NHS
Salisbury
NHS Foundation Trust

FINAL

QUALITY ACCOUNT

2020 – 2021

Patient-centred & Safe
Professional
Responsive
Friendly

Outstanding **every** time

Quality account 2020 – 2021 contents

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

Antibiotic prescriptions

Best practice in the treatment of lower urinary tract infection in older people –

59% (20/21) vs **55%** (19/20)

Target 90%

I've had my

seasonal

flu vaccination

82%

of our staff had the flu vaccine

Target 100%

I've had my first

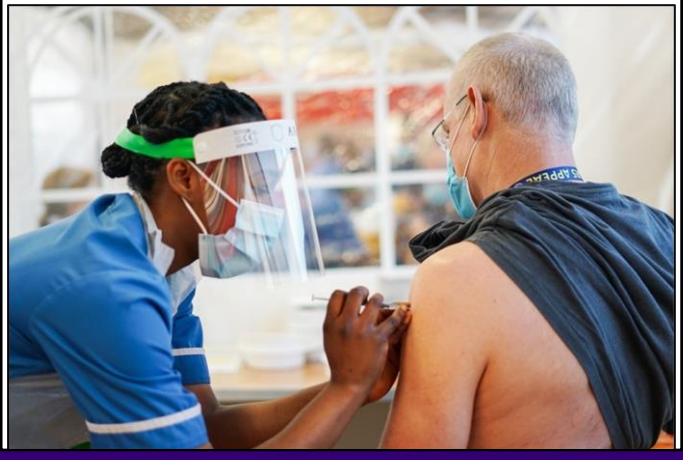
COVID

vaccination

85% (Jan 21)

of our staff had the COVID vaccination

Target 100%



Improvements made to reduce the risk of COVID transmission in hospital

- Testing and re-testing all new admissions.
- Pre-admission testing of patients 48 to 72 hours prior to planned surgery / procedure.
- COVID-19 test results available within 12 – 24 hours.
- COVID-19 lateral flow testing twice a week of all asymptomatic staff.
- All staff wear face masks in clinical areas, public areas and corridors.
- No shortages of personal protective equipment.
- Patient risk assessment on admission and ward placement according to level of risk.
- Inpatients beds socially distanced.
- Alcohol hand gel stations increased.
- A team of senior doctors & nurses meet regularly to decide on whether patients can stop being isolated or need to be re-isolated in a side room.
  This helps reduce outbreaks of infection.

Priority 2 – Improve patient safety to reduce avoidable harm in our key quality concerns

NHS 7 day services standard – once daily review at a weekend **97%** (20/21) vs **77%** (19/20) *Target 90%*

Pressure Ulcers

Category 2 – **286** (20/21) vs **199** (19/20)
Category 3 – **9** (20/21) vs **18** (19/20)
Category 4 – **1** (20/21) vs **3** (19/20)

100%

of patients had their vital signs scored and recorded

Escalation recorded for patients who trigger score 5+

60% (20/21) vs **83%** (19/20) *Target 95%*

Emergency Department sepsis treatment in 1 hr

61% (20/21) vs **63%** (19/20)

Inpatient sepsis treatment in 1 hr

40% (20/21) vs **55%** (19/20) *Target 90%*

Wessex - survival from sepsis improved

Maternity Day Assessment Unit

Women triaged within 15 mins of arrival

75%

Women reviewed within the correct time frame

83%

Target 85% *(Q2-Q420/21)*

Missed / delayed cancer diagnosis

5 cases (20/21)

2 cases (19/20)

10 cases (18/19)

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

Vision

Working hand in hand with our community health and care partners we will ensure all people with Learning Disabilities, Autism or both receive high quality and person-centred individualised care, based on excellent communication.

Increased the use of hospital passports

14 staff trained as Learning Disability Ambassadors

107 patients (20/21)
51 patients with a learning disability recorded on our alert system (18/19).

Improved the quality of reasonable adjustments in outpatients by:-

- offering a longer appointment time for considered communication.
- introducing quiet spaces & noise-reducing headphones.

Priority 4 – Work with our local communities & partners to implement phase 3 of our response to the pandemic

COVID-19 showed unacceptable health inequalities for different groups in the UK. NHS England asked all Trusts to take 8 urgent actions to recover services by March 21:

1.Protect the most vulnerable from COVID-19

- We worked with our partners to make sure that the people who are most likely to get seriously ill from COVID-19 can get the care they need.

2.Restore NHS services inclusively

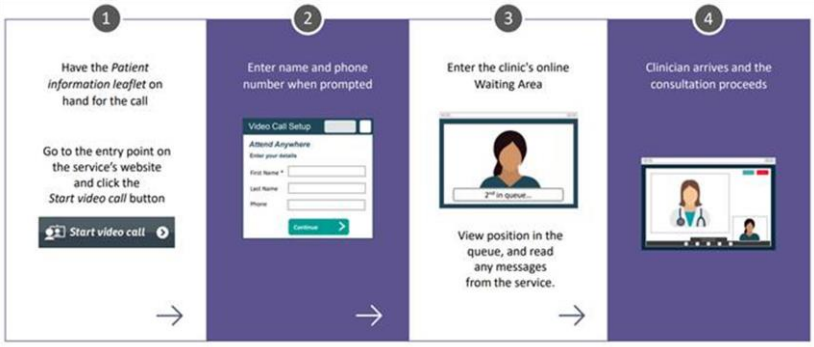
- We are part of an Acute Hospital Alliance with RUH, Bath and GWH, Swindon & have worked towards a shared approach to waiting list management & diagnostic services.

	2020/2021	Standard
Referral to treatment 18 week performance (incomplete)	69.4%	92%
MRI, CT, endoscopy, ultrasound scan – 6 week wait	81.1%	99%
Cancer 2 week wait	83%	93%
Cancer 62 day wait for treatment	83.6%	85%

Priority 4 – Work with our local communities & partners to implement phase 3 of our response to the pandemic

3. Develop digitally enabled care pathways in ways which increase inclusion

'Attend anywhere' – the number of virtual outpatient appointments increased so that patients could speak to a doctor or nurse in the comfort of their own home.



34.8% of patient outpatient contacts were by virtual appointments (20/21)

95% of patients said they would be seen again by video appointment.

78% of patients said the consultation was the same or better than a face to face appointment.

4. Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes

- Our Maternity Department is working on increasing continuity of carer for women.

Continuity of carer	Number 2019/2020	Number 2020/2021
Women who gave birth	2236	2130
Women who received continuity of carer	257 (11.5%)	256 (12%)

5. Particularly support those who suffer mental

- We have worked with our mental health partners who have continued to support people with mental health problems.

n leadership and accountability

- Our Chief Medical Officer is the lead for tackling health inequalities.

Ethnicity completeness data for hospitals:
RUH 82-86%
GWH 99.5%
SFT 91-93%

7. Ensure datasets are complete and timely

- This includes finding out more about people who are most likely to become seriously ill from COVID-19.

8. Collaborate locally in planning and delivering action

We worked together with our partners to ensure that the most needed services were able to get back to normal by 21 Sept 20. This includes:

- Improving the way we listen to communities
- Making stronger partnerships with local authorities, voluntary and community sector organisations.
- Discharge before midday **19.4%** (20/21) vs **16%** (19/20) – Target **33%**

Quality Account

Introduction

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

Quality accounts look back on the previous year's performance explaining where the Trust is doing well and where improvement is needed. They also look forward, explaining the areas that have been identified as priorities for improvement as a result of consultation with patients and the public, our staff and governors in 2020/2021, although this has been limited this year due to our response to the COVID-19 pandemic.

Part 1

Our commitment to quality - the Chief Executive's view

I am pleased to present our quality account for 2020/2021 for Salisbury NHS Foundation Trust, which shows how we have performed against our priorities this year and sets out the main areas of focus for 2021/2022.

This year has been an extremely difficult year with unrelenting pressure on our services caused by the COVID-19 pandemic, but despite the challenges we have faced, when we take the time to reflect on the year, there is a lot that that we can be extremely proud of.

I joined Salisbury NHS Foundation Trust in September 2020 at a time when the immediate focus was on resetting services following the first wave of COVID-19. From November 2020, the Trust was hit with the second wave of the pandemic resulting in a significant increase in the number of people needing care in our hospital.

January 2021 was a particularly challenging month for our local communities and our teams. We were treating four times as many COVID-19 patients as we saw in the first wave with a large number of people needing to be looked after by our critical care team. The organisation adapted quickly to ensure that we could cope with the surge in demand.

While some of our services needed to be paused again, others including Maternity Services, continued to provide care to patients with non-COVID-19 related illnesses In addition, hundreds of outpatient appointments were carried out by phone and video call.

I am incredibly proud of how our colleagues have responded to ensure that patients received high quality care in the face of such exceptional circumstances. Wards and departments were reconfigured to safely treat both COVID and non-COVID-19 patients. Robust social distancing and hand hygiene measures were put in place and face masks were introduced across the site. Staff were engaged and encouraged to adhere to the guidance in innovative ways - from social distancing buddy signage, to weekly cartoons, and clear screen partitions.

The COVID-19 pandemic has reiterated and exposed the health inequalities that exist in our population and served as a reminder that there is more for us to do to design and deliver services that prioritise those inequalities. Our local response has shown partnership working at its best to protect those most vulnerable in our population. Social and community services, voluntary organisations and NHS organisations joined together to provide support to the shielded and vulnerable in our local communities and the provision of mutual aid between partners. We will continue to invest and build these partnerships to continue to care for local people.

Despite the pandemic, we have made some progress in improving the quality of care. We are proud of the improvements we have made in the implementation of the national learning disability and autism standards. We have improved inpatient sepsis screening and survival from sepsis has improved. However, there is still work to do to improve compliance with the escalation response to deteriorating patients. The increased rate of pressure ulcers and in-patient falls resulting in high harm this year is a concern and will continue to be a priority and focus for us.

This has been a year like no other in the NHS and I cannot thank staff enough for everything they have been doing over this exceptionally challenging period, I am proud of just how much our teams have achieved and believe this report serves as an open and honest account of where we have been able to move forward, and where we still have further improvements to make.

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

Stacey Hunter
Chief Executive
4 June 2021

On behalf of the Trust Board,
4 June 2021

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

This section of the quality account describes the progress made against the priority areas for improvements identified for 2020/2021 set out in the 2019/2020 quality account and our priorities for 2021/2022. It includes why the new priorities have been chosen, how the Trust intends to make the improvements and how it plans to measure them. It also sets out a series of statements of assurance from the Board on key quality activities and provides details of the Trust's performance against core indicators.

2.1 Progress against the priorities in 2020/2021

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

Our quality priorities were set out in the Quality Account 2019 – 2020 with the proviso they would need to be changed in the light of the COVID-19 pandemic and the need to reset our services.

The Trust's quality priorities for 2020/2021 agreed by the Board in June 2020 were:

Priority 1: Work with our partners to prevent avoidable ill health

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

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

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

The Trust's revised quality priorities for 2020/2021 and reason for change are:

Priority 1: Work with our partners to prevent avoidable ill health and reduce health inequalities – COVID-19 has further exposed some health and wider inequalities.

Priority 2: Improve patient safety to reduce avoidable harm in our key quality concerns – the new national patient safety strategy due to be published in 2020 has been delayed to 2022.

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

Priority 4: Work with our local communities and partners to implement phase 3 of the NHS response to the COVID-19 pandemic and value patient's time by ensuring that they are only in hospital when necessary – the third phase of the NHS response is to focus on accelerating the return to near normal levels of health services prior to COVID-19 by 31 March 2021.

2.2 Quality priorities in 2021/2022

A similar process has been used to identify the quality priorities for 2021/2022. These priorities fit with our strategic objectives and were considered by the Clinical Governance Committee and recommended to and agreed by the Trust Board. We have also taken into consideration the NHS Long Term Plan, the B&NES, Swindon and Wiltshire Integrated Care System and our clinical strategy, our corporate risk register and quality concerns in deciding our quality priorities to ensure we continue to provide an outstanding experience for every patient.

The Trust's quality priorities for 2021/2022 are:

Our Trust quality priorities link to our strategic objectives:

Priority 1	Sustain the recovery from COVID-19 through effective partnership working and improve the quality and experience of care for patients and staff
Priority 2	Improve the health and wellbeing of our staff in the recovery from COVID-19.
Priority 3	Continue to improve patient safety and reduce avoidable harm based on our known risks
Priority 4	Provide ward to board assurance on fundamental standards of patient care at ward and department level
Priority 5	Strengthen our partnerships with other healthcare organisations to improve the health of our local population

What we did in 2020/2021:

The numbered points below indicate the quality priorities set for 2020/2021; the paragraph that follows is the progress made towards their achievement.

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

Description of the issue and reason for prioritising it:

The NHS Long Term Plan sets out commitments for action that the NHS must take to improve prevention of avoidable illness and its exacerbations. It does so whilst recognising that a comprehensive approach to preventing ill health also depends on action that only individuals and communities can take to tackle the wider threats to health. The NHS Long Term Plan is our opportunity to not only treat people, but also prevent them from getting ill in the first place and improve their quality of life. In particular, better antibiotic prescribing will reduce treatment failure and antimicrobial resistance and improve outcomes. COVID-19 has further exposed some health and wider inequalities and it is important we put into practice learning from experience and research by reviewing the care of patients who died from COVID-19. Our staff seasonal flu vaccinations are crucial for reducing the spread of flu during winter months with a significant impact on the health of patients, staff and their families and this now includes a COVID-19 vaccination programme.

What we did in 2020/2021:

1.1 To reduce antimicrobial resistance, achieve 90% of all antibiotic prescriptions for lower urinary tract infection in older people meeting the National Institute for Health and Care Excellence (NICE) guidance for diagnosis and treatment of lower urinary tract infection

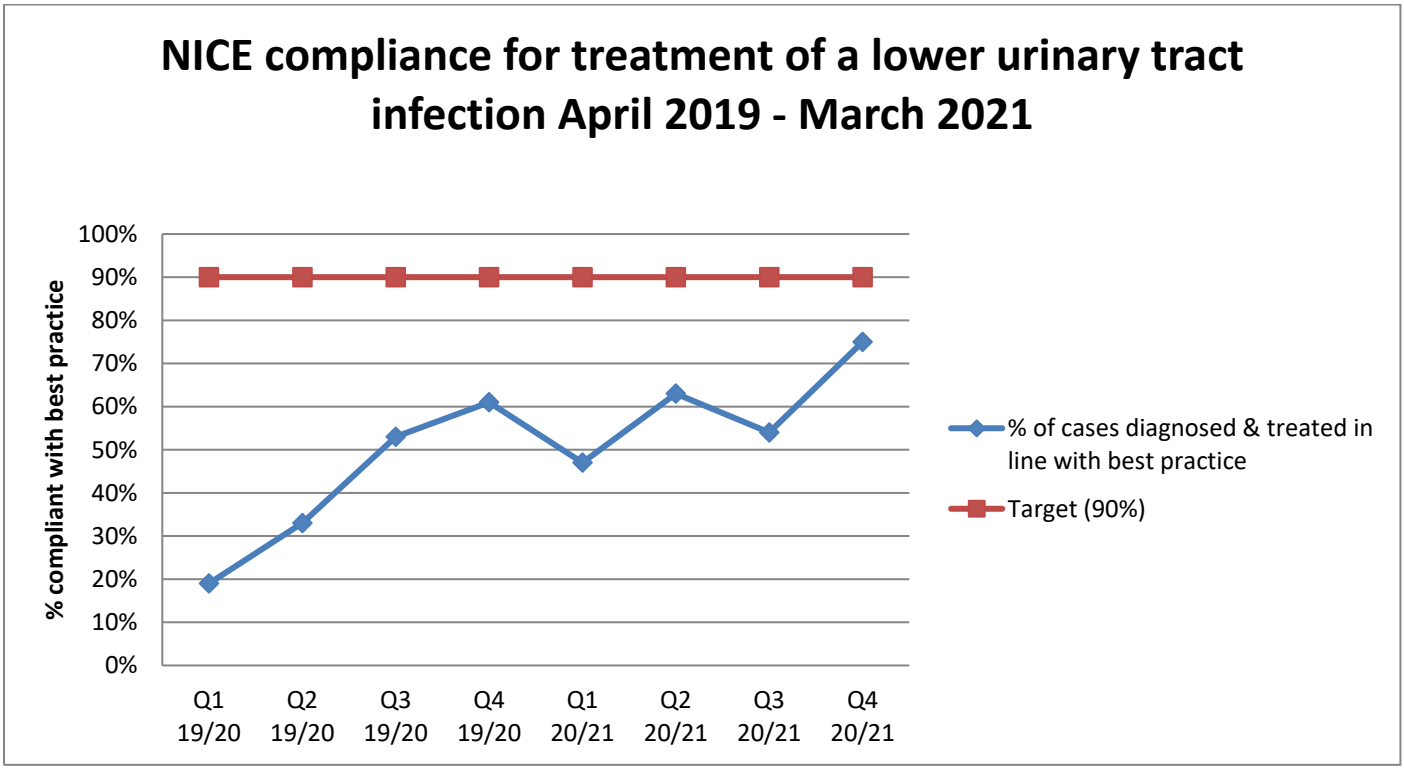
Resistance to antibiotics arises when the organisms that cause infection evolve ways to survive treatments. Resistance is a natural biological phenomenon but is increased by various factors such as misuse of medicines, poor infection control practices and global trade and travel. Many of the medical advances in recent years, such as organ transplants and cancer chemotherapy treatment need antibiotics to prevent and treat infections in patients made more susceptible by the treatment. Without effective antibiotics, even minor surgery and routine operations could become high risk procedures if serious infections cannot be effectively treated.

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

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

This year, our pharmacy team continued to lead an improvement programme working with doctors and nurses to raise awareness of antibiotic resistance by education and information. Figure 1 shows progress has been made but there is still more work needed to improve to reach the standard of 90%.

Figure 1: Overall compliance with NICE guidance for treatment of a lower urinary tract infection



1.2 Achieve 90% of our frontline staff having the seasonal flu vaccination and the COVID-19 vaccination programme when Trusts receive the vaccine

In October 2020, our seasonal flu campaign was launched by our Health and Wellbeing Service. It is essential that our frontline staff have the vaccination to reduce the risk of the flu virus spreading across the hospital and our community.

The Government asked the NHS to prepare to deliver a COVID-19 vaccination programme as soon as a vaccine was ready. As part of these plans, it was important that seasonal flu vaccinations were completed for all frontline staff by the end of November.

82% of our frontline staff had received the seasonal vaccination by mid December 2020. This put the Trust in the best possible position to vaccinate healthcare workers for COVID-19 when the vaccine became available, without the risk of interaction between vaccines.

The COVID-19 vaccination programme started on 29 December 2020 for our staff and vulnerable patients and by the end of January 2021, 85% of our staff had received the first dose of the COVID-19 vaccine and by the end of March 2021 our staff had received the second dose of the COVID-19 vaccine.

1.3 Implement improvement actions identified in the review of patients who died from COVID-19 between March and June 2020

On 11 March 2020, the World Health Organisation declared a COVID-19 pandemic and a national lockdown was imposed on 23 March 2020. During this time guidance received from Public Health England was used to develop our own response. This advice changed rapidly on a weekly, and even daily basis in response to this unprecedented event.

65 deaths attributed to COVID-19 were reviewed to establish whether patients were involved in decisions about their care, were escalated to the Intensive Care Unit, whether they would benefit from ventilation and, if so, whether they received it. Our findings indicated care was provided in accordance with NICE critical care guidance and adapted as new learning emerged from clinical experience and research.

However, it became evident that a number of patients may have acquired COVID in hospital as a result of nosocomial (contracted by a patient in hospital from another patient, staff or visitor) transmission. We then tracked where patients were placed and their contacts. Hospital onset was presumed to have definitely occurred if the first positive COVID-19 test collection date was 15 days or more after admission. National guidance at the point the patient was admitted was compared to our local standard operating procedures as part of the COVID-19 response. This showed the Trust followed national guidance as evidenced in our COVID-19 response plan.

Interpreting the COVID-19 test results was challenging as the accuracy may have varied depending upon the site and quality of the sample. It is recognised that the COVID-19 test is only 70% reliable and therefore interpretation was considered alongside the clinical presentation of the patient. Overall, the reviewers concluded that 4 patients definitely acquired COVID-19 in hospital. These patients had been admitted prior to the pandemic declaration without COVID-19 symptoms and spent a long time in hospital. It was difficult to be certain where or from whom the patients may have acquired COVID-19, but they had been admitted for other reasons and the incubation period was consistent with exposure to the virus. Duty of Candour will be applied to patients who definitely and probably acquired COVID-19 in hospital.

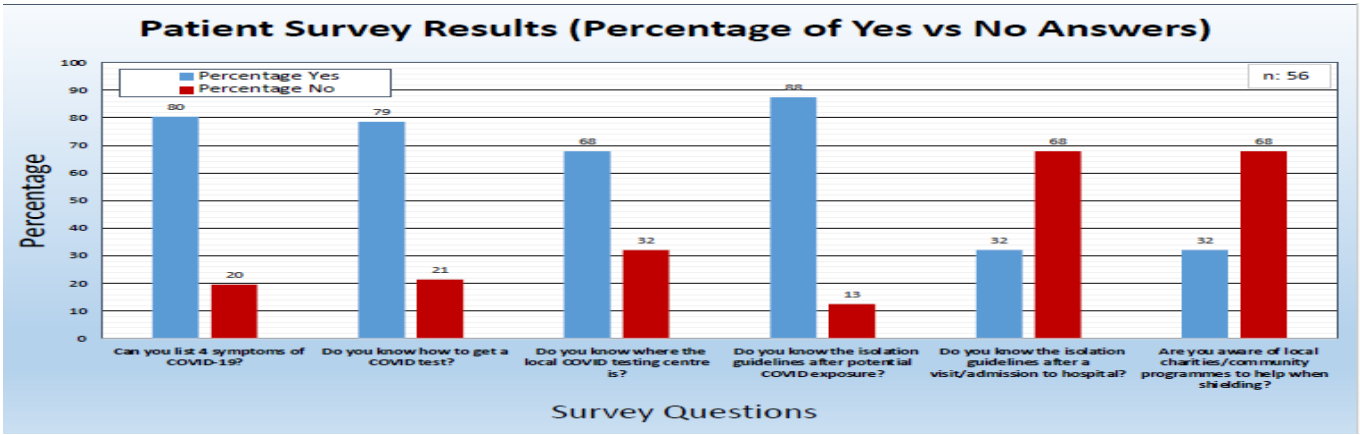
Since the end of April 2020, the likelihood of nosocomial transmission has been reduced with measures already put in place. These are:

- Testing all new admissions on the day of admission and re-testing patients on day 5 of admission.
- Pre-admission testing of patients 48 to 72 hours prior to admission for planned surgery or a procedure.
- Improved turnaround times of COVID-19 test results to 12 – 24 hours.
- In November, a twice weekly COVID-19 self-test of all frontline healthcare workers was introduced to identify staff who are asymptomatic. If the self-test is positive, staff are required to have an antigen test and if positive, to self-isolate for 14 days.
- In September, all staff started to wear face masks in clinical areas, public areas and corridors.
- On admission all patients have a risk assessment to decide whether they have a high, medium, or low suspicion of COVID-19 prior to being placed in a ward and the level of precautions the staff need to take, such as the use of personal protective equipment (PPE) or isolation in a side room, to protect the patient from cross infection.
- Inpatients beds are placed 2 metres apart to comply with social distancing requirements.

- The number of alcohol hand gel stations were increased to make it as easy as possible for patients and staff to clean their hands.
- A team of senior doctors, nurses, infection control specialists and Occupational Health specialists meet regularly to make decisions on whether patients can out of isolation and moved to a bay with other patients or re-isolated in a side room. This process reduces outbreaks of infection in the hospital.

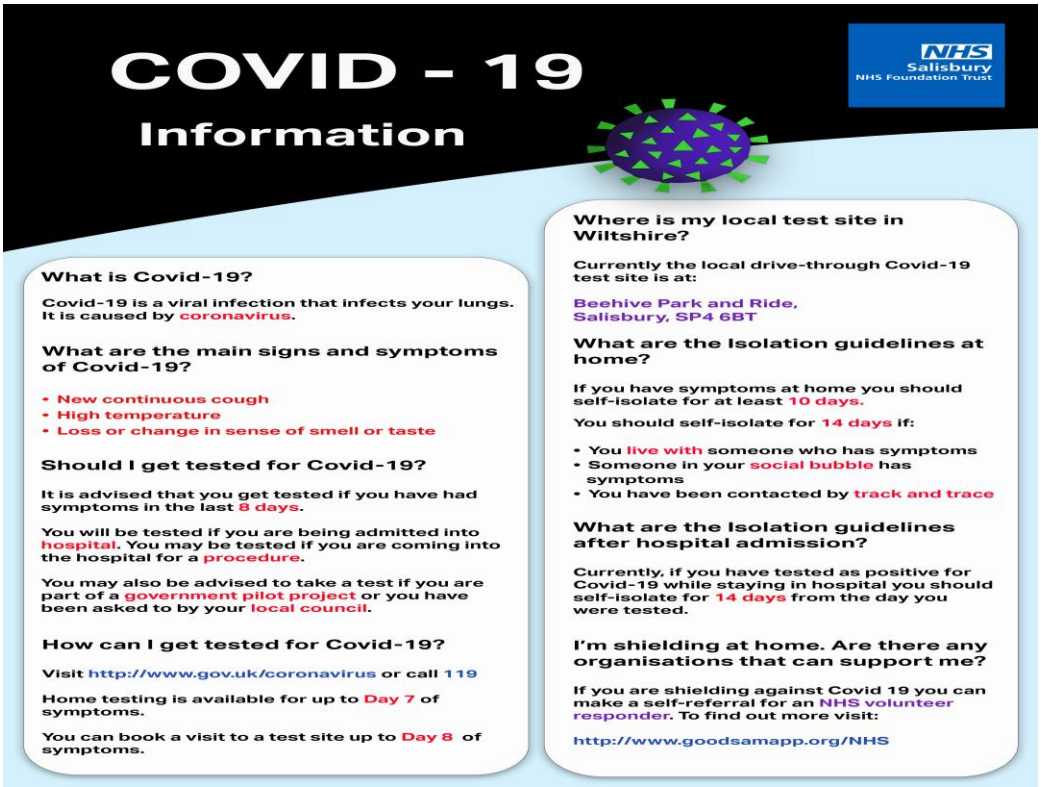
To help patients know what to do if they develop COVID-19 symptoms, a group of our doctors led an improvement project and asked 56 patients about their knowledge of COVID-19 and isolation guidelines after potential exposure to COVID-19 – see figure 2.

Figure 2: Patient survey of knowledge of COVID-19 and isolation guidelines



The survey showed that patients were more knowledgeable about COVID-19 than expected but few patients were able to answer all the questions. The group co-designed a poster with patients shown in figure 3 and displayed it in wards and departments to ensure all the key information is available in one place.

Figure 3: Co-produced COVID-19 information poster



How we reported progress throughout the year

Progress with antibiotic prescribing was reported to the Antibiotic Reference Group and Infection Prevention and Control Committee. Progress of the seasonal flu campaign was reported to the Flu Working Group and the review of deaths of patients with COVID-19 was reported to the Morality Surveillance Group.

What our patients and staff have told us:

A patient – ''Just wanted to say a massive thank you to the COVID vaccination team. I get fairly anxious about injections in general, but the nurse was lovely, and when I explained that I was anxious, she made me feel totally at ease and did the injection so quickly and efficiently I didn't even feel it being done. Everybody I met today was friendly and, despite everyone wearing masks, I felt like they were smiling underneath. I felt reassured by the measures in place to keep all staff, and us 'outsiders' who don't work on the site safe and welcomed''

A member of staff attending the vaccine centre - "The whole experience – the staff were excellent working under social distancing and COVID infection control. Superb. Top marks".

Priority 2 – Improve patient safety to reduce avoidable harm in our key quality concerns

Description of the issue and reason for prioritising it:

Patient safety is a priority for the NHS which aims to be the best and safest healthcare system in the world. Patient safety is the avoidance of unintended or unexpected harm to people during the provision of health care such as medication errors, never events, harm from sepsis, pressure ulcers, infection and cross infection. Improving maternity and neonatal safety is also a priority. Restarting our services safely from the impact of COVID-19 is a key priority.

A new national NHS Patient Safety Strategy is due to be launched in 2022. The aim of the strategy is to enable the NHS to continuously improve patient safety and to do this the NHS will build on two foundations: a patient safety culture and a patient safety system. The aim will support the development of both foundations by:

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

The impact will be continuous improvement in the safety culture, better incident reporting to inform patient safety work streams, reducing death and complication rates, improve patient experience and reduce the cost of litigation. In preparation, we have identified a Patient Safety Specialist to lead the programme in the hospital and set up a new Patient Experience and Patient Safety Steering Group to oversee the work. In the meantime, we have continued to focus improvement on our key quality concerns.

What we did in 2020/2021:

2.1 Continue to screen all patients admitted as an emergency for COVID-19 and isolate high risk patients to prevent cross infection. Continue to re-screen patients on day 5 of their admission

It is standard practice to test all patients admitted as an emergency on the day of admission. This is followed by a risk assessment to decide whether the patient has a high, medium, or low suspicion of COVID-19 prior to being placed in a ward, and the level of precautions staff need to take, such as the use of personal protective equipment (PPE) or isolation of the patient in a side room, to protect patients from cross infection.

All patients are re-tested on day 5 of admission and the risk re-assessed to ensure patients remain in an appropriate ward and are protected from cross infection. A team of senior doctors, nurses, infection control specialists and Occupational Health Specialists meet regularly, to make decisions on whether patients can be moved out of isolation and moved to a bay with other patients, or re-isolated in a side room. This process reduces outbreaks of infection in the hospital.

Patients admitted for planned surgery or for a procedure are tested for COVID-19, 2 – 3 days prior to admission. For those who test positive, patients are required to self-isolate at home for 14 days and offered a later date for their operation or procedure. Once admitted patients are re-tested on day 5.

2.2 Continue to train our staff in infection prevention and control procedures, including the donning and doffing of personal protective equipment (PPE) in high risk areas to reduce the risk of cross infection in the hospital

All our staff are required to complete an infection control e-learning module and test every year which covers standard infection control precautions as well as undertaking a practical hand hygiene assessment. Overall, our staff are 94% compliant with infection control e-learning and 80% compliant compared to the Trust target of 90% with hand hygiene assessments in January 2021. Hand hygiene assessments have been limited by the requirement to socially distance, so more sessions are being held this year.

Frontline staff in contact with suspected or confirmed patients with COVID-19 are required to wear personal protective equipment (gloves, plastic apron and a surgical face mask) and in high risk areas, such as the Intensive Care Unit, wear a filtering face mask level 3 or a respiratory face mask or hood and eye protection. All staff who are required to wear a level 3 mask must attend 'fit test' training to ensure the mask fits properly to reduce the risk of transmission. At the start of the pandemic frontline staff attended training on how to put on and remove personal protective equipment.

2.3 Continue to undertake risk assessments of visitors to high risk areas and help them to put on and take off personal protective equipment safely

National guidance indicated visitors should be restricted to essential visitors only, a risk assessment should be undertaken and personal protective equipment (PPE) made available to visitors including the instruction and supervision of how to put it on and take it off. In line with this guidance, we have restricted visitors to immediate family members or carers and limited visitors to one per patient for an hour a day. Visitors are asked to wash their hands for 20 seconds on entering and leaving the ward and shown how to put on PPE. A visitor risk assessment is used in every ward and recorded in the patient's health care record. Staff are able to help patients stay in contact with their loved ones by arranging a virtual call with them and the feedback has been very positive.

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

NHS seven day services standards are designed to ensure patients that are admitted as an emergency receive high quality care whatever day they enter hospital. In 2013, a Seven Day a Week Forum chaired by the National Medical Director, Sir Bruce Keogh was established to consider how services could be improved across 7 days, particularly patients admitted at the weekend. In 2016, four of the ten clinical standards were prioritised for their potential to positively impact patient outcomes. Standard 8 is about ongoing review by a consultant once daily for patients who need it.

Each year, the Trust undertakes a survey of care compared to the clinical standards. In September 2019, our survey showed that only 77% of patients who needed a daily review at a weekend by a consultant received it. A working group to improve the safety and effectiveness of services at a weekend was set up and a successful trial completed by the Critical Care Outreach Team who tested a co-ordinator role on a Sunday from 2.00 – 10.00 pm to improve the allocation of the workload which improved the number of patients seen, but this was put on hold when the COVID-19 pandemic started and the team were redeployed to oversee the management of patients needing non-invasive ventilation on the Respiratory Care Unit.

In September 2020, a repeat survey of 70 patients showed an improvement to 97% of patients who needed a once daily review at a weekend, received it. This improvement can be explained by a change in the working practices by the Acute Medical Team. The on call teams now work more flexibly so that inpatient

reviews are assigned to the most appropriate grade. Two consultants work multiple four hour shifts, staying on site for 10-12 hours. Feedback for these changes has been uniformly positive. In addition, two more Consultants joined the Acute Medical Team which has helped the workforce shortage present in the survey in 2019.

Figure 4: Standard 8: Ongoing review (standard 90%)

Standard	April 18	March 19	Sept 19	Sept 20
Proportion of patients who required a **once** daily review at a **weekend** and received it.	**93%**	**80%**	**77%**	**97%**

2.5 Reduce the number of patients who acquire a category 2, 3 or 4 pressure ulcers during a hospital admission by 20% in 2020/21

Pressure ulcers occur when the skin and tissue beneath it becomes damaged and in serious cases the muscle and bone can also be damaged. Pressure ulcers are caused by pressure as the weight of the body presses down on the skin. Most are preventable by making regular and frequent changes to a patient's position and by regular skin inspection of high risk pressure areas to detect early signs of any ulcers. Pressure ulcers can cause pain and distress and lengthen a patient's stay in hospital. A number of pressure ulcers have been recorded in association with the use of medical devices such as masks and tubes that have been used to support patients with respiratory problems due to COVID-19 infections.

We have continued to work hard to prevent patients from getting an avoidable pressure ulcer in hospital. This year, we have seen an increase in the number of category 2 pressure ulcers from 199 in 2019/20 to 286 in 2020/21 (figure 5), but a reduction in the most serious category 3 pressure ulcers from 18 in 2019/20 to 9 in 2020/21 (figure 6) and a reduction in the number of category 4 pressure ulcers from 3 in 2019/20 to 1 this year (figure 7). The overall rate for all pressure ulcers per 1000 bed days has increased from 1.41 in 2019/20 to 2.19 in 2020/21.

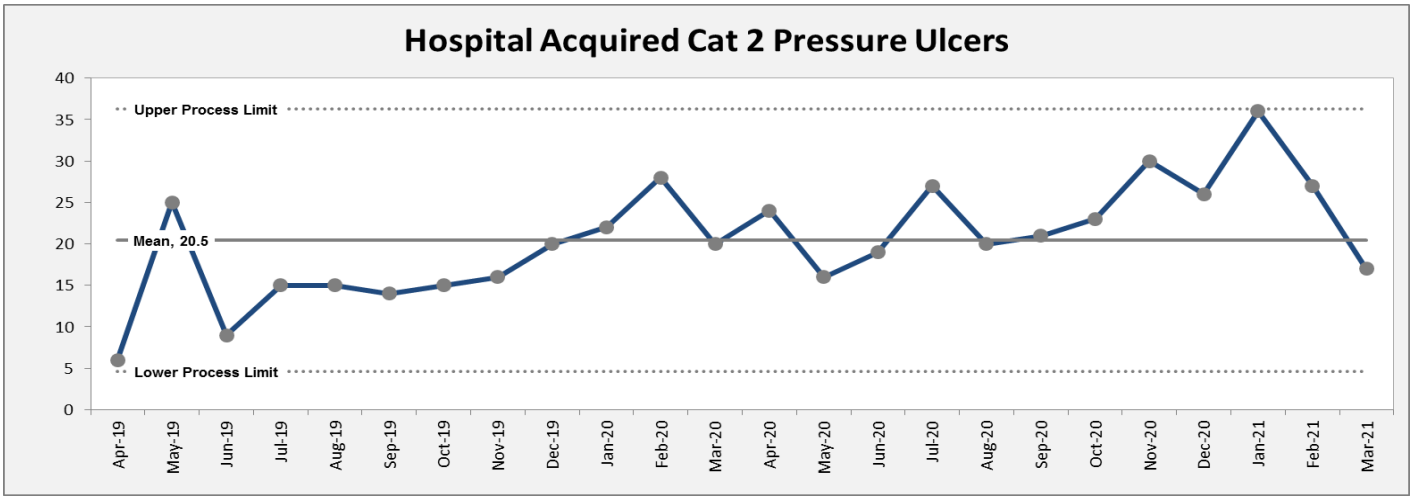
We know that we need to do more to improve so our Tissue Viability Team undertook an observational visit on one of the hotspot wards and identified that information about wound care was not always being discussed at the handover from one shift to the next. The Senior Nurse has reviewed the handover process to make sure wound care is highlighted within the safety brief to ensure it is a priority in each patient's care.

A pressure ulcer quality improvement project has focused work in the Acute Medical Unit. An observational audit was undertaken of patients admitted to the assessment area and showed that a task orientated approach is taken to prepare the patient for a medical assessment. A trial is planned to offer a gown to high risk patients likely to be admitted to aid skin inspection within 1 hour of arrival, as well as tests required and enables an accurate plan to be put in place, to heal the ulcer and prevent any further deterioration.

A Trust wide improvement plan is in place and progress has been reported to the Clinical Governance Committee by the Divisional Heads of Nursing this year.

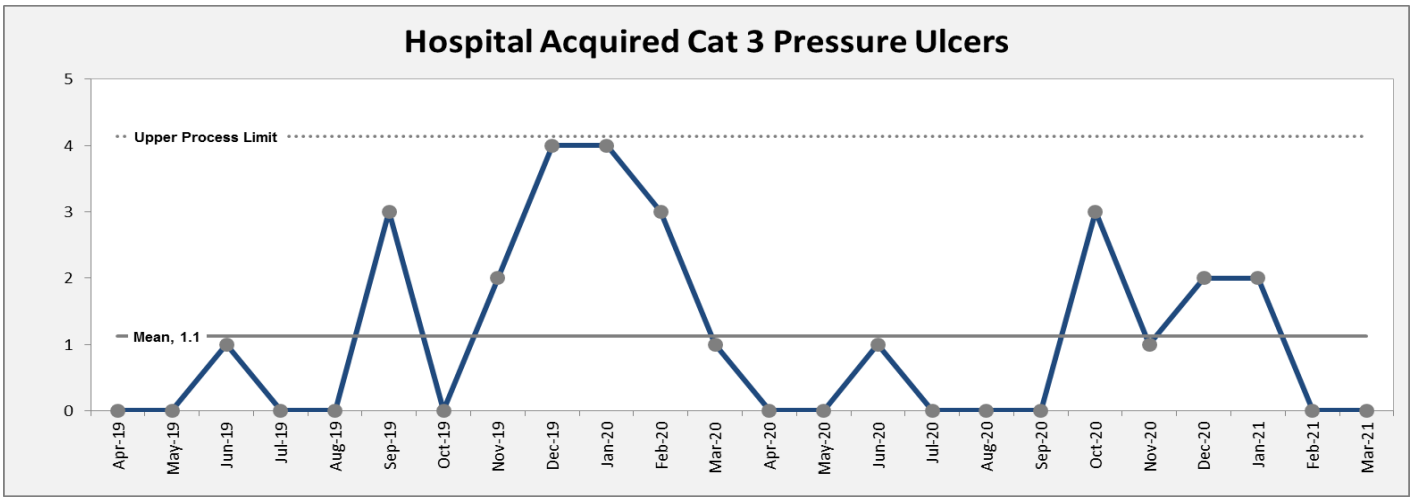
A 'Stop the pressure' campaign is underway which focuses on education of our staff supported by an e-learning package on the prevention and management of pressure ulcers. An additional Tissue Viability Nurse has joined the team to improve education and support teams in the management of patients with pressure ulcers.

Figure 5: The number of hospital acquired category 2 pressure ulcers



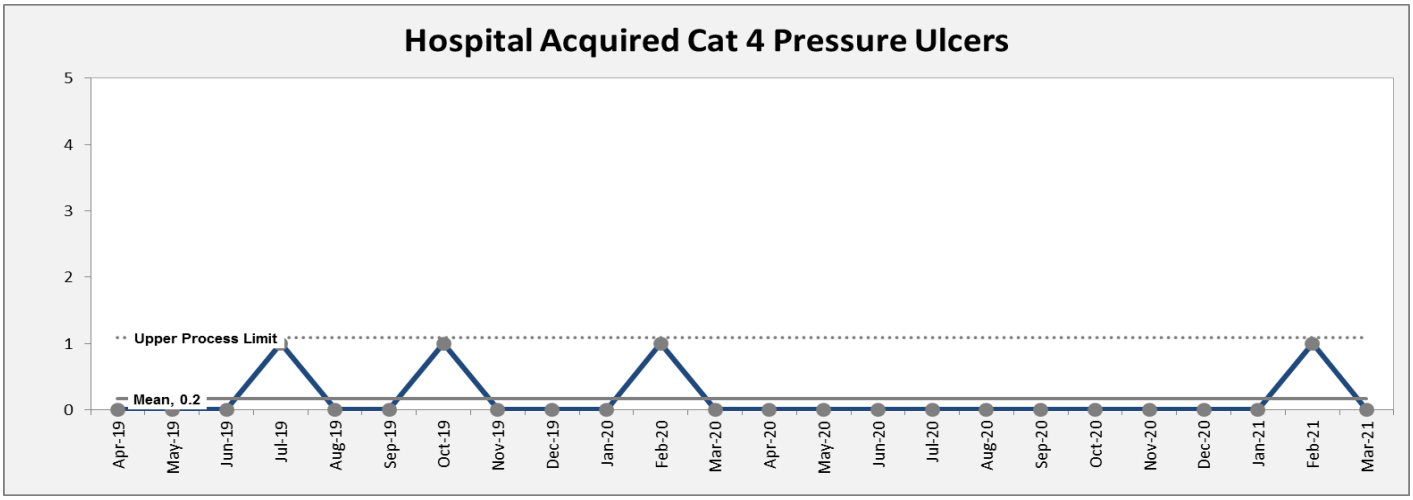
See appendix 1 page 100 – Reading a statistical process chart.

Figure 6: The number of hospital acquired category 3 pressure ulcers



See appendix 1 page 100 – Reading a statistical process chart.

Figure 7: The number of hospital acquired category 4 pressure ulcers



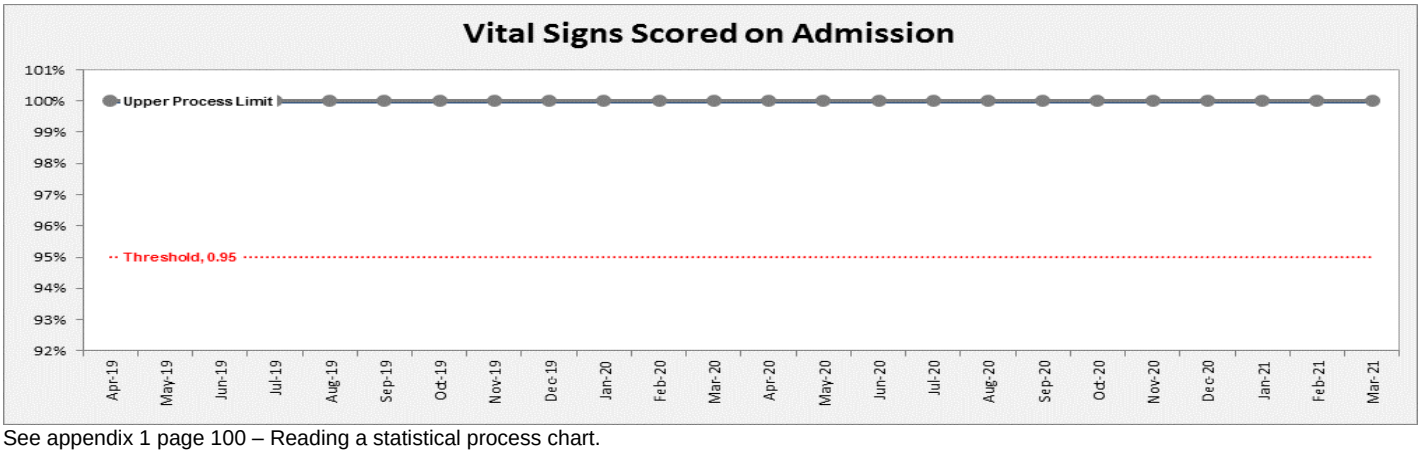
See appendix 1 page 100 – Reading a statistical process chart.

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

Sepsis is a time critical condition that can lead to organ damage, multi-organ failure, septic shock and death. Rapid diagnosis and treatment are crucial to survival.

Since February 2019 (figure 8) we have sustained 100% of adults screened for sepsis admitted both to the Emergency Department and as inpatients. This was achieved by the full implementation of the National Early Warning Score (NEWS2) to standardise the assessment of acutely ill and deteriorating patients. Patient's vital signs (temperature, pulse, blood pressure, respiration rate, oxygen levels, and level of consciousness or new confusion) are recorded and each vital sign is given a score. The higher the score the more unwell the patient is and this triggers an escalation response to a member of the medical or surgical team.

Figure 8: Vital signs scored on admission

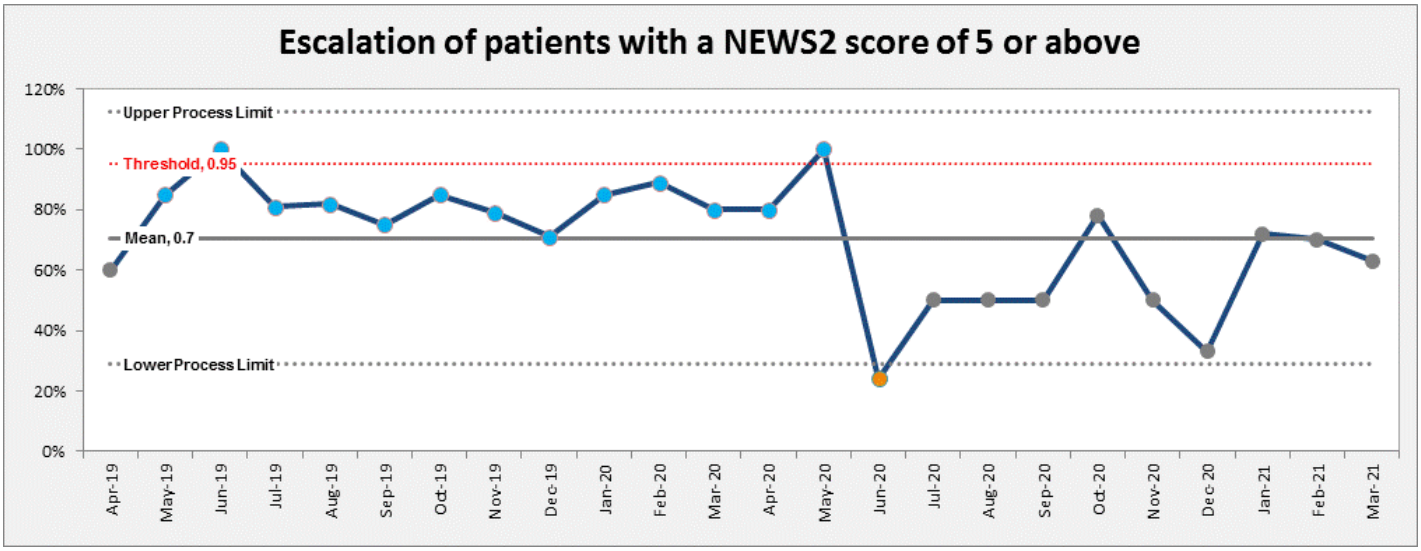


See appendix 1 page 100 – Reading a statistical process chart.

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

Compliance with escalation improved last year following the introduction of electronic hand held devices to record the patient's clinical observations and prompts staff to escalate to a senior decision maker. Our data in 2020/21 shows this needs to continue as a focus of improvement (figure 9).

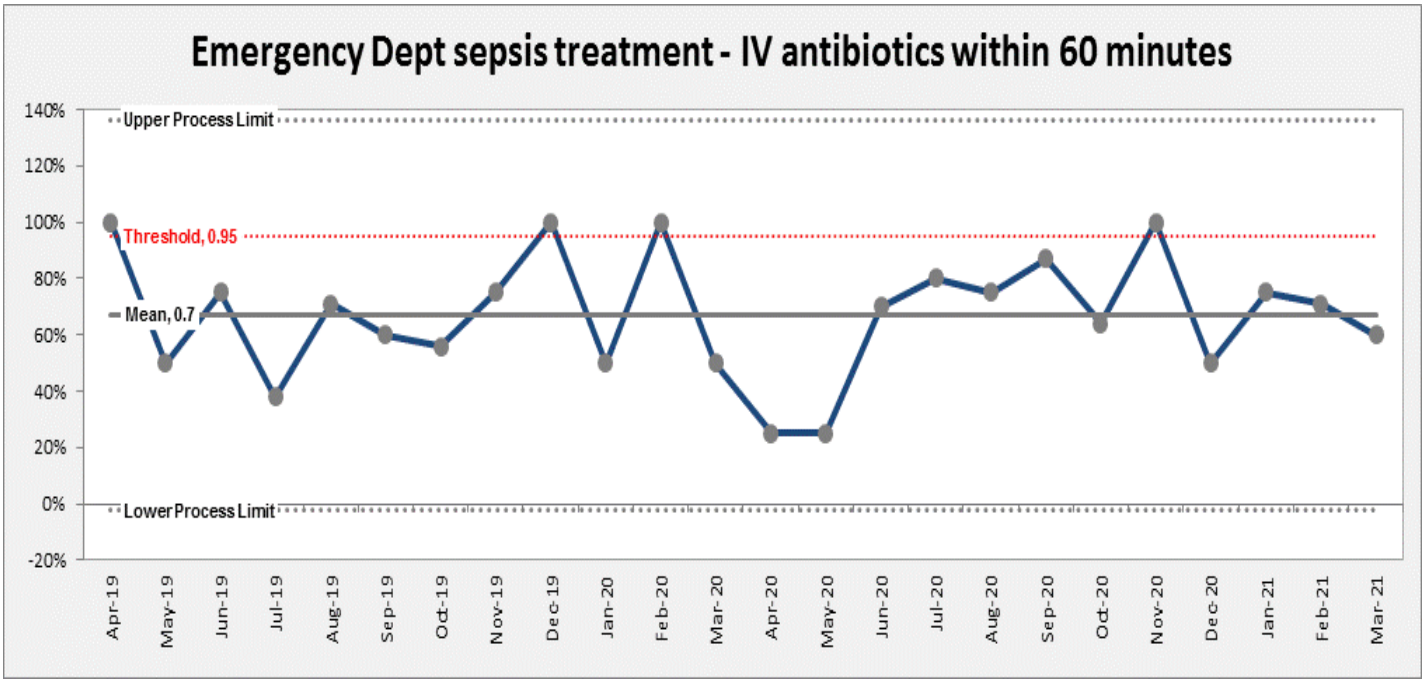
Figure 9: Escalation of patients with a NEWS2 score of 5 or above



See appendix 1 page 100 – Reading a statistical process chart.

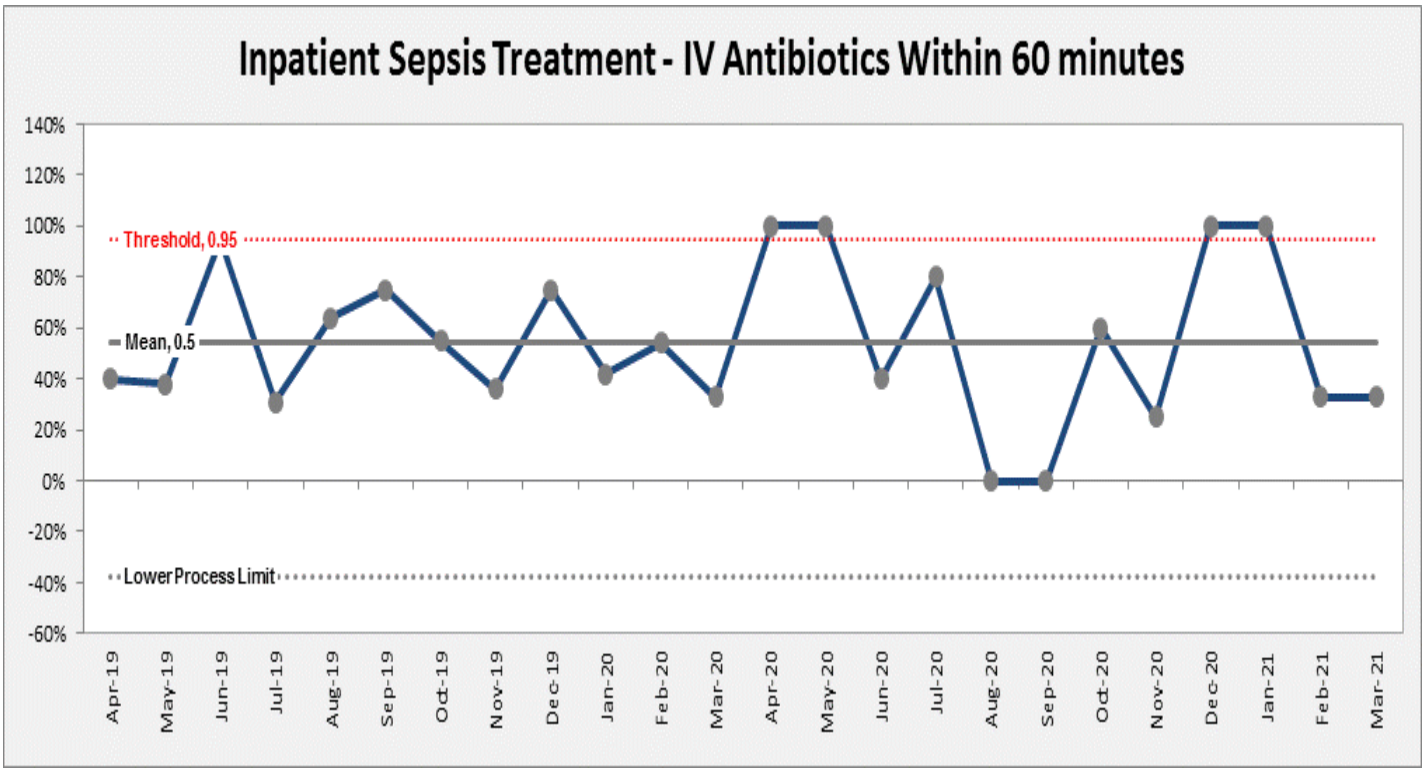
The data in figures 10 and 11 show variation across two years with no sustained improvement over time in in the administration of intravenous antibiotics within 60 minutes of diagnosis. This may be due to the small numbers of adults being treated with antibiotics for sepsis (average 3 patients per month in the Emergency Department, range 1 to 9 patients and 8 patients per month of inpatients, range 1 – 21 patients) and this continues to be a focus of our improvement work. However, the survival rate from sepsis has shown improvement in 2020/21 (figure 12).

Figure 10: Sepsis treatment of patients in the Emergency Department



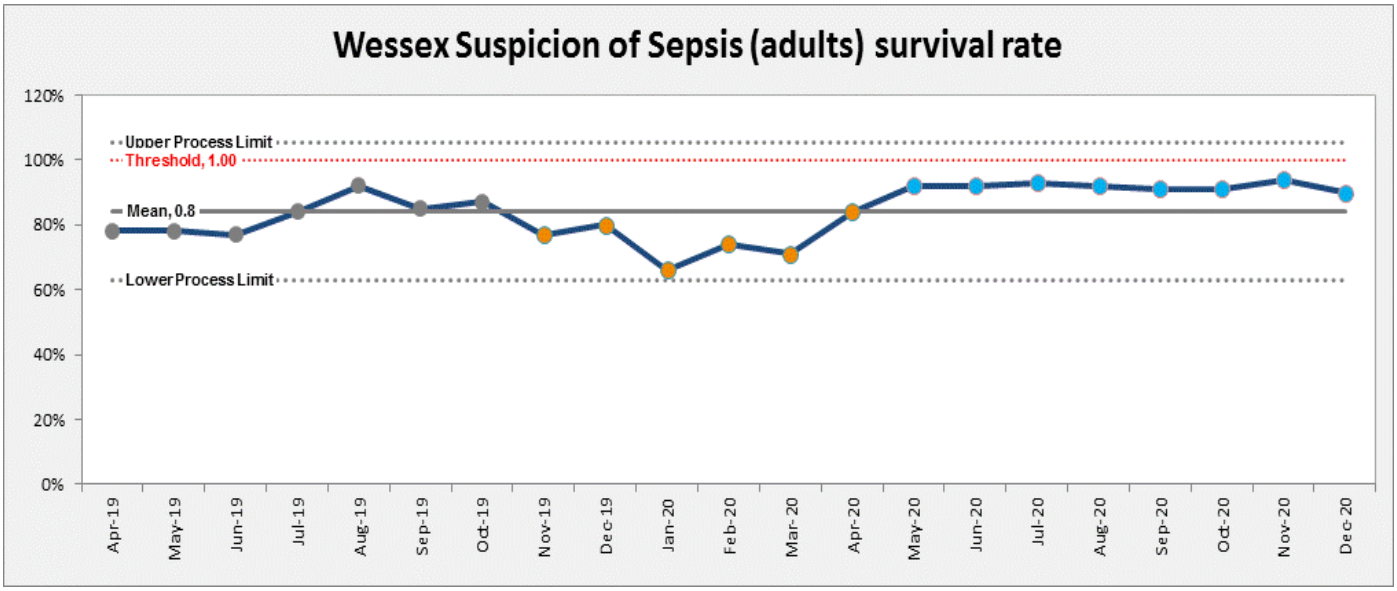
See appendix 1 page 100 – Reading a statistical process chart.

Figure 11: Sepsis treatment of inpatients



See appendix 1 page 100 – Reading a statistical process chart.

Figure 12: Suspicion of sepsis (adults) survival rate (data only available to December 20)



See appendix 1 page 100 – Reading a statistical process chart.

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

The Maternity Day Assessment Unit is designed for the assessment and management of all antenatal women with a pregnancy related problem and postnatal women up to 6 weeks after the birth of the baby. Women are either referred to the Unit or contact the service themselves for advice on any concerning symptoms.

In the early part of 2020/21, the Maternity Day Assessment Unit was closed and relocated to the Labour Ward as it was recognised that improvement work needed to take place to update care pathways and train staff in triage assessment. Assessment pathways were introduced for abdominal pain, bleeding in pregnancy, high blood pressure, reduced fetal movements, early rupture of membranes, suspected labour, being unwell and postnatal problems and the staff trained in their use. The Maternity Day Assessment Unit re-opened in July 2020 following the successful completion of improvement work.

Our guidance makes it clear that every woman who attends the Day Assessment Unit is expected to have a triage assessment within 15 minutes of arrival using one of the triage assessment pathways to identify the presenting problem. The midwife takes a brief history of the problem and asks the woman about the baby's movement. A set of clinical observations are recorded, an assessment of pain, palpation of the abdomen and listening to the baby's heart rate. The triage assessment enables the midwife to decide on a category of clinical urgency using the symptoms described by the woman and guides the timing of a subsequent assessment and care either immediately, within 15 minutes or within 1 or 4 hours of arrival. Figures 13 and 16 shows improvement is needed in timeliness of the triage on arrival and subsequent review.

Figure 13: Maternity Day Assessment Unit - percentage of women triaged within 15 minutes of arrival

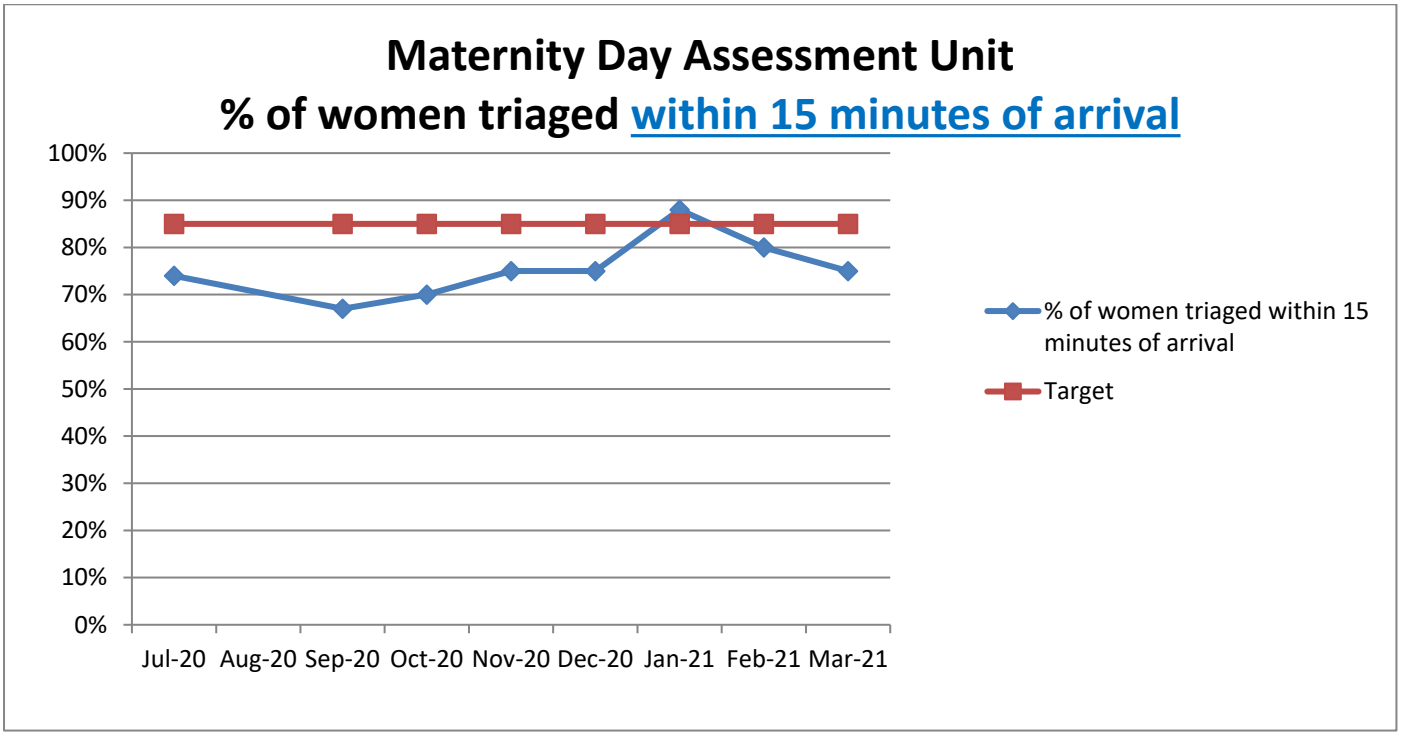


Figure 14: Maternity Day Assessment Unit - percentage of women who had a correct triage action card

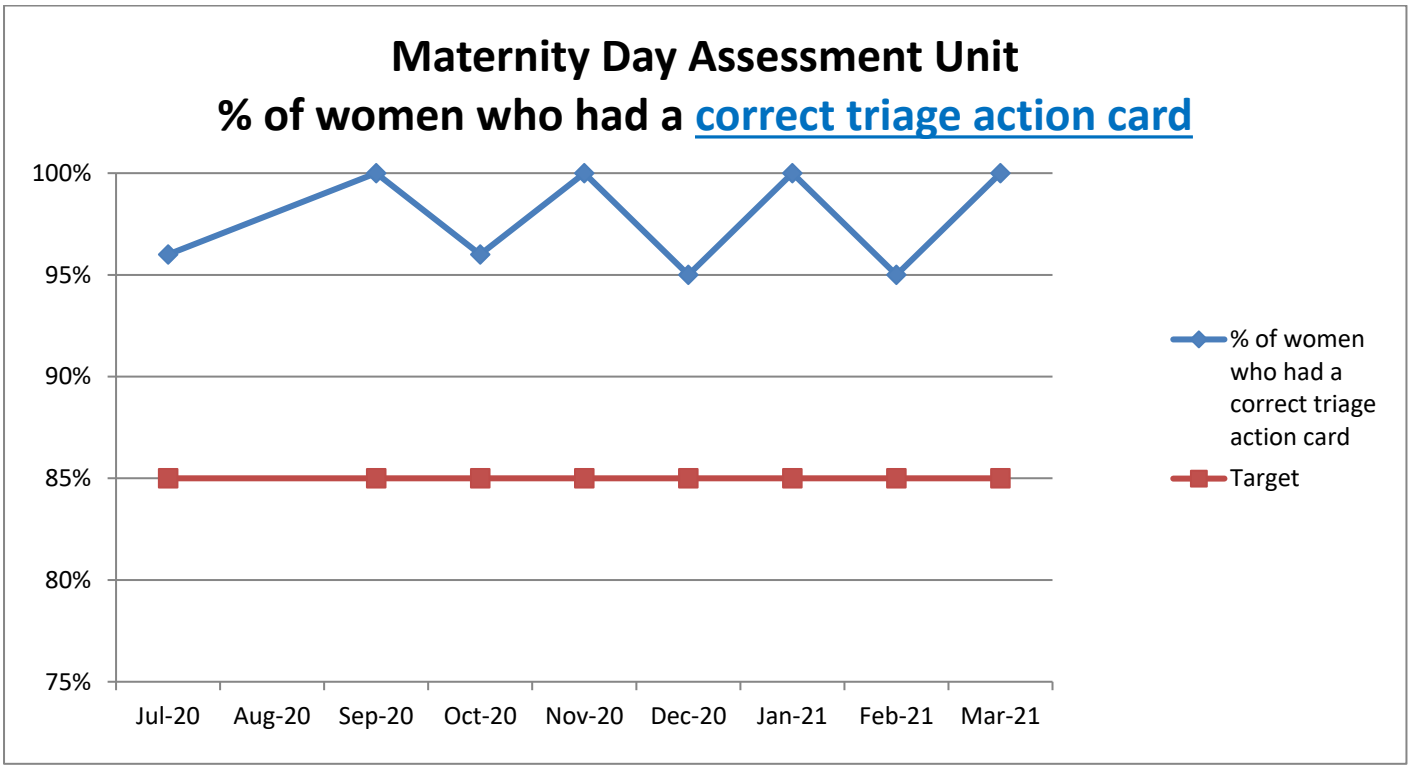


Figure 15: Maternity Day Assessment Unit - percentage of women who had an appropriate triage level

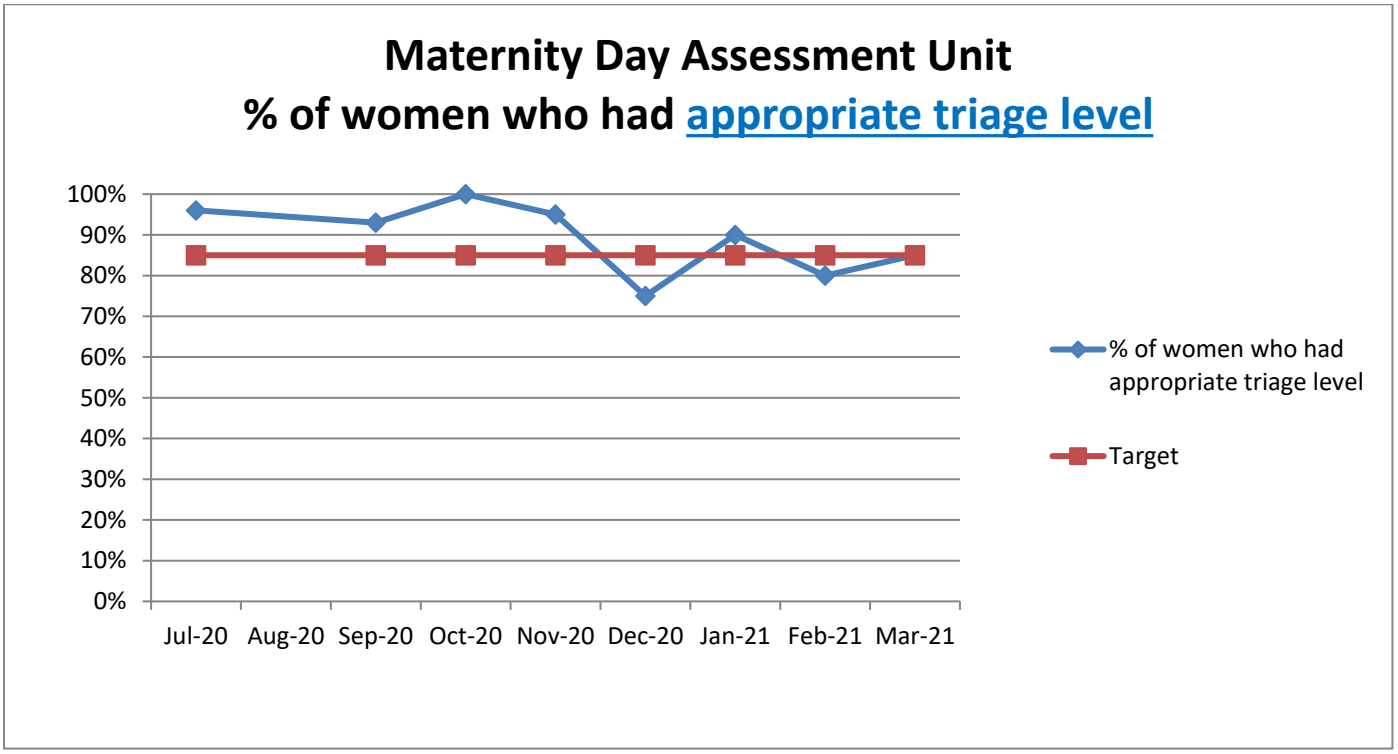
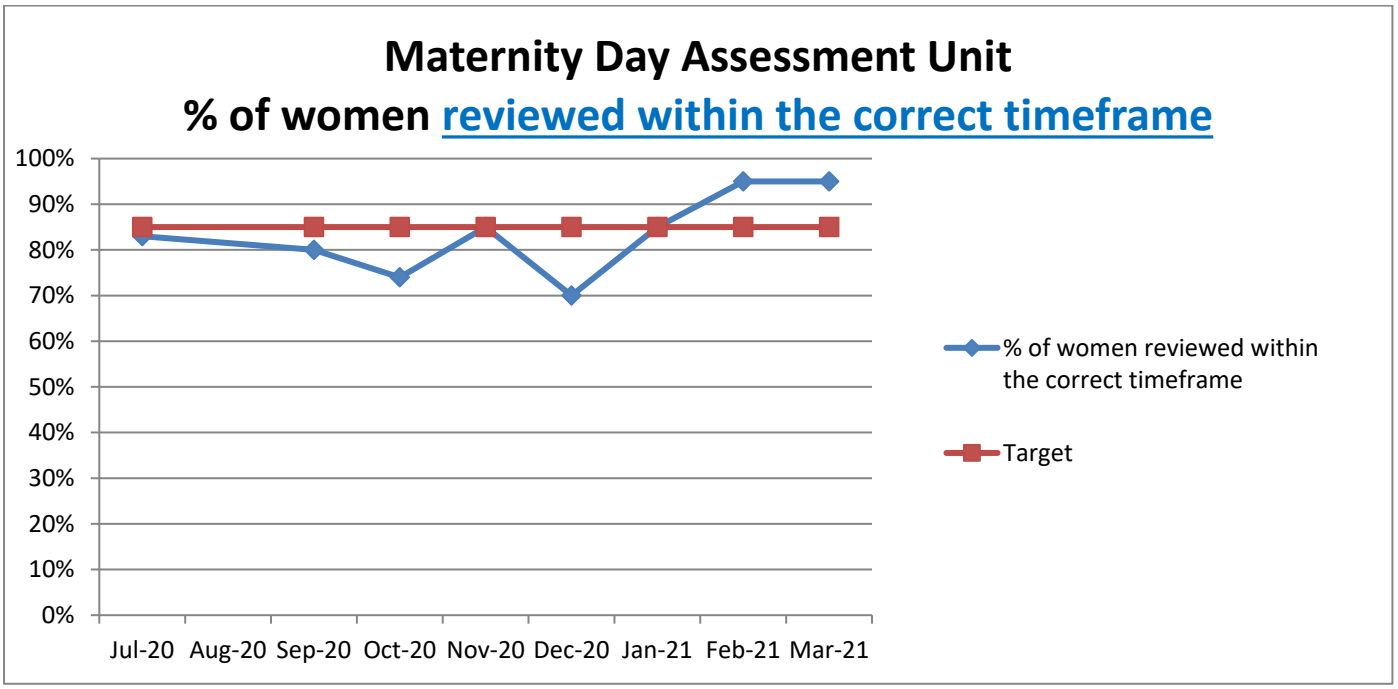


Figure 16: Maternity Day Assessment Unit - percentage of women reviewed within the correct time frame



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

In 2018/2019, the Trust had a total of ten serious incidents related to a missed or delayed cancer diagnosis due to administration processes or patients not sent a follow up clinic appointment at the expected time.

As a result, a significant number of safety improvements were made in the administration processes, multidisciplinary team meetings, the review and response to investigation results, the appointments process

and clinic outcome forms. Improvements also included the introduction of a number of failsafe mechanisms, such as a coordinator for each tumour site, whose sole responsibility was to check each patient's pathway and take action where delays had occurred to reduce the risk of similar incidents. In 2019/2020, the number of delayed cancer diagnoses had reduced to two serious incidents.

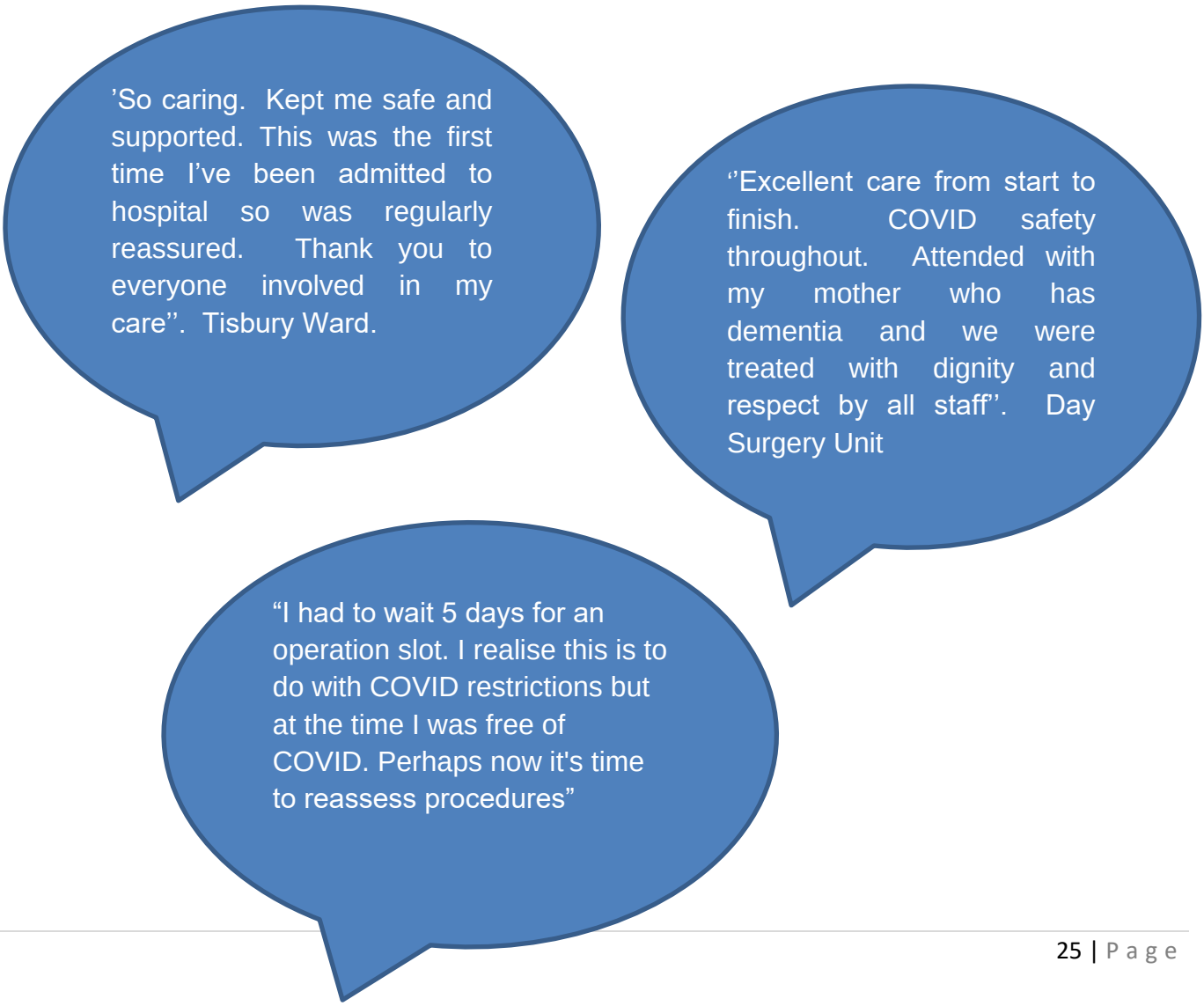
An internal audit of the cancer pathway took place in January 2020, to check whether the changes we had made were effective and had become part of the day to day work. The audit found that whilst good progress had been made in the appointments system and the multidisciplinary team meetings, further work was required to improve the clinic outcome form process and the receipt and acknowledgement of results.

In 2020/2021, five serious incidents occurred due to patients delayed diagnosis and not being given a follow up clinic appointment. Improvement work will continue until we are confident that the situation has been resolved and progress will continue to be monitored by the Cancer Board.

How we reported progress throughout the year

COVID-19 related issues were reported to the Infection Prevention and Control Committee. Deteriorating patients and sepsis and pressure ulcer improvement work have all been reported to the newly formed Patient Experience and Patient Safety Steering Group. Maternity safety has been reported to Maternity Governance meetings and the Clinical Governance Committee along with the NHS 7 Day Services compliance with the clinical standards. Cancer improvement work was reported to the Cancer Board.

What our patients have told us:



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

Description of the issue and reason for prioritising it:

People with learning disabilities, autism or both and their families and carers should be able to expect high quality care across all services provided by the NHS. They should receive treatment, care and support that is safe and personalised and have the same access to services and outcomes as non-disabled people. In Wiltshire, there are 9000 adults with a learning disability who make up 1.54% of the population.

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

In June 2018, NHS England and NHS Improvement published four national standards that hospitals must meet:

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

These standards are supplemented by improvement measures or actions that Trusts are expected to take to deliver the outcomes that people with learning disabilities, autism or both and their families expect and deserve. The Trust has submitted data for 2 years to compare our practice with the national benchmark. Only one national report was published in 2018/2019.

This year we have set out our vision for Learning Disability, Autism or both and a plan for improving our care:

Vision

Working hand in hand with our community health and care partners we will ensure all people with Learning Disabilities, Autism or both receive high quality and person-centred individualised care, based on excellent communication.

What we did in 2020/2021:

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

We planned to increase the number of alerts on our electronic patient record system, so that our staff know when an adult with a learning disability, autism or both is admitted to hospital to ensure reasonable adjustments are put in place and patients are supported through considered communication. In 2018/2019, 51 patients with a learning disability were recorded on our electronic patient care record alert system which increased to 107 in 2020/2021.

3.2 With the help of matched national funding we will build a Changing Places toilet for patients on the hospital site

The Trust has secured national funding for a Changing Places toilet but the work planned to convert the facility that was due to start in March 2020 was delayed due to the COVID-19 pandemic. The work is planned to be completed by March 2021.

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

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

A 'Treat me well' campaign was established in 2019 working with our staff, service users and carers in Mencap. This campaign is dedicated to improving how people with a learning disability are treated in hospital by making simple adjustments that make a big difference to the person. More time, staff education and awareness, better communication and clearer information can all help to make sure someone with a learning disability is treated well in hospital.

We have increased the use of hospital passports which are designed to give hospital staff important information about the patient. Doctors and nurses are asked to look at the passport before they do any interventions with the patient. It includes:

- Things you must know about me
- Things that are important to me
- My likes and dislikes

We have recruited 14 staff to become Learning Disability Ambassadors from across the hospital to help spread best practice and awareness. Plans for training are in the development phase and will ensure greater capability and capacity at a ward level to support patients, families and carers.

The COVID-19 pandemic has seen lower numbers than usual of adults with a learning disability admitted to the hospital and we do not know what longer term health impact this may have for these patients. We have supported carers during restricted visiting and continued to engage with the 'Treat me well' campaign via virtual meetings.

3.4 Introduce minimum reasonable adjustments in outpatient departments

This year, we are working to improve the quality of reasonable adjustments in our outpatient departments.

This has included offering patients with a learning disability, autism or both a longer appointment time to enable considered communication.

We have introduced quiet spaces and noise reducing headphones to help patients with sound sensory issues. This helps patients remain calm in an unfamiliar setting.

How we reported progress throughout the year

Work towards the implementation of the national learning disability and autism standards was reported to the Clinical Governance Committee.

What our patients and carers have told us:

A mother - "Excellent service by the whole staff. The team looked after our daughter with learning disability needs. Well done to the team"

A parent about an online consultation "It was harder for my child to communicate with the team (he has learning difficulties and communication difficulties)"

Priority 4: Work with our local communities and partners to implement phase 3 of the NHS response to the COVID-19 pandemic and value patient's time by ensuring that they are only in hospital when necessary

Description of the issue and reason we prioritised it:

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

This year, we have simplified our improvement work and focused on two key areas:

1) Early discharge – a third of our patients should be discharged from the ward before midday.

2) Introduced criteria-led discharge – to enable nurses and therapists to used agreed criteria compared to the patient's clinical status to guide clinical decisions about discharge from hospital.

Although this was our aim, on 11 March 20, the World Health Organisation declared a COVID-19 pandemic and a national lockdown was imposed on 23 March 20 in response to this unprecedented event. As a consequence, all planned surgery and procedures were cancelled and many outpatient appointments were changed to virtual consultations. This was in preparation for receiving an anticipated high number of very sick patients with COVID-19 and significantly, changed the whole way the patient discharge pathway was managed. We worked closely with Wiltshire Council and the Clinical Commissioning Groups and when patients with complex needs were ready to leave hospital, our teams notified the Clinical Commissioning Groups who took responsibility for finding a suitable placement for the patient.

On 7 August 2020, NHS England issued guidance about the third phase of the NHS response to COVID-19 on urgent actions Trusts must take to address inequalities in NHS provision and outcomes. NHS England asked Trusts to work collaboratively with local communities and partners to take the following 8 urgent actions;

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

What we did in 2020/2021:

4.0 Work with our local communities and partners to implement phase 3 of the NHS response to the COVID-19 pandemic

1. Protect the most vulnerable from COVID-19

We have worked together with our health and care partners in the newly formed Bath and North East Somerset, Swindon and Wiltshire Health and Care system (BSW) Integrated Care System (ICS) to improve patient care and protect those most vulnerable to COVID-19. System working enables us to better address the significant challenges that we face and draws on the diversity of expertise and experience that exists across BSW. The aim of the system is to improve the health and wellbeing and address inequalities in the population.

Our local response to the COVID-19 pandemic has shown our partnership working at its best, with social and community services, voluntary organisations and NHS organisations joining up to provide support to the shielded and vulnerable in local communities and the provision of mutual aid between partners.

An example of this good practice at local level, is a care home working group was established which brought together local authority adult social care, public health and commissioners. The benefits were:

- Clear communication with care homes on infection control, outbreak management and clinical support through a single point of contact. Any patient discharged from this hospital to a care home was tested for COVID-19 and the result communicated before the patient was transferred to the care home.
- No large-scale outbreaks were reported in care homes since the end of April 2020. Current outbreaks are identified through routine testing and identification of staff without COVID symptoms. The rapid response resulted in self-isolation of staff and protection of residents.
- Deaths in care homes are at pre COVID-19 levels
- Complex hospital discharges of patients to care homes were arranged by the commissioners following a request by the ward team. This reduced delays, discharges were managed safely and feedback from care homes showed they had confidence in the system.

To protect all our patients from acquiring COVID-19 in hospital, it is standard practice to test all patients admitted as an emergency on the day of admission. This is followed by a risk assessment to decide whether the patient has a high, medium, or low suspicion of COVID-19 prior to being placed in a ward where beds are socially distanced, and the level of precautions staff need to take, such as the use of personal protective equipment or isolation of the patient in a side room, to protect patients from cross infection.

All patients are re-tested on day 5 of admission and the risk re-assessed to ensure patients remain in an appropriate ward and are protected from cross infection. A team of senior doctors, nurses, infection control specialists and Occupational Health Specialists meet regularly to make decisions on whether patients can be de-isolated and moved to a bay with other patients, or re-isolated in a side room. This process reduces outbreaks of infection in the hospital.

Patients admitted for planned surgery or for a procedure are tested for COVID-19, 2 – 3 days prior to admission. For those who test positive, patients are required to self-isolate at home for 14 days and offered a later date for their operation or procedure. Once admitted patients are re-tested on day 5.

To protect our staff from acquiring COVID-19 at work, all staff have a COVID-19 risk assessment undertaken based on their age, gender, ethnicity, weight and underlying health conditions. The risk factors determine which of the four categorises a staff member is in. Category A is low risk where staff can continue working in their current environment following all safety precautions (Hands, Face, Space) and

use of personal protective equipment where appropriate. Category D is the highest risk where staff are advised not to work with patients with confirmed or suspected COVID and are offered re-deployment to non-clinical duties or to work at home. BSW Integrated Care System achieved 100% of risk assessments completed for all staff by September 2020.

Our social distancing campaign

All our staff are required to wear a face mask in clinical and public areas, wash and clean their hands and maintain social distancing. In December 2020, we introduced a twice weekly staff COVID screening test. Staff with a positive screening test must have a further antigen COVID test and, if positive, must self isolate for 14 days before returning to work.

2. Restore NHS services inclusively

The third phase of the NHS response to COVID-19 focuses on accelerating the return to near normal levels of pre-COVID health services. We are part of an Acute Hospital Alliance which meets regularly to foster effective and collaborative working relationships between our Trust, the Royal United Hospital, Bath and Great Western Hospital, Swindon. The short term focus of the Alliance is to deliver the next phase recovery plan over the next 90 days. A key component is to test out a model of sharing planned elective care capacity, work towards a shared approach to waiting list management for the whole system and share diagnostic services.

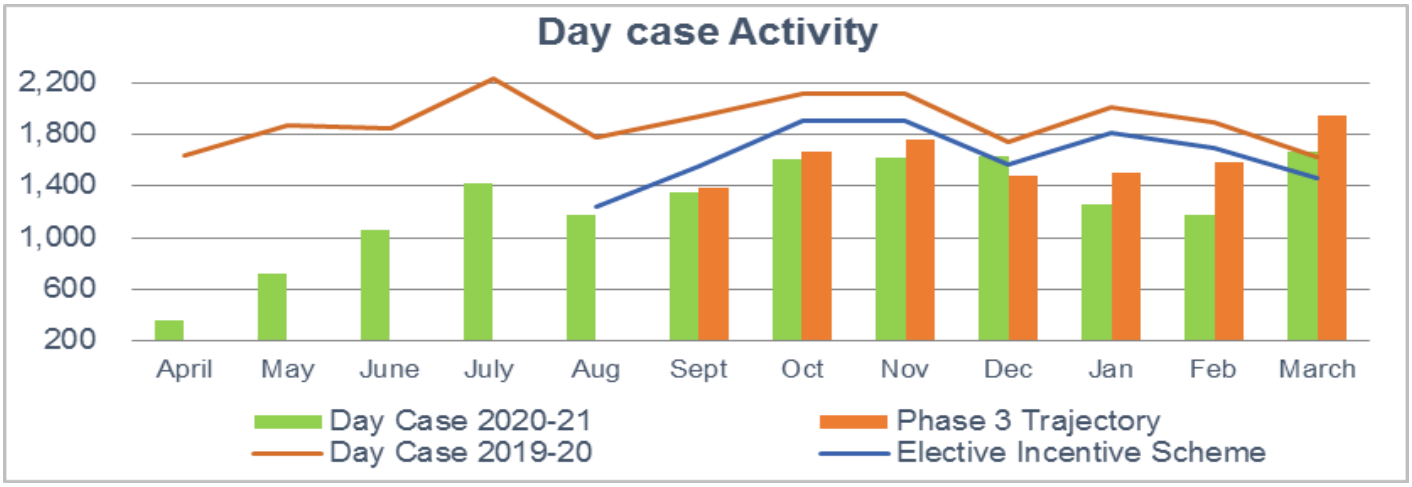
2.1 Planned and emergency surgery

As part of the NHS response to COVID-19, NHS England asked Trusts to postpone all non-urgent planned operations from 15 April 2020 for at least 3 months. Emergency surgery, cancer surgery and clinically urgent care continued unaffected. The Royal College of Surgeons of England published a clinical guide to surgical prioritisation during the COVID-19 pandemic https://www.rcseng.ac.uk/coronavirus/surgical-prioritisation-guidance/ and each patient on our waiting list was assessed against the criteria to decide on their clinical priority for surgery or offered an alternative option if one was available. Patients with the highest priority are offered surgery first. A process of continuous re-assessment is in place to review whether any patient needs to be re-categorised. All new patients listed for surgery are assessed in the same way and allocated a clinical priority when added to the waiting list. The waiting list is monitored on a weekly basis and patients are listed for surgery according to the highest priority rather than the longest

waiting time. In addition, the Trust has been working closely with Ramsey New Hall* hospital to make use of NHS commissioned capacity, particularly for planned orthopaedic surgery. The Trust is planning jointly with New Hall hospital to ensure that priority patients have access to care where appropriate.

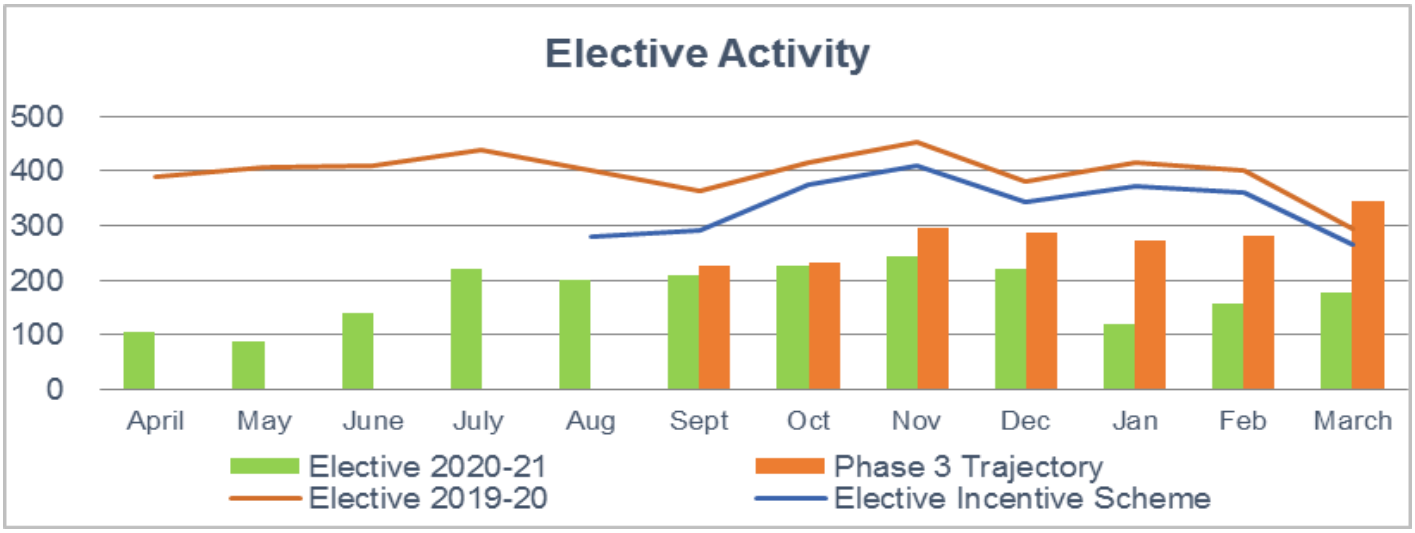
NHS England expected Trusts to have re-established services by the end of September 2020 to at least 80% of last year's activity for patients admitted for planned surgery, outpatients and day case procedures. Figure 14 shows day case activity increased up to December 2020. However, January 2021 was a particularly challenging month in relation to the number of patients in hospital with COVID-19 and the response to, and effects of this, impacted on both theatre capacity and activity. Day case activity in March 2021 increased to 1674 cases compared to 1162 cases in February 2021. This meant that the activity was 265 cases below our Phase 3 trajectory. Figure 15 shows planned surgical activity was also significantly impacted by the COVID-19 challenges. The number of cases in March 2021 increased to 174 cases compared with our Phase 3 trajectory of 346 cases, resulting in an overall shortfall of 172 cases against our plan. This has been the most challenging for us with a slow return of planned surgery (due to theatre capacity used for Intensive Care Unit beds) and an increase in the number of patients waiting over 52 weeks for treatment. The four specialties with the highest variance from the plan were Orthopaedics, Plastic Surgery, ENT and Gynaecology. Many of the patients in these specialities have a low clinical priority compared to other specialities which have larger numbers of clinically urgent cases which are prioritised first. In these specialities, some of these patients are being offered surgery at Ramsey New Hall Hospital.

Figure 14: Activity recovery – Day case (target 80%)



*Ramsey New Hall hospital activity is not included in figure 14.

Figure 15: Activity recovery – Elective (planned) surgery (target 80%)



*Ramsey New Hall hospital activity is not included in figure 15.

A significant amount of work has been undertaken to reset the way services are delivered – primarily to establish the overall bed capacity within the constraints of social distancing and infection prevention and control procedures.

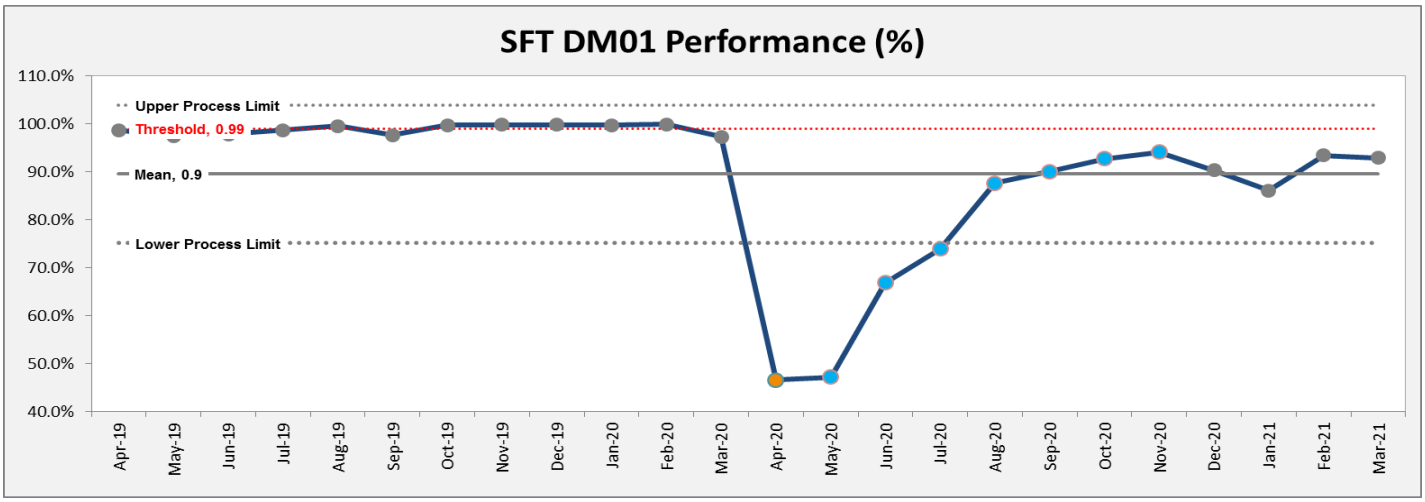
2.2 Diagnostic waiting times and referral to treatment times

COVID-19 has had a significant impact on the Trust's capacity to deliver diagnostic activity as lists were reduced to accommodate social distancing in waiting rooms, to give staff time to change their personal protective equipment in-between cases and staff sickness levels.

We restarted routine plain X-ray at Westbury, Fordingbridge and Shaftesbury hospitals and continued to use MRI and CT scan capacity in the independent sector at Ramsey New Hall hospital. We increased the number of sessions for planned X-rays over weekends to ensure social distancing for patients who need to attend routine appointments at the main hospital.

NHS England expected Trusts to have re-established MRI and CT scans and endoscopy procedures by the end of September 2020 to at least 90% of last year's activity. Figure 16 shows that diagnostic waiting times reached the 90% target by the end of September and although was impacted by the second wave of the COVID-19 pandemic achieved 92.8% performance by March 2021.

Figure 16: Diagnostic waiting times (target 99%)



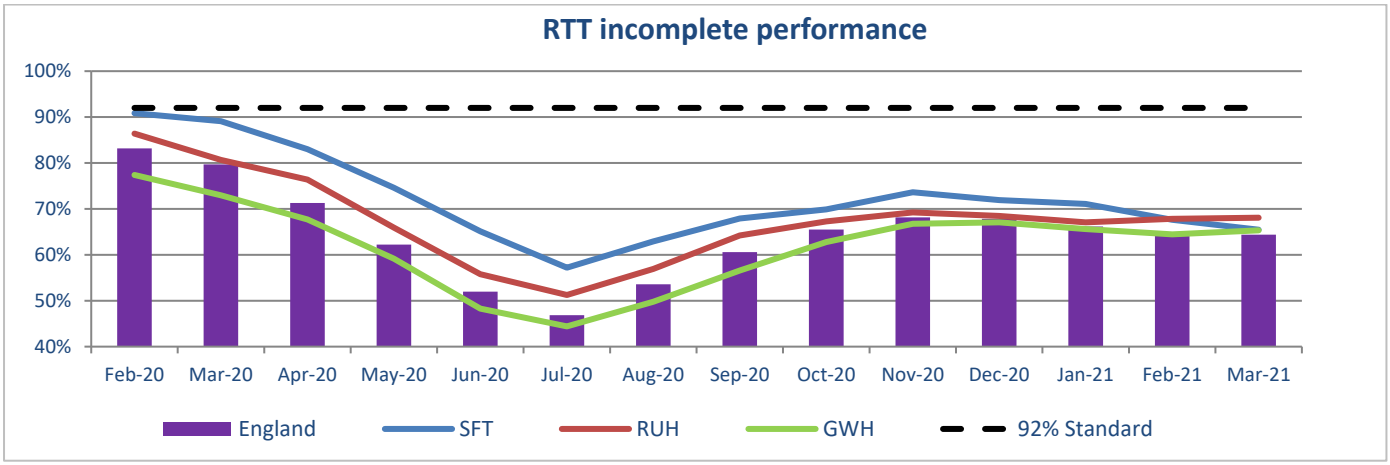
See appendix 1 page 100 – Reading a statistical process chart.

Referral to treatment time performance against the 18 week referral to treatment standard shown in figure 17 at all three BSW acute hospitals remained just above the national average of 64.4% in March 2021. This Trust was at 65.5%, the Royal United Hospital, Bath at 68.8%, and Great Western Hospital, Swindon at 65.3%.

Three specialities with the largest number of patients waiting more than 52 weeks are focusing on:

- Ophthalmology – increasing outpatient capacity to enable patients to socially distance due to the proportion of vulnerable patients in this group and the use of 2 other sites than this hospital.
- Ear Nose and Throat and Oral Surgery – an air change solution to reduce the risk of COVID transmission during aerosol generating procedures has been installed and will improve capacity.
- Orthopaedic patients – patients are being offered their elective surgery at Ramsay Newhall Hospital as an NHS patient.

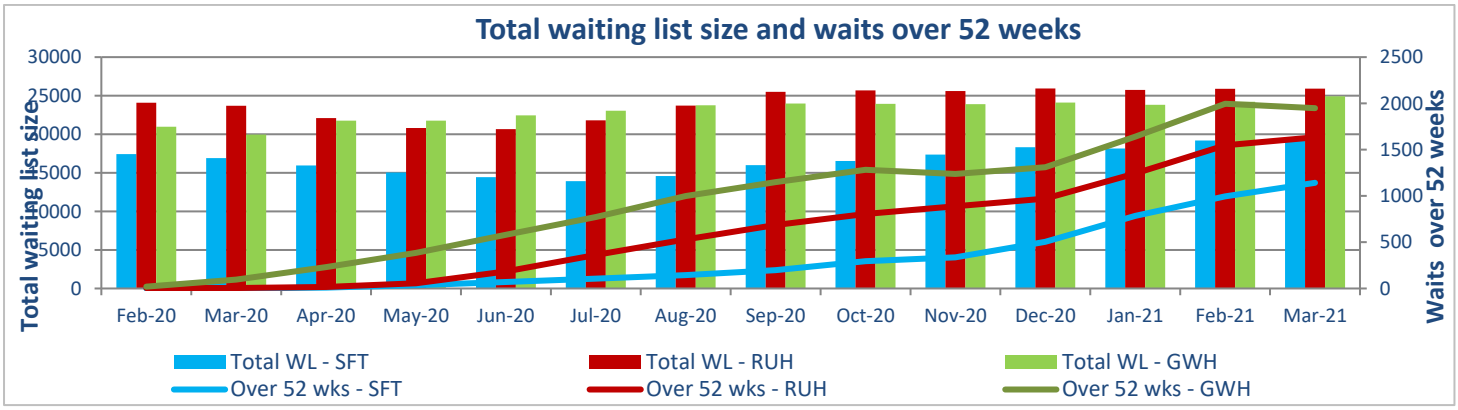
Figure 17: Referral to treatment time (RTT) – incomplete pathway performance (92%)



SFT = Salisbury NHS Foundation Trust, RUH = Royal United Hospital, Bath, GWH = Great Western Hospital, Swindon

Figure 18 shows the size of the total waiting list which grew at all three acute Trusts, along with the number of patients waiting over 52 weeks for elective treatment. The proportion of patients waiting over 52 weeks at Salisbury NHS Foundation Trust is 5.8% (1142 patients) compared to 6.3% (1634 patients) at RUH, Bath and 7.8% (1949 patients) at GWH, Swindon at the end of March 2021. A BSW ICS elective waiting list working group is in place with representatives from each of the 3 hospitals. The aim is to increase elective activity by working together to use the resources available and improve equity for patients on waiting lists across the system.

Figure 18: Total waiting list size and patients waiting over 52 weeks for treatment

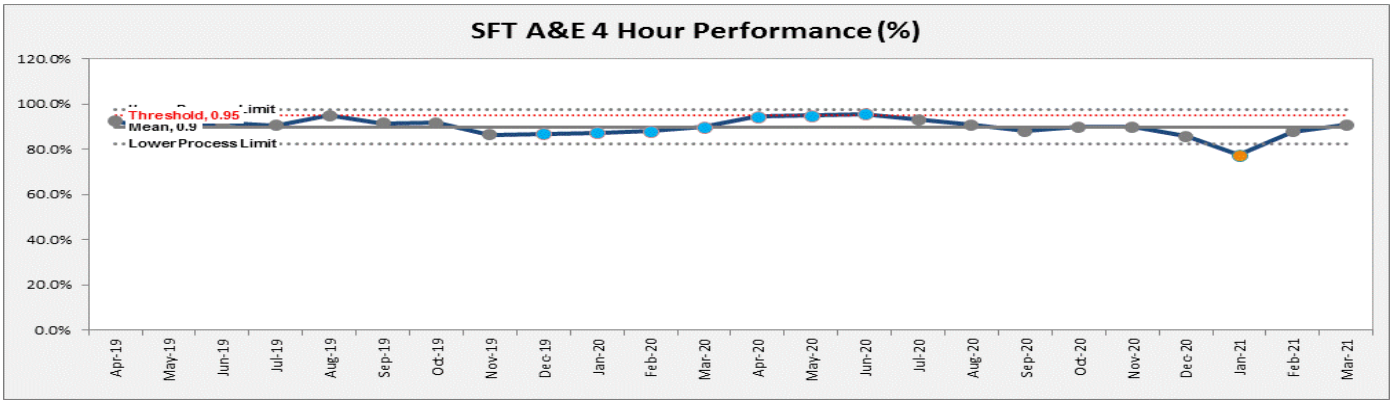


WL = waiting list, SFT = Salisbury NHS Foundation Trust, RUH = Royal United Hospital, Bath, GWH = Great Western Hospital, Swindon

2.3 Emergency admissions

The Trust received £2 million to improve the waiting space in the Emergency Department to ensure social distancing. During the pandemic, the minor injuries area was moved from the Emergency Department and relocated in the fracture clinic and Orthopaedic outpatient department waiting areas. A modular build is to be installed and will provide increased provision for these outpatient clinics to allow the Emergency Department to expand and maintain a separate Respiratory Assessment Zone for patients with suspected COVID-19. This is planned to be completed in the autumn 2021. Our Respiratory Care Unit (RCU) opened in March 2020 which specialises in the care of COVID-19 positive patients. As the second wave of COVID-19 subsided the RCU reduced from 30 beds to 10 beds and remains operational. Figure 19 shows the Trust sustained performance at 90% in patients admitted or discharged within 4 hours of arrival in the Emergency Department. The end of the 3rd national lockdown has seen an increase in daily attendance rates, back to near normal pre COVID-19 levels, and a decrease in the percentage (30.3%) and acuity of patients requiring admission.

Figure 19: Emergency Department (A&E) 4 hour wait (target 95%)



See appendix 1 page 100 – Reading a statistical process chart.

2.4 Cancer services

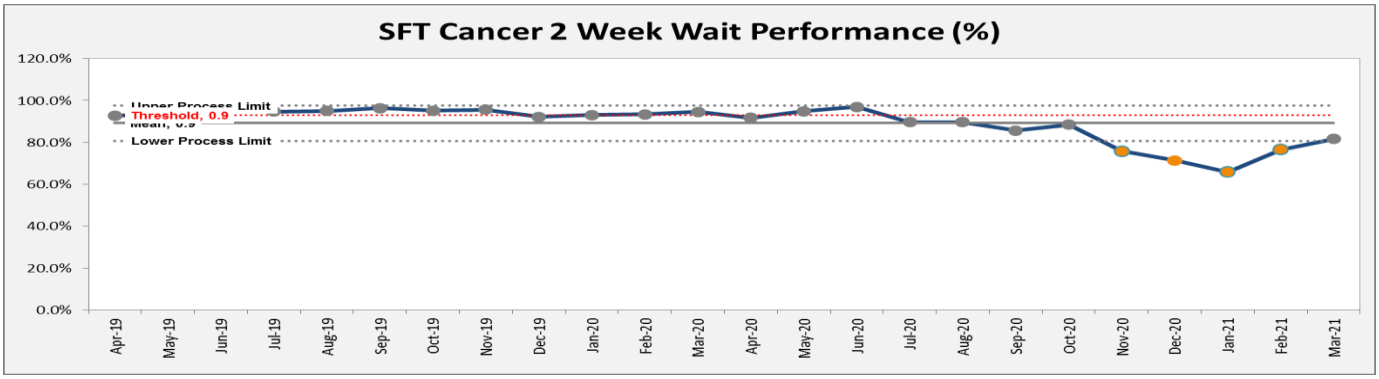
All cancer surgery has continued unaffected throughout the pandemic. Waiting list meetings are held every week to ensure patients are seen within the 2 week wait time and 62 day standard and those waiting longer than 104 days. Some patients have chosen to delay their treatment due to concerns about attending the hospital or clinic during the pandemic and is the reason we continue to encourage patients to take up a virtual outpatient appointment. We have worked with GPs to develop patient information to encourage patients to attend their appointments.

In partnership with the South West Cancer Alliance, we worked in accordance with the national guidance on how to manage patients who chose not to attend for cancer investigation and treatment due to pandemic concerns.

The faecal immunochemical test (qFIT) is an improved screening test that works by detecting hidden traces of blood in faeces that could indicate bowel cancer or pre-cancerous growths known as polyps and has an overall diagnostic accuracy of 95%. GPs have implemented the new qFIT test of suspected colorectal cancer patients prior to referral and this is expected to reduce the demand for colonoscopy by up to 80%.

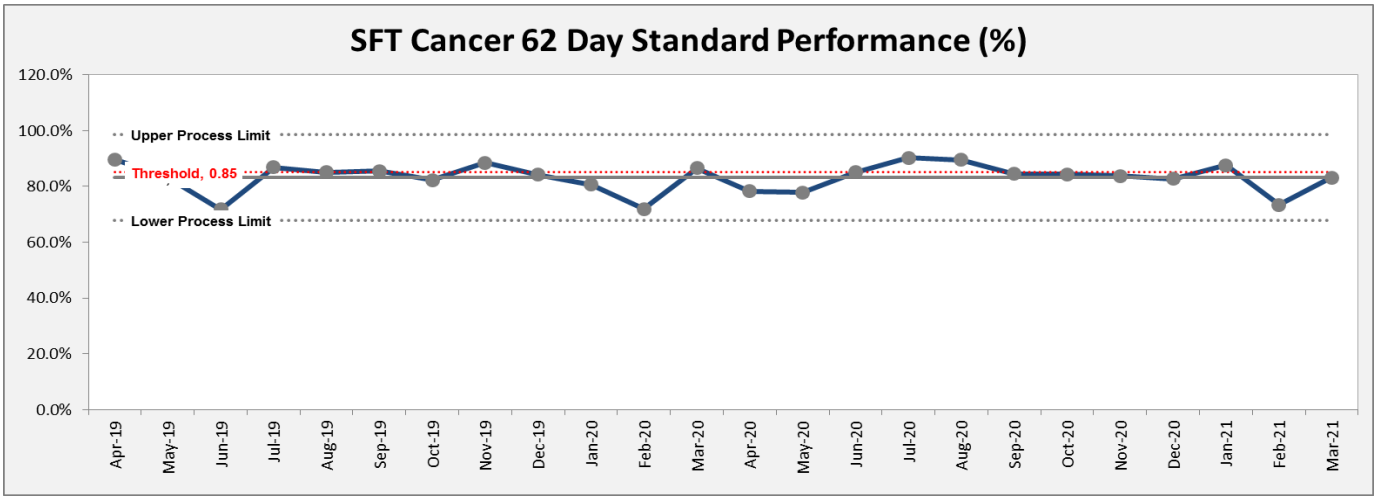
NHS England expected Trusts to restore full operation of all cancer services by September 2020. Figure 20 shows the Trust was performing close to the standard for the 2 week wait until October 2020 when the second wave of the COVID-19 pandemic occurred. The reduction in the number of patients seen between November 2020 to January 2021 was due to the need for face to face appointments predominantly associated with the breast one stop clinic (increased referrals, need to socially distance and outpatient capacity) and patient choice. A fifth one stop breast clinic is now in place and is expected to reduce waiting times by April 2021. Figure 21 shows the Trust achieved 83.6% compared to an 85% target in 2020/21 as cancer treatments continue to be prioritised.

Figure 20: Cancer 2 week wait performance (target 93%)



See appendix 1 page 100 – Reading a statistical process chart.

Figure 21: Cancer 62 day standard performance (target 85%)



See appendix 1 page 100 – Reading a statistical process chart.

3. Develop digitally enabled care pathways in ways which increase inclusion

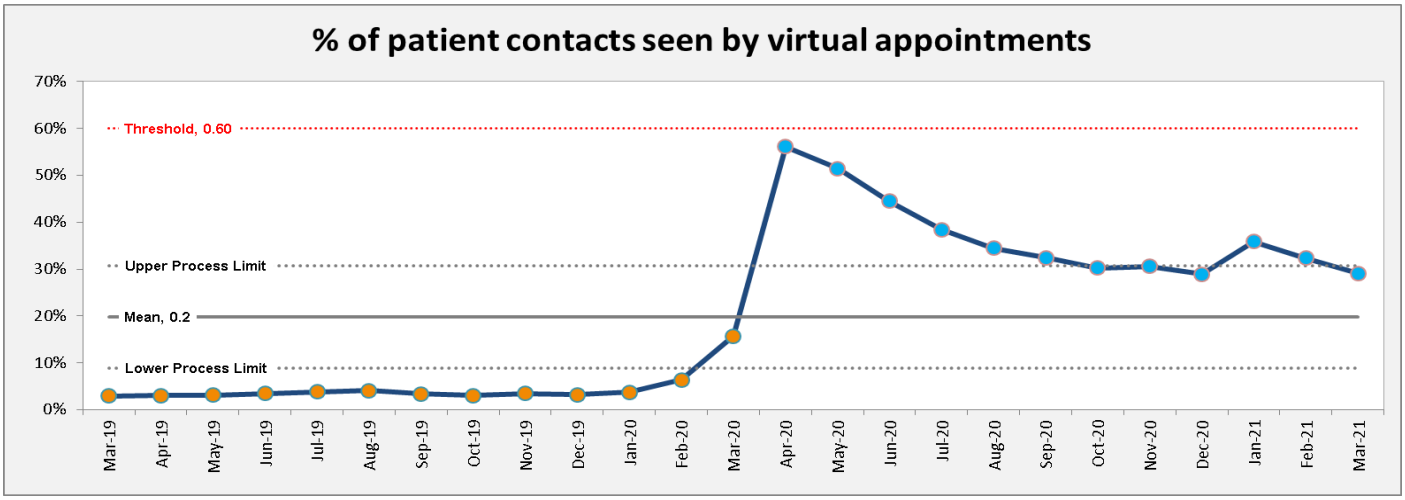
NHS England expected Trusts to have re-established 100% of our last year's activity for first outpatient attendances and follow ups from September 2020. A national benchmark was set that at least 25% of appointments should be conducted by telephone or digitally including 60% of all follow up appointments. We have continued to see recovery of outpatients but the numbers of patients requiring face to face appointments has increased (require physical examination/tests) and physical space in outpatients is a constraint. A modular building to increase space is expected to be opened on 4 May 2021.

During the response to COVID-19, the health and care system has seen an unprecedented level of uptake of digital tools and services, helping keep patients, carers, families and our staff safe in ensuring that essential care can continue. Digitally enabled services provide an opportunity to create a more inclusive health and care system, creates more flexible and responsive services and gives access for people who might otherwise find it hard to access a service in person.

We have increased the use of 'virtual' or digitally-enabled clinics, including telephone clinics, virtual review clinics and video call clinics using 'Attend Anywhere' during the pandemic. Patients are able to have a consultation in the comfort and privacy of their own home, workplace or school using a computer, laptop, tablet or smartphone in the same way as a face to face appointment at the hospital. Figure 22 shows patients how to use 'Attend Anywhere'. Our priority is to maintain the level of virtual appointments achieved during the COVID-19 pandemic. Initially, the uptake of appointments declined because patients needed a physical examination (see figures 23 and 24) and ended the year at 34.8%. This and restoration of access to consultant led clinics in community hospitals and venues is a key component in recovering outpatient activity to the national requirement.

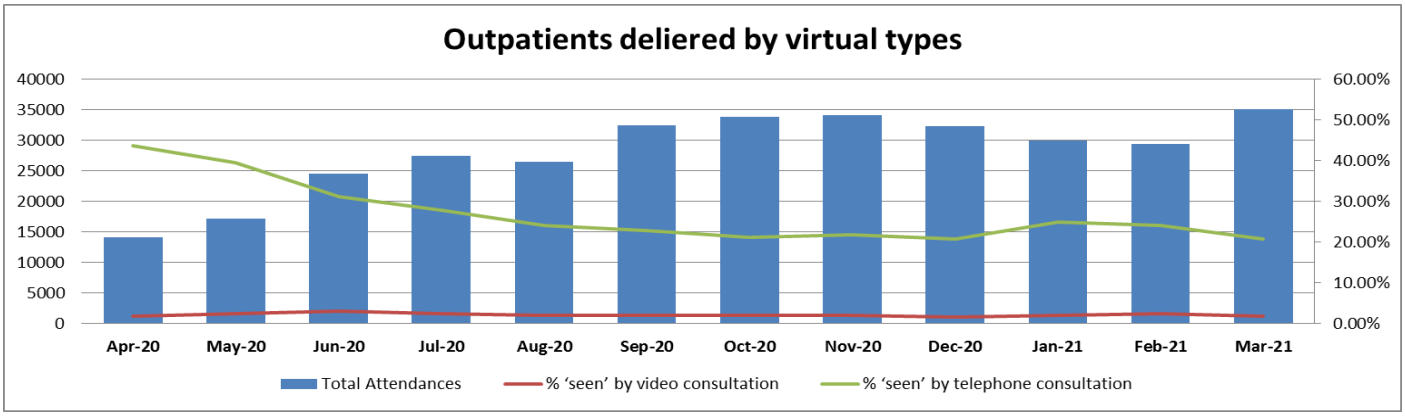
Figure 22: Information for patients on how to use 'Attend Anywhere'

Figure 23: The percentage of patient appointments seen via 'Attend Anywhere'



See appendix 1 page 100 – Reading a statistical process chart.

Figure 24: The proportion of video and telephone consultations as a proportion of total outpatient attendances



A survey of patient feedback was undertaken between November 2019 to September 2020 to find out about patients experience and improvement actions that need to be taken.

When asked the question 'Would you be seen by a video appointment again?' 1035 (95%) of 1085 patients who responded said they would be seen again by video appointment.

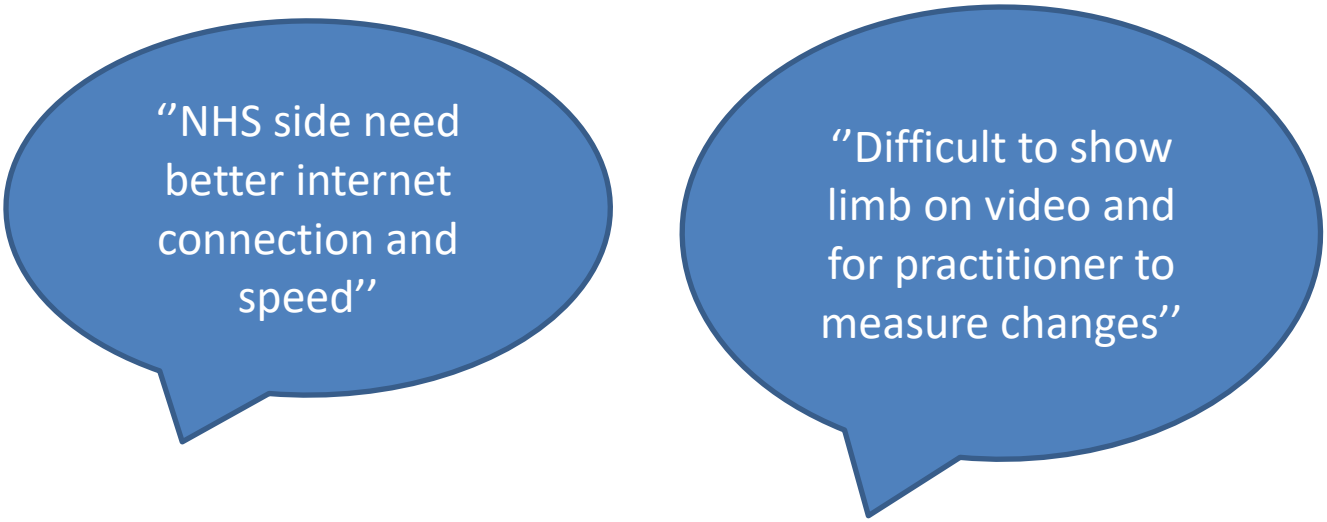
Patients were also asked whether their consultation was the same or better than a face to face appointment. 800 (78%) of 1026 patients responded to say that the consultation was the same or better than a face to face appointment. The main reason given for it being worse than a face to face appointment was digital connectivity and interrupted consultations. We are planning a number of technology upgrades to improve the connectivity of video to increase confidence in its use.

Patient experience comments:

''It was the first time I had had a video call and I found it a very positive experience. Would be happy to have a video call appointment again''

''Was no different than a normal face to face, if anything it was better, as due to my condition I find it exhausting actually attending the clinic at the hospital so this was less stressful''.

Patient comments on areas for improvement:



We recognise that not all patients have access to a computer or know how to use the technology. We are working with NHS England regional teams to explore the option of GP hubs and other venues closer to patient's homes where they could attend locally to have a virtual appointment and receive help to use the technology.

4. Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes

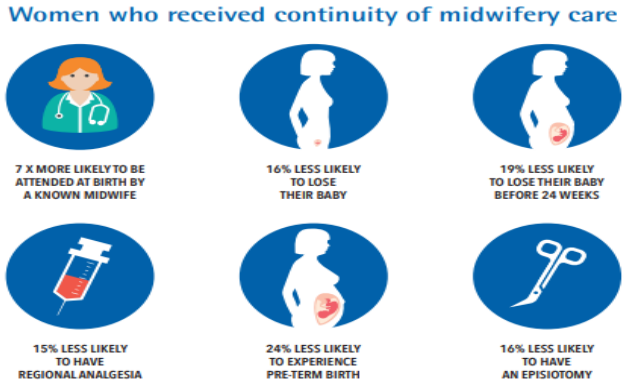
Some of the most significant, specific contributions the NHS can make to reduce health inequalities are to improve preventative services, maternity services and services for children and young people including immunisation.

Our seasonal flu vaccination campaign for our frontline staff started in October and by mid December 2020, 82% of our frontline staff had received the vaccine.

We have worked with NHS England and our local partners to not only vaccinate our own staff with the COVID-19 vaccine but also to run a mass vaccination programme for the local population of Salisbury at the City Hall.

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

Figure 25: Evidence shows continuity of carer is safer than conventional care (Cochrane Database of Systematic Reviews 2016) – midwife-led continuity models versus other models of care for childbearing women https://doi.org/10.1002/14651858.CD004667.pub5



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

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

In Salisbury's maternity services, continuity of midwifery care is provided by the Ivy Team who offer individualised care to women who have had a previous difficult pregnancy or are in a vulnerable group. The team cared for the women during pregnancy, by a known midwife during labour, birth and the postnatal period. The aim is to achieve continuity of carer for at least 35% of women by March 2021. Figure 26 shows more work needs to be done to increase the number of women who benefit from continuity of midwifery care.

Figure 26: Salisbury maternity services continuity of midwifery carer (Target – 35% by March 2021)

Continuity of carer	Number 2019/2020	Number 2020/2021
Women who gave birth	2236	2130
Women who received continuity of carer	257 (11.5%)	256 (12%)

5. Particularly support those who suffer mental ill health

Mental ill-health is a significant contributor to long term health inequalities and the immediate and longer-term impacts of COVID-19 have the potential to contribute to or exacerbate mental health problems.

We have worked with our mental health partners who have continued to provide an adult Mental Health Liaison Team, 7 days a week to see patients with mental health needs in the Emergency Department and in-patients. We have seen an increase in the number of children and young people with mental health concerns during and following the national lockdowns. A clinical nurse specialist works on site 5 days a week to see children who attend the Emergency Department and as in-patients. A child psychiatrist is on call in the evenings and overnight to give telephone advice.

We recognised that there were issues arising from the COVID-19 pandemic that would impact on the bereaved due to:

- Anxiety and distress over COVID-19 and in some cases multiple bereavements.
- Restricted visiting resulting in many relatives not seeing loved ones prior to or at the time of death
- No face to face support at the bereavement suite after a death or Registrar of Births and Deaths office as all paperwork was completed online
- Limited funeral options

To support bereaved relatives and families of patients that died during this period our bereavement support team contacted 162 relatives. Some bereaved relatives were referred on to Salisbury Specialist Palliative Care Service Family Support Team, but the vast majority required no further follow up or were sign posted to external agencies such as Cruise. The call also allowed the bereaved to raise any concerns and the caller was able to sign post them to the appropriate service including PALS if this was required.

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
- 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 the lockdown and family being able to support more.
- 8 commented on negative aspects of care, usually around poor communication.

Following the feedback from families, we have looked at visiting regulations and now enable some limited visiting of close family members especially if their loved one is dying, but where this is not possible, we have been able to put patients and their family in touch with the use of iPads and WhatsApp.

We know that the COVID-19 pandemic has had an impact on the mental wellbeing of our staff and we have provided additional support through:

- Listening ears – the chair of the Black, Asian and minority ethnic network and Mental Health First Aider and the Head of Diversity and Inclusion and Mind Blue Light Champion.
- Psychological support – clinicians trained in psychological therapies provide support for staff on an individual or team level by telephone, video-link or a face to face appointment.
- Wellbeing helpline - staff are able to call the free NHS mental health phone line to speak to volunteers who listen and give psychological support 7 days a week on 0300 131 7000.
- Occupational Health department
- Bereavement support – the palliative care team at Salisbury Hospice offer bereavement support to staff for work-related or personal bereavement loss.
- Chaplaincy – the chapel is open during the day for quiet reflection or prayer and chaplains are available 24 hours a day for all staff.
- Staff counselling - for short term counselling and psychological support from our staff counsellor.

6. Strengthen leadership and accountability

Action and wider measures needed to increase the pace and scale of progress to reduce inequalities rest on clear and accountable leadership. Every hospital is required to identify a named executive board level lead for tackling inequalities. In this organisation, our Chief Medical Officer is the lead for tackling inequalities who will oversee work to ensure that new patient pathways and arrangements are put in place or sustained to minimise the risk to patients of COVID-19 (such as telephone and video consultations), and do not create any disadvantage in the population. We are planning to pilot a scheme to track 'linked' pairs of patients on the same cancer pathway to provide assurance that patients from vulnerable groups are prioritised for treatment in a fair and equitable way.

The aim of BSW Integrated Care System is to work together to empower people to lead their best life. We recognise as a system that we need to tackle the wider determinants of health and focus greater attention on prevention and wellbeing. We are doing this by developing a population health management approach across BSW to identify the priority populations and the right interventions. This means we must start by looking at the population's health data, identify what is wrong with them and the root causes, decide how the causes can be improved and the workforce needed to do it and learn collectively as a system. The current programme of work is focused on:

- Ageing well
- End of life care
- Learning disabilities and autism
- Maternity
- Mental health

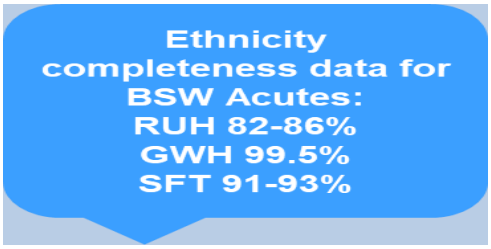
Accountability for tackling inequalities will rest with the BSW Integrated Care System Board expected to be formally established by April 2021.

7. Ensure datasets are complete and timely

There is clear evidence that COVID-19 does not affect all population groups equally. Many analyses have shown that older people, ethnicity, male gender and geographical area are associated with the risk of getting COVID-19 infection, experiencing more severe symptoms and higher rates of death. It is important therefore, to gain an insight into understanding need and monitoring progress. All hospitals are required to review the quality and accuracy of their patient ethnicity data and ensure this is recorded in the patient's record by 31 December 2020.

We have worked with our partners in the BSW Integrated Care System to identity the completeness of our patient ethnicity data as a baseline position in September 2020. The data will help us to develop our population health management approach described in action 6.

Figure 27: Patient ethnicity data – our hospital (SFT) compared to Royal United Hospital (RUH) Bath and Great Western Hospital (GWH), Swindon



We know that recording of our patient ethnicity data needs to improve. Actions we have taken and plan to take to improve the Trust's overall data quality are:

- Regular Trust wide daily staff bulletins to remind staff of the importance of recording ethnicity data
- Targeted staff bulletins to outpatients departments (90.7% compliance) to stress the importance of recording ethnicity data
- Recruitment of data quality champions across the Trust led by a full time Data Quality Manager who starts in January 2021 and will have overall responsibility for improving data quality.

8. Collaborate locally in planning and delivering action

As part of the BSW Integrated Care System, a system plan to restore critical NHS services was submitted to NHS England by 21 September 2020 and this included how we intend to understand the needs of the population and build new partnerships to address health inequalities. BSW Integrated Care System assesses the progress of the plan regularly and will submit an overall account of delivery against the actions 1 – 7 by 31 March 2021. Actions planned to address inequalities are:

- Agree the BSW Integrated Care System level inequality metrics to provide a baseline from which to measure improvement.
- Publish our Workforce Race Equality Standard (WRES) in relation to Black, Asian and ethnic minority representation on local Boards and within senior staff at hospitals and system level.

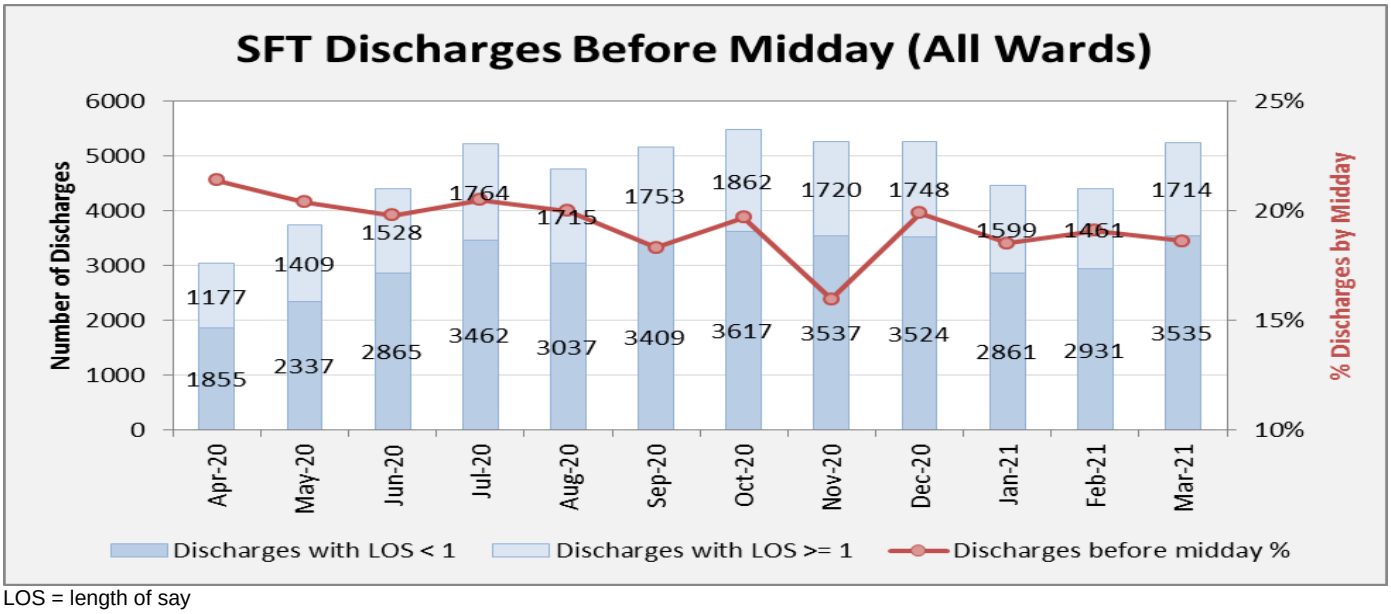
- Start reporting access and outcomes by protected characteristics and deprivation for our population to be overseen by the Executive Leads and reported to Boards.

4.2 Continue to work with our partners so that 33% of patients go home before midday on the day of discharge

Evidence shows that changing the time of when patients are discharged from hospital can improve the flow of patients through the hospital and enable patients waiting in the Emergency Department to be admitted to hospital and moved to a bed within 4 hours of arrival. Our aim is that on the day of discharge, a third of patients should go home before midday.

Figure 28 shows that discharges before midday improved this year to 19.4% compared to 16% in 2019/2020. This has been achieved by our teams ensuring each patient has an expected date of discharge discussed at the daily ward whiteboard round and discussed with the patient and family, as well as, ensuring take home medication, the discharge summary and transport home are all arranged the day before the patient goes home. .

Figure 28: Patients discharged before midday from all wards (target 33%)



LOS = length of say

4.3 Implement criteria led discharge to enable nurses to discharge patients from hospital

Criteria-led discharge can be used with existing care pathways to speed up a patient's discharge from hospital. The senior doctor for a patient's care identifies the clinical criteria for their discharge, such as normal vital signs. These criteria are discussed with the patient and the wider team and are recorded in the patient's record. A member of the team, usually a nurse, then discharges the patient when the clinical criteria for discharge have been met.

Evidence indicates the benefit of criteria-led discharge is a reduction in a patient's length of stay in hospital as well as an increase in discharges before 9.00 am. There was no increase in complication rates, re-admissions or contact with GPs. Patient satisfaction did not reduce and staff satisfaction increased with criteria-led discharge

A criteria-led discharge pilot started in December on Britford and Pitton wards led by the Chief Registrar. However, due to the second wave of the COVID-19 pandemic, the work was temporarily paused and will be restarted again in 2021/22. The plan is to extend criteria-led discharge across all the wards in the hospital.

How we reported progress throughout the year

Staff health and wellbeing is reported by the Health and Wellbeing Strategy Group to the Organisational Development and People Committee. Progress of the phase 3 NHS response to the COVID-19 pandemic is reported to the Trust Board and Patient Flow to the Transformation Board.

Part 2B: This section sets out our quality priorities for 2021/2022

2.1 Our priorities for quality improvement in 2021/2022 and why we have chosen them

This year our quality priorities have been dominated by the need to reset our services in response to the COVID-19 pandemic. Initially, this showed a positive picture of recovery up until the second wave when there was a significant increase in the number of patients admitted with COVID-19 in December and January 2021 and a high level of staff absence. The COVID-19 pandemic has exposed health inequalities but our local response has shown our partnership working at its best to protect the most vulnerable in our population. We are proud of the good progress made in the implementation of the national learning disability and autism standards. Positive improvements have been seen in the daily consultant review at a weekend and in the redesigned Maternity Day Assessment triage and assessment pathways.

Patient safety remains a key priority and whilst survival from sepsis has improved, compliance with an escalation response to deteriorating patients and the administration of intravenous antibiotics within 1 hour of diagnosis of sepsis remains a challenge. Antibiotic prescribing for lower urinary tract infection in older people has improved but there is more work to do. The increased rate of pressure ulcers and in-patient falls resulting in high harm this year is a concern and improvement work is underway.

Our main focus next year is to continue to reset our services to pre-COVID levels and support the health and well-being of our staff and this will dominate our quality priorities in 2021/2022. We have combined the learning from this year with information gathered from a broad range of methods to generate our priorities for improvement in 2021/2022.

These priorities were identified by listening to patient feedback, the public, our staff and governors, our community partners, local GPs and our commissioners. Some of their comments are included in this report. Our priorities are also influenced by the NHS Long Term plan, the B&NES, Swindon and Wiltshire Integrated Care System (BSW ICS), our strategic priorities, corporate risk register and existing quality concerns and our aspiration to achieve an outstanding rating by the Care Quality Commission at our next inspection.

This year, no national patient surveys have been published in 2020/2021 due to the COVID-19 pandemic. We have used the themes from our staff survey 2020 and identified learning from mortality case reviews, themes from complaints and concerns, adverse incidents where we have caused harm and clinical audit, to help us decide on our quality priorities.

In 2020/2021, we had five broad priorities with different work streams. Some of these work streams will continue to be reported in this quality account in section 2.2.

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

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

Our priorities for 2021/2022* are:

Priority 1	Sustain the recovery from COVID-19 through effective partnership working and improve the quality and experience of care for patients and staff
Priority 2	Improve the health and wellbeing of our staff in the recovery from COVID-19.
Priority 3	Continue to improve patient safety and reduce avoidable harm based on our known risks
Priority 4	Provide ward to board assurance on fundamental standards of patient care at ward and department level
Priority 5	Strengthen our partnerships with other healthcare organisations to improve the health of our local population

*These priorities are **not** ranked in order of priority. The Trust Board agreed the 2021/2022 priorities on **x** June 2021.

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

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

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

Description of the issue and reason for prioritising it:

2020/21 was dominated by the need for the whole health and care system to respond to the COVID-19 pandemic and subsequently to recover our services and take action to address some of the wider health inequalities exposed by COVID-19.

On 7 August 2020, NHS England issued guidance about the third phase of the NHS response to COVID-19 on urgent actions Trusts must take to address inequalities in NHS provision and outcomes. NHS England asked Trusts to work collaboratively with local communities and partners to take the following 8 urgent actions and these remain a priority in 2021/2022:

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

What we will do in 2021/2022:

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

1.2 To restore our services inclusively, we will continue to work with our Acute Hospital Alliance partners to share planned elective care, work towards a shared approach to waiting list management, and system wide pathway reform.

1.3 Achieve 60% of patient contacts seen by virtual appointments and work with our system partners to procure a virtual solution so that all Trusts can use the same system regardless of geographical location and improve the patient experience.

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

1.5 Evaluate the impact on practice of our clinical leadership programme. This supports clinical leaders from all professional backgrounds to develop high quality, safe and compassionate care and to work with local leaders to re-design care pathways and systems.

1.6 Use population health management data to identify areas of health inequalities and work with our partners and system leaders to plan improvement programmes.

1.7 Working with our partners, start reporting access and outcomes by protected characteristics and deprivation for our population and take improvement actions where needed

How we will report progress throughout the year:

Progress of the recovery of services from the COVID-19 pandemic and reducing health inequalities will be reported to the Trust Board and Patient Flow improvement work to the Transformation Board.

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

Description of the issue and reason we prioritised it:

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

Below are a range of staff health and wellbeing support available to all our staff during the pandemic that will continue into 2021/22:

- Free online fitness classes taught by the professionals at the Odstock, Health and Fitness Centre.
- Listening ears – for staff to be able to talk to a named person confidentially.
- Psychological support - provided by clinicians trained in psychological therapies for individual staff and teams.
- Food and refreshments – to help staff keep hydrated and reminding staff to have food breaks with discounts in Springs Restaurant and Hedgerows Café
- Creative therapy - free on-line ArtCare activities to uplift and inspire wellbeing and creativity through music, arts, poetry, history, stories and more with new content each week to help staff unwind.
- Occupational Health – to support individual wellbeing.
- Bereavement support – the Palliative Care Team at Salisbury Hospice offer bereavement support to staff for work-related or personal bereavement and loss.
- Chaplaincy - the chapel is open during the day for quiet reflection or prayer and can be accessed at night. The Chaplains are available 24/7 for all staff whatever their beliefs.
- Staff counselling – counselling and psychological support is available from the staff counsellor
- Mental health nurse – to help staff cope with everything they are going through
- Taking a break – for staff to get away from their busy workplace and socially distance in the chill out zone available to all staff in the Odstock Health and Fitness Centre and other rest areas. Taking a walk along one of the wellbeing walking routes and to explore outside spaces
- Stars Appeal – distributed thousands of morale-boosting treats, meals and uniform bags, kindly donated by local people and organisations delivered to staff around the hospital.

What we will do in 2021/2022:

2.1 Ensure our staff, including Black, Asian and Minority Ethnic (BAME) staff and anyone who is vulnerable or who needs additional support has a COVID risk assessment and action taken where needed.

2.2 Ensure every member of staff has a health and wellbeing conversation as part of their annual appraisal and regular meetings with their line manager.

2.3 Introduce a re-designed induction programme for staff new to the Trust that includes information and a discussion about health and wellbeing.

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

2.5 Progress actions identified by the Board and the staff Cultural Change Team in the Best Place to Work diagnostic assessment so that staff networks are able to contribute to and inform decision making and create a culture of civility, support and compassion.

2.6 Commence an intensive quality improvement programme to increase the spread of an improvement culture to ensure sustainable change.

How we will report progress throughout the year:

Staff health and wellbeing will be reported by the Health and Wellbeing Strategy Group and to the Organisational Development and People Committee.

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

Description of the issue and reason for prioritising it:

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

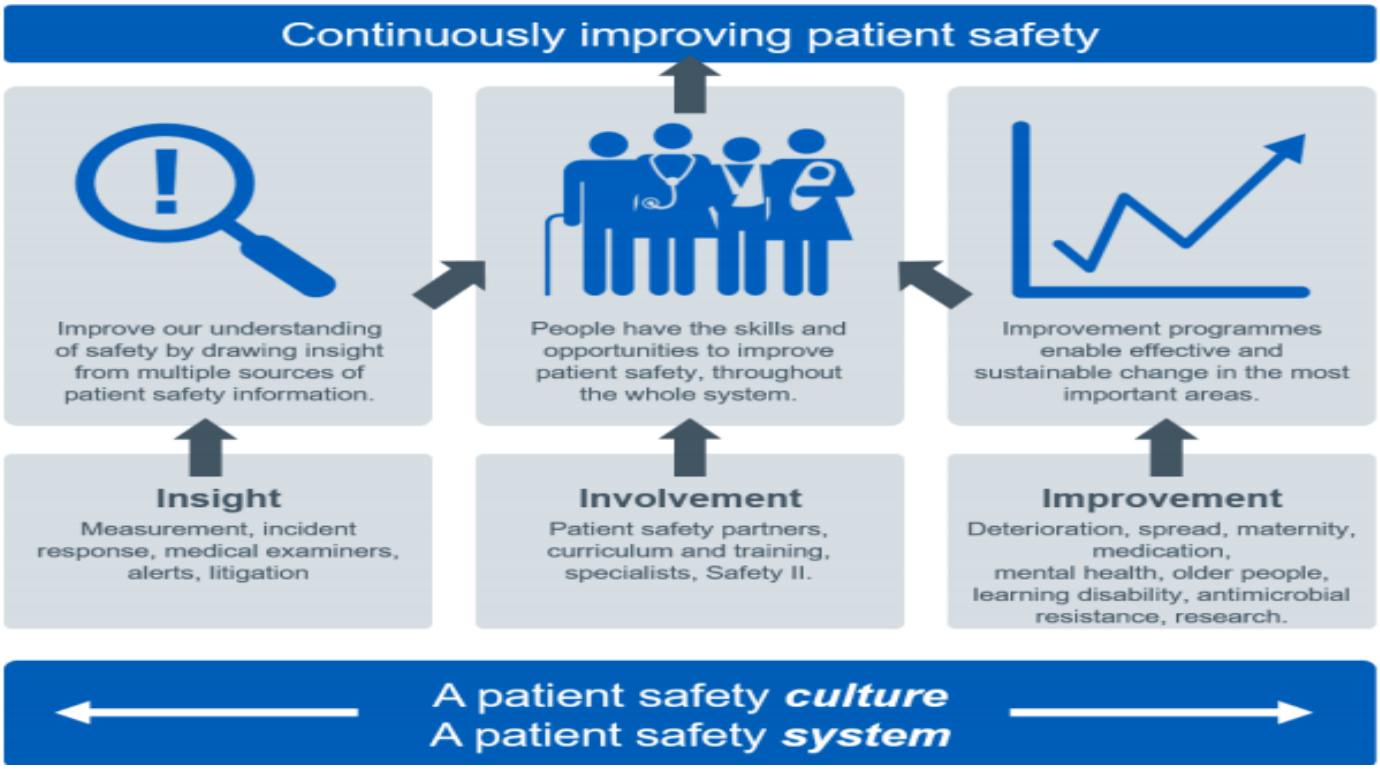
Safety is integral to the NHS definition of quality in healthcare, alongside effectiveness and patient experience. The vision for patient safety in the NHS is to continuously improve patient safety. To do this the NHS is building on two foundations:

1) a patient safety culture – the key features are staff who feel safe to report incidents or near misses and feel valued and respected, good leadership at all levels, a sense of teamwork and openness and support for learning.

2) a patient safety system – every hospital is responsible for the safety of their patients. Every hospital shares local information about risks and best practice with local partners, such as the integrated care system and clinical commissioning groups who oversee the provision of safe care and can tackle problems at system level and make improvements.

The NHS patient safety strategy published in July 2019 describes 3 strategic aims to support the development of a patient safety culture and a patient safety system. These are:

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



The national patient safety strategy is to be implemented in 2022 and in preparation, we have nominated a Patient Safety Specialist, whose role is to lead safety improvements across the Trust to ensure that systems thinking, human factors and just culture principles are part of all patient safety activity. We plan to build on this and designate a senior doctor as a Patient Safety Specialist. The work will be overseen by the Patient Experience and Patient Safety Steering Group.

What we will do in 2021/2022:

3.1 Prepare for the implementation of the national patient safety strategy in 2022.

3.2 Introduce electronic prescribing and medicines administration which is known to improve patient safety.

3.3 Reduce the number of patients who acquire a category 2 pressure ulcer by 20% during a hospital admission from 286 in 2020/21 to 229 in 2021/22 and reduce category 3 and 4 pressure ulcers to zero.

3.4 Reduce the number of patients who have a preventable fall in hospital by 30% from 10.96 per 1,000 occupied bed days in 2020/21 to 7.68 per 1,000 bed days in 2021/22.

3.5 Fully implement risk assessment throughout pregnancy and record it at every contact with the woman including a review of the intended place of birth as recommended in the Ockenden national report for all Maternity Services.

3.6 Ensure women attending the Maternity Day Assessment Unit are triaged appropriately in accordance with the clinical guideline for her presenting condition and in line with Birmingham Symptom Specific Obstetric Triage System and time frames. This will inform assessment by a senior doctor in a timely manner.

3.7 Fully implement consultant led labour ward rounds twice a day, 7 days a week as recommended in the Ockenden national report for all Maternity Services.

3.8 Reduce the number of missed or delay cancer diagnoses from 5 in 2020/2021 to zero in 2021/2022. by ensuring robust processes are in place across the patient pathway.

3.9 Improve compliance of antibiotic prescriptions for lower urinary tract infection in patients over 16 to meet the National Institute for Health and Care Excellence guidance for diagnosis and treatment from 59% in 2020/21 to 90% in 2021/22.

3.10 Reduce the number of new catheter associated urinary tract infections to show improvement as measured by the Safety Thermometer.

3.11 Improve the escalation response when a patient triggers a NEWS2 (national early warning scoring system) score of 5 or more

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

How we will report progress throughout the year:
Progress of our patient safety improvement work will be reported to the Patient Experience and Patient Safety Steering Group.

Priority 4: Provide ward to board assurance on fundamental standards of patient care at ward and department level

Description of the issue and reason for prioritising it:

Ward accreditations schemes have been shown to promote safer patient care in hospitals by motivating staff and sharing best practice between ward areas. They aim to promote better health outcomes, better patient experience and ensures the ward is a better place to work, train and learn.

The overall aim is to:

- Improve the standards and quality of care at ward level and reduce variation in standards between wards.
- Increase staff pride within their ward area

The scheme involves regularly completing audits and assessments to provide information on how well a ward is doing in meeting standards of patient care. Accreditation brings together key measures of nursing and clinical care into one overarching framework to enable a comprehensive assessment of the quality of care at ward or team level. When used effectively, if can drive continuous improvement in patient outcomes and satisfaction and improve staff experience. It creates a collective sense of purpose necessary to help staff who have been trained in quality improvement to work with their teams to learn and improve and make positive changes for patients and their families as well as make the hospital the best place to work for staff.

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

What we will do in 2021/2022:

4.1 Pilot the first full ward accreditation on two wards and share the learning to enable other wards to adopt the programme.

4.2 Ensure all wards take part in a ward performance review process with the Chief Nurse and report progress via a ward accreditation dashboard.

4.3 Ensure all patients aged 65 years and over are screened for dementia and delirium within 72 hours of admission and, if positive, have a diagnostic assessment and where needed are referred to the their GP, memory clinic or mental health team.

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

How we will report progress throughout the year:

Progress of our patient safety improvement work will be reported to the Patient Experience and Patient Safety Steering Group. Ward performance and accreditation will be reported to the Nursing, Midwifery and Allied Health Professionals Forum and Patient Flow improvement work to the Transformation Board.

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

Description of the issue and reason for prioritising it:

Integrated care is about giving people the support they need, joined up across local councils, the NHS and other partners, such as the voluntary, community and social enterprise sectors. It removes traditional divisions between hospitals and family doctors, between physical and mental health and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care. Integrated Care Systems (ICS) are new partnerships between organisations that meet health and care needs across an area, to co-ordinate services and plan in a way that improves population health and reduce inequalities between different groups and thereby improve the quality and experience of care.

An important part of an ICS is that decisions about how services are arranged should be made as closely as possible to the people who use them. For most people, their day to day health and care needs are met locally where they live or work. Partnerships in these places is an important building block of integration and one of the strengths of the system is that arrangements can be adapted to reflect local needs.

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

What we will do in 2021/2022:

5.1 The Trust will play a full role in achieving an effective newly formed BSW Integrated Care System.

5.2 Develop a programme of work with our local Primary Care Networks tailored to the needs of our local population.

5.3 Work with our partners to develop and deliver an integrated frailty model.

How we will report progress throughout the year:

Progress of our contribution to integrated care and population health management will be reported to the BSW Partnership Board and our Trust Board.

2.2 Statements of assurance from the Board

Review of Services

During 2020/2021 Salisbury NHS Foundation Trust provided and/or subcontracted 55 relevant health services. Salisbury NHS Foundation Trust has reviewed all the data available to us on the quality of care in all 55 of these relevant health services. The income generated by the relevant health services reviewed in 2020/2021 represents 100% of the total income generated from the provision of relevant health services by Salisbury NHS Foundation Trust for 2020/2021.

In April 2020, the Integrated Governance Framework was updated and sets out the means by which the Trust Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the organisation's objectives. The framework is designed to ensure the strategic aim of delivering 'an outstanding experience for every patient', by an organisation that is well managed, cost effective and has a skilled and motivated workforce. At the same time the Accountability Framework was updated which specifies how the performance management systems are structured and tracked, to ensure delivery of the corporate objectives at every level of the organisation focusing across the breadth of quality, operational, finance and workforce performance.

The Clinical Governance Committee is the quality assurance committee of the Trust Board. It is responsible for overseeing the continuous improvement of the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care flourishes. The committee hears directly from clinical teams where risks to quality are identified to seek assurance that action is being taken to improve. Any recurrent themes are included as key objectives for improvement in the Trust service plan or in the Quality Account priorities. Our four quality priorities in 2021/2022 reflect these themes.

Each year the Trust has a number of external agency and peer review inspections. The reports, recommendations and action plans are discussed at one of the assuring committees. For example, the Royal College of Paediatrics and Child Health, National Diabetes Quality Programme (NDQP) peer review team visited the service in July 2020. They found the service had met the majority of the NDQP standards and identified many areas of good practice and acknowledged the team's commitment and dedication to their patients and family members.

The peer review team raised two serious concerns related to the multidisciplinary core membership and recommended the consultant team have a job plan which accurately reflected the paediatric medical time required to deliver high quality care to the increasing size and complexity of the caseload and to ensure the governance of the service was effective. The second concern related to a vacant paediatric diabetes dietician post so that patients and families were able to benefit from dietetic support including level three carbohydrate counting teaching and the offer of an additional dietetic appointment. By September 2020, a business case for funding additional consultant time to support the diabetes service was agreed and implemented. In addition, a Band 7 specialist dietician post was agreed and advertised with a temporary dietician in post until the successful recruitment of a permanent post holder. The outcome of the inspection was reported in a bi-annual report on progress of actions arising from national reviews, national confidential enquiries and external agency visits to the Clinical Governance Committee

Participation in Clinical Audits

During 2020/2021, 54 national clinical audits and 11 clinical outcome review programmes covered relevant health services that Salisbury NHS Foundation Trust provides. During this period, Salisbury NHS Foundation Trust participated in 53 (98%) national clinical audits, and 11 (100%) clinical outcome review programmes of the national clinical audits and clinical outcome review programmes which it was eligible to participate in.

The national clinical audits and clinical outcome review programmes in which Salisbury NHS Foundation Trust was eligible to participate in during 2020/2021 are listed in Figure 29.

The national clinical audits and clinical outcome review programmes that Salisbury NHS Foundation Trust participated in, and for which data collection was completed during 2020/2021, are listed in Figure 31 alongside the number of cases submitted to each audit or programme as a percentage of the number of registered cases required by the terms of that audit or programme.

Figure 29: Eligible national audits and clinical outcome review programmes and those the Trust participated in during 2020/2021

National Clinical Audit/ Clinical Outcome Review Programme	Eligible	Participation	% of cases submitted	Purpose of the audit
Antenatal and Newborn national audit protocol	Yes	Yes	100%	The audit is designed to get a better understanding of some critical points in the screening pathways.
BAUS Urology Audits: Renal Colic	Yes	Yes	100%	To examine data on the assessment and management of all emergency admissions with suspected or confirmed renal/ureteric colic.
BAUS Urology Audits: Bladder Outflow Obstruction audit	Yes	Yes	100%	To determine variations in assessment and treatment, including waiting times and indications for surgery.
British Spine Registry	Yes	Yes	100%	To publish and monitor the outcomes of spinal procedures, to better understand procedures and techniques and a patient's experience and quality of life.
Case Mix Programme (CMP)	Yes	Yes	100%	The CMP is an audit of patient outcomes from adult general critical care units.
Elective surgery (National PROMs Programme)	Yes	Yes	2019/20 74.7% vs 86.6% for hip replacement and 86.4% for knee replacement nationally	Patient reported outcome measures (PROMs) survey patients before and after surgery for the following planned procedures; - Hip replacement - Knee replacement The Trust is not an outlier.
Emergency Medicine Quality Improvement Programme:				Aim to support effective local and national quality improvement.
1) Infection Control	Yes	Yes	100%	To support Trusts in maintaining and improving high standards of patient care and organisational effectiveness on infection control.
2) Fractured NOF	Yes	Yes	100%	To ensure high quality care including pain relief (including nerve blocks) and making the correct diagnosis through the use of MRI and CT scans where necessary.

3) Pain in Children	Yes	Yes	100%	To improve patient care by reducing pain and suffering, in a timely and effective manner.
Endocrine and Thyroid National Audit	Yes	Yes	100%	The audit provides information on outcomes of endocrine surgery, principally on the thyroid, parathyroid and adrenal glands in the UK.
Falls and Fragility Fractures Audit Programme (FFFAP)				
1) Fracture Liaison Service Database	No	N/A	N/A	N/A
2) National Audit Inpatient falls	Yes	Yes	100%	Evaluates compliance against best practice standards in reducing the risk of falls within hospitals.
3) National Hip Fracture Database	Yes	Yes	100%	Provides data on the care of patients with fragility fractures and inpatient falls received in hospital to facilitate improvements.
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes	Yes	100%	To improve the care of patients and understanding of the treatments they receive, to enable research, and to increase knowledge about IBD in the UK.
Major Trauma Audit: The Trauma Audit & Research Network (TARN)	Yes	Yes	73%*	Examines trauma care data to improve emergency care management and systems. *National case ascertainment target = 80%. Absence & turnover of ED TARN administrators.
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	Yes	100%	All acute Trusts report on each case of C difficile to Public Health England.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)				
1) Perinatal mortality surveillance	Yes	Yes	100%	Analyses and reports national surveillance data in order to stimulate and evaluate improvements in health care for mothers and babies.
2) Perinatal mortality & morbidity confidential enquiries	Yes	Yes	100%	Identifies potentially preventable failures of care along the whole care pathway for improvement in care in the future.
3) Maternal mortality surveillance and mortality confidential enquiries	Yes	Yes	100%	As above
Medical and Surgical Clinical Outcome Review Programme:				Explores the overall quality of care of patients admitted to hospital and have died.
1) Physical Health in Mental Health Hospitals	Postponed due to the COVID-19 pandemic			As above
2) Alcohol Related Liver Disease	Yes	Yes	100%	As above
Mental Health Care Pathway - CYP Urgent & Emergency Mental Health Care and Intensive	No	N/A	N/A	N/A

Mental Health Clinical Outcome Review Programme	No	N/A	N/A	N/A
National Asthma and COPD Audit Programme (NACAP)				To drive improvements in the quality of care and services provided for asthma & COPD patients.
1) Paediatric asthma: secondary care	Yes	Yes	100%	As above
2) Asthma (Adult & paediatric) & COPD: primary care	No	N/A	N/A	N/A
3) Adult asthma: secondary care	Yes	Yes	100%	As above
4) Chronic obstructive pulmonary disease (COPD)	Yes	Yes	100%	As above
5) Pulmonary rehabilitation	Yes	Yes	100%	As above
National Audit of Anxiety and Depression	No	N/A	N/A	N/A
National Audit of Breast Cancer in Older People	Yes	Yes	100%	Improves the quality of hospital care for older patients with breast cancer by looking at the care received and outcomes.
National Audit of Cardiac Rehabilitation	Yes	Yes	100%	To monitor and support cardiovascular rehabilitation teams and commissioners in delivering high-quality and effective services.
National Audit of Care at the End of Life (NACEL)	Postponed due to the COVID-19 pandemic			Focuses on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals in England and Wales.
National Audit of Dementia (Care in general hospitals)	Postponed due to the COVID-19 pandemic			Measures criteria relating to care delivery which are known to impact on people with dementia admitted to hospital.
National Audit of Pulmonary Hypertension	No	N/A	N/A	N/A
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	Yes	100%	To improve the quality of care for children and young people with seizures and epilepsies.
National Bariatric Surgery Registry (NBSR)	No	N/A	N/A	N/A
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%	Audit of in-hospital cardiac arrests in the UK and Ireland.
National Cardiac Audit Programme (NCAP)				
1) National Audit of Cardiac Rhythm Management (CRM)	Yes	Yes	100%	Examines the implant rates and outcomes of all patients who have a pacemaker, defibrillators or cardiac resynchronisation therapy implanted in the UK.
2) Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	100%	To examine the quality of the management of heart attacks in hospital
3) National Adult Cardiac Surgery Audit	No	N/A	N/A	N/A

4) National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Yes	100%	Examines the quality and process of care and compares patient outcomes.
5) National Heart Failure Audit	Yes	Yes	100%	Examines clinical practice and patient outcomes of patients discharged following an emergency admission with a primary diagnosis of heart failure.
6) National Heart Failure Audit National Congenital Heart Disease (CHD)	No	N/A	N/A	N/A
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Case submission optional due to COVID-19 pandemic.			Examines the quality of care for people living with inflammatory arthritis in England and Wales.
National Clinical Audit of Psychosis	No	N/A	N/A	N/A
National Diabetes Audit – Adults				Measures the effectiveness of diabetes care compared to NICE guidance.
1) National Diabetes Foot Care Audit	Yes	Yes	100%	As above
2) National Diabetes Inpatient Audit - data on services in England and Wales	Yes	Yes	100%	As above
3) National Diabetes Inpatient Audit - harms reporting in England	Yes	Yes	100%	As above
4) National Core Diabetes Audit	Yes	Yes	100%	As above
5) National Diabetes Transition	Yes	Yes	100%	As above
6) National Pregnancy in Diabetes Audit	Yes	Yes	100%	As above
National Emergency Laparotomy Audit (NELA)	Yes	Yes	92%	Compares inpatient care and patient outcomes undergoing emergency abdominal surgery in England and Wales.
National Gastro-intestinal Cancer Programme				
1) National Oesophago-gastric Cancer (NOGCA)	Yes	Yes	100%	Investigates whether the care received by patients with oesophago-gastric cancer is consistent with national standards.
2) National Bowel Cancer Audit (NBOCA)	Yes	Yes	100%	Measures the quality of care and survival rates of patients with bowel cancer in England and Wales.
National Joint Registry (NJR)	Yes	Yes	100%	Data analysis of joint replacement surgery in order to provide an early warning of issues relating to patient safety.
National Lung Cancer Audit (NLCA)	Yes	Yes	100%	Examines lung cancer care and outcomes to bring the standard of all lung cancer multidisciplinary teams up to that of the best.

National Maternity and Perinatal Audit (NMPA)	Yes	Yes	100%	Evaluates processes and outcomes to identify good practice and areas for improvement in the care of women and babies in NHS maternity services.
National Neonatal Audit Programme (NNAP)	Yes	Yes	100%	Examines whether babies admitted to neonatal intensive and special care units received consistent care.
National Ophthalmology Audit	Yes	Yes	100%	Examines key indicators of cataract surgical quality.
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100%	Examines the quality of paediatric diabetes care by comparing outcomes to NICE quality and clinical standards.
National Prostate Cancer Audit	Yes	Yes	100%	Data analysis on the diagnosis, management and treatment of every patient newly diagnosed with prostate cancer and outcomes.
National Vascular Registry	No	N/A	N/A	N/A
Neurosurgical National Audit Programme	No	N/A	N/A	N/A
Paediatric Intensive Care (PICANet)	No	N/A	N/A	N/A
Perioperative Quality Improvement Programme (PQIP)	Yes	No	N/A	To improve patient outcomes from major non-cardiac surgery.
Prescribing Observatory for Mental Health (POMH-UK)	No	N/A	N/A	N/A
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	100%	Continuous patient level data analysis of in hospital care of patients with a stroke and TIA compared to national stroke standards.
Serious Hazards of Transfusion (SHOT): UK National Haemo-vigilance	Yes	Yes	100%	Examines adverse events and reactions in blood transfusion with recommendations to improve patient safety.
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Yes	100%	Point prevalence audit of the care provided for acutely unwell medical patients in the UK.
UK Cystic Fibrosis Registry (Paediatrics)	Yes	Yes	100%	Registry data to improve the health of children with cystic fibrosis through research, to guide quality improvement & to monitor the safety of new drugs.

The participation in the audits in Figure 29 is in line with the Trust's annual clinical audit programme which aims to make sure that clinicians are actively engaged in all relevant national audits and confidential enquiries as well as undertaking baseline assessments against all NICE guidelines and quality standards. This enables the Trust to compare our performance against other similar Trusts and to decide on further improvement actions. The annual programme also includes a number of audits agreed as part of the contract with our Clinical Commissioning Groups.

The reports of 42 national clinical audits and clinical outcome review programmes that were published in 2020 were reviewed by Salisbury NHS Foundation Trust in 2020/2021. Of these, 17 (40%) were formally reported to the Clinical Management Board by the clinical lead responsible for implementing the changes in

practice, and Salisbury NHS Foundation Trust has taken or intends to take the following actions to improve the quality of healthcare provided set out in Figure 30.

Figure 30: Examples of national clinical audit reports reviewed during 2020/2021 with actions taken or planned by Salisbury NHS Foundation Trust (SFT)

Society of acute medicine benchmarking audit (SAMBA) (data: 2019)

142 Acute Medical Units took part in a 1 day point prevalence audit in June 2019.

No	Standard	SFT Sept 20	National 2019
CQI 1	All patients should have their NEWS score measured within 30 minutes of arrival at hospital – standard 100%	**82%**	80.7%
CQI 3	All patients should be assessed by a Consultant Physician within 6 hours of arrival at hospital (in hours)	**60.2%**	59.1%
CQI 3	All patients should be assessed by a Consultant Physician within 14 hours of arrival at hospital (out of hours) – standard 90%	**88.8%**	87.5%

NEWS = national early warning score.

The national key message from this audit is that whilst the numbers and acuity of admissions are rising, the key performance indicators pertaining to time of assessment have been maintained. Overall, outcomes for death rates and planned discharge rates were unchanged, ambulatory emergency care shows a marginal increase and greater levels of activity are being undertaken by non-medical practitioners. The Trust's Acute Medical Unit has 2 established advanced nurse practitioners. Improvements continue to be driven by the overarching strategy with a focus on consultant recruitment, expanding pharmacy support and pathway redesign.

National emergency laparotomy audit (NELA) 2019 (data: 2018) YEAR FIVE

142 hospitals submitted data who provide 24/7 care.

No	9 key standards	SFT 2016 Year 3	SFT 2017 Year 4	SFT 2018 Year 5	NELA RAG rating Year 5
	Number of cases	54	76	90	
	Final case ascertainment	55.1%	78%	78.3%	**Amber**
1.	CT scan reported before surgery	88.9%	80%	**76%**	**Amber**
2.	Risk of death documented pre-operatively	40.7%	67%	**94%**	**Green**
3.	Arrival in theatre with a timescale appropriate to urgency	88.6%	91%	**77%**	**Amber**
4.	Pre-operative review by a consultant surgeon and anaesthetist when risk of death >5%		94%	**98%**	**Green**
5.	Consultant surgeon & consultant anaesthetist both present in theatre when risk of death >5%	91.3%	83%	**93%**	**Green**
6.	Consultant surgeon present in theatre when risk of death >5%	91.3%	93%	**100%**	**Green**
7.	Consultant anaesthetist present in theatre when risk of death >5%	100%	89%	**93%**	**Green**
	Direct admission to ICU if risk of death >5%	87.5%	72%	**81%**	**Amber**
8.	Direct admission to ICU if risk of death >10%	100%	86%	**87%**	**Green**
9.	Assessment by a care for the older person specialist for patients aged 70 and over	3.7%	16%	**16%**	**Red**
	Unplanned return to theatre	5.6%	3%	7%	
	Unplanned ICU admission within 7 days	1.9%	1%	3%	
	Median length of stay	11 days	9 days	9.4 days	
	Risk adjusted mortality within 30 days	6.7%	11.7%	11.5%	**As expected**

This audit showed that the assessment of risk of mortality pre-operatively has improved significantly following improvement work in 2018. Time to surgery decreased from 2017. SFT is in the top quartile in the country for surgeon and anaesthetist present in theatre. The time to the Intensive Care Unit (ICU) for high risk patients improved but was affected by extended stays in recovery. Unplanned returns to theatre and ICU admission within 7 days is less than 10%. Length of stay is better than the national average. 30 day mortality decreased slightly. The main area for improvement is the need for frail older patients to have a post-operative assessment by a Consultant in Elderly Medicine who are currently able to provide input on a case by case basis.

Best practice tariff (BPT) was introduced in 2018 for high risk patients (target 80%). The Trust achieved 72% BPT in 2018/2019 and work is underway to improve the pathway.

Actions: (By general surgical team and lead anaesthetist by 31/8/21)

1. Continue to invite Consultants in Elderly Medicine to review this group of patients and encourage surgical colleagues to do the same.

Falls and Fragility Fractures Audit Programme (FFFAP): Inpatient Falls Audit 2020 - (data: 2019)

A continuous audit of the care and management of patients who sustain a hip fracture as an inpatient and to enable Trusts to examine where to prevent inpatient falls and improve hip fracture care. 7 inpatients who fell and fractured their hip as an inpatient were submitted. All the patients fell out of hours.

4 key quality metrics	National 2019	SFT 2019
Time to commencing hip fracture care	6.3 hours	**3.3 hours**
% of patients who had a documented check for injury and injury was suspected before moving from floor	45%	**86%**
Use of flat lifting equipment	20%	**29%**
Medical assessment within 30 minutes	54%	**29%**

The Trust has continued to use the NICE recommended multifactorial falls risk assessment tool and standardised post falls assessment documentation. Training on the use of flat lifting device has been incorporated into falls simulation sessions and Falls Forums, an updated falls leaflet was published and attendance at the bimonthly Falls Working Group has increased.

The Trust inpatient high harm falls data shows a decrease over the last 5 years. Medical assessment within 30 minutes of a patient fall is lower than the national average. Of the 7 patients who fell the average time to assessment was 55 minutes compared to our local policy standard of 60 minutes. The Clinical Management Board considered the triage system at night worked well.

Actions (Consultant in Elderly Medicine, Patient Safety Facilitator and OPAL team by 30/6/2021):

1. Ensure access to walking aids for newly admitted patients 7 days a week.
2. Ensure improved documentation in the patient record of the handling method post-fall – completed.

National Audit of Care at End of Life (NACEL) (2019 data) 2020

40 cases were submitted of expected deaths. 11 surveys were completed by bereaved families.

Six domains	SFT 2019	National 2019
Communication with the dying person	**7.5**	7.8
Communication with families and others	**6.1**	6.9
Needs of families and others considered	**5.5**	6.0
Individualised plan of care	**7.3**	7.2
Families and others experience of care	**6.3**	7.0
Workforce/specialist palliative care	**9.4**	7.4

The Trust did not perform as well nationally as in the 2018 audit but when the findings were compared to our own findings last year, the Trust had improved in 2019. Many end of life care service improvements have been introduced in the last 2 years, such as the personalised care framework, comfort observations, condolence cards, compassion roses, an increase in the number of discharges to the preferred place of care and education and training. The findings suggest that staff have a greater awareness of the need to carry out holistic assessments and record decision making about end of life care.

For both the National Audit of Care at the End of Life (NACEL) 2018 and 2019 audits, the Trust had a poor response rate to the qualitative survey and this adversely impacted the summary scores. In this survey, 3 families out of 11 responses reported poor experiences. However, the views of bereaved families expressed through the Trusts own 'Your Views Matter' bereavement survey (n = 45 people) did not share the experiences of those responding to the NACEL survey, and are not representative of our bereaved families as a whole. The NACEL findings emphasise the importance of reaching out to bereaved families and giving them a voice to express how we can learn from their experiences and improve end of life care.

Two themes need to be addressed - to ensure families know who has overall clinical responsibility for their loved one's care, and families are able to be involved to the extent that they would like to be. Reinstating the Trust's own bereavement survey, as well as establishing the medical examiner role, is a priority.

Action plan (Specialist Palliative Care Team and End of Life Care Team by 31/8/21):

1. Improve communication with the dying person and their loved ones and how this is evidenced, in particular with regards to nutrition and hydration.
2. Inform patients and their loved ones of the name of the senior clinician responsible for their care.
3. Ensure the environment in which a dying patient is cared for is appropriate.
4. Involve loved ones in discussions and support them to provide care to the extent that they would like.
5. Continue to engage with the bereaved after death - Medical Examiner scrutiny of all deaths includes a discussion with relatives started in August 2020.
6. Support implementation of ReSPECT (is a national patient held document, completed following an advance care planning conversation between a patient and a health care professional) - the national team published v3 of the ReSPECT form and the BSW Integrated Care System has established a working group to introduce it system wide but has been delayed by the COVID-19 pandemic.
7. Make end of life care education mandatory for all staff – target 80% of all new staff from September 19 and 75% of existing staff to complete by March 2021 (currently 46%).

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Bone Anchored Hearing Aid Service (BAHA) Specialised services quality indicator dashboard Q2 2019/2020

A multidisciplinary approach (patients, parents, audiology and surgeon) is taken to bone anchored hearing aid service (BAHA) implantation. Patients must meet the criteria for a BAHA before the device is implanted and have a detailed hearing assessment, trial of a BAHA conductor for 2 weeks, discussion with a surgeon and complete a before and after surgery satisfaction score. Patients must also meet the Clinical Commissioning Group criteria to be eligible for an implant for either permanent bilateral conductive or mixed hearing loss or profound unilateral sudden hearing loss.

No	Key quality indicator	SFT Q2 19/20	National average Q2 19/20
IHA01	% of patients discussed by the MDT with a specialist surgeon & audiologist present	**94%**	96%
IHA02	% of patients discussed by the MDT who go on to have surgery	**75%**	72%
IHA03	% of patients that have a pre-trial and surgery speech audiogram	**100%**	85%
IHA04	% of patients that have a post-trial speech audiogram following surgery	**100%**	60%
IHA05	% of patients with a bone conducting hearing device that complete a pre-trial assessment	**100%**	90%
IHA06	% of patients with a bone conducting hearing device that complete a post-trial assessment	**100%**	85%
IHA07	% of patients with a bone conducting hearing device that complete a pre and post- trial assessment within a 3 month window	**100%**	60%
IHA08	% of devices that suffer implant failure within 6 months of implant	**0%**	1.6%
IHA09	% of patients requiring revision of soft tissue around their implant within 1 year of surgery	**2.5%**	2.3%
IHA10	% of patients whose device requires being sent for repair who receives a replacement device or has their device repaired within 7 days	**70%**	81%
IHA11	% of patients receiving at least 2 post loading assessments within the first 12 months of post loading	**100%**	63%

The Trust undertakes 35 – 40 cases per year, more cases than large centres. Patients are given the choice of two different device suppliers (Oticon or Cochlear) following a 2 week trial of a BAHA conductor. The BAHA takes 45 minutes to implant as a day case and most are under general anaesthetic. The patient is followed up 2 weeks after surgery and the BAHA is fitted at 8 weeks along with an annual audiology review. 50 BAHAs are repaired annually of which 70% are within 7 days. Patient outcomes are good with low infection rates, low skin overgrowth and low device failure. Patient satisfaction post procedure is very high.

Local clinical audits

The reports of 171 (100%) local clinical audits were reviewed by the Trust in 2020/2021 and Salisbury NHS Foundation Trust intends to take, or has taken, the following actions to improve the quality of healthcare provided.

Emergency Department patient safety checklist audit 2018 – 2021

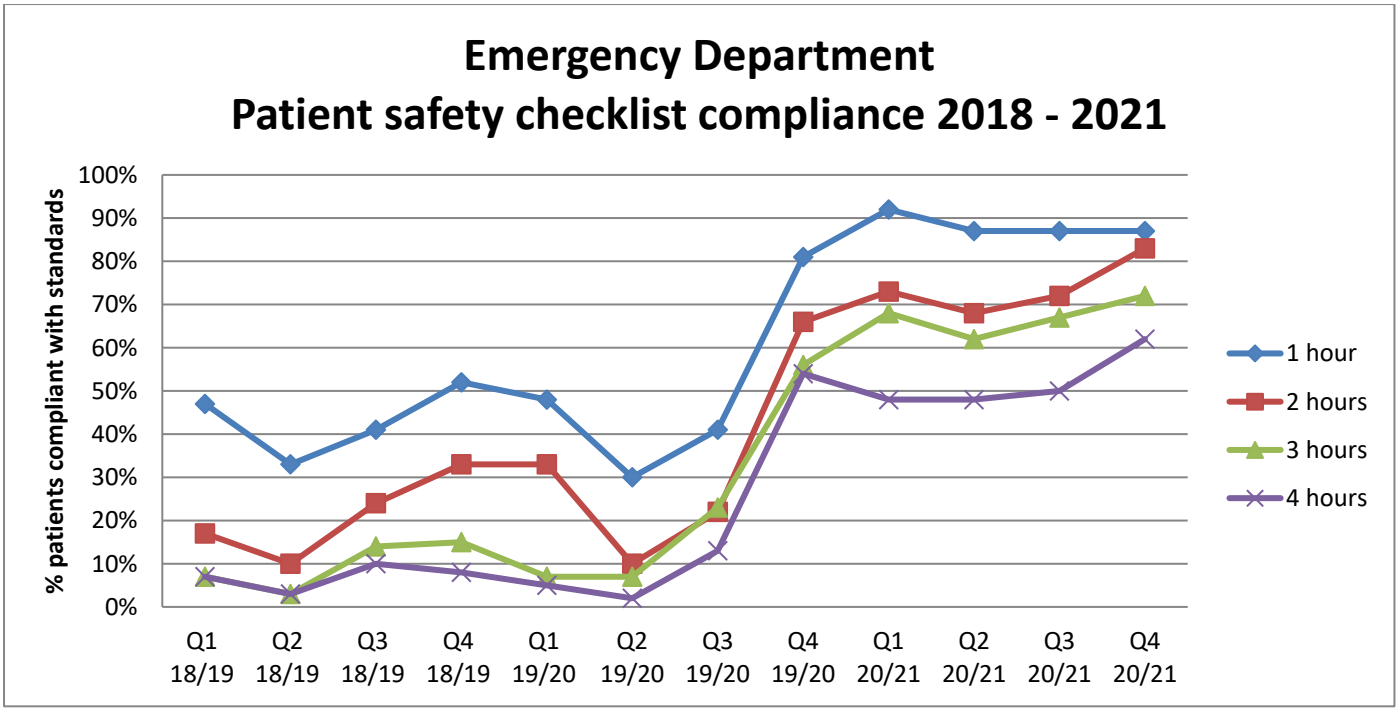
Crowding in the Emergency Department has a major impact on the ability of staff to deliver safe care. Delays in recognition and treatment of severe illness are common with associated poor outcomes. This is particularly problematic for patients suffering from time critical conditions such as sepsis, although SFT outcomes for this condition is good. As staff become overwhelmed by the tasks they need to complete, while faced with constant interruptions, there is a risk of omission in the delivery of care elements which contribute to harm and difficulty in identifying the deteriorating patient in a crowd.

Safety checklists have been shown to improve standardisation and demonstrate improvements in patient safety and care. The checklist is a time based framework for vital sign measurement and calculation of the National Early Warning Score (NEWS2), pain scores, administration of drugs and investigations. The checklist is intended for use with majors and resuscitation patients, but not for those with minor injuries or conditions. The checklist also acts as a trigger for specific pathways for stroke/transient ischaemic attack (TIA), fractured neck of femur and sepsis patients. The recommendations for best practice advocated by the Royal College of Emergency Medicine are that the following must be recorded:

- Vital signs and the NEWS2 score calculated regularly
- Investigations undertaken such as blood test, X-rays, scans, ECG and other relevant tests
- Pain relief

In December 2019, the team introduced a combined nursing communication and patient safety checklist document and this has been successful in sustaining and improving compliance with the patient safety standards. The results are regularly feedback to the staff and monitored at the Executive Ward Performance meetings.

Emergency Department patient safety checklist run chart 2018 – 2021



Theatres World Health Organisation (WHO) Patient Safety checklist audit 2019 – 2021

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

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

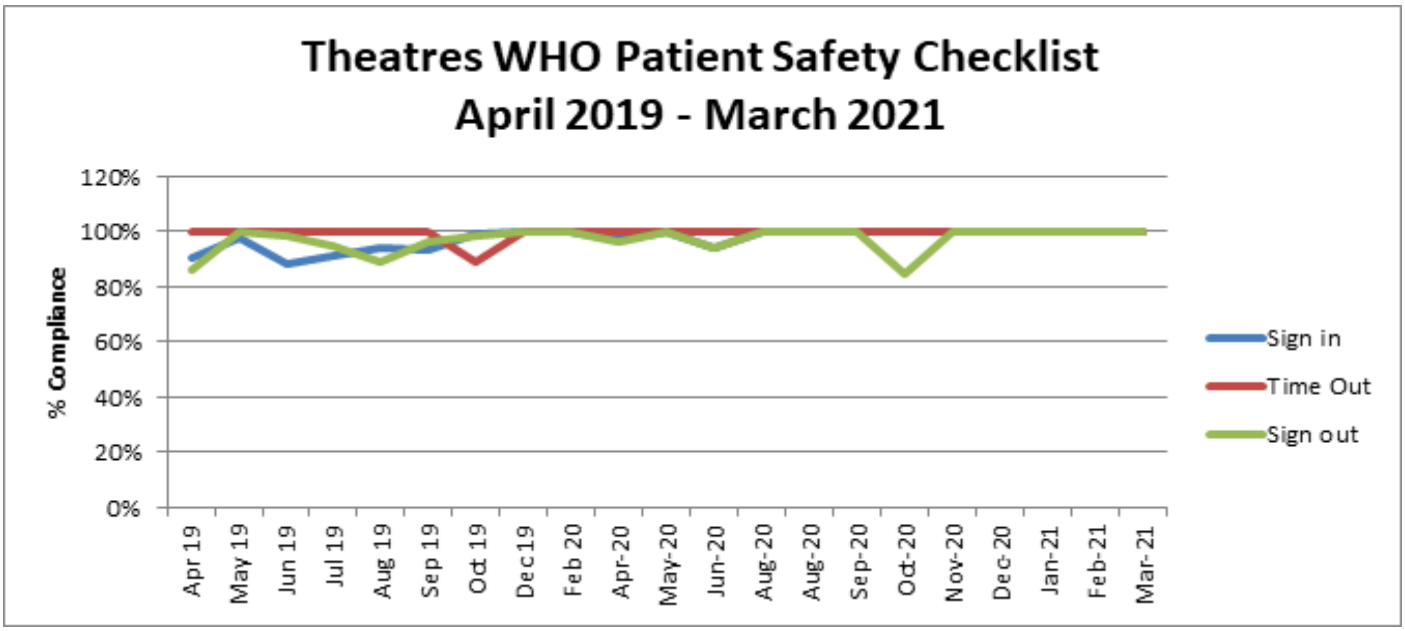
Next, is the 'sign in' phase which is done with the patient awake to ensure the patient is the correct patient having the correct operation, the surgical site is marked and consent confirmed. It is also noted whether the patient has any allergies, is a diabetic (blood glucose monitoring during the procedure), has any teeth work that must be avoided or a difficult airway.

Once the patient is in theatre and before the surgeon makes the incision the next phase is 'time out', which includes a check as to whether the patient has been given antibiotics, VTE (blood clot prevention) prophylaxis and imaging displayed where applicable. This also includes an additional patient check to ensure the correct patient is having the correct procedure.

Before the patient leaves theatre, the nurse completes an essential items count check to ensure all items are present and correct. At the end of the case there is a 'sign out' phase. This ensures the operation is recorded appropriately and post-operative instructions are written, throat packs are removed and antibiotics and VTE prophylaxis administered if appropriate.

Once the list is completed the whole team meet again to debrief as to how the list went and whether there were any problems, including human factors, and any areas for improvement next time if needed.

The Trust results show consistent performance in the 'sign in' and 'time out' phase but improvement is needed in the 'sign out' phase.



The Trust has not had any 'never events' (events that should never happen such as a retained swab) reported between in 2020/2021.

Salisbury NHS Foundation Trust will take the following improvement actions (Clinical lead, Theatres by 31/12/21):

- Develop an e-learning WHO safety checklist training module which includes human factors training.
- Ensure all theatre staff undertake and pass an annual competency assessment.

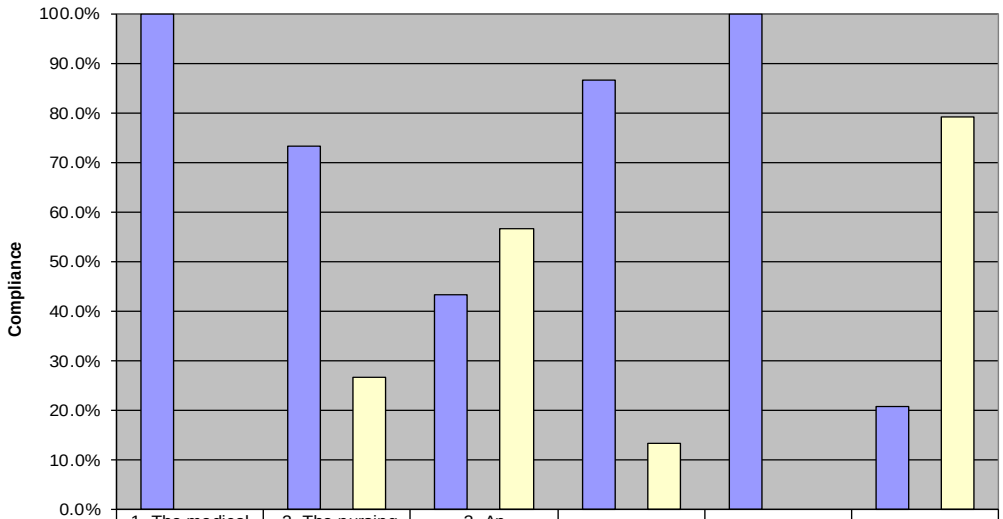
Discharge policy audit report 2020

An audit of 30 discharged adult patients to measure compliance with 6 standards set out in the discharge policy and plan improvement actions where needed
When patients are admitted to hospital it is important to ensure an estimated date of discharge (EDD) is recorded and discussed and agreed by the patient and multidisciplinary team (MDT). This should happen at the first consultant post-take ward round within the first 12 hours of admission. This enables the team to ensure all services such as therapies and tests are in place early to prevent delayed or failed discharges.

Early discharge before midday enables admitted patients to be placed in the right place at the right time and be looked after by the right team aiding patient flow through the hospital.

The audit shows room for improvement in the setting of a meaningful EDD and discharging patients before midday. The Project Management Office is leading a piece of work to improve 'home for lunch' along with a review of delays in discharge and actions required to address them.

Discharge Policy Audit 2020: %compliance against audit standards 1-6



	1. The medical assessment document was completed within 6hrs of admission	2. The nursing assessment document was completed within 6hrs of admission	3. An estimated date of discharge is recorded within 24hrs of admission	4. The patient had a discharge plan agreed with the patient & family/carer	5. A discharge summary was completed	6. The patient was discharged by 12:00 (target 33%)
% Yes	100.0%	73.3%	43.3%	86.7%	100.0%	20.7%
% Ex	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
% No	0.0%	26.7%	56.7%	13.3%	0.0%	79.3%

Actions (Discharge Team and Programme Management Office by 31/3/2021)

1. Introduce and test criteria led discharge on two wards.
2. Understand the reasons for delays in discharge by undertaking an audit of discharge process.

Research

The number of patients receiving relevant health services provided or subcontracted by Salisbury NHS Foundation Trust in 2020/2021 that were recruited during that period to participate in research approved by the National Institute for Health Research were 2222 patients into 33 studies. 1914 participants were recruited into 9 COVID-19 studies, including RECOVERY and REMAP-CAP. These interventional studies offered participants additional treatments. Findings from RECOVERY and REMAP-CAP have informed standard clinical care for COVID patients around the world. This compares with 1238 patients recruited into 82 studies in 2019/2020.

During the last year research has focused almost entirely on Urgent Public Health COVID-19 studies. 2000 participants were recruited into 9 COVID-19 studies. This local involvement and national collaboration has had a global impact, with updates reported regularly in the Downing Street pandemic press briefings. This has included:

- Vaccine development, including collaboration with the Wessex Vaccine Hub to support development of the Novavax &Janssen vaccines. The Janssen vaccine has recently received regulatory approval in the USA, and will be key to the USA vaccination programme. Both vaccines were being considered for regulatory approval in the UK.
- Vaccine efficacy, including research to show high levels of protection from the first dose of the Pfizer/BioNTech vaccine, which informed the UK Government's pathway out of lockdown;
- Dexamethasone helps save lives of COVID-19 patients with severe respiratory complications. This treatment alone has been shown to have saved 650,000 lives globally in the second half of 2020.
- Tocilizumab reduces deaths in patients receiving organ support
- Gene research, identifying five genes that make patients susceptible to severe COVID-19 symptoms.
- Developing mortality and deterioration tools, to stratify adults hospitalised with COVID-19 risk according to risk;
- Immunity research, identifying that most people that contract Covid-19 are protected from re-infection for at least five months; and
- Maternity research, helping to identify the need for enhanced precautions and practice due to risks of pre-term delivery and raised infant mortality

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

Further information on research activity is in the annual report at:
https://www.salisbury.nhs.uk/about-us/trust-reports-and-reviews/

Goals agreed with Commissioners

Prior to the COVID-19 pandemic, a proportion of Salisbury NHS Foundation Trust's income each year was conditional on achieving quality improvement and innovation goals agreed between Salisbury NHS Foundation Trust and any person or body with whom the Trust entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

In response to the COVID-19 pandemic NHS England and NHS Improvement published guidance in July 2020 which confirmed the operation of the 2020/2021 CQUIN schemes was suspended for the remainder of the year until 31 March 2021.

Care Quality Commission (CQC) registration

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

Salisbury NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission in 2020/2021.

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

Care Quality Commission unannounced inspection

On 31 March 2021, the Trust had an unannounced inspection of the Maternity Services and Spinal Treatment Centre. Progress of the work will be overseen by the Maternity Improvement Board and reported to the Clinical Governance Committee.

The Spinal Treatment Centre are required to implement 6 ‘must do’ actions related to governance and risk and 13 ‘should do’ actions. Progress of the work will be overseen by the Divisional Management Team and reported to the Clinical Governance Committee.

Well-led action plan

A well-led action plan was already in place and this was expanded following the CQC inspection. Significant progress was made against the plan across all domains. The majority of actions were completed however, it is acknowledged that there are on-going areas of work which require further consideration, based on on-going programmes of work within the existing plan. These include:

Vision and Strategy
- Health and Safety Strategy
- Clinical Strategy

Culture
- Staff engagement
- Corporate communications

Improvement and Innovation
- Systematic approach to quality improvement

Accurate Information
- Ward to Board reporting

Roles and Responsibilities
- Divisional Governance arrangements (including clinical governance)
- Executive Performance Reviews

Risk management
- Links to Divisional governance arrangements

The Trust is planning to undertake a self-assessment against the well-led framework during Q3 2021/2022. NHSI guidance sets out the requirement for Trusts to undertake an external review of the CQC

Well-Led Framework every 3 to 5 years. The last Trust review was in May 2018. The Trust is planning this review for 2022.

Data quality

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

Over 2020/21, the Trust has embarked on a business intelligence project which includes replacing our data warehouse and delivering modern tools to support the improvement in data quality and the use of information more widely. We have also introduced a data quality maturity assessment for our core reporting to ensure there is assurance on the quality of information. The assessments have been completed for key Trust committee reports and has been expanded to cover other key performance indicators this year.

Underpinning all of this, is our data quality policy and an implementation plan to support the journey of continuous improvement and ownership of data quality has been developed and approved at our Information Standards Group.

Salisbury NHS Foundation Trust submitted records during 2020/2021 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and valid General Medical Practice Code is set out in Figure 31. These are important because the NHS number is a key identifier for patient records and an accurate record of the General Medical Practice Code is essential to enable the transfer of clinical information about the patient.

Figure 31: Patient records with a valid NHS number and General Medical Practice code

Data item	Salisbury District Hospital 19/20	National benchmark 19/20	Salisbury District Hospital 20/21 (M1 only)	National benchmark 20/21
Valid NHS number				
% for admitted patient care	99.7%	99.5%	99.8%	Not available since Apr 20
% for outpatient care	99.8%	99.7%	99.9%	Not available since Apr 20
% for Emergency Department care	98.8%	97.8%	99.4%	Not available since Apr 20
Valid General Medical Practice code				
% for admitted patient care	99.8%	99.8%	99.6%	Not available since Apr 20
% for outpatient care	99.9%	99.8%	99.9%	Not available since Apr 20
% for Emergency Department care	99.8%	98.2%	99.6%	Not available since Apr 20

Data Security and Protection Toolkit Attainment levels

Salisbury NHS Foundation Trust's chose to complete the 2019/2020 Data Security and Protection Toolkit self-assessment in line with the NHS Digital guidance associated with the national emergency caused by coronavirus (COVID-19). Salisbury NHS Foundation Trust confirmed that it achieved and submitted a Standard Met Data Security and Protection Toolkit assessment on 30 September 2020. This decision provided us with the opportunity to refocus our resources to combat COVID-19. Whilst, Salisbury NHS Foundation Trust recognised the submission deadline of March 2020 was relaxed, we remain resolved in our commitment to maintaining and continually look for ways to proactively improve the security and confidentiality of personal information entrusted to us. The Trust' 2020/2021 submission will be made on 30 June 2021.

Clinical Coding Error Rate

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

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

Salisbury NHS Foundation Trust was not subject to an external Information Governance clinical coding audit (due to the COVID-19 pandemic) by an independent company during 2020/2021 and the correct coding rate reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was:

Figure 32: Overall results of coding accuracy 2016 – 2021

	Annual external coding audit Correct % 2016/17	Annual external coding audit Correct % 2017/18	Annual external coding audit Correct % 2018/19	Annual external coding audit Correct % 2019/20	Annual external coding audit Correct % 2020/21
Primary Diagnosis	98.5%	99.0%	98.5%	96.5%	No audit due to COVID-19
Secondary Diagnosis	95.1%	97.2%	98.1%	98.5%	No audit due to COVID-19
Primary Procedure	96.7%	98.8%	99.1%	97.8%	No audit due to COVID-19
Secondary Procedure	95.8%	97.8%	99.7%	95.6%	No audit due to COVID-19

The following improvement actions were progressed in 2020/2021:

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

The Trust is planning to take the following actions to sustain good practice in 2021/2022:

1) Improve the coding of the primary diagnosis assigned to paediatric patients by using the information recorded in the patient's discharge letter.
2) Continue to monitor the comorbidities coding to ensure all relevant codes are captured and national coding guidance is followed and report findings to the Mortality Surveillance Group.
3) Introduce Apprenticeship training for newly appointed coders to develop knowledge and skills in coding activity.

Learning from deaths

During 2020/2021, 884 patients died in Salisbury NHS Foundation Trust. This comprised the following number of deaths which occurred in each quarter of 2020/2021 (Figure 33).

Figure 33: Deaths at the Trust 2020/2021

	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Total
Number of deaths	207	178	218	281	**884**
1st screen (Qualified Attending Practitioner)	198	164	207	261	**830 (94%)**
Medical Examiner (ME) scrutiny (from 1/8/2020)		65	173	234	**472 (77%)**
Case review (structured judgement review)	80	11	35	138	**264 (30%)**
COVID-19 deaths	51	0	22	134	**207**
Deaths with a Hogan score 1*	194	174	214	275	**857**
Deaths with a Hogan score 2 – 3 **	11	4	4	6	**25**
Deaths with a Hogan score 4 - 6***	2	0	0	0	**2**
Deaths investigated as a serious incident inquiry	2	1	6	2	**11**
Serious incident inquiry - case rated as catastrophic	0	1	4	2	**7**
Unexpected deaths	2	2	7	5	**16**
Learning points identified	19	6	21	24	**70**

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

On 1 August 2020, Medical Examiners who are senior medical doctors were introduced to scrutinise deaths, agree the proposed cause of death and offer a point of contact for bereaved families to raise concerns about the care provided prior to the death of their loved one. By 31 March 2021, 830 (94%) of deaths had been screened by a Qualified Attending Practitioner to ascertain whether each case required a

case record review (structured judgement review) and 472 (77%) deaths had been scrutinised by a Medical Examiner.

By 31 March 2021, 264 (30%) case record reviews and 11 investigations (serious incident inquiries) had been carried out in relation to 884 of the deaths included in Figure 33. In 11 cases, a death was subjected to both a case record review and a serious incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 80 (39%) in the first quarter (April – June 2020)
- 11 (6%) in the second quarter (July – September 2020)
- 35 (16%) in the third quarter (October – December 2020)
- 138 (49%) in fourth quarter (January – March 2021)

9 cases representing 1.01% of the patient deaths during 2020/2021 were judged to be more likely than not to have been due to problems in the care provided to the patient based on a Hogan score of 4 – 6 or graded as catastrophic harm as an outcome of a serious incident inquiry.

In relation to each quarter this consisted of:

- 2 representing 0.96 % for the first quarter (April – June 2020)
- 1 representing 0.56% for the second quarter (July – September 2020)
- 4 representing 1.83% for the third quarter (October – December 2020)
- 2 representing 0.71% for the fourth quarter (January – March 2021)

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

The Trust has learnt the following from case record reviews (structured judgement reviews) and investigations conducted in relation to the deaths in 2020/2021:

Trust wide:

- A review of 65 deaths of patients who died from COVID – learning from experience and research saw the introduction of new treatments and management. The risk of nosocomial transmission was mitigated by changes in testing, retesting and patient placement.
- Deterioration and sepsis – improvements seen in screening and the administration of antibiotics in the Emergency Department and inpatients. This year compliance in the timeliness of antibiotic administration across the Trust has decreased. However, our Suspicion of Sepsis dashboard shows improved survival over this period.
- Serious incident inquires – learning shared with relevant teams and compliance monitored by the Clinical Risk Group following recognition of repeated themes. More work is required.
- End of life care - learning of the importance of staff education. Improved recognition of dying patients, improved personalised care at the end of life and in the care of the bereaved – bereavement survey and contact with the majority of relatives of patients who died during the first wave of the pandemic showed positive feedback.

Department/teams:

- Improvement actions completed since the review of 33 deaths of patients with a hip fracture in October 2019 has shown a steady decline in the mortality rate attributed to prioritising hip fracture patients for surgery within 36 hours (83% in November 2020 compared to 68% nationally), an increase in spinal anaesthetics (from 14% in October 2019 to 34% in November 2020) and more nerve blocks given pre-theatre (from 31% to 75%) leading to fewer opioids and less delirium.
- A review of 18 patients who died following a gastrointestinal haemorrhage (GI) identified improvements needed in referral and booking processes, use of the acute upper GI bleed care bundle, continuity of care by the GI team and improved governance around learning from deaths. The review was discussed at an Endoscopy User Group and GI team mortality and morbidity meeting. Actions completed. The GI bleed mortality ratio decreased and is as expected
- The stroke team introduced a monthly multi-disciplinary mortality review meeting in June 2020 to share learning with the wider team and improve communication with families especially around the 'uncertain recovery period' and transition from active treatment to palliative care. Inpatient mortality at 7 and 30 days reduced from 2019/20 and is well below the national upper limit.
- The maternity services introduced a Perinatal Mortality Review Tool to identify learning across the whole patient pathway. Cardiotocograph interpretation was identified as a theme. Cardiotocograph training levels improved to over 90% and a Fetal Surveillance Midwife was appointed to support midwives and doctors in practice.

Individual level:

- Individual case discussion with doctors and nurses to enable reflection on practice.
- Quarterly Mortality Matters bulletins – outline learning achieved and case vignettes, published on the intranet
- Medical Examiner case discussion with trainees – feedback from the trainees is a learning opportunity

The Trust has taken the following actions as an outcome of the learning identified from case record reviews in 2020/2021:

During the first wave of COVID-19 pandemic (March 2020 – June 2020):

- Patient testing switched from Bristol to in-house from mid-May, increasing the turnaround time from 3-5 days to 12 – 24 hours. Rapid testing became available for 30 cases a day from mid-May.
- All patients, rather than symptomatic patients only, started to be routinely tested on admission from 29 April and results were available within 24 hours. Routine re-testing on day 5 of all inpatients also commenced.
- On 20 August 20, Public Health England published guidance on managing patients on high risk (red), medium risk (amber) and low risk (green) pathways to reduce the risk of patient to patient transmission and keep patients safe. The Trust adopted this guidance and risk stratified all patients and placed patients according to their level of risk.
- The benefit of starting Continuous Positive Airway Pressure (CPAP) as soon as the patient developed an increased oxygen requirement and proning was put into practice in April 2020.
- The use of low-dose dexamethasone shown to reduce mortality was introduced as soon as the research was published. Remdesivir shown to reduce the length of severe illness was also routinely introduced.
- The main risk identified from patient tracking was the number of ward moves patients experienced and the number of moves within each ward increasing the risk of nosocomial transmission. The risk was mitigated by risk stratification and appropriate placement on admission and virtual board rounds held to monitor this process.

- Any patient re-admitted within 14 days either from this hospital or another hospital should be considered high risk and isolated until the result of an admission test is known. The risk has been mitigated by the risk stratification on admission and the virtual board meeting held to discuss all COVID positive patients, appropriate placement and contact tracing to reduce the risk of nosocomial transmission. The board round also includes a discussion of symptomatic and COVID-19 positive staff and contacts.

During the second wave of COVID-19 pandemic (October 2020 – March 2021):

Additional measures put in place to mitigate the risk of nosocomial transmission were:

- As the number of cases increased additional bed capacity was opened including the Day Surgery Unit for inpatient capacity.
- To enable beds to be socially distanced some beds were removed from wards.
- Enhanced existing Level 1 PPE for staff working in close contact with patients within the ward environment and wards that had COVID-19 positive patients cohorted in bays. The enhancement was a change from wearing the recommended Level 1 surgical face mask to a Level 3 FFP3 face mask for which each individual was successfully fit tested.
- A team was set up to support the wards in testing inpatients for COVID in accordance with our standard operating procedure.
- A maternity lateral flow hub was set up to enable partners to attend scans and clinic appointments as well as being with them during labour.
- Provided mutual aid to the Mental Health Trust (AWP) where an outbreak of COVID affecting 63 patients was declared at Fountain's Way Hospital. This Trust provided oxygen and oxygen saturation monitors and a respiratory consultant to review patients at the hospital, thus reducing admissions to this hospital.
- Invited NHS Improvement to review practice which took place in January. The main advice was to increase the level of audits so rapid changes could be made where needed.

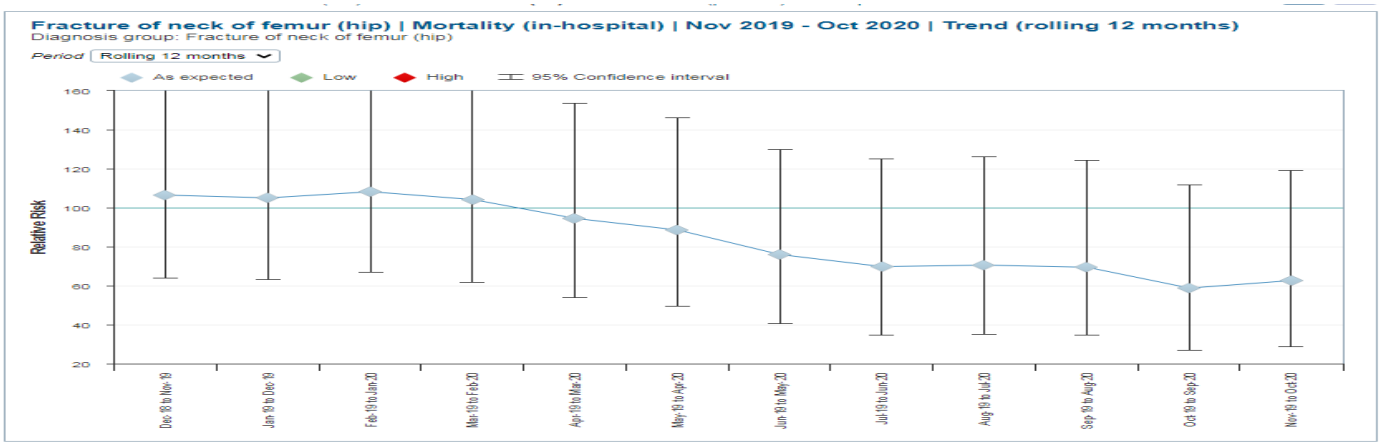
The Trust is planning to take the following actions as an outcome of the learning identified from case record reviews in 2021/2022:

- Re-energise the deterioration and sepsis working group to improve the compliance with the timeliness of antibiotic administration within an hour of diagnosis of sepsis.
- Working with our BSW ICS partners to introduce the ReSPECT form.
- Undertake a cluster review of stillbirths in 2020/2021 and further improvements where needed.
- Improve the use of the acute gastro-intestinal bleed care bundle to ensure the best outcome.

The impact of the actions taken in 2020/2021:

- Improvement actions completed since the review of 33 deaths of patients with a hip fracture in October 2019 have shown a steady decline in the mortality rate since February 2020. This can be attributed to prioritising hip fracture patients to ensure they are operated on within 36 hours (83% in November 2020 compared to 68% nationally), an increase in spinal anaesthetics (from 14% in October 2019 to 34% in November 2020) and more nerve blocks given pre theatre (from 31% to 75%) leading to fewer opioids. Figure 34 shows an improving trend in the relative risk of death following a fractured hip.

Figure 34: Trend in relative risk for fracture of neck of femur



252 case record reviews and 10 serious incident inquiries of deaths which occurred in 2019/2020 were completed by 2020/2021. These deaths which took place in 2019/2020 are not included in the total number of deaths reported in Figure 35. The case record reviews were undertaken as a result of problems in care or concerns about the quality of care or as a serious incident inquiry into an adverse incident that caused serious harm or death.

6 of the 137 deaths representing 4.37% of the patient deaths subject to a case record review as a result of CUSUM (cumulative sum) alert in 2019/2020 (CUSUM alerts are statistical quality control measures which alert the Trust to when the number of deaths observed exceeds the number expected in a diagnostic or procedure group) or as a request by the Care Quality Commission to investigate, were judged to be more likely than not to have been due to problems in the care provided to the patient.

Of the 10 deaths subject to a serious incident inquiry or clinical review in 2019/2020 and graded as catastrophic harm, represented 1.27**%** of the total deaths (784) in 2019/2020 were judged to be more likely than not to have been due to problems in care provided to the patient. The number has been calculated using the grading of catastrophic harm as an outcome of the serious incident inquiry or clinical review.

In total, 16 deaths representing 2.0% of 784 deaths in 2019/2020 were judged to be more likely than not to have been due to problems in care provided to the patient.

These deaths were not included in the total number of deaths in 2020/2021 reported in Figure 35.

Seven day hospital services – implementing the priority clinical standards

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

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

In September 2020, we assessed ourselves against the four priority standards as part of a national survey run by NHS Improvement.

Figure 35: Standard 2: Consultant review within 14 hours of admission to hospital (standard 90%)

Standard	Sept 17	April 18	March 19	Sept 19	Sept 20
Proportion of patients reviewed by a consultant within 14 hours of admission to hospital	93%	93%	90%	90%	94%

Figure 36: Standard 5: Access to diagnostic tests

	Week Sept 19	Weekend Sept 19	Week Sept 20	Weekend Sept 20
CT	Yes	Yes	Yes	Yes
Echocardiogram	Yes	Yes	Yes	Yes
Microbiology	Yes	Yes	Yes	Yes
MRI	Yes	Yes	Yes	Yes
Ultrasound	Yes	Yes	Yes	Yes
Upper GI endoscopy	Yes	Yes	Yes	Yes

Figure 37: Standard 6: Access to interventions at this hospital or by formal arrangement with another hospital

Service	Weekday Sept 19	Weekday Sept 20	Weekend Sept 19	Weekend Sept 20
Critical care	Yes	Yes	Yes	Yes
PPCI	Yes	Yes	Yes	Yes
Cardiac pacing	Yes	Yes	Yes	Yes
Thrombolysis	Yes	Yes	Yes	Yes
Emergency general surgery	Yes	Yes	Yes	Yes
Interventional endoscopy	Yes	Yes	Yes	Yes
Interventional radiology	Yes	Yes	Yes	Yes
Renal replacement	Yes	Yes	Yes	Yes
Urgent radiotherapy	Yes	Yes	Yes	Yes

Figure 38: Standard 8: Ongoing review (standard 90%)

	Survey	
	Sept 19	Sept 20
% receiving required **twice** daily reviews	100%	100%
% receiving required **once** daily reviews	92%	99%

The Trust has taken the following actions to improve and sustain good practice in 2020/2021:

- The survey was undertaken during the COVID-19 emergency at the very start of the 2nd wave, although in September 20 no new COVID patients were admitted and the bed occupancy rate was 86.6%, lower than in the September 2019 survey.

- Improved the proportion of patients seen by a suitable consultant within 14 hours of admission both during the week and at weekends by a change in the working practices by the Acute Medical Team. The on call teams now work more flexibly so that inpatient reviews are assigned to the most appropriate grade. Two consultants work multiple four hour shifts, staying on site for 10-12 hours. Feedback from these changes has been uniformly positive. In addition, two Acute Medical Team locums have been employed which has helped the workforce shortage present in the previous survey.

- The Trust provided all 6 diagnostic tests during the week and at weekends either on-site or by formal arrangement. In December 19, the Chief Medical Officer invited the Royal College of Physicians to review the gastroenterology service. A number of recommendations were made including the formation of a Gastrointestinal Unit (GI). By May 20, a combined GI unit had been formed, led by a Consultant Surgeon.

- Improvements completed in the endoscopy unit include the introduction of an electronic endoscopy requesting system, introduction of the acute upper GI bleed care bundle, ongoing audits of patients with a GI bleed who needed an emergency gastroscopy, introduction of key performance indicators and review of deaths and morbidity at the Endoscopy User Group.

- The current provision of upper GI endoscopy is that during the week it is provided by the duty endoscopist and out of hours, including weekends, it is provided locally on a 1 in 5 basis with the University Hospital Southampton (UHS). The remaining 4 in 5 slots are covered by UHS. The pathway works well with good working relationships between UHS and Salisbury teams.

- The interventional radiology service at Salisbury is provided two days a week on site and out of hours emergency patients are transferred to the Royal Bournemouth Hospital.

- A significant improvement in the proportion of patients reviewed at the weekend considered to be a change in the Acute Medical Team rota detailed above.

The Trust is planning to take the following actions to sustain good practice in 2021/2022:

- Continue to review and improve the gastroenterology service as recommended by the Royal College of Physicians.
- Improve compliance with discharge within 48 hours of being fit to go home and introduce criteria led discharge on all the wards.
- Improve the documentation of the weekend plan in the stroke service.

Freedom to Speak Up (whistleblowing and raising concerns)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If the concern is about quality of care or a patient safety incident, an investigation is carried out by someone independent of the case, to examine the concerns and wider circumstances. The person is advised how long it will take and is kept up to date with progress. The investigation report focuses on identifying the cause and making recommendations to promote patient safety and learning. The person is told about the outcome of the investigation and change is monitored to ensure it is working effectively.

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

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

Consolidated annual report 2020/21 on doctors and dentist in training rota gaps & improvement plan

The COVID-19 pandemic has impacted doctors in training over the period of 2020/2021. A number of rotations have been delayed and trainees have been redeployed from specialities to assist the Trust with the pandemic response. This was agreed nationally through the British Medical Association and NHS Employers.

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

The Trust continues to monitor the junior doctor contract in particular relating to the 1:3 weekend rotas. Just two areas, the Emergency Department and Paediatric Department remain non-compliant with this and the Junior Doctor Forum has extended the agreement that these rotas can continue to operate.

Improvement actions taken or planned to be taken are:

- Continue to focus on the 1:3 weekend rotas to generate compliance in the two outstanding areas.
- Action plans are in place in each clinical Division to fill hard to recruit posts and these include redesigning models of care, often provided by other health care professionals.

Reporting against core indicators

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

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

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

Summary Hospital Level Mortality (SHMI)

Figure 39 presents the Trust's performance against the SHMI. Salisbury NHS Foundation Trust considers that the SHMI data is as described for the following reasons:

- SHMI is published by NHS Digital and compares the number of deaths in hospital and within 30 days of discharge with expected levels. It is not adjusted for patients admitted for end of life care, for example to Salisbury Hospice. Our SHMI for January 2020 to December 2020 was 103 and is within the expected range. If the number of deaths was exactly as expected the SHMI would be 100. However, some natural variation is to be expected and a number above or below 100 can still be within the expected range. In 2020/2021, 43.5% of our deaths were patients admitted for palliative or end of life care compared to 47.4% in 2019/2020.

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

- Introduction of the Medical Examiner system in August 2020 to scrutinise all deaths, except those subject to a coroner's inquest, and to discuss the medical certificate of the cause of death with relatives to ascertain if they had any concerns about care and investigate them.
- Reduction in the mortality rate associated with a hip fracture by improvements in the pathway (time to theatre within 36 hours, increase in regional anaesthesia and local pain blocks with a reduction in the use of opioids).
- Reduction in the mortality rate associated with an acute gastro-intestinal haemorrhage (improved referral and booking process, implementation of the acute upper GI bleed care bundle, better continuity of care with patients cared for by the GI team, ongoing audit to understand the reason for any delays of patients who need emergency and urgent endoscopy and improvement actions).
- In October 2020, our bereavement survey 'Your Views Matter' was adapted and relaunched to acknowledge the COVID-19 pandemic including the impact of visiting restrictions. The survey is sent a month after a death to a nominated person for every patient who died in the acute Trust. The majority of feedback from these surveys contained positive comments about the kindness, care and compassion relatives saw and experienced themselves. Relatives who were able to be with their loved ones at end of life, expressed their appreciation at being able to do so. The main concern was about communication – specifically not being able to get through on the telephone to the wards and our PALS team offered a go-between service encouraging families to contact them directly if they were unable to get through. The PALS team then contacted the wards to obtain the relevant information and relay in back to relatives. able to provide support by taking messages to patients on the ward or

- During the COVID-19 pandemic, the Specialist Palliative Care Team and the End of Life Care team provided a one off bereavement call to families of patients who were supported by them. This occurred between 1-4 weeks after the death and was an opportunity to offer condolences, listen and support the bereaved. and enable families to ask questions or raise concerns which can either be resolved at the time or a second call is arranged once action has been taken. If the patient was supported by the Specialist Palliative Care Team a referral to the family support team can be made if formal bereavement support is indicated.

Salisbury NHS Foundation Trust intends to take the following actions in 2021/22 to ensure the SHMI remains as expected by:

- In partnership with BSW ICS, introduce the national ReSPECT form.
- Complete a review of all patients who died from COVID-19 disease in the 2nd wave of the pandemic to ensure that treatment shown to be effective in clinical research trials was given, Do Not Attempt Resuscitation orders were appropriate and national guidance was followed to reduce the risk of nosocomial transmission and implement any improvement actions required.

Figure 39: Summary Hospital-level mortality indicator (SHMI)

NHS Outcomes Framework Domain	Indicator	2017/18	2018/19	2019/20	2020/21	National average	Highest & lowest average other Trusts 2020/21
Domain 1: preventing people from dying prematurely	SHMI value	106	101	101*	103 (Dec 20)	100	113.55 (Aug 20) higher than expected
	SHMI banding	As expected	As expected	As expected	As expected	As expected	87.95 (Aug 20) lower than expected
Domain 2: Enhancing quality of life for people with long term conditions	Percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust.	48.5%	41.7%	47.4%	43.5%	Not available	

* In 2019/2020 SHMI was reported as 103.9 to October 2019. The full year SHMI was 101 to March 2020.

Patient Reported Outcomes Measures (PROMs)

Figure 40 presents the Trust's performance against PROMS. Salisbury NHS Foundation Trust considers that the PROMs are as described for the following reasons:

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

- Salisbury NHS Foundation Trust PROMs provisional data for April 2019 to March 2020 showed that patients rated the success of their hip replacement as higher than for a knee replacement. Satisfaction may have been lower in patients who had a knee replacement because more patients reported severe scores for knee pain, difficulty walking and kneeling compared to those who had a hip replacement. The commonest reported symptoms prior to hip surgery was moderate or severe hip pain (93.8%) and limping when walking most or all of the time (84.6%). After the operation, 12% of patients reported

moderate or severe pain and 12% continued to limp after hip surgery. The adjusted health gain for a primary hip replacement on the Oxford hip score was 22.9 compared to 22.8 for England. The Trust was not an outlier compared to other hospitals.

- Salisbury NHS Foundation Trust PROMs provisional data for April 2019 to March 2020 showed that the commonest reported symptoms prior to knee surgery was moderate or severe knee pain (97.4%) and extreme difficulty or impossible to kneel and get up again (84%). After the operation, 22% of patients reported moderate or severe pain but there was less improvement in being able to kneel and get up again (55%). The adjusted health gain for a primary knee replacement on the Oxford knee score was 16.29 compared to 17.4 in England. The Trust was not an outlier compared to other hospitals.

Salisbury NHS Foundation Trust will be taking the following actions:

- As part of COVID-19 recovery, restart the 'joint school' before surgery to enable patients to learn about hip and knee exercises needed after the operation to ensure they get the best outcome from surgery. The plan will be to deliver sessions by 'Attend Anywhere' rather than face to face.

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

Figure 40: Patient Reported Outcome Measures (PROMs)

<table>
<tr><th>NHS Outcomes Framework Domain</th><th>Indicator</th><th>2018/19*</th><th>2019/2020**</th><th>National average

2019/2020</th><th>Highest average other Trusts

2019/2020</th><th>Lowest average other Trusts

2019/2020</th></tr>
<tr><td rowspan="6">Domain 3: helping people to recover from episodes of ill health or following injury</td><td>Patient reported outcome measures scores for:</td><td colspan="5">Average health gain where full health = 1</td></tr>
<tr><td>i) groin hernia surgery</td><td colspan="5">From 1 October 2017
NHSE no longer report this data</td></tr>
<tr><td>ii) varicose vein surgery</td><td colspan="5">From 1 October 2017
NHSE no longer report this data</td></tr>
<tr><td>iii) hip replacement surgery</td><td>0.434</td><td>0.462</td><td colspan="3" rowspan="2">NHS Digital indicated there is insufficient data to present on hip and knee replacement surgery in 2020/21</td></tr>
<tr><td>iv) knee replacement surgery</td><td>0.311</td><td>0.323</td></tr>
</table>

*In the 2019/2020 quality account provisional data for 2018/2019 was presented. The data is now finalised.
** Data for 2019/2020 is indicative. Final data will be available in August 2021.

Emergency re-admissions within 28 days of discharge

Figure 41 presents the Trust's performance on emergency re-admissions within 28 days. Salisbury NHS Foundation Trust considers that the percentage of emergency re-admissions within 28 days of discharge from hospital is as described for the following reasons:

- Every time a patient is discharged and re-admitted to hospital staff code the episode of care.
- The re-admission data is given a score using the data quality assurance framework which is currently green.
- All patients who are re-admitted to hospital are validated by the Validation Officer, Central Booking Department to compare the patient's first admission primary diagnosis with the re-admission primary diagnosis to establish whether they were linked.
- Emergency re-admission rates within 7, 14 and 30 days of discharge are reported to the Board at every meeting.
- Between September 2019 and August 2020, our re-admission HSMR relative risk was 107.4 with 95% confidence interval. This was based on 2060 patients who were re-admitted where the expected number would be 1918. This represents 'as expected' relative risk when compared to other hospital Trusts nationally taking into account the Trust's case mix.

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

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

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

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

- Work with our BSW ICS partners to develop and deliver an integrated frailty model so that frail older patients who are able to go home with support are able to avoid admission or re-admission.

Figure 41: Emergency re-admissions within 28 days of discharge

NHS Outcomes Framework Domain	Measure:	2018/19	2019/20	2020/21	National average 2020/21	Highest average other Trusts 2020/21
Domain 3: helping people to recover from episodes of ill health or following injury	0 to 15	5.82%	*9.56%	*15.98%	Not available	Not available
	16 or over	6.56%	6.81%	7.25%	Not available	Not available
Indicator: Percentage of patients readmitted within 28 days of discharge from hospital of patient by age group						

*Prior to December 2019, children who attended the paediatric day assessment unit were classed as outpatient attendances. From 1 December 2019, all children who attend the paediatric day assessment unit are classed as admissions (to ensure full coding). All children are offered temporary open access to the children's ward for those with

an acute illness and are counted as a re-admission rather than an outpatient attendance if they re-attend for a review. In 2020/2021 during the COVID-19 pandemic more children that would normally be clinically assessed in the Emergency Department were assessed in the paediatric department. The paediatric team continued to provide same day emergency care for children. Instead of a child remaining in hospital for intravenous antibiotics often they were able to go home and return the following day for the next dose or return for further tests and clinical review. This is regarded as good practice but as there is no short stay tariff for paediatric patients the case is classed as a re-admission.

Responsiveness to the personal needs of patients

Figure 42 presents the Trust's performance on the responsiveness to the personal needs of patients. Salisbury NHS Foundation Trust considers that the mean score of responsiveness to in-patient personal needs is as described for the following reasons:

- Each year the Trust participates in the national adult inpatient survey. A nationally agreed questionnaire was sent to a random sample of 1250 patients and the results analysed independently by the Patient Survey Co-ordination Centre. The national inpatient survey will be published in November 2021 when the number of patients who responded to the survey in 2020 will be known and reported in the Quality Account 2021/2022.
- Themes from the national adult inpatient survey, the Friends and Family Test, complaints and concerns are identified by each ward and an improvement plan prepared.
- In 2020 we also took part in the following national surveys which will be reported in the Quality Account 2021/2022:
  - Urgent and Emergency Care Survey from September 2020
  - Children and Young Persons survey from November 2020
  - Maternity Survey from February 2021 to collect feedback on women's experiences of the maternity service to improve the quality of care.

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

- Art Care and the patient experience team worked with the maternity team to gather women's views including hard to reach groups on the new Birthing Centre. Face to face focus groups were held and then moved online once the COVID-19 pandemic occurred covering topics such as facilities and décor of the new centre. Building work started in February 2021.
- Work started with the paediatric team to ensure children with complex needs who move to adult services when they are 18 years old have a smooth handover of care. A focus group was held with parents along with one to one telephone conversations to understand what is important to young people when making the move to adult services.
- Radnor Ward was able to benefit from a large donation to make improvements to the unit. The improvements were planned as a result of feedback from patients who had been cared for in the Intensive Care Unit. The donation paid for the addition of a shower room and toilet for patients when they are able to get out of bed.

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

- Work with ward teams to reduce noise on the wards.
- Continue to improve the signage and information about directions throughout the Trust
- PALS team to continue to be a point of contact for relatives unable to get through to wards to enquire about the progress of their loved one, send a message or set up a video or WhatsApp call.

Figure 42: Responsiveness to the personal needs of in-patients

NHS Outcomes Framework Domain	2017/18	2018/19	2019/20	2020/21	National average 2020/21	Highest average other Trusts 2020/21	Lowest average other Trusts 2020/21
Domain 4: ensuring that people have a positive experience of care	6.9	6.9	6.8*	To be reported in Nov 21	To be reported in Nov 21	To be reported in Nov 21	To be reported in Nov 21
Indicator: Responsiveness to the personal needs of its patients (mean score)							

* In 2019/20 the provisional figure of 6.8 was reported. The final figure was 6.8.

The Friends and Family Test – Patients

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way for people to give their views after receiving NHS treatment.

Since the FFT was launched in 2013, millions of patients have submitted feedback. It's used by most NHS services, including community care, hospitals, mental health services, maternity services, GP and dental practices, emergency care and patient transport.

Due to the COVID-19 pandemic, NHS England suspended FFT data submission in March 2020. Data submission resumed from December 2020 and retrospective data submissions have been made so that a complete picture of patients' experiences throughout the year can be seen.

The FFT question

Following feedback from Trusts and people who had given their feedback using the FFT tool, the question that has been used since its inception was changed in April 2020. Response rates will no longer be published because there is now no limit on how often a patient can give feedback. Healthcare organisations will, however, continue to submit the same data items, and NHS England will continue to publish an indicator which will put the number of responses collected in the context of the size of the service provided, which will help to give commissioners and regulators a sense of how effectively the FFT is being implemented by each organisation.

There is a new standard question for all settings: "Thinking about…" (Britford Ward for example) "Overall, how was your experience of our service?"
The new question has a new response scale:

- ❑ Very good
- ❑ Good
- ❑ Neither good nor poor
- ❑ Poor
- ❑ Very poor
- ❑ Don't know

In addition to the new question there are two new free text boxes for patients to give specific feedback:

- What was good about your experience?
- Please tell us about anything we could have done better?

Individual comments collected through FFT can make a difference that improves the quality of care for all patients. Taken collectively, feedback can identify themes and issues that can be investigated, alongside

other data, resulting in significant changes to how care is provided. Teams using FFT across England have shown that it is often the small improvements that make the biggest difference to patients, such as quieter wards at night, better food, or shorter fasting time before an operation.

Salisbury NHS Foundation Trust has taken the following actions to improve the indicator rate and the percentage of patients who report a very good or good experience of our services and to improve the quality of its services by:

- Providing a range of different methods for patients to give their feedback, such as postcards, child-friendly postcards and the Trust website.

- Publishing the percentage of patients reporting a very good or good experience every quarter and reporting it to the Board, along with patient comments and any improvements we have made in response to feedback.

- Displaying the results on wards and departments with 'you said, we did' feedback.

Salisbury NHS Foundation Trust intends to improve the percentage of patients who report a very good or good experience and improve the quality of its services by:

- Exploring alternative means for patients to give their feedback (such as via test message).

Figure 43: Friends and Family test response rates

NHS Outcomes Framework Domain	Response rate:	2018/19	2019/20*	2020/21	National average 2020/21	Highest other Trusts 2020/21	Lowest other Trusts 2020/21
Domain 4: ensuring that people have a positive experience of care	Wards:	16.1%	14.2%	5.5%	NHSE suspended data collection due to COVID-19 pandemic		
	Emergency Department	0.9%	1.2%	0.2%	NHSE suspended data collection due to COVID-19 pandemic		
	Trust Overall:	4.4%	2.1%	1.0%	NHSE suspended data collection due to COVID-19 pandemic		
Indicator: ➢ 2018/2020 - Response rate of patients who would recommend the ward or Emergency Department to friends or family needing care ➢ 2020/2021 – Friends and Family Test response rates (percentage)							

In last year's Quality Account 2019/20* data was only available to February 2020. The full year is reported to March 2020.

Figure 44: Friends and Family test - percentage of patients whose experience met their expectation in the Emergency Department and inpatient wards

NHS Outcomes Framework Domain	Score:	2018/19	2019/20*	2020/21	National average 2020/21	Highest other Trusts 2020/21	Lowest other Trusts 2020/21
Domain 4: ensuring that people have a positive experience of care	Wards:	97.2%	96.6%*	98.4%	NHSE suspended data collection due to COVID-19 pandemic		
	Emergency Department	93.8%	93.0%*	84.3%	NHSE suspended data collection due to COVID-19 pandemic		
	Trust Overall:	97.3%	97.7%*	98.6%	NHSE suspended data collection due to COVID-19 pandemic		
Indicator: ➢ 2018- - /2020 score of patients who would recommend the ward or Emergency Department to friends or family needing care. ➢ From 2020/21 the measure changed to percentage of patients whose experience met their expectation in the Emergency Department and inpatient wards							

In last year's Quality Account 2019/20* data was only available to February 2020. The full year is reported to March 2020.

The Friends and Family Test – Staff

Figure 45 presents the Trust's performance on staff who would recommend the Trust to family and friends. Salisbury NHS Foundation Trust considers that the percentage of staff employed by, or under contract to the Trust during 2020/2021 who would recommend the hospital as a provider of care to their friends and family is as described for the following reason:

- Each year the Trust participates in the National Staff Survey. All staff are sent a nationally agreed questionnaire and the results are analysed by the Staff Survey Co-ordination Centre. The response rate of our staff survey was 54% (2062 people) in 2020 compared to an average rate of 45% across other Trusts..
- In September 2020, the Best Place to Work discovery work was published which describes the experience of our workforce. The report acknowledged the Trust as a caring, friendly organisation with professional staff who strive to provide the best possible care for patients. Staff are proud of the hospital and proud of the care and treatment we give to our local community. The Board discussed the recommendations at its meeting in October 2020 and a Board seminar was held on 11 February 2021 to discuss the top 3 themes and work towards a commitment to inform the Trust strategy.

Figure 45: National staff survey 2020 percentage of staff employed or under contract to the Trust who would be happy with the standard of care provided by the Trust and recommend it to a friend or relative needing treatment

NHS Outcomes Framework Domain	2017/18	2018/19	2019/2020	2020/21	Acute benchmark group in 2020/21
Domain 4: ensuring that people have a positive experience of care	79.1%	77.4%	78.1%	78.7%	Best result 91.7% Worst result 49.7%
Indicator: If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Question 18d)					

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

- Undertake a programme of work to ensure that the hospital is the Best Place to Work.
- Support our staff to recover from the COVID-19 pandemic through our health and wellbeing programme.
- Continue to train and support our staff in quality improvement to develop their capacity and capability to lead and sustain change.

Venous thromboembolism (VTE)

Figure 46 shows the Trust's performance on VTE risk assessment. Salisbury NHS Foundation Trust considers that the percentage of patients admitted to hospital and who were assessed for the risk of VTE (blood clots) is as described for the following reasons:

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

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

- Salisbury NHS Foundation Trust continues to be an exemplar for the prevention and treatment of VTE (blood clots) and achieved 96.8% of patients being assessed for the risk of developing blood clots and 96.9% receiving appropriate preventative treatment. We continue to monitor our progress and feedback the results to senior doctors and nurses.
- We continued to conduct detailed enquiries of patients who developed blood clots in hospital to ensure we learn and improve.
- Updated our VTE clinical COVID-19 protocols in line with the most recent National Institute for Health and Care Excellence (NICE) guidance on VTE prevention, prophylaxis and treatment.
- In January 2021, there was a significant increase in the number of inpatients with a hospital onset thrombosis (17 with a pulmonary embolism and 5 with a deep vein thrombosis). The majority occurred in COVID-19 patients who developed micro-thrombi in the lungs vessels due to an increase in viral load and inflammation. Root cause analysis of all hospital acquired VTEs is undertaken and showed that patients having continuous positive airway pressure (CPAP) respiratory support had an intermediate dose of prophylaxis compared to the standard dose in accordance with NICE guidance. A root cause analysis report is presented to the Thrombosis Committee quarterly.
- Introduced a VTE risk assessment for children.

In 2021/22 as an exemplar site, Salisbury NHS Foundation Trust intends to continue with the actions described above to sustain the percentage of patients admitted to hospital who are risk assessed for VTE and given preventative treatment. The VTE team intend to:

- Increase education on VTE prevention across the Trust.
- Introduce written information on VTE for patients admitted as an emergency. Although this information is already available it is only routinely given to patient admitted for planned surgery or procedure.
- Once published, review and implement the new national guidelines on Venous thromboembolic disease

Figure 46: Patients admitted to hospital who were risk assessed for Venous Thromboembolism

NHS Outcomes Framework Domain	2018/19	2019/20*	2020/21	National average 2020/21	Highest other Trusts 2020/21	Lowest other Trusts 2020/21
Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm	99.5%	99.6%	96.8%	Suspended due to COVID-19	Suspended due to COVID-19	Suspended due to COVID-19
Indicator: Percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism						

*In last year's Quality Account 2019/20 data was only available to February 2020 was 99.6%. The full year is reported to March 2020 as 99.6**%**

Clostridium difficile infection

Figure 47 shows the Trust's C difficile performance. Salisbury NHS Foundation Trust considers that the rate per 100,000 bed days of cases of C.difficile infection are as described for the following reason:

- In February 2019, NHS Improvement published 'Clostridium difficile infection objectives for NHS organisations in 2019/20'. This document set out changes to the C.difficile reporting in 2019/20. The guidance added a prior healthcare exposure element for community onset cases when a patient had been an inpatient in the Trust in the previous four weeks, and reduced the number of days to apportion hospital onset healthcare associated cases from three or more days to two or more days following admission.

- From 1st April 2020, in line with this guidance the Trust reported cases assigned as follows:
  - Hospital onset healthcare associated: cases that were detected in the hospital three or more days after admission.
  - Community onset healthcare associated: cases that occurred in the community (or within two days of admission) when the patient had been an inpatient in the Trust in the previous four weeks.

- For 2020/21, there has been no C.difficile case objective set by NHS Improvement and NHS England for the Trust. However, the Trust has continued to work and focus on reducing the numbers of cases from previous year's figures.

- To date, the impact of the changes in the definitions showed that 15 of the 28 cases were hospital onset with the remaining 13 cases classed as community onset healthcare associated (where patients had been discharged within the previous 4 weeks). The increase in *C.difficile* is part of the overall national picture and may be related to an increase in antibiotic prescribing for the treatment of chest infection associated with the COVID-19 pandemic.

- The Trust rate of C.difficile hospital onset cases was 11.7 per 100,000 occupied bed days in 2020/21. The national report which compares this Trust's rate with the rate in the South West and in England is not available this year. Due to the increased workload for the Infection Prevention & Control Nurses during the declared COVID-19 pandemic, no healthcare associated cases have been submitted for appeal with the relevant local Clinical Commissioning Groups (CCGs) for this time period. This could not be achieved with the ongoing priorities of the pandemic work.

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

Due to the COVID-19 pandemic, the Trust has seen a reduction in the number of patients being admitted to Salisbury NHS Foundation Trust. The following actions have been taken in 2021/2020 to reduce the rate per 100,000 bed days of cases of C. difficile infection and improve the quality of its services by:

- Maintaining and monitoring good infection control practices including hand hygiene, wearing of personal protective equipment, prompt isolation nursing and sampling of patients with suspected infectious diarrhoea.
- Maintaining and monitoring standards of environmental and patient care equipment cleanliness and taking actions to improve.
- Improved best practice in antibiotic prescribing and review from auditing.

Salisbury NHS Foundation Trust intends to take the following actions in 2021/2022 to reduce the rate per 100,000 bed days of cases of C. difficile infection to improve the quality of its services by:

- Continued vigilance through the above actions.
- Undertaking monthly audits of antibiotic prescribing practice and focus on improvement actions.
- Continue collaborative working partnerships with the local Clinical Commissioning Groups to share learning and best practice.

Figure 47: Rate per 100,000 bed days of C difficile infection reported within the Trust amongst patients aged 2 or over

NHS Outcomes Framework Domain	2017/18	2018/19	2019/20	2020/21	National average 2020/21	Highest average other *SW Trusts 2020/21	Lowest average other *SW Trusts 2020/21
Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm	5.1	4.4	5.9	11.7	Not available	Not available	Not available
Indicator: The rate per 100,000 bed days of C difficile infection reported within the Trust amongst patients aged 2 or over							

*SW = South West

Patient safety incidents

Figure 48 shows the Trust's performance on patient safety incidents. Salisbury NHS Foundation Trust considers that the rate of patient safety incidents reported and the number and percentage of such incidents that resulted in severe harm or death are as described for the following reasons:

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

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

- Investigating incidents and sharing the lessons learnt across the Trust and ensuring recommendations are implemented through the Executive Divisional Performance Review meetings.
- Continuing to monitor the completion of recommendations from reviews at the Clinical Risk Group, Clinical Management Board and Clinical Governance Committee.
- Ensuring timely identification of themes, trends and learning.
- Cancer pathway improvement following a cluster of serious incidents related to missed or delayed diagnosis of cancer. Four work streams were set up: 1) introduce and embed eOutcome forms across all specialities 2) Implement additional functionality in the results reporting system 3) Review current standard operating procedures and processes for results requesting, reviewing and sign off with actions agreed to improve 4) Monitoring of cancer pathway follow up appointment compliance. This has resulted in a new clinical alert being added to the patient record to support easier identification, reporting and re-conciliation of patients on a cancer pathway and a follow up code is being added to the patient's referral to support monitoring of follow up activity. The cancer action group was established and meets weekly to monitor and progress actions.
- A maternity safety improvement plan including actions required from recommendations in the Ockenden report 2020.

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

- Reviewing data from the National Reporting Learning System (NRLS) (figure 50) shows an increase in the number of incidents reported and the NRLS indicates there is no evidence for potential under reporting of incidents and the Trust remains within the expected range.
- The Trust will continue to improve its safety culture by actively promoting reporting, investigation of clinical incidents and serious incidents and share learning across the Trust and with our commissioners to ensure improvement.

Our national staff survey 2020 showed that when asked:

- My organisation treats staff who are involved in an error, near miss or incident fairly - 58.8% of staff felt they were treated fairly compared to the national average 61.4%.
- When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again – 70.1% of staff felt the Trust took action to ensure errors, near misses or incident do not happen again compared to the national average of 72.7%.
- We are given feedback about changes made in response to reported errors, near misses and incidents – 56.7% of staff felt they were given feedback about changes made compared to a national average of 61.9%.

Figure 48: National Reporting Learning System rate of patient safety incidents reported and the percentage of incidents that resulted in severe harm or death

NHS Outcomes Framework Domain	Indicator	2018/2019	2019/2020*
Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm	The number and rate of patient safety incidents reported within the Trust.	39.77 incidents per 1000 bed days	43.79 incidents per 1000 bed days
	The number and percentage of such incidents that resulted in severe harm or death	25 incidents 0.38%	33 incidents 0.52%

*2019/2020 data was not available by 1/5/20. The full year is now reported.

Duty of Candour

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

Part 3: Other information

Review of Quality Performance

This section gives an overview of the quality of care offered by Salisbury NHS Foundation Trust based on performance in 2020/2021 against a range of selected indicators on patient safety, effectiveness and experience. These areas have been chosen to cover the priority areas highlighted for improvement in this Quality Account, as well as areas which our patients have told us are important to them, such as cleanliness and infection prevention and control. Our commissioners measure all these areas and our improvement schemes support these metrics.

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

Figure 49: Trust performance of patient safety, clinical effectiveness and patient experience indicators

Patient Safety Indicators							
Indicators	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**National average**	**What does this mean?**	**Data source**
1a.Mortality rate (HSMR)	101	106	103*	115.8 (Jan 21)	100	Lower than 100 is good	National definition of HSMR & SHMI
1b. SHMI	106	101	101*	103 (Dec 20)	100		
2. MRSA notifications**	0	3	0	3	Not available	0 is excellent	National definition
	0	(3)	(0)	(4)			
3. C. difficile infection per 1,000 bed days							
a. Trust and non-Trust associated	0.12	0.12	0.14	0.21	Not available	Lower than national average is good	National definition
b. Trust associated only	0.05	0.05	0.06	0.11			
4. 'Never events' that occurred in the Trust***	3	3	2	0	325 (April 20 – Feb 21)	0 is good	National Patient Safety Agency
	These were associated with surgery	2 related to surgery, 1 with an air flow meter	1 related to a retained swab & 1 associated with an air flow meter	0			
5. Patient falls in hospital resulting in a fracture or major harm	29	36	24	23	Not available	Lower number is good	

Clinical Effectiveness indicators							
6. Patients having surgery within 36 hours of admission with a fractured hip	78.6%	85.2%	81.9%	83.4%	90%	Higher number is good	National definition with data taken from hospital system and national database.
7. % of patients who had a risk assessment for VTE (venous thromboembolism)	99.5%	99.5%	99.6%	96.8%	90%	Higher number is better	
8. % patients who had a CT scan within 12 hrs of admission with a stroke	within 12 hours						
	97.8%	99.2%	96.9%	96.1%	Not available	Higher number is better	Local indicator
9. Compliance with NICE Technology Appraisal Guidance published in year	90%	89%	74%	82%	Not measured	Higher number is better	Local indicator
Patient experience indicators							
10. Number of patients reported with ****category 3 & 4 pressure ulcers	3	3	21	10	Not available	Lower number is better	National definition (data taken from hospital reporting systems)
11. % of patients who felt they were treated with dignity and respect							
a. Yes always:	85%	83%	84%	Report Nov 21	Not available	Higher number is better	National in-patient survey
b. Yes sometimes:	12%	15%	14%	Report Nov 21			
12. Mean score of patients' rating of quality of care #	8.2	8.2	8.3#	Report Nov 21	Not available	Higher number is better	National in-patient survey
13. % of patients in mixed sex accommodation	6%	8.7%	8%	Report Nov 21	Not available	Lower number is better	
14. % of patients who stated they had enough help from staff to eat their meals	67%	54%	63%	Report Nov 21	Not available	Higher number is better	
15. % of patients who thought the hospital was clean	69%	67%	67%	Report Nov 21	Not available	Higher number is better	
16. % of patients who got enough to drink	91%	90%	92%	Report Nov 21	Not available	Higher number is better	

* In 2019/2020 HSMR was reported as 105 to December 2019. The full year rate was 103 to March 20. In 2019/2020 SHMI was reported as 103.9 to October 2019. The full year rate was 101 to March 2020.
** In previous annual reports the Trust quoted Trust and non-Trust apportioned MRSA notifications as a total figure. This will have included community hospital and GP patients. The total figure is quoted in brackets in the table.
*** Never events are adverse events that should never happen to a patient in hospital. An example is an operation that takes place on the wrong part of the body. The national never events list was revised in April 2018 describing 15 categories of never events.
**** From 1 December 2018 pressure ulcers terminology changed from a 'grade' to a 'category'.
# The patient safety indicator name has been changed from '13. Mean score of patients stating the quality of care was very good or better' to 'Mean score of patients rating of quality of care' as it is no longer rated between excellent and poor but is on a sliding scale from 10 to zero. In 2019/20 report the mean score of patient's rating of quality of care was reported as 8.3. The finalised rating was **8.3.**

NHS Oversight Framework 2019/20 Indicators

Figure 50: Trust performance indicators

Measure & indicator	2018/2019	2019/2020	2020/2021 (M10)	Standard 2020/2021
Acute emergency care and transfer of care A&E maximum waiting time of 4 hours from arrival to admission, transfer or discharge.	91.01%	90.06%	89.95%	95%
Cancer Services All cancers – maximum 62 day wait for first treatment from: • Urgent GP referral for suspected cancer • NHS Cancer Screening Service referral	 84.6% 93.5%	 83.3% 87.9%	 83.6% 43.3%	 85% 90%
Planned care Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	93.06%	91.9%	69.4%	92%
Planned care Maximum 6 week wait for diagnostic procedures	99.0%	98.8%	81.1%	99%
Dementia assessment and referral: the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours • Who had a diagnosis of dementia or delirium or to whom case finding is applied • Who, if identified as potentially having dementia or delirium are appropriately assessed and • Where the outcome was positive or inconclusive are referred on to specialist services	 94% 100% 100%	 96% 100% 100%	 NHSE suspended this metric in 2020/2021 due to the COVID-19 pandemic	 90% 90% 90%
Mixed-sex accommodation breaches (number of non-clinical occurrences)	57	92	89	0
MSSA bacteraemias (hospital onset healthcare associated)	9	5	3	0
E.coli bacteraemias (hospital onset healthcare associated)	16	16	18	0

*This includes Type 1, 2, & 3 Emergency Department attendances from 1 April 2017.
**In 2019/2020, 8 successful appeals for no lapses in care were made to NHS Wiltshire and NHS West Hampshire Clinical Commissioning Groups who agreed they could be removed from the Trust's figures as there were no lapses in care. The figure reported is the total number of hospital onset health care associated cases including the 8 cases successfully appealed.
***In 2019/2020 SHMI was reported as 103.9 to 30/10/2019. The full year rate was 101 to March 20.

Figure 51: Type 1, 2 and 3 attendance to the Emergency Department

Performance	2018/19	2018/19	2020/21
Type 1	87.16%	86.03%	87.04%
Type 1+2	87.97%	86.89%	87.81%
Type 1+2+3*	91.01%	90.06%	89.95%

Type 1 = Attendances to the Emergency Department at Salisbury District Hospital
Type 2 = Attendances to the Emergency Department (Ophthalmology) Outpatient Clinic at Salisbury District Hospital
Type 3 = Attendances to the Salisbury Walk-in Clinic (offsite). In 2019/20 the Salisbury Walk-in Centre was managed by Salisbury NHS Foundation Trust from 1 April 2019.
*Type 1 & 2 & 3 are under the management of Salisbury NHS Foundation Trust and shows the performance of the Trust as 89.95% in 2020/21.

NHS
Salisbury
NHS Foundation Trust

Reading a Statistical Process Control (SPC) Chart

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

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

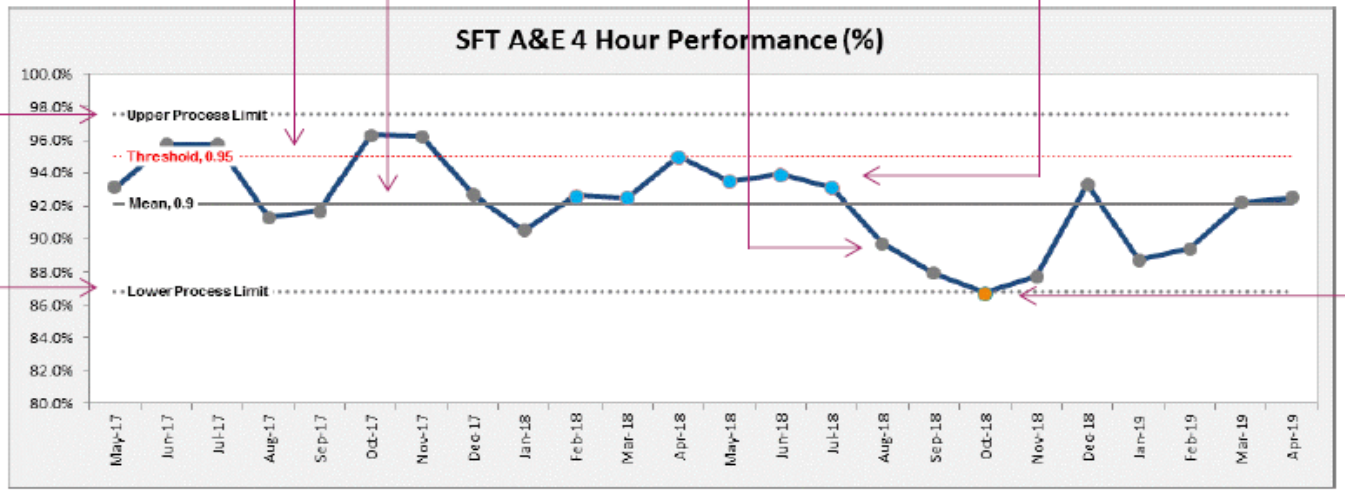
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

Blue markers indicate that there has been a marked improvement in performance, showing 6 or more points above the Mean or one point greater than the upper limit

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



Statistical Process Control Chart Key:

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

Part 3: Annex 1

Statement from Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group on Salisbury NHS Foundation Trust 2020 - 2021 Quality Account – 27 May 2021

Bath and North East Somerset, Swindon and Wiltshire CCG
West Hampshire Clinical Commissioning Group

Statement from Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group (CCG) in collaboration with Hampshire, Southampton and Isle of Wight CCG on Salisbury Hospital NHS Foundation Trust 2020/21 Quality Account.

NHS Bath and North East Somerset, Swindon and Wiltshire CCG welcome the opportunity to review and comment on the Salisbury Hospital NHS Foundation Trusts' (SFT) Quality Account for 2020/2021. In so far as the CCG has been able to check the factual details, the view is that the Quality Account is materially accurate in line with information presented to the CCG via contractual monitoring and quality visits and is presented in the format required by NHS Improvement 2019/2020 presentation guidance. The CCG supports the Trusts' identified quality priorities for 2021/22.

It is the view of the CCG that the Quality Account reflects the Trusts' on-going commitment to quality improvement and addressing key issues in a focused and innovative way, as well as utilising the nationally set CQUIN schemes to support the achievement of many 2020/21 quality priorities. The Trust priorities for 2020/21have outlined achievement in:

- Reduction in antimicrobial resistance.
- Screening of all patients admitted as an emergency for Covid-19 to prevent cross infection.
- Increasing the percentage of patients requiring a consultant review at the weekend from 77% in 2019 to 90% in 2020, thereby improving the safety and effectiveness of the hospital at the weekend.
- Improving patient safety to reduce avoidable harm by using multiple sources of patient safety information and involving patients and staff.
- Implementation of the national learning disability improvement standards by increasing the use of alerts on the Trust's electronic patient record system, and continuation of the Trust's 'Treat Me Well' campaign in improving the experience of patients with a learning disability.

The CCG welcomes continued focus on:

- Review of antenatal pathways and use of the Maternity Day Assessment Unit to ensure women are assessed by a senior doctor in a timely manner.
- Reducing the number of patients who acquire a category 3 or 4 pressure ulcer in hospital.
- Sustaining 100% screening for sepsis in adults admitted both to the Emergency Department and as inpatients.
- Reducing the number of falls resulting in harm through the use of QI to spread improvement throughout the organisation.
- Infection Prevention and Control, working with community partners to improve rates of infection such as C.Diff.
- Improving cancer pathways to avoid long waits and delayed diagnosis.

The CCG would also like to acknowledge the work of the Trust in supporting staff, noting its success in recruiting staff whilst also recognising the work still to do.

In addition, the CCG would like to highlight the continued work of the trust in relation to its response to and recovery from the Covid-19 pandemic and the impact this has had on staff. The Trust has worked and continues to work with local communities and partners to focus on health inequalities as patients continue to be seen virtually, reducing waiting times for treatment and valuing patient's time by ensuring that they are only in hospital when necessary.

The Trust has continued to take steps to learn from patient safety incidents and monitor this through the Clinical Management Board and Clinical Governance Committee providing the CCG with assurance on how they are addressing these areas of improvements and embedding the learning to ensure that appropriate actions are taken to avoid reoccurrence. In particular, taking note of the requirements of the Patient Safety Strategy in further supporting a safety culture and linking with the Trust's priority for 2021/22 in continuing to improve patient safety and reduce avoidable harm

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

Yours sincerely

Gill May
Director of Nursing and Quality

Wiltshire Council

Salisbury NHS Foundation Trust (SFT)

Statement from Wiltshire Council Health Select Committee, dated 15 June 2021

The Wiltshire Health Select Committee welcomes the opportunity to comment on the quality account, especially when SFT could have chosen not to produce full Quality Accounts this year due to the COVID - 19 pandemic. The 2021 election period and subsequent time before the Health Select Committee membership was finalised has meant that this review has been accelerated to meet the account deadline.

As was also the case last year, the committee recognised the depth and detail of the Quality Accounts and appreciated the clarity of the information provided. The tremendous challenges in responding to the COVID-19 pandemic whilst simultaneously maintaining service delivery was noted, as were the achievements and opportunities documented within the account.

The move to digitally enabled pathways and the feedback that 78% of patients said the consultation was the same or better than a face to face appointment, demonstrated impressive flexibility to the impacts of the pandemic. The committee welcomed the 'stop the pressure' campaign which would hopefully provide the education to staff to respond to the increased number of pressure ulcers amongst patients. The Trust is commended for training 14 staff as learning disability ambassadors. The commitment to patient safety was extremely positive. The committee looks forward to the seeing the improvements in the administration of intravenous antibiotics within 1 hour of sepsis and antibiotic prescribing for lower urinary tract infections in older people. The Acute Hospital Alliance with RUH and GWH and its potential positive impact on waiting list management and diagnostic services was another excellent example of applying a system approach to the support of patients. Overall, it is hoped that the resetting of services will address the ongoing gap between outcomes and performance levels in respect of bedsores and sepsis.

Looking forward, the focus on 2021 /2022 to reset service levels to pre-COVID levels and to the support the health and well-being of staff is well received by the committee. Councillors are extremely interested in the transfer from the current 'response' mode to one of 'recovery'. The impacts on patients and staff over this period is something the committee would like to explore in more detail and will be extending an invite to members of the Trust to attend a future committee meeting to outline these proposals.

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

Healthwatch Wiltshire is the independent champion for people using health and care services in Wiltshire. We listen to what people like about services and what they think could be improved and share their views with those who have the power to make change happen.

Healthwatch Wiltshire thanks the Trust for sharing its Quality account and welcomes the opportunity to comment.

We recognise the significant challenges faced by the Trust over the past year due to the COVID-19 pandemic and the changes that have had to rapidly be put into effect. We appreciate the commitment and dedication of staff working at this critical time. This has been reflected in comments we have received from local people.

The systems put in place by the Trust to reduce the spread of COVID-19 should be applauded and we are pleased to see learning was put into place, as well as the involvement of patients in developing an information poster for all wards. We also recognise the significant partnership working with other statutory and voluntarily organisations to support the most vulnerable and hope this is able to continue.

We are pleased to see that weekend consultant reviews have increased and feel that this will have a positive impact on patients, especially those who are admitted over the weekend.

Healthwatch Wiltshire notes that the rate of pressure ulcers has increased and that this is an area of concern. We are pleased to see that work has been undertaken to identify areas that could be improved and that this is continuing though an education package.

Work towards the implementation of the national learning disability improvement standards has progressed and we are pleased that adjustments have been made to outpatient appointments including longer appointment times and quiet waiting spaces. Hearing from people with Autism has been a priority area for Healthwatch Wiltshire over the last year and we would be happy to share what we have heard with you so that this can help inform any future plans in this area.

We note that the Trust has not met its targets for referral to treatment times, but recognise the reasons for this, including the COVID-19 pandemic. We note actions put in place to reduce the wait times for the three speciality areas and commend this.

We are pleased to see that cancer services remained largely unaffected by the pandemic and feedback that we received reflected the importance to people that this was able to continue. We recognise that some patients may have opted to delay their treatment due to concerns relating to the pandemic but are pleased that you have worked with GP's to encourage people to attend their appointments. We would be interested to hear how successful this was.

We recognise the growing use digital technology and virtual appointments, and this works well for many people. Healthwatch Wiltshire has also received many positive comments about the use of technology, particularly video consultations. However, these types of appointments aren't suitable for everyone and could disadvantage some, so we commend work underway to explore options to support people with this. We would be interested to hear more as it progresses and the outcomes.

We were interested to read about the criteria led discharge and will be interested to follow this as it is rolled out across more wards and the impact that this will have on patient experience.

We welcome the priorities set for 2021/22 and look forward to seeing the progress made against these.

Statement from the Governors – 14 May 2021

The quality account is for a year during which the declaration of the coronavirus pandemic was manifest to all. The Trust, operating as part of the national emergency response, amended its priorities to ensure the hospital had the capacity to respond effectively to local outbreaks whilst maintaining access to urgent and essential treatments and care. Working relationships established in the formation of the Bath, Swindon and Wiltshire (BSW) integrated care system (ICS) proved beneficial in ensuring access to care was coordinated across the health and social care sectors while minimising the risk of disease transmission between hospital and community settings.

The Trust decided to publish the quality account to record how it maintained a state of readiness to respond to COVID-19 while it worked to improve care quality, recover the waiting time standards and minimise the number of people waiting for non urgent appointments and care, enshrining into practice alternative and beneficial ways of working. The report also sets the quality improvement targets for 2021/22 which have the support of the governors.

The second wave of COVID-19 driven by the more transmissible 'Kent' variant led to the hospital coming under extreme pressure from mid-December through January. Prevalence in the communities served by the Trust rose alarmingly resulting in over 50% of allocatable beds being occupied by patients with the disease. Coupled with institutional outbreaks in the community and the launch of a successful and much appreciated vaccination programme the demand on the organisation was unprecedented.

The effective response required exceptional and innovative action by the Trust leadership. It required all staff to work as one, committed to ensuring every patient was provided with the best possible care. More than 200 patients died in hospital from COVID-19; many more were successfully treated. The year was one from which every member of staff will carry personal memories that will remain with them. Being justifiably proud of what has been achieved should be one such memory.

John Mangan
Lead Governor

How to provide feedback

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

Part 3: Annex 2

Statements of Directors' Responsibilities for the Quality Report

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

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

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

- The content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2020/21.

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

    - Board minutes and papers for the period April 2020 to March 2021.

    - Papers relating to quality reported to the Board over the period April 2020 to March 2021.

    - Feedback from commissioners NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group dated 27 May 2021.

    - Feedback from governors dated 14 May 2021.

    - Feedback from Healthwatch, Wiltshire dated 13 May 2021.

    - Feedback from Wiltshire Council Overview and Scrutiny Committee dated xx June 2021.

    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 2 April 2020, 2 July 2020, 5 November 2020, 14 January 2021.

    - The 2020 national patient survey will not be published until November 2021.

    - The 2020 national staff survey dated 11 March 2021.

    - The Head of Internal Audit's annual opinion of the Trust's control environment dated 20 May 2021.

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

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

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

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

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

- NHS Improvement published updated guidance 'NHS foundation trust annual reporting manual 2020/21' in February 2021. The guidance indicated there is no requirement for a foundation trust to prepare a quality report and include it in its annual report for 2020/21. This is optional. The Trust decided to prepare the report in the usual way and publish it alongside the annual report. https://www.england.nhs.uk/wp-content/uploads/2021/02/B0322-nhs-foundation-trusts-annual-reporting-manual-20-21.pdf

- In accordance with NHS Improvement guidance 'NHS foundation trust annual reporting manual 2020/21' February 2021 there is no requirement for a foundation trust to commission external assurance of its quality account/report in 2020/21. Therefore, no limited assurance report is available on the quality account report in 2020/2021. In addition, NHS foundation trusts are advised that from 2021/22 onwards it is intended that the quality report in foundation trusts' annual reports will be replaced with reporting within the performance report https://www.england.nhs.uk/wp-content/uploads/2021/02/B0322-nhs-foundation-trusts-annual-reporting-manual-20-21.pdf

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

By order of the Board.

Nick Marsden
Chairman
4 June 2021

Stacey Hunter
Chief Executive
4 June 2021

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

In accordance with NHS Improvement guidance 'NHS foundation trust annual reporting manual 2020/21' February 2021 there is no requirement for a foundation trust to commission external assurance of its quality account/report in 2020/21. Therefore, no limited assurance report is available on the quality account report in 2020/2021.