Bundle Trust Board Public 7 July 2022

1 OPENING BUSINESS

1.1 10:00 - Presentation of May and June SOX certificates

May SOX of the month - Dr Prashant Dwivedi, Speciality Registrar, Gastroenterology
May Patient Centred and Safe SOX - Sarah Singleton, Simon Dennis, Callum Hunter, Kasia Konieczny, Marcel Geyer and the ENT Team
June SOX of the month - Chippy Joy, Staff Nurse, Day Surgery Unit
June Patient Centred and Safe SOX - Jo Pyke, Receptionist ED and Dr Jen Kelly, Oral Surgery

1.2 10:10 - Patient Story

Presented by Victoria Aldridge

1.3 10:30 - Welcome and Apologies

1.4 Declaration of Interests

1.5 10:35 - Minutes of the previous meeting

Minutes attached from meeting held on 5 May 2022
For approval

1.5 Draft Public Board mins 5 May 2022.docx

1.6 Matters Arising and Action Log

1.6 Public Trust Board Action Log July 2022.pdf

1.7 10:40 - Chairman's Business

Presented by Nick Marsden

1.8 10:45 - Chief Executive Report

Presented by Stacey Hunter
For information

1.8a CEO Board Report - June for July Board.docx

1.8b Appendix 1 AHA_June_Briefing_270622_ V1.0.pdf

2 ASSURANCE AND COMMITTEE REPORTS

2.1 10:55 - Clinical Governance Committee - 28 June

Presented by Eiri Jones
For assurance

2.1 Escalation report - from June 2022 CGC to July Board 2022.docx

2.2 11:00 - Finance and Performance Committee - 28 June

Presented by Eiri Jones
For assurance

2.2 Finance and Performance Committee escalation paper 28th June 2022 (002).docx

2.3 11:05 - Trust Management Committee - 22 June

Presented by Stacey Hunter
For assurance

2.3 TMC Escalation Report for Board.docx

2.4 11:10 - People and Culture Committee - 30 June

Presented by Rakhee Aggarwal
For assurance

2.4 Escalation report template 2021.docx

2.5 11:15 - Integrated Performance Report to include exception reports

Presented by Melanie Whitfield
For assurance

2.5a IPR Trust Board cover 070722.docx

2.5b IPR July 2022 finalTB.pptx

3 QUALITY AND RISK

3.1 11:45 - Q4 Patient Experience Report

Presented by Judy Dyos
For assurance

3.1 Patient Experience Report Q4.docx

3.2 11:55 - Q4 Learning from Death Report

Presented by Peter Collins
For assurance

3.2a Cover Sheet Q4 Learning From Deaths Report.docx

3.2b Q4 Learning From Deaths Report.pdf

3.3 12:05 - Director of Infection Prevention Control Annual Report

Presented by Judy Dyos
For assurance

3.3a DIPC cover sheet.docx

3.3b DIPC Report Annual Update 2021-22 (Final v.1).doc

4 STRATEGY AND DEVELOPMENT

4.1 12:15 - Improving Together Highlight Report - Quarter 1 2022/23

Presented by Esther Provins
For assurance

4.1 Improving together quarterly report for Trust Board - June 2022 v0.3.docx

4.2 12:30 - BREAK

5 FINANCIAL AND OPERATIONAL PERFORMANCE

5.1 13:00 - SIRO Annual Data Security and Protection Assurance Report

Presented by Naginder Dhanoa
For assurance

5.1 DSPT - DPO Report to Trust Board HDL.docx

5.2 13:10 - Housekeeping Review

Presented by Andy Hyett
For assurance

5.2a Trust Board cover sheet and report template - Housekeeping.docx

5.2b Housekeeping Review Paper - May 2022.docx

6 PEOPLE AND CULTURE

6.1 Health and Safety Annual Report - deferred to September

6.2 Freedom to speak up Guardian - deferred to September

7 GOVERNANCE

7.1 13:20 - Annual Report and Accounts

Presented by Fiona McNeight
For information

7.1a Annual Report and Accounts 2021 22 Cover sheet.docx

7.1b FINAL SFT Annual Report and Accounts 1 April 2021 to 31 March 2022.pdf

7.2 13:30 - Q1 Register of Seals

Presented by Fiona McNeight
For information

7.2 Register of seals.docx

8 CLOSING BUSINESS

8.1 13:35 - Agreement of Principle Actions and Items for Escalation

8.2 13:40 - Any Other Business

8.3 13:45 - Public Questions

8.4 Date next meeting

8 September 2022

9 Resolution

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

Salisbury NHS Foundation Trust

Draft

Minutes of the Public Trust Board meeting held at 10:00am on Thursday 5th May 2022, MS Teams Salisbury NHS Foundation Trust The Staff Club, Salisbury

Board Members:

Nick Marsden (NM)	Chairman
Paul Kemp (PK)	Non-Executive Director
Paul Miller (PM)	Non-Executive Director
Eiri Jones (EJ)	Non-Executive Director
David Buckle (DB)	Non-Executive Director
Tania Baker (TB)	Non-Executive Director (via teams)
Rakhee Aggarwal (RA)	Non-Executive Director
Lisa Thomas (LT)	Chief Finance Officer
Judy Dyos (JD)	Chief Nursing Officer
Andy Hyett (AH)	Chief Operating Officer
Stacey Hunter (SH)	Chief Executive
Melanie Whitfield (MW)	Chief People Officer
Michael Von Bertele (MvB)	Non-Executive Director
Peter Collins (PC)	Chief Medical Officer

In Attendance:

Esther Provins (EP)	Director of Improvement and Partnerships
Kylie Nye (KN)	Head of Corporate Governance (minutes)
Fiona McNeight (FMc)	Director of Integrated Governance
Jane Podkolinski (JP)	Governor (observer)
Mark Summerill (MS)	Staff Nurse - Britford Ward (item TB1 5/5/1.2)

ACTION

TB1 7/4/1 OPENING BUSINESS

TB1 5/5/1.1 Presentation of SOX (Sharing Outstanding Excellence) Certificates

NM noted the following members of staff had been awarded a SOX Certificate and details of the nominations were given:

- **April SOX of the month – Abi Shattock, SHO Emergency Dept**
- **April Patient-centered and Safe SOX – Kiereen Lock, Speech and Language Therapy**

NM noted the wide variety of nominations that are put forward each month and the great work underway during extremely challenging times. NM and the Board congratulated the members of staff who had received a SOX award.

TB1 5/5/1.2 Staff Story

MS joined the meeting and provided the Board with a detailed summary of his experience of working in the Trust.

MS explained that he had roots in the NHS as many of his family had worked in the Trust. He started as a nursing assistant and had completed his training in the Trust. In between working for the NHS, he

had left to work as a graphic designer for a number of years. However, he missed the enjoyment and fulfilment of work and retrained as a nurse in his 40's. This included 150 hours of unpaid work and included studying and essay writing. MS wanted to work in Salisbury as he knew there was a strong preceptorship programme here.

MS had received his NMC pin number and, within a day, COVID had hit the Trust. The preceptorship programme was attempted but he was redeployed to several areas. MS had really wanted to work on Britford ward but due to COVID people were separated and redeployed and this has had a lasting effect on the team

During this time MS explained that his father was admitted to ITU and sadly passed away. MS explained that the care he received was outstanding despite the pressures. Also, around the same time, the team unexpectedly lost two members of staff and it had felt important for the team to be together and support each other.

The leadership during this time has been brilliant and compassionate. However, many staff have left and the people who have remained are fragile. MS explained that, due to the ongoing pressures and shortness of staff on more than one occasion, he had likely made bad decisions. MS explained that there is not enough staff to do the job required and keep things going and people feel destroyed. This is one of the reasons teams are disappearing and moving to non-clinical roles.

MS noted that the team achieve so much when they work together and, despite being way from families and loved ones for extended periods of time, they work incredibly hard to provide the care they give. However, in many cases the joys of nursing have somewhat eroded.

MS added that a further frustration in the ward is the IT infrastructure, which feels very outdated and does not help the team to undertake their roles effectively.

MS also noted that the way in which teams look after the dying has changed and there is a need for cohesive team work to facilitate that journey.

MS added that the Band 2 Health Care Assistants (HCAs) provide an invaluable service and are essential but the high turnover is not helping to provide consistent care. The role requires more investment to ensure staff are retained and feel valuable in their role.

MS noted that the organisation has historically had a culture and is well led and a good place for students to come and learn. However, the last two years have been hard and in many ways some of the staff do not recognise the job anymore.

Discussion:
NM thanked MS for taking the time to tell his story and noted how incredibly useful it is to understand what the impact of the last two years meant for MS personally and the wider team.

SH reiterated NM's point and noted that his story had really bought the impact on nursing teams to life and the added depth is useful for the Board to be aware of. The key items SH took from the story is the powerful sense of teamwork and belonging, which is recognised in NHS People Plan. Additionally, the point around the experiences and employment we're offering to HCAs and why that is causing a high turnover.

SH asked MS if there are there any missed opportunities that could be within the Board's gift to do. MS suggested that the Board could be more informed of how people from a variety of different bands and from different departments are feeling.

JD thanked MS and noted that shortage of staffing and absence has been spoken about for some time. This story demonstrated how it feels on the other end and is helpful to get across to the Board. What is clear is that there is a genuine feeling of fear when being redeployed. There needs to be respect for the different disciplines.

EJ thanked MS for the story which she found very moving. EJ asked MS how the Board could support him to share his passion for the role. MS noted that he would think about this question and email EJ outside of the meeting.

PC referred to MS's other skills outside of the nursing profession. PC noted that the Board need to consider how the Trust captures the other useful skills that staff have and harness that talent in a useful way. MS noted that knowing your team well is useful to help channel skills.

SH referred to MS's comments in relation to IT infrastructure and noted that there is work underway and there are business cases coming forward to improve the Trust's IT systems.

PM reflected that what came across from the story is the hidden damage of breaking teams up during COVID because of sickness absence and redeployment. There is a hidden cost as well as impacting quality, safety, and morale.

LT suggested that Mark's story would be a great addition to the Trust podcast.

MS left the meeting.

TB1 5/5/1.3 **Welcome and Apologies**

NM welcomed everyone to the meeting and noted the following apologies:

- Lucinda Herklots, Lead Governor

TB1 5/5/1.4 **Declarations of Conflicts of Interest**

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

TB1 5/5/1.5 **Minutes of the part 1 (public) Trust Board meeting held on 7th April 2022.**

NM presented the minutes from 7th April 2022, and they were approved as a correct record of the meeting.

TB1 5/5/1.6 **Matters Arising and Action Log**

NM presented the action log and noted the following key updates:

TB1 7/4/3.2 - Learning from Death Report Q3 – SH noted that this action needed further clarification as it tied into Board development and did not exclusively relate to Learning from Deaths. SH and FMc to work with JD and PC to consider outcome measures and how this is tied into assurance delivered at Board level. **SH/ FMc/ PC/ JD**

It was agreed that all other matters arising were either on a future agenda or closed.

TB1 5/5/1.7 **Chairman's Business**

NM reflected on the previous month and acknowledged that a critical incident had been declared the previous week due to the pressures the Trust is experiencing. Whilst the incident was stood down after 48 hours, it is important to consider these pressures in a wider political context as the NHS faces increasing criticism. NM noted that the current political environment is unsettled and the Local Authority elections will increase the amount of focus and the Board needs to be aware of this. SH is due to discuss this with Amanda Pritchard, CEO of NHS England.

This meeting will focus on the challenges the Trust currently face and the impact on staff.

TB1 5/5/1.8 **Chief Executive's Report**

SH presented her report and highlighted the following key points:

- An Acute Hospital Alliance (AHA) briefing had not been referenced in the written report but it is included in Board papers across the 3 acute Trusts for info.
- The hospital continues to be under consistent and extreme pressures and on 27th April escalated from OPEL 4 to a critical incident. Set clear criteria to bring us out of critical incident so we were not in it for a prolonged period of time. It is important for the Board to be cited on the unprecedented circumstances the Trust finds itself in and the impact this has on the Trust's staff and patients.
- F&P Committee in April signed off the 2022/23 Operational Plan and there has been a lot of ongoing work to ensure the plan is realistic reflection of the what the Trust is able to achieve in this financial year.
- The Trust is supporting the work in relation to the Integrated Care Board development. A number of colleagues are

contributing to the partnership work and it is important to note the current crowded leadership landscape.

- There was due to be an Administrative and Clerical Governance Group on 27th April, which was stood down due to the critical incident. As a result of recent discussions with different teams, it was a reminder of how often admin teams can feel forgotten and that their work isn't celebrated. It is important to acknowledge that clinical staff would be unable to provide a service without the support of the Trust's admin teams.
- Our podcast "Cake with Joe and Jayne" that explore what makes us who we are has now exceeded 1000 downloads and a fourth Easter/springtime special episode has been added.
- SH noted that in Private Trust Board, she would share a letter of escalation to the regional team from the three acute Trusts in relation to concerns about a lack of response from the system to support in the current circumstances.

Discussion:
AH referred to the critical incident, noting that it had not been initiated lightly. AH thanked the Trust's staff for the tremendous response and noted the positive feedback over the two-day period. There were good lessons learnt too, which has led to work to embed different mitigations in certain situations going forward.

PK referred to the recent communications about holiday carry-over and buy back and noted the long-term issues this could cause. MW explained that the guidance about carrying over leave was based on the national promise in the response to COVID. The national guidance to extend 5 days of leave over a two-year period is due to come to an end. The Trust has offered this to staff and but also encouraged people to take holiday. It is accepted that there are pros and cons and line managers have the responsibility to carefully manage any requests for buying back or carrying over leave. The current figures report that 94 staff have chosen to sell some holiday. However, none of these staff have sold back more than 5 days' worth of leave.

TB1 5/5/2 ASSURANCE AND REPORTS OF COMMITTEES

TB1 5/5/2.1 Clinical Governance Committee (CGC) 26th April 2022

EJ presented the report, providing a summary of escalation points from the meeting held on 26th April. EJ asked for the report to be taken as read and highlighted the key points:

- The Committee's discussions focused on the overwhelming impact the Trust is experiencing and the need to keep a focus on maintaining safety and being open and transparent. What is clear is there has been an adverse impact on quality since December 2021, due to ongoing staffing absence and the number of patients with No Criteria to Reside (NCTR) in the Trust.
- A verbal update was provided that progress has been made with the NatSSIPS and LocSSIPS (national and local standards) and that a further update will come to the May committee to provide assurance.

- The Committee considered the annual effectiveness report and it was agreed that the Committee is compliant with its own Terms of Reference.
- The Director of Midwifery presented the Maternity Incentive Scheme and Ockenden 1-year reports to the committee. Both reports demonstrated the improvements that have been made but noted that the Trust were not yet fully compliant in either area. This will come to the committee in the next quarterly report due in May 2022.

Discussion:
PK referred to the Safer Surgery report and noted that it is not best practice to place assurance on future audit reports. There needs to be some self-assessment and management should be encouraged to develop their own independent testing. EJ noted the good challenge and explained that assurance had been received in relation to the processes currently in place. The Committee also received an honest opinion that there was a lot of cultural work to be done. EJ noted that full assurance can only be gained from the future and there is commitment from the new senior team that this is on agenda.

JD explained that the team are undertaking their own audits and it is acknowledged that there are cultural behaviours which need addressing.

PM referred to the discussion around the Board Assurance Framework (BAF) and the increasing risk scores triangulated with the information provided in the IPR. The Committee was assured that the Executives and divisional teams were fully sighted on the challenges and were mitigating as much as possible in the current situation.

TB1 5/5/2.2 **Finance and Performance Committee (F&P) 26th April 2022**

PM provided a summary of escalation points from the Finance and Performance Committee held on 26th April. PM asked for the report to be taken as read but noted the following key points.

- The NHS has a history of adapting and evolving to the environment that it is in. However, the Trust is not in that situation and the symptoms in the IPR reflect the stress on the organisation. The underlying issue is how the hospital can operate if there is a shortage of staff and no flow. No hospital can operate effectively in this situation.
- Therefore, the key escalation point is the considerable stresses in a challenging environment and the impact this is having on the hospital.

Discussion:
SH noted that NCTR has become a huge strategic issue and is one of the key drivers of the planned deficit.

The Committee had a detailed discussion about the operational plan and there was not a consistent view. The plan has no line of sight to £4m of savings and this has not taken lightly. The Trust need to find a

route to deliver the £4m and this requires leadership time and effort away from normal business. The senior management team need to focus on making these difficult decisions that will help to achieve that. LT is working on this and will be bringing to the Executive Directors meeting and then the Board on 9th June. PM asked for the report to be explicit about what is non-recurrent and recurrent once the £4m is worked up.

PK noted that he more concerned that the Trust does not have a deliverable operating plan. SH disagreed, noting that the plan details a realistic set of metrics in the sense of NCTR not changing and elective work not dramatically increasing. PK noted that further to his comments in F&P Committee, he had not been provided with the assurance to agree with the plan. PK explained that it is very unlikely that the Trust can recruit the staff required to deliver the plan and it does not allow any space for error.

SH noted that the recruitment detailed in the plan is not only to achieve elective recovery. Additionally, in relation to having the space for error, the Trust is physically unable to open anymore beds than are already open. PK noted that turnover and vacancies are going up and the focus should also be on operational delivery, not only financial.

It was discussed that, as a category 1 provider, the Trust is unable to close the front door and stop services. The plan was devised with divisional and clinical input and is realistic based on the current set of circumstances.

TB1 5/5/2.3 **Trust Management Committee (TMC) - 27th April 2022**

SH noted that TMC scheduled to take place on 27th April had been condensed due to operational pressures. There is nothing to escalate from the meeting that took place.

Discussion:
PM asked if there was any feedback from TMC about the operational and financial plan. LT noted that pre-COVID, the senior management teams would have been individually engaged in the process but this is currently not the case. The plan represents the triangulated work around activity, capacity, and demand. There is a national ask for specific deliverables and the plan is based on the reasonable and realistic ambitions of the Trust.

LT noted that the plans are owned by the divisional teams but, in terms of ownership of delivery, this is different. SH explained that the divisions are in different places, e.g., medicine are challenged as the work to support ED and flow largely sits with them. SH noted that the Clinical Director is not able to fulfil his leadership commitment as he is having to substitute clinically.

TB1 5/5/2.4 **People and Culture Committee (P&C) – 28th April 2022**

MvB provided a summary of escalation points from the People and Culture Committee held on 28th April. MvB asked for the paper to be taken as read but noted the following key points:

- The Committee discussed the Board Assurance Framework, and it was agreed that the risks are not adequately described to reflect the current situation
- There is diagnostic work to investigate why people are leaving and resource has been allocated to complete that.
- The front line and divisional teams have been unable to release people to move Improving Together training forward.
- Following publication of the Staff Survey the Divisions have each been tasked with evaluating and responding to the specific concerns raised within their own staff groups.
- The number of volunteers able to operate on site are starting to return to pre-pandemic levels and there has been a renewed focus on volunteering across the NHS, in the form of cadets and Reserves.
- MvB noted that this all ties into the strategic plan for OD and People which is a focus for the team over the coming months.

Discussion:
The Board noted that the Staff awards ceremony will be in the same format as last year. This event will coincide with a volunteer thank-you lunch and the Annual General Meeting.

EJ noted that the NHS does not capitalise on volunteers as well it should and noted what a valuable resource they are. EJ noted that the Trust could learn from other, bigger organisations who have a wealth of programmes and resource and have built an interactive relationship with their volunteers.

The Board discussed the impact of operational pressures on the delivery of the Improving Together programme. EP noted that the team are looking to reframe the approach to establish a method of delivery which aligns to the current pressures in the Trust.

TB1 5/5/2.8 **Integrated Performance Report (IPR) (M12)**

PC presented the Integrated Performance Report which provided a summary of March 2022 performance metrics. PC noted that the operational challenges to the Trust had been discussed in detail but highlighted a few key points:

- The Trust is maintaining its position in relation to elective recovery; however, the trajectory does keep increasing.
- The small number of Friends and Family Test (FFT) responses received suggest that people are happy with the service provided.
- PC was pleased to report that there has been an improvement in the mortality metrics as the Trust moves into a new financial year.

Discussion:
SH noted the importance of highlighting good feedback and referred to a letter she had received from a veteran who had praised the excellent

care he had received as an inpatient. This does not detract from the challenges currently experienced but there are some fantastic colleagues who work here and positive letters of thanks are received weekly. This needs to be communicated back to colleagues.

The Board also noted the good news that colleagues in the Orthopaedic team have completed their very first Day Case hip replacement. It was reported that the patient in question is home and recovering well.

JD noted that in relation to C. Difficile, the Trust benchmarks in the top 25% of NHS Trusts which is positive.

EJ noted that the pressure ulcer data indicates that there has been an increase in grade 2 pressure ulcers. However, when looking at the overall trend analysis, there has been a reduction in cases since last year.

EJ further referred to Stroke performance and the subsequent impact on patients. The Board Committees have discussed this at length and the challenges are known. The next steps have been mapped out and it has been noted that this is an improvement journey.

DB noted that the IPR covers a multitude of issues and therefore asked PC if he had any specific risks or safety concerns to escalate. PC noted that one thing to highlight in particular is the impact on staff absence to small, fragile teams. The added burden of COVID and stretching a service so thin that their ability to react and provide a sustainable service is concerning. There is a constant need for senior management level intervention with only short-term planning possible.

DB queried if the Trust had managed to get through these difficult periods due to staff loyalty and teamwork. PC explained that there have been huge discretionary efforts made by staff and the Trust is now at a point where staff are exhausted, and understandably prioritising life outside of work.

PM noted that the Trust have fragile teams because of how the NHS Chose to manage COVID. PM asked that at what point is the Trust going to further loosen the Infection, Prevention and Control guidelines to avoid the significant harm to other patients. PC noted that the Trust is taking every opportunity to explore this, although pointed out that new guidance has recently been issues reinforcing lateral flow tests for front line staff. PM noted that the Boards development in relation to risk appetite will hopefully make a different in managing this.

AH reminded the Board that the impact of being in a level 4 major incident is still very much ongoing with meetings every week and requests for data placing an additional burden on staff resource.

TB1 5/5/3 QUALITY AND RISK

TB1 5/5/3.1 Infection Prevention Control Update

JD provided an update on Infection, Prevention and Control Measures and highlighted the following key points:

- At the last private Trust Board, a presentation was provided around the proposed changes on IPC guidance and how the Trust tests patients and staff.
- On the Friday pre-Bank Holiday national guidance was published which meant the Trust was in fact not out of line with most of these recommendations.
- One deviation in the Trust's guidance, compared to the national publication is that SFT has stopped routine testing for covid as it is now treated as an infection. The national guidance advocates that the Trust should test at 3 and 5 days using Lateral Flow Tests (LFT). The Trust is upholding its position on not undertaking this routine testing.
- The team are producing duty of candour style leaflets to make patients aware of the new guidance and the testing rules and the rationale behind this decision.

Discussion:
DB asked if patients regularly request LFTs. JD explained that this has not been raised as an issue but patients do turn up to ED COVID-positive. There are LFTs available on wards. One of the issues currently being worked through is the recording of LFTs since the move from PCR tests as they were formally reported through the system.

SH noted that following the last discussion in private Trust Board she and PC proactively alerted the CQC to the Trust's proposals on IPC and testing. SH and PC have formally written to the CQC liaison who will escalate to south west team. No response has been received and we have discharged responsibilities in full.

TB1 5/5/3.2 **Ockenden - One year on**

JD presented the report, providing assurance against the recommendations in the part one Ockenden report from December 2020. JD noted that the report had come slightly later than planned due to staff absence. JD highlighted the following key points:

- This is the first round of Ockenden requirements. Ockenden part 2 was published in March 2022 and a set of further recommendations are currently being worked through.
- There is one area marked as red which is the Trust's ability to submit maternity services dataset to the required standard. His down to digital immaturity of some of our systems and there is a national drive to implement a way forward to manage this.
- There are several amber recommendations throughout report but JD noted that action is being taken to address these recommendations.
- The key learning from the review against the recommendations is learning, failure to learn and quality of internal investigation.

- JDy noted that she was content that the department is focusing on specific areas of improvement and acknowledged the huge amount of progress achieved in the past two years.

Discussion:
EJ commented that implementing the new senior leadership team into Maternity has meant a huge step forward in the service. JD explained that a specific area of risk is ensuring people receive the right training which is important but time consuming.

PM noted that when the management team were strengthened this was initially on a short timescale. SH noted that this has been reviewed and the Trust is progressing with the current arrangements. JD referred to the cultural behaviour programme which will also include multi-professional learning.

EJ noted that there will be another review but learning should be and is continuous.

TB1 5/5/4 FINANCIAL AND OPERATIONAL PERFORMANCE

TB1 5/5/4.1 Board Assurance Framework and Corporate Risk Register

FMc presented the Board Assurance Framework (BAF) and the Corporate Risk Register and noted the following key points:

- The BAF has been completely revised to align to the recently approved Trust Strategy and Strategic Objectives of Population, People and Partnerships. The format has been amended to strengthen the presentation and alignment of corporate risks to the corporate priorities, making the link more explicit.
- As part of the Improving Together Programme and revision of the Trust corporate priorities, the BAF will be amended to reflect any changes for 2022/23.
- As reporting at the Board Committees, the Trust's risk profile has increased.
- There will be a development session at the end of March to discuss the Trust's approach to risk appetite.
- There have been discussions with ICS colleagues about what the collective Board Assurance Framework will look how and how this will be presented to the board.
- It is important to note that the style and presentation of the BAF is not as important as the level of discussion it invokes in the Board Committees.
- There are 8 extreme risks which are summarised in the paper and have been discussed in the Board Committees.
- The BAF reflects level of risk, with a few further risks to work up following discussion in the Board Committees.

Discussion:
PM referred to risk 6654 and 6570 and noted that there should be a better balance between the risk of COVID outbreaks compared to the consequences. JD noted that the risk of outbreaks has risen due to the

change in guidance but agreed she would review both risks. **ACTION: JD/FMc** **JD/ FMc**

DB referred to the risk in relation to the Pharmacy Aseptic Unit and asked if there should be a broader risk relating to the overall lack of pharmacists. PC agree that there is a workforce risk but this relates to a specific risk around the aseptic unit. PC noted that generic workforce risks highlighted in the BAF covers the wider shortage of staffing and the impact on service provision. FMc noted that this was covered in the strategic risks.

TB1 5/5/4.2 **Corporate Priorities 2021/22**

LT presented the report which asked the Board to note the progress and Q4 updates against the 2021/22 corporate objectives agreed by the Board.

LT noted that this closed the previous financial year and noted that the areas the Trust has been most challenged in delivering is aligned to the discussions at Board today.

Discussion:
EJ noted that often solutions can be found in the challenges, for example with the Older Persons assessment and Liaison Services (OPAL) work underway, where good practice has been demonstrated.

TB1 5/5/5 GOVERNANCE

TB1 5/5/5.1 **NHSI Self-Certification (FT4, G6, CoS7)**

FMc presented the report which asked the Board to consider and approve the evidence aligned to each element of the provider licence conditions, which the Board is required to self-certify against. It was noted that the self-certification had been to F&P Committee and had been supported.

Decision:
The Board approved the NHSI Self Certification FT4, G6 and CoS7.

TB1 5/5/6 CLOSING BUSINESS

TB1 5/5/6.1 **Agreement of Principle Actions and Items for Escalation**

NM noted the key points from the meeting as follows:

- The sustained theme around the exceptional challenges the Trust is experiencing and the impact this has on our staff and patients.
- NM appreciated the team highlighting the positives and noted that staff are trying to deliver the best level of care they can.
- Mark Summerill delivered an impactful and sobering staff story.
- The Trust has made good progress with the Ockenden recommendations and continues to work through the next phase.
- The Trust have updated the IPC measures in relation to COVID testing and social distancing.

TB1 5/5/6.2 **Any Other Business**

There was no other business.

TB1 5/5/6.3 **Public Questions**

There were no public questions.

TB1 5/5/6.4 **Date of Next Public Meeting**

Thursday 7th July 2022, Board Room, Salisbury NHS Foundation Trust

TB1 5/5/7 **RESOLUTION**

TB1 5/5/7.1 Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

Master Action Log
Open Actions

Contact Kirsty McAllister, kirsty.mcallister@nhs.net, 4439, for any issues or feedback

1	Deadline passed
2	Progress made, please detail
3	Completed
4	No progress made

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Grandfield	1 10/3/2.4, TB1 7/4/1.6 - IPR / Maternity Dashbo	24/05/2022	Judy Dyos, JD	Further work required to maternity dashboard in the IPR as it is difficult to understand . JD to speak with TB.	**JD explained that the improvements on the Maternity dashboard will be coming to Clinical Governance Committee (CGC) in May. Item to remain open until then**	N	2
Trust Board Public	Sasha Grandfield	TB1 7/4/1.6, TB1 13/1/5.4 - Equality, Diversity and Inclusion (EDI) Annual Report/ Staff Networks	08/09/2022	Melanie Whitfield, MW	A formal update on EDI progress to come to the Board in July.	**Defer to September's meeting**	N	4
Trust Board Public	Sasha Grandfield	TB1 7/4/3.1 - Patient Experience Report Q3	07/07/2022	Judy Dyos, JD	EJ asked that the graph, indicating how many concerns and enquiries were dealt with by PALs before they led to a possible complaint, could be added back into the report.	**Report on July's agenda.**	N	2
Trust Board Public	Sasha Grandfield	TB1 7/4/3.2 - Learning from Death Report Q3	09/06/2022	Peter Collins, PC	There is a requirement for further assurance re HSMR and SH asked PC to bring this back to the Board	**Next quarterly report due in July**	N	2
Trust Board Public	Sasha Grandfield	TB1 7/4/3.2 - Outcome focus at the Board/ Learning from Death Report Q3.	04/08/2022	Peter Collins, PC Fiona McNeight, FMC Stacey Hunter, SH Judy Dyos, JD	TB reflected that the Board does not spend time looking at outcome measures and there needs to be a way of building and demonstrating these. It was agreed that SH and FMc would liaise with JD and PC to think about introducing an outcome focus at Board.	**SH and FMc to work with JD and PC to consider outcome measures and how this is tied into assurance delivery at Board level - August 22.**	N	4

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	1.8
Date of Meeting:	07 July 2022		

Report Title:	Chief Executive's Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			
Approval Process (where has this paper been reviewed and approved)	N/A			
Prepared by:	Stacey Hunter, Chief Executive Officer			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive Officer			
Appendices (list if applicable):	Appendix 1 – AHA June Briefing			

Recommendation:
The Board is asked to receive and note this paper as progress against the local, regional and national agenda and as an update against the leadership responsibilities within the CEO portfolio.

Executive Summary:
The purpose of the Chief Executive's report is to highlight developments that are of strategic relevance to the Trust and which the Board of Directors needs to be aware of. This report covers the period since the last public board meeting on the 5th May 2022. Key points to note: • BSW have resubmitted the 21/22 operational plan mid-June as per the national requirement. The plan demonstrates the path to a break-even position for the system. The details of this have been shared with Board members at our meeting on the 16th June. • SFT position has changed to reflect the change in plan and is now revised to deliver a deficit of £12.4m rather than a deficit of £18m. This will require a material improvement in productivity across elective services and an improved response from the system to reduce the number of people in hospital who have no criteria to reside. • Our clinical and operational teams worked alongside system colleagues delivering a SAFER event for 5 weeks which identified opportunities to increase effective discharges and test alternative models of care that reduce the need for people to

be admitted to hospital. The work was successful in reducing the run rate of people with no criteria to reside by circa 20 people per day. The next steps are to agree how to build on this and sustain a reduction in this key metric.

- Our operational context remains challenging with escalation beds still open, demand for urgent services consistently pressurised, the on-going need to deliver elective recovery and staff availability day to day creating significant pressure for the teams.

- Despite the challenges our elective recovery is currently on track in respect of delivering the headline requirements for waiting times i.e., no patients waiting over 104 weeks for care by end of July, continued reduction in those waiting over 78 and 52 weeks respectively.

- There has been a deterioration in our performance against the 6-week diagnostic standard which is a concern. The detail is within the IPR and those modalities that are failing to deliver are working on their recovery plans. The underlying constraint is insufficient capacity in respect of the skilled workforce required.

- Over the last 3 weeks the number of people with COVID in the community and the number of people requiring hospitalisation for COVID has increased. At the time of writing this report there are 36 inpatients receiving care in hospital and increase to 80 members of staff not able to work as they have COVID. This is up from single figures in the previous period. The modelling for the BSW suggests we will continue to see increases over the coming 4-6 weeks aligned to the national picture. This inevitably poses some risk to our elective activity plan which we continue to manage closely.

- The Board will want to note that by the time we are our Board meeting the Integrated Care Board for BSW will have met on July 1st, 2022 in the first meeting of the newly created ICB. I will provide a verbal update at our Board meeting

- The plans to develop formal arrangements for place-based governance are continuing to progress. The Wiltshire place-based leadership team which I am a member of has agreed draft terms of reference that will need to be ratified by the ICB in due course. We are due to be joined at a future Board meeting by the ICB Chair and CEO which will provide a good opportunity to discuss collaborative working across the partnership.

- Our work with the Acute Hospital Alliance continues to develop and gather momentum. The committee in common are due to meet in a strategy session on the 11th July 2022 to consider how we build on the current work programme over the coming 12-24 months. The report of the current AHA work programme is attached for your information (Appendix 1)

- The Board will want to note that our Paediatric inpatient team continue to experience challenges caring for adolescents with mental health illnesses who are unable to access care from mental health services in a timely way. This is aligned

to the known capacity challenges in this sector and whilst I am confident partners are working collaboratively to help respond, we need to recognise that this can be distressing for our colleagues.

- Our podcast series Cake with Joe and Jayne continues to build in popularity with our colleagues. They are helping us raise the profile and understanding of key priorities within our commitments to building a more inclusive culture and are gaining excellent feedback from listeners.

- We have launched our call for nominations for our annual staff awards in September. This gives us another fantastic opportunity to recognise the contributions colleagues deliver to our local communities.

- Our team in the minor injury services opened their new facilities in June providing a significantly improved environment for patients and staff. This has been a complex capital scheme involving several service changes and it is great to see it come to fruition.

- The up-and-coming changes in our executive team which the Board are appraised of have been communicated to the organisation and our partners.

Board Assurance Framework – Strategic Priorities	Select as applicable
Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒
Other (please describe) -	☐

1. Our Population

1.1 Operational Context

Our activity in urgent care pathways remains high which coupled with limited progress on the overall reduction in people with No Criteria to Reside (NCTR) is creating continued pressure across the hospital. Whilst we have seen improvements in the number of hours lost to ambulance handover delays because of the constraints on flow, it remains significantly worse than it was prior to the pandemic. Alongside colleagues in the BSW system we have submitted a revised plan to address this. The critical success factor from an SFT perspective focused on reducing the length of stay in those patients with NCTR. Elective recovery has been sustained in respect of delivering the key waiting time standards in the current operating plan. There is further work reviewing how we increase overall elective activity which is a combination of continued recruitment to theatre vacancies, productivity measures in theatres/surgical pathways and ensuring sufficient access to beds for elective patients.

We have seen an increase in the numbers of people in the community and hospital with COVID-19 over this last 3-4 weeks. An element of the increase in hospitalisations includes nosocomial transmission which the Chief Nurse and the Infection Prevention Control team are working with colleagues to manage.
The numbers of staff unable to work due to COVID has also increased again which is impacting on our availability of staff in our clinical and operational teams.
The latest modelling for BSW predicts continued increases over the next 4-6 weeks which is a similar pattern for the rest of the SW and England. If the modelling is accurate, we would see similar levels of patients needing care in hospital as the wave we had in Feb/March 2022. This will pose further risks to our elective recovery.

1.2 Quality Metrics.

The Stoke SSNAP position has deteriorated due to the flow challenges in the organisation which is disappointing and an on-going concern. Since this period the team have returned to their pre COVID configuration and increased the number of Stroke Consultants which should help with the challenges. It is clear there needs to be a continued focus to recover the position.
Overall, the number of people with falls improved per 1000 bed days but falls with harm still a focus in the Improving Together breakthrough objective.
It was positive to see the number of Patient moves reduced in May possible attributed to the safer event which brings benefits for patients and staff. It is clear when we can run with a more optimum bed occupancy circa 92 percent there are significant benefits.
There was no hospital; onset C difficile, MRSA, E. coli bacteraemia's or MSSA reported in month which sustains good progress.
Our SHMI remains in expected range

1.3 Financial sustainability

The financial challenge faced by the Trust and the wider NHS will be significant in 2022/23. At the end of May the Trust has a cumulative deficit of £2.2m, which although in line with all our planning is a clear demonstration of the challenge faced in the context of dealing with pressures on emergency pathways and reducing waiting lists.

Along with our BSW colleagues we have been undertaking an exercise to establish a route to 'breaking even' as a system, this includes several cost reductions measures such as system working to support the reduction of patients in hospital beds who are fit for discharge, as well as additional national funding to support providers in coping with the costs of inflation. Following this exercise, we have played our part, with a reduction in our planned deficit from an initial £18.0m to a revised £12.4m.

1.4 New Minor Injury Unit Facilities

On the 23rd June 2022 colleagues formally opened our new minor injury unit following completion of a significant capital scheme. The team who works in the service have been instrumental in the design and delivery of the scheme and are delighted with their new environment. It will provide increased capacity and improved facilities for patients and families using it and is a much better working environment for staff. I understand from listening to colleagues that this has been long wished for and it was fantastic to join them at their opening.

2.0 Our People

2.1 Staffing

Our staffing situation has not significantly improved, and turnover rose slightly over the previous month from 12.74% to 12.93%. Significant within the reasons for leaving were "retirement" and "relocation" and we will be encouraging use of the Retire and Return policy and other initiatives to help stabilise small but gradual increases in staff turnover. Numbers of available staff remains a challenge, with holidays been carefully managed within agreed parameters, we continue to experience significant sickness absence and despite recent successful recruitment campaigns our vacancy rate remains high, particularly among healthcare assistants.
We have appointed a HCA Recruitment and Retention Facilitator who will look to support HCA in their onboarding and settling into role with the aim of providing a better employee experience.

Staff sickness continued to decline falling to 4.34% against the rolling 12-month trend of 4.56%. Absence remains above our target level, but the decline is welcome. Staff availability continues to challenge our KPI results for training and appraisal.

2.2 NHS Reservists

SFT has taken the lead role for the integrated system initiative to implement the NHS Reservists programme and we have received and replied to 43 expressions of interest from members of the public interested in working between Bath, Salisbury, and Swindon. The programme is being supported by all system partners and the aim is to begin formal recruitment activity before the autumn, once the organisational infrastructure has been set up. The system ambition is to be able to deploy 350 reservists by the second year of operation.

2.3 Actions taken during the period to support colleagues include:

Well-being Conversations

We launched a successful pilot of Well-being Conversations aimed at helping colleagues who may be wrestling with tensions in their domestic, social, and working lives, "bite size" practical training for line managers has been made available and well received. The pilot has been extended to clinical areas in surgery (Amesbury ward) and if the

feedback continues to be positive, we will look to a Trust wide launch along with a call for wellbeing champions in the late summer.

2.4 Staff Network Events

On 10th May, the national day for Staff Networks a social event was held - open to all staff to learn about the Trust's staff networks. Representatives from the Race Equality, Women's. LGBTQ+ and Disability networks were joined at the event with talks by CEO Stacey Hunter MD Peter Collins and David Corbin South West Region Workforce Race Equality Lead.

Our LGBTQ+ network hosted a series of events to recognise and celebrate Pride month. This included bake sales raising money for a local charity who works in support, representation at the Price Event in Salisbury on Saturday 2nd July and a panel who hosted a "Ask any question" session for colleagues. Feedback has been very positive. I would like to thank James Juden our new Chair for this network who generated and organised all the ideas to celebrate Pride. He has brought new energy and passion which is brilliant.

2.5 Support with Onboarding

Three films – 'Hello', 'SDH the Movie' and 'SDH at Play', were edited and introduced for inclusion at induction. These films have received a great response and look set to continue to improve our staff inductions.

2.6 Podcast Series – Cake with Joe & Jayne

Our Communications team produced ten episodes (Royalty, Volunteering, Mental Health, Disability, Spring/Easter, Faith, Race & Place, Sexuality, Age, Prejudice) and the podcasts have now been downloaded more than 2,000 times. The podcasts can be found on Apple, Spotify or wherever you get your podcasts, or available on our Trust website. The feedback from listeners has been excellent.

2.7 Power Outage

The trust responded and reacted to the External power outage critical incident in May. It was a real 'Team' effort and a true reflection of how we all continue to improve the way we work together, especially when dealing with emergency planning.

2.8 Staff Awards

2022 Staff Awards are now open for nominations. Planning currently in progress for the whole 'Thank You Week' - Staff Awards, Volunteers Recognition and Long Service Awards, Disco Night & Family Fun Day

2.9 Education and Training:

The Education team have led the work to update the long serving Kallidus classic platform for our online learning materials, with a modern and fully supported online learning system now known as the LEARN platform was successfully completed and becomes fully operational in June.

Our Simulation Team have been able to relaunch much of their regional training, supporting the training of colleagues from across the system to improve a wide range of patient journeys

A Cultural Change package of Organisational Development support has been designed to directly support the Front-Line Teams in their adoption of Improving Together methodology. Specifically, this centres on developing individuals in their ability to coach, to lead through and adapt in a changing environment and a deeper awareness of self and teams.

We continue to deliver a suite of Leadership, organisation development and coaching courses in direct support of our trust vision and values. Moreover, we hope to launch x3 new offers to directly support our 'new to leadership' promotions and hires and a programme to develop our aspiring clinical leads.

Finally, our Best Place to Work programme is on its third phase of delivery with a fourth phase planned in late 2022. 106 of Trust Leaders have now attended this course, which represents >10% of our Leadership. The team are building a strong base line of evaluation

2.10 Improving Together

This week sees the re-start of our formal Improving Together training programme, designed to help us embed culture of continuous improvement, which we temporarily paused to enable colleagues to focus on the recent SAFER/MADE event. All divisional management teams and a small number of front-line teams are part of this first training cohort, which will be offered out to all other teams in due course.

Although the formal training programme was paused, we practiced using some of our Improving Together ways of working in the SAFER/MADE event – for example, we used improvement huddles to help us collaboratively generate improvement ideas and track progress. You will start to see our 'huddle boards' on walls around the Trust as we embed this new way of working.

3.0 Our Partnerships

3.1 SAFER 5-week event and learning

Our Deputy Chief Operating Officer led the above on behalf of SFT with support from key place-based partners (Community services, adult social care and the locality team from the CCG) to work with key wards on increase the volume and timeliness of discharge for patients with NCTR. The engagement from our clinical and operational teams was excellent and having partners on site helped increased knowledge and understanding of the respective challenges and opportunities.
There was an immediate impact from this level of senior focus and on-site presence which helped us reduce the daily run rate of people with a delayed discharge from circa 125 to circa 100. It has been challenging to sustain this beyond the SAFER event and it isn't viable for colleagues to work in this way on a long-term basis as it impacts of other work and care delivery. The team utilised some of the Improving Together tools to support testing new ways of working with support from the coach house team and collated a significant number of ideas and feedback from front line teams over this period. The Deputy COO is working through this with Divisional teams and will bring forward some recommendations to the Executives and system partners about different ways of working from this learning on a more sustainable basis.
I would like to thank everyone who supported this our system partners for providing on-site support.

3.2 Acute Hospital Alliance

The regular report of current activities is provided in the appendix for information reporting progress against the key workstreams – EPR, Joint Clinical Strategy for secondary care and Corporate services.

3.3 BSW ICS

The work for BSW over this last period has focused on finalising the arrangements to ensure the CCG can safely transition to the Integrated Care Board on July 1st as per the requirements set out in the legislation.

There is also work underway to review the BSW transformation programmes to ensure they are fit for purpose in respect of supporting the priorities within the BSW operational plan over the coming year. Several executives and senior leaders will have contributed to the review – the output of these is due in the middle of July

3.4 Specialist Commissioning

Dorset, Southampton, Hampshire and Salisbury Hospitals have a senior leadership group in place to support the specialist commissioned work that falls across and between our hospitals give it spans different ICBs and regions.
The group is supported by the clinical leads for Spec Comm and regional colleagues from the South East and South West. The main activities and focus for the group centres around the intention for the regional teams to step down some of the Spec Comm responsibilities to the individual ICBs. This was originally due for April 22 but has been put back to running in Shadow form from April 23.
From an SFT perspective our aim is to ensure continued access to those services on behalf of our population and from a provision perspective how we influence this for Burns and Spinal Injury services.

Bath and North East Somerset, Swindon and Wiltshire Partnership
Working together for your health and care

Meeting of Board of Directors

Report Summary Sheet

Report Title	**Acute Hospital Alliance Briefing, May - June 2022.**					**Agenda item**		
Date of meeting	July 2022							
Purpose	Note X		Agree		Inform		Assure	
Author, contact for enquiries	Ben Irvine, Programme Director (ben.irvine@nhs.net)							
Appendices	Appendix 1. AHA Briefing							
This report was reviewed by	• Cara Charles-Barks, CEO RUH, Senior Responsible Owner • Kevin McNamara, CEO GWH • Stacey Hunter, CEO SFT							
Executive summary	This short briefing provides an update on the activities of the Acute Hospital Alliance (AHA) from late May to June 2022, as well as a description of priorities for the forthcoming period. Work of the AHA Committees in Common of the three Trusts, and the AHA Programme Executive is described. The following areas are covered in the briefing: 1. Committees in Common: priority project development. 2. Programme Executive Activities (PMO; Clinical & Corporate Workstreams) 3. Decisions taken 4. AHA in BSW Integrated Care System 5. Resources update 6. Risks & Issues 7. Communications 8. AHA Forward Meeting Cycle For further information on the AHA Programme please contact Programme Director Ben Irvine (ben.irvine@nhs.net).							
Equality Impact Assessment	An AHA Programme Equality Impact Assessment has been started, as part of the process to create a refreshed three-year AHA Programme 2022-25.							
Public and patient engagement	Our AHA Clinical Strategy work is closely linked with the BSW Care Model – which has been through a significant public engagement exercise. A clinical strategy workshop held on 20th May confirmed our intention to include our service users in service design activities.							
Recommendation(s)	To note the AHA briefing.							

Risk (associated with the proposal / recommendation)	High		Medium		Low X		N/A	
Key risks	The development of the BSW Acute Hospital Alliance is in line with national policy and strategic direction on provider collaboration. The AHA Programme Executive, SRO and Programme Director identify and manage risks associated with programme delivery.							
Impact on quality	The AHA maintains a strong focus on quality and patient safety and assumes continuous focus on quality improvement – the Improving Together programme is one of the AHA core activities. The AHA clinical workstream is designed to improve clinical service effectiveness, patient experience and quality. The corporate workstream aims to deliver value for money, quality, and resilience of corporate services.							
Resource implications	May-June saw discussions regarding required budget to complete the next phase of the EPR Programme. Approval of budget requirements is anticipated in early July. A cost centre has been established at GWH to host the core AHA budget. **SFIs** are being developed by the Directors of Finance to maintain balance in financial contributions between the three Trusts.							
Conflicts of interest	None known.							
This report supports the delivery of the following BSW System Priorities:	☒ Improving the Health and Wellbeing of Our Population ☒ Developing Sustainable Communities ☒ Sustainable Secondary Care Services ☒ Transforming Care Across BSW ☒ Creating Strong Networks of Health and Care Professionals to Deliver the NHS Long Term Plan and BSW's Operational Plan							

Appendix One.

Acute Hospital Alliance, May – June 2022 Briefing

Working together to support: Equity – for our local population; Sustainability and Improvement.

Introduction

This short briefing provides an update on the activities of the Acute Hospital Alliance (AHA) from May to June 2022, as well as description of priorities for the forthcoming period. The following contents are included in each monthly briefing:

1. Committees in Common: Priority Project Development
2. Programme Executive Activities (PMO; Clinical & Corporate Workstreams)
3. Decisions Taken
4. AHA in BSW Integrated Care System
5. Resources Update
6. Risks & Issues
7. Communications
8. AHA Forward Meeting Cycle
9. Appendix

1. Committees in Common: Priorities

The AHA Committees in Common (CIC) is designed to set strategic direction and provide oversight of the AHA programme. The CIC last met on 10th June and reflected on system planning. The group reaffirmed our focus on five core projects where AHA expects to have collective strategic impact as a provider collaborative in BSW - refer **Table 1** for sponsors and executive leads of the five projects. Throughout June, leads have been scoping these priority areas of work in advance of a CIC away day planned on 11th July. By the end of July, the CIC and Programme Executive are aiming to create a well-defined and resourced 3-year AHA Programme.

Table 1. AHA Five Priority Projects, Sponsors and Executive Leads

Ref	Project Title	Sponsor	Executive Lead/s
1	**Open book financial baseline** across AHA parties	Kevin McNamara	Lisa Thomas
2	**Consistent methodology for staff modelling across AHA** – includes nursing establishment baseline work.	Kevin McNamara	Antonia Lynch & Melanie Whitfield
3	Delivery of a **secondary care clinical strategy for BSW**	Cara Charles-Barks	Peter Collins, Jon Westbrook, Bernie Marden
4	Delivery of **single capital strategy** [multi-year: five+ years]	Stacey Hunter	Simon Wade
5	Delivery of the **Single EPR roll-out** and effective integration with partners	Stacey Hunter	Bernie Marden

2. Programme Executive Activities (PMO; Clinical & Corporate Workstreams)

The Programme Executive drives programme delivery, meeting monthly, most recently on 24th June. Updates on the delivery in the Corporate and Clinical streams follow.

AHA Corporate Stream:

- **EPR Alignment Programme –** The EPR Programme Board meets fortnightly and has overseen production of tender documentation to allow the procurement phase to begin. Following a quality assurance process, the initial Opt-in procurement stage was launched on 20th June. AHA Executive has given approval to issue finalised tender documentation on 18th July. The EPR Programme Board and Finance Working Group has been developing a proposed budget for the next stage of the programme. Confirmation of budget is anticipated in coming weeks; an update will be provided in next month's briefing. The programme has received confirmation of NHSE commitment of £21m capital funding to support system purchase. The Full Business Case preparation has begun and is scheduled to complete late in 2022. The Clinical Design Authority, led by Jon Westbrook and Peter Collins, is establishing a detailed work programme. Finally, the recruitment of a new Programme Director with significant EPR experience is underway to support the next stages of the Programme.
- **Improving Together**– rollout continues across the three Trusts of Improving Together, common improvement methodology.
- **Corporate Back-Office Programme – Finance team:** good progress continues to be made in **procurement collaboration.** Focus is now on delivering a strong programme for 2022-23 [£5m]. Recruitment to the procurement team is progressing. The programme Executive reflected on national supply chain challenges being experienced in NHS, noting that our ability to manage in such an environment is significantly enabled through the Trusts' collaborative procurement approach.
- **Legal services**. Collaboration scoping in legal services is underway; opportunities in training, service optimisation, and improved value for money through in-housing have been identified. A project plan and business case timetable are in place and being followed. The next period will see a series of workshops to identify options.
- **People / HR** services directors are actively preparing for an away day on 29th July which will help confirm potential collaboration opportunities.

AHA Clinical Stream:

- **Secondary Clinical Services Strategy Development.** A review of secondary clinical services, closely linked to BSW care model has begun. A multi-disciplinary team from the three Trusts is being created to lead the strategy development and establishment of a programme of collaborative service transformation work. The timetable for the next three months has been confirmed – leading up to a second Clinical Summit workshop on 2nd September. The summer period will see finalisation of the draft Clinical Strategy, completion of an AHA clinical stocktake and a detailed clinical network mapping exercise.
- **Virtual Clinical Teams – Dermatology** work continued in June. RUH advice & guidance mutual aid to SFT area has continued. The **Ophthalmology** team has also continued its pathway improvement work, working with colleagues in community setting.
- **Respiratory Medicine. Sleep Services.** Following discussion in the May Programme Executive, the Medical Directors have commissioned Duncan Murray to lead a piece of work to review the current provision of ***Sleep services*** within BSW and to develop a strategic options appraisal.

3. Decisions Taken – May – June 2022-23

AHA Priorities

- Priority Project No 5. EPR. Procurement Opt-in process initiation approved by Programme Board and Programme Executive. Release of final tender documentation on 18th July approved by Programme Executive – subject to quality assurance sign-off being secured.

Resources & Budget Hosting

- GWH has established a cost centre to host the core AHA budget.

AHA CIC Nomination of Integrated Care Board Partner Member with Acute Experience

- On 10th June CIC confirmed its approval of the BSW Integrated Care Board Partner Member nominations list. NB the list included Stacey Hunter, CEO Salisbury NHS Foundation Trust and Dominic Hardisty, CEO Avon & Wiltshire Mental Health Partnership Trust.

Projects Commissioned, Projects Halted/ Passed to Business as Usual

- The 27th May Programme Executive agreed to commission a piece of work to review the current provision of ***Sleep services*** within BSW, developing a strategic options appraisal for the medium and long-term.

4. AHA in BSW Integrated Care System

- With strong relationships between Trust leadership teams built over the past years, the AHA intends to meet national policy expectations playing a full role as reliable provider collaborative, maximising opportunities to work together at scale to the benefit of the population we serve. AHA contributes to system stability, modelling the impact of collaboration.

5. Resources Update

The Acute Alliance has a small core team in-post. The AHA Programme is funded by equal contributions from the three Trusts. Posts are hosted by all three Trusts. During the period covered by this report:

- AHA Programme Manager role (AfC 8B) interviews have been arranged for 29th June.
- In June, the Programme Executive discussed potential for Trust staff to take part in collaborative project teams. A wide range of clinical and non-clinical staff have completed/ are embarked on training and leadership development programmes – often requiring project/ improvement work. The Programme Executive asked for a short proposal to be developed on how this could be coordinated.
- The EPR Programme budget is being reviewed – in the context of the system financial position; an update will be provided in next month's briefing.

The Clinical programme also receives programme and project management support from the CCG Strategy & Transformation Directorate. Work has continued in June to define the priorities and associated resource requirements of the programme for 2022-2025; updates will be reported in July 2022.

6. Risks & Issues

A range of risks and issues continue to be managed by the programme team. A risk register is held centrally, with significant items being reported to Programme Executive. No new and significant risks have emerged over the past month. In May and June, the following risks & issues were reported to the Programme Executive and CIC.

1. ***Capacity constraint:*** Response: Recognise need to balance between short-medium & long-term priorities; capacity for operational and transformation work required. Prioritisation

of activities required. AHA programme leads will define resource requirements and work internally and with BSW system colleagues to secure resource.

2. ***Uncertainty regarding priorities***. Responses: CIC & Executive to confirm and communicate priorities generating common understanding. Regular and consistent communications campaign being planned. CEOs will sponsor workstreams, and executive leads for priority streams have been identified (refer sections 1 & 3 above).
3. ***Leadership Transition in BSW. Transition of CCG*** and establishment of new ICS leadership team creates destabilising effect. Response: Maintain focus on effective delivery by AHA, contributing to system stability, modelling impact of collaboration.
4. [Project 5] **Access to EPR Funding** (Capital & Revenue**).** Response: CIC support will be required over next 12 months to ensure require funds are secured. £21m capital support confirmed by NHSE. Revenue budget for the next phases to be confirmed.
5. [Project 2] **Staffing Methodology**. Note: Nursing establishment baseline work being led by the three CNOs has potential cost implications. The team are developing a plan to confirm potential investment decision timelines.

7. Communications

An AHA Communications strategy is in place, created by Communications lead, Tim Edmonds (GWH), with internal and external strands including:

- *Monthly Board Briefings*. This briefing paper is issued to Boards monthly, following Programme Executive meetings.
- *A Monthly Newsletter* for wider dissemination through Trusts and BSW was first released in May.
- *Monthly ICS Highlight Report* – for CIC, Programme Executive and BSW Integrated Care Board.
- *National profile raising*. The AHA's successes as a Provider Collaborative provide sharing and learning opportunities for colleagues across the NHS. For example, our Paediatric oral surgery work was referenced in June's NHS Confederation Expo conference. As AHA SRO, Cara Charles-Barks is due to present on our AHA Provider Collaborative experience at a forthcoming NHS Providers conference.

8. AHA Forward Meeting Cycle

The table below sets out the dates of our CIC meetings, CIC Away Days, Programme Executive and Clinical Summits for 2022-23. A detailed meeting planner, providing a clear view of key decision points and milestones is being prepared by the programme team and will be shared once the three-year programme refresh is complete.

Table 2. Forward Meeting Cycle: Key Dates

AHA Committee in Common Dates 2022								
8th April		10th June			21st October		9th December	
Committee in Common Away Days 2022/23								
11th July 2022		30th September 2022			5th December 2022		TBC Feb 2023	TBC May/July/Oct 2023
AHA Programme Executive Dates 2022								
29th April	*27th May*	24th June	29th July	26th August	30th September	28th October	25th November	16th December
AHA Clinical Summit Dates 2022/23								
20th May 2022		2nd September 2022		23rd November 2022	1st March 2023		25th May 2023	28th September 2023

Appendix

Figure 1. CIC and Programme Executive Membership

Committees in Common	Programme Executive *(monthly)*
• Liam Coleman (*Chair*), Chair, GWH • Alison Ryan, Chair, RUH • Nick Marsden, Chair, SFT • Cara Charles Barks, CEO, RUH • Kevin McNamara, CEO, GWH • Stacey Hunter, CEO, SFT • *Ben Irvine, Programme Director*	• Cara Charles Barks (*Chair*), CEO RUH • Stacey Hunter, CEO, SFT • Kevin McNamara, CEO, GWH • Bernie Marden, MD RUH • Jon Westbrook, MD, GWH • Peter Collins, MD SFT • Claire Thompson, Director of Partnerships & Improvement, GWH • Libby Walters, DoF, RUH • Lisa Thomas, DoF SFT • Simon Wade, DoF, GWH • Melanie Whitfield, HRD, SFT • Antonia Lynch, Chief Nurse, RUH • *Ben Irvine, Programme Director*

Close

Drafted by Programme Director, Ben Irvine
27th June 2022

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	7th July 2022		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	28th June 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	X	
Prepared by:	Miss Eiri Jones, Chair CGC			
Board Sponsor (presenting):	Miss Eiri Jones, Chair CGC			

Recommendation

Trust Board members are asked to note and where relevant, discuss the items escalated from the Clinical Governance Committee (CGC) meeting held on the 28th June 2022. The report both provides assurance and identifies areas where further assurance has been sought and is required.

Key Items for Escalation

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - This month's deep dive focussed on deteriorating patients, a theme identified in serious incident reviews. Assurance was provided in relation to the process in place and that there is a comprehensive work programme in progress to address this meeting both national standards and areas the Trust has identified for improvement. Key areas requiring further assurance include communication, documentation and delay in assessment. The Executives committed support for an A3 approach to managing the ongoing variation identified. The committee agreed to seek further assurance through the CMB.
  - Whilst the IPR is discussed at Board each month, the CGC review the quality and care sections in detail. The committee noted the continuing workforce challenge due to both the high numbers of No Criteria to Reside patients and the increasing impact of the current phase of Covid. Grade 2 pressure ulcers had increased in month and stroke performance had deteriorated in the SNAPP audit. Despite these challenges, positive performance was also noted in areas of infection prevention and control and continued positive patient feedback.
  - Following on from the deep dive and on discussion of the IPR, the committee requested assurance from the Divisions in relation to their quality performance. This would be programmed for the September agenda.
  - From an incident management perspective, the workforce situation has meant that there is a backlog of Datix incidents awaiting closure. The Executives

were able to provide assurance that the weekly safety summit scrutinises all moderate and above incidents. An A3 process is being undertaken in relation to the requirements of the new incident management arrangements when they come into force.

- The Q4 learning from deaths report provided assurance that 100% of the acute hospital deaths were scrutinised (83% of deaths reviewed including hospice). Current alerts were being reviewed. Whilst the HSMR was higher than expected, this included hospice mortality. The SHMI was noted as within expected range.
- The two safeguarding annual reports were received. Key challenges across both related to training though some of this issue was linked to the way MLE processes training data (online e-learning system). Other themes included increasing workload and the challenge to providing supervision due to the previously mentioned workforce issues. It was noted that the Liberty Protection Standards have now been published with expected go live in April 2023. It was proposed that a Board Development Session be held on these to ensure all Board members were informed of this legal requirement.
- A report was provided in relation to the Covid medicines delivery unit (MDU), an unfunded service that was established on the direction of NHSE/I last December. It was noted that this has been delivered through the goodwill of staff and the committee thanked all involved. A concern was raised that with the current increasing Covid numbers in the community this service would be unsustainable and different models were being explored across the system.
- At the request of the Board at the last meeting, a presentation on housekeeping and cleaning was brought to CGC to consider the quality implications of the new standards (2021). The new standards are mandated, a change from the 2007 standards where Trusts were given flexibility. Challenges to full implementation are focussed around the cost and the ability to recruit appropriate staff. The Head of Facilities outlined how the high-risk areas were compliant in his professional opinion, however audit of the new standards is not currently possible due to the workforce challenge. The Trust had agreed to fund a staged approach to the new standards. The committee asked for a further update at a date to be confirmed requesting that the audits of the standards be prioritised.
- The committee received the End-of-Life annual report. The report contained a lot of good practice with the hospice scoring higher than national average in the national audit of care at the end of life (NACEL) audit. The local ‘Your Views Matter’ survey also outlined positive feedback from 80% of those responding. The 10% who reported a poor experience were followed up by the team to identify learning and improvement opportunities. The hospice lead doctor outlined how the workload had increased over the last two years and that this would be monitored this coming year before reviewing the current staffing.

The Board is asked to note and discuss the content of this report.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.2
Date of Meeting:	7th July 2022		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	28th June 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Eiri Jones, Non-Executive Director			
Board Sponsor (presenting):	Eiri Jones, Non-Executive Director			

Recommendation
To note and discuss key aspects of the Finance and Performance (F&P) Committee meeting held on the 28th June 2022

Items for Escalation to Board
(1) Integrated Performance Report (finance and performance) – A detailed discussion was had in relation to the current pressures on the organisation and the impacts on key performance areas. Of note was the ongoing challenge in relation to No Criteria to Reside (off trajectory) and the impact this is having on capacity, ambulance waits and operational performance. Additional challenges this month include the impact of increasing community numbers of Covid which is again affecting workforce availability. This in turn has impacted adversely on diagnostics performance. Further assurance was sought with a request for more detailed modelling of the ongoing impact of both No Right to Reside and Covid on the signed off annual plan. **(2) Cardiac Rhythm Management Devices –** The committee considered the proposal in relation to this tender. The committee supported the proposal

and it is escalated to Board for approval due to the Tender value. Of note is that this is an ICS approach and that recurrent savings are clearly identified across ICS and the Trust.

(3) **IT Hardware –** The committee considered the proposal in relation to this tender. This approach is across 6 organisations. The committee approved the SFT element.

(4) **Genetics** – The committee was provided with an update on the in year and recurrent financial risk arising from this commissioner led service change. The CFO has written to NHSE/I in relation to this risk.

(5) **2022 Costings Cost Collection –** The committee was provided with assurance that it would meet the requirements of this process in year. The process has restarted post Covid. The committee was also informed that the Trust is starting a joint approach with one of its Acute Alliance partners, Great Western Hospital.

The Board is asked to note and, where relevant, discuss the content of this upward report.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	07 July 2022		

Report Title:	Trust Management Committee Escalation Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Approval Process (where has this paper been reviewed and approved)	Reviewed and signed off by Stacey Hunter Chief Executive Officer.			
Prepared by:	Gavin Thomas, Executive Services Manager			
Executive Sponsor (presenting):	Stacey Hunter Chief Executive Officer			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the report from the Trust Management Committee.

Escalation Summary:
The Trust Management Committee was scheduled for 22nd June and was held face to face in the boardroom, a first in nearly two years following Covid. The committee had a full agenda with several business cases to review namely, Investment in Advanced Clinical Practitioners (ACP) to support the frailty service in (Same Day Emergency Care Pathways, People Services and Robotic Process Automation. All the business cases had been scrutinised by the Trust Investment Committee and recommended to TMC following this. TMC agreed with the business case in respect of the benefits of creating 2 wte ACPs for the purposes outlined in the case. The business case as presented only identified sufficient funding for 1 wte hence TMC approved 1 wte ACP. The Chair asked the COO and CD for Medicine to review the options for funding the second post and agreed to take Chair's action once this had been actioned. TMC noted that the COO and CD for Medicine confirmed the budget for the 2nd ACP following the TMC meeting (utilising vacant Consultant Geriatrician budget) and the Chair agreed this on behalf on TMC In respect of the People services business case, following discussion at committee, the business case to invest £248k for FY22/23 to enable the OD & People Services Team to deliver against the Salisbury 2022-2026 Strategy for People, the Salisbury People Plan and the OD&P

Strategy was approved. TMC confirmed that the budget to cover this investment had been agreed and allocated as part of the operational plan for the year.

In relation to the business case for Robotic Process Automation, the business case related to a proposal for investment in resource to support the implementation of Robotic Process Automation (RPA), a technology used to automate standardised manual processes. The committee heard that the investment would enable the Trust to establish an initial RPA team within SFT, in order to commence a 12-month proof of concept period for the RPA platform across SFT. The SFT RPA team would work in close collaboration with the RPA teams across the ICS, in order to share learning and skills, reduce duplication of effort and identify areas where the automation of processes will have greatest benefit to the Trust. TMC requested that the team working on this ensured continued alignment with the Acute Hospital Alliance project to ensure consistency and greater potential benefit across all three trusts.

The committee received the escalation reports from the sub committees and in relation to Operational Management Board (OMB) report, it was noted that there are to be a significant number of policies going to the meeting in July for approval.

The committee received an escalation report from the Health and Safety committee where it was noted that there had been an IRMA breach where we had not responded in a timely manner and SH reminded everyone of the need to ensure that any requests in relation to IRMA are dealt with in a timely manner. TMC received assurance from the Division that this had now been dealt with.

The committee received the first of the new iteration of the IPR this month following its revamp as part of the Improving together work and it was noted that this would continue to evolve. TMC received some initial feedback which the Director of Improvement noted in respect of refining the report.

The committee received the finance report and noted that in month 2 the Trust recorded a control total deficit of £1.35m against a target of £1.21m - an adverse variance of £0.3m. The underlying position was in line with that planned, albeit with vacancies offsetting the premium costs of agency on wards and in theatres. It was also noted that the period saw increased pressure on Non-Pay. Once accounting for tariff excluded costs and non-recurrent items, the Trust is circa £0.2m off plan.

Board Assurance Framework – Strategic Priorities	Select as applicable
Population: Improving the health and well-being of the population we serve	☐
Partnerships: Working through partnerships to transform and integrate our services	☐
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☐
Other (please describe) -	☐

Salisbury NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	2.4
Date of Meeting:	7 July 2022		

Report from: (Committee Name)	People and Culture Committee		**Committee Meeting Date:**	30th June 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Rakhee Aggarwal, Non-executive Director			
Sponsor (presenting):	Rakhee Aggarwal, Non-executive Director			

Recommendation
Trust Board is asked to note the items escalated from the People and Culture Committee meeting held on 30th June 2022. The report provides assurance as well as areas for information and those that are a risk.

Items for Escalation
Please find below a summary: **1. Occupational health service** There are serious concerns with respect to the staffing of the occupational health service- there are difficulties in recruiting and retaining occupational health staff. A hybrid model of containment was forwarded which includes TP Health; Consultancy and SFT. This will enable SFT to meet its legal obligations in the provision of occupational health services. This does not include provision of services such as physiotherapy and will be considered once we have embedded this hybrid model of working. **2. CPO Report** **Staffing:** the key hotspot areas for staffing are healthcare assistance and maternity support workers. It could be surmised that the high turnover of this group of staff is related to economics, where people do not feel remunerated for the work undertaken, resultant in work poverty. **Projects:** There are currently 18 projects identified in OD and People- many of these are near closure and inform the foundations of what is required going forward. These will be reduced as we continue through the calendar year. **Risk:** Recruitment and sustainment of staff across SFT is an identifiable risk. Work has been completed with PwC to unpack, understand, and put forward key recommendations.

3. **People Promise**

SFT is one of 23 NHS E/I People Promise exemplar sites working towards the purpose:

"To test the assumption that optimum delivery of all NHS People Promise interventions delivered in one place simultaneously can deliver improved staff experience and retention outcomes, beyond the sum of the individual components."

SFT has submitted its implementation plan to NHS E/I, based on numerous conversations with key stakeholders. These will continue with aim to identify what we are doing well; explore our gaps and theme these.

This work very much underpins the core of best place to work incorporating culture shift, and therefore impacting on recruitment and turnover.

4. **PwC**

Since mid-January 2022, several projects have been initiated to improve the use of workforce systems to build firm foundations upon which OD&P services can effectively operate. SFT has been operating its numerous workforce systems with involvement of at least 3 directorates, misaligned data, inadequate policies, delayed and inefficient processes, upgrades not implemented and sub-optimal usage.

Several projects have been initiated and with collaborative working and considerable effort benefits are starting to flow with data now largely aligned, upgrades and interfaces going live to automate manual processes, reviews nearing completion to define optimal policies and processes, resources, and organisational structures.

There is much more to do to ensure that these new policies and processes are implemented and operate well with the aim that all workforce systems are optimally used, interface with ESR as the 'single source of truth' for workforce establishment and staff in posts and Power BI becomes the reliable/'trusted' source of workforce information.

Two areas presented at People and Culture:

Recruitment and Onboarding: This examined the candidate and subsequently the employee onboarding. Many efficiencies can be implemented to standardise the candidate journey; enable clarity for the employee journey; enabling an alumni approach to build reputation and re-attract people back and enable a positive and fairer experience for all.

E-Rostering: An internal audit produced by PwC dated January 2022 highlighted a few shortcomings that related to the sub-optimal use of workforce systems, including the lack of adequate establishment control, gaps in workforce reporting, lack of Executive leadership for eRostering and lack of strategic workforce planning. Three key projects have been identified to enable efficiencies: ESR/ E-rostering interface; annual leave project; ESR/ Establishment Control.

5. **Guardian of Safe Working**

We have seen a reduction in exceptional reporting over the last two months, especially when the notable outlier in spinal/rehab is taken into consideration. This is not uncommon for this time of year.

The issues in spinal/rehab have been recognised and raised to senior levels. Although our rotas are reasonably well staffed, we still have a significant shortfall of WTE due to LTFT

working. This is particularly notable at senior (ST3+) level.

Our spend is significant where we require cover for junior doctor rota gaps, which includes LTFT, sickness and isolation and other issues such as a doctor not being able to work nights due to health conditions.

Work is being done with medical HR to look at moving locally employed doctors onto a contract that is more like the 2016 contract that deanery trainees are employed under. This should provide more visible parity between doctors working the same job as deanery trainees and allow LEDs the ability to exception report, which will provide more data for the trust about workforce requirements.

6. Freedom to Speak Up

Nurses remain the largest reporting group, followed by administrative and clerical staff and then corporate service staff. Themes include patient safety, bullying and harassment as well as unhappiness with systems and processes. Medicine presents with highest number of concerns.

Feedback from staff regarding what they experience after speaking up is: collated: asking if they would speak up again, how they found the experience and if they have suffered detriment due to speaking up. Approximately 18% of staff returned the form, and there have been positive and negative experiences from staff who have raised concerns:

“My situation was helped immensely by speaking to the FTSUG. I am extremely grateful. Until I spoke to her I was despondent and felt completely let down by the Trust. As a result of her informative and helpful advice and also her presence at a meeting, the very distressing situation I was in has now been resolved. I found the Guardian to be very understanding. Would definitely recommend to colleagues”

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

Liz Swift is now a national representative for Freedom to Speak Up.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	07 July 2022		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	Sections approved by responsible committee: Operational Performance & Resources – Finance & Performance Committee Quality and Care – Clinical Governance Committee Workforce – People and Culture Committee			
Prepared by:	Louise Drayton, Performance & Capacity Manager			
Executive Sponsor (presenting):	Melanie Whitfield, Chief People Officer			
Appendices (list if applicable):				

Recommendation:
The Trust Management Committee are asked to note the Trust's performance for Month 2 (May 2022).

Executive Summary:
Throughout M2 a 'safer' focus event was run with the aim of focusing on reducing or removing delays that result in patients being required to stay longer in hospital. The hospital remained busy however occupancy reduced slightly to 96.6% (97.2% in M1), the number of occupied bed days in escalation beds reduced from around 2700 to circa 1900, and the number of patients moved more also reduced. There was significant improvement in the number of hours lost by the ambulance service in delays handing patients over to the Emergency department – this was 750 hours in M1 and fell to 256 in M2. With fewer escalation beds open the Trust was able to perform more elective surgery and exceeded the plan with 510 theatre cases. The number of patients waiting over 52 weeks for surgery reduced to 551, and there were no patients waiting longer than 104 weeks. The Trust reported an SSNAP score of D for stroke performance in Q4, which is a further deterioration. Issues remain around reaching the stroke unit within 4 hours of admission (17% in M2), and 60% of patients spending at least 90% of their admission in a stroke unit. In M2 there was some improvement in time to CT with 55% receiving a CT within one hour and 100% received a CT within four hours.

In month 2 the Trust recorded a control total deficit of £1.35m against a target of £1.21m - an adverse variance of £0.3m. The underlying position was in line with that planned, albeit with vacancies offsetting the premium costs of agency on wards and in theatres.

The trust continues to not achieve all the cancer standards with 3 out of 8 of the cancer standards achieved in M2. There was further deterioration of the 62 Day referral to treatment standard at 65.2% the lowest performance to date post the Covid pandemic. Challenges are associated with a number of pathways, with most patients affected being complex, however there remains some capacity related delays which the Trust is working to eliminate. Positively, there was improvement in the number of patients seen within two weeks of a suspected cancer referral from a GP.

There was a small improvement in the number of patients received a diagnostic within 6 weeks, but problems remain with MRI, Cardia Echo and Audiology. Recovery of the standard is not expected in Q1. The trust remains above the national average of 71.6% with performance of 83.6%.

There were no hospital onset healthcare associated reportable C. difficile cases in May and no MRSA or E. coli bacteraemia cases. There was one category 3 pressure ulcer identified and no category 4 pressure ulcers. There were a further 33 category 2 pressure ulcers reported in M2, an increase from 26 in M1.

In M2 there were 3 falls resulting in patient harm (2 moderate, 1 catastrophic). Over-all in M2, there has been a decrease in falls from 136 in M1 to 107, equating to a drop in falls per 1000 bed days from 9.96 to 7.86.

Board Assurance Framework – Strategic Priorities	**Select as applicable**
Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒
Other (please describe) -	☐

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Integrated Performance Report

Trust Board

July 2022

(May 2022 data)

Summary

Throughout M2 a ‘safer’ focus event was run with the aim of focusing on reducing or removing delays that result in patients being required to stay longer in hospital. The hospital remained busy however occupancy reduced slightly to 96.6% (97.2% in M1), the number of occupied bed days in escalation beds reduced from around 2700 to circa 1900, and the number of patients moved more also reduced. There was significant improvement in the number of hours lost by the ambulance service in delays handing patients over to the Emergency department – this was 750 hours in M1 and fell to 256 in M2.

With fewer escalation beds open the Trust was able to perform more elective surgery and exceeded the plan with 510 theatre cases. The number of patients waiting over 52 weeks for surgery reduced to 551, and there were no patients waiting longer than 104 weeks.

The Trust reported an SSNAP score of D for stroke performance in Q4, which is a further deterioration. Issues remain around reaching the stroke unit within 4 hours of admission (17% in M2), and 60% of patients spending at least 90% of their admission in a stroke unit. In M2 there was some improvement in time to CT with 55% receiving a CT within one hour and 100% received a CT within four hours.

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The trust continues to not achieve all the cancer standards with 3 out of 8 of the cancer standards achieved in M2. There was further deterioration of the 62 Day referral to treatment standard at 65.2% the lowest performance to date post the Covid pandemic. Challenges are associated with a number of pathways, with most patients affected being complex, however there remains some capacity related delays which the Trust is working to eliminate. Positively, there was improvement in the number of patients seen within two weeks of a suspected cancer referral from a GP.

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Summary Performance May 2022

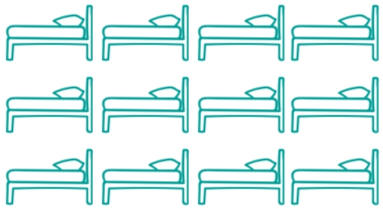
NHS Salisbury NHS Foundation Trust

There were **2,759** Non-Elective Admissions to the Trust

We delivered **36,270** outpatient attendances, **16.8%** through video or telephone appointments

We met **3 out of 8** Cancer treatment standards

We carried out **361** elective procedures & **1,960** day cases



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

RTT 18 Week Performance: **68.49%** ↑

Total Waiting List: **19,943** ↑

83.6% ↑ of patients received a diagnostic test within **6 weeks**

Our income was **£25,803k** (£750k above plan)

17.4% ↓ of discharges were completed before 12:00

Emergency (4hr) Performance **75.3%** ↓

(Target trajectory: 95%)

93 patients stayed in hospital for longer than 21 days

Our overall vacancy rate was **12.0%** ↓

Reading a Statistical Process Control (SPC) Chart

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

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

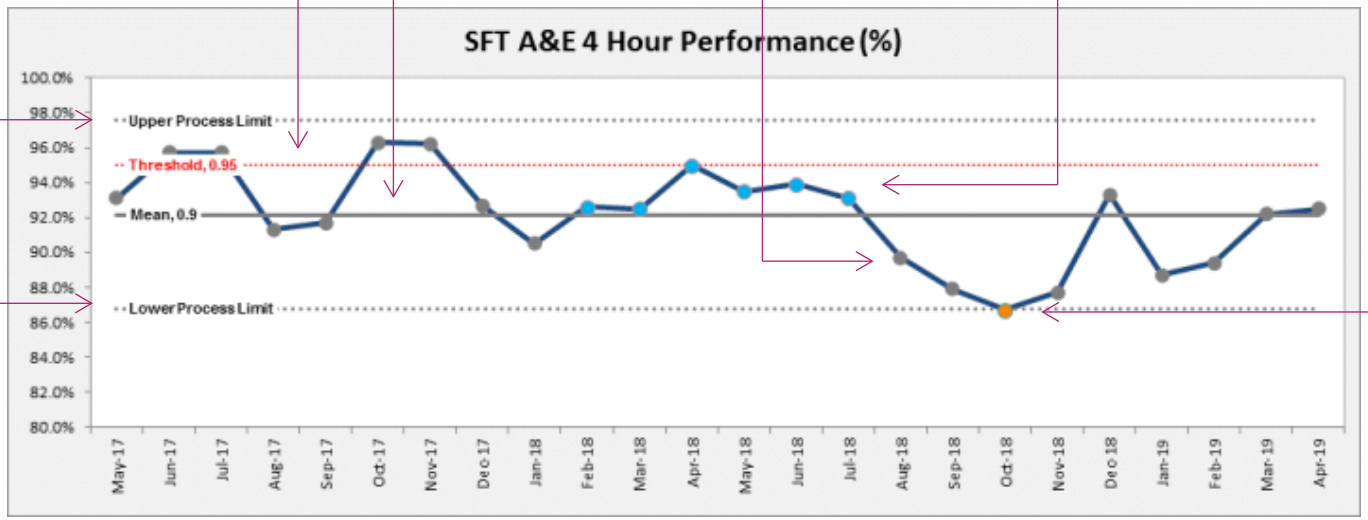
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

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

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



Statistical Process Control Chart Key:

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

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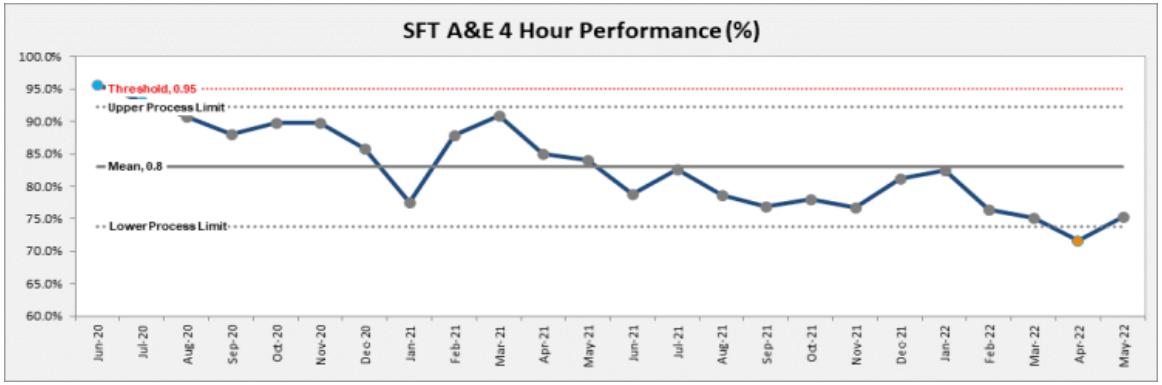
Part 1: Operational Performance

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

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

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	75.3%
Attendances:	6575
12 Hour Breaches:	7
ED Conversion Rate:	28.8%

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

Attendances in M2 were high at 6575, the highest level in one month collectively across Type 1, 2 and 3 to date. Within this levels were increased compared to M1 for Type 1 (SFT ED) at 4470 versus 4185 in M1, and decreased for Type 3 (Walk in Centre) at 1788 versus 1917 in M1.

There were seven 12 hour breaches which occurred over 2 dates when hospital capacity was limited affecting flow out of the department.

There has been an increase in the 4-hour performance standard to 75.3% compared to M1 of 71.6%, likely linked to improvements in flow seen throughout the SAFER event.

Capacity across the Trust and flow out of ED continues to be of the biggest contributory factors to the failing of the 4-hour performance target.

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

Phase 2 of the minors rebuild was due for completion at the end of M2, but the project has experienced some delays, the confirmed date to open the new area is now at the end of M3. The new minors build will incorporate separate waiting areas for adults and paediatrics which improves patient experience and also complies with CQC regulations.

The ongoing use of a HALO at times of escalation to assist with identification of deteriorating patients being held in ambulances is proving to be successful and is furthering the close working partnership with SWAST.

The Pilot of a Wiltshire Health & Care ACP based at the Front Door to provide Rapid Frailty Response with the aim of admission avoidance where possible has now finished. Initial feedback and data shows it to be a successful pilot with ~10% of admissions being managed. The senior management team are working on joint case with WH&C to try to make the service a permanent addition to SFT ED.

Recruitment into vacant nursing, medical and administration posts are ongoing.

Some investments into staff wellbeing within ED were made in M2 by utilising charitable donations. This has provided new seating in staff room along with welfare boxes for staff on duty. These have been welcomed by the staff in the department.

Risks to delivery and mitigations

Flow out of the department and capacity across the Trust continues to the biggest challenge for the 4-hour performance standard. Most of the flow out of the department continues to be in the late evening, adding extra pressures on staffing resources across the Trust.

AMU SDEC area (Same Day Emergency Care) has remained escalated into overnight. This then impacts on the teams ability to provide SDEC and has a knock on effect to flow and the medical take being diverted to ED. This continues to be a major contributory factor to capacity challenges within ED and the ability to off load ambulances in a timely manner.

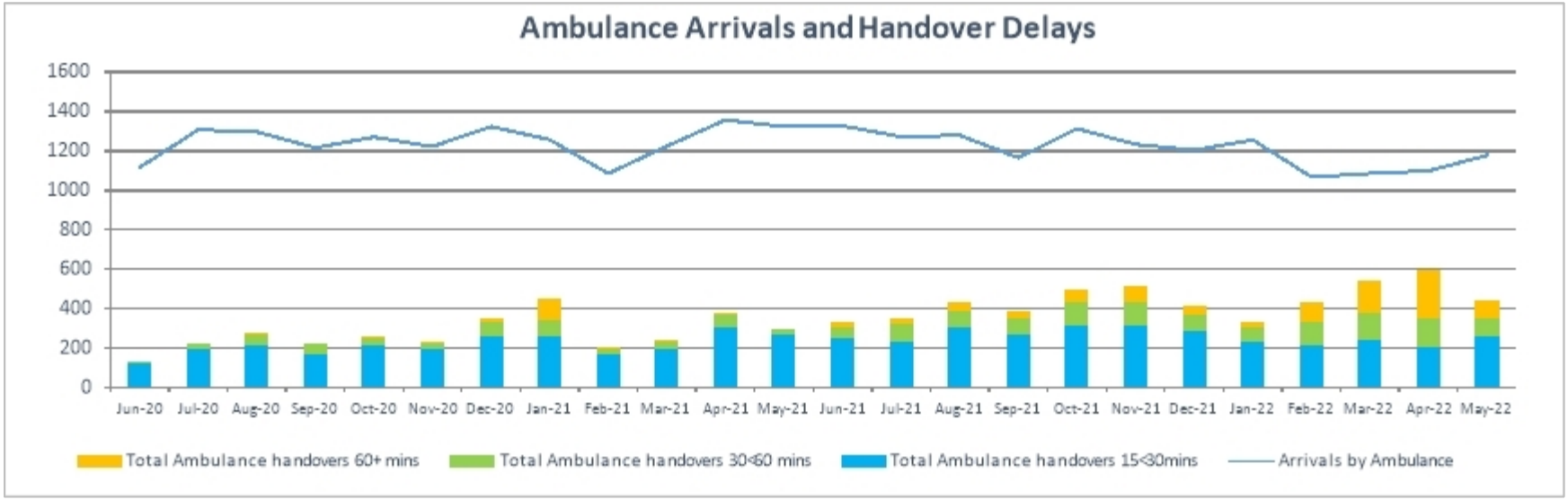
Staffing Gaps continue to impact on existing staff and the department as a whole. The management team are working hard with the department to address this.

Statistical Process Control Chart Key:

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

Ambulance Handover Delays

National Key Performance Indicators



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

M2 saw a slight increase in the number of ambulances presenting to SFT of 1178 compared to M1 of 1098. There has been a significant increase in performance for ambulance handovers, 84.38% compared to 71.58% in M1.

There was a significant reduction in the number of handovers that were delayed by over an hour, which contributed to the reduction in hours lost – 256 in M2 compared to 750 in M1.

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

Signage is now complete for ambulance only parking on the ramp. This has been welcomed by SWAST to ensure there is adequate parking for ambulances in the event of ambulances having to queue to offload. Comms have been sent out to the public.

There is another SWAST reset day in M3. A Wiltshire ACP will be at front door to provide rapid frailty response and admission avoidance where possible. Halo will be available throughout the day.

The Halo continues to be present in times of escalation and is conducive to collaborative working with SWAST. It has been agreed that SFT will gain a permeant HALO officer with recruitment taking place in Jun 22. This exciting development ensures the identification of any deteriorating patients held in ambulances waiting to off load.

SFT continue working collaboratively with SWAST and BSW partners in order to provide good quality of care for our patients.

Risks to delivery and mitigations

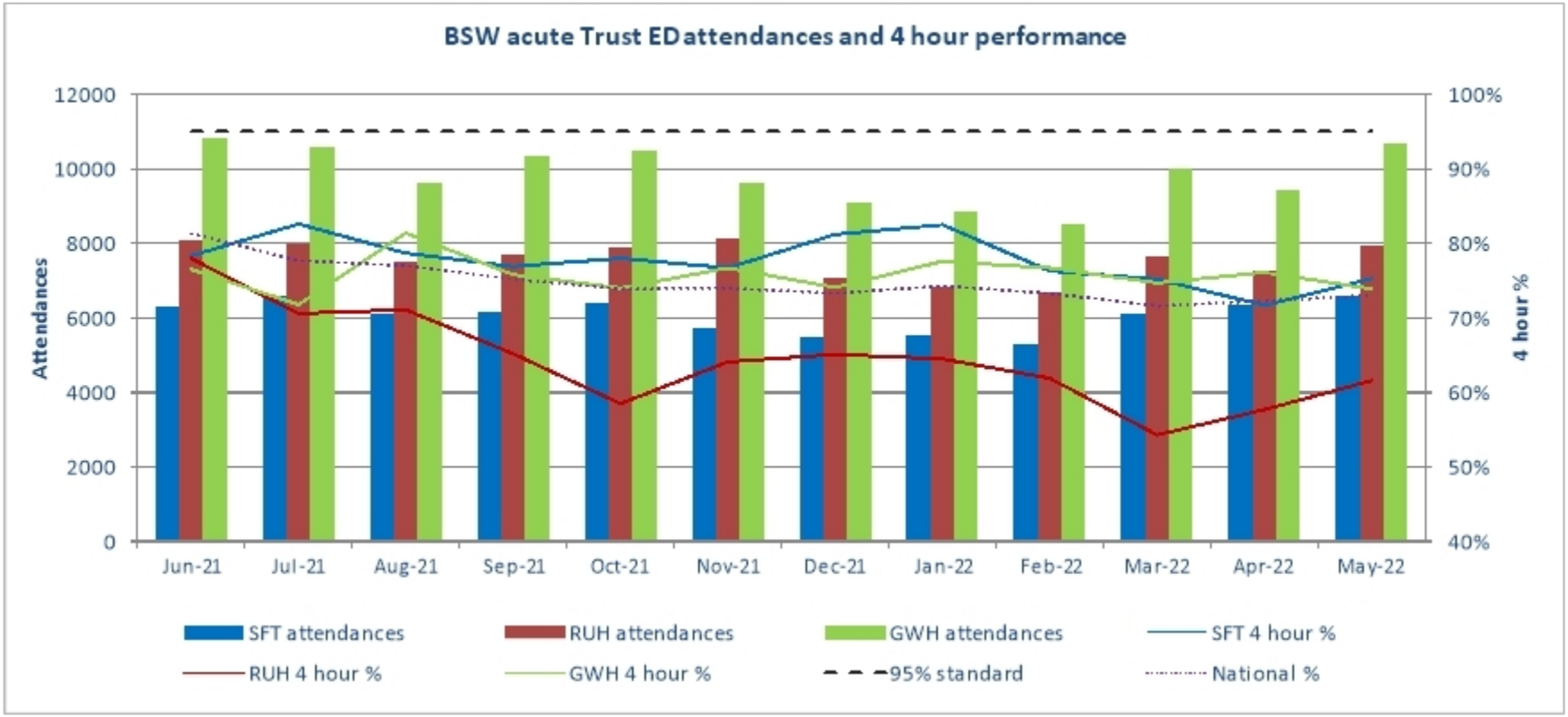
Hospital flow constraints and the resulting impact of the department reaching capacity, continues to remain the biggest challenge in being able to off load ambulances in a timely manner. The UEC Service Manager continues to monitor ambulance conveyance in hours.

Same Day Emergency Care (SDEC) ambulatory area within AMU continues to be escalated into overnight. The impact of this often means the medical take is diverted to ED and adds pressure to the ambulance conveyance performance overall.

The Pilot of a Wiltshire Health & Care ACP based at the Front Door to provide Rapid Frailty Response with the aim of admission avoidance where possible has now come to a close. Initial feedback and data shows it to be a successful pilot with ~10% of admissions being managed. The senior management team are working on joint case with WH&C to try to make the service a permeant addition to SFT ED.

BSW Context – Emergency Access (4hr) standard

Are We Effective?

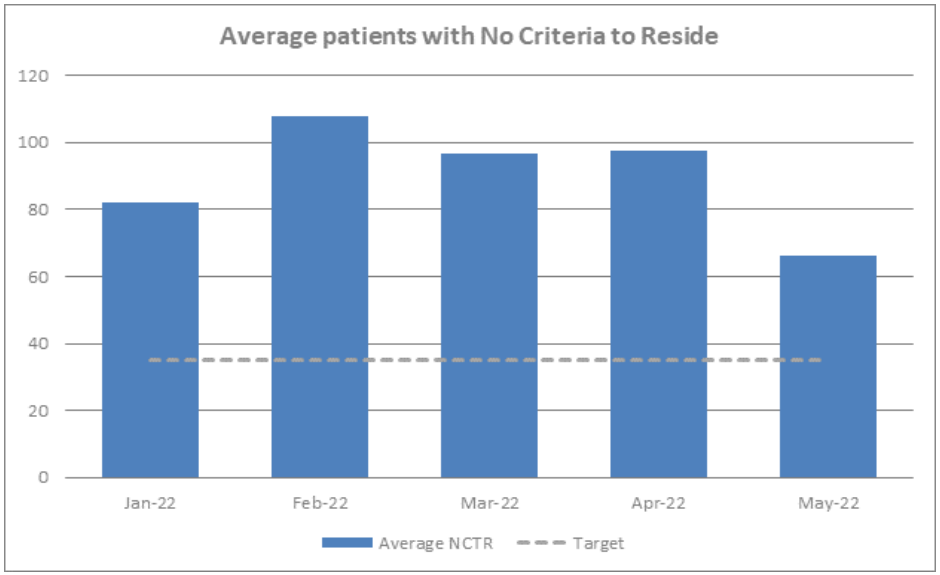


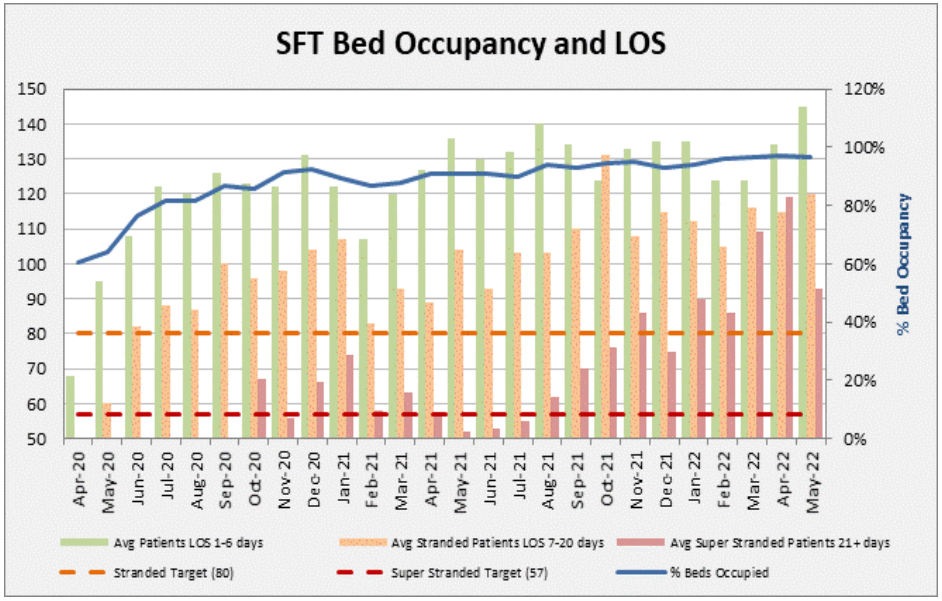
Attendances to Emergency Departments continue to trend upwards, and performance against the 4-hour standard remains challenging. Type 1 performance was 63.7% at SFT, 61.6% at RUH and 54.8% at GWH.

The number of patients waiting longer that 12 hours from decision to admit to admission reduced from 158 in M1 (25 at SFT, 7 at RUH and 126 at GWH) to 107 (7 at SFT, 2 at RUH and 98 at GWH in M2.

Patient Flow and Discharge

Are We Effective?





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

During May, the Trust and it's system partners undertook a concerted effort using SAFER and MADE principles to impact flow through the acute hospital. The data shows a reduction in the average number of patients with no criteria to reside together with a reduction in the number of patients in the longest length of stay groups (7-20 and 21 days +)

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

The SAFER/MADE event captured issues and suggestions that influence flow and improved patient journeys. This is being compiled by the transformation team at SFT and will be considered as a potential program of works in the coming months. A report is expected in June describing findings from both SFT and system partners.

Risks to delivery and mitigations

SAFER/MADE events rely on extraordinary efforts and the re prioritization of existing business as usual commitments. The activities undertaken during the 5 week period are not all sustainable in the long term as an ongoing strategy but more the principles underpinning the work should be integrated into normal working practices.
This will require buy in and the capacity to engage from staff, and so if staffing levels or demand become under pressure embedding improvements will be at risk.
Although COVID restrictions are decreased, any upsurge in COVID will put pressure on maintaining the improvement seen in May.

Theatre Performance

Theatre KPI's

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
19/20	497	532	501	531	453	522	524	555	476	548	481	364
20/21	239	294	327	317	346	362	379	401	328	248	263	383
21/22	301	378	379	442	455	473	507	520	465	469	472	419
22/23 Actual	301	510										
22/23 Plan	477	501	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC

Measure - Theatre Performance & Efficiency	Area	Target	May 22
% Utilisation	Day Surgery Theatres	90%	72.5%
	Main Theatres	85%	87.7%
Turnaround	Day Surgery Theatres	8 mins	14 mins
	Main Theatres	12 mins	32 mins
% short notice Hospital Cancellations (0-3 days)	Total	2%	0.9%
% Short notice Patient Cancellations (0-3 days)	Total	2%	8.6%

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

List utilisation in both DSU and Main Theatre improved in month, supported by the ongoing productivity work being undertaken, although daycase activity continued to be impacted by escalation in DSU. The benefits of the focus of the SAFER/MADE event were also seen in M2 with the escalation beds in DSU closed at some points in the month.13th in week theatre open but continuing high staff sickness and elective cancellations meant that this increase was not fully realised. Some lists at lower list numbers due to bed pressures and a continuing high levels of patient cancellations although these have reduced when compared to M1.

Elective activity in M2 was significantly ahead of plan at 128% of 22/23 plan, a surplus of 78 cases, although remains short of pre-Covid levels, at 81%. Underperformance of daycase activity accounts for overall theatre activity remaining lower than plan in M2 with daycase activity below plan, at 95%, however this was still over pre-COVID levels, at 103%, this demonstrates the focus on main theatre activity in M2 to accommodate the escalation in DSU. This has been further exacerbated by challenges in the GI Unit clinical workforce which impacted Endoscopy capacity accounting for the below plan daycase numbers.

Continuing high levels of cancellations were also seen throughout M2 reflected in the high percentage of patient driven cancellations, capacity driven cancellations, and workforce challenges in some clinical teams.

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

Going forward weekend lists are being covered by SFT staff rather than agency staffing, as we move towards reducing reliance on agency staffing and plan underway to phase out weekday TXM reliance as transition now taking place from TXM (insourced staff) to a more stable substantive workforce

Theatre Education continues with increased numbers of Scrub Nurses, ODP's and SFA's in full time training.

SFT IPC guidelines continue to reflect most national processes for low-risk pathways, improving the ability to book patients into cancelled slots with less notice required, in turn improving utilisation. Move to pre-surgery LFT testing rather than PCR for all patients except those undergoing, or those who have recently undergone, chemotherapy. This continues to further improve booking efficiency and flexibility reflected in the improved list utilisation.

Continuation of High-Volume Low Complexity (HVLC) lists running both in week and at weekends for several specialties as targeted Waiting List Initiatives focusing on Plastic Surgery and Urology as the specialties with the highest volume of elective surgery backlog and high levels of 52w+ wait times.

Productivity and efficiency work continues focussing on the Day Surgery Unit. This has been supported by the weekly specialty Scheduling Meetings, which have returned to a F2F medium, and bring together representation from multidisciplinary teams, including the theatre lead for the specialty, supported by the theatre management team and the booking teams.

Risks to delivery and mitigations

An ongoing risk to elective activity remains high levels of trauma, in both Plastic Surgery and T&O, and other non-elective emergency demand which continue to be higher than pre-COVID levels at 111%. This is being mitigated by daily reviews by the Specialty, Theatre and DMT to ensure patients are clinically prioritised appropriately.

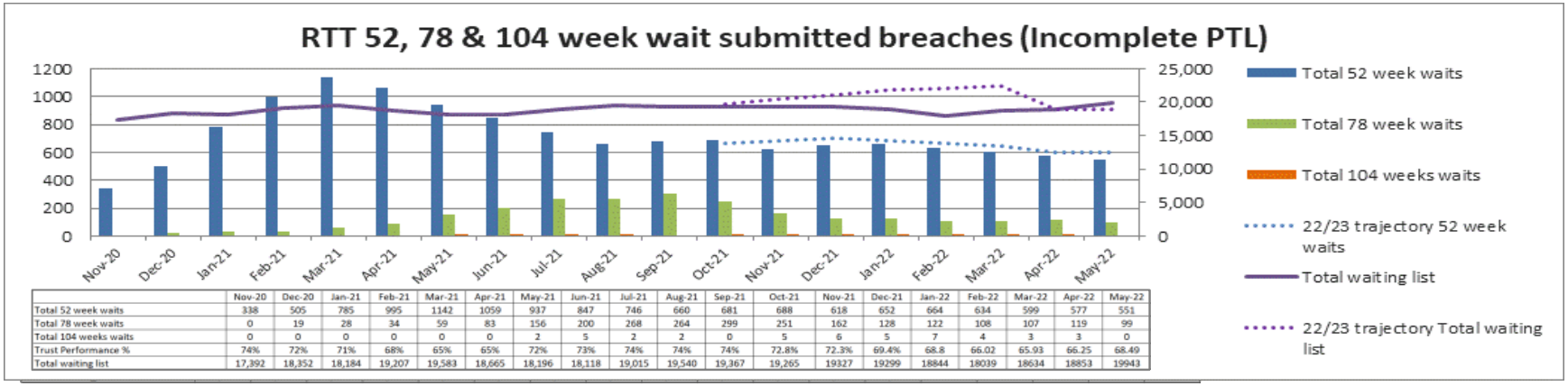
Bed pressures continue to impact the elective programme and have led to cancellations throughout M2 of elective cases and the use of DSU for inpatients has also impacted daycase performance. Daily review by the Matrons and DMT undertaken as required, avoiding cancellations whenever practical. The work of the SAFER/MADE event has supported this focusing on increasing discharges creating capacity to both improve patient flow and support the activity of the elective programme. Daily elective planning meeting set up chaired by Surgery Silver and attended by lead for theatres and lead for Chilmark elective to ensure the most efficient use of capacity to minimise cancellations.

Ongoing risk due to high levels of patient cancellations which in M2 remain at 8.6%.

Theatre access is now being allocated in order to give the best opportunity to achieve planned activity. This plan has incorporated the need for trauma/cancer etc. balanced with clinical priority and performance targets. Work to relaunch the theatre timetable looks to support this and stabilise access to theatre across the specialties.

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

National Key Performance Indicators



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Total 52 week waits	338	505	785	995	1142	1059	937	847	746	660	681	688	618	652	664	634	599	577	551
Total 78 week waits	0	19	28	34	59	83	156	200	268	264	299	251	162	128	122	108	107	119	99
Total 104 weeks waits	0	0	0	0	0	0	2	5	2	2	0	5	6	5	7	4	3	3	0
Trust Performance %	74%	72%	71%	68%	65%	65%	72%	73%	74%	74%	74%	72.8%	72.3%	69.4%	68.8	66.02	65.93	66.25	68.49
Total waiting list	17,392	18,352	18,184	19,207	19,583	18,665	18,196	18,118	19,015	19,540	19,367	19,265	19327	19299	18844	18039	18634	18853	19943

Longest Waiting patient (Weeks)	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
	108	112	103	106	110	110	107	111	116	120	99

Treatment function	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	% change from previous month
Plastic Surgery	129	129	111	121	132	130	130	117	124	6%
Urology	54	59	60	63	57	60	59	80	75	-6%
Oral Surgery	63	44	38	38	38	37	34	34	32	-6%
Trauma and Orthopaedic	59	56	48	39	45	41	26	28	25	-11%
Ophthalmology	90	71	55	44	25	24	24	21	11	-48%

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

The number of patients waiting longer than 52 weeks decreased to 551 in M2.

There were no reportable patients waiting 104 weeks at the end of M2 with the Trust on track to achieve the target to eliminate these by the end of June 22.

Of the patients waiting on non-admitted pathways the highest volumes are now seen within Respiratory, Plastic Surgery and Dermatology. Of the patients on admitted pathways awaiting surgery Plastic Surgery, Gynaecology and Urology are the most challenged specialties.

Overall, the most challenged areas remain Plastics, Gynae and Urology at both the 78 week and 52 week interfaces. Overall PTL size in M2 was 19,943 which is above the target.

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

HVLC lists for Plastics LA procedures have continued to run throughout May for this long waiting cohort although this was reduced due to consultant cover reducing lists. Capacity was picked up by Urology another of the most challenged specialties.

SFT on track to achieve the national targets to eliminate 104-week breaches (unless P6 patient choice to wait) by the end of July 22 and work is ongoing to deliver the activity required to support the achievement of the national target to eliminate 78 week waits by the end of March 23.

Ongoing use of IS with the transfer of clinically appropriate Orthopaedic patients to Newhall continuing.

Risks to delivery and mitigations

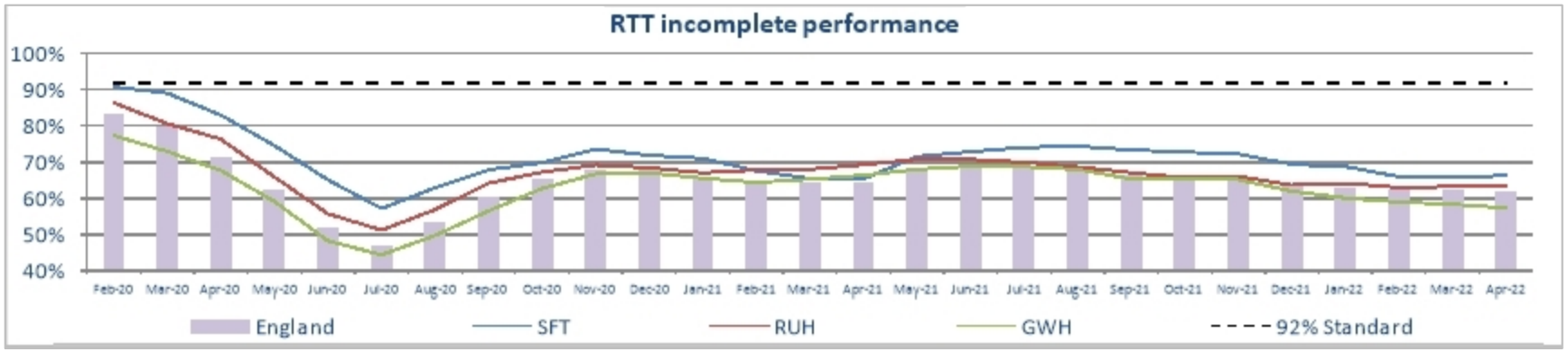
As with theatre activity continued risks remain in relation to theatre workforce for local lists including the risk of high levels of sickness. The mitigation for this issue is linked to the Theatre Workforce Business Case which has been approved. Risks associated with staffing levels as a direct result of COVID-19 reduced in M2 but high levels of non-COVID absence seen especially impacting the GI Unit clinical team reflected in the lower than plan daycase numbers.

Ongoing risk remains high levels of trauma, in both Plastic Surgery and T&O, and other non-elective emergency demand as this may continue to result in cancellations especially of long waiting, clinically routine patients. This is being mitigated where possible by daily reviews by the Specialty, Theatre and DMT to ensure patients are clinically prioritised appropriately minimising elective cancellations wherever possible. Capacity pressures continue to impact the elective programme and have led to elective cancellations in M2 exacerbated by use of DSU as an escalation area.

A SAFER/MADE approach continued throughout May focusing on increasing timely discharges creating capacity to both improve patient flow and support the activity of the elective programme. Continued high levels of patient led cancellations are also a risk to delivery.

BSW Context – Referral To Treatment (RTT)

Are We Effective?



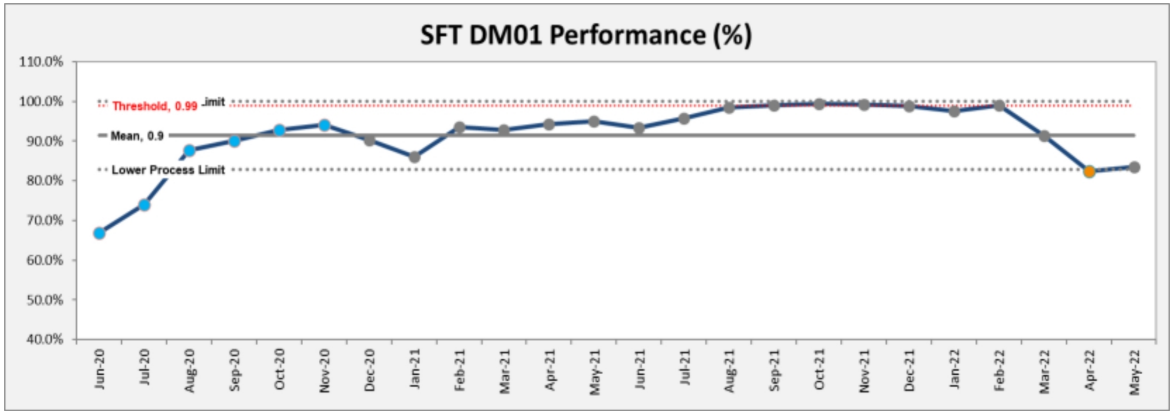
*Due to the time it takes to for NHSE to publish the data, RTT benchmark data on this slide is a month behind the reporting month.

Total waiting list size increased across BSW at all three acute providers, with the number of patients waiting longer than 52 weeks also increasing at RUH and GWH. A small reduction in the number of patients waiting longer than 52 weeks was seen at SFT (576 in M1 compared to 599 in M12).

This mirrors the position seen nationally with total waiting list size increasing from 6.36m to 6.48m, and the backlog of patients waiting over 52 weeks increasing by 5% from 306,286 in M12 to 323,093 in M1.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month: 83.58%

Waiting List Volume: 5297

6 Week Breaches: 870

Diagnostics Performed: 7396

Modality performance

MRI	62.2%	US	94.8%	Audio	79.7%	Neuro	99.0%	Flexi sig	98.5%
CT	99.4%	DEXA	100.0%	Cardio	59.7%	Colon	94.1%	Gastro	97.0%

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

M2 saw a slight improvement in compliance against the DM01 standards as compared to M1 (83.58% vs. 82.3%. However, this was as a result of an increased waiting list size as opposed to the number of patients impacted by a breach. M2 total breaches are recorded at 870 and M1 was 838.

Waiting list total size has increased from 4410 at end of M1 vs 5297 at end of M2.

Key contributing areas of non-compliance are within MRI (420 breaches), USS (95 breaches), Audiology (37 breaches) and Cardiology Echo (296 breaches). Of note, USS and Audiology total breaches have reduced compared to M1 (reduced from 150 and 51 respectively).

Key contributing factors for the volume of breaches are workforce availability (across all areas), power outage (impacting MRI in particular) and consequential equipment failures and downtime (total of 10 days impacted by various issues, impacting 80 patients requiring rebooking into alternative capacity).

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

The three ongoing areas of concern for DM01 are MRI, USS and Echo:

MRI recovery options paper in discussion between Radiology & CSFS DMC. Restoration of MRI DM01 position circa six months to improve (MRI1 replacement project and reporting capacity issues constrain the options for a quicker solution).

USS seeking additional agency Sonographer resource as there are further leavers in the team M2-M5.

Echo continue to seek agency and outsourcing support although options are limited. Improved position on M1 due to team picking up additional capacity where possible. Looking to system partners (e.g., community heart services) for support.

Risks to delivery and mitigations

MRI scans take up to 1 hour per scan – backlog will require a high volume of lists to clear and require medium/long term 'fix'. Could consider insourcing from private provider for 'quicker fix' but financial impact will be high.

MRI1 replacement project from late M4 resulting in one less scanner in operation for 4 months. Mobile van scanner has recently been replaced; service will plan to utilize 10-14 session per week.

USS substantive workforce – reducing numbers, hard to recruit to posts. Rolling advert and agency staff to mitigate. Long term have trainees in team.

Echo – sustainability risk of overtime within small team. Mitigate with agency but very limited options of candidates.

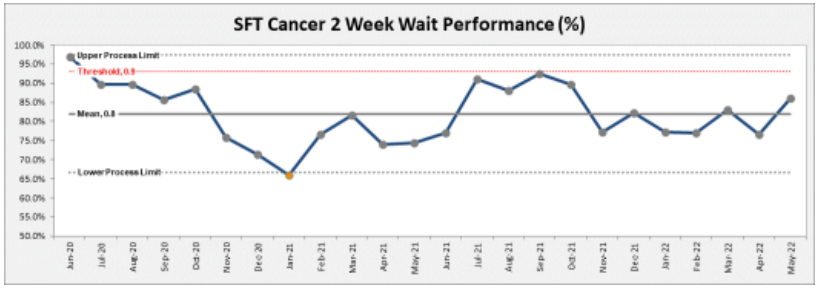
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or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

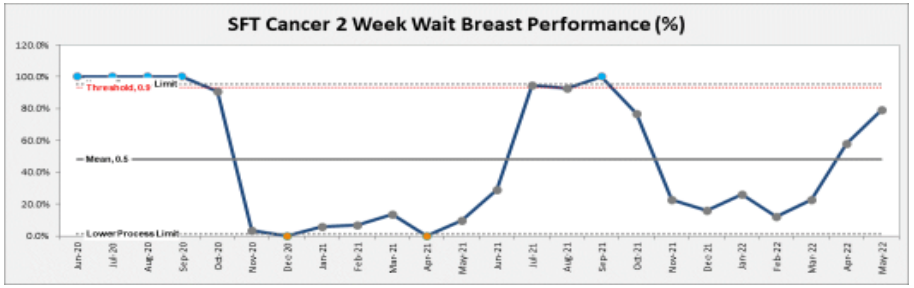
Cancer 2 Week Wait Performance Target 93%

National Key Performance Indicators

Performance Latest Month	Performance	Num/Den	Breaches
Two Week Wait Standard:	86.07%	964/1120	156 (64 patient choice)
Two Week Wait Breast Symptomatic Standard:	79.31%	23/29	6 (6 patient choice)

Data Quality Rating:





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

Two week wait standard not achieved for Month 2, with validated month end performance of 86.07% (1120 patients seen; 964 in target; 156 breaches). Breach reasons associated with:

- Clinic capacity: 47 breaches (across all services)
- Patient choice: 64 breaches
- Delayed triage: 6 breaches
- Endoscopy capacity: 15 breaches
- COVID-19 delay: 2 breaches
- Incomplete GP referrals: 10 breaches
- Clinical delay: 0 breaches
- Administrative delay: 5 breaches
- Prison delay: 2 breaches

Breast symptomatic two week wait standard not achieved for Month 2 (29 patients seen; 23 in target; 6 breaches). Breaches associated with patient choice.

28-day Faster Diagnosis Standard achieved for Month 2, with month end performance of 84.68% (594 patients diagnosed; 503 in target; 91 breaches).

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

Cancer Waiting Times Guidance Consultation: Consultation on revised national standards has now concluded. The proposal includes the phase out of the two week wait standard, to be replaced by the 28-day faster diagnosis standard. National team have suggested that revised guidance is due to be published from July 2022, with changes enforced from October 2022 onwards.

CQUIN 2022/23 re compliance with timed diagnostic pathways for cancer services: Expectation that 65% of prostate, colorectal, lung and OG cancers meet the pathway milestones outlined within the national optimum timed diagnostic pathways. Services have already completed a plan on a page to facilitate delivery, and retrospective data collection is underway.

Timeliness of Head and Neck triage: Surgery DMT working closely with Head and Neck Services to implement more robust triage process in line with national best practice recommendations.

Colorectal Consultant Capacity: GI Unit looking to recruit a locum Colorectal Consultant from ID medical to alleviate OPA capacity pressures and assist with Endoscopy lists.

Risks to delivery and mitigations

Patient choice: Ongoing challenges associated with patient choice delays and cancellations. There are however limited opportunities to offer a second appointment with the two-week timeframe due to capacity constraints.

Timeliness of consultant triage within head & neck:

Robust process not currently in place to facilitate daily triage. Surgery DMT currently working alongside MDT lead to resolve.

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)
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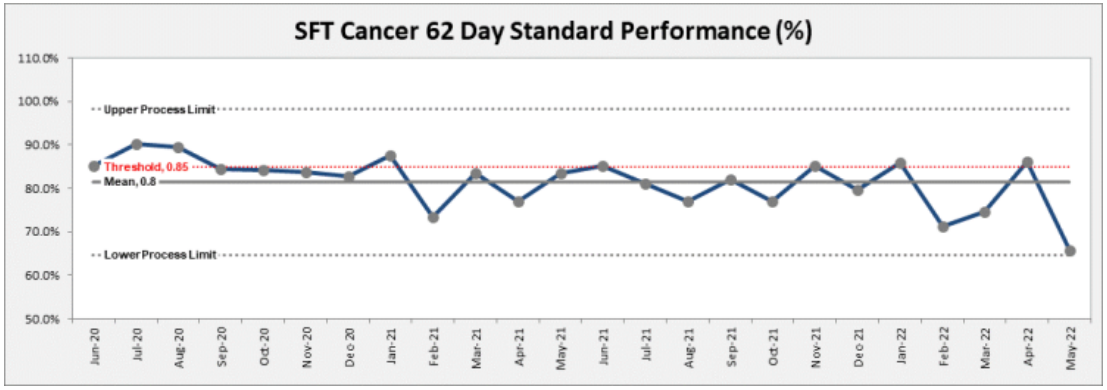
- Common Cause Variation

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

March 22	Performance	Num/Den
62 Day Standard:	65.2%*	47/72
62 Day Screening:	0%	0/1

*62 day performance is subject to change prior to final submission

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

Month 2 62-day performance standard not achieved, with validated month end performance of 65.2% (72 patients treated; 47 in target; 26 breaches).

- **Colorectal:** 7.5 breaches (complex pathways, consultant capacity, oncology capacity)
- **Gynae:** 2 breaches (complex pathway, clinical delay)
- **Haematology:** 2 breaches (complex pathway, patient choice)
- **Lung:** 1.5 breaches (complex pathways)
- **Upper GI:** 2 breaches (complex pathways)
- **Urology:** 10 breaches (insufficient prostate cancer diagnostic capacity, incomplete diagnostic resections)

62-day screening standard not achieved for Month 2, with validated month end performance of 0% (1 patient treated, 0 in target, 1 breach). Breach associated with insufficient bowel cancer screening diagnostic capacity.

31 day performance standard achieved, with validated month end performance of 97.12% (104 patients treated; 101 in target; 3 breaches).

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

Impact of pharmacy capacity on delivery of chemotherapy: Business case within pharmacy to increase staffing capacity and provide resilience under discussion

Establishment of vague symptoms/non-specific symptom pathway: pathway currently being scoped with BSW ICS to support patients with "vague symptoms" who may otherwise undergo lengthy diagnostic pathways. Pathway Navigator due to commence in post from August 2022, although unsuccessful recruitment of GP lead. Re-advertisement of GP lead role across BSW currently being considered.

Prostate Pathway Improvement: Surgery DMT working alongside Urology services to develop an improvement plan to reduce the length of cancer diagnostic and treatment pathways for prostate patients.

Access to PET-CT: Capacity constraints raised directly with Alliance Medical, as well as through SWAG/Wessex cancer alliances and BSW ICS. Working group established with regards to mobile PET-CT scanner for Salisbury patients. Timescales yet to be confirmed.

Cancer waiting times guidance consultation: Consultation on revised national standards has now concluded. Proposal includes the amalgamation of all 31-day standards (including subsequent treatments) and all 62 day standards (including upgrading and screening). National team have suggested that revised guidance is due to be published from July 2022, with changes to be enforced from October 2022 onwards.

Risks to delivery and mitigations

Patient fitness: Increase in number of 62-day breaches associated with patient fitness and comorbidities.

Access to PET CT: Service provided by Alliance Medical. Capacity has the potential to adversely affect pathways across all tumour sites and could affect delivery of the 62-day standard.

Histopathology reporting turnaround times: Ongoing challenges associated with Consultant Histopathologist capacity, which often results in cancer pathology being outsourced. This in turn increases the timeframes for reporting and can delay diagnosis and treatment. National shortage of specialist staff.

Diagnostic capacity within the prostate cancer pathway: Challenges associated with diagnostic pathway for prostate patients, in part due to historical pathway processes but also insufficient template biopsy capacity and accessibility to equipment. This is impacting 28- and 62-day performance.

Fragility of existing workforce: Ongoing pressure on services has resulted in an increase in reported stress, staff burnout and need for annual leave. This has meant that several services have had insufficient consultant, nursing and administrative staff available to reduce waiting times.

Oncology capacity: Issues in aseptic and staff workforce have had a knock-on effect to waiting times for chemotherapy.

Capacity at tertiary centre: capacity issues around radiotherapy at tertiary centres, because of an increase in demand, has resulted in longer waits

Statistical Process Control Chart Key:
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- Mean
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- Common Cause Variation

Stroke & TIA Pathways

Are We Effective?

SSNAP Case Ascertainment Audit

Highest level = Grade A

Lowest level = Grade E

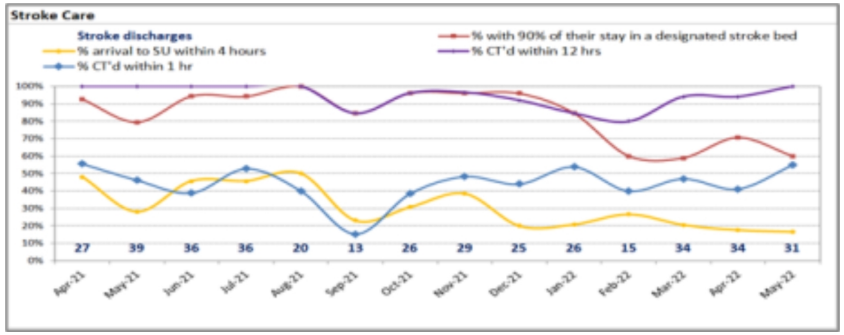
Quarterly	Q1	Q2	Q3	Q4
2020-21	Not Reported	Not Reported	Not Reported	Not Reported
2021-22	C	C	C	D
2022-23				

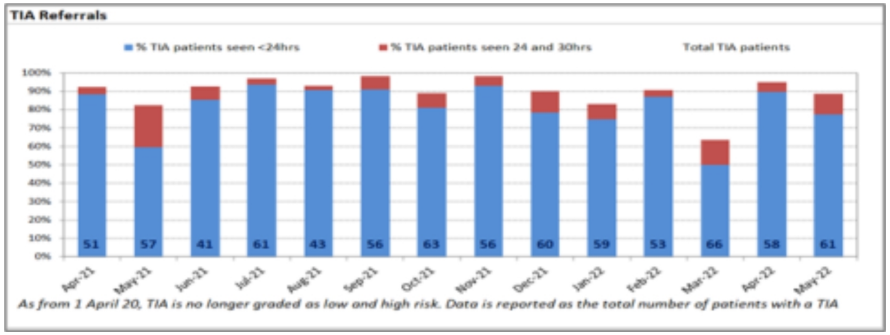
Data Quality Rating:

% Arrival on SU <4 hours: 17.6%

% CT'd < 12 hours: 100%

% TIA Seen < 24 hours: 77.4%





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

[Please note: Data is often only partially validated with informatics at the time of publishing. Coding can sometimes result in minor adjustments to the data at a later date].

- An SSNAP Level of D (score of 54.2) was reported for Q4 2021/22.
- There were 31 stroke discharges this month.
- There were 0 stroke deaths within 7 days and 1 death within a 30-day period in May.
- 90% stay in the stroke unit was 60% this month which is a decrease from last month; 1 to AMU first, 1 moved to Breamore, 1 IP stroke, 9 SLOS.
- The number of patients reaching the stroke unit within 4 hours is 17%.
- Average Stroke unit length of stay was 15 days and an average total length of 15 days.
- 55% of patients had a CT within an hour which is an increase from the last month. CT within 12 hours was at 100%.
- 5 patients were thrombolysed with an average door to needle time of 79 minutes.
- 13 of the eligible 24 patients were referred to ESD in May.
- 77% of the 62 TIA's had treatment complete within 24hrs; with 8 full clinics, 1 MRI next day, 1 delayed referral, 2 re-booked appointments due to 1 missed appointment and one couldn't attend, 2 declined other service providers (Poole/Bournemouth).

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

- The stroke team has been joined by a new locum consultant, replacing the previous locum and providing continuity of cover.
- As of the 6 May, Farley has returned to a fully operational Stroke Unit and patients are no longer required to go to Breamore Ward for rehab – we should start to see an improvement on the 90% stay on the Stroke Unit target.
- There are ongoing plans in place for collaborative efforts with the team leaders, emergency department, radiology and site matrons to discuss multiple factors impacting on targets and how to improve future targets.
- There will be simulation training to the Emergency Department to improve recognition of a stroke and hyperacute care and the importance of timely transfers to the Stroke Unit – date to be confirmed.
- Training has been started with all new staff members on the ward which focuses on the stroke targets to give more of an understanding of the importance of these and how to achieve them more effectively.

Salisbury NHS Foundation Trust

Part 2: Our Care

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Maternity

Are We Safe?

SFT Assurance Dashboard		Guidance	Standard	Improvement Direction	Rolling 6 months						
					Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Rolling 6m average
Perinatal Morbidity and Mortality (M&M)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)			Down	2	0	0	0	0	0	0
	Number of stillbirths (>+ 24 weeks excl TOP)	ONS	3.8 per 1000 live births	Down	2	0	0	2	0	0	1
	Number of neonatal deaths : 0-28 days	ONS	2.7 per 1000 live births	Down	2	0	0	0	0	1	1
	Medical termination over 24 +0 registered			Down	NA	1	0	0	0	0	0
Maternal M&M	Number of Maternal Deaths	ONS	9.1 per 100,000 women who delivered	Down	0	0	0	0	0	0	0
	Number of women requiring admission to ITU	6 month SFT rolling		Down	0	0	0	0	0	0	0
Insight	Number or daytix incidents - moderate or above	6 month SFT rolling		Down	1	0	2	1	1	2	1
	Datix incidents moderate harm (not SII)	6 month SFT rolling		Down	1	0	2	1	0	1	1
	Datix incidence SII	6 month SFT rolling		Down	0	0	0	1	0	1	0
	HSIB referrals	6 month SFT rolling		Down	0	0	0	0	0	0	0
	HSIB/NHSR/CQC or other organisation with a concern or request	6 month SFT rolling		Down	0	0	0	0	0	0	0
	Coroner Reg 28 made directly to trust	6 month SFT rolling		Down	0	0	0	0	0	0	0
Workforce	Minimum safe staffing in maternity services :Obstetric cover	RCOG guidence		NA	40	40	40	40	40	40	40
	Midwife to Birth ratio	RCM;NHSR;BR +	1.28	NA	1.25	1.26	1.31	1.28	1.31	1.32	NA
	Midwifery vacancy rate (black= over establishment; red =under establishment)			up	NA	10 WTE	14.65	14.65	17.2	17.4	NA
	Provision of 1 to 1 care in established labour (%)	NICE, RCM, MIS	100%	Up	100	100	NA	NA	100	100	NA
	Datix relating to workforce	6 month SFT rolling		Down	0	1	0	2	3	1	1
	Compliance with supernumery status of the LW coordinator - %	NICE;RCM;NHSR	100% rostered	Up	NA	100	NA	NA	100	100	NA
	Numbers of times maternity unit on divert	6 month SFT rolling		Down	0	0	0	0	0	0	0
Involvement	Service user feedback : Number of Compliments	6 month SFT rolling		Up	2	19	31	32	27	31	24
	Service user feedback : Number of Complaints	6 month SFT rolling		Down	1	2	4	2	2	0	2
	Number of SOX	6 month SFT rolling		Up	5	5	11	7	8	7	7
Assurance	Progress in achievement of 10 safety actions(CNST)	NHSR	10	Up	4	4	4	4	5	5	4
	Training compliance - MDT PROMPT %	NHSR	90%	Up	NA	74	74.2	75.2	72.3	83.63	NA

Perinatal Quality Surveillance Tool

The information provided represents the recommendation from the Ockenden report. SFT is further developing this dataset to ensure the Board is informed of safety metrics and indicators.

What does the data tell us ?

Midwifery vacancy increasing
Progress on MIS scheme – predict 8/10 by submission
Training compliance increasing across the MDT

What actions are being taken to improve?

Recruitment ongoing with targeted support from the recruitment team around making the process as seamless as possible in order to assist new starters into the workplace, and support from comms around a media campaign.
International recruitment continues with GWH and Gloucester, 5 midwives to be recruited via this programme, with an option to expand the programme if it is successful. Expected to be in post August 2022.
Practice development lead for international midwives recruited into.
New programme designed to enable targeted support to newly qualified midwives, and support retention in this staff group.
RGN recruited to support high risk post surgical care alongside midwives.
Registered on workforce support programme with NHSE/I and receiving targeted support.

Ockenden

Successfully bid for CTG monitors which aligns with the standards pertaining to central monitoring and the digital agenda as outlined by the Ockenden recommendations.

Maternity Clinical Dashboard

Data Quality Rating:

Are We Safe?

Measure	Min	Median	Max	Improve direction	Green	Red		May-22
Babies (incl Non Reg)	180	180	180					178
Women Delivered	175	175	175					179
Homebirth rate	3.3%	3.3%	3.3%					3.4%
Inductions %	43.4%	43.4%	43.4%					36.4%
Total CS rate (planned & unscheduled)	25.1%	25.1%	25.1%	Down		32.0%	32% National Dash Mar21	27.84%
Elective caesarean sections %	12.0%	12.0%	12.0%	Down		15.0%	15% National Dash Mar 21	13.1%
Emergency caesarean sections %	13.1%	13.1%	13.1%	Down	17.0%	20.0%	17% National Dash Mar 21	8.4%
Instrumental deliveries %	11.7%	11.7%	11.7%	Down	12.0%	12.5%	12.5% NMPA	11.7%
Apgar less than 6 @ 5 min %				Down	1.2%	3.5%	Green <1.2%, red >3.5% NMPA	0.5%
PPH >= 1, 500 %	4.0%	4.0%	4.0%	Up	2.7%	5.6%	Green <2.7%, red >5.6% NMPA	4.6%
Term babies admitted to NNU unexpectedly %	1.7%	1.7%	1.7%	Down	5.5%	5.8%	<5.8% NMPA	4.5%

Clinical outcomes within expected ranges.

Maternity Incentive Scheme (CNST) year four

Increased compliance with action 8, this is due to increased PROMPT training compliance (83%) and we expect this compliance to increase to over 90% by July.

Pertaining to saving babies lives, reintroduction of C0 Monitoring has demonstrated improvement through audit, currently at 85% at 36 weeks (Q3 was 67%). There have been issues nationally with the reintroduction of C0, so to mitigate this, the audit has become monthly instead of quarterly to monitor the standard.

Uterine artery Dopplers has not yet been introduced at SFT, although relevant staff have received training. SFT has been in the top 10 Trusts nationally who follow Perinatal Institutes GAP/ GROW for the last full year, however, and continue to detect < 3rd centile babies on average >90% of cases.

We are fully compliant with Element 3 (reduced Fetal Movements) and are continuing to improve our training compliance with fetal monitoring but have met challenges to achieving this due to staffing, acuity and the pandemic. Currently 77% Midwives have attended the face-to-face training, and 86% have completed the online element. 65% of Doctors have attended face to face and 50% are in date with the online element. This has been escalated to the Clinical Director and the Fetal Monitoring Lead Obstetrician, with ongoing work to improve this.

We recently introduced PeriPrem at SFT and are now fully compliant with this element.

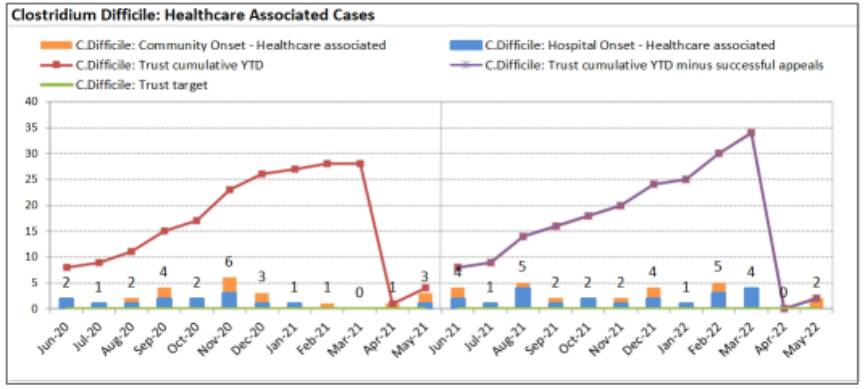
Infection Control

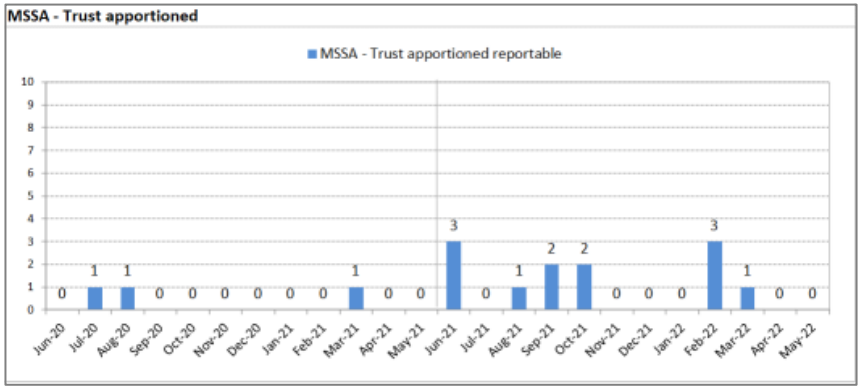
Data Quality Rating:

Are We Safe?

Clostridium Difficile	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22
Cases Appealed	0	0	0	0	0	0	0	0	0	0
Successful Appeals	0	0	0	0	0	0	0	0	0	0

MRSA	2021-22	2022-23
Trust Apportioned	3	0





Summary including learning outcomes and actions – May 2022

- No MRSA bacteraemia cases identified
- One community onset healthcare associated MSSA bacteraemia case identified. Source of bloodstream infection linked to wound infection from recent cardiac surgery
- No hospital onset healthcare associated reportable *C.difficile* cases identified
- Two community onset healthcare associated reportable *C.difficile* cases identified. Additional investigation ongoing for one of these cases as the patient was a readmission
- No hospital onset *E.coli* bacteraemia cases identified

Pressure Ulcers

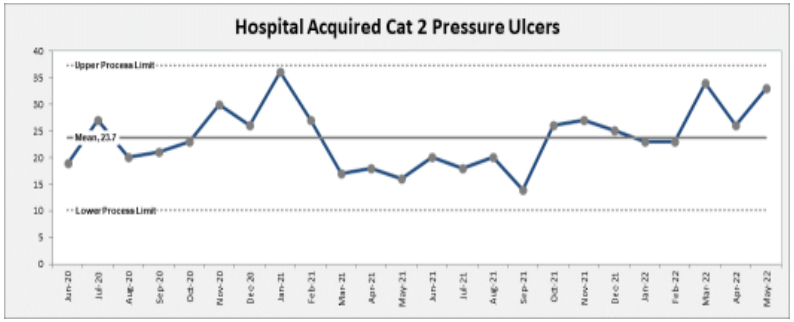
Are We Safe?

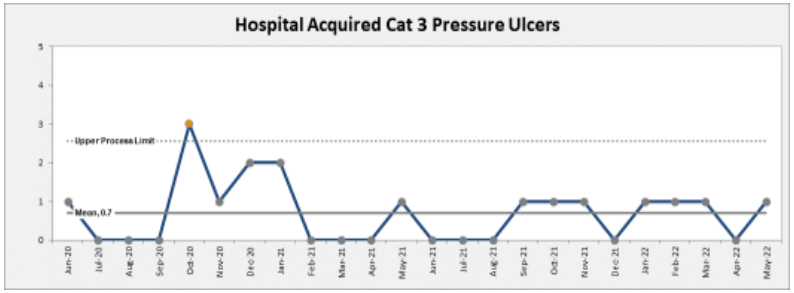
Per 1000 Bed Days	2020-21 Q4	2021-22 Q1	2021-22 Q2	2021-22 Q3	2021-22 Q4
Pressure Ulcers	2.21	1.47	1.30	1.84	1.88

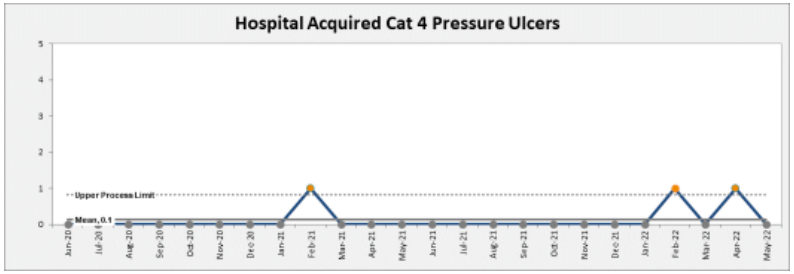
Data Quality Rating:

Summary and Action

- There have been 33 Category 2 PU's in May, which is an increase from 26 in April. Medicine contributed to 27 of this number, with one ward in particular having a significant number. The Tissue Viability team will work with this ward to provide teaching and structured discussion about potential themes or causes for this increased number. There were 5 Category 2 PU's acquired within Surgical division and 1 within CSFS. Cat 2 PU's continue to be most commonly found on sacrum/buttocks and heels and are often shear injuries due to various reasons including bedpan use or sliding down the bed when profiled. As in previous months, we have found that the majority of patients with hospital acquired PU's are being nursed on pressure relieving mattresses.
- One Category 3 PU was identified in May- This was a device related PU due to an above knee closed cast in situ on a patient with LD and complex health needs who is minimally communicative. A 72-hour report has been completed which did not identify any significant omissions in care and this case has been discussed at the Patient Safety Summit meeting and an SII was commissioned.
- No Category 4 PU's were identified in May.
- 7 Deep Tissue Injuries were identified in May; this is a decrease from the 10 identified in April. Most of this number were found on patient heels. We continue to encourage use of pressure relieving boots as a preventative measure rather than the use of pillows to elevate heels. However, we find that boots are often requested as a reactive measure, after a PU has been identified. As in previous months, it is likely that there were missed opportunities for early identification of vulnerable areas due to operational pressures and missed education opportunities leading to DTI's.
- Pressure Ulcer Prevention education continues to be available twice a month and can be booked via MLE. Tissue Viability also undertake education and training with wards informally, providing bitesize education on skin checks and pressure ulcer prevention methods during ward visits and attending ward arranged training days to deliver education in areas that have had significant PU numbers or hospital acquired cat 3/4 PUs.
- The monthly Share and Learn meeting took place in May and attendance, whilst improved, remains below average. Mini RCAs for pressure ulcers were largely not completed despite requests to do so; this coupled with poor ward attendance to present PU's meant that no significant themes or actions were identified on this occasion.







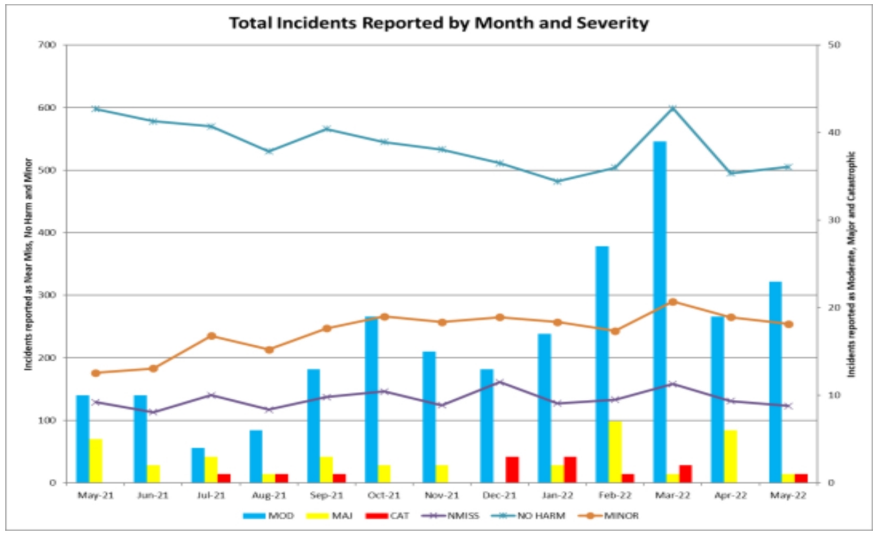
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or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

Incidents

Are We Safe?

Year	2021-22	2022-23
Never Events	3	0

Data Quality Rating:



Summary:

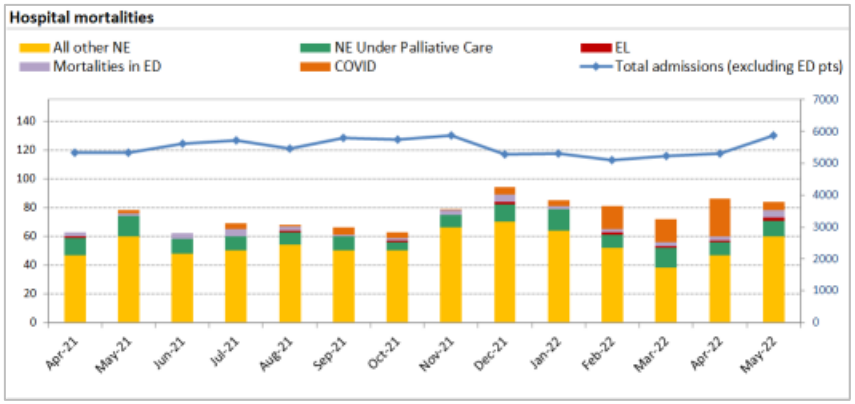
SIIs in May:

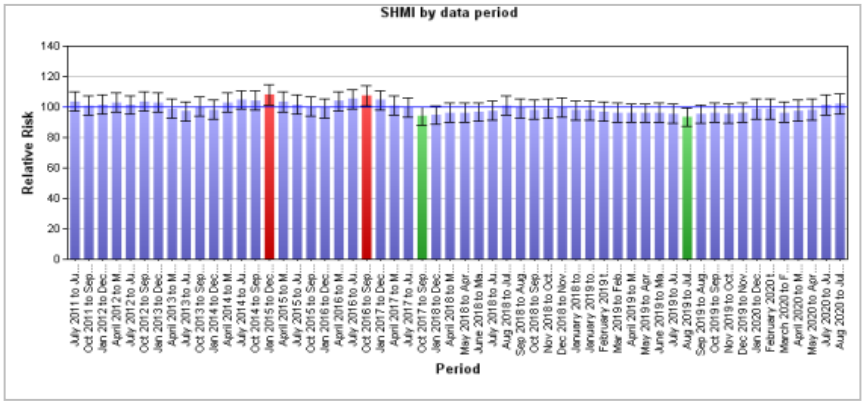
- **478** A cancelled MRI scan, no follow up, and a potential delay in diagnosis
- **482** Enhanced nursing care and use of security - A patient fall whilst a security guard left to get help
- **483** A potential delay in diagnosis
- **484** Term admission to NICU - Readmission of a baby who had abnormal observations prior to discharge

Mortality Indicators

Data Quality Rating:

Are We Safe?

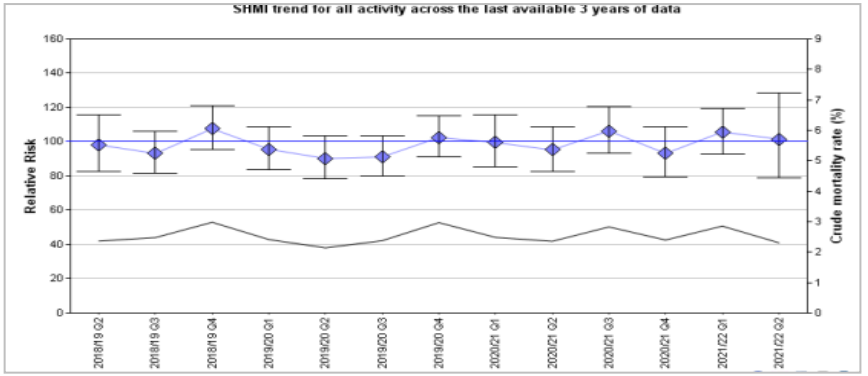


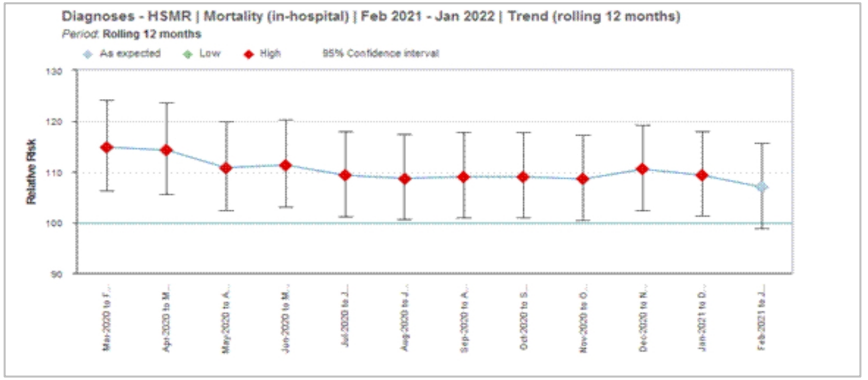


Summary and Action

- **The latest SHMI** for Salisbury District Hospital represents the 12-month period of January 2021 – December 2021 and is 1.0270. This is within the expected range.
- **The latest HSMR** represents the 12-month rolling period of March 2021 – February 2022. The relative risk is 109.1 and this is statistically higher than expected.
- There were 6 reported COVID deaths in May (deaths within 28 days of a positive PCR test and/or COVID on death certificate).

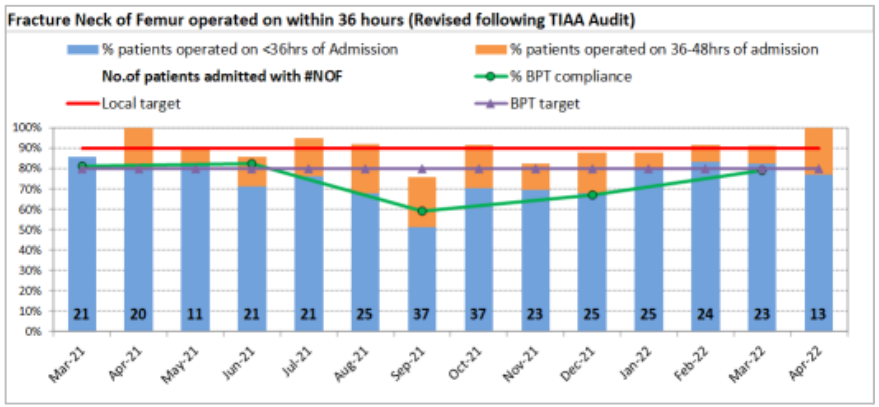
Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value
RNZ02	Salisbury District Hospital	33,305	920	895	1.0270
RNZ78	Salisbury Hospice	100	65	25	2.4331





Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?



(Please note: due to the time it takes to complete clinical coding, the fracture neck of femur data for the current month may not be displayed on the graph above)

BPT %: May 2022

- Total Patients Discharged: 36
- Not applicable for BPT: 5 (3 PP# & 2 No operation)
- Number of patients who failed to meet BPT: 7

Reasons for failure:

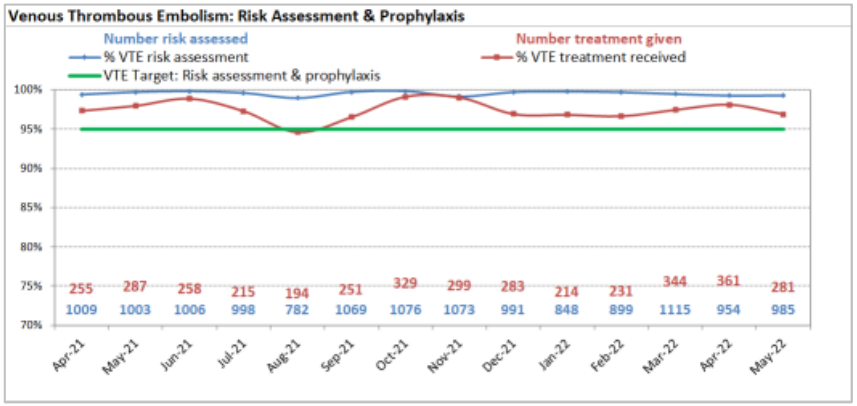
- Awaiting Theatre Space: 6 patients
- Awaiting medical review/investigation or stabilisation: 1 patient

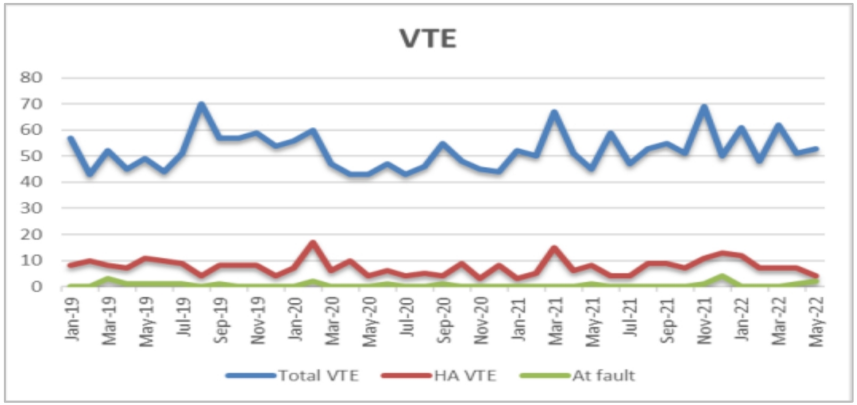
BPT %: 77.4 %

Average LOS: 22.64 days

The percentage of patients operated on within 36hrs of admission increased this month to 77.4%. This is a significant improvement on the numbers reported in April.

Data Quality Rating:





Hospital Associated VTE

- Total number of VTE in May 2022: 53
- Hospital Acquired (HA) VTE: 4 – 7.5% of total VTE (national average 25%)
- 0.08% of total admissions (national average 0.5 – 1.6%)

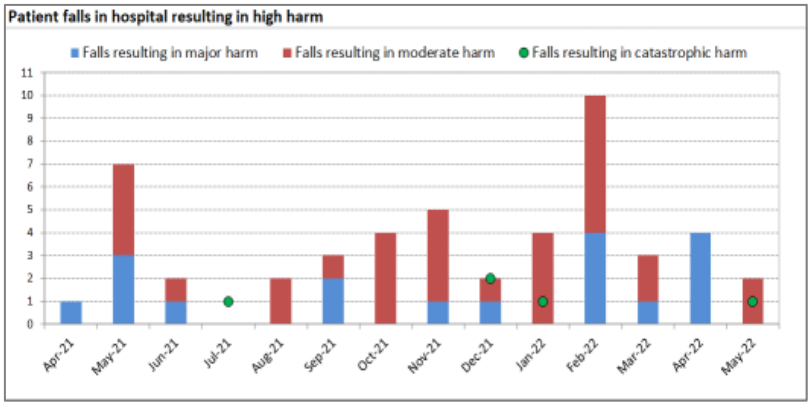
All patients diagnosed with a VTE are assessed and flagged as HA if associated with a hospital admission/surgery within 90 days of their diagnosis and a root cause analysis is completed.

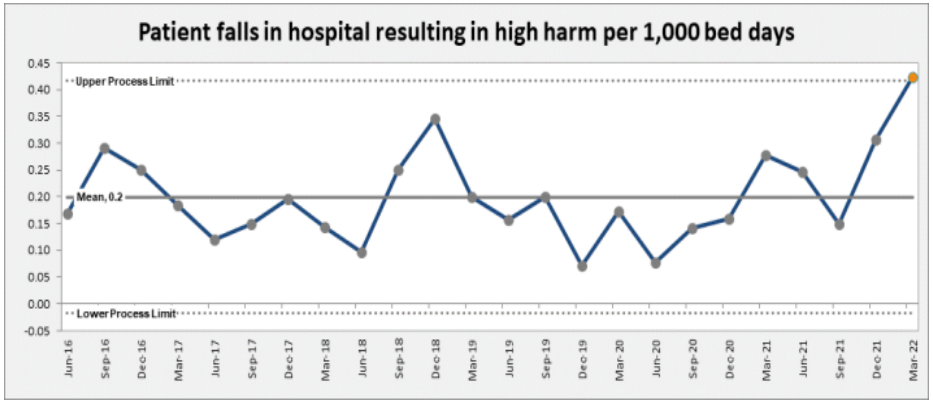
- 2 cases appear to have been preventable but they were both cases where the prophylaxis was held due to bleeding but there was a delay in providing an alternative
- All other VTE events in May developed a VTE despite being provided with appropriate VTE prophylaxis

Patient Falls

Are We Safe?

Data Quality Rating:





Summary and Action

For May there were 3 falls resulting in patient harm:

- 1 fractured shaft of humerus
- 2 cerebral hemorrhages (1 moderate and 1 catastrophic)

Over-all in May there has been a decrease in falls from 136 in April to 107. This equates to a drop in falls per 1000 bed days from 9.96 to 7.86. Themes continue to be non-compliance with lying and standing BP and documentation regarding risk assessments, both of which are embedded in the training and reinforced when patients who fall are reviewed on the wards.

Training has continued at ward level with 87 members of staff receiving training. A national training module has been added to MLE eLearning. Training from the Falls Reduction Specialist has been organsied to be delivered to Junior Doctors on induction as well as HCA and overseas nurses induction programs.

The *Improving Together* program has been put on hold due to capacity to train staff, with a plan to re-commence in July. However, work around falls, including improvement projects, will be trialed on one of the elderly care wards in June.

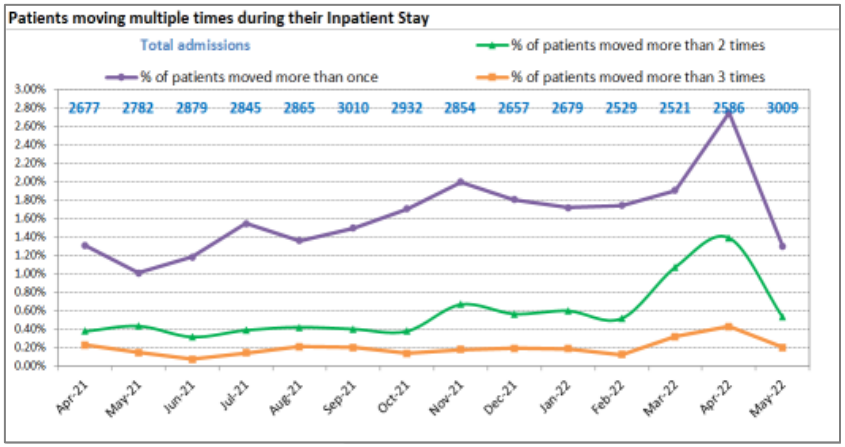
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or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

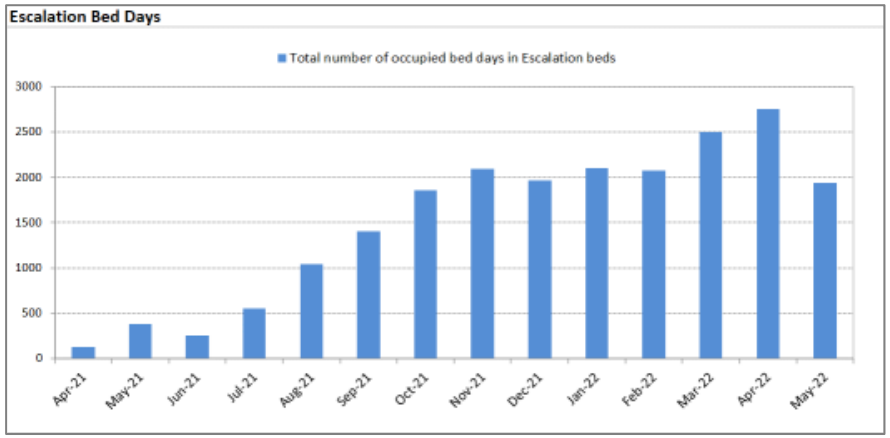
Patient Experience

Are We Safe?

Last 12 months	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22
Bed Occupancy %	90.8	90.0	93.9	93.0	94.6	95.0	93.2	93.8	96.3	96.7	97.2	96.6

Data Quality Rating:





Summary and Action

The data for May shows a change in both the number of moves patients experienced, and number of occupied bed days in escalation beds. It has been a positive change, meaning patients were more likely to be cared for in the right place at the right time in locations designed to accommodate their needs.

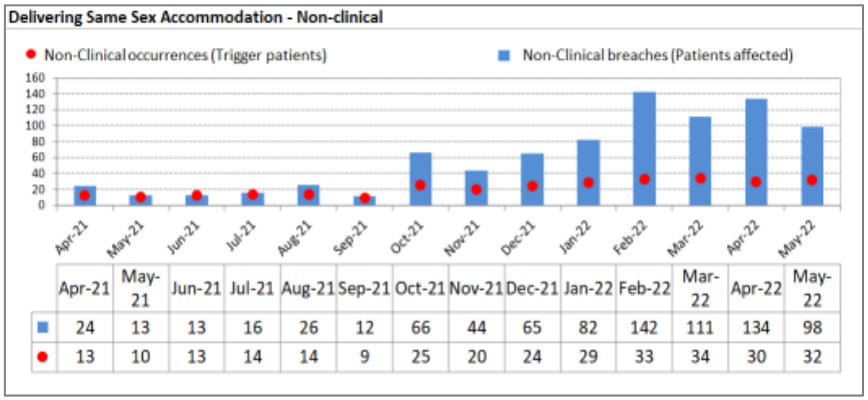
This has occurred at the same time as the SAFER/MADE event throughout May, where significant efforts across the Trust and with community partners has resulted in improved flow, allowing for the opportunity for improved patient experience.

Challenges remain and the Teams continue to prioritise the safety and quality of care for patients at SFT. There are elements of the work undertaken in SAFER that will be taken up as longer-term developments to ensure the momentum seen in the work done in May is continued as far as possible as business as usual.

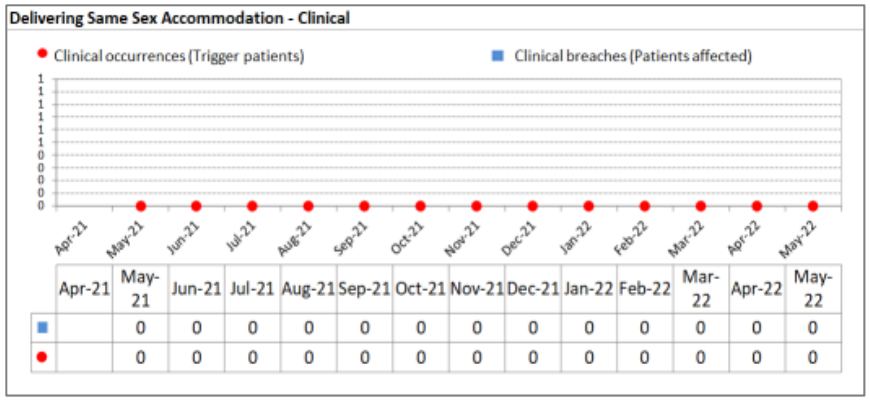
Patient Experience

Are We Safe?

Data Quality Rating:



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
■	24	13	13	16	26	12	66	44	65	82	142	111	134	98
●	13	10	13	14	14	9	25	20	24	29	33	34	30	32



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
■		0	0	0	0	0	0	0	0	0	0	0	0	0
●		0	0	0	0	0	0	0	0	0	0	0	0	0

Summary and Action

Delivering Same Sex Accommodation (DSSA) in May:

There were18 breaches affecting 18 patients which occurred on Radnor. These were all patients who were unable to be moved off the department within 4 hours of being declared fit to move:

- 8 breaches were resolved within 24 hours
- There were 10 patients who had a breach time of over 1 day while awaiting a speciality bed
- Privacy and dignity was always maintained within the patients' bed space

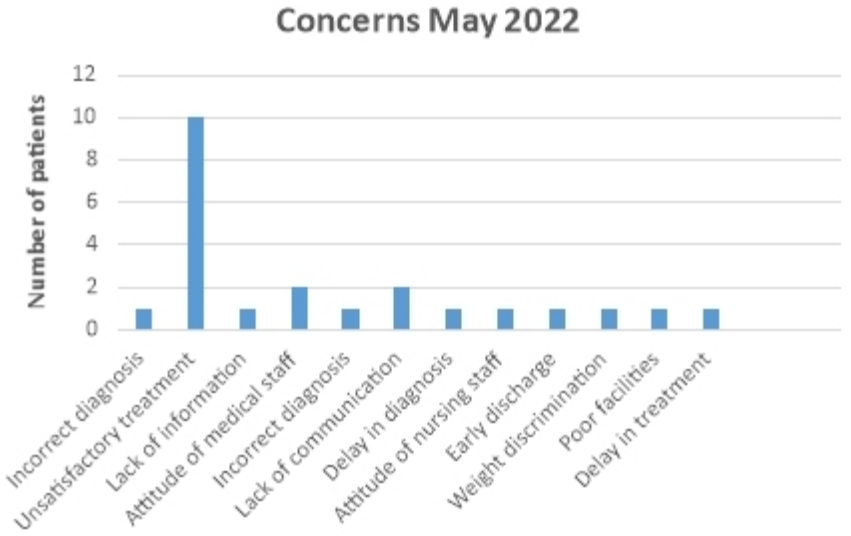
There were 14 breaches affecting 80 patients on AMU Assessment Bay. All patients had access to single-sex bathrooms within the ward and screens were used to maintain privacy and dignity:

- 13 of the breaches were resolved within 24 hours
- The remaining breach was resolved within 48 hours

Patient & Visitor Feedback: Complaints, Concerns & Compliments

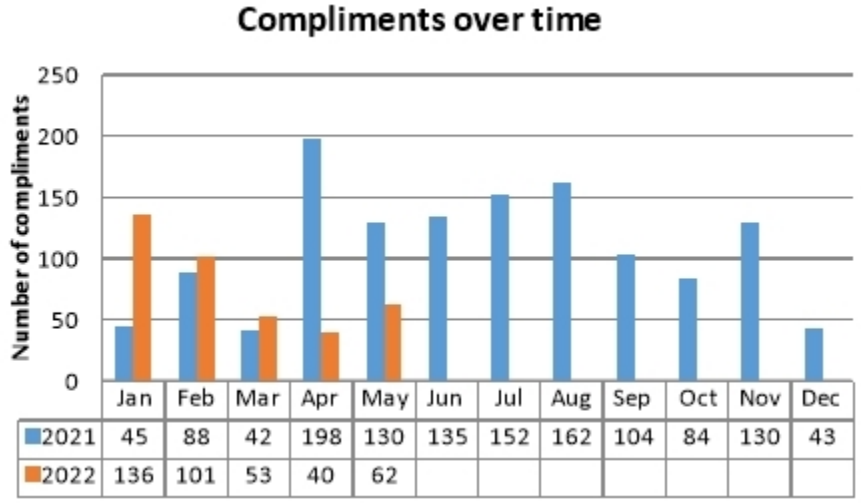
Are We Responsive?

Data Quality Rating:



Summary and Action

- Compliments in May were slightly higher than April.
- 19% of complaints in May were themed as neglect.
- The main concerns for May were themed as unsatisfactory treatment.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2021	45	88	42	198	130	135	152	162	104	84	130	43
2022	136	101	53	40	62							

Salisbury NHS Foundation Trust

Part 3: Our People

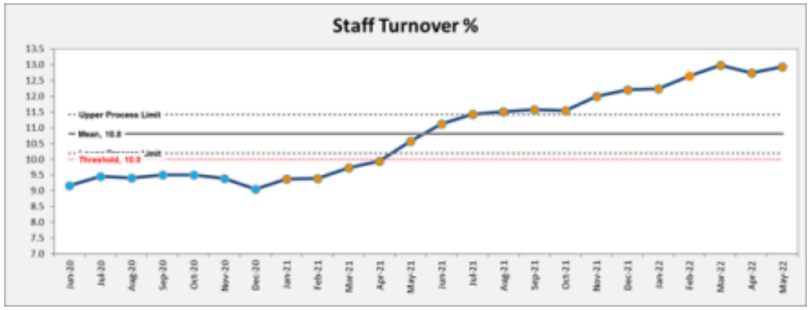
Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Workforce – Turnover

Use of Resources

Total Workforce vs Budgeted Plan - WTEs



Background – What is the data telling us, and underlying issues.

12-month turnover for month 2 (May) is 12.93%. This is a slight increase from last month's position of 12.74%.

In the month there were 39 leavers and 34 starters by headcount

Where recorded, principal reasons for leaving were "Retirement/Age" and "Relocation", which combined form 36% of all reasons for leaving.

Highest turnover by division was Women and Newborn (16.55%). Best performance in Surgery (11.29%).

Highest churn (roles most often filled) was among Additional Professional, Technical and Scientific (17.37%) and Additional Clinical Services staff (16.41%).

BSW Benchmarking Nov 2021 - RUH Bath : 9.61%, GWH Swindon 14.32%.

2022 Q1			
	March	April	May
Leavers	62	40	39
Exit Q's	15	10	5 (to date)
%	24%	25%	13%

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

We have been reorganising OD&P Ops to free up time for BPs to be fully focused on their main role of delivering the OD&P plan across the organisation.

Reorganisation is incomplete and will not deliver a significant change in BAU results before the end of June. The main headline is that positive change is in motion. The revised focus in the BP role will major on:

Reducing turnover and achieving correct resourcing for the foreseeable future with key deliverables of: -

Increased dept. stability based on agreed (Finance, Ops and OD&P) figures for establishment – These targets are been agreed.

Driving career conversations aimed initially at retaining 18-25s, 45-55s and international nurses. Driving up compliance with, and manager capability for, appraisals - becoming employee wellbeing champions to support the delivery of the wellbeing plan are priorities which require OD&P BPs to design the process, propose and negotiate targets before reporting on attainment

A plan is needed to reverse the decline in exit interviews

Risks to delivery and mitigation

Risk - defaulting on career conversation as per 22/23 planning guidance

Mitigation: Re-organising & targeting monthly completion as above

Risk: Line Managers not insisting staff complete exit interviews, in spite of regular communications designed to ensure that staff are aware of the opportunity and benefits.

Mitigation TBC

Workforce – Vacancies

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

May 22	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	490.6	446.95	43.7
Nursing	1,104.6	1075.3	29.3
HCAs	516.3	506.43	9.9
Other Clinical Staff	715.6	657.96	57.7
Infrastructure staff	1,436.0	1347.07	88.9
TOTAL	**4,263.1**	**4,033.7**	**229.4**

Background – What is the data telling us, and underlying issues.

Vacancy rate in month 2 (May) has seen a decrease to 12.00%, compared to 12.20% in April. Vacancy rate in April saw a step change increase to 12.20%, compared to 3.88% in March as a result of the early calculations of a WTE increase in workforce establishments to meet elective recovery targets and funded service developments. Targets subject to final review and confirmation

Taking the additional establishment out, the vacancy rate would be 4.36% which would be below (better than) target (green).

The Division with the highest vacancy rate was Women and Newborn at 16.29%. The Corporate area with the highest number of Vacancies was Procurement (14.91 FTE), followed by Informatics (14.25 FTE).

BSW benchmarking Nov 2021 – RUH Bath : 4.75%, GWH Swindon 6.55% (Dec 21)

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

International RN recruitment – A total of 21 offers have been made to direct hires along with 4 agency offers as part of the collaborative. Interviews continue weekly through the BSW agency collaborative. Pre-employment checks are already underway for those that are direct hires.

International midwives – An additional agency has been brought online to support with the collaborative recruitment. 6 more candidates to be interviewed early June. The Band 7 Practice Educator to support with OSCE training and pastoral support has been recruited to. Expected commencement date 01.07.2022.

HCA's – 60.08 wte vacancies. Successful recruitment event held on 21 May which resulted in 26 job offers (15 for Medicine, 11 for Surgery). These new starters will commence in 3 cohorts June 20th, July 5th and July 19th. Additional recruitment administration support is in place to ensure that individuals will start on time as planned. 8 HCAs commenced in April and 13 commenced in May which were from previous recruitment campaigns.

HCA Recruitment and Retention Facilitator, Mark Docksey, commenced 30th May 2022. Mark has been busy introducing himself to HCAs and Ward Managers as part of his induction programme. A communications plan is in place to ensure that HCA's and Ward Managers know how to contact (email and mobile). Mark will be supporting Ward Managers with exit interviews, pastoral support for HCAs on the ward, training and induction as well as investigating additional retention ideas e.g., internal transfer scheme for HCA's. Mark will also provide support to the HCA Summit planned to be held later in the year with the Chief Nursing Officer.

Recruitment & attraction process and practices overhaul via PWC - due to complete and repot in June.

Reservist Programme – 43 expressions of interest received and contacted. Concern that only one is a HC professional. ICU are supplying resources to get us off the ground. We are behind the ideal schedule but by no means the slowest to respond.

Risks to delivery and mitigation.

Step change in Divisions requiring recruitment support-Mitigation: review and prioritise support resourcing plan by Division

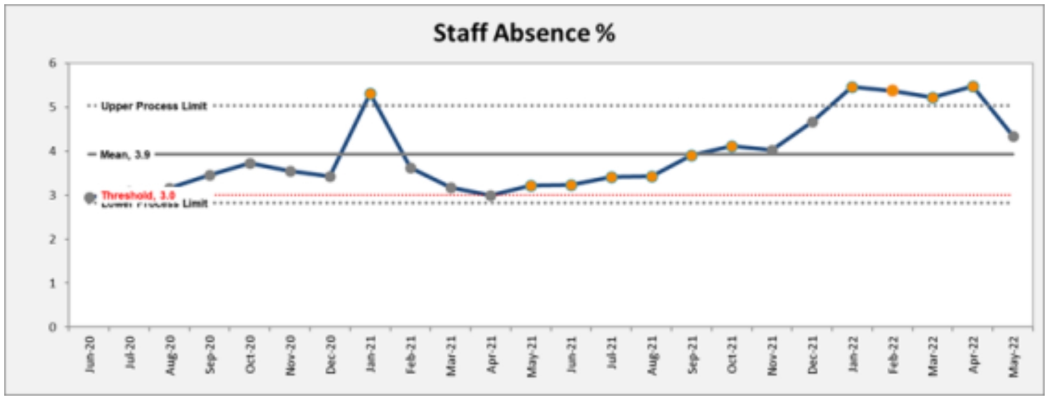
No of LM trained as recruiters and available to lead the process – Mitigation: hosting LM training

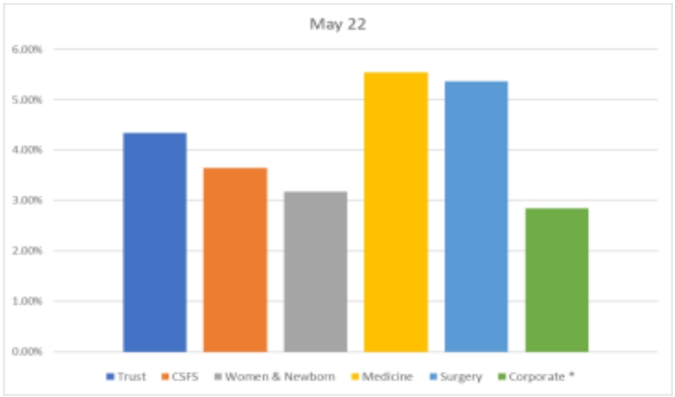
Depleted resources in recruitment team due to recent resignation -

Mitigation: to secure rapid, specialist help to resource the recruitment team

Workforce - Sickness

Use of Resources





Background – What is the data telling us, and underlying issues.

Sickness in month 2 saw a decrease to 4.34%, sickness for the rolling year was at 4.56%. All Divisions are above the Trust target of 3%. For the month of May, "Infectious Diseases" (Coronavirus) continued to be the top cause of sickness across all Divisions, just ahead of Anxiety/Stress/Depression/Other Psychiatric Illnesses.

BSW Benchmarking data for Nov 2021: RUH Bath 5.63%, GWH Swindon : 5.29%

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

Month 2 review of cases shows that despite falling absence percentage levels the number of cases has increased. The team is overseeing and advising on the management of 51 LTAs (28 consecutive days or more) and 110 STA cases.

To deliver a better response the strategy has been to better priorities hands on case management actions around: -

1. STA trigger points – e.g., focusing on those with more than one or more frequent absences
2. Potentially higher levels of ER risk
3. Where the management process has reached stage 4 in our process
4. Where a case has gone to appeal stage

From a futures perspective, we have:

1. Supplied content to OD and Leadership for them to develop management training
2. Our revisions to Attendance Management Policy are working their way through the consultation process to be completed for OMB approval in June.
3. We will introduce departmental absence management plans by department and by exception in conjunctions with DMTs and OD&P

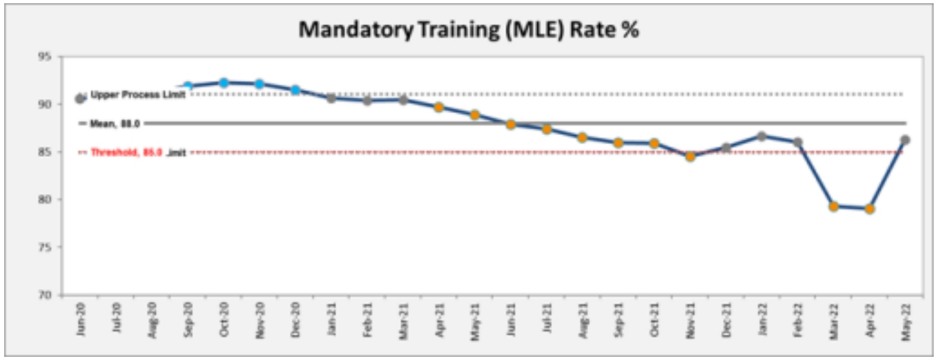
Risks to delivery and mitigation.

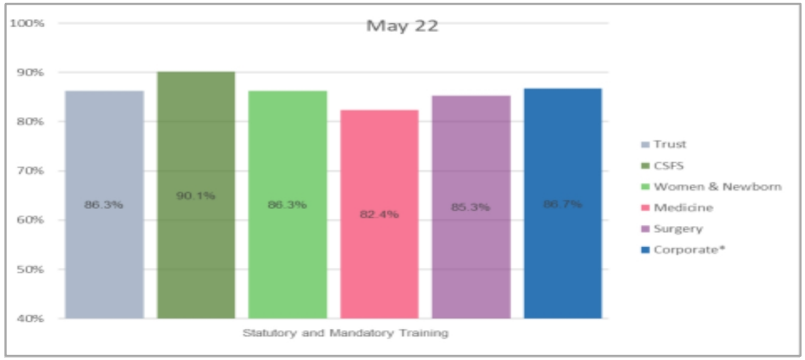
Risk: - Operational pressures reducing managers time to undertake return to work interviews.

Mitigations: BP interventions/ & coaching conversations, best/worst/league table reporting etc. Considering implications of introducing a KPI around average length of case resolution.

Workforce – Staff Training

Use of Resources





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

Reporting of Trust compliance for Statutory and Mandatory training has been impacted in recent months resulting in irregularities in compliance figures and a subsequent lack of confidence in the data provided.

There has been an ongoing project to migrate our current Managed Learning Environment (MLE), Kallidus Classic to Kallidus LEARN. This has been delayed due to the errors created within MLE as a result of changes that were made to the cost codes within Finance. Training is assigned to employees based on these cost codes and so the changes have resulted in employees having incorrect training assigned to them, which in turn impact compliance figures.

The Kallidus migration will take place the week beginning the 13th June 2022 and part of that migration is the plan to ensure that issues effecting the data have been resolved or mitigated against.

Compliance Data

The result of the actions taken regarding training levels have resulted in an overall Trust compliance of 86.25%, up from 79.11% last month. Whilst this remains below the 90% target (95% for Information Governance) this is can be considered accurate.

Corporate and Medicine Divisions are showing the lowest compliance overall, with Facilities, Quality and CSFS all achieving over 90% compliance.

Basic and Advanced Life Support and Hand Hygiene have the lowest levels of compliance, with Prevent, Safeguarding Children Level 1, Safeguarding Adults Level 1, Infection Control and Equality and Diversity all over 90%.

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

The main issues and actions taken/to be taken are:

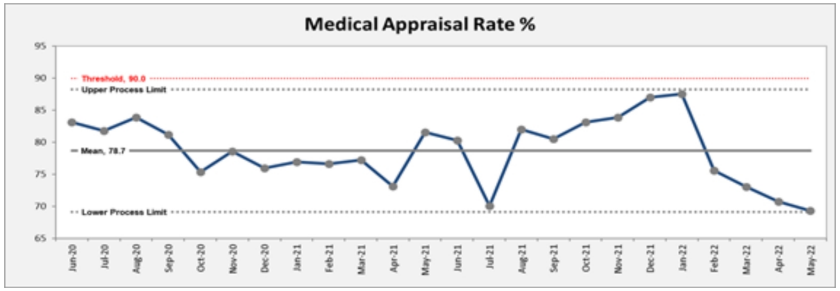
- Training Levels- Some staff have completed a higher level of training, e.g. Safeguarding level 3, but are being asked to also complete levels 1 and 2 when they do not need to. This has now been resolved so staff will show as compliant for the subject they have completed and all sub-levels.
- Starters/Movers/Leavers- when employees move roles or leave the organisation, their ESR records are not always being updated to ensure lines of supervision remain accurate. There are also delays to employees being added to ESR and so multiple accounts may be created for them. This will be picked up as part of the Starters/Movers/Leavers Project and the PwC review of ESR/erostering. This effects small numbers of staff and is managed manually at present as the incidents are identified.
- Cost code errors- detailed above. The training matrix which assigns employees training according to role/department has been completely rewritten and will be applied at the point of migration.

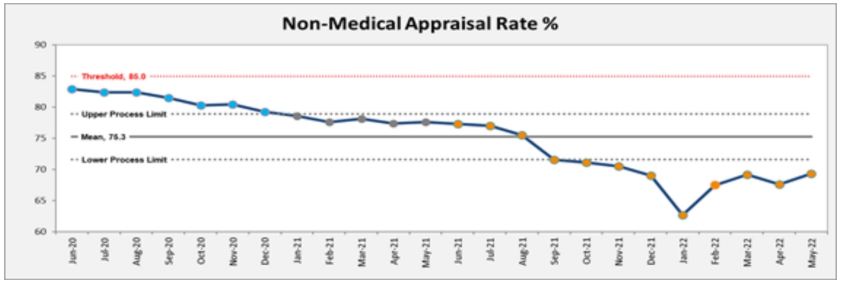
Risks to delivery and mitigation.

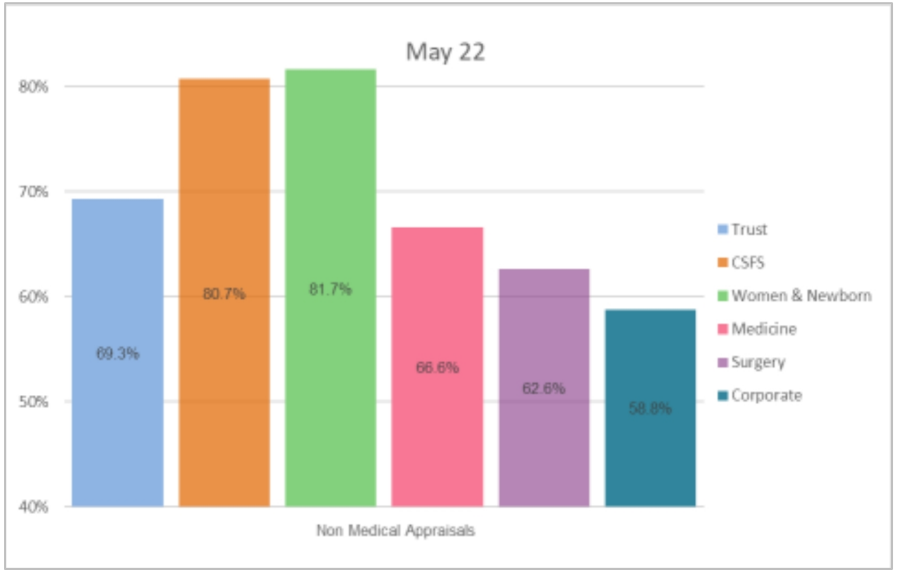
Accuracy of data requires line managers/supervisors to identifying any outstanding errors- this process will commence after the migration and will require formal response.

Workforce – Appraisals

Use of Resources







Background – What is the data telling us, and underlying issues.

Non-Medical Appraisals for month 2 remain under target at 69.3%, this is an improvement on the previous month's position (67.6%).

Hotspot areas are Corporate (58.8%) and Surgery (62.6%)

BSW Benchmarking - (update needed)

RUH Bath: 61.9% (Nov 21), GWH Swindon 74.17% (Dec 21)

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

BPs agreeing end of August targets for outstanding appraisals, asking LMs to schedule each month over holiday season.

CFSF hit 80% plus and have 27 more appraisals booked for June and a plan for the rest of Q2 and into Q3

Targeting of Corporate teams will take place through the summer . An investigation into the reasons and a list of names etc. is needed.

Medicine – managers undertaking appraisal training with Education team in June over 4 dates and ensuring correct system access.

Surgery BP reviewing knowledge gaps training.

Risks to delivery and mitigation.

Risk – Lack of management time from operational pressures to undertake the appraisals.

Mitigation - To be revised after deep dive. It is likely that we will need to resume focus from informatics team or OD&P admin, to add weight to increase compliance. One key threat to our organisation is if / when NHSE reinstates the completion of objectives and training as a hurdle to pay increases.

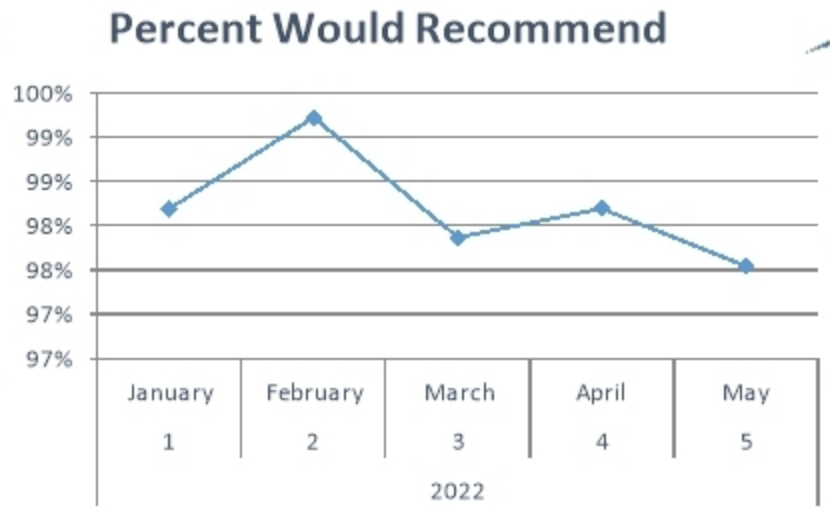
Feedback from Friends and Family test – May 2022

Are We Responsive?

"From A&E to plaster room to physio. I found everyone so friendly. I can't thank them enough for repairing my broken wrist" Wessex rehab, ED and orthopaedics

"The nursing staff and HCAs. HCAs are like a little squad of superstars, helping with the most bonkers of queries, not necessarily medical. They are so important and full of TLC. A shout out to fab cleaner Dan. So friendly" Downton ward

"Some of your younger nursing assistants could be trained in more a caring and rapport with the elderly that need help with their feeding and drinking. They tended to put it down and leave it"



"The kindness and care shown to me. Explanation of the procedure. Willingness to answer questions. Of course the professionalism shown which allayed any fears." Endoscopy

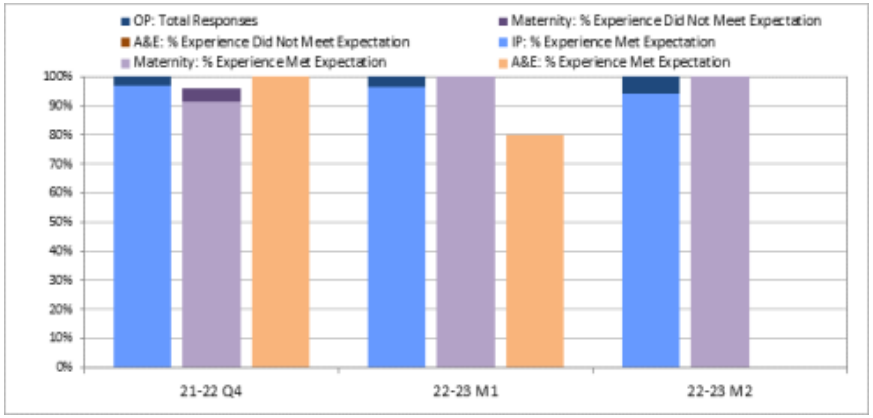
The staff were so amazing. Very caring. They made sure all was fine and comfortable before my discharge. From admission to theatre and recovery were all lovely!" Main Theatres

"The nurses and doctor were so kind and helpful. Sometimes amazed at their patience, after working such long hours!" Tisbury

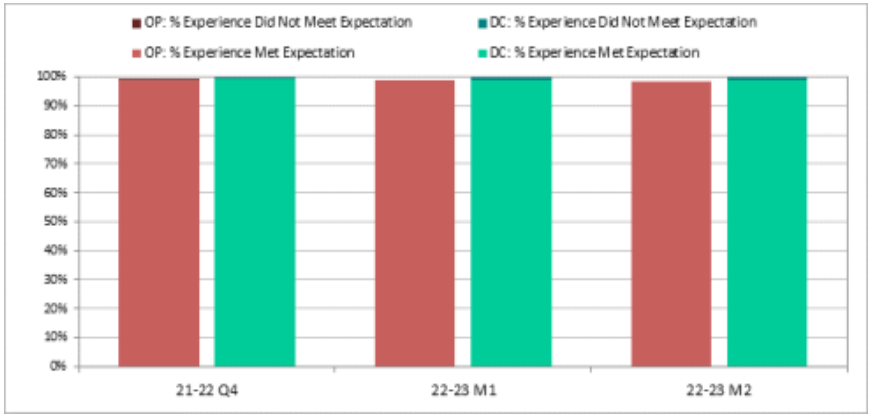
Friends and Family Test – Patients and Staff

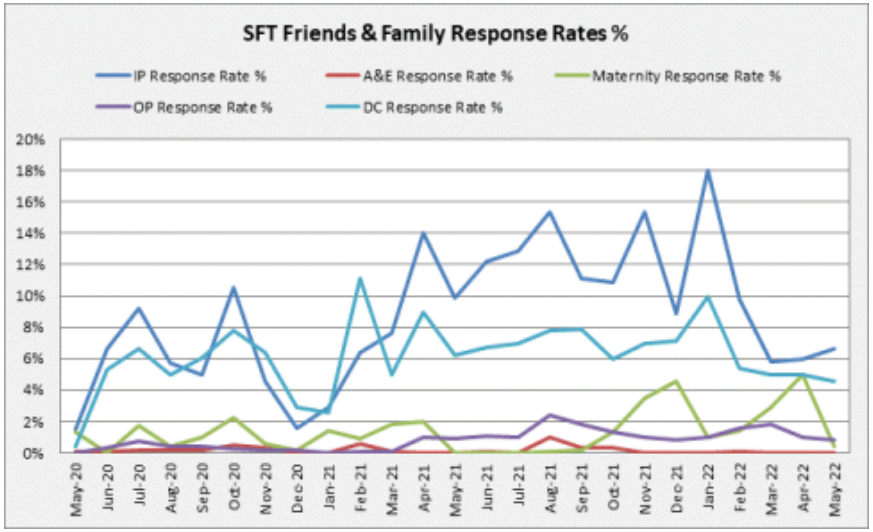
Use of Resources

Patient Responses: Inpatient, Maternity and A&E



Patient Responses: Outpatient and Daycase





Summary:

- Friends and family feedback numbers have decreased further again this month – work is on-going to improve the response rate.
- Only 1.5% of patients gave feedback.
- 24 areas received 100% positive feedback.
- Cardiac suite received feedback from 18% of patients this month.

Salisbury NHS Foundation Trust

Part 4: Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

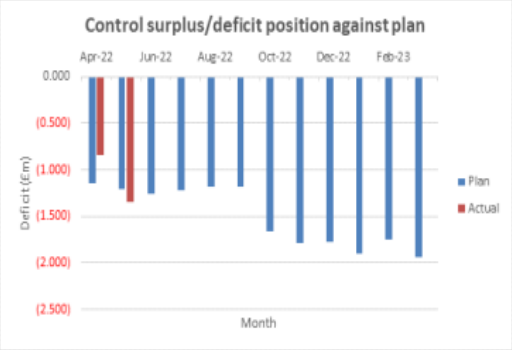
Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

	May '22 In Mth			May '22 YTD			22-23 Plan
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	21,480	21,771	291	42,960	43,204	244	257,761
Other Clinical Income	676	825	149	1,352	1,515	163	8,111
Other Income (excl Donations)	2,897	3,207	310	5,794	6,574	780	34,164
Total income	**25,053**	**25,803**	**750**	**50,106**	**51,293**	**1,187**	**300,036**
Operating Expenditure							
Pay	(16,548)	(16,818)	(270)	(33,020)	(33,259)	(239)	(199,429)
Non Pay	(8,058)	(8,562)	(504)	(16,128)	(16,799)	(671)	(98,413)
Total Expenditure	**(24,606)**	**(25,380)**	**(774)**	**(49,148)**	**(50,058)**	**(910)**	**(297,842)**
EBITDA	**447**	**423**	**(24)**	**958**	**1,235**	**277**	**2,194**
Financing Costs (incl Depreciation)	(1,660)	(1,770)	(110)	(3,320)	(3,431)	(111)	(20,213)
Share of Gains on Joint Ventures	**(1,213)**	**(1,347)**	**(134)**	**(2,362)**	**(2,196)**	**166**	**(18,019)**
NHSI Control Total	*0*	*(60)*	*(60)*	*0*	*(119)*	*(119)*	*0*
Add: impact of donated assets	***(1,213)***	***(1,407)***	***(194)***	***(2,362)***	***(2,316)***	***46***	**(18,019)**
Surplus/(Deficit)	21,480	21,771	291	42,960	43,204	244	257,761



Variation and Action

The 2022/23 financial arrangements are transitional following the Covid block payments of the last two years and are designed to promote additional elective activity to address the Covid backlog. Although the majority of the Trusts NHS contractual income base is fixed, the guidance allows for additional income to be earned through the Elective Services Recovery Fund (ESRF), this is earned at a BSW system level. Although £28m is available to BSW as a whole, SFT has only assumed £1.4m in the 2022/23 plan, as this is agreed as a minimum 25% 'floor' payment.
Based on the planned level of activity, the Trust is planning for a control total deficit of £18.0m in 22-23; inflation, bed base pressures, increased costs in the Elective pathway, and investment in 24/7 services during the pandemic are driving this financial pressure.

22-23 also sees the return of an efficiency requirement and recurrent savings targets totalling £6.6m have been allocated to corporate and clinical divisions, £4.5m has been formally identified, with the balance currently offsetting non-recurrent vacancies.

In month 2 the Trust recorded a control total deficit of £1.35m against a target of £1.21m - an adverse variance of £0.3m. The underlying position was in line with that planned, albeit with vacancies offsetting the premium costs of agency on wards and in theatres.

Income & Activity Delivered by Point of Delivery

Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	May'22 YTD		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	1,766	1,690	(76)
Day Case	3,286	2,979	(307)
Elective inpatients	1,997	2,131	134
Excluded Drugs & Devices (inc Lucentis)	3,688	3,747	59
Non Elective inpatients	11,493	12,262	769
Other	14,771	14,789	18
Outpatients	5,959	5,606	(353)
TOTAL	**42,960**	**43,204**	**244**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW CCG	152,272	161,251	8,979
Dorset CCG	24,968	25,332	364
Hampshire, Southampton & IOW CCG	18,790	19,065	275
Specialist Services	33,984	36,028	2,044
Other	18,274	19,069	794
TOTAL	**248,288**	**260,745**	**12,456**

Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
A&E	11,793	12,339	546	10,902	1,437
Day case	3,836	3,586	(250)	3,240	346
Elective	503	578	75	481	97
Non Elective	4,819	4,670	(149)	5,598	(928)
Outpatients	42,120	40,999	(1,121)	43,084	(2,085)

Variation and Action

The Trust is now ahead of plan which is predominantly due to more income being receivable from NHS E in respect of cost and volume activity, and the HIV contract. A&E activity has been relatively high in May with steady increases noted in the Walk-In-Centre and ED activity levels this month. Activity in May in Day cases recorded 246 more spells less than in April and fell short of the plan for the month by 98 cases with shortfalls in Gastroenterology (109 cases). Activity improved this month in colorectal surgery (77 cases) adn Cardiology (64 cases). Activity in elective inpatients improved notabley above plan by 73 cases and actual activity in May but was higher than in April by 96 spells with improved T&O numbers. Outpatient activity reported this month was also lower than planned levels, although there may be a timing issue with some attendances not being fully reported in the data. Non elective activity was higher than the plan and there was more activity than in April in Obstetrics but less in general medicine. The level of uncoded inpatient spells is 54% of planned activity uncoded in May and still 19% of activity uncoded in April at the time the activity was taken for reporting purposes.

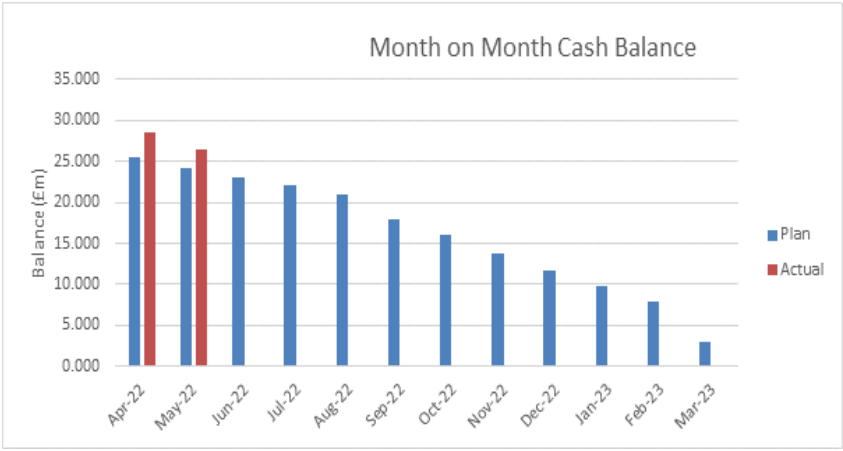
The Trust is unlikely to achieve ESRF funding this year above the base 25% rate as the expected activity increase on 2019/20 out-turn is not considered to be deliverable.

Contracts with commissioners are in the main block agreements although there remains some cost and volume elements related to drugs and devices for NHSE Specialised services. The BSW system is required to have a breakeven financial plan before contracts can be signed in line with national planning guidance. Contracts with commissioners are required to be signed by the 20th June.

Cash Position & Capital Programme

Capital Spend:  **Cash & Working:** 

Use of Resources



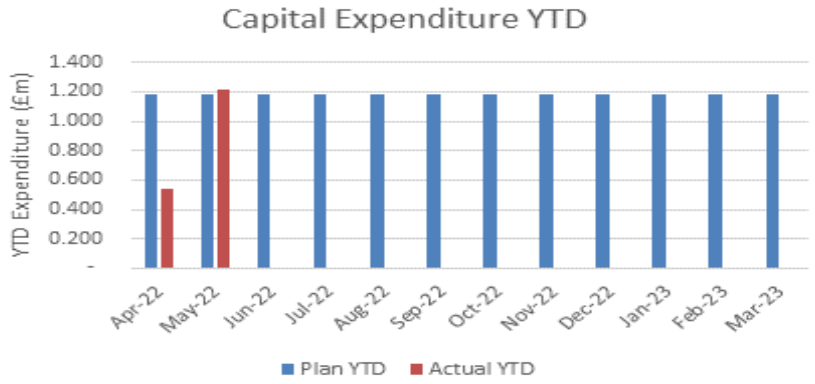
Variation & Action

Creditors have decreased significantly since the year end, and this is largely due to the payment of large 21-22 invoices relating to capital.

The Trust cash balance is currently heathy, partly due to the level of significant capital creditors remaining on the balance sheet relating to 21-22.

Due to the size of the deficit planned for 22-23 the cash balance is forecast to reduce significantly over the year, and cash levels will need to be monitored closely to ensure early warning of any requirement for external support.

Capital Expenditure Position				
		May'22 YTD		
Schemes	Annual Plan £000s	Plan £000s	Actual £000s	Variance £000s
Building schemes	3,758	626	209	417
Building projects	2,740	457	290	167
IM&T	4,106	684	371	313
Medical Equipment	2,207	368	272	96
Other	1,414	236	71	165
Additional Funds approved in year	**14,225**	**2,371**	**1,213**	**1,158**
TOTAL	3,758	626	209	417



Summary and Action

22-23 capital allocations have again been made at a system level and the Trust remains capital constrained, particularly in the Estates area: recently confirmed by the findings of a six facet survey.

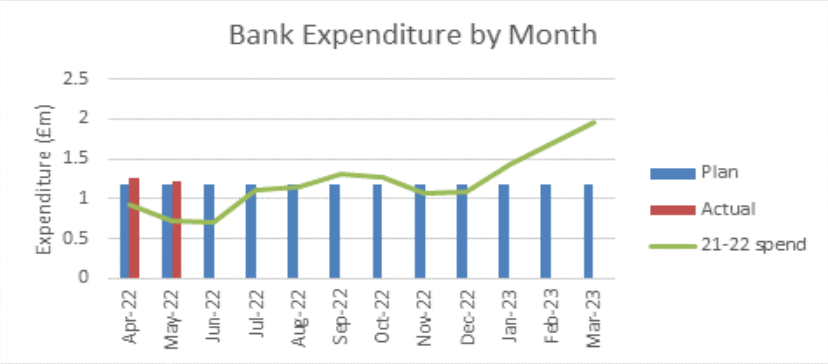
The 22-23 Capital Plan was approved by the Board in April 22 and included an unallocated £989k at the time of approval, however £740k will be required for the BSW shared EPR should the business case be approved. the remainder badged as contingency against which capital priorities for each of the groups will be allocated by the end of Q1. This contingency is included in the Other category.

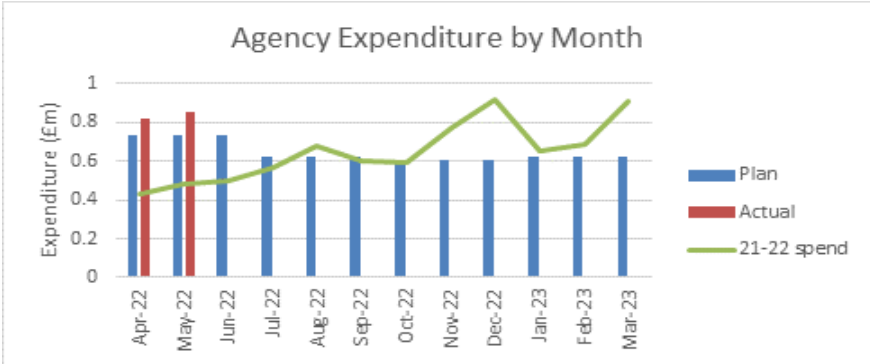
There remains the likelihood that further national funding will be available in the IM&T workstream, although allocations are not expected to be confirmed until the summer.

Workforce and Agency Spend

Pay:

Use of Resources





Summary and Action

Pay costs are £239k (0.7%) above plane, as premium costs of covering staff absence continues. The Trust's SAFER event began to reduce the Trust's reliance on escalation spaces over and above those planned for, driven by pressure on Emergency admissions and then compounded with significant numbers of patients with needs for ongoing care, but not requiring the acute environment.

Significant vacancies remain within the NHS Infrastructure Support category, these are drive by Procurement (where the NSW team are hosted and recharged to GWH and RU based on costs incurred), Estates, central booking, and informatics.

Report to:	Trust Board (Public)	Agenda item:	3.1
Date of Meeting:	07 July 2022		

Report Title:	Q4 Patient Experience Report			
Status:	Information	Discussion	Assurance	Approval
		x	x	
Approval Process (where has this paper been reviewed and approved)	Clinical Governance Committee 24th May 2022			
Prepared by:	Victoria Aldridge, Head of Patient Experience Deborah Stott, Head of PALS			
Executive Sponsor (presenting):	Judy Dyos, Chief Nurse Officer			
Appendices (list if applicable):	Guidance Framework for Responding to Complaints [DRAFT[Patient Experience – Interim Strategy 2022 [DRAFT]			

Recommendation:
The Board is asked to note this report.

Executive Summary:

This report provides a summary of complaints, concerns, compliments and Friends and Family Test Feedback for Quarter 4 of 2021/22. An annual overview of these areas is also included to provide further insights into themes and trends.

To summarise the contents of this paper:

- There has been a notable decrease in the percentage of complaint responses taking place within the agreed timeframe (55% to 34%). This reduction is felt to be due to a combination of the closure of longstanding complaints and staffing levels within the Divisions contributing to the difficultly in timely response.
- 50 complaints were received which is a complaint rate of 0.7 per 1,000 patients seen at the hospital (includes Inpatients, Outpatients, and the Emergency Department)
- High level themes deriving from complaints/concerns (Q1-Q4) are consistent with being **unsatisfied with treatment or outcome**, **attitude of staff** and **communication**.
- There has been an increase in the number of re-opened complaints in Quarter 4, the themes of which are being considered as part of the complaints process review.
- Friends and Family Test response rates fell in Q4, work is in progress to increase response rates and to establish more robust mechanisms for analysis and insight – with a view to triangulating

these with our complaints, concerns and compliments. However, 99% of patients who did complete the FFT questions during their period felt their experience was **good** or **very good**

- New NHS Complaint Standards have been published by the Ombudsman and will be introduced across the NHS in 2022. We continue to review our own processes to bring these into line by April 2023. We also working to develop relationships across our system partners with a view to aligning (where possible) to assist with benchmarking and insightful comparison.

- The results from the urgent and emergency care 2020 survey and adult inpatient 2020 survey were published in September 2021 by the CQC and full results can be found at Urgent and emergency care survey 2020 | Care Quality Commission (cqc.org.uk) and Adult inpatient survey 2020 | Care Quality Commission (cqc.org.uk)

- This report also summarises the development of the Patient Experience Steering Group and the Patient Experience Strategy – introducing an interim strategy to cover the remainder of 2022 and set the framework for 2023 onwards. As part of this update, the Board are asked to consider the suggested mitigation for the gap in production of Patient Stories that has become apparent following staff changes within the department since Christmas.

Board Assurance Framework – Strategic Priorities	**Select as applicable**
Population: Improving the health and well-being of the population we serve	☐
Partnerships: Working through partnerships to transform and integrate our services	☐
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☐
Other (please describe) -	☐

Patient Experience Quarter 4 and Combined Annual Report

Purpose of paper

To provide assurance that the Trust is responding appropriately to complaints from patients and demonstrate that learning and actions are taken to improve services in response to this feedback.

To provide assurance of moves towards increasing patient and public involvement, with particular focus on service co-design and improvement.

To provide assurance that the development of the Patient Experience Steering Group remains an integral part of the overall strategy and is aligning to the necessary governance structures.

Background

Patient experience is defined as “the sum of all interactions, shaped by an organisation’s culture that influence patient perceptions across the continuum of care. Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and feedback is an imperative. This includes learning from feedback, transparency and honesty on when healthcare goes wrong.

Concerns and complaints can surface, and the quality of the investigation, response and actions allow improvements in the safety and quality of care delivery. We strive to create an open culture where concerns and complaints are welcomed and learnt from. This can also be said of the many compliments received that far outweigh the complaints and concerns. Compliments also help improve practice by allowing shared good practice to be disseminated toother areas.

Contents

1. Complaints, Concerns and Compliments Overview

Table 1.1 demonstrates the total recorded feedback via the PALS team in Quarter 4, this has been presented in correspondence with the total number of patient activity across the Trust this quarter.

We would like the Board to consider whether these activities being presented using a "per 1,000" average will assist in making clearer conclusions on whether numbers of complaints, concerns, compliments (and Friends and Family Testing) are increasing or decreasing in line with changes in patient activity.

Throughout this report, this method of presenting has been used consistently to enable easier comparison quarter on quarter and also to more accurately compare Divisions.

There were 7 items of feedback posted on the NHS Website in Q4.

- Negative – 1
- Positive – 6

All feedback is available here: Ratings and reviews - Salisbury District Hospital - NHS (www.nhs.uk)

Compliments are sent directly to the Chief Executive, PALS or via the SOX inbox and are acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment the PALS team complete a SOX which is sent to the Quality Directorate for forwarding onto the individual and their line manager.

Table 1.1 shows the quantity and types of feedback received in Quarter 4. Patient activity across the Trust is used to calculate these rates per 1,000.

Table 1.1 – Patient activity vs documented feedback in Q4

	Number of Inpatient activity (day cases, non-elective, and regular day attendees)	Number of Emergency Department patient activity	Number of Outpatient activity (excludes telephone calls)	Total patient activity across the Trust
	16,276	16,935	66,732	99,943
Compliments				305 (2.3 per 1,000)
Complaints				50 (0.7 per 1,000)
Concerns				61 (0.8 per 1,000)
Comments				219 (2.3 per 1,000)
Enquiries				89 (0.9 per 1,000)

Figure 1.1 shows that complaints and concerns have remained relatively stable this quarter, and compliments have seen a sharp increase in Q4. This increase is in part due to a change in the PALS recording system following an internal review on the way compliments were collected and recorded. These are now more formally recorded on Datix as we focus on showcasing and evidencing the great work within the Trust. We plan to develop this further in the future, looking to apply these with theme analysis and eventually triangulate with Friends and Family Testing (FFT) feedback.

Figure 1.1 Number of Complaints, Concerns, and Compliments – 3year Summary

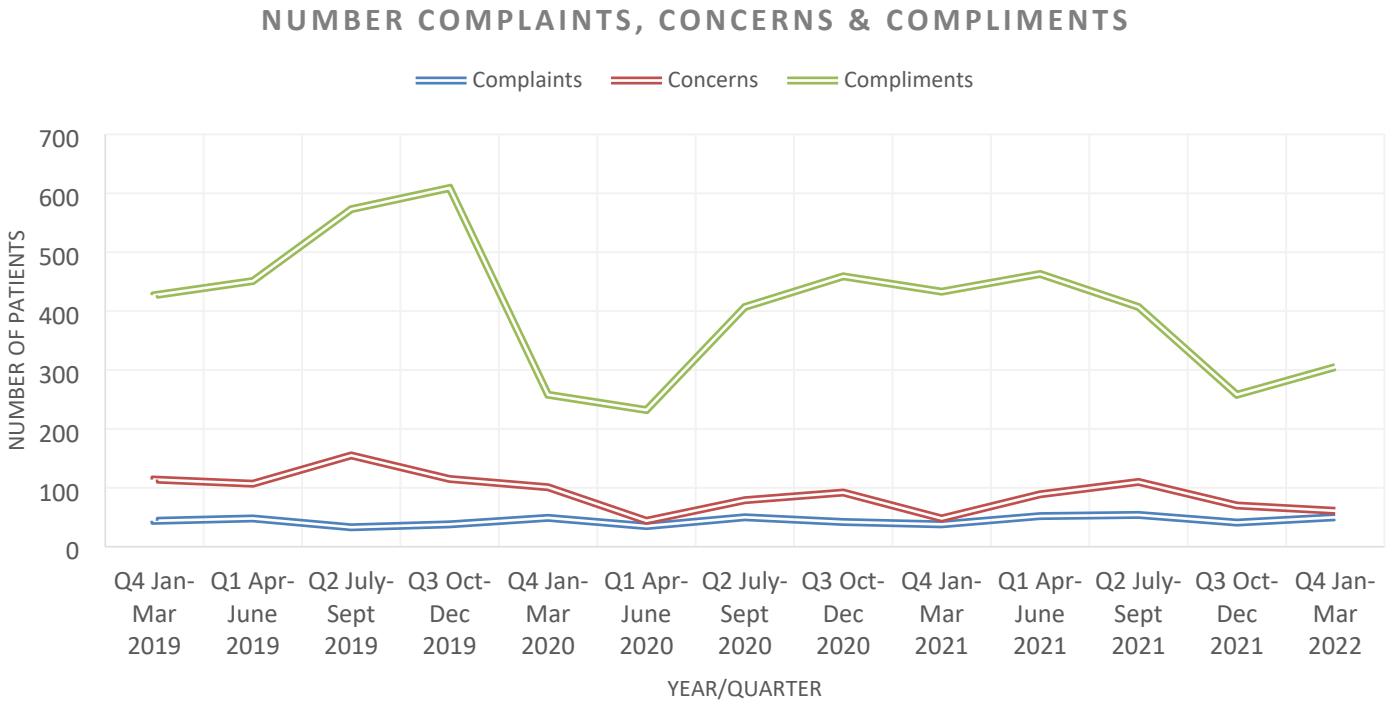


Table 1.2 is comparing the number of complaints, concerns and compliments received across the Trust per 1000 patient activity, quarter on quarter.

This helps to more clearly demonstrate if these different types of feedback are increasing or decreasing in accordance with the number of patients seen across the Trust.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

Table 1.2 – Complaints, concerns and compliments, per 1000 patient activity (across Trust)

	Q1 21-22	Q2 21-22	Q3 21-22	Q4 21-22
Complaints across the Trust by patient activity (per 1,000)	0.5 (95,166)	▲ 0.6 (101, 978)	▼ 0.5 (100, 369)	▲ 0.7 (99,943)
Concerns across the Trust by patient activity (per 1,000)	1.3 (95,166)	▼ 1.1 (101, 978)	▼ 0.9 (100, 369)	▼ 0.8 (99,943)
Compliments across the Trust by patient activity (per 1,000)	4.7 (95,166)	▼ 4.5 (101, 978)	▼ 3.4 (100, 369)	▼ 2.3 (99,943)

Table 1.3 shows the raw theming for complaints and concerns received in Quarter 4. These have been grouped into high level themes in Figure 1.2. The top three "high level" themes are **attitude of staff**, **delay or cancellation of treatment** and **communication**. Attitude of staff is the most consistent theme across all Divisions.

Table 1.3 Raw data - Themes from Q4 Complaints and Concerns (Clinical)

Complaint/Concern	CSFS	Medicine	W&NBS	Surgery	Other	Total
Appointment postponed	1			2		**5**
Attitude of nursing staff	1	2				**3**
Attitude of staff - admin		1				**1**
Attitude of staff - medical		1	4	7		**12**
Attitude of staff - other	1					**1**
Clinical Treatment - Surgical Group				1		**1**
Clinical Treatment – Obs & Gyn			2			**2**
Consent to Treatment	1	1				**2**
Correct diagnosis not made		1		1		**2**
Covid-19				1		**1**
Data protection		1				**1**
Death				1		**1**
Delay in making diagnosis	1	1		3		**5**
Delayed treatment		3		6		**9**
Discharge issues		2				**2**
Discrimination on grounds of disability				1		**1**
Drug Error		1				**1**
Falls		1				**1**
Further complications/poor outcome	1		4	5		**10**
Lack of communication	3	6	2	3		**14**
Lost Property		1				**1**
Neglect		1		2		**3**
Nursing Care				3		**3**
Operation cancelled			1			**1**
Poor facilities/environment	1					**1**
Treatment unavailable	1					**1**
Unsatisfactory treatment	1	12	5	7		**25**
Waiting time in clinic	1					**1**
Administration error					2	**2**
Total	**13**	**35**	**18**	**43**	**2**	**111**

The number of complaints regarding medical staff attitude in particular has risen from 12, compared to 2 in the previous quarter. 6 of the complaints relate to two Consultants in equal measure. These Consultants were also a focus in the Q2 report and were the subject of a deep dive by the Chief Medical Office. Lack of communication as a theme has also had a notable increase.

On review of the annual data, (Figure 1.3) **"unsatisfied with treatment or outcome"** was the top theme, followed by **"attitude of staff"** and **"communication"**.

Figure 1.2 – Complaints – High Level Theme by Division – Q4

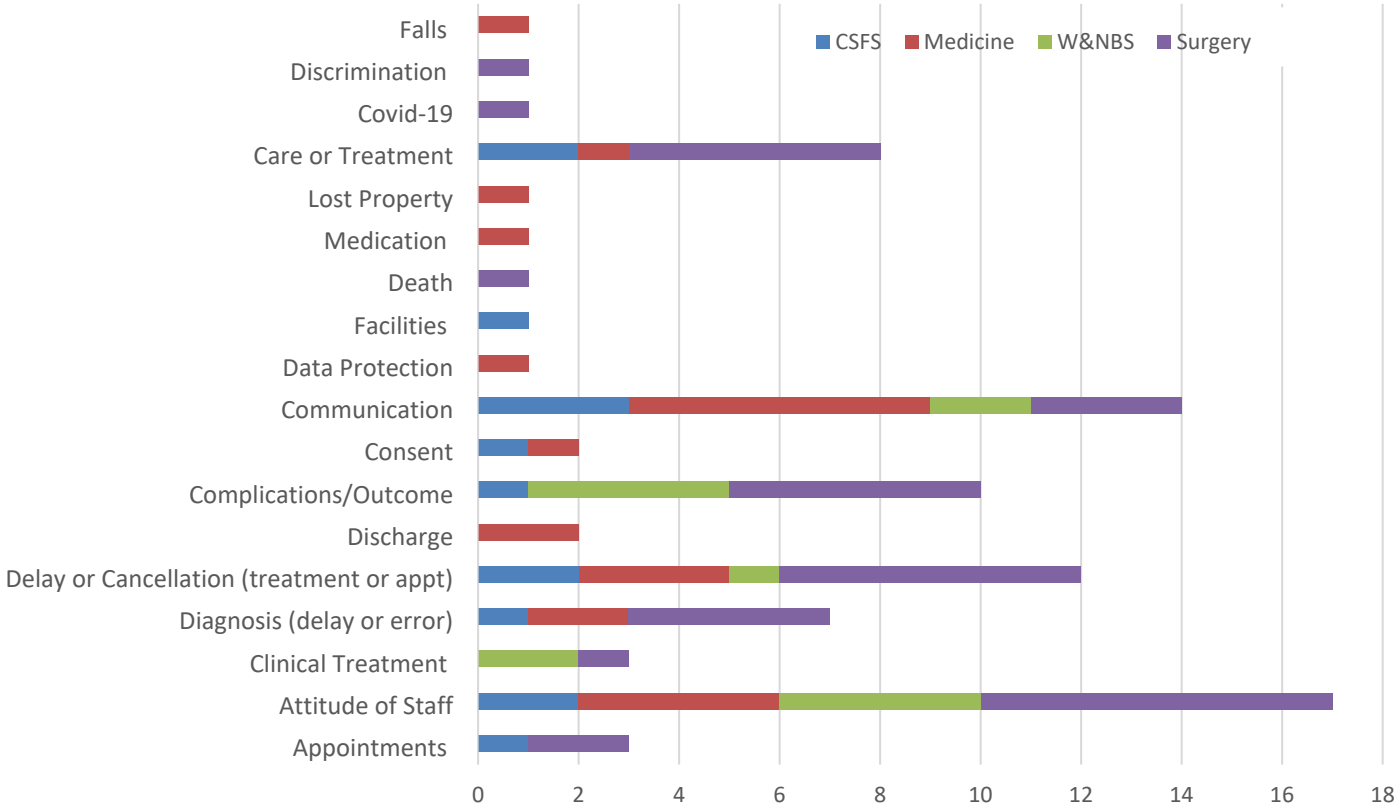


Figure 1.3 – Complaints – High Level Theme by Division – Q1-Q4 2021/22

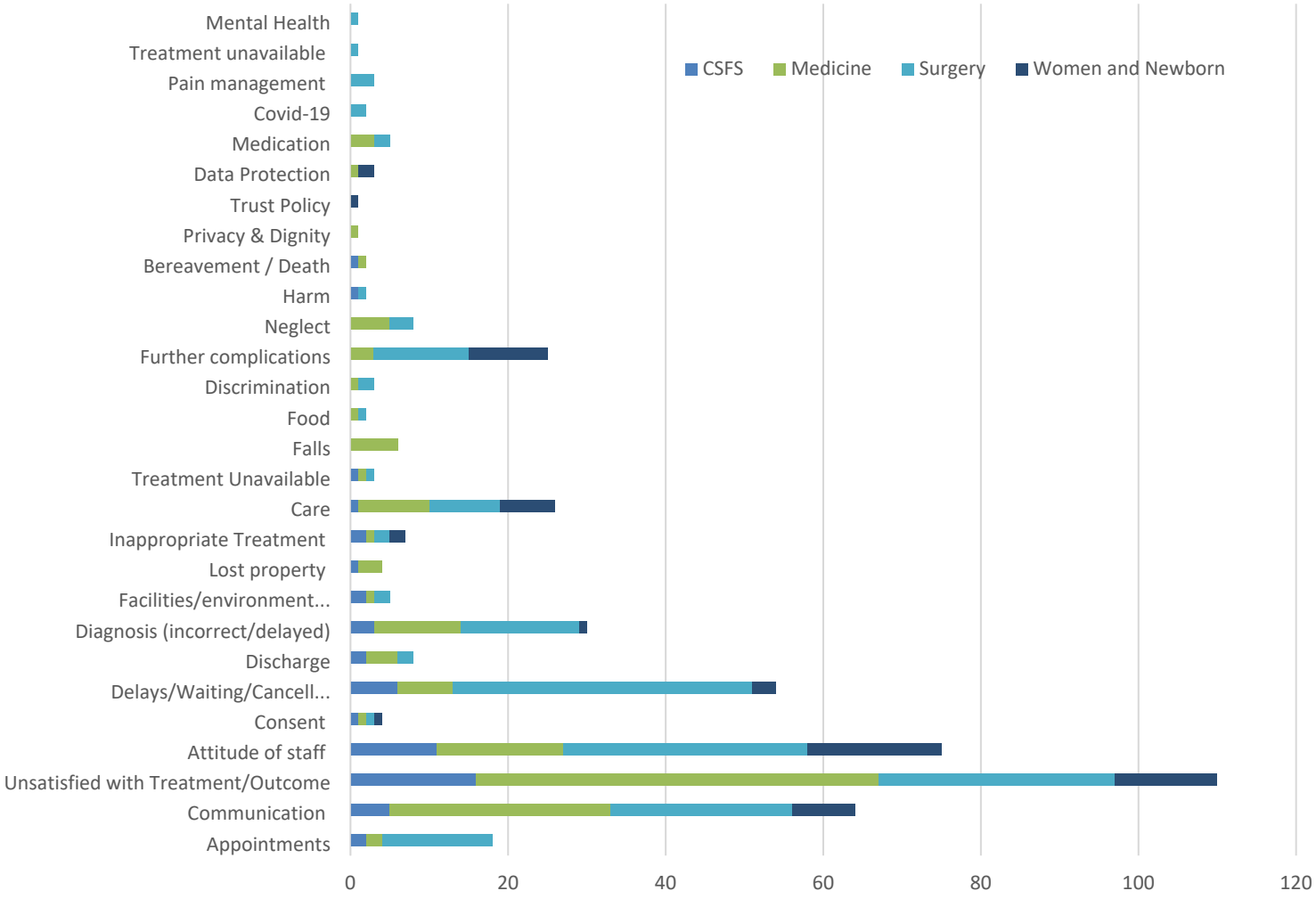


Table 1.4 Themes from Q4 complaints and concerns (non-clinical divisions)

Directorate admitted	Location (exact)	Description	Outcome
Transformation & IM&T	Information Governance	Patient has been sent a letter for an appointment they did not have	
Facilities	Post Room	Staff member from Southampton Hospital sent a letter to Pensions via recorded delivery and it has never been received by department	In the absence of any evidence that your item of registered post was delivered to the Trust and no further engagement with the Royal Mail, I have concluded that your item of registered post was scanned by Royal Mail staff (in their vehicle), but it is likely that this was not returned to the mail sack and was not delivered into our post room.

Overdue Complaints

Figure 1.4 – Overdue Complaints – by Division – Q4

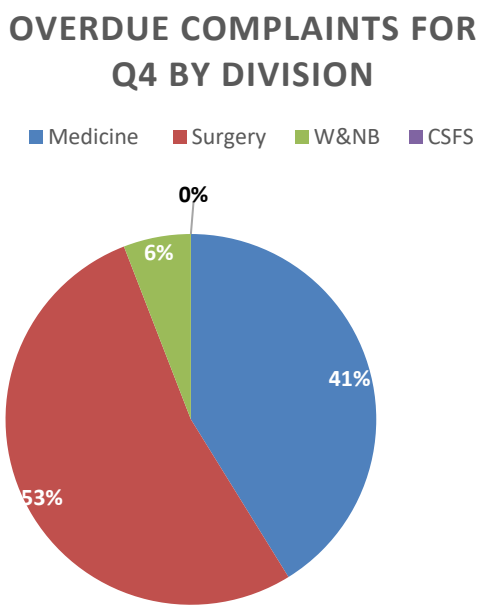


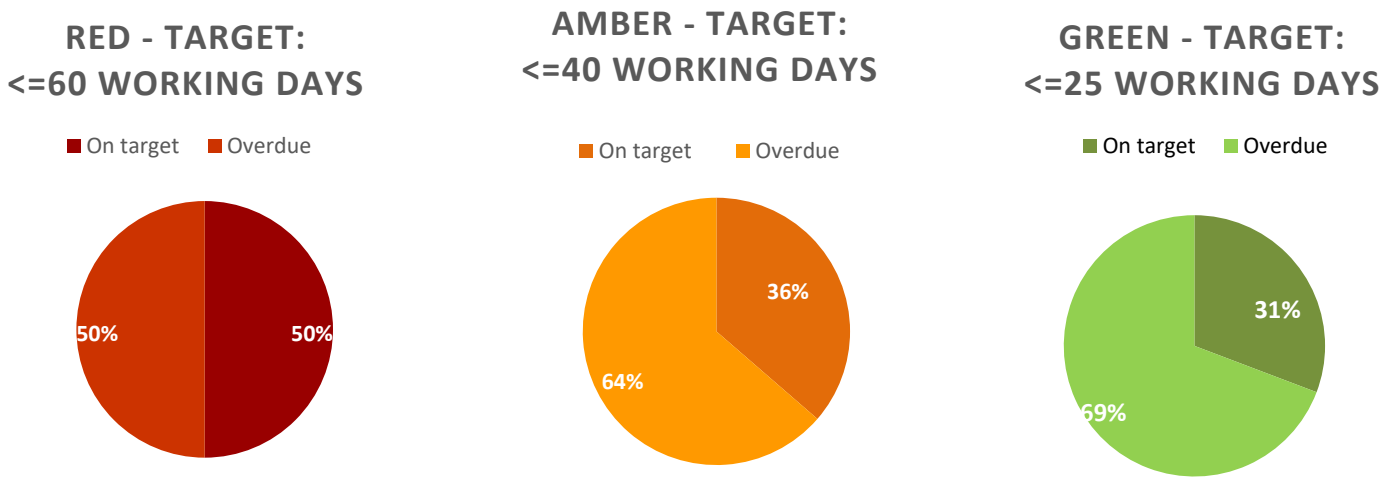
Figure 1.4 shows that Surgery and Medicine continue to have the highest number of overdue complaints, they also have the highest volume of complaints, which is noted to be a contributor to the continued difficulty in meeting these timescales. It also important to acknowledge that these two Divisions have a larger patient activity of patients when compared with the other Divisions. Despite this significantly larger volume of complaints for these two Divisions, the number of complaints per 1,000 patient activity are relatively low – see Divisions Summaries.

A weekly review meeting was established with the PALS complaints coordinators to address and review overdue responses. And this has been successful in aiding the closure of a number of historic complaints this quarter, this in turn however has also led to a decrease in the number of complaints closed within timescale (when compared with quarter 3) – See figure 1.5 below.

Head of PALS and Head of Patients Experience have met with Division Leads to understand how the current processes can be streamlined or how divisions can be supported to enabled timelier responses.

Feedback from Divisions indicated lack of resources and capacity are the main prohibitor in timely response. This is acknowledged to be an issue outside the remit of PALS and Patient Experience and instead the team are looking to develop more proactive strategies to reduce the number of complaints.

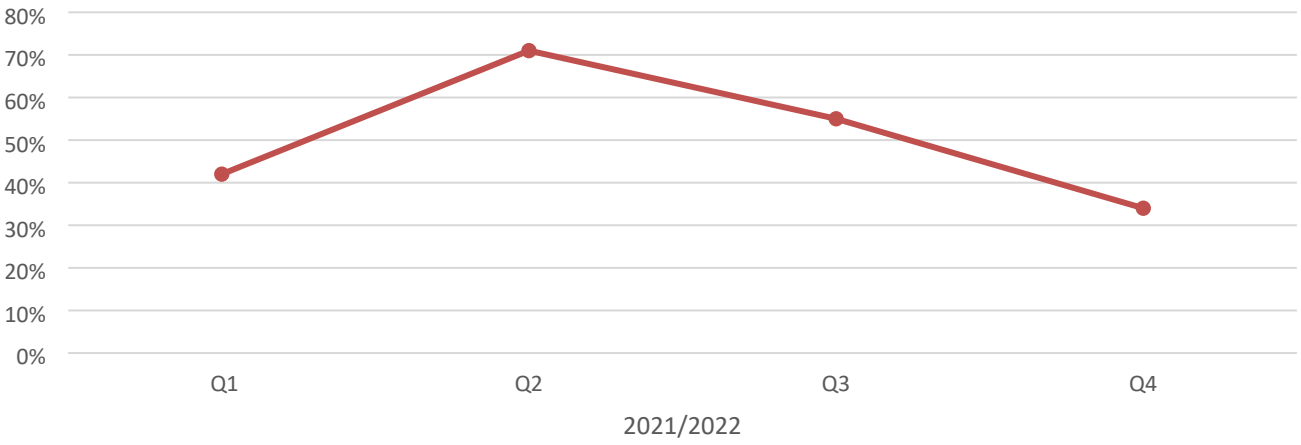
Figure 1.5 – Complaints Closure Targets



The Complaints Policy review is now in progress as we work to align the Trust to the new NHS Complaints Standard. We will be doing this in conjunction with patient feedback, using focus groups faciliated by an independent party (Healthwatch Wiltshire) as well as our system partners across Bath and Swindon. The focus of feedback with Healthwatch Wiltshire will be on the patients experience of the complaints process, whilst the aim with our system parters is to ensure more simiplify target metrics, ideally using one timescale, and aligning these with our conterparts to enable easier benchmarking.

Across Q4, 34% of total complaints closed, were within their closure timescale. This is decrease on Q3 and Q2 as demonstrated in Figure 1.6. It is recognised that this decline was a result of the notable pressures across all divisions, which will have impacted on response times to new complaints, however this figure will also have been affected by the succesful closure of quite a few longstanding complaints.

Figure 1.6 – Percentage of complaints responded to within an agreed timeframe

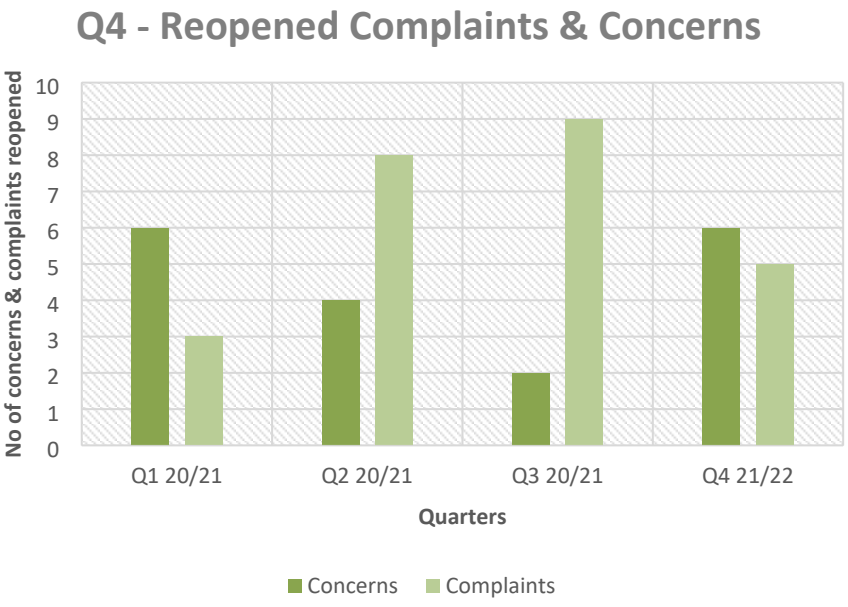


Summary of actions taken in Quarter 4 to improve timescales to closures:

- Medicine have changed their process in relation to making the complaints process more straight forward by ensuring they are directed to the most appropriate person for investigation and closure in a timely manner.
- The Surgical Division have implemented a process whereby they try and solve more concerns by telephoning the patient as son as they receive the complaint to see if this can be resolved over the phone.
- More staff have been employed in Gastroenterology to tackle the backlog of patients requiring Endoscopy
- PALS department have implemented a weekly meeting to review all overdue complaints, this is to keep them cited and to consider how we can improve the patient experience of the process for example interim responses/holding contacts.
- End of Life Care have commenced communication training for frontline admin staff to improve communication skills and support staff to have difficult conversations.

Reopened Complaints and Concerns for Q4

Figure 1.7 – Number of re-opened complaints or concerns



In Q4 there was a decrease in reopened complaints but an increase in concerns which was triple that seen in Q3.

In all cases complainants were unhappy with the original response received – this included **issues or questions not being fully addressed**, or an **inadequate apology**.

Significant work has been undertaken to consider how the reopening of complaints and concerns can be avoided. Based on the conclusion above, work has been instigated to support Divisions with improving quality of initial complaint responses. Under the new NHS Complaints Standards, the use of template letters is not recommended, however in consideration of staff feedback, which indicated that a template format would be useful - a hybrid approach was considered. Appendix 1 is the draft "Guidance Framework for Responding to Complaints" which is currently being trialled with the Surgical Division. See Appendix 1.

In addition, the PALS team are developing a training programme, initially for F2 doctors to form part of their induction. The first presentation was on the 26th of April 2022, this was a mixture of face to face and virtual participants – 20 in total. The focus of the training is to communicate key elements of the new standards and focus on the importance of a timely response and a meaningful apology.

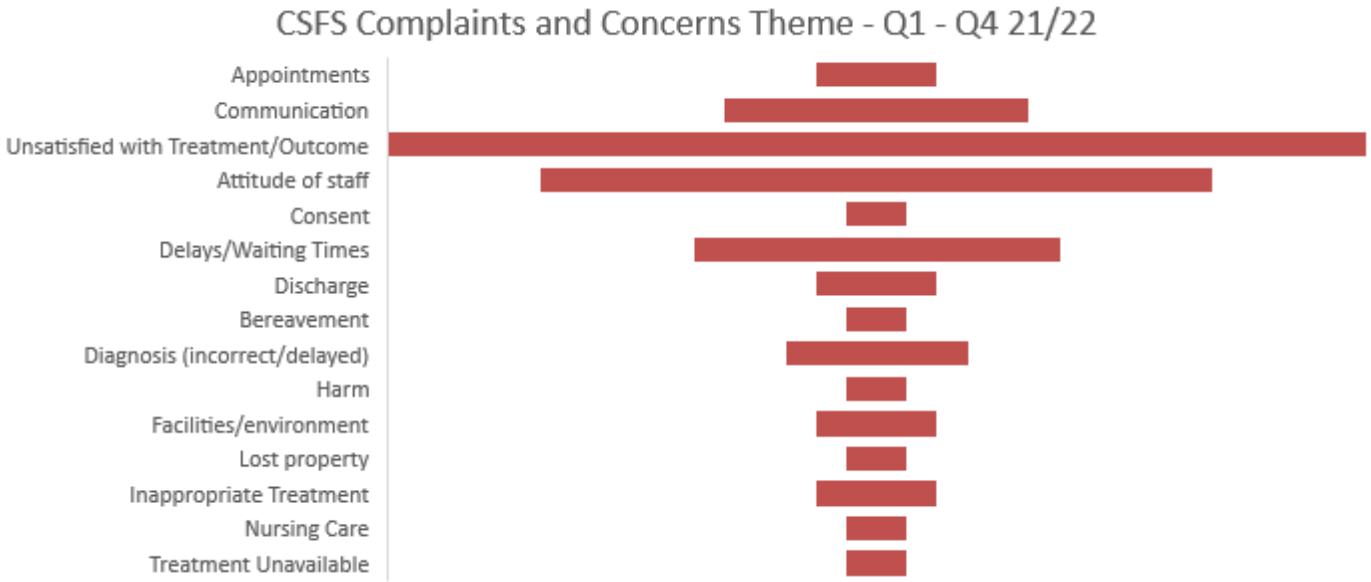
2. Division Summaries – Complaints, Concerns and Compliments

Clinical Support and Family Services (CSFS)

Table 2.1 Summary of number of received, reopened and response within timeframe – annual summary.

	Q1 21-22	Q2 21-22	Q3 21-22	Q4 21-22
Complaints	13	▼ 4	▲ 5	▼ 3
Concerns	21	▼ 10	▼ 5	▲ 10
Compliments	95	▼ 53	▼ 3	▶ 3
Re-opened complaints	0	▶ 0	▲ 1	▼ 0
% closed complaints responded to within agreed timescale	45%	▲ 60%	▼ 50%	▲ 60%
Complaints closed in this quarter	11	5	4	5
% closed concerns responded to within 25 working days	64%	▼ 63%	▲ 78%	▲ 86%
Complaints & Concerns by Division activity (per 1,000)	0.9 (35,792)	▼ 0.4 (35,886)	▼ 0.3 (30,529)	▲ 0.4 (30,057)
Compliments by Division activity (per 1,000)	2.7 (35,792)	▼ 1.5 (35,886)	▼ 0.1 (30,529)	▼ 0.1 (30,057)

Figure 2.1 – Summary of themes for Complaints and Concerns – Q1-Q4 2022/23



- There were 3 complaints raised in Q4 and the themes for them were consent to treatment; unsatisfactory treatment and lack of communication.
- 5 complaints were closed in Q4; with 60% being responded to within the agreed timescale.
- 10 concerns were raised in Q4. There were no themes for the concerns raised.

Figure 2.1 demonstrates high-level themes across this Division to be in relation to **unsatisfactory outcome or treatment**, **staff attitude** and **delays to treatment/waiting times.**

There are no action plans outstanding from the division from 1 April 2021 or overdue complaints for this division for Q4

Table 2.2 Themes and actions from concerns and complaints closed in this quarter

Complete
Ongoing/In progress
Incomplete/Outstanding

Q4 2021/22		
Department	**Themes**	**Actions**
Child Health	Communication, Attitude of Staff	Child Health Governance meeting relaunched and has met in Quarter 4. ***CSFS DMT are awaiting update from Child Health into complaints, concerns, and themes as well as the actions they will be taking to address themes.***

Compliments – Clinical Support and Family Services

Compliments continue to be received directly to the wards and therefore these should be considered in addition to those noted earlier in this report, which are recorded via the PALS feedback mechanisms.

There were **3** compliments for CSFS in Quarter 4.

Pathology **(2)** Radiology **(1)**

Women and Newborn

Table 2.3 Summary of number of received, reopened and response within timeframe – annual summary.

	Q1 21-22	Q2 21-22	Q3 21-22	Q4 21-22
Complaints	*Directorate not established at this time.*	10	▼ 5	▲ 11
Concerns		10	▼ 8	▼ 7
Compliments		39	▼ 20	▲ 75
Re-opened complaints		1	▶ 1	▼ 0
% closed complaints responded to within agreed timescale		42%	▲ 63%	▼ 50%
Complaints closed in this quarter		7	8	6
% closed concerns responded to within 25 working days		36%	▲ 63%	▲ 100%
Complaints & Concerns by Division activity (per 1,000)		(data not available)	7.3 (5,916)	▲ 9.7 (4,850)
Compliments by Division activity (per 1,000)		(data not available)	15.6 (5,916)	▼ 8.0 (4,850)

- There were 11 complaints raised in Q4 which is a significant increased from the previous quarter. The Labour Ward received the most, the main themes being further complications and attitude of medical staff. Antenatal and Gynaecology received 3 complaints each but with no particular theme.
- 6 complaints were closed in Q4; with 50% responded to within the agreed timescale. The reason for these delays in response were staff sickness/annual leave commitments.
- 7 concerns were raised in Q4, again with no particular themes.

The PALS department received 15 comments and enquiries for Women and Newborn in Quarter 4 which were investigated, managed, and responded to by the team.

Figure 2.2 – Summary of themes for Complaints and Concerns – Q2 - Q4 2022/23

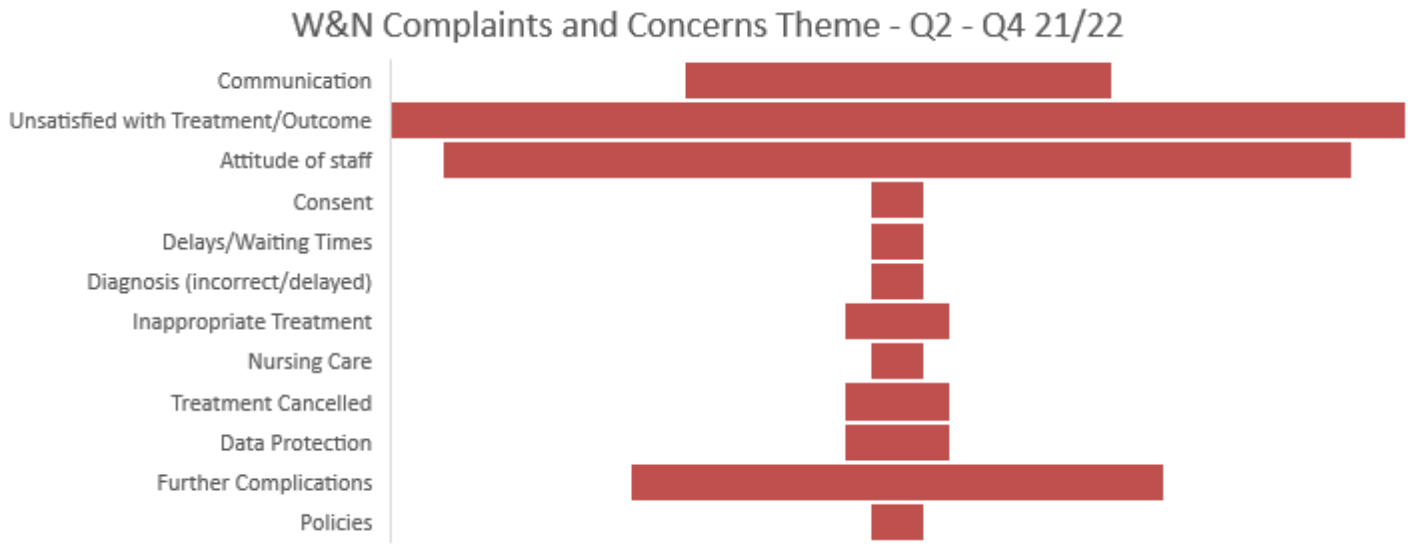


Figure 2.2 demonstrates high-level themes across this Division to be in relation to **unsatisfactory outcome or treatment**, **staff attitude** and **further complications.** Q1 data is not available as Women and Newborn were not a directorate at the time.

Table 2.4 Themes and actions from concerns and complaints closed in this quarter

Complete
Ongoing/In progress
Incomplete/Outstanding

Q4 2021/22		
Department	**Themes**	**Actions**
Labour ward	Further complications and attitude of medical staff	Staff encouraged to escalate if the staffing levels do not meet the acuity needs. ***A wider transformation project is ongoing regarding escalation on Day Assessment Unit*** (DAU) Supervised reflection with the staff member's line manager. Update: **completed** As a result of the Perinatal Mortality Review Tool review, we intend to consider postnatal follow up appointments for women with severe pre-eclampsia to discuss preconception care. Review the guidance surrounding the management and care of women with cervical sutures Update: **completed.** Outcome from the resolution meeting to be shared with the midwife cited in the complaint.

Gynaecology	Prompt to be added to the 'Medical Management of the Miscarriage Care Plan', to serve as a reminder to ensure that woman have had a risk assessment for Venous Thromboembolism (VTE) Update: **completed** Development of a leaflet detailing support groups for families when a baby has died. Update: **completed** Prompt to be added to the 'Medical Management of the Miscarriage Care Plan', to serve as a reminder to ensure that the bereavement midwife has been notified of the sad loss. Update: **completed** Care of the woman in the latent phase of labour will be a subject for discussion at the 'Live Learning' sessions. Update: **completed** Arrangements to be made for the member of staff to receive additional training on SGA/ GAP protocols and foetal surveillance. Update: **completed** All reasonable measures will be taken to ensure that all written correspondence is sent to the complainant in a larger font size. Update: **completed** An alternative date for surgery has been offered to the patient. Update: **completed** Second Gynaecology opinion requested; appointment date received. Update: **completed**

Compliments – Women & Newborn

Compliments continue to be received directly to the wards and therefore these should be considered in addition to those noted earlier in this report, which are recorded via the PALS feedback mechanisms.

There were **75** compliments for CSFS in Quarter 4.

Antenatal **(1)** Com Antenatal **(1)** Community Midwives **(9)** Labour ward **(15)** Maternity **(15)** NICU **(10)**
Postnatal **(18)** Community Midwives **(9)** Labour ward **(15)** Maternity **(15)** NICU **(10)**

Medicine

Table 2.5 Summary of number of received, reopened and response within timeframe – annual summary.

	Q1 21-22	Q2 21-22	Q3 21-22	Q4 21-22
Complaints	15	▼ 14	▼ 13	▲ 16
Concerns	30	▼ 19	▲ 27	▼ 23
Compliments	170	▲ 250	▼ 159	▼ 148
Re-opened complaints	1	▲ 5	▼ 2	▲ 4
% closed complaints responded to within agreed timescale	40%	▲ 62%	▼ 46%	▼ 25%
Complaints closed in this quarter	20	8	15	12
% closed concerns responded to within 25 working days	69%	▼ 58%	▲ 81%	▼ 39%
Complaints & Concerns by Division activity (per 1,000)	1.4 (33,326)	▼ 0.9 (35,224)	▲ 1.3 (30,901)	▼ 1.2 (32,715)
Compliments by Division activity (per 1,000)	5.1 (33,326)	▲ 7.1 (35,224)	▼ 5.1 (30,901)	▼ 4.5 (32,715)

- 16 complaints were received in Q4. The Emergency Department received the most with 4 but with no clear theme.
- 12 complaints were closed in Q4 and of these 25% were responded to within the agreed timescale. Delays in responses being sent out on time were due to clinical pressures.
- 4 complaints were re-opened in Q4, this was due to the complainants not feeling their concerns were appropriately investigated and required further answers.
- There were 23 concerns raised in Quarter 4. The Emergency Department received the most with 7 but again with no clear themes identified.

The PALS department received 138 comments and enquiries for Medicine in Quarter 4 which were investigated, managed, and responded to by the team.

Figure 2.3 – Summary of themes for Complaints and Concerns – Q1 - Q4 2022/23

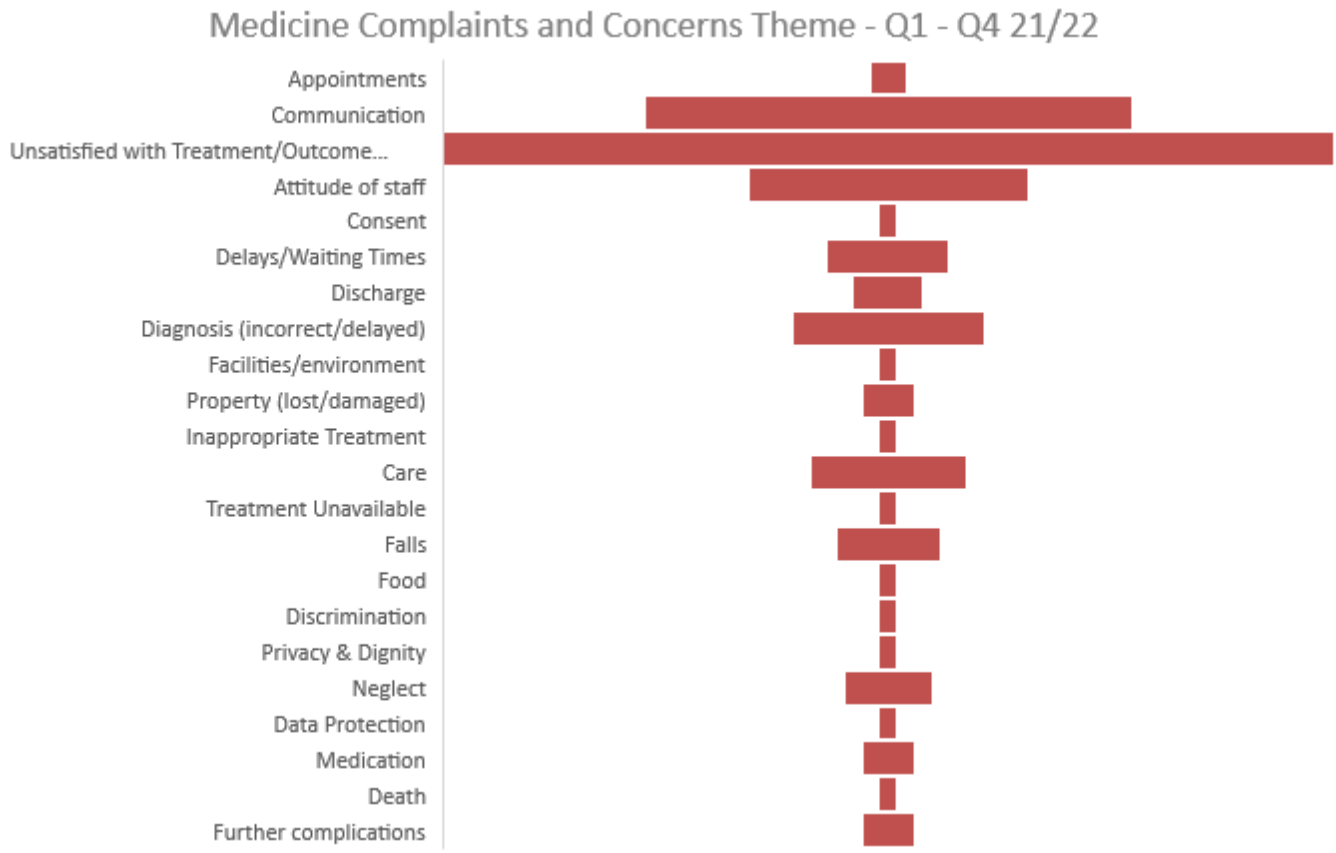


Figure 2.3 demonstrates high-level themes across this Division to be in relation to **unsatisfactory outcome or treatment**, **communication** and **staff attitude.**

Table 2.4 Themes and actions from concerns and complaints closed in this quarter

Q4 2021/22		
Department	**Themes**	**Actions**
		No themes this quarter.

Compliments Medicine

Compliments continue to be received directly to the wards and therefore these should be considered in addition to those noted earlier in this report, which are recorded via the PALS feedback mechanisms.

There were **148** compliments for Medicine in Quarter 4.

AMU **(11)** Emergency Department **(3)** Breamore **(15)** Hospice **(45)** Laverstock **(1)** Pembroke **(23)** Redlynch **(7)** Respiratory **(1)** Tisbury **(9)** Spire **(18)** Wessex Rehab **(2)** Whiteparish **(13)**

Surgery

Table 2.5 Summary of number of received, reopened and response within timeframe – annual summary.

	Q1 21-22	Q2 21-22	Q3 21-22	Q4 21-22
Complaints	11	▲ 24	▼ 16	▲ 25
Concerns	34	▲ 36	▼ 27	▼ 22
Compliments	90	▼ 79	▲ 92	▼ 39
Re-opened complaints	6	▼ 5	▲ 6	▼ 4
% closed complaints responded to within agreed timescale	29%	▲ 73%	▼ 48%	▼ 14%
Complaints closed in this quarter	7	15	21	18
% closed concerns responded to within 25 working days	74%	▼ 55%	▼ 35%	▲ 55%
Complaints by Division activity (per 1,000)	3.5 (12,753)	▲ 4.4 (13,540)	▼ 1.3 (33,023)	▲ 1.5 (32,321)
Compliments by Division activity (per 1,000)	7.1 (12,753)	▼ 5.8 (13,540)	▼ 2.8 (33,023)	▼ 1.2 (32,321)

- There were 25 complaints received this quarter which is an increase of approximately a third compared to quarter 3 with Orthopaedics, Gastroenterology and Day Surgery Unit having 3 complaints each. The main themes are Attitude of Medical Staff (6); Unsatisfactory treatment (4); Operation cancelled or delayed following admission (3). Ophthalmology was linked with 3 of the complaint themes for Attitude of Medical Staff.
- There were 22 concerns raised in Quarter 4. The main theme was for unsatisfactory treatment, wrong Information, and nursing care.
- There was 1 complaint and 3 concerns re-opened in Quarter 4. Two are still open and one is now closed after a meeting was held to try and resolve issues. One has had a further response letter sent.
- The PALS department received 95 comments and enquiries for Surgery in Quarter 4 which were investigated, managed and responded to by the team with a slight increase of 5 on the previous quarter.
- There are no action plans outstanding from closed complaints since 1st January 2022 for the Surgery Division.

Figure 2.4 Summary of themes for Complaints and Concerns – Q1 - Q4 2022/23

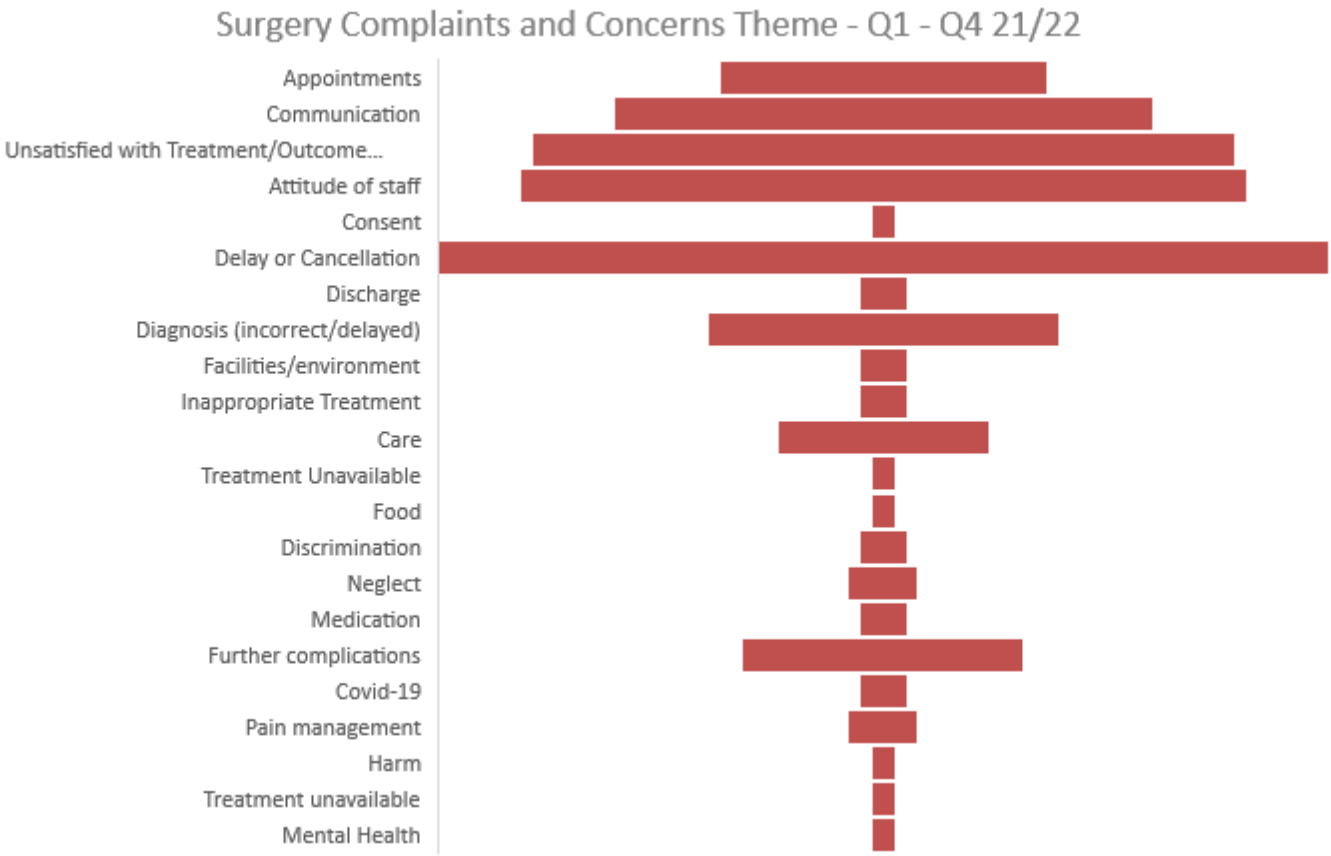


Figure 2.4 demonstrates high-level themes across this Division to be in relation to **delay or cancellation to appointments or surgery, staff attitude** and **dissatisfied with treatment or outcome.**

Table 2.6 Themes and actions from concerns and complaints closed in this quarter:

Q4 2021-2022 themes		
Department/Ward	**Topic**	**Action and update:** There were 16 complaints closed in this quarter.

Compliments Surgery

Compliments continue to be received directly to the wards and therefore these should be considered in addition to those noted earlier in this report, which are recorded via the PALS feedback mechanisms.

There were **39** compliments for Surgery in Quarter 4.

Bowel Screening **(15)** Radnor Ward **(7)** Amesbury Suite **(8)** Endoscopy **(5)** Gastroenterology **(1)** Laser **(1)** ENT **(1)** Orthopaedics **(1)**

3. Parliamentary and Health Service Ombudsman (PHSO)

There were 2 requests for information' made by the PHSO in Q4. 1 in relation to a complaint that has not yet gone through the Trust's complaints process and 1 which requested more information.

For the first time the PHSO has published data about their recommendations for upheld and partially upheld cases. They have also published a data table of complaints received, assessed and investigated about NHS Organisations. This data will be published every quarter alongside their existing health complaints statistics report.

NHS Complaint Standards

The NHS Complaint Standards set out how organisations providing NHS services should approach complaint handling. They apply to NHS organisations in England and independent healthcare providers who deliver NHS-funded care.

The Standards aim to support organisations in providing a quicker, simpler and more streamlined complaint handling service, with a strong focus on early resolution by empowered and well-trained staff. They also place a strong emphasis on senior leaders regularly reviewing what learning can be taken from complaints, and how this learning should be used to improve services.

The Complaint Standards are based on My Expectations, which set out what patients expect to see when they make a complaint about health or social care services (see appendix 5). You can read a summary of the new Standards here.

4. Friends and Family (FFT)

Survey Results and Response Rates

A total of **1148** patients provided feedback during the quarter through the Friends and Family Test (FFT). This is a further reduction from 1598 and 1820 in the last two quarters.

We continue to work with individual departments to re-start this offering now that Covid restrictions are lifting. Ward audits have been conducted, which consider the prominence, appearance and location of the FFT displays. As part of these audits we are also looking to share good practice, an example of which showed that areas that were including the cards with any discharge paperwork/packs, had a much higher response rate.

Table 4.1 Response rating by Directorate

		Rating											
	Total Responses Received	Very good		Good		Neither Good nor poor		Poor		Very poor		Don't know	
Day Case	379	354	93%	23	6%	1	-	-	-	1	>1%	-	-
Emer Dept	6	6	100%	-	-	-	-	-	-	-	-	-	-
Inpatients	384	311	80%	61	15%	8	2%	1	>1%	3	>1%	-	-
Maternity	24	20	84%	2	8%	1	4%	1	4%	-	-	-	-
Outpatients	271	235	87%	27	10%	5	2%	2	>1%	2	>1%	-	-

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

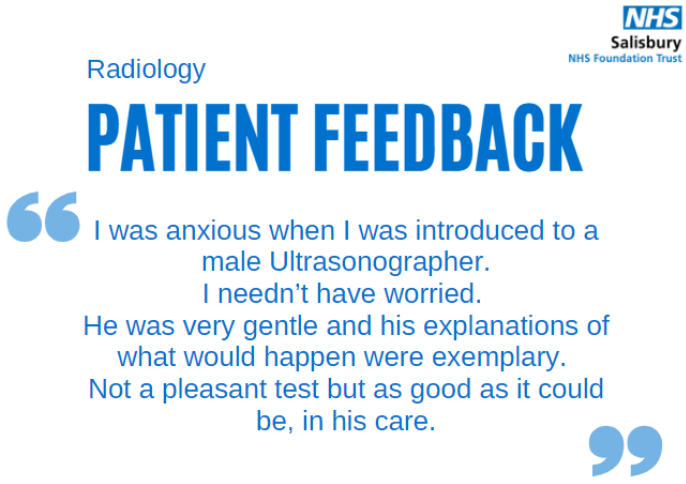
Table 4.2 Response rate across the Trust by per 1,000 patient activity – annual summary

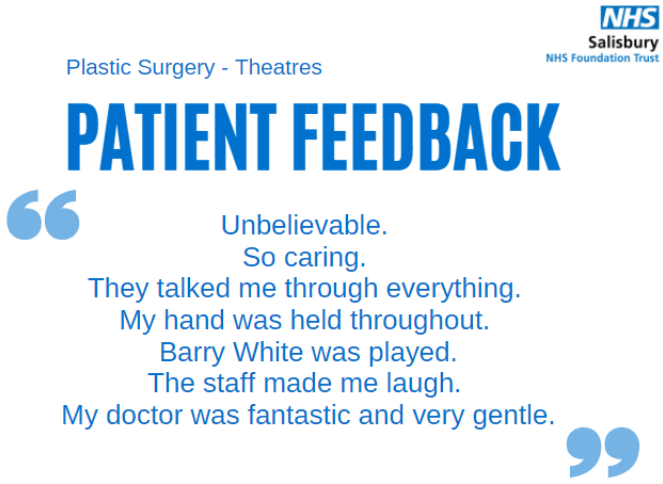
	Q1 21-22	Q2 21-22	Q3 21-22	Q4 21-22
Across all Directorates	*Not available* (95,166)	17.8 (101, 978)	▼ 15.9 (100, 369)	▼ 11.5 (99, 943)

Interim actions taken to increase response rates

- Ward audits for availability and accessibility of FFT information will continue to be regular feature and actions plans will be developed to improve consistency in these across the Trust.
- Updated online FFT form is now live on the Trust website.
- Plans underway to obtain QR codes, which can be added to posters and be displayed around the site.
- Enquiries are taking place on the permissions to incorporate extend options on the survey to help with demographic insight (increasing gender options and the addition of ethnicity)
- Changes to Trust website to ensure easier navigation to PALS information and in particular to the new FFT online form.
- Regular social media plugs to request patients to complete an FFT following their recent stay.

Comments are also regularly displayed on Social Media outlets under "*Thank you Thursday*" and "*Feedback Friday*" to showcase and encourage feedback





Future development of FFT

The Head of Patient Experience is developing relationships with counterparts across Bath and Swindon (BSW system) to consider how FFT data is collected, analysed and used to improve patient experience.

External providers, who are being used across BSW are now being consider, to utilise digital technologies to provide more reliable analysis and insight in to trends and themes that derive from this feedback.
These providers also have various options for increasing accessibility including SMS messages, patient interviews via telephone and voice message facilities.
The platform comprises of algorithms (which would be determined by the Trust) that are then used to create themes and develop meaningful real-time insight. This work is also being considered in anticipation

of aims to increase response rates – ensuring our method of analysing can also scale up in conjunction with this.

In addition, these providers may also have solutions to help increase the availability of the FFT in different, more accessible formats (i.e., sight impairments and languages).

There is a cost implication with outsourcing this and the various departments (informatics, information governance and procurement) are in consultation to ensure the correct business case process will be followed for the Board's consideration at a later date.

5. Patient and Public Involvement – National Surveys

National Urgent and Emergency Care Survey

The results from the urgent and emergency care 2020 survey and adult inpatient 2020 survey were published in September 2021 by the CQC and full results can be found at Urgent and emergency care survey 2020 | Care Quality Commission (cqc.org.uk) and Adult inpatient survey 2020 | Care Quality Commission (cqc.org.uk)

This will commence again in September 2022.

Adult Inpatient Survey 2021

Results are due in October 2022

Children and young person's survey 2020

The report has been published by the CQC and is awaiting presentation at the Patient Experience Group. This will commence again in November 2022.

National Maternity Survey 2022

Currently underway, Patient Perspective reports are anticipated in September 2022.

National Cancer Survey

Results are anticipated imminently.

6. Patient Experience & Engagement

Interim Draft Strategy

The **Improving Together** programme had identified areas of focus around complaint responses and new framework compliance, as well as increased responses to FFT.

The current **Patient Experience Strategy** is also in its final year and will be due for review at the end of 2022.

An interim strategy has been developed – see Appendix 2, aligned with the Trust's three P's (**People, Population and Partnerships**) to focus on the continued progress of the *Improving Together* metrics and introducing some additional focuses in order to create a framework on which to develop the new strategy for next year.

This draft strategy has been shaped with involvement of the PALS team and has been presented to the Patient Experience Group in May 2022.

Patient and Public Engagement Database

Work is near completion for a Patient and Public Engagement Database. This required completion of a Data Protection Impact Assessment (DPIA), and development of a Policy and Standard Operating Procedure to assure data protection procedures are adhered.

This will enable the Trust to develop a central register of patients, visitors and carers who have expressed interest in engaging with the Trust in various ways:

- ✓ **Supporting service redevelopment** – using their experiences/views to help us think about how our services can be improved
- ✓ **Monitoring the quality of our services** – for example patient -led audits, with a view to co-designing actions and improvements
- ✓ **Serving on committees and working groups** – taking an active role as a committee member/chair and providing the patient/carer viewpoint
- ✓ **Patient Safety Partners** – involving patients, carers and their families in their own safety, as well as being partners alongside staff in improving patient safety in our organisation
- ✓ **Recruitment** – taking an active part in the interview process for our staff
- ✓ **Making sure information for patients, carers and families is clear** – involving patients with the development/critical review of written information and/or questionnaires. Helping us to design these and make sure they are understandable, accessible and being delivered in the right way.

Once the database is fully operational, further work will be considered (under the interim strategy) to ensure that those on that registered are retained and engaged.

7. Patient Experience Steering Group (PESG)

The Patient Experience Group continues to take place monthly. This group is working with sub-group chairs to improve escalation reporting governance and to assist with more timely reporting into the Clinical Management Board, changes to the timing of PESG are also being considered to aid this and to support Divisions with ensuring adequate representation. The Head of Patient Experience is working with sub-group chairs to encourage adoption of the escalation report, hopefully reducing the pressure on turnaround of the more comprehensive minutes, whilst ensuring items of importance are escalated/highlighted.

The most recent PESG (May 2022) was the highest turnout so far this year. We continue to work on attendance levels as part of the groups ongoing development.

A patient story also continues to be shared at the start of each PESG meeting.

As highlighted on the summary page of this report, the change in staffing within the Patient Experience team has resulted in a skills/knowledge gap in the production of these going forward. To ensure that this essential component is continued and is undertaken by those with the correct skills to ensure these are produced to the highest quality - the Board are asked to consider whether it is appropriate for the Communications team to work in collaboration with Patient Experience on the future production of these.

It is acknowledged that this may have some impact on resources in that area, however, the inclusion of the team in these future productions we believe will give these stories much more versatility in where they are viewed and how/who they are shared with (consenting processes will need to be updated in accordance).

APPENDIX 1: Guidance Framework for Responding to Complaints [DRAFT]

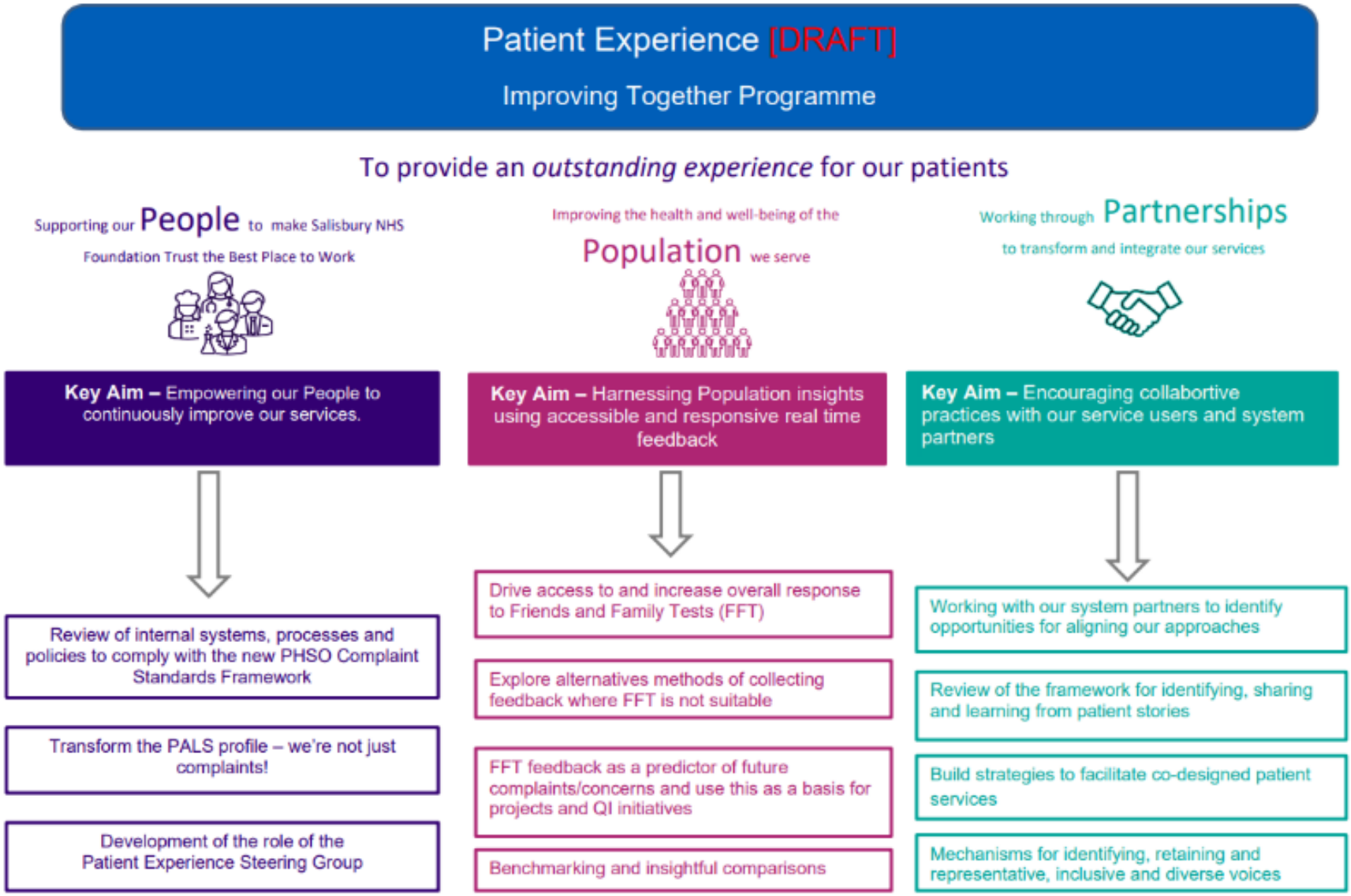
W:\Chief-Executive-Directorate\Customer Care\Training\Responding to Complaints

Guidance Framework for Resp

Surgical Team pilot considerations:

- Does this help you to ensure everything is covered?
- Does it still allow you to keep the letter personal to the patient?
- Are there any prompts missing?
- Does this help with turning complaints around any sooner?
- Would this approach work with a particularly lengthy of complex response?
- What else could we do to support staff with complaint responses?

APPENDIX 2: Guidance Framework for Responding to Complaints [DRAFT]



Salisbury
NHS Foundation Trust

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.2
Date of Meeting:	07 July 2022		

Report Title:	Q4 Learning from Deaths Report 2021 - 2022			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	Clinical Effectiveness Committee			
Prepared by:	Dr Ben Browne, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Peter Collins, Chief Medical Officer			
Appendices (list if applicable):				

Recommendation:
The paper is to provide assurance that the Trust is learning from deaths and making improvements.

Executive Summary:

- There were 898 inpatient deaths in 2021/22 and 255 deaths occurred in Q4. This figure is inclusive of patients who died in either the Emergency Department or the Hospice.

During Q4:

- There were 37 inpatient deaths from COVID-19 (death within 28 days of a positive swab result / COVID-19 reported on the death certificate).
- There were 2 stillbirths and no neonatal deaths reported.
- There were no maternal deaths.
- There were 2 deaths reported in patients with a learning disability.
- There was 1 death reported in a patient with serious mental illness.

- 112 families gave consent for the Trust's Your Views Matter bereavement survey to be posted and 44 completed surveys were returned
    - 86% of respondents rated care as being either good or very good.

- The HSMR for the twelve-month period ending in February 2022 is 109.1 and is statistically higher than expected.
- Weekday HSMR is 108.4 and weekend HSMR is 113.5 (within expected ranges respectively).

- The SHMI for Salisbury District Hospital for the twelve-month period ending in December 2021 is 1.0270. This is within the expected range.

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

Quarter 4 2021/22 Learning from Deaths report

June 2022

GLOSSARY OF TERMS

CUSUM
A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues. The CQC monitor CUSUM's at a 99.9% threshold to determine outliers.

HSMR
The Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity.

ME
Medical examiners (MEs) are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. The purpose of the medical examiner system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths, ensure the appropriate direction of deaths to the coroner, provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased, improve the quality of death certification, and improve the quality of mortality data. The Medical Examiner (ME) system was introduced in April 2020 and was established in the Trust by August 2020.

MSG
The Mortality Surveillance Group (MSG) meets bi-monthly and is responsible for reviewing deaths to identify problems in care and commissioning improvement work, to reduce unwarranted variation and improve patient outcomes. To identify the learning arising from reviews and improvements needed.

PALS
The Patient Advice and Liasion Service (PALS) offers confidential advice, support and information on health-related matters and they provide a point of contact for patients, their families and their carers. A complaint is an expression of dissatisfaction made to an organisation, either written or spoken, and whether justified or not, which requires a formal response from the Chief Executive. A concern is a problem raised that can be resolved/responded to by the clinical or non-clinical teams concerned. Concerns include issues where the patient/family member has said that they don't want to make a formal complaint.

SFT
Salisbury NHS Foundation Trust.

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

SII
Serious Incident requiring Investigation.

SJR
The Structured Judgement Review (SJR) is a process for undertaking a review of the care received by patients who have died.

SMR
A calculation used to monitor death rates. The Standardised Mortality Ratio (SMR) is the ratio of observed deaths to expected deaths, where expected deaths are calculated for a typical area with the same case-mix adjustment. The SMR may be quoted as either a ratio or a percentage. If the SMR is quoted as a percentage and is equal to 100, then this means the number of observed deaths equals that of expected. If higher than 100, then there is a higher reported mortality ratio.

SOX
Sharing Outstanding Excellence (SOX) is a method of paying a compliment to a team or a member of staff. It is a way of learning from when things go well.

QUARTER 4 (Q4) LEARNING FROM DEATHS MORTALITY REPORT 2021/22

1. Purpose

To comply with the national requirements of the Learning from Deaths framework, Trust Boards must publish information on deaths, reviews and investigations via a quarterly report to a public board meeting.

2. Background

The Learning from Deaths initiative aims to promote learning and improve how Trusts support and engage bereaved families and carers of those who die in our care.

3. Summary of Learning

The Trust MSG met on 08th March 2022 in Q4, where learning, improvement themes, and actions around in-hospital deaths were discussed. Some of the learning and themes discussed are summarised below.

3.1. SJRs and The Medical Examiner System

The requirement for non-coronial deaths to be scrutinised by a Medical Examiner will be statutory from summer this year, and should include all deaths in both the hospital and the community. The regional CCG has commenced fortnightly meetings to support the service set-up and GPs are now being invited to become Medical Examiners. We are piloting a new process for undertaking mortality reviews (SJRs) and a new template was recently approved. One of the challenges has been finding enough staff to undertake these reviews, especially where the hospital has been experiencing significant operational pressures.

3.2. Formal Alerts and Reports

The perinatal mortality review tool of stillbirths was presented. There continues to be a good working relationship between the Paediatric, Obstetric, and Maternity teams to support parents with making difficult decisions. Some improvements are being made to provide more education and training to staff and to update patient information. For instance, improving accessibility of information and providing this is in other languages. A indepth review of Chronic Obstructive Pulmonary Disease (COPD) and Bronchiectasis patients remains underway following a previous alert and the findings will be presented at the next Trust mortality meeting (July 2022).

3.3. Serious Incidents Requiring Investigation (SIIs) / Case Reviews

There were no SIIs resulting in death discussed at the March meeting.

3.4. Bereavement

The majority of bereaved families rate the end of life care as being good or very good. A key theme from recent bereavement survey results relates to communication. Further information can be found in section 6 of this report.

4. Summary of Mortality Data for Q4

- There were 898 inpatient deaths during 2021/22, of which 255 deaths occurred in Q4 (2021/22). This figure is inclusive of patients who died in either the Emergency Department or the Hospice. This compares to 237 deaths occurring in Q3 (2021/22).
- There were 37 inpatient deaths from COVID-19 in Q4 (death within 28 days of a positive swab result / COVID-19 reported on death certificate).
- There were 2 stillbirths and no neonatal deaths in Q4.
- There were no maternal deaths in Q4.
- There were 2 deaths reported in patients with a learning disability in Q4.
- There was 1 death identified in a patient with serious mental illness in Q4.

2021/22	Q1	Q2	Q3	Q4	YTD TOTAL
Covid Deaths	2	10	7	37	56
Stillbirth	2	1	2	2*	7
Neonatal Deaths	1	1	1	0	3
Maternal Deaths	0	0	0	0	0
Learning Disability Deaths	0	2	0	2	4
Serious Mental Illness	2	2	1	1	6
TOTAL DEATHS	204	202	237	255	898

Pregnancy losses by definition for Q4:

20/21 (excluding terminations for abnormalities)	**Q4**
Stillbirths (>37^{+0} weeks)	1
Stillbirths (>24^{+0} weeks - 36^{+6}weeks)	1
Late miscarriage (22^{+0} weeks - 23^{+6}weeks)	0
Neonatal deaths	0
Total	**2**

5. Medical Examiner (ME) and Structured Judgement Reviews (SJRs)

The ME system was introduced to ensure excellence in care for the bereaved and learning from deaths to drive improvement. The Medical Examiners aim to scrutinise all acute hospital deaths, and a local network of MEs exists to share learning and provide an independent review facility if needed. The system was established in the Trust by August 2020.

- **21 Structured Judgement Reviews were requested by the Medical Examiner System in Q4.**

A summary of the reasons for each requested review has been outlined and cateogrised into problem themes and stage of care (see Table 1)

Table 1: Reasons for SJR Requests and Themes–Quarter 4, 2021-22 (Q4 data shown in brackets)

Type of problem	*Stage of Care* →						
	Admission and initial assessment (first 24 hours)	Ongoing care	Care during a procedure	Perioperative/procedure care	End of life care (or discharge care)	Concerns about over all care	**TOTAL**
1. Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)	*5*	*7(3)*			*2(1)*	*3*	***17***
Problem with medication / IV fluids / electrolytes / oxygen		*3*					***3***
Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)	*2*	*2(1)*		*1*	*1(1)*	*1(1)*	***7***
Problem with infection control							***0***
Problem related to operation/invasive procedure (other than infection control)			*3*	*1*			***4***
Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)		*10(1)*		*1*	*1*	*1*	***13***
Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR))							***0***
Problem of any other type not fitting the categories above	*2*	*2*				*20(14)*	***24***
TOTAL	***9***	***24***	***3***	***3***	***4***	***25***	

Summary of Reviews Requested in Q4

JANUARY 2022	***FEBRUARY 2022***	***MARCH 2022***
-Drug error *-Family request due to visiting restrictions* *-Falls and a delay in communication of scan results* *-Falls [x2 cases]* *-A patient with a learning disability*	*-Falls [x4 cases]* *-Family concerns regarding communication* *-A patient with a serious mental illness* *-Review level of specialist care*	*-Falls [x2 cases]* *-Management of sodium levels* *-Doctor request* *-Family concerns about advanced care plan and CPR* *-A patient with a learning disability* *-A patient with a serious mental illness*

The predominant theme triggering a request for a review by the medical examiner in Q4 was inpatient falls (8 cases)

6. Your Views Matter Survey & End of Life Care

The your views matter survey is offered to all bereaved families, providing them with an opportunity to feedback their experiences of support given to themselves and the care given to dying patients in their last days of life.

- In Q4, 112 families gave consent for the Trust's Your Views Matter bereavement survey to be posted and 44 completed surveys were returned (compared to 83 and 33 respectively in Q3).
- 86% of respondents rated the overall end of life care as good or very good.

	Q1	Q2	Q3	Q4	2021/22 TOTAL
Consent for survey to be posted	**101**	**77**	**83**	**112**	**373**
Completed surveys returned	**42**	**26**	**33**	**44**	**145**
Return rate	**42%**	**34%**	**40%**	**39%**	**39%**
% Rating care as good or very good	**76%**	**81%**	**76%**	**86%**	**79%**
% Rating care as poor or very poor	**12%**	**12%**	**12%**	**5%**	**10%**

Since July 2021 every family who has rated End of Life Care (EOLC) as 'poor' or 'very poor' has been contacted by the Lead Nurse for EOLC. Often concerns are addressed by phone. However, on three occasions bereaved families were supported to raise formal concerns (usually because the nature of the concerns extend beyond that of end of life care). The completed surveys enable common themes to be identified and steps to be taken to address these.

One recurring theme highlighted by the survey, poor communication, has prompted the development of a comprehensive communication training programme for ward staff. The Lead nurse for EOLC has collaborated with PALS, the Risk Team, and the Education team to write a one day participative communication skills course using professional actors to simulate real life communication scenarios. Funding has been agreed for seven courses this calendar year with up to 140 places available. In addition, the following actions to address poor communication have also been taken:

- Providing communication skills training for up to 40 administrators with a patient/public facing role
- A bedside communications poster to inform inpatients of communication channels available to them
- Promotion of *messagetoalovedone* and PALS video calls via social media

Another theme identified is the confusion and distress felt when a patient's condition fluctuates. The advice given to families can change and this is particularly exacerbated when visiting allowances are impacted. In response, a significant collaborative project is being undertaken this year to improve future care planning discussions with patients and families.

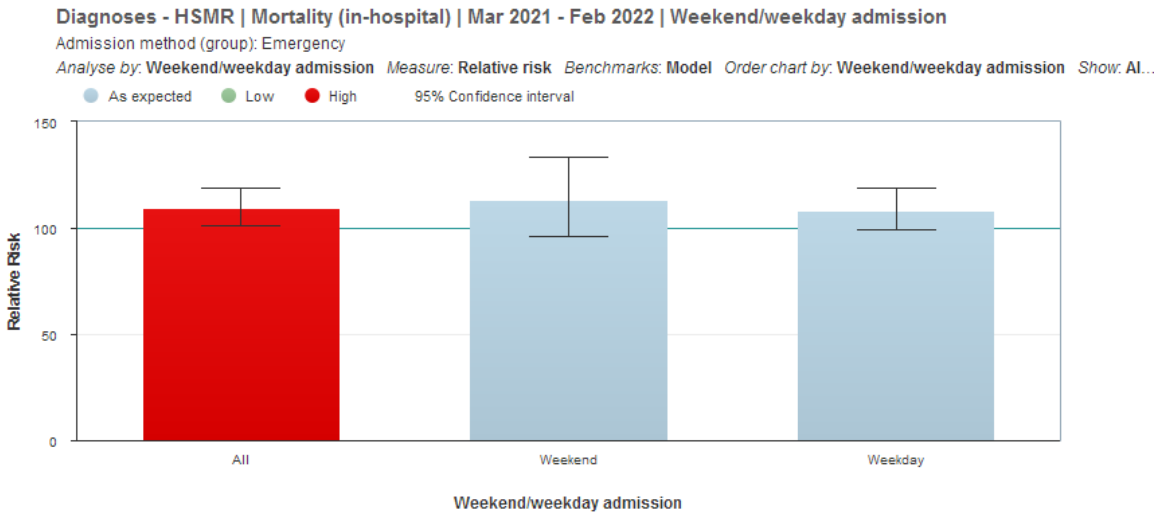
7. Mortality Benchmarking

7.1. HSMR rolling 12 month trend to February '22

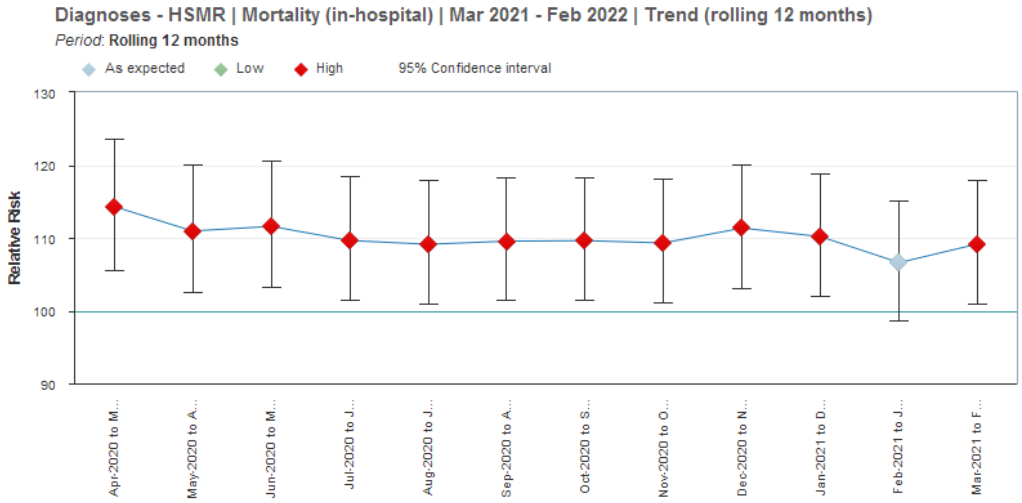
- **The HSMR (relative risk) for the twelve month period ending in February 2022 is 109.1 and is statistically higher than expected (100.9 – 117.9, 95% confidence limits).**

- **Weekday HSMR is 108.4 and weekend HSMR is 113.5. Both are within their expected ranges respectively.**

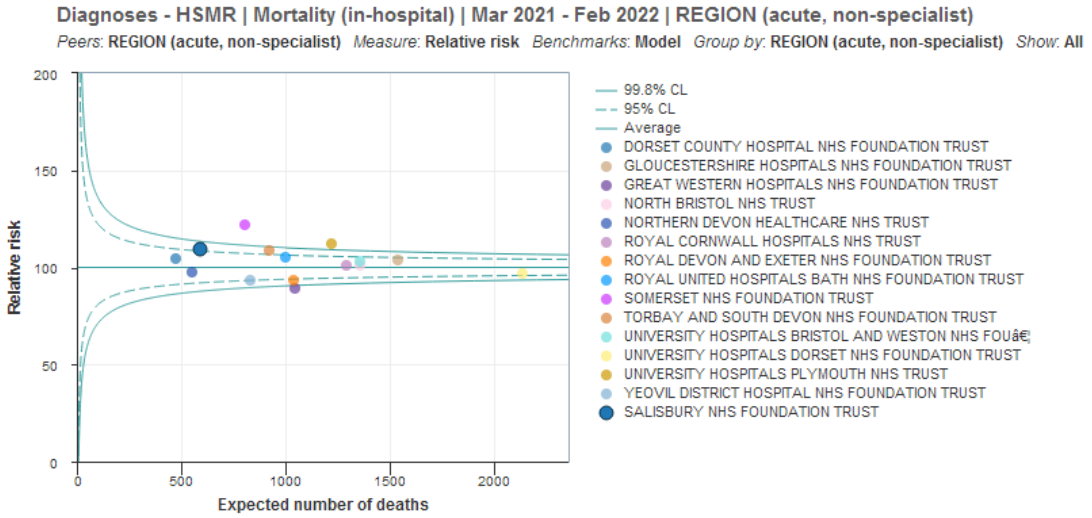
Weekend/Weekday HSMR [Graphs provided by *Dr Foster, Telstra Health UK*]



HSMR (Rolling 12-month trend to year-end February 2022)



Peer comparison of HSMR (Rolling 12-month trend to year end February 2022)



7.2. Summary Hospital-Level Mortality Indicator (SHMI) for January 2021 – December 2021

The SHMI is an indicator which reports on mortality at Trust level across the NHS in England and it is published as an official statistic by NHS Digital. The latest available data is published in this report.

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value
RNZ02	Salisbury District Hospital	33,305	920	895	1.0270
RNZ78	Salisbury Hospice	100	65	25	2.4331

- **SHMI is 1.0677 for the twelve month period ending in December 2021 for SFT. When comparing SHMI by site, Salisbury District Hospital is 1.0270 and Salisbury Hospice is 2.4331.** When compared with regional peers, the Trust has a SHMI within the expected range.

- The tables in the supplementary data pack show the SHMI data for SFT as a breakdown for specific conditions for the twelve month period ending December 2021.

7.3. New Alerts

- All new alerts are discussed at the MSG meeting, where a further review or investigation into these deaths may be requested. We have had recent CUSUM alerts for 'COPD and Bronchiectasis' and 'Other Destruction of Haemorrhoid' which are being investigated. We are currently working with our partners at *Telstra Health UK* to develop a new local action tracker to improve how we monitor these alerts.

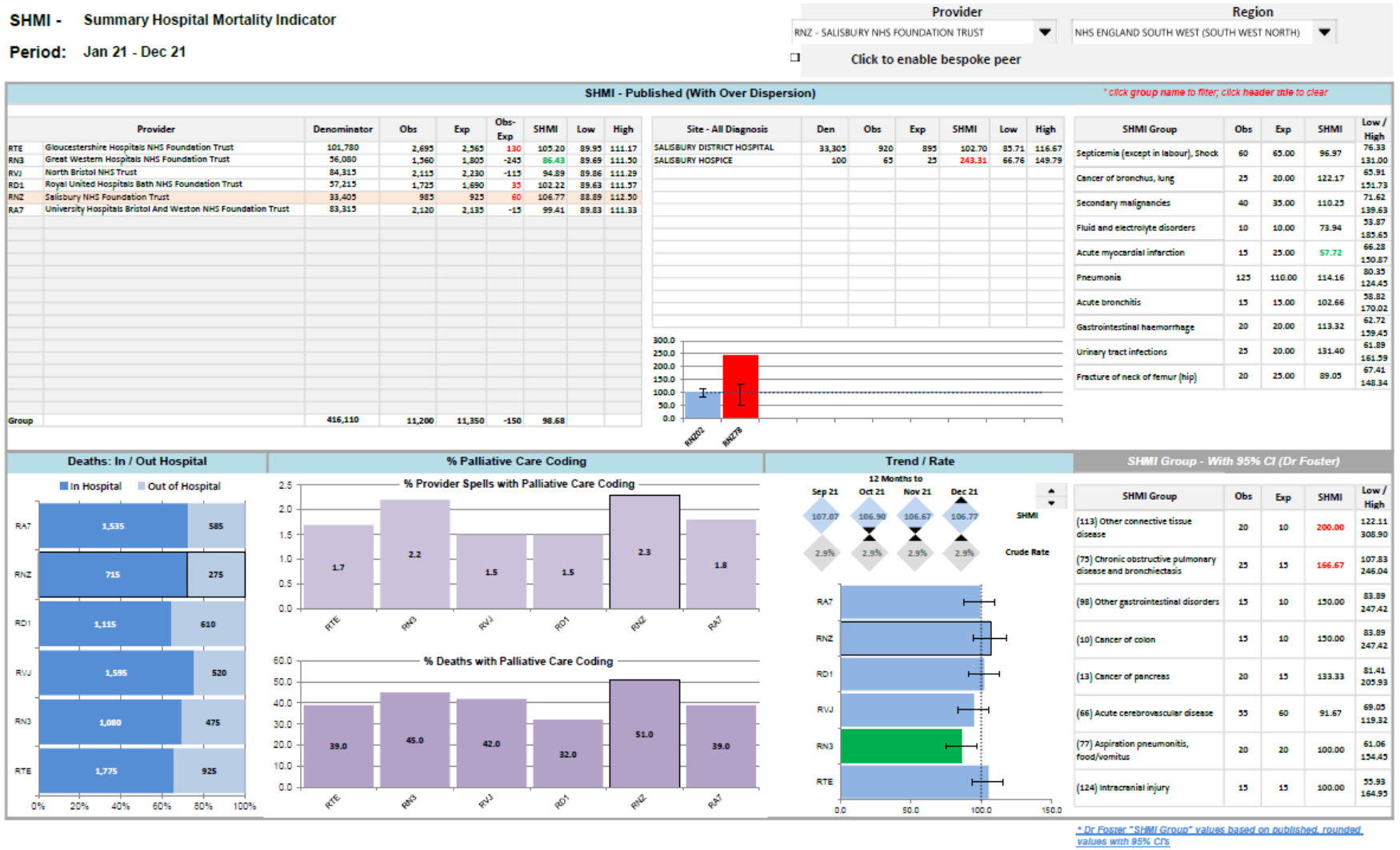
8. Recommendations

The report is provided for assurance that the Trust is learning from deaths and making improvements.

Author:
Dr Ben Browne, Head of Clinical Effectiveness, 6th June 2022
Approved by Dr Peter Collins
Chief Medical Officer, June 2022

9. Supplementary Data

SHMI Data for the 12 Month Period Ending December 2021



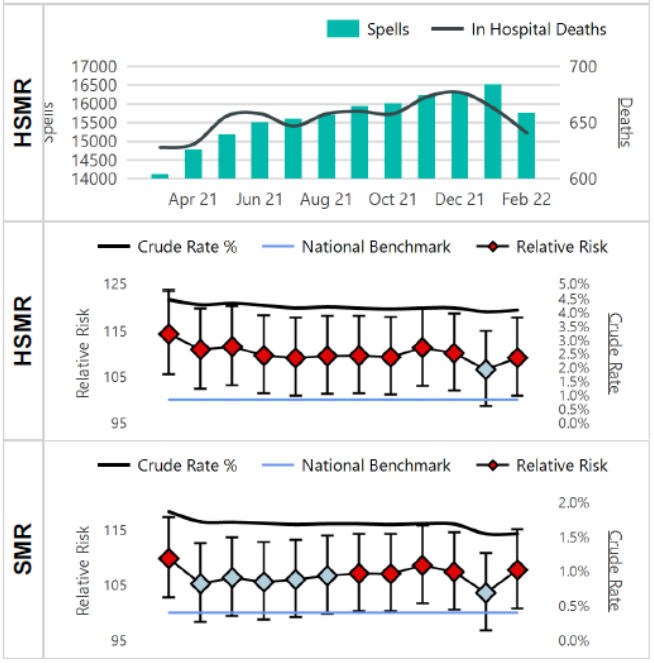
HSMR Data for 12 month period to February 2022 for SFT (Inclusive of Hospice Data)

HEALTH | dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Feb-2022 as at 30/05/2022

SALISBURY NHS FOUNDATION TRUST - All Sites

Rolling 12 month trends



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	1	23	13.7	167.5	106.1	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	1	23	13.7	167.5	106.1	
Other connective tissue disease	1	16	9.8	162.6	92.9	
Cancer of bronchus, lung	1	19	14.9	127.5	76.7	
Cancer of ovary	1	6	3.5	170.5	62.3	
Noninfectious gastroenteritis	1	1	0.7	133.7	1.7	

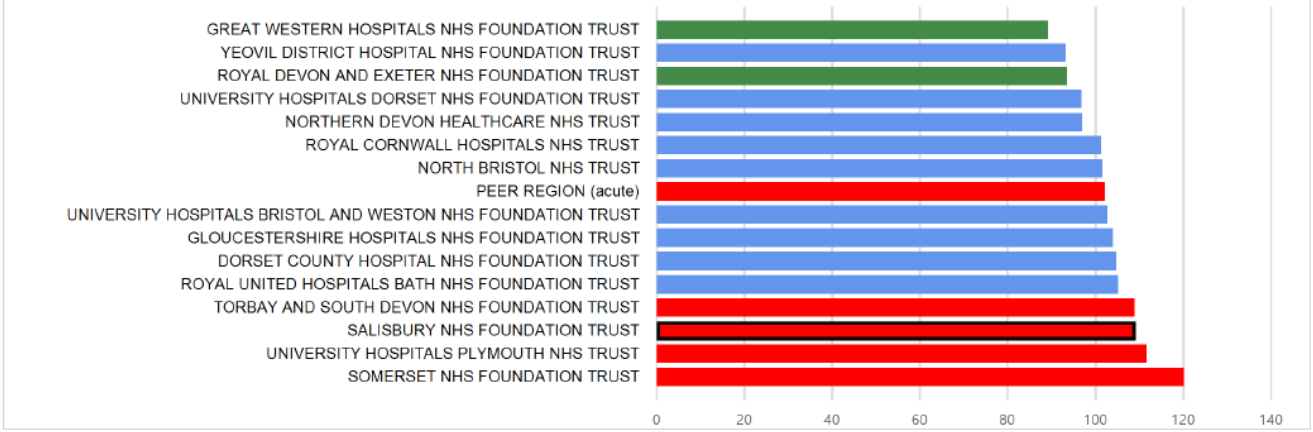
CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Gastrointestinal haemorrhage	1	15	13.8	108.6	60.7	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR		109.1	102.2	96.7
SMR		107.8	101.8	95.4
Non-elective (HSMR)		109.7	102.2	96.4
Weekday, emergency (HSMR)		108.4	100.2	94.8
Weekend, emergency (HSMR)		113.5	108.4	100.7
Saturday, emergency (HSMR)		121.9	105.2	100.4
Sunday, emergency (HSMR)		105.1	111.2	100.9
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)		55.8%	41.0%	39.3%
% Non-elective spells with palliative care (HSMR)		6.5%	4.6%	4.8%
% Spells in Symptoms & Signs chapter		11.8%	9.2%	7.5%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)		46.2%	42.7%	41.4%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)		13.9%	14.8%	15.7%
% Non-elective spells in Risk Band (0-10%) (HSMR)		84.5%	84.8%	84.4%

HSMR Peer Comparison



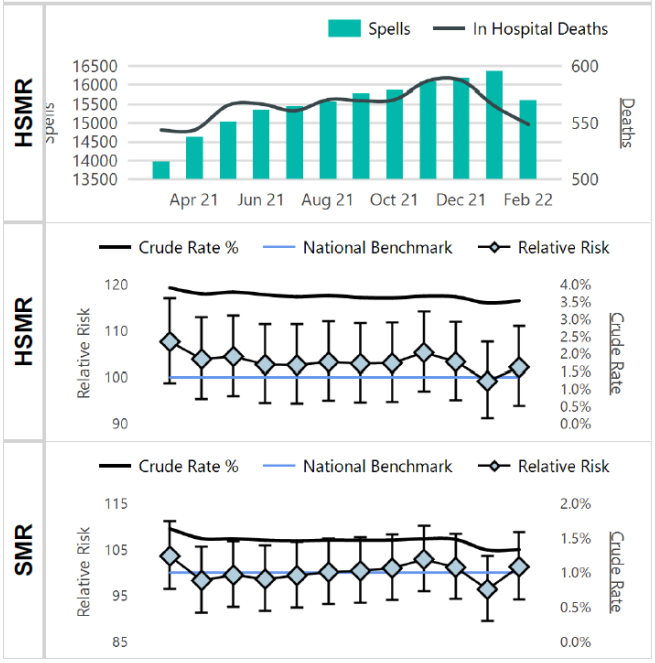
HSMR Data for the 12 month period to October 2021 for SFT (Excluding Hospice Data)

HEALTH | dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Feb-2022 as at 30/05/2022

SALISBURY NHS FOUNDATION TRUST - SALISBURY DISTRICT HOSPITAL (RNZ02)

Rolling 12 month trends



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	1	22	13.4	164.3	103.0	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	1	22	13.4	164.3	103.0	
Other connective tissue disease	1	13	8.4	155.0	82.4	
Systemic lupus erythematosus and connective tissue disorders	1	1	0.1	865.9	11.3	

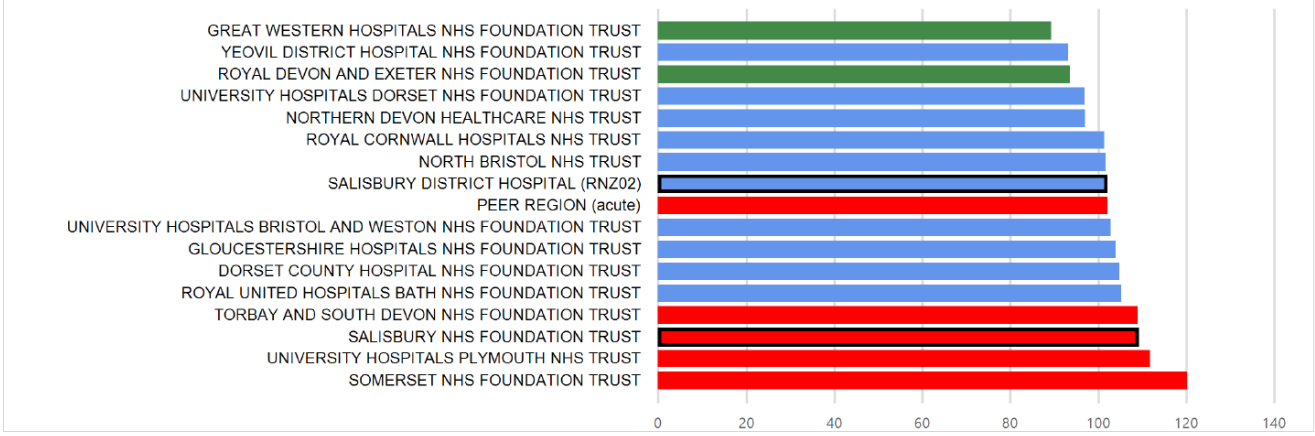
CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR	102.1	109.1	102.2	96.7
SMR	101.2	107.8	101.8	95.4
Non-elective (HSMR)	102.4	109.7	102.2	96.4
Weekday, emergency (HSMR)	101.0	108.4	100.2	94.8
Weekend, emergency (HSMR)	106.4	113.5	108.4	100.7
Saturday, emergency (HSMR)	116.4	121.9	105.2	100.4
Sunday, emergency (HSMR)	95.9	105.1	111.2	100.9
Coding/Casemix	Site	Trust	Peer	National
% Non-elective deaths with palliative care (HSMR)	48.3%	55.8%	41.0%	39.3%
% Non-elective spells with palliative care (HSMR)	5.1%	6.5%	4.6%	4.8%
% Spells in Symptoms & Signs chapter	11.8%	11.8%	9.2%	7.5%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	46.8%	46.2%	42.7%	41.4%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	13.5%	13.9%	14.8%	15.7%
% Non-elective spells in Risk Band (0-10%) (HSMR)	85.7%	84.5%	84.8%	84.4%

HSMR Peer Comparison

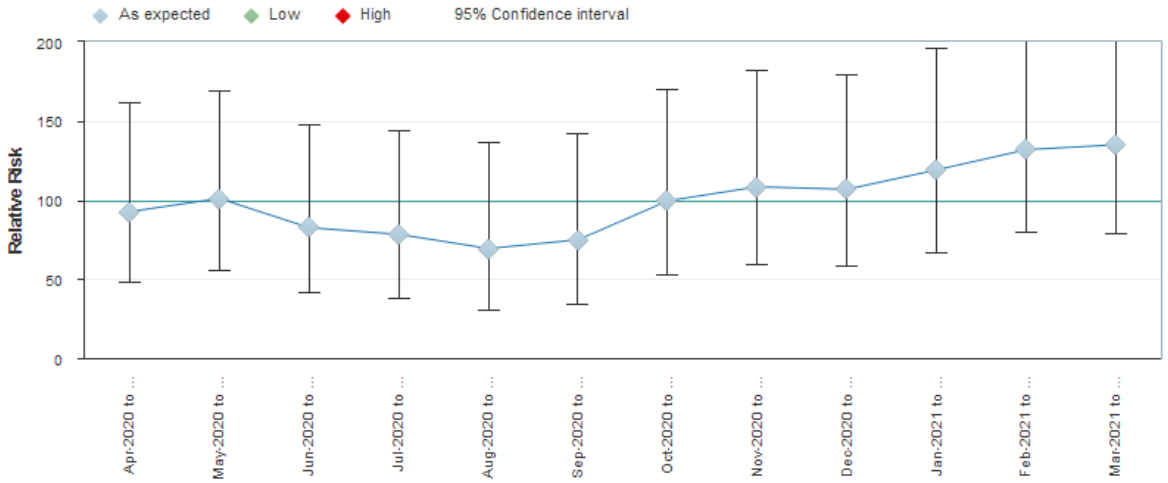


12-Month Trends in Relative Risk for High Risk Diagnosis Groups

Acute and unspecified renal failure | Mortality (in-hospital) | Mar 2021 - Feb 2022 | Trend (rolling 12 months)

Diagnosis group: Acute and unspecified renal failure

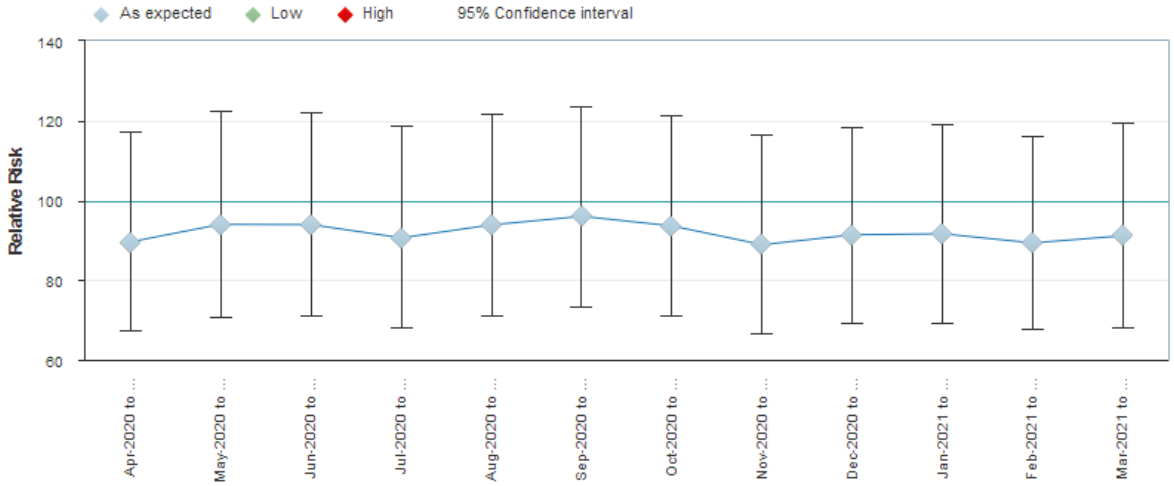
Period: **Rolling 12 months**



Acute cerebrovascular disease | Mortality (in-hospital) | Mar 2021 - Feb 2022 | Trend (rolling 12 months)

Diagnosis group: Acute cerebrovascular disease

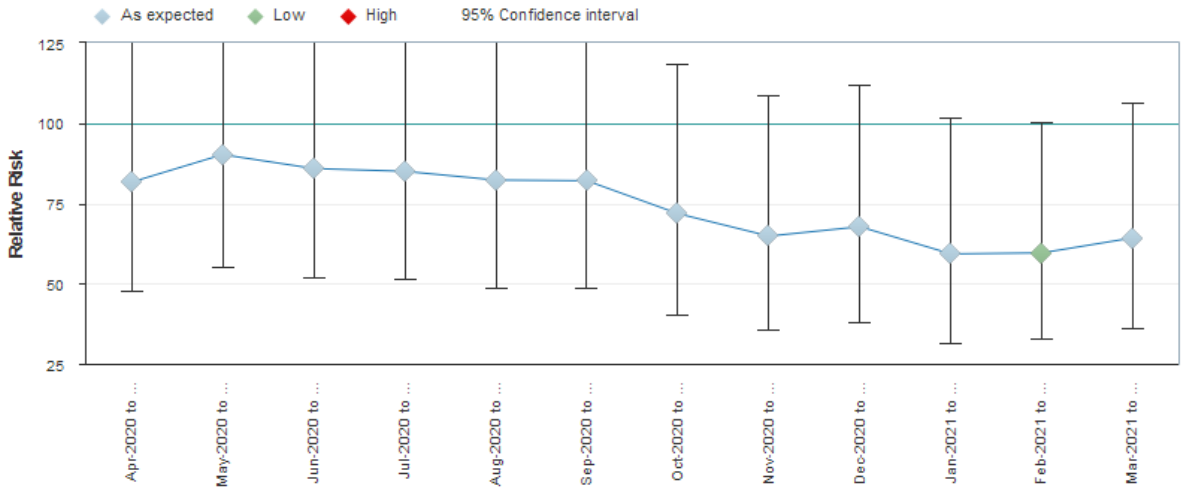
Period: **Rolling 12 months**



Acute myocardial infarction | Mortality (in-hospital) | Mar 2021 - Feb 2022 | Trend (rolling 12 months)

Diagnosis group: Acute myocardial infarction

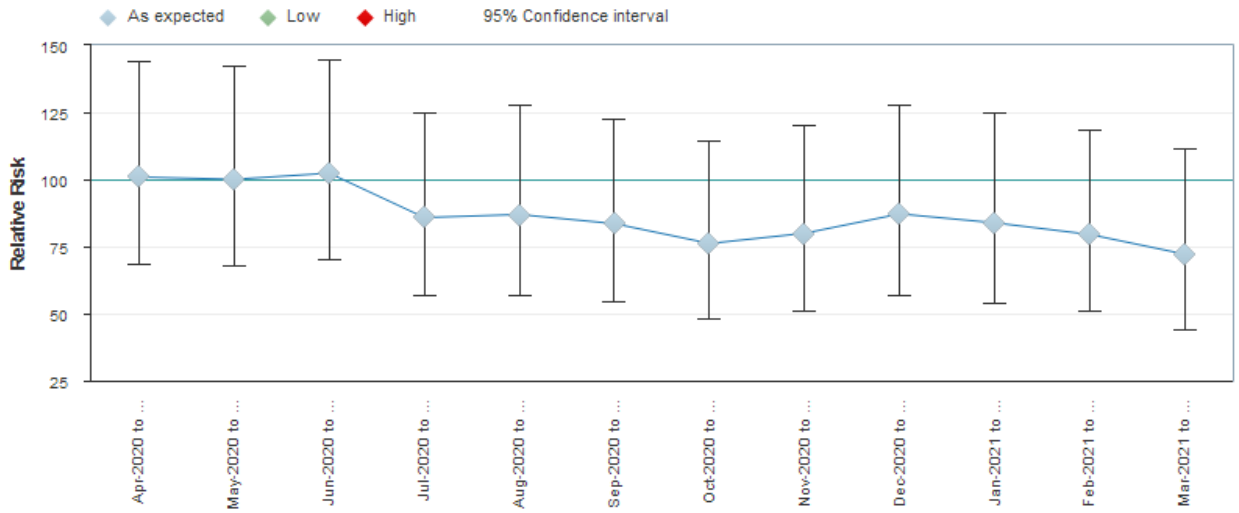
Period: **Rolling 12 months**



Congestive heart failure, nonhypertensive | Mortality (in-hospital) | Mar 2021 - Feb 2022 | Trend (rolling 12 months)

Diagnosis group: Congestive heart failure, nonhypertensive

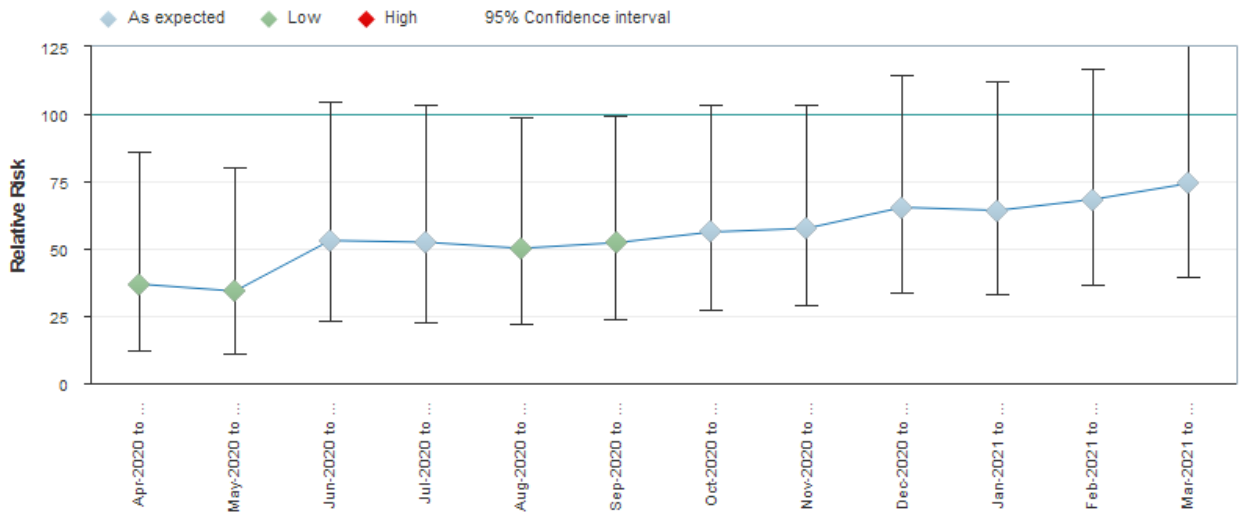
Period: **Rolling 12 months**



Fracture of neck of femur (hip) | Mortality (in-hospital) | Mar 2021 - Feb 2022 | Trend (rolling 12 months)

Diagnosis group: Fracture of neck of femur (hip)

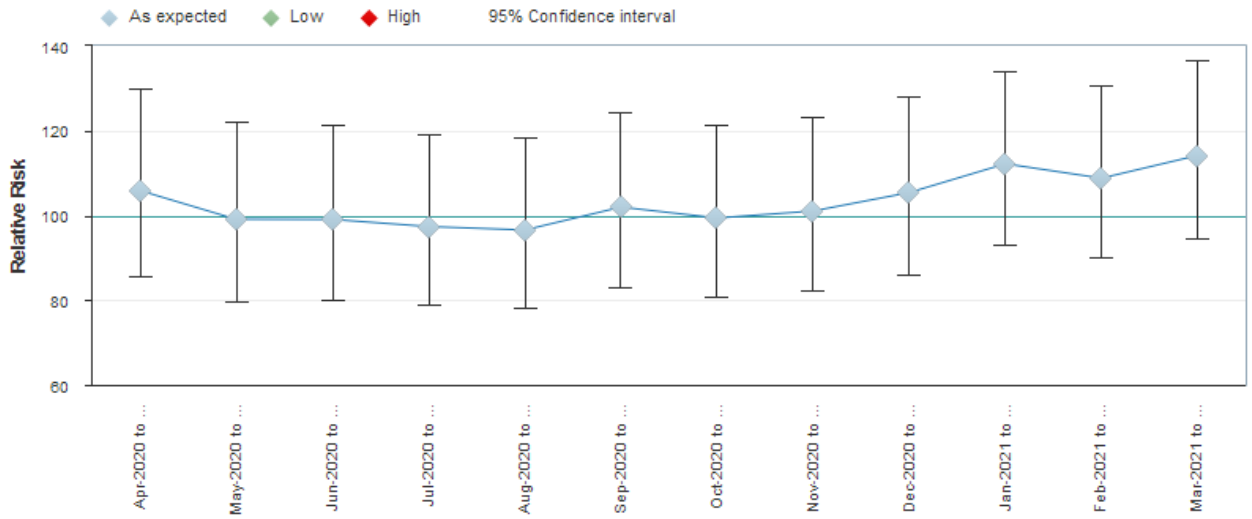
Period: **Rolling 12 months**

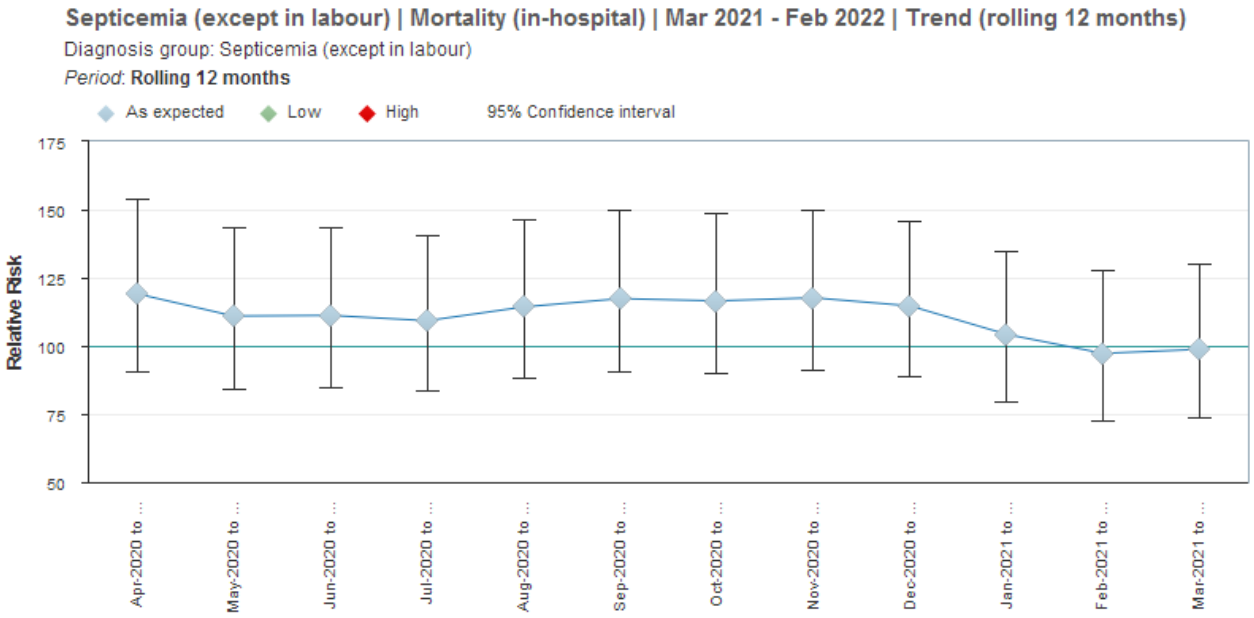


Pneumonia | Mortality (in-hospital) | Mar 2021 - Feb 2022 | Trend (rolling 12 months)

Diagnosis group: Pneumonia

Period: **Rolling 12 months**




Septicemia (except in labour) | Mortality (in-hospital) | Mar 2021 - Feb 2022 | Trend (rolling 12 months)
Diagnosis group: Septicemia (except in labour)
Period: Rolling 12 months
As expected
Low
High
95% Confidence interval
Relative Risk
175
150
125
100
75
50
Apr-2020 to ...
May-2020 to ...
Jun-2020 to ...
Jul-2020 to ...
Aug-2020 to ...
Sep-2020 to ...
Oct-2020 to ...
Nov-2020 to ...
Dec-2020 to ...
Jan-2021 to ...
Feb-2021 to ...
Mar-2021 to ...

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.3
Date of Meeting:	07 July 2022		

Report Title:	Director of Infection Prevention and Control Annual Report April 2021-April 2022			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		x	
Approval Process (where has this paper been reviewed and approved)				
Prepared by:	Fiona McCarthy			
Executive Sponsor	Judy Dyos CNO			
Appendices (list if applicable):	Appendix A Annual action plan 2021-2022			

Recommendation:

The purpose of this annual DIPC Report is to provide assurance to the trust board on the infection prevention work undertaken at Salisbury NHS Foundation Trust and inform the Trust Board of the progress made against the 2021/22 Annual Action Plan to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

Executive Summary:

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

For the reported period, the Trust has experienced a challenging twelve months for infection prevention and control, with the major incident response to the ongoing COVID-19 pandemic. This has involved:

- One Norovirus outbreak period lasting less than 15 days
-
- The Trust continues to report low HCAI rates overall and remains in the top 25% of lowest cases regionally and nationally, with no Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia cases identified
- Significant amounts of work have been completed and remain ongoing for antibiotic stewardship, decontamination, cleaning services and water safety.

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

- Gap in Antimicrobial Pharmacist position with vacancy filled but not yet in post
- Low hand hygiene assessment compliance with a review of the process being undertaken

- Delay in the Trust implementation of the national programme *'Every Action Counts'* due to the Infection Prevention and Control Team (IPCT) nursing vacancy and the ongoing COVID-19 workload impacting roll out.

Appendix A provides an update of the actions in the annual action plan included current status and responsible officers. There are no required actions without suitable oversight and supporting policy to notify the board of.

Board Assurance Framework – Strategic Priorities	**Select as applicable**
Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☐
Other (please describe) -	☐

Salisbury
NHS Foundation Trust

INFECTION PREVENTION AND CONTROL

DIRECTOR OF INFECTION PREVENTION AND CONTROL

ANNUAL REPORT

April 2021 – March 2022

JUDY DYOS
Director of Infection Prevention and Control (DIPC)

June 2022 (Final v.1)

CONTENTS **PAGE**

APPENDICES

1. INTRODUCTION

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

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

The purpose of this annual DIPC Report is to summarise the work undertaken at Salisbury NHS Foundation Trust and inform the Trust Board of the progress made against the 2021/22 Annual Action Plan (Appendix A), to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

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

For the reported period, the Trust has experienced a challenging twelve months for infection prevention and control, with the major incident response to the ongoing COVID-19 pandemic. This has involved:

- One Norovirus outbreak period lasting less than 15 days
- The Trust continues to report low HCAI rates overall and remains in the top 25% of lowest cases regionally and nationally, with no Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia cases identified
- Significant amounts of work have been completed and remain ongoing for antibiotic stewardship, decontamination, cleaning services and water safety.

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

- Gap in Antimicrobial Pharmacist position with vacancy filled but not yet in post
- Low hand hygiene assessment compliance with a review of the process being undertaken
- Delay in the Trust implementation of the national programme *'Every Action Counts'* due to the Infection Prevention and Control Team (IPCT) nursing vacancy and the ongoing COVID-19 workload impacting roll out.

2. GOVERNANCE ARRANGEMENTS

The work towards achieving the objectives of the Annual Action Plan 2021/22 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) and onto the Clinical Governance Committee (CGC), which completes the governance arrangements.

3. INFECTION PREVENTION & CONTROL ARRANGEMENTS

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

The IPCT currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 4.0 whole time equivalent (w.t.e) ICNs (one of which is a secondment post funded by COVID-19 monies until 31st March 2022) and secretary (0.6 w.t.e). In addition, there are 3 Consultant Microbiologists, one of whom is the Trust Antimicrobial Lead. *Of note: one of the established ICNs resigned in January 2022 (having been on long term sickness leave from July 2021), with the vacancy remaining unfilled as of 31st March 2022.*

4. ASSURANCE ACTIVITIES

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

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

Of note: creation of Ventilation Working Group during quarter 4 of 2021/22, with regular reports to be provided to the IPCC.

5. HEALTHCARE ASSOCIATED INFECTION (HCAI) STATISTICS AND SURVEILLANCE

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

The Trust is also required to record these incidents on the strategic executive information system (STEIS) in line with the *Serious Incident Framework: Supporting learning to prevent recurrence (NHS England, March 2015)*, and the *Public Health England (PHE) HCAI: Operational Guidance & Standards for Health Protection Units (HPUs) (July 2012),* PHE now UK Health Security Agency (UKHSA) from 1st October 2021.

During 2021/22, the Trust has had **no** declared internal outbreaks of:

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

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

The ICNs provide clinical teams with infection control advice, support and education on a daily basis to all inpatient and outpatient areas. The management of patients admitted with suspected and known alert organisms is discussed, and risk assessments undertaken. The Isolation Risk

Assessment Tool (IRAT), Flowchart for the Management of Inpatients with Diarrhoea, and Diarrhoea Pathway have been developed and implemented to assist staff competency and confidence in the management of cases.

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

5.1 Coronavirus (Wuhan CoV)

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

From January 2020, the Trust initiated emergency planning and resilience response measures utilising significant PHE guidance and updates published as the situation continued to evolve. This included the identification of emergency assessment/triage areas, respiratory assessment zones and care areas, testing programme and personal protective equipment practice management. The Trust has followed established Emergency Preparedness, Resilience and Response (EPRR) protocols which include the instigation of strategy planning and Incident Management Team (IMT) meetings, with key personnel to agree actions and develop iRespond cards across the divisions and disciplines. This work has remained ongoing throughout 2021/22.

The IPCT has continued to provide representation within the various identified workstreams, which has included IMT, Clinical Review Group (CRG), Workforce, Recovery, Personal Protective Equipment (PPE) and Virtual Board Round (VBR). (*Of note: in relation to PPE supplies, the Trust continues to work exceptionally hard to ensure adequate stock levels of the required standard are maintained).*

An Infection Prevention and Control (IPC) 'Task and Finish' Group was set up in June 2020 to provide a forum to review and action the continual changes to the IPC guidance published by PHE related to COVID-19. There was representation in the group from all clinical divisions as well as Corporate, Estates and Facilities. Key achievements of the group included providing evidence to populate the IPC Board Assurance Framework (BAF) document versions; Outbreak Management Framework/Policy and process agreement; reviewing and final agreement for use of portable fans in clinical environments Standard Operating Procedure (SOP) and risk assessment document; patient visiting protocol and related risk assessment documentation; review of risk assessments for COVID secure workplaces, with adaptations (where possible) of the environments and feedback of national learning.

The IPC Task and Finish Group was stood down during quarter 3 of 2020/21, with ongoing work feeding into other existing meetings already attended by the IPC Task and Finish members. This included the Ventilation Task and Finish Group, PPE Group, VBR, and IPC update meetings with Matrons in attendance, with appropriate escalation to existing CRG and IMT meetings. As the IPC BAF was updated nationally, the required changes and amendments were completed internally,

with the document presented via the IPCWG to the IPCC, and to follow the established governance pathway to Trust Board.

The ICNs have worked closely with the divisions and Clinical Site Coordinators around COVID-19 management. All newly identified COVID-19 positive cases for inpatients were discussed at the VBR meetings. This group is chaired by the Deputy DIPC, with core attendance including Consultant Microbiologists, ICNs, Occupational Health Lead/Advisor and divisional representatives. All cases are reviewed to ensure the correct management and classification of positive cases; the management of any identified patient contacts; and consideration of any potential links between positive cases. The numbers of staff positive cases are also reported to the VBR group, with a similar process of scrutiny applied to the details presented by the Occupational Health team. Any matter deemed to require escalation from the VBR group are taken by the Chair to the IMT meeting.

At the start of quarter 4 of 2021/22, the timeframe for the isolation of COVID-19 contacts was reduced to 10 days post exposure. This was a Bath and North East Somerset (BANES), Swindon and Wiltshire (BSW) system agreed risk-based assessment decision to alleviate the impact of bed closures across the region for COVID-19 management. In addition, the Trust set out a further risk-based approach to the mixing of COVID-19 contact patients if required for the management of patient flow and safety in extreme pressure situations. Later during the quarter, a similar process was employed for the risk assessment of de-isolating COVID-19 contact patients at 7 post exposure (provided set criteria were met). This aided the release of available beds to enable patient flow and increase capacity.

IPC guidance has continued to evolve throughout the pandemic, with several key documents being published during quarter 1 of 2022/23 by UKHSA. This has included new COVID-19 pathogen specific advice for health and care professionals and a National Infection Prevention and Control Manual (NIPCM) for England. All healthcare settings should now be transitioning back towards their own pre-pandemic policies however, it is recognised that there may be a period of transition as the Trust makes changes to SOPs, dependent on local variation in COVID-19 infection levels.

5.2 COVID-19 outbreak prevention and management

During 2020/21, updates to the outbreak management and reporting iRespond card were completed to reflect the changes to external reporting requirements. This included an amended definition of an outbreak for all communicable diseases in addition to COVID-19. The aim of the card continues to ensure that the Trust implements a rapid and well coordinated response to an outbreak of COVID-19 infection, in line with requirements set out in the South West Regional COVID-19 Healthcare Setting Outbreak Framework. The roles and responsibilities of all individuals and departments involved in outbreak management are clearly defined, making efficient use of available resources in order to limit the spread of infection and minimise the disruption of clinical services.

It was necessary for the Trust to implement the planned outbreak response process during 2021/22, with the declaration of 14 COVID-19 outbreaks (13 for inpatient areas within the medical and surgical divisions and one staff outbreak):

- **Pitton Ward** (Acute Frailty Unit) declared on **20th April 2021**, with positive results for 4 patients and no staff member linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 24th May 2021.
- **Spire Ward** (Care of older persons) declared on **8th October 2021**, with positive results for 4 patients and 3 staff members were linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 11th November 2021.
- **Redlynch Ward** (Gastroenterology) declared on **14th January 2022**, with positive results for 12 patients and 7 staff members were linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 22nd February 2022.
- **Pitton Ward – 2nd outbreak** declared on **19th January 2022**, with positive results for 39 patients and 12 staff members linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 20th April 2022.

- **Amesbury Suite** (Trauma and Orthopaedics) declared on **25th January 2022**, with positive results for 4 patients and 3 staff members were linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 28th February 2022.
- **Longford Ward** (Spinal Injuries Unit) declared on **27th January 2022**, with positive results for 12 patients and 4 staff members were linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 16th March 2022.
- **Endocrinology Team** declared on **8th February 2022**, with positive results for 4 staff members linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 7th March 2022.
- **Spire Ward – 2nd outbreak** declared on **8th February 2022**, with positive results for 13 patients and 2 staff members were linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 25th March 2022.
- **Breamore Ward** (Stroke Rehabilitation) declared on **18th February 2022**, with positive results for 13 patients and no staff members were linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 25th March 2022.
- **Durrington Ward** (Acute medical) declared on **22nd February 2022**, with positive results for 21 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 20th April 2022.
- **Redlynch Ward – 2nd outbreak** declared on **3rd March 2022**, with positive results for 21 patients and no staff member linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 11th May 2022.
- **Whiteparish Ward** (Endocrinology) declared on **11th March 2022**, with positive results for 7 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 20th April 2022.
- **Tisbury CCU** (Cardiology) declared on **25th March 2022**, with positive results for 14 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 27th April 2022.
- **Breamore Ward – 2nd outbreak** declared on **25th March 2022**, with positive results for 17 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the ICNs on the external reporting system on 11th May 2022.

For these outbreaks, the Outbreak Management Group (OMG) was formed with review meetings held throughout. The meetings were well attended by all required individuals and departments within the Trust and by representatives from PHE and BSW CCG. The OMG ensured that appropriate arrangements were in place to care for the affected patients and staff, instigating and monitoring the effectiveness of the control measures implemented in containing the spread of infection. The impact on service delivery was constantly reviewed, with communication to all relevant groups, including patients, relatives, carers and staff completed as appropriate. The production and distribution of meeting notes and actions was undertaken by the ICNs.

The outbreaks were reported externally to the NHS Outbreak System on the Insights Platform (NHS England & NHS Improvement) within the expected reporting timeframes (within 24 hours of declaration). Updates were reported on the same system when additional cases were identified and/or following an outbreak management review meeting. A further notification was made on the same system at the ending of an outbreak, defined as when there had been no confirmed cases with onset dates in the 28 days since the last positive result.

For the declared COVID-19 outbreaks, application of the national COVID-19 case definitions to these 181 patient cases classifies 100 as hospital onset; definite healthcare associated. The Trust recognises that where any infections are classified as hospital onset healthcare associated then there is clearly scope for learning, and that this is the same for COVID-19 infections.

5.3 Norovirus (viral gastroenteritis)

During 2021/22, the Trust has experienced a fairly consistent level of activity associated with patients experiencing diarrhoea and vomiting. This included patients admitted with symptoms of diarrhoea and/or vomiting and isolated in a sideroom from admission, and patients who were nursed in a bay environment and developed symptoms during their admission period.

During quarter 4 of 2021/22, the Trust declared four outbreaks of viral gastroenteritis (Norovirus), from 11th to 24th March 2022, following the closure of 3 wards initially within the medical and surgical divisions (Pitton, Redlynch and Britford Wards). A total of four wards were affected with bay closures/ward closures during the declared outbreak. These closures ensured the safe management of patients and continued service provision. The Trust Norovirus Outbreak Management policy was followed with the appropriate internal and external personnel involved.

The DIPC has commissioned the divisions to undertake a clinical review for these events which will be completed during quarters 1 and 2 of 2022/23, with a final report detailing recommendations and identified actions to be written.

6. MANDATORY SURVEILLANCE

Alert organism and alert condition surveillance data is collected and used by the Trust to detect outbreaks and monitor trends. It is a mandatory requirement for NHS Acute Trusts to report Methicillin Resistant *Staphylococcus aureus* (MRSA) and Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias, and *Clostridioides difficile* infections to the Department of Health (DH) via the HCAI Data Capture Site (DCS) system, hosted by UKHSA (*Mandatory enhanced MRSA, MSSA and Gram negative bacteraemia, and Clostridioides difficile infection surveillance Protocol (version 4.3) updated January 2020).*

6.1 Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias

During 2021/22, there have been no hospital or community onset MRSA bacteraemia cases reported by the Trust. The Trust's MRSA hospital onset case target for 2021/22 is zero.

From the Model Hospital Benchmarking Data for MRSA bacteraemias, the NHS England Model Health System metrics show for 2021/22 the Trust is within the lowest 25% in quartile 1 (provider value 0.00), with peer median value recorded as 0.60 in quartile 2 and the national median value recorded as 0.71.

6.2 Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias

During 2021/22, there have been 12 unrelated hospital onset MSSA bacteraemia cases, where the sources of infection were identified as:

- Skin or soft tissue (3 cases)
- Pancreatitis (1 case)
- Endocarditis (2 cases)
- Central venous catheter (CVC) associated (1 case)
- Unknown/unclear source (5 cases).

Post infection reviews were completed by the ward teams, with one of these infections associated with a vascular access device. The review highlighted the requirement for ensuring completion of documentation and other practice audits (as appropriate).

Of note: Currently, there is no national guidance for data definition of MSSA bacteraemia cases for reduction targets to be set. UKHSA are collating data which may act as a baseline for trajectory setting in the future. Therefore, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the MSSA bacteraemia cases recorded within the Trust. This allows the cases to be classified as either hospital onset or community onset.

6.3 Gram-negative organism bloodstream infections (GNBSIs)

The increase in gram negative organism bacteraemia infections is a national concern and mandatory surveillance of *Escherichia coli (E.coli), Klebsiella species (spp.)* and *Pseudomonas aeruginosa* bacteraemias continues. This reporting at the Trust now requires enhanced investigation and data entry onto the UKHSA DCS website. This work is undertaken by the ICNs.

A national action plan ‘Tackling antimicrobial resistance 2019 – 2024’ (January 2019) advises that work should continue to reduce healthcare associated GNBSIs, adopting a systematic approach to

preventing infections and delivering a 25% reduction by 2021/22 with a full 50% reduction by 2023/24.

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

Of the 26 hospital onset cases identified during 2021/22, an unknown or no underlying focus of infection was identified for 7 cases, and the remaining 19 cases had a source of infection identified. Of these unrelated 19 cases, the sources of infection were:

- Hepatobiliary (3 cases)
- Lower urinary tract (9 cases)
- Gastrointestinal or intra-abdominal collection (1 case)
- Skin/soft tissue (1 case)
- Upper respiratory tract (1 case)
- Bone and joint (no prosthetic material) (1 case)
- Intravascular device (1 case)
- Lower respiratory tract (2 cases).

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

The Trust's *E.coli* case threshold for 2021/22 is no more than 27 healthcare associated cases (*as detailed in the Official NHS Standard Contract 2021/22 document (version 1) published 12th July 2021).*

6.3.2 *Klebsiella spp.* and *Pseudomonas aeruginosa*
During 2021/22, there have been a total of 10 hospital onset *Klebsiella spp.* bacteraemia cases and 8 hospital onset *Pseudomonas aeruginosa* bacteraemia cases.

The Trust's *Klebsiella spp.* case threshold for 2021/22 is no more than 9 healthcare associated cases and for *Pseudomonas aeruginosa,* no more than 7 healthcare associated cases (*as detailed in the Official NHS Standard Contract 2021/22 document (version 1) published 12th July 2021).*

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

6.4 *Clostridioides difficile (C.difficile) Infection*
The control of this infection is managed by the combination of adherence to the correct infection control practices, environmental cleaning, equipment decontamination and prudent antibiotic stewardship.

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

For 2021/22, the *C.difficile* case threshold objective set for the Trust by NHS England (NHSE) and NHSi is no more than 22 healthcare associated reportable cases. All Trust thresholds are derived

from a 2019 calendar year baseline, to avoid capturing changes related to the pandemic and include healthcare associated cases only. Guidance for testing and reporting *C.difficile* cases remained unchanged and the safety and care of patients remains our concern and priority.

Of note: we are unable to provide any Model Hospital Benchmarking Data for C.difficile as the NHS England Model Health System metrics have not been updated since March 2019.

During 2021/22, the Trust has reported 34 healthcare associated *C.difficile* cases to UKHSA, of which 12 cases were community onset and 22 cases were hospital onset. Incident investigations are carried out for all hospital onset cases using a 'SWARM' approach. This process is facilitated by the ICNs with the relevant Clinical Leader and divisional Matron to assess whether there were any lapses in quality care provided to the patient and whether this contributed to the case. In addition, the ICNs review the community onset cases to establish whether any lapses in care occurred during their previous hospital admission (in the preceding 4 weeks).

Due to lapses in care identified from the incident reviews, no healthcare associated *C.difficile* cases have been identified for submission to the relevant CCGs for the Appeals Process Panel. From the completed incident investigations for the hospital onset cases, lapses in care were identified. Key learning has included improvements required for the use of the Diarrhoea Pathway, timeliness of sampling symptomatic patients, and timeliness of clinical reviews for these patients.

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

Representatives from the Trust were involved in the South West Regional HCAI *C.difficile* infection improvement collaborative event held during quarter 2 of 2021/22. The aim is to reduce harm to the population of the South West Region from *C.difficile* infection and share wider learning, with outcomes fedback to the DIPC and IPCWG.

6.4.1 Periods of increased incidence (PII) of *C.difficile*

During 2021/22, four unrelated PIIs of *C.difficile* were declared within the medical and surgical divisions for four separate wards (Redlynch, Spire, Whiteparish and Odstock Wards). The required incident investigations were completed for the positive cases with the involvement of relevant personnel. Further measures were also implemented across the areas, including additional environmental cleaning by Housekeeping and extra audits and monitoring of practices, overseen by the relevant senior staff including the Head of Nursing (HoN) and Matrons.

During quarter 2 of 2021/22, the PII was extended for Spire Ward following the identification of two further hospital onset reportable cases of *C.difficile.* To date, the ribotyping results have all been different. However, it has been acknowledged by the Consultant Microbiologists that not all samples identified to be sent for ribotyping were retained by the Laboratory. This was investigated by the Laboratory Manager and processes reviewed and updated.

From the samples sent for ribotyping, the ICD noted there were no similarities apart from 2 samples related to patients from Odstock Ward (during quarter 3 of 2021/22). These samples were sent to the External Reference Laboratory for enhanced fingerprinting analysis which confirmed they were not the same type and therefore not related.

At the request of the IPCWG, all ribotyping results from 2021/22 were reviewed by the ICD with final reporting to the DIPC, with no outbreaks declared retrospectively.

Please see Appendix B for the Infection Prevention & Control 'Dashboard' of 2021/22 for further detail of HCAI data.

6.5 NHS Standard Contract 2022/23

Table 1 below shows the threshold levels for the Trust's count of healthcare associated (i.e. hospital onset healthcare associated (HOHA) and community onset healthcare associated (COHA)) cases for 2022/23 (*as detailed in the Official NHS Standard Contract 2022/23 document; Minimising Clostridioides difficile and Gram-negative bloodstream infections (version 1) published 27th April 2022).*

Organisation code	Name	Case thresholds for 2022/23			
		C.difficile	*E.coli*	*P.aeruginosa*	*Klebsiella spp.*
RNZ	Salisbury NHS Foundation Trust	23	35	12	14

(Table 1)

6.6 Surgical Site Infection Surveillance (SSIS)

The ICNs coordinate data collections for the national SSIS programme of various surgical procedures, which are applicable to the Trust. For the mandatory surveillance of SSI following orthopaedic surgery, Trusts must participate in a minimum of one surveillance period in at least one category of orthopaedic procedures during a financial year. The Trust complies with this annual requirement to undertake SSIS.

Final data collection for quarter 4 of 2020/21 was reconciled within the required timeframe set by UKHSA. There were a total of 47 cases entered onto the national database, with one deep infection (organ/space) identified. This was followed up with the Consultant for the patient, who reviewed the case identifying nothing unexpected and with no clear trends. Active data collection for the category of repair of fractured neck of femur (NOF) surgery has continued from quarter 4 of 2020/21 into quarter 1 of 2021/22, to ensure than an extended cohort number of cases is attained.

- From the data collected during quarter 1 of 2021/22, a total of 63 cases were entered onto the national database with 49 cases reconciled within the required time frame set by UKHSA, with one deep infection (organ/space) identified. This was followed up with the Consultant for the patient, who reviewed the case identifying nothing unexpected and no clear trends, and fedback to the Mortality and Morbidity meeting for the orthopaedic specialty. This case was also discussed at a Patient Safety Summit meeting at the request of the Lead ICN and Risk Department.
- Data collection continued in quarter 2 of 2021/22, with a total of 47 cases entered onto the national database and reconciled within the required time frame set by UKHSA, with no infections identified.
- Data collection continued in quarter 3 of 2021/22, with a total of 56 cases entered onto the national database and reconciled within the required time frame set by UKHSA, with one deep infection (organ/space) identified. This was followed up with the Consultant for the patient, who reviewed the case identifying nothing unexpected and with no clear trends.
- Data collection continued in quarter 4 of 2021/22, with final records to be entered onto the national database and submitted for reconciliation by the end of quarter 1 of 2022/23.

Formal reports outlining progress with SSIS have been presented at the IPCC meetings and disseminated to relevant Trust personnel.

The IPCT have requested that the orthopaedic team complete a review of the NICE guideline (NG125) for Surgical site infections during quarter 1 of 2022/23 to provide additional assurances around pre-operative, intra-operative and post-operative practices in reducing the incidence of SSI.

6.7 MRSA screening

The Trust has continued to report MRSA screening rates for all elective and emergency admissions to ensure continued improvement in reducing infections. These screening compliance rates are monitored by the Divisional Management Teams (DMTs) and reported as a KQPI. The

ICNs undertake a monthly emergency admission MRSA screening audit, and a quarterly elective admission MRSA screening audit.

Feedback is provided to DMTs about compliance rates and any identified missed screens for follow up actions. For 2021/22, the Trust compliance rates for MRSA emergency screening ranged from 89.26% - 95.85%. For MRSA elective screening, the Trust compliance rates ranged from 58.62% - 81.82%. However, it must be acknowledged that the number of elective patients within one of the elective screening cohorts was exceptionally small.

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

6.8 Infection in Critical Care Quality Improvement Programme (ICCQIP)
From April 2017, the Trust has participated in the surveillance of bloodstream infections in patients attending the Intensive Care Unit (ICU) and Neonatal Unit (NNU). From the data submitted so far, report updates have been provided by PHE and cascaded to the area leads.

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

From the data provided to the ICNs for review, there have been no externally reportable infection alert organisms identified for this patient group during 2021/22.

7. HAND HYGIENE

Fifty-three areas (including wards and departments) across the four clinical divisions carry out a monthly audit of hand hygiene compliance in their area against the World Health Organisation's (WHO) '5 moments for Hand Hygiene'.

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

Due to the ongoing COVID-19 pandemic, there have been no audits completed by the external auditor during 2021/22. However, the clinical divisions have been continuing to undertake cross auditing within their areas and specialities to further validate the audit process.

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

For the internal hand hygiene audits completed, the overall average compliance rate for 2021/22 ranges from 62.98% - 100%. It should be noted there had been an initial improvement with areas completing these audits. However, there has been a fluctuating rate of non-completion/non-return

of audits from areas since quarter 3 of 2021/22, which has reduced the overall average compliance score.

The 'Red, Amber and Green' (RAG) rating for the hand hygiene compliance audits continues and includes actions to be identified for areas that do not achieve the 'pass threshold' of 85% or show improvements. This RAG rating was further revised and the impact of these measures being monitored by the IPCWG, DMTs and Patient Led Assessment in the Clinical Environment (PLACE) Steering Group.

8. ANTIBIOTIC STEWARDSHIP

The Antimicrobial Reference Group (ARG) have experienced several challenges this year as the Antimicrobial Pharmacist post has been vacant since July 2021. Antimicrobial Stewardship (AMS) ward rounds are still going ahead with Dr Flanagan, Consultant Microbiologist, accompanied by the Antimicrobial Pharmacy Technician, Rebecca Stonell. Regular visiting of all clinical ward areas is positively reinforcing AMS and the multidisciplinary teams (MDTs) appear much more confident in approaching Dr Flanagan for help and advice.

8.1 Commissioning for Quality and Innovations (CQUINs) for 2021/22

All CQUINs were held for 2021/22. However, the Antimicrobial/CQUIN Pharmacy Technician continues to collect data as a Quality Improvement Project which also includes catheter associated urinary tract infections (UTIs) for the first time. This has shown an increase in the number of UTI patients treated as per national guidance which will in turn reduce inappropriate antibiotic prescribing and antimicrobial resistance. We have been informed by the Regional Lead that a CQUIN for all UTIs will recommence in April 2022. The work done has now managed to attain an overall compliance of 73% for quarter 1 and 70% compliance for quarters 2 and 3 of 2021/22. Quarter 4 data should be available in quarter 1 of 2022/23 as the audit has now closed.

8.2 Total antibiotic consumption

Reducing total antimicrobial usage has now become part of the NHS contract. Our target is to reduce antimicrobial use by 2% every year. Our in-house 12 monthly figures show a 1.75% reduction in antimicrobial usage compared to our 2018 baseline target. Although this does not quite meet the target this is the first time we have seen a decrease in antimicrobial consumption and is a great achievement. This decrease is thought to be due to the initiation of antimicrobial ward rounds and greater awareness of antimicrobial resistance through continued training across the Trust.

8.3 Action plan for 2021/22

The CQUINs for 2021/22 were held due to the ongoing pandemic. However, a new CQUIN started in April 2022 to include all UTIs in patients over 16 years. The Quality Improvement work that is ongoing is anticipated to put us in a good position to do well. Target compliance for this CQUIN is between 40-60% and although it is still unknown if a financial incentive will be attached to this CQUIN, we are confident that the previous work puts the Trust in a good position.

The Antimicrobial Pharmacy Technician has already made some links and educational plans for the junior doctors and anticipates running some much needed lunch time sessions in the near future. A Trust grade doctor has also been delivering some training and the Antimicrobial Pharmacy Technician is hoping to run a collaborative session involving both Pharmacy and junior doctors.

8.4 Ongoing challenges

We will continue our weekly antimicrobial stewardship ward rounds as these have had a significant impact in ensuring compliance with the Trust's anti-infectives guidelines and reducing inappropriate use of antibiotics. A Lead Antimicrobial Pharmacist has been recruited to join the team and is anticipated to start in the Trust during quarter 1 of 2022/23 (June 2022), and much anticipated clinical audits of ward areas can hopefully restart soon after.

9. AUDIT

The ICNs have not undertaken any formal policy audit during 2021/22 but have been actively involved in supporting identified clinical areas to complete the Tendable inspections *(formerly Perfect Ward Application)* for infection prevention and control. This process ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust. *Of note: these inspections include policy practice standards as part of audit criteria.*

Any observations/findings are fedback verbally to the clinical leader/nurse in charge at the time with instruction to access the results report to identify any required actions. The results are also available for the HoN and Matrons to access (via the application), with formal reports fedback via the PLACE Steering Group. (*Completion of these audits has been in addition to the 'spot checks' and observational practice audits undertaken by the ICNs during daily clinical visits to ward areas*).

The HoN, Matrons and clinical leaders also complete the additional Tendable quick COVID-19 assessment inspections within identified clinical areas. These focus on monitoring and assurance around a number of measures, including signage, provision of hand hygiene opportunities, provision of PPE and observations of PPE practices, and adherence with the relevant COVID-19 pathway in the area. It also includes the questioning of staff around COVID-19 symptoms for patients and staff and the resulting actions indicated, isolation and decontamination practices, and demonstrating awareness of visiting guidance and how to escalate any staffing concerns. When required, the ICNs have continued to support the areas and staff with addressing any concerns arising from these inspections. For 2021/22, the overall average IPC compliance scores reported have ranged from 87.1% – 98.63%.

Please see Appendix C for further details, the results continue to provide transparency across a number of IPC indicators at practice level.

10. EDUCATION AND TRAINING ACTIVITIES

Education and training continues to be an important part of the work of the IPCT. Mean compliance scores for 2021/22 were 72.08% for staff completion of hand hygiene assessments and 91.16% for staff completion for IPC computer-based learning (CBL) package *(monthly MLE data accessed).*

The low hand hygiene assessment compliance is an ongoing concern and may be attributed to the access opportunities for staff due to the COVID-19 pandemic. In response, the ICNs have continued to focus on the promotion of different working opportunities for staff to complete their hand hygiene assessment. This has included arranging extra sessions within specific work areas and enabling identified staff to be trained to undertake hand hygiene assessments. Furthermore, the clinical divisions facilitated the completion of hand hygiene assessments for staff by utilising an ultra-violet (UV) light box for rotation through their divisional areas and departments. In addition, the ICNs are working with the Education Department to improve compliance for staff completing these mandatory training modules.

During March 2022, the DIPC requested a review of the method currently used for assessing hand hygiene technique to simplify the process and improve compliance. It has been agreed to trial an alternative process with one of the clinical wards reporting a low compliance, with the support of the Practice Education Team. This work will be progressed during quarter 1 of 2022/23 with outcomes reported via the IPCWG.

The ICNs have contributed to formal and informal teaching sessions within clinical areas and other Trust departments. Several of the core infection prevention and control sessions have been delivered for different staff groups, in addition to specific topic requests. The ICNs have also met with small groups and teams or on a one-to-one basis, to provide guidance and aid improved understanding of policies and practices. There has been a continued focus on promoting learning through the daily clinical visits undertaken by the ICNs.

There has been a delay in the Trust implementation of the national programme *'Every Action Counts'* due to the IPCT nursing vacancy and the ongoing COVID-19 workload impacting roll out.

Formal 'virtual' meetings with the Infection Control Link Professionals (ICLPs) group were recommenced during quarter 2 of 2021/22. Communications via e-mail and through discussions with various ICLPs as part of both routine and additional visits undertaken by the ICNs to clinical and non-clinical areas have continued. Details of education opportunities provided are available from the ICNs.

11. DECONTAMINATION

11.1 Key Success stories in 2021/22

We have concluded the upgrade of our automated cleaning system (Trophon) in Radiology and Obstetrics & Gynaecology Outpatients, with the training and roll out of five new devices. These have been introduced using a managed service contract which ensures software updates or system improvements are included during the lifetime of the contract, without further outlay for the Trust.

All six Dry Storage Cabinets (DSCs) are now fully functional in Endoscopy. This has resulted in a significant increase in storage capacity (from 24 to 60 scopes), longer validated storage times (from three to fourteen days) and the ability to safely store our newer scope range (previously incompatible with the old cabinets) preferred by clinicians for patient treatment. There have been challenges when the servicing was due as each cabinet must be taken out of use in turn. The increased number of cabinets caused significant disruption to both clinical and reprocessing teams, ultimately disrupting patient lists. Quarterly servicing is a Health Technical Memorandum (HTM)01-01 requirement so a way to make the process less disruptive was required.

At each quarterly service this year, the process has been reviewed and revised, including establishing a process for notification of the operational status of the individual shelves in each cabinet to both clinical and re-processing teams. The process during servicing at the end of quarter 4 of 2021/22 was improved and less disruptive but will continue to be monitored and amended if required.

The Decontamination Lead received notification of potential Creutzfeldt-Jakob disease (CJD) patient. Although the diagnosis was quickly excluded, the Decontamination Lead continued to undertake a 'look back' exercise to pro-actively test our ability to track and trace instrumentation. There were areas of positive assurance identified, but also opportunities for future discussion in order to clarify processes, acknowledge and agree our limitations and explore options to facilitate the process in future linked with electronic record keeping.

11.2 Progress on actions during 2021/22

Decontamination audits were reintroduced during quarter 2 of 2021/22 in a new format. Areas previously audited were limited to departments which undertook their own local decontamination of specialist equipment. The Decontamination Lead has extended the audit schedule to include general ward areas, enabling identification of aspects previously overlooked. This captures wider evidence of local decontamination processes for general equipment, providing assurance for the IPC Board Assurance Framework, Section 2.15. The new audit format also captures reviews of SOPs at the same visit, rather than a separate schedule, offering a more cohesive approach.

Unfortunately, not all areas were completed by year end, partly due to operational pressures and conflicting priorities during quarter 4 of 2021/22. Compliance will continue to be monitored at the Decontamination Working Group and there are plans to include the audits as part of the 'Tendable' app in future.

The Authorised Engineer (Decontamination) (AE(D)) continues to visit and support the Trust whilst the Authorised Person (Decontamination) post remains vacant. The Estates Team continues to work on appointing to vacant posts. The AE(D) provided an audit report during quarter 3 of

2021/22, identifying areas for improvement and actions from this will be monitored at the Decontamination Working Group.

Work to review High Level Disinfection (HLD) of invasive ultrasound probes Trustwide continues. Whilst the work in Radiology and Obstetrics & Gynaecology is completed, the desire to find a suitable automated solution for Fertility Clinic progresses, though intermittently. An alternative device has been identified for further exploration and potential trial. Depending on the outcome, other clinical areas may also benefit.

Work commenced to review the contract between the Trust and our sterile services provider because the existing contract did not reflect current arrangements. This exercise has been undertaken jointly with the current provider and given both teams opportunity to evaluate what is required and improve governance arrangements. There is still no date for commencement of the refurbishment work.

11.3 Key challenges for quarters 1 and 2 of 2022/23

- Continue to work with the Fertility Clinic to review HLD of their invasive ultrasound probes and support a transition towards Best Practice using an automated system.
- Work to support the surgical division to meet their future requirements for scope storage within surgery (bronchoscopes) and urology (cystoscopes).
- Take forward the learning points from the CJD 'look back' exercise.
- Ensuring progress against workplans and actions in aspects of 'business as usual' activity, against a backdrop of continued operational pressures which challenge priorities.

12. CLEANING SERVICES

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

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

The Trust is drafting (with ward leaders) a programme of PLACE audits to commence from June 2022 following a suspension of these audits from June 2020 in ward areas. We plan to undertake approximately 60 internal PLACE audits over the coming year.

The result of each PLACE assessment is submitted to the Health and Social Care Information Centre using the PLACE Lite tool and discussed with ward leaders at the monthly PLACE Steering Group. To support social distancing and to minimise footfall within clinical areas the number of participants in PLACE inspections will be limited, with limited Governors or Volunteers present.

12.2 National PLACE

We have been informed by NHSi that this year's National PLACE inspection will be taking place between September 2022 and January 2023.

12.3 Deep clean programme/rapid response team

The deep clean programme commenced in May 2021 and was fully completed at the end of April 2022 with every bedspace and sideroom completed. The 2022/23 deep clean programme will commence on the 1st May 2022 *(a copy of the Deep Clean programme is available from the Housekeeping Department).*

12.4 Improvement Work Over the past 6 months

To support the Trust's COVID-19 response the Housekeeping Team is still providing a 24 hour service with a small cleaning team on site out of hours. We are currently funding this out of existing Housekeeping Department budgets and will continue to review with a desire to scale this back as hospital activity allows.

Below are tables from the past 3 years indicating the increased activity during the pandemic.

2021/22 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTIONS	1076	934	850	1106	1105	1127	1180	1114	1386	1322	1436	1807	**14443**
ENHANCED HRS	67.75	67.50	50	66.5	70.75	70.25	73.50	71	65.50	86.50	124.75	113.75	**927.75**
DOUBLE CLEANS HRS	104	84.75	79.5	88.0	93.25	60.50	44.75	35.75	50.50	91	51	65.75	**846.75**
BIOQUELL	39	40	38	61	56	49	36	35	60	40	38	51	**543**

(Table 2)

2020/21 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTIONS	1564	1726	1558	1408	1121	1180	1200	1304	1575	2589	1694	1341	**18260**
ENHANCED HRS	38.5	48.25	47.5	72.25	95	56	53.75	96.5	105.5	102.25	65.25	57	**837.75**
DOUBLE CLEANS HRS	4.5	0	40.25	82.25	60.25	77.5	105	149.5	140.25	0	26.25	27	**712.75**
BIOQUELL	30	29	37	62	36	42	39	30	50	10	58	50	**473**

(Table 3)

2019/20 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTIONS	521	720	519	670	589	528	612	650	937	647	604	1189	**8186**
ENHANCED HRS	55	90.75	68.5	91.75	74.25	79.75	87.75	94	122	92.75	95	70	**1021.50**
DOUBLE CLEANS HRS	75	50.25	73	61.75	69	85.5	76.50	39.25	47	60.75	54.75	28.75	**721.50**
BIOQUELL	37	58	53	43	46	42	58	35	66	35	23	30	**526**

(Table 4)

12.5 Successes from the past 12 months

The Housekeeping Department were awarded “Team of the Year (Non-Clinical)”, which was gratefully received and a boost to the morale following a tough 12 months.

Housekeeping have procured an additional hydrogen peroxide vapour (HPV) decontamination machine to help support good infection control measures and patient flow.

Housekeeping was successful in purchasing a new ride on corridor floor machine after submitting a capital bid (with delivery due May/June 2022).

12.6 Challenges for the coming 6 months

Housekeeping will continue to review the new National Cleaning Standards including key elements, task lists, risk categories, audit requirements and any cost pressures associated to any changes. A paper is being prepared to scope out the recommendations; changes required and associated costs, to implement the new cleaning standards.

Recruitment remains a challenge due to a reduction in applicants and the incentives associated with clinical posts (HCSW). The Housekeeping Team is working with the Trust’s Recruitment Team to further support the recruitment of Housekeeping staff.

13. WATER SAFETY MANAGEMENT

This section summarises the water safety management precautions that the Trust has taken over 2021/22.

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

To assist the management process in respect of the water systems across the site, regular meetings of teams (RP and dRP water) from ETS and FES Ltd (PFI maintenance contractor) are held on a monthly basis, to review progress with PPM's and actions in respect of Water Safety.

13.1 Legionella

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

Emergency review meetings (see Table 5 below) for Legionella (listing counts reported >1000 cfu/l) and high counts for *Pseudomonas* (Table 6) have taken place in the Trust as a result of the sample results). The actions and results of the ongoing checks have been circulated to senior members of the Trust in a series of e-mails as events occur, and as regular reports to the WSG and IPCC. Actions taken have included the cleaning and disinfection of outlets, with temperature checks and increased flushing where necessary.

Legionella						
	Ward/ Department	LG Ref	Location	Action plan	Test result as of 26/04/2022	
					Pre	Post
1	Sarum Ward	07	4.05.02	Outlet back in use and resampled.	560	80
2	Breamore Ward	27 + 28	WHB far end of ward	Outlet back in use, PAL fitted, remedial on systems required.	4600	4800
3	Emergency Department	33	Majors cubicle 11	Outlet left in use, PAL filter fitted. Additional sample to be taken for Cubicle 9.	400	1200
4	Block 67	51	WHB 67.21	Outlet in use, PAL fitted, additional samples for showers clear. Plans to replace pipework agreed, dates to be confirmed for these works.	50,000	20
5	Tisbury CCU	112	Bay 2 WHB	Outlet left in use, PAL fitted.	800	1800
6	Tisbury CCU	113	Bay 4 WHB	Outlet left in use, PAL fitted, carry out additional flushing and sample shower in Rm 4.01.22	1000	120
7	Whiteparish Ward	114	Bay 2 WHB	ETS to complete additional flushing of outlet and resample	1000	20
8	Block 05	119 (IVF)	Room 6 WHB	Outlet tap replaced, additional samples required.	4000	20
9	Main switchboard		Kitchen	Outlet back in use with PAL fitted, works required on system, fed from Sector 04.	25000	16000

(Table 5)

13.2 Pseudomonas Sampling

Live counts are being managed on Sarum Ward and Odstock Ward, the latest actions and results from resampling as listed on Table 6 below.

Pseudomonas						
	Ward/ Department	PS Ref	Location	Action plan	Test result as of 26/04/2022	
					Pre	Post
1	Sarum Ward	109	4.06.09	Clean, disinfect and resample.	50	1
2	Sarum Ward	114	4.06.12	Clean, disinfect and resample.	14	1
3	Sarum Ward	108	4.06.08	Clean, disinfect and resample, PAL fitted.	>100	>100
4	Odstock Ward	171	S/C 4.11.07	Remedial works required. PAL fitted.	>100	
5	Odstock Ward	197	SHW 4.11.20	Remedial works required, PAL fitted.	>100	
6	Odstock Ward	200	SHW 4.11.21	Remedial works required, PAL fitted.	>100	
7	Odstock Ward	209	SHW 4.11.29	Remedial works required, PAL fitted.	>100	
8	Odstock Ward	216	SHW 4.11.33	Remedial works required, PAL fitted.	>100	
9	Odstock Ward	228	SHW 4.11.43	Remedial works required, PAL fitted.	>100	
10	Odstock Ward	231	SHW 4.11.41	Remedial works required, PAL fitted.	>100	
11	Odstock Ward	235	SHW 4.11.43	Remedial works required, PAL fitted.	>100	
12	Odstock Ward	241	SHW 4.11.51	Resample pre and post.	1	ND

(Table 6)

13.3 Achievements for 2021/22

- Water Safety Audit completed on the 14th of July based on NHS Premises Assurance Model SAQ SH 8. An action plan is being developed from the recommendations from the Audit.
- Completion of routine Legionella and *Pseudomonas* testing and development of subsequent action plans.
- Maintenance and monitoring of the temperature of the main circulated hot and cold water systems across the SFT Estate.
- A new hot water generation system has been installed (funded via the SFT Capital) in SDH North. This has replaced the calorifiers (hot water storage) that were installed in 1992. The new generation (plate heat exchangers) will ensure that the temperature of the hot water systems is maintained, is more efficient and will reduce the energy required for the generation of hot water.
- A complete site risk assessment (RA) of the hot and cold water systems was completed by external consultants in January/February 2022. This survey will inform the Trust of all risks associated with the generation, storage and distribution of water systems within the Trust and will identify actions required with the level of risk associated with defects with the systems.
- The flushing compliance for clinical areas for quarters 3 and 4 of 2021/22 is 78% for Priority 1 areas and 92.4% for Priority 2 areas.
- Good temperatures have been maintained for the hot water systems across the site, this in general is as a result of significant investment new plant in the last 5 years.

13.4 Key Focus for quarters 1 and 2 of 2022/23

- Maintaining the temperature of the hot and cold water systems across the Trust.
- Progressing testing programme for Legionella and *Pseudomonas*.
- Follow up works from action plans associated with high Legionella and *Pseudomonas* testing e.g. removal of dead legs, etc.

- Maintaining levels of flushing compliance for clinical areas across the Trust.
- Develop action plan and secure funding for remedial works identified from the site RA completed by Water Hygiene Centre in quarter 4 of 2021/22.

14. CONCLUSION

This annual DIPC Report has provided the Trust Board with evidence of the measures in place that have made a significant contribution to improving infection prevention and control practices across the Trust. The report has detailed the progress against the Action Plan for 2021/22 in reducing HCAI rates for the Trust.

For quarters 1 and 2 of 2022/23, the key ambitions for the Trust will include:

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

15. ACKNOWLEDGEMENTS

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

- Fiona McCarthy, Lead Nurse, Infection Prevention and Control Team (Sections 1, 2, 3, 4, 5, 6, 7, 9, 10, 14 and 15)
- Louise Whittles, Deputy Chief Pharmacist (Section 8)
- Clare Goodyear, Trust Decontamination Lead and Medical Device Safety Officer (Section 11)
- Michelle Sadler, General Manager, Facilities and Amanda Urch, Head of Housekeeping and Portering (Section 12)
- Terry Cropp, Technical Services Manager, Estates Department (Section 13).

APPENDIX A

Infection Prevention & Control – Annual Action Plan 2021/22

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

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

Domain and Key Actions	Who By	Status
1.4 Duty to provide and maintain a clean and appropriate environment for health care		
Ensure maintenance and monitoring of high standards of cleanliness via policy management and audit, and environmental audits	DIPC/Housekeeping Manager	Monthly
Review schedule of cleaning frequency and standards of cleanliness, making them publicly available	DIPC/Housekeeping Manager/Matrons	Monthly
Ensure adequate provision of suitable hand washing facilities, hand products/alcohol gel and continued implementation of 'WHO - Five Moments' and use of 'CleanYourHands' resources	ICNs	Continuous
Continue IP&C involvement in overseeing all plans for construction & renovation	Head of Estates	Continuous
Ensure effective arrangements are in place for appropriate decontamination of instruments and other medical devices/equipment	DIPC/Decon. Lead	Continuous
Ensure the supply and provision of linen and laundry adheres to health service guidance	Head of Facilities	Continuous
Ensure adherence to the uniform and Bare below the elbow (BBE) policies and workwear guidance through audit and formal reporting via the monthly Matrons Monitoring Group meetings (renamed PLACE Steering Group from quarter 2 of 2020/21).	DIPC/HoNs/Matrons	Continuous
1.5 Duty to provide information on HCAIs to patients and the public **1.6 Duty to provide information when a patient moves from one health care body to another** **1.7 Duty to ensure co-operation**		
Ensure publication of DIPC report via the Trust website	DIPC	6 monthly
Review Capacity Management policy & documentation to ensure communication regarding an individual's risk, nature and treatment of HCAI is explicit	DIPC	Completed
Include obligations under the Code to appropriate policy documents.	DIPC	Ongoing
1.8. Duty to provide adequate isolation facilities		
Continue implementation and monitoring of the Isolation policy and monitoring of practice via audit.	HoNs/Matrons/ IPCT	Ongoing
1.9. Duty to ensure adequate laboratory support		
Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation.	ICD/Microbiologists/ Laboratory Manager	Continuous

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

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

APPENDIX B (April 2021 – March 2022)

		***Clostridioides difficile* - all cases (reportable and not reportable)**			**Bacteraemias - all cases are reportable to UK Health Security Agency (UKHSA, formerly Public Health England)**													
		Sample taken			***MRSA***		***MSSA***		***E.coli***		***Pseudomonas aeruginosa***		***Klebsiella sp.***		**Outbreak declared**	**PII declared**	**Hand Hygiene (mean %)**	**IPC PWA (mean %)**
Clinical Directorates	**Inpatient areas/wards**	Hospital onset; healthcare associated	Community onset; healthcare associated	**No lapses in care**	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	Hospital onset	Community onset	See main repot for details			
Clinical Support & Family Services	Sarum Ward (inc. Children DAU)		1 + 1					1		1			1	1			↑83.13%	↓98.63%
	CS&FS Totals:		**1 + 1**					**1**		**1**			**1**	**1**				
Women & Newborn	Labour Ward							1									↑79.83%	N/A
	Neonatal Unit							1									→100%	N/A
	Post-natal Ward																↓83.34%	N/A
	W&N Totals:							**2**										
Medicine	AMU	1	1 + 2					4	1	8		1		3			↓77.36%	↓96.75%
	Breamore Ward	3							2		2				2 C19		↑83.13%	↓92.03%
	Durrington Ward								1						1 C19		↓62.98%	↓87.31%
	ED (inc. SSEU)						1	15		67		9		12			↑76.44%	↓93.97%
	Farley Ward including RCU	1							1								↑89.87%	↓91.45%
	Hospice Unit								1								↓82.86%	↓93.01%
	Laverstock Ward										1		1				↓77.16%	↓94.22%
	Longford Ward	2					1		1						1 C19		↓98.59%	↑93.92%
	Pembroke Ward	1					1		5				2				↓99.11%	↓94.52%
	Pembroke Suite									1							↑82.41%	N/A
	Pitton Ward	1	1				1		1	1					2 C19; 1 N		↑73.11%	↓88.13%
	Redlynch Ward	2 + 1	1				1		1				1		2 C19; 1 N	04.06.21	↓83.80%	↓87.17%
	Spire Ward	4 + 2							3		1				2 C19; 1 N	21.06.21	↑95.36%	↓94.08%
	Tisbury CCU	1					1						1		1 C19		↓95.13%	↓94.76%
	Whiteparish Ward	1					1		1				1		1 C19	06.10.21	↓89.26%	↓89.57%
	Nunton Unit									2								N/A
	Medicine Totals:	**14 + 6**	**2 + 3**				**7**	**19**	**18**	**79**	**4**	**10**	**6**	**15**				
Surgery	Amesbury Suite	2 + 1													1 C19		↓83.13%	↓87.40%
	Britford Ward including SAU	1 + 1	1						2	4			1		1 N		↓78.94%	↓91.22%
	Chilmark Suite	2															↓81.72%	↓90.85%
	Day Surgery Unit									1							↑63.42%	↑97.54%
	Downton Ward		1							1							↑67.56%	↓90.02%
	Odstock Ward	3					4		1		1					11.11.21	↓92.14%	↓95.46%
	Radnor Ward	2 + 2					1	1	5	1	3		2				↓97.40%	↓95.15%
	Surgery Totals:	**8 + 6**	**1 + 1**				**5**	**1**	**8**	**7**	**4**		**3**					
Additional info: Other C.difficile samples, e.g. GP, Emergency Assessment, SAU, OPD, Mortuary, Private Hospital			**8 + 5**								*1 Private Hospital sample*							

All SFT samples including inpatient and outpatient areas, GP and other e.g. Emergency Assessment *C.difficile* **reportable** cases = **red** *C.difficile* **not** reportable cases = **blue**

Outbreak codes: C19 is COVID-19 outbreak declared, N is Norovirus outbreak declared

Tendable (previously Perfect Ward) scoring:

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

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

Hand hygiene scoring:

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

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

APPENDIX C

Tendable Infection Prevention & Control (IPC) Inspection Compliance scores for Quarters 1 & 2 of 2021/22

Ward/ Dept	Division	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
Sarum Ward	Clinical Support & Family Services	29.04.2021 (91.7%)	10.05.2021 (100%)	25.06.2021 (100%)	30.07.2021 (95.9%)	30.08.2021 (100%)	
Acute Medical Unit	Medicine		06.05.2021 (98%) 28.05.2021 (76.9%) 31.05.2021 (96.2%)	13.06.2021 (96.2%)	07.07.2021 (98.1%)	04.08.2021 (100%)	03.09.2021 (100%)
Breamore Ward	Medicine	26.04.2021 (100%)	23.05.2021 (100%)	21.06.2021 (100%)	06.07.2021 (78.8%)	28.08.2021 (98.1%)	
Durrington Ward	Medicine		05.05.2021 (88.5%) 07.05.2021 (78.8%)		04.07.2021 (94.1%) 22.07.2021 (78.8%)	10.08.2021 (88.7%)	
Emergency Department				08.06.2021 (93.2%)	05.07.2021 (95.7%)	31.08.2021 (95.6%)	
Farley Ward	Medicine	30.04.2021 (92.5%)	31.05.2021 (82.4%)	30.06.2021 (88.7%)	31.07.2021 (98.1%)	31.08.2021 (90.4%)	
Hospice Unit	Medicine	19.04.2021 (100%)	04.05.2021 (92.3%)	04.06.2021 (88.9%) 22.06.2021 (88.6%)	07.07.2021 (91.1%)	04.08.2021 (95.6%)	
Laverstock Ward	Medicine	24.04.2021 (100%)	17.05.2021 (92.5%)	21.06.2021 (82.4%)	02.07.2021 (88.7%)	11.08.2021 (90.4%)	04.09.2021 (100%)
Longford Ward	Medicine	11.04.2021 (96.2%)	13.05.2021 (86%) 31.05.2021 (98.1%)	06.06.2021 (96.2%)	04.07.2021 (100%)	05.08.2021 (96.2%)	08.09.2021 (98.1%)
Pembroke Ward	Medicine	26.04.2021 (98%)	24.05.2021 (94.2%)	25.06.2021 (94.2%)	20.07.2021 (94.2%)	09.08.2021 (100%)	05.09.2021 (96.2%)
Pitton Ward	Medicine	27.04.2021 (82.7%)	13.05.2021 (96.2%)	10.06.2021 (80.8%)	07.07.2021 (92.5%) 07.07.2021 (96.2%)	11.08.2021 (96.2%)	04.09.2021 (90.4%)
Redlynch Ward	Medicine	12.04.2021 (77.1%) 18.04.2021 (96.1%)	16.05.2021 (98.1%)	04.06.2021 (73.1%) 08.06.2021 (100%) 24.06.2021 (74.5%)	09.07.2021 (96.2%)	31.08.2021 (96.2%)	
Spire Ward	Medicine	03.04.2021 (90.6%)	08.05.2021 (96.2%) 24.05.2021 (92.2%)	20.06.2021 (96.2%) 25.06.2021 (96.2%)	05.07.2021 (94.3%)	09.08.2021 (96.2%)	
Tisbury CCU	Medicine	03.04.2021 (100%)	02.05.2021 (94%) 10.05.2021 (82%)	02.06.2021 (94.1%)	01.07.2021 (98.1%)	04.08.2021 (96.2%)	12.09.2021 (100%)
Whiteparish Ward	Medicine	04.04.2021 (86.5%)	16.05.2021 (98.1%)	03.06.2021 (80.8%) 18.06.2021 (94.3%)	06.07.2021 (96.2%) 23.07.2021 (80.8%)	22.08.2021 (92.5%)	15.09.2021 (78.8%) 28.09.2021 (90.4%)
Amesbury Suite	Surgery	02.04.2021 (96.2%)	12.05.2021 (98%) 19.05.2021 (92.3%)	17.06.2021 (95.7%) 23.06.2021 (74.5%)	23.07.2021 (100%) 23.07.2021 (92.5%)	07.08.2021 (86%) 11.08.2021 (94.3%)	02.09.2021 (96.2%)
Britford Ward	Surgery	14.04.2021 (82.7%)	19.05.2021 (96.2%)	20.06.2021 (98.1%) 22.06.2021 (88%)	05.07.2021 (86.5%)	10.08.2021 (80.8%)	27.09.2021 (96.1%)
Chilmark Suite	Surgery	17.04.2021 (96.1%) 26.04.2021 (86.8%)	16.05.2021 (96.2%) 21.05.2021 (95.7%)	20.06.2021 (89.1%) 22.06.2021 (98.1%)	06.07.2021 (96.1%) 30.07.2021 (86.5%)	12.08.2021 (86.3%)	16.09.2021 (95.7%)
Day Surgery Unit	Surgery	13.04.2021 (100%)	17.05.2021 (100%)	16.06.2021 (100%)	14.07.2021 (100%)	20.08.2021 (93%)	27.09.2021 (100%)
Downton Ward	Surgery	19.04.2021 (98.1%)	13.05.2021 (78.4%) 19.05.2021 (96.1%)	07.06.2021 (98.1%) 14.06.2021 (76.6%) 15.06.2021 (78.3%) 25.06.2021 (90.6%) 29.06.2021 (92.3%)	08.07.2021 (96.2%)	27.08.2021 (80.4%)	27.09.2021 (100%)
Odstock Ward	Surgery	09.04.2021 (98.1%)	09.05.2021 (96.2%)	11.06.2021 (94.1%) 18.06.2021 (97.8%)	23.07.2021 (92.2%)	29.08.2021 (96.2%)	26.09.2021 (98%)
Radnor Ward	Surgery	20.04.2021 (96%)	15.05.2021 (100%) 28.05.2021 (94.2%)	23.06.2021 (95.7%)		01.08.2021 (100%) 30.08.2021 (98%)	30.09.2021 (98.1%)

APPENDIX C

Tendable Infection Prevention & Control (IPC) Inspection Compliance scores for Quarters 3 & 4 of 2021/22

Ward/ Dept	Division	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
Sarum Ward	Clinical Support & Family Services	17.10.2021 (98%)	24.11.2021 (100%)	21.12.2021 (100%)	20.01.2022 (100%)	16.02.2022 (100%)	25.03.2022 (2 audits same day - 100% & 98%)
Acute Medical Unit	Medicine	06.10.2021 (100%)	10.11.2021 (98.1%)	03.12.2021 (96.2%)	04.01.2022 (100%)	02.02.2022 (98.1%)	09.03.2022 (100%)
Breamore Ward	Medicine	10.10.2021 (92.5%) 28.10.2021 (65.2%)	26.11.2021 (97.6%)	25.12.2021 (94.3%)	11.01.2022 (100%)	01.02.2022 (94%) 22.02.2022 (94.3%) 23.02.2022 (96.2%) 24.02.200 (96.2%) 26.02.2022 (90.6%) 27.02.2022 (94.3%) 28.02.2022 (90.6%)	07.03.2022 (87%) 24.03.2022 (78.4%) 29.03.2022 (92.5%)
Durrington Ward	Medicine		03.11.2021 (80.8%)		06.01.2022 (96.2%)	19.02.2022 (100%) 25.02.2022 (73.1%)	02.03.2022 (91.8%) 14.03.2022 (90.6%) 24.03.2022 (86.3%)
Emergency Department				02.12.2021 (93.3%)	03.01.2022 (91.7%)	17.02.2022 (94.3%)	
Farley Ward	Medicine	25.10.2021 (92.5%)	24.11.2021 (92.3%)	21.12.2021 (92.2%)	11.01.2022 (92.5%)	01.02.2022 (96.2%)	14.03.2022 (96.2%)
Hospice Unit	Medicine	06.10.2021 (94%)	04.11.2021 (86%)		07.01.2022 (94.2%)	04.02.2022 (96.2%)	10.03.2022 (96.2%)
Laverstock Ward	Medicine	04.10.2021 (92%)	02.11.2021 (98.1%)	06.12.2021 (94.2%) 28.12.2021 (100%)			01.03.2022 (98.1%)
Longford Ward	Medicine	09.10.2021 (92.2%)	07.11.2021 (98.1%)	07.12.2021 (98.1%)	11.01.2022 (94.3%) 27.01.2022 (76.9%)	04.02.2022 (96.2%)	01.03.2022 (94.3%)
Pembroke Ward	Medicine	18.10.2021 (94%) 31.10.2021 (94.3%)	15.11.2021 (94.2%)	19.12.2021 (90.6%)	17.01.2022 (94.3%)	27.02.2022 (90.4%)	12.03.2022 (94.2%)
Pitton Ward	Medicine	12.10.2021 (90.4%)	03.11.2021 (90.2%) 14.11.2021 (94.1%)	30.12.2021 (90.6%)	26.01.2022 (69.2%)	01.02.2022 (100%) 11.02.2022 (78.4%) 22.02.2022 (88.5%) 25.02.2022 (92.5%)	18.03.2022 (64%) 24.03.2022 (98.1%)
Redlynch Ward	Medicine	04.10.2021 (98%)	06.11.2021 (92.2%)	05.12.2021 (100%) 16.12.2021 (72.5%)	02.01.2022 (86.8%) 16.01.2022 (96.2%)	10.02.2022 (84%) 25.02.2022 (90.2%)	18.03.2022 (94.2%) 19.03.2022 (69.2%) 25.03.2022 (61.5%)
Spire Ward	Medicine	04.10.2021 (96.2%) 25.10.2021 (70%)	07.11.2021 (96.2%)	14.12.2021 (94.3%)	02.01.2022 (94.3%)	03.02.2022 (96.2%) 11.02.2022 (93.9%) 17.02.2022 (98.1%) 24.02.2022 (96.2%)	03.03.2022 (100%) 26.03.2022 (96.2%)
Tisbury CCU	Medicine	12.10.2021 (80.8%)	08.11.2021 (96%)	05.12.2021 (92.3%)	08.02.2022 (94.2%)	02.02.2022 (100%) 06.02.2022 (98%)	01.03.2022 (96.2%) 22.03.2022 (98.1%) 28.03.2022 (96.2%)
Whiteparish Ward	Medicine	03.10.2021 (92.3%) 25.10.2021 (74.5%)	29.11.2021 (90.6%)	17.12.2021 (90.6%)	02.01.2022 (92.5%)	04.02.2022 (94.2%)	05.03.2022 (94.2%) 24.03.2022 (92.5%) 31.03.2022 (92.5%)

Ward/ Dept	Division	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
Amesbury Suite	Surgery	29.10.2021 (82.7%)	10.11.2021 (94.3%)	15.12.2021 (90.2%)	04.01.2022 (94.3%) 27.01.2022 (65.4%)	01.02.2022 (78.8%) 08.02.2022 (88.5%) 23.02.2022 (73.1%)	02.03.2022 (90.6%) 07.03.2022 (55.8%) 27.03.2022 (90.6%)
Britford Ward	Surgery	22.10.2021 (96.0%)	30.11.2021 (98.1%)	31.12.2021 (90.4%)	07.01.2022 (98.1%) 14.01.2022 (76.5%)	18.02.2022 (88.7%)	15.03.2022 (98.1%)
Chilmark Suite	Surgery	28.10.2021 (91.1%)	24.11.2021 (92.3%)	19.12.2021 (92.2%)	19.01.2022 (90.2%)	09.02.2022 (88.2%)	08.03.2022 (91.3%) 16.03.2022 (72.5%)
Day Surgery Unit	Surgery	19.10.2021 (95.5%)	22.11.2021 (97.6%)	13.12.2021 (100%)	17.01.2022 (94.9%)	14.02.2022 (92.1%)	16.03.2022 (97.4%)
Downton Ward	Surgery	12.10.2021 (96.2%)	09.11.2021 (100%)	23.12.2021 (80.8%)	03.01.2022 (90.4%)	18.02.2022 (79.2%) 24.02.2022 (90.6%)	28.03.2022 (84.6%)
Odstock Ward	Surgery		03.11.2021 (94.1%)	27.12.2021 (94%)	13.02.2022 (98%)	13.02.2022 (92.5%)	17.03.2022 (94.3%)
Radnor Ward	Surgery	28.10.2021 (92.2%)	30.11.2021 (84.3%)	31.12.2021 (94.1%)	25.01.2022 (100%)	26.02.2022 (98%)	15.03.2022 (86.3%)

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	07 July 2022		

Report Title:	Improving Together highlight report – Quarter 1 2022/23			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	X	
Approval Process (where has this paper been reviewed and approved)	n/a			
Prepared by:	Emma Cox, Head of Quality Improvement and Coach House			
Executive Sponsor (presenting):	Esther Provins, Director of Improvement & Partnerships			
Appendices (list if applicable):				

Recommendation:
That the Board note this report.

Executive Summary:
The purpose of this report is to provide the Board with a quarterly progress update of the Improving Together programme. At the end of April 2022 the Trust declared a critical incident due to excessive pressure in the hospital caused by issues with patient flow and discharge. The critical incident was stood down 48 hours later however to support ongoing challenges with flow and discharge, the Trust along with health and care partners across BSW, agreed to participate in a 5 week 'SAFER' event designed to embed all elements of best practice in operational processes. This event involved improvement activity across all wards, with leadership and oversight from all divisional teams. In this context, the Executive Team made a decision to pause the formal rollout of Improving Together programme. As a result of this pause, **all** workstreams are now behind the initial roadmap that was developed in 2021 and which was presented to Board in quarter 4. Although the formal training programme was paused, the SAFER/MADE 5 week event provided a key opportunity for the Trust to run the event using Improving Together methodology and tools, thus creating an 'action learning' environment for the new ways of working. Therefore, although the formal training was temporarily paused colleagues were still able to practice and mature their use of continued improvement ways of working.

The pause has also provided an opportunity to reflect on the programme content and approach to date, and lessons learned are being reflected in plans going forward.

There are two main activities scheduled over the next reporting period:

1. To re-start **all** face to face and coaching sessions for division and front-line staff,
2. To develop a new programme roadmap

Programme spend is underspent against plan across pay, non-pay and our contract with KPMG. This is due to the programme pause and delivery of original roadmap being behind plan. A new roadmap is due to be agreed in July and a programme budget re-forecast completed as part of this exercise.

The risk score relating to the programme has increased, with this also being reflected in the Board Assurance Framework (BAF).

Board Assurance Framework – Strategic Priorities	Select as applicable
Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒
Other (please describe) -	☐

1. Introduction and purpose

1.1 The purpose of this report is to provide the Board with a quarterly progress update of the Improving Together programme.

1.2 This is the third Improving Together highlight report the Board have received, the first being presented at the Trust Board meeting in January 2022.

2. Background and context

2.1 Improving Together is a long-term initiative to embed a culture of continuous improvement across the Trust. It aims to introduce a new way of working that will help to remove blocks to outstanding patient experiences and enable all staff to feel empowered to do what is best for patients.

2.2 At its heart, the Improving Together makes sure that Trust priorities are clear to all, and that our resources are utilised in the best possible way to deliver our vision of an outstanding experience.

3. Quarter 1 Key challenges and highlights

3.1 Challenges

3.1.1 At the end of April 2022 the Trust declared a critical incident due to excessive pressure in the hospital caused by issues with patient flow and discharge. The critical incident was stood down 48 hours later however to support ongoing challenges with flow and discharge, the Trust along with health and care partners across BSW, agreed to participate in a 5 week 'SAFER' event designed to embed all elements of best practice in operational processes. This event involved improvement activity across all wards, with leadership and oversight from all divisional teams.

3.1.2 In this context, the Executive Team made a decision to pause the formal rollout of Improving Together programme. This decision was taken for two main reasons:

a) to ensure that all staff groups could maintain a continued focus after the recent critical incident and the 5 week SAFER/MADE event, which were the main focus of the Trust at this time, and
b) to allow colleagues to fully participate in, and benefit from Improving Together training.

3.1.3 As a result of this pause, all workstreams are now behind the initial roadmap that was developed in 2021 and which was presented to Board in quarter 4.

3.1.4 It is acknowledged that capacity challenges within some divisions have impacted on their ability to fully participate in Improving Together. Discussions on how best to support divisions with approach to Improving Together training continue

3.2 Highlights

3.2.1 Although the formal training programme was paused, the SAFER/MADE 5-week event provided a key opportunity for the Trust to run the event using Improving Together methodology and tools, thus creating an 'action learning' environment for the new ways of working. Therefore, although the formal training was temporarily paused colleagues were still able to practice and mature their use of continued improvement ways of working. This approach proved successful a summary found in Section 4.

3.2.2 In line with a continuous improvement approach and following the publication of the NHS England 2022/23 operational priorities, the Executive Team have reviewed the four breakthrough objectives originally agreed to ensure they are reflective of current priorities. The Executive Team have agreed to reflect the strong focus of elective recovery in Trust wide priorities over the next 12-18 months, and have therefore replaced the priority around same day emergency care with elective recovery. whilst still recognising the vital importance of same day emergency care in our urgent and emergency care provision.

3.2.3 The second round of divisional executive performance review meetings in the new structure and style have taken place. The performance review meetings now include a more structured focus on agreed divisional improvement priorities, as well assurance

regarding standard domains such as workforce, finance, quality etc. This is a new way of working that will require time to embed, however it was apparent from the second round of meetings that there is increasing levels of comfort with the new approach. Reflection is built into the end of each performance review meeting, and lessons learned are being actioned. The key focus at present is for divisions to develop clear action plans regarding their agreed improvement priorities, balancing this with necessary assurance elements.

3.2.4 Some teams (Women & Newborn division) participating in the first cohort of training, and where capacity allowed it, continued with their Improving Together coaching sessions, even though the formal training had paused. This enabled those teams to practice the new ways of working and consolidate what they have learned so far. Colleagues involved in the first wave of training are keen to restart the programme.

3.2.5 Despite the operational pressures and more recent programme pause, opportunities to publicise the benefits of Improving Together, and new ways of working have continued to be released through the Trust's daily news bulletin, word of mouth and the Improving Together microsite. Improving Together identity was approved and this is now widely available for use. Further branding items are being identified and ordered in to support various events being planned.

3.2.6 Internal processes to support prioritisation of corporate improvement projects in line with Trust strategic priorities have been improved. A new group now meets monthly, acting as gatekeeper of internal trust wide improvement programmes, to ensure that a) approved programmes of work are key enablers of Trust priorities, b) that change resources have been appropriately allocated, and c) that the impact of change on frontline teams and services is manageable. This group sits alongside the Trust Investment Group and will report into the Trust Management Committee.

3.2.7 Working relationships with the coach house teams facilitating Improving Together training at Royal United Hospitals Bath and Great Western Hospitals, Swindon continue to be strengthened, to maximise learning and peer support.

4. Learning from SAFER / MADE 5-week event

4.1 The SAFER/MADE event provided the opportunity to test and use Improving Together tools such as improvement huddles, use of visual management / huddle boards and coaching conversations.

4.2 During the 5 weeks detailed data gathering was undertaken and there was a noticeable shift in obtaining information and then identifying key areas of opportunity and focus. This follows the 'inch wide, mile deep' focus of Improving Together. There was excellent engagement during the process and value of this approach was clear.

4.3 The introduction of coaching conversations during this event provided the space for colleagues to feel supported and listened to, and for senior colleagues to observe and learn about challenges being experienced in our frontline teams. An 'executive ward buddy' approach was established, and the coaching questions being asked as part of this provided teams with an opportunity to consider how they could weave improvement tools into their daily routines. Following good feedback, the executive ward buddy approach will continue going forwards.

4.4 The event has allowed the Trust to understand how best to use 'rapid improvement events' to support the improvement of persistent challenges, and this will be considered as part of the new roadmap design.

5. Reflection and Lessons learned so far

5.1 The pause has been a good opportunity to reflect on the programme approach and implementation to date. Feedback was sought across various teams engaged in the first training cohort (Executive Team, Divisional teams, Front line teams and the Coach House) with themes from this exercise shared below:

What has gone well:

Protected time away from day-to-day activity to focus and work together has been valued.

Commitment to new way of working with one agreed methodology.

Support to use an evidenced based approach - to get below the data, to stop and understand the evidence prior to problem solving.

Focus on a 'go and see' approach.

Opportunity to practice new ways of working to support an urgent operational priority.

What has not gone so well:

Transition from one way of working to another and double running of some processes has been challenging.

Conflicting priorities creating difficulty in giving enough time to Improving Together.

Operational pressures has meant attendance and engagement has not always been possible.

How would we like it to be going forwards?

A more flexible approach to learning needed, particularly in light of operational pressures.

Increased senior leadership presence at coaching sessions to share ideas and discuss rather than development in isolation.

Realistic alignment with organisational priorities.

6. Plans for next period

6.1 Lessons learned are being used to shape the restart of the programme to ensure that the new roadmap meets the needs of the organisation. A new roadmap is due to be agreed by the Executive Team in July and presented back to Board in Quarter 2.

6.2 The key deliverables for the next period are as follows:

- The re-start of **all** face to face training and coaching sessions for divisional and front-line staff. This is due to start w/c 4th July, and proactive support to maximise attendance is in place
- The production and agreement of a new revised roadmap for all workstreams, cover the next 6-12 months, to include transition away from formal KPMG support and an agreed sustainable internal leadership and delivery model.
- Identification of programme management resource to deliver the entire Improving Together programme
- Criteria for selecting teams and services to participate in second cohort of training agreed.

7. Programme status

7.1 The Improving Together programme is currently rated red due to the impact on delivery against timetable following the critical incident, operational pressures and SAFER/MADE event, all of which have been described in detail above.

8. Improving Together roadmap and programme plan

8.1 A replanning exercise is underway and a new roadmap is due to be approved by the Executive team on 11th July. Delivery against this new roadmap will be included in the next highlight report to Board.

9. Programme expenditure

9.1 Programme spend is underspent against plan across pay, non-pay and our contract with KPMG. This is due to the programme pause and delivery of original roadmap being behind plan.

9.2 Summary position for internal costs is contained in the table below

	Budget YTD (£'000)	**Actual YTD (£'000)**	**Variance (£'000)**
Pay	85	70	(16)
Non pay	17	1	(16)

9.3 The KPMG contract is being managed on a time and materials basis which provides the Trust with optimum flexibility, therefore the programme pause has not had a detrimental impact from a financial perspective. Currently the programme is circa £146k underspent against our forecasted KPMG position in Q1.

9.4 A new roadmap is due to be agreed in July and a detailed programme expenditure re-forecast will be completed as part of this exercise and a summary provided in the Q2 highlight report to Board.

10. Programme Risks and Issues

10.1 Since the last report, the risk score associated with the programme has increased, driven by the challenges outlined in this report.

10.2 The related risk contained in the Board Assurance Framework has also been reviewed and has increased in line with this revised score.

	Risk	**Description / Mitigation**	**Mitigated score**
1	There is a risk that the programme does not 'land' well with colleagues across the Trust.	The current programme 'pause' has increased this risk. Communications and engagement plan being reviewed to align with a new implementation approach and roadmap.	12 (Increased from 9)
2	There is a risk that the Coach house team do not have the required skills or experience to sustain the approach going forwards.	Comprehensive support and development package agreed with KPMG and learning & development team. Peer support in place. Review of resources planned for Q4 2022/23.	6
3	There is a risk that operational and severe staffing pressures result in an inability to support the current planned training dates or a significant lack of attendance.	Re-planning exercise in response to implementation pause and challenges with programme approach.	15 (increased from 9)
4	There is a risk that the Trust will not fully realize value for money from KPMG support.	Re-planning exercise in response to implementation pause and challenges with programme approach. Flexible use of KPMG resources agree, to ensure maximum value for money. Use of KPMG resources reviewed monthly and planned monthly in advance.	9

11. Recommendation

11.1 The Trust Board note this highlight report

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda items:**	5.1
Date of Meeting:	07 July 2022		

Report Title:	SIRO Annual Data Security and Protection Assurance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		x	
Prepared by:	Heidi Doubtfire-Lynn, Data Protection Officer (DPO) Jon Burwell, Chief Information Officer (CIO)			
Executive Sponsor (presenting):	Naginder Dhanoa, Chief Digital Officer			
Appendices (list if applicable):	2021/22 Data Security & Protection Toolkit Assurance External Audit NHS NCSC Email confirmation that the Trust achieved a Standards Met Data Security and Protection Toolkit Return 2021-22			

Recommendations:

Members of the Trust Board are asked to note the content of the report.

Record discussions made and actions agreed.

Executive Summary:

This report is the quarterly SIRO report, providing an update on progress made by the organisation since the last report. It highlights areas of improved compliance, and areas of concern within the Trust's compliance with statutory and regulatory standards overseen by the Information Commissioner's Office (ICO).

This report confirms that the Senior Information Risk Owner, Chief Information Officer, Data Protection Officer, and members of the IGSG, regularly, scrutinises the Trust Risk Register, in compliance with the DSPT, and legislative standards. Where appropriate, action is taken to improve performance and compliance with the Trust's risk management and governance framework.

The Trust's Freedom of Information compliance consistently exceeds the 90% set by the ICO and hovers around 96%.

The Trust's FOI publication scheme meets the standards set by the ICO.

The Trust self-declared three incidents to the Privacy Regulator the Information Commissioners Office (ICO). The ICO assessed each and found no actions would be taken against the Trust.

The report confirms that the Trust has successfully completed 99% of the 2021/22 DSPT assertions. This represents 107 of the 109, mandatory evidence items required.

The Trust will be submitting a Standards Met DSPT for 2021-22 on or before the 30th June 2022.

The outcome of the DSPT NHS National Cyber Security Audit conducted in February 2022 was favourable and highlighted no areas for concern or risk. The Results of the audit have been submitted to the Trust Internal Audit and IGSG committees for scrutiny and comments.

The work programme associated with Data Protection Impact Assessments (DPIAs), asset management and subject access requests continue to be closely monitored.

Full compliance with the Privacy and Electronic Communications Regulation (PECR) will be achieved imminently following the removal of a departmental subordinate website.

The Trust's Data Protection Officer continues to fulfil their statutory duties by being accessible to patients, staff and the Trust, providing advice and guidance on privacy related matters and acting as the contact for the ICO. Any areas of concern are discussed documented and escalated to senior management.

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

1. Introduction and Purpose

1.1. This report confirms and combines the annual Data Security and Protection Toolkit (DSPT) online submission due on or before the 30th June 2022, and the Data Protection Officer yearly report.

1.2. This report serves to inform and advise the Board of the Trust's statutory compliance, whilst recognising areas of good practice, to ensure personal and corporate information is handled legally, securely, efficiently and effectively to deliver the highest standard of care by staff and the organisation. Information Governance plays a vital role as the foundation of all governance by supporting integrated governance within the Trust.

1.3. It provides an update on progress made by the organisation since the last report in February 2022. It highlights areas of improved compliance and areas of concern within the Trust's compliance, with statutory and regulatory standards overseen by the Information Commissioner's Office (ICO).

1.4. In addition, the report provides an update on progress made in respect of our mandatory cyber security programme and the 2021-2022 Data Security and Protection Toolkit which is overseen by NHS Digital.

2. Current Risk Level

2.1. The number of risks being overseen by the IGSG Members has decreased by 10 since February 2022. **Table 1** below provides a breakdown of the risks by Division. The split is as follows:

Division/Department	No. of Risks May 2022
Transformation and Informatics	40
Clinical Support and Family Services	10
Surgery	8
Organisational Development and People	4
Facilities	3
Finance and Procurement	1
Operations	2
Medicine	2
Total	**70**

2.2. During this period the number of risks passed their review date has deceased by ten (10) to twenty-three (23). A further sixteen (16) risks require review prior to the 1st June 2022. All risks associated with the IGSG are supported by action plans.

2.3. Of the seventy (70) risks, thirteen (13) have a rating of between 1 to 3 (low), thirty-three (33) have a risk rating of 4 to 6 (moderate), twenty-four (24) are rated between 8-12 (high risk). This report confirms there are no critical risks on the IGSG register.

2.4. The risks rated either twelve (12) or below, continue to be managed and reviewed regularly at a divisional level. This is in line with the Trust's Risk Management Policy unless Executive support is required.

2.5. Between, 1st February and 1st June 2022, the number of risks passed their review date have decreased by thirty-five percent (35%) from thirty-three (33) to twenty-three (23). A further twenty-six (26) risks require review prior to the 1st September 2022. All risks associated with the IGSG are supported by action plans.

2.6. The CIO on behalf of the Senior Information Risk Owner (SIRO) has requested all risk owners to review the 33 risks passed their review date as a matter of urgency.

3. Covid 19 Risks

3.1. The risk of the external staff Covid website not being secure (6330) continues to be tolerated and remains likely to be resolved once the programme to refresh the Intranet is completed.

3.2. The increased risk of cyber-attack due to Covid 19 (6322) has been closed and its contents incorporated into the risk of cyber or ransomware attack (5360), which recognises that appropriate and proportionate business-as-usual controls and actions are in place to handle such an incident.

4. Top Three Risks

4.1. This report confirms the Trust has a clear and established organisational risk management framework in place. This is overseen by the Trusts SIRO and Deputy SIRO, which is used to identify, record and review risks related to sensitive data and their security.

4.2. Since December 2021, there has been a sixteen percent (16%) reduction in the number of risks requiring oversight by the IGSG members, from eighty-one risks (81) to seventy (70).

4.3. There has been a thirty-five percent (35%) decrease in the number of risks passed their review date, from thirty-three (33) to twenty-three (23).

4.4. The Trusts top three (3) cyber security risks remain the same. There are 5446 subsidiary licences compliant with an associated risk score of twelve (12). There have been 6558 Critical Care Certs not applied within 14 days. Whilst 5360 risk of cyber ransomware attacks, have been associated with a risk sore of ten (10). The detail of these top three risks have been submitted to support DSPT Assertion point 1.3.5.

4.5. Log4shell or Log4j (7180), is an actively exploited remote code execution vulnerability in the open-source Log4j 2 logging library. Log4j is used in numerous Java applications and is present in many services as well as a wide range of cloud services.

4.6. The Trust continues to proactively engage and take advice from NHS National Cyber Security Centre (NCSC) and NHS Digital. To ensure in-house applications or services using Log4j are updated to a minimum of Log4j 2.17.0 by contacting our relevant suppliers to ensure all affected third-party applications and services are fully up to date.

4.7. The existence of the Log4j vulnerability does not require reporting via the DSPT Incident Reporting tool.

5. CareCert Compliance

5.1. Microsoft Defender Endpoint (MDE) monitors the Microsoft Windows operating system on a PC, laptop, or server, to identify any indicators of cyber security comprise or attack. It can then take immediate action to address the problem before it spreads. It also alerts local system managers and the DSC.

5.2. Threat intelligence bulletins are issued by NHS Digital weekly via email when assessed as medium or low severity. High severity threats are immediately sent to organisations, rather than waiting for the weekly bulletin. Specific local threats to individual organisations are also provided when identified. There is an expectation that all Microsoft vulnerabilities will be actioned and completed within the specified 14-day time frame.

5.3. Timescales for resolving high, medium, and low CareCERT advisories are rarely set by NHS Digital. However, when they are, the Trust reports on progress through the NHS Digital portal. Where organisations are not able to meet set timescales mitigations are reported through the portal and approved by the SIRO and CEO.

5.4. Overall, the current exposure score on Microsoft Defender has increased by 2% to 53 out of a total score of 100. The exposure score changes daily depending on any risks identified and the mitigation activities the Trust undertakes. The largest security recommendations are:

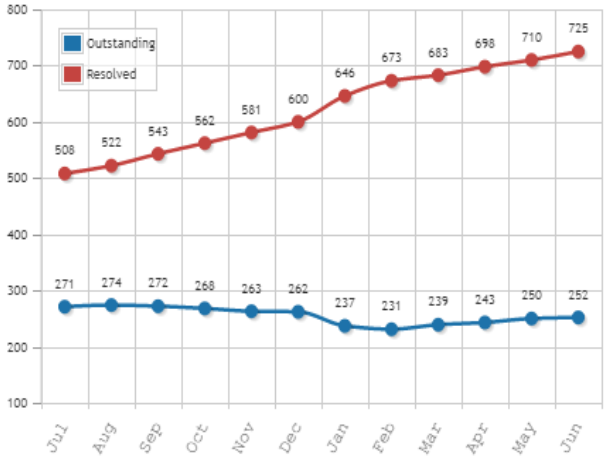
5.4.1. Supporting the removal of vulnerabilities associated with Log4j. The CIO provided an update to Trust Board on the Log4j critical CareCERT in December 2021 alongside existing mitigations which remain in place. The Trust is now five months into the 12-month plan for this CareCERT to be resolved given the extent at which the logging software is used in applications. The Cyber Security Team continue to work with suppliers to understand possible risk mitigations and will apply patches as soon as they are released and tested.

5.4.2. The removal of Office 2010. The NHS has procured centrally extended support until May 2022 given the complexities with the national tenancy. The Trust has an active project looking at migration onto Microsoft 365 working in conjunction with NHS Digital.

5.4.3. The Trust has reduced the number of Windows 7 devices from 24 to 15 and continue to engage with NHS Digital to update on the actions to remove these devices. All these devices are currently protected by an extended support licence until 14th January 2023.

5.4.4. The programme to remove unsupported operating systems (servers) continues, with the aim to reach only 7 unsupported servers by March 2023. Given the amount of work being undertaken on upgrades, archiving and decommissioning activities, external support has been procured to help undertake the final stages of decommissioning to avoid servers needlessly remaining (albeit turned off).

5.5. The IT Health Assurance Dashboard (ITHAD) is used to monitor compliance with the latest trend report shown on the right. The Trust is working with the supplier to improve the dashboard's usefulness; around excluding old operating systems which are protected by Trend Micro (virtual patching), but do not have relevant CareCERT patches about to be directly applied. By resolving this and replacing the final c.16 Windows 7 devices, this is expected to reduce the outstanding CareCERTs by around 60. Comments have been added to the ITHAD noting where Trend Micro is present to help manage the outstanding CareCERT position.



6. Since the last report, the Cyber Security Team have got additional capacity back since the Windows 10 project.to allow them to focus on reducing the lower risk CareCERTs working in conjunction with wider IT operational teams. There has been a slight increase in the number of outstanding CareCERTS, which has risen by four (4) to two hundred and fifty-two (252) as of the 23rd June 2022. **2020/21 Penetration Test**

Assessment Section	2021	2021 Retest
External (Internet) Network Vulnerability Assessment	High	High
External (N3/HSCN) Network Vulnerability Assessment	High	High
Patient Administration System	N/A	N/A
File Shares Review	Critical	High
Active Directory Security Review	Critical	High
Central Security Systems Review	Critical	Medium
Mobile Device Security Review	High	High
Workstation and Laptop Security Review	Critical	Critical
Wireless Security Review	None	None
Network Device Default Credential Scan	Medium	Medium

6.1. As outlined in the previous quarterly digital update report, there is an action plan in place. This is to both remove immediate risks identified in the recent Penetration test reported in October 2021. This ensures any gaps in business-as-usual IT general controls are remedied. The latter improvement in IT general controls ensures the Trust has

robust mechanisms to provide assurance that the Trust understands, actively monitors and seeks to resolve potential cyber risks to the Trust.

6.2. Four of the six critical risks identified in the initial report have been remediated and ratified through retest. The remaining two critical risks relate to:

- 75% of the unsupported software, in particular Office 2010 have been installed to date. The deadline to replace Office 2010 for the NHS has been extended to end May 2022. However, the Trust will achieve this by 30th June 2022.
- House on the Hill, the IT Service desk, has now been replicated in the Cloud and the CVIS migration has been completed.

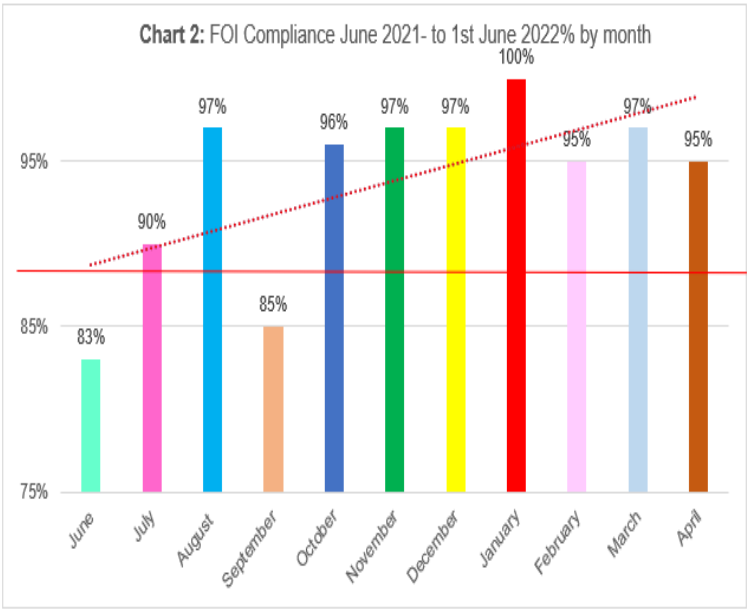
6.3. All actions have been progressed. Any outstanding actions and those passed their initial date have been given revised dates agreed for completion. The reason for delay predominantly has been Covid sickness related within Informatics.

6.4. The next Penetration Test is expected to be in Q3 2022/23.

7. Freedom of Information (FOI) Compliance

7.1. Between 1st July 2021 and 22nd June 2022, the Trust received four hundred and forty-seven (447) requests for information. Twenty-seven (27) were processed as line of business requests and the remaining four hundred and twenty (420) as FOI's.

7.2. The Trust applied thirty-one (31) exemptions. The breakdown of the exceptions is as follows. Fourteen (14) related to Section 38, Health and Safety. Eight (8) sighted Section 36, the release of information would prejudice effective conduct of public affairs. Three (3) sighted Section 43 and therefore would have resulted in legal action being taken against the Trust by breaching the commercial interests of a third-party. Four (4) sighted Section 12 and were refused on the grounds of cost for exceeding the appropriate 18hr time limit. A single Section 40 exemption was applied prohibiting the release of personal data.



7.3. Seventeen (17) FOIs responses breached the 20day response timeframe in between July 2021 and June 2022.

7.4. The ICO has mandated that authorities must respond to 90% of requests within 20 working days. **Chart 2**, right, confirms the Trust is now consistently exceeding the 90% target, hovering between 95 and 97%.

7.5. **Internal Reviews**

7.5.1. The Trust received correspondence from two requestors challenging the Trust's decision to apply an exemption under Section 17(7) of the FOI Act 2000.

7.5.2. It is the responsibility of the Data Protection Officer/FOI Lead and Director of Integrated Governance to conduct the internal review process.

7.5.3. In response to FOI 6487 internal review, the findings confirmed the number of Covid 19 vaccinations administered by each employee on or off site was not held by the Trust. Information relating to lawful consent was accessible to the requester by other means on the UK Government websites. Therefore, a Section 21 exemption, was appropriate and proportionate. However, to assist the applicant in locating the information a list of relevant websites was shared.

7.5.4. In response to FOI 6391 internal review, the FOI asked the Trust to supply details of the registration numbers, makes and model of all fleet vehicles between March 2019 and 26th November 2021. The Trust rejected this request and applied a Section 38, Health and Safety exemption under the FOI Act. The reviewing officers, considered the release of a single or multiple number plates associated with the Trust into the public domain could significantly increase the risk of a vehicle being cloned to evade parking or congestion charges and could potentially compromise the security and safety of lone working staff carrying medication, records and or supplies. The Section 38 exemption was upheld.

7.6.1 **Publication Scheme**

7.6.1.1 The Trust website complies with the ICO publication scheme guidance. The model publication scheme is a summary of information which sets the organisations high-level commitment to proactively publish information and making it publicly accessible. This consists of seven commitments and seven classes of information which include the following:

- **Who we are and what we do.**
  Organisational information, locations and contacts, constitutional and legal governance.
- **What we spend and how we spend it.**
  Financial information relating to projected and actual income and expenditure, tendering, procurement, and contracts.
- **What our priorities are and how we are doing.**
  Strategy and performance information, plans, assessments, inspections and reviews.
- **How we make decisions.**
  Policy proposals and decisions. Decision making processes, internal criteria and procedures, consultations.
- **Our policies and procedures**
  Current written protocols for delivering our functions and responsibilities.
- **Lists and registers**
  Information held in registers required by law and other lists and registers relating to the functions of the authority
- **The services we offer**
  Advice and guidance, booklets and leaflets, transactions, and media releases. A description of the services offered

  https://www.salisbury.nhs.uk/about-us/freedom-of-information-foi/publication-scheme/

8. Mandatory UK GDPR, Information Governance and Cyber Security Training

8.1. This report confirms that as of the 15th June 2022 the Trust exceeded the minimum target, which requires at least 95% to have successfully completed annual Data Security and Awareness training between 1st July 2021 and 30th June 2022. Details of the requirement are set out in DSPT Standard 3.1.

8.2. This report recognises that exceeding the 95% target has been a monumental task for all departments. The SIRO thanks each employee for their continued commitment to maintaining their knowledge, skills and awareness of data protection, security, and confidentiality polices, processes, themes and threats, which could potentially undermine patient Trust and the security of our systems.

8.3. **Table 3** below provides a breakdown of the percentage compliance by Division.

8.4. Sixty-six percent (66%) of the Trust employees (2953), sit within the Clinical Divisions. Clinical Support and Family Services and Women and New-born achieved a ninety-seven percent (97%), whilst Surgery continue to hover around ninety-two percent (92%) and are determined to exceed the ninety-five percent (95%) by the end of June 2022. The Medicine Division continue to engage and strive to improve their current compliance of eight six percent (86%).

IG TRAINING COMPLIANCE BY DIVISION/DIRECTORATE

	Number complete	Number incomplete	Number in target group	Compliance
Bank Staff*	280	76	356	79%
Clinical Support & Family Services (Direct)	945	31	976	97%
Corporate (Trust HQ, Finance, OD&P, Informatics, and Estates) *	554	11	565	98%
Facilities Directorate (Direct)	304	12	316	95%
Medicine Directorate (Direct)	728	100	828	86%
Quality Directorate (Direct)	60	0	60	100%
Surgery (Direct)	1039	81	1120	92%
Women and Newborn (Direct)	241	8	249	97%
Trust Totals	**4151**	**319**	**4470**	**93%**
Adjustments (based on known errors in MLE data)		117		
Revised Totals	**4151**	**202**	**4353**	**95.4%**

Report data last refreshed on 17/06/2022 KEY: 0-79% 80-94% 95-100%

8.5. The remaining forty-four percent (44%) of staff collectively sit within the Corporate Services function of the Trust which comprises of, Facilities, Estates, Trust Head Quarters (HQ), Quality, Organisational Development and People (OD&P) and all have exceeded the ninety-five percent (95%) apart from the bank office who continue to review individuals' contractual status.

8.6. The Data Security and Protection Toolkit requires the Trust to report the number of Trust Board members who are compliant with their relevant data and security protection training. An extract from the Managed Learning Environment (MLE), confirms 100% of the substantive Executive Directors have completed their annual IG training.

9. Specialist Information Asset Owner (IAO) and Information Asset Administrator (IAA) Identification and Training

9.1. The number of designated Information Asset Owners/Division and Service Managers (IAOs) remains at 15. One hundred and twenty-five (125) Information Asset Administrators (IAAs) provide specialist support to the IAOs.

9.2. There are two hundred and eighty (280) assets appearing on the Information Asset Register (IAR), an increase of two (2) since the last report. Asset criticality is reviewed annually as part of the Informatics Business Continuity Plan which is being refreshed at the time of submitting this report. The number of critical assets on the IAR has risen by one (1) and now stands at sixty-nine (69).

9.3. Sixty-seven percent (67%) of the Trust's assets process healthcare or staff data. Fifty-six percent (56%) relate to patient's healthcare data, with the remaining eleven percent (11%) processing staff data. Eight (8) assets are currently in the process of being decommissioned. A further three historical clinical information systems, in Patient Manager (iPM), Symphony and the in-house built Electronic Discharges (EDS) are being assessed to establish if the data held within them can be deleted, in line with the NHS Digital Records Management Code of Practice 2021 retention schedules.

9.4. Covid-19 continues to negatively impact on the Trusts ability to refresh the critical information asset documentation and other related tasks carried out by clinical operational staff. The number of critical asset audits being completed has risen by 14% to 75%.

9.5. Six (6) of the Divisions/departments have completed their annual review. This equates to seventy-five (75%) of the IAR reviews. A further three, CS&FS, Medicine and Surgery have achieved between eighty-three percent (83%) and eight-nine (89%) of their IAR reviews.

9.6. Women and New-born have reviewed fifty percent (50%), which represents two (2) of their four (4) assets.

9.7. Informatics administer thirty-three percent (33%) of the critical assets on behalf of the Trust. Informatics have completed fifty-five (55%) of the 2021-22 audit programme. Work continues to improve compliance.

9.8. The IAR, has undergone a major revamp during the 2021-22 DSPT year. Work continues to support IAO and IAAs to ensure the IAR remains accurate and up to date.

9.9. IAOs responsible for critical assets have been asked to provide a system specific business continuity plan, which complements the department business continuity plans in place with the EPRR team. The completion of the system specific plans is monitored routinely at OWG.

10. Subject Access Requests

10.1. The Trust's organisational oversight of the number of SARs being processed continues to improve and there is greater engagement across the organisation. There have been no additional reports of subject access requests being delayed beyond the statutory 1-month timeframe since October 2021.

10.2. The number of complaints/concerns raised about subject access request in the preceding 12 months remains unchanged at six.

10.3. All departments releasing and handling SARs maintain statistical compliance information which is incorporated into an overarching disclosure compliance report to IGSG measuring the trends, number of complaints received, in addition to lessons learnt and action taken.

10.4. The report confirms the Trust has responded to the following: Six hundred and forty-two (642) medical records requests. Twenty-two (22) Court Orders. One hundred and twenty-one (121) Police requests. Thirty-six (36) Inquests. Four (4) CCTV requests. Two hundred and fifty-one (251) Radiology/MRI images. Seven (7) OD&P/Occupational Health requests. Fifty-nine (59) requests from solicitors. The Trust only claimed one-time limit extension on the grounds of complexity in relation to an OD&P request from an employee.

11. Data Protection Impact Assessments

11.1. A Data Protection Impact Assessment (DPIA) is a process mandated under the GDPR Articles 35 and 36 to help the Trust identify and minimise data protection risks.

11.2. There has been an increase in the number of DPIAs being completed from twenty-nine (29) in 2018, thirty-eight (38) in 2019, ninety-two (92) in 2020, sixty-six (66) in 2021 and so far, fourteen (14) in 2022 (including No DPIA required and no longer required/cancelled).

11.3. Thirty-five (35) DPIAs appear on the 2022 register. Two (2) have been cancelled, ten (10) have been completed and signed off. One (1) is not processing personal data and therefore doesn't require a DPIA to be completed. Ten (10) are in progress, six (6) of which have not yet started/awaiting further information and the remaining 5 are awaiting prioritisation and further information from the project lead(s).

11.4. Royal United Hospitals Bath confirmed in the week of 2nd May 2022, that they have adopted the Salisbury NHS Foundation Trust DPIA template to reduce duplication and standardise practices.

11.5. The IG department continues to offer advice, guidance, and support to internal departments and external agencies, companies, charities and suppliers it engages with.

11.6. Inline with the Trusts commitment to public accountability, openness and transparency, DPIAs are published on the Trust's website.

12. Data Security and Protection Toolkit 21-22

12.1. At the beginning of 2021-2022, the DSPT contained one hundred and ten (110) mandatory items, one less than the preceding year. The number of non-mandatory items decreased by six (6) from thirty-eight (38) to thirty-two (32).

12.2. A revision of the Toolkit in June 2022 removed assertion 1.2.4 National Data Guardian opt-out from the mandatory evidence section. Consequently, the number of mandatory items has decreased by one (1) to one hundred and nine (109) and the non-mandatory has risen to thirty-three (33).

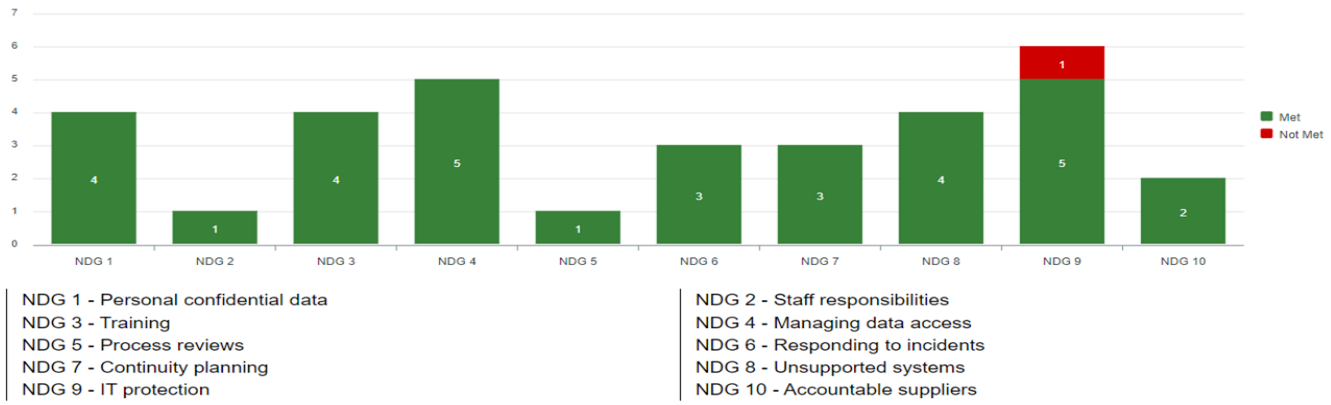
12.3. Between the 3rd February and 26th June 2022, the Trust has increased the number of completed mandatory assertions from eighty-two (82) to one hundred and seven (107).

12.4. **Chart 1** below, confirms the following Standards: 1 personal confidential data, 2 staff responsibilities, 3 training, 4 managing data access, 5 process reviews, 6 responding to incidents, 7 continuity planning, 8 unsupported systems and 10 accountable suppliers have been completed in full.

12.5. Standard 9, IT protection, requires two pieces of evidence to be submitted for review to the CIO before it can be marked as complete.

12.6. This report confirms the Trust will be submitting a 'Standards Met' toolkit on or before the 30th June 2022.

Chart 1: Data Security and Protection Toolkit 20/06/2022 Source: https://www.dsptoolkit.nhs.uk/



12.4 External Assurance Audit by the NHS National Cyber Security Centre

12.4.1 In July 2020, Salisbury NHS Foundation Trust was selected to take part in an external audit conducted by auditors Tiaa on behalf of the NHS NCSC in February 2022.

12.4.2 The audit conducted was aligned to the mandated areas in the Toolkit as selected by NHS Digital for 2021-2022 and included 13 mandatory assertions – 1.3, 2.1, 3.4, 4.1, 4.2, 4.5, 5.1, 6.3, 7.2, 7.3, 8.3, 9.3 and 10.1.

12.4.3 The objective of the independent assessment/audit from the Trust's perspective is to understand and help address data security and data protection risk. Identify opportunities for improvement, whilst also satisfying the annual requirement for an independent assessment of the DSP Toolkit submission.

12.5 DSPT Audit Assessment Findings & Governance

12.5.1 This report confirms the outcome of the DSPT Tiaa Audit 2021-22 was submitted and discussed at the Trust's Audit Committee on the 3rd of March 2022, in appendix 3 to the Cyber Update Report, presented by the Chief Information Officer (CIO).

12.5.2 The Tiaa, DSPT Audit report has also been submitted to the Finance and Performance (F&P) Committee on the 24th May 2022 as part of the SIRO escalation report to the Trust Board.

12.5.3 This report confirms the Tiaa Audit has been uploaded as evidence to support item 9.4.5.

13 External Data Security Incident Reporting

13.1 The Trust reported three incidents to the ICO in the last DSPT year (July 2021 to 13th May 2022) and confirmed all were reported within the statutory 72hr reporting time-fames within the UK GDPR and the Network and Information Systems Regulation (NIS)

13.2 ICO decided no formal action would be taken against the Trust in each instance.

13.3 Incident 26653 occurred on the 15th December 2021, after the in-house built Electronic Discharge System (EDS) was upgraded. Unbeknown to the system developers, the printed EDS forms contained incorrect information regarding the patient having a ReSPECT decision in place. All affected patients were contacted, their records updated, and GP systems updated with the correct information. No patients were adversely affected by the incident.

13.4 On the 27th January 2022, the Trust reported to the ICO that an NHS employee's pension documents had not been received. A subsequent investigation concluded the Trust had not received the package from Royal Mail. The Trust is pleased to report the staff member received their pension on time.

13.5 In March 2022, the Trust notified NHS Digital and the ICO in compliance with the (NIS) that it had experienced a Trust-wide systems outage due to the NetApp hardware failing, which fed several servers. This affected the in-house built systems including the Electronic Discharge Summary (EDS), Consultant's List, Endoscopy, Tquest/Review Order Comms and the interfacing between systems.

13.6 The incident has been investigated as a Serious Incident Investigation (SSI) in line with Trust polices.

14 Data Protection Officer

14.4 Under UK GDPR public authorities are required to appoint a Data Protection Officer (DPO). The legislation requires the DPO to undertake specific tasks to monitor the Trust's compliance with UK GDPR and with regards to impacting legislation. This includes, but is not limited to, the Privacy and Electronic Communications Regulation (PECR), Protection of Freedoms Act 2012 (PFA 2012), Human Rights Act 1998 (HRA 1998), Data Protection Act 2018 (DPA 2018), Network and Information Systems Regulation (NIS), CCTV and Surveillance, Freedom of Information Act 2000 (FOI 2000), in addition to the Common Law Duty of Confidentiality and NHS legislation.

14.5 UK GDPR and DPA 2018

14.5.1 This report confirms the DPO acts as a contact point for the ICO. They co-operate with the ICO regarding incidents, concerns or complaints and if appropriate, consults with the regulator (ICO) prior to high-risk processing being introduced in compliance with UK GDPR Article 36.

14.5.2 The Trust supports the DPO in compliance with UK GDPR Article 38(2) by providing the resources necessary to carry out their duties, tasks and access to personal data and processing operations.

14.5.3 With regards to Article 38(3), the Trust recognises and guarantees the autonomy and independence of the role of the DPO under UK GDPR. This is done by ensuring the DPO does not receive any instructions regarding the exercise of their tasks.

14.5.4 In line with the UK GDPR guidelines, the DPO reports to the highest level of Management (Chief Information Officer, Chief Digital Officer and Medical Director/Caldicott Guardian) within the Trust.

14.5.5 In accordance with Article 35(1), the Trust ensures DPIAs are carried out by the organisation and not the DPO. By ensuring the DPO advice and guidance is sought prior to high-risk processing commences, in compliance with the principle of data protection by design, Article 35(2) which specifically states that the controller/Trust 'shall seek advice' of the DPO when carrying out a DPIA.

14.5.6 Article 39(1)(c), in turn tasks the DPO with the duty to 'provide advice were requested as regarding DPIAs and monitor its performance as per Article 35'. If the Trust disagrees with the advice provided by the DPO. The Trust DPIA documentation specifically justifies in writing why the advice has not been taken into account. This activity is recorded within the DPIA documentation.

14.5.7 This report also confirms the Trust's registration with the ICO has been renewed for 2022 and expires on the 4th April 2023. The contact details of the DPO are made available to staff, patients and the public on the Trust's website: www.salisbury.nhs.uk

14.5.8 The Trust demonstrates compliance with the 'Rights of the data subject' (individual UK GDPR, Chapter 4 (Articles 12-23)) by ensuring individuals are provided clear and transparent information about the following: how and why their information is collected. Their right to object, restrict, access, be forgotten. Request personal data errors are rectified. Decisions made by automated machines are processed by an individual. This is achieved through staff training, awareness, policies, procedures, consent controls, incidents complaints and concerns which are overseen by the DPO and reported to the Board through the executive sponsor (SIRO).

14.6 Privacy and Electronic Communications Regulation (PECR)

14.6.1 The Privacy and Electronic Communications Regulations (PECR) sit alongside the Data Protection Act and the UK GDPR. They give people specific privacy rights in relation to electronic communications. There are specific rules on:

- marketing calls, emails, texts and faxes
- cookies (and similar technologies)
- keeping communications services secure
- customer privacy as regards traffic and location data, itemised billing, line identification, and directory listings
- Advice and guidance booklets and leaflets, transactions and media releases.
- A description of the services offered

14.6.2 The DPO conducted a review of the Trust's compliance with the PECR regulations. This confirmed, all bar one of the Trusts subordinate sites complied with the 'cookie' standards and consent procedures. The non-compliant site is in the process of being rebuilt in-house and decommissioned.

15 Recommendations

The Committee is asked to note this report, and in particular:

15.4.1 Data protection and information security risks are proactively managed by members of the IGSG on behalf of the Chief Digital Officer

15.4.2 The Trust will be submitting a Standards Met DSPT submission on or before the 30th June 2022.

15.4.3 FOI compliance exceeds the 90% compliance figure set by the ICO for all Trusts.

15.4.4 The Trust self-declared three incidents to the Privacy Regulator and the Information Commissioners Office (ICO). Two have been assessed as requiring no action and the remainder is still being considered by the ICO and NHS Digital.

15.4.5 The report confirms that the Trust has successfully completed 99% of the 2021/22 DSPT assertions. This represents 107 of the 109 mandatory assertion and will be submitting a 'Standards Met' toolkit on or before the 30th June 2022.

15.4.6 The Results of the NHS Cyber Security Centre Audit have been submitted to the F&P, Audit and IGSG committees for scrutiny and comments.

15.4.7 The outcome of the NHS NCSC conducted in February 2022 was favourable and highlighted no areas for concern or risk.

15.4.8 The work programme associated with Data Protection Impact Assessments (DPIAs) and Asset Management continue to be closely monitored by the Data Protection Officer and IGSG Member.

15.4.9 The Trust's Data Protection Officer continues to fulfil their statutory duties by being accessible to patients, staff and the Trust. Providing advice and guidance on privacy related matters and acting as the contact for the ICO. Any areas of concern are discussed documented and escalated to senior management.

From: donotreply.dspt@nhs.net <donotreply.dspt@nhs.net>
Sent: 29 June 2022 14:40
To: DOUBTFIRE-LYNN, Heidi (SALISBURY NHS FOUNDATION TRUST) <heidi.doubtfire@nhs.net>
Subject: Confirmation of the publication of your assessment

Dear heidi doubtfire-lynn,

Thank you for publishing your 21/22 Standards Met Data Security and Protection Toolkit assessment for SALISBURY NHS FOUNDATION TRUST on 29/06/2022 14:38.

Everyone who uses health and care services should be able to trust that their personal confidential data is protected. Publishing your Data Security and Protection Toolkit provides assurance that your organisation is practising good data security and that personal information is handled correctly.

Your DSP Toolkit status of Standards Met is publicly available for your service users, commissioners, partner organisations and the public at https://www.dsptoolkit.nhs.uk/OrganisationSearch/RNZ

Thanks

DSPT Toolkit team.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.2
Date of Meeting:	07 July 2022		

Report Title:	Housekeeping Review Paper			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Approval Process (where has this paper been reviewed and approved)	£238k of additional funding for 2022/23 and £408k of recurrent funding from 2023/24 was approved by TMC, on May 25th 2022. The Housekeeping Paper was presented to Clinical Governance Committee on 28th June 2022.			
Prepared by:	Ian Robinson, Head of Facilities			
Executive Sponsor (presenting):	Andy Hyett, COO			
Appendices (list if applicable):				

Recommendation:
Additional finding for cleaning services is requested to support a staged approach to full implementation of new mandated NHS cleaning standards. Recognising the lead time to recruit and train the (17) additional staff, the investment request for 2022/23 is £238k (funding from 1st September 2022) with £408k of recurrent funding from 2023/24.

Executive Summary:
In May 2021 NHSE/I published new NHS mandated cleaning standards with an expectation that Trusts would adhere to these new standards from May 2022. The Trust current adheres to the 2007 NHS Cleaning specifications for very high and high risk areas, with the lowest spend (in England), per occupied metre for small acute Trusts. Accordingly, the investment we are required to make (to deliver these new standards) is significant and greater than all other small acute Trusts. To achieve full implantation of the new cleaning standards investment of £1.12m (as @ April 2022), would be required. As a staged approach to full implementation of these new standards £408k pa (recurring), an 18.1% increase on the 2021/22 housekeeping budget, is requested, and reduced in 2022/23 to reflect the lead time for implementation. Investment at this level will not deliver compliance with the new NHS cleaning standards.

Board Assurance Framework – Strategic Priorities	**Select as applicable**

Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☐
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☐
Other (please describe) -	☐

Salisbury
NHS Foundation Trust

Housekeeping Review Paper

May 2022

Ian Robinson
Head of Facilities

Contents

Housekeeping Review Paper

1 Executive Summary

Cleaning is an important part of infection prevention and control, ensuring the environment is visibly clean and environmental contamination is reduced to a safe level. Cleaning in the NHS is risk based, to ensure resources are focused into areas, and functions that present the greatest risk. There have been national standards for cleaning, outlining the risk based approach since 2001 and these were updated in 2007 with non-mandatory cleaning specifications.

New National Standards of Healthcare Cleanliness were published on 4th May 2021 and replace the National Specifications for Cleanliness in the NHS (2007).

These new standards are a mandated standard which all healthcare organisations are required to meet through the Health and Social Care Act, these minimum mandated cleaning frequencies require a significant increase in the current cleaning resource.

NHSE/I have identified that Trusts who had implemented the 2007 NHS cleaning specifications, in full, would not require significant additional resources, accordingly, an implementation date for these new standards (May 1st 2022) has been set by NHSE/I.

The 2007 cleaning specifications were not mandated and were not adopted in full, by the Trust. Accordingly, the investment required from our current position to full adoption of the new national standards, is significant.

To achieve these mandated standards additional recurrent funding of £1.12m pa, would be required. This represents a 49.9% increase in the Housekeeping budget, increasing our cleaning cost per occupied metre square from £24.51 (2020/21) to £36.74 per metre square.

This paper seeks approval for a staged approach to full implementation of these new standards, mapped to our ability to recruit and train new staff and measure the benefits of further investment.

This paper sets out a request for £408k pa (recurring) an 18.1% increase on the 2021/22 housekeeping budget. Recognising the lead to the recruit the (17) proposed staff, the investment request for 2022/23 is £238k (funding from 1st September 2022).

Investment at this level would increase cleaning cost per occupied metre square (in a full year, as defined by the ERIC definition), from £24.51 (2020/21) to £28.97 and deliver increased cleaning in outpatient and public areas (including corridors and entrances) and provide resilience in the delivery of cleaning to theatres and in-patient areas.

2. National Position

Standards for cleanliness in the NHS were first published in 2001, and were updated in 2007. The 2007 document (National Specifications for Cleanliness in the NHS) has been the accepted standard for hospital cleanliness. The previous standards (2001 & 2007) were advisory and flexibility was built in to allow Trusts to amend the standards with local agreement.

In 2009 the Deputy Director of Nursing, Infection Prevention and Control team and the Head of Facilities developed and published cleaning frequencies for each cleaning risk category. These were based on the 2007 National Specifications with permitted local flexibility applied;

the 2007 specifications were not adopted in full, cleaning schedules developed at the time remain in place today (see appendix 1 & 2).

3.0 Trust Position

The Housekeeping Service was market tested in 1998, following a tender exercise the provision of cleaning services was awarded to the in-house team. Thereafter and in line with guidance (published at the time) from NHS Estates, the Housekeeping service were required to demonstrate 'Best Value' to the Board, based on cost, quality and outcomes based on results from the Patient Environment Action Team (PEAT until 2012) assessments and from the Patient Led Assessment of the Care Environment (PLACE – from 2013) programme.

Between 2000 and 2012 Salisbury NHS Foundation Trust was the only Acute NHS Trust (in England), and one of only three hospital sites to achieve the highest rating (in the PEAT assessment programme) for cleanliness. Since 2013, the Trust has maintained high standards of cleanliness as measured by PLACE (annual assessments), patient feedback and internal audit cleaning scores.

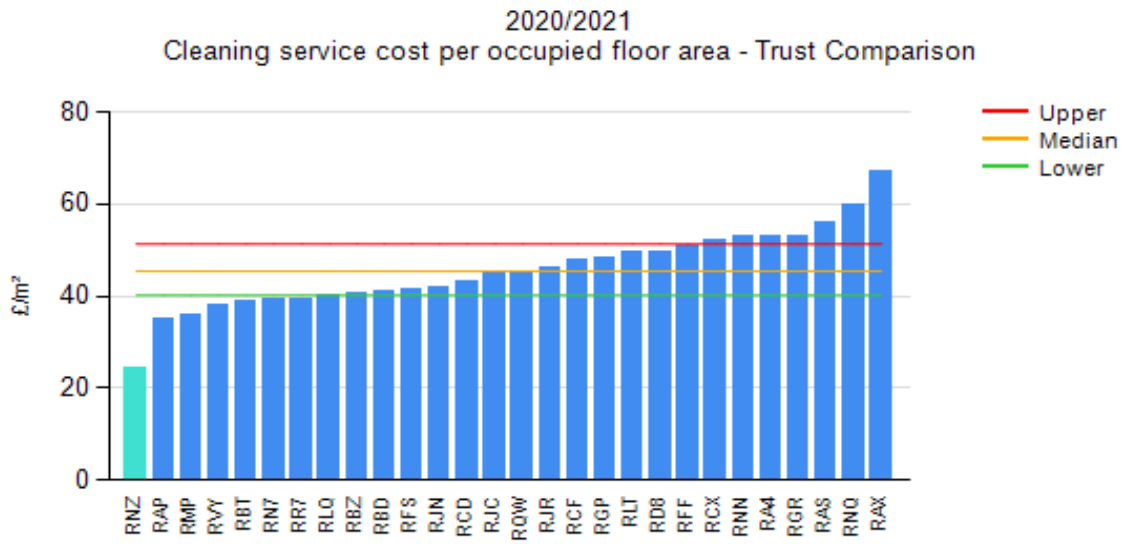
3.1 Dimensions and Benchmarking

NHS Trusts are required to participate in the Estates Return Information Collection (ERIC) annual assessment, completed on behalf of NHSE/I. With improvements in data definitions and data quality, confidence in the ERIC return has significantly improved, supporting benchmarking.

ERIC Data - Acute Trusts in BSW 2020/21

Trust Code	Trust Description	Region	Trust Type	Gross internal floor area (m²)	Cleaning service cost (£)	Cleaning staff (WTE)	Cleaning service cost per occupied floor area (£/m²)
RNZ	SALISBURY NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - SMALL	91,624	2,245,303	95.21	24.51
					Proposed Option 3 - Additional Investment of £408k pa		28.97
					Proposed Option 2 – Additional Investment of £1.12m pa		36.76
RD1	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - MEDIUM	96,425	5,596,664	217.56	59.25
RN3	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	SOUTH WEST COMMISSIONING REGION	ACUTE - MEDIUM	79,179	4,174,940	168.02	54.08

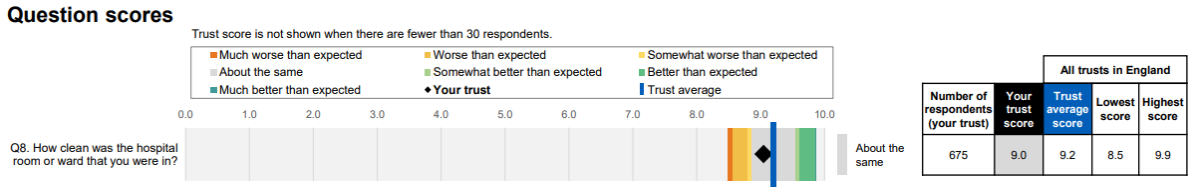
ERIC Data – Small Acute Trusts 2020/21

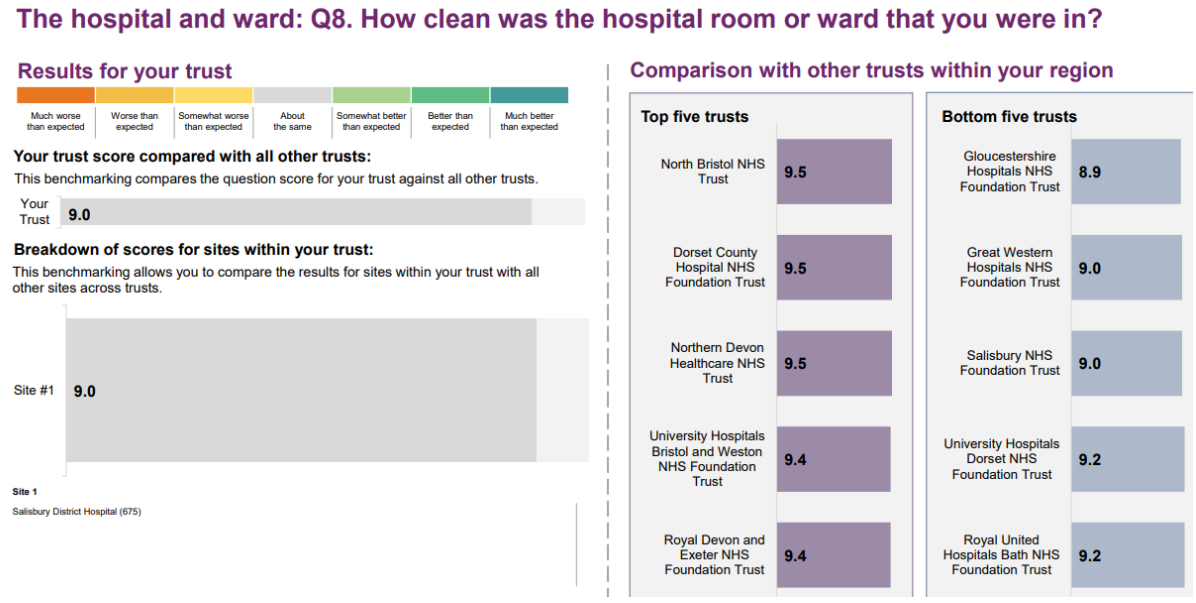


Local Small Acute Trusts			
Site Code	Hospital Site	Cleaning service cost per occupied floor area (£/m²)	
RA4	Yeovil District Hospital	52.95	
RBD	Dorset County Hospital	40.98	
RNZ	Salisbury Hospital	24.51	

3.2 Patient Feedback

In the Adult in-Patient Survey (2020), patients rated cleanliness with a score of 9.0 against the average for Trusts being 9.2.





Complaints and Concerns
No formal complaints have been received regarding cleaning standards in the past 5 years. In the same period the Housekeeping Department have received 2 concerns from patients, 1 in 2018 and 1 in 2019.

3.3 Housekeeping Performance

Cleaning standards are determined by the cleaning risk category (see appendix 2), cleaning frequencies and housekeeping resource is applied to meet the risk category target score.

Risk Categories:

1. Very High Risk (98%) * Theatres, ED, SSEU, Pembroke
2. High Risk (95%)* General Wards, Maternity, Spinal Unit, Public areas
3. Significant Risk (85%)* Outpatients, clinics, labs, Pathology, Pharmacy
4. Low Risk (75%)* Offices, Admin, Stores, Records

*Risk Category Target Score – Measured over a 13 week average, the Trusts cleanliness score being an average of all 4 areas.

Current performance
All **very high risk** areas meet the 2007 target of 98% and all **high risk** areas excluding public entrances and corridors, also meet the 2007 target of 95%.

Areas within the **significant risk** and **low risk** areas are not currently audited and would not meet the 2007 target score.

In the 2007 specifications, the Trusts overall cleanliness score is an average of the 4 cleaning risk areas, accordingly, the Trusts Cleanliness score would not achieve the 2007 target.

Housekeeping performance is reported monthly to ward leaders through the PLACE steering group and to the quarterly Infection Control meeting.

The following information is a sample of the performance data shared:

Rapid Response Update:

April 2022: the team have carried out deep cleans/extra cleans in ED, Main Theatres, Genetics and the Hospice.
Sewerage incidents were reported in Radiology, Vascular, Breamore Ward and Britford Ward and water leaks reported in Gynae Clinic.

Enhanced/Post Infection cleans

The high demand for additional cleaning in very high and high risk areas has significantly reduced cleaning in significant risk areas and almost removed all cleaning from low risk areas.

2022/23 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTIONS	1305												
ENHANCED HRS	66.50												
DOUBLE CLEANS HRS	42.25												
BIOQUELL	34												
Total Hrs	1447.75												

2021/22 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTIONS	1076	934	850	1106	1105	1127	1180	1114	1386	1322	1436	1807	**14443**
ENHANCED HRS	67.75	67.50	50	66.5	70.75	70.25	73.50	71	65.50	86.50	124.75	113.75	**927.75**
DOUBLE CLEANS HRS	104	84.75	79.5	88.0	93.25	60.50	44.75	35.75	50.50	91	51	65.75	**846.75**
BIOQUELL	39	40	38	61	56	49	36	35	60	40	38	51	**543**
Total Hrs													**16,760.5 pa 1,396.7 pm**

2020/21 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTIONS	1564	1726	1558	1408	1121	1180	1200	1304	1575	2589	1694	1341	**18260**
ENHANCED HRS	38.5	48.25	47.5	72.25	95	56	53.75	96.5	105.5	102.25	65.25	57	**837.75**
DOUBLE CLEANS HRS	4.5	0	40.25	82.25	60.25	77.5	105	149.5	140.25	0	26.25	27	**712.75**
BIOQUELL	30	29	37	62	36	42	39	30	50	10	58	50	**473**
Total Hrs													**20,283.5 pa 1,690.3 pm**

Internal PLACE Results

AREA	PRIVACY, DIGNITY & WELLBEING				CLEANLINESS				CONDITION & APPEARANCE				DEMENTIA				DISABILITY			
	2016/17	2017/18	2018/19	2019/20	2016/17	2017/18	2018/19	2019/20	2016/17	2017/18	2018/19	2019/20	2016/17	2017/18	2018/19	2019/20	2016/17	2017/18	2018/19	2019/20
AMESBURY	92.6%	87.5%	79.5%	73.3%	97.3%	98.6%	100.0%	98.6%	94.4%	81.7%	93.0%	100.0%	82.1%	65.3%	76.7%	60.8%	85.7%	66.6%	85.7%	61.5%
ACUTE MEDICAL (NEW)	-	-	63.6%		-	-	98.9%		-	-	95.6%		-	-	84.3%		-	-	87.5%	
AVON WARD	82.3%	70.5%	76.5%		98.5%	96.4%	99.3%		85.1%	65.6%	73.0%		N/A	50.0%	56.7%		85.7%	65.6%	57.1%	
BENSON SUITE	88.8%	80.0%	100.0%		96.6%	98.1%	98.1%		97.0%	93.7%	94.0%		N/A	N/A	N/A		85.7%	90.0%	100.0%	
BREAMORE WARD	57.3%	70.8%	85.9%	*85.00%	94.2%	99.3%	99.6%	*97.22%	69.8%	91.9%	87.5%	*96.30%	34.3%	56.6%	79.3%	*69.23%	21.4%	57.1%	84.6%	*64.29%
BREAST CARE (NEW)	-	-	74.7%	88.8%	-	-	100.0%	100.0%	-	-	89.5%	100.0%	-	-	79.1%	81.8%	-	-	75.0%	75.0%
BRITFORD WARD	67.3%	71.4%	67.3%		98.2%	99.6%	100.0%		73.3%	91.6%	91.2%		70.3%	65.3%	50.0%		76.9%	69.2%	61.5%	

Cleaning Scores - April 2022 (week 1)

WEEKLY - VERY HIGH RISK
Apr-22
Score Rating - Pass, Qualified Pass, Fail
Target Cleanliness score – 98%

AREA AUDITED	DATE	AUDITOR	WARD/DEPARTMENT	SCORE	%
Week 1			AUDITOR		
Britford Acute Female/Male	30-Mar-22	P Tomlinson	J Sapiago	P	100%
Burns Theatre	31-Mar-22	B Considine	no one available	P	100%
Cardiac Theatres	31-Mar-22	B Considine	J Cule	P	100%
Day Surgery Theatres (Downstairs)	30-Mar-22	J Studholme	no one available	P	100%
Day Surgery Theatres (Upstairs)	30-Mar-22	J Studholme	no one available	P	100%
Emergency Department	30-Mar-22	P Tomlinson	V Golden	P	100%
Longford Ward High Care	31-Mar-22	A Miller	R Joseph	P	100%
Main Theatres	03-Apr-22	K Scott	J Cacho	P	100%
NICU	02-Apr-22	K Scott	J Eadle	P	100%
Obs & Gynae Theatre	31-Mar-22	B Considine	S Hutchby	P	100%
Oncology Day Unit	01-Apr-22	A Miller	no one available	P	100%
Pembroke Suite	30-Mar-22	A Miller	C Smith	P	100%
Pembroke Ward	31-Mar-22	A Miller	C Smith	P	100%
Plastic & Oral Surgery Theatres	30-Mar-22	P Tomlinson	no one available	P	100%
Radnor	02-Apr-22	K Scott	E Papai	P	100%
Short Stay Emergency Unit	30-Mar-22	P Tomlinson	L Rodell	P	100%

MONTHLY - HIGH RISK
Apr-22
Score rating - Pass, Qualified Pass, Fail
Target Cleanliness score – 95%

AREA AUDITED	DATE	AUDITOR	WARD/DEPARTMENT	SCORE	%
			AUDITOR		
ADL Flat	08-Apr-22	A Miller	no one available	QP	99%
Amesbury Suite	22-Apr-22	B Considine	L Comiso	QP	99%
A.M.U. Acute Medical Unit	25-Apr-22	B Considine	no one available	P	100%
Breamore Ward	20-Apr-22	B Considine	A Abraham	P	100%
Britford Ward	20-Apr-22	B Considine	no one available	P	100%
Cardiac Suite	21-Apr-22	B Considine	A Mcgeaorge	QP	99%
Chilmark Suite	22-Apr-22	B Considine	no one available	QP	99%

Day Surgery Unit GF	06-Apr-22	B Considine	D Waters	P	100%
Day Surgery Unit FF	06-Apr-22	B Considine	D Waters	P	100%
Downton Ward	21-Apr-22	B Considine	C Gribben	P	100%
Durrington Suite	25-Apr-22	B Considine	O Swaffield	P	100%
Farley Ward	28-Apr-22	B Considine	no one available	QP	99%
Gynae Clinic	11-Apr-22	B Considine	no one available	P	100%
Labour Ward	11-Apr-22	B Considine	L Lichfield	P	100%
Laverstock Ward	28-Apr-22	B Considine	no one available	P	100%
Longford Ward Leftside	08-Apr-22	A Miller	R Joseph	QP	99%
Longford Ward Rightside	08-Apr-22	A Miller	R Joseph	QP	99%
Main Public Toilets	18-Apr-22	B Considine	no one available	P	100%
Main Theatres	01-May-22	S Down	M Jimenes	P	100%
Maternity Day Assessment Unit	11-Apr-22	B Considine	no one available	P	100%
Odstock Ward	21-Apr-22	B Considine	no one available	QP	99%
Palliative Care/Hospice GF	06-Apr-22	B Considine	N Muir	QP	99%
Pitton Ward	21-Apr-22	B Considine	no one available	P	100%
Post Natal Ward	26-Apr-22	B Considine	S Renshaw	P	100%
Radiology - Room 7	25-Apr-22	B Considine	no one available	P	100%
Redlynch Ward	21-Apr-22	B Considine	no one available	P	100%
SAL	01-May-22	S Down	no one available	P	100%
Sarum Ward	25-Apr-22	B Considine	C Thompson	P	100%
SDU	29/04/22	B Considine	No one available	P	100%
Spire Ward	28-Apr-22	B Considine	J Baby	QP	99%
Tisbury/CCU Ward	22-Apr-22	B Considine	no one available	P	100%
Whiteparish Ward	22-Apr-22	B Considine	T Cleetus	QP	99%

Significant Risk Areas – Not routinely audited
Low Risk Areas - Not audited

4.0 New National Standards

NHS England commenced consultation on a revised national standard in 2018 and the new National Standard for Healthcare Cleanliness was published on 4th May 2021. The new standard will apply, for the first time, to all healthcare settings and also for the first time, is mandated through the Health and Social Care Act. The Care Commission and NHS England will include compliance with the new standard within their inspection regimes. Compliance will also be monitored through existing annual returns such as the Premises Assurance Model.

The mandatory requirements within the standards are:

- Functional risk categories
- Elements
- Frequencies and performance parameters
- Cleaning responsibilities
- Audit frequencies
- Published Star ratings

- Efficacy checks
- Commitment to Cleanliness Charter

A number of these requirements are in place including – functional risk categories, elements, cleaning responsibilities and audit frequencies, however these would require significant change to achieve the new standards.

Star ratings are a new, simpler way of presenting audit scores to members of the public requiring public display of performance against the new standard. The publication of Star ratings on ward and department doors is designed to raise standards but has the potential of increasing anxiety.

Efficacy checks are a new style of audit, focusing on ensuring the correct methods of cleaning are being followed – previous standards focused all audits on the visual standard following cleaning, rather than ensuring the correct cleaning procedure are followed.

Commitment to the Cleanliness Charter demonstrates the Trusts commitment to cleanliness to members of the public, and show information on how frequently and by whom each element in an area is cleaned. We would be required to display the Cleanliness Charter (A3 size) (appendix 1), where it will be seen e.g. outside lifts and at the entrances to wards and departments, making it easily accessible.

An element is an item, group of items or building element, such as ‘hard floor’, ‘sink and taps’, ‘waste bin’, ‘bed frame’, ‘over-bed table’ etc. Some elements are the responsibility of nursing staff, some the responsibility of Facilities and others the responsibility of Estates colleagues.

Functional Risk (FR) levels are used in the cleaning standards to define the required frequency of cleaning and the required audit score levels. The highest risk areas – FR1 (ICU, theatres etc.) are cleaned more frequently, and require the high audit score (98%). Most in-patient ward areas are FR2, Outpatients are FR4, and staff office areas are FR6. FR6 is cleaned the most infrequently and the required audit score is 75%.

The most significant change for the Trust being the change in cleaning frequencies, the new National Standards identify a minimum frequency for cleaning each element in each area risk level. A Cleaning Frequency Gap Analysis has been completed comparing current practice and the new standards.

The current cleaning schedules, excluding the temporary changes made in response to the COVID pandemic, focus cleaning within our in-patient areas on weekday mornings, with limited cleaning during the afternoon or at weekends. Special (terminal) cleans requested by clinical teams (during the morning) are completed by the ward cleaner, reducing available time for routine cleaning. A response team is available during the afternoon, evening and overnight for special (terminal) cleans.

A large number of our current cleaning frequencies fall below the required minimum set out in the new national standards for example side rooms and bays are currently fully cleaned

once per day, the national standard require these areas to be fully cleaned once per day, with an additional check clean later in the day, to ensure the standard is being maintained.

As part of the Trust's COVID response, additional cleaning was introduced in April 2020, including a night cleaning team, this additional cleaning ceased on September 2021 in line with the Trusts step back from additional COVID funding.

4.1 Implementation of the New National Standards
The Trust will not require a complete and extensive re-design of the service to meet the new cleaning standards, however, the significant increase in cleaning frequencies and auditing will require significant additional resource, including cleaners, Housekeeping supervisors and housekeeping consumables.

Some example of the cleaning frequency changes are highlighted below:

Area	Descriptive Element	Current Frequency	New Required Frequency
Outpatient areas (SFT have 42)	Sink taps toilets	Once a day	Twice a day
Outpatient areas	Clean touch points and doors, both sides	Weekly	Full Clean Daily
All areas	Dusting of lighting	Monthly	Daily
All Areas	New Element Cleaning of trolleys	Currently undertaken if infection clean -clinical staff	Full clean daily
All Areas	Cleaning of both Hard and Soft floors	Clinical - Daily And Lower risk areas/staff areas X2 weekly	Daily clean with X2 check cleans daily.
All Areas	Internal glazing	Weekly	Full clean daily

In order to manage the increase in frequencies across all risk categories, it is proposed that ward cleaners remain on their assigned ward, currently a ward cleaner will also clean other areas within the hospital during their shift, including out-patient departments.

It is proposed that we recruit 15 wte (Band 2) cleaners to clean to the required new standards within the outpatient departments.

The recruitment of additional staff, in addition to current turnover, is likely to take approx. 14-20 weeks.

5. Options

5.1 Options appraisal

Three options are being presented within this case.

Option 1- Do Nothing

Do nothing, requiring no additional investment.
Option1 does not meet the cleaning frequencies mandated within the new National Standards for Healthcare Cleanliness (2021).

Description:	Return to pre-COVID levels of cleaning, which do not meet the minimum mandated cleaning frequencies of the National Standards of Healthcare Cleanliness or the 2007 Cleaning Specifications.
Benefits:	• Lowest cost option • No change for cleaning staff as continue using existing practices and shift patterns
Risks:	• The Trust will not comply with the mandated National Standards of Healthcare Cleanliness or the 2007 Cleaning Specifications, risk of a reduction in CQC rating and affecting the reputation of the Trust • No 24/7 response team, risk on patient flow. • Reduction in cleaning frequency through annual leave and sickness and increased demand upon the service, increasing risk of infection transmission through a contaminated environment • Inadequate supervisory provision – the majority of cleaning is unsupervised. • Band 3 Supervisors will remain responsible for the management of 28 staff (including appraisals), reduces direct supervision • Auditing remains at current levels, measured against the 2007 specifications – excluding significant and low risk areas • The new Star rating is not implemented.
Cost:	No additional investment required

Option 2 – Minimum mandated cleaning frequencies

To implement the minimum mandated cleaning frequencies as outlined in the new National Standards of Healthcare Cleanliness (2021).

Option 2 includes cover for Band 2 cleaners and Band 3 supervisors and additional window cleaning. The predominantly (band 2) cleaning team is a large workforce (135 wte) working across the site, the workforce require support and supervision to ensure required tasks and cleaning frequencies are being adhered to. In line with the increase in the number of cleaners, an enhanced supervision team has been included.

Currently, band 3, cleaning supervisors have up to 28 appraisals to complete each year. An increase in the supervisory team will support a reduction in the number of appraisals each supervisor is required to complete (to approx. 16 – 20 each) and take on the extra auditing tasks and star rating, within each area.

Description:	Implementation of New Cleaning Standards, reviewing staff allocation to ensure the minimum mandated cleaning frequencies of the National Standards of Healthcare Cleanliness. Increase in Auditing across all risk categories with a Star on the doors rating.
Benefits:	• Enables the Trust to meet the mandated requirements of the National Standards of Healthcare Cleanliness • Increased cleaning frequency of elements in in-patient areas reducing risk

	of infection spread through the environment • 24/7 response team (night shift) for all special (terminal) cleans, maintaining scheduled cleaning frequency • Annual leave and sickness cover included in costs to ensure all in-patient areas and departments are cleaned to required frequencies • Adequate supervision to ensure all cleaning staff are supported in their work, receive meaningful annual appraisal and undertake additional auditing requirements. • Appropriate time provided in cleaning schedules to clean all elements at required schedule.	
Risks:	• Significant increase in cost • Significant recruitment required to meet planned staffing levels.	
Costs:	Cost of additional 15 x band 2 cleaners (7 days per week 6am to 2pm) inclusive of 19%.	**£736,689 pa**
	Cost of additional 4 x band 2 cleaners (7 days per week 2pm to 8pm) inclusive of 19%.	**£139,435 pa**
	Cost of additional 1 x Band 3 supervisor (7 days per week 6am to 2pm) inclusive of 19%.	**£52,412 pa**
	Cost of additional 1 x Band 3 supervisor (7 days per week 12 to 8pm) inclusive of 19%.	**£50,933 pa**
	Additional 12% for cleaning material for Band 2 hours	**£117,536 pa**
	Window Cleaning (contractor)	**£15,000.00**
	Credits for cleaning (auditing software) upgrade to encompass new auditing requirements	**£4,650.00**
	Extra Linen provision (Mops)	**£6,000**
	Recurring - Total cost	**£1,122,655**
	Non-Recurring Costs	
	Cleaning Trolleys	**£3,000**
	Uniforms (21 staff)	**£1,680**
	Non-Recurring Costs Total	**£4,680**

Option 3 – Enhanced Cleaning Service

Option 3 seeks to support the Housekeeping team in responding to service pressures, but does not follow the specified cleaning frequencies or risk categories stated within the new National Cleanliness standard.

Description:	Supports the Housekeeping team in responding to current service pressures and increases cleaning frequencies within patient areas in a stepped approach, moving towards the new national cleaning standards. **Critically, this option will not follow the specified cleaning frequencies or risk categories stated within the new National Cleanliness standards.**	
Benefits:	• Improved levels of supervision – reducing the amount of unsupervised cleaning (undertaken by band 2 staff). • Increased cleaning frequency in out-patient and public areas, reducing risk of infection spread through the environment • 24/7 response team (night shift) for all special (terminal) cleans. • Increased cleaning in high risk areas – including Public areas • Increased cleaning in significant risk areas – including Outpatients • Auditing of Significant risk areas would commence	
Risks:	• The Trust **will not** comply with the mandated National Standards of Healthcare Cleanliness risking a reduction in CQC rating and affecting the reputation of the Trust • No increase in the cleaning of low risk areas • No monitoring or auditing of low risk areas • The new Star rating is not implemented. • Increased cost of cleaning service • Recruitment of additional staff	
Costs:	Cost of additional 5 (wte) band 2 cleaners (5 days per week 6am to 2pm) inclusive of 19%.	**£ 82,558 pa**
	Cost of additional 5 x (0.5 wte) band 2 cleaners (5 days per week 6am to 10am) inclusive of 19%.	**£58,708 pa**
	Cost of additional 4 x band 2 cleaners (7 days per week 2pm to 8pm) inclusive of 19%.	**£139,435 pa**
	Cost of additional 1 x (wte) Band 3 supervisor (5 days per week 12 to 8pm) inclusive of 19%.	**£24,141 pa**
	Night Time Team Cost of additional 2 x Band 2 cleaners (7 days per week 23:45hrs – 06:00hrs) inclusive of 19%.	**£47,338 pa**
	Additional 12% for cleaning material for Band 2 hours	**£56,317 pa**

	Recurring - Total cost	**£408,497**
	Non-Recurring Costs	
	Uniforms (17 staff)	**£1,360**
	Non-Recurring Costs Total	**£1,360**

Preferred Option
Option 3 is the preferred option
Option 3 seeks to support the Housekeeping team in responding to service pressures, but does not follow the specified cleaning frequencies or risk categories stated within the new National Cleanliness standards.

Low risk areas would still not achieve the 2007 cleanliness target score.

Investment of £408k pa (recurring) an 18.1% increase on the 2021/22 housekeeping budget. Recognising the lead to the recruit the (17) proposed staff, the investment request for 2022/23 is £238k (funding from September 1st 2022) and £408k recurring from 2023/24.

Investment at this level would increase cleaning cost per occupied metre square (in a full year, as defined by the ERIC definition), from £24.51 (2020/21) to £28.97.

This option is not compliant with mandated minimum cleaning standards and will not deliver compliance against the new National Cleanliness Standard.

Appendix 1

Cleaning - National Specifications (2007) Summary

The National Specifications for Cleanliness in the NHS, published by the National Patient Safety Agency (NPSA, 2007). provides guidance from which Trusts can set local specifications to provide an assurance framework, to support compliance with the core cleanliness standard (C21) and the Health Act 2006.

Summary

Wards, Departments and Units within the Trust are described as **functional areas**. Each Functional area is assigned one of four **risk categories** to represent the different degrees of risk and therefore, require different **cleaning frequencies.** Each area has been issued one of four different **cleaning schedules**, these in turn will attract different levels of monitoring and auditing.

Risk Categories:

5. Very High Risk — Theatres, ED, SSEU, Pembroke
6. High Risk — General Wards, Maternity, Spinal Unit, Public areas
7. Significant Risk — Outpatients, clinics, labs, Pathology, Pharmacy
8. Low Risk — Offices, Admin, Stores, Records

Associated internal adjoining areas e.g. corridors, toilets and offices, are treated as having the same risk category as the department, ward or unit. Risk categories may be changed with approval from the Director of Infection, Prevention and Control.

Cleaning tasks are grouped and described as **Elements**, there are 49 Elements, however, not all will apply in each **Functional area**..

Audit Scores

The overall performance target for the Trust and targets for each risk category will be agreed with the Director for Infection, Prevention and Control.

Cleaning Schedules

Cleaning schedules are displayed in publicly accessible areas on all wards, in all clinics and in other patient areas and are displayed in all non-clinical areas (e.g. offices, stores). These must not be removed, covered or altered and aim to::

- Support the drive to reduce healthcare associated infections
- Provide a common understanding of what is to be cleaned, by whom & how often
- Ensure cleaning related risks are identified and managed on a consistent, long term basis
- Form a basis for developing cleaning services further
- Set a standard against which cleaning services may be benchmarked
- Establish the right staffing levels
- Form part of our ongoing performance management process

- Improve patient, staff and visitor satisfaction.

Cleaning schedules will be routinely reviewed and updated as necessary, with the approval of the Director for Infection, Prevention and Control.

Ian Robinson
General Manager, Hotel Services
1st October 2008

Appendix 2

CLEANING RISK CATEGORIES
NATIONAL SPECIFICATIONS OF CLEANLINESS (2007)

Different functional areas within the Trust represent different degrees of risk and therefore, require different cleaning frequencies and different levels of monitoring and auditing. Consequently, all functional areas are assigned one of four risk categories:

9. Very High Risk
10. High Risk
11. Significant Risk
12. Low Risk

1. Very High Risk Functional Areas

Consistently high cleaning standards must be maintained. Both informal monitoring and formal auditing of standards takes place continuously, audited at least once a week.

Very High Risk Functional Areas:-

- Theatres
- Radnor Ward
- Pembroke Suite
- Pembroke Ward
- Britford High Care
- Day Surgery Unit
- NICU (Neonatal Intensive Care Unit)
- Emergency Department
- SSEU(Short Stay Emergency Unit)

2. High Risk Functional Areas

Both informal monitoring and formal auditing of standards takes place continuously, audited at least once a month.

High Risk Functional Areas:-

- General Wards
- Sterilisation and Disinfection Unit
- Public toilets
- Spinal Unit
- Hospice
- Burns Unit
- Leisure Centre
- Maternity Services
- Day Nursery
- Public corridors & entrances

3. Significant Risk Functional Areas

In these areas, high standards are required for both hygiene and aesthetic reasons. Both informal monitoring and formal auditing of standards takes place continuously, audited at least once every three months.

Significant Risk Functional Areas:-

- Pathology
- Out-patient Departments
- Nunton Day Unit
- Mortuary
- Laboratories
- Pharmacy
- All Clinic Areas

4. Low Risk Functional Areas

In these areas, high standards are required for aesthetic reasons and to a lesser extent, hygiene reasons. Both informal monitoring and formal auditing of standards takes place continuously, audited at least twice a year.

Low Risk Functional Areas:-

- Administration areas - offices
- Non sterile supply areas
- Records storage/archives
- Procurement and storage areas.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	7.1
Date of Meeting:	07 July 2022		

Report Title:	Final Annual Report and Accounts 2021/22			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x			
Approval Process (where has this paper been reviewed and approved)	Audit Committee 16th June – Approved			
Prepared by:	Kylie Nye, Head of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Integrated Governance			
Appendices (list if applicable):	N/A			

Recommendation:
The Board is asked to note the Trust's final 2021/22 Annual Report and Accounts.

Executive Summary:
The Trust's Annual Report and Accounts was approved at the Audit Committee on 16th June 2022. The report was laid before Parliament on 28th June 2022 and can therefore be published in the Trust's public board papers and on the website. The communications team will be producing an 'Annual Review' which summarises the key points from the 2021/22 Annual Report.

Board Assurance Framework – Strategic Priorities	Select as applicable
Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒
Other (please describe) -	☐

Salisbury NHS Foundation Trust

Salisbury NHS Foundation Trust Annual Report and Accounts 1 April 2021 to 31 March 2022

Salisbury NHS Foundation Trust

Annual Report and Accounts

2021 to 2022

Presented to Parliament pursuant to
Schedule 7, paragraph 25(4)(a) of the National Health Service Act 2006.

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If you would like further copies of this report, need a copy in larger print, another language or on tape please contact the Chief Executive's Department.

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www.salisbury.nhs.uk

PERFORMANCE REPORT

PERFORMANCE OVERVIEW FROM THE CHIEF EXECUTIVE

Overview of Performance

This overview provides a summary of the Trust and its activities. It highlights the Trust's performance against both the NHS national performance standards and the Trust's own corporate and strategic aims. It sets out the primary risks and challenges the Trust has encountered in the delivery of its objectives and how these have impacted on performance.

Chief Executive's Statement

As the hospital community has adapted to the changes in the management of the COVID-19 pandemic, we have adapted our work to meet the challenges of both ongoing and rapid changes in the virus and its impact on our populations. We have been agile in responding to the impact this has had on staff and alert to the wider need to recover our services and meet the current and future needs of the people who use our services.

There has been little respite and 2021-22 has been marked by a significant transition from a national incident management of the pandemic, through to ambitious plans to recover our elective activity whilst still responding to COVID-19. This has included working to return to pre-pandemic levels of productivity, particularly in our planned care services. This has not been an easy transition, notably because the absence rates in our workforce due to COVID infection or isolation plus an increasing turnover rate in colleagues joining or leaving the Trust has put relentless pressure and challenge on an already stretched workforce.

Both the hospital and the wider health system has spent much of the year on the highest operational escalation level (OPEL 4). This has put significant strain on our bed capacity with the requirement to have all escalation beds open throughout much of Q4. There has been a significant increase in the numbers of people delayed in the hospital waiting for ongoing care in the community (nationally described as No Criteria to Reside), which we are committed to resolving with the help of our health and local authority system partners.

The Trust has continued to engage with our partners to address the significant risk that the increase in people with a delayed discharge has posed to both effective flow in the hospital and to those waiting for elective care. Some patients are experiencing longer waiting times in our Emergency Department and our ability to increase elective activity levels to pre-pandemic levels has been impacted by the number of beds available on a day-to-day basis. Nevertheless, I am extremely proud of the teams in the hospital who have not only remained committed to providing outstanding care for our communities but have also continued to deliver our elective recovery plans, significantly reducing the number of patients waiting over 52 weeks for their planned treatment. We have kept pace with other hospitals in respect of both urgent and elective care which is testament to the dedication and efforts of our staff.

As part of our overall recovery from COVID-19, I am delighted that we launched our new Trust strategy 2022-26 in September 2021, which sets out our priorities for the next five years. This is supported by our Improving Together programme, which will help us both meet our strategic priorities of Population, Partnerships and People and is focused on developing a culture and ways of working that promotes continuous improvement across our organisation.

I would like to thank all our staff and partners for their continued efforts and recognise that many of them have been working in a highly pressurised environment on a sustained basis over this last year. I would also like to acknowledge that this environment has meant we have not always been able to provide the level and responsiveness of care and service that we commit to in our vision to provide an outstanding experience. I am confident, however, that the dedication of our teams and support from system partners will enable us to take further positive steps to achieving the best possible health outcomes for our local populations.

Stacey Hunter
Chief Executive (Accounting Officer)
16/06/2022 (on behalf of the Trust Board)

Purpose and Activities of the Trust

Introduction to Salisbury NHS Foundation Trust

Salisbury NHS Foundation Trust is a statutory body, which became a public benefit corporation on 1 June 2006.

We deliver a broad range of clinical care to approximately 270,000 people in Wiltshire, Dorset and Hampshire which includes:

- Emergency and elective inpatient services
- Day Case services
- Outpatient services
- Diagnostic and therapeutic services
- Specialist spinal rehabilitation, plastics and burns

Specialist services, such as burns, plastic surgery, cleft lip and palate, rehabilitation and the Wessex Regional Genetics Laboratory extend to a much wider population of more than three million people. Salisbury District Hospital includes the Duke of Cornwall Spinal Treatment Centre. This is a purpose built, 45 bed unit which specialises in caring for people who have spinal cord injury and serves a population of 11 million covering an area across most of southern England.

Our services are delivered by 4,800 staff who work tirelessly to deliver high quality care to our local population.

Our clinical services are delivered through a divisional management structure which co-ordinates and delivers high quality services. Services are provided through the following Clinical Divisions:

- Medicine
- Surgery
- Clinical Support and Family Services
- Maternity and Newborn

The clinical divisions are supported by a number of corporate functions including estates and facilities, finance, quality, human resources and information technology. Divisions are led by divisional management teams, with a clinical director, supported by a Divisional Director and Divisional Head of Nursing or allied health professional. This means that the hospital's clinically trained staff have direct responsibility for budgets and patient services, within their Division. The Divisions have a clear line to the Board reporting to the Chief Operating Officer who in turn reports to the Chief Executive.

As an NHS Foundation Trust, the Trust has a Council of Governors. The Trust Board is accountable to the Council of Governors. In addition, Governors have a wider role which includes ensuring that the local community and staff have a say in how services are developed and delivered by the Trust.

The Trust has two subsidiary companies, Odstock Medical Ltd and Salisbury Trading Limited. Odstock Medical Ltd (OML) was set up in 2005 to market worldwide its experience and knowledge of functional electrical stimulation and its own pioneering electrical devices for patients who have had a stroke or other neurological disorders. Income generated is used for research and for new initiatives.

Salisbury Trading Limited provides a laundry service to Salisbury District Hospital and other NHS organisations. The Trust also works with other organisations in joint ventures. For instance, we work with our Acute Hospital Alliance partners, the Great Western Hospitals NHS Foundation Trust and the Royal United Hospitals Bath NHS Foundation Trust to provide adult community services across Wiltshire through Wiltshire Health and Care. It also works with Sterile Supplies Ltd to provide sterilisation and disinfection services to Salisbury District Hospital and other NHS organisations. Our procurement and payroll services provide support for a number of local NHS organisations.

The Stars Appeal is the official NHS Charity for Salisbury District Hospital. The Stars Appeal has been integral to our pandemic response, funding projects and distributing care packages which bring the hospital and our community together and make a positive impact on the lives of the people we serve and the staff who work at the Trust. The Stars Appeal has also been our primary link to NHS Charities Together throughout the course of the pandemic and we are extremely grateful for the charitable support that has been provided to enhance the care we provide. In 2021-22, we have implemented a wide-ranging governance review of the charity to establish a renewed vision, mission, goals and objectives.

Our Role in the Bath, North East Somerset, Swindon and Wiltshire Partnership (BSW)

We have made strides towards the statutory recognition of BSW as an Integrated Care Board from 1 July 2022. We recognise that we need to balance a system partnership approach with the Trust's priorities and promote relationships (formal and informal), clinical pathways and NHS structural reform which support solutions to our local challenges.

In order to achieve an outstanding experience in our health system, integrating service provision across BSW and locally in Wiltshire offers the best opportunity of addressing the challenges that lie ahead. This transformation approach has continued, and COVID-19 has accelerated an ever-closer collaboration between community services, Wiltshire Council and our local Primary Care Networks. The Trust has a shared vision for improving health and care for the local population.

In 2021-22 we have made significant steps in implementing our Acute Hospital Alliance with Great Western Hospital (Swindon) and Royal United Hospital (Bath) and are benefitting from increasingly collaborative clinical networks across BSW as a result. Our BSW Urgent Care and Elective Care Boards are leading our improvement work to drive recovery of our services from the pressures of COVID-19. Our Wiltshire Integrated Care Alliance is taking formal shape and is leading on work particularly associated with providing outstanding out of hospital care for our communities – or supporting patients who have had a spell in our hospital. As we learn more about how our services need to adapt in a post-pandemic period, our relationships with primary care continue to strengthen and we continue positive developments in our joint working.

Our Strategy 2022-26

Our updated strategy is a key step for the hospital as we set out our future plans and priorities. It articulates the important commitments we are making to our communities over the next five years, and is underpinned by our vision:
To provide an outstanding experience for our patients, their families and the people who work for and with us.
The strategy confirms our three new priorities:

- Improving the health & well-being of the Population we serve
- Working through Partnerships to transform and integrate our services

- Supporting our People to make Salisbury NHS Foundation Trust the Best Place to Work

These three priorities will guide how we work in the future as part of an integrated care system, along with Bath and Swindon. Publication of the updated strategy is the first step in using these priorities to continuously improve the way we work and focus on the things that are most important to our communities and staff.

As Improving Together, our new way of working, is rolled out across the Trust, we will increasingly prioritise our work through identification of key short- and long-term improvement projects:

Strategic initiatives. These are 'must do, cannot fail' programmes of work that apply Trust-wide, and running for several years. Because they are so important to the successful delivery of the strategy, they have dedicated delivery teams working to ensure they are delivered consistently to every SFT colleague. We have four strategic initiatives of which Improving Together is one, and the other three are:

- Digital Care
- Delivering our People Promise
- Improving Health and reducing health inequalities

12-month break-through objectives. These are operational in nature and where we will focus our improvement. As the name states, they will change every year and those set in 2021-22 are:

- Reducing falls
- Time to first outpatient appointment
- Same Day Emergency Care (SDEC)
- Time between no right to reside (NR2R) and discharge.

This continuous improvement approach applies to every aspect of our strategy, which everyone in the Trust has a role to play in achieving improvement and our priorities.

Corporate Objectives 2021-22

Prior to the roll out of Improving Together, corporate priorities for 21/22 were agreed as part of the annual business planning process. Five themes emerged which our priorities were framed around:

- Improving our patient flow
- Recovery from COVID-19
- Improving our maternity services
- Responding to staff health & wellbeing
- Improving our digital capability

These in turn drove particular projects – as set out in the table below:

Corporate Objective	Area of Focus
Improving patient flow	Frailty Integrated pathway
	Discharge improvement programme, including therapy rehab model
	Integration of Urgent care services
Recovery from COVID-19	Elective recovery programme
	QIA process to support decision making around increased activity and staffing models to support

Improving our maternity services	Review of maternity services
Responding to staff health and wellbeing	Best place to work
	Improving Together
	Staff health and wellbeing
Improving our digital capability	ePMA, Pathology LIMS, shared EPR, SBS (ledger)

Progress against our 2021-22 corporate objectives

Progress against the priorities has varied; the prolonged pandemic and sustained periods of operational pressure have limited ability to progress some of the work identified. Staffing pressures in relation to increased absence due to COVID sickness and isolation, and vacancies is identified as a challenge or risk to achieving almost all of the priorities. As we move in to 2022/23 some of the priorities remain a focus for the Trust and feature as Breakthrough objectives or vision metrics in the Improving Together programme.

Improving Patient Flow

Our front door frailty liaison service (OPAL) has developed Same Day Emergency Care pathways throughout the year and offers this to patients in our Emergency Department, Short Stay Emergency Unit and Acute Medical Unit over 50 hours a week – further hours have been approved and we expect a fully operational service to be in place in 2022-23.

While the hospital has experienced significant patient flow challenges throughout the year, remaining on OPEL 4 escalation for most of Q3 and Q4, we are making progress with improvement work in this area, guided particularly by Same Day Emergency Care and reducing the number of patients with no criteria to reside in hospital being identified as Breakthrough Objectives in Q3 of 2021-22. The work in this area has not been successful in improving performance in this area, and total bed occupancy has increased throughout the year, with escalation areas including Day Surgery and expansion to areas in our Spinal Unit remaining open as inpatient areas throughout Q3 and Q4. The Trust experienced a significant increase in patients with no criteria to reside occupying inpatient areas – in March 2022 this had increased to 20.2% of our available beds.

High levels of bed occupancy made flow through our Emergency Department challenging and unfortunately our patients have regularly experienced long waits for treatment in the department, with increased handover delays between our ambulance services and the department. We are continuing to expand our Same Day Emergency Care services to improve flow through the department (and reduce the number of inpatient admissions made from the Emergency Department) and this will continue to be a priority through 2022-23.

Recovery from COVID-19 – Elective Recovery

We have made good progress in returning elective care to previous levels. Theatre recruitment has continued strongly, with overseas staff now firmly embedded across the theatre's footprint. Additional staffing has supported the opening of two further theatres. These are component parts of a wider 3-year development plan for theatres which has been approved for implementation and is now overseen by a new Head of Theatres. As a consequence, we were able to meet our waiting list management objectives throughout Q3 and Q4. A further review of our waiting list assisted in an improvement against our trajectory in reducing overall waiting list size, which stood at 18,634 cases in March 2022.

Our outpatient activity has remained strong throughout the year, but there is renewed focus to free up capacity in outpatient services by reducing the number of follow up appointments that the Trust offers and undertakes – the national target is a reduction of 25% in 2022-23.

Supporting elective recovery, our diagnostic performance remained consistently strong throughout the year and met the standard in most modalities through Q2 and Q3. Increasing demand towards the end of the year and availability of workforce made this more challenging and performance reduced to 91.3% of patients receiving diagnostics within 6 weeks of referral in March 2022.

The most significant challenge has and continues to be elective bed capacity and escalation into our Day Surgery Unit, at the latter part of Q3 and throughout Q4. This has significantly impacted on the volume of elective activity that has been able to be undertaken, resulting from the consistently high numbers of no criteria to reside patients across the Trust's bed base.

Improving our Maternity Services

The Trust has worked with the Care Quality Commission (CQC) following their inspection of our maternity services on 31 March 2021, and subsequent improvement notice. The requirements set out in this notice were reported to have been met in December 2021. We proudly opened our new entrance and reception area providing improved and integrated access to maternity services including the labour ward, day assessment unit, antenatal clinic and the maternity scanning department (where we approved a business case to expand the service). Recruitment to vacant posts has been prioritised and an international recruitment campaign jointly with Gloucester and Great Western Hospitals has been launched. We have fully embedded our new management and divisional structure in Maternity and Newborn services.

The final report from Ockenden into Shrewsbury and Telford Hospital Trust was published on the 30th March 2022. The review detailed 1,600 clinical incidents and identifies repeated care and governance failures and sets out clear recommendations for all Trusts providing maternity services. The Board have had oversight of our progress against the interim Ockenden recommendations and work will continue with the Maternity and Newborn Division and triumvirate leadership team to respond to the full report. Whilst the focus on the report is on Maternity services there are broader lessons in respect of leadership and governance that the Trust will reflect on.

Responding to Staff Health and Well Being

2021-22 has continued to be very challenging for our staff across all professions – and our workforce has been profoundly affected particularly by absences relating to the Omicron variant of COVID-19. Substantial and ongoing absences have put additional pressures on our teams, our vacancy rates and turnover have increased and this has contributed to a challenging operational environment.

The Trust has been identified as an exemplar/pilot organisation for the implementation of the NHS People Plan and has worked to develop a Trust-level People Plan to support this. This has included a specific focus on supporting staff wellbeing. Our Health and Well Being strategy and plans have been refreshed over the year and we have delivered immediate wellbeing interventions for staff, particularly as part of our winter plan. We have made significant investments, including through the Stars Appeal, in projects to support staff both while they are at work and to give support during breaks and between working times.

Best Place to Work: Over 360 of our staff have benefitted from attending professional development training

National Staff Survey Results 2021

In 2021, 1,881 Trust employees completed the staff survey which was available between September and November. This year the results have been aligned with the NHS People Promise to see how the Trust compares against the seven elements in the Promise, and in comparison, with other acute trusts around the country. 90% of respondents felt that their role makes a difference to patients or service users. We know that the past two years have been difficult and exhausting for all our colleagues. The COVID-19 pandemic has disrupted our work and home lives in ways we could never have imagined, so it is important for us to understand the impact that has had on our experiences at work. It is good to see the positive results in some areas as this gives us the opportunity to learn and improve across the Trust.

However, there are other areas where the results are not as positive as we would like, and it is important that we understand more about that, and what would make SFT a better place to work for everyone. We know that many staff have said they are experiencing 'burnout' and the Trust acknowledges that staffing levels have been, and continue to be, a real challenge. The full survey results are available here:
https://cms.nhsstaffsurveys.com/app/reports/2021/RNZ-benchmark-2021.pdf

Improving our Digital Capability

We have made progress in our plans to transform our electronic prescribing (ePMA), electronic patient records systems (EPR) and pathology laboratory management systems (LIMS), and successfully replaced our financial ledger system using the nationally supported SBS service. We are now able to move forward, with our partners in BSW and the wider health and care system, to implement a shared records service and pathology systems and will continue this work in 2022-23. We have further identified improving Digital Healthcare as a Strategic Initiative for the Trust for the next 5 years, with an initial focus on these projects and improved Business Intelligence and analytics tools (having launched the use of Power BI in 2021). This will be supported by a costed 5-year digital plan.
We continue to improve digital access to our services for both patients and clinicians – our outpatients transformation programmes have included the roll out of a new Advice and Guidance system for our clinical partners and we continue to promote and develop the use of virtual appointments in many of our specialties where appropriate.

Trust Risks, Opportunities and Sustainability

The key emergent risks for the Trust are regularly reviewed as part of the Corporate Risk Register and are reported to Board and Committees through the Board Assurance Framework each quarter. The key risks that we are planning for as we continue recovery from COVID-19, and the plans we have to mitigate them, are summarised below:

Risk	Mitigation strategies
Increased or uncertain demand for COVID-19 related activity and COVID-19 forcing further staff absences.	• Bed modelling undertaken on worse/best/expected scenarios • TIF bid for dedicated elective capacity • Escalation plans adjusted to protect elective areas

IPC and ongoing designation of beds limits flexibility on delivery of elective care	
Uncertainty over future referral patterns and impact on waiting lists	• Increased visibility to Primary Care on waiting times • Implementation of Advice and Guidance platform
Workforce shortages across key clinical areas through inability to recruit, continued increased turnover	• 4 streams of work in People Plan including overhaul of recruitment practices, flexible working policy, rostering and offer to temporary / bank staff
Failure of system-wide plans to address high numbers of patients in hospital with no right to reside	• Creation of protected elective capacity • SDEC and No Criteria to Reside Breakthrough Objectives and resultant plans
Estates risks disrupt delivery of elective activity	• Estates Transformation programme, shared leadership with RUH (Bath) • Targeted Investment Fund bid for ward capacity • Prioritisation of capital programme
Ability of Trust to deliver efficiencies through priority projects	• Further focus on benefits realisation in Breakthrough Objectives • Approved business case evaluation to ensure savings
Inflationary increases beyond planned cost base	• Review procurement opportunities • Continue with implementation of Green Plan to mitigate increases in energy costs

Going Concern

Our Board considered an assessment of the Trust as a going concern at its meeting on 7 April 2022. A number of risks to this position were identified including a planned deficit position for 2022-23 and the uncertainty on material inflation rises throughout the next financial year.

After making enquiries the directors have a reasonable expectation that the services provided by the NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Looking forward to 2022-23

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

Increasingly, our ability to deliver our operational plan is reliant on interdependencies across our health and care system and achieving a consistent and coherent picture across BSW has been a priority to ensure we can align our own plans and ambitions with the support of the wider BSW partnership.

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

Ultimately, our plan for 2022-23 is based on a series of balances – a commitment to move forward with the Trust strategy and make progress against our priorities of People, Population and Partnerships, renewed drive for improvement through Improving Together, a clear and ambitious national expectation for elective recovery and a recognition that the pandemic has increased our challenges in managing non-elective activity and the inter-relationships between acute hospital care and community and social care services. In managing these balances, we have submitted a plan that does not fully achieve with the national recovery requirements and seeks to manage a significant £18m planned deficit but represents a realistic view of the activity recovery and workforce sustainability that the Trust can achieve in the next 12 months.

PERFORMANCE ANALYSIS

The Trust publishes a monthly Integrated Performance Report (IPR) which provides both the Board and the public with an overview of our performance. The report is structured around the strategic and enabling priorities identified by the Trust, and divided into performance sections of Operational, Quality, Workforce and Resources. The report evolves to reflect new areas of monitoring or national focus.

Our monthly integrated performance reports are available on our website as part of monthly Board papers and can be downloaded via:

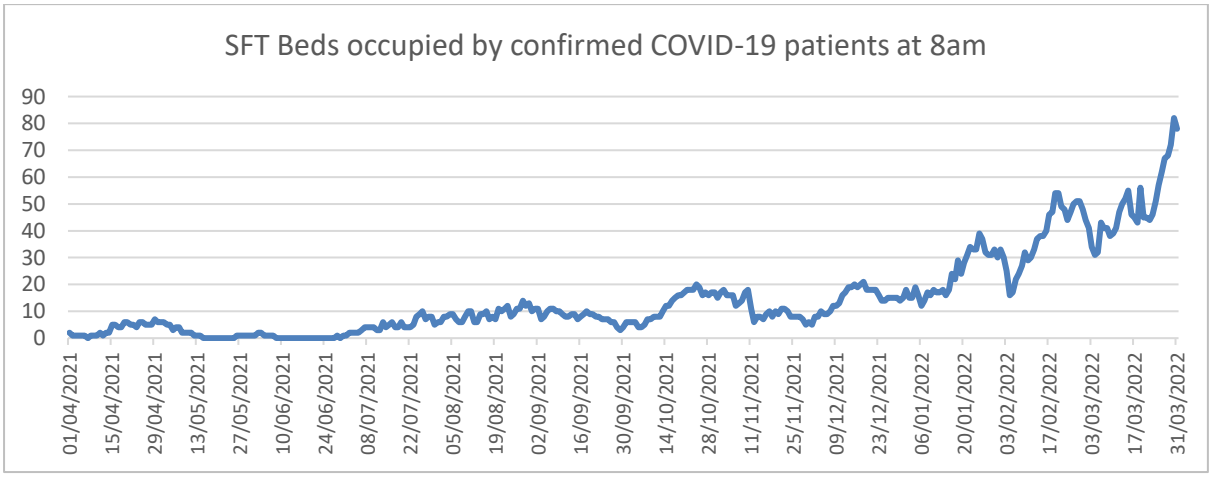
https://www.salisbury.nhs.uk/about-us/the-trust-board/board-papers/

Each of the four performance sections of the IPR are presented at Board Committees, and then brought together into one integrated document for presentation and scrutiny at Trust Board. The statistical process charts allow our Board and Committees to see trend analysis for the previous 24 months, which in an extraordinary year affected by the presence of COVID-19 provides more depth and understanding around our performance.

Performance overview

COVID-19 bed occupancy

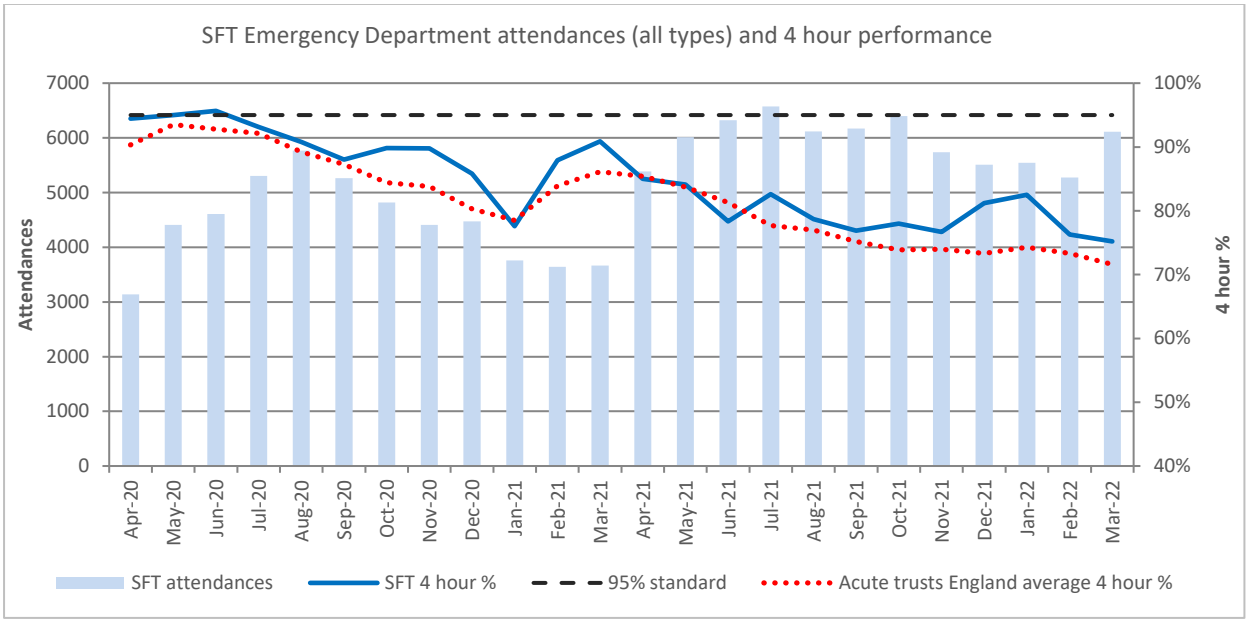
The management of processes around COVID-19 continued to put some additional pressure on the Trust, both in terms of managing patients presenting at the Hospital with COVID-19 symptoms, and the impact from reduced staffing levels as a result of increased sickness due to infection or isolation. There was sustained growth in the number of beds occupied by patients with confirmed COVID-19 throughout the year, peaking at around 82 beds on 31st March 2021, with a small number requiring ITU facilities. In the previous peaks bed occupancy for COVID-19 reached 44 (April 20) and 188 (Jan 21).



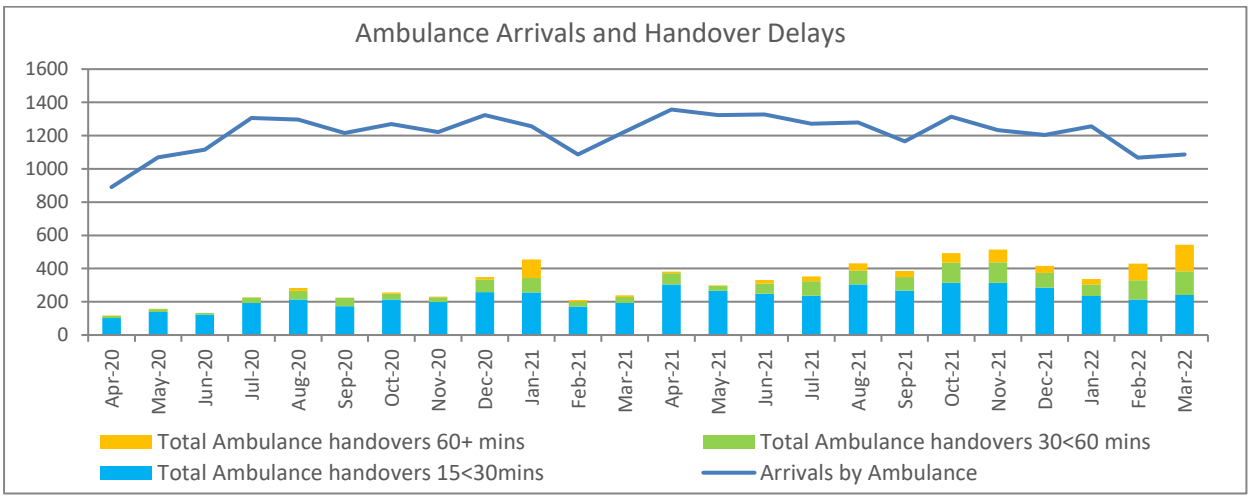
Emergency access

In the first year of the pandemic attendances to the Emergency Department (ED) fell, but across 2021/22 attendances returned to near pre-pandemic levels, with Type 1 (Salisbury Hospital Main Emergency Department) attendances exceeding prior levels in many months. Joint communication strategies with the Walk in Centre (WIC) were trialled which had some success in directing appropriate paediatric patients directly to the Walk in Centre, and the

department increased the number of Same Day Emergency Care pathways they were able to access.



The number of patients who were treated and discharged or admitted within 4 hours from the Emergency Department reduced throughout the year. The Trust did not achieve the 95% national target, however, the performance of our departments compared favourably with the average for acute trusts in England.

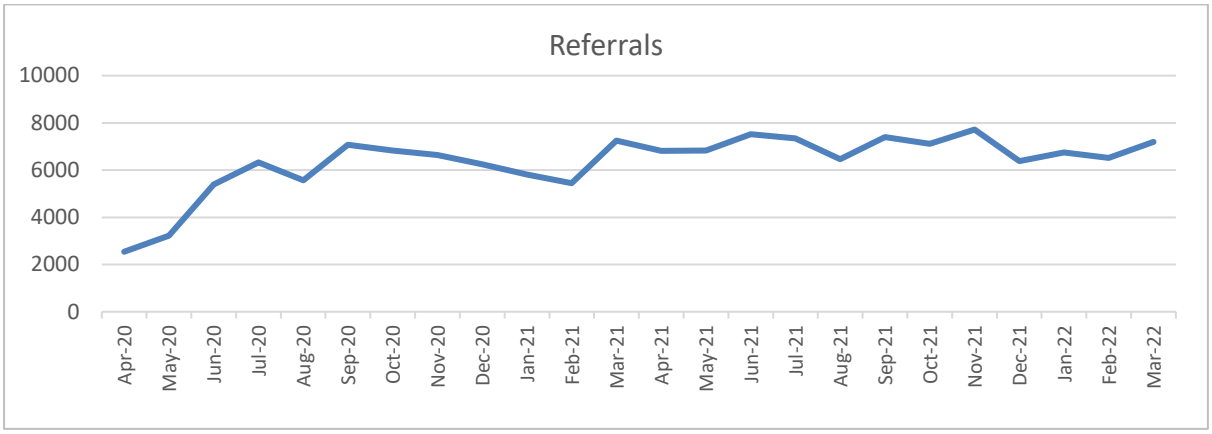


Bed occupancy levels in the Trust remained high throughout the year, with continued impact from COVID-19 and high numbers of inpatients no longer requiring acute care but waiting for alternative care options outside of the hospital. High occupancy levels in the Trust put pressure on flow from the Emergency Department into the hospital for patients requiring admission, and as a result there was an increase in the number of ambulances that were delayed handing over patients into the Emergency Department.

Elective waiting times

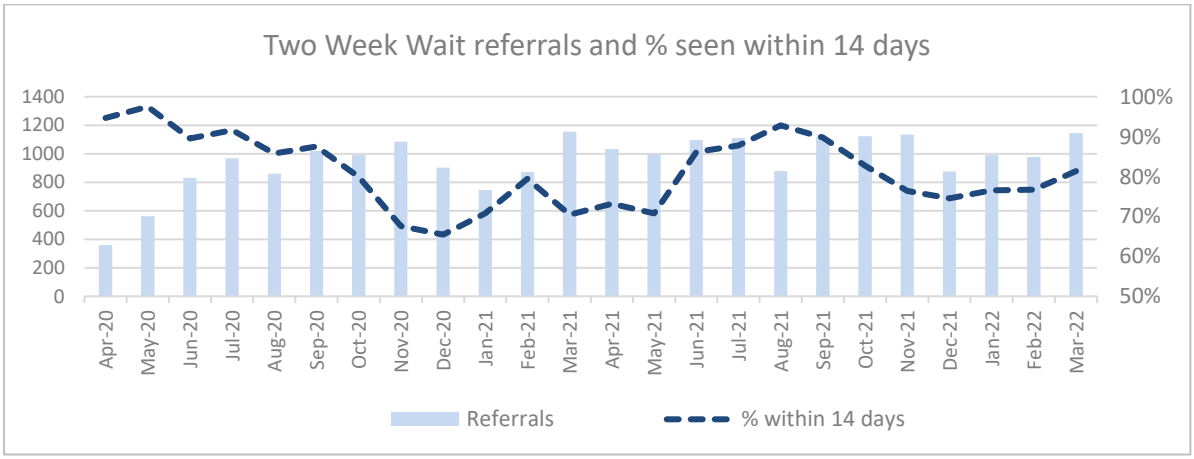
Referrals

A significant reduction in referrals was seen immediately post-pandemic, and although they have continued to rise, they are yet to exceed levels pre-pandemic. The Trust continued to build on its communication and relationships with GP practices to ensure awareness of service availability.



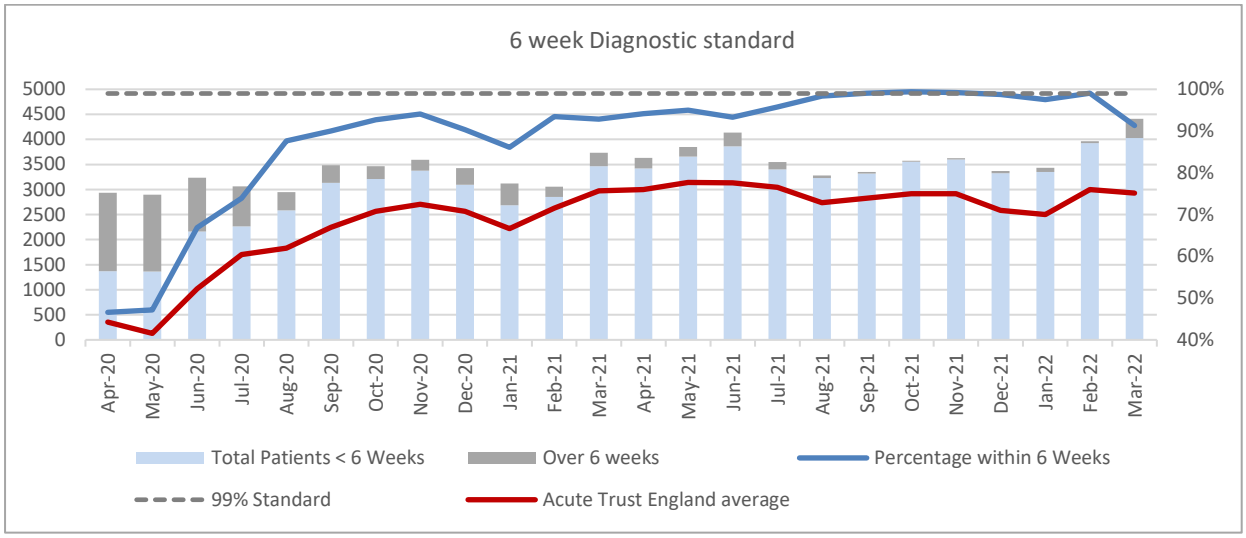
Two Week Wait Suspected Cancer referrals

The volume of cancer referrals received by the Trust has continued to rise following the initial reduction in the first wave of the pandemic, and by the end of the year had recovered to pre-pandemic levels. The 93% two-week standard was not achieved consistently throughout the year, with particular challenges in the Breast tumour site. Average waiting times for Breast two week wait services were around 16-17 days, with minimal impact upon the 31- or 62-day standard for the Breast tumour site. Patient choice continues to be a big factor across all tumour sites, the requirement to isolate and high COVID-19 community prevalence also influenced patients' abilities to be able to attend appointments within 14 days.



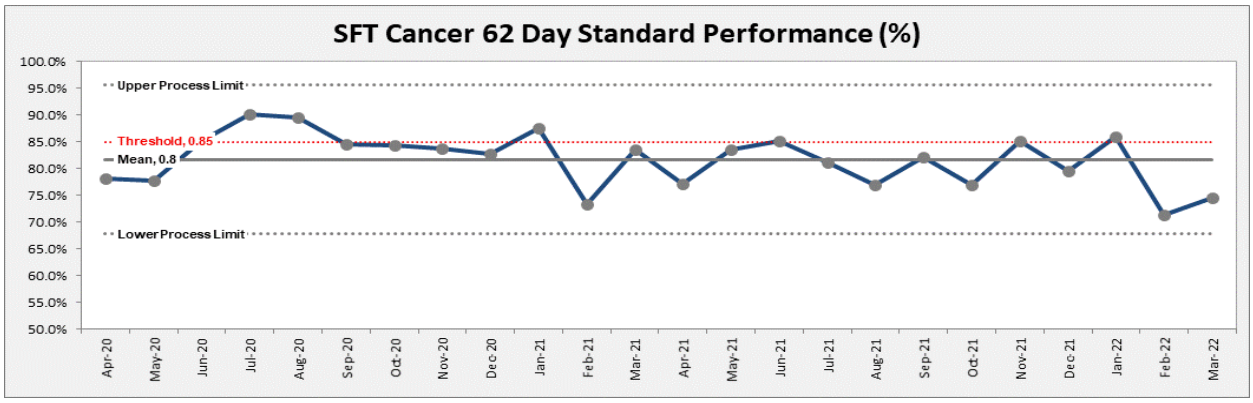
Diagnostics

Good progress has been made in recovery of the 6 week standard, with the Trust significantly ahead in comparison to the acute Trusts in England average. Vulnerabilities in maintaining achievement remain, with small services affected by increased sickness when COVID-19 prevalence increases, performance was affected by this in quarter 4.



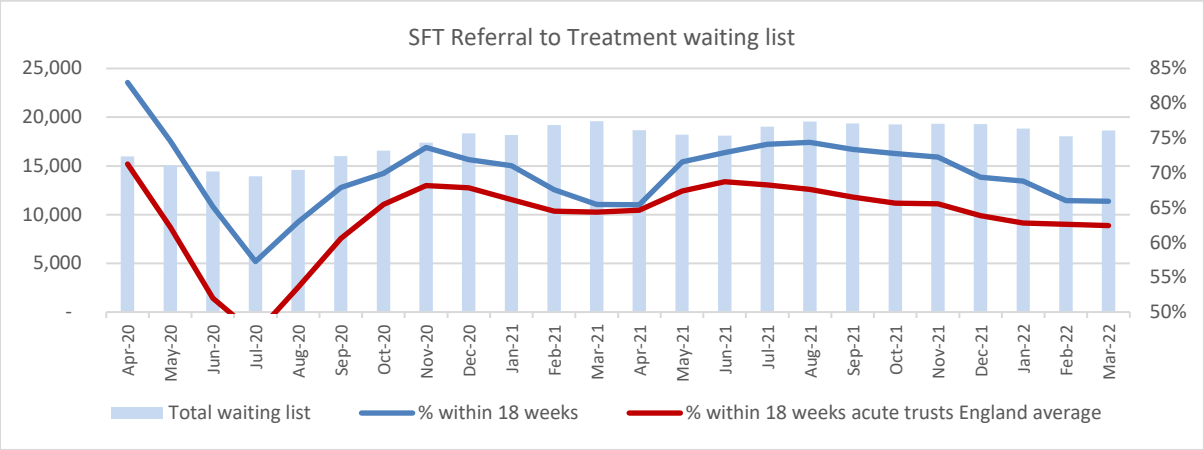
Cancer 62 Day standard – referral to first definitive treatment

Cancer services were protected throughout the pandemic the proportion of patients on a cancer pathway who received their first treatment within 62 Days remained broadly static overall, but not consistently achieving the standard. The trust benchmarks above the acute trusts England average, but continues to strive towards further improvement in cancer waiting times.

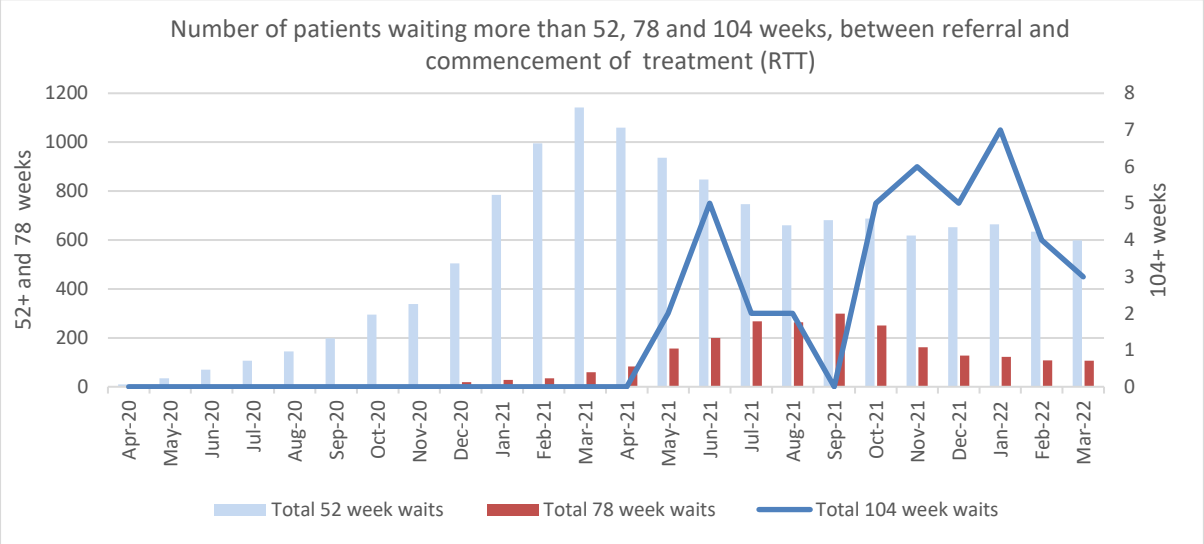


Elective waiting lists (Referral to Treatment)

The Trust has maintained focus on restoring elective activity levels in order to reduce the number, and length of time patients are waiting for elective surgery. A clinical prioritisation framework is used to ensure that clinically urgent patients are identified and treated within appropriate timeframes. The total waiting list size has been maintained despite increasing elective referrals, and challenges in increasing elective activity when the Trust is operating in excess of 95% bed occupancy levels.



The number of patients waiting longer than 52 weeks for a first treatment has reduced from 1059 in Apr 21, to 599 by Mar 22, and the number waiting over 78 weeks peaked at 264, reducing to 107 by Mar 22. There remains a small number of patients waiting over 104 weeks (three by Mar 22) which have been complex cases. Progress has been made in restoring theatre activity which has been complicated by challenges in recruitment and high absence rates for theatre staff.



Tackling Inequalities

Reducing inequalities in access to healthcare and clinical outcomes is a central theme in the NHS recovery plans from the COVID pandemic. Reducing inequalities is one of our 4 strategic initiatives, and a Health Inequalities Group, chaired by the Chief Medical Officer, has been established to oversee work in this area. Our initial focus has been:

- Consideration of how we address inequalities through clinical prioritisation and access to our elective care and maternity services. We are required to compile a system Equalities and Health Inequalities Impact Assessment relating to Elective Recovery plans and this will be completed by 30 June 2022.

- Improved visibility of data relating to inequalities in our population – focused on economic and social deprivation and inequalities for people with protected characteristics
- Addressing how our services cater for people with learning disabilities.
- Continued partnerships to support access to healthcare for our military and veteran populations and their families – including achieving Employee Recognition Scheme Gold status and Veterans Covenant Healthcare Alliance reaccreditation.
- We have continued participation and learning from BSW's participation in Wave 3 of the national Population Health Management programme.

We will report on our plans and progress in addressing Health Inequalities to the Trust Board and re-establish the Non-Executive lead role for Health Inequalities. We are adopting the national CORE20PLUS5 approach to reducing inequalities.

ACCOUNTABILITY REPORT

DIRECTORS' REPORT

Board of Directors

The Board of Directors is accountable, through the Chair, to NHS England and NHS Improvement and is collectively responsible for the strategic direction and performance of the Trust. It has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation.

Directors of Salisbury NHS Foundation Trust during 2022-22

Dr Nick Marsden	Chairman
Stacey Hunter	Chief Executive
Dr Peter Collins	Chief Medical Officer
Andy Hyett	Chief Operating Officer
Judy Dyos	Chief Nursing Officer
Lisa Thomas	Chief Finance Officer
Melanie Whitfield	Chief People Officer
Susan Young	Interim Director of Organisational Development and People
Lynn Lane	Interim Director of Organisational Development and People
Michael von Bertele CB, OBE	Non-Executive Director
Tania Baker	Non-Executive Director (Senior Independent Director)
Paul Kemp	Non-Executive Director
Paul Miller	Non-Executive Director
Eiri Jones	Non-Executive Director
Rakhee Aggarwal	Non-Executive Director
David Buckle	Non-Executive Director

Register of Directors' Interests

NHS employees are required to be impartial and honest in the conduct of their business. It is also the responsibility of all staff to ensure they are not placed in a position which risks, or appears to risk, conflict between their private interests and NHS duties.

Members of the Board of Directors are required to disclose details of company directorships or other material interests in companies held which may conflict with their role and management responsibilities at the Trust. There is an annual review of the Register of Interests and compliance with the Fit and Proper Persons Requirements. As a standing agenda item, the Directors declare any interests before each Board and Board Committee meeting which may conflict with the business of the Trust and excuse themselves from any discussion where such conflict may arise. The Trust Board considers that all its Non-Executive Directors are independent in character and judgement.

The Register of Declared Interests is made available to the public by contacting the Head or of Corporate Governance, Trust Offices, Salisbury NHS Foundation Trust, Salisbury District Hospital, Salisbury, SP2 8BJ. This can also be found on the Trust website following the link below:
https://www.salisbury.nhs.uk/media/314gxu1z/public-register-of-interests-2021_22_web_doc.pdf

NHS Improvement's Well Led Framework

The Trust has considered NHS Improvement's well-led framework in arriving at its overall evaluation of the organisation's performance and in developing its approach to internal control, board assurance framework and the governance of quality.

The Care Quality Commission (CQC) undertook an inspection of the well-led question in December 2019 and rated the Trust as 'Good'. The CQC stated that 'There was effective, experienced and skilled leadership, a strong vision for the organisation and embedded values. The leadership had the capacity and capability to deliver high-quality sustainable care. Leaders understood the challenges to quality and sustainability and they were visible and approachable. There was a clear vision for the Trust and strong values.'

During 2021-22, the Trust has focussed on the response to the COVID-19 pandemic and there have also been a number of changes to the Executive Directors. Acknowledging this, there was Trust Board agreement to undertake a self-assessment against the well-led framework in October 2021. An external well-led review will be commissioned in Autumn 2022.

The Annual Governance Statement describes in further detail the Trust's approach to ensuring services are well-led and quality governance. The Quality Account describes quality improvements in more detail.

Other disclosures

Modern Slavery Act 2021-22 annual statement

At the Trust we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. We are fully aware of the responsibilities we hold towards our service users, employees, and local communities. We are guided by a strict set of ethical values in all our business dealings and expect our suppliers (i.e., all companies that we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking.

Cost allocation and charging guidance issued by HM Treasury

Salisbury NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance.

Political Donations

The Trust has made no political donations of its own.

Better Payment Practice Code

The Trust conforms to the principles of the Better Payment Practice Code and aims to pay its bills promptly. Performance against the code can be viewed below. No interest was paid under the late Payment of Commercial Debts (Interest) Act 1998.

Better payment practice code	By Number	By Value £'000
Non-NHS	87.2%	89.5%
NHS	68.4%	69.9%
Total	86.7%	88.3%

Information on fees and charges

Please see table below which provides an aggregate of all schemes that, individually, have cost exceeding £1million.

		2021-22	*2020-21*	*2019-20*
	Expected sign			
Income	+	*14,028*	*13,065*	*14,535*
Full cost	-	*12,787*	*12,103*	*-11,577*
Surplus/Deficit	+/-	***1,241***	***962***	***2,958***

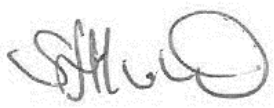
Income Disclosure

The Trust can confirm that income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

Other Income and Impact on Provision of Services

The Trust provides a variety of services to patients, visitors, staff and external bodies that generate income which cover the cost of the service and makes a contribution towards funding patient care. Services that generate income include payroll services, accommodation, catering, car parking, private patient treatment, pharmacy products and sterile supplies. The total income from all these areas amounted to around £6.3 million. The other areas contributed surpluses, which have been applied to meeting patient care expenditure. In addition, the Trust received £9.6 million through Salisbury Trading Ltd (excluding laundry undertaken for the Trust) and £2.2 million through Odstock Medical Ltd.

The Accountability Report has been approved by the Trust Board.



Stacey Hunter
Chief Executive (Accounting Officer)
16/06/2022 (on behalf of the Trust Board)

REMUNERATION REPORT

Chairman of the Remuneration Committee's Annual Statement on Remuneration

In accordance with the requirements of NHS England and NHS Improvement, this remuneration report consists of the following parts:

- An Annual Statement on remuneration
- The Senior Manager Remuneration Policy
- The Annual Report on remuneration

As the Chairman of the Remuneration Committee, I am pleased to present our remuneration report for 2021-22.

Senior managers have the authority or responsibility for directing and controlling the major activities of the Trust and for Salisbury NHS Foundation Trust this covers the Chairman, the Executive and Non-Executive Directors. It is important to note that the Remuneration Committee of the Board has responsibility for setting the terms and conditions for the Executive Directors, while responsibility for setting the terms and conditions for the Chairman and Non-Executive Directors lies with the Council of Governors, which is advised by the Performance Committee.

The Remuneration Committee reviewed the salaries and the individual reward packages of the Executive Directors for 2021-22. Salaries are set in comparison with those given to holders of equivalent posts within the NHS. Advancement within the individual salary scales of Executive Directors is based on successful appraisal outcomes and this is the only performance-related element of the Executive Director's remuneration. The Remuneration Committee works closely with the Chief Executive in reviewing each Executive Director's performance and the Chairman advises the committee on the performance of the Chief Executive.

2021-22 major decisions on remuneration

During 2021-22, the Remuneration and Nominations Committee did not make any major decisions affecting remuneration for very senior managers. Three Executive Directors have received an uplift in pay in 2021-22 in consideration of national benchmarking and guidance.

The changes to the Trust's Executive team during 2021-22 were:

- Lynn Lane left her post as Interim Director of OD and people on 6 April 2021
- Susan Young left her post as Interim Chief People Officer on 31 August 2021
- Melanie Whitfield started her role as Chief people Officer on 6 September 2021

Nick Marsden
Remuneration Committee Chairman
16/06/2022

Senior Managers' Remuneration Policy

The following report details how the remuneration of senior managers is determined. A 'senior manager' is defined as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust'. The Trust deems this to be the Executive and Non-Executive members of the Board of Directors.

The remuneration of the Chief Executive and Executive Directors (with the exception of the Chief Medical Officer*) is determined by the Board of Directors' Remuneration Committee taking into account market levels, key skills, performance and responsibilities. In reviewing remuneration, including making decisions about whether to pay the Chief Executive and any of the individual Executive Directors more than £150,000 per annum, as outlined in the guidance issued by the Cabinet Office, the Committee has regard to the Trust's overall performance, delivery of agreed objectives, remuneration benchmarking data in relation to similar NHS Foundation Trusts and the wider NHS and the individual Director's level of experience and development of the role.

*The pay, terms and conditions for the Chief Medical Officer are determined by the national Consultant Contract and the associated Medical Terms and Conditions. An additional payment is made which reflects the additional responsibilities for the role of Chief Medical Officer. The Chief Medical Officer is eligible to apply for discretionary performance-related pay under Medical Terms and Conditions.

The Trust's overarching approach to remuneration is designed to ensure that senior managers' remuneration supports its strategy and business objectives. The approach has been developed to support the provision of high-quality services for patients through its strategic aim of delivering an outstanding experience for every patient, financial stability and improved service performance. The Trust is mindful of a broad range of factors in setting this approach including the equality, diversity and inclusion agenda.

The Trust's remuneration principles are that rewards to senior managers should enable the Trust to:

- Attract, motivate and retain senior managers with the necessary abilities to manage and develop the Trust's activities fully for the benefit of patients
- Align remuneration with objectives that match the long-term interests of the Trust
- Drive appropriate behaviours in line with the Trust's values
- Focus senior managers on the business aims and appraise them against challenging objectives
- Comply with the Public Sector Equality Duty under the Equality Act 2010, our compliance with equality and diversity requirements of the NHS Constitution and Care Quality Commission and meet the standards set within the Trust Equality, Diversity and Inclusion Policy.

Future Policy Table

Element of pay (Component)	How component supports short- and long-term strategic objective/goal of the Trust	Operation of the component	Performance metric used and time period

Basic salary	Provides a stable basis for recruitment and retention, taking into account the Trust's position in the labour market and a need for a consistent approach to leadership. Stability, experience, reputation and widespread knowledge of local needs and requirements supports the Trust's short term strategic objectives and its long-term strategic priorities of: • Improving the health and well-being of the population we serve. • Working through partnerships to transform and integrate our services. • Supporting our people to make Salisbury NHS Foundation Trust the Best Place to Work	Individual pay point is set within a predesigned pay band which has a minimum and maximum limit. (See salary scales at the end of the Future Policies table which sets out the rates payable). Please note that this does not include additional payments over and above the role such as clinical duties, Clinical Excellence Awards. Total remuneration can be found in the Remuneration tables in the Annual Report on Remuneration. Initial positioning on this pay band is based on experience and benchmarked against the NHSI Guidance for pay for very senior managers.	Pay is reviewed annually in relation to individual performance based on agreed objectives set out prior to the start of that financial year which runs between 1 April and 31 March.
Benefits	Benefits in kind relate to either the provision of a car, training or additional pension contributions. Salary for Executive Directors includes any amount received (See Basic salary on how this component supports short and long term strategic objective/goal of the Trust)	(See above)	(see above)
Pension	Provides a solid basis for recruitment and retention of top leaders in sector. Supports the Trust's short term strategic objectives outlined in its annual priorities and its long-term	Contributions within the relevant NHS Pension Scheme	Contribution rates are set by the NHS Pension Scheme

	strategic goals stated in the basic salary component.		
Bonus	N/A	N/A	N/A
Fees	N/A	N/A	N/A

The components above apply generally to all Executives and there are no particular arrangements that are specific to an individual Executive Director. The Remuneration Committee adopts the principles of the Agenda for Change framework when considering Executive Director's pay. However, unlike Agenda for Change, there is no automatic salary progression within the salary scale, even if individual directors meet their annual objectives.

The performance measures were chosen to reflect the Trust's adopted values and its strategic goals form the basis for Directors' objectives. Objectives for each Executive are set at the start of the financial year in order to deliver the strategic intentions (longer term) and the operational plans (short to medium term). These SMART objectives are the performance measures for the individual Executives. The objectives / performance measures are reviewed during the year and progress recorded.

There is no specific minimum level of performance that affects the payment and no further levels of performance which would result in additional amounts being paid. There is no specific provision for the recovery of sums paid to directors or for withholding the payment of sums to senior managers that relate to their basic salary. However, the Remuneration Committee in respect of the Executive Directors and the Council of Governors for the Non-Executive Directors does have the authority to decide on whether any pay increase should be awarded each year based on performance.

No Executive Directors have been released to undertake other paid work elsewhere. Where an individual Director is paid more than the Prime Minister, the Trust has taken steps to assure itself that remuneration is set at a competitive rate in relation to other similar NHS Foundation Trusts and that this rate enables the Trust to attract, motivate and retain senior managers with the necessary abilities to manage and develop the Trust's activities fully for the benefit of patients. This has been benchmarked against the NHSI guidance for pay for very senior managers.

Remuneration of Non-Executive Directors

Element of pay (Component)	How component supports short and long term strategic objective of the Trust	Operation of the component	Performance metric used and time period
Basic salary	The pay level reflects the part time nature of the role. It is set at a level that gives recognition for the post holder's commitment and responsibility of the role. Supports the Trust's short term strategic objectives outlined in its annual priorities and its long-term strategic priorities of:	It is one single pay point based on research of NHS pay for Non-Executive Directors in other NHS Foundation Trusts	The pay level is reviewed annually by the Council of Governors, advised by the Performance Committee

	• Improving the health and well-being of the population we serve. • Working through partnerships to transform and integrate our services. • Supporting our people to make Salisbury NHS Foundation Trust the Best Place to Work.		
Benefits	N/A	N/A	N/A
Pension	N/A	N/A	N/A
Bonus	N/A	N/A	N/A
*Fees	N/A	N/A	N/A

*Non-Executive Directors Fees: Responsibility for setting the terms and conditions for the Chairman and Non-Executive Directors lies with the Council of Governors. The policy on remuneration is that the Non-Executive Directors are paid a basic salary (see Salary Scales). No additional duties which require a fee are carried out by the Non-Executive Directors.

Statement of consideration of employment conditions elsewhere in the Trust

While the Trust did not consult with employees on the remuneration policy regarding senior managers, it did take into account the national pay and conditions on NHS employees.

Responsibility for setting the terms and conditions of appointment for Non-Executive Directors rests with the Council of Governors, which is advised by the Performance Committee and takes into account remuneration in other NHS organisations by reviewing available national comparisons in NHS Employers information. This was determined when the Trust was authorised, on the basis of independent advice. Please note that no additional fees are paid to the Chairman and the Non-Executives Directors, other than travel and subsistence costs incurred.

Annual Report on Remuneration

Service contracts obligations

None of the current substantive Executive Directors are subject to an employment contract that stipulates a length of appointment. The appointment of the Chief Executive is made by the Non- Executive Directors and approved by the Council of Governors. The Chief Executive and Executive Directors have a permanent employment contract and the contract can be terminated by either party with six months' notice. The contract is subject to normal employment legislation. Executive Directors are appointed by a committee consisting of the Chairman, Chief Executive and Non-Executive Directors.

There are no specific obligations on Salisbury NHS Foundation Trust that impact on remuneration payments or payments for loss of office that are not disclosed elsewhere within the Remuneration Report.

The Service Contract for Non-Executive Directors is not an employment contract. Non-Executive Directors are appointed for an initial term of up to four years and are eligible for a further term of up to four years. Where a director has served eight years, their appointment may be renewed for a further year provided that exceptional circumstances exist in relation to the renewal. The Council of Governors is responsible for appointing, suspending and dismissing the Chairman and Non-Executive Directors as set out in the Trust's Constitution.

Name	Role	Current term of office	Notice Period
Nick Marsden	Chairman	Commenced December 2021	3 months
Rakhee Aggarwal	Non-Executive Director	Commenced January 2020	3 months
Tania Baker	Non-Executive Director	Commenced May 2022	3 months
Michael von Bertele	Non-Executive Director	Commenced October 2019	3 months
David Buckle	Non-Executive Director	Commenced January 2020	3 months
Margaret (Eiri) Jones	Non-Executive Director	Commenced November 2019	3 months
Paul Kemp	Non-Executive Director	Commenced January 2021	3 months
Paul Miller	Non-Executive Director	Commenced March 2021	3 months
Peter Collins	Chief Medical Officer	Commenced October 2020	6 months
Judy Dyos	Chief Nursing Officer	Commenced June 2020	6 months
Stacey Hunter	Chief Executive	Commenced September 2020	6 months
Andy Hyett	Chief Operating Officer	Commenced April 2015	6 months
Lisa Thomas	Chief Finance Officer	Commenced September 2017	6 months
Susan Young	Interim Chief People Officer	Left 31 August 2021	N/A as interim
Lynn Lane	Interim Director of OD and People	Left 6 April 2021	N/A as interim
Melanie Whitfield	Chief People Officer	Commenced September 2021	6 months

The remuneration and expenses for the Trust Chairman and non-executive directors are determined by the Council of Governors, taking account of any National guidance.

Remuneration Committee

The Remuneration Committee decides the pay, allowances and other terms and conditions of the Executive Directors. The Trust's Chairman is chair of the Remuneration Committee and all Non-Executive Directors are members of the committee.

The Remuneration Committee reviews the salaries and where relevant, the individual reward packages of the Executive Directors. Most other staff within the NHS have contracts based on Agenda for Change national terms and conditions, which is the single pay system in operation in the NHS. Doctors, dentists, very senior managers and directors have separate terms and conditions. Pay circulars inform of changes to pay and terms and conditions for medical and dental staff, doctors in public health medicine and the community health service, along with staff covered by Agenda for Change. The Trust follows these nationally set pay polices in negotiating with Trade Unions on areas of local discretion.

Name	Role	Attendance from six meetings
Nick Marsden	Chairman	6/6
Rakhee Aggarwal	Non-Executive Director	3/6
Tania Baker	Non-Executive Director	6/6
Michael von Bertele	Non-Executive Director	6/6
David Buckle	Non-Executive Director	6/6
Margaret (Eiri) Jones	Non-Executive Director	5/6
Paul Kemp	Non-Executive Director	5/6
Paul Miller	Non-Executive Director	6/6

External advice is not routinely provided to the Remuneration Committee. However, the Chief Executive, Chief People Officer and the Director of Integrated Governance attend and provide internal advice to the committee.

Disclosures in accordance with the Health and Social Care Act

Expenses for Senior Managers and Governors

Year	Number of Directors in Office	Number of Directors Reimbursed	Amount Reimbursed to Directors	Number of Elected Governors in Office	Number of Elected Governors Reimbursed	Amount Reimbursed to Elected Governors
2020/2021	18	6	£22,011	22	3	£299
2021/2022	15	5	£13,040	22	1	£133
Expenses incurred during the course of their duties relate to travel, accommodation and subsistence. Directors include those who were in post in an interim capacity during the year						

Salary and Pension Entitlement

Name and Title	Remuneration Year to 31 March 2022					
	Salary	Benefits in Kind	Annual Performance Related Bonus	Long-Term Performance Related Bonus	Pension Related Benefits	Total
	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Nick Marsden - Chairman	45-50	0	0	0	0	45-50
Paul Kemp - Non-Executive	10-15	0	0	0	0	10-15
Tania Baker - Non-Executive	15-20	0	0	0	0	15-20

Paul Miller - Non-Executive	10-15	0	0	0	0	10-15
Michael von Bertele OBE - Non-Executive	10-15	0	0	0	0	10-15
Rakhee Aggarwal - Non-Executive	10-15	0	0	0	0	10-15
Margaret Jones - Non-Executive	10-15	0	0	0	0	10-15
David Buckle - Non-Executive	10-15	0	0	0	0	10-15
Stacey Hunter - Chief Executive	170-175	0	0	0	122.5-125	295-300
Lisa Thomas – Chief Finance Officer	135-140	0	0	0	67.5-70	205-210
Peter Collins – Chief Medical Officer	175-180	0	0	0	225-227.5	405-410
Judy Dyos – Chief Nursing Officer	110-115	0	0	0	65-67.5	175-180
Andy Hyett - Chief Operating Officer	125-130	0	0	0	70-72.5	195-200
Susan Young - Interim Chief People Officer	45-50	0	0	0	0	45-50
Lynn Lane - Interim Director of OD and People	50-55	0	0	0	0	50-55
Melanie Whitfield - Chief People Officer	65-70	0	0	0	15-17.5	85-90

This table is subject to audit

The amount shown above for Peter Collins Chief Medical Officer represents his total salary and any remuneration received from his clinical roles. No other member above received remuneration for additional duties. No remuneration was received from another body and no severance payments were made within the year.

Lynn Lane left her position as interim Chief People Officer on 6 April 2021. Her remuneration figure includes a contractual payment in lieu of notice of £44k.

Susan Young left her post as interim Chief People Officer on 31 August 2021 and Melanie Whitfield started as Chief People Officer on 6 September 2021

There were no taxable benefits paid to Directors in the year. Salary for Executive Directors includes any amount received for car allowance.

There is no additional benefit that will become receivable by a director in the event that that senior manager retires early.

This table is subject to audit

Remuneration 1 April 2020 – 31 March 2021						
	Salary and fees (Bands of £5,000) £000	**Taxable Benefits Rounded to the nearest £100**	**Annual Performance Related Bonus (Bands of £5,000) £000**	**Long term Performance Related Bonus (Bands of £5,000) £000**	**Pension Related Benefits (Bands of £2,500) £000**	**Total (Bands of £5,000) £000**
Cara Charles-Barks Chief Executive	80-85	0	0	0	27.5-30	110-115
Rakhee Aggarwal - Non-Executive	10-15	0	0	0	0	10-15
Tania Baker - Non-Executive	15-20	0	0	0	0	15-20
Michael von Bertele - Non-Executive	10-15	0	0	0	0	10-15
Christine Blanshard - Medical Director	75-80	0	0	0	30-32.5	105-110
David Buckle - Non-Executive	10-15	0	0	0	0	10-15
Peter Collins - Medical Director	95-100	0	0	0	10-12.5	105-110
Rachel Credidio Non-Executive	0-5	0	0	0	0	0-5
Judy Dyos - Director of Nursing	80-85	0	0	0	102.5-105	180-185
Stacey Hunter - Chief Executive	95-100	0	0	0	95-97.5	190-195
Andy Hyett - Chief Operating Officer	115-120	0	0	0	40-42.5	160-165
Margaret Jones - Non-Executive	10-15	0	0	0	0	10-15

Paul Kemp - Non-Executive	10-15	0	0	0	0	10-15
Lynn Lane - Interim Director of OD & People	135-140	0	0	0	0	135-140
Nick Marsden - Chairman	45-50	0	0	0	0	45-50
Paul Miller - Non-Executive	10-15	0	0	0	0	10-15
Lisa Thomas - Director of Finance	130-135	0	0	0	57.5-60	190-195
Lorna Wilkinson Director of Nursing	25-30	0	0	0	55-57.5	85-90

The amount shown above for Christine Blanshard, and Peter Collins Chief Medical Officer, represents their total salary and any remuneration received from their clinical roles. No other member above received remuneration for additional duties. No remuneration was received from another body and no severance payments were made within the year.

There were no taxable benefits paid to Directors in the year. Salary for Executive Directors includes any amount received for car allowance.

There is no additional benefit that will become receivable by a director in the event that that senior manager retires early.

Christine Blanshard left her post on 25 August 2020 and Peter Collins started as interim Medical Director on 5 October 2020
Cara Charles-Barks left her post as Chief Executive on 31 August 2020 and Stacey Hunter started as Chief Executive on 1 September 2020
Rachel Credidio left her post as Non-Executive Director on 30 Aril 2020
Lorna Wilkinson left her post as Director of Nursing on 29 June 2020 and Judy Dyos started on 15 June 2020

No member above received remuneration for additional duties. No remuneration was received from another body and no severance payments were made within the year.

There were no taxable benefits paid to Directors in the year. Salary for Executive Directors includes any amount received for car allowance.

Pension Benefits

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 1 April 2021 £000	Employers Contribution to Stakeholder Pension £000
Stacey Hunter - Chief Executive	5-7.5	10-12.5	55-60	105-110	1,001	112	860	0
Peter Collins – Chief Medical Officer	10-12.5	22.5-25	55-60	115-120	1,064	199	835	0
Judy Dyos – Chief Nursing Officer	2.5-5	2.5-5	30-35	65-70	539	52	469	0
Lisa Thomas – Chief Finance Officer	2.5-5	2.5-5	40-45	75-80	629	47	560	0
Andy Hyett - Chief Operating Officer	2.5-5	5-7.5	50-55	105-110	880	63	796	0
Melanie Whitfield – Chief People Officer	0-2.5	0	10-15	0	141	10	105	0
Lynn Lane - Interim Director of OD & People	0	0	0	0	0	0	0	0

This table is subject to audit

Notes to Remuneration and Pension Tables

Susan Young chose not to be covered by the pension arrangements during the reporting year.

As Non-Executive directors do not receive pensionable remuneration, there are no entries in respect of any pensions.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a

senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Pay ratio information

This section is subject to audit

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2021-22 was £180,000 (2020-21 £185,000). This is a change between years of -2.7%, which was caused by a higher paid Director leaving the Trust in 2020-21.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2021-22 was from £14,000 to £233,000 (2020-21 £14,000 to £213,000). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 4.9%. Four employees received remuneration in excess of the highest-paid director in 2021-22.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest-paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2021/2022	25th percentile	Median	75th percentile
Salary component of pay	£ 23,200	£ 33,300	£ 44,900
Total pay and benefits excluding pension benefits	£ 23,200	£ 33,300	£ 44,900
Pay and benefits excluding pension: pay ratio for highest paid director	7.65	5.33	3.95

The banded remuneration of the highest paid director was 5.79 (restated) times the median remuneration of the workforce in 2020-21. The Trust's median remuneration reduced in 2021-2022 compared with the previous year. This resulted from the highest paid director leaving the Trust in 2020-21.

Payments for loss of office

There were no payments made to senior managers for loss of office in 2020-21.

Payments to past senior managers

None to report in 2021-22.

The Remuneration Report has been approved by the Trust Board

Stacey Hunter
Chief Executive (Accounting Officer)
16/06/2022 (on behalf of the Trust Board)

STAFF REPORT

Analysis of average staff costs (subject to audit)

	Total 2021/22 £000	Permanently employed Total £000	Other Total £000
Salaries and wages	**151,408**	151,408	0
Social security costs	**14,788**	14,788	0
Pension cost- defined contribution plans employer's contributions to NHS pensions	**17,123**	17,123	0
Paid by NHSE on provider's behalf (6.3%)	**7,460**	7,460	0
Pension cost – other	**42**	42	0
Temporary staff/agency contract staff	**7735**	0	7,735
Apprenticeship levy	**737**	737	0
TOTAL STAFF COSTS	**199,293**	191,558	7,735
Less: Costs capitalised as part of assets	**(758)**	(758)	0
TOTAL STAFF COSTS IN OPERATING EXPENDITURE	**198,535**	190,800	7,735

Analysis of average staff numbers (subject to audit)

	Total 2021/ 2022 number	Permanently employed 2021/ 2022 number	Other 2021/ 2022 number	Total 2020/ 2021 number	Permanently employed 2020/2021 number	Other 2020/ 2021 number
Medical and Dental	459	450	9	444	432	12
Administration and Estates	1,327	1,252	75	1,289	1,214	75
Healthcare assistants and other support staff	673	673	0	668	668	0
Nursing, midwifery & health visiting staff	1,049	1,006	43	1,067	1,061	6
Scientific, therapeutic and technical staff	527	512	15	493	475	180
Total	**4,035**	**3,893**	**142**	**3,961**	**3,851**	**110**

The figure shown under the other column relates to other staff engaged on the objectives of the organisation such as, short term contract staff, agency/temporary staff, locally engaged

staff overseas and inward secondments where the organisation is paying the whole or the majority of their costs.

The comparative numbers have been restated to bring them in line with the occupation codes within the electronic staff record, the NHS human resource and payroll database system.

The number of male and female directors, senior managers and employees at 31 March 2022

Head Count	Female	Male	Total
Directors	7	7	14
***Senior managers**	6	4	10
All other staff	3722	1178	4,900

**Senior managers are defined as members of the Trust Management Committee which provides a forum for the Chief Executive, supported by the Executive Directors and Clinical Directors, to advise on the strategic direction of the Trust and the Trust's involvement in the wider health economy. Senior managers in this context include members of the Trust Management Committee who are not included in the two remaining groups.*

Staff Turnover

Staff turnover information can be found on the NHS Digital website:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Sickness Absence

Year April March	Overall absence days lost	%of total available days	% Short term <28 days	% Long term >28 days	Absence Recorded with No reason given
20/21	27,491	3.75%	2.03%	1.72%	4.36%
21/22	31,218	4.15%	2.11%	2.04%	3.25%
22/23 Forecast	29,738	3.95%	1.95%	2.00%	3.00%

Between April 2021 and March 2022, the Trust has experienced the impact of an Increase in sickness absence levels from 27,491 working days lost in 2020-21, to 31,218 days lost in 2022-23.

It remains our aim to reduce sickness absence to our stretch target of 3%. During 2021 -22 absence rates increased above the previous year's level of 3.75% to 4.15%. Within this figure, 2.11% related to short term absence whilst long term absence accounts for 2.04% in total. We saw significant absence in January to March 2022 due to COVID-19

Overall, COVID-19 has impacted sickness absence rates during this period. The Trust's Occupational Health Department has been following up on cases of COVID-19 for contact tracing and ensuring compliance with the Government regulations of the time regarding isolation and testing. Pro-active support for staff on long term sickness has been a focus

during the year, in particular in quarter 4, where additional support of wellbeing phone calls has been put in place. Clinical Psychology services have also been offering wellbeing interventions to staff as a supportive mechanism of preventing sickness absence.

Managers can view team absence data via ESR Manager Self Service. This tool highlights the number of episodes of sickness absence, enabling managers to identify where additional interventions and support are required. Data is also shared with staff side representatives on a regular basis.

Over a fifth of our workforce absence was due to mental ill health and we are aware that some employees experience personal stress and/or work-related stress. The Trust offers a range of proactive wellbeing initiatives to promote better health and wellbeing for all colleagues. Services include physiotherapy, counselling, support from a mental health nurses' practitioner and a psychologist.

We are also planning a Head of Wellbeing role which will provide greater focus to all these services and promote better health in conjunction with our Occupational Health service. Our aim is to widen the remit of the role to include financial legal and other matters that may be underlying causes of stress.

The Trust has monthly health and wellbeing topics/events, trained mental health first aiders, and health improvement coaches for weight management, alcohol, smoking cessation support, healthy eating, increasing physical activity and building confidence and motivation.

Staff continue to enjoy access to the onsite health and fitness centre, green spaces and walking routes.

A health and wellbeing presentation has been implemented for all new starters as part of their induction. COVID-19 risk assessments are completed for all staff to protect their health and wellbeing at work. Flu and COVID-19 vaccinations continue to be available to all staff.

Policies

This year has seen a number of policies reviewed and also seen the introduction of one new policy and a specific focussed revision of the disciplinary policy. In May 2021 a new Workforce Investigation Policy was ratified by the Trust, and in July 2021 the Trust Disciplinary Policy was updated, in line with national requirements, to reflect the principles of our aim to have a restorative just and learning culture.

During the financial year work has been underway to review the 'Employment of People with Disabilities' Policy and this was approved in May 2021. A working group has been established to renew the Trust's registration for Disability Confident Employer Status. The Trust took part in a national pilot program to achieve Level 3 Disability Confident Leaders status. On the 31st March 2022 after working with the working group and the Shaw Trust Salisbury NHS Foundation Trust completed a Disability Confident self-assessment which achieved Level 2 Disability Confident Employer status.

The Shaw Trust has made a number of recommendations regarding progress to Level 3 and an action plan is being developed. As part of this the Trust is currently re-establishing its Ability Network to provide support for staff with disabilities. This network will also act as a lived experience panel to help the Trust achieve Level 3 Disability Confident Leaders status in the next 12 months.

Regular consultation takes place with staff and staff representatives in relation to policy changes and organisational change policy consultation is also discussed with the Trust's Inclusion Network. The Trust's counter fraud specialists receive all HR policies going for ratification and are consulted on those relating to counter fraud

In January 2022 a comprehensive review of 66 OD & People policies commenced to ensure legal compliance, and that policies are in line with Trust values and the NHS People Promise and the aim for a restorative just and learning culture. This work is scheduled to be completed by the end of quarter 1 2022-23.

The Trust is also in the process of reviewing its recruitment processes in line with the national six-point plan for overhauling recruitment processes across the NHS. This will help us to address some of the issues arising from the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports about disparities across our workforce in relation to opportunities and experiences.

Health and Safety

The Health and Safety function is supported by a Health and Safety Committee, which includes representatives from every area of the Trust and staff side representatives. The Committee meets every two months and disseminates policy and information to the wider Trust. There are also sub-committees for specific areas for example Fire Safety, Waste and Radiation Protection. The Health and Safety Committee is responsible for monitoring risk and maintaining appropriate records.

Health and Safety is part of a wider Health and Wellbeing function which encompasses the Occupational Health and the Chaplaincy teams. The regulatory requirements for health and safety are set out through the Trust's Health and Safety Policy that describes the organisation and arrangements for health and safety, and through a series of policies and standards on specific subject areas. Although the ultimate responsibility lies with the Chief Executive Officer, the day-to-day management is delegated through with the Chief People Officer and their Deputy responsible for the monitoring and assurance mechanisms and advice to the Chief Executive Officer.

As a matter of routine, the Health and Safety function provides training at induction for all new starters in the Trust, so that everyone is aware of their responsibilities in respect of protecting their own and colleagues' health and safety. Additionally, the team also provides training and 1:1 support as necessary for managers undertaking risk assessments which can be quite technical and/or complex.

The Health and Safety Department undertakes a programme of inspections to monitor the implementation of the required polices and standards by clinical and non-clinical areas. In addition, monitoring of the outcomes is examined through analysis of accident and incident reports. During the pandemic the department has supported the management of COVID-19 requirements for the Trust.

The Health and Safety Management System is currently under review to ensure there is appropriate interpretation of the legal framework into Trust policies and standards and assurance of their implementation to the Trust Board.

Consultancy Expenditure - Off Payroll Payments

Table 1: Highly paid off-payroll worker engagements as at 31 March 2022 earning £245 per day or greater **For all off-payroll engagements as of 31 March 2022**	
	Number
Number of existing engagements as of 31 March 2022	**124**
Of which:	
Number that have existed for less than one year at the time of reporting	**114**
Number that have existed for between one and two years at the time of reporting	**2**
Number that have existed for between 2 and 3 years at the time of reporting	**3**
Number that have existed for between 3 and 4 years at the time of reporting	**3**
Number that have existed for 4 or more years at the time of reporting	**3**

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2022 earning £245 per day or greater.	
	Number
Number of off-payroll workers engaged during the year ended 31 March 2022	**466**
Of which...	
Not subject to off-payroll legislation	**16**
No. assessed as caught by IR35	**0**
No. assessed as not caught by IR35	**450**
No. of engagements reassessed for consistency / assurance purposes during the year.	**16**

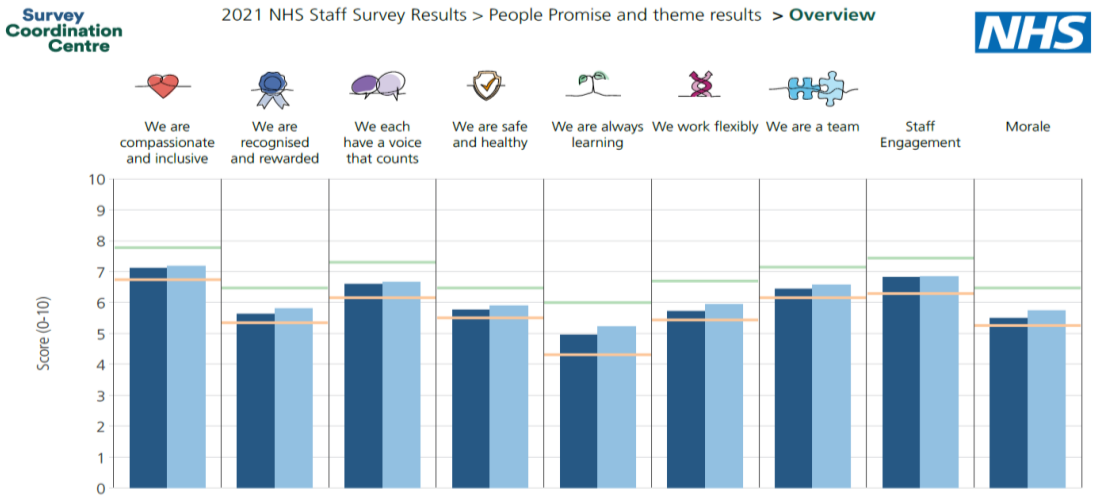
No. of engagements that saw a change to IR35 status following the consistency review	**0**
Table 3: Off-payroll board member/senior official engagements **For any off-payroll engagements of board members and/or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022**	
Number of off-payroll engagements of board members and/or senior officers with significant financial responsibility, during the financial year (1)	**0**
Total number of individuals on payroll and off-payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year. This figure must include both on payroll and off-payroll engagements. (2)	**18**

Staff Survey

The NHS staff survey is conducted annually. From 2018 to 2020, the results from questions were grouped to give scores in ten indicators. The indicator scores were based on a score out of 10 for certain questions with the indicator score being the average of those. For the first time, in 2021, the questions were aligned with the NHS people promise to track progress against the ambition to make the NHS the workplace we all want it to be by 2024. All staff survey elements nationally are therefore reported against the seven elements of the people promise, and two of the original themes of the staff survey: morale and staff engagement.

The response rate for the 2021-22 survey among trust staff was 48.5% (1881 responses) compared with 54.2% for the 2020 survey (2062) responses. By comparison the median response rate in 2021 for our benchmarking group (acute and acute and community trusts) was 46%.

Scores for each indicator together with the average, best and worst scores in the benchmarking group are presented below:



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.1	5.6	6.6	5.8	5.0	5.7	6.4	6.8	5.5
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	1,816	1,851	1,786	1,809	1,744	1,839	1,822	1,858	1,848

Actions are currently being developed to address the key themes arising from the survey which was published on 30 March 2022. These are being aligned with the Trust's 'Improving Together' programme. Last year our action planning was limited by the need to respond to COVID-19. Our actions were therefore prioritised in relation to health and wellbeing of our staff and we will continue to focus on keeping our people safe and healthy. 'Wellbeing walkarounds' enabled managers to take feedback from staff and put actions in place to address concerns raised. Specific focus groups were held with staff to discuss their wellbeing and other actions included a 'take five' campaign to encourage people to take breaks, and the offer of an additional day's 'birthday holiday' for all staff. We have provided a number of relevant wellbeing workshops such as a sleep workshop. We held a 'Thank you' week in September with events in Salisbury for Trust staff and their families. We have reconfigured the staff restaurant to enable its use outside of normal hours and have announced a new Inclusion Network to address the sense of belonging and have given protected time to the network leads.

Following the latest results, we will build on the previous actions and are holding a series of listening events for staff across all of our divisions to encourage them to get involved in further feedback sessions which will generate ideas for improvement. The health and wellbeing of staff continues to be our highest priority, alongside improving morale and developing our leaders across the Trust.

Staff survey action plans will be monitored by the Organisational Development and People Committee on behalf of the Trust Board.

Staff engagement

The Trust is committed to engaging with staff at all levels and through many different media. Whilst COVID-19 has limited our opportunities to come together face to face, we have continued to hold regular briefings and dialogue through MS Team. Our monthly Cascade briefings give the Trust the opportunity to share information and to take views from staff on a wide range of topics. These are well attended and give all staff an opportunity to engage with colleagues at all levels.

Board safety walks give our Board members the opportunity to engage directly with staff. These occur monthly with an Executive Director, Non-Executive Director and divisional management team visiting patient and non-patient facing areas, speaking to staff and listening to their concerns. 'Back to the floor' sessions have also taken place with Executive colleagues shadowing colleagues for half a day on a regular basis to learn from and engage with staff.

Our staff awards were a key part of our engagement activity. In 2021 we presented14 awards to our remarkable staff covering a mix of categories from the Chairman's award, to the COVID-19 Award and Volunteer of the Year to name a few of the categories. It was a great evening and well received by staff. Our Family Fun Day was also well attended by hospital staff, their families, and the local community.

In addition to the annual staff survey, we also run a more regular Pulse Survey to take up to date feedback from staff.

Our staff network groups also play a large part in our staff engagement activity.

Equality, Diversity & Inclusion (ED&I)

During the year we had an audit of our approach to Equality, Diversity and Inclusion (EDI) which made a number of recommendations:

- To formally define an EDI Strategy.

- Revise the EDI action plan including measures of success in response to the newly developed strategy.
- To improve our data analysis capabilities for EDI metrics
- Improve the EDI governance structure and management information in order to successfully track progress
- Further opportunities for embedding EDI
- Review available EDI resource both within the Trust and across the integrated care system.

A draft EDI strategy has been developed for consultation with staff and stakeholders. It is designed to link with the NHS People Plan and People Promise. The EDI networks are key players in this consultation.

Our Workforce Race Equality Standard (WRES) report and Workforce Disability Equality Standard (WDES) report have been reviewed and incorporated into the new strategy which also builds on the evidence form the NHS staff survey, and the gender pay gap (GPG) report as well as the EDI audit. A key part of our 'Improving Together' programme is 'Creating an inclusive culture'.

We will measure our success using data from the Electronic Staff Record (ESR) system, staff survey, WRES and WDES data and GPG data. Future actions will include exploring opportunities to work with our integrated care system (ICS) partners to better understand community demographics.

Our aim is for EDI to be embedded as part of our day-to-day activities. The Board has had EDI development sessions when staff members were invited to come and discuss their experiences with Board members. It was agreed that each Board member will have and EDI objective. Trust Executives sponsor the following staff support networks which have recently been reinvigorated:

- Race Equality Network
- Mental Health First Aiders Network
- Rainbow Shed (LGBTQ+) Network
- Ability Network
- Women's Network.

Protected time of one day per month has been agreed for our staff network leads to facilitate the development of their networks.

The Trust also plays a large part in the development of and support for EDI across the Bath Swindon and Wiltshire (BSW) ICS in the following ways:

- Scoping and engaging with EDI resources/staff across the system
- Identifying active EDI staff networks, best practice, learning and sharing.
- Setting up relevant EDI system networks.
- Collating WRES/WDES (and equivalent data from other system partners) to determine the benefit of BSW system priorities/focus.

In terms of representation of Black Asian or Minority Ethnic (BAME) people the Trust is already more diverse than the local community, for example, 20% of the workforce are from a BAME background as opposed to approximately 4% of the local community. In 2022 we now have 809 staff who declare themselves as BAME compared with 638 in 2020. Staff declaring that they have a disability now number 116 compared with 98 two years ago.

There has been a small increase in the number of staff declaring themselves as LGBTQ+ (89 in 2022 compared with 85 in 2020).

The Freedom to Speak Up Service is provided by the Trust to empower staff to raise a concern outside of an individual's management chain should they require it. The service is led by a Freedom to Speak Up Guardian, supported by a team of Ambassadors. The remit of the service is to support the development of a culture that is open and transparent so that raising concerns becomes business as usual for all staff. The Trust's Guardian is responsible for providing confidential advice and support to staff in relation to any concerns about patient safety or any concern that has a detrimental effect on their working conditions. They can also offer advice and support to ensure concerns raised are handled appropriately and result in a clear outcome. The Trust's Freedom to Speak Up Guardian has direct access to all senior leaders including the Chief Executive and all Board members. This year the Trust has shown commitment to Freedom to Speak Up by making online 'Speak Up' Level 1 training mandatory for all staff ensuring every staff member knows how to raise concerns safely. It has also been agreed that the Level 2 Freedom to Speak Up enhanced online training, 'Listen Up' package will apply to all staff with line management responsibilities. This will form part of the Management Training offer which is currently being developed by the Education Department. This approach will enable consistency and quality when concerns are raised.

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

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

**Please note that some cases record more than one theme*

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

Apprenticeships

The government's 2020 vision for creating a highly skilled workforce and addressing the UK's skill shortages and stimulating economic growth across all areas, has resulted in the reform of apprenticeships.

The 2020 NHS People Plan states that we should: *"Offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles."* Our Trust and Integrated Care System (ICS) plans support that.

Salisbury NHS Foundation Trust currently pays 0.5% (c. £60k) of its total pay bill into the Apprenticeship Levy per month, with a current total of £1.35 million available for us to access. This is used to pay training providers to provide apprenticeship training which makes up a minimum of 20% of the apprentices' time. Any Levy not utilised within 2 years of

being paid into the fund will expire and be returned. Levy utilisation has improved in the last 12 months.

	2019/2020	2020/2021	2021/2022
Total Number of apprentices	84	128	153
Current Funds	£1,207,780.00	£1,318,012.00	£1,481,729.00
Total Spent to Date	£407,238.17	£832,402.11	£1,265,125.39
Total Spend in Year	£325,294.01 Of which £6,000 (1.8%) was transferred to other organisations	£445,354.91 Of which £12,557 (2.8%) was transferred to other organisations	£432,724.28 Of which £6,918.43 (1.6%) was transferred to other organisations
Annual Expired Levy	£102,815.50	£87,493.45	£112,685.57

The impact of COVID-19 on our apprenticeship programme has not been as significant as anticipated and we have continued to see a small rise in apprentices starting training and a reduction in our expired levy. It has resulted in staff being redeployed into different departments, reduced staffing numbers and significant increases in work pressures across the organisation. Understandably, there has been less capacity to support and train staff on apprenticeships in a way that we would like to. As expected, the focus on training and development has shifted as staff prioritise operational pressures.

There have been challenges regarding procurement of apprenticeships with one Higher Education Institution making last minute cancellation of a degree level apprenticeship that we had recruited to. This affected the credibility of apprenticeship programmes.

The range of apprenticeships being utilised across has increased and we have apprenticeships available at every academic level and across a range of staff groups. See table below

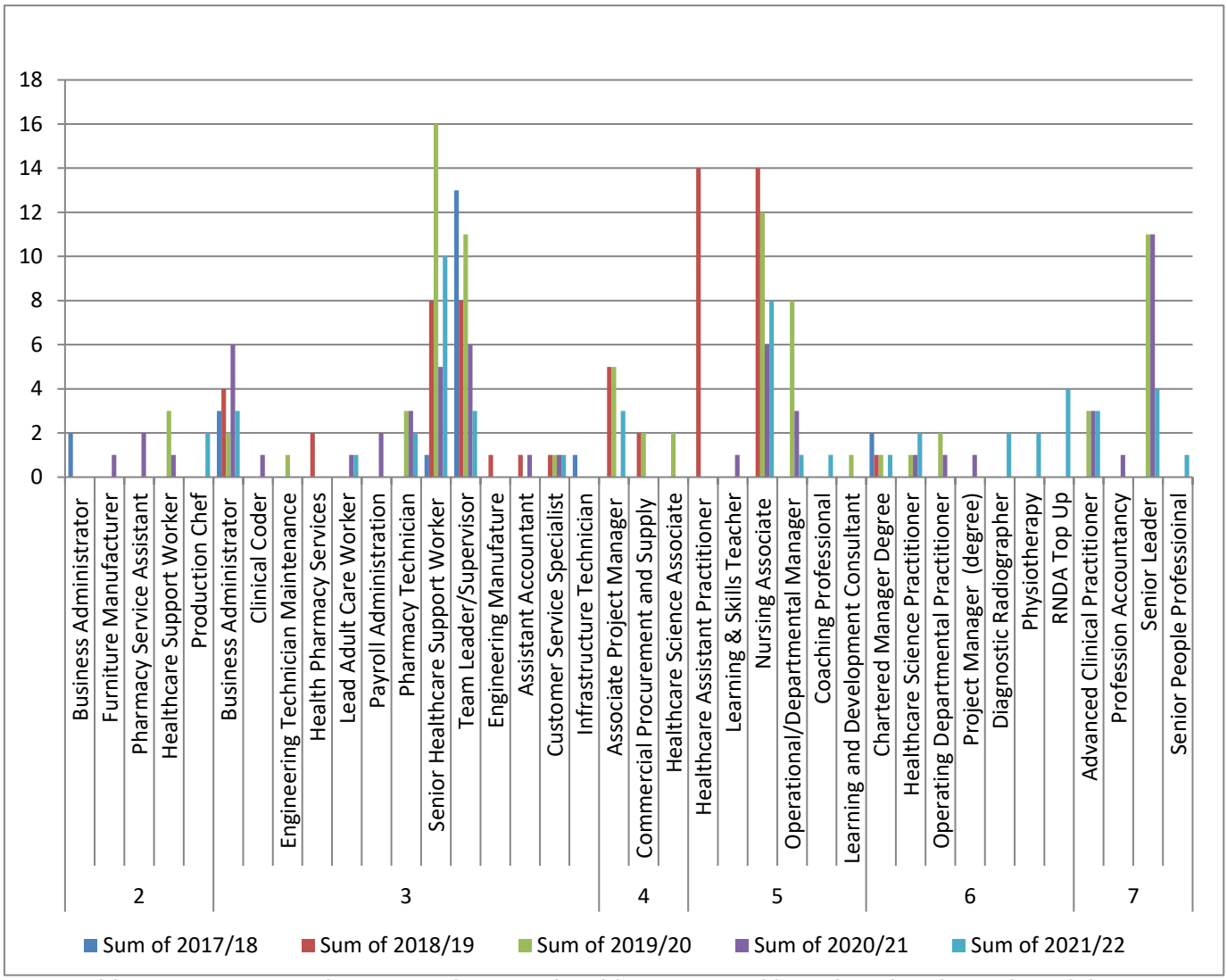


Table: Demonstrates the range of apprenticeships accessed by Educational Level, and the number of apprentices starts each of year on programme.

Levy utilisation has improved in the last 12 months, and we are on track for a decrease over the whole year. Currently a business case for a Registered Nurse Degree Apprenticeship Programme is being considered and if agreed in full will result in additional utilisation of the Levy. This will eliminate any expiry of Levy and support us towards a target 100% utilisation. SFT has already committed to support a further nine apprentices through Levy transfer in 2021-22, with an aim of increasing this further up to 25% of our total levy, to increase accessibility onto apprenticeships for our community.

The target this year, in the current climate, has been to maintain our current apprenticeships and continue to support them through to completion, whilst also responding to any requests for new programme and enrolments.

SFT engaged in regional and system wide procurement of a number of degree level apprenticeships and have internally recruited onto these. This was carried out on a much

larger scale than last year and carried out across the South West instead of just the BSW region.

Across BSW since April 2021, there has been a 15% increase in apprenticeship starts and a 100% increase in Levy transfers, which is testament to the great work that is being achieved in the network and reflects the identified maturity of the learning pillar.

Leadership and Development

During the year a number of key events took place that signalled a requirement to re-evaluate our approach to Leadership & Development for the Trust and re-write our Leadership Strategy to support these shifts, including

- The Launch of a new Trust Strategy.
- Our NHS People Promise – and our Trust's intent on being an 'exemplar site'.
- The launch of our Improving Together Programme and the Leadership behaviour and culture needed to support this endeavour.

Alongside planning these changes, a significant and impactful offer of Leadership content and wider Organisational Development (OD) has continued to be delivered. A large proportion of the Leadership and OD activity has been in response to the previous year's Best Place to Work (BPTW) Diagnosis. This highlighted a number of themes for development such as compassionate leadership, innovation and learning and the development of psychologically safe environments. Development activities have addressed the requirement to support our Leaders in their development of an awareness, capability and belief that the values and behaviours they promoted and used supported the transition from a 'Command and Control' style to a more collaborative and compassionate style of Leadership.

We are pleased that over 4097 Hours of Personal Development have been delivered in the past 12-18 months. Over 937 of these hours have been supporting our staff to become better coaches, and over 3160 hours have been staff attending one of our Leadership development courses. In total, over 360 of our staff have benefited from attending this professional development.

We are developing a new OD & Leadership Strategy, which will support our people to develop themselves to have an awareness, capability and desire to shape the culture we need to deliver our new strategy, our People Promise and the Improving Together programme.

Our Leadership Way identifies three core behavioural foundations of which our strategy and OD & Leadership offer will support, they are:

- **Compassion** – we are inclusive, promote equality and treat people with kindness, compassion and respecting diversity
- **Collaboration** – supporting our people to be the best they can be and grow effective partnership to achieve our goals
- **Curiosity** – We aim for the highest standards and seek to continually improve and harness our ingenuity

In future we will develop a clear 'pathway' for aspiring leaders and current leaders that supports talent management, core Management skills/capabilities, and opportunities for growth in role.

Staff Exit Packages

Staff exit packages include those made under nationally agreed arrangements or local arrangements for which Treasury approval is required. This does not include retirements due to ill health. Figures for 2021-22 are included in this table. The 2020-21 figure is in brackets.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Under £10,000	0 (1)	0(9)	0(10)
£10,000 - £25,000	0(0)	1(3)	1(3)
£25,001 – £50,000	0(1)	1(0)	1(1)
£50,001 - £100,000	0(0)	0(1)	0(1)
£100,001 - £150,000	0(0)	0(0)	0(0)
£150,001 - £200,000	0(0)	0(0)	0(0)
Total number of exit packages by type	0(2)	2(13)	2(15)
Total resource cost	£0(£43,000)	£59,000(£164,000)	£59,000(£207,000)

This table is subject to audit.

The other departures shown above relate to contractual payments in lieu of notice.

Trade Union Facility Time Disclosures

Since April 2017, public sector organisations are required to report on trade union facility time.

Table 1 - Relevant Union Officials

Number of employees who were union reps	24
FTE union reps	21.97

Table 2 Percentage of time spent on facility time

Percentage of time	%
0%	10
0-50%	14
51-99%	0
100%	0

Table 3 Percentage of pay bill spent on facility time

Percentage of pay bill on facility time	
Total cost of facility time	£26,937.67
Total pay bill	£198.154m
Percentage facility time	0.1%

Paid Union Activities	
Time spent	0

NHS FOUNDATION TRUST CODE OF GOVERNANCE

Disclosure Statement

Salisbury NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board considers that for the 2021-22 year the Trust has been fully compliant with the provisions of the Code, with the exception of provision B.6.2 that states “evaluation of the boards of NHS foundation trusts should be externally facilitated at least every three years”. An external review was delayed until autumn 2022, given the ongoing executive recruitment and the continued focus on COVID-19 recovery. The Trust Board has undertaken a self-assessment which has highlighted specific areas of focus for improvement, prior to the external review later this year.

The Board is committed to the highest standards of good corporate governance and follows an approach that complies with this code through the arrangements that it puts in place for our governance structures, policies and processes and how it will keep them under review. These arrangements are set out in documents that include:

- The Constitution of the Trust
- Standing orders
- Standing financial instructions
- Integrated Governance Framework
- Accountability Framework
- Terms of reference for the Board of Directors, the Council of Governors and their committees
- Annual declarations of interest
- Annual Governance Statement

Council of Governors

The Trust’s Governors are the representatives of members, staff, our stakeholders and public interests, and are an integral part of advising us on how best to meet the needs of patients and the wider community. Our Governors have a number of statutory duties but their key role is to hold the Non-Executive Directors to account individually and collectively for the performance of the Board of Directors. Other statutory duties of the Council of Governors’ role include:

- Appointing the Chairman and Non-Executive Directors
- Approving the appointment of the Chief Executive
- Deciding on the remuneration of the Chairman and Non-Executive Directors
- Receiving the Trust’s Annual Accounts, Auditors Report and Annual Report
- Reviewing the Membership and Public Engagement Strategy

The Council has been placed into groups to consider various topics over which they can have an influence. In 2021-22 these covered:

- Membership and Communications Committee

- Performance Committee (Chairman and Non-Executive Directors)
- The Trust's Annual Plan prior to submission to the regulator
- Nominations Committee
- Staff Governors Committee
- Patient Experience Group
- The strategic direction of the Trust
- Volunteers

The Governors review their work programme and the make-up of their working groups annually. They appreciate that, statutory roles apart, their principal duties are to monitor, advise and inform. Governors are also party to discussions about elements of the Trust's strategy when items are taken at meetings of the Trust Board and Council of Governors.

The public and staff members of the Council are elected from and by the Foundation Trust membership to serve for three years. They may stand for re-election but they may not serve for more than nine years in total.

In addition, some of the organisations we work most closely with nominate stakeholder Governors. An appointed Governor may hold office for three years and can be re-appointed in line with elected Governors.

The representatives of public constituencies must make up at least 51% of the total number of Governors on the Council of Governors.

The Council of Governors hold four meetings a year, in addition to the Annual General Meeting (AGM). The Governors canvass opinions of the members and public through their constituency meetings and at the AGM. It should be noted that constituency meetings have been put on hold due to the COVID-19 pandemic but plans are in place to reintroduce these in 2022-23.

Elected Governors – Public Constituency

Name	Constituency	Elected or Re-elected	Term of Office	Attendance from 5 meetings
Kevin Arnold	Salisbury City	June 2020	Three years	3 / 4
Lucinda Herklots	Salisbury City	May 2018	Three years	4 / 4
Joanna Bennett	Salisbury City	June 2020	Three years	4 / 4
Sir Raymond Jack[2]	South Wiltshire Rural	May 2018	Three years	1 / 1
Jennifer Lisle[3]	South Wiltshire Rural	May 2018	Three years	1 / 1
William Holmes[4]	South Wiltshire Rural	May 2018	Three years	1 / 1
Dr James Robertson	South Wiltshire Rural	Sept 2019	Three years	2 / 4
Anthony Pryor-Jones	South Wiltshire Rural	June 2020	Three years	4 / 4
Angela Milne	South Wiltshire Rural	June 2021	Three years	2 / 2
Andrew Rhind-Tutt	South Wiltshire Rural	June 2021	Three years	2 / 2
Peter Russell	South Wiltshire Rural	June 2021	Three years	1 / 2
Michael Glover	South Wiltshire Rural	June 2021	Three years	1 / 2
John Parker	North Dorset	May 2018	Three years	4 / 4
Christine Wynne	North Dorset	May 2018	Three years	4 / 4

John Mangan (Lead)	New Forest	Feb 2018	Three years	4 / 4
Peter Kosminsky[1]	Kennet	June 2020	Three years	1 / 4
Mary Clunie	Rest of England	Feb 2018	Three years	4 / 4

[1] Peter Kosminsky took an agreed leave of absence as agreed by the Chair during 2021/22 and attended whenever possible
[2] Sir Raymond Jack came to the end of his final term of office in May 2021
[3] Dr Jennifer Lisle came to the end of her second term on 31st May 2021 and did not seek re-election
[4] William Holmes came to the end of his first term on 31st May 2021 and did not seek re-election

Elected Governors - Staff Constituency

Name	Constituency	Elected or Re-elected	Term of Office	Attendance from 5 meetings
Paul Russell	Clerical, Administrative and Managerial	June 2020	One year	4 / 4
Pearl James[1]	Volunteers	May 2018	Three years	1 / 1
Jane Podkolinski	Volunteers	June 2021	Three years	2 / 3
Jonathan Cullis[2]	Medical & Dental	May 2018	Three years	0 / 1
Anita Nazeer	Medical & Dental	June 2021	Three years	1 / 3
Lee Phillips[3]	Scientific, Technical & Therapeutic	May 2018	Three years	0 / 1
Mark Brewin	Scientific, Technical & Therapeutic	June 2021	Three years	3 / 3
Jayne Sheppard	Nurses & Midwives	May 2018	Three years	3 / 4

[1] Pearl James' second term ended on the 31st May 2021 and she did not seek re-election
[2] Johnathan Cullis' first term ended on 31st May 2021 and he did not seek re-election
[3] Lee Phillips first term ended on 31st May 2021 and did not seek re-election

Nominated Governors

Name	Constituency	Appointed or Re-appointed	Term of Office	Attendance from 5 meetings
Vacant	Wiltshire Council	N/A	N/A	N/A
Cllr Richard Rogers	Wiltshire Council	9 March 2022	Three Years	N/A
Steve Donald[1]	Wessex Community Action	June 2021	Three years	2 / 3
Vacant	Dorset CCG	N/A	N/A	N/A
Dr Edward Rendell[2]	BaNES, Swindon and Wiltshire (BSW) CCG	June 2020	Three years	2 / 4
James House	West Hampshire CCG	July 2021	Three years	3 / 3
Sarah Walker	Military	July 2021	Three years	3 / 3

[1] Steve Donald stood down from his role as nominated Governor in March 2022
[2] Edward Rendell stood down from his role as nominated Governor in March 2022

During the year the Directors have used a variety of methods to ensure that they take account of, and understand, the views expressed by Governors and members. The Council of Governors is chaired by the Chairman and these meetings are attended by the Chief Executive, who presents a performance report and answers questions. This is an opportunity for Governors to express their views and raise any other issues, so that the Chief Executive can respond.

There have been no formal requests for Director attendance at the Council of Governors meetings, but it has been standard practice for the Chief Executive and Director of Nursing to attend. The Chief Operating Officer also attends when operational queries have been raised. Dependent on the agenda, other Executives attend as required.

An informal meeting is normally held between the Governors and the Non-Executive Directors a week after a public board meeting approximately four times a year. However, due to the prevalence of COVID-19 and at the request of our Governors the Trust scheduled an informal briefing with the Non-Executive Directors after every Public Board meeting.

The Trust Board is aware of the work carried out by the Governor committees and information is fed back to the directors.

In 2021-22, the Trust Board met regularly in public and, as part of its commitment to openness, Governors and members are invited by the Chairman to comment or ask questions on any issues that they may wish to raise at the end of the public session. A response is provided by the appropriate member of the Trust Board.

Public Trust Board papers are made available on the website and Governors alerted so that these can be viewed prior to the meetings.

The Trust Board has invited the lead Governor to attend as an observer at the private meetings of the Board and has also invited Governor observers to attend the meetings of the Board's Finance and Performance Committee, its Clinical Governance Committee and its People and Culture Committee.

Register of Governor Interests

A register of interests is held in the Trust Offices. Information regarding the Governors' interests and whether they have undertaken any material transactions with Salisbury NHS Foundation Trust can be obtained by contacting:

Head of Corporate Governance,
Trust Offices,
Salisbury NHS Foundation Trust,
Salisbury
SP2 8BJ

Dispute Resolution

There are a number of mechanisms in place that allow an issue or concern to be discussed and escalated. Informally, there are meetings between the Lead Governor and the Chairman and there are regular meetings between the Governors and the Non-Executive Directors. A formal procedure is in place (see point 51, Dispute Resolution in the Trust's Constitution) should there be a dispute between the Council of Governors and Trust Board.

The Board of Directors

The Board comprises the Chairman, Chief Executive, five other Executive Directors and seven other Non-Executive Directors. There is a clear separation between the roles of the Chairman and the Chief Executive, which has been set out in writing and agreed by the Board. As Chairman, Nick Marsden has responsibility for the running of the Board, setting the agenda for the Trust and for ensuring that all Directors are fully informed of matters relevant to their roles. The Chief Executive has responsibility for implementing the strategies agreed by the Board and for managing the day-to-day business of the Trust.

All of the Non-Executive Directors are considered to be independent in accordance with the NHS Foundation Trust Code of Governance. The Board considers that the Non-Executive Directors bring a wide range of business, commercial and financial knowledge required for the successful direction of the Trust. All directors are equally accountable for the proper management of the Trust's affairs.

All directors are subject to an annual review of their performance and contribution to the management and leadership of the Trust.

The Board Committees including the Clinical Governance Committee, Audit Committee, Finance and Performance Committee and People and Culture Committee have completed a self-assessment of committee effectiveness. These reviews concluded that these Committees were meeting the requirements as set out in their terms of reference.

There were no commissioned external reviews of the Board during the reporting year.

The Trust has Board approved Standing Financial Instructions and a Scheme of Delegation and Reservation of Powers, which outline the decisions that must be taken by the Board and the decisions that are delegated to the management of the hospital. These documents include, but are not limited to, instructions on budgetary control, contracts and tendering procedures, capital investment and security of the Trust's property, delegated approval limits, fraud and corruption and payroll.

The Board is satisfied as to its balance, completeness and appropriateness but will keep these matters under review.

Trust Board Members

Dr Nick Marsden – Chairman (Independent)

Nick Marsden joined the Trust in January 2014. Before this he was an NHS Non-Executive Director and Vice Chairman at Southampton. He has an engineering Ph.D and also commercial experience having held several senior executive roles at IBM, before becoming Senior Vice President for Service at Danka Europe.

Stacey Hunter – Chief Executive

Stacey is an experienced NHS Board Director with over 34 years' experience working in the NHS and a decade operating in Chief Operating Officer, Divisional Director and Executive System Transformation roles. She has spent time working in large scale teaching hospitals, an integrated acute and community trust and is passionate about reducing the inequalities patients experience in respect of their access to, experience of and outcomes from care.

A nurse by background Stacey spent several years working in clinical leadership roles before expanding her experience in general management. She has invested in her leadership development having undertaken the NHS Leadership Academy Aspiring CEO programme and is keen to continue to support the Trust to develop an inclusive culture that develops clinical and operational leaders to seek to continuously improve their services. Stacey has experience of being a trustee in a number of different charities over the last 20 years most of them related to health and care. Stacey joined the Trust in September 2020.

Rakhee Aggarwal – Non-Executive Director (Independent)

Rakhee Aggarwal joined the Trust in January 2020 on a three-year term. Rakhee has been a mental health nurse since 1999; She has a BSc in Behavioural Studies (Psychology); and a Master's in teaching and Learning for Health Professionals. She has worked for the University of the West of England for the past 15 years as a Senior Lecturer; Associate Head of Nursing and Midwifery - Mental Health and Learning Disability Nursing; Associate Head of Nursing and Midwifery - Adult Nursing; and as Associate Head of Nursing and Midwifery - Continuing Professional Development. Rakhee is leading and developing the CPD Education provision for the NHS and private and voluntary sectors. In addition to her work at the University she has been a Non-Executive Director with the South Western Ambulance Trust since 2017.

Tania Baker - Non-Executive Director (Independent)

Tania Baker joined the Trust in June 2016 for a three-year period. Her term of office was extended for a further two years in February 2019. She was Chief Executive Officer at health analytics company, Dr Foster where she was involved in developing the business nationally and internationally. Before this Tania held senior appointments in private healthcare and was Commercial Director at Aviva Health insurance. Tania is the Senior Independent Director.

Michael von Bertele CB, OBE - Non-Executive Director (Independent)

Michael joined the Trust in November 2016 for a three-year period. His term of office was extended for a further three years in October 2019. As an army junior doctor, he trained in occupational and environmental medicine, and became a consultant in 1992. Michael has served in the UN Protection Force in Croatia, was chief medical planner in the Ministry of Defence and was Director General of the Army Medical Services. He retired in 2012 and worked for Save the Children International until 2015.

Dr David Buckle – Non-Executive Director

Dr David Buckle joined the Trust in January 2020 on a three-year term. He is MB BS, DRCOG and MRCGP qualified and is a Fellow of the Royal College of General Practitioners. He was a practising GP until 2017 whilst latterly working part-time (until May 2018) as the Medical Director for Herts Valley Clinical Commissioning Group, where he was the Director of General Practice development. He has previously held other roles comprising various positions within Berkshire East and Berkshire West Primary Care Trusts and with NHS Berkshire West Primary Care Trust. David currently has a portfolio of Non-Executive appointments, as the President of the Society for Assistance of Medical Families, Non-Executive Director with Berkshire Healthcare NHS Foundation Trust, Non-Executive Director with East and North Hertfordshire NHS Hospitals Trust; and Vice Chair (clinical) of the Stroke Association. David became a voting member of the Board in May 2020.

Mr Peter Collins – Medical Director

Peter trained as a liver specialist and was the clinical lecturer at the Sheila Sherlock Liver Centre at the Royal Free Hospital prior to taking up a consultant post at University Hospitals Bristol Foundation Trust in 2005. He has a research interest in primary liver cancer and alcohol related liver failure and led the regional Primary Liver Cancer Service for the West of England. He has had a number of senior leadership positions in research, education and hospital care.

In 2017 Peter was appointed to the role of Medical Director at Weston Area Health Trust where he played a key role in developing models of integrated care, reconfiguring services across Bristol and North Somerset and readying the organisation for a successful merger with University Hospitals Bristol. Since the merger Peter worked as a Deputy Medical Director for the large organisation focusing on the delivery of safe and effective COVID-19 care and the restoration of non-COVID services for the Trust and the local Healthcare system. Peter joined the Trust as Interim Medical Director in October 2020 and was successfully appointed to the substantive position in March 2021.

Judy Dyos – Director of Nursing

Judy joined the Trust from Isle of Wight NHS Trust where she was formerly Deputy Director of Nursing and was instrumental in the Isle of Wight Trust obtaining a CQC rating of Good in many areas. Prior to this she was the Lead for Clinical Assurance and Quality Governance at University Hospital Southampton. Judy joined the Trust as Interim Director of Nursing in June 2020 and was successfully appointed to the substantive position in March 2021.

Andy Hyett – Chief Operating Officer

Andy Hyett has a wide range of NHS experience. He started his career as a biomedical scientist at Dorset County Hospital in the 1990s and moved into NHS management in Winchester. He continued to progress through senior management positions in Portsmouth and then University Hospital Southampton NHS Foundation Trust where he was Deputy Chief Operating Officer. Andy joined the Trust in 2015.

Eiri Jones – Non-Executive Director (Independent)

Eiri Jones joined the Trust in November 2019 for a three-year period. Eiri is a registered adult and children's Nurse, has an MA in Professional Development and is a QSIR Practitioner. She has clinical, managerial and executive leadership knowledge and skills gained during a career spanning over 40 years.

Eiri has held senior and board positions in a range of Trusts in England and Wales and has also held regional (Trust Development Authority), national (Welsh Government and State of Qatar) and regulatory (Nursing and Midwifery Council) appointments. Her last UK Executive role was as the Director of Nursing for the United Lincolnshire Hospitals NHS Trust (2012 – 2014). Since then, she has held roles as an interim Quality Manager at NHS Crawley CCG; interim Director of Quality Governance at Barts Health NHS Trust; Implementation Director of GIRFT in the South West of England and most recently as a Quality Programme Director for Cwm Taf Morgannwg Health Board. Eiri is also Non-Executive Director at Homerton University Hospital Foundation Trust and sits on Allocate's Advisory Board.

Paul Kemp – Non-Executive Director (Independent)

Paul Kemp joined the Trust in February 2015 for a three-year period having completed 34 years in industry, initially as a development chemist before concentrating on finance, IT and business change leadership. His term of office was extended for a further two years in

November 2020. He has worked for a number of large multinational companies, including British Airways and Cobham plc, the multinational aerospace and defence company. In 2018, Paul was appointed as a Justice of the Peace, sitting on the Dorset bench and in 2019 took up the role of Trustee and Honorary Treasurer for the Magistrate's Association, a charity supporting the magistracy across England and Wales.

Paul Miller – Non-Executive Director (Independent)

Paul Miller joined the Trust in March 2018 for a three-year period. His term of office was extended for a further three years in November 2020. His experience spans 23 years as an executive director in a wide variety of organisations. It includes five years as a Chief Executive in both Wales and England and 16 years as a Director of Finance in specialist regional, mental health and acute organisations. These roles covered finance, strategy, organisational leadership and successful working at a very senior level in a wide variety of health systems.

Lisa Thomas – Director of Finance

Lisa has over 18 years' finance experience in a number of NHS organisations having started her career in 1999 on the Graduate Financial Management Training scheme. She was previously Deputy Director of Finance at Royal United Hospitals Bath NHS Foundation Trust, and prior to that she spent time working in Basingstoke, Winchester and Gloucestershire NHS organisations in senior roles. Lisa joined Salisbury in 2017.

Melanie Whitfield – Chief People Officer

Melanie is an accomplished HR leader and coach with many years' experience leading on significant programmes of change and people strategy in both the private and public sector.

With many years of organisational HR experience, including Board level experience within private equity and public charity sectors, Melanie joined the national team at NHS England and Improvement as one of the founding authors of the People Plan.

Melanie began her career in retail working for some of the best-known brands on the high street including The John Lewis Partnership, Sainsbury's, and Boots. She has continued both her formal academic studies and professional development and has a particular interest in the value and impact of team coaching. On joining the Trust Melanie expressed her wish to support all staff to be the best they could be, by helping create the kind of environment where everyone can thrive and in doing so, provide the best possible care to the community we serve.
Within the Trust's executive team, she is the responsible leader for our Operational HR Services, Resourcing, Organisation design and Development, Education and Communication strategies alongside our Health and Safety and Occupational Health services.

Directors that left the Trust during 2021-2022

Susan Young, Interim Chief People Officer – Susan joined the Trust on 1st March 2021 and left the Trust on 31st August 2021.

Lynn Lane, Interim Chief People Officer – Lynn left the Trust on 6th April 2021.

Board of Directors' Attendance (Member's attendance only)

	Appointment Date		Trust Board (12 meetings)	Audit Committee (6 meetings)	Remuneration Committee (6 meetings)	Finance & Performance (12 meetings)	Clinical Governance Committee (12 meetings)	People and Culture Committee (9 meetings)	Subsidiary Governance Committee (3 meetings)	Council of Governors (4 meetings)
	From	To								
Rakhee Aggarwal Non-Executive	01/01/20	-	9		3			9		1
Tania Baker Non-Executive	01/06/16	-	11	5	6					3
Michael Von Bertele Non-Executive	01/11/16	-	12	5	6			9		2
Dr David Buckle Non-Executive	27/01/20	-	11		6		12			2
Peter Collins Medical Director	05/10/20	-	9				11	9		2
Judy Dyos Director of Nursing	15/06/20	-	11				12	9		4
Andy Hyett Chief Operating Officer	13/04/15	-	11			9	8			0
Stacey Hunter Chief Executive	01/09/20	-	11	3		9	8			4
Eiri Jones Non-Executive	11/11/19	-	12		5	11	12			3
Paul Kemp Non-Executive	01/02/15	-	12	6	5	11			3	1
Nick Marsden Chairman	01/01/14	-	12		6				2	4
Paul Miller Non-Executive	16/04/18	-	12	6	6	12	12		3	2
Lisa Thomas Director of Finance	03/07/17	-	11	6		12			3	0
Melanie Whitfield Chief People Officer	06/09/21		7			4		4	1	0

The Audit Committee

Name	Committee Role	Attendance out of six meetings
Paul Kemp	Chairman	6
Michael von Bertele	Non- Executive Director	5
Tania Baker	Non- Executive Director	5
Paul Miller	Non- Executive Director	6

The Work of the Audit Committee in Discharging its Responsibilities

The Audit Committee is in place to provide the Board with assurance as to the effectiveness of the processes overseen by the Board itself and by the Finance & Performance, People and Culture, and Clinical Governance Committees.

The committee is supported by the Appointed Auditor, Grant Thornton LLP who took office from November 2018. In October 2019 the Council of Governors approved the appointment of Grant Thornton as the Trust's External Auditor for the next four years.

During 2021-22, the internal audit service was provided by PwC UK.

The Committee has an annual work programme as well as dealing with other items that arise during the year. It also agrees annual work programmes with the auditors and the Executive.

The Audit Committee is chaired by Paul Kemp, Non-Executive Director. The Audit Committee is responsible for:

- Monitoring the integrity of the financial statements of the Trust, any formal announcements relating to the Trust's financial performance and reviewing significant financial reporting judgements contained in them.

- Assisting the Board of Directors with its oversight responsibilities and independently and objectively monitoring, reviewing and reporting to the Board on the adequacy of the processes for governance, assurance, and risk management; where appropriate, facilitates and supports through its independence, the attainment of effective processes.

- Reviews the effectiveness of the Trust's internal audit and external audit function.

- In discharging its role and function, the Committee shall provide assurance to the Board of Directors that an appropriate system of internal control is in place to ensure that business is conducted in accordance with the law and proper standards.

In addition to its standing items of business, which includes payroll analysis, internal audit recommendation tracker, Internal Audit Reports, External Audit Reports and Counter-Fraud progress reports, the Audit Committee has reviewed risk management systems and processes.

Although the peak of the direct impact of the pandemic on patient numbers occurred during 2020-21, the delta variant in the early part of the current year and the subsequent omicron variant were significant factors in the management of the hospital. Although public restrictions were reduced in the latter part of the year, many of the hospital virus control measures were maintained. There was also a significant, if indirect, impact on the ability to be able to release otherwise fit patients, with the numbers identified as having No Criteria to Reside rising significantly and disrupting patient flows throughout. This latter problem has not yet been resolved and continues to disrupt patient flow. These phenomena are prevalent across the whole of the NHS and are not particularly focused in Salisbury.

The committee reviewed the draft financial statements and governance statements for the 2020-21 annual report and recommended their adoption to the Board. As in the previous year, there were some disruptions to the process and the final signing of the accounts was slightly delayed. However, these issues related to delays in the audit process, rather than

issues with the accounts and did not impact the outcome. The Audit Committee signed off the Annual Accounts on the 18th June 2021, acting on the delegated authority of the Board.

During the financial year 2021-22, PWC carried out reviews in eight areas, agreeing a total of 39 actions with management. Three of the eight reports were rated as "High Risk" overall. On a positive note, the auditors were complimentary about the attention that was being given by management to the closure of agreed actions. Unlike previous years, there were only three actions still open relating to reviews from previous periods, and these were long term actions that were not yet due for completion. Overall, the Head of Internal Audit Opinion remained the same as for the last two years. That is to say that the formal opinion was that the control environment within the Trust was independently judged to be "*Generally satisfactory with some improvements required."*

During the year, the committee continued its practice of inviting management teams to give a detailed presentation on a specific management process or area of concern. The Audit committee has received presentations on the implementation of the new financial ledger system, programme management processes, diagnostic wait time management and improvements in medicine controls in the pharmacy. All the presentations were of a good standard and led to a good discussion in the committee on the issues raised.

During the year the Local Counter Fraud Officer (LCFO) continued to work with management on both proactive and reactive work packages, linking in with guidance from the NHS Counter Fraud Authority. Good progress was achieved through the year on the actions required to improve the Trust's rating in the NHS Counter Fraud Functional Standard Return, with the two outstanding red rated items improved to green.

The Audit Committee is also responsible for monitoring the external auditor's independence and objectivity, including the effectiveness of the audit process. The committee reviews the effectiveness of the audit process including verifying compliance with statutory requirements and deadlines, communication with key senior management personnel, satisfactory planning processes, and confirmation that the provision of staff to carry out work for the Trust are those named and qualified.

Grant Thornton has not provided any non-audit services for the Trust in 2021-22.

Membership of the Audit Committee

The Audit Committee is comprised of three of the eight eligible Non-Executive Directors. The other main assurance committees of the Board are the Finance & Performance, People and Culture and Clinical Governance committees.

Financial Audit

The external auditors for the Trust are Grant Thornton. During the 2021-22 period, the Trust has incurred the following costs on external audit:

- Audit services: £85,885 (plus VAT)
- Other services: £12,000 (plus VAT)

As mentioned above, no other remuneration was paid to the auditor and the auditor was not involved in any other work for the Trust that may have compromised their independence.

The Trust has an internal audit function which was delivered under contract by PwC in 2021-22. The work programme is reviewed and approved by the Audit Committee. Senior representatives of PwC report to the audit committee and a working protocol is in place with Grant Thornton, the Trust's appointed auditor. The delivery of the contract with PwC is overseen by the Chief Finance Officer and the internal audit fee for 2021-22 was £95,000.

Revaluation of Property and Land

The Trust's accounting policies requires a land and buildings revaluation to be undertaken at least every five years, dependent upon the changes in the fair value of the property. The five-yearly revaluations are carried out by a professional qualified valuer in accordance with the Royal Institute Chartered of Surveyors (RICS) Appraisal and valuation manual. The valuations are carried out on the basis of a Modern Equivalent Asset, as required by HM Treasury. The annual reviews are carried out using the most appropriate information available at the date of the review. The last full revaluation was carried out during 2019-20. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – modern equivalent depreciated replacement cost

Annual desktop valuations and annual impairment reviews are carried out in all other years where a full revaluation has not taken place.

Recognition of Income

Of the Trust's income, 89% is received from other NHS organisations, with the majority being receivable from NHS Bath and North East Somerset, Swindon and Wiltshire CCG. The Trust participates in the Department of Health and Social Care's agreement of balances exercise. This exercise seeks to identify all income and expenditure transactions and payable and receivables balances that arise from Whole Government Accounting (WGA) bodies. The Audit Committee is satisfied that by participating with this exercise it helps to provide further assurance that the vast majority of income and expenditure with WGA have been properly recognised and WGA receivable and payable balances are appropriately recorded. The Trust's external auditors will review the outcome of the exercise and report their findings to the Audit Committee.

Directors' Responsibilities for Preparing the Annual Report and Accounts

The Directors are aware of their responsibilities for preparing the annual report and accounts and are satisfied that they meet the requirements as reflected in the statement of Chief Executive's Responsibilities as the Accounting Officer at Salisbury NHS Foundation Trust. This can be found in the Annual Accounts for Salisbury NHS Foundation Trust. In Summary, the Annual Report and Accounts taken as a whole are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

NOMINATIONS COMMITTEE

The purpose of the Directors' Nominations Committee is to conduct the formal appointment to, and removal from office, of Executive Directors of the Trust, other than the Chief Executive (who is appointed or removed by the Non-Executive Directors subject to approval by the Council of Governors).

The Committee membership includes the Trust Chairman, as Chair and all Non-Executive Directors.

In 2021-22 Melanie Whitfield was appointed as Chief People Officer and started at the Trust on 6th September 2021.

FOUNDATION TRUST MEMBERSHIP

The membership of the Trust is made up of local people, patients and staff who have an interest in healthcare and their local hospital. Public members have to be aged 16 and over.

The staff membership has five classes to reflect the following occupational areas:

- Medical and Dental
- Nurses and Midwives
- Scientific, Therapeutic and Technical
- Administrative, Facilities and Managerial
- Voluntary

Public members (including volunteers) can only be a member of one constituency. Staff members can only be a member of the staff constituency. Eligibility requirements for joining different membership constituencies, including the boundaries for public membership, are shown in the Trust's Constitution, which is available on the Trust's website.

During the year the Trust sought to broadly maintain membership numbers. At 31st March 2021 the membership for Salisbury NHS Foundation Trust is as follows:

Public Constituency	Number
Salisbury City	2,524
South Wiltshire Rural	4,664
Kennet	1,214
North Dorset	1,413
East Dorset	582
New Forest	1,033
Rest of England	1,115
Staff Constituency	1,997
Total	**14,567**

Ownership of the Trust's membership strategy rests with the Governors with support from the Trust. A key objective of the strategy is to maintain an engaged membership of Salisbury NHS Foundation Trust which broadly represents the population it serves, taking account of age, ethnicity and diversity in the population of the catchment area.

The Trust's Membership Strategy was revised and approved by the Council of Governors in November 2020, which identified several areas of development that are already in-progress. Currently, the Trust uses its public meetings to highlight the benefits of membership and encourage recruitment. Additionally, members' newsletters are used to encourage existing members to promote membership amongst friends and acquaintances.

During 2021-22 the Trust hoped to widen the scope of the Trust's membership recruitment. However, due to the ongoing impact of COVID-19, reduced public gatherings and footfall in the hospital, recruitment has been challenging. The Memberships and Communications

Committee led by Governors is focusing on different methods of recruitment, including using the Trust's social media platforms. Furthermore, it is hoped that a focused membership page on the Trust's website and the re-introduction of constituency meetings in 2022-23 and other events like 'Medicine for Members' will attract a more representative membership and is a focus for 2022-23.

This year, a digital summary of the Annual Review was distributed to enable a wider reach. This document was published on the Trust website, promoted to our members and provided a succinct and informative summary of the year's events, including our ambitions for the year ahead.

During 2021 Governors continued to join their Committee's and groups virtually due to the COVID-19 pandemic. Towards the end of 2021, due to changing restrictions, Governors started meeting in hybrid settings with some attending in person whilst allowing others to attend meetings virtually. They have been focusing on their statutory duties and have also been involved in the development of the Trust's Annual Plan and Quality Account. A number of other public initiatives that Governors have previously been involved in were put on hold during this time. However, Governors have still been able to participate virtually on Trust-led working groups, such as Food and Nutrition and the Transport Strategy. It is hoped that, with the prevalence of COVID-19 declining, Governors will once again be provided with the other opportunities to be involved in or sample the 'patient experience'.

A dedicated section on the Trust's website and intranet provides details of each Governor, their interests and a means for members to communicate with them. There are also members' newsletters for staff and people in the public constituencies.

Table 1 below sets out the Code of Governance Provisions to be included in the Annual Report and their location.

Table 1: Code of Governance Provisions included in the Annual Report and their location

Relating to	***Code of Governance* reference**	**Summary of requirement**	**Annual Report Location**
Board and Council of Governors	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of Governors. This statement should also describe how any disagreements between the council of Governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of Governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Code of Governance 'Board of Directors'/ 'Council of Governors'

Board, Nomination Committee(s), Audit Committee, Remuneration Committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Part of this requirement is also contained within paragraph 2.24 as part of the directors' report.	Code of Governance 'Board of Directors'/ Accountability Report 'Directors Report'
Council of Governors	A.5.3	The annual report should identify the members of the council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead Governor.	Code of Governance 'Council of Governors'
Council of Governors	n/a	The annual report should include a statement about the number of meetings of the council of Governors and individual attendance by Governors and directors.	Code of Governance 'Council of Governors'/ 'Board of
Board	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	Code of Governance 'Board of Directors'
Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Code of Governance 'Board of Directors'
Board	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	Code of governance 'Board of Directors'/ Remuneration Report

Nominations Committee(s)	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Code of Governance 'Nominations Committee'
Nominations Committee(s)	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	N/A – external consultancy agency used
Chair/Council of Governors	B.3.1	A chairperson's other significant commitments should be disclosed to the council of Governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of Governors as they arise and included in the next annual report.	Code of Governance 'Board of Directors'
Council of Governors	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed Governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Code of Governance 'Council of Governors'

Council of Governors	n/a	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a Governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trusts or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Code of Governance 'Council of Governors'. No issues identified in the reporting year.
Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Code of Governance 'Board of Directors'
Board	B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	Code of Governance 'Board of Directors' No commissioned external reviews.
Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 2.97.	See Annual Accounts and Annual Report. 'Directors Responsibilities for preparing the Accounts, the Independent Auditor's Report to the Governors and the Annual Governance Statement'

Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Annual Governance Statement
Audit Committee/control environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Code of Governance 'Financial Audit'
Audit Committee/ Council of Governors	C.3.5	If the council of Governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of Governors has taken a different position.	No issues identified in the reporting year.
Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed. • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Code of Governance 'Audit Committee'

Board/ Remuneration Committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Nil to report for the reporting year
Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of Governors and members about the NHS foundation trust, for example through attendance at meetings of the council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	Code of Governance 'Foundation Trust Membership' and 'Council of Governors'
Board/ Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Code of Governance 'Foundation Trust Membership'
Membership	E.1.4	Contact procedures for members who wish to communicate with Governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Code of Governance 'Foundation Trust Membership'
Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership. • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Code of Governance 'Foundation Trust Membership'

Board/Council of Governors	n/a	The annual report should disclose details of company directorships or other material interests in companies held by Governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of Governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 2.24 as directors' report requirement.	Accountability Report 'Board of Directors'

NHS OVERSIGHT FRAMEWORK

NHS Improvement's (NHSI) Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs.
The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence. The Trust is currently segmented at 3 and was subject to enforcement undertakings due to the suspected breach of licence from January 2018 for the deteriorating financial position.

This segmentation information is the Trust's position on 31 March 2022. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Statement of the Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities, as the accounting officer of Salisbury NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are

answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Salisbury NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Salisbury NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

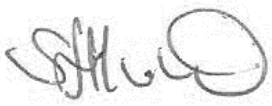
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and, hence, for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.



Stacey Hunter
Chief Executive (Accounting Officer)
16/06/2022 (on behalf of the Trust Board)

ANNUAL GOVERNANCE STATEMENT

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Salisbury NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Salisbury NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

As the Chief Executive, I have overall responsibility for risk management within the Trust. The day-to-day oversight has been delegated to an executive lead for risk (the Chief Nursing Officer), who is responsible for reporting to the Trust Board on the development and progress of risk management and for ensuring that the Risk Management Strategy is implemented and evaluated effectively.

The Trust's Senior Leadership Team Committee, which I chair, has the remit to ensure oversight of the adequacy of the management of key risks facing the organisation. The Audit Committee provides a key forum through which the Trust's Non-Executive Directors bring independent judgement to bear on issues of risk management and performance. The constructive interface between the Audit Committee and Board supports the effectiveness of the Trust's systems of internal control.

The Board brings together the corporate, financial, workforce, clinical and operational risk agendas. The Board Assurance Framework (BAF) ensures that there is clarity about the risks that may impact on the Trust's ability to deliver its strategic objectives together with any gaps in control or assurance.

The day-to-day management of risks is undertaken by Divisions and corporate managers, who are charged with ensuring that risk assessments are undertaken proactively throughout their area of responsibility and remedial action is carried out where issues are identified. There is a process of escalation to Executive Directors through Executive Performance Reviews, relevant committees and governance groups as required where there are challenges in implementing mitigations.

The Trust has a Risk Management Strategy in place which provides the framework for managing risk across all levels of the organisation. The strategy provides a clear, systematic

approach to the management of risks to ensure that risk assessment is an integral part of all clinical, managerial, and financial processes. Risk management is supported in the following ways: a central risk management team and a Director of Integrated Governance in place. Divisional Governance committees were introduced in 2019 to further strengthen the governance arrangements. The Trust's capacity to handle risk was evidenced through the Care Quality Commission (CQC) Inspection report 1 March 2019 that "The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected". The CQC rated the Trust Good for the Well-led domain which recognised the strong culture of good governance.

The Head of Risk Management supports the Executive Lead and is responsible for ensuring that staff are trained and equipped to manage risk in a way appropriate to their authority and duties. This is achieved through risk training programmes and through supporting and facilitating departments and teams directly. The National Patient Safety Strategy that was published in 2019 has revised several of the original strategy timeframes following the disruption arising from the pandemic. New timescales are being initiated to reflect this, which in turn will inform more specific training going forward in line with the Patient Safety Incident Framework that will be replacing the current Serious Incident Framework.

Board members received development sessions in risk management, risk appetite and risk tolerance which includes an overview of the risk systems. The Board is responsible for the periodic review of the overall governance arrangements, both clinical and non-clinical, to ensure that they remain effective.

The Risk and Control Framework

The Trust understands that healthcare provision and the activities associated with caring for patients, employing staff, providing premises and managing finances will always involve an inherent degree of risk. Good risk management practice requires that identified risk is analysed, evaluated, treated and actions followed up for the purposes of monitoring and review to further improve.

The overall objective of the Risk Management Strategy is to ensure that robust risk management processes are in place which provide assurance to the Board that the Trust is discharging its responsibilities as an NHS Foundation Trust in ensuring business and financial acumen, improving services and the quality-of-care provision, whilst operating as a model employer and service provider in achieving the Trust's operational and strategic objectives. The strategy is updated every three years to ensure that it continues to reflect best practice in risk management methodologies and sets out the key responsibilities and accountabilities and includes a review of the Trust's risk appetite. The Risk Management Strategy sets out the strategic goals towards which the Trust is working with regard to risk management and provides a framework that sets out the key responsibilities for managing risk within the organisation, including ways in which risk is identified, evaluated and controlled.

Risk management requires participation, commitment, and collaboration from all staff. The process starts with the systematic identification of risks via structured risk assessments. These risks are documented on risk registers throughout the organisation.

These risks are then analysed to determine their relative importance using a risk scoring matrix. Low scoring risks are managed by the area in which they are found, whilst higher scoring risks are managed at progressively higher levels within the organisation.

Risk control measures are identified and implemented to reduce the potential for harm. The potential consequence and likelihood of the risk occurring are scored along with the effectiveness of existing control measures. It is the sum of these scores which determines the level in the organisation at which the risk is reported and monitored to ensure effective mitigation.

Each Division maintains risk registers containing clinical and non-clinical risks. All unresolved risks affecting multiple departments or the division are recorded within the Divisional risk register whilst individual departments/specialties maintain departmental risk registers containing risk to the achievement of individual department's objectives. The escalation process between these risk registers is monitored monthly via the divisional management team with oversight through the Divisional Governance Committees. Deep dives of the Divisional risk registers are undertaken in conjunction with the Chief Nursing Officer and Chief Medical Officer to provide additional scrutiny and oversight. Escalation of Divisional risks to the Corporate Risk Register is via the Executive Performance Reviews.

Risks are identified through third-party inspections, recommendations, comments, and guidelines from external stakeholders and internally through incident forms, complaints, risk assessments, audits (including clinical and internal), information from the Patient Advice and Liaison Service (PALS), benchmarking and claims and national survey results. External stakeholders include the Care Quality Commission, NHS England/Improvement, the Health and Safety Executive, NHS Resolution (previously the NHS Litigation Authority), the Medicines and Healthcare Products Regulatory Agency and the Information Commissioner's Office.

The Audit Committee oversees and monitors the performance of the risk management system, with internal and external auditors working closely with this committee. The internal auditors use a risk-based model to undertake reviews and provide assurances on the systems of internal control operating within the Trust. The results of internal audit reviews are reported to the Audit Committee which oversees that weaknesses in the system are addressed. Procedures are in place to monitor the implementation of control improvements and to undertake follow-up reviews if systems are deemed less than adequate. Internal Audit recommendations are tracked via reports to the Audit Committee. The Counter Fraud programme is also monitored by the Audit Committee.

The Clinical Effectiveness Steering Group, reporting to the Clinical Management Board consider evidence that the Trust's comprehensive programme of clinical audit effectively supports improving clinical quality in alignment with the Trust's quality objectives.

The Trust's Board Assurance Framework (BAF) details the principle strategic risks to the achievement of the Trust's corporate objectives. This is received by the Board on a quarterly basis together with the Corporate Risk Register and a report detailing progress against delivery of the objectives. The Finance and Performance Committee, People and Culture Committee and Clinical Governance Committee have oversight of the BAF and Corporate Risk Register on a quarterly basis where the risk profile is reviewed and discussed in detail. The work plan of the Board Committees is linked so that the Board is assured that there is an aligned independent and executive focus on strategic risk and assurance. Referral of issues between committees ensures a respective understanding of risk and assurance concerns.

The management of the coronavirus pandemic has meant the Trust has seen the overall risk profile for 2021-22 dominated with risks associated with the impact of COVID-19, in particular the National requirements for staff testing and isolation. Key risks include:

- Impact on patients, staff and service delivery as a result of COVID-19.

- Staffing availability impacting on service delivery and health and well-being of staff.
- Impact of delayed discharge from hospital including management of an increasing number of No Criteria to Reside patients
- Information technology, clinical systems and technical infrastructure.
- Critical plant and building infrastructure within limited capital funding.

The Trust established controls or implemented actions to manage these risks as summarised below:

- Incident management structure in response to the National Level 4 incident
- System response to address operational and capacity pressures.
- Implementation of National Infection, Prevention and Control measures including vaccination programme.
- Incentive schemes to minimise staffing shortfalls.
- Creative use of volunteers to support ward staff e.g., ward buddies
- Occupational Health and wellbeing support for staff including clinical psychology support
- Implementation of the digital strategy and continued focus development of the infrastructure and controls.
- Robust capital prioritisation processes to ensure resources are deployed effectively.

Major risks 2022/23

As we enter 2022/2023, the Trust is focused on enacting recovery plans following de-escalation from the National Level 4 incident. The focus will be on the delivery of NHS England Operational Planning Priorities 2022/23:

- Supporting the health and wellbeing of staff
- Accelerate the restoration of elective and cancer care and reduce waiting times
- Working with partners to transform community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
- Working collaboratively across systems to deliver on these priorities.
- Ability to achieve financial sustainability

Key risks include:

- Pace of recovery
- Impact of COVID-19 on the health and wellbeing of staff
- Balancing business as usual with recovery plans
- Financial constraints

Within this context, we acknowledge the great opportunity in our closer integration with local partners and will continue to prioritise this and the benefits it provides in the delivery of our wider strategic objectives. We will review these to ensure the Trust is best placed to deliver the NHS and Bath, Swindon and Wiltshire Integrated Care System (BSW ICS) Long Term Plans and we will embrace the priorities of the NHS People Plan with the vision to make the Trust 'the Best Place to Work.'

Our underlying financial position remains a significant challenge. The financial regime for 2021-22 was very different due to the funding arrangements in response to COVID-19, which meant the Trust reported a breakeven position. However, 2022-23 signals a move back to a funding settlement in line with the long-term plan, which would return the Trust to a deficit. As a healthcare system, financial sustainability is also a priority; BSW ICS is

developing plans to address the system deficit where Salisbury will play a significant role. The changes in pathways and services in response to COVID-19 present both a challenge and opportunity to deliver and redesign services ultimately at a lower cost.

The future sustainability of the Trust will also be dependent on our ability to progress the delivery of our Estates masterplan. The operational resilience of areas such as Day Surgery and the Maternity Unit remain regular concerns, alongside managing the risk of high capital expenditure on reactive maintenance in the ageing parts of our Estate.

Quality Governance

The Trust is committed to and expects to provide excellent healthcare services that meet the needs of our patients and their families and provides the highest quality standards. The Board and Senior Management Team have a critical role in leading a culture which promotes the delivery of high-quality services. All efforts are focussed on creating an environment for change and continuous improvement.

The Trust has a robust Quality Governance reporting structure in place through an established Clinical Governance Committee. The Quality Governance arrangements are described in both the Integrated Governance Framework and Accountability Framework. These frameworks are a means by which the Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the strategic objectives. The Integrated Governance Framework makes it clear that quality governance is the responsibility of the Board supported by the Clinical Governance Committee for continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. The Quality Account published alongside this Annual Report and Accounts describe quality improvements and quality governance in more detail.

The Chief Executive is the Accountable Officer for quality governance. Each Director is a lead for a number of Board objectives. The responsible officers for quality are the Chief Medical Officer who leads on clinical effectiveness and the Chief Nursing Officer who leads on patient safety and patient experience.

Improving Together is a new Board approved initiative introduced during 2021, focused on continuous improvement and supported by the development of a coaching culture. Evidence shows that Trusts that have a continuous improvement approach provide better patient care, and colleagues working in these Trusts have greater job satisfaction. Ultimately Improving Together is all about improving the quality-of-care provision, by improving the way that we work and our systems and processes. It covers the following main areas:

- Alignment of priorities – from board to ward focusing on the same priorities, helping achievement of our goals more efficiently.
- Empowerment – Every member of SFT will develop and improve their skills in order to be able to identify and adopt and know that they are empowered to make process changes at a local level.
- Developing our culture – by empowering every member of staff to have a voice and supporting our leaders to adopt compassionate leadership approaches.
- Improving quality – by adopting an evidenced based continuous improvement approach to understand and continually improve the services we offer
- Stopping doing things that do not add value

With the simple goal of delivering an outstanding experience for patients, their families and the people who work with us - and being in a position where everyone can proudly say that Salisbury NHS Foundation Trust is the best place to work

The Trust has a robust approach to the assessment of the potential impact of cost reduction programmes on the quality of services. The quality impact assessment process involves a structured risk assessment using a standard template which requires Divisional Management Team sign off. The Chief Medical Officer and Chief Nursing Officer are responsible for assuring themselves and the Board that Cost Improvement Programmes will not have an adverse impact on quality.

Delivery of the Trust's strategic objectives is underpinned by the publication of the annual quality account which sets out the progress made against our quality priorities in 2021-22 and the quality priorities selected for 2022-23. Progress of the priorities is monitored via the Clinical Governance Committee; reviewing a suite of quality metrics that track performance against key quality indicators. There is no requirement currently for Foundation Trusts to produce a separate quality report.

The Integrated Performance Report, which comprises of detailed reports on quality, operational performance, finance and workforce, has been received by the Board monthly and is considered in detail.

Dedicated data quality teams pro-actively manage data quality within core systems and provide appropriate training and guidance to service colleagues across the Trust. Independent assurance regarding data quality is provided using SUS dashboards, internal audits which review internal processes and the annual Data Security and Protection Toolkit self-assessment review by internal audit.

Risks to data quality and data security are continually assessed and added to the Trust's risk register and scored appropriately. These are all managed following internal governance processes, overseen at the Information Standards Group and assured through the Information Governance Steering Group. Escalation of issue goes to the Trust Management Committee and the Trust's Finance and Performance Committee where appropriate.

The Trust has a Freedom to Speak Up Guardian (FTSUG) to act in an independent and impartial capacity to support staff who raise concerns and whom has access to the Chief Executive and the Trust's nominated Non-Executive Director for 'Freedom to Speak Up'.

Risk management is embedded in the activity of the organisation in a variety of ways. A suite of risk management policies underpins the Risk Management Strategy and are available to staff on the intranet. Training and awareness sessions are available to staff across the Trust and via mandatory training. Divisions and Corporate Functions proactively identify risks which are recorded on risk registers. The specialties and Divisions also retrospectively identify risk through adverse incident reporting, receipt and response to complaints and claims, patient and staff surveys and feedback, and concerns raised by the Coroner.

Due to the devolved nature of risk management and compliance of incident reporting and investigation at a local level, quality and quantity of incident reporting continues to improve and develop. 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 takes place and improvement actions are taken. The Trust submits patient safety incident data to the National Reporting Learning System. The Trust works in partnership with our commissioners to share learning and improvement actions. The Trust reviews all incidents graded moderate or severe together with compliance with Duty of Candour on a weekly basis through the Patient Safety Summit.

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

- Determining the Trust's quality priorities and monitoring delivery against key objectives. This is reported quarterly to Trust Board and Board Committees together with the Board Assurance Framework.
- Monitoring ward to board reporting on key patient safety and experience indicators and reporting these monthly to Board via the Integrated Performance Report.
- Service level deep dive reviews through the Clinical Governance Committee receiving assurance on the quality-of-service provision and areas for improvement.
- Reviewing a proportion of deaths in hospital through the Trust's Medical Examiners, Learning from Deaths Process and Mortality Review Group.
- Review of all COVID related deaths for wave 1 and 2.
- Weekly review of all reported incidents graded moderate and above to agree the appropriate level of investigation.
- Monitoring the identification and timely investigation of incidents and delivery of actions resulting in serious harm through a weekly patient safety summit meeting and executive exit process.
- Ensuring that learning from incidents is maximised and disseminated via Clinical Risk Group, Clinical Management Board and Divisional Governance Committees.
- Weekly oversight of duty of candour to ensure we are transparent with people that use our services if aspects of their care needs.
- Deep dive of Divisional Risk registers with the Chief Nursing and Chief Medical Officers to support risk management.
- Refreshed Clinical and Divisional governance structure and lines of communication to strengthen ward to Board information flows.

The Trust's patient and public involvement and consultation process ensures compliance with relevant legislation, and is described in the Patient and Public Involvement Strategy. All departments, both clinical and non-clinical, are responsible for planning and undertaking patient and public involvement initiatives, where appropriate. The Trust completes an annual patient and public engagement report, which is reported to Trust Board.

When developing plans for significant service changes, the Trust has to show how stakeholders might be affected and to ensure they are consulted and how their views will be taken into consideration in developing proposals for change. Equality impact assessments are part of this process. The Trust works closely with patients and public stakeholders to ensure that the impact of any changes on patients is minimised.

The Trust works with Healthwatch Wiltshire through regular liaison and communication to identify opportunities for the involvement of Healthwatch in Trust activities. Focus groups with people who had completed their complaints journey with the Trust is scheduled this year, in partnership with HealthWatch as an independent facilitator. This is forming part of our internal complaints process review as we continue to align ourselves to the new Parliamentary and Health Service Ombudsman (PHSO) NHS Complaint Standards Framework.

The Trust's Council of Governors engage with the quality agenda through its relevant working groups and a nominated Governor attends the Clinical Governance Committee. There is nominated Governor representation on all Board and Board Committees.

The Maternity Voices Partnership (MVP) is a forum for maternity service users, providers and commissioners of maternity services to come together to design services that meet the needs of local women, parents and families. Working together to share ideas and identify solutions for the design and improvement of maternity care. The function of the MVP is more than simply to listen; it is a way of discussing and overcoming challenges. The group aims to support the development and improvement of maternity care for everyone, regardless of who they are or where they live, so that everyone has access to the same quality of care.
The Trust has assessed compliance with the NHS provider condition 4. The Trust believes that effective systems and processes are in place to maintain and monitor the following conditions:

- The effectiveness of governance structures
- The responsibilities of Directors and subcommittees
- Reporting lines and accountabilities between the Board, its subcommittees and the executive team
- The submission of timely and accurate information to assess risks to compliance with the trust's licence *and*
- The degree and rigour of oversight the Board has over the Trust's performance.

These conditions are detailed within the Corporate Governance Statement, the validity of which is assured via the Finance and Performance Committee. Finance and Performance Committee reviewed the assessment in detail at its meeting on26 April 2022 and confirmed that no material risks had been identified.

The Trust implements key approaches and mechanisms to ensure that the short, medium and long-term workforce strategies and staffing systems are in place to assure the Board that staffing processes are safe, sustainable and effective. These include the following:

- Operating a resourcing programme with a strong focus on hard to recruit posts, including registered nurses, consultants, and other professionals.
- Measuring and continually working on reducing our use of bank and agency
- Optimise the use of the Electronic Staff Record (ESR) and the ongoing roll-out of eRoster.
- Plans to implement fuller use of the e-OPAS (Occupational Health) system portal.
- Working more collaboratively between our client areas and workforce informatics through our Organisation Development and People business partners to optimise workforce planning and deployment of staff to ensure safe staffing levels.
- Commissioned an external end-to-end review of our resourcing practices.

Assurance on the above is provided by:

1. Regular board updates on key strategic staffing issues, including staff wellbeing and systems to support staffing processes. These include care hours per patient day.
2. Formal reports on nurse staffing to Board and Board Committees.
3. Integrated performance reports showing safe staffing levels and bank/agency usage.
4. Executive Performance Review meetings consider staffing issues with escalation of any concerns

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust was last subject to a full CQC inspection, including Use of Resources and Well-Led, in November and December 2018, receiving an improved rating of 'Good'.

CQC unannounced inspection of core services

On 31 March 2021, the Trust had an unannounced inspection of the Spinal and Maternity Services, with the report published in May 2021. The overall rating for the Spinal Services was unchanged from 'Requires Improvement'. The Maternity Services rating changed from 'Good' to 'Requires Improvement' and a Section 29A Notice was served, focused on:

- leadership and culture
- governance and risk management

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

The teams in both the Spinal and Maternity Services have been committed to making improvements as identified in their respective 'must do' and 'should do' actions following the May 2021 report. In addition, the Maternity Services team have engaged in the NHSE/I Maternity Safety Support Programme. Progress of all work has been overseen by the Divisional Management Teams and reported to the Clinical Governance Committee.
Our engagement with the CQC has continued through scheduled meetings via Teams. These include bi-monthly meetings with designated Executives and the Head of Compliance and bi-monthly meetings with the Head of Risk Management and Head of Compliance to monitor our Clinical Reviews and Serious Incident Investigations. Transitional Monitoring Approach with core services was put on hold in the past year. Learning from our engagement processes and the most recent inspection has been identified and was shared as part of a CQC preparedness report to the Trust Management Committee in January 2022. The Trust's internal peer review programme has been intermittent due the pandemic but there is a plan to review and reintroduce this in a new format.

There are no material inconsistencies between the Annual Governance Statement, the annual and board statements required by NHS Improvement and the corporate governance statement.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the *Managing Conflicts of Interest in the NHS* guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS

programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of Economy, Efficiency and Effectiveness of the use of Resources

The Trust regularly reviews the economy, efficiency, and effectiveness of the use of resources through benchmarking, reference costs, regular meetings between directorates and the Executive Directors, and assessing performance against plans. Investments are determined against detailed business plans and outcomes are reviewed against those plans.

The Audit Committee gives specific consideration to matters of probity, the propriety, regularity of public finances and value for money, which arise from the work of the external auditors and the Trust's "local counter fraud specialist" and internal audit service.

The Trust continues to actively pursue the opportunities as identified through the model hospital, GIRFT and the right care data, increasingly the Trust is working with system partners to identify how working collaboratively can reduce the cost base. This is reviewed at the Acute Alliance and BSW Directors of Finance meetings.

Arrangements to operate efficiently, economically and effectively are formally reviewed by external audit. Departmental cost improvement programmes and their delivery is tracked through the Directorate Performance Reviews and through the Trust Transformation programme. This will continue to be taken forward as a key part of financial governance and controls.

The Trust's finances are reviewed by the Finance and Performance Committee at its monthly meetings. Monthly performance, workforce and quality information is scrutinised each month by the Board through the Integrated Performance Report.

Information Governance

The Trust acknowledges the importance patients and staff place on the security, confidentiality, integrity and availability of corporate and personal information. The Trust is committed to proactively managing all its resources through clear leadership and accountability, which is underpinned by the Trusts values and behaviours through awareness and education.

The Chief Medical Officer, Caldicott Guardian and Chief Digital Officer, Senior Information Risk Owner (SIRO), who oversee compliance and adherence to the Trusts Confidentiality, Information Risk and Security policies and procedures which define how the Trust proactively manages the security and confidentiality of personal information and systems.

Information Governance arrangements within the organisation are constantly reviewed by the Trust. The Data Security and Protection Toolkit (DSPT) year now runs from the 1st July to the 30th of June. Since July 2021, the Trust reported four security incidents to the Information Commissioners Office and NHS Digital. The incidents related to an undelivered letter, a system issue which resulted in paper documents displaying incorrect information, the publication of information on the Trust website and a system failure. The Information Commissioners Office considered the information provided by the Trust and decided in all instances that no further action was necessary.

Work continued to ensure that a comprehensive and robust evidence-based assurance programme exists to reinforce the work of the DSPT to demonstrate that the organisation

can be trusted to maintain the confidentiality and security of personal information, in an open and transparent manner thereby increasing public confidence.

In line with the NHS Digital guidance, the Trust confirms it will submit the 2021/2022 Data Security and Protection Toolkit assessment on or before the 30th June 2022.

Data Quality and Governance

There is corporate leadership for data quality with the Chief Digital Officer (SIRO) holding responsibility for the quality of performance data which is reported monthly at the Trust Board and assurance committees.

The Trust has an up-to-date Data Quality Policy that is reviewed annually and was last refreshed during 2021-22. The policy outlines a strengthened approach to data quality, focussing on the following key areas:

- Raising awareness of the importance of high-quality data.
- Assisting all staff in understanding their role and responsibility in maintaining high quality data.
- Assisting staff in getting data quality 'Right First Time' through supporting staff in putting in working practices and processes which enable high data quality at the first time of input.
- Minimising risks arising from poor data quality.
- Monitoring the quality of data used by the Trust and where needed, to highlight where data is inaccurate and needs to be checked and improved.
- Establishing a framework within which data quality issues can be raised and actioned.

The Trust's Information Standards Group, chaired by the Head of Information, oversees implementation of the Data Quality Policy. This includes the routine assessment of data quality maturity for all metrics used in core external returns and internal monitoring by Trust committees. Where required improvements have been highlighted a full analysis of the impact on reporting is completed and undergoes a robust change control process.

During 2021-22 the Trust has continued its development of a new business intelligence platform underpinned by a new data warehouse. 2021-22 has seen the introduction of Power BI, a modern and intuitive self-service business intelligence platform which will help inform decision making and analysis across the Trust. In addition, a new system to provide notification of data quality issues direct to staff who have entered data has now been rolled out to help improve the response to any data quality issues identified.

The Trust is an active participant in a system wide Business Intelligence Group which seeks to standardise the approach to reporting, ensuring best practice methodologies are followed and build a shared pool of expert resource across the system in the use of tools such as Power BI and demand and capacity. During 2021-22 a system wide Business Intelligence strategy has been developed, part of which sets out a direction towards convergence on cloud-based technology for our underpinning business intelligence infrastructure in the coming years. This will enable improved collaborative working, reduce duplication of reporting and increase the ability to support detailed interpretation and predictive analysis on areas such as population health management.

All data used for quality reporting is derived from operational clinical systems which are well known and reviewed by the staff using them. With regular analysis and use of data coming

from the system comes a degree of assurance about the accuracy of reporting. The weekly division-led Delivery Performance Group regularly reviews performance data, including patient level information especially on elective waiting times.

Waiting list data is updated daily and this feeds into a suite of reports that allow various operational teams to monitor the size and performance of the waiting list. There is a dedicated team that review and validate the waiting list daily, ensuring that records are accurate and up to date as far as possible, and there is close review of the longest waiting patients by the divisional teams, providing the Trust with the greatest possible opportunity to meet waiting list targets and be assured of data accuracy. All key performance related external submissions are reviewed and signed off at Executive level before being submitted. Waiting list size data is included as part of the integrated performance report which is reviewed monthly at Trust Board. This is supported by the use of Statistical Process Control (SPC) charts to allow close monitoring of specialty level performance over time, highlighting any deteriorating or improving trends or outliers.

Data Quality features within the roles and responsibilities of key staff members who are inputting data into systems, and those who review and assess data accuracy.

One of the Data Quality Policy's activities is to improve the education of staff in the role they play in meeting the high standards of data quality the Trust aspires to; and data quality champions have been introduced across the Trust during 2021-22. The work the data quality champions undertake will be built upon during 2022-23.

A Data Quality Improvement Group reviews key data quality issues and oversees data quality improvement across the following headings:

- Training – design and delivery of targeted training to support high quality data.
- Awareness – using existing forums (e.g. ward clerk meetings) to communicate data quality issues.
- Process change – use of structured Standard Operating Procedures to meet operational and reporting requirements.
- Information systems – regular checks to ensure data being used is compliant and accurate.
- Data quality monitoring – reviewing nationally and locally developed data quality reports, use of spot checks (e.g., monthly review of waiting list data) and software such as coding software to check data quality.
    - Data Quality Standards - agree and approve different DQ standards within the Trust e.g., Identifying an Admitting Consultant. This is created as a document (which is reviewed annually) and published to the Intranet.

The Improvement Group also feeds up any persistent DQ issues to the Data Quality Champion Group which meets bi-monthly, this is an opportunity to reflect current performance to operational staff.

The Trust receives both internal audit and external audit reviews to check processes and compliance with regards to data quality.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and

maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Clinical Governance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors and its committees have met regularly and kept arrangements for internal control under review through discussion and approval of policies and practice and monitoring of outcomes agreed as indicators of effective controls. The Board and its committees review the Integrated Performance Report monthly which covers the key national priority and regulatory indicators and locally derived key performance indicators. The report provides more detailed briefings on any areas of adverse performance. This report is supported by a number of more granular reports reviewed by Board committees and regular Executive performance review meetings with the Divisions.

The selection of appropriate metrics is subject to regular review, with changes in definitions or strategic priorities reflected in the selection.

The Audit Committee has provided the Board of Directors with an independent and objective review of financial and corporate governance, and internal financial control within the Trust. The Audit Committee has received reports from external and internal audit, including reports relating to the Trust's counter fraud arrangements. There is a full programme of clinical audit in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit opinion for 2021-22 remains unchanged from the opinion given for the year 2020-21. The opinion on the adequacy and effectiveness of governance, risk management and control is that this is "Generally satisfactory with some improvement noted". This demonstrates the continued commitment to robust governance including the improvement in timely closure of recommendations.

During 2021-22, Internal Audit conducted eight internal audits. The finalised reports have resulted in the identification of four high, 24 medium and 11 low risk findings to improve weaknesses in the design of controls and/or operating effectiveness.

A summary of the four high risk findings were taken into account in forming the opinion as to the adequacy and effectiveness of the Trust's framework of governance, risk management and control is set out below:

- Capacity Management and Discharge: Inconsistency between decision recorded on the Criteria to Reside checklists and patient notes. Action deadline is 30/06/2022.
- Key Financial Systems: Expenditure transactions and payments were not being approved in line with the Trust's Standing Financial Instructions (SFIs) and bank mandate. Since the review, the audit sponsor has confirmed that action has been taken to correct the authorisation levels within the ledger and the payment authorisation controls.
- IT Disaster Recovery (ITDR): Absence of robust and monitored ITDR action plans. Action deadline is 30/06/2022.
- Workforce Planning: Lack of a strategic workforce plan. Action deadline is 31/03/2023.

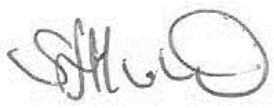
A report is produced at the conclusion of each audit assignment and, where scope for improvement is found, recommendations are made and appropriate action plans agreed with management. Reports are issued to and followed up with the responsible Executive Directors, with the results of audit work reported to the Audit Committee. In addition to the planned programme of work, internal audit provides advice and assistance to senior management on control issues and other matters of concern. Where Internal Audit issued a limited assurance report, the relevant audit executive lead attended the Audit Committee to discuss the report and actions taken. A process was implemented that any extension to action deadlines requires collective executive approval and is presented by the executive Sponsor for the audit.

The Trust is focused on action plans to address the identified risks reported in 2021-22 which have been approved by the Trust Audit Committee. The Trust implemented an electronic solution to track all audit recommendations and actions to enhance monitoring and oversight. The success of this is demonstrated by the closure of 58 of the 61 actions generated from the previous year findings.

Conclusion

The Trust Board is committed to the continuous improvement of its governance arrangements to ensure that systems are in place to identify and manage risks correctly. Any serious incidents or incidents of non-compliance with standards and regulatory requirements are escalated and are subject to prompt and effective remedial action. This is to ensure that patients, service users and staff and stakeholders can be confident in the quality of the services delivered and the effective, economic and efficient use of resources.

Overall, there is in place a dynamic process for the management of internal control which is reviewed and updated regularly by the Executive Team and various Board Committees that are in place in the Trust to help me meet my responsibilities as Accounting Officer. The risks the Trust has faced, together with the actions taken to address each of these areas are detailed within this annual governance statement. My review confirms that Salisbury NHS Foundation Trust has sound systems of internal control up to the date of approval of the annual report and accounts and no significant internal control issues have been identified.



Stacey Hunter
Chief Executive (Accounting Officer)
16/06/2022 (on behalf of the Trust Board)

SALISBURY NHS FOUNDATION TRUST

CONSOLIDATED FINANCIAL STATEMENTS

FOR THE YEAR TO 31 MARCH 2022

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FOREWORD TO THE ACCOUNTS

These consolidated accounts for the year ended 31 March 2022 have been prepared by Salisbury NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Signed:

Stacey Hunter - Chief Executive

Date: 16 June 2022

Independent auditor's report to the Council of Governors of Salisbury NHS Foundation Trust

Report on the Audit of the Financial Statements

Qualified opinion on financial statements

We have audited the financial statements of Salisbury NHS Foundation Trust (the 'Trust') and its subsidiaries, associates and joint ventures (the 'group') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Consolidated Statement of Changes in Taxpayers Equity, the Consolidated Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, except for the possible effects on the corresponding figures of the matter described in the Basis for qualified opinion section of our report, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2022 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for qualified opinion

Due to the national lockdown arising from the Covid-19 pandemic in March 2020, we were not able to observe the counting of the physical inventories at 31 March 2020 or satisfy ourselves by alternative means concerning the inventory quantities held at that date, which had a carrying amount in the Trust Statement of Financial Position of £5.892 million and the Group Statement of Financial Position of £7.514 million. Consequently, we were unable to determine whether there was any consequential effect on the drug costs and supplies and services for the year ended 31 March 2021. Our audit opinion on the financial statements for the year ended 31 March 2021 was modified accordingly. Our opinion on the current year's financial statements is also modified because of the possible effect of this matter on the comparability of the current year's figures and the corresponding figures.

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group's and the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the group or the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the group and Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the group and Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the group and Trust and the group and Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Accounting Officer with respect to going concern are described in the 'Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the annual report , other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

As described in the basis for qualified opinion section of our report, we were unable to satisfy ourselves concerning the Trust inventory quantities of £5.892 million and the group inventory quantities of £7.514 million held as at 31 March 2020, and whether there was any consequential effect on the drug costs and supplies and services for the year ended 31 March 2021. Accordingly, we are unable to conclude whether or not the other information is materially misstated with respect to this matter.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2021/22 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006; and

- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or

- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2021/22, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of the services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the group and Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

•We obtained an understanding of the legal and regulatory frameworks that are applicable to the group and Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).

•We enquired of management and the Audit Committee, concerning the group and Trust's policies and procedures relating to:

- the identification, evaluation and compliance with laws and regulations;
- the detection and response to the risks of fraud; and
- the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

•We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

•We assessed the susceptibility of the group and Trust's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and the risk of inappropriate revenue and expendiuture recognition. We determined that the principal risks were in relation to:

- High risk and unusual journals, management estimates including land buildings and dwellings valuations, private finance initiative liability (PFI) and depreciation and transactions outside the course of business;
- fraudulent recognition of revenue:we rebutted income received under block contract arrangements, where income received could be verified to agreements with third parties and where income received was immaterial. For variable income streams, we did not consider that we were able to rebut the presumption of fraud;

•Our audit procedures involved:

- evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
- sample testing of revenue transactions where income was not received under block contract arrangements;
- due to the implementation of a new financial ledger, we undertook testing on journal entries made in both the old and new systems. Our journal entry testing, was focussed on high risk and unusual journals including those posted by staff with elevated access privileges, journals posted by senior officers, journals with related parties,material post year end manual journals, unusual account combinations from revenue and expenditure, journals posted by unauthorised users; journals with blank descriptions and journals posted by officers who had left the organisation.
- challenging assumptions and judgements made by management in its significant accounting estimates in respect of land, buildings and dwellings valuations and the PFI liability;
- assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

•These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we

•The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to land, buildings and dwellings valuations and the PFI liability.

•Our assessment of the appropriateness of the collective competence and capabilities of the group and Trust's engagement team included consideration of the engagement team's;

- understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
- knowledge of the health sector and economy in which the group and Trust operates
- understanding of the legal and regulatory requirements specific to the group and Trust including:
  - the provisions of the applicable legislation
  - NHS England's rules and related guidance
  - the applicable statutory provisions.

•In assessing the potential risks of material misstatement, we obtained an understanding of:

- The group and Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation processes, expected financial statement disclosures and business risks that may result in risks of material misstatement.
- The group and Trust's control environment, including the policies and procedures implemented by the group and Trust to ensure compliance with the requirements of the financial reporting framework.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the

We have nothing to report in respect of the above matter.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of Salisbury NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Signature:

Barrie Morris

Barrie Morris, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol
Date: 20 June 2022

STATEMENTS OF COMPREHENSIVE INCOME
For The Year Ended 31 March 2022

		Group		Trust	
		2021/22	2020/21	**2021/22**	2020/21
	Note	**£000**	£000	**£000**	£000
Revenue from patient care activities	3	**278,480**	243,623	**278,480**	243,623
Other operating revenue	5	**39,252**	51,672	**26,887**	40,274
Operating expenses	7	**(311,781)**	(289,341)	**(299,976)**	(277,623)
OPERATING SURPLUS		**5,951**	5,954	**5,391**	6,274
FINANCE COSTS					
Finance income	12	**309**	287	**233**	170
Finance expense	13	**(2,002)**	(2,122)	**(2,002)**	(2,122)
PDC Dividends payable		**(4,073)**	(3,322)	**(4,073)**	(3,322)
NET FINANCE COSTS		**(5,766)**	(5,157)	**(5,842)**	(5,274)
Losses on disposal of assets	17	**(249)**	(156)	**(249)**	(156)
Share of profit of associates/ joint ventures	33	**65**	93	**65**	93
Movement in fair value of other investments	18	**438**	1,417	**-**	-
RETAINED SURPLUS/ (DEFICIT) FOR THE YEAR		**439**	2,151	**(635)**	937
OTHER COMPREHENSIVE INCOME:					
Items that will not be reclassified to income and expenditure					
Revaluations		**10,261**	4,601	**10,042**	4,549
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**10,700**	6,752	**9,407**	5,486
NOTE: ALLOCATION OF PROFIT/(LOSSES) FOR THE YEAR					
(a) Surplus/(Deficit) for the period attributable to:					
(i) Minority interest, and		**27**	3	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**412**	2,148	**(635)**	937
TOTAL		**439**	2,151	**(635)**	937
(b) Total comprehensive income/ (expense) for the year attributable to:					
(i) Minority interest, and		**27**	3	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**10,673**	6,749	**9,407**	5,486
TOTAL		**10,700**	6,752	**9,407**	5,486

The notes on pages 5 to 52 form an integral part of these financial statements.
All revenue and expenditure is derived from continuing operations.

STATEMENTS OF FINANCIAL POSITION
31 MARCH 2022

	Note	Group		Trust	
		31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
		£000	£000	**£000**	£000
NON-CURRENT ASSETS					
Intangible assets	16	**9,896**	10,952	**9,896**	10,952
Property, plant and equipment	17	**162,419**	149,210	**158,532**	146,956
Investments in subsidiaries	32	**-**	-	**-**	5
Investments in joint ventures	33	**246**	181	**246**	181
Investments	18	**8,225**	7,893	**-**	-
Other financial assets	19	**2,497**	2,395	**4,006**	4,551
Receivables	21	**656**	762	**656**	762
Total non-current assets		**183,939**	171,393	**173,336**	163,407
CURRENT ASSETS					
Inventories	20	**7,939**	7,634	**6,311**	6,050
Receivables	21	**14,211**	12,077	**13,103**	11,783
Investments	18	**337**	113	**-**	-
Other financial assets	19	**-**	-	**1,940**	1,027
Cash and cash equivalents	22	**39,306**	31,169	**30,819**	22,309
Total current assets		**61,793**	50,993	**52,173**	41,169
Total assets		**245,732**	222,386	**225,509**	204,576
CURRENT LIABILITIES					
Trade and other payables	23	**(46,071)**	(36,727)	**(44,755)**	(35,364)
Borrowings	24	**(1,714)**	(1,608)	**(1,546)**	(1,608)
Provisions	25	**(1,234)**	(971)	**(1,234)**	(971)
TOTAL CURRENT LIABILITIES		**(49,019)**	(39,306)	**(47,535)**	(37,943)
TOTAL ASSETS LESS CURRENT LIABILITIES		**196,713**	183,080	**177,974**	166,633
NON-CURRENT LIABILITIES					
Borrowings	24	**(18,145)**	(18,680)	**(17,146)**	(18,680)
Provisions	25	**(895)**	(1,256)	**(895)**	(1,256)
TOTAL NON CURRENT LIABILITIES		**(19,040)**	(19,936)	**(18,041)**	(19,936)
TOTAL ASSETS EMPLOYED		**177,673**	163,144	**159,933**	146,697
FINANCED BY:					
TAXPAYERS' EQUITY					
Minority Interest		**80**	53	**-**	-
Public dividend capital	34	**94,826**	90,997	**94,826**	90,997
Revaluation reserve		**75,780**	65,738	**75,780**	65,738
Income and expenditure reserve		**(9,239)**	(8,896)	**(10,673)**	(10,038)
Charitable fund reserves	35	**16,226**	15,252	**-**	-
TOTAL TAXPAYERS EQUITY		**177,673**	163,144	**159,933**	146,697

The notes on pages 5 to 52 form an integral part of these financial statements.
The financial statements on pages 1 to 52 were approved by the Board on 16 June 2022 and signed on its behalf by:

Signed:

Stacey Hunter - Chief Executive

CONSOLIDATED STATEMENTS OF CHANGES IN TAXPAYERS EQUITY

	Trust				Subsidiary		Charitable Fund	Group
	Public dividend capital (PDC)	Income and expenditure reserve	Revaluation reserve	Trust Reserves	Profit & Loss Reserves	Minority interest	Charitable Funds reserve	Total taxpayers' equity
	£000	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and Others' Equity at 1 April 2020	58,650	(10,979)	61,193	108,864	1,200	50	13,931	124,045
Changes in taxpayers' equity for 2020/21								
Retained surplus/(deficit) for the year	-	937	-	937	(58)	3	1,269	2,151
Other recognised gains and losses	-	-	-	-	-	-	-	-
Impairment of property plant and equipment	-	4	(4)	-	-	-	-	-
Net gain/(loss) on revaluation of property plant and equipment	-	-	4,549	4,549	-	-	-	4,549
Transfers between reserves	-	-	-	-	-	-	-	-
Revaluations and impairments - charitable fund assets	-	-	-	-	-	-	52	52
Fair Value gains/(losses) on Available-for-sale financial investments	-	-	-	-	-	-	-	-
Other reserve movements	-	-	-	-	-	-	-	-
Public dividend capital received in year	32,419	-	-	32,419	-	-	-	32,419
Public dividend capital repaid in year	(72)	-	-	(72)	-	-	-	(72)
Balance at 31 March 2021	**90,997**	**(10,038)**	**65,738**	**146,697**	**1,142**	**53**	**15,252**	**163,144**
Changes in taxpayers' equity for 2021/22								
Retained surplus/(deficit) for the year	-	(635)	-	**(635)**	292	27	755	**439**
Other recognised gains and losses	-	-	-	**-**	-	-	-	**-**
Impairment of property plant and equipment	-	-	-	**-**	-	-	-	**-**
Net gain/(loss) on revaluation of property plant and equipment	-	-	10,042	**10,042**	-	-	-	**10,042**
Transfers between reserves	-	-	-	**-**	-	-	-	**-**
Revaluations and impairments - charitable fund assets	-	-	-	**-**	-	-	219	**219**
Fair Value gains/(losses) on Available-for-sale financial investments	-	-	-	**-**	-	-	**-**	**-**
Other reserve movements	-			**-**	-	-	**-**	**-**
Public dividend capital received in year	4,112	-	-	**4,112**	-	-	**-**	**4,112**
Public dividend capital repaid in year	(283)	-	-	**(283)**	-	-	**-**	**(283)**
Balance at 31 March 2022	**94,826**	**(10,673)**	**75,780**	**159,933**	**1,434**	**80**	**16,226**	**177,673**

The notes on pages 5 to 52 form an integral part of these financial statements

CONSOLIDATED STATEMENTS OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2022

	Note	Group 2022 £000	Group 2021 £000	Trust 2022 £000	Trust 2021 £000
CASH FLOWS FROM OPERATING ACTIVITIES					
Total operating surplus		**5,951**	5,954	**5,391**	6,274
NON-CASH INCOME AND EXPENSE					
Depreciation and amortisation charge	7	**13,682**	12,370	**13,481**	12,084
Impairments	7	**474**	318	**474**	318
Non-cash donations credited to income		**(685)**	(1,253)	**(685)**	(1,253)
(Increase)/ decrease in trade and other receivables	21	**(2,036)**	3,311	**(1,229)**	1,910
(Increase)/ decrease in inventories	20	**(305)**	(120)	**(261)**	(158)
Increase/ (decrease) in trade and other payables	23	**4,608**	5,905	**4,665**	5,955
Increase/ (decrease) in provisions	25	**(96)**	775	**(96)**	775
NHS charitable funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		**(17)**	7	**-**	-
Net cash inflow from operating activities		**21,576**	27,267	**21,740**	25,905
CASH FLOWS FROM INVESTING ACTIVITIES					
Interest received		**32**	-	**115**	74
Purchase of financial assets		**-**	-	**-**	-
Payments to acquire property, plant and equipment	17	**(7,839)**	(12,309)	**(7,390)**	(12,269)
Receipts from sale of property, plant and equipment		**50**	57	**50**	57
Payments to acquire intangible assets	16	**(1,922)**	(4,379)	**(1,922)**	(4,379)
NHS charitable funds - net cash flows from investing activities		**57**	54	**-**	-
Net cash (outflow) from investing activities		**(9,622)**	(16,577)	**(9,147)**	(16,517)
CASH FLOWS FROM FINANCING ACTIVITIES					
New public dividend capital received	34	**4,112**	32,419	**4,112**	32,419
Public dividend capital repaid	34	**(283)**	(72)	**(283)**	(72)
Loans received		**-**	-	**40**	-
Loan to subsidiary		**-**	-	**(306)**	(500)
Loan to joint venture	19	**-**	-	**-**	-
Loan repayment received		**-**	-	**-**	-
Movement in loans from the Department of Health and Social Care		**(631)**	(21,713)	**(631)**	(21,713)
Capital element of finance lease rental payments		**(435)**	(434)	**(435)**	(434)
Capital element of Private Finance Initiative obligations	29	**(525)**	(479)	**(525)**	(479)
Interest paid		**(44)**	(190)	**(44)**	(190)
Interest element of finance lease rental payments		**(20)**	(24)	**(20)**	(24)
Interest element of Private Finance Initiative obligations	29	**(1,944)**	(1,939)	**(1,944)**	(1,939)
PDC dividend paid		**(4,047)**	(3,234)	**(4,047)**	(3,234)
Net cash inflow/ (outflow) from financing		**(3,817)**	4,334	**(4,083)**	3,834
Increase/ (decrease) in cash and cash equivalents		**8,137**	15,024	**8,510**	13,222
Cash and cash equivalents at the beginning of the financial year		**31,169**	16,145	**22,309**	9,087
Cash and cash equivalents at the end of the financial year	22	**39,306**	31,169	**30,819**	22,309

The notes on pages 5 to 52 form an integral part of these financial statements.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern.

After making enquiries, the directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

1.3 Critical accounting estimates and judgements

International accounting standard IAS1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The purpose of evaluation is to consider whether there may be a significant risk of causing material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts.

Critical accounting judgements employed in the year are outlined in note 36.

Critical accounting estimates made in the year are outlined in note 37.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.4 Basis of Consolidation

1.4.1 NHS Charitable Fund

The Trust is the Corporate Trustee to Salisbury District Hospital Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The consolidation is for reporting purposes only and does not affect the charity's legal and regulatory independence and day to day operations.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

1.4.2 Subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the previous year together with draft figures for the current year.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Unless otherwise stated the notes to the accounts refer to the Group and not the Trust. Where the Trust's balances are materially different, these are stated separately.

1.4.3 Associates

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, e.g., share dividends are received by the Trust from the associate.

1.4.4 Joint ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement.

Joint ventures are accounted for using the equity method.

1.4.5 Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement.

The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Income Recognition

1.5.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at a Sustainability and Transformation Partnership level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Income Recognition (continued)

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Education and training
Income for training and education is received from Health Education England. The Trust recognises the income when the conditions of the contract have been met.

1.5.2 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Income received by the Charity
Charitable incoming resources are recognised once the charity has entitlement to the resources, it is certain that the resources will be received and the monetary value of the incoming resources can be measured with sufficient reliability.

Legacy income is accounted for within the charity as incoming resources, either upon receipt, or where the receipt of the legacy is probable; this will be once confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made, or property transferred, and once all conditions attached to the legacy have been fulfilled.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Expenditure on employee benefits

1.6.1 Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.6.2 Pension costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

National Employment Savings Trust (NEST)
Employees that are not entitled to enrol on the NHS Pension Scheme are auto-enrolled into the Government NEST defined contribution workplace pension scheme.

Under the terms of the NEST scheme employees retain the right to opt-out after having been auto-enrolled.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Subsidiary pension scheme
The subsidiary companies operate defined contribution schemes for employees who have contracts of employment directly with the companies. Employer's pension costs are charged to operating expenses as and when they become due.

These schemes comply with legislative requirements.

1.7 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.8 Intangible assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost (DRC) and the value in use where the asset is income generating. The Trust uses historic cost less depreciation as an approximation of DRC. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

Software 1 - 7 Years

1.9 Property, plant and equipment

1.9.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.9.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust’s Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Useful lives of property, plant and equipment
Items of property, plant and equipment are depreciated over their remaining useful lives, as follows:

Buildings (excluding dwellings)	5 - 70 years
Dwellings	8 - 59 years
Plant and Machinery	1 - 15 years
Transport equipment	3 - 10 years
Information Technology	1 - 10 years
Furniture and Fittings	5 - 15 years

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

1.9.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds, less costs associated with the sale, and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.9.4 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

1.9.5 Private Finance Initiative (PFI) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate. The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Services received

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Property, plant and equipment (continued)

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator
Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.10 Investments

Investments in subsidiary undertakings, associates and joint ventures are treated as fixed asset investments and stated at cost.

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cash flow statement.

Investments in quoted stocks, shares, gilts and alternative investments are included in the Statement of Financial Position at mid-market price, ex-dividend.

All gains and losses are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening market value (or value at purchase date if later).

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.11 Borrowing costs

Borrowing costs are recognised as expenses as they are incurred.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured on the First In, First Out (FIFO) method. Work-in-progress comprises goods in intermediate stages of production. The Laundry stock value is based on the original cost less an adjustment to reflect usage, over a three year life (except for Towels and Scrub Suits which have a two year life), in determining an approximation of net realisable value.

In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.14 Financial assets and financial liabilities

1.14.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

1.14.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure.

Financial liabilities classified as subsequently measured at amortised cost.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.14.3 Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.14.4 Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The Trust does not normally recognise expected credit losses in relation to other NHS bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.14.5 De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.15.1 The Trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.15.2 The Trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

1. ACCOUNTING POLICIES (CONTINUED)

1.16 Provisions (Continued)

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
	Exceeding 40 years	0.66%	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.3% in real terms (prior year: minus 0.95%)

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 25 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

A Contingent liability is disclosed unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

1. ACCOUNTING POLICIES (CONTINUED)

1.18 Public dividend capital (continued)

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at:

https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.19 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 Corporation Tax

The Trust does not have a corporation tax liability for the year 2021/22 (2020/21 £nil). Tax may be payable by the Trust on activities described below:

- The activity is not related to the provision of core healthcare as defined under Section 14(1) of the HSCA. Private Healthcare falls under this legislation and is not therefore taxable.
- The activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax.
- Annual profits from the activity must exceed £50,000

The Trust's subsidiary companies have made a modest profit leading to a corporation tax liability of £37k (2020/21: £30k).

1.21 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.22 Foreign exchange

The functional and presentational currency of the Trust is sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note (note 31) to the accounts in accordance with the requirements of HM Treasury’s FReM.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.24 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22

1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.27 Standards, amendments and interpretations in issue but not yet effective or adopted (continued)

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	Group £'000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	2,419
Additional lease obligations recognised for existing operating leases	(2,265)
Changes to other statement of financial position line items	-
Net impact on net assets on 1 April 2022	**154**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(1,149)
Additional finance costs on lease liabilities	(28)
Lease rentals no longer charged to operating expenditure	1,040
Other impact on income / expenditure	-
Estimated impact on surplus / deficit in 2022/23	**(137)**
Estimated increase in capital additions for new leases commencing in 2022/23	**2,818**

	Trust £'000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	1,026
Additional lease obligations recognised for existing operating leases	(847)
Changes to other statement of financial position line items	-
Net impact on net assets on 1 April 2022	**179**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(700)
Additional finance costs on lease liabilities	(28)
Lease rentals no longer charged to operating expenditure	583
Other impact on income / expenditure	
Estimated impact on surplus / deficit in 2022/23	**(145)**
Estimated increase in capital additions for new leases commencing in 2022/23	**2,818**

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI liability will be remeasured when a change in the index causes a change in future repayments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

NOTES TO THE ACCOUNTS

2. Segmental Analysis

Group and Trust

The business activities of the Group can be summarised as that of 'healthcare'. The Trust's activities comprise five key operating areas where costs are closely monitored during the year. The chief operating decision maker for Salisbury NHS Foundation Trust is the Trust Board. Key decisions are agreed at monthly Board meetings and sub-committee meetings of the Board, following scrutiny of performance and resource allocation. The Trust Board review and make decisions on activity and performance of the Trust as a whole entity, not for its separate business activities. The activities of the subsidiary companies, Odstock Medical Limited and Salisbury Trading Limited, and of the charity, Salisbury District Hospital Charitable Fund, are not considered sufficiently material to require separate disclosure.

NOTES TO THE ACCOUNTS

3 Revenue From Patient Care Activities

3.1 Revenue by Nature

	Group and Trust	
	2022	2021
	£000	£000
Block contract / system envelope income	**233,471**	207,419
High cost drugs income from commissioners	**20,952**	18,645
Other NHS clinical income	**2,882**	2,602
Total revenue at full tariff	**257,305**	228,666
Private patient revenue	**2,416**	1,759
Elective recovery fund	**3,440**	-
Additional pension contribution central funding*	**7,460**	7,073
Other clinical income	**7,859**	6,125
Total income from patient care activities	**278,480**	243,623

Other types of activity revenue above includes amounts due for specialist services (e.g. spinal, burns, genetics, cleft lip and palate), direct access, intensive care, community and hospice services.

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

3.2 Revenue by Source

	Group and Trust	
	2022	2021
	£000	£000
NHS England	**59,779**	53,483
Clinical commissioning groups	**206,667**	181,501
Department of Health and Social Care	**7**	42
Other NHS providers	**3,853**	2,787
NHS other	**553**	152
Local authorities	**1,553**	1,554
Non NHS:		
- Private patients	**2,416**	1,759
- Overseas patients (chargeable to patient)	**93**	107
- NHS Injury cost recovery scheme	**640**	725
- Other	**2,919**	1,513
	278,480	243,623

NHS Injury Scheme revenue is subject to a provision for doubtful debts of 23.76% (2021: 22.43%) to reflect expected rates of collection. The doubtful debt provision is included in the allowance for impaired contract receivables included in note 21.3.

NOTES TO THE ACCOUNTS

3 Revenue From Patient Care Activities (continued)

3.3 Commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Group and Trust	
	2022	2021
	£000	£000
Income from services designated as commissioner requested services	**259,382**	227,289
Income from services not designated as commissioner requested services	**19,098**	16,334
	278,480	243,623

3.4 Overseas visitors (relating to patients charged directly by the provider)

	Group and Trust	
	2022	2021
	£000	£000
Income recognised this year	**93**	107
Cash payments received in-year	**90**	113
Amounts added to provision for impairment of receivables	**-**	-
Amounts written off in-year	**2**	24

4. Private patient revenue

The Health & Social Care Act 2012 removed the restriction on the amount a Foundation Trust could earn from private patient income as a percentage of total income, provided a ceiling of 49% is not exceeded for non-NHS income.

Salisbury NHS Foundation Trust private patient income in 2021/22 (and 2020/21) was substantially below the revised level permitted.

NOTES TO THE ACCOUNTS

5. Other operating revenue

	Group		Trust	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Reimbursement and top up funding	**3,050**	15,644	**3,050**	15,644
Research and development	**916**	842	**916**	842
Education and training	**10,142**	9,022	**10,142**	9,022
Non-patient care services to other bodies	**3,980**	2,383	**3,980**	2,383
Received from DHSC group bodies for COVID response- donated assets	**-**	869	**-**	869
Received from NHS charities - donated assets	**-**	-	**685**	384
Contributions to expenditure - equipment donated from DHSC group bodies for COVID response below capitalisation threshold	**-**	2	**-**	2
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	**883**	3,640	**883**	3,640
Salisbury Trading Limited	**9,593**	9,324	**-**	-
NHS Charitable Funds: Incoming Resources excluding investment income	**1,820**	1,228	**-**	-
Odstock Medical Limited	**2,151**	1,686	**-**	-
Accommodation	**1,259**	1,268	**1,259**	1,268
Administrative services provided to Sterile Supplies Limited	**229**	311	**229**	311
Car Parking	**198**	256	**198**	256
Catering	**500**	413	**500**	413
Payroll services provided to other organisations	**1,961**	1,676	**1,961**	1,676
Other	**2,570**	3,108	**3,084**	3,564
	39,252	51,672	**26,887**	40,274

Included within 'Other' revenue above are: Royalty Income £890k (2021: £nil), procurement framework income re: apprenticeships £433k (2021: £346k), Leisure Centre income £121k (2021: £10k), income from the rent and hire of rooms £166k (2021: £105k), Vat recoveries £nil (2021: £210k), Central funding in respect of annual leave and overtime £nil (2021: £1,129k), cancer transformation £432k (2021: £nil) and overseas recruitment £23k (2021: £133k).

6. Operating lease income

6.1 As lessor

The Trust has entered into short term commercial leases on buildings, which primarily relate to the rental of an area within the hospital main entrance to a high street retailer and properties rented to subsidiary companies

6.2 Receipts recognised as income

	Group		Trust	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Rental revenue from operating leases - minimum lease receipts	**166**	177	**413**	425

6.3 Total future minimum lease income

	Group		Trust	
	2022	2021	**2022**	2021
Receivable:	**£000**	£000	**£000**	£000
Within 1 year	**93**	175	**257**	423
Between 1 and 5 years	**361**	408	**568**	893
After 5 years	**323**	462	**323**	511
Total	**777**	1,045	**1,148**	1,827

NOTES TO THE ACCOUNTS

7. Operating Expenses

Operating expenses comprise:

	Group		Trust	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Purchase of healthcare from NHS and DHSC bodies	**3,871**	3,469	**3,871**	3,469
Purchase of healthcare from non-NHS and non-DHSC bodies	**3,097**	2,991	**3,097**	2,991
Staff and executive directors costs	**198,535**	183,346	**191,336**	176,803
Non-executive directors	**166**	168	**166**	168
Supplies and services – clinical (excluding drugs costs)	**25,943**	24,612	**25,127**	24,030
Supplies and services - general	**4,861**	5,897	**3,684**	4,392
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	**25,213**	22,516	**25,213**	22,516
Inventories written down	**99**	64	**99**	64
Consultancy costs	**680**	2,016	**680**	2,016
Establishment	**3,065**	2,059	**3,065**	1,505
Premises	**16,838**	13,707	**15,649**	12,427
Transport	**1,660**	1,541	**1,056**	1,541
Depreciation on property, plant and equipment	**10,714**	10,090	**10,513**	9,815
Amortisation on intangible assets	**2,968**	2,280	**2,968**	2,280
Impairments net of (reversals)	**474**	318	**474**	318
Movement in credit loss allowance: contract receivables / contract assets	**15**	-	**15**	-
Provisions arising /(released) in year	**(43)**	79	**(43)**	79
Change in provisions discount rate(s)	**4**	6	**4**	6
Operating lease expenditure (net)	**94**	108	**136**	150
Audit fees payable to the external auditor				
audit services- statutory audit	**117**	104	**117**	94
Internal audit costs	**111**	82	**111**	82
Clinical negligence	**8,190**	7,041	**8,190**	7,041
Legal fees	**67**	504	**67**	504
Insurance	**292**	361	**292**	361
Research and development	**46**	40	**46**	40
Education and training	**1,465**	906	**1,465**	906
Charges to operating expenditure for on-SoFP PFI scheme	**1,114**	1,110	**1,114**	1,110
Other	**2,125**	3,926	**1,464**	2,915
	311,781	289,341	**299,976**	277,623

The total employer's pension contributions are disclosed in note 9.1.

Redundancy payments totalling £nil (2021: £43k) are included in staff costs.

There is a limitation on the Auditor's liability of £2.0m (2021: £2.0m). The fees payable to auditors for the statutory audit and additional services above are quoted gross of VAT at 20%, reflecting the Trust's inability to reclaim VAT on this type of expenditure.

Other expenses include professional fees associated with the hospital site development £0.3m (2021: £0.9m), a contractual dispute with a supplier £nil (2021: £0.5m), home testing kits £0.2m (2021: £0.3m) as well as costs attributable to Salisbury Trading Limited £0.1m (2021: £0.3m) and charitable fund expenses of £0.6m (2021: £0.7m).

NOTES TO THE ACCOUNTS

8. Operating leases expenditure

8.1 As lessee

The Group has entered into commercial leases on certain items of property, motor vehicles and equipment. The principal arrangements are in respect of motor vehicles. For these, rentals are for an agreed mileage over a three year term. Excess mileage is charged at a price per mile determined at the inception of the lease.

8.2 Payments recognised as expense

	Group		Trust	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Minimum lease payments	**94**	108	**136**	150

8.3 Total future minimum lease payments

	Group		Trust	
	2022	2021	**2022**	2021
Payable:	**£000**	£000	**£000**	£000
Within 1 year	**28**	52	**42**	87
Between 1 and 5 years	**27**	26	**27**	40
After 5 years	**-**	-		-
Total	**55**	78	**69**	127

9. Employee benefits

9.1 Staff costs

	Group		Trust	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Salaries and wages	**151,408**	140,670	**145,387**	135,398
Social security costs	**14,788**	14,144	**14,788**	14,144
Apprenticeship levy	**737**	676	**737**	676
Employer's contributions to NHS pensions	**24,583**	23,277	**24,489**	23,208
Pension cost - other	**42**	42	**42**	41
Temporary staff (including agency)	**7,735**	5,391	**6,651**	4,190
Total gross staff costs	**199,293**	184,200	**192,094**	177,657
Of which				
Costs capitalised as part of assets	**758**	854	**758**	854

NOTES TO THE ACCOUNTS

9. Employee benefits (continued)

9.2 Directors' remuneration

	Group and Trust	
	2022	2021
	£000	£000
Salaries and wages	**1,040**	991
Social Security Costs	**127**	108
Employer contributions to Pension Schemes	**161**	141
	1,328	1,240

The total number of Directors accruing benefits under pension schemes is 6 (2021: 6). The Directors Remuneration only relates to the Group.

10 Pension costs

The total cost charged to income in respect of the Group's obligations to the NHS Pension Agency and the defined contribution schemes for Odstock Medical Limited and Salisbury Trading Limited was £17.1m (2021: £16.2m). With the exception of employer contributions to NHSPA paid by NHSE on provider's behalf (6.3%), as at 31 March 2022 (and 2021), contributions of £2.53m (2021: £2.29m) due in respect of the current reporting period (representing the contributions for the final month of the year) had not been paid over to the schemes by the balance sheet date.

10.1 NHS Pension Schemes

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

NOTES TO THE ACCOUNTS

10 Pension costs (continued)

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 that set out the technical detail of how the costs of remedy are included in the 2016 valuation process.
The directions are available here:
Amending Directions 2021

Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at:
https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports

11. Retirements due to ill-health

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

During the year to 31 March 2022 there was 5 (2021: 1) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £474k (2021: £56k). The cost of the 2022 ill-health retirements will be borne by the NHS Business Services Authority -Pensions Division.

NOTES TO THE ACCOUNTS

12. Finance income

	Group		Trust	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Interest receivable	**309**	287	**102**	96
Other loans and receivables	**-**	-	**131**	74
	309	287	**233**	170

13. Finance costs

Group and Trust

	2022	2021
	£000	£000
Interest on capital loans from the Department of Health and Social Care (DHSC)	**40**	49
Revenue support / working capital loans from DHSC	**-**	-
Interest on obligations under finance leases	**20**	24
Finance costs on obligations under Private Finance Initiatives	**1,098**	1,130
Contingent finance costs - PFI	**846**	809
Total finance expense - financial liabilities	**2,004**	2,012
Other finance costs - unwinding of discounts on provisions	**(2)**	110
Total	**2,002**	2,122

14. The Late Payment of Commercial Debts (Interest) Act 1998

There were no amounts payable arising from claims made by businesses under this legislation (2021: £Nil).

15. Losses and special payments

	Group and Trust			
	2022		2021	
	Number	**Value**	Number	Value
		£000		£000
Losses				
Cash losses	**-**	**-**	-	-
Fruitless payments and constructive losses	**1**	**-**	-	-
Bad debts and claims abandoned	**445**	**308**	470	181
Stores losses	**5**	**100**	2	2
	451	**408**	472	183
Special payments				
Compensation payments	**-**	**-**	-	-
Extra-contractual payments	**-**	**-**	-	-
Ex-gratia payments	**23**	**247**	20	17
Special severance payments	**-**	**-**	-	-
Extra-statutory and extra-regulatory payments	**-**	**-**	-	-
	23	**247**	20	17
Total losses and special payments	**474**	**655**	492	200

There were no case payments that exceeded £0.1m.

NOTES TO THE ACCOUNTS

16. Intangible Assets

16.1 Intangible assets at the balance sheet date comprise the following elements:

Group and Trust

	Assets under Construction £000	Software Licences £000	Total £000
Cost or valuation			
At 1 April 2021	2,143	19,077	21,220
Additions - purchased	1,922	-	1,922
Additions - donated	-	-	-
Impairments charged to operating expenses	-	-	-
Reclassifications	(759)	759	-
Disposals	-	(1,967)	(1,967)
At 31 March 2022	**3,306**	**17,869**	**21,175**
Amortisation			
At 1 April 2021	-	10,268	10,268
Provided during the period	-	2,968	2,968
Impairments charged to operating expenses	-	-	-
Disposals	-	(1,957)	(1,957)
Amortisation at 31 March 2022	**-**	**11,279**	**11,279**
Net book value at 31 March 2022			
- Purchased at 31 March 2022	3,306	6,579	9,885
- Donated at 31 March 2022	-	11	11
Total at 31 March 2022	**3,306**	**6,590**	**9,896**

Cost or valuation			
At 1 April 2020	1,637	15,179	16,816
Additions - purchased	4,379	-	4,379
Additions - donated	-	30	30
Impairments charged to operating expenses	(5)	-	(5)
Reclassifications	(3,868)	3,868	-
Disposals	-	-	-
At 31 March 2021	**2,143**	**19,077**	**21,220**
Amortisation			
At 1 April 2020	-	7,988	7,988
Provided during the period	-	2,280	2,280
Impairments charged to operating expenses	-	-	-
Disposals	-	-	-
Amortisation at 31 March 2021	**-**	**10,268**	**10,268**
Net book value at 31 March 2021			
- Purchased at 31 March 2021	2,143	8,760	10,903
- Donated at 31 March 2021	-	49	49
Total at 31 March 2021	**2,143**	**8,809**	**10,952**

NOTES TO THE ACCOUNTS

17. Property, plant and equipment

Group

17.1 Property, Plant and equipment at the balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2021	1,813	106,610	7,587	6,082	50,207	251	14,432	3,708	190,690
Additions - purchased	-	-	-	12,574	1,166	-	-	-	13,740
Additions - donated	-	351	-	-	289	-	7	38	685
Impairments	-	(456)	-	-	(18)	-	-	-	(474)
Reclassifications	-	5,373	-	(12,649)	5,209	33	1,877	157	-
Revaluation	588	4,831	351	-	-	-	-	-	5,770
Transfer to assets held for sale	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(8,323)	(174)	(2,965)	(534)	(11,996)
At 31 March 2022	**2,401**	**116,709**	**7,938**	**6,007**	**48,530**	**110**	**13,351**	**3,369**	**198,415**
Accumulated depreciation									
At 1 April 2021	-	-	-	-	29,190	202	9,495	2,593	41,480
Provided during the period	-	4,362	219	-	4,077	11	1,762	282	10,713
Revaluation	-	(4,271)	(219)	-	-	-	-	-	(4,490)
Impairments	-	129	-	-	(129)	-	-	-	-
Disposals	-	-	-	-	(8,040)	(174)	(2,965)	(528)	(11,707)
Accumulated depreciation at 31 March 2022	**-**	**220**	**-**	**-**	**25,098**	**39**	**8,292**	**2,347**	**35,996**
Net book value at 31 March 2021									
Owned	1,813	85,874	7,587	6,082	20,005	49	3,869	1,115	126,394
Finance leased	-	-	-	-	143	-	1,068	-	1,211
On balance sheet PFI	-	20,736	-	-	-	-	-	-	20,736
Donated	-	-	-	-	869	-	-	-	869
Total at 31 March 2021	**1,813**	**106,610**	**7,587**	**6,082**	**21,017**	**49**	**4,937**	**1,115**	**149,210**
Net book value at 31 March 2022									
Owned	2,401	94,593	7,938	6,007	21,592	71	4,379	1,022	138,003
Finance leased	-	-	-	-	1,286	-	680	-	1,966
On-SoFP PFI	-	21,896	-	-	-	-	-	-	21,896
Donated	-	-	-	-	554	-	-	-	554
Total at 31 March 2022	**2,401**	**116,489**	**7,938**	**6,007**	**23,432**	**71**	**5,059**	**1,022**	**162,419**

On 31 March 2022 Gerald Eve LLP revalued the Trust's land, buildings and dwellings on a Modern Equivalent Asset basis in accordance with the guidance included in the Royal Institution of Chartered Surveyors Valuation Standards. As a result, these assets were revalued to bring them to their current value at that date.

NOTES TO THE ACCOUNTS

17. Property, plant and equipment (continued)

Group

17.2 Property, plant and equipment at the previous balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2020	1,715	103,528	7,793	3,441	70,514	361	12,995	3,882	204,229
Additions - purchased	-	-	-	13,879	40	-	-	-	13,919
Additions - donated	-	-	-	-	1,193	-	15	15	1,223
Impairments	-	(244)	-	(69)	-	-	-	-	(313)
Reclassifications	-	2,658	2	(11,169)	6,881	25	1,565	38	-
Revaluation	98	668	(208)	-	-	-	-	-	558
Disposals	-	-	-	-	(28,421)	(135)	(143)	(227)	(28,926)
At 31 March 2021	**1,813**	**106,610**	**7,587**	**6,082**	**50,207**	**251**	**14,432**	**3,708**	**190,690**
Accumulated depreciation									
At 1 April 2020	-	-	-	-	53,305	332	8,033	2,476	64,146
Provided during the period	-	3,823	220	-	4,104	5	1,605	333	10,090
Revaluation	-	(3,823)	(220)	-	-	-	-	-	(4,043)
Impairments	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(28,219)	(135)	(143)	(216)	(28,713)
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**29,190**	**202**	**9,495**	**2,593**	**41,480**
Net book value at 31 March 2020									
Owned	1,715	82,906	7,793	3,441	17,044	29	3,505	1,406	117,839
Finance leased	-	-	-	-	165	-	1,457	-	1,622
On-SoFP PFI	-	20,622	-	-	-	-	-	-	20,622
Donated	-	-	-	-	-	-	-	-	-
Total at 31 March 2020	**1,715**	**103,528**	**7,793**	**3,441**	**17,209**	**29**	**4,962**	**1,406**	**140,083**
Net book value at 31 March 2021									
Owned	1,813	85,874	7,587	6,082	20,874	49	3,869	1,115	127,263
Finance leased	-	-	-	-	143	-	1,068	-	1,211
On-SoFP PFI	-	20,736	-	-	-	-	-	-	20,736
Donated	-	-	-	-	-	-	-	-	-
Total at 31 March 2021	**1,813**	**106,610**	**7,587**	**6,082**	**21,017**	**49**	**4,937**	**1,115**	**149,210**

On 31 March 2021 Gerald Eve LLP reviewed the Trust's land, buildings and dwellings on a Modern Equivalent Asset basis in accordance with the guidance included in the Royal Institution of Chartered Surveyors Valuation Standards. As a result, these assets were revalued to bring them to their current value at that date.

NOTES TO THE ACCOUNTS

17. Property, plant and equipment (continued)

Trust

17.3 Property, Plant and equipment at the balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2021	1,010	106,610	6,647	6,082	46,732	251	14,432	3,708	185,472
Additions - purchased	-	-	-	12,125	-	-	-	-	12,125
Additions - donated	-	351	-	-	289	-	7	38	685
Impairments	-	(456)	-	-	(18)	-	-	-	(474)
Reclassifications	-	5,373	-	(12,200)	4,760	33	1,877	157	-
Revaluation	450	4,831	294	-	-	-	-	-	5,575
Transfer to assets held for sale	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(7,076)	(174)	(2,965)	(534)	(10,749)
At 31 March 2022	**1,460**	**116,709**	**6,941**	**6,007**	**44,687**	**110**	**13,351**	**3,369**	**192,634**
Accumulated depreciation									
At 1 April 2021	-	-	-	-	26,236	202	9,495	2,593	38,526
Provided during the period	-	4,362	196	-	3,900	11	1,762	282	10,513
Revaluation	-	(4,271)	(196)	-	-	-	-	-	(4,467)
Impairments	-	129	-	-	(129)	-	-	-	-
Disposals	-	-	-	-	(6,803)	(174)	(2,965)	(528)	(10,470)
Accumulated depreciation at 31 March 2022	**-**	**220**	**-**	**-**	**23,204**	**39**	**8,292**	**2,347**	**34,102**
Net book value at 31 March 2021									
Owned	1,010	80,588	6,647	6,082	17,245	49	3,851	868	116,340
Finance leased	-	-	-	-	143	-	1,068	-	1,211
On balance sheet PFI	-	20,736	-	-	-	-	-	-	20,736
Donated	-	5,286	-	-	3,118	-	18	247	8,669
Total at 31 March 2021	**1,010**	**106,610**	**6,647**	**6,082**	**20,506**	**49**	**4,937**	**1,115**	**146,956**
Net book value at 31 March 2022									
Owned	1,460	89,049	6,941	6,007	18,792	71	4,358	804	127,482
Finance leased	-	-	-	-	120	-	680	-	800
On-SoFP PFI	-	21,896	-	-	-	-	-	-	21,896
Donated	-	5,544	-	-	2,571	-	21	218	8,354
Total at 31 March 2022	**1,460**	**116,489**	**6,941**	**6,007**	**21,483**	**71**	**5,059**	**1,022**	**158,532**

On 31 March 2022 Gerald Eve LLP revalued the Trust's land, buildings and dwellings on a Modern Equivalent Asset basis in accordance with the guidance included in the Royal Institution of Chartered Surveyors Valuation Standards. As a result, these assets were revalued to bring them to their current value at that date.

NOTES TO THE ACCOUNTS

17. Property, plant and equipment (continued)

Trust

17.4 Property, plant and equipment at the previous balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2020	940	103,528	6,853	3,441	67,079	339	12,995	3,882	199,057
Additions - purchased	-	-	-	13,879	-	-	-	-	13,879
Additions - donated	-	-	-	-	1,193	-	15	15	1,223
Impairments	-	(244)	-	(69)	-	-	-	-	(313)
Reclassifications	-	2,658	2	(11,169)	6,881	25	1,565	38	-
Revaluation	70	668	(208)	-	-	-	-	-	530
Disposals	-	-	-	-	(28,411)	(113)	(143)	(227)	(28,894)
At 31 March 2021	**1,010**	**106,610**	**6,647**	**6,082**	**46,742**	**251**	**14,432**	**3,708**	**185,482**
Accumulated depreciation									
At 1 April 2020	-	-	-	-	50,603	310	8,033	2,476	61,422
Provided during the period	-	3,823	196	-	3,852	5	1,605	333	9,814
Revaluation	-	(3,823)	(196)	-	-	-	-	-	(4,019)
Impairments	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(28,219)	(113)	(143)	(216)	(28,691)
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**26,236**	**202**	**9,495**	**2,593**	**38,526**
Net book value at 31 March 2020									
Owned	940	77,636	6,853	3,441	13,814	29	3,493	1,098	107,304
Finance leased	-	-	-	-	165	-	1,457	-	1,622
On-SoFP PFI	-	20,622	-	-	-	-	-	-	20,622
Donated	-	5,270	-	-	2,497	-	12	308	8,087
Total at 31 March 2020	**940**	**103,528**	**6,853**	**3,441**	**16,476**	**29**	**4,962**	**1,406**	**137,635**
Net book value at 31 March 2021									
Owned	1,010	76,417	6,647	6,082	17,245	49	3,851	868	112,169
Finance leased	-	-	-	-	143	-	1,068	-	1,211
On-SoFP PFI	-	20,736	-	-	-	-	-	-	20,736
Donated	-	9,457	-	-	3,118	-	18	247	12,840
Total at 31 March 2021	**1,010**	**106,610**	**6,647**	**6,082**	**20,506**	**49**	**4,937**	**1,115**	**146,956**

On 31 March 2021 Gerald Eve LLP reviewed the Trust's land, buildings and dwellings on a Modern Equivalent Asset basis in accordance with the guidance included in the Royal Institution of Chartered Surveyors Valuation Standards. As a result, these assets were revalued to bring them to their current value at that date.

NOTES TO THE ACCOUNTS

17. Property, plant and equipment (continued)

17.5 Net Book Value of Assets Held Under Finance Leases

Group

	Plant & Machinery £000	Information technology £000	On-SoFP PFI £000	Total £000
Cost or valuation				
At 1 April 2021	228	1,943	20,736	22,907
Additions - Purchased	1,166	-	440	1,606
Revaluations	-	-	720	720
Disposals	-	-	-	-
At 31 March 2022	**1,394**	**1,943**	**21,896**	**25,233**
Accumulated depreciation				
At 1 April 2021	86	875	-	961
Provided during the period	23	388	594	1,005
Revaluation	-	-	(594)	(594)
Disposals	-	-	-	-
Accumulated depreciation at 31 March 2022	**109**	**1,263**	**-**	**1,372**
Net book value at 31 March 2022				
- Purchased	1,285	680	21,896	23,861
Total at 31 March 2022	**1,285**	**680**	**21,896**	**23,861**
Cost or valuation				
At 1 April 2020	844	1,943	20,622	23,409
Additions - purchased	-	-	449	449
Revaluation	-	-	(396)	(396)
Disposals	(616)	-	-	(616)
At 31 March 2021	**228**	**1,943**	**20,675**	**22,846**
Accumulated depreciation				
At 1 April 2020	679	486	-	1,165
Provided during the period	23	389	573	985
Revaluation	-	-	(573)	(573)
Disposals	(616)	-	-	(616)
Accumulated depreciation at 31 March 2021	**86**	**875**	**-**	**961**
Net book value at 31 March 2021				
- Purchased	142	1,068	20,675	21,885
Total at 31 March 2021	**142**	**1,068**	**20,675**	**21,885**

NOTES TO THE ACCOUNTS

17. Property, plant and equipment (continued)

17.5 Net Book Value of Assets Held Under Finance Leases (continued)

Trust only

	Plant & Machinery £000	Information technology £000	On-SoFP PFI £000	Total £000
Cost or valuation				
At 1 April 2021	228	1,943	20,736	22,907
Additions - Purchased	-	-	440	440
Revaluations	-	-	720	720
Disposals	-	-	-	-
At 31 March 2022	**228**	**1,943**	**21,896**	**24,067**
Accumulated depreciation				
At 1 April 2021	86	875	-	961
Provided during the period	23	388	594	1,005
Revaluation	-	-	(594)	(594)
Disposals	-	-	-	-
Accumulated depreciation at 31 March 2022	**109**	**1,263**	**-**	**1,372**
Net book value at 31 March 2022				
- Purchased	119	680	21,896	22,695
Total at 31 March 2022	**119**	**680**	**21,896**	**22,695**
Cost or valuation				
At 1 April 2020	844	1,943	20,622	23,409
Additions - purchased	-	-	449	449
Revaluation	-	-	(396)	(396)
Disposals	(616)	-	-	(616)
At 31 March 2021	**228**	**1,943**	**20,675**	**22,846**
Accumulated depreciation				
At 1 April 2020	679	486	-	1,165
Provided during the period	23	389	573	985
Revaluation	-	-	(573)	(573)
Disposals	(616)	-	-	(616)
Accumulated depreciation at 31 March 2021	**86**	**875**	**-**	**961**
Net book value at 31 March 2021				
- Purchased	142	1,068	20,675	21,885
Total at 31 March 2021	**142**	**1,068**	**20,675**	**21,885**

18. Investments

Non-current	**Group**		**Trust**	
	31 March 2022 £000	31 March 2021 £000	**31 March 2022 £000**	31 March 2021 £000
Carrying value at 1 April	**7,893**	6,319	-	-
Additions	**7,415**	4,961	-	-
Fair value (losses)/ gains taken to I & E	**438**	1,417	-	-
Fair value movements taken to OCI	**-**	-	-	-
Disposals	**(7,521)**	(4,804)	-	-
Carrying value at 31 March	**8,225**	7,893	-	-
Current				
Financial assets designated at amortised cost	**337**	113	**-**	-

Non-current investments represents an investment portfolio managed by HSBC Private Bank (UK) Limited on behalf of the charitable fund.

Current asset investments are the cash balances held by HSBC Private Bank (UK) Limited on behalf of the charitable fund and represents dividend income, interest income and the proceeds of fixed asset investment disposals which have not yet been reinvested.

NOTES TO THE ACCOUNTS

18. Investments (continued)

Fair value measurement of investments
Financial assets and financial liabilities measured at fair value in the Statement of Financial Position are grouped into three levels of a fair value hierarchy. The three levels are defined based on the observability of significant inputs to the measurement, as follows:

Level 1: quoted prices (unadjusted) in active markets for identical assets or liabilities
Level 2: inputs other than quoted prices included in level 1 that are observable for the asset or liability, either directly or indirectly
Level 3: unobservable inputs for the asset or liability

The investments in the group financial statements are all level 1 investments and are measured at quoted prices at the date of the Statement of Financial Position.

19. Other financial assets

Non-current	**Group**		**Trust**	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Carrying value at 1 April	**2,395**	2,299	**4,551**	4,982
Loans provided in year	**-**	-	**306**	500
Transfer (to)/ from current assets	**-**	-	**(913)**	(1,027)
Amortisation at the effective interest rate	**102**	96	**102**	96
Repayments in year	**-**	-	**(40)**	-
Carrying value at 31 March	**2,497**	2,395	**4,006**	4,551
Current				
Carrying value at 1 April	**-**	-	**1,027**	-
Transfer from/ (to) non-current assets	**-**	-	**913**	1,027
Loans	**-**	-	**-**	-
Carrying value at 31 March	**-**	-	**1,940**	1,027

Current other financial assets represent loans made to:
a) Salisbury Trading Limited to purchase laundry equipment and laundry stocks from Salisbury NHS Foundation Trust on the commencement of the subsidiary business due in less than one year; and
b) Salisbury Trading Limited to purchase laundry stocks following the successful tender to acquire new business.
c) Odstock Medical Limited to assist with working capital requirements

Non-current other financial assets represent loans made to:
a) Salisbury Trading Limited to purchase laundry equipment and laundry stocks from Salisbury NHS Foundation Trust on the commencement of the subsidiary business due after more than one year: and
b) Sterile Supplies Limited to re-develop a new production facility with a third party.
c) Odstock Medical Limited to assist with working capital requirements

Details of the loans to Salisbury Trading Limited are as follows:
1. £1.3m to purchase the laundry stock.
2. £2.0m to purchase the laundry equipment.
3. £0.5m to purchase laundry stocks.
4. £0.7m to purchase laundry stock.
5. £0.5m to purchase laundry stock to assist with the Covid 19 pandemic.

NOTES TO THE ACCOUNTS

19. Other financial assets (continued)

The first four of the loans with an outstanding balance of £2.682m at 31 March 2022 were amalgamated into one loan during the year. This loan will be repaid over the next five years culminating in the final repayment on 1 April 2026.

The remaining fifth loan of £0.5m at 31 March 2022 is subject to ongoing discussions with regard to also amalgamating this into the above agreement.

Details of the loan to Sterile Supplies Limited is as follows:
In March 2016 the Trust made a loan to its then wholly owned subsidiary company, Sterile Supplies Limited. The intention was for this sum to be used to help finance a joint venture arrangement with a third party, which will deliver cost savings into the future. Until the joint venture agreement was finalised and formal agreement signed, the loan remained repayable on demand.

During 2016-17 Sterile Supplies Limited became the joint venture vehicle between the Trust and a third party, Steris Plc (Registered in Ireland (formerly Synergy Health Plc)). As part of the joint venture agreement the Trust ceded control of Sterile Supplies Limited and the loan agreement was formalised as long term.

The long term loan of £2.0m is to assist the development of a new production facility. Loan repayments will commence when the building becomes operational. Interest is payable at 4% above the Bank of England base rate and is capitalised and added to the principal sum.

Details of the loan to Odstock Medical Limited is as follows:
During 2021-22 the Trust made a loan to its wholly owned subsidiary company, Odstock Medical Limited, to assist with its working capital requirements. The loan repayments commenced in November 2021. Interest is payable at 3.5% above the Bank of England base rate and is capitalised and added to the principal sum.

20. Inventories

	Group		Trust	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Drugs	**1,395**	1,329	**1,395**	1,329
Consumables	**4,554**	4,275	**4,554**	4,275
Laundry	**1,628**	1,405	**-**	-
Other	**362**	625	**362**	446
	7,939	7,634	**6,311**	6,050
Inventories recognised as an expense in the period	**54,095**	45,963	**52,697**	44,726

In response to the Covid pandemic, The Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During the year the Trust received £883k (2020-21: £3,640k) items free of charge.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

NOTES TO THE ACCOUNTS

21. Receivables

21.1 Amounts falling due after more than one year:

	Group		Trust	
	31 March 2022 £000	31 March 2021 £000	**31 March 2022 £000**	31 March 2021 £000
Clinician pension tax provision reimbursement funding from NHSE	**656**	762	**656**	762
	656	762	**656**	762
Of which receivables from NHS and DHSC group	**656**	762	**656**	762

21.2 Amounts falling due within one year:

	Group		Trust	
	31 March 2022 £000	31 March 2021 £000	**31 March 2022 £000**	31 March 2021 £000
Contract receivables	**11,079**	9,445	**9,900**	9,124
Allowance for impaired contract receivables / assets	**(954)**	(1,351)	**(954)**	(1,351)
Prepayments (non-PFI)	**2,930**	3,262	**2,930**	3,262
PDC dividend receivable	**31**	57	**31**	57
VAT receivable	**950**	627	**950**	627
Clinician pension tax provision reimbursement funding from NHSE	**9**	-	**9**	-
Other receivables	**166**	37	**237**	64
	14,211	12,077	**13,103**	11,783
Of which receivables from NHS and DHSC group	**3,464**	2,179	**3,464**	2,179

The majority of transactions are with Clinical Commissioning Groups (CCGs) or NHS England's Specialist Commissioners, as commissioners for NHS patient care services. As CCGs and Specialist Commissioners are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

The average credit period taken on sale of goods is 17 days (2021: 14.4 days). No interest is charged on trade receivables.

21.3 Allowance for credit losses

Group and Trust

	31 March 2022		31 March 2021	
	receivables and contract assets £000	**All other receivables £000**	receivables and contract assets £000	All other receivables £000
Allowance for credit losses at 1 April - brought forward	**1,351**	**-**	1,569	-
New allowances arising	**15**	**-**	-	-
Utilisation of allowances (write offs)	**(412)**	**-**	(218)	-
Balance at 31 March	**954**	**-**	1,351	-

An allowance for impairment is made where there is an identifiable event which, based on previous experience, is evidence that the monies will not be recovered in full.

NOTES TO THE ACCOUNTS

22. Cash and cash equivalents

	Group		Trust	
	31 March 2022 £000	31 March 2021 £000	**31 March 2022 £000**	31 March 2021 £000
Balance at beginning of year	**31,169**	16,145	**22,309**	9,087
Net change in year	**8,137**	15,024	**8,510**	13,222
Balance at end of year	**39,306**	31,169	**30,819**	22,309
Made up of:				
Cash with Government Banking Service	**30,791**	22,201	**30,791**	22,201
Cash at commercial banks and in hand	**8,515**	8,968	**28**	108
Cash and cash equivalents as in balance sheet	**39,306**	31,169	**30,819**	22,309
Bank overdrafts	**-**	-	**-**	-
Cash and cash equivalents as in cash flow statement	**39,306**	31,169	**30,819**	22,309

23. Trade and other payables

	Group		Trust	
	31 March 2022 £000	31 March 2021 £000	**31 March 2022 £000**	31 March 2021 £000
Amounts falling due within one year:				
Trade payables	**18,942**	11,522	**17,614**	10,200
Capital payable	**9,289**	4,554	**9,289**	4,554
Accruals and deferred income	**2,514**	1,693	**2,514**	1,693
Receipts in advance	**2,140**	3,057	**2,140**	3,057
Social security and other taxes payable	**4,115**	3,754	**4,115**	3,754
Pay and pensions related	**5,449**	5,648	**5,449**	5,648
Other	**3,622**	6,499	**3,634**	6,458
	46,071	36,727	**44,755**	35,364
Of which payables from NHS and DHSC group bodies:	**2,845**	3,076	**2,845**	3,076

Included in 'Other' payables is £1.2m (2021: £0.9m) potential exposure following change in Vat guidance, £0.9m (2021: £0.9m) funds due as an agent on an education training contract, £0.3m (2021: £nil) Public Dividend capital repayable.

All Trade and other payables are current liabilities.

NOTES TO THE ACCOUNTS

24. Borrowings

Group	Current		Non-current	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Obligations under finance leases	**458**	434	**999**	292
Amounts due under PFI (note 30)	**612**	526	**15,564**	16,175
Capital loans from Department of Health and Social Care (DHSC)	**644**	648	**1,582**	2,213
Revenue support / working capital loans from DHSC	**-**	-	**-**	-
	1,714	1,608	**18,145**	18,680

Trust	Current		Non-current	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Obligations under finance leases	**290**	434	**-**	292
Amounts due under PFI (note 30)	**612**	526	**15,564**	16,175
Capital loans from Department of Health and Social Care (DHSC)	**644**	648	**1,582**	2,213
Revenue support / working capital loans from DHSC	**-**	-	**-**	-
	1,546	1,608	**17,146**	18,680

The Trust finance leases relate to the purchase of medical equipment and hardware infrastructure. Both are for a term of 5 years. For the year ended 31 March 2022 the effective borrowing rates were 3.4% and 5.1% respectively. Interest rates are fixed at the contract date.

The additional lease liabilities at a Group level are due to a finance lease agreement for new laundry equipment for Salisbury Trading Limited.

The capital loan from the Department of Health and Social Care is unsecured and for a 10 year period, repayable in equal instalments commencing on 18 May 2016. Interest is payable on the loan at a rate of 1.64% pa.

Department of Health and Social Care revenue support/ working capital loans taken out during 2017-18 and 2018-19 were repayable at the end of three year periods from the inception date of each loan; interest accruing at 1.5% - 3.5% per annum and payable twice yearly. However, on 1 April 2020 DHSC, NHSE and NHSI implemented reforms to the NHS cash regime. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment.

Amounts payable under finance leases:

Group	Minimum lease payments		Present value of minimum lease payments	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Within one year	**502**	459	**458**	434
Between one and five years	**1,172**	306	**999**	292
After five years	**-**	-	**-**	-
	1,674	765	**1,457**	726
Less finance charges allocated to future periods	**(217)**	(39)		
	1,457	726		
Included within:				
Current borrowings			**458**	434
Non-current borrowings			**999**	292
			1,457	726

NOTES TO THE ACCOUNTS

24. Borrowings (continued)

Trust	Minimum lease payments		Present value of minimum lease payments	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Within one year	**306**	459	**291**	434
Between one and five years	**-**	306	**-**	292
After five years	**-**	-	**-**	-
	306	765	**291**	726
Less finance charges allocated to future periods	**(15)**	(39)		
	291	726		
Included within:				
Current borrowings			**291**	434
Non-current borrowings			**-**	292
			291	726

25. Provisions for liabilities and charges

Group and Trust	Current		Non-current	
	31 March 2022	31 March 2021	**31 March 2022**	31 March 2021
	£000	£000	**£000**	£000
Pensions - early departure costs	**13**	19	**25**	13
Pensions - injury benefits	**24**	23	**214**	236
Legal claims	**973**	453	**-**	-
Clinician pension tax reimbursement	**9**	-	**656**	762
Other	**215**	476	**-**	245
	1,234	971	**895**	1,256

	Pensions - Early departure costs	Pensions - Injury benefits	Legal claims	Clinician pension tax	Other	**Total**
	£000	£000	£000	£000	£000	**£000**
At 1 April 2021	32	259	453	762	721	**2,227**
Change in the discount rate	-	4	-	-	-	**4**
Arising during the year	20	1	528	-	-	**549**
Utilised during the year	(14)	(24)	(8)	-	-	**(46)**
Reversed unused	-	-	-	(97)	(506)	**(603)**
Unwinding of discount	-	(2)	-	-	-	**(2)**
At 31 March 2022	**38**	**238**	**973**	**665**	**215**	**2,129**
Expected timing of cash flows:						
Within 1 year	13	24	973	9	215	**1,234**
1 - 5 years	5	96	-	6	-	**107**
5-10 years	20	118	-	650	-	**788**
	38	**238**	**973**	**665**	**215**	**2,129**

Pension provisions arise from early retirements which do not result from ill health. These liabilities are not funded by the NHS Pension Scheme.

Legal claims relate to the Trust's provision for personal injury and employee claims. These are based on valuation reports provided by the Trust's legal advisers.

NOTES TO THE ACCOUNTS

25. Provisions for liabilities and charges (continued)

Clinician pension tax reimbursement provision arises in respect of clinicians who are members of the NHS Pension Scheme, and wh as a result of work undertaken, face a tax charge in respect of the growth of their NHS pension benefits above their pension saving annual allowance threshold. Government policy is that the Trust will reimburse the NHS Pension Scheme on the retirement of th clinician in exchange for the Scheme paying the additional tax due.

Other provisions relate to the early termination of a supplier contract, a contractual dispute with a supplier and additional tax liabilite following revised guidance by HMRC.

£122.9m is included in the provisions of NHS Resolution at 31 March 2022 in respect of clinical negligence liabilities of the Trust (202 £79.4m).

26. Capital and other commitments

Capital commitments - Group and Trust

Commitments under capital expenditure contracts at the balance sheet date were £1.68m (2021: £2.77m).

27. Contingent liabilities

The Trust has agreed in principle to underwrite any loans to its subsidiary company, Odstock Medical Limited, up to a value of £0.5m

28. Related Party Transactions

Salisbury NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The Department of Health and Social Care is regarded as a related party. During the year ended 31 March 2022 the Foundation Trust has had a significant number of material transactions with other entities for which the Department is regarded as the parent. These entities include Clinical Commissioning Groups, NHS England, Health Education England, NHS Resolution and other Trusts and Foundation Trusts.

Salisbury NHS Foundation Trust also has transactions with its subsidiary companies, joint ventures and charitable funds (for which it is the Corporate Trustee) These are listed below:

	Income £000	Expenditure £000	Receivables £000	Payables £000
Year ending 31 March 2022				
Salisbury Trading Limited	**261**	**817**	**239**	**59**
Odstock Medical Limited	**214**	**-**	**78**	**1**
Salisbury District Hospital Charitable Fund	**724**	**42**	**543**	**-**
Sterile Supplies Limited	**1,178**	**1,988**	**243**	**199**
Wiltshire Health and Care LLP	**616**	**269**	**64**	**21**
Year ending 31 March 2021				
Salisbury Trading Limited	200	787	258	65
Odstock Medical Limited	215	-	380	-
Salisbury District Hospital Charitable Fund	423	42	586	-
Sterile Supplies Limited	1,066	1,949	177	198
Wiltshire Health and Care LLP	697	380	-	72

During the period none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Salisbury NHS Foundation Trust.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies.

NOTES TO THE ACCOUNTS

29. Private Finance Initiative Schemes (PFI)

29.1 PFI schemes deemed to be on-Statement of Financial Position

Contract start date: 3 March 2004
Contract end date: 31 January 2036
The PFI scheme provides modern clinical buildings for patient services
At the end of the contract term the hospital buildings revert back to the Trust
There were no changes to the terms and conditions of the PFI agreement

Terms of the Arrangement - the unitary payment is comprised of two elements, an Availability fee which is fixed for the duration of the contract and a service fee which is subject to indexation based upon 'the Retail Prices Index (RPI) All items'. At the end of the project term the Agreement will terminate with no compensation payable. In the event of re-financing of the PFI the Trust is entitled to receive half of the re-financing cash flow benefits.

29.2 PFI scheme - Charge to operating expense in Statement of Comprehensive Income

	Group and Trust	
	2022	2021
	£000	£000
Amounts included within operating expenses in respect of the 'service' element of PFI schemes deemed to be on-Statement of Financial Position	**1,114**	1,110
Depreciation of PFI asset	**594**	573
Net charge to operating expenses	**1,708**	1,683

29.3 PFI scheme - Analysis of amounts payable to service concession operator

	Group and Trust	
	2022	2021
	£000	£000
Interest	**1,098**	1,130
Repayment of finance lease liability	**526**	479
Service element	**1,114**	1,110
Capital lifecycle maintenance	**440**	449
Contingent rent	**846**	809
Unitary payment payable to service concession operator	**4,024**	3,977

29.4 Annual commitments under Private Finance Transactions - On Statement of Financial Position

The Trust is committed to make the following service payments on the PFI:	**2022**	2021
	£000	£000
Due within one year	**1,166**	1,114
Due within 2 to 5 years	**4,794**	4,500
Due after 5 years	**11,190**	11,845
	17,150	17,459

The annual charge will be indexed each year. Indexation will be increased in line with the Retail Price Index.

Imputed finance lease obligations comprise:	**Minimum lease payments**		**Present value of minimum lease payments**	
	2022	2021	**2022**	2021
	£000	£000	**£000**	£000
Rentals due within one year	**1,673**	1,624	**612**	526
Rentals due within 2 to 5 years	**6,936**	6,868	**3,159**	2,895
Rentals due thereafter	**16,761**	18,501	**12,405**	13,280
	25,370	26,993	**16,176**	16,701
Less: interest element	**(9,194)**	(10,292)		
Total	**16,176**	16,701		

NOTES TO THE ACCOUNTS

29. Private Finance Initiative Schemes (PFI) (continued)

29.5 Total future payments committed in respect of PFI

	2022	2021
	£000	£000
Total	**70,510**	71,223
of which due:		
Within one year	**4,329**	4,025
Within 2 to 5 years	**18,424**	17,130
Due thereafter	**47,757**	50,068
Total	**70,510**	71,223

30. Financial instruments

IFRS 7 and IFRS 9 require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The main source of income for the Group is under contracts from commissioners in respect of healthcare services. Due to the way that the Commissioners are financed, the Group is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Group in undertaking its activities.

30.1 Currency risk

The Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Group has no overseas operations although the charity holds a small number of investments denominated in United States dollars and Euros, these are immaterial and, as a result, the Group has low exposure to currency fluctuations.

30.2 Liquidity risk

The NHS Foundation Trust's net operating costs are incurred under contracts with commissioners, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government. Salisbury NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

30.3 Interest-rate risk

The Group's financial liabilities carry either nil or fixed rates of interest. The Group is not exposed to significant interest-rate risk.

30.4 Liquidity and interest risk tables

The interest rate profile of the non-derivative financial liabilities of the Group, their contractual maturity profile and their weighted average effective interest rates are as follows:

As at 31 March 2022

	Weighted average effective interest rate	Less than one month	1-3 months	3 months to 1 year	1-2 years	2-5 years	over 5 years	Discount	**Total**
	%	£000	£000	£000	£000	£000	£000	£000	**£000**
Fixed rate									
Finance lease obligations	**3.4 - 5.1**	**16**	**33**	**453**	**195**	**586**	**391**	**(217)**	**1,457**
PFI obligations	**6.5**	**139**	**278**	**1,256**	**1,718**	**5,218**	**16,761**	**(9,194)**	**16,176**
DHSC capital loan	**1.64**	**-**	**334**	**331**	**655**	**966**	**-**	**(73)**	**2,213**
Floating rate									
Trade and other payables	**-**	**30,745**	**-**	**-**	**-**	**-**	**-**	**-**	**30,745**

As at 31 March 2021

	Weighted average effective interest rate	Less than one month	1-3 months	3 months to 1 year	1-2 years	2-5 years	over 5 years	Discount	**Total**
	%	£000	£000	£000	£000	£000	£000	£000	**£000**
Fixed rate									
Finance lease obligations	3.4 - 5.1	-	-	459	306	-	-	(39)	726
PFI obligations	6.5	135	270	1,219	1,673	5,195	18,501	(10,292)	16,701
DHSC capital loan	1.64	-	339	336	665	1,621	-	(117)	2,844
Floating rate									
Trade and other payables	-	17,769	-	-	-	-	-	-	17,769

NOTES TO THE ACCOUNTS

30. Financial instruments (continued)

30.5 Credit risk

As the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk, the maximum exposures at 31 March 2022 are in receivables from customers, as disclosed in note 21.

30.6 Carrying values of financial assets

Group	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2022				
Trade and other receivables excluding non financial assets	**10,557**	**-**	-	**10,557**
Other investments / financial assets	**2,497**	**-**	-	**2,497**
Cash and cash equivalents	**33,448**	**-**	-	**33,448**
Consolidated NHS Charitable fund financial assets	**6,197**	**8,225**	**-**	**14,422**
Total at 31 March 2022	**52,699**	**8,225**	**-**	**60,924**

Group	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2021				
Trade and other receivables excluding non financial assets	8,512	-	-	8,512
Other investments / financial assets	2,395	-	-	2,395
Cash and cash equivalents	25,415	-	-	25,415
Consolidated NHS Charitable fund financial assets	6,248	7,893	-	14,141
Total at 31 March 2021	42,570	7,893	-	50,463

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2022				
Trade and other receivables excluding non financial assets	**9,848**	-	-	**9,848**
Other investments / financial assets	**6,192**	-	-	**6,192**
Cash and cash equivalents	**30,819**	-	-	**30,819**
Total at 31 March 2022	**46,859**	**-**	**-**	**46,859**

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total carrying value £000
Carrying values of financial assets as at 31 March 2021				
Trade and other receivables excluding non financial assets	8,599	-	-	8,599
Other investments / financial assets	4,737	-	-	4,737
Cash and cash equivalents	22,309	-	-	22,309
Total at 31 March 2021	35,645	-	-	35,645

NOTES TO THE ACCOUNTS

30. Financial Instruments (continued)

30.7 Carrying values of financial liabilities

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2022			
Loans from the Department of Health and Social Care	**2,226**	**-**	**2,226**
Obligations under finance leases	**1,457**	**-**	**1,457**
Obligations under PFI, LIFT and other service concession contracts	**16,176**	**-**	**16,176**
Trade and other payables excluding non financial liabilities	**39,486**	**-**	**39,486**
Provisions under contract	**1,820**	**-**	**1,820**
Total at 31 March 2022	**61,165**	**-**	**61,165**

Group	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2021			
Loans from the Department of Health and Social Care	2,861	-	2,861
Obligations under finance leases	726	-	726
Obligations under PFI, LIFT and other service concession contracts	16,701	-	16,701
Trade and other payables excluding non financial liabilities	28,464	-	28,464
Provisions under contract	2,227	-	2,227
Total at 31 March 2021	50,979	-	50,979

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2022			
Loans from the Department of Health and Social Care	**2,226**	**-**	**2,226**
Obligations under finance leases	**291**	**-**	**291**
Obligations under PFI, LIFT and other service concession contracts	**16,176**	**-**	**16,176**
Trade and other payables excluding non financial liabilities	**38,217**	**-**	**38,217**
Provisions under contract	**1,820**	**-**	**1,820**
Total at 31 March 2022	**58,730**	**-**	**58,730**

Unless otherwise stated above, carrying value is considered to be a reasonable approximation of fair value.

NOTES TO THE ACCOUNTS

30. Financial Instruments (continued)

Trust	Held at amortised cost £000	Held at fair value through I&E £000	Total carrying value £000
Carrying values of financial liabilities as at 31 March 2021			
Loans from the Department of Health and Social Care	2,861	-	2,861
Obligations under finance leases	726	-	726
Obligations under PFI, LIFT and other service concession contracts	16,701	-	16,701
Trade and other payables excluding non financial liabilities	27,147	-	27,147
Provisions under contract	2,227	-	2,227
Total at 31 March 2021	49,662	-	49,662

Maturity of financial liabilities - undiscounted future cash flows

	Group		Trust	
	31 March 2022 £000	31 March 2021 £000	**31 March 2022 £000**	31 March 2021 £000
In one year or less	**43,251**	33,599	**42,262**	32,282
In more than one year but not more than five years	**9,836**	9,567	**9,836**	9,567
In more than five years	**17,549**	19,649	**17,549**	19,649
Total	**70,636**	62,815	**69,647**	61,498

31. Third Party Assets

The Trust held £0.5k cash at bank and in hand at 31 March 2022 (2021: £0.1k) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

32. Investment in subsidiary

32.1 Odstock Medical Limited

Salisbury NHS Foundation Trust established, following Department of Health approval, a subsidiary company, Odstock Medical Limited (registered in England), to market and develop a technology created at Salisbury District Hospital. The technology assists patients to obtain increased mobility following illnesses which reduce their muscular co-ordination. The company was established in August 2005 and commenced trading on 1 April 2006. Salisbury NHS Foundation Trust owns 70% of Odstock Medical Limited.

	Trust 2022 £'000	Trust 2021 £'000
Shares at cost		
At 31 March	**-**	**5**

The Trust established the company and received an interest in the company equal to the fair value of assets on its formation.

In the year the Trust charged the goodwill on the purchase of shares from former employees of the subsidiary to expenditure.

The Trust's charity, Salisbury District Hospital Charitable Fund, owns a further 18% of Odstock Medical Limited.

NOTES TO THE ACCOUNTS

32. Investment in subsidiary (continued)

32.2 Salisbury Trading Limited

Salisbury NHS Foundation Trust established a subsidiary company, Salisbury Trading Limited (registered in England), to market and deliver laundry and linen services. The company commenced trading on 1 October 2013. Salisbury NHS Foundation Trust owns 100% of Salisbury Trading Limited. The company has experienced steady growth since commencing to trade by winning new linen contracts. It has increased operational capacity through arrangements involving the management of another NHS laundry facility, which will provide an additional base for future expansion.

	Trust
Shares at cost	£
At 31 March 2022 and 31 March 2021	**1**

No goodwill arose in respect of the subsidiary as the reporting Trust established the company and received an interest in the company equal to the fair value of assets on its formation.

33. Investment in Joint Ventures

33.1 Sterile Supplies Limited

Salisbury NHS Foundation Trust owns 50% of the issued share capital of Sterile Supplies Limited, the remaining 50% is owned by Steris Plc (Registered in Ireland (formerly Synergy Health Plc)). The Board structure and voting rights are such that the Trust is not able to exert overall control of Sterile Supplies Limited, the Trust therefore recognises the company as a joint venture. The joint venture is re-developing a new production facility, from which it will market and deliver sterilisation services. The Joint Venture currently trades from the Trust's existing sterilisation and Disinfection Unit.

Group and Trust	**2022**	2021
	£000	£000
Carrying value of investment at 1 April	**68**	88
Share of profit/ (loss) in the period	**18**	(20)
Carrying value of investment at 31 March	**86**	**68**

33.2 Wiltshire Health and Care

The Trust is a one third partner in Wiltshire Health and Care LLP. The other equal partners being Royal United Hospitals Bath NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust. Wiltshire Health and Care is focused solely on delivering improved community services in Wiltshire and enabling people to live independent and fulfilling lives for as long as possible.

Salisbury NHS Foundation Trust has not invested any capital sum in this partnership.

Group and Trust	**2022**	2021
	£000	£000
Carrying value of investment at 1 April	**113**	-
Share of surplus in the period	**47**	113
Carrying value of investment at 31 March	**160**	**113**

NOTES TO THE ACCOUNTS

34. Movements on Public Dividend Capital

Group and Trust	2022 £000	2021 £000
Public Dividend Capital at 1 April	**90,997**	58,650
New public dividend capital received	**4,112**	32,419
Public dividend capital repaid	**(283)**	(72)
Public Dividend Capital at 31 March	**94,826**	90,997

The new public dividend capital received in the year relates to the conversion of revenue loans to PDC £nil (2021: £21,082k) and the net receipt of additional funding to purchase capital items of £3,829k (2021: £11,337k).

35. Charitable fund balances

Group only	2022 £000	2021 £000
Restricted funds	**6,217**	8,408
Unrestricted funds	**10,000**	6,835
Endowment funds	**9**	9
	16,226	15,252

Restricted funds are funds that are to be used in accordance with specific restrictions imposed by the donor, or where the donor has restricted the use of their donation to a specified ward, patients', nurses' or project fund. Where the restriction requires the gift to be invested to produce income but the trustees have the power to spend the capital, it is classed as expendable endowment.

Unrestricted income funds comprise those funds that the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include general funds, where the donor has not specified or restricted the use the Charity may make of their donation. General funds additionally generate income from Gift Aid, investment income, interest and donations given specifically to cover running costs.

Endowment funds are funds which the trustees are required to invest or to keep and use for the Charity's purposes.

36. Critical accounting judgements

The Trust has made no critical judgements in the application of the accounting policies set out on pages 5 to 21.

37. Critical accounting estimates

In the application of the Trust's accounting policies, the Trust has made estimates and assumptions in a number of areas, as the actual value is not known with certainty at the Statement of Financial Position date. By definition, these estimations are subject to some degree of uncertainty; however in each case the Foundation Trust has taken all reasonable steps to assure itself that these items do not create a significant risk of material uncertainty. Key areas of estimation include:

- The valuation of the Trust's estate of land and buildings was carried out on 31 March 2022 by Gerald Eve, Chartered Surveyors. Gerald Eve valued the land and buildings (including dwellings) at £125.1m, of which £116.7m relates to specialised assets valued on a depreciated replacement cost basis."

  It is the rebuilding cost values determined by the valuer using industry standard rates that gives rise to the uncertainty in the valuation.

  A 10% change in the valuation would have £11.7m impact on the statement of financial position with a £409,000 impact on the PDC dividend due to be paid next year and accrued in these financial statements."

NOTES TO THE ACCOUNTS

38. Reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time the establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend..

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Group and the Trust.

Minority interest
Minority interest relates to the ownership stake in the subsidiary companies which is under 50% of the total shares in terms of voting rights and hence doesn't exercise control of the company.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	7.2
Date of Meeting:	07 July 2022		

Report Title:	Register of Seals – Quarter 1			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓			
Approval Process (where has this paper been reviewed and approved)	Approved by Lisa Thomas, Director of Finance and Stacey Hunter, Chief Executive			
Prepared by:	Sasha Grandfield, PA and Board Support Officer			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices				

Recommendation:
The Board is asked to note the entries to the Trust's Register of Seals which, while not formally authorised by resolution of the Trust Board, have been authorised through powers delegated by the Trust Board.

Executive Summary:
To report entries in the Trust's Register of Seals since the last report to Board in January 2022. None of the signatories who witnessed the fixing of the seal of Salisbury NHS Foundation Trust had an interest in the transactions they witnessed.

Register of Seals entries

No.	Date signed in Register	Approval Details	Held on file with:	Signature one:	Signature Two:
368	14 March 2022	Lease between SFT (landlord) and Inspire (tenant) for part of Block 90 for a term of 1 year.	Laurence Arnold	Lisa Thomas	Stacey Hunter
369	10 May 2022	Lease between SFT (landlord) and Oxford Health NHS Foundation Trust (tenant) for part of Block 40 for a term of 3 years	Laurence Arnold	Lisa Thomas	Stacey Hunter

Board Assurance Framework – Strategic Priorities	Select as applicable
Population: Improving the health and well-being of the population we serve	☐
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☐
Other (please describe) -	☐