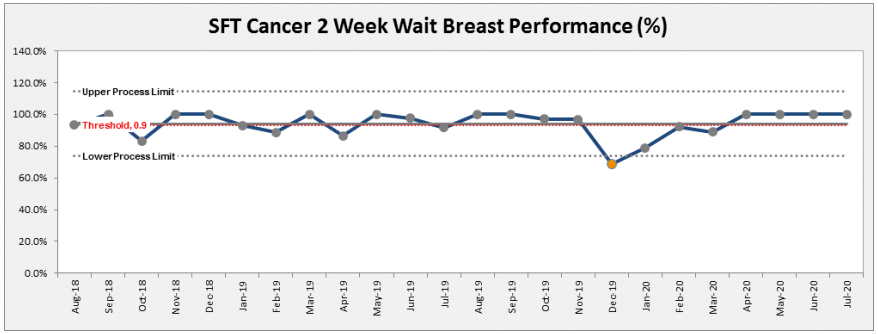
Performance Latest Month:

Two Week Wait Standard: 89.8%

Two Week Wait Breast Standard: 100%

Data Quality Rating:





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

Two week wait standard not achieved for M4. This is due to a number of reasons including the significant increase in referrals when compared to March – June 2020, a lack of face to face capacity in medical and surgical outpatients in line with social distancing rules, patient choice and diagnostic capacity impacting upon existing straight to test pathways.

Breast symptomatic two week wait performance achieved in M4.

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

Weekly cancer ops meetings re-instated to focus on 2ww appointments and clinic capacity.

Booking teams continue to prioritise cancer patients, though ongoing concerns related to patient choice and gear in attending hospital remain; this is likely to impact on service delivery for a significant period of time.

Weekly PTL meetings in place, which look to determine any upcoming breaches. This then enables cancer services to work with the relevant team to expedite where possible.

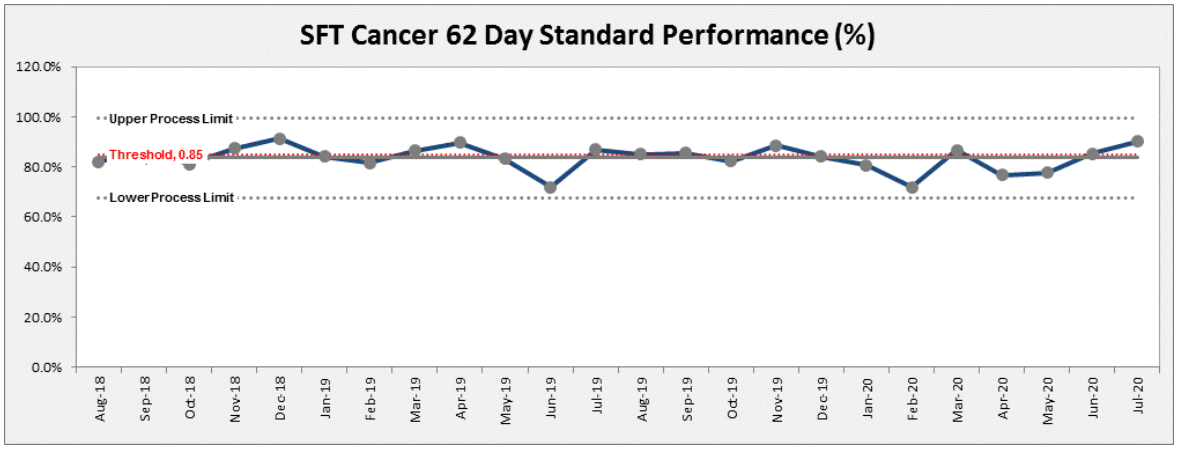
Risks to delivery and mitigations

Diagnostic capacity (linked to previous backlog) is likely to significantly affect our ability to achieve the 2ww standard going forward, predominantly for services with well established straight to test pathways. The alternative is to increase the number of patients seen in outpatients, however this is hindered in light of space restrictions and social distancing.

CWT guidance has temporarily been amended to include telephone appointments as a first appointment during the COVID-19 pandemic; performance is at risk of deteriorating once this temporary amendment is removed.

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month:

62 Day Standard: 90.2%

62 Day Screening: 2 patients

Risks to delivery and mitigations

M4 62 day performance of 90.23%, with a total of 6.5 breaches in month.

Future performance remains fragile in light of significant number of long waiters, predominantly due to patient choice. Cancer services continue to focus on such long waiters and the overall PTL backlog (patients waiting over 62 days). SWAG cancer alliance are currently in the process of developing a policy associated with how secondary care providers should expect to manage patients who decline multiple appointments; this is being developed in conjunction with primary care to ensure there is sufficient safety netting in place.

Screening services have now restarted, though very low referral numbers. Of the two screening patients treated in July, both unfortunately breached due to complex pathways, partly associated with previous diagnostic delays (as per national restrictions).

Statistical Process Control Chart Key:

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

Stroke & TIA Pathways

Are We Effective?

SFT SSNAP Case Ascertainment Audit Score:

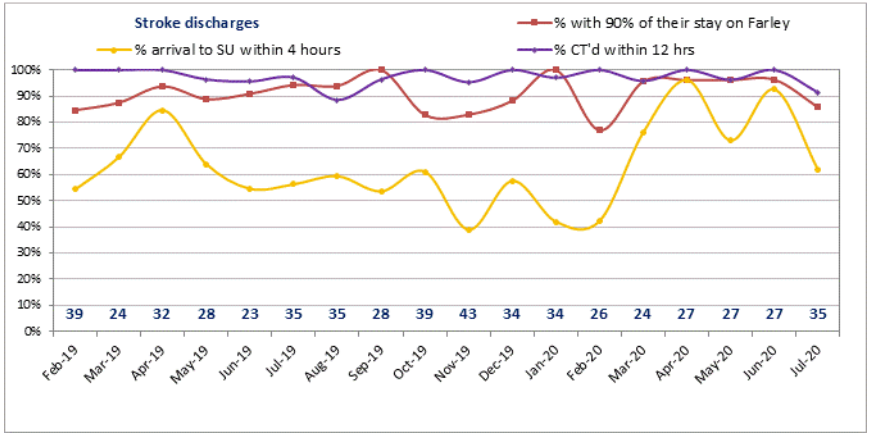
Year	Q1	Q2	Q3	Q4
2019-20	B	B	B	Not Reported
2020-21	Not Reported			

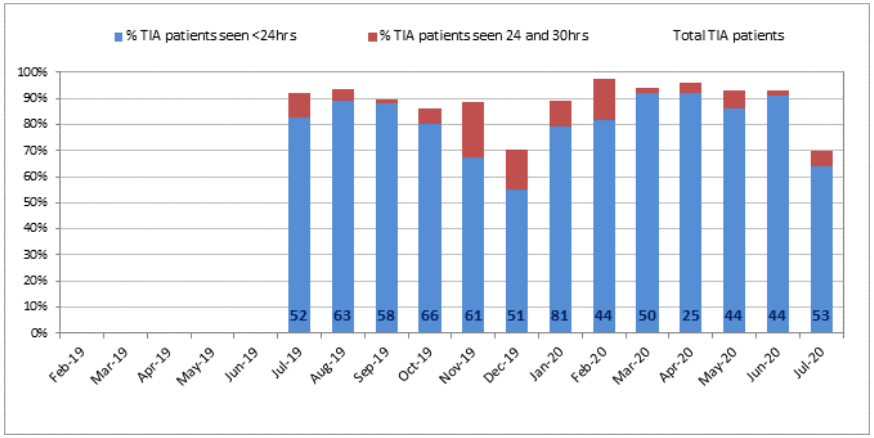
Data Quality Rating:

% Arrival on SU <4 hours: 61.8%

% CT'd < 12 hours: 94.1%

% TIA Seen < 24 hours: 64.2%





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

The stroke unit remains on Laverstock ward but plans to return to level 2 by mid-September. 43% of stroke patients had a CT within 1 hour (target 50%) reflecting the number of patients arriving out of hours and the increased pressures in ED where attendances have reached near normal levels with high acuity. Door to needle time for patients suitable for thrombolysis (4 patients) was 58 minutes. A decline in performance in patients reaching the stroke unit within 4 hours : waiting to see a doctor in ED, waiting for diagnostics, waiting for a bed,. There were 2 inpatient strokes and 1 patient at end of life who died on SSEU. 5 (14%) stroke deaths in July – lower than expected (17%). 86% of patients spent 90% of their time on the stroke unit exceeding the national target (80%).

SSNAP have confirmed that Q4 19/20 and Q1 20/21 scores will not be published as many hospitals have not submitted data during the COVID-19 emergency. SFT continued to submit data throughout this period.

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

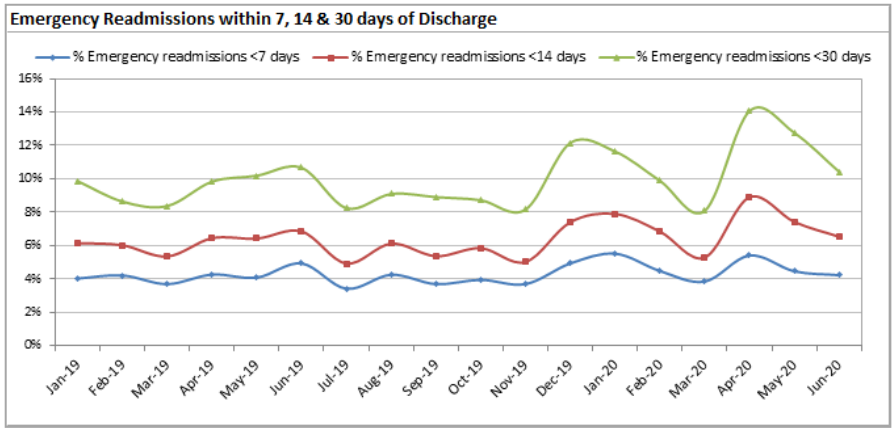
The Early Supported Discharge (ESD) service was curtailed as part of the Covid-19 arrangements and replaced by a 'discharge to assess' at home model with therapy provision in the community. East Dorset and West Hampshire community teams have returned to a normal service and the ESD stroke service in Wiltshire restarted on 1 August.

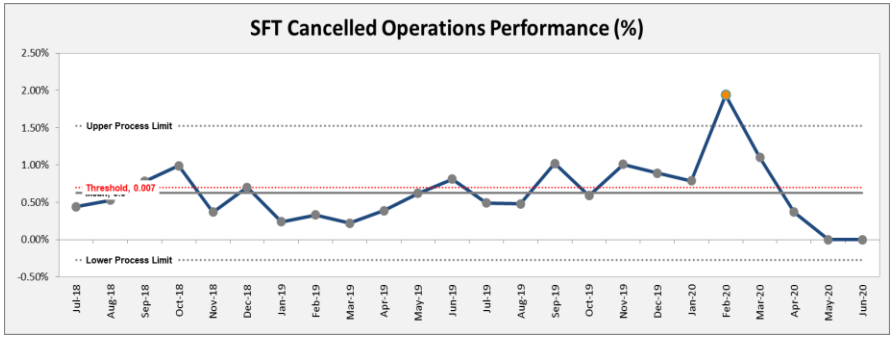
Risks to delivery and mitigations

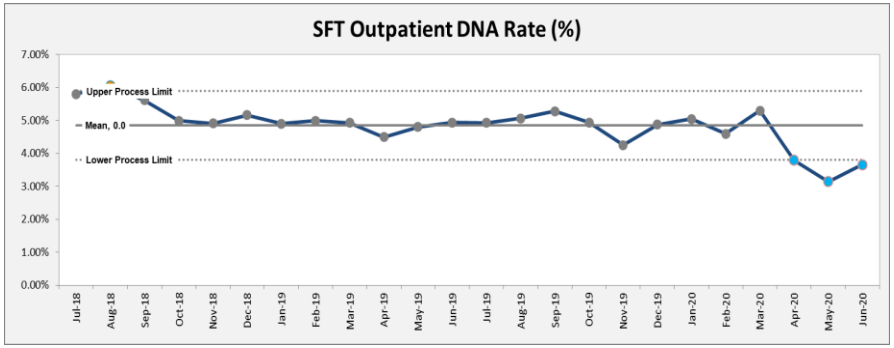
The number of stroke admissions and TIA patients has increased to almost normal levels. TIA performance fell to 64% due to full clinics, caused initially by a number of patients declining to travel to Bournemouth for weekend appointments and coinciding with a busy period. 2 extra clinics were created to ease the situation. Additionally, 3 patients required MRI scans which occurred the next day

Other Measures

Are We Effective?







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

Salisbury NHS Foundation Trust

Part 2: Our Care

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

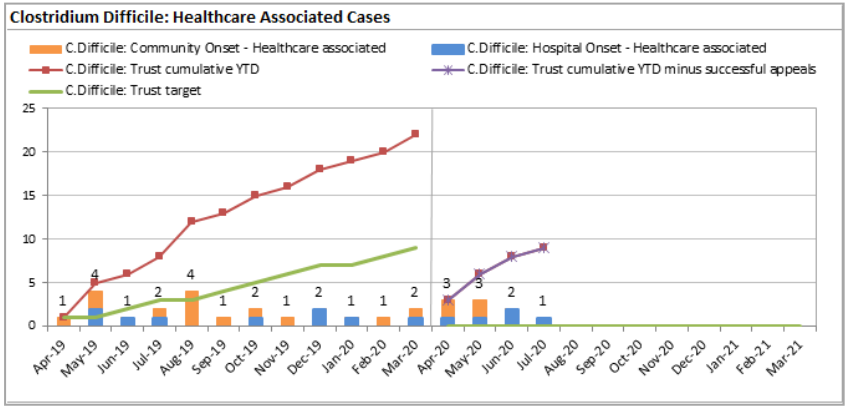
Infection Control

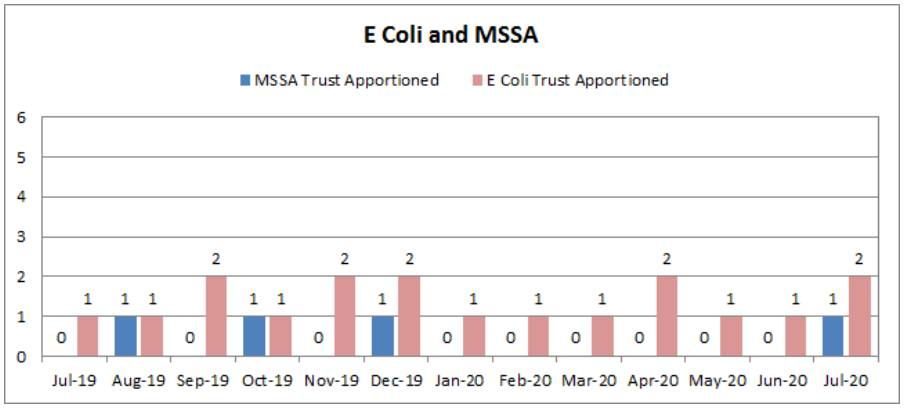
Data Quality Rating:

Are We Safe?

Clostridium Difficile	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20
Cases Appealed	0	0	0	1	0	0	0	0	0	0
Successful Appeals	0	0	0	1	2	0	0	0	0	0

MRSA	2019-20	2020-21
Trust Apportioned	0	1





Summary and Action

PHE have not yet set a C.Difficile upper limit for hospital onset healthcare associated and community onset healthcare associated cases.

In July, 1 hospital onset healthcare associated case of C.difficile of a patient on the Cardiology Unit. The case is currently under investigation.

Investigations from hospital onset healthcare associated cases in:

- April 2020 - Downton ward case remains under investigation.
- May 2020 - Redlynch ward case. Learning: delay in specimen being requested and a missed opportunity for sampling as unable to differentiate between Covid-19 related bowel presentation and C.difficile symptoms.
- June 2020 - Pembroke Ward case 1. Learning: Good learning from previous C.difficile positive cases. However, there was no clear documentation for isolation nursing. Pembroke Ward case 2. Learning: Delay in administering prescribed treatment. Ribotyping showed no links between case 1 and 2.

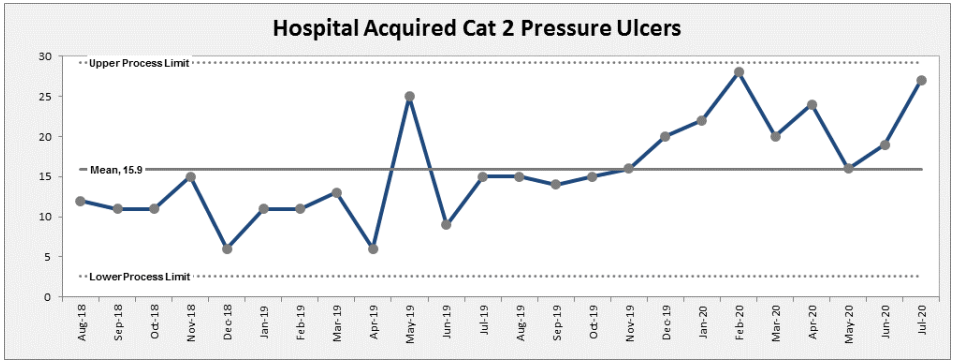
One hospital onset healthcare associated MSSA bacteraemia of a patient with a wound/soft tissue injury as the possible source. The patient was transferred from Portsmouth with a burn which had been debrided in Portsmouth. The patient also had a long term urinary catheter and permanent pacemaker.

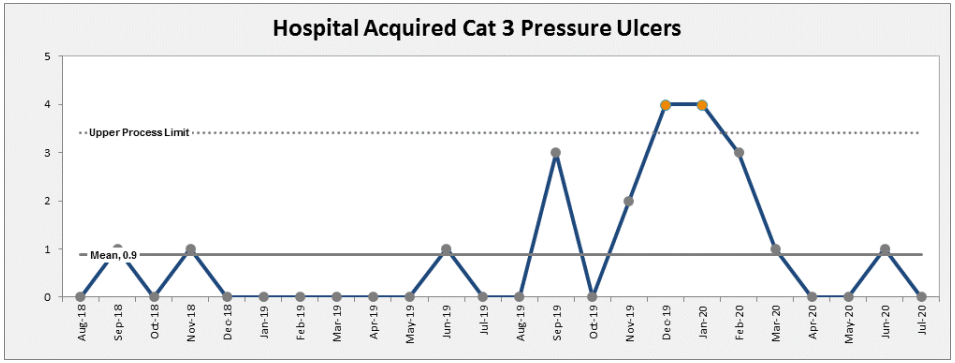
Two hospital onset healthcare associated E. Coli bacteraemias. Case 1- the source of infection was lower urinary tract (urinary catheter in situ). The patient was initially admitted and transferred to another Trust on the same day and returned 10 days later to the Stroke Unit. E Coli was identified in urine samples. Case 2 was a blood culture taken from a patient attending the Salisbury Dialysis Unit and was an inpatient at the time on the Stroke Unit. The source of infection was an intravascular device. The sample was taken on day 3 of admission and it is expected that PHE will classify it as a hospital onset healthcare associated case.

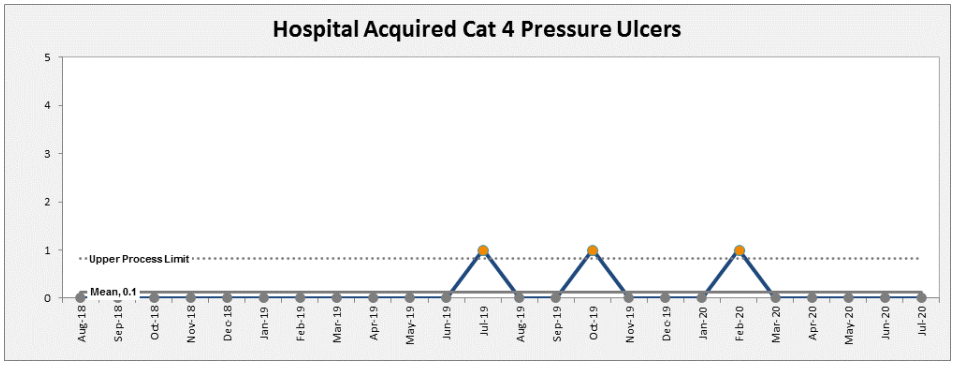
Pressure Ulcers

Are We Safe?

Data Quality Rating:







Per 1000 Bed Days	2019-20 Q1	2019-20 Q2	2019-20 Q3	2019-20 Q4	2020-21 Q1
Pressure Ulcers	1.05	1.10	1.22	1.73	2.27

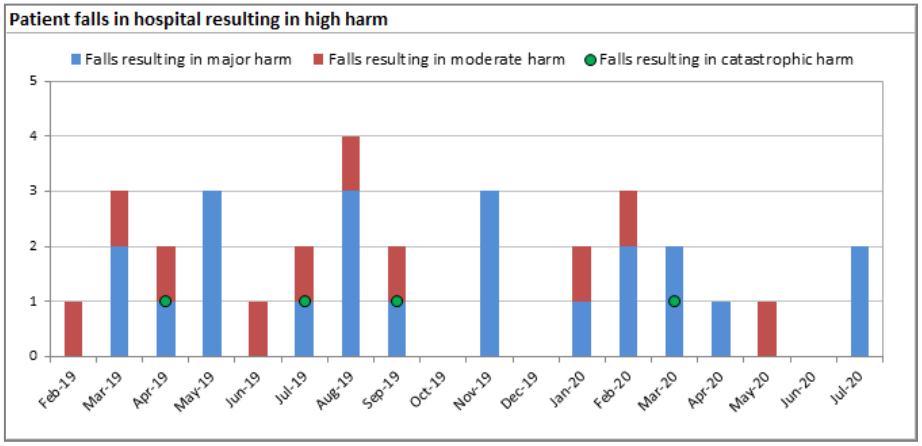
Summary and Action

An increase in the number of category 2 pressure ulcers from 19 in June to 27 in July with hotspots in 3 wards. The quality improvement project has focused work in ED and AMU and increased the number of pressure ulcers reported on admission. This shows skin inspections are being undertaken. In total, approximately 200 staff have received education in the recognition, assessment and care planning of pressure ulcers over the last 4 months. The reason for the increase in category 2 ulcers in July is not entirely clear. The Tissue Viability Team plan to undertake longer observational visits and will work with teams in the hotspot areas in September.

The cluster review and improvement plan was reported to the Clinical Governance Committee in June by the Heads of Nursing. The review highlighted a concern regarding baseline knowledge and education in our nursing staff on prevention of pressure damage. The cluster review and progress of the improvement plan was discussed with BSW Clinical Commissioning Group quality lead and Tissue Viability lead in July. There has been a similar rise in pressure ulcers both at the RUH, Bath and GWH, Swindon. The CCG are considering setting up an improvement collaborative to share learning.

Patient Falls

Are We Safe?



Data Quality Rating:

Per 1000 Bed Days	2019-20 Q1	2019-20 Q2	2019-20 Q3	2019-20 Q4	2020-21 Q1
Patient Falls	0.16	0.20	0.07	0.17	0.08

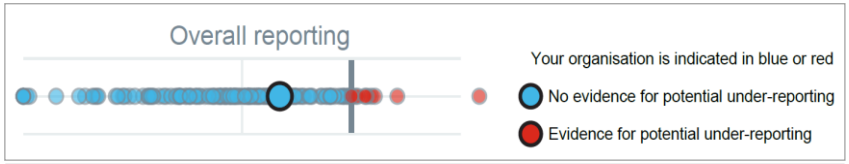
Summary and Action

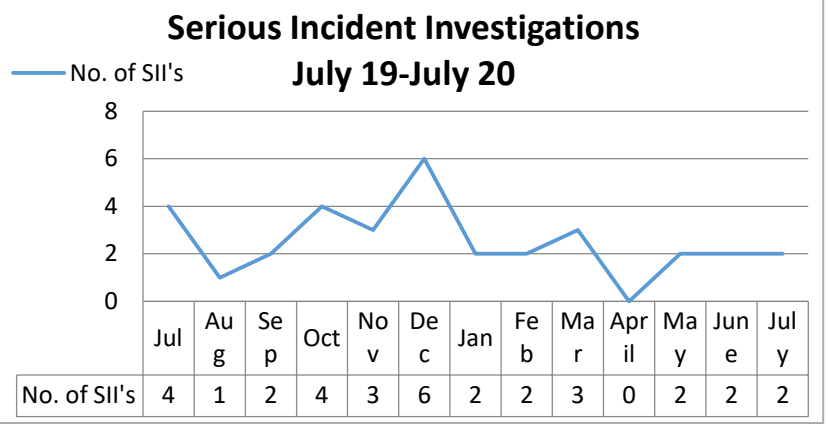
In July there were 2 high harm falls. Two patients fell and suffered a hip fracture. Both required surgical treatment and suffered major harm. The cases were not investigated as serious incidents as there were no lapses in care and no new learning.

Incidents

Are We Safe?

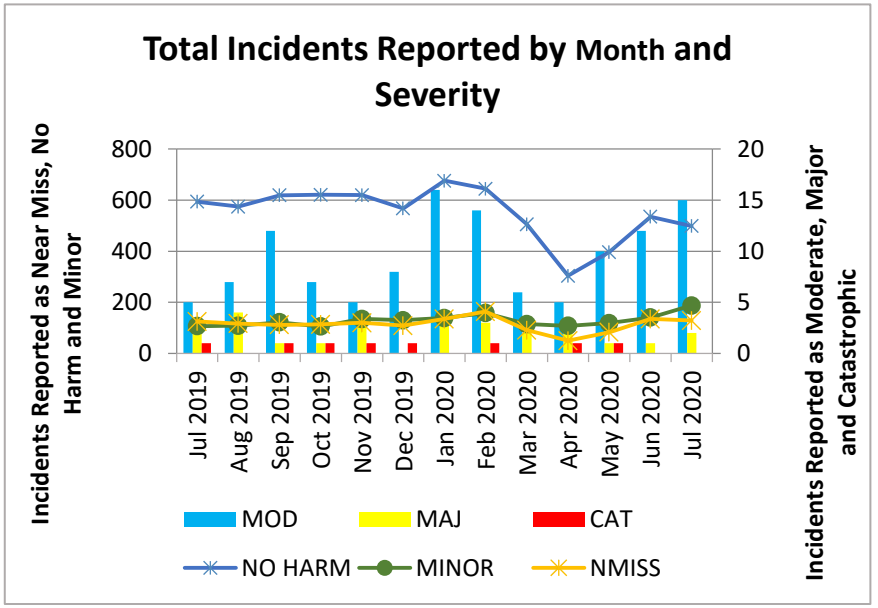
Year	2019-20	2020-21
Never Events	2	0





	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July
No. of SII's	4	1	2	4	3	6	2	2	3	0	2	2	2

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



Summary and Action

There were 2 commissioned serious incidents in July;

A delay in a cancer diagnosis of a possible brain malignancy of a joint Salisbury and Southampton patient.

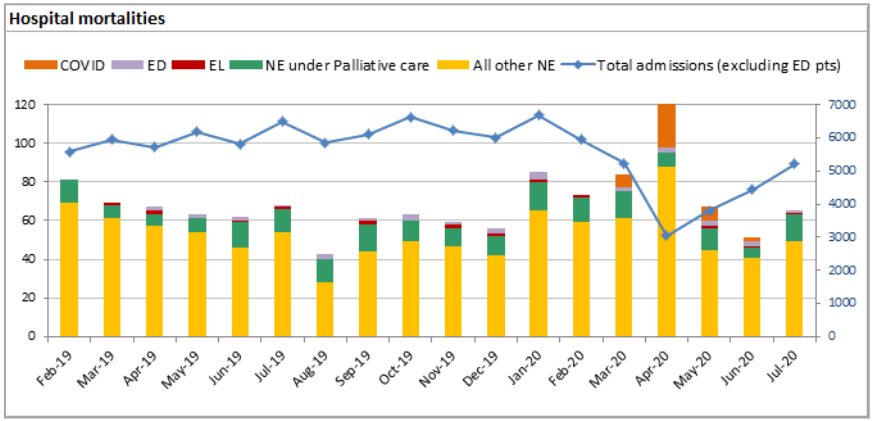
An emergency transfer from Portsmouth of a patient for a thumb replantation but the operation was delayed to the next morning because of unavailability of theatre space.

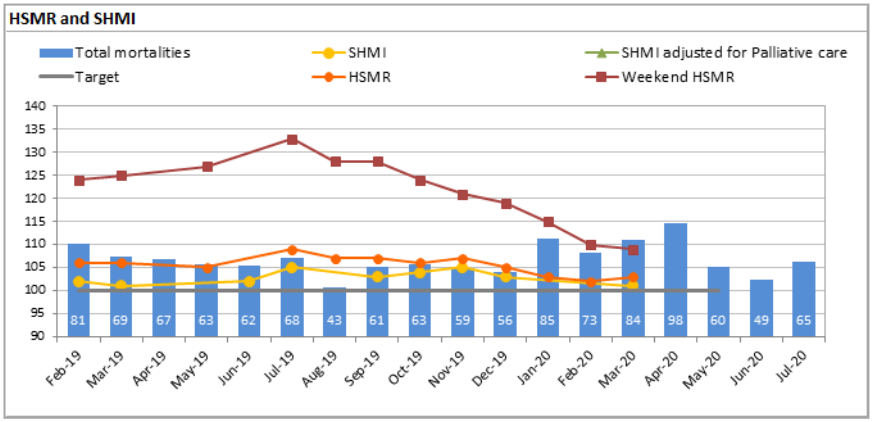
The Clinical Governance half day in July was focused on patient safety. Topics presented were the Trust response to the Covid-19 emergency, progress of the pressure ulcer quality improvement plan , deteriorating patients and NEWS2 . The maternity services presented on the Preventing Cerebral Palsy in Preterm Labour (PReCePT) programme. The session was attended by 71 staff and favourably evaluated.

Mortality Indicators

Are We Safe?

Data Quality Rating:





Summary and Action

HSMR is as expected. The weekend HSMR has decreased again and is within the expected range. No deaths associated with COVID in July. The Mortality Surveillance Group has partially completed a review of the deaths from Covid-19 to ascertain whether patients were involved in decisions about their care, escalation was appropriate, and if patients required ventilation, received it. This review will be reported to the Mortality Surveillance Group in September 2020.

The Specialist Palliative Care Team and bereavement service contacted 162 relatives whose loved ones died during the COVID emergency to provide bereavement support. The calls were purely supportive and made by staff with experience in undertaking bereavement calls. Staff did not ask any specific questions about the care of their loved one but frequently documented themes included:

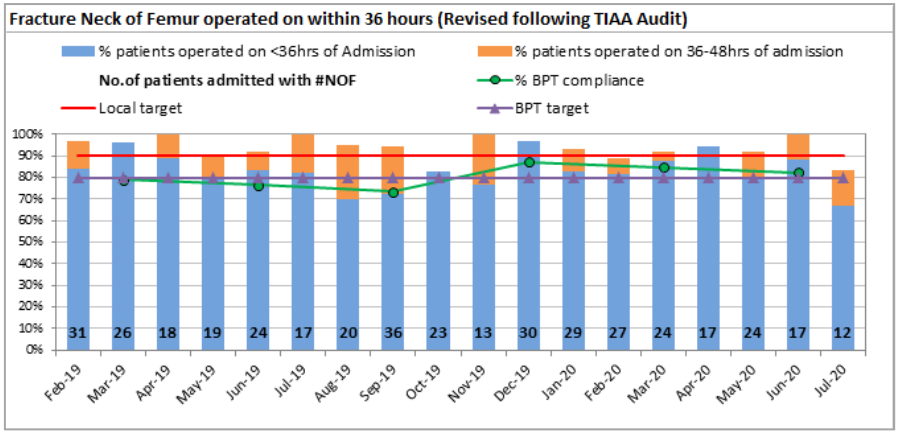
- 51 specifically mentioned that they appreciated the bereavement call.
- 46 commented on the excellent care and support they received from staff at SFT.
- 30 commented on funeral arrangements, most mentioning sadness at not holding a usual funeral. There were a few positives over the funeral being more intimate.
- 27 commented on visiting in the acute Trust, where family were able to visit, this was felt to be really positive.
- 18 commented on excellent family support as a result of lockdown and family being able to support more.
- 8 commented on negative aspects of care, usually around poor communication.

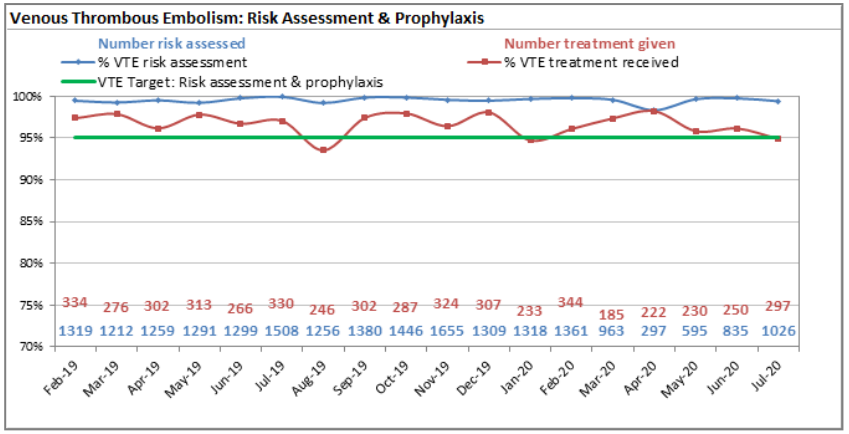
This initiative will end at the end of August as the medical examiner system comes on line.

Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?

Data Quality Rating:





Summary and Action

In July, 5 patients did not receive hip surgery for a fractured neck of femur within 36 hours. All 5 patients waited for theatre space. 4 patients had surgery between 40 – 47 hours and 1 patient at 66 hours. No evidence of harm.

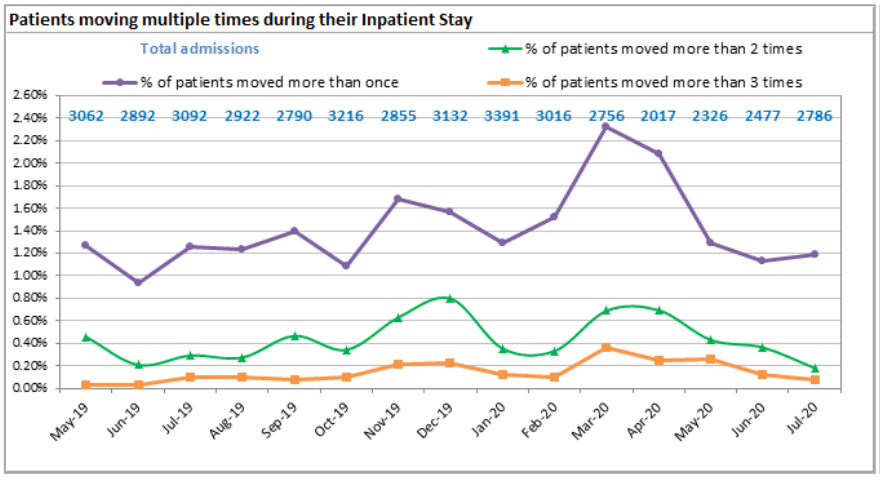
The Trust continued to report good performance in VTE risk assessment and prophylaxis.

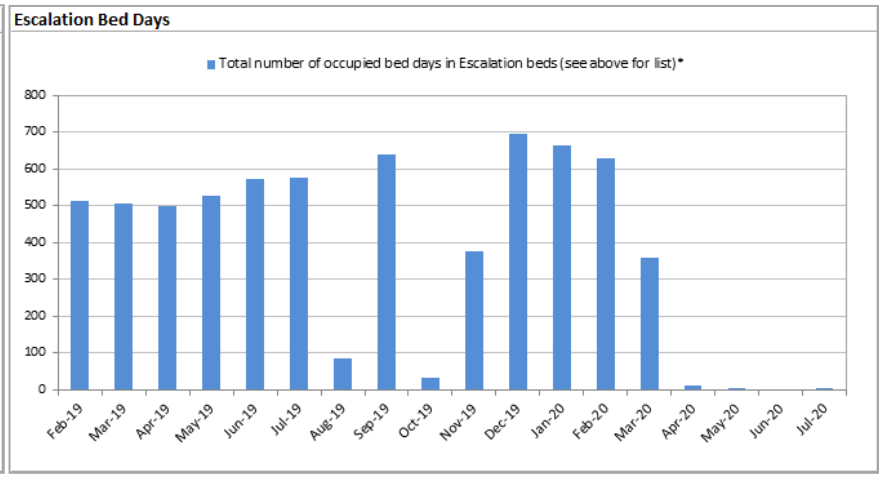
Patient Experience

Are We Safe?

Last 12 months	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20
Bed Occupancy %	94.1	96.9	94.9	97.1	95.9	94.4	96.1	81.8	60.5	64.0	76.4	81.7

Data Quality Rating:





Summary and Action

No escalation bed capacity was opened in July as bed occupancy was at 81%. The percentage of multiple ward moves was maintained at a low level.

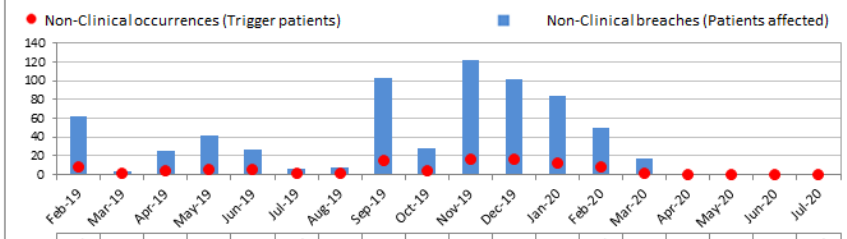
In July, when the national lockdown was lifted, all staff wore facemasks in public areas to stop the transmission of Covid-19 as an additional layer of protection to social distancing and hand hygiene. A staff antibody testing programme was completed and showed a 13% antibody positive rate compared to a less than 3% positive rate in the South West general population.

Patient Experience

Are We Safe?

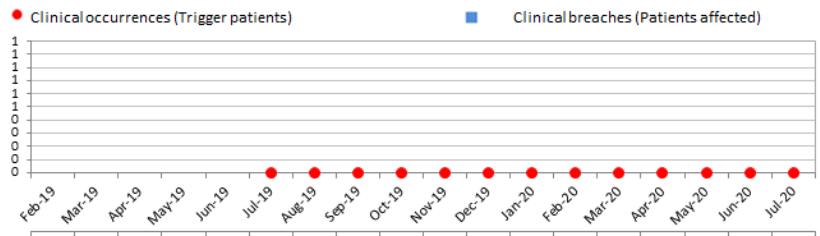
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
■	62	3	26	42	27	7	8	103	28	122	102	84	50	17	0	0	0	0
●	9	1	4	6	5	1	1	15	4	17	16	13	8	2	0	0	0	0

Delivering Same Sex Accommodation - Clinical



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

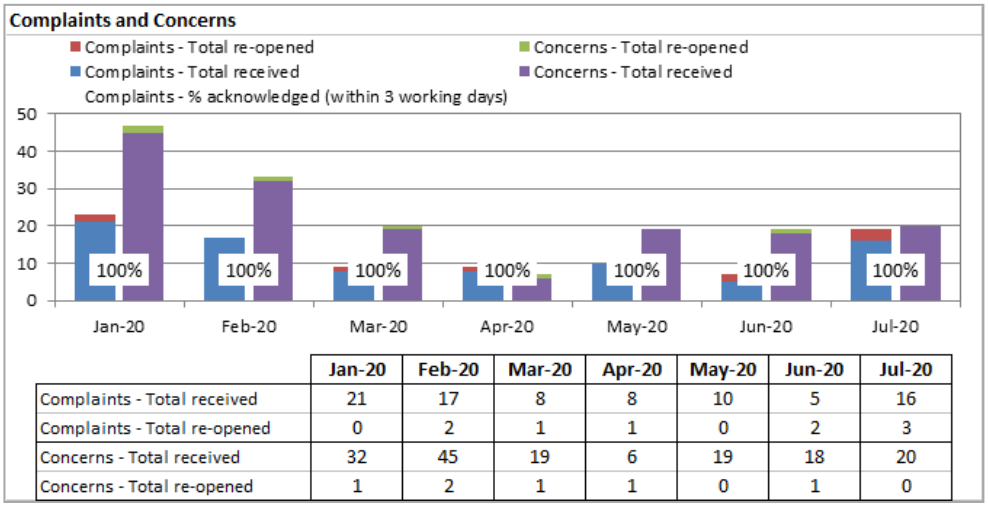
Summary and Action

No reported mixed sex accommodation breaches in July.

From August, the Trust will start reporting Critical Care mixed sex accommodation breaches of patients not transferred out of the unit within 4 hours of the decision to transfer to the ward.

Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?



	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Complaints - Total received	21	17	8	8	10	5	16
Complaints - Total re-opened	0	2	1	1	0	2	3
Concerns - Total received	32	45	19	6	19	18	20
Concerns - Total re-opened	1	2	1	1	0	1	0

Summary and Actions:

The top 4 main themes of complaints are in relation to:

- Attitudes of medical staff
- Delay in making a diagnosis
- Early discharge
- Unsatisfactory treatment

The top 4 themes of concerns include:

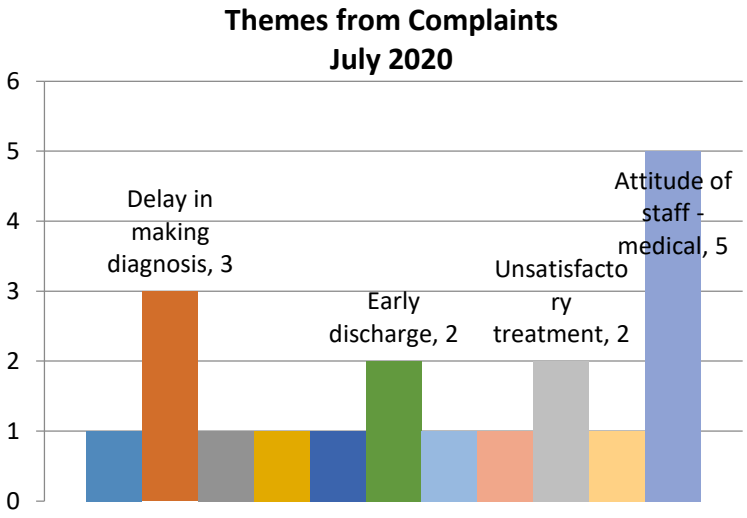
- Lack of communication
- Covid19
- Insensitive communication
- Delayed operations.

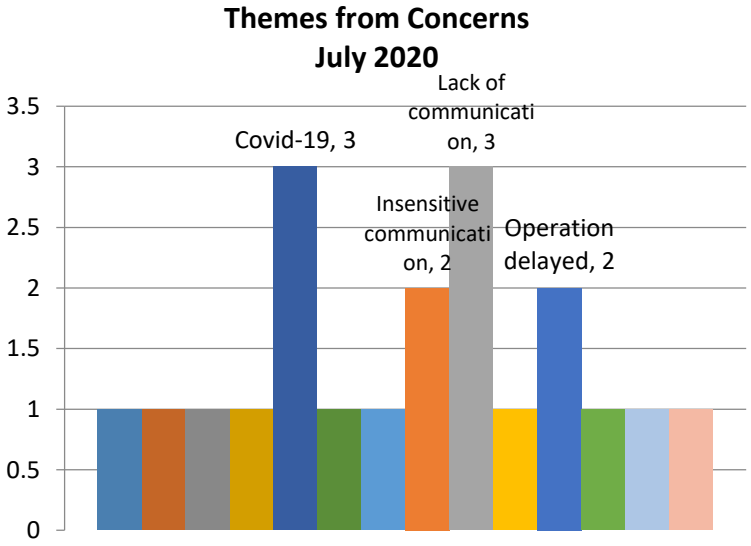
The overall theme in July is either lack of, or insensitive communication by staff

Actions:

There were 13 closed complaints in July. In the main, any actions were related to sharing learning with the relevant workforce.

Data Quality Rating:





Part 3: Our People

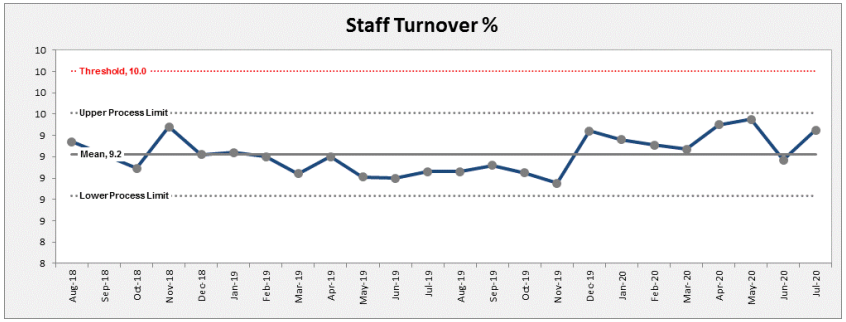
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

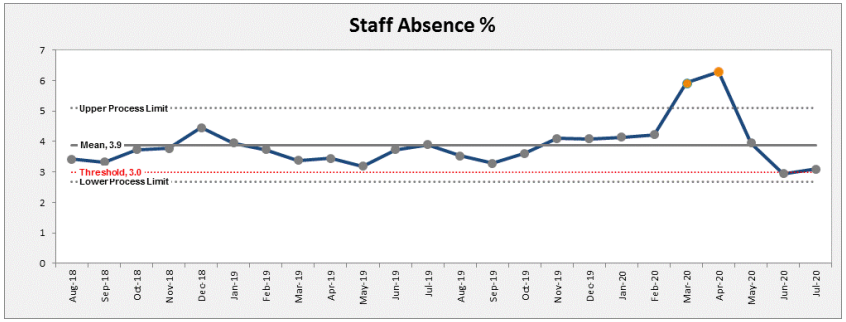
Workforce - Total

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	Jun '20		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	425.1	508.6	(83.4)
Nursing	950.5	1002.2	(51.8)
HCAs	412.1	497.4	(85.3)
Other Clinical Staff	619.3	611.5	7.9
Infrastructure Staff	1,227.9	1,011.6	216.3
TOTAL	**3,634.8**	**3,631.2**	**3.6**





Summary and Action

The number of leavers has increased sharply to 33 in July, with 13 of these being in Medicine. Many of these leavers appear to be in different areas of therapy across the division. The HRBP for the division is undertaking some bespoke work with the Head of Therapies to try to understand to underlying reasons behind this, so that we can try to address this problem quickly.

Our current system for gathering exit intelligence through either interviews of questionnaires is not robust. Only 2 questionnaires were returned during this month. The Heads of Resourcing and People Operations are working together to create a new system which we plan to trial from September.

Sickness absence has marginally increased this month, to 3.09% thus over our 3% target. Estates and Facilities saw the largest increase , up from 3.34% in June to 4.38% in July. The HRPB for the area is working with managers to understand if there is any specific reason for the increase. Anxiety/Stress/depression (mostly non- work related) continue across the board to be our key reasons for absence with 31.5%, of our total sickness being attributed to these reasons during the month. It is vital that we further develop our health and wellbeing support for staff in these areas.

There are a total of 101 staff in short-term absence management processes, at Stages 2-4, with the aim of supporting them to improve their attendance. 24 of these staff are in Theatres. We are also actively supporting those staff on long term sick leave through case management programs.

At least one of the Divisions has requested some additional support in relation to health and wellbeing as there are residual effects for some staff related to the first wave of the Covid-19 incident.

Centrally, we are refreshing our HAWB Strategy and will be launching monthly HAWB calendar events from September.

Workforce – Nursing and Care

% Fill of Registered Nurse/HealthCare Assistant Shifts

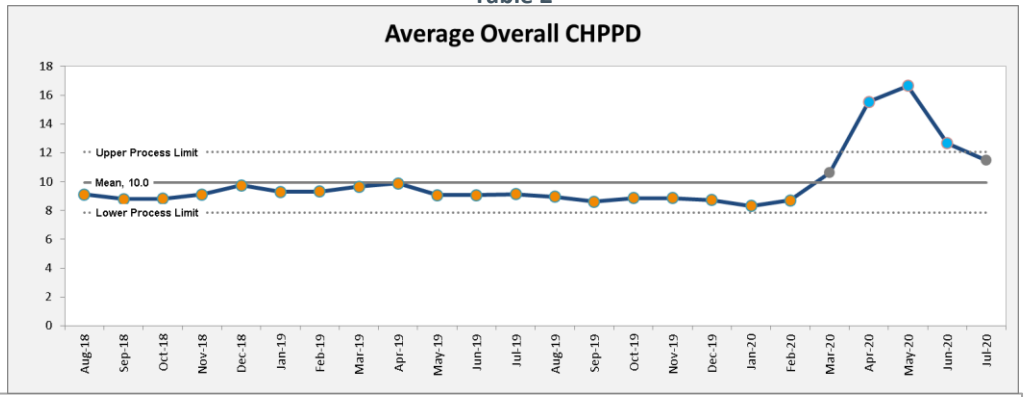
Table 1 – July Data

Day	RN	HCA
Total Planned Hours	37783	18926
Total Actual Hours	40988	19439
Fill Rate (%)	108%	102%

Night	RN	HCA
Total Planned Hours	26872	11949
Total Actual Hours	28968	12818
Fill Rate (%)	107%	107%

Care Hours Per Patient Day (CHPPD) - Monthly, 12 Month Trend

Table 2



Summary and Action

Table 1 shows planned vs actual hours for RNs and HCAs across the wards for July. The graph on the right shows planned vs actual Care Hours per Patient Day at Trust level. (CHPPD is a simple calculation dividing the number of actual nursing/midwifery (both registered an unregistered) hours available on a ward per 24-hour period by the number of patients on the ward that day It therefore nominally represents the average number of nursing hours that are available to each patient on that ward.) The graph on the right shows the average overall CHPPD across all wards and the impact of bed closures for COVID can be clearly seen from April – as services start to realign to 'normal' then CHPPD can be seen to be returning to previous levels.

Table 1 shows the overall planned vs actual fill rate for July. Overall the RN rate has increased to 104% and the HCA to 108% - the HCA increase is due to an increase starting to be seen in the requirements for additional staff for enhanced care which is slowly increasing. All wards had sufficient staff for the numbers of patients admitted, with staffing templates remain set for normal bed occupancy and a slow return to normal bed occupancy is starting to be seen. Twice daily staffing meetings continue to provide review of actual staffing requirements and ensuring staff are redeployed before temporary staffing use approved.

The skill mix of RN:HCA has remained consistent with last month with RN 68% /HCA 32%. The broad recommendation is 65%:35%.

2019/20 saw an overall nursing underspend. At the end of M4 (2020/21) there is a £531k overspend, which is a £27k deterioration on last month although this is a slow down on the previous months. The deep dive undertaken as reported last month has seen budget being applied to nursing for the 65 nursing/midwifery students on paid placement (actual expenditure in M4 circa £425k). On-going into July the issues of staff shielding/pregnant not working clinically requiring backfill, increased establishments for RCU and ICU and long established gap in headroom remain. Compared to M1 there has remains a 50% reduction in spend on bank and agency from nearly £600k to £300k.

With regards to Nurse Sensitive Indicators no specific concerns at present, increases in NSI's can be associated with suboptimal staffing. Trust wide programme for pressure ulcers improvement as previously reported continues.

Workforce – Staff Training and Appraisals

Use of Resources

Summary and Action

Medical Appraisals

Overall these have continued to dip to 81.79%, below the target of 90%, although following the GMC guidance to cancel appraisals due March to September, this figure will be adjusted.

Non Medical Appraisals

Compliance is at 82.41%, below the 85% target and slightly decreased from last month. Some managers are finding it challenging conducting appraisals remotely, plus we continue to have issues around the availability of rooms and social distancing for face to face meetings to take place.

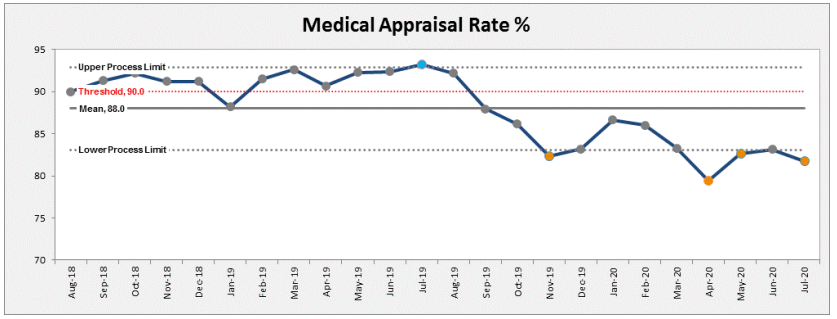
Managers have been asked to re-prioritise this activity as we move towards a reset/recovery and DMTs are tracking through area performance reviews. Managers are also being asked to attend appraisal refresher training which focusses on the quality of the appraisal conversation, which was one of our areas of concern raised by staff in the 2019 staff survey.

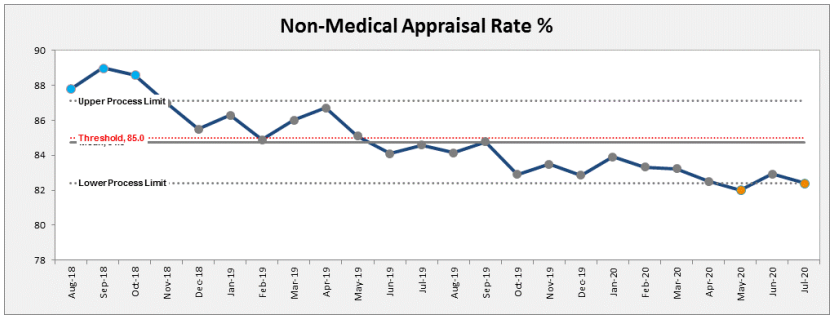
Training

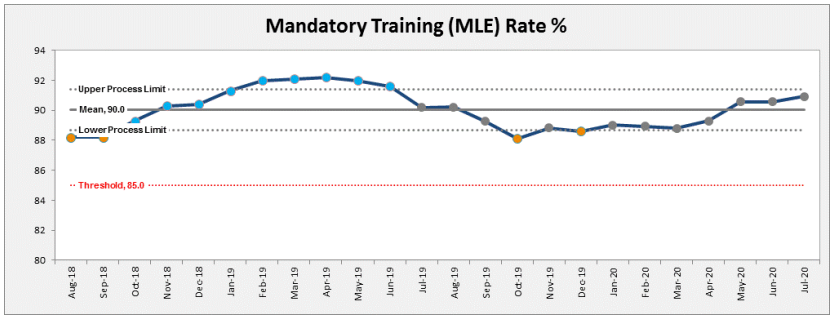
From this month we have revised the target to 90%, having been at or close to this since January. Compliance this month is 90.92%, with CSFS, Medicine and Corporate all under target.

Divisions are reporting "hot spot" subjects as Hand Hygiene (almost all) combined variously with IG, Safeguarding and Prevent training. There are some issues in recording of different levels of training, particularly in safeguarding, which we need to look into further as it appears that staff having completed (for example) level 3 would not automatically be recognised as having completed Levels 1 & 2.

Additionally, we need to formalise a method for agreeing which staff groups are allocated which mandatory training. People Operations and Learning & Development are working on this together.



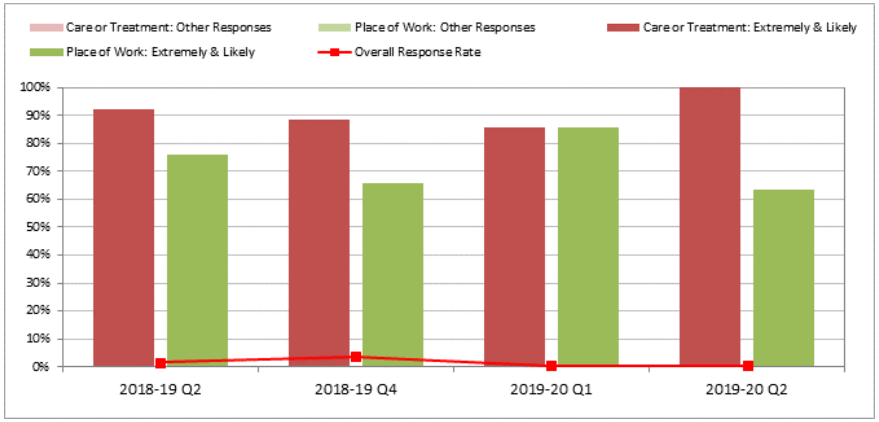




Friends and Family Test – Patients and Staff

Use of Resources

Staff Responses: Place of Work and Place of Care



In April, NHSE advised Trusts to cease collecting paper based Friends and Family Test cards due to health and safety concerns. The new Friends and Family Test question will go live in September 2020 and be reported from October.

The staff Friends and Family test was also suspended in Q4 19/20 and Q1 20/21 due to Covid-19.

Part 4: Use of Resources

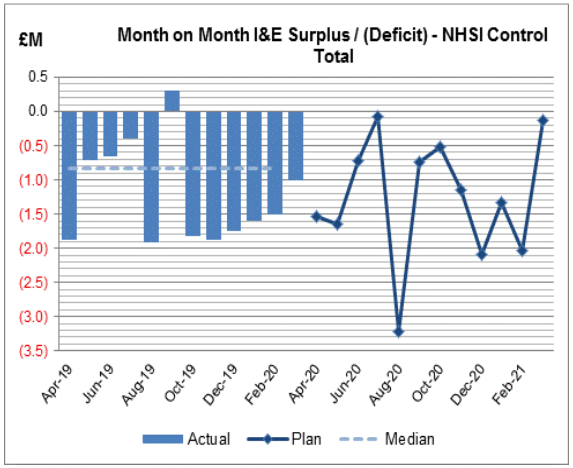
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

Position	Jul '20 In Mth			Jul'20 YTD			2019/20
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Income							
NHS Clinical Income	18,713	17,425	(1,288)	71,247	69,453	(1,794)	220,952
Other Clinical Income	886	2,563	1,677	3,482	9,082	5,600	
Other Income (excl Donations)	2,416	2,115	(301)	9,664	8,627	(1,037)	28,992
Total income	**22,015**	**22,103**	**88**	**84,393**	**87,162**	**2,769**	**249,944**
Operating Expenditure							
Pay	(13,635)	(13,829)	(194)	(54,545)	(56,244)	(1,699)	(163,634)
Non Pay	(7,011)	(6,912)	99	(28,046)	(25,442)	2,604	(84,050)
Total Expenditure	**(20,646)**	**(20,742)**	**(96)**	**(82,591)**	**(81,686)**	**905**	**(247,684)**
EBITDA	**1,369**	**1,361**	**(8)**	**1,802**	**5,476**	**3,674**	**2,260**
Financing Costs (incl Depreciation)	(1,452)	(1,361)	91	(5,799)	(5,476)	323	(17,474)
NHSI Control Total	**(83)**	**(0)**	**83**	**(3,997)**	**(0)**	**3,997**	**(15,214)**
Add: impact of donated assets	*(48)*	*(66)*	*(18)*	*0*	*(265)*	*(265)*	*1,626*
Add: Impairments	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: Central MRET	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: FRF	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Surplus/(Deficit)	***(131)***	***(66)***	***65***	***(3,997)***	***(265)***	***3,732***	***(13,588)***



Variation and Action

For the purposes of financial reporting during the Phase 1 Covid-19 response the Trust is using the original 2020/21 plan as a baseline. This had assumed a deficit of £0.1m for the month, and a £15.2m deficit for the year, no central MRET or FRF was therefore assumed.

While a significant proportion of Covid-19 specific capacity has been de-escalated a minimum level at premium cost will be required for the foreseeable future. This combined with an increase in costs associated with the return of some of the Trust's 'routine' workload mean that a retrospective top up over and above the block contracts and 'top up' payments of £432k has been claimed year to date. This is inclusive of the recognised £0.3m per month 'shortfall' in the top up methodology caused by the instruction from NHSE&I not to invoice for provider-to-provider genetics tests.

Pay showed a decrease of £0.2m in the period as Covid-19 capacity is de-escalated, and non-pay increased by £0.5m (8%) as the increase in elective capacity got underway, particularly around electives (activity up 74% in month) and day cases (activity up 33% in month), as well a an increase in the costs of prescribing.

Income & Activity Delivered by Point of Delivery

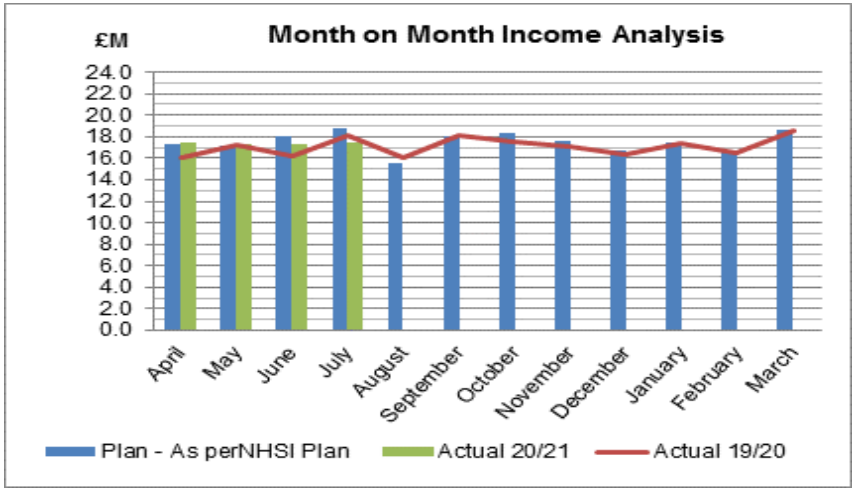
Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Jul '20 YTD		
	Plan (YTD)	Actual (YTD)	Variance (YTD)
	£000s	£000s	£000s
A&E	3,192	2,513	(679)
Day Case	5,948	2,677	(3,271)
Elective inpatients	6,300	1,521	(4,779)
Excluded Drugs & Devices (inc Lucentis)	6,468	5,483	(985)
Non Elective inpatients	20,880	16,868	(4,012)
Other	17,137	34,408	17,271
Outpatients	11,322	5,983	(5,339)
TOTAL	**71,247**	**69,453**	**(1,794)**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW CCG	39,696	37,770	(1,926)
Dorset CCG	8,123	8,281	158
West Hampshire CCG	5,835	5,742	(93)
Specialist Services	10,998	10,810	(188)
Other	6,595	6,850	255
TOTAL	**71,247**	**69,453**	**(1,794)**

Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
A&E	24,786	16,659	(8,127)	23,608	(6,949)
Day case	7,868	3,572	(4,296)	7,581	(4,009)
Elective	1,669	559	(1,110)	1,666	(1,107)
Non Elective	10,688	8,035	(2,653)	8,743	(708)
Outpatients	87,986	54,441	(33,545)	85,768	(31,327)



Variation and Action

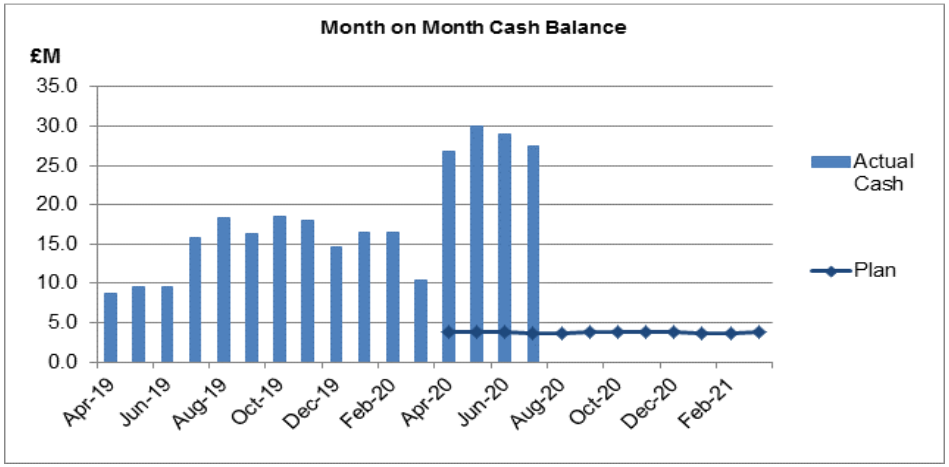
Activity in July has increased above June levels across all of the main points of delivery with the exception of Maternity and Intensive Care. The most significant increases by specialty are General Surgery, Plastic Surgery and Gastroenterology Day cases, Colorectal Surgery, Plastic Surgery and Gynaecology Elective, General Surgery and Accident and Emergency Non Elective and Ophthalmology and Respiratory Medicine Outpatients.

Contracts payment values with main commissioners have been based on Month 9 agreement of Balances (from a provider perspective), adjusted by 2.803% for inflationary pressures. Over the first four months of the year underlying activity has been valued at less than the agreed block by £20,745k (30%), owing to the temporary cessation of non-urgent planned work and phased recovery response. The July adjustment has reduced by £2,075k.

Cash Position & Capital Programme

Capital Spend:  **Cash & Working:** 

Use of Resources



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

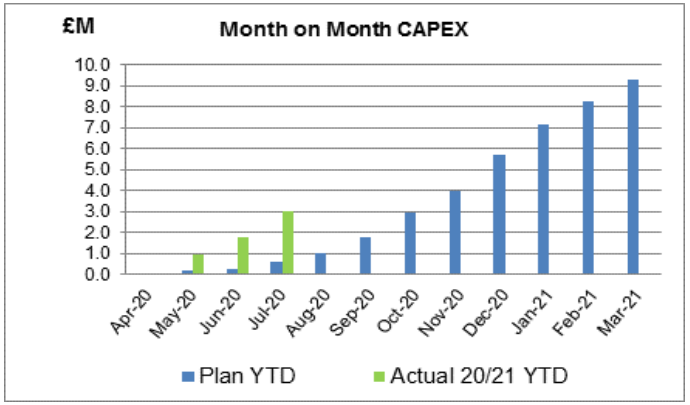
Payments on account in advance up until 31st August 2020 have been received. Plans for the next phase have yet to be communicated - this brings with it risk as at present there is no certainty around any payment from September onwards, although balances are currently sufficient to return to a payment in arrears arrangement.

As an interim arrangement the NHSE&I SW regional team agreed commissioner payments on account would be made in August, effectively continuing the payments in advance.

Borrowings had included £21m of working capital loans due for repayment by 31 March 2021. The Trust has now received confirmation that these have been converted to PDC on 1 April 2020.

Capital Expenditure Position

	Annual	Jul '20 YTD		
	Plan	Plan	Actual	Variance
Schemes	**£000s**	**£000s**	**£000s**	£000s
Building schemes	850	0	11	(11)
Building projects	2,600	150	129	21
IM&T	2,600	150	1,469	(1,319)
Medical Equipment	2,778	250	848	(598)
Other	449	149	149	0
Covid 19	778	484	387	97
TOTAL	**10,055**	**1,183**	**2,993**	**(1,907)**



Summary and Action

Delays in capital works at the end of 2019/20, including those due to the Covid-19 response, has meant slippage into 2020/21. While agreed items were brought forward to offset a proportion of this slippage, the final 2019/20 outturn was c£900k short of that initially planned for. This has inevitably affected the phasing of the plan as the delays to committed spend has mostly been incurred in the first three months of 2020-21. The most material element falls in IT, where the Microsoft environment replacement project phases out Windows 7.

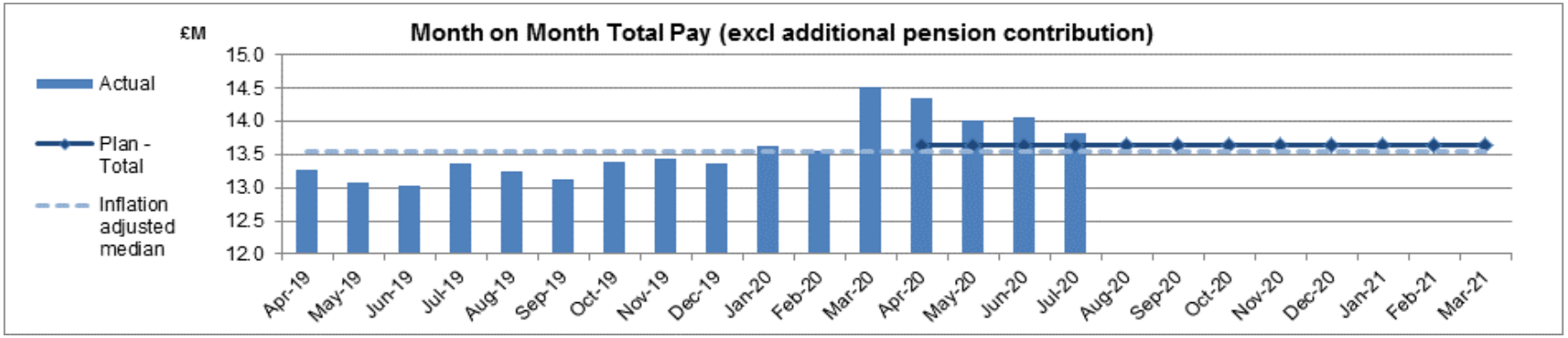
The Trust had £778k of funding for medical and IT equipment in 2020-21 as part of the Covid-19 response approved by the NHSE&I regional team and passed to the national team for final decision. A further emergency bid for the relocation of ICU escalation capacity has also been approved by the regional team and passed to the national team for final review.

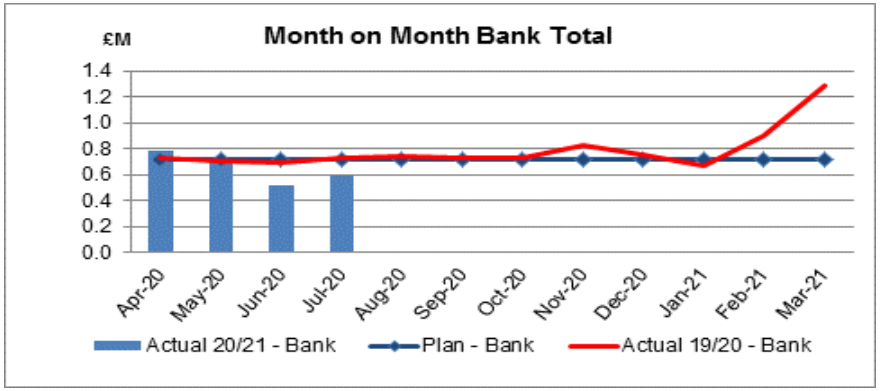
The Trust has this month received notification of £3.55m Critical Infrastructure and £2m Emergency Department Configuration additional funding. Plans are underway to ensure schemes are fully developed, with the necessary resources in place, to complete these projects in 2020-21.

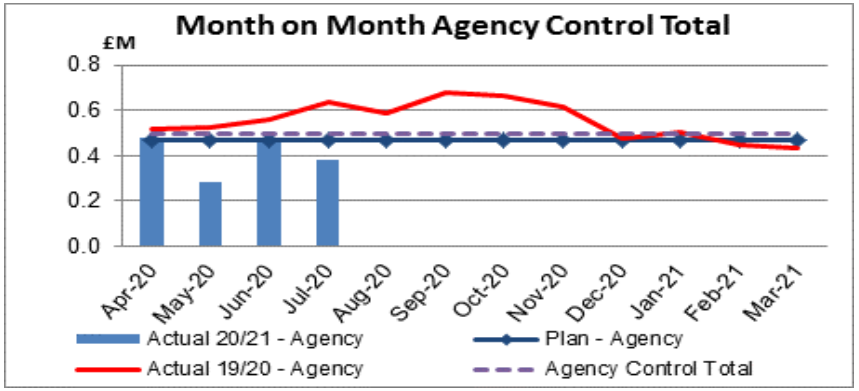
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

Pay expenditure has reduced by 231k, or 1.65% month on month, although there is still a YTD adverse variance to plan of £1,699k. There has been a reduction in the costs of the Covid-19 response as dedicated escalation capacity and associated rosters have been scaled back. The constrained bed base and theatre capacity mean that ward nursing and theatres agency spend remains at near-zero levels. However, as we move forward the maintained costs of streaming patients and responding to Phase 3 of the NHSI response to the pandemic, combined with the reopening of theatres and Elective beds is likely to see pay costs increase.

Sickness and self isolation due to Covid-19 continues to fall, although overall sickness absence rate in July was 3.09%, up slightly from 2.95% in June.

Salisbury NHS Foundation Trust

Report to:	Executive Directors Meeting	**Agenda item:**	3.1
Date of Meeting:	03 September 2020		

Report Title:	2021 Trust Board and Committee Dates			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		x		x
Prepared by:	Kylie Nye, Corporate Governance Manager Sasha Grandfield, Board Support Officer			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):	Meeting Schedule			

Recommendation:
Support the proposed Board and Committee meeting schedule for 2021.

Executive Summary:
A Board Governance Structure Review was undertaken this year following the Internal Audit of Board Compliance and Reporting in November 2019. This process was undertaken to strengthen governance arrangements, which clearly identify the delivery and assurance pathways in the organisation. In light of this review and based on previous years it is recognised that the flow of reporting from sub-groups to Board Committees and then to Trust Board required improvement. The Corporate Governance team has worked on a new schedule which better reflects the reporting structure. It is important to note that these are only proposed dates for further discussion and amendment if required. The key changes are as follows: • The new meeting, Organisational Development and People Management Board (ODPMB) has been added to the meeting cycle. • TMC is now the last Wednesday of the month. This allows for OMB, CMB, ODPMB (Organisational Development and People Management Board) and the Transformation Board to meet the week before and escalate items to TMC appropriately. Historically, CMB has been the week after TMC, however this meeting is meant to report to TMC.

- The new schedule is colour coded to highlight the reporting months.

If supported the dates will go to September's Board for approval.

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

Trust Board, Committees and Council of Governors – Meetings 2021 – new schedule

	Trust Board Thursday Week 1 All day		Operational Management Board Tuesday Week 3 11 - 1	OD & People Management Board Tuesday Week 3 2 - 4	Clinical Management Board Wednesday Week 3 11 - 1	Transformation, Innovation and Digital Board Wednesday Week 3 1.30 – 3.30	Audit Committee Thursday Week 3 9.30 - 12	Subsidiary Governance Committee Thursday Week 3 1 – 2.30	Charitable Funds Committee Thursday Week 3 3 – 4.30	Clinical Governance Committee Tuesday Week 4 9.30 – 12	Finance and Performance Committee Tuesday Week 4 1 – 3.30	Trust Management Committee Wednesday Week 4 10 - 12	People and Culture Committee Last Thursday 10 - 12
Chair	Nick Marsden		Andy Hyett	Lynn Lane	Christine Blanshard	Esther Provins	Paul Kemp	Mike Hawker	Nick Marsden	Eiri Jones	Paul Miller	Stacey Hunter	Lynn Lane
January	**14 pub/pri**	**M8**	**19**	**19**	**20**	**20**	**-**	**21**	**-**	**26**	**26**	**27**	**28**
February	**4 private**	**M9**	**16**	**16**	**17**	**17**	**-**	**-**	**-**	**23**	**23**	**24**	**25**
March	**4 pub/pri**	**M10**	**16**	**16**	**17**	**17**	**18**	**-**	**18**	**30**	**30**	**31**	**25**
April	**8 private**	**M11**	**20**	**20**	**21**	**21**	**-**	**-**	**-**	**27**	**27**	**28**	**29**
May	**20 pub/pri**	**M12**	**18**	**18**	**19**	**19**	**20**	**20**	**-**	**25**	**25**	**26**	**-**
June	**3 private**	**M1**	**15**	**15**	**16**	**16**	**-**	**-**	**17**	**29**	**29**	**30**	**24**
July	**8 pub/pri**	**M2**	**20**	**20**	**21**	**21**	**22**	**-**	**-**	**27**	**27**	**28**	**29**
August	**5 private**	**M3**	**17**	**17**	**18**	**18**	**-**	**-**	**-**	**31**	**31**	**25**	**-**
September	**9 pub/pri**	**M4**	**21**	**21**	**22**	**22**	**23**	**23**	**23**	**28**	**28**	**29**	**30**
October	**7 private**	**M5**	**19**	**19**	**20**	**20**	**-**	**-**	**-**	**26**	**26**	**27**	**28**
November	**4 pub/pri**	**M6**	**16**	**16**	**17**	**17**	**-**	**-**	**-**	**30**	**30**	**24**	**25**
December	**9 private**	**M7**	**14**	**14**	**15**	**15**	**16**	**-**	**16**	**21**	**21**	**22**	**-**

	Council of Governors	**Non Exec/Governor informal**
	Nick Marsden	Nick Marsden
January	-	-
February	22	8
March	-	-
April	-	12
May	31	-
June	-	14
July	26	-
August	-	-
September	27 AGM	-
October	-	11
November	29	-
December	-	-

BANK HOLIDAYS	
1 Jan	**Friday**
2 April	**Good Friday**
5 April	**Easter Monday**
3 May	**Monday**
31 May	**Monday**
30 Aug	**Monday**
25 Dec	**Saturday**
26 Dec	**Sunday**
27 Dec	**Monday**
28 Dec	**Tuesday**

Room booking notes:

- Trust Board – always book Board room 9-5 – will include any RemCo & Seminar
- Trust Board – Start/finish times can vary depending on if there is a full public Board. However, public Board generally starts at 10am.
- All meetings book 30 minutes ahead of start and end times
- NEDs/Governors – book rooms D&E
- CoG – book Boardroom from 2.30 pm (set-up plus 3 pm pre-meeting)

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.2
Date of Meeting:	03 September 2020		

Report Title:	Board and Committee Effectiveness Review			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Prepared by:	Fiona McNeight, Director of Corporate Governance Kylie Nye, Corporate Governance Manager			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):				

Recommendation:
For Trust Board to note the process and outcome for the annual review of Board and Committee effectiveness.

Executive Summary:
The NHS FT Code of Governance sets out the requirements that the Board of Directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors. In order to do this, the Board used a range of information to determine whether they are working effectively. The Board agreed at the August 2019 Trust Board meeting that the following evidence should inform the board evaluation: • Facilitated 360 review • Board member questionnaire • Board member self-assessment against the Good Governance Maturity Matrix • Annual report 2018/19 overview of performance • Review of board papers – the purpose of papers to better understand the balance of items being considered This paper summarises the annual evaluation process to date and provides assurance that there has been a rigorous process implemented. The outcome of the review was reported to Trust Board at the February meeting, with the exception of the outcome of the facilitated 360 review. This is still awaited due to Covid-19.

In addition, Internal Audit completed a Board Governance and Compliance Audit in November 2019. Following the audit, the Corporate Governance function completed an extensive governance review which was reported to Trust Board on 4 June 2020. This included several recommendations to strengthen the committee governance arrangements; these are currently being implemented.

As part of the annual Committee business cycle, Clinical Governance Committee, Audit Committee and Finance and Performance Committee have completed a self- assessment of Committee effectiveness. These reviews concluded that these Committees were meeting the requirements as set out in their terms of reference.

The People and Culture Committee did not undertake a self-assessment as the Internal Audit had identified improvements required. This has now been supported with the introduction of the OD and People Management Board, commencing in September 2020.

All Board and Committee terms of reference have been reviewed and agreed at Board in July 2020 as part of the revised Integrated Governance Framework.

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.4
Date of Meeting:	03 September 2020		

Report Title:	Board Assurance Framework (BAF) and Corporate Risk Register (CRR)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		x		x
Prepared by:	Fiona McNeight, Director of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices (list if applicable):	Board Assurance Framework v1_Revised August 2020			

Recommendation:
The Board to consider and approve the revised Board Assurance Framework and note the changes in reporting.

Executive Summary:
The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance. This informs the Annual Governance Statement and annual cycle of business. The BAF has been revised during August 2020 to incorporate the revised corporate objectives for the remainder of 2020/21. The format of the document has been simplified with the aim of ensuring that any gaps in control or assurance against each strategic aim and the corporate objectives is clear, and that there are identified actions to address any gaps. In addition, the document is now aligned to the Board corporate priorities update report produced by the Associate Director of Strategy; including alignment to the Integrated Performance Report where relevant. These documents, together with the Corporate Risk Register, will provide the Board with comprehensive assurance regarding delivery of the corporate objectives to meet the strategic aims and identify any associated risks to delivery and mitigating actions. With the Public Board meeting moving to bi-monthly, there has been a review of reporting to

Board to align to the revised meeting structure. In order for the BAF and CRR to be presented to the Public Board meeting following scrutiny by the Board Committees, this will be presented to Public Board in January and subsequently every 4 months during 2021 This is an interim report setting out the revised arrangements and change to the BAF format going forwards.

The full BAF and CRR will continue to be presented to Board Committees bi-monthly to maintain oversight and scrutiny, with assurance provided to Board through the Committee escalation reports.

Changes to the risk profile to note:

- Risk 6247 related to the critical estates infrastructure has had a full review and as a consequence, the risk score has been increased from 12 to 20 with the residual risk increasing from 4 to 12.
- The Director of Nursing has completed a risk assessment relating to maternity services which is with the Chief Operating Officer and Director of OD & People for review before being escalated to the CRR.
- The risk relating to the genetics service (6134) has significantly reduced from 16 to 6. This scoring reflects the remaining financial risk associated with the move in service provision.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
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Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

Board Assurance Framework

Incorporating the revised Corporate Objectives for 2020/21

2020/21

Trust Vision: An Outstanding Experience for Every Patient

V1_Revised August 2020

Delivery of our vision and the strategic objectives is underpinned by our Trust Values and Behaviours: Patient Centred and Safe, Professional, Responsive, and Friendly. A drive to be 'outstanding every time.' It is also recognised (as illustrated above) that woven throughout the delivery of the strategy is the need to successfully develop and work across partnerships and collaborations which is why the Corporate Risk Register highlights both internal and external risks to delivery of our objectives.

Strategic Priorities

Local Services – We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.

Specialist Services – We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.

Innovation – We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered

Care – We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm

People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams

Resources – We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources

Board Assurance Framework – Glossary

Strategic priority	Executive Lead and Reporting Committee	Key Controls	Assurance on Controls	Positive Assurances	Gaps in Control	Gaps in Assurance
What the organisation aims to deliver	Executive lead for the risk The assuring committee that has responsibility for reporting to the Board on the risk.	What management controls/systems we have in place to assist in securing delivery of our objective	Where we gain independent evidence that our controls/ systems, on which we are placing reliance, are effective.	What evidence demonstrates we are reasonably managing our risks, and objectives are being delivered **Level 1 Internal Assurance** – Internally generated report or information which describes the effectiveness of the controls to manage the risk. For example – the Integrated Performance Report, self-assessments. **Level 2: semi-independent Assurance** For example – Non-Executive Director walk arounds, Internal Audits **Level 3 External Assurance** – Independent reports or information which describes the effectiveness of the controls to manage the risk. For example – External Audits, regulator inspection reports/reviews.	Where do we still need to put controls/systems in place? Where do we still need to make them effective?	Where do we still need to gain evidence that our controls/systems, on which we place reliance, are effective?

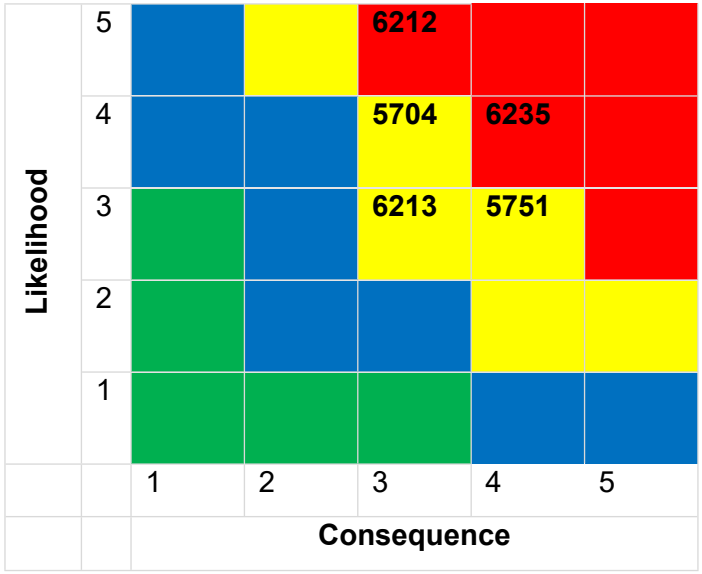
	Low Risk (Score 1-3)
	Moderate Risk (Score 4-6)
	High Risk (Score 8-12)
	Extreme Risk (Score 15-25)

Strategic Priority: Local Services

We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do.

Executive Lead: **Chief Operating Officer** **Reporting Committee:** **Finance & Performance Committee**

Distribution of Corporate Risks for Local Services



5704 – Inability to provide a full gastroenterology service due to a lack of medical staff capacity
5751 – Patient safety risk due to high numbers of delayed transfers of care due to lack of community capacity
6235 - Risk of increased ED attendances in relation to suspected Covid-19 cases with potential to impact on patient flow due to isolation requirements.
6213 - Risk of patients on the cancer pathway being missed or delayed with potential for patient harm as a result of having three systems involved in the pathway that are not contextually linked.
6212 - Risk that patients with cancer will experience clinical deterioration as a result of not receiving a follow up appointment in the required timeframe which may result in mis-management, disease progression, limited treatment options and patient harm.

Linked risks

5972 Risk that improvement and transformation is not delivered in a timely manner (Innovation)
6143 - Risk of the ability to provide the same quality of service 24 hours a day, 7 days a week with potential impact to patient care (Care)

Principle Internal Risk: Risk of insufficient capacity and capability to deliver the required cultural change to meet the needs of the local population	
Key Controls	**Assurance on Controls**
• Established performance monitoring and accountability framework • Access policy • Accountability Framework • Engagement with commissioners and system (EDLDB) • Escalation processes in line with the Trust's OPEL status • Weekly Delivery Group meeting • Executive membership of Wiltshire Health and Care • Project management board structure • Executive membership at Wiltshire Delivery Group (COO) and Wiltshire Integration Board (CEO) • Workforce plans	• Integrated performance report • Performance review meetings with CCG • Whole system reports (EDLDB) • Market intelligence to review competitor activity and commissioning changes • Performance reports to weekly Delivery Group
Principle External Risk: Managing the complexity of relationships with our partners to lead and share our joint strategy plans for a place based integrated care system	
Monitoring information	**Areas of influence**
• Integrated Performance Report – impact on metrics • Monthly Urgent Care dashboard from the CCG • System dashboard (STP performance dashboard) • STP Operational Plan	• Requested improvement trajectories for decreased attendances and delayed transfers of care • STP Executive Board (CEO) • STP Sponsorship Board (CEO and Chair) • Wiltshire Integration Board (CEO) • Stakeholder meetings / engagement • Acute Hospital Alliance

2020/21 Corporate Objectives – Local Services

Objective	Target Measures
Develop with partners initiatives to ensure patients do not stay in hospital any longer than they need.	• Achieve average of 30% discharges before 1200 • Reduce Super Stranded Patients to 14%

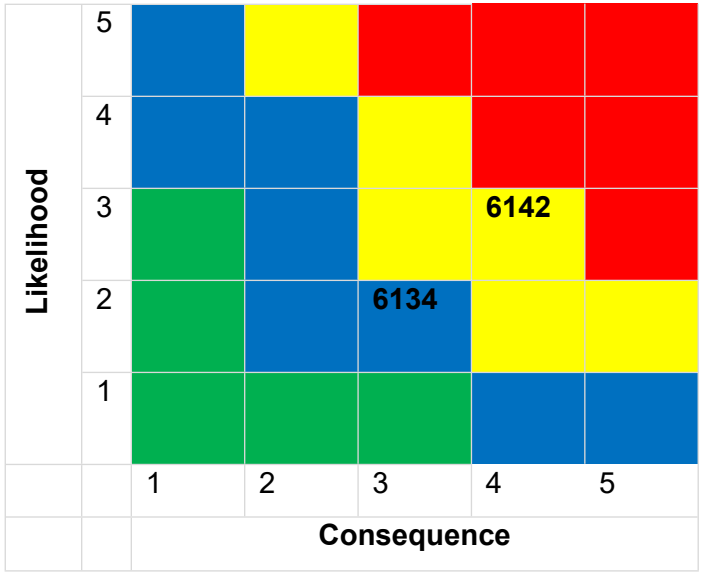
Gaps in Control/Assurance	Action	Deadline	Lead
Local Authority adopting a change to the approval process for packages of care (GC)	Chief Operating Officer to liaise with the CCG	Review 30/09/2020	Chief Operating Officer
Community capacity being directed to areas with Covid-19 peaks (GC)	No internal action		

Strategic Priority: Specialist Services

We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population.

Executive Lead: **Chief Operating Officer** **Reporting Committee:** **Finance & Performance Committee**

Distribution of Corporate Risks for Specialist Services



6134 – Financial and workforce risk as a result of NHS England Specialist Commissioners driving centralisation of genetics and genomics clinical testing into fewer laboratories resulting in laboratory testing unlikely to be provided at the Trust in the longer term

6142 - Risk to recruitment, retention and staff morale within the genetics service as a result of the uncertainty of the future of the service

Principle Internal Risk: Risk of balancing delivery of services that are 'outstanding' against the risk of economies of scale and cost effectiveness	
Key Controls	**Assurance on Controls**
• NHS England contract standards • Access Policy • Work with key network partners in Plastic Surgery - Solent Alliance/Plastics Venture Board • COO Delivery Group • Genomics Consortium Board • Established performance monitoring and accountability framework • Accountability Framework • Engagement with commissioners and system (EDLDB) • Escalation processes in line with the Trust's OPEL status • Weekly Delivery Group meeting • Executive membership of Wiltshire Health and Care • Project management board structure • Executive membership at Wiltshire Delivery Group (COO) and Wiltshire Integration Board (CEO)	• Integrated Performance Report • Specialist Services dashboards • Performance review meetings with CCG • Whole system reports (EDLDB) • Market intelligence to review competitor activity and commissioning changes • Performance reports to weekly Delivery Group

Principle External Risk: National drive and policy regarding further centralisation	
Monitoring information	**Areas of influence**
• Integrated Performance Report	• Plastics network

2020/21 Corporate Objectives – Specialist Services

Objective	Target Measures
Refresh the clinical strategy	• Strategy approved by CGC, and implementation plan agreed.

Gaps in Control/Assurance	Action	Deadline	Lead
Current strategy does not reflect changes in service delivery as a result of: • Working towards the BSW ICS • Covid pandemic and recovery phase • Shift in national priorities	Refresh of the Clinical Strategy to reflect changes and Phase 3 proposals	30.10.2020	Medical Director

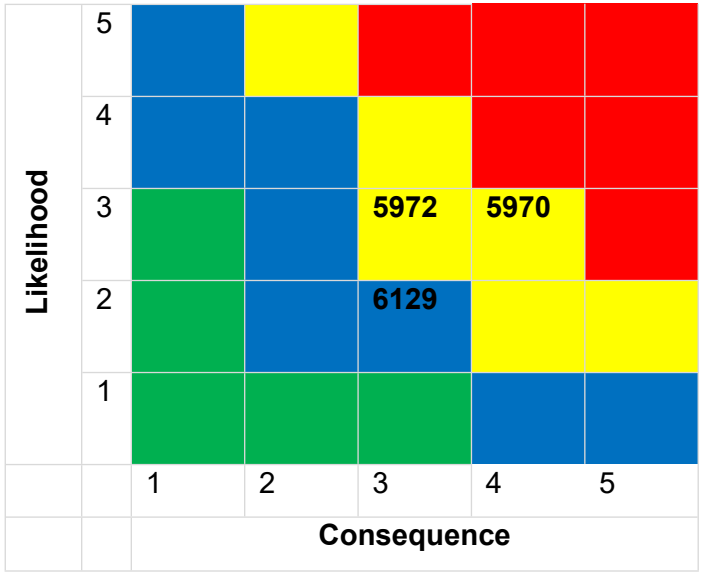
Strategic Priority: Innovation

We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered

Executive Lead: **Director of Transformation**

Reporting Committee: **Clinical Governance Committee**

Distribution of Corporate Risks for Innovation



5970 - Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff

5972 – Risk that improvement and transformation is not delivered in a timely manner

6129 - Risk of the non-delivery of the IT Improvement Plan

Principle Internal Risk: Risk of a lack of capability and capacity to deliver innovation	
Key Controls	**Assurance on Controls**
• Transformation Board • QI Operational plan and improvement strategy • QI Steering Group • People and Culture Committee • Clinical Governance Committee • Research Governance Framework • F&P Committee • Trust Board • Digital Steering Group • IT Improvement Plan • Digital Strategy Implementation Plan	• Model Hospital benchmarking • NIHR Wessex compliance reports • QI KPIs to evaluate success • Staff survey • Committee effectiveness review • Internal reports to F&P Committee, Trust Board and CGC

Principle External Risk: Risk of indecisiveness/fluidity in National policy and best practice	
Monitoring information	**Areas of influence**
• NHS Provider briefings • NHS Improvement briefings • NHS England briefings • Research networks	• Consultation on National policy • Representation on policy groups where appropriate • Contract negotiation

2020/21 Corporate Objectives – Innovation

Objective	Target Measures
No Going Back programme - Embed the use of virtual outpatient appointments	• 60% of outpatient appointments carried out virtually

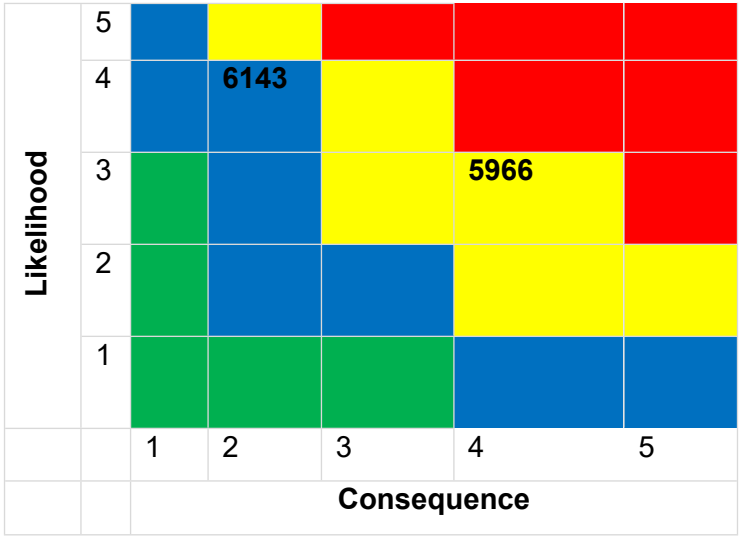
Gaps in Control/Assurance	Action	Deadline	Lead
Reduction in virtual appointments since April (40% in July 2020) (GA)	Delivery of Phase 3 recovery actions to increase the use of virtual appointments	Review 31/10/2020	Director of Transformation

Strategic Priority: Care

We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm

Executive Lead: **Medical Director and Director of Nursing** **Reporting Committee:** **Clinical Governance Committee**

Distribution of Corporate Risks for Care



5966 – Risk of compromised services due to hub and spoke model
6143 - Risk of the ability to provide the same quality of service 24 hours a day, 7 days a week with potential impact to patient care

Linked Risks
6235 - Risk of increased ED attendances in relation to suspected Covid-19 cases with potential to impact on patient flow due to isolation requirements (Local)
6213 - Risk of patients on the cancer pathway being missed or delayed with potential for patient harm as a result of having three systems involved in the pathway that are not contextually linked(Local)
6212 - Risk that patients with cancer will experience clinical deterioration as a result of not receiving a follow up appointment in the required timeframe which may result in mis-management, disease progression, limited treatment options and patient harm (Local)
5704 - Inability to provide a full gastroenterology service due to a lack of medical staff capacity (Local)
5751 - Risk of impact on patients from high numbers with a delayed transfer of care (Local)

Principle Internal Risk: Insufficient resources (skilled staff and infrastructure) to deliver safe effective care	
Key Controls	**Assurance on Controls**
• Integrated Governance Framework • Accountability Framework • Clinical and HR policies and procedures • Workforce plan • Clinical Management Board • People and Culture Committee • Divisional Performance Meetings • Contract Quality Review Meeting / contractual monitoring • Annual audit programme (national and local) • GIRFT Programme • Safety programme • Infection Prevention and Control Governance Framework and plan • Infection Control Board Assurance Framework • Learning from Deaths Policy • Appraisal and revalidation of doctors	• Internal reporting processes to Committees and Board • External reporting and benchmarking mechanisms • Internal audit programme • CQC inspection regime – last inspection report March 2018 • Patient Surveys/Friends and Family Test/Real Time Feedback • Executive Board safety Walks • Well led review completed March 18 • Internal Audit report on morbidity and mortality meetings • CQC peer review process • GIRFT reports and action plans • Annual appraisal quality assurance review

Principle External Risk: National initiatives may be unsuitable to deliver high quality care to the population of a small rural DGH	
Monitoring information	**Areas of influence**
• Integrated performance report – impact on metrics • National Policy – horizon scanning • Commissioning/decommissioning of services	• STP Boards and sub-groups • NHS Rural Hospitals Alliance • Clinical senates and networks • NHSE Specialist Commissioning • Local MPs

2020/21 Corporate Objectives – Care

Objective	Target Measures
1. Implement the National Patient Safety Strategy 2. Agree a Quality Assurance Framework incorporating ward accreditation and ward performance review process 3. Ensure that service delivery during the COVID-19 recovery phase is supportive of changing staff and patient needs.	• Patient Safety Strategy implementation plan agreed with time lines for delivery signed off • 2 Pilot wards undertaken first full ward accreditation and 100% of wards have undertaken first Ward Performance Review • Review of IPC Covid-19 BAF with Trust Board signoff. Target 90 % compliance with KLoE

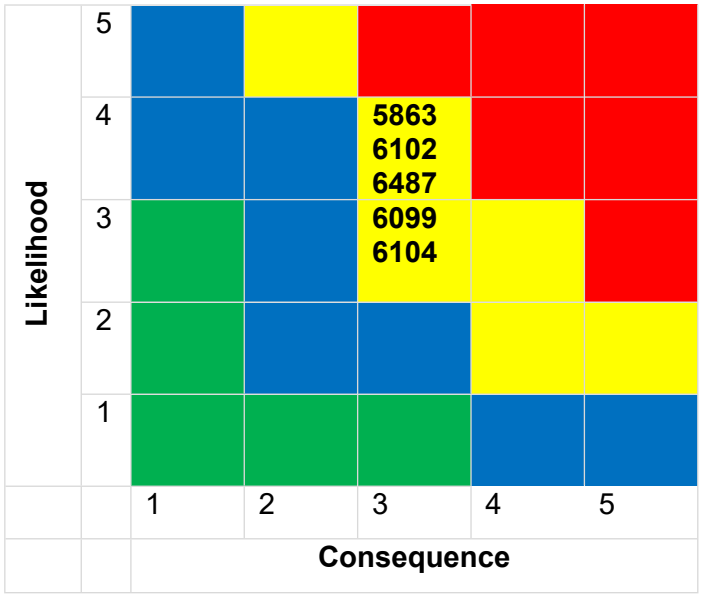
Gaps in Control/Assurance	Action	Deadline	Lead
Lack of ward accreditation system (GC)	Development of a ward accreditation system	31/03/2021	Director of Nursing
Lack of a clinical summary dashboard (GC)	Development of a clinical summary dashboard	31/12/2020	Director of Nursing
External estates review identified inadequate ventilation standards (GA)	Executive lead task and finish group to oversee delivery of the estates action plan	Commenced – in place	Chief Operating Officer
	Quotes for critical areas requested by Chief Operating Officer	Review 30/09/2020	
Non-compliance with Constitutional standards (GA)	Weekly monitoring of recovery through the Delivery group	Review 30/10/2020	Chief Operating Officer
Infection Prevention Board Assurance Framework non-compliance regarding anti-microbial stewardship (GA)	Additional 0.3wte microbiologist and improved ventilation in areas of aerosol generating procedures (linked to external estates review gap in assurance above)	30/09/2020	Director of Nursing

Strategic Priority: People

We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams

Executive Lead: **Director of Organisational Development and People** **Reporting Committee:** **People and Culture Committee**

Distribution of Corporate Risks for People



5863 – Risk of new HMRC rules for the NHS Pension Scheme impacting on consultant capacity across the Trust
6099 - Risk of not being able to recruit to hard to fill non-clinical posts resulting in continued use of high cost agency/locum support and/or outsourcing and/or discontinued services.
6102 - Risk of being unable to fill medical workforce gaps resulting in use of high cost agency/locum support and/or outsourcing and/or discontinuation of service.
6104 - Failure to retain overseas nurses could result in increased reliance on temporary staff and need to run further recruitment campaigns.
6487 - Risk of not being able to safely staff ward areas, ED and Critical Care as a result of the potential second wave of Covid-19

Principle Internal Risk: Risk that the Trust will be unable to recruit and sustain an engaged and effective workforce	
Key Controls	**Assurance on Controls**
• People and Culture Committee • OD & People Management Board • Health and Wellbeing strategy Board (from 19/7) • HR Policies • Directorate Performance meetings • People strategy Delivery Board • Safer Staffing Group • Equality, Diversity and Inclusion Committee (launch 29 July) • Health and Safety Committee • Freedom to Speak Up Guardians • JCC Staff Side Meeting • JLNC Committee (medical staff) • Vacancy control group • People Plan • Best Place To Work Programme	• Staff Survey • Staff Friends and Family Test • External Audits • Internal Audits • CQC Well Led Domain • Integrated Performance Report at Board • NHSI temporary spend caps • Leavers and starters surveys • Staff Engagement Group • Equality, Diversity and inclusion annual report • Health and safety annual report • Guardian of safe working report • Volunteers annual report • Monthly Workforce Dashboard at EWC • Executive Safety Walks

Principle External Risk: Risk that the local authority priorities for housing, retail and leisure results in Salisbury not being a place to work for your people	
Monitoring information	**Areas of influence**
• Integrated performance report – impact on workforce KPIs	Member of Wiltshire workforce group (local place based care, part of ICS)

2020/21 Corporate Objectives – People

Objective	Target Measures
• Best Place To Work Programme	Staff survey: • 65% response rate • Equality, Diversity and Inclusion score 9.4 • Health and Well-being score 6.5 • Staff engagement score 7.5

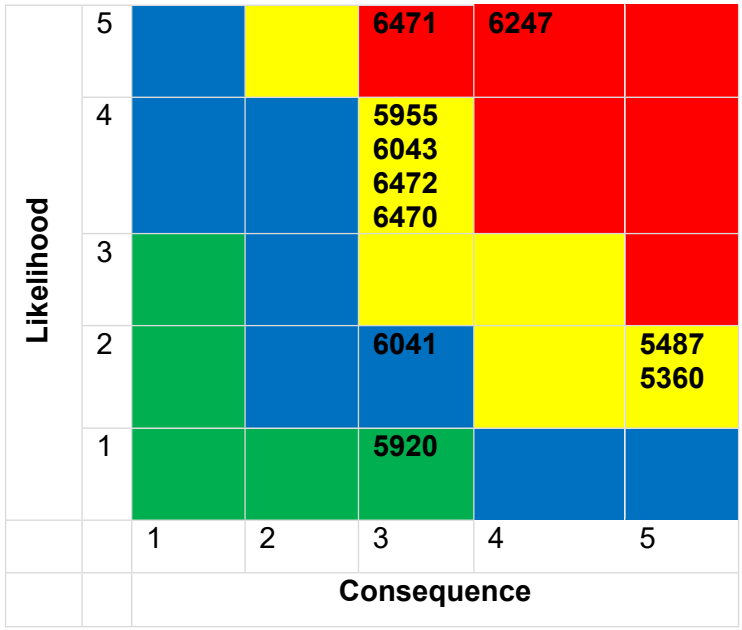
Gaps in Control/Assurance	Action	Deadline	Lead
No current identified gaps in control or assurance			

Strategic Priority: Resources

We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources

Executive Lead: **Director of Finance** **Reporting Committee:** **Finance & Performance Committee**

Distribution of Corporate Risks for Resources



5487 – The risk of a deteriorating financial position for a subsidiary company impacting on SFT cash flow and reputation
5920 – Breaches of fire compartmentation in PFI building
5955 - Insufficient robust management control processes
6041 - Risk of delivery of the NHS Long Term Plan ambitions due to a lack of capacity to build strong partnerships with the number of newly forming organisations at the pace required
6043 - Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT
6247 - Risks associated with critical plant and building infrastructure that may result in utility or system failure.
5360 - Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss.
6472 – Risk of not delivering key objectives aligned to operational, activity and workforce plans in year due to Covid-19 and the final elements of the 2020/21 planning round not being completed in line with national guidance.
6470 – Financial uncertainty for 2020/21 in light of Covid-19 disrupting the normal financial and planning regimes. Risk that cash flow is challenged.
6471 – Shortfall in funding available for capital programme with potential risk to safety and availability of buildings and equipment to deliver services.

Linked Risks
5972 - Risk that improvement and transformation is not delivered in a timely manner (Innovation)

Principle Internal Risk: Risk that the Trust will be unable to reach sustainability (income, cash, capital) and inability to shift the culture to meet priorities	
Key Controls	**Assurance on Controls**
• Finance and Performance Committee • Digital Steering Group • Accountability Framework – Directorate Performance Reviews • Contract monitoring systems • Contract performance meetings with commissioners • INNF Policy • Transformation Board • Capital control group • Budget setting process • Internal Audit Programme • Trust Investment Committee (TIG) • IT Improvement Plan • Digital Strategy Implementation Plan • Acute Alliance Programme Board • Local urgent and planned care boards	• Internal Performance reports to Trust Board • Audit Committee Reports • Internal Audit Reports • External Audit Reports • NHSI Benchmarking Report • Campus Joint Venture Agreement

Principle External Risk: Risk of a lack of available and qualified clinical resource	
Monitoring information	**Areas of influence**
• Workforce Committee • HEE Board reporting • NHSI Board reporting	

2020/21 Corporate Objectives – Resources

Objective	Target Measures
With Partners, develop BSW Integrated Care System	• ICS rated as maturing by April 2021

Gaps in Control/Assurance	Action	Deadline	Lead
Lack of National guidance on finance regime for 2020/21 M6+ and future years	No internal action		

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	03 September 2020		

Report Title:	Annual Health Safety Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Paul Knight, Health & Safety Manager Glennis Toms, Deputy Director of OD & People			
Executive Sponsor (presenting):	Lynn Lane, Director of OD & People			
Appendices (list if applicable):				

Recommendation:
The Trust Board is asked to review and note the contents of the annual report.

Executive Summary:
All organisations have a legal duty to put in place suitable arrangements to manage for health and safety. Ideally, this should be recognised as being a part of the everyday process of conducting business and/or providing a service, and an integral part of workplace behaviours and attitudes. Notwithstanding, a comprehensive legislative framework exists, within which the main duties placed on employers are defined and enforced. The Trust Board is responsible for providing leadership in the recognition and management of principal health and safety risks, and in the continuous improvement in health and safety performance. The Board fulfils its obligations through the designated Board lead for health and safety management, the Director of OD & People who, in turn, is responsible for the activities of a team of health and safety qualified professionals, including at least one Institute of Occupational Safety and Health (IOSH) chartered member. The team is led by the Trust's Health and Safety Manager. • Accident and incident statistics are at a stable level with increased activity and no key areas of concern. Violence and abuse to staff has increased but incidents resulting in physical harm have reduced • RIDDOR reports have decreased with no discernible trend

- Audit reports show good understanding and levels of health and safety, some workplace areas are not to standard but these are known with plans in place
- The HSE inspection have reported satisfactory compliance in 2 key areas with one material breach for asbestos management which was quickly rectified
- The SME's for manual handling & violence & aggression management are working to a HSE directed plan to strengthen protection of staff in these areas
- Independent assessment of H&S Risks

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

1 Purpose

1.1 The purpose of this report is to provide the Trust Board with summary information relating to principal activities associated with the promotion and management of health and safety issues for the period 1 April 2019 to 31 March 2020. The report highlights the current key priorities for the Health and Safety team in delivering a programme of work during this current financial year.

2 Background

2.1 All organisations have a legal duty to put in place suitable arrangements to manage health and safety. Ideally, this should be recognised as being a part of the everyday process of conducting business and/or providing a service, and an integral part of workplace behaviours and attitudes. Notwithstanding, a comprehensive legislative framework exists, within which the main duties placed on employers are defined and enforced.

2.2 The Health and Safety Executive (HSE) are the regulatory body with responsibility for enforcing health and safety legislation. The HSE also fulfils a major role in producing advice on health and safety issues, and practical guidance on the interpretation and application of the provisions of the legislative framework.

2.3 Regardless of the size, industry or nature of an organisation, the keys to effectively managing for health and safety are:
- leadership and management (including appropriate and effective processes);
- a trained/skilled workforce;
- an environment in which people are trusted and involved.

3. Local Health & Safety Governance

3.1 The Trust Board is responsible for providing leadership in the recognition and management of principal health and safety risks, and in the continuous improvement in health and safety performance. The Board fulfils its obligations through the designated Board lead for health and safety management, the Director of OD & People who, in turn, is responsible for the activities of a team of health and safety qualified professionals, including at least one Institute of Occupational Safety and Health (IOSH) chartered member. The team is led by the Trust's Health and Safety Manager.

3.2 With the support of the Board Lead for Health and Safety, and under the direction of the Health and Safety Manager, the principal responsibilities of the health and safety team are as follows:
- Developing and reviewing associated Trust policies, procedures and guidance;
- assisting the Board lead in the development of strategic health and safety objectives;
- establishing and implementing a programme of health and safety audits;
- co-ordinating and monitoring the effectiveness of safety arrangements across the Trust;
- identifying health and safety risks and implementing response plans;
- providing accessible and responsive advice and guidance to Trust staff on all health and safety-related matters;
- ensuring that all health and safety training needs and competence reviews are identified and met;
- Reporting RIDDOR incidents to the HSE and liaising with external statutory bodies.

3.3 The Deputy Director of OD & People, on behalf of the Board Lead, chairs the Trust Health and Safety Committee, which meets on a bi-monthly basis. Providing assurance to the Workforce Committee, the Committee is responsible for ensuring the development, implementation and maintenance of a health and safety policy, and supporting procedures, and for overseeing all aspects of health and safety management. The Committee membership includes all members of the health and safety team, representation from the Occupational Health and Wellbeing Service, nominated representatives of the clinical and corporate Divisions, and staff side health and safety representatives.

3.4 A number of health and safety sub-committees routinely report to the main Committee. The sub-committees are as follows:

- Waste management group
- LSMS and security development group (Including violence and aggression)
- Radiation protection committee
- Fire working party
- Medical gases group
- Central alerting system
- Risk report card
- Water safety group
- Laboratory safety group (Genetics and Pathology)

Following changes to the reporting structure the minutes of these groups are received from the sub-committees. A summary of their activities in this period are available. The minutes of the Health and Safety Committee are tabled at the Workforce committee (now People & Culture Committee) and are posted on the intranet.

3.5 The Trust aims to establish and maintain sensible and proportionate standards of health and safety management that will ensure the welfare of employees and others who may be affected by its activities, and to minimise its losses (both financial and reputational) arising from ill health and injury.

3.6 In 2019/2020 the achievement of this principal aim was supported by the achievement of a number of key objectives, which are summarised as follows:

- Continue to develop and support the health and safety union representatives with regulatory updates
- Spot audits on targeted key risk areas
- Monitor and act on CAS alerts, Safety Action Bulletins, and Field Safety Notices
- Monitoring the comprehensive investigation of serious incidents and ensuring prompt and appropriate measures are put in place to prevent recurrence
- Assess the relevant sections of the Risk Register
- Update of MLE packages where appropriate
- Policies to be kept up to date
- Induction and voluntary sector training
- Support all the various sub-committees
- Specific training on Risk Assessments
- Support and invigilate the capital bid system
- Integrate a food hygiene and food safety monitoring committee function within the auspices of the health & safety committee

3.7 Some elements have yet to be delivered in full:

- Develop, in conjunction with Occupational Health, a strategy for identifying and then implementing health surveillance through policy. This is part way through as part of the HSE plan
- Assessment of space usage under the workplace regulations is a continuous programme of work as the Trust continues to develop.

3.8 In addition to completing the above, aims for 2020/21 have been identified as follows:

- Targets for this coming year have to some extent been overwhelmed by the risks posed to staff by COVID19, working practices, and the provision of technical expertise on all aspects of PPE especially RPE. There have been challenges around the supply chain and decisions made as to what constitutes 'fit for purpose' and networking with other DGH's around the South and South West has become invaluable.
- Resolve central recording of individual fit testing for PPE.
- Finish the environmental assessments across the site as required by HSE
- Work with the Estates team to create an open audit system with staff engagement

4 Health & Safety Audit System

The audit system has been in place since 2016 and has this year been completed by Genetics, Central Booking, Day Surgery Unit and Hospice. The areas are determined by the health and safety committee and completed by a responsible person from each area. The audit consists of 25 health and safety topics, each populated with a number of questions (Yes/No or N/A) or fields to enter data.

It is a mixture of subjective and objective questions but it does give clear indication to strengths and weaknesses whether that is for individual areas, subjects or questions. The audit also requires the management to complete a short safety tour of their area which is very objective and an accurate snapshot of what is in place.

The system provides a valuable view of the Health and Safety within the specific area and identifies action required by local management, where necessary with support from Health & Safety professionals. The details of the audits, including scores and action plans, may be viewed in the department on request.

Overall, clinical waste, COSHH, water safety, fire safety, work equipment, PPE, security incident reporting and infection prevention and control were high. Low scores did not show any specific pattern.

Four further areas will be selected at the September 2020 H&S committee meeting for audit by Mach 2021.

5. Activity of the Health & Safety Committee (H&SC)

Five scheduled meetings took place as COVID19 accounted for March 2020 meeting to be cancelled. The attendance was 65% for the year compared to last year's 58%.
Its routine activities are:-

- Consider RIDDOR reports for the period and analyse yearly figures
- Analyse incident trends
- Consult on and validate policies

- Ensure that the committee is fully informed of H&S activity across the south/southwest and nationally
- Assess and update the risk register
- Assess the impact of health & safety legislation

In addition this year the Committee also managed:

- The HSE inspection and its recommendations
- Risk Assessment training
- PFI fire compartmentation
- Upgrade of the Radionuclide laboratory
- Food safety which has now been incorporated into the remit
- Driver Safety (including Tugs)
- Diathermy smoke effects
- Car Park safety and lighting
- Chemical safety, specifically Chlorohexidine
- Entonox levels maternity
- Smoking support for staff
- Waste contract
- Anonymous H&S Complaints and NHS national Alerts
- Recommendations of the fire working party

6. HSE and Enforcement Visits

The Trust fielded a major visit from 9 inspectors from the HSE over the 3rd and 4th of July.

They were visiting specifically to test the Trust on three major areas:

- its systems to protect staff from manual handling injuries,
- the physical and mental protection from violence, aggression and abuse and
- whether the Trust had sound foundations under the control of asbestos at work regulations.

A project plan was launched and a planned approach undertaken.

The areas visited were ED, Security Services, PMO, Occupational Health, Maternity, Theatres, Community Midwifery, Estates, Chilmark, AMU, Whiteparish, Redlynch, Estates, Facilities, Farley, Spire, Avon, Tamar, and a whole site visit in relation to Asbestos.

The Inspectors interviewed a range of people from the Chief Executive, Executive Directors & senior managers, to staff working in all of these areas.

The feedback at the end of the second day was positive although issues had emerged about occupational health and health surveillance. Assurances were given on the day by the health & safety manager and this was followed up in writing to confirm the discussion to the acceptance of the lead inspector. The lead inspector then returned to the Trust some 2 weeks later to deliver the findings of the inspection to the executive group.

1. Manual Handling – Full compliance with the standards
2. Prevention of Violence and Aggression – Full compliance with the standards
3. Asbestos management – Notification letter of a material breach

On the first 2 elements, the inspector outlined verbally some of his teams' thoughts whereby we could strengthen our approach. He then confirmed this in writing to the Trust. That letter has formed the basis of 3 project plans which the SME's have either completed or near to completion. Outstanding elements are a Trust wide assessment of noise, vibration

and particulate exposure and the update of the violence and aggression policy. The asbestos breach was rectified by an outside specialist contractor. The material breach was complied with and confirmed by the inspector. The full detail of the project plan is available.

7. RIDDOR Reports

This year there was 10 involving staff compared to last year's 12, and the lowest number since recording in 2011. There were no patient RIDDORs.

2011 – 2012	30
2012 – 2013	26
2013 – 2014	35
2014 – 2015	21
2015 – 2016	21
2016 – 2017	24
2017 – 2018	21
2018 – 2019	12
2019 – 2020	10

Most incidents were slips trips and falls, which were investigated and general advice was given to take more care. All manual handling, musculoskeletal injuries were investigated, general good practice was reinforced but no systemic failures were unearthed. There were no needlestick injuries reported.

8. Incident reporting and trend analysis

This year there was a total of 241 staff accidents and incidents; this is showing a very stable situation over the past 5 years. This is encouraging in light of the increased activity of the Trust and the non-standard activities experienced over the periods. There has been a slight uplift in contact with an object but slips trips and falls are down in number. The 18/19 year's reduction of violence and aggression numbers which directly correlates to the introduction of security on site has risen for the second year running. However, there are some underlying factors in that a specific small number of patients generated a significant contribution to the total.

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Slips Trips Falls	106	84	46	50	50	88	44
Hit By Object or Contact	53	33	52	48	55	21	36
Needlestick Sharp	117	115	72	93	81	91	86
Electricity/Substance/ Infection	78	67	48	36	47	37	28
Lifting accidents	125	76	54	48	55	48	47
Total	479	375	284	287	288	285	241

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Verbal Violence & Aggression	180	66	58	38	54	81
Physical Assault Violence Weapon	81	61	59	58	91	79
Those above resulting in injury	64	35	38	36	39	33
Total	261	127	117	96	145	160

8. Risk Profile

The following information is based on the 'risks open' and the 'risks closed' currently held on the Datix database. The search criterion was on 'organisational risks' as these are, in the main, health and safety related.

Category	Total No			Average			Range		
	17/18	18/19	**19/20**	17/19	18/19	**19/20**	17/18	18/19	**19/20**
New Risks	3	2	**4**	8.1	6.0	**8.5**	6-10	4-8	**6-10**
Open Risks	29	38	**40**	5.6	5.8	**6.0**	2-10	2-12	**2-12**
Closed Risks	88	101	**112**	4.7	4.5	**4.5**	0-12	0-12	**0-12**

Summary of significant open risks

These risks events have been generated by individuals in the organisation; the RAG rating below is an assessment of the potential for action/mitigation and residual risk. The PPM risk is still in place and deteriorating as is the nature of the risk. There has been a reduction from the provision of lead gowns as an assessment has been conducted and funding made available. It remains a risk however, because we have not moved to a managed system, which is the preferred option. There have been no changes to the ratings but 1 new risk has been identified.

Long Term Risks

Risk Score 3 DR=0	Compliance with the electricity at work regulations	Acceptable with continued rotational 5 year funding to a programme to test the Trusts infrastructure (to be removed). There has been a contractor appointed for fixed wire testing and we

		in the process of developing a plan for the work with the 1st phase to include the Trust's accommodation flats / houses.
Risk Score 4 DR=8	Fire Door wear and tear	Acceptable with programme of replacement and modification on an annual basis. Works on the doors on-going with the in-house 'New Works' team.
Risk Score 6 down to 4 DR=6	Fire Dampers PFI	No funding required as it is excessive compared to the risk and revolves around the reset ability in PFI – Work close to completion with the majority of the works being completed, there are circa 30 locations where access isn't possible.
Risk Score 9 DR=0	Fire Alarm Tone has been resolved	No funding required as it is excessive compared to the risk, an emergency tone is still being generated (to be removed) and work has been completed on the tone pattern in SDH North.
Risk Score 9 DR=9	Capacity of Medical Records	This is a risk that will continue to grow with time in the short term but may alleviate with digitalisation
Risk Score 10 up to 12 DR=12	Planned Preventative Maintenance resources	This is a risk that carries the greatest potential in that the outcomes are many and unknown. The Estates review has identified this area and has recommended a dedicated PPM fix.
Risk Score 8 up to 10 DR=10	Provision of Lead Gowns (PPE) is still deteriorating even with added money this last year	This is a risk that will continue to grow as gowns continue to grow older, there has been 1 off capital input followed by a second

Last year (18/19)

Risk Score 6 DR=9	Provision of manual handling advice, the score has reduced as some measures have been implemented	There is growing pressure on the MHA as clinical input on bariatric patients increases, there is no cover for this role and the provision of this service is being evaluated
Risk Score 8 DR=6	Provision of a Radiation Protection Adviser, score has gone up as per the number of HSE notices served 2019/20	Trusts are being put under pressure by the HSE (more inspectors recruited by HSE and CQC) and there needs to be a contingency plan for this role as again, it is a single point of failure.

This year (19/20)

Risk Score 9 DR=12	CL3 containment laboratory pressure not maintained in power failure	Cabinets are on UPS systems and continue working but the motors that maintain the lab pressure will power down in a mains failure for a period

DR = Datix Risk Score

9 Summary

9.1 Accident and incident statistics are at a stable level with increased activity and no key areas of concern. Violence and abuse to staff has increased but incidents resulting in physical harm have reduced

9.2 RIDDOR reports have decreased with no discernible trend

9.3 Audit reports show good understanding and levels of health and safety, some workplace areas are not to standard but these are known with plans in place

9.4 The HSE inspection have reported satisfactory compliance in 2 key areas with one material breach for asbestos management which was quickly rectified

9.5 The SME's for manual handling & violence & aggression management are working to a HSE directed plan to strengthen protection of staff in these areas

9.6 Independent assessment of H&S Risks

10. Conclusions

10.1. The Trust has fielded the largest concentration of HSE inspectors seen in Acute Service Hospitals. It is testament to the hard work and diligence of our staff that we emerged from the 3rd and 4th July 2019 with the leading inspector stating that we met all the requirements of the areas under scrutiny. We did receive over 50 recommendations for further strengthening our approach.

10.2 The material breach in our asbestos controls, identified in the letter by the specialist inspector, was a timely reminder. Our approach and management systems, which would have in the past been in keeping with the regulations, had drifted behind current expectations. It was a quick fix to bring our register up to current standards and although they thought our records were too simplistic, they did not identify that anyone was being put at risk.

10.3 The occupational health assessment has been started but to some extent, been stalled by the COVID19 situation, this should be completed to form a report back to the H&S Committee later this year.

10.4 The major challenge going forward is radiation protection. It is an area invigilated by 3 regulators and they have an MOU, so one can flag any shortfalls to the other. Plus, there are far more specialised inspectors in this area than ever before. We have received statutory notices in the past in relation to this issue. The Radiation Protection Committee has lost 2 key members, and new members need to develop rapidly to maintain this complex, technical and ever moving set of standards.

10.5 The assessment of risk to the estate from a failing PPM system has not been remedied, however, there has been identified resources to do the work and a compliance post to undertake due diligence.

5 Recommendations

5.1 The Trust Board is asked to review and note the contents of the annual report.

Paul C Knight, CMIOSH
Health & Safety Manager

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.2
Date of Meeting:	03 September 2020		

Report Title:	Guardian of Safe Working Annual Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		x	
Prepared by:	Dr Juliet Barker			
Executive Sponsor (presenting):	Sallie Davies			
Appendices (list if applicable):				

Recommendation:
The committee notes a reduction in exception reporting from junior doctors in most areas; however F1s remain high reporters.

Executive Summary:
In this reporting period there have been 112 exception reports detailing 148.5h overtime, almost exclusively from doctors within the medical division – predominately F1s. The vast majority are reporting weekday overtime hours, and the general theme is that there are not enough doctors to do all the work within hours. There have been no immediate safety concern reports. One report cited lack of support. There have been no reports citing missed educational opportunities. Compensation payment has been agreed in 74 cases and 13 received time off in lieu. Nine are still 'pending' and 12 are recorded as 'no further action'. There has been one small fine issued, for working >13h. There are significant rota gaps particularly at senior (middle grade trainee) level. Trust doctors are used to fill many of the gaps, however: 105 WTE months remain unfilled in the year across the junior doctor spectrum: an average of 8.75 WTE posts each month. This does not include hours 'lost' by less than full time working. Of note, the F1 rota has been completely filled and additional F2 posts have been secured for 2020-21. These data are a significant improvement on last year.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐

Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☐
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☐

1 Purpose

The 2016 Junior doctor contract introduced the role of the guardian of Safe working and requires that the guardian reports to the board (or via a committee) every quarter and produces a consolidated annual report, which is included as a statement in the Quality Account

2 Background

The Trust is allocated approximately 150 trainees by the Deanery, with numbers of trainees across the region controlled and limited by the General Medical Council and Health Education England. The junior doctors contract was negotiated in 2016 but not formally adopted until 2019 at which time additional restrictions on hours, consecutive long shifts and weekend working were introduced, with the aim of protecting junior doctors from overwork and protecting their training opportunities.
Since 2016 trainees are required to report any instance that they work beyond the hours in their work schedule (national andlocal guidance gives a leeway of up to 15 minutes), any missed training opportunities and “immediate safety concerns” when they believe patients are being put at risk by excessive hours or insufficient doctors. Excess hours can arise for a number of reasons including:

- Rota gaps resulting in fewer doctors than planned – for example due to the Deanery failing to recruit trainees, less than full time trainees, maternity leave, sick leave or poor annual leave planning.
- Unrealistic work schedules that do not meet the needs of the service
- Junior doctor factors including capability, organisational skills and clinical experience
- Supervision factors including lack of support, unrealistic expectations
- Infrastructure issues particularly IT, but also bleeps and telephones
- Lack of support from other health care professionals including nurses, pharmacists and admin staff.

We also employ an increasing number of locally employed doctors at junior and senior trainee level to fill rota gaps and provide additional staffing. Although their terms and conditions and work schedules mirror those of the deanery trainees they are not required to exception report.

3 Rota Gaps

The rota gaps in this report occurred between August 2019 and August 2020

Number of doctors / dentists in training (total):	164
Number of doctors / dentists in training on 2016 TCS (total):	164
Number of trainees expected to be supplied by the deanery:	150

<u>Covid-19</u>

This year, it has been particularly difficult to manage the workforce due to the effects of Covid-19. Trainees did not rotate into their expected jobs and hospitals from April. There was significant internal redeployment, often for short periods of time and at short notice. We did not receive specific complaints about this, bar from one person. This was investigated and found to be in part due to workload issues and in part due to the doctor in question struggling on a more personal level. There were no exception reports from mid March to June.

The guardian of safe working was on sick leave for a portion of the year and was covered internally.

Comment

It has become increasingly apparent over the year that extracting accurate data on rota gaps is very difficult. This is because there seems to be no one department/individual who has oversight of all staffing – trainees are managed by one area and trust doctors, particularly those employed on a short term/ad hoc basis are managed within departments. An e-rostering system is planned to make this information much more transparent.
The tables below show the gaps in expected deanery appointments. Those shaded green are filled with trust grades (non deanery appointed, non training-pathway doctors of appropriate experience). Please note that from April-August the figures described are what was *planned* to happen. What actually happened in these months (due to trainees not rotating) is more closely reflected in the data from Dec-March.

Junior Trainees (F1-CT2)

	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Ed/GPVTS							2	2	2	2	2	2
Anaesth CT2	1	1	1	1	1	1	1	1	1	1	1	1
Dental					1	1	1	1	1	1	1	1
Gastro F1					1	1	1	1				
Public health F1									1	1	1	1
Stroke/CoE CMT									1	1	1	1
Gastro CMT	1	1	1	1								
GIM CMT					1	1	1	1				
T&O CST2	1	1	1	1	1	1	1	1	1	1	1	1
Plastics ST2	1	1	1	1	1	1	1	1	1	1	1	1
Plastics CST2							1	1	1	1	1	1
Surgical F1	1	1	1	1								
WTE Gap	5	5	5	5	6	6	9	9	9	9	9	9
Filled by trust grade	4	4	5	5	5	5	4	4	3	3	3	3
Unfilled gap	1	1	0	0	1	1	5	5	6	6	6	6

Senior Trainees ST3-7

	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Resp	1	1										
Cardiology							1	1	1	1	1	1
O&G MTI	1	1	1	1	1	1	1	1	1	1	1	1
Gastro			1	1	1	1	1	1	1	1	1	1
Ophthal					1	1	1	1	1	1	1	1
Paeds	2	1	1	1	1	1	1					

ENT			1	1	1	1	1	1	1	1	1	1
Plastics	1	1	1	1	1	1						
Rehab/spinal	1	1	1	1	1	1	1	1	1	1	1	1
WTE Rota gap	6	5	6	6	7	7	7	7	8	8	8	8
Filled with trust grade	1	1	2	2	2	2	1	1	1	1	1	1
Unfilled Gap	5	4	4	4	5	5	6	6	7	7	7	7

Issues arising

The rota gaps are due to a variety of issues including, maternity leave, paternity leave and no doctor being allocated by the deanery. I estimate we have about a 9% shortfall on average – which is partially filled with trust grades. 44% of gaps are unfilled at junior level and 80% of gaps are unfilled at senior level. Nationally, there is about a 10% vacancy rate among medical staff. Specialties which are particularly hard to fill at SDH (e.g. paediatrics at senior trainee level) are often also under-recruited nationally. There are difficulties in recruiting due to a lack in appropriately qualified doctors for the posts that remain unfilled

We believe we are under-doctored as a hospital (ie other hospitals of a similar size have more doctors). This is historical – the conversion from Calman posts (house officer, senior house officer, registrar etc) to MTAS posts c2007 was not direct and we believe the new post number was too low.

We have not been able to clearly ascertain the vacancies in trust grade doctors, as this report should include. Asking the departments has either met with the response that there are no gaps in their expected trust grade roles, or there has been no response.

Actions taken to resolve issues

- Several workforce reviews have occurred throughout the year to try to better understand the main areas of concern and difficulty due to staffing problems. Junior doctor night shifts have been highlighted as an issue, as has weekend working. Task forces have been developed to look at these areas specifically, but the work was paused during the Covid pandemic.
- Significant numbers of rota gaps have been filled with trust grade doctors, across all specialties and grades. However, some of these are not contracted to cover night or weekend working, which makes the picture less clear.
- Internal locums have been provided to help during weekend medical takes and have had a notable effect on reducing the workload.
- Additional senior nursing staff input made weekend working subjectively better over the winter, but this was a pilot initiative not substantively funded or recruited to. A full evaluation of this pilot has been delayed due to Covid

4 Exception Reports

The exception reports in this report were submitted between 24th June 2019 and 23rd June 2020. In this reporting period there have been 112 exception reports detailing 148.5h overtime, almost exclusively from doctors within the medical division – predominately F1s. The vast majority are reporting weekday overtime hours, and the general theme is that there are not enough doctors to do all the work within hours.

There have been no immediate safety concern reports.
One report cited lack of support.
There have been no reports citing missed educational opportunities.
Compensation payment has been agreed in 74 cases and 13 received time off in lieu. Nine are still 'pending' and 12 are recorded as 'no further action'. There has been one small fine issued, for working >13h.

5 Summary

The Guardian of Safe Working has a responsibility to raise concerns about junior doctor staffing levels and excessive hours impacting on patient safety. In this Trust junior doctor vacancies are slightly lower than the national average but despite this doctors are exception reporting and can feel over-worked. We have successfully recruited locally employed doctors and we are currently recruiting a Training and Development lead to ensure they are adequately trained and supported, to improve retention. Whenever additional trainee posts are offered by the Deanery we accept, and we have secured an additional six FY2 posts from August which will provide support for the Hospital at Night and ED rotas.
Night working and senior decision makers at night continue to be a worry and the medical registrar rota from August is under-recruited, requiring agency doctors to fill vacant shifts.
The onerous weekend working for juniors in the Medical division has been mitigated by the extra locum shifts and during the Covid pandemic weekend staffing was identical to that during the week.
Using our own juniors and those from neighbouring trusts to do additional locum shifts risks them breaching their safe working hours and is very difficult to monitor. It is not a sustainable proposition.
In order to provide safe medical staffing and high quality training at this Trust in the face of a national shortage of doctors and a new contract with more constrained working hours, we need to continue to press the Deanery to provide additional trainees and recruit, support and develop our locally employed doctors. It is hoped that the more junior LEDs will with the right support and training be able to progress into senior decision-making roles. In addition non-medical support (physicians assistants, phlebotomy services, prescribing pharmacists, extended scope practitioners etc.) will need to be found a place in the workforce without adversely impacting on training opportunities, and our consultants will almost certainly need to be providing more hands on clinical service including weekend and out of hours.

6. Recommendations

The committee notes a reduction in exception reporting from junior doctors in most areas; however F1s remain high reporters.

Dr Juliet Barker
Guardian for Safe Working Hours
Consultant Anaesthetist.
July 2020

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.1
Date of Meeting:	03 September 2020		

Report Title:	Director of Infection Prevention & Control (DIPC) Annual Report for 2019/20			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Fiona McCarthy, Senior Nurse, Infection Prevention & Control Team			
Executive Sponsor (presenting):	Judy Dyos, Director of Nursing and DIPC			
Appendices (list if applicable):	Included within the report			

Recommendation:

The Board is asked to:

1. Note the report, and the performance against Infection Prevention and Control requirements for the year.

2. Minute/document that the Board continues to acknowledge their collective responsibility as described within the DIPC report and confirm receipt of assurance on IPC actions and controls for the year.

Executive Summary:

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is delegated to the Director of Infection Prevention & Control (DIPC) who is the Director of Nursing.

The DIPC Reports together with the monthly Key Quality Performance Indicators Report are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of this annual DIPC Report is to inform the Trust Board of the progress made against the 2019/20 Annual Plan, to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

For the reported period, the Trust has experienced a positive twelve months for infection prevention and control performance. The Trust has achieved good outcomes to date and maintained compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Department of Health, 2015).

This annual report takes the opportunity to celebrate the successes and highlights the increasing challenges moving forward:

1. There has been one Norovirus outbreak period lasting less than 13 days, and no other declared outbreaks of healthcare associated infections (HCAIs) or alert organisms.

2. The Trust continues to report the lowest HCAI rates overall across the South West region, with the exception of *Pseudomonas aeruginosa* bacteraemia (third lowest rate in the region) and no Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia cases identified.

3. *Clostridioides difficile (C.difficile)* definition changes (April 2019) have resulted in higher numbers reported as 'healthcare associated' which include a group of cases where the onset was in the community. This is a significant performance challenge for the organisation. The Trust has had 22 reported healthcare associated *C.difficile* cases against a trajectory of no more than 9 cases for 2019/20. For this reported period, a total of 8 healthcare associated *C.difficile* cases have been successfully appealed with the relevant Clinical Commissioning Group (CCG), as no lapses in care were identified from the incident investigations undertaken by the Trust.

4. Mandatory surveillance of orthopaedic surgery has continued with one identified deep infection for knee replacement surgery.

5. Antimicrobial stewardship continues to be one of the key measures to reduce the risk of *Clostridioides difficile* infection and the single most important measure to reduce the selection of multiple antibiotic resistant bacteria. There have been considerable achievements with antibiotic prescribing standards over the years and concerted effort continues with decreasing consumption for the use of all antibiotics. There will be continued focus on our antibiotic stewardship campaign and audit work.

6. Continued use of the Perfect Ward App provides transparency of infection prevention and control practices through audit within each ward area.

7. Significant amounts of work have been completed and remain ongoing with our decontamination services, which has been escalated to executive level.

8. Environmental cleanliness standards, which are monitored regularly and validated quarterly, are maintained to a high standard. The Patient Led Assessment of the Care Environment (PLACE) scores showed an improvement to what was already a high standard of environmental cleanliness and is above the national average.

9. Water safety has been the subject of ongoing focus, with our ageing estate and environment posing challenges, to ensure we have effective controls and proactive management in place.

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

Salisbury
NHS Foundation Trust

INFECTION PREVENTION AND CONTROL

DIRECTOR OF INFECTION PREVENTION AND CONTROL

ANNUAL REPORT

April 2019 – March 2020

LORNA WILKINSON
Director of Infection Prevention and Control (DIPC)

June 2020 (Final v.2)

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APPENDICES

1. INTRODUCTION

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is delegated to the Director of Infection Prevention & Control (DIPC) who is the Director of Nursing.

The DIPC Reports together with the monthly Key Quality Performance Indicators (KQPI) Report are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of this annual DIPC Report is to inform the Trust Board of the progress made against the 2019/20 Annual Action Plan (Appendix A), to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The action plan focuses on the Trust achieving the standards identified in 'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (2015), to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible.

For the reported period, the Trust has experienced a positive twelve months for infection prevention and control performance. This has involved:

- One Norovirus outbreak period lasting less than 13 days
- The Trust continues to report the lowest HCAI rates overall across the South West region, with the exception of *Pseudomonas aeruginosa* bacteraemia (third lowest rate in the region) and no Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia cases identified
- Significant amounts of work have been completed and remain ongoing for antibiotic stewardship, decontamination and cleaning services
- Water safety has been the subject of ongoing focus, with our ageing estate and environment posing challenges, to ensure we have effective controls and proactive management in place.

However, it is important to note that the following risks to delivery were identified:

- The retirement of a Consultant Microbiologist who supported the antimicrobial stewardship work. There is a locum Microbiologist in place and one of the substantive Consultant Microbiologists will focus on the antimicrobial work, so this gap lessened into the second half of the year
- *Clostridioides difficile (C.difficile)* definition changes (April 2019) have resulted in higher numbers reported as 'healthcare associated' which include a group of cases where the onset was in the community. This has had a direct impact on workload for the Infection Control Nurses (ICNs) as all require a full root cause analysis and substantial time commitment in not only the investigation but preparation for appeals panels
- Fragility of the decontamination services which has been escalated to executive level.

2. GOVERNANCE ARRANGEMENTS

The work towards achieving the objectives of the Annual Action Plan 2019/20 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) and onto the Clinical Governance Committee (CGC), which completes the governance arrangements (Appendix B).

3. INFECTION PREVENTION & CONTROL ARRANGEMENTS

A comprehensive infection prevention and control service is provided Trust wide. The Infection Prevention and Control Team (IPCT) provides a liaison and telephone consultation service for all inpatient and outpatient services, with additional arrangements for seven day service cover by an Infection Control Nurse (ICN) during declared Norovirus outbreaks.

The IPCT currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 3.0 whole time equivalent (w.t.e) ICNs and secretary (0.6 w.t.e). In addition, there are 2 Consultant Microbiologists, one of whom is the Trust Antimicrobial Lead. *(Of note: one Consultant Microbiologist retired in June 2019, with a locum currently covering that position until March 2020).*

4. ASSURANCE ACTIVITIES

The IPCC monitors the action plan on behalf of the Trust Board, which is achieved through the following actions:

- Agree an annual infection control programme and monitor its implementation
- Oversee the implementation of infection control policies and procedures
- Monitor and review the incidence of HCAI
- Develop and review information regarding infection prevention and control
- Monitor the activities of the Infection Prevention and Control Team
- Benchmark the Trust's delivery of control of infection standards in various accreditation systems, and against Care Quality Commission (CQC) Regulations
- Monitor the implementation of infection prevention and control education
- Receive regular updates from the Antibiotic Reference Group (ARG)
- Receive regular updates from the IPCWG
- Monitor compliance and formal reporting on Legionellosis and Pseudomonas water management, via the Water Safety Group (WSG)
- Receive regular reports from the Decontamination Working Group (DWG)
- Receive regular reports from the Facilities directorate regarding cleaning programmes.

5. HEALTHCARE ASSOCIATED INFECTION (HCAI) STATISTICS AND SURVEILLANCE

The Trust is required to report any HCAI outbreaks externally as a serious incident (SI). An outbreak is defined as the occurrence of two or more related cases of the same infection over a defined period. When a HCAI outbreak is declared, the Trust initially reports the outbreak to the relevant Clinical Commissioning Group (CCG) and other regulatory bodies, e.g. NHS Improvement (NHSi), within 2 working days, and must undertake an investigation and submit a formal written report within 45 working days.

The Trust is also required to record these incidents on the strategic executive information system (STEIS) in line with the Serious Incident Framework: Supporting learning to prevent recurrence (NHS England, 2015), and the Health Protection Agency HCAI Operational Guidance & Standards (2012), Health Protection Agency now Public Health England (PHE) from 1st April 2013.

During 2019/20, the Trust has had **no** declared outbreaks of:

- *Clostridioides difficile* (*C.difficile*)
- *Staphylococcus aureus*, including Methicillin Resistant *Staphylococcus aureus* (MRSA)
- Methicillin Sensitive *Staphylococcus aureus* (MSSA)
- Carbapenemase producing enterobacteriaceae (CPE)
- Invasive Group A Streptococcus (iGAS)
- Multi-drug resistant Acinetobacter baumannii (MDRAB)
- Chickenpox (Varicella zoster)
- Extended Spectrum Beta Lactamase (ESBL) producers, including *Klebsiella Pneumoniae*
- Pertussis
- Respiratory Syncytial Virus (RSV)
- Influenza ('flu)
- Vancomycin Resistant Enterococcus (VRE)
- Tuberculosis (TB).

Additional information regarding alert organisms can be accessed from the PHE website: https://www.gov.uk/government/organisations/public-health-england

The ICNs provide clinical teams with infection control advice, support and education on a daily basis to all inpatient and outpatient areas. The management of patients admitted with suspected and known alert organisms is discussed, and risk assessments undertaken. The Isolation Risk Assessment Tool (IRAT), Flowchart for the Management of Inpatients with Diarrhoea, and Diarrhoea Pathway have been developed and implemented to assist staff competency and confidence in the management of cases.

The availability of sideroom facilities across the Trust site to isolate infected patients can be limited at times when demands on bed capacity are high. In such instances, risk based decisions are necessary. Patients with alert organisms can be safely managed either within cohort bays, or isolation nursed in a bedspace. The ICNs continue to review patients nursed in siderooms on a daily basis to prioritise high risk patients. Information and guidance is communicated to the ward nursing and medical teams and the Clinical Site Coordinators (CSC), with additional written documentation provided to support staff in the ongoing management of these patients.

5.1 Norovirus (viral gastroenteritis)
During 2019/20, the Trust has experienced a fairly consistent level of activity associated with patients experiencing diarrhoea and vomiting. This included patients admitted with symptoms of diarrhoea and/or vomiting and isolated in a sideroom from admission, and patients who were nursed in a bay environment and developed symptoms during their admission period.

During quarter 3 of 2019/20, the Trust declared an outbreak of viral gastroenteritis (Norovirus), from 8th to 20th December 2019, following the closure of two wards initially within the surgical and medical directorates (Downton and Spire Wards). A total of six wards were affected with bay closures/ward closures during the declared outbreak. These closures ensured the safe management of patients and continued service provision. The Trust Norovirus Outbreak management policy was followed with the appropriate internal and external personnel involved.

A review meeting for this serious incident was held during quarter 4 of 2019/20 (February), with the final report (Serious Incident Inquiry (SII) 345) detailing recommendations and identified actions written. This report is for final agreement by the DIPC and IPCWG members during quarter 1 of 2020/21.

5.2 Coronavirus (Wuhan CoV)
On 31st December 2019, the World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province in China. On 12th January 2020, it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak. The virus is referred to as SARS-CoV-2, and on 11th February, WHO named the syndrome caused by this novel coronavirus COVID-19. The source of the outbreak has not yet been determined. According to current evidence, it is primarily transmitted between people through respiratory droplets and contact routes. Airborne transmission is possible in specific settings in which procedures or support treatments that generate aerosols are performed. The first cases were confirmed in the United Kingdom (UK) at the end of January 2020 and WHO declared a pandemic on 11th March 2020, when at that time there were more than 118,000 cases globally across 114 countries, with 4291 reported deaths.

From January 2020, the Trust initiated emergency planning and resilience response measures utilising significant PHE guidance and updates published as the situation continued to evolve. This included the identification of emergency assessment/triage areas, respiratory assessment zones and care areas, testing programme and PPE practice management. The Trust has followed established Emergency Preparedness, Resilience and Response (EPRR) protocols which include the instigation of strategy planning and Incident Management Team (IMT) meetings, with key personnel to agree actions and develop iRespond cards across the directorates and disciplines. This work remains ongoing into quarter 1 of 2020/21 and further information will be included within the next DIPC mid year report.

6. MANDATORY SURVEILLANCE

Alert organism and alert condition surveillance data is collected and used by the Trust to detect outbreaks and monitor trends.

It is a mandatory requirement for NHS Acute Trusts to report Methicillin Resistant *Staphylococcus aureus* (MRSA) and Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias, and *Clostridioides difficile* infections to the Department of Health (DH) via the HCAI Data Capture Site (DCS) system, hosted by Public Health England (PHE).

6.1 Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias

During 2019/20, there have been no MRSA bacteraemia cases. The Trust's MRSA hospital onset case target for 2019/20 is zero.

6.2 Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias

During 2019/20, there have been 5 hospital onset MSSA bacteraemia cases, with one of these cases identified to be probably line related (peripheral device). In depth post infection reviews were carried out and key learning included:

- Continuing monitoring of all invasive devices by staff and maintaining the required care documentation
- Adhering to the relevant Trust policies relating to the taking of blood cultures and skin disinfection/decontamination.

Of note: Currently, there is no national guidance for data definition of MSSA bacteraemia cases for targets to be set. Therefore, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the MSSA bacteraemia cases recorded within the Trust. This allows the cases to be classified as either hospital onset or community onset.

6.3 Gram-negative organism bloodstream infections (GNBSIs)

The increase in gram negative organism bacteraemia infections is a national concern. Mandatory surveillance of *Escherichia coli* (E.coli), *Klebsiella species (spp.)* and *Pseudomonas aeruginosa* bacteraemias has been introduced by the Department of Health (DH). This reporting at the Trust now requires enhanced investigation and data entry onto the PHE DCS website. This work is undertaken by the ICNs. National targets have been applied to reduce GNBSIs by 50% by 2021 and the latest statistics show, the Trust is heading in the right direction to achieve this.

6.3.1 *Escherichia coli (E.coli)*

Following the identification of a positive blood culture result for E.coli, a Consultant Microbiologist completes a PHE mandatory enhanced surveillance form. In consultation with the relevant clinician, key patient factors are considered in order to establish if the case is likely to be healthcare related. However, it may not be possible to determine.

Of the 16 hospital onset cases identified during 2019/20, five were unknown or unclear source of infection and the remaining eleven cases had a source of infection identified. Of these unrelated eleven cases, the sources of infection were:

- Hepatobiliary (one case)
- Lower urinary tract (six cases)
- Upper urinary tract (two cases)
- Skin or soft tissue (one case).

For one case, there were no clinical signs of bacteraemia identified however, following clinical review of the patient; a decision was made to proceed with antibiotic therapy.

The Trust will continue to work closely with local community and hospital partners to reduce the incidence of *E.coli* bloodstream infections (BSIs) for the whole health economy, with the initial focus on reducing those infections related to urinary tract infection (UTI). In addition, the ICNs are working collaboratively with the relevant CCGs who are leading on achieving this Quality Premium guidance.

6.3.2 *Klebsiella sp.* and *Pseudomonas aeruginosa*

During 2019/20, there have been a total of 3 hospital onset *Klebsiella spp.* bacteraemia cases and 3 hospital onset *Pseudomonas aeruginosa* bacteraemia cases.

Further information relating to official statistics and benchmarking of performance can be found at: https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis

6.4 *Clostridioides difficile (C.difficile) Infection*

The control of this infection is managed by the combination of adherence to the correct infection control practices, environmental cleaning, equipment decontamination and prudent antibiotic stewardship.

The Trust continues to apply DH guidance for *C.difficile* testing and all *C.difficile* positive stool samples that test toxin positive are reportable to PHE. For 2019/20, changes have been made to the *C.difficile* reporting algorithm. This has included the addition of a prior healthcare exposure element for community onset cases, and reducing the number of days to apportion hospital onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.

For 2019/20, the *C.difficile* case objective set for the Trust by NHSi and NHS England (NHSE) is no more than 9 healthcare associated reportable cases. This was a 50% reduction on the previous year's limit. These objectives have been set using the Trust data from 1st April 2018 to 31st December 2018. Guidance for testing and reporting *C.difficile* cases remains unchanged and the safety and care of patients remains our concern and priority. It is important that the Trust Board are aware that this poses a risk when such small numbers are considered, as it is one of the lowest ceilings set across the South West region due to previous good performances.

Unfortunately, during 2019/20 the Trust has reported 22 healthcare associated *C.difficile* cases to PHE, of which 13 cases were community onset and 9 cases were hospital onset. Incident investigations are carried out for all hospital onset cases using a 'SWARM' approach. This process is led by the ICNs to assess whether there were any lapses in quality care provided to the patient and whether this contributed to the case. In addition, the ICNs undertake a case review for the community onset cases to establish whether any lapses in care occurred during their previous hospital admission (in the preceding 4 weeks).

In 12 of these 22 cases, lapses of care were identified. Key learning included improvements required for the use of the Diarrhoea Pathway and completion of stool charts; timeliness of patient reviews and sampling of symptomatic patients.

For the reported period, a total of 8 healthcare associated *C.difficile* cases were submitted to the 'Appeals Process Panel' with the relevant CCG. This appeals process was successful for all 8 cases. *(Of note: there are two cases from 2019/20 that have been identified for the appeals process which will be submitted during quarter 1 of 2020/21).*

During quarter 3 of 2019/20, a 'deep dive' exercise to review all *C.difficile* cases (hospital and community onset) was completed, with the involvement of key personnel including the Heads of Nursing (HoN). Learning and actions are identified below, with monitoring by the directorates with outcomes/progress reported via the IPCWG:

- Nominated clinical champion for antibiotic stewardship
- Follow up of delays with ribotyping and enhanced fingerprinting service results from the External Reference Laboratory
- Review of *C.difficile* round timetable and attendance
- Review of Junior Doctors handbook content related to inpatient diarrhoea management information

- Relaunch of personal protect equipment (PPE) practices related to coloured aprons use to define areas to help eliminate cross contamination between bays or siderooms within patient areas.

During 2019/20, the ICNs have completed additional investigations for *C.difficile* cases identified within the community setting, where these patients have previously had a recent inpatient episode of care at the Trust. This has resulted in the implementation of enhanced environmental cleaning of identified clinical areas.

6.4.1 Periods of increased incidence of *C.difficile*

During quarter 1, a period of increased incidence (PII) of *C.difficile* was declared within the medical directorate for Spire Ward (June 2019). This was due to an increase in the number of patients with *C.difficile* (both reportable and not reportable to PHE) being isolation nursed for different periods of time on the right hand side of Spire Ward. (*Of note: since April 2019, it was acknowledged that a number of these patients had been transferred to the ward with either confirmed or previous C.difficile or symptoms of diarrhoea).* One of these patient's died and on further investigation a SII was commissioned (SII 324) by the DIPC to review the care management of the patient and identify any future learning. This report was completed during quarter 3 of 2019/20. Of the four samples sent for ribotyping by the External Reference Laboratory, three identified a different ribotype (002, 005 and 015) and no *C.difficile* was detected in the fourth sample. Therefore, these cases could not be linked.

During quarter 3, a PII of *C.difficile* was declared within the medical directorate for Whiteparish Ward (December 2019). This was due to a second *C.difficile* case being identified (one reportable and one not reportable to PHE). *(Of note: the second C.difficile positive case was also Norovirus positive).* The Trust was experiencing a Norovirus outbreak at the time and the ward closed due to diarrhoea activity. Ribotyping of the samples by the External Reference Laboratory confirmed the same ribotype (014). However, on completion of further analysis by the enhanced fingerprinting service, these samples were identified as different sub-types and therefore, the cases could not be linked.

As previously reported for 2018/19 (February 2019), the PII for Pembroke Ward was extended to include the suite facility. The required incident investigations were completed with the involvement of relevant personnel. Further measures were also implemented across the areas, including additional environmental cleaning by Housekeeping and extra audits and monitoring of practices, overseen by the relevant senior staff including HoN and Matrons. At the request of the IPCWG, ribotyping and enhanced fingerprinting service results were reviewed by the ICD for final reporting to the DIPC.

Please see Appendix C for the Infection Prevention & Control 'Dashboard' of 2019/20 for further detail.

6.4.2 Notification of intention to review financial sanctions and sampling rates from 2020/21

The faecal sampling and *C.difficile* infection testing rates for all NHS providers will be reviewed to determine how they compare, especially for similar institutions. PHE already collects Laboratory data on such sampling and testing rates on a quarterly basis. PHE are aware that workload variation between Laboratories will affect *C.difficile* infection testing rates, e.g. the proportion of all faecal samples received that originates from the community as opposed to from hospitalised patients.

Preliminary analyses of the data already submitted to the PHE DCS system shows marked workload variations between Laboratories, which need to be explained/addressed to minimise the risk of ascertainment bias on *C.difficile* infection rates. Failure to diagnose *C.difficile* infection raises the possibility of poor outcomes for patients and missed opportunities for control. There will be a particular focus on providers with high *C.difficile* infection rates but low sampling/testing rates relative to their peers. The option to review financial sanctions and the current lapses in care process will be undertaken ahead of objective setting for 2020/21.

6.5 Surgical Site Infection Surveillance (SSIS)
The ICNs coordinate data collections for the national SSIS programme of various surgical procedures, which are applicable to the Trust. Where orthopaedic surgical procedures are performed, Trusts are required to undertake mandatory SSIS every year. This must be for a minimum of a three months surveillance period or until a cohort of 50 cases has been achieved.

The Trust complies with this annual requirement to undertake SSIS. There was one identified deep incisional wound infection for hip replacement surgery during quarter 1 of 2019/20, when active surveillance was undertaken.

6.6 MRSA screening
The Trust has continued to report MRSA screening rates for all elective and emergency admissions to ensure continued improvement in reducing infections. These screening compliance rates are monitored by the Directorate Management Teams (DMTs) and reported as a KQPI. The ICNs undertake a monthly emergency admission MRSA screening audit, and a quarterly elective admission MRSA screening audit.

Feedback is provided to DMTs about compliance rates and any identified missed screens for follow up actions. For 2019/20, the Trust compliance rates for MRSA emergency screening ranged from 84.82% - 93.85% and for MRSA elective screening, 68.66% - 85.24%.

Outcomes of any follow up of actions undertaken by the clinical directorates are included within their current reporting processes and to include any shared learning. The current Trust screening policy exceeds the requirements outlined within the Department of Health (DH) guidance published in 2015, and continues following further review by the Trust during 2019/20.

6.7 Infection in Critical Care Quality Improvement Programme (ICCQIP)
From April 2017, the Trust has participated in the surveillance of bloodstream infections (BSIs) in patients attending the Intensive Care Unit (ICU) and Neonatal Unit (NNU). From the data submitted so far, a report update has been provided by PHE (for April 2018 – December 2019 period), and cascaded to the area leads.

6.8 Private Healthcare Information Network (PHIN)
The Trust is now mandated to report externally regarding private patients via PHIN. In relation to infection prevention and control, this involves the ICNs undertaking monthly cross checking of a dedicated SharePoint database of private patients. If it is identified that a patient has a HCAI that is externally reportable (as per national mandatory reporting definitions), then this is added to the SharePoint database for the relevant patient, for submission to PHIN by the Trust.

From the data reviewed and provided by the ICNs, there have been no externally reportable infection alert organisms identified for this patient group.

7. HAND HYGIENE
Fifty two areas (including wards and departments) across the four clinical directorates carry out a monthly audit of hand hygiene compliance in their area against the World health Organisation's (WHO) '5 moments for Hand Hygiene'.

The Trust target for hand hygiene compliance rates is >85%, with formal reporting by the directorates of measures implemented to improve non-compliance. When compliance is poor, the ICNs support individual clinical areas and staff groups promoting patient safety and hand decontamination. The audit results continue to be disseminated according to staff groups for each area. This action has provided evidence to strengthen the feedback process for the directorates to take the necessary action.

For quarters 1 and 2 of 2019/20, the overall compliance rate from 10 external audits completed across 9 clinical areas at different times was 71.24%, with one clinical area being audited twice during the six month period. This is a decrease on the previously reported overall compliance rate of 75.85% from 15 external audits completed across 13 clinical areas (with several areas audited more than once), during quarters 1 and 2 of 2018/19. No audits were completed during quarters 3 and 4 of 2019/20 due to additional work commitments of the external auditor and latterly COVID-19 pandemic.

Detailed analysis was undertaken to identify the key areas of non-compliance, which were predominantly staff missing moment number 5, handwashing after contact with patient surroundings and also following removal of gloves. The results were reported via the DIPC and the IPCC and feedback was provided to the clinical leaders and DMTs to address the shortfall in practice. Additional education and support has been provided by the ICNs to staff groups focusing on these audit findings.

For the internal hand hygiene audits completed by the clinical areas the overall average compliance rate for 2019/20 ranges from 75.61% - 86.48%. The 'Red, Amber and Green' rating for the hand hygiene compliance audits continues and includes actions to be identified for areas that do not achieve the 'pass threshold' of 85% or show improvements. This RAG rating was further revised and the impact of these measures being monitored by the IPCWG, DMTs and Matrons Monitoring Group (MMG).

8. ANTIBIOTIC STEWARDSHIP

The reported year has been very challenging for the Antibiotic Reference Group (ARG). We have not had the resources to progress with our antimicrobial stewardship campaign this year and due to reduced staffing within Microbiology, our fortnightly ward antibiotic audits have been on hold since May 2019.

In August 2019, we successfully recruited our first antimicrobial/CQUIN Pharmacy Technician, and this post has now been made permanent. This role has been focusing on the lower urinary tract infections (UTI) in older people CQUIN work and we have seen a dramatic improvement in our compliance since commencement of the post.

8.1 CQUIN CCG1a: Improving the management of lower urinary tract infections in older people

The aim of this CQUIN was to improve the diagnosis and treatment of lower UTI in patients aged over 65 years. Research shows that elderly patients in particular are often treated for a urinary tract infection based on a positive dipstick but lack of clinical symptoms.

Initial results from quarter 1 of 2019/20 showed a compliance of only 19% adherence to all standards. Other Trusts had similarly poor results and the NHS National CQUIN Team made the decision to remove the quarter 1 data from this CQUINs earnings calculation to ensure that all providers had the opportunity to fully deliver CQUIN goals. Our quarter 3 (2019/20) compliance was 53% increasing to 61% in quarter 4 (2019/20), giving us a year end result of 51% compliance. Although this does not meet the 90% target, this is a significant improvement and puts us in a good position for next year's CQUIN.

8.2 CQUIN CCG1b: Improving surgical prophylaxis in elective colorectal surgery

This CQUIN focused on improving surgical prophylaxis in patients undergoing colorectal surgery by ensuring patients received a single dose of prophylaxis prescribed in accordance with local antibiotic guidelines. The Trust's year end target was 90% compliance. Quarter 1 (2019/20) results were poor but a Consultant Surgeon led on this piece of work and we have seen a significant improvement in results. Quarter 3 (2019/20) results achieved 90% compliance, and quarter 4 results were 87.5% compliance, giving us a year end result of 76% compliance.

8.3 Antifungal Medicines optimisation CQUIN
All targets for 2019/20 have been met with the formation of an antifungal stewardship team and review of our antifungal guidelines. As per the CQUIN requirements, all patients prescribed an antifungal for an invasive fungal infection were reviewed by the antifungal stewardship team during quarter 4 of 2019/20. As our antifungal use is very low, only two patients were eligible to be included. Due to our low antifungal usage it is unlikely that we will qualify for the ongoing CQUIN in 2020/21.

8.4 Total antibiotic consumption
Reducing total antimicrobial usage has now become part of the NHS contract. Our target is to reduce by 1% every year. Quarters 1 and 2 data shows that our total antibiotic usage increased by 1.8% in comparison to quarters 1 and 2 of 2018/19. However, our in-house year end figures show our total antibiotic usage increased by only 0.24%. Although this does not meet our target, this is a significant improvement on previously reported figures.

8.5 Action plan for 2020/21
The CQUINs for 2020/21 are currently on hold due to the COVID-19 pandemic. The lower UTI CQUIN will be extended to include all patients over 16 years with a diagnosis of UTI, including upper, lower and catheter-associated UTI. We are already making plans as to how to tackle this CQUIN.

We would also like to introduce an antibiotic ward round this year (2020/21) in order to promote antimicrobial stewardship further, provide better education on the wards and to have a greater input into direct patient care. This will be dependent on the recruitment of a third Consultant Microbiologist.

9. AUDIT

In line with the requirements of the Health and Social Care Act 2008, a programme of infection prevention and control audits is illustrated in the annual audit programme. The programme ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust.

The ICNs have not undertaken any formal policy audit during 2019/20, but have been actively involved in supporting identified clinical areas to complete the *'Perfect Ward' Application'* infection prevention and control inspections. *(Of note: these inspections include policy practice standards as part of audit criteria).* Findings are fedback verbally to the clinical leader/nurse in charge at the time with instruction to access the results report to identify any required actions. The results are also available for the HoN and Matrons to access (via the application), with formal reports fedback via MMG meetings. (Completion of these audits has been in addition to the 'spot checks' and observational practice audits undertaken by the ICNs during daily clinical visits to ward areas). Please see Appendix D for further details, the results show an improving direction and continue to provide transparency across a number of IPC indicators at practice level.

10. EDUCATION AND TRAINING ACTIVITIES

Education and training continues to be an important part of the work of the IPCT. Compliance scores for 2019/20 were 78% for staff completion of hand hygiene assessments and 97% for staff completion for IPC computer based learning (CBL) package (as of 6th April 2020).

The ICNs have continued to focus on the promotion of opportunities for staff to complete their hand hygiene assessment. This has included arranging extra sessions within specific work areas and enabling identified staff to be trained to undertake hand hygiene assessments. Furthermore, the clinical directorates facilitated the completion of hand hygiene assessments for staff by utilising a ultra-violet (UV) light box for rotation through their directorate areas and departments.

The ICNs have contributed to formal and informal teaching sessions within clinical areas and other Trust departments. These include core induction sessions in addition to specific topic requests. The facilitation of learning has also involved members of staff shadowing of the ICNs in addition to the monthly scheduled Infection Control Link Professional (ICLP) meetings. Details of education opportunities provided are available from the ICNs.

The ICNs continue to explore different methods for educational opportunities/activities e.g. use of social media (Twitter account) and physical IPC 'Trolley Dash' (completed during quarter 1 of 2019/20).

11. DECONTAMINATION

11.1 Progress on actions for 2019/20

- Standard operating procedures (SOPs) are in place for the use of invasive ultrasound probes: there has been some progress on this for those areas still outside 'best practice'. We are exploring the potential for transferring our Trophon automated cleaning cabinets to a managed service contract. This will facilitate the expansion of their use within the Trust. There are minimal ongoing cost pressures when compared to the Tristel 3 wipe system and it offers the added assurance of an electronically recorded automated high level disinfection (HLD) process which is best practice.
- The responsibility of maintenance of decontamination equipment in Sterile Services Limited (SSL) has been transferred from Salisbury NHS Foundation Trust (SFT) Estates Technical Services (ETS) team to STERIS.
- The Business Continuity Plan has not yet been practically tested for reprocessing of surgical instrumentation. This was work suggested by the previous chair of SSL Operational Management Board (OMB) but has stalled. In addition, there is currently no confirmed start date for the refurbishment work in SSL, though schematic plans and a timeframe have been agreed.
- Decontamination audits continue in order to monitor compliance of areas. This year we are trialling a new option of allowing self-audit for some areas who have proven sustained compliance previously.
- The new electronic scope tracking system within SSL was successfully used to provide evidence for the recent Joint Advisory Group (JAG) for Gastrointestinal Endoscopy audit.
- There is now a process in place for approval of instrumentation introduced via procurement to ensure it meets processing parameters. Non-compliance issues are addressed on a case by case basis and exceptions usually able to be agreed with the manufacturer.

11.2 Key success stories for 2019/20

- Electronic scanning has been installed in SSL to facilitate tracking of scopes through the decontamination process.
- Two new automated endoscope reprocessors (AERs) and two automated washer disinfectors (AWDs) have been installed within SSL to replace ageing equipment and improve reliability.
- There has been a successful appointment of a proactive Authorised Engineer for Decontamination (AE(D)) who has agreed to give additional onsite support to the Trust until a new Authorised Person for Decontamination (AP(D)) is appointed. The AE(D) is willing to work with specialist teams/areas to review processes and offer suggestions for improvement.
- The bid for six dry storage cabinets (DSCs) was successful. This will offer an increase in storage capacity, longer validated storage times and ensure safe storage of our full range of endoscopes within the Endoscopy Unit. The DSCs are currently being built, including bespoke software to integrate to our existing systems.

11.3 Key challenges for quarters 1 and 2 of 2020/21

- Encourage the need to reconvene SSL OMB (or equivalent) to ensure opportunity for formal operational and strategic dialogue between the Trust and SSL. This would include

contingency testing and proactive engagement in the refurbishment work to ensure any impact to the Trust is communicated and managed appropriately.
- Develop contingency plans for endoscope processing with the support of the AE(D) and service users.
- Support the successful installation of the new DSCs including testing of software, storage validation times, building work to optimise their geographical location and training of staff.

12. CLEANING SERVICES

This section summarises the key components of the Trust's cleaning programme, to ensure the provision of a safe and clean environment for patients and their relatives, visitors and staff. The following areas of work are managed by the Housekeeping Department and Facilities directorate.

12.1 Patient led assessment of the care environment (PLACE) internal audits

The Trust developed (with ward leaders) and implemented a programme of PLACE audits for 2019/20 and planned to undertake 60 internal PLACE assessments between June 2019 and March 2020, using the new NHSi PLACE criteria.

The result of each PLACE assessment is submitted to the Health and Social Care Information Centre using the PLACE lite tool and discussed with ward leaders at the monthly MMG meeting.

Due to the COVID-19 pandemic, the Director of Nursing approved the internal PLACE assessments and Housekeeping audits to be temporarily suspended in March 2020. These will resume once it is safe to do so. Any Housekeeping concerns/issues would be highlighted on the Perfect Ward Application (PWA) inspections in addition to continued communications between ward leads and their allocated Housekeeping Supervisor.

12.2 National PLACE

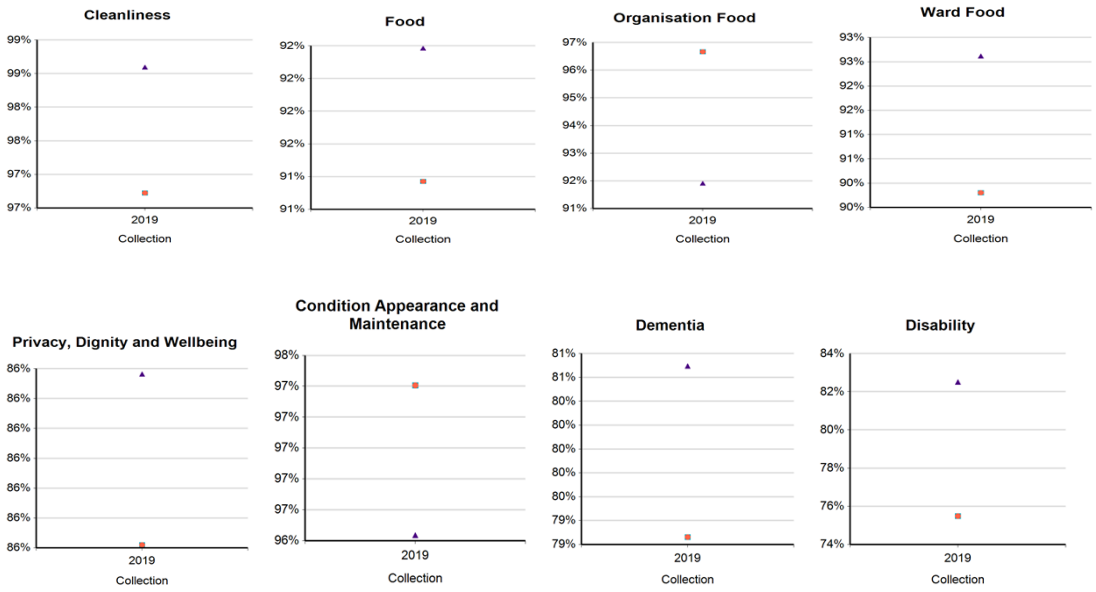
The Trust completed the 2019 National PLACE assessment on Friday 18th October. In accordance with NHSi PLACE criteria, a total of 10 wards and the Emergency Department (ED) were visited, 4 food assessments undertaken, 6 outpatient areas audited. External spaces (including car parking), signage and communal areas were also assessed.

The results were published on 30th January 2020, and action plans have been put into place to ensure any improvements that can be made are investigated and actioned where possible *(Of note: detailed PLACE Report submitted to Trust Board on 5th March 2020; Agenda item:15).*

SFT PLACE Scores for 2019			
Cleanliness	96.72%	Food	91.37%
Organisation Food	96.67%	Ward Food	89.80%
Dementia	79.26%	Disability	75.48%
Condition Appearance and Maintenance	97.41%	Privacy, Dignity and Wellbeing	85.8%

(Table 1)

Site Scores Organisation Average National Average



(Table 2)

12.3 Deep clean programme/rapid response team

The deep clean and decorating programme commenced in April 2019 *(a copy of the Deep Clean programme is available from the Housekeeping Department)*. A monthly review of this plan is undertaken at MMG meeting and discussed with the ICNs and HoN/Matrons at weekly meetings. Again, due to the COVID-19 pandemic the formal deep clean plan is on hold as Housekeeping are undertaking additional cleans across the whole site.

12.4 Improvement Work

Due to the current COVID-19 pandemic situation, the Housekeeping Team have extended their services temporarily to run a twenty four seven service. Current staff have changed their hours to cover a service from 23.30hrs until 06.00hrs, and additional staff have been employed to backfill positions.

The two Bioquell hydrogen peroxide vapour (HPV) machine systems are fully operational and we currently undertake approximately 41 to 46 HPV cleans per month.

During quarters 1 and 2 of 2019/20, the Housekeeping Team completed 3547 terminal cleans, of which 9 fell outside of our KPI, to commence the clean within 3 hours of request and 99.75% of terminal cleans were commenced within 3 hours. For quarters 3 and 4 of 2019/20, the Housekeeping Team completed 4639 terminal cleans, 1000 more than the previous 6 months.

Housekeeping routinely monitors those bedspaces requiring a terminal clean (post infection clean) where furniture (including bed) is not present in the bedspace or room at the time of the clean. This information is feedback to ward leaders, HoN/Matrons and ICNs for further investigation and to ensure risks are reduced.

12.5 Future challenges

The Housekeeping Department continue to see the demand for terminal cleans increase. During May 2019, the Housekeeping Team undertook 720 terminal cleans against 287 cleans in May 2014. We continue to resource the later shift with extra staff in order to deliver the demand for terminal cleans later in the day.

13. WATER SAFETY MANAGEMENT

This section summarises the water safety management precautions that the Trust has taken during of 2019/20.

The Trust manages the safety of water systems in line with the Health Technical Memorandum (HTM) 04-01 (Pt B) Safe Water in Healthcare Premises and HTM 04-01 (Pt C) *Pseudomonas* (guidance for augmented care units), together with the technical guidance document HSG274 part 2.

To assist the management process in respect of the water systems across the site, regular meetings of teams (Responsible Person (RP) and Deputy Responsible Person (dRP) water) from ETS and FES Ltd (Private Finance Initiative (PFI) maintenance contractor) are held on a monthly basis, to review progress with planned preventive maintenances' (PPMs) and actions in respect of water safety.

The Trust continues to keep the domestic hot water temperature elevated above 65°C as a precaution in the challenge of Legionella control. The water systems within hospitals are complex; therefore the testing and controls we have in place are designed to mitigate the risks to our patients and staff.

Emergency review meetings (see tables below) have taken place in the Trust as a result of the positive sample results for Legionella and Pseudomonas, the actions and results of the ongoing checks have been circulated to senior members of the Trust in a series of emails as events occur, and as regular reports to the Water Safety Group (WSG) and IPCC. Actions taken have included the cleaning and disinfection of outlets, with temperature checks and increased flushing where necessary.

Legionella					
	Ward/ Department	Location	Action plan	Latest test result	
				Pre	Post
1	Durrington Ward	2.1.18 + 2.1.20	No further action required 3 clear results obtained	Not detected	Not detected
2	Pembroke Suite	Far bay	Outlet fitted with PAL & re-sampled	80	220
3	Amesbury Ward	4.10.245	Outlet cleaned and re-sampled by PFI team	1540	570
4	Paediatric Therapy	3.06.38	Outlet fitted with PAL filter, further investigation/remedial works planned for the outlet/system	3000	680
5	Tisbury CCU	Bay 2 (WHB)	Outlet fitted with PAL filter, further investigation/remedial works planned for the outlet/system	8200	7200

(Table 3)

Pseudomonas					
	Ward/Department	Location	Action plan from review meeting	Test result as of 16.01.20 x 3 clear result	
				Pre	Post
1	Sarum Ward	Shower 4.06.12	Clean/disinfect outlet and re-sample, pre & post	Not detected	Not detected
2	Sarum Ward	Shower 4.05.06	Clean/disinfect outlet and resample, pre & post	Not detected	Not detected
3	Sarum Ward	Shower 4.06.08	Clean/disinfect outlet and resample, pre & post	Not detected	Not detected

(Table 4)

ETS have completed a full survey of the hot and cold water system on Level 3 Paediatric Outpatients Department (OPD), which identified some issues with local thermostatic mixer valves (TMVs) and strainers, which were removed and replaced. An updated action plan was circulated to the WSG and the clinical teams in the affected areas.

ETS are now reviewing the hot and cold water systems on Tisbury CCU and ED, and currently in the process of removing some 'dead legs' pipework and faulty TMVs.

13.1 Achievements for 2019/20

- New heating and hot water system installed and commissioned for the accommodation Blocks Compton, Grovely and Langley and Odstock Health + Fitness. The new boilers plus new hot water generation (plate heat exchangers) will greatly improve the temperatures of the hot water systems which feed these areas.
- The level of flushing compliance for clinical areas has been maintained and the figures for quarters 1 and 2 are 93.6% for Priority 1 areas and 98.5% for Priority 2; and for quarters 3 and 4 are 78% for Priority 1 areas and 92.4% for Priority 2.
- Good results (2 x clear results as of the 10th of September) have been received on the re-sampling of Durrington Ward which has been a problematic area for some time with PALL filters fitted in siderooms 2.2.18 and 2.2.20 to provide a safe hot water system.
- Competent person (CP) training has been delivered to ETS staff that monitor and maintain the Trusts hot and cold water system. The training was completed on the 10th of June and staff from Band 2 to Band 5 received the training which was delivered by the Trust's Authorised Engineer for Water (AE Water) Mr Paul Limbrick.
- A new heating a hot water system has been installed for the Hospice Unit funded by the Trust's Capital Programme. The replacement of these systems was scheduled for the 2020/21 programme; however the works were moved forward due to a complete failure of one of the boilers in February. This new equipment has greatly improved the temperatures and reliability of the hot water system for this area which has been problematic for several years.
- The Estates team have spent a significant amount of time completing remedial works on the hot and cold water systems across the Trust in areas that have had reduced activity due to the impact of COVID-19. This has included work on Whiteparish Ward, Day Surgery Unit (DSU) and the Staff Club. These works have greatly improved the performance of these systems and will clearly assist in the control of water borne bacteria.

13.2 Key focus for quarters 1 and 2 of 2020/21

- Maintaining the temperature of the hot and cold water systems across the Trust.
- Completion of routine sampling for Pseudomonas on the augmented wards – Radnor, Sarum, Odstock (Burns & Plastics) and Longford Wards (previously Avon Ward), NNU and Pembroke Unit.
- Commence Legionella sampling for the Trust site in quarter 2 of 2020/21.

- Ensuring sufficient resources (labour and financial) to complete all PPMs directly associated with water safety as recommended in the Mark Cammies review of ETS in December 2019 and supported by the Trust Board.
- Securing Capital Funding for replacement of hot water systems.
- Continued engagement of key members (DIPC, Deputy DIPC, Consultant Microbiologist, ICNs) of the Water Safety Group in supporting action plans and attending quarterly meetings of the WSG.
- Developing the Operational Procedures for Water Safety with the assistance of the Trust Authorised Engineer (AE).
- Training for the Trusts dRP Water (Operations Manager).
- Completion of the tender for the works associated with a new site water risk assessment.
- Form the Operational Management meeting for water safety to report into the WSG.

14. CONCLUSION

This annual report has provided the Trust Board with evidence of the measures in place that have made a significant contribution to improving infection prevention and control practices across the Trust. The report has detailed the progress against the Action Plan for 2019/20 in reducing HCAI rates for the Trust.

For 2020/21, the key ambitions for the Trust will include:

- Continued response to the impact of the COVID-19 pandemic
- Ongoing focus on the reduction of all reportable HCAIs and ensure preventable infections are avoided
- Continued reinforcement to improve compliance with hand hygiene practices and behaviours
- Maintaining achievements with antimicrobial stewardship
- Sustain progress with contingency planning and improvement plans for decontamination services
- Maintaining progress with education, training and audit relating to infection control practices and policies
- Monitor and manage water safety
- Maintaining a clean and safe environment for patients and staff through the Trust Housekeeping service.

15. ACKNOWLEDGEMENTS

The author would like to acknowledge the assistance of the following people in the compilation of this report:

- Fiona McCarthy, Senior Nurse, Infection Prevention & Control Team
- Louise Whittle, Principal Antimicrobial Pharmacist
- Clare Goodyear, Trust Decontamination Lead and Medical Devices Safety Officer
- Michelle Sadler, General Manager, Facilities
- Terry Cropp, Head of Estates.

APPENDIX A

Infection Prevention & Control – Annual Action Plan 2019/20

Please note: The numbering **does not** depict the order of priority for the Trust, but reflects the numbered duties within the Hygiene Code.

Domain and Key Actions	Who By	Status
1 Management, Organisation and the Environment **1.1 General duty to protect patients, staff and others from HCAIs** **1.2 Duty to have in place appropriate management systems for Infection Prevention and Control**		
Continue to promote the role of the DIPC in the prevention & control of HCAI	Chief Executive	Continuous
DIPC as Chair of the Infection Prevention and Control Committee	Chief Executive	In place
Lead infection prevention & control in the Trust and provide a six monthly public report to the Trust Board	DIPC	In place
Monitor and report uptake of mandatory training programme	IPCT	In place
Continue contribution to implementation of the Capacity Management policy	DIPC	In place
Ensure a programme of audit (incorporating Saving Lives High Impact Interventions) is in place to systematically monitor & review policies, guidelines and practice relating to infection prevention & control	IPCWG/IPCC	Monthly
Continue to review staffing levels via Workforce Planning	DDIPC	Continuous
Complete bedpan washer replacement and dirty utility room upgrade programme within the Trust (for inpatient clinical areas), including the Spinal Unit.	DIPC	Complete
1.3 Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks		
Maintain the role of DIPC as an integral member of the Trust's Clinical Governance & risk structures (including Assurance Framework)	Chief Executive	Continuous
Ensure active maintenance of principle risks relating to infection prevention and control, and that the system of Root Cause Analysis (RCA) is used to review risks relating to these	DIPC/JH/ICNs	In place
Active Surveillance & Investigation:		
Continue implementation of mandatory Surveillance Plan for HCAI & produce quarterly reports for IPCC	ICNs	In place
Review implementation of 'alert organism' & 'alert condition' system	JH/SC/PR	Continuous
Use comparative data on HCAI & microbial resistance to reduce incidence & prevalence	JH/SC/PR	In place
Promote liaison with Public Health England (PHE) for effective management & control of HCAI	DIPC/JH/ICNs	Continuous

Domain and Key Actions	Who By	Status
1.4 Duty to provide and maintain a clean and appropriate environment for health care		
Ensure maintenance and monitoring of high standards of cleanliness via policy management and audit, and environmental audits	DIPC/IR/MS	Monthly
Review schedule of cleaning frequency and standards of cleanliness, making them publicly available	DIPC/IR/MS/ Matrons	Monthly
Ensure adequate provision of suitable hand washing facilities, hand products/alcohol gel and continued implementation of 'WHO - Five Moments' and use of 'CleanYourHands' resources	ICNs	Continuous
Continue IP&C involvement in overseeing all plans for construction & renovation	TC	Continuous
Ensure effective arrangements are in place for appropriate decontamination of instruments and other medical devices/equipment	DIPC/CG	Continuous
Ensure the supply and provision of linen and laundry adheres to health service guidance	IR	Continuous
Ensure adherence to the uniform and Bare below the elbow (BBE) policies and workwear guidance through audit and formal reporting via the monthly Matrons Monitoring Group meetings	DIPC/HoN	Continuous
1.5 Duty to provide information on HCAIs to patients and the public **1.6 Duty to provide information when a patient moves from one health care body to another** **1.7 Duty to ensure co-operation**		
Ensure publication of DIPC report via the Trust website	DIPC	6 monthly
Review Capacity Management policy & documentation to ensure communication regarding an individual's risk, nature and treatment of HCAI is explicit	DIPC	Completed
Include obligations under the Code to appropriate policy documents	DIPC	Ongoing
1.8. Duty to provide adequate isolation facilities		
Continue implementation and monitoring of the Isolation policy and monitoring of practice via audit	DSNs/IPCT	Ongoing
1.9. Duty to ensure adequate laboratory support		
Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation	JH/SC/PR	Continuous

Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control		
Core policies are:		
Standard infection control precautions	ICNs	In place
Aseptic technique	ICNs	In place
Major outbreaks of communicable infection (Outbreak policy)	ICNs	In place
Isolation of patients	JH	In place
Safe handling and disposal of sharps	PK/GL	In place
Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries	ICNs	In place
Management of occupational exposure to BBVs and post exposure prophylaxis.	PK/AE	In place
Closure of wards, departments and premises to new admissions (Outbreak & Capacity Management)	SK	In place
Disinfection policy	MS	In place
Antimicrobial prescribing	JH/LW	In place
Mandatory reporting HCAIs to Public health England (PHE)	JH	In place
Control of infections with specific alert organisms; MRSA and *C.difficile*	IP&CT	In place
Additional policies:		
Transmissible Spongiform Encephalitis (TSE)	JH	In place
Glycopeptide Resistant Enterococcus (GRE)	JH	Included in
Acinetobacter species	JH	Isolation
Viral Haemorrhagic fever (VHF)	JH	Policy
Prevention of spread of Carbapenem resistant organisms	JH	In place
Diarrhoeal infections	JH	In place
Surveillance	ICNs	In place
Respiratory viruses (RSV)	JD	In place
Infection control measures for ventilated patients	MF	In place
Tuberculosis	JH	In place
Legionellosis risk management policy and procedures, including pseudomonas	TC	In place
Strategic Cleaning Plan & Operational Policy	MS	In place
Building & Renovation – Inclusion of Infection Control within Building Change, Development & Maintenance	TC	In place
Waste Management Policy	TC	In place
Linen Management Policy	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	CG	In place

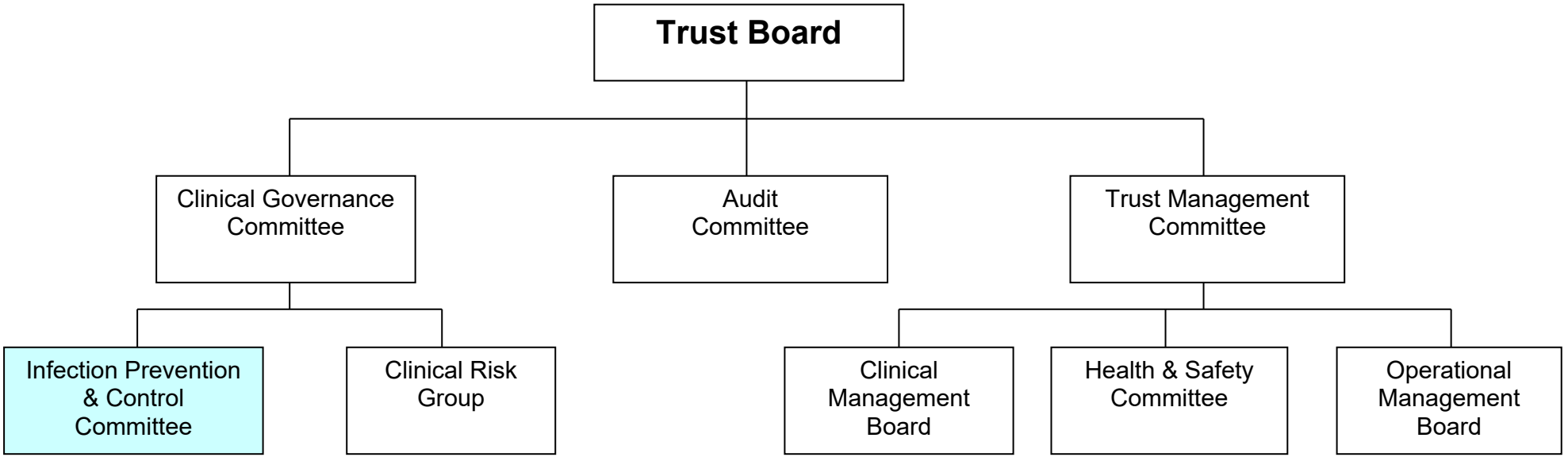
Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonable practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs.		
Ensure all staff can access relevant occupational health & safety services (OHSS)	PH/AE	Continuous
Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place	PK/AE	Continuous
Continue the provision of infection prevention and control education at induction	IPCT	Continuous
Continue the provision of ongoing infection prevention and control education for existing staff	IPCT	Continuous
Continue recording and maintaining training records for all staff via the MLE	Education Dept.	Continuous
Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and objectives of all staff	DIPC/DMTs	In place
Enhance and monitor the role of the Infection Control Link Professionals	HoN/Matrons/ICNs	Continuous

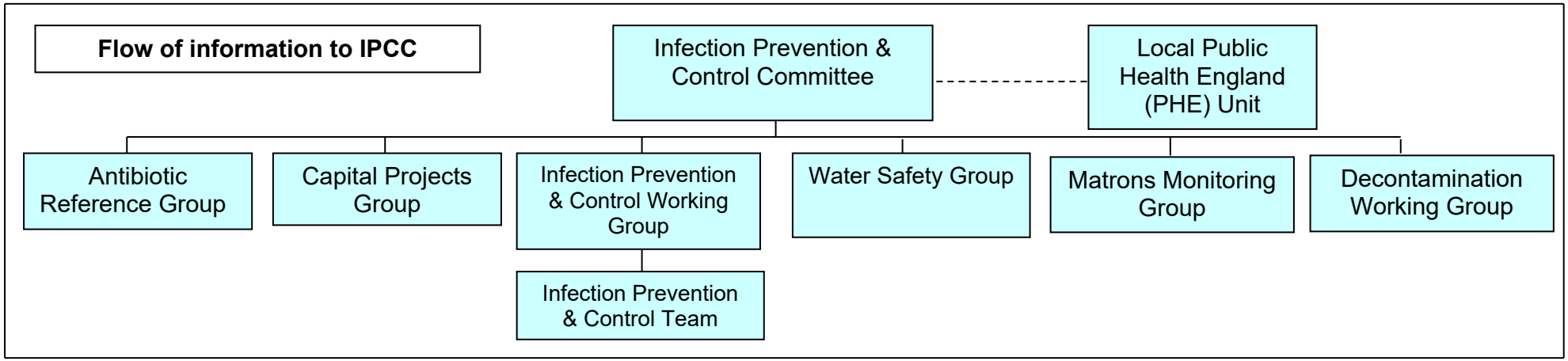
KEY INITIALS

DIPC Lorna Wilkinson, Director of Infection Prevention & Control (DIPC)
DDIPC Denise Major & Fiona Hyett, Deputy DIPCs
CG Trust Decontamination Lead
JH Julian Hemming, Consultant Microbiologist & Infection Control Doctor (ICD)
SC Stephen Cotterill, Consultant Microbiologist & Deputy ICD *(Retired June 2019)*
PR Paul Russell, Consultant Microbiologist & Antimicrobial Lead
IR Ian Robinson, Head of Facilities
TC Terry Cropp, Responsible Person for Water & Head of Estates
HoN Heads of Nursing *(previously Directorate Senior Nurses)*
SK Sarah Knight, Head of Patient Flow
PK Paul Knight, Health & Safety Manager, OH Department
GL Geoff Lucas, Safety Advisor, OH Department
LW Louise Whittles, Principal Pharmacist
JD Jacqui Dalley, Neonatal Unit Sister
MF Maria Ford, Quality Improvement Matron *(previously Nurse Consultant in Critical Care)*
PH Paul Hargreaves, Director of Human Resources *(until September 2019)*
LL Lynn Lane, Interim Director of Organisational Development & People
MS Michelle Sadler, Facilities Manager
AE Alison Evans, Occupational Health Lead *(until December 2019) new appointment commencing April 2020*

APPENDIX B

Formal Trust Reporting Structure





APPENDIX C (End of year 2019/20)

Clinical Directorates	Inpatient areas/wards	*Clostridium difficile* - all cases (reportable and not reportable)			Bacteraemias - all cases are reportable to Public Health England (PHE)										Outbreak declared	PII declared	Hand Hygiene (mean %)	IPC PWA % (mean score)
		Sample taken			*MRSA*		*MSSA*		*E.coli*		*Pseudomonas aeruginosa*		*Klebsiella sp.*					
		Hospital onset; healthcare associated	Community onset; healthcare associated	No lapses in care	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	Number of days in outbreak			
Clinical Support & Family Services	Labour Ward																88.8 ↓	N/A
	Neonatal Unit																98.3 =	N/A
	Post-natal Ward																97.7 ↑	N/A
	Sarum Ward									1				1			99.6 ↑	94.32 ↑
	CS&FS Totals:	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**				
Medicine	AMU		1* + 1	1				4	1	16		2		1			58.16 ↑	93.64 ↑
	Durrington Ward		1				1			1							83.91 ↑	88.3 ↓
	Emergency Department (inc. SSEU)		1 + 2					25		66		6		19			78.84 ↓	N/A
	Farley Stroke Unit												1				81.08 ↑	93.42 ↑
	Hospice Unit																82.08 ↓	91.2 ↓
	Laverstock Ward										1						25	
	Pembroke Ward	2 + 2							1				1				87.43 ↑	84.9 ↓
	Pembroke Suite							1		2							91.6 ↑	82.9
	Pitton Ward	3	1*	1					1								63.31 ↓	89.21 ↑
	Redlynch Ward	1	1*	1			1		4	2	1						87.41 ↑	90.22 ↑
	Spire Ward	1 + 4							3							June 2019	93.23 ↑	85.38 ↑
	Tisbury CCU		1* + 1	1			1		2	1				1			86.79 ↑	89.27 ↑
	Whiteparish Ward	3 + 3							1							December 2019	94.31 ↑	79.38 ↑
	Medicine Totals:	**6 + 13**	**5 + 5**	**4**	**0**	**0**	**3**	**30**	**13**	**88**	**2**	**8**	**2**	**21**				
Musculoskeletal	Amesbury Suite							1									78.03 ↓	86.25 ↑
	Avon Ward (Longford Ward 04.11.19)	1															54.95 ↑	95.38 ↓
	Chilmark Suite	1*		1						1							75.98 ↓	89.95 ↑
	Longford Ward																96.84	90.56
	Odstock Ward						1				1		1				95.09 ↑	90.67 ↑
	Tamar Ward (Longford Ward 04.11.19)	1							1								97.5 ↑	94.08 ↓
	MSK Totals:	**1 + 2**	**0**	**1**	**0**	**0**	**1**	**1**	**1**	**1**	**1**	**0**	**1**	**0**				
Surgery	Breamore Ward	1								2							59.35 ↓	90.68 ↓
	Britford Ward/SAU	1 + 1	1					1		3				1			86.17 ↓	92.42 ↑
	Day Surgery Unit																57.25 ↓	85.87 ↑
	Downton Ward	1						1	1	3		1					95.04 ↑	94.99 ↑
	Radnor Ward						1		1	1							77.75 ↓	96.59 ↓
	Surgery Totals:	**2 + 2**	**1**	**0**	**0**	**0**	**1**	**2**	**2**	**9**	**0**	**1**	**0**	**1**				
Additional info: Other samples e.g. GP, Emergency Assessment, OPD, Mortuary, Private Hospital			4 + 3* + 4	3													23	

* denotes reportable C.difficile cases that have been submitted for appeal at the Clinical Commissioning Group (CCG).

All SFT samples including inpatient and outpatient areas, GP and other e.g. Emergency Assessment

C.difficile reportable cases = red
C.difficile not reportable cases = blue

Perfect Ward scoring:

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed

Hand hygiene scoring:

	Score above 85%
	Score 61% - 84%
	Score below 60%

Please note additional information:
Laverstock Ward open from December 2019
Avon & Tamar Wards renamed Longford Ward November 2019
Breamore Ward closed end of March 2020 (21st)

APPENDIX D

Perfect Ward Application (PWA) Infection Prevention & Control (IPC) Inspection Compliance scores 2019/20

Ward/ Dept	Directorate	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Sarum	Clinical Support & Family Services	16.04.19 (95.6%)		28.06.19 (77.8%)		01.08.19 (92.5%)	
Acute Medical Unit	Medicine	02.04.19 (98.1%) 26.04.19 (98.1%)	29.05.19 (63.5%) 31.05.19 (96.2%)		12.07.19 (88.7%)	11.08.19 (94.3%)	
Durrington Ward	Medicine	08.04.19 (90.4%)	08.05.19 (92.3%)	03.06.19 (92.3%)	14.07.19 (94.3%)	16.08.19 (74%)	
Farley Ward	Medicine	05.04.19 (76.9%) 26.04.19 (88.5%)	15.05.19 (90.4%) 30.05.19 (92.3%)		26.07.19 (92.3%)	17.08.19 (94.2%) 31.08.19 (100%)	
Hospice Unit	Medicine	08.04.19 (89.8%)		10.06.19 (95.6%)			20.09.19 (89.6%)
Pembroke Ward	Medicine		30.05.19 (88.2%)		**Pembroke Suite** 24.07.19 (82.9%)		
Pitton Ward	Medicine	26.04.19 (92.5%)	24.05.19 (80.8%)	12.06.19 (84.6%)	19.07.19 (98.1%)	12.08.19 (74%)	
Redlynch Ward	Medicine	22.04.19 (88.5%)		14.06.19 (74%)	29.07.19 (100%)	12.08.19 (76%)	
Tisbury CCU	Medicine		21.05.19 (90.4%)	19.06.19 (90.4%)	08.07.19 (94.2%)	13.08.19 (72.5%)	
Whiteparish Ward	Medicine		15.05.19 (88.2%)			02.08.19 (73.1%)	20.09.19 (73.3%)
Spire Ward	Medicine		15.05.19 (76.9%)	14.06.19 (74.5%)	29.07.19 (69.2%)	04.08.19 (90%) 13.08.19 (82.7%) 24.08.19 (88.5%)	22.09.19 (96.1%)
Amesbury Suite	Musculoskeletal	17.04.19 (86.5%)	02.05.19 (82.7%)	07.06.19 (78.8%)		02.08.19 (90.4%)	18.09.19 (90.4%)
Chilmark Suite	Musculoskeletal	26.04.19 (84.9%) 29.04.19 (90.4%)	30.05.19 (87.8%)	20.06.19 (86.7%)		02.08.19 (88.7%)	17.09.19 (80.4%)
Odstock Ward	Musculoskeletal	04.04.19 (86.3%)	25.05.19 (90.4%)	18.06.19 (88.2%)		13.08.19 (83.3%)	
Avon Ward	Musculoskeletal	05.04.19 (95.5%) 23.04.19 (98.1%)	28.05.19 (98%)		11.07.19 (94.2%)	13.08.19 (96.1%)	
Tamar Ward	Musculoskeletal	22.04.19 (96%)		06.06.19 (96%)	10.07.19 (100%)	15.08.19 (100%)	09.09.19 (80%)
Breamore Ward	Surgery	16.04.19 (84.3%)	21.05.19 (98%)		11.07.19 (97.7%)	16.08.19 (85.7%)	
Britford Ward	Surgery	17.04.19 (92.3%)	29.05.19 (86.3%)		29.07.19 (90%)	15.08.19 (96.2%)	23.09.19 (92.5%)
Downton Ward	Surgery	11.04.19 (80.4%)	14.05.19 (88.5%)	16.06.19 (96.2%)	22.07.19 (96.2%)	29.08.19 (92.3%)	24.09.19 (96.2%)
Radnor Ward	Surgery	25.04.19 (95.5%)		19.06.19 (98%)	07.07.19 (100%)	31.08.19 (98.1%)	30.09.19 (98.1%)
Day Surgery Unit	Surgery	25.04.19 (42.9%)	08.05.19 (76.2%)	17.06.19 (88.1%)	17.07.19 (97.6%)	20.08.19 (92.5%)	10.09.19 (95.2%)

APPENDIX D

Perfect Ward Application (PWA) Infection Prevention & Control (IPC) Inspection Compliance scores 2019/20

Ward/ Dept	Directorate	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Sarum	Clinical Support & Family Services		26.11.19 (100%)		30.01.20 (100%)	29.02.20 (100%)	
Acute Medical Unit	Medicine	07.10.19 (98.1%)	07.11.19 (94.3%)	15.12.19 (100%)	16.01.20 (96.2%)	14.02.20 (98.1%)	23.03.20 (98.1%)
Durrington Ward	Medicine		06.11.19 (96.2%) 14.11.19 (82.4%)	05.12.19 (92.5%)	30.01.20 (74.5%)		16.03.20 (94.1%)
Farley Ward	Medicine	16.10.19 (94.3%)	04.11.19 (98.1%)	04.12.19 (96.2%) 10.12.19 (92.3%) 22.12.19 (96.2%)	16.01.20 (94.2%)	08.02.20 (96.1%) 18.02.20 (94.2%)	21.03.20 (93.9%) 25.03.20 (98%)
Hospice Unit	Medicine				22.01.20 (89.8%)		
Pembroke Ward	Medicine	21.10.19 (80.8%)			14.01.20 (85.7%)		
Pitton Ward	Medicine	18.10.19 (94.3%)	06.11.19 (94.3%)		15.01.20 (90%)		01.03.20 (94.3%)
Redlynch Ward	Medicine		05.11.19 (95.7%)	12.12.19 (95.6%)	02.01.20 (94%)	21.02.20 (92%)	21.03.20 (96.2%)
Tisbury CCU	Medicine	16.10.19 (86.5%)	15.11.19 (78.4%)	30.12.19 (94%)	06.01.20 (94.2%)	05.02.20 (97.8%)	09.03.20 (94.3%)
Whiteparish Ward	Medicine		08.11.19 (71.1%) 29.11.19 (94.1%)			18.02.20 (76.5%)	
Spire Ward	Medicine				23.01.20 (94.3%)		14.03.20 (96.2%)
Amesbury Suite	Musculoskeletal	06.10.19 (88.2%)	04.11.19 (88.2%)	05.12.19 (90.6%)		18.02.20 (77.8%)	21.03.20 (88.9%)
Chilmark Suite	Musculoskeletal	16.10.19 (98.1%)		05.12.19 (98.1%)	07.01.20 (98%)	19.02.20 (84%)	17.03.20 (98.1%)
Odstock Ward	Musculoskeletal	01.10.19 (94.1%)	27.11.19 (98.1%)	11.12.19 (88.2%)	27.01.20 (94.1%)	29.02.20 (90%)	24.03.20 (94%)
Avon Ward	Musculoskeletal	27.10.19 (90.4%)	09.11.19 (92.2%)	24.12.19 (90%)	24.01.20 (88.2%)	29.02.20 (94.2%)	26.03.20 (88.2%)
Tamar Ward	Musculoskeletal	27.10.19 (92.5%)					
Breamore Ward	Surgery		12.11.19 (86.5%)	13.12.19 (96.2%)	08.01.20 (84.8%)	05.02.20 (92.2%)	
Britford Ward	Surgery		24.11.19 (98.1%)	23.12.19 (96.2%)	28.01.20 (94.2%)	25.02.20 (84.6%)	11.03.20 (90.2%)
Downton Ward	Surgery	10.10.19 (96.2%)	21.11.19 (100%)	26.12.19 (95.9%)	19.01.20 (98%)	22.02.20 (100%)	18.03.20 (100%)
Radnor Ward	Surgery	21.10.19 (98%)	20.11.19 (98%)	22.12.19 (92.2%)	31.01.20 (92.3%)	19.02.20 (95.7%)	
Day Surgery Unit	Surgery		18.11.19 (92.9%)	18.12.19 (90.5%)	27.01.20 (88.4%)	11.02.20 82.9%)	30.03.20 (97.4%)
Laverstock Ward					31.01.20 (72.34%)		

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed

(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.2
Date of Meeting:	3 September 2020		

Report Title:	Infection Prevention and Control Board Assurance Framework IPCBAF) July 2020			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		✓		✓
Prepared by:	Denise Major - Deputy Director of Nursing			
Executive Sponsor (presenting):	Judy Dyos - Director of Nursing			
Appendices (list if applicable):	N/A			

Recommendation:

Members of the Trust Board to approve the content of the document and confirm any gaps in assurance with mitigating actions are appropriate.

Executive Summary:

As a healthcare provider organisation, the Trust is required to provide assurance both internally and externally that effective policies, practices and monitoring are in place to effectively manage IPC practices during the COVID-19 pandemic. The IPCBAF provides a risk framework to confirm the approved practices within the Trust are in line with national guidance with evidence for assurance. Any non-compliance and risk must be identified and managed within the Trust risk management policies and procedures.

- The Trust has robust policies and documented action cards but has limited evidence to provide assurance that these are adhered to at all times and the impact of a 2nd wave is not predicted.
- Level of ventilation provision across some clinical areas is unknown and currently under review in-line with national guidance.
- Despite falling levels of COVID-19 nationally, hospital environments remain high risk for cluster outbreaks amongst staff and patients groups.

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

Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☒
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒

Publications approval reference 001559

Infection prevention and control board assurance framework, version 1.2

22nd May 2020

Updates since version 1, published on 4 May 2020, are highlighted in yellow

SFT DOCUMENT 1.0 DRAFT 16TH JUNE 2020

Link to national IPC guidance;

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886668/COVID-19_Infection_prevention_and_control_guidance_complete.pdf

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance
Systems and processes are in place to ensure:					
1.1 Infection risk is assessed at the front door and this is documented in the patient notes.	DIVISIONS	Non-elective in- patients tested on admission. Categories applied to patients according to perceived risk. Elective patients tested as part of the elective pathway. Outpatients screened for symptoms on arrival.	1. Non-elective patients may be categorised as low risk and be transferred into open bay before test result. 2. Patients may become positive after admission either due to being incubation stage on admission or due to hospital acquired covid. 3. No current auditing of documentation for front door assessment.	1. Fast tests used for low risk patients as higher risk are not cohorted on test result alone. 2. All patients with negative test are retested in accordance with the testing action card.	
1.2 Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission.	DIVISIONS	1. Patients cared for in 'red' cubicles in Sarum, NNU and Maternity as reflected in action cards (03.116, 03.136 & 03.146). 2. Reference to action card 03.148 and 03.151, non elective surgical and medical admissions pathway and flow for testing. Acute admission and A, B, C categories, reference to de - isolation action card 03.149. 3. Virtual Board identifies new and potential pathway changes/complexities that require review and cascade	1. Inappropriate patient move.	1. Virtual Board Round meeting monitors positive patients and timeline of positive patients with contact tracing. 2. Fast covid swab used on admission and attempt made to isolate until result available. 3. Fast tests used for low risk patients as higher risk are not cohorted on test result alone. 4. All patients with negative test are retested in accordance with the testing action card.	
1.3 Compliance with the national guidance around discharge or transfer of COVID- 19 positive patients.	DIVISIONS	1. Not been required in Paediatrics and Maternity. 2. All patients who are contacts or confirmed positive are told to continue quarantine until 14 days. Patients transferred to residential homes are all tested negative prior to transfer. Reference to action card 3.110, management of suspected coronavirus cases and transportation home.	1. Unknown compliance of documentation of isolation post-discharge instructions.	1. Care facilities informed of positive result and confirmed at Virtual Board Round.	
1.4 All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance.	IPC	1. Action cards for all PPE requirements in-line with PHE guidance and accessible via Trust intranet portal. PPE compliance monitored through PWA COVID specific and PWA IPC inspections (in-patient areas). Hand hygiene audits monthly (all clinical departments). 2. PPE group commenced at the beginning of the outbreak with a co-ordinated response between Procurement, OH&SS, Divisional Management Teams, DD'soN, IPC and Executive incidence response leads. 3.Individual and department reviews by IPC as required. 4. Specific discussions with high risk areas (Radnor, RCU, ED/RAZ) when making changes to PPE agreed via the PPE group and documented practices within local SOPs. 5. Training records by IPC.	1. PWA available within in-patient areas. No specific PPE auditing in outpatient departments. 2. Continue to have departments with < 85% compliance with hand hygiene audits and non-submission of audits. 3. Risk in staff knowledge and keeping updated with continued changes to PPE requirements.	1. Use of Matron's rounds to reiterate PPE compliance. 2.IPC team continual rounds and ongoing 'on the spot' education and support. 3. Weekly PPE meeting as part of co-ordinated Trust COVID tactical response.	
1.5 National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way.	IPC	1. Additional IPC meetings to focus on COVID specific changes commenced on 10/06/20 (runs 3/4 weeks with 1/4 weeks on IPC 'business as usual'). All changes are updated on the action cards and cascaded in the Comms and available on the Trust intranet site.	1. COVID -19 PWA inspections monthly on in-patient wards. 2. Matrons rounds provide oversight. 3. Action tracker from the IPC meeting records dates of changes. Representatives from clinical divisions.	1. Limited monitoring in out-patient settings.	
1.6 Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	IPC/DIPC	1. Departmental risk assessments on DATIX and escalated via the Trust process to Board. 2. Key risks identified at the IMT incident meeting. 3. Risk assessments for COVID secure areas reviewed at IPC meeting. Additional risks identified via the clinical divisions. 4. IPC BAF currently in draft.	IPC BAF to be presented at CMB, TMC, CGC and TB July - August 2020.	1. Key risks escalated as required via Covid meetings and not delayed until existing Trust assurance meetings.	
1.7 Risks are reflected in risk registers and the board assurance framework where appropriate.	ALL	1. As above. 2. Internal audit of the Trust risk process. 3. Discussion of divisional risk assessment via Governance Meetings.	There are variations in the Divisional Governance and performance meetings agenda. (CSFS definitely have COVID as a standing agenda item).	As above Risk assessment in place regarding the potential outbreak risk amongst patients and/or staff - Risk No 6570	

1.8 Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens.	IPC	1. RCA documents of all reportable HCAIs with robust appeal process in place with the CCGs. 2. National data submission on HCAI's. 3. IPCWG/ICC meetings documented with minutes and action tracker. 4.Trust KQI reporting monthly for reportable HCAIs at CMB 5. Bi-annual DIPC report through Trust governance pathway to TB. 6. Policies and procedures for managing infection and prevention e.g. Outbreak policy. Policy compliance monitored via IPC Team and incorporated into RCA documentation and PWA inspections. 7. PWA inspections. 8. Risk assessments in place for example risk of flu outbreak; risk of increasing C.difficile cases against trajectory in the contract. 9. Monthly review of reportable HCAI cases at 'Share and Learn'.		1. New Matrons Round inspection currently being formatted on PWA as an assurance inspection undertaken by Matrons and senior nursing management.	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance
Systems and processes are in place to ensure:					
2.1 Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas.	DIVISIONS	1. Designated unit (RCU) for management of suspected and confirmed COVID-19 patients. 2. RCU management by designated Matron with cohort of senior nursing team who remained on the RCU (6x Band 6, 4 x B6 Staff). 3. Respiratory specialist nurses, education department and CCOT with support from quality directorate , worked through competencies and upskilling to ensure all reached a level of competence and confidence to work with this group of patients. 4.Staffing ratio was supported to allow high numbers of staff with additional support of day and night rota for CPAP and respiratory support. The team were supported by the respiratory consultants and doctors on the ward at all times. 5. ITU/RCU training and induction, use of runners, task teams, theatre SOP. 6. Reference to action card 3.101 standard infection control principles. Action card 3.102 & 3.102A regarding infection control PPE, and donning and doffing of PPE with support provided by IPC Team and use of PPE 'wardens'. 7. High risk areas supported by Chaplaincy, Clinical Psychology and Palliative Care Teams for staff and patients experiencing end of life care. 8. PWA Quick Covid 19 assessment to ensure staff understanding in these areas. 9. Standard judgement review commissioned for Covid 19 related deaths in hospital 10. Currently no high harm incidents related to this group of patients or staff	Unknown timeframe or impact of any 2nd wave	Continued monitoring of national and regional intelligence. Review locally when any national learning identifed (such as Trust outbreaks)	
2.2 Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to COVID-19 isolation or cohort areas.	FACILITIES	1. Housekeeping staff have been Fit tested for level 3 mask, MLE PPE units in date and practical training given by supervisors and shadow training with other experienced housekeepers. No trends within incident reporting regarding practices by housekeeping staff. Designated cleaners to clinical areas.	Overnight cleaning team will have to cross all areas. On risk register (no 6571).	All staff aware of regimes and PPE.	
2.3 Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance.	FACILITIES	1. Training guides/practical training and shadow training given prior to undertaking an infection clean. Additional training given to under HPV decontamination for specific supervisors and senior housekeeping staff. All cleaning requests are validated, form completed and signed off by ward sister on completion. Discussions with Housekeeping and IPC to agree any additional cleaning including 'double cleans' and reviewed daily and as required.	1. Continued changes in IPC guidance.	1. Membership of IPC Group.	
2.4 Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance.	FACILITIES	1. RAZ areas increased cleaning hours and cleaning after every patient transfer, in addition to the "normal" ward cleaning. Implementation of double cleaning required for side rooms, Infection control will inform housekeeping daily Mon - Fri where they require double cleans. Sign off sheet and decontamination sheets are available for review.			
2.5 Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas.	FACILITIES	1. Housekeeping undertake X3 cleaning of toilets and bathroom in public and ward areas. Additional cleaning will be undertaken by the specific areas if required. Cleaning task sheets are available for review.	Risk assessment noted on DATIX regarding additional cleaning requirements linked to Outpatient areas.	Additional cleaning staff confirmed via agency.	
2.6 Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.	FACILITIES	1. Our chlorine based products are in use across the site. These products meet the national guidance and have been signed off by Infection Control and Occupational Health. COSHH sheets are available.	A challenge remains that many non-clinical equipment providers are not familiar with providing data/information on this level of cleaning and therefore decisions were made where necessary on standard Trust practice, and any reports of device damage will be monitored.	Wipes are available for non-clinical equipment in clinical areas (e.g. keyboards, photocopiers, phones etc.) which have been agreed with IPCT, Decontamination Lead and IT. External providers have been asked to provide guidance where appropriate.	
2.7 Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products.	FACILITIES	1. Our chlorine based products are not washed off, so appropriate contact time is in place.			
2.8 As per national guidance: • 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily • rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily).	FACILITIES	1. Increased number of cleaners who undertake additional touch point cleaning every day. 2. Non-clinical areas have identified cleaning regimes to provide self cleaning of areas and equipment. 3. Individual users will decontaminate electrical equipment, mobiles and tablets etc. 4. Room cleaning will be undertaken by the departmental staff when PPE is removed.	1. No auditing in place of non clinical areas. 2. Potential challenges of changing supply of wipes. 3. No auditing of cleaning of electronic devices such as tablets, keyboards, phones (including personal phones).	COVID secure risk assessments require confirmation that staff are meeting the requirements. Continued discussion with Procurement re supplies and decision via IPC. Refreshed posters have been circulated to remind staff of correct methods of decontamination of re-usable equipment and incorporated IT equipment to recognise the increase use of electronic devices and technology within clinical areas (see 2.6)	

2.9 Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken.	FACILITIES	A process is in place for contaminated linen which is returned to the on-site laundry and decontaminated to the appropriate standard in line with BSEN14065 and HTM01-04. Process posters have been circulated to all linen areas.			
2.10 Single use items are used where possible and according to single use policy.	DECON LEAD	Disposable mops and cloths are used in RED zone areas including any side rooms. Single use equipment is used as per Trust policy where possible.	No monitoring of single use items.	For PPE would be monitored and managed via PPE Group.	
2.11 Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance.	DECON LEAD	Any items left in the room are cleaned. Ward staff undertake the decontamination of equipment and use Clinell "clean" tape to highlight this action has been completed. All reusable equipment to be decontaminated as per Trust Policy. In-patient areas monitored via PWA.	Limited audit evidence.	Refreshed posters have been circulated to remind staff of correct methods of decontamination of re-usable equipment and incorporated IT equipment to recognise the increase use of IT within clinical areas. In addition during the COVID pandemic, additional items have been added to stock availability such as single use blood pressure cuffs and pulse oximeter probes to provide an alternative to our normal re-usable items for areas to order if appropriate.	
2.12 Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission.	ETS	Walk-round of all areas completed as part of recovery with capacity and flow reviewed. Space allocation committee reviewing appropriate spaces for specific services.	Unknown air exchanges and ventilatory levels in many areas.	Areas undertaking AGPs to be identified and assessment of air exchanges to be completed.	

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance
Systems and processes are in place to ensure:					
3.1 Arrangements around antimicrobial stewardship are maintained.	IPC CONSULTANT		1. Current dependence on ward pharmacists to flag antibiotic issues.	1. Micro staffing levels will now permit the establishment of an antibiotic ward round. This is to start w/b 13/07/20. Currently established for once a week with aspiration for possibly twice weekly	
3.2 Mandatory reporting requirements are adhered to and boards continue to maintain oversight.	IPC	1. RCA documents of all reportable HCAIs with robust appeal process in place with the CCGs. 2.National data submission on HCAI's. 3.IPCWG/ICC meetings documented with minutes and action tracker. 4.Trust KQI reporting monthly for reportable HCAIs at CMB 5. Bi-annual DIPC report through Trust governance pathway to TB. 6. Policies and procedures for managing infection and prevention e.g. Outbreak policy. Policy compliance monitored via IPC Team and incoroprated into RCA documentation and PWA inspections. 7. PWA inspections. 8. Risk assessments in place for example risk of flu outbreak; risk of increasing C.difficile cases against trajectory in the contract.	None		

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance
Systems and processes are in place to ensure:					
4.1 Implementation of national guidance on visiting patients in a care setting.	DM/KG	1. Action card on patient visiting with restrictions and guide for staff. Specific areas detailed for individual approaches and agreed at IMT. No serious complaints raised regarding visiting restrictions. 2. High risk patients in Spinal Unit subject to separate action card to protect shielding patients. 3. Action card for delivering patient belongings co-ordinated by PALS. 4. Capacity for relatives/carers to communicate virtually expanded and detailed on Trust external website .	Evidence of staff undertaking risk assessment with visitors who require PPE. Variation in PWA inspections.	COVID-19 quick assessment completed on PWA.	
4.2 Areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access.	DR/LA	1. Entry to clinical areas restricted with use of 'SALTO locks' . 2. RCU specific signage regarding designated status (now removed due to reduced numbers).	1. Sudden influx of numbers will require reinstating of signage.	1. Numbers discussed via IMT and actions agreed . Signage can be reinstated quickly.	
4.3 Information and guidance on COVID-19 is available on all trust websites with easy read versions.	KG/DR	Easy read information available. Additional added and noted by Healthwatch Wiltshire. No complaints or concerns raised regarding information. Links with Mencap and local LD partners. Internal communications - via IMT for general communications to staff and the public. With traditional broadcast and print media being agreed by a combination of CEO, COO and Exec OD&P based on recommendations from Head of Communications (or Deputy).			
4.4 Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved.	DIVISIONS	1. In Surgical division use of SBAR handover process and sticker in patient medical notes on any transfer. Taking in to consideration action card 3.130 & 03.138 management of identified contact patients. 2. In Medical division - wherever clinically appropriate patient with Covid 19 are nursed within the RCU template and not transferred out unless proven negative following the de-escalation policy. Discharges to residential placements are only allowed after negative screens. Any contact are advised as such on discharge.	1. No audited evidence of SBAR or other patient transfer.	1. Currently nil identified serious incidents due to harm from lack of infection status . 2. Nil poor outcomes discussed in Virtual Board Round. 3. Descalation action card. 4. No reported incidents on DATIX due to harm from lack of infection status .	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	**Compliance**
Systems and processes are in place to ensure:					
5.1 Frontdoor areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidance.	DIVISIONS	1. Medical division - RAZ and standard Majors process in place as per action card. Any resp symptoms or common complications are directed through RAZ (Reference to action card 3.098A & B ED and clinical response management of Covid 19 patients. ED configuration and service delivery action card). 2. Surgical division - No 3.129. SAU action card and outpatient action cards. 3. CS&FS - Action cards (03.116, 03.136, 03.146), risk register, SOPs.	1. Patients may present without Covid symptoms and be sent through cold majors. 2. Designated 'red and green' areas to be approved and signed off by DIPC by September 2020.	1.All patients swabbed and all staff are wearing PPE appropriate to activity. 2. Screening undertaken in outpatient settings.	
5.2 Mask usage is emphasized for suspected individuals.	DIVISIONS	1. Mask usage for staff as per action cards and monitored via PWA Quick Covid 19 assessment to ensure staff understanding of management of suspected individuals. 2. Reference to action card 3.102 re PPE and infection control and for patients action card 03.154. 3. Identification of PPE requirements via PPE Group including the procurement of hoods for where masks are not suitable.	1. Ongoing informal observation and reports of poor compliance with wearing of masks.	1. All management teams responsible for being up-to-date with mask requirements and provide ongoing feedback to staff. Messages via daily briefing regarding PPE requirments and external communications to patients.	
5.3 Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	DIVISIONS	1. Screens provided in outpatient areas and/or social distancing floor tape. Waiting areas marked out for maximum usage.	1. Lack of consistency and difficulty for areas to recover with service requirements.	1. Walkrounds of all non-in patient areas undertaken and reported via Recovery Cell. Review of service delivery via Space Allocation Committee.	
5.4 For patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible.	DIVISIONS	1. Wards and medical staff review all patients with new resp symptoms and all patients are screened on admission and rescreened every 7 days. Reference to action card 03.148 & 03.151 non elective medical and surgial admission pathway and flow of testing. Also reference action card 3.098A regarding clinical response to suspected coronaviruses. 2. Designated person to undertake contract tracing which commences on notification and undertaken by B7 Sister at the weekend. 3. Positive patients reviewed at the Virtual Board Round and correct contact tracing verified.	1. Risk to number of available of siderooms for isolation. 2. If 2nd wave occurs and high volumes of patients, additional resources will be required to provide timely contact tracing. Unknown pressure on capacity for testing.	1. Twice daily review of siderooms by IPC. 2.Regular review of covid result and senior decisions made as to appropriateness of cohorting patients to allow isolation capacity. Use of ward area with high number of siderooms.	
5.5 Patients with suspected COVID-19 are tested promptly.	DIVISIONS	1. All patients are tested on admission and retested in accordance with action card . Any patients with new symptoms are also isolated and tested. Reference to action card 03.148 & 03.151 non elective medical and surgial admission pathway and flow of testing. Also reference action card 3.098A regarding clinical response to suspected coronaviruses.			
5.6 Patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced.	DIVISIONS	1. Process and SOP in place for cohorting and de-isolating negative patients which includes senior clinical review and is not reliant on test results. Use of whiteboard to trace patients. 2.Virtual Board Round meetings to highlight and discuss. 3.PWA quick covid 19 assessment feedack to remind staff are procedures.			
5.7 Patients who attend for routine appointments and who display symptoms of COVID-19 are managed appropriately.	DIVISIONS	1. Patients are contacted regarding symptoms prior to testing and asked again on arrival. Wherever possible patients are seen using "Attend Anywhere". 2. STOP Station SOP for consistency of practice across departments.	1. Lack of audited evidence regarding management.	1. Nil serious incidents raised regarding possible transmission in out patient areas.	

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance
Systems and processes are in place to ensure:					
6.1 All staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe.	IPC/DIVISIONS	1. Monthly hand hygiene submission in all clinical areas. 2. PPE training provided by IPC Team and records kept. 3. IPC Training on MLE and monitored via IPCWG. 4. Following the introduction on 15/06/20 of masks in non-clinical areas a risk assessment to validate COVID -Secure areas introduced and signed off via the IPC Group and then via IMT. 5. Requirements regarding social distancing within working environments identified with maximum occupancy room signage and link to number 4. 6. Staff shielding, redeployment, working from home guidance and associated safety overseen by Trust Workforce Group. 7. Staff well being and direction to OH support identified via daily bulletin and encouraged discussion with line managers.	1. Continued changes to guidance could result in out-of-date practices.	1. Immediate updating of action cards on receipt of new guidance which has been reviewed at IPC Group. 2. Updated guidance to staff via Trust daily comms and intranet. 3. National update to the quick COVID 19 PWA assessment by the PWA organisation.	
6.2 All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it.	IPC	Refer to section 1.6			
6.3 A record of staff training is maintained.	IPC/DIVISIONS	1. IPC record of training delivered by the IPC Team. 2. FIT Testing register.	1. Continued challenges with the supply of PPE and repetitive FIT testing required.	1. Co-ordinated via the PPE Group.	
6.4 Appropriate arrangements are in place so that any reuse of PPE in line with the CAS alert is properly monitored and managed.	DIPC/PPE	1. All reuse of PPE is agreed via the PPE group.	Degradation of reuse items.	1. Monitored with Trust H & S Manager and regulated via PPE Group. Any significant risks would be added to the risk register.	
6.5 Any incidents relating to the re-use of PPE are monitored and appropriate action taken.	IPC/DIVISIONS	1. All incidents would be reported via DATIX and identified by Trust H &S Manager/Procurement with discussion at PPE Group.			
6.6 Adherence to PHE national guidance on the use of PPE is regularly audited.	DIVISIONS	1. Surgical division - Covid secure risk assessments-red, green and blue areas. PPE champions and PPE meetings. Reference to action card 5.037, PHE guidance for healthcare workers. 2. PPE champions in CS &FS from 26/06/20. 3. PWA quick COVID-19 inspection and existing PWA inspections.	1. Currently no standardised inspection/audit within non in-patient areas.		
6.7 Staff regularly undertake hand hygiene and observe standard infection control precautions.	DIVISIONS	1. Monthly hand hygiene submission in all clinical areas. 2. PWA IPC Inspection.	1. Standard precautions are not routinely audited within non in-patient areas.		

6.8 Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance • guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	ETS/IPC	1. Hand driers removed from use on the 13th of July from the following areas:- SDH North public toilets, Spinal Unit, Hedgerows, Block 29 and the Staff Club. Note:- a decision was made to also remove from use the hair driers that are installed in the Staff Club changing areas. 2. Procurement have been informed of the increase in paper towels and they do not believe stock will be a problem. 3. Extra bins are also in place within the facilities.	1. Increased risk of sewage leaks via blockages caused by wipes in the waste system.	Link to RA 6545 - actions completed	
6.9 Staff understand the requirements for uniform laundering where this is not provided on site.	DIVISIONS/FACILITIES	1. Laundering of uniforms to be completed within existing washing guidelines provided with uniforms. Addition of reinforcement of the requirement to change on-site and courier uniform within a laundry bag or similar. 2. Clinical staff not usually in uniform provided with scrubs in high risk areas and/or required to wear work specific clothing changed into and out of at work.	1. Not formally monitored.	1. Staff made aware of this requirement within own scope of personal responsibility.	
6.10 All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance, if they or a member of their household displays any of the symptoms.	ALL	1. Reference to action card 5.037 PHE guidance for healthcare workers. Staff seeking appropriate and prompt testing for themselves or household. 2. Trust Comms directed to OH services with 7 day cover to provide guidance on testing and isolation requirements.			

7. Provide or secure adequate isolation facilities

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance
Systems and processes are in place to ensure:					
7.1 Patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate.	DIVISIONS	1. Patients isolated within the RCU/Radnor template unless specialty requirements denote higher risk and then isolated within a sideroom facility. Use of siderooms,cohorting, signage, red/amber areas etc. Liaison of site management team and IPC team with ward staff to ensure appropriate patient placement within the Trust. Reference to action card 3.130 and 3.101, standard infection control principles and ongoing management of identified contact patients. Discussed with IPC Team and monitored via Virtual Board Round meeting.	1. Unpredicted positive patients.	1.Moved on positive screening and contact tracing undertaken as required. Actions reviewed at Virtual Board Round.	
7.2 Areas used to cohort patients with possible or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance.	DIVISIONS/ETS	No positive or negative pressure rooms in use within the Trust. Patients are all in designated ward/clinical specific environments. No non-clinical environments utilised for clinical capacity.	See 2.12 re ventilation		
7.3 Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	DIVISIONS/IPC	1. Management between clinical teams and Microbiology/IPC Team. All standard policies and processes in place. Trust wise reporting regarding HCAI. Ongoing regular monitoring via PWA.	Policy audits not undertaken over 2019/20. Previous internal audit not identified concerns. Good feedback from CQC framework review July 2020.	Daily monitoring with ward visits by IPC and links with Site and clinical teams regarding practice. Audit plan to be identified.	

8. Secure adequate access to laboratory support as appropriate

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance
Systems and processes are in place to ensure:					
8.1 Testing is undertaken by competent and trained individuals.	DIVISIONS		No specific training logged	1. National video available and PR to create in-house info to be circulated by Divisions to staff with check in that staff have watched training info.	
8.2 Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance.	DIVISIONS/OH	Symptomatic staff (days 1-5) are referred for swabbing on the day they report their symptoms to us and are placed on the swabbing list for the next day. Antibody testing in progress.			
8.3 Screening for other potential infections takes place.	DIVISONS	As per existing pathways for e.g. MRSA screening and C.difficile. Sepsis pathway in place.			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance
Systems and processes are in place to ensure:					
9.1 Staff are supported in adhering to all IPC policies, including those for other alert organisms.	IPC/DIVISIONS	Refer to section 1.8			
9.2 Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff.	IPC/DIVISIONS	Refer to section 1.4; 1.6; 1.6			
9.3 All clinical waste related to confirmed or possible COVID-19 cases is handled, stored and managed in accordance with current national guidance.	FACILITIES	All potential COVID 19 waste is placed in orange bags and picked up as per Trust Policy via the waste teams. Waste stream for masks in non-clinical areas is managed at increased level than national guidance (which only requires a black bag) to ensure consistency and risk of incorrect disposal.			
9.4 PPE stock is appropriately stored and accessible to staff who require it.	PROCUREMENT	1. PPE stock and usage closely monitored and discussed at PPE Group. Access processes robust as evidenced by no incidents of PPE unavailibity for staff. 2. CS &FS Comms directly to heads of service and leads. PPE update given at weekly DMC and disseminated by HoS to teams. Monthly Divisional PPE Champions group.			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

KLoE	Completed by	Evidence	Gaps in assurance	Mitigating actions	Compliance
Systems and processes are in place to ensure:					
10.1 Staff in 'at-risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported.	DIVISIONS/OH	1. Undertaking of individual staff risk assessment, use of occupational health, welfare check of redeployed staff, debriefing in all areas of impact. Reference to action card 03.134, 03.153 & 03.144, guidance for Trust employees defined as vulnerable/extremely vulnerable. This would be covered and met within the COVID risk assessment which ensures the correct work task is being offered according to the nature of the risk e.g. pregnancy, BAME, age, health and the risk assessment also has a psychological wellbeing section on that should be completed between manager and employee. Also, when the pandemic first affected the UK, any staff member could ring our covid OH line for guidance and support. Three telephone lines in our call centre room was attended 12hrs/day, seven days/wk. This support line continues but is 8-6pm Mon-Fri now. On these calls, we would aim to answer any questions or signpost people if we cant and we also would write a letter to the manager to reflect the clinical advice we gave to ensure the advice is communicated thoroughly. Physical and Psychological wellbeing is also supported via the signposting details on the microsite available to all staff. Consistency panel set up to review the Vulnerable staff risk assessments - selection reviewed each week and managers invited to attend meetings to discuss any concerns with scores or actions taken. Staff risk assessment has been initially focused on vulnerable staff including BAME, but have been expanded to all staff. COO and HRD meeting monthly with BAME staff.	1. Staff choice to remain at work where advised not.	1. PPE worn at all times and staff offered alternative areas to work.	
10.2 Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained.	MEDICAL DEVICES	Written information (in line with manufacturer and PHE guidance) is issued with each system to provide step by step instructions on their use and management. It additionally acts as a resource out of hours and is available as part of the COVID response action pack. Decontamination Lead provides briefing on collection and signature sheet in place for tracking systems. Hoods being used for staff who fail fit testing. Fit testing programme in place. Hoods use signed off by COO/DoN. Task and finish group established to review and implement 'Southampton hoods'. Decontamination process in line with manufacturers guidance and Trust IPC policy.	No previous record of briefing and staff collecting the hoods are not always the end users. Risk of requiring more hoods than current supply but not currently an issue.	-Decontamination Lead has commenced list to evidence information signposted to staff collecting, also capturing where staff collecting are not end users. Task and Finish Group in place for procurement of new hoods. Additional hoods on order to increase current availability and managed via PPE group.	
10.3 Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance.	DIVISIONS	Housekeeping staff are allocated to specific wards and remain in that area until the end of their shift. Those staff that undertake post infection cleans do attend different areas, however strict PPE and decontamination processes are followed. Divisional teams have not embraced reducing movement between staff areas. Daily staffing meeting in place, red and green zones not clearly defined. Mitigation - antigen testing on Pembroke and Spinal where patient group vulnerable has not shown any positive results. Virtual Board Round looking at any hotspots of staff absence.		Link to Risk assessment 6568 for Surgical Division	
10.4 All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	ALL	1. COVID secure risk assessments in place with approval process. Trust wide signage for floors and for maximum occupancy with wearing of masks if this is breached. 2. Security teams and allocated staff to provide guidance and reminders to staff regarding social distancing. Social distancing Task and Finish group established, floor signs, posters, rooms labelled. Public areas not deemed as COVID safe.		Risk register of high-risk areas (labs, pharmacy) have had walkarounds with Sue Biddle	
10.5 Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas.	ALL	1. Surgical division - Creation of spinal bubble staff testing. Retraining of delayed staff. Dedicated Chilmark elective surgery team. Staffing meetings. Liaison between IMT and DMT teams. 2. Medical division - On opening of the RCU staff were identified to work in the area and moved over on the roster. Wherever possible staff were working in the same location. 3. CS&FS - maximum numbers in rooms for doctors . 4. Estates and Facilities staff have a variety of shifts running all days each staff areas has room loading, decontamination stations and appropriate masks with good promotion of social distancing.	Lack of assurance across all clinical areas	Raised with ward leaders via NMAHP Forum - examples of taped handover, use of different spaces for handover were given. Ward offices/rest rooms labelled with room numbers, chairs taken out etc. Training rooms limited and use of virtual training. Staff canteens been converted to staff only, tables distanced etc.	
10.6 Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing.	ALL/OH	All staff isolating whether its for 7 days or 14 days are logged on a spreadsheet in OH and on our OH diary system called cohort. Antigen testing on Pembroke and Spinal and roll out of Antibody testing. Virtual Board Rounds on hotspots. COO and OD&P Executive Director meeting with Bame group monthly to seek their views on the Health and wellbeing agenda	Unknown within the Divisions how the supporting of staff who are at home and self-isolating - feedback from shielding group has been poor re contacts from line managers (and redeployed staff too).		
10.7 Staff who test positive have adequate information and support to aid their recovery and return to work.	OH	When staff test positive, OH use a comprehensive assessment process to ensure guidance is being followed accordingly, the staff member and manager is advised accordingly and a system in place that if someone isn't well enough to RTW after the 7 days, that they seek further OH input so we can update our records and advise them and their manager again. There are also some cases where staff are particularly unwell and OH will do a welfare call with them too to provide additional support.	As 10.6		

CLASSIFICATION
Unrestricted

Salisbury NHS Foundation Trust

Report to:	Clinical Governance Committee	**Agenda item:**	**5.3**
Date of Meeting:	03 September 2020		

Report Title:	Annual clinical governance report 2019 - 2020			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	
Prepared by:	Claire Gorzanski, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Christine Blanshard, Medical Director Lorna Wilkinson, Director of Nursing			
Appendices (list if applicable):				

Recommendation:

The report is presented for assurance that the clinical governance arrangements are effective in identifying key risks to the quality of care and escalated to the Board to ensure they are sighted on the key risk and the mitigation in place. The report was presented at the Clinical Governance Committee on 23 June 20.

Executive Summary:

Overall, the Integrated Governance Framework and Accountability Framework has ensured that the clinical governance function is effective in routinely sighting the Board on key risks and mitigation to the strategic objectives of the organisation.

Achievements, issues escalated and high priority areas for improvement in 2020/21 are highlighted in the report.

High priority areas 2020/21:

- Progress the recovery work associated with the COVID-19 emergency to reduce risks of delays in diagnosis or treatment in clinical pathways.
- Reduce the number of category 3 and 4 pressure ulcers.
- Reduce avoidable harm from sepsis by improving the administration of IV antibiotic treatment within an hour of diagnosis.
- Progress the maternity safety improvement plan in response to the number of serious incidents and submit a report to the Clinical Governance Committee.
- Continue to make improvements in the cancer pathways to eliminate delayed or missed cancer diagnoses and track actions through to completion.
- Continue to make improvements in the Gastroenterology service and plan for service sustainability and report progress to the Clinical Governance Committee
- Implement the new Liberty Protection Safeguards when published and understand the impact on patients and staff and report to the Clinical Governance Committee.
- Work alongside the divisional management teams to embed risk management, clinical effectiveness and learning in governance processes.

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

SALISBURY NHS FOUNDATION TRUST

ANNUAL CLINICAL GOVERNANCE REPORT 2019 – 2020

1.0 Purpose

This report sets out the progress made in continuously improving the quality of care and provides assurance that appropriate governance processes are in place to ensure the Board is routinely sighted on key risks and assured that mitigation is in place.

2.0 Clinical governance arrangements

Clinical governance is a framework used throughout the NHS which ensures organisations are accountable for continually improving the quality of services and safeguarding high standards of care by creating an environment in which excellence will flourish. The elements of clinical governance are – patient safety and risk management, patient experience, clinical effectiveness, workforce, learning and development and data quality. The elements of clinical governance can be mapped against the Care Quality Commission five domains of quality – safe, caring, effective, responsive and well-led.

In 2017, the Trust adopted an Integrated Governance Framework underpinned by an Accountability Framework. The Board approved a revised version of the Framework in April 2019. The Integrated Governance Framework sets out the Board's relationships with its committees and outlines the relationship with the clinical divisions and into services areas. It describes the quality governance arrangements as a means by which the Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the strategic objectives.

The purpose of the Accountability Framework is to ensure that the Trust has sufficient mechanisms in place to monitor and drive the delivery of the Trust's strategic and operational plans. It sets out the expectations of the Trust as a whole and as individual Divisions. It provides a framework for how the Trust will monitor and manage its own performance to ensure delivery of the corporate objectives and that sufficient escalation triggers are in place so the Board is routinely sighted on and involved in the mitigation of key risks.

The Accountability Framework is aligned with the NHS Improvement Single Oversight Framework, November 2017. This framework reflects the requirements of the Care Quality Commission, financial sustainability, performance management and improvement capability. The Performance Framework sets out the metrics that each Division is held accountable for and assigns a rating of red, amber or green based on performance against the domains of quality, operational, financial and workforce performance as well as delivery of the Divisional operational plan at the monthly Executive Performance Review meeting. The overall rating for each Division acts as a trigger for additional support or escalation to the Board.

Clinical governance is the responsibility of the Trust Board supported by the Clinical Governance Committee for seeking assurance on continuous improvement in the quality of care. The Chief Executive is the accountable officer for clinical governance. The responsible officers for quality are the Medical Director who leads on clinical effectiveness and the Director of Nursing who leads on patient safety and patient experience.

The Integrated Governance Framework provides evidence to the Board that the organisation complies with quality and safety standards. Feedback is enhanced by Board Safety Walks where staff are able to raise safety concerns directly with an Executive and Non-Executive Director.

3.0 Safe

3.1 Care Quality Commission (CQC)

In December 2018, the Trust was inspected by the CQC who rated the Trust as requires improvement for safety, the same as in 2015. This was mainly due to only four core services being inspected, which meant that the potential for improving the overall rating was constrained.

Four core services (urgent and emergency services, surgery, critical care and spinal services), were inspected by the Care Quality Commission (CQC) in 2018. Overall, the CQC found 26 areas that the Trust should do to improve and in March 2019 a quality improvement plan was written which identified 18 actions. Good progress has been made with 13 actions completed with 5 that remain in progress. Progress was monitored through the CQC core service task and finish group meetings until September 2019. On-going monitoring of improvement is through service meetings, Divisional Management Teams or committees.

3.2 Patient safety

Our patient safety programme was renewed as a three year programme in 2019 and aligned with the Wessex Patient Safety Collaborative which focuses our improvement work in four key areas. These are: 1) Improve the safety culture 2) Reduce avoidable harm of patients who deteriorate 3) Reduce stillbirths and intra-uterine deaths 4) Reduce harm in frailty – falls and pressure ulcers.

The safety culture was addressed by training our staff in human factors to reduce never events, errors and its consequences for the patient. A total of 201 multidisciplinary staff attended a human factors training day in November 2019 given by an external Consultant Orthopaedic Surgeon and Patient Safety expert. We had 2 never events associated with an air flow meter and retained swab but neither patient suffered harm. Clinical simulation training continues to be provided for our staff of scenarios which focus both on the technical and human factor elements of clinical care.

There has been a notable improvement in the proportion of deteriorating patients escalated to a doctor when a NEWS2 score triggers action (83% in 2019/20 compared with 73% in 2018/19) and a reduction in the relative risk of death from sepsis. Positive assurance of a reduction in high harm falls from 36 in 2018/19 to 24 in 2019/20. Of concern however, is the number of category 3 and 4 pressure ulcers which increased from 3 in 2018/19 to 21 in 2019/20. A cluster review and aggregation of the key contributory factors was completed along with a quality improvement action plan. Progress will be monitored by the Nursing, Midwifery and AHP Forum and reported to the Clinical Governance Committee.

The National Maternal and Neonatal Health Safety Collaborative was launched in 2017. In April 2019, our Maternity Services joined the 3rd wave of a structured year long, supported, work stream where a small team of doctors and midwives attended initial quality improvement training. There were no stillbirths which were small for gestational age this year reflecting the improvements made by the use of the Saving Babies Lives care bundle.

3.3 Safeguarding

Trust quarterly reports provided positive assurance on sustained compliance with level 2 safeguarding children training at 87% and level 3 at 87.6% at the end of 2019/20. Level 4 training for named professionals was 100%. 89% of identified staff have received Neglect Toolkit training. Safeguarding supervision compliance for all departments remains over 50% but arranged sessions for March were cancelled due to COVID-19 which has affected the overall compliance. This will be mitigated by ad hoc supervision sessions in Q1 2020/21 and beyond.

Positive assurance was noted in compliance with level 1 & 2 adult safeguarding training at 97% and 86% respectively. However, Mental Capacity Act and Deprivation of Liberty training was at 71% compared to a target of 85%, mitigated by Divisional teams tasked with increasing compliance within their services. Work in 2020/21 will continue to focus on implementing the Adult Intercollegiate training requirements and delivery plan and the introduction of the Liberty Protection Safeguards (which may be delayed in light of the COVID-19 emergency). These safeguards are likely to shift the responsibility of assessments from the Local Authority to the acute Trust.

3.4 Staffing

SFT continues with its model for systematically reviewing nursing staffing levels across all in-patient wards, strengthened year on year using nationally recognised methodologies. The review in 2019 showed that all areas meet the staffing level recommendations set to achieve an average of 1:5 to 1:8 registered nurse to patient ratio during the day. Of note, is that the registered nurse vacancy rate at the end of 2019/20 is 0.66% due to on-going recruitment and retention initiatives.

This year, we have successfully recruited to consultant posts in microbiology, radiology and histopathology and had fewer junior doctor rota gaps. A review of weekend working took place to improve co-ordination of the workload.

In general, the Trust continues to review against the Developing Workforce Safeguards document which is broadly compliant for nursing, but is ongoing work for other professional groups.

3.5 Patient safety incidents

Our national staff survey 2019 showed staff feel confident to report errors, are treated fairly if involved in an incident, and believe that the Trust takes action to ensure they do not happen again. All scores were better than the national average.

Our National Reporting Learning System rate of patient safety incidents reported, showed an increase from 40.81 incidents per 1000 bed days in Q3/4 2018/19 to 43.76 incidents per 1000 bed days in Q1/2 2019/20. The number of incidents that resulted in severe harm or death increased from 14 (0.4%) incidents in Q3/4 2018/19 to 18 (0.6%) incidents in Q1/2 2019/20. Overall, the number of serious incident inquiries remained static (40 SIIs in 2019/20 compared to 39 in 2018/19) but the number of clinical reviews increased (12 in 2019/20 compared to 5 in 2018/19). The Clinical Governance Committee continued to seek assurance of improvements required in the cancer pathway and gastroenterology service. In 2019/20, the key safety themes that emerged were an increase in pressure ulcers and maternity services in light of 17 serious incidents over 18 months which resulted in a thematic review and maternity safety improvement plan.

As part of our ongoing commitment to promoting a learning culture we continued to monitor the statutory Duty of Candour when patients suffered moderate or severe harm. Duty of Candour compliance was reported monthly to the Clinical Risk Group of patients who suffered moderate harm and to drive further improvement.

4.0 Caring

The CQC rated the Trust as good for caring in 2015 and 2018.

The national maternity survey 2019 showed women had a good experience with a good safety culture. The national children and young people survey 2019 had many positives and a CQC letter noted the Trust excelled in the 8 – 15 age group. The suitability of the Day Surgery Unit scored low was noted as a theme due to estates constraints.

The number of patients who completed a Friends and Family Test (FFT) questionnaire after an outpatient or inpatient admission remains lower than we would like. New guidance from NHSE recommends that an electronic option is included as this is recognised as being more accessible for more people. A link to the FFT question is available on our website and we are exploring the use of text messages that could be sent after a patient has visited the hospital.

A quarterly patient experience report provided assurance on lessons learnt and changes in practice as a result of patient feedback. The PALS team have been relocated and a free short-stay car parking space provided for visitors to PALS.

The Patient and Public Engagement Strategy 2019/22 was shared with and shaped by patients and the general public. Three overarching priorities for patient engagement were identified as communication, working together and outstanding care. Progress against these priorities is presented in a bi-annual report.

5.0 Effective

The CQC rated the Trust as 'good' for effective. A bi-annual national clinical audit report was presented to the Clinical Governance Committee which showed overall good patient outcomes with actions plans in place where standards were not met. An annual NICE guidance report was also presented to the Clinical Governance Committee and showed a similarly high level of compliance with actions in place where needed. Similarly, progress of our response to national enquiries and reports was presented to the Committee for assurance that lessons are learnt and practice improved.

In 2019/20, the Trust recruited 1054 patients into 77 studies and remained in the top quartile of small acute Trusts nationally for patients recruited into clinical research trials. This demonstrates our commitment to improving the quality of care we offer and to making a contribution to wider health improvement.

Microguide a web based tool, which contains all clinical and non-clinical policies and guidelines has been embedded in practice. Metrics demonstrate a high level of use (thousands of hits).

Getting It Right First Time (GIRFT) is a clinically–led, national NHS Improvement programme. It is designed to improve the quality of care by reducing unwarranted variation. A total of 16 specialities have engaged in the programme since it started in 2018 and Rheumatology and Radiology are the services with the most recent reviews. Many examples of good practice were identified with further refinement of the governance process in Rheumatology.

A review of Directorate (Divisional) Governance meetings in March 20 showed a requirement to focus on clinical effectiveness, learning and triangulation of quality intelligence.

6.0 Responsive

The CQC rated the Trust as 'good' for responsive in 2018. They found that the Trust planned and provided services in a way that met the needs of local people. There was good access to urgent and emergency care and patients attending received personalised care. Critical care was rated as outstanding in recognition of the way they had managed the major incidents related to nerve agent poisoning.

The Trust was very close to delivering the targets for referral to treatment, diagnostic and cancer standards in 19/20 and the Emergency Department four hour standard was at 90.06% compared to a target of 95%.

7.0 Well-led

Following the CQC inspection in December 2018 which rated the Trust 'Good' for Well-Led, significant progress has been made to date against the Well-Led action plan, across all domains, with a continued focus for further improvement. Key progress highlights are outlined below.

Leadership Capacity and Capability

- Clinical Directorate re-structure completed, led by the Chief Operating Officer
- On site, NHS Provider facilitated Board Development sessions; extended to Directorate Management Teams
- Development of a suite of leadership development programmes which will continue into 2020/21.
- Bi-monthly leadership forum providing masterclasses on a range of topics

Vision and Strategy

- Associate Director of Strategy commenced in post in March 2019. The focus of the postholder has been to establish a clear link between corporate and the clinical strategy, the delivery of corporate operational plans and strategic service review.
- A quarterly review process against the Corporate Strategy has been put in place (September 2019) to ensure that the Executive Team, relevant Board Committees and the Trust Board can assess progress on the delivery of the Trust's strategic priorities.
- The Trust undertook a development programme resulting in the approval of a financial sustainability strategy at Trust Board in February 2020.

Culture

- In response to the CQC visit, the Trust's Freedom to Speak Up Guardian (FTSUG) worked collaboratively with NHSI to develop an action plan. These recommendations have been reviewed at board sub-committees at quarterly intervals, and the FTSUG continues to maintain contact with NHSI to ensure that the recommendations are delivered within the agreed timescales.
- Refresh of the Raising Concerns Policy and a FTSU and EDI Board awareness session
- The FTSUG has commenced another 12 month peer supervision/action learning set with the London FTSUG network as it has proven to be very beneficial to both the Guardian and the organisation
- Significant progress made on the Trust's equality journey including re-establishment and development of staff networks and 1058 members of staff and volunteers took part in some form of EDI training. Increased focus on the Gender Pay Gap, Workforce Race Equality Standards and the Workforce Disability Equality Standards.

Roles and Responsibilities

- Directorate Governance meetings have been reviewed to strengthen governance arrangements and escalation of risk within the Directorates and from specialty level.
- Completed review of the Board and organisational committee structure to strengthen governance arrangements and Board assurance
- Strengthened corporate governance arrangements including declaration of interests and declaration of hospitality and gifts process.

Risk Management

- The patient safety agenda is very much being guided by the recently published National Patient Safety Strategy which is informing Trusts on the expectations going forward. Embedding the concepts of the Strategy is reliant on both national and local actions.

Accurate Information

- The Integrated Performance Report (IPR) was completely revised in collaboration with data owners. The financial forecasting process is established with monthly reporting to Finance and Performance Committee and quarterly reporting to Board.
- With support of South Central and West Commissioning Support Unit, the Trust has made use of a demand and capacity planning tool specifically for planning its winter capacity. This assisted in forecasting future bed base requirements and the impact of actions on average length of stay and the Trust's delayed transfers of care rate and volume.
- Data quality oversight and assurance processes have been strengthened over the last year, with a revised data quality policy and a new Information Standards Group now in place.

Engagement

- The communications department have commenced implementation of the corporate communications strategy agreed by the Board in May 2019.
- A variable complaint response time set out in the Complaint Handling Policy, went live on 1 August 2019. The impact has shown a significant (38.5% in Q2) increase in compliance to complaint responses being sent out within the timescale agreed with the complainant.
- The PALS complaint coordinators have initiated weekly ward rounds with the aim of facilitating real-time and prompt resolution to concerns patients may disclose; preventing concerns escalating to more formal complaints

Improvement and Innovation

- In April 2019 the Board approved 'Our Strategy for Improvement' and associated Quality Improvement implementation plan.

8.0 Quality account

The quality account provides information on the quality of services the Trust provides for patients and the public. The key message in the quality account is that quality is our number one priority. It shows a positive picture of improvements in quality in 2019/20, particularly in:

- Alcohol and smoking screening, brief advice and referral.
- Successful launch with Mencap of the 'Treat me well' campaign.
- Successful pilot of midwifery continuity of care and very positive feedback from women.
- Positive benchmarks on a range of infection prevention and control measures.
- Good outcomes in the management of sepsis and best practice management of patients with COPD.
- Increase in the number of patients discharged to their preferred place of care at end of life.
- Care of older people through the OPAL team frailty pathway.
- Increase in same day emergency care.
- Outpatient transformation – 'Attend Anywhere' and 'Consultant Connect'.

Priorities for improvement in 2020/21 are:

- Work with our partners to prevent avoidable ill health
- Introduce the new national patient safety strategy to reduce avoidable harm
- Work towards the implementation of the national learning disability improvement standards.
- Work with our partners to value patient's time by ensuring that they are only in hospital when necessary

Progress of the priorities will be monitored via a mid-year report and an annual report to the Clinical Governance Committee

9.0 Key issues escalated from the Clinical Governance Committee to the Board in 2019/20

- Vascular services - interventional radiology vascular procedures were no longer supported by neighbouring Trusts in March 2019. By September 2019 a service model was agreed with Royal Bournemouth Hospital for an onsite provision 2 days a week.
- Closure of outstanding serious incident investigation recommendations for Q4 2018/19. As an outcome, a clearer executive summary was written to highlight where outstanding actions were 'stuck'. A theme of IT infrastructure emerged mitigated by a Digital strategy.
- Weekend HSMR was significantly higher than expected in July 2019 at 133 and was escalated directly to the Board. To establish the cause, a case notes review of patients who died when admitted as an emergency on a Sunday was completed along with an improvement plan. This included additional resources to strengthen weekend working as part of the 2019/20 winter plan (7 day pharmacy AMU service and additional ward clerk cover on AMU). By February 2020, weekend HMSR had reduced to 110 (and continues to do so).
- NHS 7 day services assurance framework broadly met the 4 priority standards for patients admitted as an emergency. Of concern, was the standard for daily review at a weekend not being met. This too, was escalated directly to the Board. Mitigation is the same as actions linked to the weekend HSMR above. In addition, a working group was set up to improve the co-ordination of the workload at weekends.
- Positive assurance – annual research report 2018/19 met 4 of the 5 standards and the Trust was one of the top performing small acute Trusts in the country for research.
- A cluster of incidents related to the cancer pathway. A cancer risk summit was held in September 2019 which included the impact of two patient stories. Variation in practice was noted and 3 task and finish groups were set up to review pathways and processes. A follow up summit was held in April and the 3 task and finish group leads presented progress of their individual work streams. In 2019/20, there were two cases, one bowel cancer patient and one skin cancer patient lost to follow up compared to 10 cancer patients (all SIIs) in 2018/19. Progress was reported to the Cancer Board and will continue to be reported to the Clinical Governance Committee.
- National reporting changes for Clostridium difficile 2019/20. Although the Trust exceeded its upper limit of 9 cases, 8 hospital onset healthcare associated cases were successfully appealed to the CCG for no lapses in care. PHE data showed the Trust rate of C.difficile hospital onset cases was 5.8 per 100,000 occupied bed days in 2019/20 compared to a rate of 13.42 in the South West and 15.42 in England.

- Maternity services Clinical Negligence Scheme for Trusts supports the delivery of safer maternity care. The Trust demonstrated compliance with all 10 actions and sign off was agreed.
- Maternity services risk management report highlighted 17 serious incidents between 2018 and 19. A thematic review revealed CTG interpretation, risk assessment and communication as the key areas for improvement. A maternity safety action plan is in place.
- Gastroenterology service review and plan for service sustainability – mitigated by an independent provider to support the consultant workforce and two trainees supporting the medical on call rota as a short term measure. The Medical Director invited the Royal College of Physicians to undertake a review of the service in November 2019 who recommended the formation of a GI unit within 3 months of the report to bring together GI surgery, medicine and endoscopy, improve recruitment and ongoing collaboration with other providers.
- Quoracy of the committee was not always quorate with Non-Executive Directors – resolved by February 2020.
- Safeguarding adults and children internal audit report rated as a medium risk. Five recommendations were progressed within timescales.
- The impact of the new Liberty Protection Safeguards which are likely to shift the responsibility of assessments from the Local Authority to the acute Trust will require a significant training programme to ensure compliance with the regulations.
- Freedom to speak up raising concerns report – assurance that the Trust now has an effective system and process in place to facilitate staff to speak up.
- Risk management annual report assured processes and procedures in place.
- AMU flow and bed management - assurance that ED and AMU have good processes in place and recognition that patient flow is largely constrained by issues in the downstream patient pathway.
- Board assurance framework and corporate risk register escalated the lack of capability and capacity to deliver the digital strategy. Mitigated by manual work rounds.
- The national Patient Safety Strategy and actions required to implement it. Risks associated with delivery related to digital structure constraints.
- National children and young people survey. There were many positives in the report and a letter from the Chief Inspector of Hospitals, Care Quality Commission noted the Trust excelled in the 8 – 15 age group. The suitability of the Day Surgery Unit scored low was noted as a theme due to estates constraints.
- Human Tissue Authority stem cell licence retained.
- Research and Development risk of loss of income due to fewer patients recruited and risk to staffing – staffing reduced through vacancies to broadly within budget
- Divisional governance committees – strong focus on safety and need for a focus on learning and clinical effectiveness. These are aligned in the new divisional structure.
- Integrated performance report – good focus on safety metrics.
- Medicines safety bi-annual report highlighted good progress in recruitment and risks associated with no clinical pharmacy service on a Sunday, mitigated by a successful weekend pilot in AMU and move to a 7 day service in September 2020.
- Clinical strategy progress update every 6 months.
- COVID-19 pandemic – the Director of Infection Prevention and Control provided assurance that robust plans were in place, a COVID-19 clinical reference group, ethics committee were set up with a recovery cell to return to business as usual.

10.0 Areas for improvement 2020/21

High priority:

- Progress the recovery work associated with the COVID-19 emergency to reduce risks of delays in diagnosis or treatment in clinical pathways.
- Reduce the number of category 3 and 4 pressure ulcers.
- Reduce avoidable harm from sepsis by improving the administration of IV antibiotic treatment within an hour of diagnosis.

- Progress the maternity safety improvement plan in response to the number of serious incidents and submit a report to the Clinical Governance Committee.
- Continue to make improvements in the cancer pathways to eliminate delayed or missed cancer diagnoses and track actions through to completion.
- Continue to make improvements in the Gastroenterology service and plan for service sustainability and report progress to the Clinical Governance Committee
- Implement the new Liberty Protection Safeguards when published and understand the impact on patients and staff and report to the Clinical Governance Committee.
- Work alongside the divisional management teams to embed risk management, clinical effectiveness and learning in governance processes.

Priority areas:

- Implement the initial stages of the new NHS Patient Safety Strategy.
- Reduce the number of patients who fall in hospital resulting in high harm by 10%.
- Fully implement the Medical Examiner system to scrutinize all hospital deaths and report progress in the quarterly Learning from Deaths report.
- Work towards the implementation of the national learning disabilities standards.
- Continue to improve the safety and effectiveness of the hospital at the weekend so that patients who need a daily senior medical review receive it.
- Improve compliance with the lessons learnt from serious incident to provide assurance that they are acted upon and incidents reduced.
- Introduce the new Friends and Family test questions and share learning from patient feedback.
- Continue with the 'Ready Steady Go' programme to ensure patients are in the right place at the right time and cared for by the right people.
- Review reporting arrangements to the Clinical Management Board to ensure triangulation of patient safety, clinical effectiveness and patient experience.

11.0 Sharing the learning

11.1 Clinical Governance half days

There are 6 clinical governance half days a year. They are protected time to allow teams to meet together to discuss, review and improve quality as well as the opportunity to attend 4 core sessions which cover patient safety, effectiveness and patient experience. Core sessions are well evaluated by attendees; on average 94% of participants rate them as good or excellent. In December 2019, junior doctors presented their Healthcare Improvement Programme projects to an invited audience.

Date	Topic
April 2019	Patient Safety - Deteriorating Patients and Sepsis
June 2019	Salisbury Doctors Forum - GP engagement event
July 2019	Patient Experience – It is the little things that matter
Sept 2019	Non-core session
Nov 2019	Patient Safety - Introduction to the Practical Application of Human Factors in Healthcare
Feb 2020	Non-core session

11.2 Service improvement awards

The Trust held its annual service improvement awards day in April 2019 to recognise the achievements of staff and the way they have improved services for patients across the hospital. The team category was won by the end of life care team for compassion roses, the Trust category was won by the Ophthalmology Service for improvement to the cataract service and the Learning category was won the Emergency Department for the regional mortality and morbidity event.

12.0 Summary

Overall, the Integrated Governance Framework and Accountability Framework has ensured that the clinical governance structure and function is effective in identifying key risks to the quality of care. These risks have been escalated to the Board to ensure they are sighted on them and involved in the mitigation to the strategic objectives of the organisation.

Claire Gorzanski
Head of Clinical Effectiveness
11 June 2020

Approved at the Clinical Governance Committee on 23 June 2020
Presented to the Trust Board on 3 September 2020 (to be confirmed)

Report to:	Trust Board (Public)	**Agenda item:**	
Date of Meeting:	03 September 2020		

Report Title:	Research Annual Report 2019/20			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			
Prepared by:	Stef Scott, Head of Research			
Executive Sponsor (presenting):	Christine Blanshard, Medical Director			
Appendices (list if applicable):	N/A			

Recommendation:
Recommendation – the report is presented for information along with areas of risk and associated mitigation. **Assurance** – The Trust has had a difficult year, and the Trust was unable to adequately mitigate the risk. A large number of interventional studies closed to recruitment, and neither the Trust nor CRN:Wessex were able to identify replacement activity. The Trust is green for just 1 standard, amber for 2 and red for 1. The standards have been suspended for 2020/21 due to the COVID-19 pandemic, and the suspension of the majority of the research portfolio. **Risks –** Non-compliance with the standards has resulted in loss of income for 2020/21. Three members of the research team who have left have not been replaced.

Executive Summary:
The Trust is performance managed by both the NIHR and CRN: Wessex against a number of KPIs. An Annual Report for 2019/20 is appended for the Committee's information. A new format for 2020/21 reporting is proposed.

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

1. Purpose

1.1. To provide the Committee with assurance regarding Trust compliance with the Trust Key Performance Indicators for research

2. Background

2.1. The NHS is encouraged to support the National Institute of Health Research (NIHR) Clinical Research Network (CRN) research. The Trust is part of the CRN: Wessex network, and receives infrastructure funding from the network to support research staff and NIHR research activity. The Trust is performance managed by both the NIHR and CRN: Wessex against a number of KPIs.

2.2. The NIHR and CRN also require the Trust KPIs to be reported to and performance managed by Trust Boards on a regular basis. It was agreed that CGC would monitor Trust research performance via a quarterly research KPI report, and the Research Annual report. A report on the Trust's performance for Q2 2019/20 is appended for the Committee's assurance.

2.3. These reports are updated monthly, and shared with the directorate management and research teams. The Trust is also required to make mandatory, quarterly KPI submissions to the NIHR, which are published on the Trust website.

3. Summary

3.1. The attached Annual Report provides an update on Trust compliance with the Trust Key Performance Indicators for research for 2019/20.

4. Recommendations

4.1. The report is presented for information along with areas of risk and associated mitigation.

Dr Stef Scott
Head of Research

Salisbury
NHS Foundation Trust

Research Annual Report 2019/20

Abbreviations

CCF	Central Commissioning Facility
CRN	Clinical Research Network
ETC	Excess Treatment Cost
HLO	High Level Objective
HRA	Health Research Authority
NHS	National Health Service
NIHR	National Institute of Health Research
ODP	Open Data Platform
PI	Principal Investigator
RTT	Recruitment to Time and Target

Purpose

To provide Clinical Governance Committee and the Board with assurance regarding Trust compliance with the Trust Key Performance Indicators for research for 2019/20.

Executive Summary

Table 1: Targets 2019/20 – Overview of progress

	Objective	Target	Target met by Trust[1]?	National performance
HLO1	Increase the number of participants recruited into NIHR portfolio studies	Set by CRN – 1507 participants	**1118 74%**	
		7755 weighted points	**5086 66%**	
HLO2a	Increase the proportion of studies in the NIHR portfolio delivering to recruitment target and time – commercial contract studies	80%	**n/a**	**70%**
HLO2b	Increase the proportion of studies in the NIHR portfolio delivering to recruitment target and time – non-commercial studies	80%	**87%**	**87%**
HLO9a	Reduce the time taken for study set-up - site selected to date first patient recruited – commercial studies	Median time <80 days	**119**	**74 days**
HLO9b	Reduce the time taken for study set-up - site selected to date first patient recruited – non-commercial studies	Median time <60 days	**77**	**57 days**

[1] Green = over 80% achieving target; amber= between 60-80%; red = less than 60%acheiving target

Introduction

Health and care research changes lives. It is through research that we develop better treatments, as well as improve diagnosis, prevention, care and quality of life for everyone. Clinical research also has wider benefits. Research active Trusts have better health outcomes for those participating in clinical trials when compared with patients receiving standard care. There is a positive association between:

- research activity and reduced mortality[2]
- survival and participation in interventional clinical studies for all patients with Colorectal cancer[3]
- the engagement of individuals and healthcare organisations in research and improvements in healthcare performance[4]
- research activity and patient confidence in staff, and patients are better informed about their condition and medication[5]

Clinical research also makes a significant contribution to the health and the wealth of the nation in the UK[6]. Research is important to patients[7] [8] and healthcare professionals[9] [10].

NHS England has a statutory responsibility to promote research[11] [12]. The NHS Constitution for England (2015) has a commitment to "*promotion, conduct and use of research to improve the current and future health and care of the population' and to ensure that patients are made aware of research that is of relevance to them*".

The National Institute for Health Research (NIHR)[13] is funded by the Department of Health to "*deliver research to make patients, and the NHS, better*". There are 15 NIHR Clinical Research Network (CRNs) across England, each delivering research across 30 clinical specialties. The NIHR only supports research that is demonstrably of the highest quality and is eligible for the NIHR Portfolio ('the Portfolio'). The Trust is part of the CRN:Wessex, and receives infrastructure funding from CRN:Wessex to support the rapid set-up and smooth running of NIHR portfolio studies.

Information included in this report

This report describes the progress made with the NIHR High Level Objectives (HLO) which covers the following:

HLO 1:	Increase the number of participants recruited into NIHR portfolio studies
HLO2a:	Increase the proportion of studies in the NIHR portfolio delivering to recruitment target and time – commercial contract studies
HLO2b:	Increase the proportion of studies in the NIHR portfolio delivering to recruitment target and time – non-commercial studies
HLO9a:	Reduce the time taken for study set-up - site selected to date first patient recruited – commercial studies
HLO9a:	Reduce the time taken for study set-up - site selected to date first patient recruited – non-commercial studies

A summary is shown in Table 1.

This report covers the Trust's research activities in the period 01 April 2019 – 31 March 2020. The information contained in the report represents the most complete information available at the time of writing. It is important to note that data on studies and patient recruitment are uploaded to the NIHR CRN Open Data Platform (ODP) by the Chief Investigator (or their delegate) on an ongoing basis. The year end

[2] *https://pubmed.ncbi.nlm.nih.gov/29438805/*
[3] https://pubmed.ncbi.nlm.nih.gov/27797935/
[4] https://pubmed.ncbi.nlm.nih.gov/26656023/
[5] https://onlinelibrary.wiley.com/doi/10.1111/jep.13118
[6] https://www.nihr.ac.uk/documents/partners-and industry/NIHR_Impact_and_Value_report_ACCESSIBLE_VERSION.pdf
[7] NHS England (2013a) Cancer Patient Experience Survey 2013.
[8] NIHR CRN consumer poll, 2014
[9] https://www.nursingtimes.net/news/research-and-innovation/exclusive-nursing-must-overcome-barriers-to-vital-research/7015738.article
[10] Research for all https://www.rcplondon.ac.uk/projects/outputs/research-all
[11] NHS Constitution (2015)
[12] Health and Social Care Act (2012).
[13] NIHR website (www.nihr.ac.uk).

cut off for submission was on 27 April 2019. Investigators are encouraged to upload data promptly, so that data reporting is accurate. However, to ensure maximum data capture, this data upload can occur months after the end of a financial year. For this reason, data reports for the same financial year may change over the course of the reporting year. The data reported in this report were downloaded from the ODP on 27 April 2019.

Summary details for individual studies (searching for ID number or short title) may be found at: https://public-odp.nihr.ac.uk/QvAJAXZfc/opendoc.htm?document=CRNCC_Users%2FFind%20A%20Clinical%20Research%20Study.qvw&host=QVS%40crn-prod-odp-pu&anonymous=true&sheet=SH01&bookmark=Document\BM02&select=LB01,=StudyID=35622

Objective HLO1: Increase the number of participants recruited into NIHR portfolio studies

The NHS Operating Framework states that NHS Trusts are expected to "work with the NIHR CRN locally" to contribute to "the national ambition is to double the number of patients taking part in clinical trials and other well designed research studies within five years". The Trust Research Strategy endorses this ambition.

The Trust is set a recruitment target each year by CRN:Wessex. The target at the beginning of 2019/20 was 1507 participants, with a weighted recruitment of 7755.

Annual performance commentary

- Figure 1 shows 1118 study participants were recruited into 80 NIHR CRN Portfolio studies during 2019/20 (full breakdown of the NIHR snapshot of Trust recruitment on 27 April 2019 is shown at Appendix A), 74% of the recruitment target set . The complexity weighting in 2019/20 was 5086 (Figure 2), 66% of the target set. The complexity weighting informed the core funding allocation from CRN:Wessex. The Trust received the maximum cut in funding for 2019/20;
- 2019/20 was an extremely challenging year for Trust recruitment. Figure 1 shows that recruitment into observational and large scale studies was similar to 2018/19, but there was a marked decrease in recruitment into interventional studies. A large number of the Trust interventional studies closed to recruitment during 2019/20, but there were very few replacement interventional studies available. In addition, any of the interventional studies that closed to recruitment continue to be supported by the Trust have long term follow-up of study participants, which continue to be supported by the Trust (without contributing towards the HLOs). In addition the COVID-19 pandemic and accompanying lockdown meant that many research studies were suspended (either nationally by the Study sponsor, or by the Trust in line with changes to clinical services). This obviously impacted on the Trust's ability to recruit study participants, but, does not account for whole of the shortfall.
- The top recruiting study was a genetics study, 'Molecular pathogenesis of chronic myeloproliferative neoplasms' with 202 recruits during 2019/20. The study is led by led by Prof Nick Cross, and aims to identify and assess the significance of novel molecular changes responsible for establishment and progression of atypical chronic myeloproliferative neoplasms and related conditions.
- A breakdown of recruitment/ specialty is shown at Figure 3. Reproductive Health & Childbirth was the highest recruiting specialty in 2019/20, followed by genetics and cardiology. The Trust recruited into 28 of the 30 national specialties. When adjusted for complexity, reproductive health and childbirth also had the highest weighted recruitment (Figure 4).
- The Trust recruited participants into 80 studies during 2019/20 (Figure 5). The Trust offers more studies than any other Small Acute Trust in the country, and is in the top 15% of Trusts nationally. These studies were led locally by 41 Principal Investigators. The Trust slipped a place (to 5th) in the Small Acute Trust ranking for the number of study participants recruited (Figure 6); The top 2 recruiting Small Acute Trusts (Milton Keynes University NHS Foundation Trust; George Eliot Hospital NHS Trust) both have some extremely high recruiting studies which recruit only to their local area (New-born Cross Sectional Study – 2182 for Milton Keynes; Oral & Dental Health Study - 1005 recruits for George Eliot);
- The Trust secured renewed funding for both 2 CRN Research Fellows in Ophthalmology (SFT & Southampton) and Urology (SFT only).

Figure 1: Trust recruitment per year

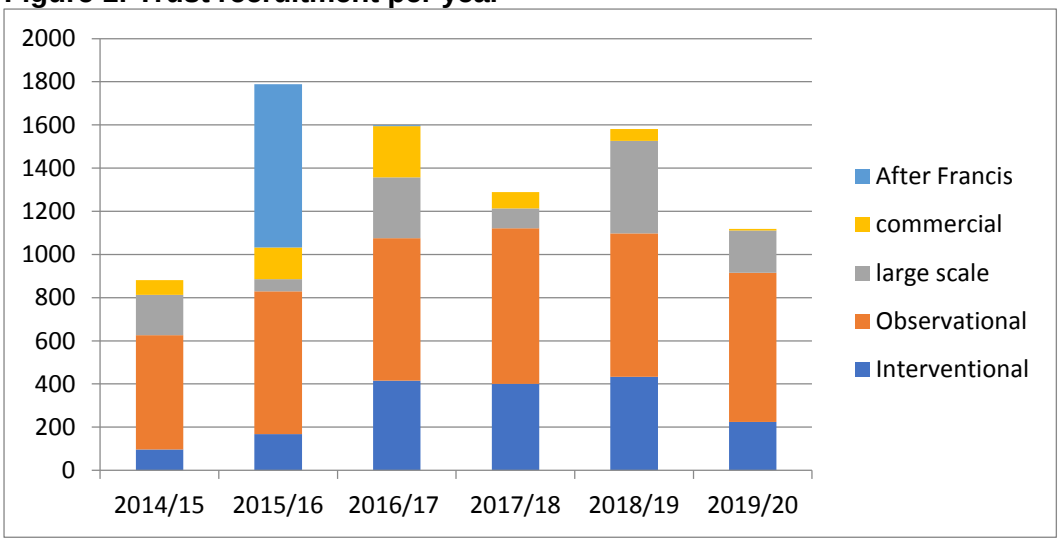


Figure 2: Trust weighted recruitment per year

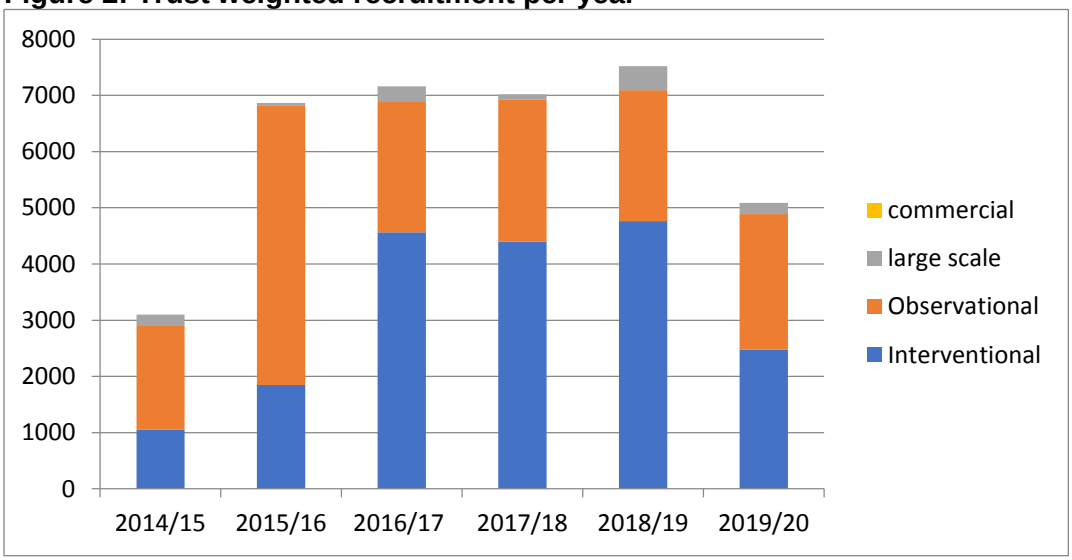


Figure 3: Breakdown of recruitment by lead specialty 2019/20

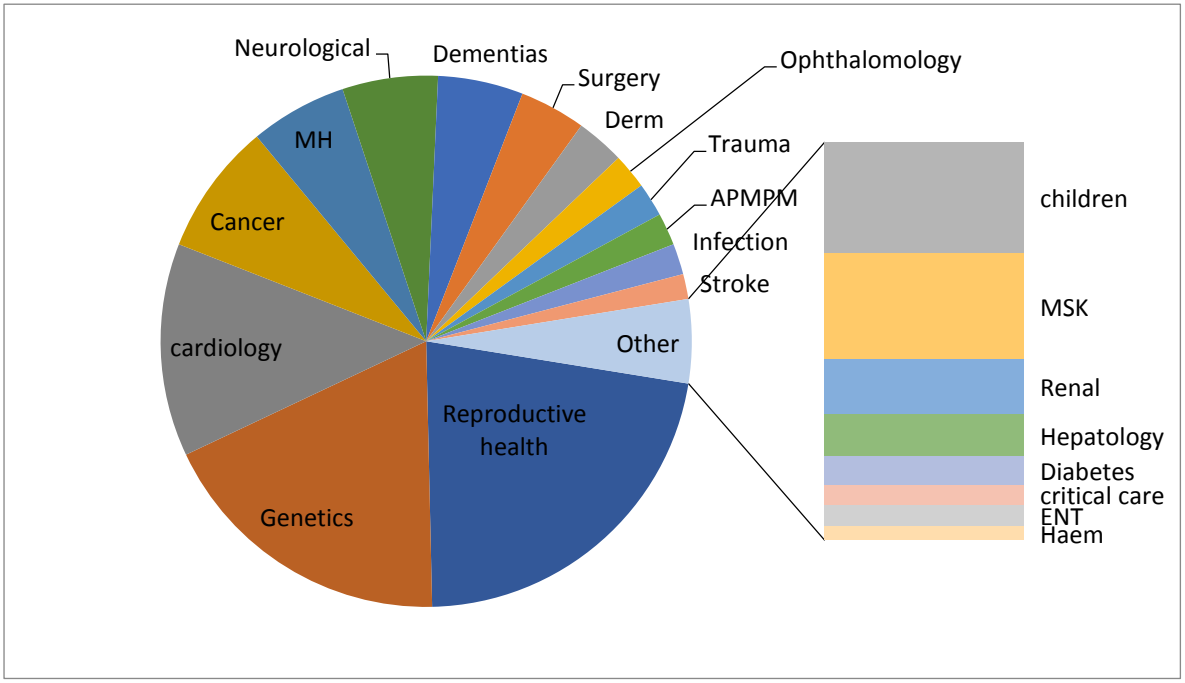


Figure 4: Breakdown of weighted recruitment by lead specialty 2019/20

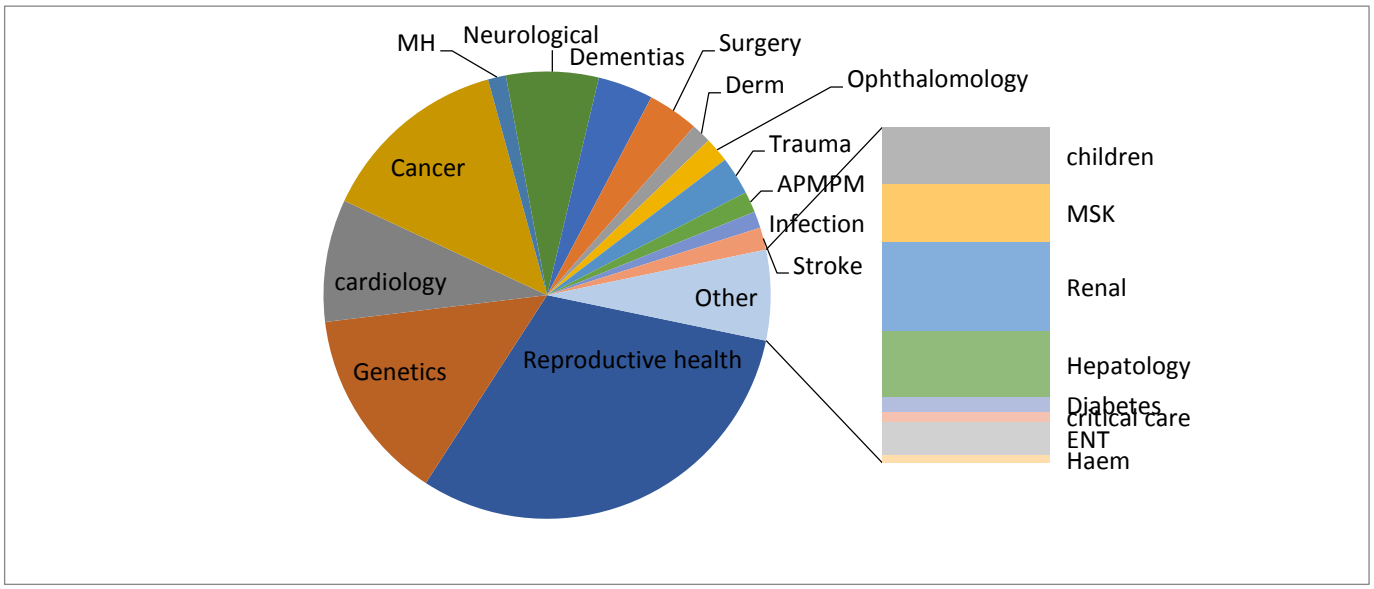


Figure 5: Ranking of small acute Trusts number of studies 2019/20

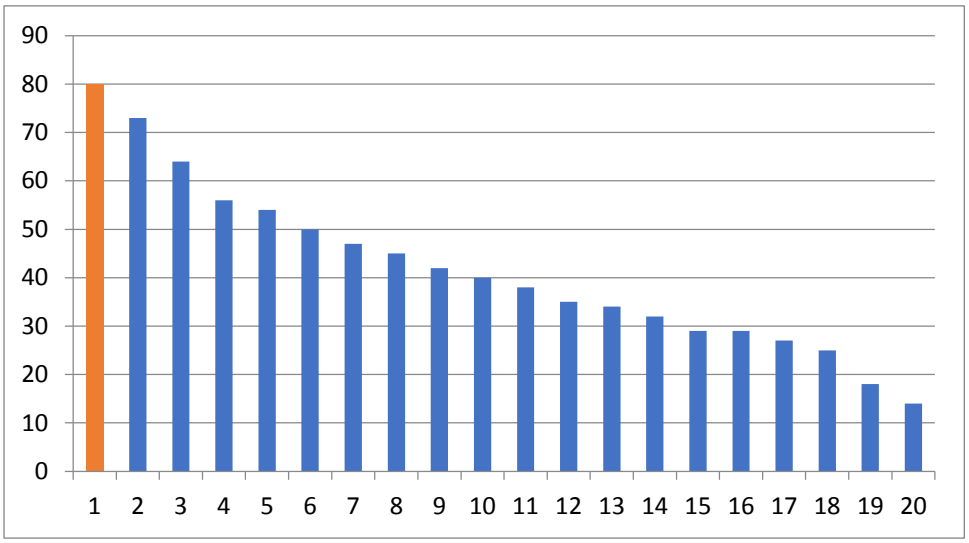
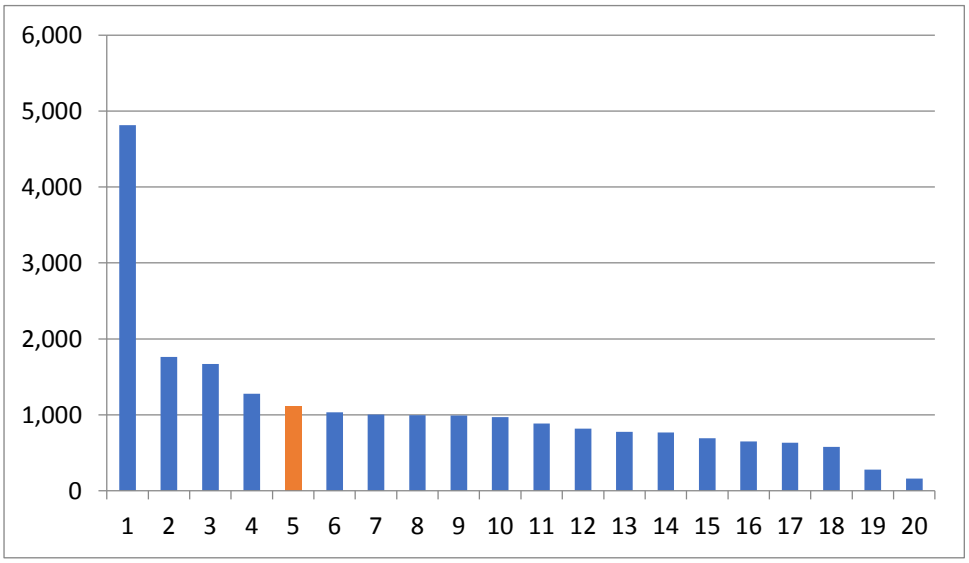


Figure 6: Ranking of small acute Trust recruitment 2019/20



HLO2a&2b: Increase the proportion of studies in the NIHR CRN Portfolio delivering to recruitment time and target: Commercial studies & non-commercial studies

Description of issue and rationale for prioritising

NIHR funding to providers of NHS services is now conditional on meeting a series of benchmarks, including the ability of Trusts to recruit the number of Trust study participants declared on the research application for NHS 'permission to proceed' in the agreed timescale (recruitment to time and target [RTT]). The Trust is performance managed by both the NIHR Central Commissioning Facility (NIHR CCF) and CRN:Wessex for commercial RTT.

Annual performance commentary

- Priority did not apply to any NIHR CRN commercial contract Portfolio studies during 2019/20 (see Table 2). The Trust did not receive a CRN:Wessex Commercial Performance Premium for 20/21.
- Priority applied to 42 NIHR CRN non-commercial Portfolio studies that closed to recruitment during 2019/20 (see Table 2). 36 of the 42 studies (87%) that closed during 2019/20 recruited to time and target, exceeds both the NIHR target of 80%, and the Trust performance for 20178/18 (81%). The majority of studies that failed to recruit to time and target missed the recruitment target because of overly optimistic target setting at the outset.
- A performance premium for non-commercial RTT was also included in the infrastructure funding for 2020/21. The payment was calculated using a retrospective model informed by both the number of studies recruiting to time and target, and the overall % for 01 Oct 2018 – 31 Mar 2020. The Trust secured a performance premium of £21,842.

Table 2: RTT for NIHR CRN non-commercial Portfolio studies during 2019/20.

Directorate	PI	Short title	Specialty	Closure date	Total recruitment	Recruitment Target	Site Pass RTT
CS&FS	Jim Baird	OPTI PREM	Children	10/11/2019	5	1	Y
CS&FS	Seb Gray	Petechiae In Children (PIC) Study	Children	30/09/2019	23	20	Y
CS&FS	Chris Anderson	ADDRESS C-Peptide	Diabetes	16/11/2019	2	1	Y
Medicine	Lorna Wilkinson	CLECC	Ageing	31/12/2019	103	64	Y
Medicine	Jonathan Cullis	FLAIR	Cancer	30/01/2020	9	6	Y
Medicine	Catherine Reed	HORIZONS	Cancer	30/06/2019	58	56	Y
Medicine	Jonathan Cullis	MCL Biobank Observational Study	Cancer	31/10/2019	4	3	Y
Medicine	Jonathan Cullis	MEASURES	Cancer	12/04/2019	18	5	Y
Medicine	Graham Branagan	NICE FIT	Cancer	31/12/2019	308	20	Y
Medicine	Jonathan Cullis	Non-Hodgkin's Lymphoma in Young Adults	Cancer	30/06/2019	1	1	Y
Medicine	Manas Sinha	Atrial Fibrillation III (AF III) Registry	Cardiovascular Disease	29/07/2019	30	12	Y
Medicine	Tim Wells	REVIVED-BCIS2	Cardiovascular Disease	19/03/2020	2	5	N
Medicine	Tim Wells	UKGRIS	Cardiovascular Disease	31/12/2019	91	46	Y
Medicine	Diran Padiachy	The Parkinson's Pain Study	Dementias &Neurodegeneration	28/08/2019	9	1	Y
Medicine	Juliette Loehry	PRED 4	Gastroenterology	31/12/2019	5	4	Y
Medicine	Jonathan Cullis	Consent and Confidentiality in Genetic Medicine	Genetics	31/03/2020	0	1	N
Medicine	Jonathan Cullis	The PEP-WARF Study	Haematology	26/02/2020	6	5	Y
Medicine	Aqeel Jamil	The UK-AIH Cohort	Hepatology	31/03/2020	15	10	Y
Medicine	Effie Grand	EASI-SWITCH v1.0	Infection	27/11/2019	9	10	N
Medicine	Toby Black	Determinants of prognosis in stroke	Stroke	16/08/2019	159	150	Y
Medicine	Toby Black	Prediction of stroke outcome using brain imaging machine-learning	Stroke	10/01/2020	29	10	Y
Medicine	Sarah Diment	The TIRED-UK Study	Trauma and Emergency Care	14/07/2019	8	1	Y
MSK	Ginettee Phippen	CLEFT-Q Fieldtest	Children	31/03/2020	44	30	Y
MSK	Mansoor Khan	FACE-Q KIDS PROM Study	Children	31/03/2020	4	2	Y
MSK	Ginettee Phippen	Speech processing in children born with cleft palate	Children	31/05/2019	6	1	Y
MSK	Aisling Coy	A study of dose reduction of biologic drugs in axial spondyloarthritis	Musculoskeletal Disorders	13/08/2019	0	1	N
MSK	Sarah Fryer	Pressure ulcer prevention after spinal cord injury	Neurological Disorders	31/03/2020	15	10	Y
MSK	Srindhar Rao	DRAFFT 2	Trauma and Emergency Care	05/04/2019	23	19	Y
Surgery	Lyn Fenner	CASAP	APMPM	29/02/2020	12	10	Y
Surgery	Graham Branagan	IMPRESS Trial	Cancer	31/08/2019	37	15	Y
Surgery	Graham Branagan	SERENADE	Cancer	20/08/2019	54	36	Y
Surgery	Graham Branagan	TRACC	Cancer	05/12/2019	45	24	Y
Surgery	Phil Donnison	POETICS 2	Critical Care	31/05/2019	10	20	N
Surgery	Simon Dennis	NAIROS	Ear, Nose and Throat	31/01/2020	17	12	Y
Surgery	Naeem Haq	A molecular genetics study of primary open angle glaucoma	Ophthalmology	09/08/2019	8	5	Y
Surgery	Sue Elliot	EuPatch	Ophthalmology	31/03/2020	2	1	Y
Surgery	Rashi Arora	Nationwide survey of prosthetic eye users	Ophthalmology	26/04/2019	4	1	Y
Surgery	Rashi Arora	STAR	Ophthalmology	31/12/2019	6	1	Y
Surgery	Rashi Arora	The CFI Study	Ophthalmology	30/06/2019	16	5	Y
Surgery	Amanda Bond	FROGS	Surgery	01/07/2019	35	1	Y
Surgery	Graham Branagan	Hartmann's procedure versus intersphincteric APE	Surgery	01/06/2019	5	5	Y
Surgery	Graham Branagan	PPAC2	Surgery	21/02/2020	0	2	N

HLO9a & 9b: Reduce the time taken for study set-up - site selected to date first patient recruited – commercial and non-commercial studies

Description of issue and rationale for prioritising

The Health Research Agency (HRA) conducts the research governance checks for all research projects on behalf of all host organisations. Following site selection, and submission of the local research paperwork, the Trust 'assesses, arranges and confirms' capacity to support the research project. Following 'confirmation of capacity', the Trust then screens, approaches and consents eligible participants. The NIHR target for site set up for commercial studies is a median time of less than 80 days, and the target for non-commercial studies is a median time of less than 67 days.

Annual performance commentary

- The Trust set up 1 commercial study during 2019/20 (Table 3). This study, DERBY, took 119 days from site selection to recruit the first study participant. This is below the both the target (median of less than 80 days) and the national performance (median of 74 days). DERBY is a complicated, double masked study, and take longer to set up in the Trust. Furthermore, an annual recruitment target 5 per year means that we would expect to recruit the first study participant every 73 days once we were fully set up and ready to approach eligible participants.
- Table 3 also shows that the Trust set up 27 non-commercial studies with a median time of 77 days. This is also below the both the target (median of less than 60 days) and the national performance (median of 57 days).
- In many cases, the reason for not consenting the first study participant within 57 days was beyond our control. For example, the majority of Trust studies have a low recruitment target (e.g. an annual target of less than 6) and would not reasonably expect to recruit the first study participant within the first few months. All of the studies (commercial and non-commercial) that failed to recruit the first study participant within the target date has an estimated annual target of less than 6. For these studies, it is important that we are actively screening patients within 30 days, so that we can approach and recruit study participants as appropriate.
- The reasons for delays to confirming capacity are varied. In some cases, the reasons are outside of the Trust's control (e.g. waiting for national approval of an amendment); others are within the Trust's control (e.g. staffing issues). The Trust continues to review (and revise, where appropriate) out internal processes to try and identify these issues at the feasibility stage (i.e. before formal submission);
- The majority of studies were suspended at the onset of the COVID-19 pandemic. Studies that had not recruited the first study participant by the beginning of March were unable to do so.
- Quarterly reports were uploaded to the NIHR and published on the Trust website in accordance with our contractual requirements. Please note the reports for 2019/20 exclude observational studies. The data published on the Trust website therefore differs from the data included in this report (which includes all studies).

Targets for 2020/21

The NIHR HLOs are temporarily suspended due to the COVID-19 pandemic. At the time of writing, the key objectives for the NIHR CRN for 2020/21 are to enable the rapid set up and delivery of the Covid-19 Urgent Public Health studies, including antibody and vaccine studies, and to support health and care organisations as they begin to restart paused research. The Trust will focus on:

- setting up and delivering the COVID-19 UPH studies, including supporting the network wide vaccine studies, and
- risk-assessing and restarting the non-COVID-19 portfolio of studies as and when the relevant clinical services restart.

Reports for 2020/21 will focus on recruitment into COVID-19 UPH studies, COVID-19 non-UPH studies and the non-COVID-19 portfolio of studies, and the format updated as the national reporting evolves.

Table 4: The time (calendar days) taken to recruit the first study participant

Directorate	NIHR Portfolio Study ID	Project Short title	Main Speciality	Project site date site selected	Project site date site confirmed	First site patient recruited (org)	Project site date site confirmed to first patient (days)	Principal Investigator	Project site estimated annual target
COMMERCIAL									
Surgery	39165	Derby	Ophthalmology	12/07/2019	08/10/2019	03/03/2020	119	Arora, Dr Rashi	5
NON COMMERCIAL									
CS&FS	40501	BPiPP study	Reproductive Health and Childbirth	28/05/2019	14/06/2019	18/07/2019	34	Rand, Mrs Abby	30
CS&FS	39901	TTTS Registry	Reproductive Health and Childbirth	22/05/2019	14/06/2019	25/07/2019	41	Rand, Mrs Abby	1
CS&FS	42129	Multi-sited, mainstreaming of the term Snuby® to all types of births	Reproductive Health and Childbirth	03/01/2020	07/01/2020	15/01/2020	8	Dalley, Jacquelyn	24
CS&FS	33964	Injectables	Diabetes	28/11/2019	17/01/2020		110	Diment, Sarah	0
Medicine	36300	ARGO	Cancer	10/04/2019	17/05/2019	11/10/2019	146	Milnthorpe, James	1
Medicine	40836	OPTIMAS Trial	Stroke	17/07/2019	16/08/2019	10/09/2019	25	Black, Dr Toby	5
Medicine	39255	CALIBRE Study	Hepatology	30/07/2019	09/09/2019	09/10/2019	30	Jamil, Dr Aqeel	8
Medicine	30540	GenOMICC	Critical Care	13/11/2019	07/02/2020	24/04/2020	77	Donnison, Dr Phil	0
Medicine	17506	Move Wales v1	Neurological disorders	22/01/2020	25/02/2020		71	Anthony, Alpha	5
Medicine	45409	CERA Study	Trauma and Emergency Care	25/03/2020	25/03/2020	21/05/2020	57	Diment, Sarah	0
Quality	41938	The TIRED-UK Study	Trauma and Emergency Care	28/06/2019	01/07/2019	05/07/2019	4	Diment, Sarah	1
Quality	44205	CLIMB	Mental Health	27/01/2020	19/02/2020		77	Anthony, Alpha	1
Surgery	41515	SCIENCE	Trauma and Emergency Care	27/06/2019	01/08/2019	15/10/2019	75	Jacobs, Mr Neal	0
Surgery	40368	PEACHY	APMPM	17/07/2019	09/08/2019		271	Fenner, Lynn	0
Surgery	33029	PLUM	Dermatology	18/07/2019	27/08/2019	22/01/2020	148	Mellor, Dr Serap	2
Surgery	41168	CASAP	APMPM	25/09/2019	08/10/2019	05/11/2019	28	Fenner, Lynn	10
Surgery	40430	SOLARIO	Surgery	10/10/2019	04/11/2019	18/11/2019	14	Jacobs, Mr Neal	0
Surgery	40221	The PITSTOP Study	Surgery	25/09/2019	04/11/2019	18/11/2019	14	Branagan, Mr Graham	20
Surgery	41480	GTSCOPE	Ophthalmology	18/09/2019	11/11/2019		177	Arora, Dr Rashi	1
Surgery	43744	Treatment of Hidradenitis Suppurativa Evaluation Study	Dermatology	09/10/2019	22/11/2019		166	Khan, Mansoor	6
Surgery	37105	CLEAR SYNERGY (OASIS 9)	Cardiovascular Disease	25/11/2019	26/11/2019	14/02/2020	80	Wells, Dr Tim	5
Surgery	42941	SeaSHeL	Ear, Nose and Throat	09/10/2019	26/11/2019		162	Kumaresan, Kala	0
Surgery	35187	PPAC2	Surgery	29/10/2019	11/12/2019		147	Branagan, Mr Graham	2
Surgery	43740	WAX	Trauma and Emergency Care	03/12/2019	03/01/2020	17/02/2020	45	Jacobs, Mr Neal	19
Surgery	39018	MET-REPAIR v1.0	APMPM	08/11/2019	08/01/2020	31/01/2020	23	Holmwood, Dr Xantha	50
Surgery	39024	MET-REPAIR-FRAILTY v1.0	APMPM	08/11/2019	08/01/2020	31/01/2020	23	Holmwood, Dr Xantha	50
Surgery	41490	The Pre-Bra Feasibility Study	Surgery	13/12/2019	17/01/2020		110	Slade-Sharman, Miss Diana	1

Appendix A: Recruitment figures for Salisbury NHS Foundation Trust 2019/20

Directorate	Managing Specialty	CPMS Study ID	Short Name	Design Type	Recruit-ment	weighted complexity points	Principal Investigator
CS&FS	APMPM	41168	CASAP	Observational	12	42	Fenner, Lynn
CS&FS	Children	32910	Speech processing in children born with cleft palate (1)	Observational	1	3.5	Ginettee Phippen
CS&FS	Diabetes	9689	DRN 552 (ADDRESS-2)	Observational	4	14	Serap Mellor
CS&FS	Genetics	9615	Molecular pathogenesis of chronic myeloproliferative neoplasms	Observational	202	707	Nick Cross
CS&FS	Neurological Disorders	37410	REGAIN	Observational	2	7	Jim Baird
CS&FS	Reproductive Health & Childbirth	40501	BPiPP study	Observational	81	283.5	Abby Rand
CS&FS	Reproductive Health & Childbirth	36323	CPIT III	Interventional	35	385	Abby Rand
CS&FS	Reproductive Health & Childbirth	39901	TTTS Registry	Observational	4	14	Abby Rand
CS&FS	Reproductive Health & Childbirth	42129	Multi-sited, mainstreaming of the term Snuby® to all types of births	Interventional	26	286	Jaquelyn Dalley
CS&FS	Reproductive Health & Childbirth	36723	The 'Big Baby Trial'	Both	22	242	Jo Baden-Fuller
CS&FS	Reproductive Health & Childbirth	36043	The FUTURE Study	Both	11	121	Melissa Davies
CS&FS	Surgery	38596	FROGS	Observational	8	28	Amanda bond
CS&FS	Surgery	40221	PITSTOP	Observational	4	14	Graham Branagan
CS&FS	Trauma & Emergency Care	19795	A study to refine the CAR burns scales	Observational	7	24.5	Mark Brewins
Medicine	Cancer	18432	PLATFORM	Interventional	2	22	Alaaeldin Shablack
Medicine	Cancer	31610	HORIZONS	Observational	2	7	Catherine Reed
Medicine	Cancer	18157	TREATT	Interventional	4	44	Effie Grand
Medicine	Cancer	18067	Add-Aspirin	Interventional	12	132	Graham Branagan
Medicine	Cancer	36300	ARGO	Interventional	1	11	James Milnthorpe
Medicine	Cancer	15938	AML18	Interventional	1	11	Jonathan Cullis
Medicine	Cancer	19626	ENRICH	Interventional	1	11	Jonathan Cullis
Medicine	Cancer	10357	LI-1	Interventional	4	44	Jonathan Cullis
Medicine	Cancer	17628	MaPLe	Observational	4	14	Jonathan Cullis
Medicine	Cancer	31076	Mature Lymphoid Malignancies Observational Study	Observational	3	10.5	Jonathan Cullis
Medicine	Cancer	17767	MCL Biobank Observational Study	Observational	1	3.5	Jonathan Cullis
Medicine	Cardiovascular Disease	40868	Atrial Fibrillation III (AF III) Registry	Observational	30	105	Manas Sinha
Medicine	Cardiovascular Disease	37105	CLEAR SYNERGY	Both	1	11	Tim Wells
Medicine	Cardiovascular Disease	42423	NSTEMI v1.0	Observational	8	28	Tim Wells
Medicine	Cardiovascular Disease	38382	ORION-4	Observational	86	86	Tim Wells
Medicine	Cardiovascular Disease	32356	UKGRIS	Interventional	18	198	Tim Wells
Medicine	Cardiovascular Disease	31982	IRONMAN	Interventional	2	22	Tom Jackson
Medicine	Children	4016	DRN100 (TrialNet)	Observational	6	21	Chris Anderson
Medicine	Critical Care	38641	POETICS 2	Observational	3	10.5	Phil Donnison
Medicine	Dementias & Neurodegeneration	20383	Vision in Parkinson's Disease	Observational	2	7	Alpha Anthony
Medicine	Dementias & Neurodegeneration	30993	Skin metabolites in Parkinson's disease	Observational	56	196	Dirian Paniachy
Medicine	Genetics	15941	NIHR BioResource - Rare Diseases	Observational	3	3	Jonathan Cullis
Medicine	Haematology	14145	UK Childhood ITP Registry	Observational	2	7	Sarah Diment
Medicine	Hepatology	39255	CALIBRE Study	Interventional	6	66	Jamil Aqeel
Medicine	Infection	20228	EASI-SWITCH v1.0	Interventional	4	44	Effie Grand
Medicine	Infection	35405	PrEP Impact Trial	Observational	17	17	Georgina Morris
Medicine	Neurological Disorders	35622	Neuro LTC Study Version 1.0	Observational	48	168	Alpha Anthony
Medicine	Stroke	30705	Determinants of prognosis in stroke	Observational	6	21	Toby Black
Medicine	Stroke	40836	OPTIMAS Trial	Interventional	3	33	Toby Black
Medicine	Stroke	32752	Prediction of stroke outcome using brain imaging machine-learning	Observational	8	28	Toby Black
Medicine	Trauma & Emergency Care	41938	The TIRED-UK Study	Observational	8	28	Sarah Diment

MSK	Children	16436	Identification of factors associated with speech disorder-cleft palate	Observational	4	14	Ginette Phippen
MSK	Children	39349	Petechiae In Children (PIC) Study	Observational	5	17.5	Seb Gray
MSK	Dermatology	8090	BADBIR	Observational	17	17	Serap Mellor
MSK	Dermatology	10646	BSTOP	Observational	12	42	Serap Mellor
MSK	Dermatology	33029	PLUM	Observational	4	14	Serap Mellor
MSK	Musculoskeletal Disorders	37199	START:REACTS	Interventional	2	22	Ahmed Elmorsy
MSK	Musculoskeletal Disorders	31501	The ACL SNNAP Trial	Interventional	1	11	Leonidas Vachtsevanos
MSK	Musculoskeletal Disorders	14059	PREVeNT RA	Observational	7	24.5	Richard Smith
MSK	Musculoskeletal Disorders	39576	Baricitinib therapy for Rheumatoid Arthritis	COMMERCIAL	5	0	Zoe Cole
MSK	Neurological Disorders	40870	Upper-body interval training in persons with chronic paraplegia	Interventional	2	22	Aisling Coy
MSK	Neurological Disorders	39514	Pressure ulcer prevention after spinal cord injury	Both	13	143	Sarah Fryer
MSK	Reproductive Health & Childbirth	14362	The Cleft Collective Cohort Studies	Observational	68	238	Ginette Phippen
MSK	Surgery	40430	SOLARIO	Interventional	4	44	Neal Jacobs
MSK	Trauma & Emergency Care	43740	WAX	Interventional	6	66	Neal Jacobs
MSK	Trauma & Emergency Care	37822	PROFHER2 Trial	Interventional	1	11	Srindhar Rao Sampalli
MSK	Trauma & Emergency Care	41515	SCIENCE	Interventional	1	11	Srindhar Rao Sampalli
Quality	Mental Health	44205	CLIMB	Observational	66	66	Alpha Anthony
Surgery	APMPM	39018	MET-REPAIR v1.0	Observational	5	17.5	Xantha Holmwood
Surgery	APMPM	39024	MET-REPAIR-FRAILTY v1.0	Observational	5	17.5	Xantha Holmwood
Surgery	Cancer	10622	CR UK Stratified Medicine Pilot study	Observational	7	7	Catherine Thompson
Surgery	Cancer	17006	IMPRESS Trial	Interventional	6	66	Graham Branagan
Surgery	Cancer	17059	SERENADE	Both	6	66	Graham Branagan
Surgery	Cancer	35640	The COMET Trial	Interventional	5	55	Graham Branagan
Surgery	Cancer	20443	TRACC	Observational	19	66.5	Graham Branagan
Surgery	Cancer	20576	TRIGGER Trial	Interventional	2	22	Graham Branagan
Surgery	Cancer	12255	OPTIMA	Interventional	7	77	Jenny Bradbury
Surgery	Cancer	19069	ROSCO	Interventional	3	33	Jenny Bradbury
Surgery	Ear, Nose & Throat	35368	NAIROS	Both	3	33	Simon Dennis
Surgery	Ophthalmology	39165	Derby	COMMERCIAL	2	0	Rashi Arora
Surgery	Ophthalmology	37988	EPIC	Observational	4	14	Rashi Arora
Surgery	Ophthalmology	18040	STAR	Interventional	2	22	Rashi Arora
Surgery	Ophthalmology	34996	The CFI Study	Observational	16	56	Rashi Arora
Surgery	Renal Disorders	30454	PUrE	Interventional	8	88	James Brewin
Surgery	Surgery	20148	Hartmann's procedure versus intersphincteric APE	Observational	1	3.5	Graham Branagan
Surgery	Surgery	35821	The CIPHER study	Observational	28	98	Graham Branagan
					1,118	5086	